

APPENDIX 4

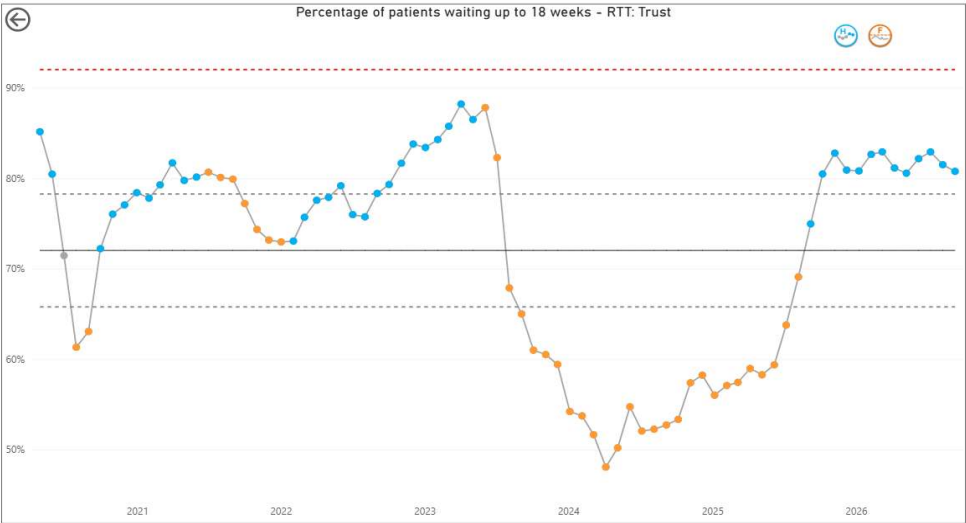
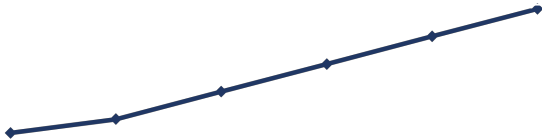
Exception Report - Action Plan

Percentage of Patients waiting up to 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	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
RTT Incomplete Pathways	%	81.13%	80.56%	82.16%	82.91%	81.50%	80.76%*	80.76%*
	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:	RTT performance remains below the national standard of 92%, with 80.76% of incomplete pathways within 18 weeks in August 2026. Performance remains flagged as improving variation and the Trust continues to perform strongly in comparison to the wider national recovery expectation, which seeks achievement of the 92% constitutional standard by March 2029. The Trust also achieved the national milestone of reducing waits above 65 weeks significantly earlier than many organisations, reaching this position by March 2026 as part of its planned recovery programme. Following improvement in May and June, performance deteriorated during July and August, resulting in August performance of 80.76%, which is 4.24 percentage points below the planned trajectory of 85.0%. Although the September milestone is unlikely to be achieved in full, teams are actively implementing a range of recovery actions to return performance to an upward trajectory. Focused work on validation, demand and capacity management, pathway productivity and waiting list reduction is underway. Performance is expected to improve incrementally over the coming months, with a dedicated workshop to re-evaluate the trajectory in line with the current planning round and options available to us across the Group. There is full confidence that we will continue to achieve ahead of the national March 2029 deadline, but local targets need reviewing. The current position for August reflects seasonal variation and the change in MSST waiting lists profile with an ongoing increase in level 2 physiotherapy demand. Detailed demand and capacity modelling was completed however due to the change in workforce demographics and clinical pathways repeating this exercise will further support improvement and recovery gain. The ongoing integration of therapy services provides assurance that there is a robust governance framework in place to support pathway redesign, improve utilisation of the existing workforce and deploy staffing resources more effectively across services. Another key remaining RTT risk relates to Oral Surgery. Whilst performance has shown early signs of improvement, recovery continues to be impacted by theatre availability and inconsistency of list provision within SaTH. Current contracted dental clinic activity remains insufficient to meet demand, resulting in an ongoing monthly shortfall in capacity. This risk is partially mitigated through additional activity delivered at RJAH and ad hoc sessions via SaTH; however, current modelling continues to identify an unresolved gap, which requires resolution through additional SaTH capacity if recovery is to remain on trajectory. Community Outpatients experienced capacity pressures over the summer due to aligned consultant annual leave across community and acute services. Despite efforts by SaTH to secure locum cover and provide additional ad hoc clinics, this was not always possible, and patient choice occasionally limited the uptake of alternative appointments. Joint PTL oversight ensured clinically urgent patients were prioritised and long waits managed equitably across organisations. Assurance has been received that consultant clinic activity will return to planned levels from September, supporting a return to an improving recovery trajectory. The recovery plans have been reviewed against the NHS England Community Health Services Waiting Times Action Checklist (May 2026) to ensure alignment with recognised best practice and that all key domains necessary to improve waiting times are being addressed.
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	As part of the MSST pathway, SCHAT clinic templates are to be 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	Complete	September 26 Update This action has been completed and closed, having successfully increased clinic utilisation to 94.2%, demonstrating that available outpatient capacity is being used effectively. However, despite this improvement, RTT performance has not improved at the pace anticipated, indicating that clinic utilisation is no longer the primary constraint within the pathway. Further analysis has identified demand and capacity imbalance, particularly within Level 2 Physiotherapy provision, as the key factor impacting recovery. As a result, the focus of improvement activity has shifted towards increasing available clinical capacity and aligning resources across the Group through the Integration of Therapies Programme. In parallel, temporary workforce options are being scoped to stabilise performance in the short term and support recovery while longer term workforce and service model solutions are implemented. Closure of this action reflects successful delivery of its intended objective, with a revised and more targeted recovery plan now in place to address the factors directly affecting RTT performance. August 26 Update Assurance can be provided that SCHAT Physiotherapy clinic utilisation has improved to 93.4% following the review and standardisation of clinic templates. Learning from this work is now being shared across the Group through the Integration of Therapies programme to support alignment of MSST clinic templates and productivity approaches across SCHAT and SaTH. Cross-organisational visits have been completed, a Therapy Leadership Development Day completed in July has supported integration and shared ways of working, and a joint workshop is scheduled for September to bring MSST service leads together to align improvement plans and drive further standardisation, efficiency and patient access improvements across the pathway. July 26 Update Work has begun to review the templates across SATH/SCHAT therapies to ensure alignment. With a slight improvement of 2% seen in clinic utilisation. Team looking at splitting admin team to focus on areas of responsibility in relation to therapy utilisation.
	Implement the Integration of Therapies Programme across the Group to align clinical pathways, optimise workforce deployment and address identified demand and capacity pressures, particularly within Level 2 Physiotherapy services. This will increase clinical capacity, support RTT recovery and reduce waiting times through a more flexible, sustainable workforce model. Temporary workforce solutions are also being explored to stabilise performance while longer-term service transformation is delivered	Sep-26	Mar-27	On Track	New Action Initial implementation activities are underway, including therapy workforce engagement workshops and ongoing recruitment to all substantive vacancies. To accelerate improvement and stabilise performance whilst the longer-term workforce redesign and integration programme progresses, a proposal will be submitted to Directors seeking approval for a three month temporary physiotherapy resource. This additional capacity is intended to support waiting list reduction, improve RTT performance and create headroom for the delivery of sustainable service transformation through the Integration of Therapies Programme.
	Roll out of T-PRO across Level 2 MSST Therapies across Group	Aug-26	Dec-26	On Track	September 26 Update Progress remains ongoing, with collaboration between the Rio team and DAST Service Manager to finalise a delivery approach. Whilst implementation has been impacted by RIO/ digital team capacity and competing priorities, solutions are being actively explored to support progression of the action during October 2026. New Action Working alongside the RIO and digital team to plan further roll out of T-Pro to support physio note taking with the aim of reducing required admin time and increasing clinical capacity.

	Dental: Formalise agreed demand and capacity requirements with SaTH and secure recurrent theatre and elective hub capacity to support delivery of the RTT long-waits recovery trajectory and sustainable waiting list recovery.	Aug-26	Dec-26	On Track	September 26 Update Capacity was delivered during August for ad hoc theatre lists. SCHAT and SaTH teams worked together to streamline the booking of patients resulting in better collaboration and understanding of requirements. Weekly meetings continue whilst the development of a sedation suite at PRH continues. New Action Weekly meetings with SaTH who are aware of requirement for an additional 8 slots a week. Ad hoc sessions provided through June and July to blitz long waits and plan is by end of Summer post theatre estates moves for SaTH to confirm regular capacity and dates.
	Review and redesign of the ENT pathway to align with Community Outpatient demand, reduce waiting times, and support improved patient access. This programme will act as an early adopter for neighbourhood transformation, testing new models of integrated, community-based care	Aug-26	Oct-26	On Track	September 26 Update This workstream remains on track, with future patient lists continuing to be made available to support the transfer of appropriate patients to Community Outpatients, helping to maximise available capacity and improve patient experience. Following the success with ENT collaborative discussions have further progressed regarding the inclusion of Physiotherapy provision within this pathway, creating an opportunity to enhance service resilience, increase treatment capacity and support RTT recovery. The development of this pathway forms part of a broader approach to optimise resources, reduce waiting times across the Group. New Action 18 patients have been transferred from the Community Outpatients waiting list to the APCS pathway and reviewed by a GPwER, enabling assessment of alternative management options and reducing reliance on consultant-led pathways. Learning from these reviews will be used to maximise opportunities for further pathway redesign, including the development of a single point of access for ENT referrals.
	GIRFT funding has been applied for to accelerate service transformation through digital innovation, enhanced clinical validation and pathway redesign, supporting improved waiting list management, increased productivity, better patient flow and more effective use of social prescribing all for MSST and community MSK .	Aug-26	Oct-26	On Track	September 26 Update Unfortunately MSST was not successful with the bid for the GIRFT funding. However the approach developed is still being implemented due to the potential impacts. Alternative funding streams are being identified for equipment and training. New Action System funding application submitted
	Collaboration with SaTH through Group to improve and streamline access to diagnostics via the Community Diagnostic Centre (CDC), identifying pathway barriers, agreeing referral criteria, and implementing changes that increase timely access to diagnostic testing and support earlier diagnosis and treatment.	Aug-26	Dec-26	On Track	September 26 Update This workstream has progressed positively, with initial scoping work completed jointly with SaTH to identify opportunities to streamline access to diagnostics through the Community Diagnostic Centre (CDC). Key pathway opportunities and potential barriers have been identified, and work is now moving into the next phase of agreeing referral pathways, operational processes and access arrangements. New Action Focus is initially on radiology and pathology access, demand profiles shared with SaTH to understand options for access.
Author	Gemma McIver /Helen Cooper/Alex Critchell	Date	09/09/2026		
Accountable Officer Approval	Claire Horsfield	Date	15/09/2026		

*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

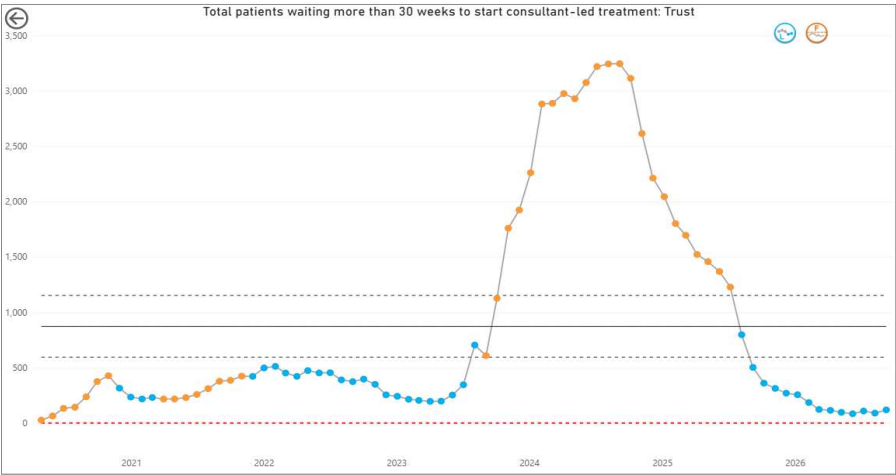
Exception Report - Action Plan

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	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
RTT 30+ week waits	Number	115	97	84	109	90	119*	119*
	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:	RTT 30+ week waits have shown a sustained improvement over time; however, performance deteriorated in August, increasing to 119 waits from 90 in July. Increases were observed across most RTT-reportable services, except for APCS and Ludlow Outpatients.
	The current position remains above the planned trajectory (119 against a trajectory of 60 in August), indicating that further improvement is required to achieve the local ambition of eliminating all RTT waits over 30 weeks by January 2027. Whilst performance is currently off trajectory, recovery plans remain in place and achievement of the January target is still considered achievable, provided identified capacity constraints are addressed and planned recovery actions are delivered as expected.
	Recovery continues to be impacted by limited dental clinic and theatre capacity within SaTH, although early improvements are now being seen. Community outpatient pathways also remain a risk, particularly where access to diagnostic capacity varies across the Group. In response, recovery trajectories have been reviewed and realigned to reflect current operational challenges whilst maintaining a clear focus on achieving the January 2027 objective.
	Robust mitigations remain in place, including speciality level recovery plans, monthly waiting list validation, enhanced performance oversight, SCHT participation in the SaTH PTL process, and alignment with the NHSE Community Health Services Waiting Times Action Checklist. Alongside this, work is progressing through the Integration of Therapies Programme, demand and capacity reviews, and pathway redesign initiatives to increase available capacity, improve patient flow and support sustainable waiting list recovery.

Action Plan		Start Date	End Date	Status	Outcome
	As part of the MSST pathway, SCHAT clinic templates are to be 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	Complete	September 26 Update This action has been completed and closed, having successfully increased clinic utilisation to 94.2%, demonstrating that available outpatient capacity is being used effectively. However, despite this improvement, RTT performance has not improved at the pace anticipated, indicating that clinic utilisation is no longer the primary constraint within the pathway. Further analysis has identified demand and capacity imbalance, particularly within Level 2 Physiotherapy provision, as the key factor impacting recovery. As a result, the focus of improvement activity has shifted towards increasing available clinical capacity and aligning resources across the Group through the Integration of Therapies Programme. In parallel, temporary workforce options are being scoped to stabilise performance in the short term and support recovery while longer term workforce and service model solutions are implemented. Closure of this action reflects successful delivery of its intended objective, with a revised and more targeted recovery plan now in place to address the factors directly affecting RTT performance. August 26 Update Assurance can be provided that SCHAT Physiotherapy clinic utilisation has improved to 93.4% following the review and standardisation of clinic templates. Learning from this work is now being shared across the Group through the Integration of Therapies programme to support alignment of MSST clinic templates and productivity approaches across SCHAT and SaTH. Cross-organisational visits have been completed, a Therapy Leadership Development Day completed in July has supported integration and shared ways of working, and a joint workshop is scheduled for September to bring MSST service leads together to align improvement plans and drive further standardisation, efficiency and patient access improvements across the pathway. July 26 Update Work has begun to review the templates across SATH/SCHAT therapies to ensure alignment. With a slight improvement of 2% seen in clinic utilisation. Team looking at splitting admin team to focus on areas of responsibility in relation to therapy utilisation.
	Roll out of T-PRO across Level 2 MSST Therapies across Group	Aug-26	Dec-26	On Track	September 26 Update Progress remains ongoing, with collaboration between the Rio team and DAST Service Manager to finalise a delivery approach. Whilst implementation has been impacted by RIO/ digital team capacity and competing priorities, solutions are being actively explored to support progression of the action during October 2026. New Action Working alongside the RIO and digital team to plan further roll out of T-Pro to support physio note taking with the aim of reducing required admin time and increasing clinical capacity.
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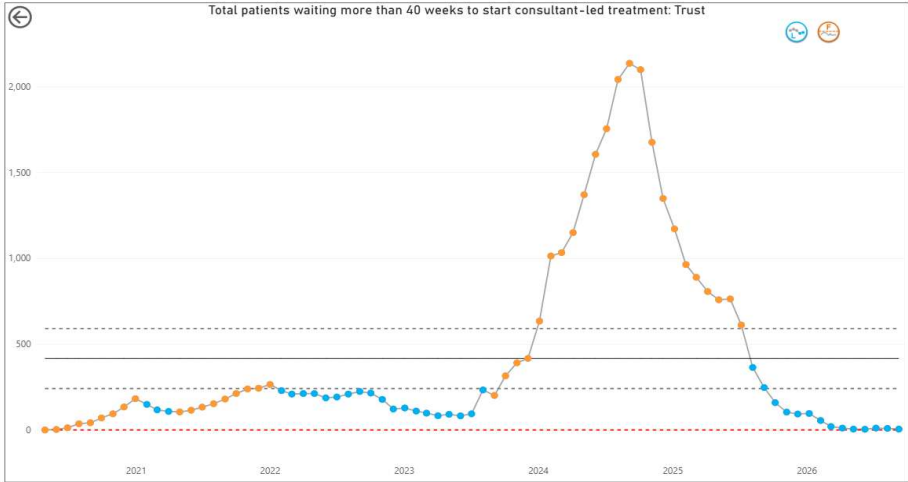
Exception Report - Action Plan

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	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
RTT 40+ week waits	Number	11	5	4	11	9	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:	RTT 40+ week waits continue to demonstrate a sustained improving trend, reducing from 9 patients in July to 5 in August. Although performance has fluctuated during the recovery period, including a temporary increase in June, the overall direction of travel remains in positive variation, with long waits significantly reduced over time.				
	The current position remains marginally above the planned recovery trajectory (5 patients against a target of 1 in Aug), indicating that further improvement is required to achieve the ambition of eliminating all 40+ week waits by September 2026 in line with the agreed trajectory. Breaches of this standard exist within MSST and Oral Surgery although there is still a degree of risk across Community Outpatients.				
	The greatest risk remains within Dental Services, followed by MSST and Community Outpatients, where recovery is constrained by capacity and, in particular, timely access to diagnostic pathways. To mitigate this, SCHT and SaTH have introduced a joint Patient Tracking List (PTL) to strengthen oversight and active management of long-wait patients. Greater use of APCS pathways is also enabling suitable ENT patients to access alternative models of care, reducing pressure on traditional outpatient services. In Dental Services, additional ad hoc clinics provided by SaTH are increasing treatment capacity and supporting faster recovery particularly for the longest waits. Monthly validation, specialty recovery plans and performance oversight remain in place to maintain progress against the agreed trajectory.				
		Start Date	End Date	Status	Outcome

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	Implement the Integration of Therapies Programme across the Group to align clinical pathways, optimise workforce deployment and address identified demand and capacity pressures, particularly within Level 2 Physiotherapy services. This will increase clinical capacity, support RTT recovery and reduce waiting times through a more flexible, sustainable workforce model. Temporary workforce solutions are also being explored to stabilise performance while longer-term service transformation is delivered	Sep-26	Mar-27	On Track	New Action Initial implementation activities are underway, including therapy workforce engagement workshops and ongoing recruitment to all substantive vacancies. To accelerate improvement and stabilise performance whilst the longer-term workforce redesign and integration programme progresses, a proposal will be submitted to Directors seeking approval for a three month temporary physiotherapy resource. This additional capacity is intended to support waiting list reduction, improve RTT performance and create headroom for the delivery of sustainable service transformation through the Integration of Therapies Programme.
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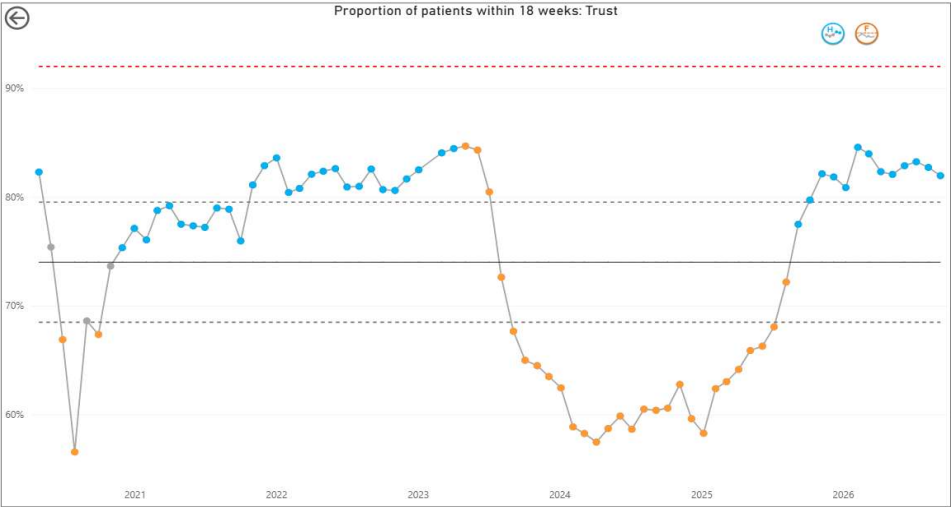
Exception Report - Action Plan

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	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
Proportion of patients within 18 weeks	%	82.33%	82.09%	82.88%	83.25%	82.73%	81.97%	81.97%
	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:

Overall performance remains relatively static. The proportion of patients seen within 18 weeks was 81.97% in August compared with 82.73% in July. Currently off track with trajectory but recovery is achievable with below actions.

Key Services Impacting Performance

- CDC (Children's Development Centre)
- Children's Speech and Language Therapy
- Community Paediatrics
- MSST
- Dental
- Community Outpatients

Performance improvement continues to be driven through robust recovery plans across all RTT and non-RTT pathways, supported by action plan workshops, divisional performance reviews and Senior PTL oversight.

Children's Speech and Language Therapy (SLT) has largely stabilised following previous performance deterioration. The service continues to maintain zero 52-week waits and is benefitting from targeted locum support, pathway redesign and digital solutions. Looking forward, the service redesign being undertaken as part of the national SEND reform programme will further future-proof the model, supporting both long-term sustainability and current recovery requirements.

Community Paediatrics has stabilised following a focused administrative improvement event which reviewed clinic templates, booking processes and clinical utilisation. The primary challenge remains the current vacancy gap within medical staffing; however, mitigations are in place through locum cover and ongoing recruitment efforts to maintain recovery momentum.

Children's Development Centre (CDC) remains the lowest performing service. A dedicated improvement and recovery workshop has been planned focusing on application of access criteria, pathway redesign and improved utilisation of available capacity.

The current stable position for August reflects seasonal variation and the change in MSST waiting lists profile with an increase in level 2 physiotherapy demand. Detailed demand and capacity modelling was completed however due to the change in workforce demographics and clinical pathways repeating this exercise should be repeated to further support improvement and recovery gain. The ongoing integration of therapy services provides assurance that there is a robust governance framework in place to support pathway redesign, improve utilisation of the existing workforce and deploy staffing resources more effectively across services.

Another key remaining risk relates to Oral Surgery. Whilst performance has shown early signs of improvement, recovery continues to be impacted by theatre availability and inconsistency of list provision within SaTH. Current contracted dental clinic activity remains insufficient to meet demand, resulting in an ongoing monthly shortfall in capacity. This risk is partially mitigated through additional activity delivered at RJA and ad hoc sessions via SaTH; however, current modelling continues to identify an unresolved gap, which requires resolution through additional SaTH capacity if recovery is to remain on trajectory.

Community Outpatients experienced capacity pressures over the summer due to aligned consultant annual leave across community and acute services. Despite efforts by SaTH to secure locum cover and provide additional ad hoc clinics, this was not always possible, and patient choice occasionally limited the uptake of alternative appointments. Joint PTL oversight ensured clinically urgent patients were prioritised and long waits managed equitably across organisations. Assurance has been received that consultant clinic activity will return to planned levels from September, supporting a return to an improving recovery trajectory.

There are other services that contribute to not meeting this target, including Diabetes, Adult Physiotherapy, APCS, Bridgnorth Hospital Day Surgery Unit, Community Neuro Rehabilitation, Continence Specialist Nursing, Paediatric Physiotherapy, Pulmonary Rehab and Wheelchair Services, all services are now operating within a consistent recovery framework with strengthened oversight, supporting confidence that the Trust remains on a positive recovery trajectory despite ongoing service-specific pressures.

		Start Date	End Date	Status	Outcome
	As part of the MSST pathway, SCHAT clinic templates are to be 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	Complete	September 26 Update This action has been completed and closed, having successfully increased clinic utilisation to 94.2%, demonstrating that available outpatient capacity is being used effectively. However, despite this improvement, RTT performance has not improved at the pace anticipated, indicating that clinic utilisation is no longer the primary constraint within the pathway. Further analysis has identified demand and capacity imbalance, particularly within Level 2 Physiotherapy provision, as the key factor impacting recovery. As a result, the focus of improvement activity has shifted towards increasing available clinical capacity and aligning resources across the Group through the Integration of Therapies Programme. In parallel, temporary workforce options are being scoped to stabilise performance in the short term and support recovery while longer term workforce and service model solutions are implemented. Closure of this action reflects successful delivery of its intended objective, with a revised and more targeted recovery plan now in place to address the factors directly affecting RTT performance. August 26 Update Assurance can be provided that SCHAT Physiotherapy clinic utilisation has improved to 93.4% following the review and standardisation of clinic templates. Learning from this work is now being shared across the Group through the Integration of Therapies programme to support alignment of MSST clinic templates and productivity approaches across SCHAT and SaTH. Cross-organisational visits have been completed, a Therapy Leadership Development Day completed in July has supported integration and shared ways of working, and a joint workshop is scheduled for September to bring MSST service leads together to align improvement plans and drive further standardisation, efficiency and patient access improvements across the pathway. July 26 Update Work has begun to review the templates across SATH/SCHAT therapies to ensure alignment. With a slight improvement of 2% seen in clinic utilisation. Team looking at splitting admin team to focus on areas of responsibility in relation to therapy utilisation.
	Roll out of T-PRO across Level 2 MSST Therapies across Group	Aug-26	Dec-26	On Track	September 26 Update Progress remains ongoing, with collaboration between the Rio team and DAST Service Manager to finalise a delivery approach. Whilst implementation has been impacted by RIO/ digital team capacity and competing priorities, solutions are being actively explored to support progression of the action during October 2026. New Action Working alongside the RIO and digital team to plan further roll out of T-Pro to support physio note taking with the aim of reducing required admin time and increasing clinical capacity.
	To support sustained improvement across all non RTT waiting list services, a Trust-wide Planned Care Task and Finish Group has now been established. The group is leading a standardised improvement programme focused on: •Consistent application of access criteria. •Strengthened waiting list management processes. •Roll out of digital solutions. •Optimisation of clinic utilisation. •Standardisation of booking and validation processes. •Shared learning and improvement methodologies across services. •Promotion of PIFU	Sep-26	Mar-27	On Track	September 26 update: The Planned Care Task and Finish Group continues to make good progress, with the improvement methodology successfully embedded within the Diabetes pathway and early benefits demonstrated through improved waiting list management and performance oversight. Building on this success, the programme is now being expanded across additional non-RTT services with a particular dedicated focus on the Childrens Diagnostic Centre and Comm Paeds, with priority pathways identified and baseline reviews completed. New Action Early results from the Diabetes pathway where this approach has been trialled have demonstrated the value of this programme, with rapid improvements in performance following implementation. The programme will now be systematically expanded across other services to support delivery of recovery trajectories, reduce unwarranted variation and improve equitable access for patients across SCHAT's planned care services.

Action Plan	Plan to join the Community Paediatrician services with the children's CDC to reduce duplication, streamline clinical pathways and improve capacity to reduce waits.	May-26	Sep-26	On Track	September 26 Update Community Paediatrics and the Children's CDC now operating under a single Service Lead, providing unified oversight of capacity, demand and pathway performance. Planning is underway for a whole-service redesign commencing this autumn, focused on aligning assessment criteria, streamlining pathways and reducing duplication between services. To support recovery during the transition, additional capacity is being secured through locum, insourcing and outsourcing arrangements, ensuring waiting list improvement can continue whilst the new service model is developed and implemented. August 26 Update CDC recovery has resumed following July's action application, with performance improving by approximately 5 percentage points from 40.86% to 45.39%, returning to a position comparable with May. A dedicated improvement and recovery workshop has been planned focusing on application of access criteria, pathway redesign and improved utilisation of available capacity. Community Paediatrics locum cover and ongoing recruitment efforts to maintain recovery momentum. July 26 Update Service Lead overseeing both services is now identifying opportunities for closer working and has identified some areas of initial focus to improve flow between the services. Resource is now being reviewed pan service to be more flexible to demand
	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 recovery 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	September 26 Update Procurement of additional outsourced CDC capacity is progressing, with a phased increase in activity commencing from the final week of September. Locum Community Paediatrician capacity has been secured from late September and early October to support waiting list recovery and delivery of the March 2027 trajectory. Recruitment of temporary Speech and Language Therapy capacity remains challenging due to national workforce pressures associated with SEND reforms; however, active recruitment and sourcing activity continues to maximise opportunities to secure additional resource and further strengthen recovery where possible. August 26 Update Funding has been secured, procurement has been completed, and outsourced capacity has been commissioned to commence in September. To further strengthen resilience and sustainability, an insourcing model is also being developed and scoped to provide greater operational flexibility and additional capacity options. Both approaches will run in parallel to ensure the immediate recovery plan is not delayed while creating a more robust long-term model. July 26 Update Plans remain on track for outsourcing 160 appointments worth of activity to commence at the end of August. Preparatory work has been completed, and the Trust is currently awaiting a review/signoff from the Procurement Team to ensure full compliance with procurement regulations and governance requirements before progressing.
	Secure additional locum Community Paediatrician capacity to support recovery of waiting lists at both the front and back end of the pathway, prioritising timely access for new referrals whilst accelerating the reduction of long-wait cohorts. This will provide short-term resilience against workforce gaps, increase clinical assessment capacity, and support delivery of the Trust's waiting list recovery trajectory.	Aug-26	Mar-27	On Track	September 26 Update Whilst the initially identified locum unexpectedly withdrew prior to commencement, the service responded quickly to mitigate impact on recovery plans. Two replacement locums have now been secured, providing a combined 1.6 WTE additional capacity, with one commencing on 21 September and the second on 1 October. This additional resource will strengthen capacity at both the front and back end of the pathway, supporting new referrals, accelerating reduction of long waits and improving resilience against workforce gaps. The phased introduction of this capacity is expected to support recovery towards the Trust's waiting list trajectory and provide a more sustainable platform for ongoing service improvement. New Action Locum provision identified and recruitment processes underway, with additional consultant capacity being mobilised

	Accelerate the rollout of Patient Initiated Follow Up (PIFU) across all appropriate Children's Services pathways, supported by standardised clinical criteria, workforce training and digital self-referral processes through support from planned care division who have achieved high PIFU across MSK pathways	Aug-26	Mar-27	On Track	September 26 Update PIFU implementation is progressing as planned. Staff training has now been completed, supported by learning from the high-performing MSK pathways and the existing Planned Care teams. Identified Children's Services pathways will go live with PIFU from mid-September, supported by agreed clinical criteria, performance monitoring and shared learning arrangements. New Action PIFU training led by planned care with all staff and performance shared with all leads to support an improvement trajectory
	Complete the rollout and embedding of ambient voice technology across Community Paediatrics, ensuring all clinicians are trained and actively using the solution to improve clinical documentation	Aug-26	Nov-26	On Track	September 26 Update Ambient AI has been successfully developed and tested for Community Paediatrics follow up clinics. Following the departure of the consultant who led the initial implementation, responsibility has now been transferred and work is progressing to finalise the wider rollout approach. A phased implementation will commence in month with follow-up activity, with a comprehensive rollout plan to all clinicians scheduled for completion by the end of November 2026 for all appointments. New Action Digital supporting clinicians with training and rollout
	Explore and mobilise an insourcing provider, utilised currently by SaTH, to work alongside the Community Diagnostic Centre (CDC) and existing Community Paediatric workforce. This will provide additional clinical capacity to accelerate assessment activity, support management of both new and long-wait cohorts for neurodiverse pathways, and improve waiting list recovery whilst substantive recruitment and locum provision are progressed.	Aug-26	Mar-27	On Track	September 26 Update Engagement with the insourcing provider continues, with CYP pathways shared and governance arrangements progressing to support mobilisation. A phased implementation approach has been agreed, with additional assessment capacity expected to commence from mid-September ahead of full rollout. New Action Identify a suitable insourcing partner capable of providing additional consultant paediatric capacity - aligning funding and confirming start dates

	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	Complete	September 26 Update The waiting list validation exercise and associated opt-in/opt-out process have now been fully implemented following the ELSEC rollout. This work has provided assurance that waiting lists accurately reflect current patient need, identifying and resolving historical cases where children may already have been receiving support through school-based provision. The validation process has strengthened data quality, improved waiting list accuracy and ensured recovery trajectories are based on a validated and reliable position. As the agreed actions have been fully delivered and embedded into operational processes, this action is now closed. August 26 Update The waiting list validation and opt-in/opt-out exercise associated with the ELSEC rollout has now commenced. All identified cohorts are under systematic review, with historical school-based activity cross-referenced against current waiting list records to ensure the accuracy of patient tracking lists. Families are being contacted through the agreed communication process and responses reviewed to confirm ongoing treatment requirements. Waiting lists are subsequently being cleansed in line with agreed protocols, with patients no longer requiring treatment removed and those requiring ongoing care retained and prioritised appropriately. July 26 Update A structured validation and patient opt-in/opt-out process is being developed to review all affected cohorts. This will include cross-referencing historical school-based activity against current waiting list records, followed by direct communication with families to confirm whether treatment is still required. Patients who no longer require an appointment will be removed from the waiting list in line with agreed protocols, while those wishing to remain under the service will be retained and prioritised appropriately. Planned Timescales July/August: Complete identification of potentially affected cohorts and undertake data validation exercise. August/September: Issue patient and family communications to confirm ongoing need for treatment through an opt-in/opt-out process. September/October: Review responses, cleanse waiting lists, and update PTLs accordingly. October: Provide assurance report confirming completion of the validation exercise, the number of records reviewed, and the impact on waiting list position and reporting. Governance oversight will be maintained throughout the process, with progress monitored through divisional performance and waiting list senior management arrangements.
	Dental: Formalise agreed demand and capacity requirements with SaTH and secure recurrent theatre and elective hub capacity to support delivery of the RTT long-waits recovery trajectory and sustainable waiting list recovery.	Aug-26	Dec-26	On Track	September 26 Update Capacity was delivered during August for ad hoc theatre lists. SCHT and SaTH teams worked together to streamline the booking of patients resulting in better collaboration and understanding of requirements. Weekly meetings continue whilst the development of a sedation suite at PRH continues. New Action Weekly meetings with SaTH who are aware of requirement for an additional 8 slots a week. Ad hoc sessions provided through June and July to blitz long waits and plan is by end of Summer post theatre estates moves for SaTH to confirm regular capacity and dates.

	Review and redesign of the ENT pathway to align with Community Outpatient demand, reduce waiting times, and support improved patient access. This programme will act as an early adopter for neighbourhood transformation, testing new models of integrated, community-based care	Aug-26	Oct-26	On Track	September 26 Update This workstream remains on track, with future patient lists continuing to be made available to support the transfer of appropriate patients to Community Outpatients, helping to maximise available capacity and improve patient experience. Following the success with ENT collaborative discussions have further progressed regarding the inclusion of Physiotherapy provision within this pathway, creating an opportunity to enhance service resilience, increase treatment capacity and support RTT recovery. The development of this pathway forms part of a broader approach to optimise resources, reduce waiting times across the Group. New Action 18 patients have been transferred from the Community Outpatients waiting list to the APCS pathway and reviewed by a GPwER, enabling assessment of alternative management options and reducing reliance on consultant-led pathways. Learning from these reviews will be used to maximise opportunities for further pathway redesign, including the development of a single point of access for ENT referrals.
	GIRFT funding has been applied for to accelerate service transformation through digital innovation, enhanced clinical validation and pathway redesign, supporting improved waiting list management, increased productivity, better patient flow and more effective use of social prescribing all for MSST and community MSK .	Aug-26	Oct-26	On Track	September 26 Update Unfortunately MSST was not successful with the bid for the GIRFT funding. However the approach developed is still being implemented due to the potential impacts. Alternative funding streams are being identified for equipment and training. New Action System funding application submitted
	Implement the Integration of Therapies Programme across the Group to align clinical pathways, optimise workforce deployment and address identified demand and capacity pressures, particularly within Level 2 Physiotherapy services. This will increase clinical capacity, support RTT recovery and reduce waiting times through a more flexible, sustainable workforce model. Temporary workforce solutions are also being explored to stabilise performance while longer-term service transformation is delivered	Sep-26	Mar-27	On Track	New Action Initial implementation activities are underway, including therapy workforce engagement workshops and ongoing recruitment to all substantive vacancies. To accelerate improvement and stabilise performance whilst the longer-term workforce redesign and integration programme progresses, a proposal will be submitted to Directors seeking approval for a three month temporary physiotherapy resource. This additional capacity is intended to support waiting list reduction, improve RTT performance and create headroom for the delivery of sustainable service transformation through the Integration of Therapies Programme.
Author	Gemma McIver /Helen Cooper/Alex Critchell	Date	09/09/2026		
Accountable Officer Approval	Claire Horsfield	Date	15/09/2026		

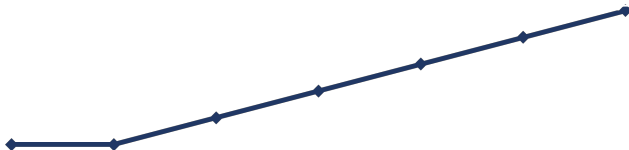
Exception Report - Action Plan

Percentage of cases waiting less than 18 weeks for community care

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

KPI Description	Latest 6 months	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
Percentage of cases waiting less than 18 weeks for community care	%	82.70%	82.08%	84.27%	84.66%	83.51%	83.97%	83.97%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	0.0%

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:	Relevant performance is described in the previous action plan				
Action Plan			Start Date	End Date	Status
	Relevant actions are detailed in the previous action plan				
Author	Gemma McIver /Helen Cooper/Alex Critchell		Date	09/09/2026	
Accountable Officer Approval	Claire Horsfield			15/09/2026	

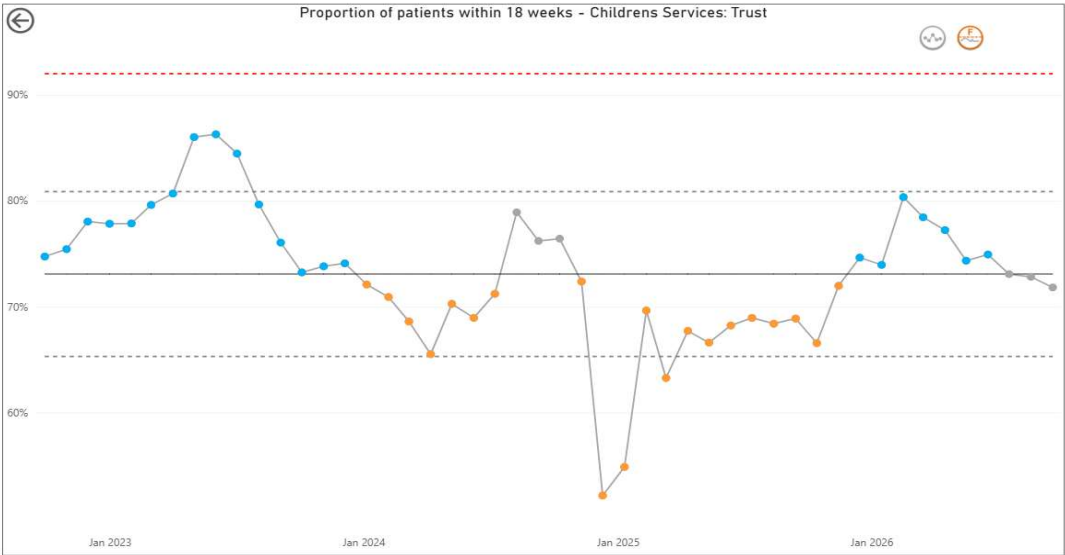
Exception Report - Action Plan

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	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
Proportion of patients within 18 weeks - Children's Services	%	77.23%	74.35%	74.93%	73.08%	72.82%	71.82%	71.82%
	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
%	76.0%	77.0%	78.0%	80.0%	82.0%	84.0%	85.0%



Reason for performance gap:

Overall Children's Services performance is now at 71.82% of children currently accessing care within 18 weeks, this is a decline from 78.45% in February 2026.

Whilst this reflects a continued deterioration in the aggregate position, A strong revision of all improvement plans has been implemented to ensure that the recovery plans now focus on rapid stabilisation and regaining an improvement position.

Key Services Impacting Performance

- CDC (Children's Development Centre)
- Children's Speech and Language Therapy
- Community Paediatrics
- Dental

Children's Speech and Language Therapy (SLT) has largely stabilised following previous performance deterioration. The service continues to maintain zero 52-week waits and is benefitting from targeted locum support, pathway redesign and digital solutions. Looking forward, the service redesign being undertaken as part of the national SEND reform programme will further future-proof the model, supporting both long-term sustainability and current recovery requirements.

Community Paediatrics has stabilised following a focused administrative improvement event which reviewed clinic templates, booking processes and clinical utilisation. The primary challenge remains the current vacancy gap within medical staffing; however, mitigations are in place through locum cover and ongoing recruitment efforts to maintain recovery momentum.

Children's Development Centre (CDC) remains the lowest performing service. A dedicated improvement and recovery workshop has been planned focusing on application of access criteria, pathway redesign and improved utilisation of available capacity.

Another key remaining RTT risk relates to Oral Surgery. Whilst performance has shown early signs of improvement, recovery continues to be impacted by theatre availability and inconsistency of list provision within SaTH. Current contracted dental clinic activity remains insufficient to meet demand, resulting in an ongoing monthly shortfall in capacity. This risk is partially mitigated through additional activity delivered at RJAH and ad hoc sessions via SaTH; however, current modelling continues to identify an unresolved gap, which requires resolution through additional SaTH capacity if recovery is to remain on trajectory.

There are other services that contribute to not meeting this target, including Paediatric Physiotherapy and Wheelchair Services.

		Start Date	End Date	Status	Outcome
	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 recovery 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	September 26 Update Procurement of additional outsourced CDC capacity is progressing, with a phased increase in activity commencing from the final week of September. Locum Community Paediatrician capacity has been secured from late September and early October to support waiting list recovery and delivery of the March 2027 trajectory. Recruitment of temporary Speech and Language Therapy capacity remains challenging due to national workforce pressures associated with SEND reforms; however, active recruitment and sourcing activity continues to maximise opportunities to secure additional resource and further strengthen recovery where possible. August 26 Update Funding has been secured, procurement has been completed, and outsourced capacity has been commissioned to commence in September. To further strengthen resilience and sustainability, an insourcing model is also being developed and scoped to provide greater operational flexibility and additional capacity options. Both approaches will run in parallel to ensure the immediate recovery plan is not delayed while creating a more robust long-term model. July 26 Update Plans remain on track for outsourcing 160 appointments worth of activity to commence at the end of August. Preparatory work has been completed, and the Trust is currently awaiting a review/signoff from the Procurement Team to ensure full compliance with procurement regulations and governance requirements before progressing.
	Secure additional locum Community Paediatrician capacity to support recovery of waiting lists at both the front and back end of the pathway, prioritising timely access for new referrals whilst accelerating the reduction of long-wait cohorts. This will provide short-term resilience against workforce gaps, increase clinical assessment capacity, and support delivery of the Trust's waiting list recovery trajectory.	Aug-26	Mar-27	On Track	September 26 Update Whilst the initially identified locum unexpectedly withdrew prior to commencement, the service responded quickly to mitigate impact on recovery plans. Two replacement locums have now been secured, providing a combined 1.6 WTE additional capacity, with one commencing on 21 September and the second on 1 October. This additional resource will strengthen capacity at both the front and back end of the pathway, supporting new referrals, accelerating reduction of long waits and improving resilience against workforce gaps. The phased introduction of this capacity is expected to support recovery towards the Trust's waiting list trajectory and provide a more sustainable platform for ongoing service improvement. New Action Locum provision identified and recruitment processes underway, with additional consultant capacity being mobilised
	Plan to join the Community Paediatrician services with the children's CDC to reduce duplication, streamline clinical pathways and improve capacity to reduce waits.	May-26	Sep-26	On Track	September 26 Update Community Paediatrics and the Children's CDC now operating under a single Service Lead, providing unified oversight of capacity, demand and pathway performance. Planning is underway for a whole-service redesign commencing this autumn, focused on aligning assessment criteria, streamlining pathways and reducing duplication between services. To support recovery during the transition, additional capacity is being secured through locum, insourcing and outsourcing arrangements, ensuring waiting list improvement can continue whilst the new service model is developed and implemented. August 26 Update CDC recovery has resumed following July's action application, with performance improving by approximately 5 percentage points from 40.86% to 45.39%, returning to a position comparable with May. A dedicated improvement and recovery workshop has been planned focusing on application of access criteria, pathway redesign and improved utilisation of available capacity. Community Paediatrics locum cover and ongoing recruitment efforts to maintain recovery momentum. July 26 Update Service Lead overseeing both services is now identifying opportunities for closer working and has identified some areas of initial focus to improve flow between the services. Resource is now being reviewed pan service to be more flexible to demand

Action Plan	Complete the rollout and embedding of ambient voice technology across Community Paediatrics, ensuring all clinicians are trained and actively using the solution to improve clinical documentation	Aug-26	Nov-26	On Track	September 26 Update Ambient AI has been successfully developed and tested for Community Paediatrics follow up clinics. Following the departure of the consultant who led the initial implementation, responsibility has now been transferred and work is progressing to finalise the wider rollout approach. A phased implementation will commence in month with follow-up activity, with a comprehensive rollout plan to all clinicians scheduled for completion by the end of November 2026 for all appointments. New Action Digital supporting clinicians with training and rollout
	Explore and mobilise an insourcing provider, utilised currently by SaTH, to work alongside the Community Diagnostic Centre (CDC) and existing Community Paediatric workforce. This will provide additional clinical capacity to accelerate assessment activity, support management of both new and long-wait cohorts for neurodiverse pathways, and improve waiting list recovery whilst substantive recruitment and locum provision are progressed.	Aug-26	Mar-27	On Track	September 26 Update Engagement with the insourcing provider continues, with CYP pathways shared and governance arrangements progressing to support mobilisation. A phased implementation approach has been agreed, with additional assessment capacity expected to commence from mid-September ahead of full rollout. New Action Identify a suitable insourcing partner capable of providing additional consultant paediatric capacity - aligning funding and confirming start dates
	Accelerate the rollout of Patient Initiated Follow Up (PIFU) across all appropriate Children's Services pathways, supported by standardised clinical criteria, workforce training and digital self-referral processes through support from planned care division who have achieved high PIFU across MSK pathways	Aug-26	Mar-27	On Track	September 26 Update PIFU implementation is progressing as planned. Staff training has now been completed, supported by learning from the high-performing MSK pathways and the existing Planned Care teams. Identified Children's Services pathways will go live with PIFU from mid-September, supported by agreed clinical criteria, performance monitoring and shared learning arrangements. New Action PIFU training led by planned care with all staff and performance shared with all leads to support an improvement trajectory

	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	Complete	September 26 Update The waiting list validation exercise and associated opt-in/opt-out process have now been fully implemented following the ELSEC rollout. This work has provided assurance that waiting lists accurately reflect current patient need, identifying and resolving historical cases where children may already have been receiving support through school-based provision. The validation process has strengthened data quality, improved waiting list accuracy and ensured recovery trajectories are based on a validated and reliable position. As the agreed actions have been fully delivered and embedded into operational processes, this action is now closed. August 26 Update The waiting list validation and opt-in/opt-out exercise associated with the ELSEC rollout has now commenced. All identified cohorts are under systematic review, with historical school-based activity cross-referenced against current waiting list records to ensure the accuracy of patient tracking lists. Families are being contacted through the agreed communication process and responses reviewed to confirm ongoing treatment requirements. Waiting lists are subsequently being cleansed in line with agreed protocols, with patients no longer requiring treatment removed and those requiring ongoing care retained and prioritised appropriately. July 26 Update A structured validation and patient opt-in/opt-out process is being developed to review all affected cohorts. This will include cross-referencing historical school-based activity against current waiting list records, followed by direct communication with families to confirm whether treatment is still required. Patients who no longer require an appointment will be removed from the waiting list in line with agreed protocols, while those wishing to remain under the service will be retained and prioritised appropriately. Planned Timescales July/August: Complete identification of potentially affected cohorts and undertake data validation exercise. August/September: Issue patient and family communications to confirm ongoing need for treatment through an opt-in/opt-out process. September/October: Review responses, cleanse waiting lists, and update PTLs accordingly. October: Provide assurance report confirming completion of the validation exercise, the number of records reviewed, and the impact on waiting list position and reporting. Governance oversight will be maintained throughout the process, with progress monitored through divisional performance and waiting list senior management arrangements.
	Dental: Formalise agreed demand and capacity requirements with SaTH and secure recurrent theatre and elective hub capacity to support delivery of the RTT long-waits recovery trajectory and sustainable waiting list recovery.		Aug-26	Dec-26	On Track	September 26 Update Capacity was delivered during August for ad hoc theatre lists. SCHAT and SaTH teams worked together to streamline the booking of patients resulting in better collaboration and understanding of requirements. Weekly meetings continue whilst the development of a sedation suite at PRH continues. New Action Weekly meetings with SaTH who are aware of requirement for an additional 8 slots a week. Ad hoc sessions provided through June and July to blitz long waits and plan is by end of Summer post theatre estates moves for SaTH to confirm regular capacity and dates.
	Integrating the group therapy teams is a programme under the local transformation agenda. The vision will result in aligned clinical pathways across group to build capacity across all services. This capacity will be utilised to innovate and transform across Group to reduce waits, improve outcomes and experience for patients.		Sep-26	Mar-27	On Track	New Action Initial actions include the delivery of workshops for the therapy teams and substantive recruitment to vacant posts. Further consultation and design of the integration continues.
Author	Gemma Mclver /Helen Cooper/Alex Critchell		Date	09/09/2026		
Accountable Officer Approval	Claire Horsfield			15/09/2026		

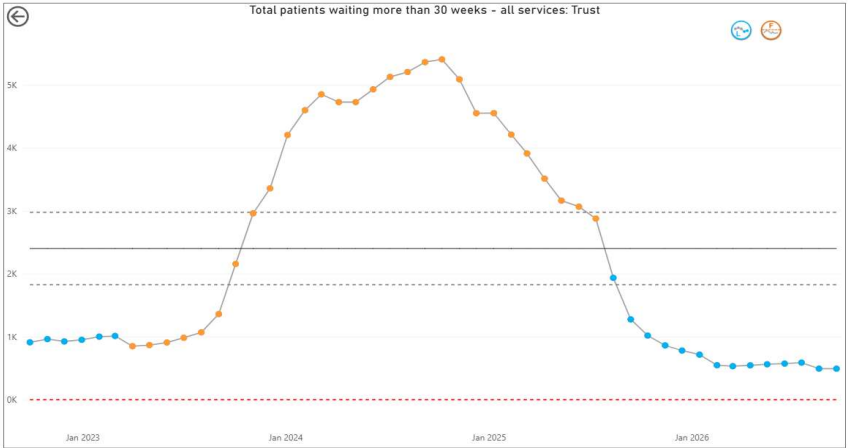
Exception Report - Action Plan

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	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
30+ Week waits - All services	Number	546	563	574	589	494	493	493
	Target	0	0	0	0	0	0	0

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



Reason for performance gap:	There has been improvement over a long period of time. This month performance has stabilised and is not meeting the trajectory.
	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 •Community Outpatients
	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, SCHAT is well positioned, having already implemented the required approach. This includes strengthened demand and capacity modelling, pathway redesign, and more structured performance management.
	Children's Speech and Language Therapy (SLT) has largely stabilised following previous performance deterioration. The service continues to maintain zero 52-week waits and is benefitting from targeted locum support, pathway redesign and digital solutions. Looking forward, the service redesign being undertaken as part of the national SEND reform programme will further future-proof the model, supporting both long-term sustainability and current recovery requirements.
	Community Paediatrics has stabilised following a focused administrative improvement event which reviewed clinic templates, booking processes and clinical utilisation. The primary challenge remains the current vacancy gap within medical staffing; however, mitigations are in place through locum cover and ongoing recruitment efforts to maintain recovery momentum.
	Children's Development Centre (CDC) remains the lowest performing service. A dedicated improvement and recovery workshop has been planned focusing on application of access criteria, pathway redesign and improved utilisation of available capacity.
	Another key remaining RTT risk relates to Oral Surgery. Whilst performance has shown early signs of improvement, recovery continues to be impacted by theatre availability and inconsistency of list provision within SaTH. Current contracted dental clinic activity remains insufficient to meet demand, resulting in an ongoing monthly shortfall in capacity. This risk is partially mitigated through additional activity delivered at RJA and ad hoc sessions via SaTH; however, current modelling continues to identify an unresolved gap, which requires resolution through additional SaTH capacity if recovery is to remain on trajectory.
	Community outpatient pathways also remain a risk, particularly where access to diagnostic capacity varies across the Group. In response, recovery trajectories have been reviewed and realigned to reflect current operational challenges whilst maintaining a clear focus on achieving the January 2027 objective.
	Diabetes continues to demonstrate strong improvement following implementation of a structured waiting list improvement programme. Performance has increased further from 81.45% to 84.51% in a single month, whilst maintaining zero 52-week waits. The service has acted as an early adopter for a new Trust-wide approach to planned care improvement, providing a model that is now being replicated across other waiting list services.
	Pulmonary Rehabilitation performance is currently 77.64%, an increase from 74.07%, in the previous period. This variation is largely attributable to seasonal fluctuations in referral and attendance patterns. To mitigate this impact, additional group capacity has been introduced through pathway remodelling, alongside mutual aid support from the Long Covid service to accelerate recovery and improve access.
	There are other services that contribute to not meeting this target, including Adult Physio, Adult Speech and Language, APCS, Bridgnorth Hospital - Day Surgery Unit, Community Neuro Rehabilitation Team, Community Nursing, Continence Specialist Nursing, MSST, Podiatry, Wheelchair Services

Plan		Start Date	End Date	Status	Outcome
	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 recovery 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	September 26 Update Procurement of additional outsourced CDC capacity is progressing, with a phased increase in activity commencing from the final week of September. Locum Community Paediatrician capacity has been secured from late September and early October to support waiting list recovery and delivery of the March 2027 trajectory. Recruitment of temporary Speech and Language Therapy capacity remains challenging due to national workforce pressures associated with SEND reforms; however, active recruitment and sourcing activity continues to maximise opportunities to secure additional resource and further strengthen recovery where possible. August 26 Update Funding has been secured, procurement has been completed, and outsourced capacity has been commissioned to commence in September. To further strengthen resilience and sustainability, an insourcing model is also being developed and scoped to provide greater operational flexibility and additional capacity options. Both approaches will run in parallel to ensure the immediate recovery plan is not delayed while creating a more robust long-term model. July 26 Update Plans remain on track for outsourcing 160 appointments worth of activity to commence at the end of August. Preparatory work has been completed, and the Trust is currently awaiting a review/signoff from the Procurement Team to ensure full compliance with procurement regulations and governance requirements before progressing.
	Secure additional locum Community Paediatrician capacity to support recovery of waiting lists at both the front and back end of the pathway, prioritising timely access for new referrals whilst accelerating the reduction of long-wait cohorts. This will provide short-term resilience against workforce gaps, increase clinical assessment capacity, and support delivery of the Trust's waiting list recovery trajectory.	Aug-26	Mar-27	On Track	September 26 Update Whilst the initially identified locum unexpectedly withdrew prior to commencement, the service responded quickly to mitigate impact on recovery plans. Two replacement locums have now been secured, providing a combined 1.6 WTE additional capacity, with one commencing on 21 September and the second on 1 October. This additional resource will strengthen capacity at both the front and back end of the pathway, supporting new referrals, accelerating reduction of long waits and improving resilience against workforce gaps. The phased introduction of this capacity is expected to support recovery towards the Trust's waiting list trajectory and provide a more sustainable platform for ongoing service improvement. New Action Locum provision identified and recruitment processes underway, with additional consultant capacity being mobilised
	Plan to join the Community Paediatrician services with the children's CDC to reduce duplication, streamline clinical pathways and improve capacity to reduce waits.	May-26	Sep-26	On Track	September 26 Update Community Paediatrics and the Children's CDC now operating under a single Service Lead, providing unified oversight of capacity, demand and pathway performance. Planning is underway for a whole-service redesign commencing this autumn, focused on aligning assessment criteria, streamlining pathways and reducing duplication between services. To support recovery during the transition, additional capacity is being secured through locum, insourcing and outsourcing arrangements, ensuring waiting list improvement can continue whilst the new service model is developed and implemented. August 26 Update CDC recovery has resumed following July's action application, with performance improving by approximately 5 percentage points from 40.86% to 45.39%, returning to a position comparable with May. A dedicated improvement and recovery workshop has been planned focusing on application of access criteria, pathway redesign and improved utilisation of available capacity. Community Paediatrics locum cover and ongoing recruitment efforts to maintain recovery momentum. July 26 Update Service Lead overseeing both services is now identifying opportunities for closer working and has identified some areas of initial focus to improve flow between the services. Resource is now being reviewed pan service to be more flexible to demand
	Complete the rollout and embedding of ambient voice technology across Community Paediatrics, ensuring all clinicians are trained and actively using the solution to improve clinical documentation	Aug-26	Nov-26	On Track	September 26 Update Ambient AI has been successfully developed and tested for Community Paediatrics follow up clinics. Following the departure of the consultant who led the initial implementation, responsibility has now been transferred and work is progressing to finalise the wider rollout approach. A phased implementation will commence in month with follow-up activity, with a comprehensive rollout plan to all clinicians scheduled for completion by the end of November 2026 for all appointments. New Action Digital supporting clinicians with training and rollout
	Explore and mobilise an insourcing provider, utilised currently by SaTH, to work alongside the Community Diagnostic Centre (CDC) and existing Community Paediatric workforce. This will provide additional clinical capacity to accelerate assessment activity, support management of both new and long-wait cohorts for neurodiverse pathways, and improve waiting list recovery whilst substantive recruitment and locum provision are progressed.	Aug-26	Mar-27	On Track	September 26 Update Engagement with the insourcing provider continues, with CYP pathways shared and governance arrangements progressing to support mobilisation. A phased implementation approach has been agreed, with additional assessment capacity expected to commence from mid-September ahead of full rollout. New Action Identify a suitable insourcing partner capable of providing additional consultant paediatric capacity - aligning funding and confirming start dates

Actor	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	Complete	September 26 Update The waiting list validation exercise and associated opt-in/opt-out process have now been fully implemented following the ELSEC rollout. This work has provided assurance that waiting lists accurately reflect current patient need, identifying and resolving historical cases where children may already have been receiving support through school-based provision. The validation process has strengthened data quality, improved waiting list accuracy and ensured recovery trajectories are based on a validated and reliable position. As the agreed actions have been fully delivered and embedded into operational processes, this action is now closed. August 26 Update The waiting list validation and opt-in/opt-out exercise associated with the ELSEC rollout has now commenced. All identified cohorts are under systematic review, with historical school-based activity cross-referenced against current waiting list records to ensure the accuracy of patient tracking lists. Families are being contacted through the agreed communication process and responses reviewed to confirm ongoing treatment requirements. Waiting lists are subsequently being cleansed in line with agreed protocols, with patients no longer requiring treatment removed and those requiring ongoing care retained and prioritised appropriately. July 26 Update A structured validation and patient opt-in/opt-out process is being developed to review all affected cohorts. This will include cross-referencing historical school-based activity against current waiting list records, followed by direct communication with families to confirm whether treatment is still required. Patients who no longer require an appointment will be removed from the waiting list in line with agreed protocols, while those wishing to remain under the service will be retained and prioritised appropriately. Planned Timescales July/August: Complete identification of potentially affected cohorts and undertake data validation exercise. August/September: Issue patient and family communications to confirm ongoing need for treatment through an opt-in/opt-out process. September/October: Review responses, cleanse waiting lists, and update PTLs accordingly. October: Provide assurance report confirming completion of the validation exercise, the number of records reviewed, and the impact on waiting list position and reporting. Governance oversight will be maintained throughout the process, with progress monitored through divisional performance and waiting list senior management arrangements.
	Accelerate the rollout of Patient Initiated Follow Up (PIFU) across all appropriate Children's Services pathways, supported by standardised clinical criteria, workforce training and digital self-referral processes through support from planned care division who have achieved high PIFU across MSK pathways	Aug-26	Mar-27	On Track	September 26 Update PIFU implementation is progressing as planned. Staff training has now been completed, supported by learning from the high-performing MSK pathways and the existing Planned Care teams. Identified Children's Services pathways will go live with PIFU from mid-September, supported by agreed clinical criteria, performance monitoring and shared learning arrangements. New Action PIFU training led by planned care with all staff and performance shared with all leads to support an improvement trajectory
	Dental: Formalise agreed demand and capacity requirements with SaTH and secure recurrent theatre and elective hub capacity to support delivery of the RTT long-waits recovery trajectory and sustainable waiting list recovery.	Aug-26	Dec-26	On Track	September 26 Update Capacity was delivered during August for ad hoc theatre lists. SCHAT and SaTH teams worked together to streamline the booking of patients resulting in better collaboration and understanding of requirements. Weekly meetings continue whilst the development of a sedation suite at PRH continues. New Action Weekly meetings with SaTH who are aware of requirement for an additional 8 slots a week. Ad hoc sessions provided through June and July to blitz long waits and plan is by end of Summer post theatre estates moves for SaTH to confirm regular capacity and dates.
	Review and redesign of the ENT pathway to align with Community Outpatient demand, reduce waiting times, and support improved patient access. This programme will act as an early adopter for neighbourhood transformation, testing new models of integrated, community-based care	Aug-26	Oct-26	On Track	September 26 Update This workstream remains on track, with future patient lists continuing to be made available to support the transfer of appropriate patients to Community Outpatients, helping to maximise available capacity and improve patient experience. Following the success with ENT collaborative discussions have further progressed regarding the inclusion of Physiotherapy provision within this pathway, creating an opportunity to enhance service resilience, increase treatment capacity and support RTT recovery. The development of this pathway forms part of a broader approach to optimise resources, reduce waiting times across the Group. New Action 18 patients have been transferred from the Community Outpatients waiting list to the APCS pathway and reviewed by a GPwER, enabling assessment of alternative management options and reducing reliance on consultant-led pathways. Learning from these reviews will be used to maximise opportunities for further pathway redesign, including the development of a single point of access for ENT referrals.
Author	Gemma McIver /Helen Cooper/Alex Critchell		Date	09/09/2026	

Accountable Officer Approval	Claire Horsfield		15/09/2026	
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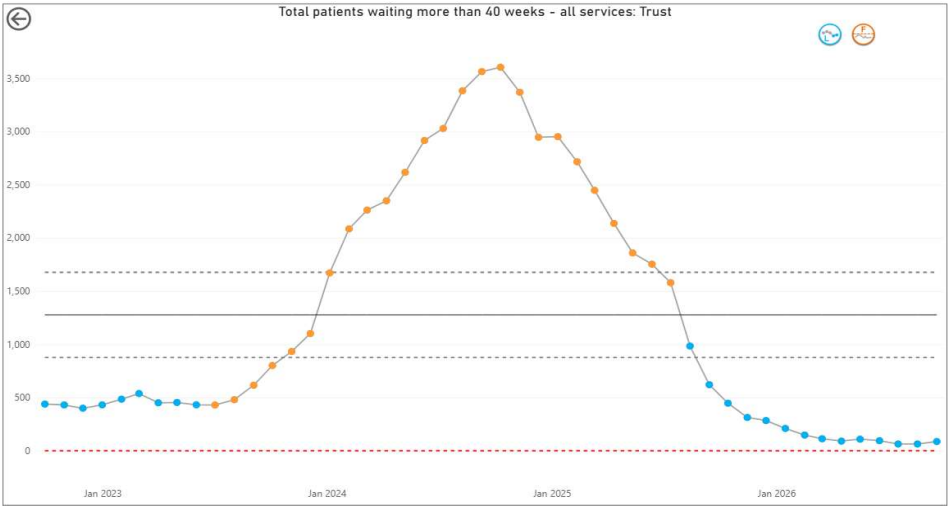
Exception Report - Action Plan

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	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
40+ Week waits - All services	Number	91	109	95	64	64	87	87
	Target	0	0	0	0	0	0	0

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



Reason for performance gap:

Performance has deteriorated this month, 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

Recovery performance is slightly off trajectory, with August delivering 87 waits against a planned trajectory of 80. 56 of the waits exist within CDC and this has grown by 33 since July position.

There are other services that contribute to not meeting this target, including Diabetes, Adult Physio, Community Neuro Rehabilitation, Community Nursing, Continence Specialist Nursing, MSST, Pulmonary Rehab, Wheelchair Services.

		Start Date	End Date	Status	Outcome
	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 recovery 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	September 26 Update Procurement of additional outsourced CDC capacity is progressing, with a phased increase in activity commencing from the final week of September. Locum Community Paediatrician capacity has been secured from late September and early October to support waiting list recovery and delivery of the March 2027 trajectory. Recruitment of temporary Speech and Language Therapy capacity remains challenging due to national workforce pressures associated with SEND reforms; however, active recruitment and sourcing activity continues to maximise opportunities to secure additional resource and further strengthen recovery where possible. August 26 Update Funding has been secured, procurement has been completed, and outsourced capacity has been commissioned to commence in September. To further strengthen resilience and sustainability, an insourcing model is also being developed and scoped to provide greater operational flexibility and additional capacity options. Both approaches will run in parallel to ensure the immediate recovery plan is not delayed while creating a more robust long-term model. July 26 Update Plans remain on track for outsourcing 160 appointments worth of activity to commence at the end of August. Preparatory work has been completed, and the Trust is currently awaiting a review/signoff from the Procurement Team to ensure full compliance with procurement regulations and governance requirements before progressing.
	Secure additional locum Community Paediatrician capacity to support recovery of waiting lists at both the front and back end of the pathway, prioritising timely access for new referrals whilst accelerating the reduction of long-wait cohorts. This will provide short-term resilience against workforce gaps, increase clinical assessment capacity, and support delivery of the Trust's waiting list recovery trajectory.	Aug-26	Mar-27	On Track	September 26 Update Whilst the initially identified locum unexpectedly withdrew prior to commencement, the service responded quickly to mitigate impact on recovery plans. Two replacement locums have now been secured, providing a combined 1.6 WTE additional capacity, with one commencing on 21 September and the second on 1 October. This additional resource will strengthen capacity at both the front and back end of the pathway, supporting new referrals, accelerating reduction of long waits and improving resilience against workforce gaps. The phased introduction of this capacity is expected to support recovery towards the Trust's waiting list trajectory and provide a more sustainable platform for ongoing service improvement. New Action Locum provision identified and recruitment processes underway, with additional consultant capacity being mobilised

Action Plan	Plan to join the Community Paediatrician services with the children's CDC to reduce duplication, streamline clinical pathways and improve capacity to reduce waits.	May-26	Sep-26	On Track	September 26 Update Community Paediatrics and the Children's CDC now operating under a single Service Lead, providing unified oversight of capacity, demand and pathway performance. Planning is underway for a whole-service redesign commencing this autumn, focused on aligning assessment criteria, streamlining pathways and reducing duplication between services. To support recovery during the transition, additional capacity is being secured through locum, insourcing and outsourcing arrangements, ensuring waiting list improvement can continue whilst the new service model is developed and implemented. August 26 Update CDC recovery has resumed following July's action application, with performance improving by approximately 5 percentage points from 40.86% to 45.39%, returning to a position comparable with May. A dedicated improvement and recovery workshop has been planned focusing on application of access criteria, pathway redesign and improved utilisation of available capacity. Community Paediatrics locum cover and ongoing recruitment efforts to maintain recovery momentum. July 26 Update Service Lead overseeing both services is now identifying opportunities for closer working and has identified some areas of initial focus to improve flow between the services. Resource is now being reviewed pan service to be more flexible to demand
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	Accelerate the rollout of Patient Initiated Follow Up (PIFU) across all appropriate Children's Services pathways, supported by standardised clinical criteria, workforce training and digital self-referral processes through support from planned care division who have achieved high PIFU across MSK pathways	Aug-26	Mar-27	On Track	September 26 Update PIFU implementation is progressing as planned. Staff training has now been completed, supported by learning from the high-performing MSK pathways and the existing Planned Care teams. Identified Children's Services pathways will go live with PIFU from mid-September, supported by agreed clinical criteria, performance monitoring and shared learning arrangements. New Action PIFU training led by planned care with all staff and performance shared with all leads to support an improvement trajectory
	Dental: Formalise agreed demand and capacity requirements with SaTH and secure recurrent theatre and elective hub capacity to support delivery of the RTT long-waits recovery trajectory and sustainable waiting list recovery.	Aug-26	Dec-26	On Track	September 26 Update Capacity was delivered during August for ad hoc theatre lists. SCHT and SaTH teams worked together to streamline the booking of patients resulting in better collaboration and understanding of requirements. Weekly meetings continue whilst the development of a sedation suite at PRH continues. New Action Weekly meetings with SaTH who are aware of requirement for an additional 8 slots a week. Ad hoc sessions provided through June and July to blitz long waits and plan is by end of Summer post theatre estates moves for SaTH to confirm regular capacity and dates.

Author	Gemma McIver /Helen Cooper/Alex Critchell	Date	09/09/2026	
Accountable Officer Approval	Claire Horsfield		15/09/2026	

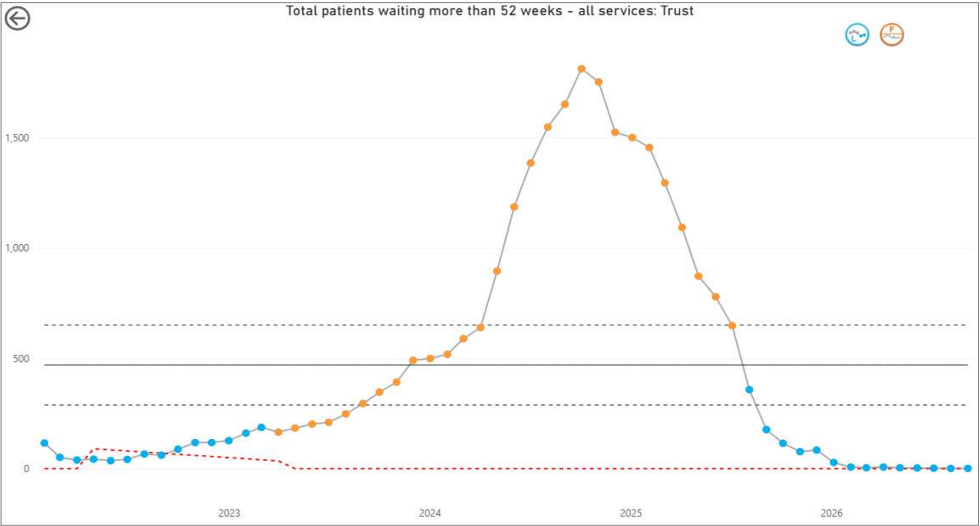
Exception Report - Action Plan

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	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
52+ Week waits - All services	Number	7	4	3	2	1	1	1
	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 has been triggered by 1 DQ issue. 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	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.		Start Date	End Date	Status	Outcome
			Jun-26	Sep-26	Complete	August 26 Update Meetings have been scheduled for the census review July 26 Update Dates are being arranged for the census review while PTL continues as a weekly focus
Author	Gemma McIver		Date	09/09/2026		
Accountable Officer Approval	Claire Horsfield			15/09/2026		

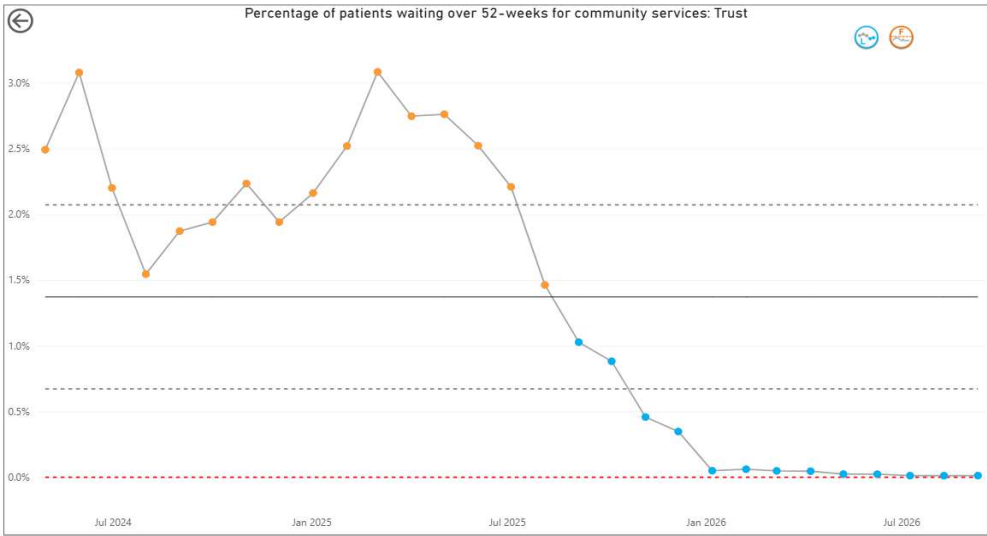
Exception Report - Action Plan

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	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
Percentage of patients waiting over 52-weeks for community services	%	0.05%	0.02%	0.02%	0.01%	0.01%	0.01%	0.01%
	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 has been triggered by 1 DQ issue. The issue was rectified ahead of the SITREP submission but still shows here as part of the performance snapshot. 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	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.		Start Date	End Date	Status	Outcome
			Jun-26	Sep-26	Complete	August 26 Update Meetings have been scheduled for the census review July 26 Update Dates are being arranged for the census review while PTL continues as a weekly focus
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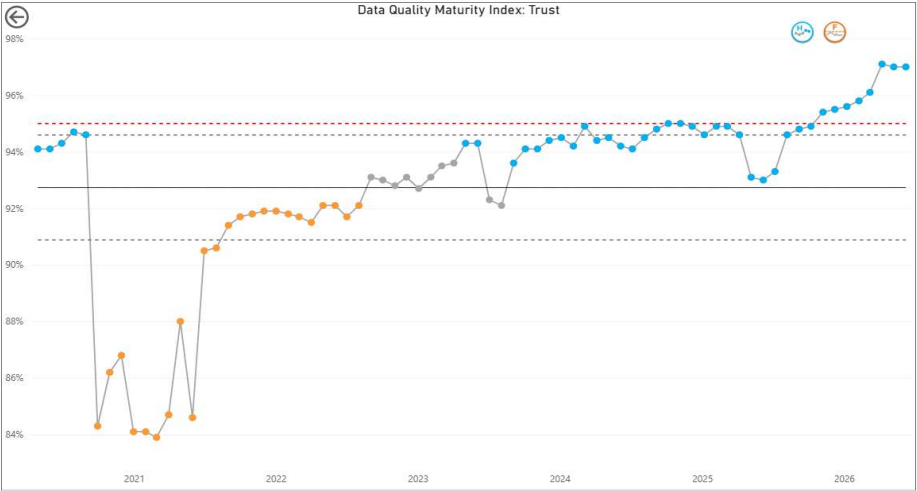
Exception Report - Action Plan

Data Quality Maturity Index

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

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
DQMI	%	95.6%	95.8%	96.1%	97.1%	97.0%	97.0%	97.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

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



Reason for performance gap:	The target for DQMI is 95%. Performance is static for May with the target still being exceeded at 97% which is the same as April performance.
	Recent improvement in MIU data items and clinical coding continues, with MIU Acuity & Chief complaint improving from 87% in July to 91% in Aug. The requirement continues to be to ensure this achievement is maintained and improved upon 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 of 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. The DAST have made a number of enhancements to front end Rio reporting, in order to assist staff in being able to proactively update data items.
	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
	Area 1A - Ethnicity: Service specific review where capture is not improving	Oct-25	Oct-26	On Track	September 26 Update Overall trust performance remains static at 81%. Some areas in C&F have remained static due to the impact of school holidays period. Impact of MAVIS Go Live to be explored. Significant increase noted for Diabetic Nursing where improvement has increased from 80% in July to 97% in Aug. August 26 Update Overall trust performance is at 81% valid ethnicity recorded in July, up from 80% in June. Amongst this there have been vast improvements in some of the Adult Community Services, including Continence Nursing that is now at 96% and where a recovery plan is having the desired effect. There has also been a huge improvement at Whitchurch Outpatients (circa 20 percentage points) so shared learning to be taken to the other outpatient units in order to implement the same processes. DAST and Information Team have developed an Ethnicity slide deck, which has been communicated out to all staff, focussing on the why, what and how, plus links to Rio reports that can help staff improve the position. A monthly long Ethnicity focus is also in place for August, with weekly comms out via the Viva Engage system, to keep staff thinking in the ethnicity space for the full month July 26 Update Robust improvement plans are in place to address data quality performance within the Children, Young People and Families (CYP&F) Division. Performance Clinics are being implemented across services to provide focused oversight of underperforming areas in relation to Data Quality. Across all Divisions data quality and a specific drill down to ethnicity recording is an established standing agenda item at the monthly performance meeting item to ensure regular review, challenge and accountability from Divisional leads. Compliance and improvement trajectories will be monitored through these forums, with clear accountability for areas that do not demonstrate the expected rate of improvement. In addition, the Information and DAST teams are jointly developing a targeted communications programme to support staff understanding of ethnicity and spoken language recording requirements. This will include guidance and access to national mapping tools to assist with the accurate interpretation and recording of ethnicity information received through GP referrals using READ Codes and SNOMED CT codes.
	Area 1B - Spoken Language Service specific review where capture is not improving	Aug-26	Apr-27	On Track	September 26 Update CYP&F are picking up as standing item. Progress hindered over school holiday period. The impact of shared learning as noted last month to be monitored and reviewed in coming months New Action Trustwide performance is slowly improving, particularly evident in Adult Community Services where the overall position across a number of services has pushed towards 50% populated, from circa 20%. Reports have been developed to provide ability to monitor at service level and front end Rio reports have been developed to support services in taking this forward. CYP&F division to ensure this is also picked up as standing item at performance meeting Whitchurch Outpatients have improved by 40 percentage points to 98% and so shared learning to be taken to the other outpatient units in order to implement the same processes.

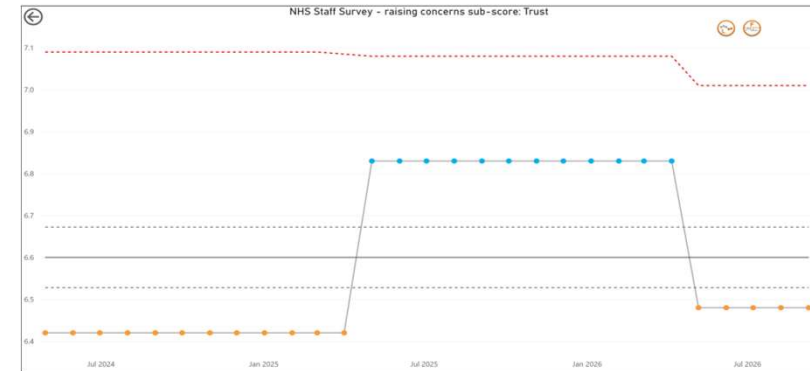
Action Plan	School Nursing Shropshire & Telford - Ethnicity Improvement has failed to continue and so target work required to embed the plan	Jan-26	Apr-26	Off Track	September 26 Update Remains a standing agenda item at performance meeting. Impact of school holidays to be taken into account. Continue to monitor and review next month in September. August 26 Update Performance has remained static in July. Standing agenda item at performance meeting has been implemented and discussed for the 1st time in July. This is a bi-monthly meeting and so improvements will be monitored in September to assess impact. July 26 Update 4% improvement in Shropshire to 72%, Telford has remained static. CYP&F Performance meeting is taking place mid July (as bi monthly) so will be discussed as standing item. Performance clinics also being established with each service lead, where DQ will also be discussed. EPR supplier have asked that request for change in functionality for Pupil Upload to be raised on user forum, to gather support from other trusts.
	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	September 26 Update Procurement process ongoing August 26 Update SaTH procurement process ongoing July 26 Update SaTH currently procuring and Shrop Comm aligning identified CYP and dental as pilot sites once products are agreed.
	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 Now extended to April 2027	Off Track	September 26 Update Performance reporting continues to be cascaded through team leaders and operational teams, with ongoing check and challenge processes reinforcing the importance of accurate ethnicity recording. To strengthen oversight further, the Service Lead will work directly with line management to ensure appropriate support and accountability arrangements are in place for reception staff responsible for data collection August 26 Update Performance static in July. Check and challenge discussions will be held with receptionists, following the same process for CSM and Team Leads, to embed requirements on checking patients in. DAST Comms will be highlighted to all staff and directed to read and implement use of reports to help monitor and improve towards 90% across all services. July 26 Update Although the overall target has not yet been achieved, performance is gradually moving in the right direction, with significant improvements seen in DAART and OPAT and 77.02% valid ethnicity recording in June across UEC services. Whilst overall compliance remains off track, there has been notable improvement in key services: •DAART: Improved from 65% (April) to 77% (June) •OPAT: Improved from 69% (April) to 78% (June) The immediate focus is to build on this progress, embed accountability at Team Lead level, and sustain improvement across all services to accelerate progress towards the 90% compliance target.

	Area 2 - 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	September 26 Update Performance has improved for Acuity and Chief Complaint to 91% in Aug which represents a significant improvement. Focus is now on sustaining improvment. August 26 Update Performance improved to 80% in June, but has dipped slightly to 74% in July for Acuity and Chief Complaint. Need to ensure that the focus on improvement doesn't drop off and so CSM to continue the check and challenge across all sites, but particular focus on Ludlow with new team lead who will meet with some new starters to ensure they are aware of the requirement July 26 Update Performance down to 64% in May, from 70% in April. New team lead now in position to support the team to improve compliance and CSM to continue weekly support.
	Area 3 - 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	Off Track	September 26 Update The rolling 12-month position has improved significantly from 957 to 772, demonstrating that the targeted recovery approach is having a positive impact. Adult Community Services continue to show sustained improvement, reducing from 299 to 249 in August. Whilst challenges remain within Children, Young People and Families services, particularly Health Visiting and School Nursing, where progress has been affected by the school holiday period, focused recovery actions remain in place. August 26 Update Position has deteriorated from rolling 12 month position of 816 to 957, with particular issue in CYP&F. Unoutcomed Appts reports are now being sent directly to service leads, so that accountability sits at their level. UEC performance has dropped very slightly in June. Specific process issue in DAART needs investigation, around doctor reviews and contacts being left open. Divisional lead to review this urgently, ensuring a clinical safety focus, to ensure this is dealt with appropriately Adult Community continues to improve from 370 in May to 299 in June, with particular improvement in Community Nursing from 189 to 82 July 26 Update Reduction in unoutcomed appointments across rolling 12 months at May 26 has shown real improvement of circa 1100 clearance, leaving approx 800 remaining. Further clearance required to a desired level, but evidence of focus showing impact
	Area 4 - 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	Apr-27	On Track	September 26 Update Data item being developed currently to enable service level reporting. August 26 Update Data Item to allow monitoring of this item is being developed into reporting flows, to enable a view at service level, in line with Ethnicity and Spoken Language. Rio front end report will also be developed during the next month July 26 Update Review took place in June, with clinical and information input, list available to select from has been streamlined and is with DAST for configuration in Rio in week commencing 13th July, with associated comms to be cascaded through divisional leads. Monitoring of impact to be analysed in coming months
Author	Gemma Mclver /Helen Cooper/Alex Critchell	Date	09/09/2026			
Accountable Officer Approval	Claire Horsfield	Date	15/09/2026			

Exception Report - Action Plan

NHS Staff survey- Raising Concerns Sub - Score

KPI Description	Latest 6 months	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
NHS Staff survey- Raising Concerns Sub - Score	Points	6.5	6.5	6.5	6.5	6.5	6.5	6.5
	Target	7.0	7.0	7.0	7.0	7.0	7.0	7.0



Narrative/Description:	The 2025 survey results are publically published, of 13 'community' Trusts Shropshire's result was the second lowest. Average rate: 7.01, Shropshire 6.48, lowest 6.4. The rate continues to be lower in 2026 than our target (7.0), we continue to embed the PSIRF approach to incident management and support a culture of openness and transparency around reporting. We also note that True North metrics- recommending SCHT as a place to work and being happy with the standard of care for friends/family are below the national averages: 59.82% would recommend SCHT as a place to work (national average 66.68%), 70.65% are happy with the standard of care provided (national average 75.16%) This should be read alongside the organisation-wide culture work being led by the People Team; the actions below focus specifically on quality, safety, speaking up, staff involvement in PSIRF learning responses and closing the feedback loop, rather than duplicating the wider culture programme. The Trust continues to embed PSIRF, strengthen Freedom to Speak Up visibility and promote an open culture where concerns are raised, listened to and acted upon. Staff are encouraged to access Staff Zone guidance and training on incident reporting and management, including shared learning from completed learning responses and distributed Permissions to Pause. Development and implementation of DCIQ will further support feedback to reporters, including lessons learnt and actions taken.				
on Plan		Start Date	End Date	Status	Outcome
	Visit high scoring comparable trusts to identify learning (SH)	Jul-26	Sep-26	In Progress	
	Release of DCIQ incident module (LR)	Jan-27	Mar-27	In Progress	This system will give us additional ability to feedback to reporters directly from the incidents they have submitted, including detailed lessons learnt and actions taken.
	Use speaking up intelligence and triangulate with patient safety incident data to identify cultural risks and potential barriers to psychological safety. (DB)	Jul-26	Aug-26	Complete	Strengthen FTSU reporting through Patient Safety Committee (PSC). FTSU reports contained triangulated information and went through PSC July 26.
	Map current PNA capacity and promote the established PNA network (TB)	Aug-26	Sep-26	Complete	

Acti	Implement the PSIRF staff feedback questionnaire via MS Forms for staff who participate in learning responses and a separate questionnaire for staff who lead PSIs; review themes at PSIP/PSC (AF)	Jul-26	Aug-26	Complete	Completed and included in PSC report for August. Re-survey to take place in 6 months time.
	Undertake analysis of the 2025 Staff Survey raising concerns domain by team/service to identify the lowest scoring teams and any common themes; triangulate with FTSU and incident reporting data. (DB)	Jul-26	Aug-26	Complete	Top 10 teams identified that were lowest scoring in this domain - FTSUG has arranged individual team sessions.
	Hold targeted listening events or focus groups with the lowest scoring teams in the raising concerns domain to understand barriers and co-produce two to three local actions with managers and staff. (DB)	Aug-26	Oct-26	In Progress	
Author	Lindsey Regan Senior Governance Manager and Sarah Hoyes - Interim Deputy Director of Nursing & Quality	Date	22/09/2026		
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	Date	22/09/2026		

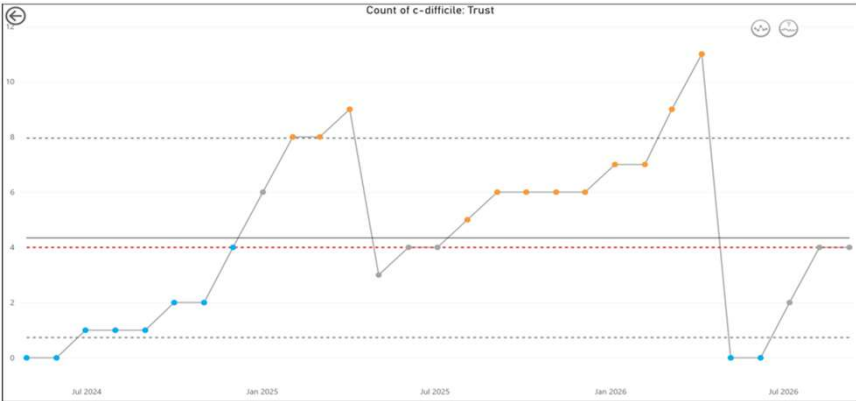
Exception Report - Action Plan

Count of Clostridioides difficile infections

Cumulative number of c-difficile incidents, financial year to date

KPI Description	Latest 6 months	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
C.difficile infections	Count in month		0	0	2	4	4	4
	Threshold Target		4	4	4	4	4	4

Trajectory	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Number	0	0	0	0	0	0	0



Narrative/Description:	There have been no cases of C. Difficile reported for the month of August.																																																																
	Two cases of C.difficile were reported in July 2026, one at Bishop's Castle Community Hospital and the second at Whitchurch Community Hospital, this is classed as a 'relapsed' case, having tested positive in SaTH over 28 days previously, and was tested again at WCCH on the advice of the Gastroenterology team. The two cases reported in June; Bridgnorth and Ludlow cases were discussed at the monthly HCAI Meetings. Key learning was the need for clearer visibility of antibiotic history on transfer and earlier discussion with IPEAT, need for system of local assurance/checks of equipment cleanliness and re-visit/re-launch on-line C.diff training aimed at Medical and Senior Nursing staff.																																																																
	The SPC chart demonstrates the cumulative number of C.difficile incidents, financial year to date. 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. A joint CDI thematic review with SATH is planned to understand themes across the patient pathway. 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.																																																																
	CDI by SCHAT Community Hospital over last 12 months Number of CDI (allocated to SCHAT) Whitchurch Ludlow Bridgnorth Bishops Castle <table><tr><td>Aug-25</td><td>1</td><td></td><td></td><td></td></tr><tr><td>Sep-25</td><td></td><td></td><td></td><td></td></tr><tr><td>Oct-25</td><td></td><td></td><td></td><td></td></tr><tr><td>Nov-25</td><td></td><td></td><td></td><td></td></tr><tr><td>Dec-25</td><td>1</td><td></td><td></td><td></td></tr><tr><td>Jan-26</td><td></td><td></td><td></td><td></td></tr><tr><td>Feb-26</td><td>2</td><td></td><td></td><td></td></tr><tr><td>Mar-26</td><td>1</td><td>1</td><td></td><td></td></tr><tr><td>Apr-26</td><td></td><td></td><td></td><td></td></tr><tr><td>May-26</td><td></td><td></td><td></td><td></td></tr><tr><td>Jun-26</td><td></td><td>1</td><td>1</td><td></td></tr><tr><td>Jul-26</td><td></td><td></td><td></td><td>1</td></tr></table>					Aug-25	1				Sep-25					Oct-25					Nov-25					Dec-25	1				Jan-26					Feb-26	2				Mar-26	1	1			Apr-26					May-26					Jun-26		1	1		Jul-26				1
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	Start Date	End Date	Status	Outcome																																																													

Action Plan	Create visual aids (videos or posters) on how to clean key pieces of equipment (i.e. beds)	Jun-25	July 2026 November 26	In progress	On recent audit over 10 types of bed in use across all 4 sites. Beds have now been standardised. The Clinical Education Team have arranged skills days aimed at HCA's, where IPEAT deliver training on how to dismantle a bed and commode and clean it. Bishop's Castle training due early August and Bridgnorth in September, Ludlow and Whitchurch have already been completed. IPEAT are finalising work on a picture guide of how to dismantle and clean a bed and commode, once approved this will be rolled out at the beginning of August. Date aligned to Group IPC Improvement Plan
	Use of AAR template / poster to disseminate and embed learning across Community Hospitals	Sep-25	04/12/2025 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	June 2026 August 2026	Complete	All roles and responsibilities have been mapped, and shared with all Community Hospitals. IPEAT met with Locality Managers on 23/07/26, to discuss the Housekeepers job roll and agree the scope of their work. IPEAT will now work to develop a training session and work folder for each HK
	Mark prescription chart of patients at risk of C. difficile infection to highlight need to select antimicrobials with care.	Apr-26	Jul-26	Complete	Following review by Lead Pharmacy Tech of the at risk patients, it was felt that almost every patient would fall into this category and marking prescription charts would not be effective. SaTH Discharge Medicines Service have shared standard letters which they send to the GPs of CDI positive and carrier patients on discharge. Pharmacy to request they are included on SaTH weekly Lab list and discuss and consider introducing a similar process.
	Using the newly formed template share and disseminate key learning from CDI thematic reviews from 25/26	May-26	Jul-26	Complete	
	SCHT to introduce standard letters to the GPs of CDI positive and carrier patients on discharge. Pharmacy to request they are included on SaTH weekly Lab list and discuss and consider introducing a similar process.	Jul-26	Sep-26	In progress	Pharmacy Team have now been added to the mailing list from the Labs. SaTH have shared the letters with us and currently considering if and how this can be incorporated in the community hospitals.
	Relaunch of C.diff online training aimed at Medical and Senior Nurses on wards to raise awareness and compliance with identification and treatment/management	Jul-26	Sep-26	In progress	Link to training re-circulated
Author	Sharon Toland, Lead IPC Nurse Clare Walsgrove, Head of Quality Excellence	Date	17/09/2026		
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	Date	22/09/2026		

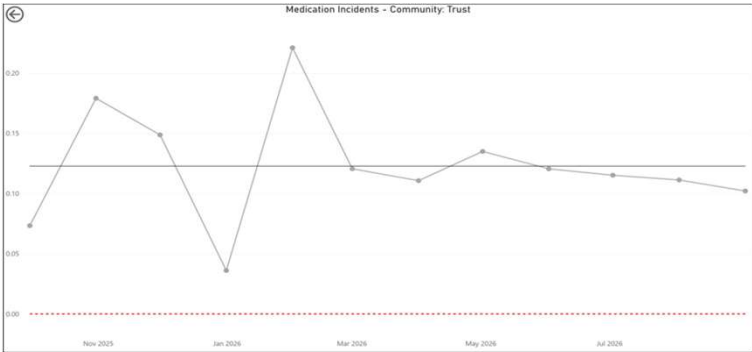
Exception Report - Action Plan

Medication Incidents with harm per 1000 community contacts

Rate of medication incidents causing harm per 1000 community contacts

KPI Description	Latest 6 months	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Current Month
Rate of medication incidents causing harm per 1000 community contacts	%	0.11	0.13	0.12	0.12	0.11	0.10	0.10
	Target	0	0	0	0	0	0	0

Trajectory	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Number	0	0	0	0	0	0	0



Action Plan	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 August 2026. Rate of medication incidents causing harm per 1000 community contacts is a new KPI and the SPC chart shows an improving picture.				
		Start Date	End Date	Status	Outcome
	MSO to liaise with education team regarding re-implementation of insulin documentation booklet	Sep-24	30/06/2026 August 2026	Complete	Following extensive time periods of review and trial in multiple areas the insulin booklet was not re-implemented as it was felt this did not enhance patient care or safety and increased staff work load.
	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

	Review and update of inpatient medicines administration chart		Apr-25	Dec-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. Due to MSO mat leave and interim MSO in place in March request to extend deadline to Dec 26 to enable assistance with project.
	Diabetes page on staff zone to be populated as resource for staff		Nov-25	Oct-26	In Progress	Sally Stubbs escalated request to diabetes Team 1/8/26
Author	Clare Walgrove - Head of Quality Pam Simmons - Interim Medicines Safety Officer		Date	22/09/2026		
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community		Date	22/09/2026		

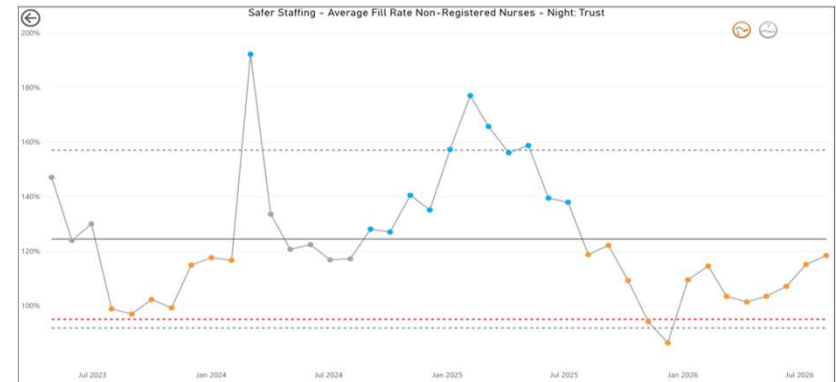
Exception Report - Action Plan

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

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

KPI Description	Latest 6 months	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	YTD
Safer Staffing	%	101.0%	103.0%	107.0%	107.0%	115.1%	118.0%	103.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Narrative/Description:	Bishops Castle - 97% Bridgnorth - 165% Ludlow - 119% Whitchurch - 99%					65% due to 27 shifts for ETOC care - due to
Action Plan		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	
	National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete		
	Review of Enhanced Supervision policy and behaviour charts to allow for more timely step down	Mar-25	01/09/2025-30/11/2025	Complete	Policy has been approved by PSC	
	Quality Improvement Project/ETOC following peer review	Apr-25	Sep-25	Complete	ongoing work with the ETOC programme continues	
	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	Meeting with the Memory and Wellbeing worker on the 15/10/25. JD reviewed and updated.	

	Review of shift patterns for inpatient areas		Apr-25	Jul-25	Complete	Shift patterns reviewed and QEIA completed
	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 closed at JNP and now teams working to implement change which will be around September/October when rotas change
	Use of NHSP as national bank to increase number of HCSW available to reduce reliance on agency		Jan-26	Mar-26	Complete	NHSP is live and we are seeing a few HCSW book with us through this route
Author	Tracie Black, Associate Director of Workforce Education and Professional Standards	Date	17/09/2026			
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community		22/09/2026			

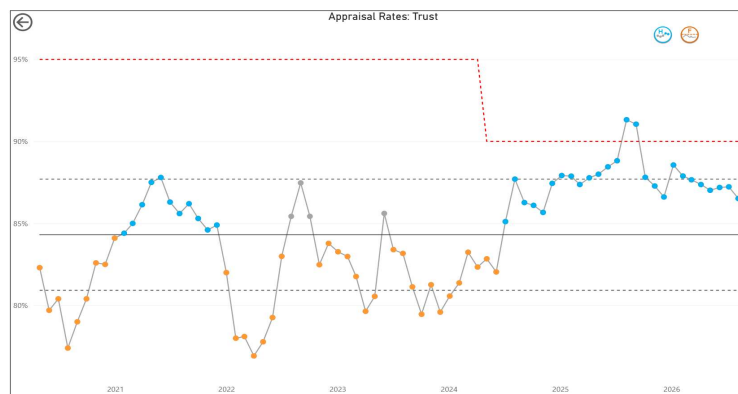
Exception Report - Action Plan

Appraisal Rates

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

KPI Description	Latest 6 months	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
Appraisals	%	87.37%	87.02%	87.19%	87.23%	86.52%	87.65%	87.21%
	Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Trajectory	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
%	90.00%	90.00%	91.00%	91.00%	91.00%	91.00%	92.00%



Reason for performance gap:	Appraisal compliance declined slightly month on month from January to April 2026, before improving in May and June. This was followed by a small reduction in July and a further improvement in August. Monthly appraisal reports continue to be shared with managers, providing visibility of records that are out of date in ESR. The current priority is to agree recovery plans with the services reporting the lowest completion rates, with outstanding appraisals scheduled for completion by the end of October, except where exceptional circumstances apply. Alongside this, managers are being supported to complete appraisals before each employee's anniversary date so that compliance is maintained within the 12-month requirement. Progress is monitored through regular oversight, targeted support, alerts and reminders. Work also continues to ensure completed appraisals are recorded accurately in ESR and reflected in the overall compliance rate.				
Action Plan	Action	Start Date	End Date	Status	Outcome
	Adults community Services Division: Operational Lead will commence check and challenge in July which will cover all workforce KPI's. 85.9% Whitchurch inpatients increased to 92.1%. Hot spots are Bridgnorth inpatients 15 people non compliant and Ludlow inpatients 11 non compliant, BCCH 94.1%, South East (6 non compliant) and North Shropshire (11 people non compliant) are community hot spots - Divisional manager linking in with Team Leaders to get assurance that appraisals are completed asap for those non compliant, 37 will become outstanding in September, 4 logged incorrectly.	Jun-26	Aug-26	Completed	To ensure there is oversight of appraisals and Team Leaders are held to account and complete their appraisals
	Review pay progression cases where progression has been approved despite required standards not being met, such as mandatory training and appraisal compliance.	Aug-26	Mar-27	On track	Ensure appraisals are completed and planned in
	Adults Community Services: Compliance increased from 85.59% in June to 86.43% in July. Current hotspots are Bridgnorth Hospital Hotel Services, Bridgnorth Inpatients and South East Community Nursing. Nine appraisals have been recorded incorrectly in ESR. The ESR representative will provide the Operational Leads for South East and Bridgnorth with appraisal status reports for review and to support completion. Due to staff absence, alternative arrangements will be put in place to ensure appraisals for Bridgnorth Hospital Hotel Services are completed. The Operational Lead will also ensure that all incorrectly recorded appraisals are corrected in ESR.	Aug-26	Oct-26	On track	Ensure appraisals are completed and planned in
	ESR to develop a video of how to add appraisals to ESR, this will be communicated via comms and also on the Staff Zone for individuals to review	Jun-26	Dec-26	On track	To ensure that appraisals are logged accurately
	Review of 30 60 90 day compliance and raise awareness of the conversation tools available	Apr-26	Mar-27	On track	To ensure individuals are receiving the relevant support when they commence with the organisation
	Planned Care; Stoke Heath 4 appraisals in July logged but great improvement overall from June. Need to plan for expiring ones within Stoke Heath so don't fall into non-compliance each month. Current focus is on stability of the service. Dental input on those due to expire this will be focused on, Operational Lead to reach out to Dental Lead for a recovery plan. Stoke Heath 84% compliant with 3 outstanding. Work has been undertaken since last month. Dental 5 outstanding lead to undertake. Sickness of appraiser has affected this.	Aug-26	Oct-27	On track	Ensure appraisals are completed and planned in

	Urgent and Emergency Care: Appraisal compliance continues to improve, reaching 84.79% in August. There are currently 33 outstanding appraisals, with completion dates agreed for all cases; eight are scheduled for September. The Operational Lead will continue to monitor progress and work with hotspot areas to ensure appraisals are completed. Records from the previous month will be reviewed to confirm that completed appraisals have been entered correctly. The Operational Lead will also meet with Team Leaders and Clinical Service Managers to understand the reasons for the remaining non-compliance and improve forward planning for appraisals approaching expiry. During the previous month, 26 appraisals were completed, comprising 14 that were already non-compliant and 12 that were due to expire.	Jun-26	Oct-26	On track	Ensure appraisals are completed and planned in
	Urgent & Emergency - anyone expired the Team Leaders will be tasked to send last years appraisal paperwork with the blank template and appraisals to be scheduled in for September and October - Operational lead will oversee	Aug-26	Nov-26	On track	Ensure all appraisals are completed and planned in
	Provide Senior Leaders in Urgent Care and Adult Community Services with monthly appraisal completion reports, enabling Clinical Service Managers and other operational leaders to maintain oversight and take timely action where required.	Aug-26	Mar-27	On track	Ensure that Operational leaders are aware of the number of appraisal completions in month
	Shropshire Children and Young People's Services and Dudley: Non-compliance in Dudley was initially reported for 16 staff and has since reduced to 15. A further nine staff within Children and Young People's Speech and Language Therapy remain non-compliant. Temporary management arrangements are in place, and the Operational Lead will follow up all outstanding appraisals to support their prompt completion.	Aug-26	Oct-26	On track	Ensure appraisals are completed and planned in
Author	Fiona MacPherson	Date	17/09/2026		
Accountable Officer Approval	Rhia Boyode	Date	24/09/2026		

Division	Team (hotspot areas are teams with 10 or more staff members with compliance of less than 81%)	Appraisals Required	Appraisals In-Date	% Compliance	Hotspot since:
825 Service Delivery Group - Adult Community Services Division	825 Bridgnorth Hospital Hotel Service	12	7	58.33	Jun-26
825 Service Delivery Group - Adult Community Services Division	825 South East Shropshire Community Nursing Service	28	14	50.00	Jan-26
825 Service Delivery Group - CYP&F Shropshire Services Division	825 Childrens Speech and Language Therapy Service	38	29	76.32	Aug-26
825 Service Delivery Group - Planned Care Division	825 Community Neuro Rehabilitation Service	15	11	73.33	Aug-26
825 Service Delivery Group - Urgent Care Division	825 MIU Service	26	20	76.92	Sep-25
825 Service Delivery Group - Urgent Care Division	825 Virtual Wards Service	56	43	76.79	Sep-25

SDGs and Divisions	Assignment Count	Reviews Completed	Reviews Completed %	
825 Digital Division	43	43	100.00	↑
825 Finance, Strategy and Estates Division	32	29	90.63	↑
825 Governance Division	20	17	85.00	↓
825 Infection Prevention and Control Division	4	3	75.00	↔
825 Medical Division	4	3	75.00	↓
825 Medicines Management Division	15	14	93.33	↓
825 Nursing and Quality Division	14	12	85.71	↔
825 Nursing and Workforce Management Division	4	3	75.00	↓
825 Operations Directorate Management Division	12	8	66.67	↓
825 People and OD Division	26	21	80.77	↑
825 Safeguarding Division	12	12	100.00	↑
825 Service Delivery Group - Adult Community Services Division	596	522	87.58	↑
825 Service Delivery Group - CYP&F Dudley Services Division	139	124	89.21	↑
825 Service Delivery Group - CYP&F Shropshire Services Division	353	317	89.80	↑
825 Service Delivery Group - Planned Care Division	202	175	86.63	↑
825 Service Delivery Group - Urgent Care Division	217	184	84.79	↑
825 Trust Board Division	8	4	50.00	↔

Previous month	Assignment Count	Reviews Completed	Reviews Completed %
825 Digital Division	45	42	93.33
825 Finance, Strategy and Estates Division	32	31	96.88
825 Governance Division	19	17	89.47
825 Infection Prevention and Control Division	4	3	75.00
825 Medical Division	3	3	100.00
825 Medicines Management Division	15	15	100.00
825 Nursing and Quality Division	14	12	85.71
825 Nursing and Workforce Management Division	4	4	100.00
825 Operations Directorate Management Division	12	10	83.33
825 People and OD Division	25	19	76.00
825 Safeguarding Division	11	11	100.00
825 Service Delivery Group - Adult Community Services Division	597	516	86.43
825 Service Delivery Group - CYP&F Dudley Services Division	141	125	88.65
825 Service Delivery Group - CYP&F Shropshire Services Division	351	312	88.89
825 Service Delivery Group - Planned Care Division	204	175	85.78
825 Service Delivery Group - Urgent Care Division	214	171	79.91
825 Trust Board Division	8	4	50.00

Exception Report - Action Plan

Sickness Rate - 12 month rolling

Percentage of staff absent over a rolling 12-month period

KPI Description	Latest 6 months	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
Sickness Rate	%	5.73%	5.69%	5.68%	5.71%	5.77%	5.78%	5.78%
	Target	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

Trajectory	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
%	5.60%	5.50%	5.50%	5.50%	5.40%	5.40%	5.40%



Reason for performance gap:	Absence remains above the 4.75% target; however, the rolling rate has been broadly stable, with only small movements since March 2026. Although long term absence is the higher proportion of absence, short-term absence is increasing and remains a key area of focus. Stress, anxiety and depression continue to be the principal causes of absence.					
	The People Team has strengthened oversight by issuing monthly short-term absence trigger reports to managers, together with clear guidance on the required actions. Compliance with the Managing Attendance Policy is being monitored, and targeted support is being provided to help managers intervene promptly and manage cases consistently. Reviews in Bridgnorth Inpatients and South East Community Nursing identified further actions relating to absence management and completion of supporting documentation; implementation is under way and progress will continue to be monitored.					
	Two absence management masterclasses were delivered to Community Team Leaders in August and September, reinforcing expectations and building management capability. Improvement work is focused on three priorities: 1. Implementing a new approach to sickness absence support. 2. Developing a Group Belonging and Wellbeing Plan. 3. Using digital innovation to strengthen sickness absence management.					
	Completion of the NHS Sickness Absence Toolkit is supporting this programme by embedding early intervention, compassionate support and positive working environments that promote staff wellbeing and help prevent avoidable absence. These measures provide a clear framework for oversight and improvement, although sustained management action will be required to reduce the rate towards target.					
	Action	Start Date	End Date	Status	Outcome	
	A new approach to sickness absence support - 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	Oct-26	On track	To confirm adherence to Trust policy and deliver tailored support to Team Leaders and Clinical Services Managers	
	Adult Services: A monthly check-and-challenge process, led by the Operational Lead with the Locality Clinical Managers with HR support, has been in place since July to provide assurance that sickness absence is being managed effectively. Discussions will now take place with the newly appointed Divisional Lead to confirm and strengthen the division's governance arrangements for ongoing oversight of absence management.	Sep-26	Nov-26	On track	Implement a governance framework that ensures there is oversight of people metrics including absence	
	Adult Services: Monthly review meetings have been arranged between the Associate Director of Professional Standards, the People Team and the Operational Lead to consider individual long-term absence cases and ensure appropriate support is in place. Central and North West have been identified as hotspots for short-term absence, and the relevant Team Leaders have attended the absence management masterclass to strengthen local management practice. The in-month absence rate increased slightly from 8.4% in July to 8.5% in August, comprising a new hot-spot of 5.4% for long-term absence.	Aug-26	Oct-26	On track	Implement a process to ensure oversight and support for long term absence management	
	Adult Services - Data Analyst to review absence data for Whitchurch Hospital In patients to establish whether the current management of absence is having an impact on absence rates	Jul-26	Sep-26	Completed	To establish whether the oversight that has been implemented at Whitchurch is having an impact on absence	
	Adult Service - Data Analyst to analyse absence data for any trends, hot spots etc for adult services	Jun-26	Aug-26	Completed	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	

Action Plan	Digital innovations to support sickness absence Explore digital solutions to support Line Managers in timely management of attendance in line with the Managing Attendance policy. This includes a review of eroster to establish absence management capabilities and other digital solutions and also explore Goodshape a digital solution that helps manage absence and provides measurable outcomes	May-26	Oct-26	On track	To provide Line Managers with tools to support the timely management of absence
	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	Nov-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 - May 6.22 % rolling absence, in month 6.02% in month - June 6.44% in month, long term 4.27% July in month 5.8% short term 1.8%. August in month 5.1% (2.89% short term 2.21%) Long term 4.27% provide data to Operational Lead to ensure they have oversight of the absences and absence triggers information. Operational Lead to remind CSM's to ensure relevant paperwork is completed. Operational Lead to liaise with Team Leaders to ensure appropriate support in place for long term absence, implement check and challenge from end of July for Operational Lead to gain assurance that absence is being supported and other workforce KPI, discuss absence at check and challenge	Jun-26	Aug-26	Completed	To ensure appropriate support and management is in place for absence management
	Data team to provide reports on long and short absence to look at hot spots teams for absence	Sep-26	Mar-27	On track	Strengthened organisational assurance through consistent and effective absence management, timely intervention and sustained action to improve attendance and staff wellbeing.
	ESR team to raise with national ESR team to see whether it is possible to add bereavement as an absence reason on ESR	Aug-26	Nov-26	On track	To ensure absence is clearly recorded
	Reinstate workforce KPIs discussion with HR, Professional standards and Operational Lead before the Performance workshop	Aug-26	Sep-26	Complete	Ensure oversight of absence
	Children and Young People's Services – Shropshire and Dudley: Continue to oversee the management of short-term absence, providing assurance that cases are managed consistently and in accordance with the Managing Attendance Policy. In Dudley, long-term absence is 2.5% and short-term absence is 2.4%. In Shropshire, the overall absence rate is 3.0%, comprising 1.9% long-term and 1.2% short-term absence.	Aug-26	Nov-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
	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.	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.
	Develop a Group Belonging & Wellbeing Plan 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	Nov-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. On hold at present	Feb-26	Jul-26	Paused	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.
	Actions to be implemented from Programme Board are as follows: - Flow chart on sickness absence management shared with Team Leaders - Publicise HWB support available - Review the staff risk assessment form - Confirm the list of good and hotspot areas and any specific leaders that we could 'buddy-up' – for sharing with operational leads - Continue, and if possible extend, the masterclasses we are already doing – confirm and report uptake	Aug-26	Nov-26	On track	To support the reduction of absence
	Complete the NHS sickness absence self assessment toolkit	Jun-26	Nov-26	On track	The toolkit emphasises early intervention, compassionate support and the creation of positive working environments that promote staff health and prevent avoidable absence.

	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	17/09/2026				
Accountable Officer Approval	Rhia Boyode	Date	24/09/2026				

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	307	387	12,135.76	35.8
S12 Other musculoskeletal problems	142	166	3,932.13	11.6
S13 Cold, Cough, Flu - Influenza	611	747	2,583.74	7.6
S98 Other known causes - not elsewhere classified	182	207	2,446.06	7.2
S25 Gastrointestinal problems	455	576	2,219.43	6.6
S11 Back Problems	86	105	1,866.12	5.5
S26 Genitourinary & gynaecological disorders	105	131	1,538.51	4.5
S17 Benign and malignant tumours, cancers	21	23	1,153.49	3.4
S30 Pregnancy related disorders	40	104	988.05	2.9
S28 Injury, fracture	55	56	969.92	2.9

Org L6	Absence FTE	Available FTE	Absence FTE % ▲ ▼
825 PCN Pharmacy Service	27.20	99.00	27.47%
825 Dudley CYP&F Management Services	95.60	492.20	19.42%
825 Whitchurch Hospital Inpatients Service	2,270.69	14,528.89	15.63%
825 Communications and Marketing Service	106.00	730.00	14.52%
825 South East Shropshire Community Nursing Service	1,392.05	10,129.21	13.74%
825 Outpatients Admin Service	326.00	2,455.27	13.28%
825 Enhanced Care Home Service	490.72	3,843.32	12.77%
825 Safeguarding Service	489.67	3,970.67	12.33%
825 Single Point of Referral Service	286.16	2,429.76	11.78%
825 Research and Development Service	191.40	1,694.00	11.30%

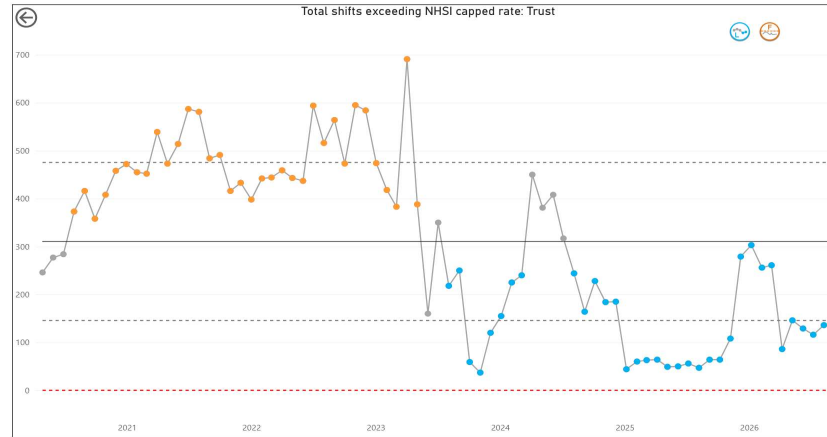
Exception Report - Action Plan

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	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD
Shifts	Number	114	146	129	116	136	138	132
	Target	0	0	0	0	0	0	0

Trajectory	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27
%	136	130	130	125	120	115	105



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 has been undertaken. Review of UEC services taking place so recruitment may be affected until this has been agreed. Stoke Heath has a 2 days a week to ensure cover over 5 days and for safety of clients. Plan to reduce once post recruited to once budget conversations with finance and taken place				
Action Plan	Action	Start Date	End Date	Status	Outcome
	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. 15/06/2026: 5 applicants have been invited to interview on 24/07/2026. 11/8/26: Offered to 1 HCS who later withdrew. Working with ops manager on readvertising. 17/09/2026: Pilot of Centralised bank across CHs & MIUs commenced.
	Expansion of UEC: medical staffing reviewed requirement for Consultant, Medical model reviewed	Oct-25	Jan-27	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. 09/7/26: Draft paper in consultation with staff and Dep Director of Ops. 11/8/26: Proposed 8 WTE medical posts for the service to be hosted/employed by SaTH. Date to be agreed once recruitment has taken place. May include jds to Royal College. 17/9/26: Virtual Ward Medics have been extended to the end of November. Review of the medical provision within UEC: medics to be recruited and employed by SaTH. Extension of end date to account for recruitment process.
	Safe service issue in Stoke Heath - locum agency in place - Review at the end of August.	Aug-26	Sep-26	On Track	11/8/26: Safe service for clients. Agency for 2 days to increase service across 5 days. 17/9/26: Locum extended to end of November - review of medical provision taking place.
	Locum consultant managing wait lists gap in September a gap awaiting a replacement	Jun-26	Mar-27	On Track	09/07/26: Ops manager to review of how working to ensure lists are managed appropriately to completion. 11/8/26: Continues to cover sickness and wait lists and now a new vacancy. Recruitment to vacancy to commence. Amended end date to reflect the medical consultant recruitment process. 17/9/26: No update.
Author	Gina Billington	Date	17/09/2026		
Accountable Officer Approval	Rhia Boyode	Date	24/09/2026		

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



Our Moving to Excellence Ambition

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

Task ID	Task <i>The tasks you need to complete to produce the deliverables</i>	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 and were reviewed and approved at the HTPAC meeting in September 2026, and will now be submitted to the	On Track

Task ID	Task <i>The tasks you need to complete to produce the deliverables</i>	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.				Board of Directors for approval. Governance arrangements continue to strengthen through the Group Local Care Transformation Assurance Committee established in June 2026, with terms of reference agreed at June 2026 private Board. Its first meeting was held on 26 June 2026 and subsequent meetings are held monthly. The Quality Committee in Common will meet on 1 October 2026 to consider its Terms of Reference and revised annual cycle of business for approval.	
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	Matthew Neal	Already started	31/03/2027	- The HTP Assurance Committee provides regular oversight of delivery of the Hospitals Transformation Programme. HTP Assurance Committee reports were presented to the public Board in May and August 2026. - Delivery remains in progress through these established governance and assurance arrangements. The September 2026 Workforce and Leadership Plan confirms that bed templates have been revised from 747 to 949 beds, with workforce templates being updated to reflect the revised bed model. - Informal engagement has commenced across all impacted areas, supported by a staff survey to identify staff who may not intend to move site including concerns relating to travel and car parking arrangements, and the support they may require. - Targeted communications and the proposed shuttle bus are being progressed in response to staff concerns about travel and car parking. Workforce models and templates for nursing, therapies and specialist nurses have been defined, and the medical workforce gap analysis against the 2025/26 model, including staffing numbers and costs, has been completed.	On Track

Task ID	Task <i>The tasks you need to complete to produce the deliverables</i>	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
	milestones and key interdependencies. - Correspondence or briefing notes provided to system partners (e.g., ICS, NHSE) demonstrating ongoing assurance. - Updated Terms of Reference or governance flow diagrams where relevant, showing the HTP Assurance Committee's role in oversight.				Informal staff consultation has also been completed. Planned cross-site moves remain scheduled for 18 and 19 March 2028.	
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 (execs only, as NHSE deals with NED appointments) - 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. Non-Executive Directors: A significant plan has been devised which will see the recruitment of two new NEDs (envisioned to be Audit Chairs, one for each of SaTH and SCHAT) to be in place by end October 2026 after 15th October interviews. Ongoing arrangements have been made so that outgoing NEDs from SCHAT (mainly due to long service) will be superseded by SATH NEDs becoming Group NEDs – interviews with NHSE / ICB Chair and Group Chair took place in June 2026. Currently, arrangements ongoing with NHSE for formal appointments being complete by January 2027. Group leadership appointments: The Group Chief Nursing Officer interviews were held on 3 March 2026, following which an appointment was made. The Group Leadership	On Track

Task ID	Task <i>The tasks you need to complete to produce the deliverables</i>	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
					Team has now been appointed. The Group Executive Team has been in place for approaching six months and now includes the Group Chief Digital Officer.	
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. • The minutes confirming approval of the Terms of Reference (and therefore the membership). • Group Transition Committee papers (agenda, minutes, packs)	Anna Milanec	01/09/2025	31/12/2027 (pending confirmation of appointment of group members)	The Group Transition Committee (joint with SCHAT) 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. Shared leadership arrangements are now across Therapies and Radiography. The Quality Committee in Common will meet on 1 October 2026 to consider its Terms of Reference and revised annual cycle of business for approval.	On Track
SaTH 4.2.8	Further develop and embed the workings of the Group People Committee held in Common 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 Group People Committee held in Common meets every two months. The first Group People Committee held in common meeting was held on 24 November 2025, followed by a further meeting on 26 January 2026. The Committee is developing well and has provided valuable learning to support other committees moving to arrangements in common. The People Committee and annual cycle of business was reviewed with the Group Chief People Officer and team in June 2026 and continues to be developed.	On Track

Task ID	Task <i>The tasks you need to complete to produce the deliverables</i>	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
SaTH 4.2.9	Implement an Accountability and Governance Group Framework for setting out shared principles, objectives, and ways of working of the two providers working together (SaTH and SCHAT). 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 SCHAT 23/09/2025 and ongoing, with meetings held in public and private. The 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 have been submitted as evidence and confirm that the Committee is overseeing the Group governance workstream. This includes the alignment of key governance documents; development of an annual Group cycle of business and a common committee template; arrangements for committees to operate jointly; development of the Group operating model; and work towards a shared Board Assurance Framework and risk appetite.	On Track
4.2.13	- Develop and implement the Freedom to Speak Up (FTSU) group model. - Promote the FTSU group model through consistent communications so that all staff receive clear and aligned messaging. 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)	Anna Milanec Jenny Fullard	01/04/2026	31/12/2026	Implementation of the Group model - Implementation of the Group FTSU model is progressing. Weekly meetings are taking place between the SaTH and SCHAT FTSU Guardians to support resilience, shared learning and operational alignment. The FTSU Champion networks have been merged across the Group, joint training has been provided, and the first Group FTSU Champion meeting was held on 24 September 2026. Four joint Champion training sessions are planned during the year, with joint messages already being circulated to SaTH and SCHAT Champions. Communications and policy development - A Group FTSU communications plan is in development to provide consistent messaging across both organisations. SaTH has recruited 50 FTSU Champions, and communication activity includes Impact Magazine, Cascade,	On Track

Task ID	Task <i>The tasks you need to complete to produce the deliverables</i>	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
					Chatterbox, digital screens, posters and the FTSU intranet page. - The refreshed SaTH FTSU/Whistleblowing Policy has completed consultation through WPPG, JNCC and the Policy Assurance Group and approved at ARAC on 7 September Boards and will go to Boards in Common in October 2026. - Work remains ongoing to finalise and fully implement the Group FTSU model and aligned communications approach.	
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	- The FTSU Improvement Plan 2026–2028 has been refreshed following the November 2025 NHSE review. It incorporates all 26 NHSE improvement suggestions alongside outstanding actions from the 2024/25 plan, MIAA audit recommendations and local improvement priorities, with accountable owners, timescales, progress and BRAG status recorded. - Delivery is monitored through the established quarterly reporting route to ARAC and the Trust Board. Progress includes implementation of Group resilience arrangements, merged Champion networks, quarterly improvement stories, strengthened training-compliance reporting and Board visibility of the improvement plan. - Remaining actions continue to be progressed through 2026–2028, including the Group communications approach, leadership visibility, evaluation of awareness and training impact, data triangulation and consideration of a follow-up review within 12–18 months.	On Track

Task ID	Task <i>The tasks you need to complete to produce the deliverables</i>	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
4.2.15	Further to the review of the SFI's/ Standing Orders/ SoRD at both organisations during 2025, align SaTH and SCHAT Standing Financial Instruction's, Standing Orders and Scheme of Reservation and Delegation. Evidence will include: - Baseline comparison document - Agreed aligned versions (draft & final) - Confirmation of approval in minutes (Audit & Risk or Board)	Anna Milanec Deborah Bryce and Shelley Ramtuhul	01/04/2026	31/03/2027	- SaTH's Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation were reviewed and approved by the Board in January 2026, providing the SaTH baseline for this work. - Alignment with the equivalent SCHAT documents is being progressed during 2026/27 with further updates due to be presented to Board for approval in Q4.	On Track
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 SCHAT. 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 SCHAT is scheduled for consideration. Group strategic objectives agreed by the Boards in July 2026 (in private). The Boards in Common approved the Group strategic pledges, 2030 objectives and True North metrics in August 2026. These will inform development of the Group Board Assurance Framework whilst also initially maintaining the Provider BAFs (SCHAT / SATH).	On Track
			BRAG Status Completed and Evidenced On Track At Risk Off Track			

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



Our Moving to Excellence Ambition

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

Workforce						
Task ID	Task	Task Owner	Start Date	End Date	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 on e-rostering. The Activity Manager module has been purchased, project resource commenced in July 2026, and the implementation plan is now monitored through the Medical Workforce Efficiency Programme.	On Track
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.	On Track
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 - Governance minutes from Strategic People Group monitoring	Simon Balderstone	1/2/2026	30/09/2026	Job planning programme for 26/27 launched with workshop and launch event.	On Track

Workforce						
Task ID	Task	Task Owner	Start Date	End Date	Updates	RAG Progress Status
SaTH 2.1.30	Staff engagement strategy to be developed and implemented to support preparations for HTP/development of a group model. 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	- Informal engagement has commenced across all areas affected by HTP. - A local staff survey has been developed to help managers understand how many staff do not intend to move site and identify the support they may require. - The HTP Toolkit is available online, has been shared through SaTH communications and issued to Change Agents for wider dissemination. - A business case for a cross-site shuttle bus is being progressed, with implementation planned for spring 2027. - HTP moves are planned for 18 and 19 March 2028.	On Track
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	- Bed templates have been revised from 747 to 949 beds, and workforce templates are being updated to reflect the revised bed modelling. - Revised workforce templates were due to be finalised by 31 July 2026. The revised workforce model is being costed and reconciled with the operational plan by 31 August 2026. - A paper seeking Executive agreement of the bed numbers and staffing templates is scheduled for 9 September 2026, with final workforce numbers due to be confirmed for inclusion in the 2027/28 Operational Plan by 23 September 2026. - Feedback from informal engagement will be used to finalise workforce, recruitment	On Track

Workforce						
Task ID	Task	Task Owner	Start Date	End Date	Updates	RAG Progress Status
					and staff retraining plans by 30 September 2026. • An informal redeployment process will be established, and areas requiring additional organisational development support will be identified, by 30 September 2026. • Job plans will be updated to support HTP changes by 1 April 2027. • Formal consultation is planned to commence through JNCC no later than 31 August 2027 and close no later than 6 December 2027. • Handover of B60 for simulation and team familiarisation is planned for September 2027. ITU and Acute Medicine at RSH are scheduled to move to B60 in October 2027, with the remaining cross-site moves planned for 18 and 19 March 2028.	

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 continues to be monitored through SIIP and system assurance arrangements.	On Track

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	• The sickness absence programme outline has been drafted, and a proposal/business case is being developed for a digital sickness management platform	On Track
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.	On Track

Workforce						
Task ID	Task	Task Owner	Start Date	End Date	Updates	RAG Progress Status
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. 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	TG/ RA/ SF	01/9/2026	31/03/2027	- The Trust is working with Higher Education Institutions and continues to strengthen education pathways and develop new clinical and vocational roles, including (ACP) and apprenticeships aligned with the strategic workforce plan. - HEI 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	On Track
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 (HWP) 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	DT	01/04/2025	31/03/2027	- The cultural transformation programme has a Group-wide focus. Poppy's Promise was launched as a pilot in July 2026. - A Board Development Day was held on 21 May 2026. A Kind Life facilitated a session at the Group Leaders Forum on 30 April 2026. 'In Your Shoes' sessions were also undertaken with A Kind Life, during which patient stories were captured. - The listening exercises with Aqua and the associated thematic review have been	On Track

Workforce						
Task ID	Task	Task Owner	Start Date	End Date	Updates	RAG Progress Status
	• OD intervention reports and outcomes • Health and well-being activity data • Staff Survey action plan progress • Reward and Recognition outputs • Quarterly People Pulse reports and improvements in scores • Papers submitted to Strategic People Group / Group People Committee in Common • Approved Group communication and engagement plan Staff engagement materials & feedback				completed. Aqua will attend the Group People Committee in September 2026. • The Leadership Framework is also being reviewed as part of the wider culture programme. The listening exercise was extended until the end of August 2026.	
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.	On Track

Leadership						
Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Progress Status
Deliverable Metric 5.3: Demonstrate collaborative decision-making at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system.						
SaTH 5.3.3	Ensure robust monitoring and oversight of delivery of all SaTH's IIP via appropriate governance and operational structures (includes ward to board) 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	CEO SaTH	In progress	31/03/2027	Robust monitoring and oversight of SaTH's Integrated Improvement Plan (SIIP) is in place through a clearly defined governance framework. Delivery is monitored through the Board Assurance Committees and escalated to the Board of Directors through regular reporting. Ward-to-Board assurance is strengthened through PMO scrutiny, Moving to Excellence (M2E) transformation oversight, executive escalation routes and alignment with NHS England's bi-monthly PRM assurance processes.	On Track

Leadership											
Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Progress Status					
<i>Deliverable:</i> <i>The outputs that you need to produce to demonstrate delivery of exit criteria</i>		Deliverable Metric 5.4: SaTH's contribution to a clear system culture and leadership improvement programme and evidence of a positive shift in staff experience through pulse survey/NHS staff survey.									
SaTH 5.4.2	Ensure Executive participation in the Executive Directors Development programme including initiating dialogue on shared expectations and collaborative leadership through STG. 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 12-month Executive Directors' Development Programme. Structured sessions have supported dialogue on shared expectations and collaborative leadership through the System Transformation Group (STG). Delivery has been formally reported and signed off through the People Committee and Board governance arrangements and the approach has been carried forward into 2026/27 to sustain system-wide collaborative leadership	On Track					
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 report was presented to the Strategic People Group in August 2026. The 2026 NHS Staff Survey is due to launch in September 2026. The Quarterly Management Survey (QMS) also includes the two advocacy questions on a regular basis.						
		<table><tr><th>BRAG Status</th></tr><tr><td>Completed and Evidenced</td></tr><tr><td>On Track</td></tr><tr><td>At Risk</td></tr><tr><td>Off Track</td></tr></table>					BRAG Status	Completed and Evidenced	On Track	At Risk	Off Track
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***

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.

Task ID	Task <i>The tasks you need to complete to produce the deliverables</i>	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 30/11/2026	Evidence will include: - Annual refresh and triangulation complete in line with annual planning submission. - Final plan submitted 12/02/2026	

Task ID	Task <i>The tasks you need to complete to produce the deliverables</i>	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 - Updated plan for FY27/28 agreed at Board in August.	
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	31/03/2027	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 <i>The tasks you need to complete to produce the deliverables</i>	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	

Task ID	Task <i>The tasks you need to complete to produce the deliverables</i>	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
					Committee (ARAC) where external audit 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, safe data storage and data analysis to meet the Trust's reporting needs and responsibilities, and processes for promoting and optimising data quality						
SaTH 1.5.1	Work with external partners to develop and implement new arrangements for information collection, storage and analysis to support timely and accurate reporting.	Helen Ainsbury	Ongoing	~~30/06/2026~~ ~~31/08/2026~~ 31/10/2026	Evidence will include: - BAU income reporting resumed through FAC - FAC report and minutes - ACM and PLD reporting reinstated with Commissioners	
SaTH 1.5.2	BI to provide data quality assurance on data flows.	Ria Powell	Ongoing	31/03/2027	Evidence will include: Minutes of Data Quality Workgroup	

BRAG Status
Completed and evidenced
On Track
At Risk
Off Track

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



Our Moving to Excellence Ambition

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Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
	<i>The tasks you need to complete to produce the deliverables</i>					
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 recovered slightly in July 2026 to 89% compared to 87.9% in June 2026. Utilisation of the service reduced slightly to 17.2%. Streaming workshops continued throughout July 2026 to increase confidence in streaming and awareness of the UTC criteria.	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	Enhanced consultant availability has been agreed to support improved access and advice for primary care colleagues. From August 2026, increased Paediatric senior clinical cover will be in place to strengthen decision-making, facilitate timely specialist input and support the development of more direct referral pathways from primary care. The extended model provides opportunities to work with the ICS to refine referral criteria, optimise access arrangements and reduce avoidable attendances where appropriate.	On Track
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	ED non-admitted 4-hour performance improved in July 2026 to 62.1% compared to 61.4% in June 2026. Feedback has been received from Nexus Consultancy on 4-hour non-admitted performance and workshops with the wider ED team took place in August 2026. A new process has been designed for walk-in patients; the process aims to reduce wait-to-be-seen times and the time taken to request diagnostics. Early testing has demonstrated positive feedback and results.	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 now working in collaboration with the Service Improvement Team to ensure that the roll out of the QMS methodology at a ward level includes relevant culture drivers aimed at supporting an overall improvement to the percentage of colleagues who would recommend the Organisation as a place to work.	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 saw a further increase in July 2026 to 146. 14+ day LOS patients increased to 204 and 21+ day LOS patients also increased to 118 compared to the previous month. Nexus Consultancy have shared recommendations regarding reducing the number of patients in our hospitals with no criteria to reside at ward level. The ward-level improvement work focuses on standardising discharge processes; ensuring the consistent use and review of expected dates of discharge; identifying and escalating patients with no criteria to reside at an earlier stage; strengthening therapy and multidisciplinary input; and using bridging and community pathways to support discharge. This work is being progressed through the Nexus improvement programme.	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	A live data quality app is now in place and issues are raised with the BI team when they arise. Previous data quality issues raised by ICB colleagues are now fully resolved.	At Risk

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 continues to remain stable within its improved state. In June 2026, 69.8% of patients were assessed within 15 minutes with an average time of 14 minutes. Both hospital sites remain above the England mean in terms of performance and are also situated within the upper quartile of performance in England. As initial assessment performance has remained in a sustained state of improvement for over 12 months, this action is proposed as "Complete and Evidenced". The Section 31 condition relating to Initial Assessment has now been lifted by the CQC following a sustained period of improvement in performance. Evidence: Initial Assessment data	Complete and Evidenced
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	Average ambulance handover time in July 2026 was 38.5 minutes against an operational target of 55 minutes.	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 teams have committed to implementing the Trust's Quality Management system, so that there can be a strong focus on improving the response rate of receiving a referral, triaging and progressing to assessment within 24 hrs, with an expected performance of over 75%.	On Track
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BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

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 commenced reporting into UECTAC. 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 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. This action was reviewed following feedback from 360 auditors with additional evidence of conitued compliance with SBL uploaded onto Monday.com.	13/07/21	15/07/21	14/09/21	H. Flavell	A. Lawrence	Monday.com

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

PROGRESS AS AT 08.09.2026
APPENDIX ONE
FIRST OCKENDEN REPORT ACTION PLAN

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

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

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

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4.88	Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.	Y	10/12/20	31/03/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	07/12/21	30/06/23	11/07/23	H. Flavell	A. Lawrence	Monday.com
4.89	The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice'.	Y	10/12/20	31/01/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	30/09/23	12/09/23	H. Flavell	G. Dashputre	Monday.com
4.90	The Trust must ensure appropriately trained and appropriately senior/experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.	Y	10/12/20		Not Yet Delivered	Not Started	Following a review of the 360 auditor findings, it was agreed at Sep-26's MNTAC that this action should revert to Not Yet Delivered while more robust evidence of implementation is devised and collated. New dates for implementation and assurance will be provided at Oct-26's MNTAC.				J.Jones	Y.Cheng	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		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	Delivered, Not Yet Evidenced	On Track	Following a review of the 360 auditor findings, it was agreed at Sep-26's MNTAC that this action should revert to Delivered, Not yet Evidenced while more robust assurance evidence is devised and collated. The team will upload examples of ombined notes in practice and conduct a new audit for assurance by Dec-26.	31/03/21	31/12/26		M.Morris	J.Plant	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		Not Yet Delivered	Not Started	Following a review of the 360 auditor findings, it was agreed at Sep-26's MNTAC that this action should revert to Not Yet Delivered while more robust evidence of implementation is devised and collated. New dates for implementation and assurance will be provided at Oct-26's MNTAC.				J.Jones	G.Kayello J.Brindley	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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IMMEDIATE AND ESSENTIAL ACTIONS (IEA): To improve Care and Safety in Maternity Services

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

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Immediate and Essential Action 2: Listening to Women and Families													
Maternity services must ensure that women and their families are listened to with their voices heard.													
2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Y	10/12/20	TBC	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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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. This action was reviewed at Sep-26's MNTAC following feedback from 360 auditors. Additional evidence was uploaded for more robustness demonstrating that quarterly education reports form part of the LMNS (now PQSG) cycle of business.	13/07/21	30/10/21	07/12/21	H. Flavell	W. Parry-Smith	Monday.com
3.2	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	30/06/21	10/08/21	H. Flavell	G. Calcott	Monday.com
3.3	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/08/21	30/09/21	10/08/21	H. Flavell	H. Flavell	Monday.com

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

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

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

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PROGRESS AS AT 08.09.2026

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

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

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

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PROGRESS AS AT 08.09.2026

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	Delivered, Not Yet Evidenced	Not Started	Following a review of the 360 auditor findings, it was agreed at Sep-26's MNTAC that this action should revert to Delivered, Not Yet Evidenced while more robust assurance evidence is devised and collated. New dates for assurance will be provided at Oct-26's MNTAC	08/11/22			M.Morris	A.Sizer	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		Not Yet Delivered	Not Started	Following a review of the 360 auditor findings, it was agreed at Sep-26's MNTAC that this action should revert to Not Yet Delivered while more robust evidence of implementation is devised and collated. New dates for implementation and assurance will be provided at Oct-26's MNTAC				M.Morris	J.Atkinson	Monday.com

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

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

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

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

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

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

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Local Actions For Learning Theme 11: Diabetes Care													
14.32	The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.	Y	30/0322	30/11/23	Evidenced and Assured	Completed	This action was accepted as back 'on track' at Jul-24's MTAC as funding was allocated to the business case. This action is currently Off Track. Recruitment 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 recruitment 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. This action was reviewed following comments from the 360 auditors. Additional audit evidence demonstrating sustained 100% compliance in 2024 and 2025 was uploaded for more robustness.	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	Delivered, Not Yet Evidenced	Not Started	Following a review of the 360 auditor findings, it was agreed at Sep-26's MNTAC that this action should revert to Delivered, Not Yet Evidenced while more robust evidence for assurance is devised and collated. New dates for implementation and assurance will be provided at Oct-26's MNTAC	08/11/22			M.Morris	S.Thacker	Monday.com

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

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

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

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

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

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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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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 journey 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	Descope (see exception report)	Action accepted as 'Descope'd 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 sufficient 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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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
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	Evidenced and Assured	Completed	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. This action was agreed as Evidenced and Assured at Jul-26's MNTAC.	09/01/24	31/6	14/07/26	P. Gardner	A. Lawrence	Monday.com
1.8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
1.9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/06/23	31/03/24	12/09/23	H. Flavell	A. Lawrence	Monday.com
1.10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/07/23	31/03/24	14/12/23	H. Flavell	C. McInnes, A. Sizer, A. Lawrence	Monday.com

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

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

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

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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	Delivered, Not Yet Evidenced	Not Started	Following a review of the 360 auditor findings, it was agreed at Sep-26's MNTAC that this action should revert to Delivered, Not Yet Evidenced while more robust evidence for assurance is devised and collated. New dates for assurance will be provided at Oct-26's MNTAC	11/04/23			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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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	28/02/27	Not Yet Delivered	On Track	Following a review of the 360 auditor findings, it was agreed at Sep-26's MNTAC that this action should revert to Not Yet Delivered while more robust evidence of implementation is devised and collated. A new Self Assessment will be completed and ratified by Feb-26 and provided to Board by Apr-27.		30/04/27		M.Morris	S.Thacker	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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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		Not Yet Delivered	Not Started	Following a review of the 360 auditor findings, it was agreed at Sep-26's MNTAC that this action should revert to Not Yet Delivered while more robust evidence of implementation is devised and collated. New dates for implementation and assurance will be provided at Oct-26's MNTAC				M.Morris	A.Sizer S.Thacker	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	Delivered, Not Yet Evidenced	On Track	Following a review of the 360 auditor findings, it was agreed at Sep-26's MNTAC that this action should revert to Delivered, Not yet Evidenced while more robust evidence for assurance is devised and collated. A new review with the MNVP will be undertaken by Mar-27.	10/01/23	31/03/27		M.Morris	S.Thacker	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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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 sufficient 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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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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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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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

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
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PROGRESS AS AT 08.09.2026

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

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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 sufficient 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
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

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11.7	Obstetric anaesthesia staffing guidance to include: The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/12/23	14/11/23	H. Flavell	J. Jones	Monday.com
11.8	Obstetric anaesthesia staffing guidance to include: Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/01/23	10/01/23	H. Flavell	J. Jones	Monday.com

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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

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

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

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

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

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Counts

Ockenden 1

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	27	2	1	24
IEA	25	2	0	23
Total	52	4	1	47
Percentage		8%	2%	90%

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
LAFL	27	2	1	0	0	24	0
IEA	25	0	0	0	0	23	2
Total	52	2	1	0	0	47	2
Percentage		4%	2%	0%	0%	90%	4%

Ockenden 2
Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	66	2	3	61
IEA	92	7	6	79
Total	158	9	9	140
Percentage		6%	6%	89%

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	3	1	0	0	61	1
IEA	92	2	5	0	0	79	6
Total	158	5	6	0	0	140	7
Percentage		3%	3.8%	0%	0%	88.6%	4.4%

Combined actions - Delivery status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	93	4	4	85
IEA	117	9	6	102
Total	210	13	10	187
Percentage		6.19%	4.76%	89.05%

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	5	2	0	0	85	1

Counts

IEA	117	2	5	0	0	102	8
Total	210	7	7	0	0	187	9
Percentage		3.3%	3.3%	0.0%	0.0%	89.0%	4.3%

Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

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

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. <u>Evidence Requirements for Assurance:</u> 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. <u>Evidence Requirements for Delivery:</u> Golden Hour Guideline - validated at Apr-24 Neonatal Governance Golden Hour Checklist - validated at Apr-24 Neonatal Governance <u>Evidence Requirements for Assurance:</u> 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. <u>Evidence Requirements for Delivery:</u> Intensive Care Days Audit - causes <u>Evidence Requirements for Assurance:</u> <u>Surveillance of ITU and HDU care days integrated into Network monitoring processes (Steering Group)</u> <u>Data points added to dashboard for ongoing monitoring</u>	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. <u>Evidence Requirements for Delivery:</u> Resuscitation Audit <u>Evidence Requirements for Assurance:</u> 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 recruitment of the FICare lead who will be essential to the embedding of this action. <u>Evidence Requirements for Delivery:</u> Family Integrated Care benchmark, gap analysis and action plan <u>Evidence Requirements for Assurance:</u> Family Integrated Care action plan fully implemented Family Integrated Care action plan audited Listed audits integrated into Forward Audit Plan	Immediate (0-3 months)	30/09/2024	08/10/2024	30/09/2026		Dr John Jones	CD's	Monday.com

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PROGRESS AS AT 08.09.2026
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 following delays in the implementation of Badgernet for neonates, changing the timeframe for green to Mar-27. <u>Evidence Requirements for Delivery:</u> NNAP review undertaken for latest available data through governance processes <u>Evidence Requirements for Assurance:</u> 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).	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. 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 Jun-26 and Oct-26 respectively. <u>Evidence Requirements for Delivery:</u> 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 <u>Evidence Requirements for Assurance:</u> 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)	30/06/2026	14/07/2026	31/10/2026		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. <u>Evidence Requirements for Delivery:</u> Training needs analysis Training plan for 2 day mandatory training Rosters and rotas demonstrating allocated time for training <u>Evidence Requirements for Assurance:</u> 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. <u>Evidence Requirements for Delivery:</u> Education Lead Job Description Education Lead in post <u>Evidence Requirements for Assurance:</u> Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/03/2025	08/04/2025	31/08/2025	08/04/2025	Paula Gardner	Julie Plant	Monday.com

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PROGRESS AS AT 08.09.2026
APPENDIX TWO
Neonatal External Mortality Review Action Plan

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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' <u>Evidence Requirements for Delivery:</u> Governance Lead Job Description Governance Lead in post <u>Evidence Requirements for Assurance:</u> 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. <u>Evidence Requirements for Delivery:</u> Family Integrated Care Lead Job Description Family Integrated Care Lead in post <u>Evidence Requirements for Assurance:</u> Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/08/2026		28/02/2027		Martina Morris	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. <u>Evidence Requirements for Delivery:</u> Infant Feeding Lead Job Description Infant Feeding Lead in post <u>Evidence Requirements for Assurance:</u> Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/03/2025	08/04/2025	31/08/2025	08/04/2025	Paula Gardner	Julie Plant	Monday.com

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NEMR6e/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Transitional Care Lead	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. <u>Evidence Requirements for Delivery:</u> Transitional Care Lead Job Description Transitional Care Lead in post <u>Evidence Requirements for Assurance:</u> Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	30/09/2025	13/01/2026	31/01/2026	11/08/2026	Martina Morris	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. <u>Evidence Requirements for Delivery:</u> Discharge Planning Lead Job Description Discharge Planning Lead in post <u>Evidence Requirements for Assurance:</u> 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 expection report with new timelines for recruitment bringing the new amber date to Nov-26 and green date to May-27. <u>Evidence Requirements for Delivery:</u> Safeguarding Lead Job Description Safeguarding Lead in post <u>Evidence Requirements for Assurance:</u> Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	30/11/2026		30/05/2027		Martina Morris	Julie Plant	Monday.com

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PROGRESS AS AT 08.09.2026 APPENDIX TWO Neonatal External Mortality Review Action Plan												
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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. <u>Evidence Requirements for Delivery:</u> IPC Leads in post - job sharing - 2 band 7s <u>Evidence Requirements for Assurance:</u> Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	28/02/2026	13/01/2026	30/06/2026		Martina Morris	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. <u>Evidence Requirements for Assurance:</u> 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 report 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. <u>Evidence Requirements for Assurance:</u> 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. <u>Evidence Requirements for Delivery:</u> 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) <u>Evidence Requirements for Assurance:</u> 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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PROGRESS AS AT 08.09.2026
APPENDIX TWO
Neonatal External Mortality Review Action Plan

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NEMR9	Team building should be undertaken to reflect on this review and enable the multidisciplinary team to identify actions. This should provide the following opportunities: a. For more junior nursing staff to develop effective working relationships with senior doctors on the unit and collaborate in projects to take the unit forward. b. To ensure debriefs, learning events, meetings, teaching and education aim for a multidisciplinary and multiprofessional theme to reflect the work environment and how care is delivered. c. To encourage psychological safety in ways of working, events, education and training, to ensure a safe space for colleagues to flag any concerns and worries.	Evidenced and Assured	Completed	Further to publication of the final report, a workshop has been held with the specialty clinical teams to discuss this recommendation. A number of actions were identified by the team that will be implemented to ensure this recommendation is delivered. Evidence of delivery will be provided to MNTAC in June 2025 followed by evidence of embedded practice by September 2025 in line with the timescale provided within the report. This action was agreed as 'Delivered, Not yet Evidenced' at Jul-25's MNTAC. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC. <u>Evidence Requirements for Delivery:</u> 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 <u>Evidence Requirements for Assurance:</u> 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. <u>Evidence Requirements for Delivery:</u> Planning in place to deliver recruitment trajectory - funding in place Leadership roles appointed to - email <u>Evidence Requirements for Assurance:</u> 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. <u>Evidence Requirements for Delivery:</u> Neonatal Leadership enrolled on SaTH leadership programmes <u>Evidence Requirements for Assurance:</u> 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. <u>Evidence Requirements for Delivery:</u> Integration of Neonates into MNTP Leadership and Specialist roles recruitment plans <u>Evidence Requirements for Assurance:</u> 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. <u>Evidence Requirements for Delivery:</u> PMRT Business Case including PMRT resources PMRT ToRs inc. externality requirement Agendas and Minutes from Quarterly Network Mortality meetings <u>Evidence Requirements for Assurance:</u> 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 <u>Evidence Requirements for Delivery:</u> 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 <u>Evidence Requirements for Assurance:</u> Ongoing compliance with PMRT and incidents reporting including monitoring of actions Monthly Quality and Safety updates to LMNS and network Clinical gems, 3 minutes brief, learning from excellence examples	Short Term (0-6 months)	30/09/2024	08/10/2024	31/05/2025	10/06/2025	Dr John Jones	CD's	Monday.com

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

PROGRESS AS AT 08.09.2026 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
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. <u>Evidence Requirements for Delivery:</u> CNST SA4 compliance for Years 4, 5, 6 Refreshed QIS trajectory - Jun-25 Staffinf papers demonstration QIS cover on shifts <u>Evidence Requirements for Assurance:</u> CNST year 7 compliance QIS compliance reached	Short Term (0-6 months)	31/06/2025	12/08/2025	31/01/2027		Dr John Jones & Martina Morris	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. <u>Evidence Requirements for Delivery:</u> Amended guideline and checklist <u>Evidence Requirements for Assurance:</u> 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 followoing delays in the implementation, changing the timframe for green tot Mar-27. <u>Evidence Requirements for Delivery:</u> Approved business case NNU EPR Decision for implementation of NNU EPR <u>Evidence Requirements for Assurance:</u> 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.

PROGRESS AS AT 08.09.2026
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
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 committed to implement any new system that is selcted by the network in future, at which time the action would be rescoped. <u>Evidence Requirements for Delivery:</u> Evidence of Engagement with network regarding cot locator provision (minutes and email exchanges) <u>Evidence Requirements for Assurance:</u>	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. <u>Evidence Requirements for Delivery:</u> Network exception reports - quarterly overview <u>Evidence Requirements for Assurance:</u> 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. <u>Evidence Requirements for Delivery:</u> Review of 18 cases completed Additional learning and QI plans presented at neonatal Governace <u>Evidence Requirements for Assurance:</u> Evidence of completed QI	Short Term (0-6 months)	30/09/2025	14/05/2026	31/12/2026		Dr John Jones & Martina Morris	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.
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PROGRESS AS AT 08.09.2026 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. <u>Evidence Requirements for Delivery:</u> Forward audit plan in place Quality Improvement plan in place Monthly dashboard with review of trends and themes <u>Evidence Requirements for Assurance:</u> 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. <u>Evidence Requirements for Assurance:</u> - 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 recruitment 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. <u>Evidence Requirements for Delivery:</u> Patient Experience Group - Neonates Nurse Specialist in post MNVP surveys and meetings Local Parent Advisor 'Champion' Benchmark against BAPM PIC standard - Gap Analysis <u>Evidence Requirements for Assurance:</u> 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				Martina Morris	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. <u>Evidence Requirements for Delivery:</u> Agenda and Minutes from Board BoD Neonatal Review appendix <u>Evidence Requirements for Assurance:</u> Evidence of progress being shared at agreed intervals - IMNR Nov-24/Jan/Mar/May-25)	Medium Term (6-12 months)	31/12/2024	14/01/25	31/05/25	10/06/25	Dr John Jones	J.Atkinson	Monday.com

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

Counts

NEMR

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
Actions	35	3	10	22
Total	35	3	10	22
Percentage		8.6%	28.6%	62.9%

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
Action	35	0	11	0	1	22	1
Total	35	0	11	0	1	22	1
Percentage		0.00%	31.43%	0.00%	2.86%	62.86%	2.9%

Glossary and Index to the Neonatal Mortality Review Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

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

Accountable Executive and Owner Index

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

Phase 2 batteries – Post Sep-26 MNTAC



Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Overall Delivery



62% (149) Not Yet Delivered
16% (38) Delivered, Not Yet Evidenced
22% (55) Evidence & Assured

Overall Progress



22% (55) Complete
45% (108) 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)	17% (5)	13% (4)	13% (4)	27% (8)	60% (18)
LMNS 3 Year Delivery Plan	4% (1)	46% (13)	50% (14)	50% (14)	46% (13)	4% (1)
Cultural Improvement Plan	92% (34)			5% (2)	3% (1)	3% (1)
CQC Neonates Action Plan	30% (3)	70% (7)		49% (18)	48% (18)	
Neonatal External Mortality Review	9% (3)	29% (10)	62% (22)	70% (7)	30% (3)	
Neonatal Unit Implementation Plan	9% (3)	29% (10)	62% (22)	62% (22)	32% (11)	3% (1)
CQC National Review	25% (1)	50% (2)	25% (1)	2% (1)	83% (39)	4% (2)
Phase 2 Internal Actions	80% (4)	20% (1)		25% (1)	75% (3)	11% (5)



Maternity Governance: August 2026

Agenda item			
Report Title		CNST MIS Year 8 - Progress Updates – August 2026	
Executive Lead		Martina Morris – Group Chief Nursing Officer	
Report Author		Stacey Thacker – Head of Midwifery Lauren Taylor – Deputy Head of Midwifery Cecile Pollitt – Project Manager	
CQC Domain:		Link to Strategic Goal:	Link to BAF / risk:
Safe	√	Our patients and community	√
Effective	√	Our people	√
Caring	√	Our service delivery	√
Responsive	√	Our governance	√
Well Led	√	Our partners	
Consultation Communication		Maternity Governance Committee Neonatal Governance Committee Divisional Committee Quality & Safety Assurance Committee Maternity & Neonatal Safety Champions LMNS PQSG Board of Directors	
Executive summary:		This paper evidences progress against Year 8 of the CNST Maternity Incentive Scheme as of August 2026. Work on evidencing compliance with Year 8 of the Maternity Incentive Scheme continues. This paper provides assurance of progress against each Safety Action and their sub-actions. Alert - At Risk - Safety Action E – Item 2: Maternity care Bundle Implementation This is a new requirement and remains At Risk. For completion, an action plan needs to developed with the help of local and system partners and then be agreed at board level. Whilst we remain confident that this action will be achieved within the required timeframe, it has been recorded as at risk pending the completion of key discussions and agreement with LMNS colleagues, Primary Care, and Digital Care partners which are essential to the full implementation of the bundle. The risk status will be reviewed following these meetings and confirmation of the implementation plan. Assure	

	- Mid-point compliance for Safety Action B which required the Trust to maintain 90% compliance for Multi-professional Obstetric Emergencies Training (PROMPT), Neonatal Resuscitation Training and Fetal Monitoring and Surveillance (in the antenatal and intrapartum period) has been achieved in July, which was the agreed period declared for the scheme. Advise - Work has started to complete a drill for the MOSS signal, as required by Safety Action F – item 2. - A CNST checkpoint with executives has been scheduled in September. - The date for the presentation to Board before sign off has been scheduled for February 11th 2027. - A dedicated folder for the evidence has been created and evidence is being collated ahead of the end of the reporting period.
Recommendations for the Committee:	Review and discuss this paper and its appendices, and advise the Head of Midwifery of any further detail required.
Appendices:	Appendix 1 – MIS Audit Tool – August 2026

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 Committee 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, 26 are In progress and On Track 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 sub-actions
A - Workforce and Capacity	0	0	7	0	0	7
B - Training	0	0	5	0	0	5
C - Learning from reviews and investigations	0	0	6	0	0	6
D - Service-user voice and equity	0	0	2	0	0	2
E - Care Bundles	0	1	2	0	0	3
F - Board oversight, governance, culture and leadership	0	0	4	0	0	4
Total	0	1	26	0	0	

3. Safety Actions Status

3.1. Safety Action A: Workforce and Capacity

3.1.1. A1 – Consultant Attendance

- **Status:** In Progress & On Track
- 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:** In Progress & On Track
- 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 but is not due yet.

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. Work has progressed in July and the refreshed format will be going through governance in August.

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. Work has progressed in July and the refreshed format will be going through governance in August.
- The most recent Birthrate+ report has been reviewed and staffing adjusted accordingly. A paper detailing the findings and changes has gone through governance channels and Board in June and July. This has been collated as part of the evidence for the scheme.

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. July's compliance with the data available in August was agreed as the mid-point timeframe. 90% Compliance has been achieved against July's data with an Interim report provided to August Governance.
- 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.
- The new guidance required a mid-point compliance check where the service would meet 90% ahead of the end of the reporting period. July's compliance with the data available in August was agreed as the mid-point timeframe. 90% Compliance has been achieved against July's data with an Interim report provided to August Governance.
- Additionally, the Neonatal Unit has assessed competency against the BAPM Neonatal Airway Safety Standards and developed an action plan to address all gaps by the end of the reporting period.

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.
- The new guidance required a mid-point compliance check where the service would meet 90% ahead of the end of the reporting period. July's compliance with the data available in August was agreed as the mid-point timeframe. 90% Compliance has been achieved against July's data with an Interim report provided to August Governance.
- 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.
- A MDT Impacted Fetal Head In situ simulation was conducted on 13th July 2026 with a Community Simulation in the planning stages.

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. The quarterly PMRT report, which includes oversight of this item is in circulation through governance channels in July and August.

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. The quarterly PMRT report, which includes oversight of this item is in circulation through governance channels in July and August.

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, for which the service is on track. This is monitored continuously and any downward trend will be escalated. The quarterly PMRT report, which includes oversight of this item is in circulation through governance channels in July and August.

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. The quarterly PMRT report, which includes oversight of this item is in circulation through governance channels in July and August.

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. The quarterly PMRT report, which includes oversight of this item is in circulation through governance channels in July and August.

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. The quarterly PMRT report, which includes oversight of this item is in circulation through governance channels in July and August.

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 interpreter 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.
- Discussions have taken place at the Perinatal Quality Surveillance Group with the LMNS and work is underway to jointly develop an action plan as set out within the guidance.

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:** In progress & On Track
- The service has never has a MOSS signal triggered and therefore needs to conduct a drill to ensure the appropriate processes are in place, should a signal be triggered.

- Work has started to complete the appropriate documentation for Quarter 1.

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

- **Status:** In Progress & On Track
- Maternity and 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.
- Records of the Perinatal Leadership and Safety Champions Bimonthly meeting held in June was included as part of August's Governance meeting.

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 Committee

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

Annex 9: Critical Safety Check (drill version)

IMPORTANT NOTE: This version of the critical safety check has been adapted to help services carry out a test drill. It is not intended to be used in response to a real signal. Services should use the critical safety check in Annex 1 in response to a real signal.

The **critical safety check** (drill version) is a rapid, structured assessment of key intrapartum care operational safety processes led by the perinatal leadership team, co-produced with staff working in these areas and approved by an accountable executive member of the trust board (see responsibilities below). It is not designed to replace comprehensive audits, investigations or case reviews. Perinatal leadership teams should practice at least one annual drill using the critical safety check, so they are prepared to respond when real signals occur. An annual drill does not need to be carried out if a service has already responded to a real signal within the calendar year using the critical safety check (Annex 1)

Objective: To practice the response to a signal and conclude whether an intrapartum service has a safety issue that needs to be addressed.

Areas of focus: Improvement timelines from known safety themes, leadership and culture, time-limited safety care pathways, risk assessment and escalation processes and safe staffing.

Responsibilities: Completed by the perinatal leadership team and approved by an accountable trust board executive (i.e. chief nurse, chief medical officer or executive trust board safety champion) within 8 working days from a signal. In real level 2 signals, an external peer review of the check should also happen before executive sign-off (see p.6 of the [standard operating procedures](#)). We recommend trying to test this as part of the drill. If a signal is received over the weekend or on a bank holiday, the timeline starts from the next working day. The check should be approved face to face or virtually where possible.

After completion and approval: Share the completed critical safety check with ICBs and regions for oversight and support if a safety issue is identified. ICBs or regions can stand down if a check does not conclude there is a safety issue.

Assumed knowledge/processes in place: The perinatal leadership team should have the below information available prior to the critical safety check (drill version):

Knowledge/process	Include summary or refer to relevant documents for the attention of accountable trust board executives
Have an early understanding of the causes of death for term events over the past 3 months	April – June 2026 (Q1)
Commissioned formal investigations where appropriate	None
Involved families in the investigation process where appropriate and listened to their insights and feedback	No MNSI reportable case. 1 Antenatal Term SB reported to MBRRACE via SPEN portal and be discussed at PMRT in Q1- RFM on admission
Emerging and known safety themes with any timelines of action plans to address	• Maternity triage – BSOTs / delays / timely medical review / self-discharge • DAU capacity – impacting triage • EM C/S cat 2 & 3 capacity and delays • IOL delays – ARM pathway (All affecting patient experience)

Advice for completing the check:

- do not share patient identifiable information on this form with anyone who does not have a lawful basis to see it – redact first
- the completed and approved check needs to be shared with ICBs and regions within 8 working days even if not all questions can be completed
- italicised text should be deleted before completing

Section 1 – MOSS pre-completion check

This section provides accountable trust board executives with additional context that may explain the signal and whether the pre-requisites for implementing MOSS are in place.

MOSS pre-completion check		
Questions	Answer	
	Yes/No	Description
Have you identified an issue with the data displayed by MOSS (for example, an event was not at term or care/delivery did not take place at the site displayed)?	No	<i>No events during this time period</i>
Is the trust site a NICU plus cardiac surgery centre?	No	
Were any of the events in MOSS that occurred over the last 3 months unavoidable? Please state why.	No	<i>None</i>
Are the pre-requisites for implementing MOSS in place (page 5-6 of standard operating procedures)?	Partially	<i>CNO & HOM will receive notification along with maternity governance team to alert QUAD and triumvirate. MOSS alert and process needs adding to local governance and Bereavement guidelines and SOP</i>

Section 2 – are key safety elements of your intrapartum service in place?

Please complete this section focussing on the activity of your intr&apartum service **over the last 3 months** (April – June 2026)

Safety culture - conversations with staff and service users		
Questions	Answer	
	Yes/No	Brief description with any action taken (bulleted only)
1. Are the perinatal leadership team, accountable trust board executives and staff (on labour ward, triage and birth centre) working well together?	Yes, this is working well	<i>Engaged Exec team – MNTAC chaired by CNO / CMO</i> <i>Safety champions meetings</i> <i>PRMs presented to trust exec team</i> <i>Senior leadership team (SLT) walkabouts and go and see visits</i> <i>(Feedback from staff - SLT has been inconsistent and DOM post vacant)</i>
2. How do you measure your leadership culture and how frequently is this done? What actions have you taken?		Staff survey National perinatal and cultural role programme Freedom to speak up – no current themes NETS survey – no current themes HR / PRM – flexible working / on calls SLT Go and see visits – feedback about senior leadership stability
3. What have MNVP leads or other service users fed back that they feel could be improved?		MNVP meet monthly with CNO / HOM / DM Regular MNVP feedback from service users; AN classes provision – review capacity Maternity triage – waiting times / medical delays / environment Partners provision for staying overnight
4. From your walkarounds and conversations with staff:		
a) What do staff feel is working well in providing safe care in labour and birth?		Safety champion and QUAD walkabout feedback – staff want to see the senior team OPEL daily reporting – green >90% overall 1 to 1 care in labour 100% / Supernumerary co-ordinator 100% Secondments and developments into band 7 roles 24/7 resident obstetric consultant

b) What do staff feel could be improved to achieve better outcomes?		More stability in senior leadership team / HOM & DOM roles has been vacant. Review staffing templates against birthrate plus (Feb 26) Review MSW role and areas they work Improve pathways for IOL Better working relationship with theatre team and understanding of C/S challenges
Are you achieving safety timelines for these care pathways?		
5. Is the maternity service achieving a triage of new cases within 15 minutes of presentation?	Yes - plans are already in place to maintain/improve this	>85% in Q1
6. Is the maternity service achieving commencement of induction of labour (IOL) within 6 hours from point of admission for induction (from home or ward)	No - we are putting plans in place to improve this and are on track	<i>This metric is not currently monitored – to consider adding to the monthly maternity dashboard</i> <i>Current QI project lead by Consultant Obstetrician and Consultant Midwife</i>
7. Is the maternity service achieving category 1 caesarean sections as soon as possible and usually within 30 minutes of the decision to deliver?	Yes - plans are already in place to maintain	100% in Q1

	n/improve this	
8. Is the maternity service achieving category 2 caesarean sections as soon as possible and usually within 75 minutes of the decision to deliver?	Yes - plans are already in place to maintain/improve this	86.5% in Q1 <i>Escalated to safety champions and theatres</i> <i>Discussion re classification of cat 2s and 3s</i>
Are you achieving regular multi-disciplinary team (MDT) communication of known or emerging risk factors on the labour ward?		
9. Are you achieving at least one MDT huddle every day on the labour ward based on NHSI guidance ?	Yes - this is already in place	MDT Consultant ward rounds 0900 & 2100 Informal ward rounds throughout the day
10. Do your huddles always include a consultant obstetrician, anaesthetist, midwifery co-ordinator and member of the neonatal team?	No/not always - we have not yet agreed a plan to put this in place	Daily Opel status reported 09:00 to the neonatal network. Plus, confirmation from the network showing the capacity for all units across the region. Additional 09:30 teams meeting with Stoke every day to review pathways and capacity as our linked level 3 NNU. The Transport team also call twice daily at 12 and 6 for capacity details.
11. Is the maternity service achieving a structured handover process in the labour ward, such as SBAR or an equivalent, that can manage known	Yes - this is already in place	Face to face handover of care between midwives at handover times Co-ordinator handover sheet Medical handover 0830 as MDT

or emerging risks and involves the MDT?		
Are your teams carrying out appropriate risk assessment and escalation?		
12. Is the service achieving compliance with element 4 of the current version of the Saving Babies' Lives Care Bundle ?	Yes - this is already in place	100%
13. Is the service achieving 90% of attendance in each relevant staff group (as per Maternity Incentive Scheme guidance) at: • fetal monitoring training • multi-professional maternity emergencies training • neonatal resuscitation training	Yes - this is already in place	<i>This relates to activity over the last 3 months, even though the Maternity Incentive Scheme requires this to be evidenced annually. Perinatal leadership teams should maintain an ongoing awareness of training needs.</i> <i>Mid-point assessment scheduled for August 26 - on track >95%</i>
Is there a stable workforce offering safe and effective care during labour and birth?		
14. Have staff been redeployed or non-clinical midwifery staff (e.g. managers / specialist midwives) utilised to meet minimum midwifery safe staffing levels as per your trust's safe staffing policy?	Yes	Daily OPEL framework and reporting – captures redeployment as needed
15. Have there been obstetric staffing shortfalls impacting on safe care delivery?	No	24/7 on site consultant cover and Gynae Consultant back up on call
16. Have there been any anaesthetic staffing	No	24/7 rota

shortfalls as per RCoA guidance impacting on safe care delivery?		
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Section 3 – is there any additional information that accountable trust board executives should pay attention to?

Please use this section if there is anything not captured above that you feel executives should pay attention to, explaining potential safety issues in your intrapartum service over the last 3 months.

- Maternity triage QI – BSOTs / delays / medical review
- DAU capacity – impacting triage
- EM c/s cat 2 & 3 capacity and delays in cat 2 compliance
- IOL delays – ARM pathway

Section 4 – conclusion from this critical safety check (drill version)

This section is used to summarise the outcome of the critical safety check (drill version) for accountable trust board executives. If more than one safety issue has been identified and these are being dealt with differently, then overall the perinatal leadership team should select the RAG rating which best describes the safety issue(s) with the highest risk.

Question	Answer
How would you summarise the outcome of this critical safety check (drill version)?	GREEN/AMBER - there is at least one known safety issue in our intrapartum service, with a plan of action already in place and progressing as planned

Section 5 – recommendation from this critical safety check (drill version)

It is recommended that the below actions are taken following the relevant conclusion of this check from section 4.

Conclusion	Action(s)	Please select
GREEN – no safety issues in our intrapartum service have been identified	no action is required other than sharing the completed check with ICB (executive with responsibility for maternity and neonatal services and director of quality) and regional colleagues (regional chief nurse, midwife, obstetrician and medical director) for awareness	☐
GREEN/AMBER - there is at least one known safety issue in our intrapartum service, with a plan of action already in place and progressing as planned	- the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures) - the perinatal leadership team should continue to report to the trust board on plans as required - the trust board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed	☐
AMBER - there is at least one known safety issue in our intrapartum service, with a plan of action already in place but it is not progressing as planned	- the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures). - an urgent discussion between the perinatal leadership team and the trust board is required within 4 weeks with an agreement get plans back on track within 12 weeks - the trust board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed	☐
AMBER/RED - there is at least one known safety issue in our intrapartum service, but a plan of action is not in place	- the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures) - an urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks - the trust board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed	☐

RED – at least one new safety issue in our intrapartum service has been identified which requires a plan of action	- the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures) - an urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks - the trust board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed	☐
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DATE:

AGREED BY MEMBERS OF THE PERINATAL LEADERSHIP TEAM AND TRUST BOARD EXECUTIVE(S) AS FOLLOWS:

NAME(S)	ROLE(S)

CNST Safety Action C – Learning from reviews and investigations

Agenda item	2026/286			
Report Title	CNST Safety Action C - Quarterly Report April-June 2026			
Executive Lead	Martina Morris, Chief Nursing Officer			
Report Author	Silje Almklow, Divisional Quality Governance Lead			
	Link to strategic goal:		Link to CQC domain:	
	Our patients and community	✓	Safe	✓
	Our people		Effective	✓
	Our service delivery	✓	Caring	✓
	Our governance	✓	Responsive	✓
	Our partners	✓	Well Led	✓
	Report recommendations:		Link to BAF / risk:	
	For assurance	✓		
	For decision / approval	✓	Link to risk register:	
	For review / discussion	✓		
	For noting			
	For information			
	For consent			
Presented to:	Maternity Governance meeting July 2026 Neonatal Governance meeting July 2026			
Executive summary:	The Trust remains on track to meet the requirements of CNST Safety Action C. During Quarter 1 2026/27, all eligible incidents were reported through the SPEN portal within required timescales, with no missed or delayed notifications identified. Three stillbirths and one neonatal death were reported during the quarter. All eligible cases have undergone, or are scheduled to undergo, review through the appropriate national and local processes. Families continue to be actively involved in investigations through the provision of information, opportunities to share their experiences, and follow-up meetings to discuss findings and learning. The Trust continues to achieve strong compliance with external review requirements, with appropriate external clinical representation included in PMRT reviews. Key themes identified include documentation, communication, escalation, health inequalities, Duty of Candour, postnatal pain management and infant feeding support. Overall, robust systems are in place to identify, review and learn from adverse events, with ongoing work focused on embedding learning into practice and improving outcomes for women, babies and families.			
Appendices	MBRRACE generated Trust Board Report			

Safety Action C – Learning from reviews and investigations

Outcome

Effective Board oversight of thematic learning and progress with actions arising from local and national reviews of adverse incidents.

Why

The focus of this Safety Action is to ensure that every perinatal and maternal death, and every baby with potential for severe brain injury, is consistently identified, investigated, and learned from using the appropriate national processes.

This includes, but is not limited to, the Perinatal Mortality Review Tool (PMRT) via MBRRACE-UK, the Maternity and Newborn Safety Investigations (MNSI), the NHS Resolution Early Notification Scheme (NHSR EN), and a Maternity Outcomes Signal System (MOSS) critical safety check. This Safety Action aims to embed a culture in which findings are not only reported but critically analysed for their meaning and impact, focusing on the essential 'so what'. The intention is that learning translates into measurable improvements in safety, equity, and outcomes across maternity and neonatal care. This should include learning from examples of excellence when good care is identified.

Recent national inquiries such as Ockenden (2020 and 2022), Kirkup East Kent and MBRRACE-UK, and coronial Prevention of Future Deaths (PFD) notices have consistently shown that failures to robustly investigate and learn from perinatal deaths, maternal deaths and patient safety incidents perpetuate avoidable harm. These findings highlight the need for Trusts to move beyond process compliance, demanding that learning from PMRT, MBRRACE-UK, MNSI, NHSR EN, MOSS and other national reports is actively used to drive change. National priorities now require that review and investigation findings should result in clear actions with a demonstrable impact on outcomes and equity, and that these are tracked and reported to ensure transparency and continuous improvement. The focus is on closing the loop. Not just identifying what happened, but understanding why, making changes where needed, and ensuring care is improved for mothers, babies, and families.

MIS Year 8: reporting period

The MIS reporting periods are structured to align approximately with Q1–Q3 of the financial year, however trusts should view the associated requirements as a continuous, year-round responsibility rather than activity undertaken solely for MIS purposes. The requirements set out in MIS reflect core operational practices that should already form part of effective routine perinatal service delivery, rather than activities undertaken solely for the purposes of the scheme.

While any assurance exercise or reverification for Year 8 will focus on activity and supporting evidence from Q1–Q3 of 2026/27 (April–December), we expect Trusts to maintain the same standards and operational processes throughout Q4 to ensure a consistent and embedded approach to patient safety and learning.



What are the minimum requirements that must be completed to achieve this outcome?

Reporting & Review

1. Notify all qualifying events

All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR Early Notification Scheme (EN) and Maternity and Newborn Safety Investigations (MNSI) as soon as possible after the death/diagnosis.

The 'Submit a Perinatal Event Notification' (SPEN) Portal is a new system designed to streamline the notification of perinatal events. It automatically forwards information to the relevant national organisation (MBRRACE-UK, MNSI and NHSR Early Notification) based on the type of event.

The rollout of SPEN was phased, and The Shropshire, Telford and Wrekin Community and Hospitals NHS Group began using SPEN on the 3rd of November 2025.

Cross-check to identify missed or late notifications:

A regular review of maternal BadgerNet, neonatal BadgerNet, and Datix is carried out to ensure that all incidents are reported in line with guidance.

No notifications were missed or submitted late in quarter 1 2026/2027.

Table of reportable incidents from Q3 onwards:

SPEN Reference	MNSI/PMRT number	Date of incident	Type of incident	Date of submission	Ethnicity / Language	Outcome
Quarter 3 2025/2026						
N/A Pre SPEN launch	100956/1	30/10/2025	Stillbirth	31/10/2025	White British English speaking	PMRT review Published 29/04/2026
MAT-000-564	MI-049260	09/11/2025	Potential severe brain injury	12/11/2025	Black African English speaking	Final report received 29/04/2026 Safety action X1 Safety prompt X7
MAT-000-588	101160/1	12/11/2025	Stillbirth	13/11/2025	White other Non-English speaking	PMRT review Published 20/01/2026 Graded B/A
MAT-000-725	101282/2	17/11/2025	Stillbirth	21/11/2025	Indian Non-English speaking	PMRT review Published 23/03/2026 Graded A/A
MAT-000-904	101466/1	02/12/2025	Stillbirth	03/12/2025	White British English speaking	Review not supported – medical termination
MAT-001-057	101617/1	11/12/2025	Stillbirth	15/12/2025	Black African English speaking	PMRT review Published 25/03/2026 Graded B/B
Quarter4 2025/2026						

MAT-001-372	101930/1	06/01/2026	Stillbirth	07/01/2026	White British English speaking	PMRT review Published 27/04/2026 Graded B/B
MAT-001-752	102291/1	01/02/2026	Stillbirth	02/02/2026	White British English speaking	Review not supported – medical termination
MAT-001-979	102509/1	12/02/2026	Stillbirth	17/02/2026	Arab Non-English speaking	PMRT review Published 21/04/2026 Graded B/B
MAT-002-068	102592/1	21/02/2026	Late neonatal death	23/02/2026	Pakistani English speaking	PMRT review Published 29/06/2026 Graded A/B/A
Quarter 1 2026/2027						
MAT-002-716	103236/1	08/04/2026	Stillbirth	09/04/2026	White British English speaking	PMRT review Published 23/06/2026 Graded B/B
MAT-002-997	103513/1	26/04/2026	Stillbirth	28/04/2026	White British English speaking	PMRT review Meeting 10/06/2026 Awaiting PM
MAT-003-173	103670/1	05/05/2026	Stillbirth	11/05/2026	White British English speaking	Review not supported – medical termination
MAT-003-943	104492/1	27/06/2026	Neonatal death	29/06/2026	White British English speaking	Review not supported – gestation < 22 weeks
MAT-003-946	104495/1	27/06/2026	Stillbirth	29/06/2026	White British English speaking	PMRT review
MAT-004-002	104544/1	Duplicate report – same incident as MAT-003-943. Review not supported – gestation < 22 weeks.				
Additional reviews or learning responses – not reportable through CNST						
PSII 2026/593	101787/1 UHNM leading on the review	27/12/2025	Early neonatal death	PSII commissioned 27/01/2026		PMRT review led by UHNM PSII led by SaTH
AAR Datix 327968	N/A	02/04/2026	Medication incident	AAR commissioned 26/05/2026		AAR ongoing

Deaths reported to MBRRACE

In the time-period from the 1st of April to the 30th of June 2026, there were 3 stillbirths reportable by the Trust. Reporting to SPEN and MBRRACE was completed in line with reporting guidelines.

Late fetal losses

There were no late fetal losses in quarter 1.

Stillbirths

- **Stillbirth 103236/1** – The woman was identified as having low pregnancy-associated plasma protein-A (PAPP-A) and abnormal umbilical artery Doppler findings during pregnancy and therefore received serial growth surveillance. Fetal growth remained within the normal range throughout. She presented at 40+1 weeks' gestation reporting reduced fetal movements and was sadly diagnosed with an intrauterine fetal death.
- **Stillbirth 103513/1** – The woman received community midwifery-led care during her pregnancy. She attended maternity triage at 29+5 weeks' gestation in spontaneous labour, at which time an intrauterine fetal death was diagnosed. The baby was found to be severely growth restricted at birth.
- **Stillbirth 104495/1** – The woman experienced recurrent episodes of reduced fetal movements during the late second trimester and was assessed in maternity triage. A growth scan was arranged, and at attendance she was sadly diagnosed with an intrauterine fetal death at 27+ weeks' gestation. Ultrasound assessment demonstrated an absence of amniotic fluid, and the baby was severely growth restricted.

Neonatal deaths

Neonatal Death 104492/1 – The woman experienced preterm prelabour rupture of membranes (PPROM) from 16 weeks' gestation. She was admitted at 21+1 weeks' gestation with vaginal bleeding and subsequently progressed to spontaneous labour and birth. The baby was born showing signs of life but sadly died at 20 minutes of age.

As the birth occurred before the gestational threshold for review through the Perinatal Mortality Review Tool (PMRT), the case does not meet the criteria for a PMRT review. A local multidisciplinary review will, however, be undertaken to identify any learning opportunities, and individualised bereavement and follow-up support will be provided to the family.

2. Seek parents' views of care

For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.

PMRT number	Date of incident	Verbal information	Written information	Follow up meeting	Outcome letter
Quarter 3 2025/2026					
100956/1	30/10/2025	31/10/2025	09/12/2025	Coroner's PM outstanding Follow-up to be arranged once available.	TBC
101160/1	12/11/2025	11/11/2025 Interpreter in attendance	01/12/2025 Romanian	05/03/2026 Interpreter in attendance	27/03/2026 Translated to Romanian

101282/2	17/11/2025	18/11/2025	20/11/2025 Punjabi	TBC Attempts to contact and offer follow up.	TBC
101617/1	11/12/2025	15/12/2025	22/12/2025	Bereavement follow up 25/06/2026	Bereavement - 26/06/2026 Additional PMRT letter to follow
Quarter 4 2025/2026					
101930/1	06/01/2026	07/01/2026	08/01/2026	20/05/2026	07/04/2026 17/06/2026
102509/1	12/02/2026	16/02/2026	20/02/2026 Arabic	Bereavement follow up 17/06/2026 Interpreter in attendance	TBC Letter is being translated prior to sending
102592/1	21/02/2026	03/03/2026	11/03/2026	Bereavement follow up 30/04/2026 PMRT feedback being arranged	Bereavement 01/05/2026 PMRT letter to follow
Quarter 1 2026/2027					
103236/1	08/04/2026	09/04/2026	20/04/2026	PMRT 22/06/2026 Bereavement 01/07/2026	PMRT - 23/06/2026 Bereavement - outstanding
103513/1	26/04/2026	07/05/2026	14/05/2026	TBC	TBC
104495/1	27/06/2026	29/06/2026	08/07/2026	TBC	TBC

3. External multi-disciplinary reviewers

For a minimum of 60% of the deaths reviewed external members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.

The supplemental guidance recommends clear arrangements for involving external reviewers from appropriate specialties (e.g. neonatology, obstetrics, midwifery, anaesthetics) to ensure the required threshold is met. This can be achieved through reciprocal arrangements with neighbouring Trusts or network partners, and include PMRT entries that clearly documents who attended, their specialty, and whether they were external to the Trust.

SaTH has interpreted this to mean that we require obstetric externality at consultant level for all cases and neonatal externality at consultant level for all neonatal deaths. Additional externality is arranged on a case-by-case basis depending on the individual circumstances. The MNVP are invited to all PMRT reviews, the lead CDOP nurse is invited for neonatal deaths, and WMAS/NTS are invited for relevant cases.

We are on track for 100% appropriate externality for our PMRT reviews.

PMRT number	Date of PMRT meeting	PMRT published	Type of incident	External obstetrician	External neonatologist	Additional externality
Quarter 3 2025/2026						
100956/1	11/02/2026	29/04/2026	Stillbirth	Yes	N/A	MNVP
101160/1	15/01/2026	20/01/2026	Stillbirth	Yes	N/A	MNVP
101282/2	11/02/2026	23/03/2026	Stillbirth	Yes	N/A	MNVP
101617/1	19/03/2026	25/03/2026	Stillbirth	Yes	N/A	MNVP
Quarter 4 2025/2026						
101930/1	19/03/2026	27/04/2026	Stillbirth	Yes	N/A	MNVP
102509/1	15/04/2026	21/04/2026	Stillbirth	Yes	N/A	MNVP
102592/1	21/05/2026	29/06/2026	Late neonatal death	Yes	Yes	N/A
Quarter 1 2026/2027						
103236/1	10/06/2026	23/06/2026	Stillbirth	Yes	N/A	MNVP
103513/1	10/06/2026	TBC	Stillbirth	Yes	N/A	MNVP
104495/1	Scheduled 19/08/2026	TBC	Stillbirth			

Sharing information with families

4. Provide relevant information

Provide relevant information regarding the role of MNSI, NHSR Early Notification (EN) scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.

Please see the table in Section 2 above for additional information.

MBRRACE and MNSI provide information for use by Trusts, and these are provided to all families. Information and letters are translated into languages that the mother can read, and meetings and conversations are supported by interpreters as required.

We are currently working with the MNVP, the MNISA and the Family Liaison Officers to develop additional information about Duty of Candour and we hope to roll this out in the next few months.

Following the release of CNST Year 8, we are reviewing the documents and the documentation of conversations to ensure that they meet the standards required.

5. Offer parents a meeting with relevant specialists

Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.

Please see the table in Section 2 above for additional information regarding PMRT reviews and follow up meetings.

The below table details the information provided to parents involved in MNSI, PSII and learning responses.

Review number	Date of incident	Initial DoC	Written DoC	Follow up meeting	Outcome letter
MI-049260	09/11/2025	09/11/2025	12/11/2025	Tripartite 22/06/2026	09/07/2026
2026/593	Born 25/12/2026 Died 27/12/2026	25/12/2026	25/02/2026 Face-to-face meeting and letter following.	TBC	TBC
AAR Datix 327968	02/04/2026	15/05/2026	15/05/2026 Face-to-face meeting and email following	TBC	TBC

Learning and governance

6. Thematic reports of learning and actions

The Trust must produce thematic reports that triangulate information and summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and Patient Safety Incident Response Framework (PSIRF) reviews, Maternity Outcomes Signal System (MOSS) critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.

These thematic reports must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.

Thematic learning

Themes identified through reviews of clinical incidents, including Perinatal Mortality Review Tool (PMRT) reviews, Maternity and Newborn Safety Investigations (MNSI), Patient Safety Incident Response Framework (PSIRF) learning responses, and local clinical incident investigations, are summarised in the table below.

Each theme will be cross-referenced against the recommendations from recent national maternity reports, including the *Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust* led by Donna Ockenden and the *National Maternity and Neonatal Investigation* led by Baroness Amos. This process will support the identification of additional opportunities for service improvement and ensure alignment with national learning and best practice.

Themes that align with national recommendations will be incorporated into the Maternity and Neonatal Improvement Programme, where they will be subject to ongoing oversight, monitoring, and reporting to support continuous quality improvement and the delivery of safer, more equitable care.

Theme	Narrative	Action	Progress
Documentation	Reviews have identified inconsistencies in clinical documentation, particularly relating to: - Documentation of counselling regarding risks, benefits and alternatives prior to intervention. - Recording decisions made by women and families, including instances where recommended interventions are declined. - Clear documentation of the rationale underpinning clinical decision-making. - Accurate recording of individual practitioner involvement in care.	- Introduce teaching on the B.R.A.I.N. decision-making tool during Mandatory Training Day 2. - Strengthen education relating to informed consent and counselling prior to elective caesarean birth, membrane sweeps and induction of labour. - Reinforce the importance of clearly documenting decision-making rationale and individual accountability within clinical records.	To commence August 2026
Communication - staff	Reviews have highlighted opportunities to strengthen multidisciplinary communication, including: - Professional challenge and collaborative working between maternity, obstetric, anaesthetic, neonatal and critical care teams. - Effective handovers that clearly communicate concerns, risk factors and potential impacts on outcomes. - Tailoring communication to the intended audience to ensure clarity and shared understanding.	Reviews have highlighted opportunities to strengthen multidisciplinary communication, including: - Professional challenge and collaborative working between maternity, obstetric, anaesthetic, neonatal and critical care teams. - Effective handovers that clearly communicate concerns, risk factors and potential impacts on outcomes. - Tailoring communication to the intended audience to ensure clarity and shared understanding.	To commence August 2026
Communication – service users	Reviews have identified a need to improve communication with women and families who do not speak English as their first language. Themes include: Access to professional interpreter services.	- Develop a service user Padlet providing access to patient information resources in multiple languages. - Deliver staff education regarding the appropriate use of interpreter services and	Health Inequalities Governance Report to commence August 2026

	• Availability of written information in alternative languages. • Understanding the importance of using professional interpreters rather than family members. • Consistent documentation of interpreter use and communication plans. Access to written information in non-English languages has been identified as a particular challenge.	associated documentation requirements. • Continue work with corporate teams to increase the availability of translated patient information materials. • Introduce a monthly Perinatal Health Inequalities Governance Report, incorporating learning from PMRT reviews, MNSI investigations, PSIRF learning responses and clinical incidents.	
Escalation	Reviews have identified occasions where escalation of concerns could have been strengthened, including: • Professional challenge between team members. • Timely access to senior clinical support and management. • Repeated escalation when concerns remain unresolved. • Ensuring concerns are communicated clearly and understood by the recipient.	• Continue teaching on speaking up, professional challenge and escalation through PROMPT and NLS programmes. • Include escalation pathways and organisational routes for escalation within Governance Teaching Day 2.	To commence August 2026
Health inequalities	Reviews have demonstrated that the potential impact of health inequalities is not always recognised or fully considered when assessing care, outcomes and patient experience. Areas identified include: • Assessment and management of pain. • Perinatal mental health. • Recognition of pallor across different skin tones. • Supporting women with disabilities, including access and parenting support. • Neurodiversity and communication needs. • Food insecurity, nutritional status, anaemia and diabetes management.	• Deliver Equality, Diversity and Inclusion (EDI) training led by the EDI Midwife. • Include teaching on the impact of health inequalities within Mandatory Training Day 2 governance sessions. • Promote consideration of health inequalities within incident reviews, learning responses and quality improvement work.	To commence August 2026
Duty of Candour	Service user feedback has identified variation in the delivery and documentation of Duty of Candour discussions, resulting in inconsistent experiences for women and families.	• Continue Duty of Candour simulation training delivered by the Family Liaison Team. • Develop and implement a Duty of Candour patient information leaflet to improve understanding of the process and support consistent communication.	Ongoing
Pain relief	Reviews have identified variation in the timely provision of analgesia on the postnatal ward, resulting in an inconsistent experience for some women.	• Maternity, obstetric and anaesthetic teams are collaborating to review and improve processes supporting the timely availability and administration of postnatal analgesia.	Ongoing

Feeding support	Reviews identified that babies with multiple risk factors for hypoglycaemia and feeding difficulties were not always consistently recognised and offered proactive feeding support at the earliest opportunity.	• Update infant feeding training to strengthen understanding of risk assessment and management pathways for reluctant feeders over 37 weeks' gestation. • Highlight the increased risk of neonatal morbidity in small-for-gestational-age (SGA) babies and infants with feeding difficulties. • Introduce routine use of the neonatal risk assessment tool within BadgerNet for all babies.	To commence August 2026
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Health Inequalities

Due to the relatively small number of service users affected by the incidents outlined above, statistical analysis has not yielded meaningful insights into health inequalities. However, each case is reviewed individually to identify any factors related to health inequalities and to assess whether these may have influenced the woman's care pathway or outcomes.

One area identified for improvement is access to written information for women whose first language is not English. A service user Padlet is currently being developed and will provide key information in the five most commonly spoken non-English languages within the local population. Many patient information leaflets used within the service are nationally produced and already available in multiple languages. For locally developed materials, discussions are ongoing with the Patient Experience Team to support translation and improve accessibility.

All women who do not speak English as their first language are provided with information about the review process in their preferred language. They are also offered the support of a professional interpreter during feedback meetings and receive a written summary of the review findings translated into their preferred language. This helps to ensure equitable access to information and meaningful participation in the review process.

Conclusion

A review of current practices provides assurance that the Trust is on track to meet CNST safety action C, with thematic reviews now in place and actions being generated. The focus of improvement work will be on communication, Duty of Candour conversations, health inequalities, and infant feeding support.

Author name and title

Silje Almklow

Divisional Quality Governance Lead - Women and Childrens

Quality Governance Team

Date 14/07/2026

Report	Saving Babies Lives Quarterly Report			
Executive Lead	Martina Morris, Group Chief Nursing Officer			
	Link to strategic pillar:		Link to CQC domain:	
	Our patients and community	✓	Safe	✓
	Our people		Effective	✓
	Our service delivery	✓	Caring	✓
	Our partners		Responsive	✓
	Our governance	✓	Well Led	
	Report recommendations:		Link to BAF / risk:	
	For assurance	✓	BAF 1, BAF 2 BAF 3, BAF 4 BAF 7, BAF 8	
	For decision / approval		Link to risk register: CRR 15	
	For review / discussion			
	For noting	✓		
	For information	✓		
	For consent			
Presented to:	Maternity Governance			
Dependent upon	n/a			
Executive summary:	This paper provides an update on the Trust’s progress of ensuring SBLCBv3 is embedding and remaining compliant with the current national and local minimum and stretched ambitions. The data provided is part of a planned review cycle. This information is shared within a quarterly System SBLCB review meeting where standards and ambition setting are undertaken (see 4.0). Quarterly system review August 2026 (additional paper 1a and 1b) – It was acknowledged by the system that the overall implementation for this quarter has decreased from the last quarter (99%→96%) There is 1 standard that remain partially implemented/not embedded - Offer of Pregnancy Specific hybrid close- loop system to Type 1 pregnant diabetics. To advise the committee, due to the change in CNST year 8 requirements quarterly SBLCB reviews have returned to Trust Board only oversight. Relating to Element 1: - Percentage of staff compliant with CO monitoring training and VBA (Very Brief Advice) on smoking is partially implemented with Midwives and Doctors meeting target, but support staff under 90% target at 87.7%. Informed PEF RM so training can be facilitated. Also informed the trust Healthy Pregnancy Support Service (HPSS) Lead and Maternity Tobacco Dependency Lead who plans to send out memo.			

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Relating to Element 2:

- Babies born <10th centile was similar to the PI national GAP average at 11.1% (GAP 11.2%). The overall linear trend continues to be reducing for the Trust in line with the current GAP trend.
- Babies born between the 10th and 3rd centile is significantly below the PI national GAP average, at 5.9%% (GAP 8.7%).
- Babies born <3rd centile is similar to the PI national GAP average (3.6 %) at 3.5%. The linear trend for the Trust continues to be reducing in line with the national GAP average trend over the past 2 years.
- <10th centile detection - The current rolling average for the Trust (41.5%) was below the National GAP data of 48.4% (SaTH was above last quarter).
- The Trusts False Positive rate (FP) remains significantly better than the national GAP average. This means less babies in the Trust were suspected as SGA but were a normal birth weight centile, which consequently will have reduced unnecessary interventions such as induction of labour for SGA/FGR.

Relating to Element 3:

- Following last quarters annual review of management of RRFM. Areas for improvement included clearer documentation of clinical decision-making and increased use of the Reduced Fetal Movements checklist. A re-audit was suggested within 3 months to assess the impact of interventions and improve documentation of communication and language needs but following discussion with audit lead, plan to review this again after 6 months to allow for awareness of review findings and improvement.
- RFM Survey conducted on 35 pregnant women over 36 weeks pregnant, or in the postnatal period. 4x participants disclosed their first language was not English and they were not given information in a language they understand. 8x comments were left in regard to Tommy's leaflet being "useful" and "good", 9x comments were left that they either didn't know about the Tommy's leaflet or did not see it in their pregnancy.
- Comments about staff attitude and "fear of wasting midwife time" have been noted and management informed in hopes to aid Triage QI project.
- A potential gap in information shared with patients was noted during this survey, as 5 out of 35 participants had anterior placentas and wished there was more information on this in regard to RFM.

Relating to Element 4:

- There were no cases in Q2 relating to incorrect risk assessment for the method of intrapartum fetal monitoring (SBLCBv3.2 reporting requirement).

Relating to Element 5:

- Quarter 2, our preterm birth rate was 7.2%. The Trust's annual rolling average is currently 6.28 %, slightly above the national target of 6%.

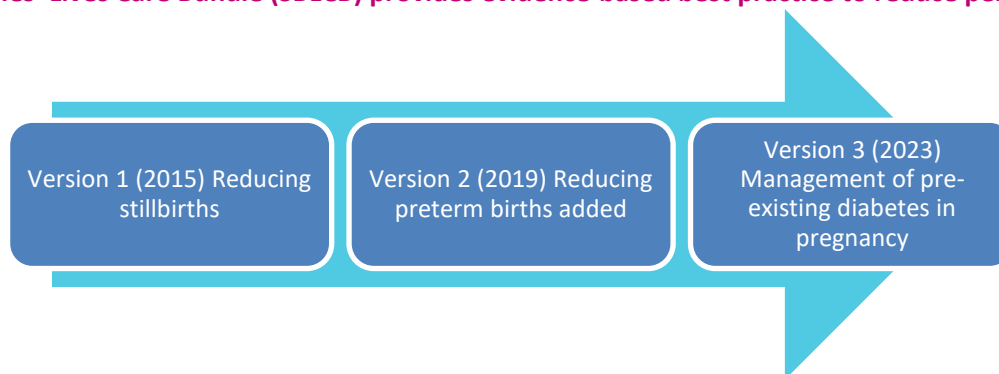
	• 0 babies were born in a unit with NICU following successful IUT. 1 woman gave birth at SATH meeting criteria for births in a unit with NICU. • NNAP extracted data Q2 2026. The Trust is demonstrating a high achievement level for administration of MgSO₄ in comparison to the network and national data. • NNAP extracted data Q2 2026. There is current discrepancy between data collected by SBL and NNAP data. Action plan - to send a memo out to all staff regarding importance of completing pre-term workflow so NNAP data is correctly updated and liaising with Digital Midwives to include this in 'Badgerbites'. NNAP data puts the trust around 8-12% lower than network, unit type and nationally. • NNAP extracted data for Q2 2026 The Trust is achieving 12-15% better temperature management in comparison to the network, unit type and nationally. • Cases where aspects of optimisation were not achieved, reviewed through the Preterm Quad Team (Obstetric and Neonatal Consultant, Midwife and Senior ANNP). • Use of the newly launched Midlands Preterm Tool. 1 case reviewed - The care was graded a B, 'Care issues identified that would of made no difference to the outcome'. Action from learning (appendices 4) - Email to all CMW and Triage staff to be following up with patients if treatment has been accessed following positive STI results. Plethora of feedback was also provided on the use of the tool. Relating to Element 6: • SBL Forums have shared that other trusts are utilising their trust's nurses to teach women to use their pumps where midwifery staff have been unavailable.
Appendices	Additional reports (separate documents) 1. Smoking and CO monitoring Memo and Visual Aids 2. RFM Survey Results 3. Quarter 2 2026 Review of Preterm Births 4. Action log – Midlands Preterm Tool
Author	Makenzie Arnold and Lindsey Reid (for Element 2) Lead Midwives' for Saving Babies' Lives The Shrewsbury and Telford Hospital NHS Trust

1.0 Introduction.

- 1.1 The Saving Babies Lives (SBL) care bundle is designed to reduce perinatal mortality, and its implementation constitutes Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), of which The Trust is a participant.
- 1.2 The Trust is now in the CNST year 7 data collection period. The conditions for Safety Action 6 remain the same as year 6, which includes, for the Trust, continuing improvement and embedding with SBL version 3.
- 1.3 The purpose of this paper is to:
 - 1.3.1 Provide updates to the Maternity Governance committee on the SBLCBv3 standards dependent on their planned review cycle.
 - 1.3.2 Provide quarterly reports of information which require sharing (as per SBLCBv3) with the Trust Board and LMNS.

2.0 Background.

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice to reduce perinatal mortality.



- 2.1 The first version of the Saving Babies' Lives Care Bundle (SBLCB) was published in March 2016 and focussed predominantly on reducing the stillbirth rate¹. The care bundle was designed to deliver the then Secretary of State for Health's announced ambition to halve the rates of stillbirths, neonatal and maternal deaths, and intrapartum brain injuries by 2030, with a 20% reduction by 2020. The care bundle consisted of four standards.
- 2.2 In November 2017, as part of the National Maternity Safety Strategy, the national ambition was extended to include reducing the rate of preterm births from 8% to 6% and the date to achieve the ambition was brought forward to 2025². This is reflected in the NHS Long Term Plan.³
- 2.3 The second version of the care bundle was published in 2019 and included a fifth element: 'Reducing preterm birth'.⁴
- 2.4 The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020. ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While

¹ <https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-care-bundle.pdf>

² https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

³ <https://www.longtermplan.nhs.uk/>

⁴ <https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf>

significant achievements have been made in the past few years, more recent data shows there is more to do to achieve the Ambition in 2025 period (SBLCBv3).

2.5 The 3rd version of the care bundle (SBLCBv3) was released in June 2023. Building on the achievements of the previous versions, Version 3.0 includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit.

There are now 6 elements of care:

Element 1- Reducing smoking in pregnancy

Element 2 -Fetal Growth: Risk assessment, surveillance, and management

Element 3- Raising awareness of reduced fetal movement (RFM)

Element 4 -Effective fetal monitoring during labour

Element 5- Reducing preterm birth

Element 6 -Management of pre-existing diabetes in pregnancy

2.6 Version 3 was updated to Version 3.2 in April 2025 to reflect evolving evidence, national policy, and clinical practice. Key updates included alignment with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, strengthening the link between care bundle compliance and national safety standards. There was an increased emphasis on addressing health inequalities and promoting continuity of carer to support personalised maternity care. Amendments were made to:

- Element 2, including clarification of guidance, removal of an outcome measure, and updates to blood pressure monitoring recommendations to improve consistency in practice.
- Element 6 (Diabetes in Pregnancy) was also revised, with updated outcome measures and the inclusion of guidance on hybrid closed-loop systems, reflecting advancements in diabetes management.
- In addition, supporting materials were streamlined, including the removal of Appendix B and updates to key clinical guidance such as pre-eclampsia risk assessment and uterine artery Doppler screening.

Overall, these changes aimed to enhance clarity, standardisation, and alignment with current best practice while maintaining the core structure of Version 3.

3.0 The Trust actively participates in engaging with regional and national Trusts and networks developed to share standards, action plans, learning and peer support. Below are the main active groups.

3.1 Regional – NHS England- Midlands

- SBLCBv3 Community of Practice
- Midlands Preterm Group (hosted by the Midlands Perinatal Team)- active members participating in developing regional pathways
- PERIPrem community of practice

3.2 National

- SBL forum – support network created for Trusts
- National Fetal Monitoring network
- Perinatal Institute
- Preterm Midwives Network – linked to UK Preterm Birth Network (represented by The Trust's Preterm Prevention Lead Midwife).
- UK Preterm Birth Network

4.0 Quarterly joint Quarterly Assurance Meeting with system partners

4.1 Quarterly system review April 2026 – It was acknowledged by the system that the overall implementation rates this quarter have moved from 99→96%.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)
Element 1	Smoking in pregnancy	Partially implemented	80%
Element 2	Fetal growth restriction	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%
Element 6	Diabetes	Partially implemented	83%
All Elements	TOTAL	Partially implemented	96%

4.1.1 Partially Implemented

There are 2 standards that are currently designated as partially implemented. This has moved from 1 to 2 since the last review.

Element 1

- Training compliance for CO monitoring and VBA (Very Brief Advice)

Percentage of staff compliant with CO monitoring training and VBA (Very Brief Advice) on smoking is implemented with Midwives and Doctors meeting target, but support staff under 90% target at 87.7%. Informed Practice Education Facilitator RM so training can be facilitated/supported.

Element 6

- Number of Pregnant Women who have Type 1 Diabetes that are offered a pregnancy specific HCL system during pregnancy.

At the final meeting with ICB, in which element 6 was discussed, an explanation was given to the review that while women already on HCL systems are being switched to pregnancy-specific hybrid closed loop systems, onboarding new patients is stalled due to staffing shortages, resulting in inequitable service provision. It currently remains unclear to SaTH maternity what the plans are within the Trust to recommence onboarding. Actions were agreed to escalate the concern.

Since meeting with SBL leads from other trusts, many have suggested utilising nurses to support with the set up and education of the HCL systems, as this is aiding compliance in their trusts. Plans to suggest this at next meeting, awaiting date for this.

- 4.1.2 To advise the committee, due to the change in CNST year 8 requirements quarterly SBLCB reviews have returned to Trust Board only oversight.

CNST year 8 Saving Babies' Lives Care Bundle (SBLCBv3.2) - Quarterly reporting to the Trust Board

"The provider must report quarterly to the Trust Board on progress against full SBLCBv3.2 implementation. Quarterly reports should demonstrate how the Trust has prioritised the requirements of the SBLCB based on local progress, implementation status, and any relevant safety intelligence, including themes and learning from local adverse incidents".

The current format of SBL standards reporting will remain the same at present.

5.0 Element 1: Reducing smoking in pregnancy

5.1 Standards relating to routine care

SBL Dashboard							previous quarter average	Jan-26	Feb-26	Mar-26	quarter average	Apr-26		May-26	#####	quarter average
Standard		Local target	Compliance			Frequency of Audit										
Element 1 - Smoking																
attending booking appt where a CO value is recorded tolerance of 3 days from booking to CO	1.1	n/a	<90%	>90%	>95%	monthly	99.3%	98.9%	97.3%	98.20%	98.13%	97.50%		95.70%	97.10%	96.80%
36 week appointment where a CO value is recorded (35 - 36+6)	1.1	n/a	<90%	>90%	>95%	monthly	94.2%	94.7%	92.9%	91.80%	93.14%	91.30%		92.40%	92.80%	92.20%
who have a recorded CO measurement at each antenatal appointment during pregnancy	1.2	no national target now set				monthly	89.7%	89.6%	76.0%	92%	85.87%	51.60%		39.50%	38.60%	43.20%
% of pregnant women at the booking appt where a smoking status is recorded tolerance of 3 days from booking to CO recording	1.3	n/a	<80%	>80%	>95%	annual					100%	99.70%		100%	100%	99.90%
% of pregnant women at the 36 weeks appointment where a smoking status is recorded (35 - 36+6)	1.3	n/a	<80%	>80%	>95%	monthly	83.2%	85.5%	84.9%	82.08%	84.15%	63.70%		63.50%	66.30%	64.50%

5.1.1 SBLCBv3 standard - Recording of CO reading and smoking status at the 36 weeks appointment (35 - 36+6).

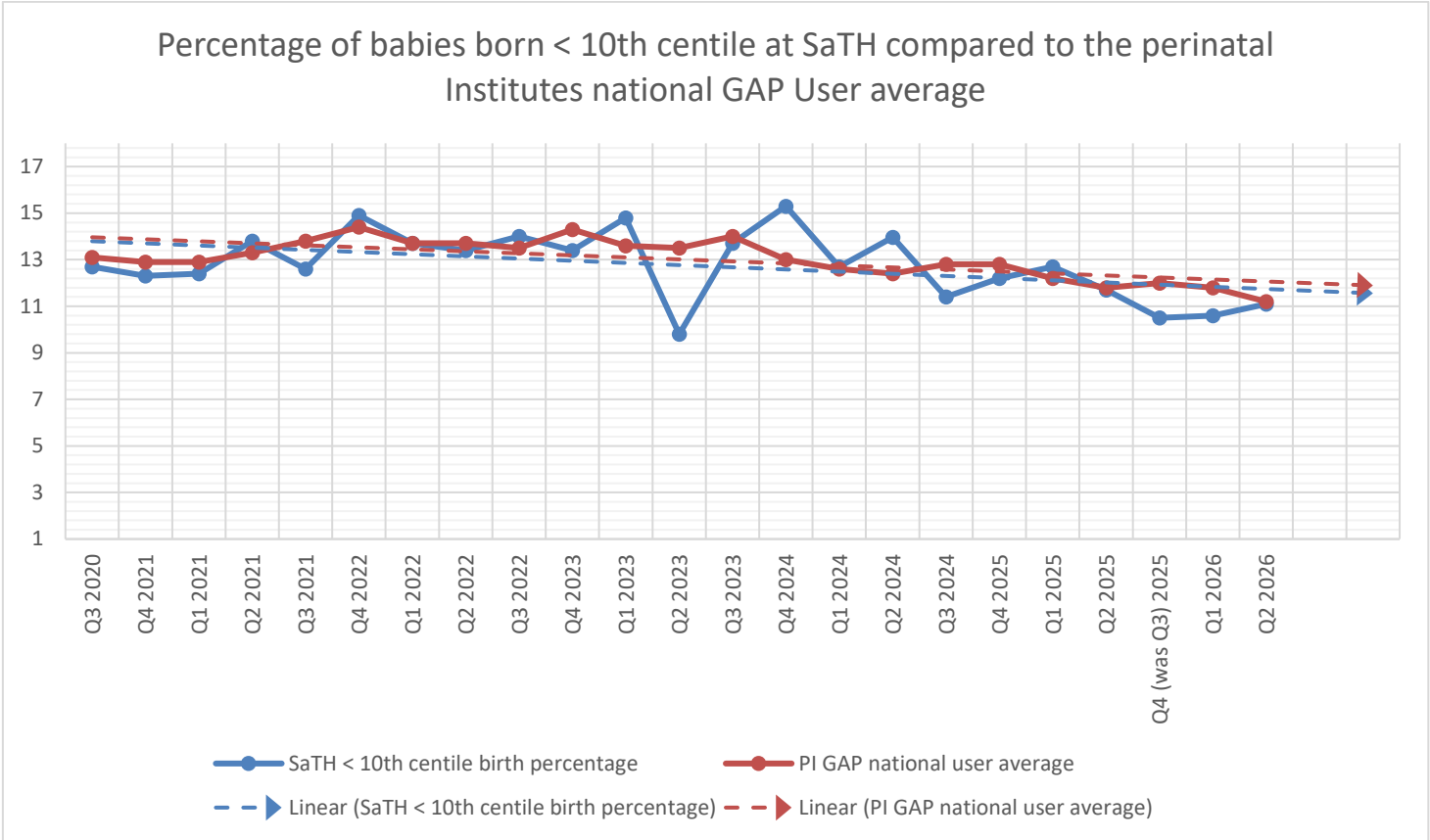
- CO monitoring at 36/40 has reduced and not met the stretch ambition for the last 4 quarters.
- Smoking status has not met the stretch ambition since March 2025.

5.1.2 Action Taken – A memo and 2x visual aids (additional report 1) have been emailed out to staff/distributed via staff group forums and printed to be put in offices and huddle folders, to raise awareness, understanding and compliance.

6.0 Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)

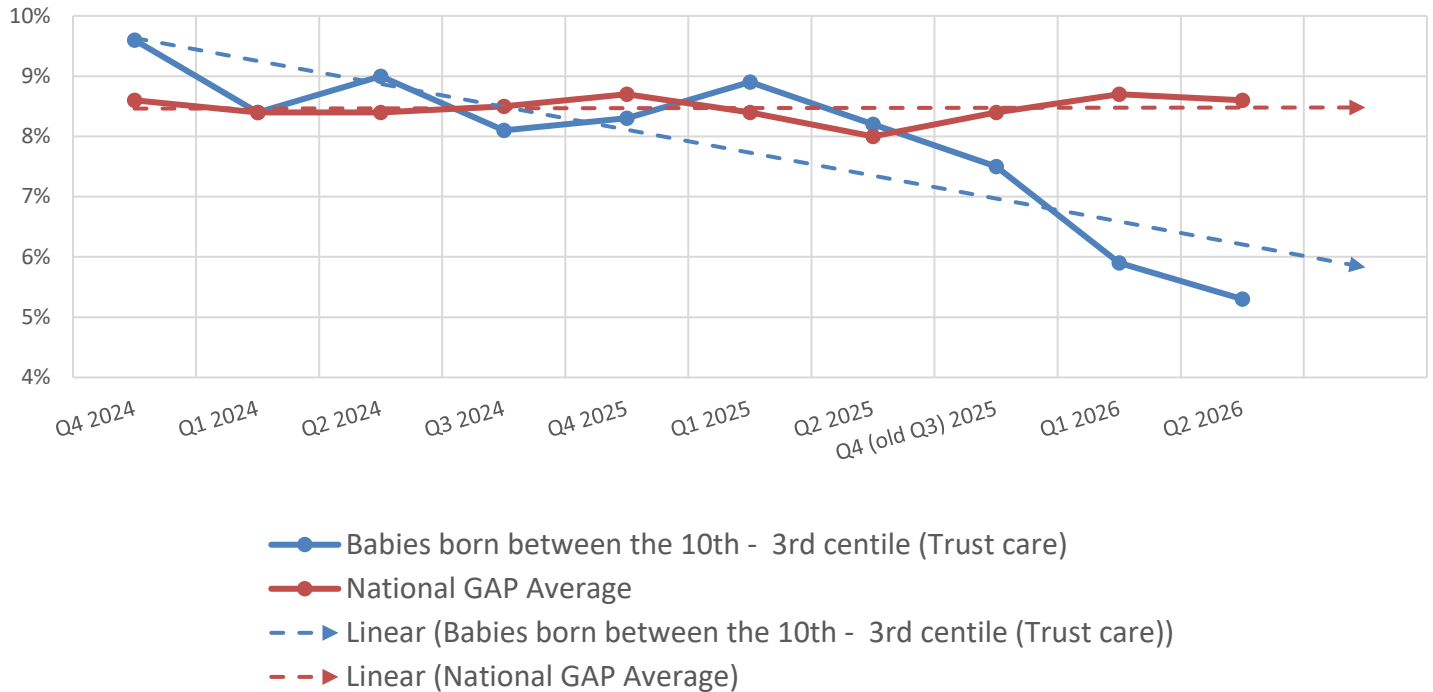
6.1 Trust data for <10th centile singleton pregnancies, prevalence and detection will be reported from data generated for the Trust from the Perinatal Institute (PI). Data from the PI is generated from the customised growth charts generated in pregnancy and the subsequent birth weight centiles (GROW 2.0).

6.1.1 Babies born <10th centile is similar to the PI national GAP average at 11.1% (GAP 11.2%). The overall linear trend continues to be reducing for the Trust in line with the current GAP trend. The overall linear trend for the Trust continues to show a reduction, consistent with the current national GAP trend.



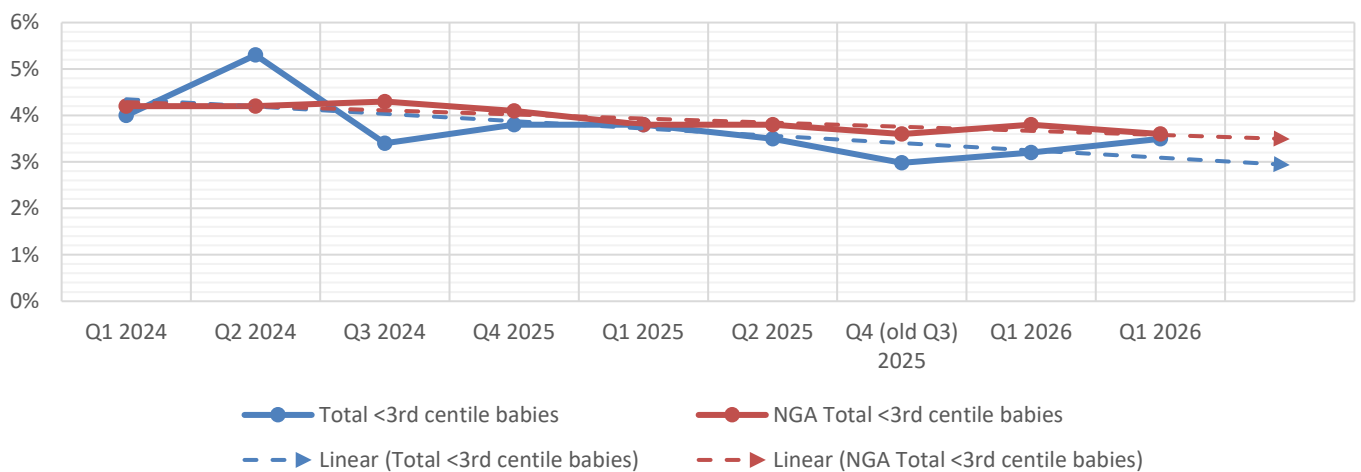
6.1.2 The proportion of babies born between the 10th and 3rd centile is significantly below the PI national GAP average, at 5.3%% (GAP 8.6%) this quarter. The Trust’s downward trend is indicating a faster rate than the national GAP average trend and potentially linked to falling SATOD rates in the Trust.

10-3rd centile Trust births

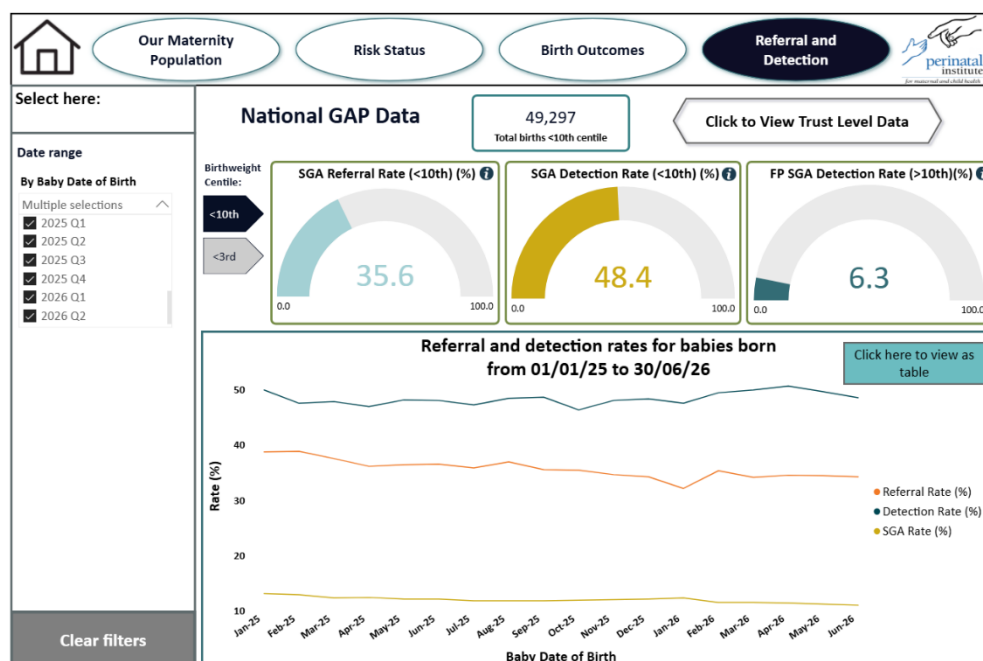
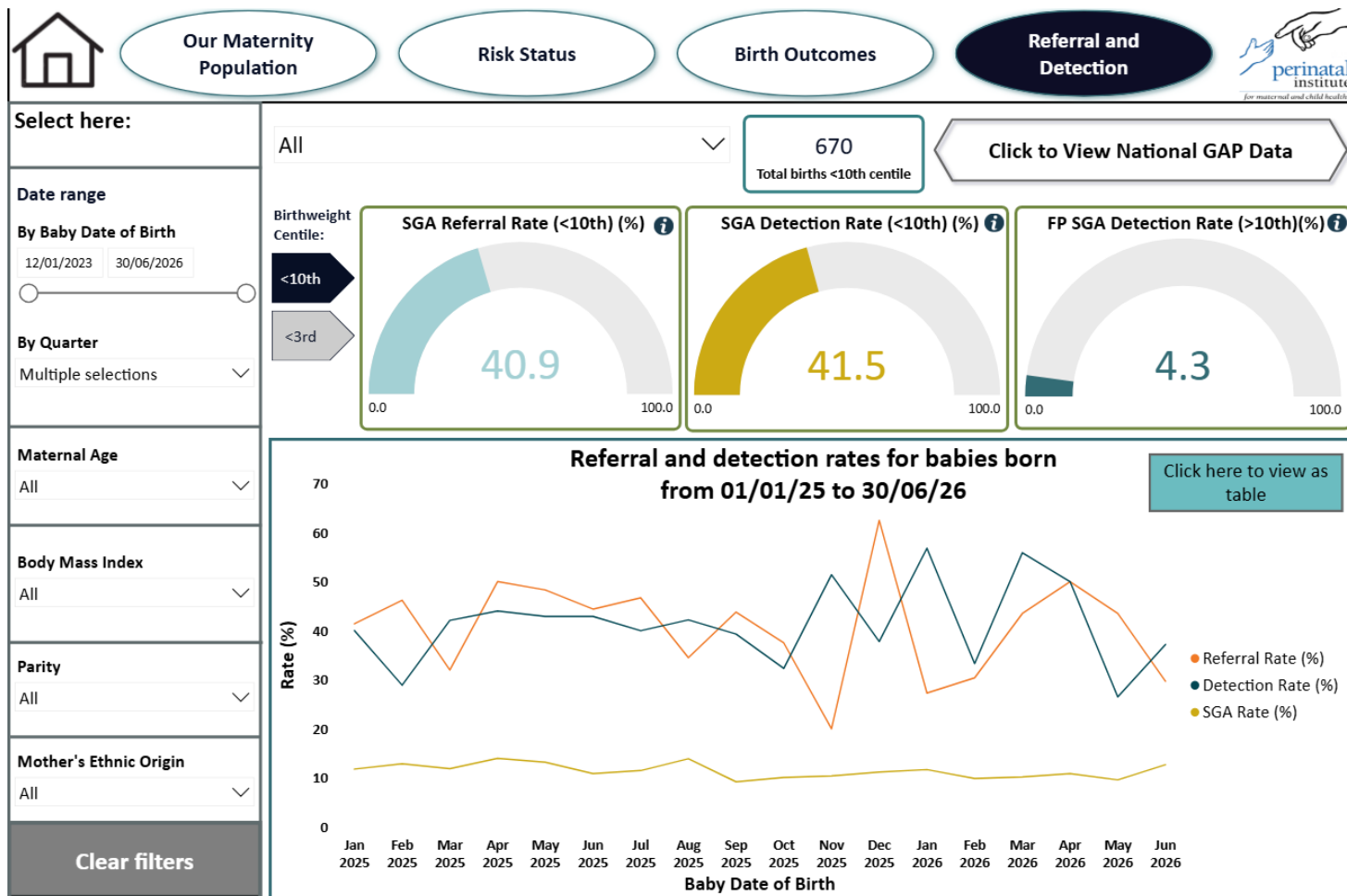


6.1.3 Babies born <3rd centile 3.5% is similarly to the PI national GAP average at 3.6 % The linear trend for the Trust continues to be reducing in line with the national GAP average trend over the past 2 years.

<3rd centile Trust births

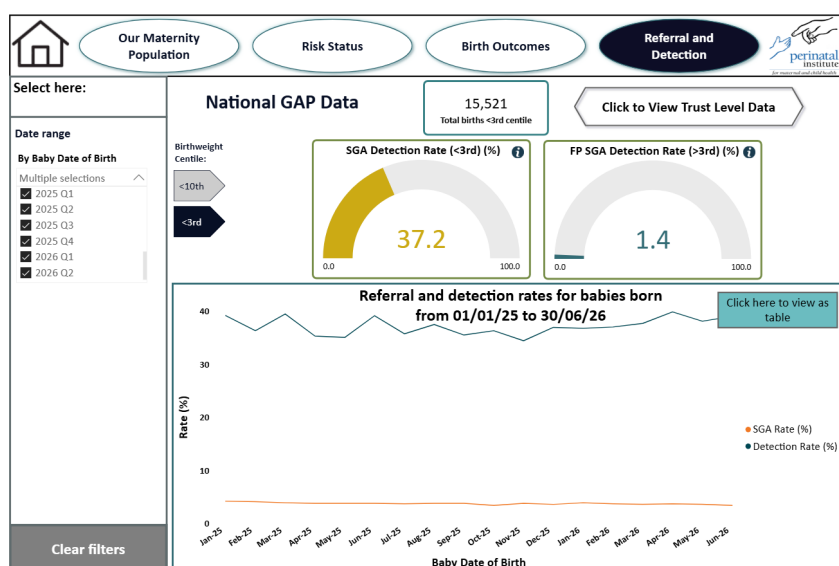
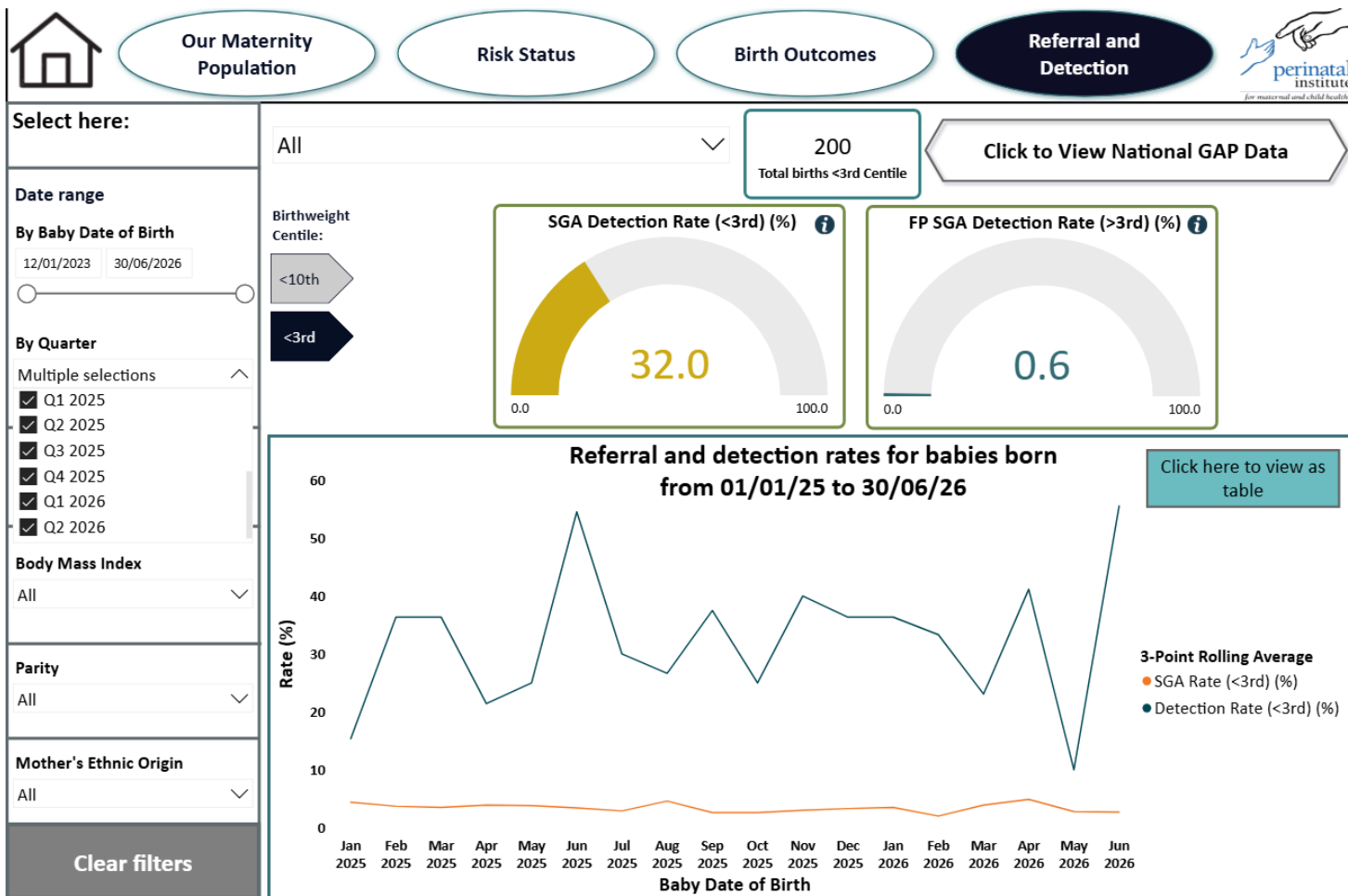


6.1.4 Detection rates for the Trust have generally improved compared to the national GAP average. <10th centile detection - The current rolling average for the Trust (41.5%) was below the the National GAP data of 48.4% (SaTH was above last quarter).



National GAP data

<3rd centile detection - The current rolling average for the Trust (32.0%) is marginally below the National GAP data of 37.0%. Although both Trust and GAP data have remained static for the past 6 months.



National GAP data

The Trusts False Positive rate (FP) is better than the national GAP average. This means less babies in the Trust were suspected as SGA but were a normal birth weight centile, which consequently will have reduced interventions such as induction of labour.

7.0 Element 3: Raising awareness of reduced fetal movements (RFM).

- 7.1 Annual audit report on RRFM management (see appendix 3)
 - 7.1.1 An annual audit on management of RRFM was completed in Q1 which the audit evaluated whether women received and had documented discussions regarding fetal movements prior to 28 weeks' gestation, whether individual communication needs such as language requirements were identified, and whether appropriate clinical management, including referral for ultrasound scanning, was undertaken in line with national guidance.
 - 7.1.2 Documentation of discussions regarding fetal movements prior to 28 weeks' gestation was present in 90% of cases, 10% while had no clearly documented evidence of such discussions. Unfortunately, 0% of cases required information in another language so we were unable to truly assess how well these needs are being met. In relation to clinical management, 83.3% of women were appropriately referred for ultrasound scanning in line with guidance. Of those who were not scanned, 66.7% had documented clinical reasons for this decision, while in 33.3% of cases no clear rationale was recorded.
 - 7.1.3 The original action plan was to re-review after 3 months but following advice from audit midwife, the plan is now to repeat review after 6 months to allow for time to raise awareness of Fetal Movements checklist, and time for improvement to implemented.
- 7.2 The RFM Survey that was circulated at the end of 2025 has also been redistributed to inpatients and triage attendees in paper form, due to limited responses previously.
- 7.3 The survey tool utilized reworded questions vetted by the MNVP to optimize readability, with a sample size of 35 participants (all identifying as female). Age Distribution represented predominantly by the 25–29 age bracket (12) and 30–34 age bracket (10). The transition to paper collection widened demographic inputs compared to historical surveys. 27 participants identified as White British, alongside representation from Indian, Asian, Black, Pakistani, and Mixed-White backgrounds. Four participants disclosed that English was not their first language (including Indian, Filipino, Punjabi, and Romanian native speakers), and one participant disclosed a diagnosis of Bipolar disorder.
- 7.4 It was noted that frontline clinicians are successfully providing information. 20 out of 35 participants received formal instruction on fetal movements by 16 weeks gestation, well ahead of the standard 28-week care bundle threshold. 30 participants actively accessed and read the digital movement materials via the BadgerNotes app, validating the digital transition strategy from historical physical photocopies. 33 out of 35 service users confirmed that a midwife or health professional had a direct discussion with them regarding movement patterns, showing a unified approach to care.
- 7.5 SBLCBv3.2 dictates that fetal movement must be discussed at every subsequent contact past 24–28 weeks. The survey demonstrated exemplary clinical compliance, with 34 out of 35 participants stating they were actively asked about their baby's movements at every single antenatal visit. 23 participants found the information "very easy" to understand, and 22 reported absolute consistency in the message delivered across different staff groups.
- 7.6 14 participants identified an episode where their baby moved less or differently between 24–28 weeks. 8 out of those who escalated contacted a professional within 1–3 hours of noticing the change. 19 individuals were directed to attend the hospital for a physical assessment throughout their entire pregnancy when RFM was disclosed. The staff reception was highly praised, with 16 participants rating the team as "very supportive".
- 7.7 4 main themes were noticed.
- 7.8 Theme 1: Bespoke Clinical Guidance. Multiple respondents highlighted that having an anterior placenta caused profound confusion regarding what constitutes a safe pattern, adding fear of "wasting staff time". This adds to increased psychological anxiety and a high risk of delayed presentation to triage due to self-doubt.

- 7.9 Theme 2: Language & Health Equity. 7 participants stated they were not told how to access translated versions of the movement material, despite 4 non-native English speakers being in the pool. Non-compliance with NHS health equity mandates; leaves vulnerable demographics without clear pathways to care.
- 7.10 Theme 3: Secondary Source Reliance. 17 users turned to Google, 9 to family/friends, and multiple qualitative comments cited using TikTok or ChatGPT for clinical reassurance. Service users are bypassing formal NHS pathways in search of "instant" digital answers, risking exposure to unsafe clinical misinformation.
- 7.11 Theme 4: Socio-Logistic Barriers. Qualitative commentary cited long triage wait times, parking issues, and childcare constraints as structural deterrents to seeking physical help. Service users knowingly delay necessary emergency clinical evaluations to avoid systemic friction point.
- 7.12 Action plan: **Anterior Placenta Care Pathway**: If not already in progress by colleagues, create a localized clinical leaflet or digital asset specifically addressing how an anterior placenta influences movement detection, aiming to mitigate patient presentation delays. Discuss **Mandatory Language Signposting**: Update the 16-week and 28-week antenatal checklist to mandate that midwives physically show non-native English speakers how to alter the language settings on BadgerNotes or access Tommy's translated leaflets.

8.0 Element 4: Effective fetal monitoring during labour

SBLCB v3.2 mandates that the following evidence for review

- 8.1 *Evidence of exception reporting for any women who have had an incorrect risk assessment for the method of fetal monitoring required.*

There were no incorrect risk assessments for the method of fetal monitoring required in Q2.

9.0 Element 5: Reducing preterm birth.

- 9.1 Review of preterm births report Quarter 2 2026 (additional report 4) areas of note.

9.1.1 Quarter 2 our preterm birth rate was 7.2%. The Trust's annual rolling average is currently 6.28 % which is slightly above the national target of 6%.

9.1.2 Place of birth – babies who are:

- born at <27 weeks' gestation
- <800 g at birth
- born as a multiple at <28 weeks' gestation

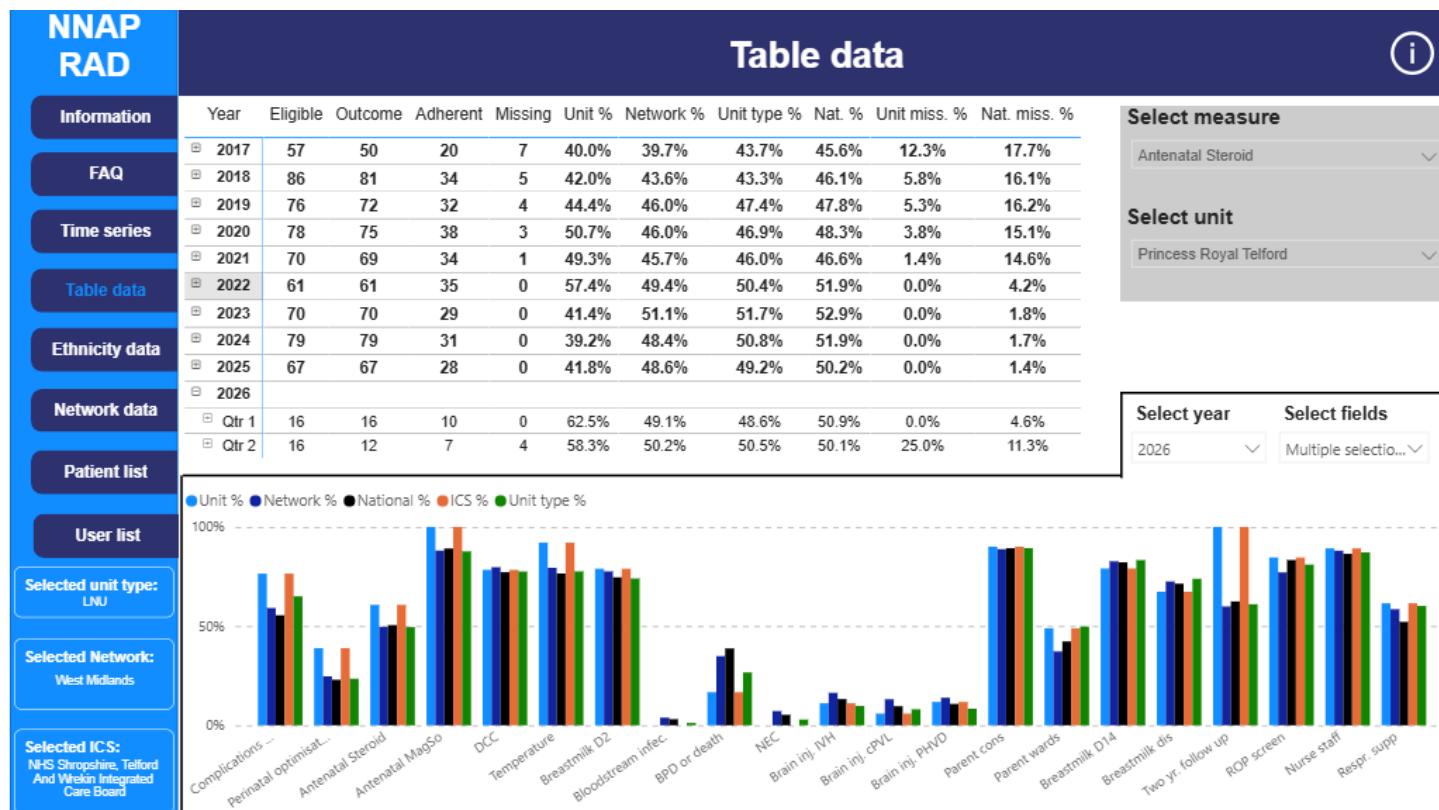
should be birthed in a maternity service on the same site as a designated neonatal intensive care unit (NICU).

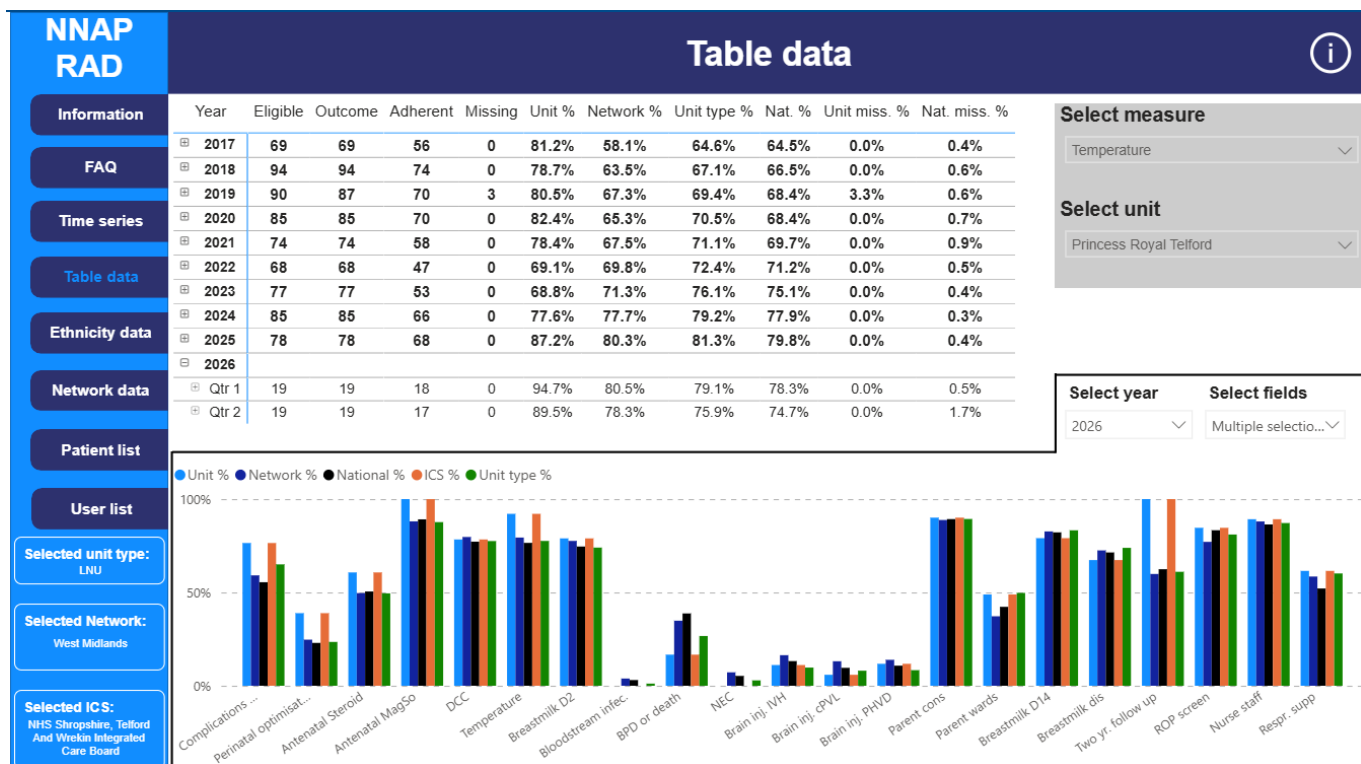
In Q2 2026, 0 babies were born in a unit with NICU following successful IUT. 1 woman was 26+2 not suitable for IUT. In May 2026, an MDT review took place to discuss this delivery, with use of the newly launched Midlands Preterm Tool. The care was graded a B, 'Care issues identified that would of made difference to the outcome'.

9.1.3 Administration a full course (2 injections, 12 to 24 hours apart) of antenatal corticosteroids within seven days of birth (< 34 weeks gestation) was 58.3% (minimum SBL ambition 40%) for Q2 2026 (NNAP data. This was better than network and national NNAP comparison data.

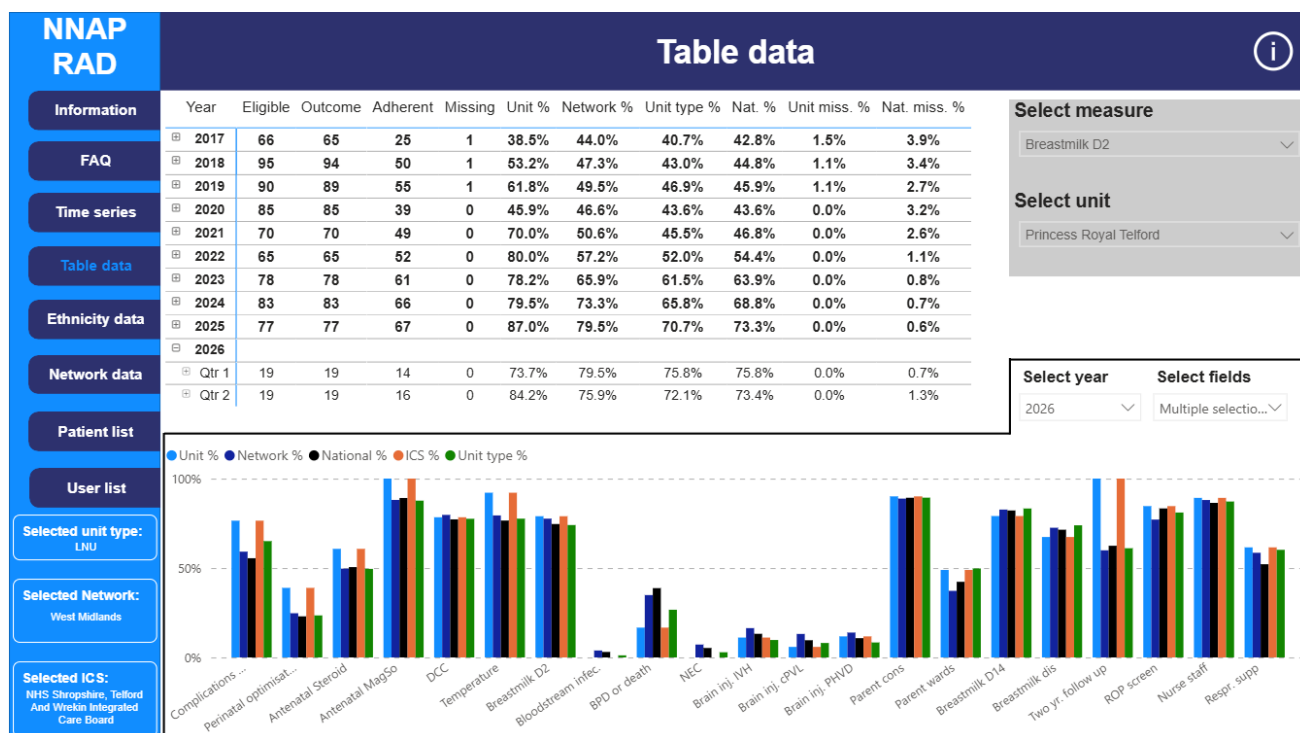
9.1.4 In the Q1 2026, there was potentially 1 missed opportunity identified for patient to have 2nd steroid, reviewed by a Consultant, confirmed patient was likely delivered when stable as PET, therefore no chance for 2nd steroid.

9.1.5 In Q2 2026, there was no missed opportunity identified for 2nd steroid.





9.1.9 NNP criteria is breastmilk within 48 hours of birth. The Trust has used SBLCB's measure of 24 hours for several years which may equate to the excellent data in comparison to unit type and national. The Trust is now working towards the PERIprem target of 6 hours.



10.0 Element 6: Management of Pre-existing Diabetes in Pregnancy

10.1 No new reviews in quarter but advice received from other trusts how they are meeting compliance of Element 6. As a trust, assurance has been provided that pregnant women already on a HCL system are being offered to change to the pregnancy specific system by the Diabetes Nurse Specialist. Maternity SLT investigating/escalating the non-offer to women not already on a HCL system. Other trusts currently using nursing staff to set pregnant women up on HCL systems who do not already have one in place.

Agenda item	2026/385			
Report	Women and Children’s Divisional Maternity & Neonatal Staffing report August 2026 data			
Executive Lead	Martina Morris, Group Chief Nursing Officer			
	Link to strategic pillar:		Link to CQC domain:	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		Link to BAF / risk:	
	For assurance	√	BAF 1204	
	For decision / approval		Link to risk register:	
	For review / discussion			
	For noting			
	For information	√		
	For consent			
Presented to:	Maternity and Neonatal Governance – August 2026			
Dependent upon:	NA			
Executive summary:	Information supplied based on August 2026 staffing data The main findings of this report are: Maternity • During August have sustained levels of positive acuity above 85%, reporting Green Acuity at 96% with 4% Amber and 0% Red. • Confidence factor in the data entry has been reported at 91% • Red Flag reporting is now in accordance with National and local guidance. 14 red flags reported in August with 86% (n=12) continue to be reported for delay in ARM. • One to one care in labour and supernumerary status of the coordinator continues to be maintained at 100% in August reflecting the ongoing risk assessment and escalation where necessary to ensure safety in the service. • This month we have seen an improved acuity and red flag reporting The main findings of this report are: Neonatal • BAPM compliance increased from 90 – 100% • QIS compliance remains stable at 59% this month and there continues to be a rolling plan for further training. We will have a further 2 staff members joining the QIS team in November.			

	• The NIC was supernumerary for 100% of the shifts during August which is an improvement from 93% last month. • The decision to close the unit to external Hospitals has decreased again from 7 – 2 times. 1 was due to capacity as we were over our ITU/HDU numbers and the other was due to staffing • Registered fill rates remain stable. Unregistered fill rates have dropped slightly due to annual leave and some sickness. • Sickness has reduced from 11.2 - 9.4% The main reasons for sickness remain anxiety/stress and fractures. There are currently 6 members of staff off on long term sickness with one member who has retired at the end of the month and another who has returned mid-month on a phased return.
Appendices	Nil

1.0 Introduction

NICE published the report Safe Midwifery Staffing for Maternity Settings in 2015, updated in 2019. This guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service. The guidance was produced in response to previous reports such as the Francis report (2013).

The Maternity Incentive Scheme (MIS) for CNST Year 8 requires

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. Regional Chief Midwives are able to support this process if required.

What good might look like includes

- A recent BR+ report (within three years) demonstrating how the funded midwifery establishment compares with the BR+ recommendations.
- Evidence of explanation where professional judgement has been used to adjust BR+ numbers (for example, reflecting local case mix, service configuration, acuity trends, development roles and headroom uplifts).
- A clear explanation for any differences between funded and required numbers, and an agreed plan for how the Trust intends to address these gaps over time (n.b. aligned midwifery establishment must be funded for MIS compliance).
- Routine monitoring of key safety indicators such as one-to-one care in labour, red flags, missed breaks, or high acuity periods, with actions taken in response.
- A monthly or quarterly update to governance groups showing workforce trends, pressures, and progress against recruitment or retention plans.

- Examples of joint conversations across maternity and neonatal teams to ensure midwifery staffing is seen as part of wider perinatal workforce planning.
- Evidence of Board oversight of compliance with this sub-action (linking to sub action A7 and Safety Action F governance and reporting).

2.0 Planned versus actual staffing levels

Each month the planned versus actual staffing levels are submitted to the national database and NHSI using the information provided from the Healthroster Allocate rostering system. Planned versus actual staffing and acuity are reviewed twice daily at the management huddle. Staff may be reallocated based on the daily huddles in order to ensure appropriate staffing in the areas. The escalation policy is implemented should any area require more midwifery staffing based on patient numbers and acuity/complexity.

Table - Fill Rates for Delivery Suite (including Triage) and Wrekin Midwifery Led Unit

	Fill Rates DS RM%		Fill Rates DS WSA%		Fill Rates Wrekin RM%		Fill Rates Wrekin WSA%	
	Day	Night	Day	Night	Day	Night	Day	Night
December 2025	91	88	68	80	84	81	89	81
January 2026	97	99	83	89	74	67	68	77
February 2026	94	98	84	87	76	69	83	81
March 2026	95	86	85	81	83	70	92	70
April 2026	95	91	79	76	95	84	79	90
May 2026	95	92	81	66	94	82	95	86
June 2026	91	92	72	84	77	86	78	75
July 2026	90	82	61	54	46	72	43	77
August 2026	92	87	74	86	77	82	77	80

Table - Fill Rates for Antenatal Ward (AN) and Postnatal Ward (PN)

	Fill Rates AN/PN Ward RM%		Fill Rates AN/PN Ward WSA & MSW%	
	Day	Night	Day	Night
December 2025	96	96	93	95
January 2026	103	96	98	101

	Fill Rates AN/PN Ward RM%		Fill Rates AN/PN Ward WSA & MSW%	
February 2026	98	96	96	96
March 2026	94	97	89	96
April 2026	101	95	97	96
May 2026	93	96	93	89
June 2026	97	79	100	99
July 2026	117	91	96	88
August 2026	94	96	90	93

Table - Fill Rates for Neonatal Unit (NNU)

	Fill Rates Neonatal unit RN %		Fill Rates Neonatal unit nonregistered HCA %	
	Day	Night	Day	Night
May 2026	82	88	96	97
June 2026	81	87	87	83
July 2026	81	90	94	84
August 2026	85	90	84	77

BAPM/QIS compliance

	June 26	July 26	August 26
BAPM Compliance of nursing shifts	95%	90%	100%
QIS Compliance	59%	59%	59%

According to the QIS trajectory based on the staff that are currently booked on QIS courses, we will reach 70% in December 2027. The process takes approximately 15 months from starting the Foundation course to completing the QIS and the 3-month supernumerary period before they are fully counted in the QIS numbers.

Unavailability -Calendar Month

Table showing unavailability by area (% sickness and % parenting leave)

AUGUST	Sickness	Parenting Leave
Delivery Suite & Triage	6.2 ↔	10.0%
Antenatal & Postnatal	2.2% ↓	4.5%
Wrekin (including community)	6.9% ↔	9.4%
Shrewsbury Maternity Team	2.4% ↑	0%
Bridgnorth & Ludlow Maternity Team	9.1% ↑ *	7.9%
Oswestry & Whitchurch Maternity Team	0%↑	15.2%
Telford & Shrewsbury Outpatients	11.5↑	0%
Midwife Scanning	0.8% ↓	12.5%
Neonatal Unit	9.2%↓	7.3%

Unavailability for parenting remains high across Maternity inpatient and outpatient areas. Bridgnorth and Telford & Shrewsbury Outpatients high levels of sickness of unregistered staff (support workers).

Neonatal sickness remains high despite reducing from 11.2 - 9.4% this month. The main reasons continue to be anxiety/stress and 2 staff members have fractures. There are 6 members of staff currently off long-term sickness.

Bank shifts filled by area

Tables showing total number of shifts filled by bank broken down into day/night showing midwives and support workers with the reason for bank requirement.

Delivery Suite and Triage- Total filled by bank 133 shifts ↑

AUGUST	Day	Reason	Night	Reason
B7 co-ordinator	4	Short term & long-term sickness	6	Short term & long-term sickness
RM (B5 & B6)	34	Short term & long-term sickness	37	Short term & long-term sickness
RM Elective list	2	Short term & long-term sickness	NA	NA
WSA/MCA	22	Short term & long-term sickness	28	Short term & long-term sickness

Antenatal & Postnatal– Total filled by bank 113 shifts ↔

AUGUST	Day	Reason	Night	Reason
RM	33	Short term & long-term sickness	17	Short term & long-term sickness
RM NIPE	9	Short term sickness	NA	NA
MSW	3	Short term & long-term sickness	20	Short term & long-term sickness
WSA/MCA	13	Short term & long-term sickness	18	Short term & long-term sickness

Wrekin – Total filled by bank 76 shifts ↔

AUGUST	Day	Reason	Night	Reason
RM	6	Long & Short-term sickness	13	Long Term sickness
RM Bookings	16	Extra capacity	0	NA
RM Community	15	Short- & long-term sickness	0	NA
MSW B3	5	Short term sickness	0	NA
WSA	4	Short/long term sickness	15	Short/long term sickness

Neonatal Vacancies

August 26	Other	Band 7	Band 6	Band 5/4	Band 3
	Fi Care specialist nurse Safeguarding lead Nurse Ward Clerk	1.4 WTE	2.6 WTE to go back out to advert	1.61 WTE	
Narrative			This includes 1 WTE developmental post	12-month fixed term to cover maternity leave	
Action	All 3 roles are going through vacancy panel				

3.0 Intrapartum Acuity

Intrapartum activity is measured using the Birthrate plus acuity tool

Birthrate defines acuity as “the volume of need for midwifery care at any one time based upon the number of women in labour and their degree of dependency.”

A positive acuity scores means that the midwifery staffing is adequate for the level of acuity of the women being cared for on delivery suite at that time. A negative acuity score means that there may not be an adequate number of midwives to provide safe care to all women on the delivery suite at the time. In addition, the tool collects data such as red flags which are defined as a “*warning sign that something may be wrong with midwifery staffing*” (NICE 2015). SaTH has adopted the red flags detailed in the NICE report.

The Royal College of Midwives in discussion with Heads of Midwifery has suggested that a target of 85% staffing meeting acuity should be set, this can be reviewed and set locally depending upon the type of maternity service. In addition, there should be a compliance with data recording of at least 85% to have confidence in the results.

Compliance with completion of the **acuity tool was 91%** this is above the target set of 85%. The compliance is based on data entry of 6 set times across a 24-hour period at the following times 03:00/07:00/11:00/15:00/19:00/23:00 - additional acuity data can be entered at any time across a 24-hour period especially in times of high acuity. We have reviewed the entries to monitor ongoing compliance and have noted the following.

- There were 186 occasions where acuity is available to be entered at the set allocated times with 169 completed and an additional 17 entries.

- A function within Birth Rate acuity tool displays missed data entries by day and time. This allows Matrons and Manager of the Day to monitor data entries in order to improve compliance.
- Missed entry timings were 11:00/15:00 and 19:00 with Friday being the most frequent day there is little evidence to suggest acuity impacted on these missed data entries in August.



Wrekin Midwife Led Unit

The staffing situation for the midwife led unit has ensured consistent service day and night. Capacity and activity are reviewed at the twice daily safety huddles by the manager of the day and decision by the senior leadership team if a divert is required due to acuity on delivery suite.

In August 29 women commenced intrapartum care on the MLU with **15 women giving birth on the MLU**.

4.0 Red Flags

Maternity services hold twice daily safety huddles in which all red flags are discussed. In order to manage the identified red flags midwives are moved to balance acuity and facilitate safe care.

We have held a number of meetings with BirthRate Plus over the last few months and have updated and revised Red Flags in accordance with local and National Guidance. This will enhance the information and data recording in order to continue to monitor safety within the service.

During August we reported **14 red flags**. Weekly reviews of incidents during this period have not highlighted any safety issues/outcomes or themes of incidents.

Of the red flags reported the majority continue to be for delay in ARM with 86% (n=12) of red flags accounting for this delay.

The most common red flag reported consistently in all previous staffing reports are related to delays in ARM.

The process for monitoring while awaiting ARM/augmentation a maternal and fetal assessment is completed every 4 hours which includes a CTG. Women who attend for augmentation for prolonged rupture of membranes remain on delivery suite and continue with maternal and fetal monitoring. This process allows for any risks to be identified along with close monitoring of any deviations to maternal or fetal condition which may require immediate attention or intervention.

Red flags are discussed at each medical handover, and plans are made for immediate management and prioritisation to maintain safe outcomes.

Number of Red Flags recorded

01/08/2026 to 31/08/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
 RF1	Delayed or cancelled time critical activity	2	14%
 RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
 RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
 RF4	Delay in providing pain relief	0	0%
 RF5	Delay between presentation and triage	0	0%
 RF6	Full clinical examination not carried out when presenting in labour	0	0%
 RF7	Delay between admission for induction and beginning of process	0	0%
 RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
 RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
 RF10	Delay in ARM of more than 8 hours	12	86%
 RF11	Co-ordinator unable to maintain supernumerary status - providing 1:1 care	0	0%
 RF12	Co-ordinator unable to maintain supernumerary status - NOT providing 1:1 care	0	0%
TOTAL		14	

*The % is rounded to nearest whole number

Table – Maternity Acuity Red Flags Recorded

Month	Red Flags	One to one Care not met	Co-ordinator not supernumerary	Positive (green) Acuity %	Acuity Amber %	Acuity Red%	Acuity Compliance Rate
July 2025	8	0	0	99%	0.5%	0.5%	91%
August 2025	3	0	0	95%	5%	0%	89%
September 2025	7	0	0	97%	3%	0%	93%
October 2025	18	0	0	98%	2%	0%	91%
November 2025	15	0	0	95%	5%	0%	86%
December 2025	19	0	0	92%	8%	1%	89%
January 2026	11	0	0	95%	5%	0%	90%
February 2026	20	0	0	96%	3%	1%	89%
March 2026	12	0	0	96%	3%	1%	89%
April 2026	35	0	0	95%	4%	1%	84%
May 2026	25	0	0	94%	6%	0%	91%
June 2026	26	0	0	88%	10%	1%	91%
July 2026	31	0	0	89%	10%	1%	88%
August 2026	14	0	0	96%	4%	0%	91%

4.1 Neonatal - Acuity Red Flags Recorded

In the month of August, we had 2 occasions when the decision was made to close the unit to external admissions, 1 was due to staffing levels and the other was due to capacity. This is an Improvement from the previous month which was 7.

We have been working hard on improving the reporting of refusals for transfers, both in-utero and ex-utero and repatriations of our babies from other hospitals alongside monitoring staffing and Opel related incidents. During August there were 5 refusals noted (one of which was a set of twins). X3 were due to capacity as we were over our IT/HDU numbers, X1 was due to staffing and X1 was an inappropriate transfer due to social circumstances of a family who would have been unable to travel to PRH to be with their baby.

5.0 One-to-one care in established labour

One-to-one care is defined as “care provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same midwife for the whole of labour)” (NICE 2015).

During August **1:1 care in labour was 100%.**

6.0 Supernumerary status of the co-ordinator

Supernumerary status of the co-ordinator is defined as the coordinator not having a caseload. The acuity tool has time built in for the co-ordinator to be supernumerary when it is recorded.

The NICE Guidance on Maternity Red Flag reporting relates to the coordinator being required to provide 1:1 care of a woman in labour, high risk antenatal or postnatal requiring 1:1 care. The Maternity co-ordinator remained 100% supernumerary not providing 1:1 care during August.

The Neonatal supernumerary co-ordinator is required to conduct day to day management of nursing care provision on neonatal units this should be undertaken by a senior nurse who has no clinical commitment during a shift. However, this role may include supporting other nurses during times of acute admissions and transfers (BAPM, 2010)

There were a possible 62 shifts in the month of August, however there was one shift with data missing, therefore this is taken from 61 shifts.

The NIC was fully supernumerary for 100% of the time (61 shifts)
This is an improvement from the previous month which was 93%

6.1 BAPM Nursing staffing compliance per shift

A review of data from the Badger system shows acuity for baby to nurse BAPM ratio was 100% for the month of August which is an increase from last month which was 90%

7.0 Midwife unavailability

Daily staffing meetings continue with the Ward Managers and Matrons. This provides the opportunity to focus on staffing two weeks ahead and action/identify solutions to maintain safe staffing levels.

8.0 Actions

8.1 Maternity Actions taken

- Staffing meetings have moved to daily with the Ward Managers and Matrons. This provides the opportunity to focus on staffing two weeks ahead and action/identify solutions to maintain safe staffing levels. Staffing is also reviewed at Senior Leadership Team meetings.
- Monthly PRM meetings are held to support managers with sickness absence and return to work. This includes Workforce who help provide strategies for return to work.
- A Maternity Manager rota is allocated daily (including weekends and bank holiday) to provide support with operational flow and staffing in all areas. This is additional to the Divisional Manager on Call Rota.
- Band 5 Preceptor Midwives are supported by the Clinical Practice Facilitators and a nominated preceptor midwife identified by a 'Tree of Life' badge. We have recently recruited newly qualified midwives on Fixed Term contracts and the midwifery workforce recruited in January 2026 have been offered permanent contracts.
- The cohort of Preceptor Midwives are completing their programme with progression to Band 6.
- Midwives from the International Cohort programme are fully included in the workforce the remaining two from 2024 cohort of re continuing with their Preceptorship Programme and are being supported to achieve their competencies.
- Specialist Midwives have allocated clinical hours to provide availability as part of existing rosters.
- Ward Managers are working at least one day clinically a week to support staffing during times of high acuity.

8.1.1 Neonatal Actions

- Continue recruitment efforts to ensure a full staffing template
- Continue with the Foundation and QIS training plan and support newly qualified QIS staff during their consolidation period
- Continue to monitor sickness levels and identify any emerging themes. All sickness policies are being adhered to.
- Seek support from Specialist Nurses to ensure adequate staffing on the ward to ensure NIC can remain supernumerary.

9.0 Conclusions

We will continue to monitor acuity and staffing daily due to Red Flag reporting and the recent trend in positive acuity reporting with a review of actions taken to maintain positive acuity and adjust/respond where appropriate to ensure continued positive acuity.

We have moved to a National Maternity and Neonatal SitRep reporting and continue to review regional acuity.

These measures will continue and be monitored by the management team.

Neonatal teams are continuing with their recruitment process to ensure that all shifts are adequately and appropriately staffed to support safe staffing on the ward and to support the timely opening of the Transitional Care unit.

Report author(s):

Jacqui Bolton, Maternity Matron

Jo Demers, Neonatal Matron

Obstetric Emergencies- Simulation in Clinical Areas

SUMMARY REPORT :
DATE 13TH JULY 2026

Date and time: Scenario: Details of any adoptions to scenario:	12:45 13th July 2026 ABC Training Programme Impacted Fetal Head. Situation: As a team you are in theatre for an Emergency Caesarean Birth because cervical dilatation has remained at 9cm Background: Hattie is 40 weeks gestation in her first pregnancy, which has been uncomplicated. She started labouring on Wrekin MLU but was transferred to Delivery Suite for Syntocinon augmentation. Cervical dilatation has not changed for the last four hours so after discussion with Hattie a decision is made for a Category 2 C/S. The CTG is normal. Assessment: Hattie has a good working Epidural insitu. Vaginal examination in theatre showed no change in dilatation and confirmed caput, moulding and OA position. Recommendation: Please proceed to C/S Neonatal: S- Bleeped to attend CAT 2 delivery, failure to progress. B- As above A - Baby was born in a poor condition: floppy, no respiratory effort and HR <60 R- Team will be expected to resuscitate the baby as per NLS- the baby will respond slowly with ineffective breathing. Recognition of need to stabilise airway with ETT. How to get the equipment Cord gases will be available if asked for and will show respiratory compromise and prompt discussion about cooling.
Faculty lead	Karen Henderson – Lead Midwife for Education Chris Clulow – Consultant Anaesthetist Mark Wilkinson – Consultant Obstetrician
Faculty present	Stacey Dixon – ANNP Liz Aaron Senior- Senior PEF Hattie Page – Senior PEF Alisha Rayward – PEF

Attendees/ participants	
Names and designation:	Theatre Team Jonathon Hales – Povey – Theatre Coordinator Scrub Nurse Theatre Support staff Midwifery Team Taylor Griffiths Alicia Higgins Rebecca Gwilt Charlene Bahia – Coordinator Anaesthetic Team Manpreet Badh Aruna Wickramasinghe Damith Silva Neonatal Team Emily Stokes – ANNP Salma Amin Amy Clifton Obstetric Team Simrat Kaur – Tier 2 Doaa Elhegazy – Tier 1 Nilanjana Singh – Tier 3

Organisational Learning

Good Practice Points

- Prompt recognition of risk factors enabling the team to anticipate the potential for Impacted Fetal head and prepare by allocating tasks to team members
- There was a clear declaration of Impacted Fetal Head by the Tier 2 Doctor leading to appropriate allocation of roles which facilitated escalation and appropriate clinical management
- There was awareness of the need for vaginal disimpaction which was correctly performed
- GTN spray was given by the Anaesthetist in discussion with the Surgeon once the emergency was declared
- Effective clinical management of Impacted Fetal Head using correct manoeuvres
- Good use of observer checklists which facilitated discussion around human factors which included communication, leadership and situational awareness.
- Good discussion around position of equipment in theatre and awareness of the contents of the Emergency Trolley.

Neonatal Team additional comments:

- There was a clear handover from Midwife to ANNP.
- The equipment was rechecked by the ANNP
- Appropriate realisation of need for senior team
- Appropriate NLS and escalation

Key Learning to share with teams?

When declaring Impacted Fetal head, state Obstetric Emergency to ensure all teams appreciate the urgency and trigger escalation.

There was clear awareness of the indication for vaginal disimpaction by the Tier 2 Doctor which was shared with the Midwife. Communication could have been improved by ensuring this was heard by the wider team so that the team could work together to assist in tasks such as head tilt, moving and supporting legs and performing the vaginal disimpaction.

Ensure that there is an individual designated to handover to incoming teams following escalation. As the Neonatal Team were across the other side of theatre it is important to ensure that communication can be heard by the team.

Recognition of the need for additional training required for Theatre staff as they do not currently attend PROMPT. To develop bespoke training for theatre staff as part of the ABC Impacted Fetal Head Training programme along with ongoing insitu simulation.

To include a bespoke ABC Impacted Fetal Head Training programme on the August Drs Induction.

Neonatal Team additional comments

- If people see others are struggling its ok to intervene and offer to help
- Awareness of what is on the emergency trollies- We did a team review of the trolley post SIM with all our medical team on shift

Faculty learning**What went well:**

Pre simulation preparation to ensure Senior Leadership and MDT support to ensure that simulation was able to go ahead. To continue to liaise with relevant departments and SLT around the timing of Insitu simulation.

MDT Faculty involvement with the simulation and debrief.

Identified the need for regular insitu simulation for the wider MDT. Proposed regular monthly simulation involving the full MDT with key learning shared with the Senior Leadership team and Managers for dissemination to all staff.

The Education Team to update the Insitu simulation schedule following changes within the MDT faculty to ensure representatives from all relevant MDT.

What could we have done differently:

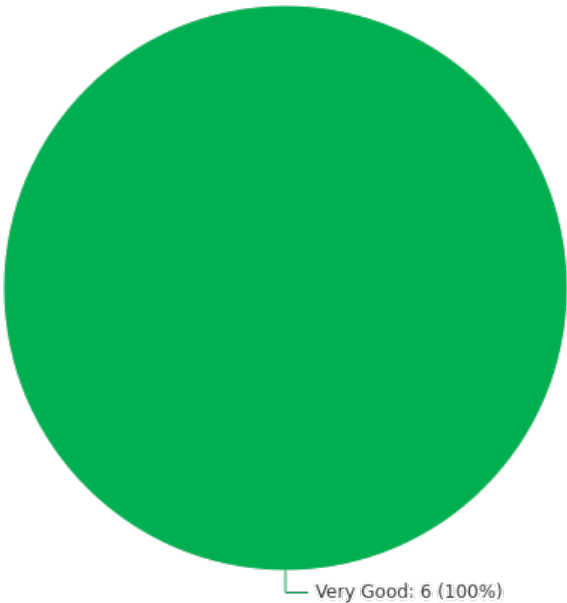
Mentimeter evaluation sent out after the simulation due to time constraints however not all staff participated in the evaluation. Mentimeter QR and code to be given at the time of the simulation to encourage wider participation.

Friends and Family Test - Maternity (Poppy's Promise version 2) Report

3rd September to 10th September 2026

Friends and Family Test Questions

Thinking about your recent visit, overall how was your experience of our service?



Answer	Total
Very Good	6
Good	0
Neither good nor poor	0
Poor	0
Very poor	0
Don't know	0
Total responses	6

What do you feel has been good about the care or experience you have received ?

Theme	Total
Positive	6

Service	Comment	Theme	Status
Wrekin Community Maternity	Midwife was lovely and explained everything thoroughly.	Positive	Private - not for display
Wrekin Community Maternity	Staff at the wrekin mlu were lovely and very informative	Positive	Private - not for display
Shrewsbury Maternity Outpatients	The whole team treated me and my partner so lovely in what was a stressful and worrying situation. I was kept informed of all information at all times and they made my c section experience very positive.	Positive	Private - not for display
Shrewsbury Maternity Outpatients	Catherine was extremely competent made us feel at ease in a very nervous situation , friendly took her time and explained matters well .	Positive	Private - not for display
Wrekin Community Maternity	Seen promptly and kind staff	Positive	Private - not for display
Shrewsbury Maternity Outpatients	Friendly and professional midwife	Positive	Private - not for display

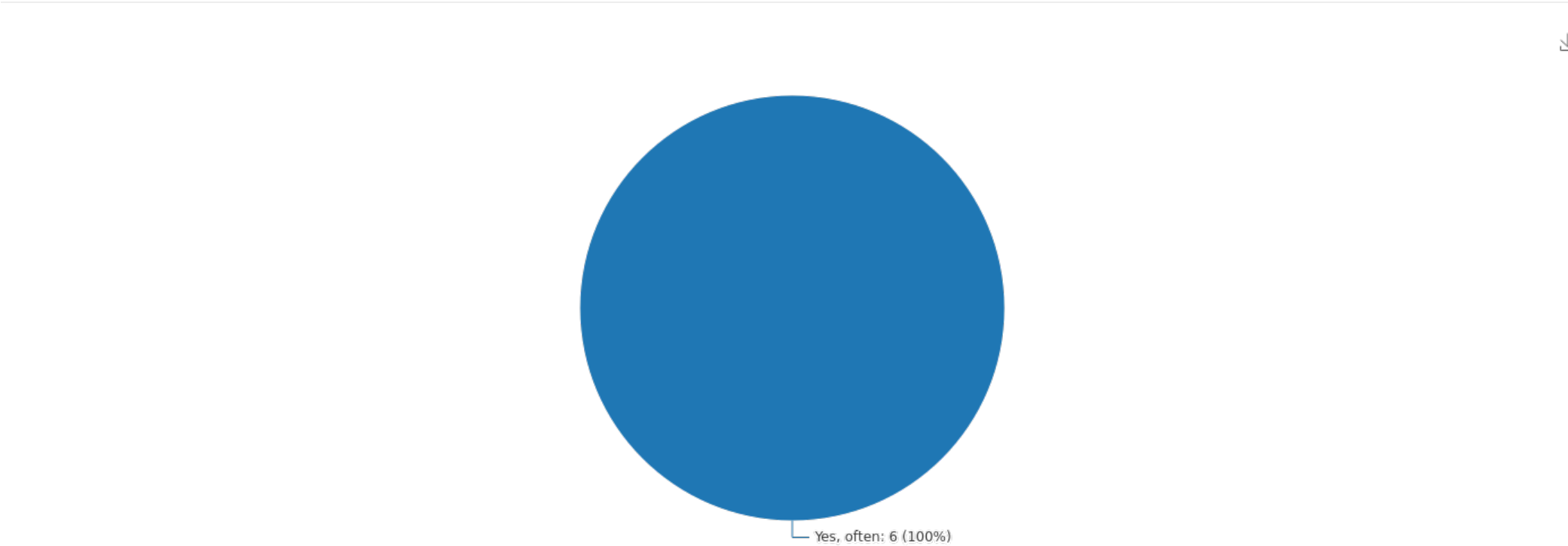
Do you want to tell us anything else about your visit and what we could improve ?

Theme	Total
Positive	3
Neutral	2
Negative	1

Service	Comment	Theme	Status
Wrekin Community Maternity	No, all good.	Positive	Private - not for display
Wrekin Community Maternity	N/A	Neutral	Private - not for display
Shrewsbury Maternity Outpatients	It could not have been better, every staff member was amazing the facilities were great.	Positive	Private - not for display
Shrewsbury Maternity Outpatients	No	Neutral	Private - not for display
Wrekin Community Maternity	Parking seemed easy and I was able to find where I needed to be.	Positive	Private - not for display
Shrewsbury Maternity Outpatients	It's not clear where the waiting room is for the windwifes centre. Clearer labels and instructions are needed	Negative	Private - not for display

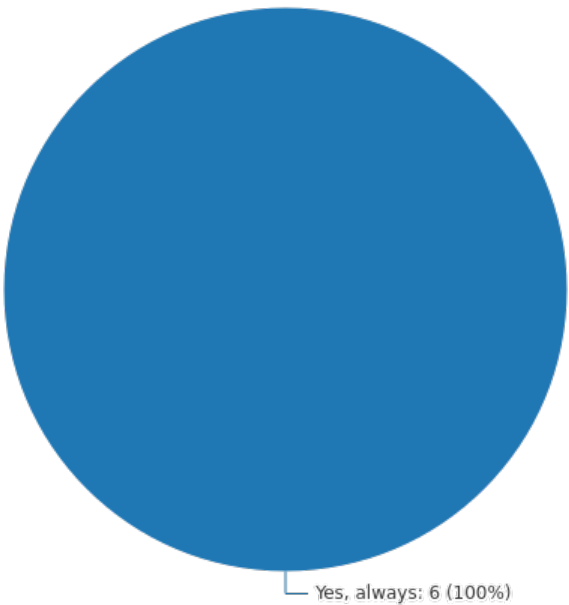
Poppy’s Promise is about listening, understanding and treating every patient and the people important to them with compassion and respect. It brings kindness and communication to the heart of care at The Shrewsbury and Telford Hospital NHS Trust. Your feedback helps us make care better for everyone.

Did you feel listened to?



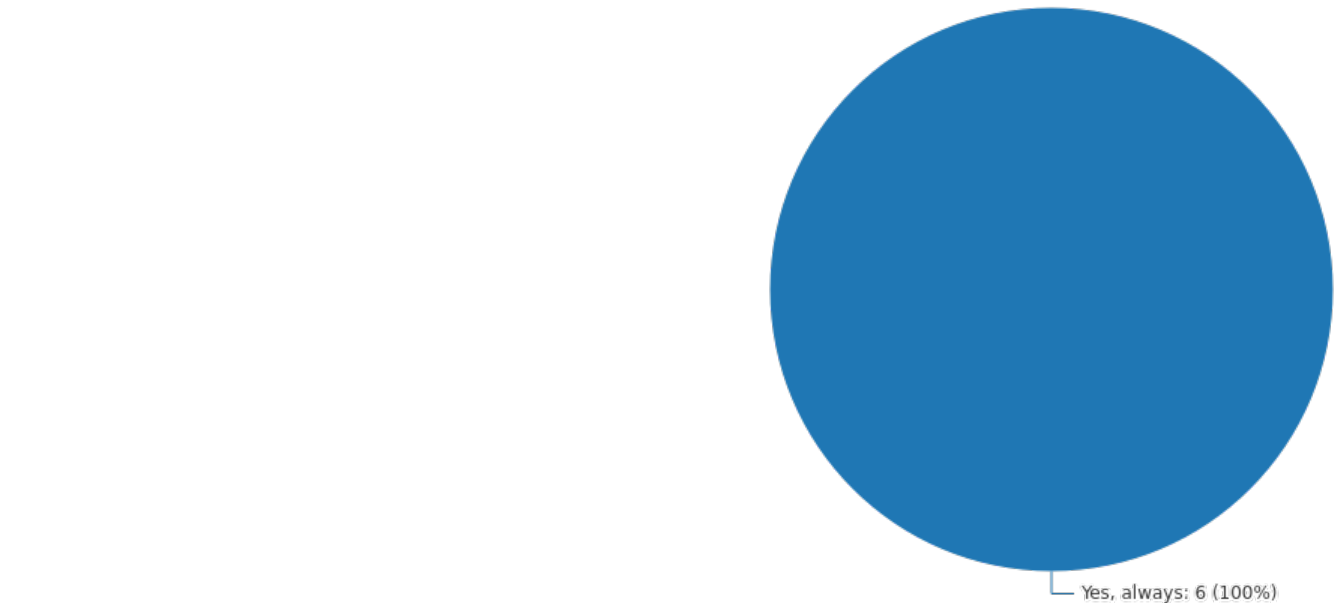
Answer	Total
Yes, often	6
Sometimes	0
No, never	0
Don't know / can't remember	0
Total responses	6

Did you feel that you were able to ask questions?



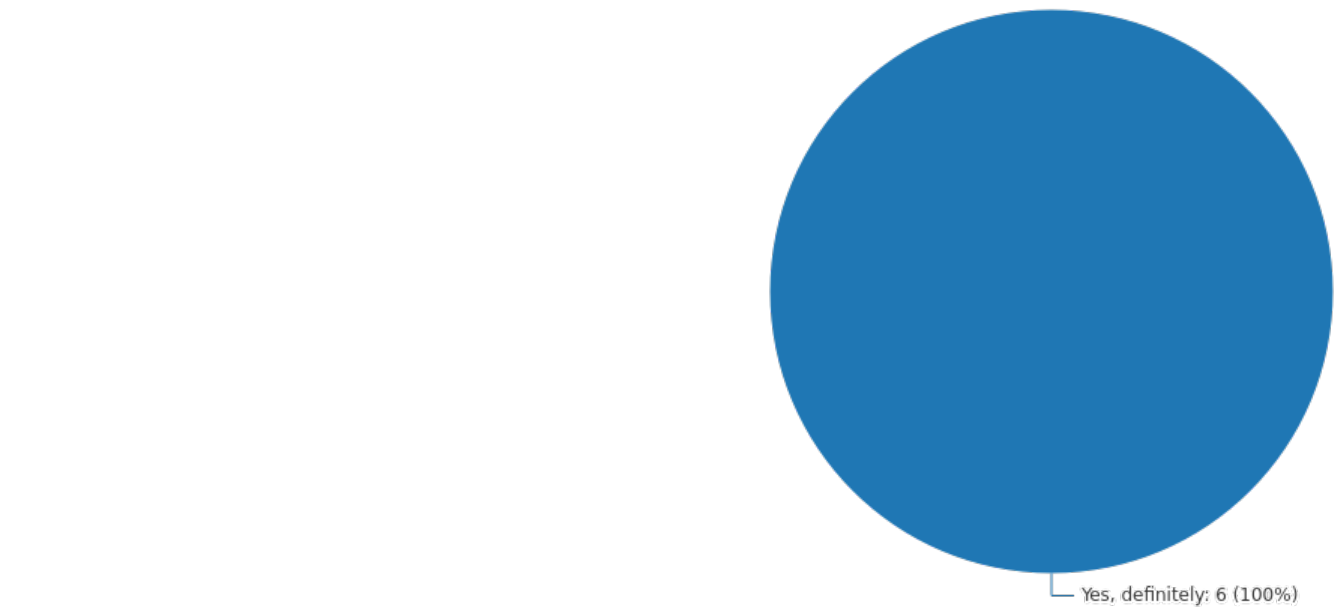
Answer	Total
Yes, always	6
Sometimes	0
No, I did not feel able to ask questions	0
I did not have any questions to ask	0
Don't know / can't remember	0
Total responses	6

Did staff explain things in a way you could understand?



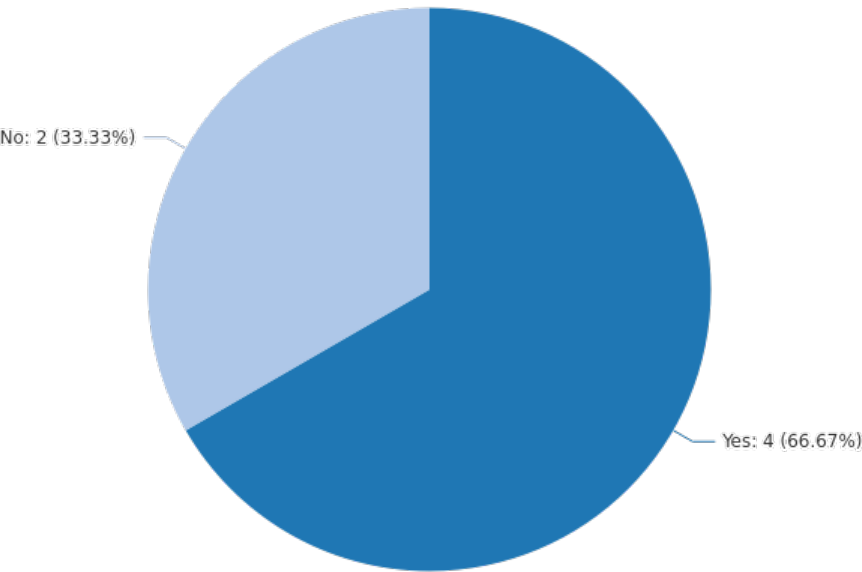
Answer	Total
Yes, always	6
Sometimes	0
No, never	0
Don't know / can't remember	0
Total responses	6

Do you understand what happens next in your care?



Answer	Total
Yes, definitely	6
Yes, to some extent	0
No	0
I did not need further care	0
Don't know / can't remember	0
Total responses	6

If this were a standalone app. for quick feedback after every visit, would you use it?



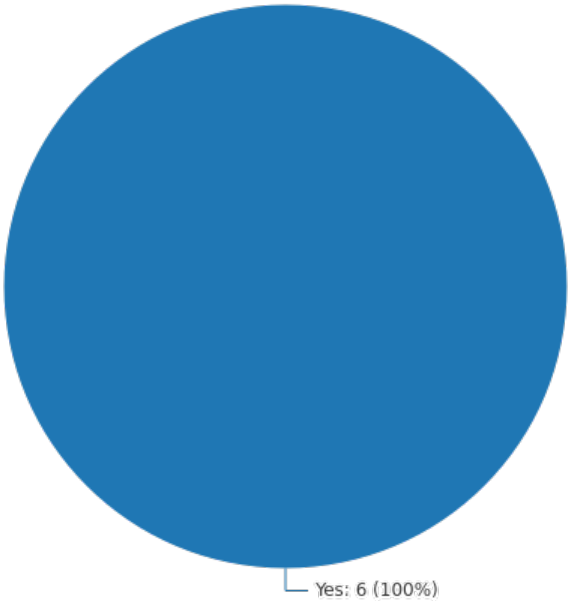
Answer	Total
Yes	4
No	2
Total responses	6

Do you have any other comments you would like to share?

Theme	Total
Neutral	6

Service	Comment	Theme	Status
Wrekin Community Maternity	NA	Neutral	Private - not for display
Wrekin Community Maternity	N/A	Neutral	Private - not for display
Shrewsbury Maternity Outpatients	No	Neutral	Private - not for display
Shrewsbury Maternity Outpatients	No	Neutral	Private - not for display
Wrekin Community Maternity	No	Neutral	Private - not for display
Shrewsbury Maternity Outpatients	No	Neutral	Private - not for display

Please confirm that you are happy for us to share your comments without any personal identifiable information (anonymously).



Answer	Total
Yes	6
No	0
Total responses	6

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors

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

21 September 2026

Thirlwall Inquiry report and recommendations

Dear colleagues,

Lady Justice Thirlwall's [report](#) is a sobering moment for all of us working in the NHS. From the devastating failure, both of individuals and the system, to act quickly enough to safeguard babies, to the questions it poses about the NHS culture that prevented this – the need for change goes beyond the walls of a single hospital ward. We must address these together now.

Our thoughts remain very much with the families affected who have experienced unimaginable loss and pain, and the NHS repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.

Recommendations

On Tuesday, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full.

Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this;
- Go further on [new guidance](#) on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death;
- Undertake a review of the 'Working Together to Safeguard Children' (April 2026) and safeguarding training nationally;
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities;
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting:** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children (SUDIC):** The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The [SUDIC protocol](#) is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably

expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within neonatal units. **All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026.** It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

- **National Bereavement Care Pathway for stillbirth and neonatal death:** ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the [NHS Medium Term Planning Framework](#) (October 2025).
- **Insulin:** By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the [GIRFT neonatology Guide to safe insulin use](#). Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.
- **Safeguarding:** Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts are reminded that the [Insightful Provider Board guide](#) is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Health and wellbeing

We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.

We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

Next steps

The report firmly underlines why the urgent work we are doing through the Maternity and Neonatal Care 10-Point Plan must be a top priority for the NHS. As the Secretary of State has clearly set out, the safety, safeguarding and wellbeing of mothers and babies must never be treated as a side issue and must be a central priority for NHS boards.

The findings of this crucial report will be a key focus of our next CEO leadership event tomorrow. It is important that we challenge each other when we meet on whether we are all doing enough to ensure that babies and children are protected, no staff member is ignored when they raise concerns, and that we are consistently acting to the highest standards of governance and leadership.

Yours sincerely,

A handwritten signature in black ink, consisting of a large loop followed by a horizontal line.

Duncan Burton

Chief Nursing Officer for England

A handwritten signature in black ink, featuring a stylized 'S' and 'J' followed by a horizontal line.

Sarah-Jane Marsh

NHS England Chief Operating Officer

Board of Directors' Meeting in Common – 8 October 2026

Agenda item	Board Information Pack Item 04		
Report Title	SaTH Annual Safeguarding Report 2025/26		
Executive Lead	Martina Morris, Group Chief Nursing Officer		
Report Author	Teresa Tanner: Lead Nurse for Safeguarding Children & Young People, SV Lead Kathy George: Head of Adult Safeguarding, MCA, Prevent and Domestic Abuse Lead Sally Burns: Lead Midwife for Safeguarding, FGM Lead		
Prior Consultation:	CQC Domain:	Link to (SATH) BAF id(s)	
Safeguarding Operational Group, 19 August 2026 Safeguarding Assurance Committee, 25 August 2026	Safe	✓	
	Effective	✓	
	Caring	✓	
	Responsive	✓	(SaTH) Risk Register id(s):
	Well Led	✓	1115 1202
Executive Summary	This SaTH Safeguarding Annual Report provides an update in relation to adult, children and maternity safeguarding across the Trust for the year 2025 to 2026 and our compliance in relation to the safeguarding statutory and regulatory requirements. Assure: - The criteria for referring into Children's Services was reviewed in November 2025. Since then, there have been fewer children referred into Social Care. Poor mental health is not a reason to raise a safeguarding concern. Overall, only 22% of the notifications to the Safeguarding Children Team, result in a referral being made to Children's Social Care. - The team undertake a quarterly MCA compliance review in respect of DoLS. Mental Capacity Assessments in relation to DoLS has remained consistently above the Trust compliance target of 90%. Advise: - Training compliance has remained above the Trust target of >90% in 2025/2026 with the exception of Safeguarding Level 3 children, training for our allocate wards, caring for 16–18-year-old patients, and Mental Capacity Act (MCA)/Deprivation of Liberty Safeguard (DoLS) - For adult safeguarding there were 64 concerns raised against the Trust. Of these, 25 (39%) converted to Section 42 Enquiries and 10 (15% of the total) of these were substantiated against the Trust, 2 partially substantiated and 2 unsubstantiated. The remaining 11 were closed with no further action and		

	did not progress further as there was no evidence of harm caused by the Trust. • The themes and trends in respect of referrals raised against the Trust include neglect and acts of omission • There was a total of 159 concerns raised by the Trust in relation to Adult Safeguarding which included concerns in respect of self-neglect, neglect and domestic abuse • Staff across the Trust completed 1386 urgent Deprivation of Liberty Safeguards in 2025/2026. Alert: • In relation to adult safeguarding, there has been a rise in the number of Section 42 enquiries over the last year as a result of one of our respective local authority's now recording Section 42 enquiries for all enquiries. As result, a number do not progress past first information sharing processes and are closed without full enquiry.
Recommendations for the Boards	The Boards are asked to note the SaTH Safeguarding Annual Report.
Appendices:	Appendix 1 – Safeguarding Annual Report 2025/26

1.0 Organisational Safeguarding Responsibilities

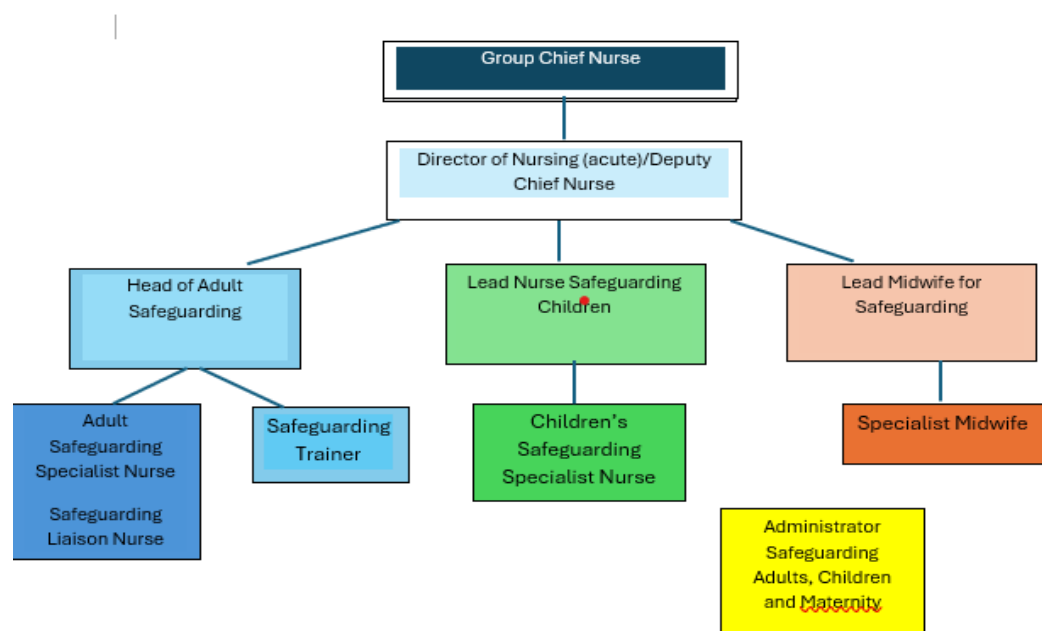
Adult and child safeguarding arrangements in NHS organisations are statutory and regulatory requirements. The Trust is accountable for delivery in relation to safeguarding requirements and this is monitored closely by Local Safeguarding Children and Adult partnerships, Integrated Care Board and the CQC.

Statutory requirements relate to:

- The Children Act 1989
- The Children Act 2004 - specifically section 11.
- Safeguarding Vulnerable Groups Act 2006
- The Care Act 2014
- Mental Capacity Act 2005

Whilst the safeguarding frameworks for adults and children are managed separately, nationally they are often inter-linked, for example in domestic abuse; concerns regarding exploitation; 'Think Family' and the impact of adverse childhood experiences on health and life chances. The Trust reflect this in its local arrangements for safeguarding with close working between the adult and child safeguarding teams and a co-ordinated approach to safeguarding education for the workforce.

This report provides a summary of 2025-2026 Safeguarding for Adults, Children and Maternity.



2.0 Safeguarding Learning and Development

It is a priority for the Trust that all members of our organisation are fully engaged in the safeguarding agenda and can confidently advocate for the rights of patients in their care and recognise and respond to safeguarding needs. Each staff member must have access to appropriate safeguarding education, skill development and advice and support to perform their role well.

2.1 Trust In- House Safeguarding Training

Safeguarding education is the foundation of safeguarding competence within the workforce.

All safeguarding training delivered within the Trust is based on the requirements specified within the Intercollegiate Safeguarding Competencies for Health Care Staff for Adults and Children, the latest versions of which were produced in 2024 and 2019 respectively. This guidance specifies the content and levels of competence that health care staff should achieve.

The children's workforce including the maternity and neonatal workforce, receives additional training at Level 3. Staff working in the Emergency Department, and on the designated adult wards across the Trust who care for patients 16-17 years of age are also expected to complete Level 3 safeguarding training.

All Named Professionals receive Level 4 training, some of this is gained through the Regional Named Professionals Network (of which the Lead Nurse for Safeguarding Children is the Chair) and the National Child Protection Network and the Association of Child Protection Professionals of which the Trust is a member. All Trust Named Nurses and Midwives have undertaken the NHSE Safeguarding Leadership training.

Training compliance is collated and reported monthly through the Safeguarding Operational Group meetings. Additionally, the Divisions report their training compliance on a quarterly basis.

Training figures are reported externally as a key performance indicator to the ICB as part of our contractual arrangements and are also required as assurance against statutory safeguarding requirements for safeguarding boards.

The first Trust Safeguarding Champions study day, arranged by the Adult and Children's Safeguarding Leads, was held on 7th November 2025 at SERII and was well attended with several external and internal speakers. Topics included Fire Safety Referrals, Safeguarding Adult Review (SAR) Learning outcomes, Domestic Abuse (DA) and Sexual Safety. Feedback has been very positive, a further study day will be arranged for late 2026/27.

The Safeguarding Children Team have continued to provide Level 3 training to the Ministry of Defence (MOD), the Community Children's Nurses within Shropshire Community Health Trust, the paediatric staff from Robert Jones and Agnes Hunt Trust and Shropdoc; this maintains our compliance for multi-Agency training. The Ministry of Defence have made very positive comments about our training and the good availability of sessions for them to access; this had started as Shropshire MOD but now seems to have rolled out cross the country. Our in-house training packages and resource materials have also been shared with local providers on the recommendation of the ICB lead.

The table below illustrates the compliance rates across the Shrewsbury and Telford Hospital NHS Trust at the end of 2025/26.

Category of safeguarding training	Q1	Q2	Q3	Q4
Safeguarding Level 1 Adults	97%	96%	96%	95%
Safeguarding Level 2 Adults	96%	95%	95%	95%
Safeguarding Level 3 Adults	92%	91%	90%	91%
Safeguarding Level 4 Adults	100%	100%	100%	100%
Safeguarding Level 1 Children	97%	97%	96%	96%
Safeguarding Level 2 Children	97%	96%	95%	94%
Safeguarding Level 3 Children (Core)	91%	88%	86%	81%
Safeguarding Level 3 Children (Specialist)	94%	93%	90%	87%
Safeguarding Children Level 4	100%	100%	100%	100%
MCA & DoLS*	85%	85%	85%	84%
Prevent – Level 1& 2	96%	95%	94%	93%
Prevent – Level 3	94%	94%	93%	93%

*MCA training compliance impacted upon by long term trainer absence

Safeguarding training compliance has remained above the Trust target of >90% in each quarter of 2025/2026 with the exception of Safeguarding Level 3 children training for our allocate wards caring for 16-18 year olds patients, and Mental Capacity Act (MCA)/Deprivation of Liberty Safeguard (DoLS) which are >80%, trajectories for improvement in compliance in 2026/27 are in place.

Compliance with The Trust has completed a review of the Training Needs analysis of all staff cohorts; this is reviewed and amended annually. The Prevent Training Needs Analysis has been updated and is in line with the updated Prevent: Training and Competencies Framework (DHSC 2025).

There are education packages incorporating learning from local and national reviews as well as internal incidents and cover all risk factors for children including contextual risks, exploitation, modern day slavery, forced marriage, domestic abuse, female genital mutilation and radicalisation. The adult safeguarding team provides practice-based training in the use of the Mental Capacity Act, including the applications to general care and the completion of the assessment.

Training Compliance by Staff Groups 2025/26

Training and Level	Staff Numbers requiring training	Staff number compliant	Staff number to complete	% Compliant	%Compliance by staff groups		
					Medical Staff	Nursing & Midwifery	Other
AS L1 (excluding induction)	7325	6980	345	95%	91%	96%	95%
AS L2	4657	4401	256	95%	90%	96%	94%
AS L3	2977	2700	277	91%	86%	92%	88%
MCA & DoLS	4167	3510	657	84%	82%	87%	81%
Prevent L1*	3567	3322	245	93%	60%	100%	93%
Prevent L3	4760	4437	323	93%	87%	95%	93%
CS L1 (excluding induction)	7313	6995	318	96%	89%	97%	96%
CS L2	4559	4292	267	94%	89%	96%	94%
CS L3 Core	662	538	124	81%	82%	81%	90%
CS L3 Spec	781	677	104	87%	93%	88%	82%

*The Prevent Level 1 medical staffing compliance has been raised with the Directorate Lead and refers to a small cohort of pathology medics only

Level 3 Children's Safeguarding Designated Adult Wards

Level 3 Safeguarding Children core training is now completed by all staff who complete their SSU 3 yearly, as the content has been amended to reflect what is required at Level 3 Core.

Training compliance is reported monthly via the ward dashboards and monitored at the Nursing Quality Metrics Assurance meetings.

This will be reviewed later in 2026, as the Intercollegiate Document for Safeguarding Children was published in November 2025 and this will inform the children's safeguarding training offer from Autumn 2026.

2.2 Understanding the Impact of Training

The Trust uses the following measures to gauge the impact of training on staff behaviour and outcomes for patients:

Compliance with the safeguarding children and adult policy and procedures.

- Staff report increased confidence in relation to responding to safeguarding issues following training and 'Ask 5 Audit' are now routinely completed pre and post training.
- Safeguarding team also tends to see a rise in either referrals or contacts following staff training.
- There has been a decrease in compliance over the last 6 months, this is in part due to long term sickness of the trainer. Some of the training has been moved to the trainer of the SSU3 specialist training and the adult safeguarding team are providing cover whenever possible, balanced against operational requirements.

3.0 Safeguarding Risk

Safeguarding risks are reviewed at the Trust Operational Safeguarding Group and reported through to the Safeguarding Assurance Committee on a quarterly basis.

In 2025/26 there was two safeguarding team risk, the details are outlined below. This table illustrates the safeguarding risk position at the end of 2025-26 after mitigating actions in place.

Risk ID	Title	Residual Risk Score	Mitigation
1155	Capacity of Children's Safeguarding Team	4	There have been no issues/incidents reported around service provision since risk was opened in Nov 2024. There is cover via the Lead nurse 0.8WTE and a Band 7 Safeguarding Children Nurse. There is also senior cover and support via the Head of Adults Safeguarding and the Lead Safeguarding Midwife. The service provision for HTP will see the service based on 1 site when services relocate making cover further robust.
1202	Access to Child Protection Information Service (CP-IS) - Maternity & Neonates	6	All Maternity & Neonatal in acute and community settings are not able to access national CP-IS system to check for pregnant women who have Children or unborns that are subject to a child protection plan or Looked After by the local authority. This applies to all outpatient clinics and wards that care for under 18s

*This risk has since been closed as of 24.4.2026, there is now a permanent member (0.8 WTE), of administrative staff for the combined safeguarding teams.

4.0. Safeguarding Children

4.1 Children's Safeguarding Referrals

One of the key indicators considered is the number of children that the Trust has referred to social care due to concerns identified through contact with the Trust.

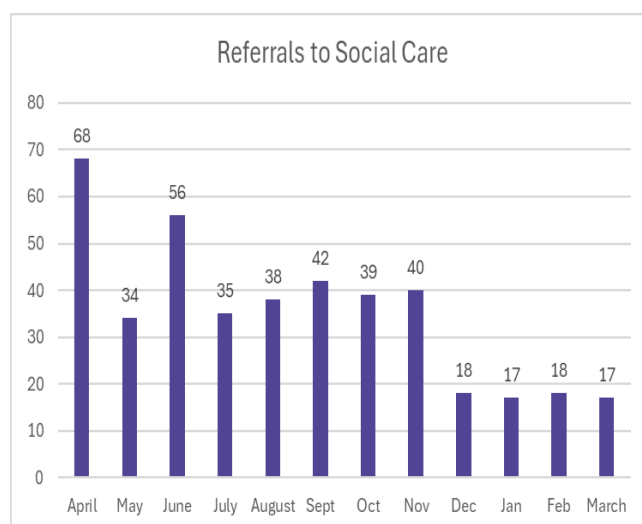
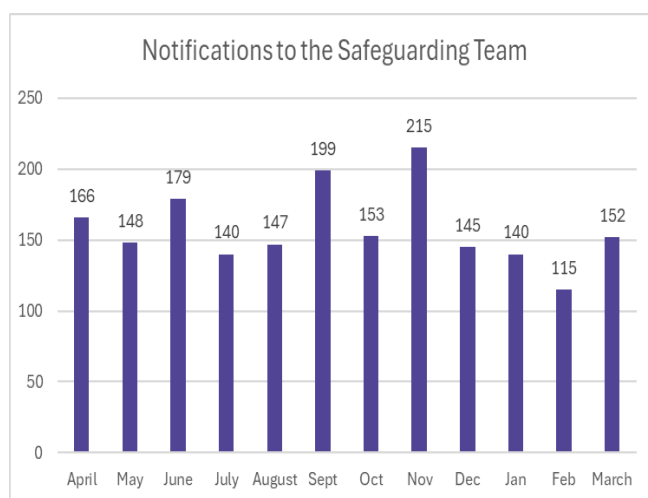
The graph shows the notifications to the Safeguarding Team contacts made by Trust staff to the Lead Nurse and Specialist Nurse for Safeguarding Children.

These contacts will include all the Looked After Children that attend both the Emergency Department as well as those children that are subject to Child Protection Plans, and those for whom there are safeguarding concerns. In 2025/2026 (April 2025 to March 2026) there was a total of 1899 contacts with the Children's Safeguarding team.

The graph shows the number of referrals in each month to Children's Social Care. For April 2025 to March 2026 there were 422 referrals made.

The criteria for referring into Children's Services was reviewed in November 2025 (see section 4.2). Since then there have been fewer children referred into Social Care. Poor mental health is not a reason to raise a safeguarding concern, staff are requirement to make their own professional judgment based on each child / young person's presentation to hospital rather than adopting the previous blanket referral.

Overall, only 22% of the notifications to the Safeguarding Children Team, result in a referral being made to Children's Social Care.



4.2 Reasons for Safeguarding Children Referrals

From December 2025 we changed our process for referrals to Telford and Wrekin Social Care to follow the processes in place for Shropshire. Previously, any young person who attended the Emergency Department with any mental health issues was referred to social care whether it was warranted or not. Telford have now come in line with Shropshire and we are triaging them as we always used to do and referring those children and young people who meet the criteria to do so i.e. admission to in patient bed, repeat episode in short space of time (trend of escalating behaviour) or other safeguarding concerns behind the deliberate self-harm. This accounts for the decrease in referrals.

4.3 Safeguarding Advice Support and Supervision

Safeguarding Supervision for staff involved in safeguarding children is a statutory and contractual responsibility and is provided to key areas in line with the Trust Supervisory Framework. All

supervision is provided by specialist safeguarding staff who have undergone additional recognised and accredited supervision training. The compliance with requirements for safeguarding supervision amongst the children's workforce is reported quarterly to the ICB.

4.4 Learning Lessons from Externally Commissioned Safeguarding Reviews

The Safeguarding Operational Group is informed of all Internal Management Reports, sign off recommendations and receive reports on implementation and themes and ensure that these drive the safeguarding strategies and work plans.

The Trust is actively involved in several case reviews with both Telford & Wrekin and Shropshire. Key themes are:

- Professional Curiosity,
- Neglect
- Information Sharing.

4.5 Managing Allegations against staff who work with children and referrals to the Local Area Designated Officer (LADO)

Where allegations are made that a member of staff is unsuitable to work with children or has harmed a child the Trust is required to make a referral to the Local Area Designated Officer.

During the year 2025/2026 there have been 5 referrals to the LADO from the Trust (2 staff have been referred due to an alleged incident occurring at work). The LADO has spoken to on a number of occasions when they have requested information about staff who work in the Trust and there have been incidents in the home. (Domestic Abuse / Child Protection cases)

4.6 Looked After Children:

The Children's Safeguarding team continue to inform the Shropshire Community Child in Care team if there is a Looked After Child on the ward. Discharge letters from the Emergency Departments are sent automatically to the team in the community as well. There is an escalation process that is used if there are young people are left in the Emergency Department when care providers serve notice. This escalation works well, with some local authorities being better than others at actioning what is required.

5.0 Maternity Safeguarding:

5.1 Maternity Safeguarding Services

The Maternity Safeguarding Team (MSGT) offers safeguarding advice, advocacy and assurance for the maternity and neonatal teams, who care for the pregnant women/young people who choose to give birth at SaTH. The Maternity Safeguarding Team are intrinsically linked with our colleagues in the Adult & Children Safeguarding Teams, which enables excellent peer support within the wider safeguarding team and provides effective, efficient and timely safeguarding supervision, to be discussed and agreed.

Governance arrangements for maternity services report through to the Safeguarding Operational Group and then through to Safeguarding Assurance Committee. This is then reported through to the Maternity Governance meetings, that the Lead Safeguarding Midwife attends on a quarterly basis. Any maternity safeguarding concerns are discussed at monthly 1:1's with the Head of Midwifery or her deputy, or more often when necessary. Complex maternity or neonatal safeguarding concerns

within pregnant/birthed families are discussed at the monthly Maternity Care Planning Meetings with the maternity Senior Leadership Team or more frequently as necessary. This is to ensure the safeguarding of the family but also other families receiving maternity care, visitors and staff. This enables all involved to be supported and to ensure there is accessibility and visibility of the Maternity Safeguarding Team. Weekly meetings on the neonatal unit are diarised, to discuss all current safeguarding families. This also offers safeguarding supervision opportunities.

Where a complex safeguarding pregnancy is identified, there must be early specialist involvement and management plans agreed by the woman, her family and her maternity team. The 'Think Family' model is followed to ensure the woman, and her family are at the centre of the safeguarding process, to ensure effective and efficient communications. Timely responses are needed to effectively 'Working Together' to safeguard the families in our care.

With the current development of the Government's Social Care Reforms named the Family First Partnership Programme (Families First Partnership programme. 2025, GOV.UK), there have been many meetings with both Local Safeguarding Partnerships; to support and be informed of the impact this may have on the maternity services, specifically the Community Midwifery Teams. The English safeguarding legislation that underpins all that we do, (Children Act 1989 and 2004), has not changed, however there has been legislation passed to support the Family First Partnership Programme. The Family First Partnership Programme Health Lead practitioner at the ICB, has attended the maternity Senior Leadership meeting, to inform and advise and take any questions, so all are informed of the current changes and updated. The Family First Partnership Programme goes 'live' in April 2027.

5.2 Training:

In relation to Maternity Services at the Shropshire and Telford Hospital NHS Trust, historical Care Quality Commissioning inspections have highlighted that the Trust must ensure that staff complete mandatory training, including training on the safeguarding of vulnerable children and adults. There has been a significant increase in the compliance in mandatory safeguarding training, for both maternity and neonatal areas. The table below provides assurance for 2025/2026:

Maternity Safeguarding Training Data 2025/2026:

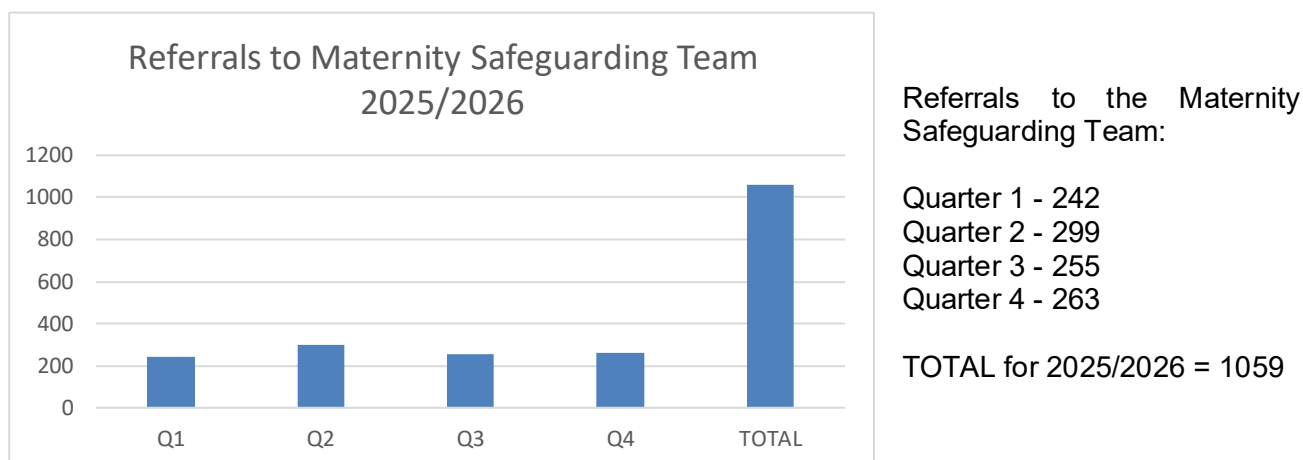
Category of safeguarding training	Q1	Q2	Q3	Q4
Safeguarding Level 1 Children	98	99	98	97
Safeguarding Level 2 Children	98	99	97	96
Safeguarding Level 3 Children - Specialist	94	94	92	84
Safeguarding Level 4 Children	100	100	100	100
Safeguarding Level 1 Adults	94	93	96	94
Safeguarding Level 2 Adults	93	92	95	92
Safeguarding level 3 Adults	89	88	87	84

Neonatal Unit Safeguarding Training Data 2025/2026

Category of safeguarding training	Q1	Q2	Q3	Q4
Safeguarding Level 1 Children	98	99	100	100
Safeguarding Level 2 Children	99	100	98	100
Safeguarding Level 3 Children - Specialist	95	93	86	95
Safeguarding Level 1 Adults	98	96	95	95
Safeguarding Level 2 Adults	98	96	95	95
Safeguarding level 3 Adults	92	90	91	93

5.3 Referrals to Maternity Safeguarding Team

The total number of referrals to the Maternity Safeguarding Team (MSGT) from April 2025 to March 2026 are shown:

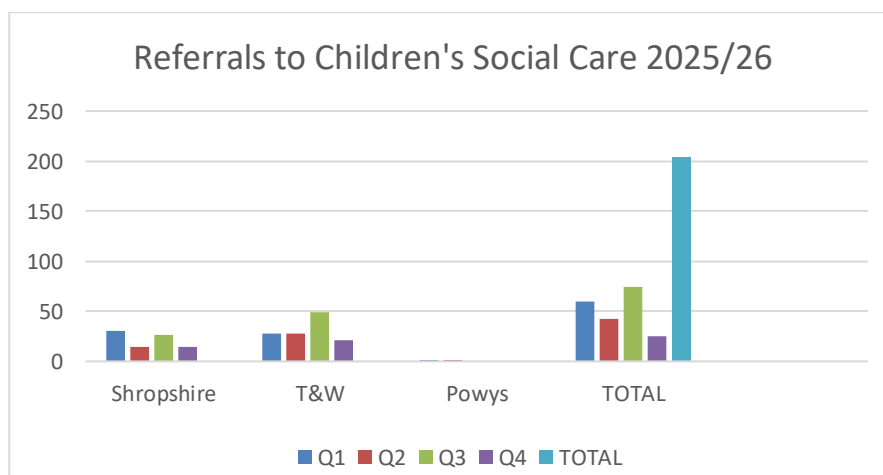


The referrals were evenly split between the two Local Safeguarding Partnerships that we mainly work with, within the County of Shropshire: Shropshire and Telford & Wrekin Local Authorities.

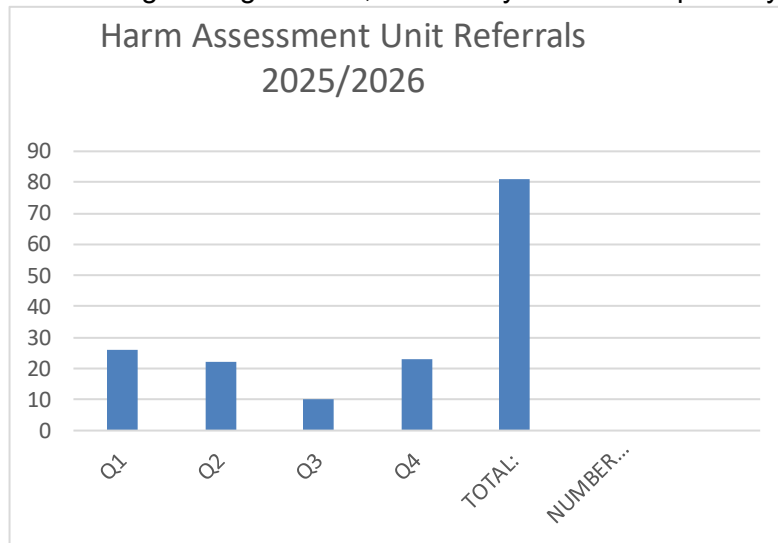
The quantitative data does not adequately reflect the increasing complexity of the safeguarding concerns that present to maternity at our Trust, for example, there is an increase in violence in domestic abuse incidents, with drugs, weapons and non-fatal strangulation being disclosed. Management plans are developed to robustly maintain the woman, her family's and the maternity staff's safety. The Maternity Safeguarding Team attend the monthly maternity Care Planning meeting, where the maternity Senior Leadership Team are notified of any complex safeguarding cases. To ensure robust communications between all agencies involved to safeguard unborn babies and newborns, the Maternity Safeguarding Team has developed and ratified a 'Safeguarding Summary Template' to complete prior to birth. It is completed by the Community Midwife and allocated Social Worker, with the parents-to-be and so fully sighted, to ensure transparency and to ensure they are fully aware of the agreed plan at birth and post-natal period, and all professionals are 'Working Together' to safeguard newborn babies. Importantly, it also demonstrates to the families that agencies communicate with each other.

5.4 Maternity Safeguarding Multi-Agency Referral Forms (MARF) to Children's Social Care in the Local Authorities (LA) of Shropshire, Telford & Wrekin and Powys, 2025/26.

The Annual Total Referrals to Children's Social Care was **203**. All referrals are saved as data for review and to ensure a timely outcome is received.



This data is triangulated with a Senior manager at Telford & Wrekin Children's Social care and the Lead Safeguarding Midwife, when they meet on a quarterly basis. They exchange and discuss the data relevant to our areas of work. This improved inter-agency working and understand our different roles in the safeguarding process.



On a bi-monthly basis the Maternity Safeguarding Team attend a 'Pre-Birth Baby Panel' with Shropshire Children's Social care meeting with their senior managers and we discuss the current pregnant families that have an allocated Social Worker. This assists in the triangulation of the maternity and social care to ensure safeguarding plans are in place and assurance is agreed, for all relevant professionals.

On receipt of a safeguarding referral, they are triaged by the Maternity Safeguarding team within 48-72 hours, to develop a safeguarding plan and to gain safeguarding assurance. The Community Midwife (CMW) or known referrer (including the family's Health Visitor and GP), is notified of the outcome of all referrals. All advice is documented on the Badgernet Maternity Information System (MIS). This includes updating the pregnancy management plan and requesting a home visit to be completed by the Community Midwife in the antenatal period. This is to assess if any further support is required via the locality Best Start for Life/Early Help offers/Family Hubs locality offers, depending on the individual family circumstances, with a focus of 'Think Family' and focusing on the lived experience of the unborn/child/siblings in their home.

All other safeguarding concerns are managed via the Early Help process and soon via Family Hubs, which are or will be located in the local communities, that we serve. The Family Hubs are a vital part of the implementation of the Family First Programme. All maternity and Neonatal teams have been informed of this update.

5.5 Harm Assessment Unit (HAU)

The number of HAUs received and triaged in maternity are shown for April 2025 to March 2026.

The total number of HAUs/Police attending Domestic Abuse incidents was 81 in 2025/2026. This data is reported bi-annually to the Safeguarding Operational Group.

Historically the CQC inspection in 2021 identified there were delays (by the maternity Safeguarding team), in the recording and the communication of the concerns raised by police, of domestic abuse incidents of pregnant and postnatal women and young people. In the past three years there have been no outstanding.

5.6 Maternity Safeguarding Supervision

In 2025/2026, 78 safeguarding supervision sessions were attended by maternity staff, this was a substantial increase from the previous year.

Safeguarding Supervision is now offered in all Midwifery Led Units on a weekly/monthly basis, to support maternity staff. The Safeguarding Supervision offer is currently being reviewed in the Wrekin Midwifery Led Unit and the Neonatal Unit, to gain assurance that the maternity and neonatal staff are allocated to the sessions to ensure they receive two, one-hour sessions annually, as per Safeguarding Supervision Policy. Other areas are considering this option to ensure staff can access this service.

One-to-one safeguarding supervision is available from safeguarding supervisors in the maternity unit.

Monthly Safeguarding Supervision is offered monthly via MSTs to improve accessibility for all maternity staff. This is reported monthly to the Safeguarding Operational and Assurance meetings.

5.7 Maternity Safeguarding Audits

Pregnancy through Surrogacy Audit June 2025, Action plan completed July 2025. No further Actions.

5.8 Updates of the Maternity Safeguarding Service

1. The Maternity Safeguarding Team arranged a joint Safeguarding Partnership meeting in quarter 4 to raise awareness in developing the Hope Box service for those families, which are not discharged with their baby due to a Family Court decision and significant safeguarding concerns. The aim is to provide continued emotional support to those families, as research shows that an increasing number of women are affected with their mental health. The guideline has been ratified this quarter.

Next Steps include:

- To train professionals from different streams of the Safeguarding Partnership, to move this service forward, linking in with the University of Lancashire that leads on the research and can support embedding this Nationally recognised service at SaTH.
 - Confirmation of finances to train 12 members of the maternity senior leadership and maternity safeguarding teams to commence the partnership development of the service.
 - Confirmed funding received for 12 places, to train for the Hold on Pain Eases (HOPE) Box service. This will be completed September 2026.
2. Developed support for the National roll-out for access of the Child Protection Information Service (CP-IS), for all elective and emergency maternity attendees: this was supported by midwifery managers, to signpost staff to access Smart cards. This service informs professionals if there are any safeguarding concerns for a woman or her child/ren or unborn baby. This will inform maternity staff of the woman or young person's risk assessment and to refer and notify relevant agencies and the Maternity Safeguarding Team.
 3. The Lead Safeguarding Midwife is in the process of recruiting to Safeguarding Liaison Nurse/Midwife for the neonatal Unit.

6.0 Adult Safeguarding

Throughout 2025/2026, the focus for the adult safeguarding team has been continuing its work to support the Trust to meet a number of key targets. A key focus has been the continued promotion of a Trust wide culture of 'Think Capacity', supporting training and embedding good practice in compliance with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards

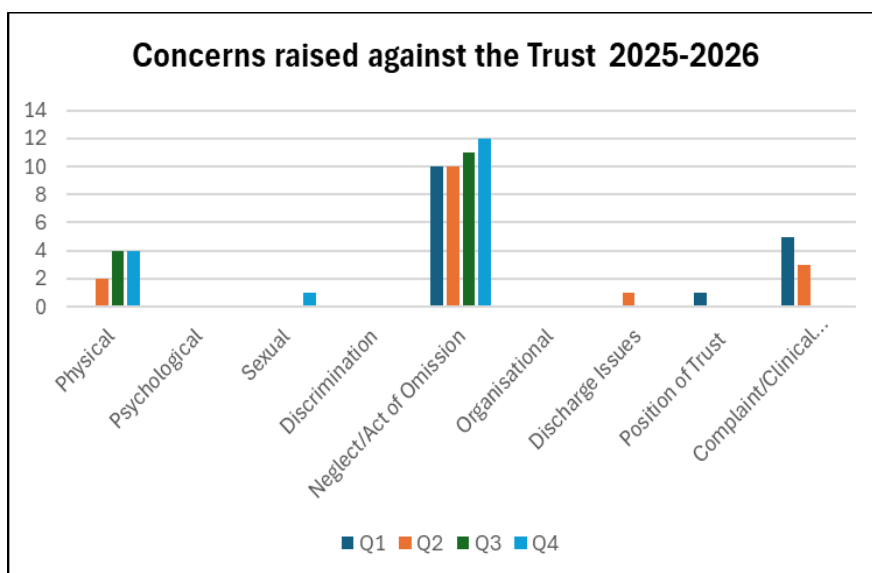
(DoLS). This support continues to be delivered by the team who are visible across both sites through daily ward contacts.

6.1 Adult Safeguarding

Concerns Raised Against the Trust

There were 64 concerns raised against the Trust. Of these, 25 (39%) converted to Section 42 Enquiries and 10 (15% of the total) of these were substantiated against the Trust, 2 partially substantiated and 2 unsubstantiated. The remaining 11 were closed with no further action and did not progress further as there was no evidence of harm caused by the Trust.

The mode of enquiry type, for example Section 42 is directed by the Local Authorities including the determination to close an enquiry on initial review without progressing to full enquiry. There has been a rise in the number of Section 42 enquiries over the last year as a result of one of our respective local authority's now recording Section 42 enquiries for all enquiries. As result, a number, do not progress past first information sharing processes and are closed without full enquiry

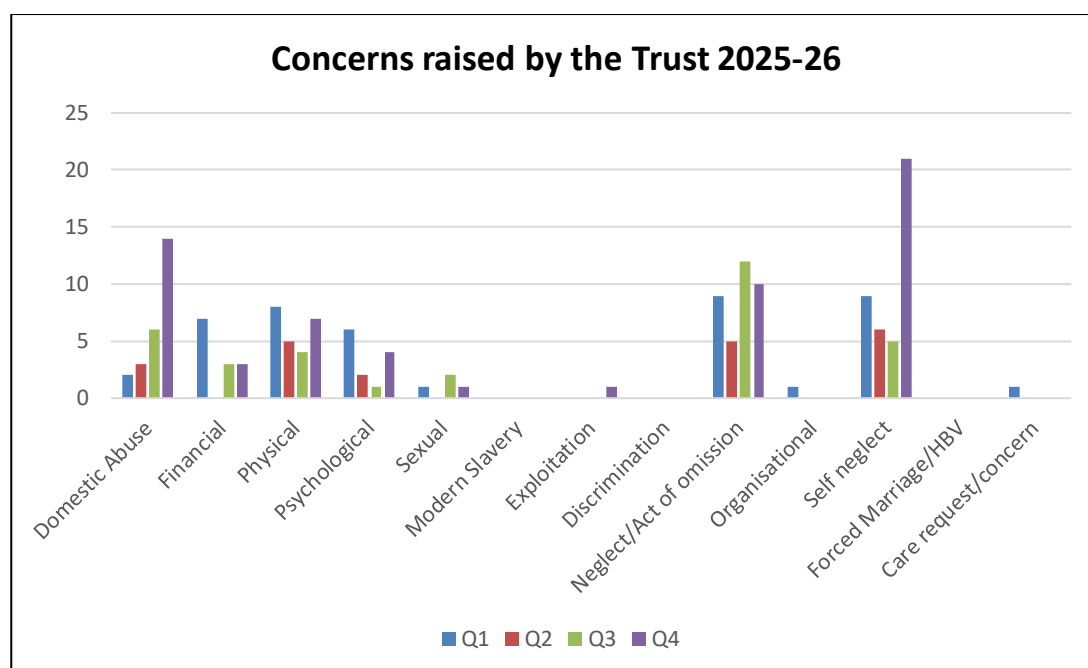


The rise in concerns over previous years has resulted due to a change in the way that one of our Local Authority's now categorises its enquiry concerns, the mode of enquiry is directed by the Local Authorities including the determination to close an enquiry on initial review without progressing to full enquiry.

Concerns raised by the Trust

The themes and trends in respect of referrals raised against the Trust are shown below:

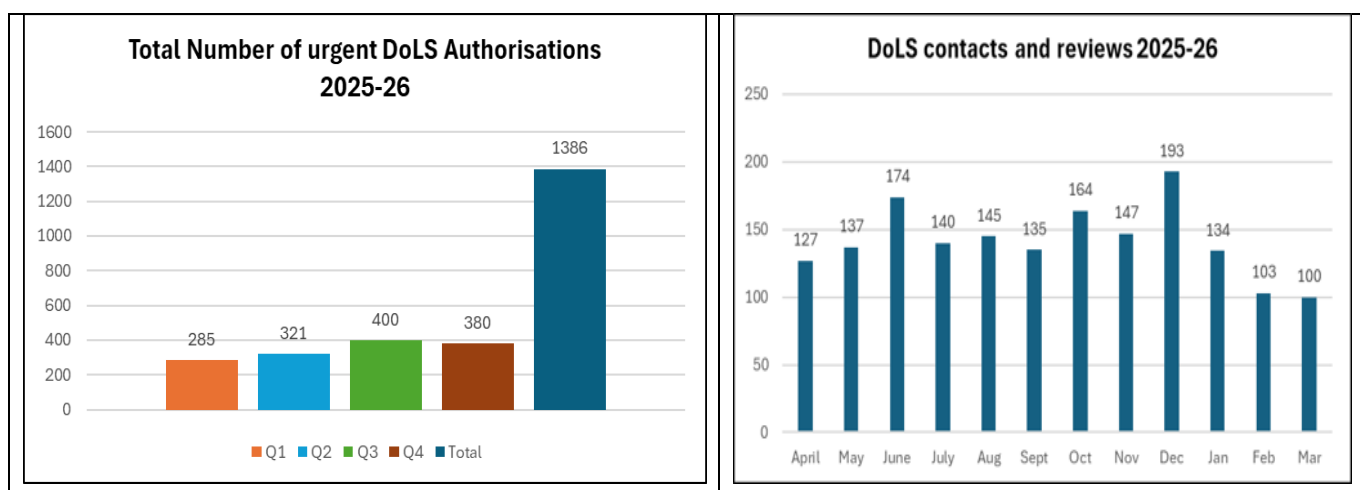
There was a total of 159 concerns raised by the Trust in relation to Safeguarding. Concerns in respect of self-neglect, neglect and domestic abuse were the most reported concerns raised by Trust staff. This identifies that training and learning in respect of self-neglect (Safeguarding Partnership Board priorities) is embedded across the Trust.



6.2 Deprivation of Liberty Safeguards

Staff across the Trust completed 1386 urgent Deprivation of Liberty Safeguards in 2025/2026.

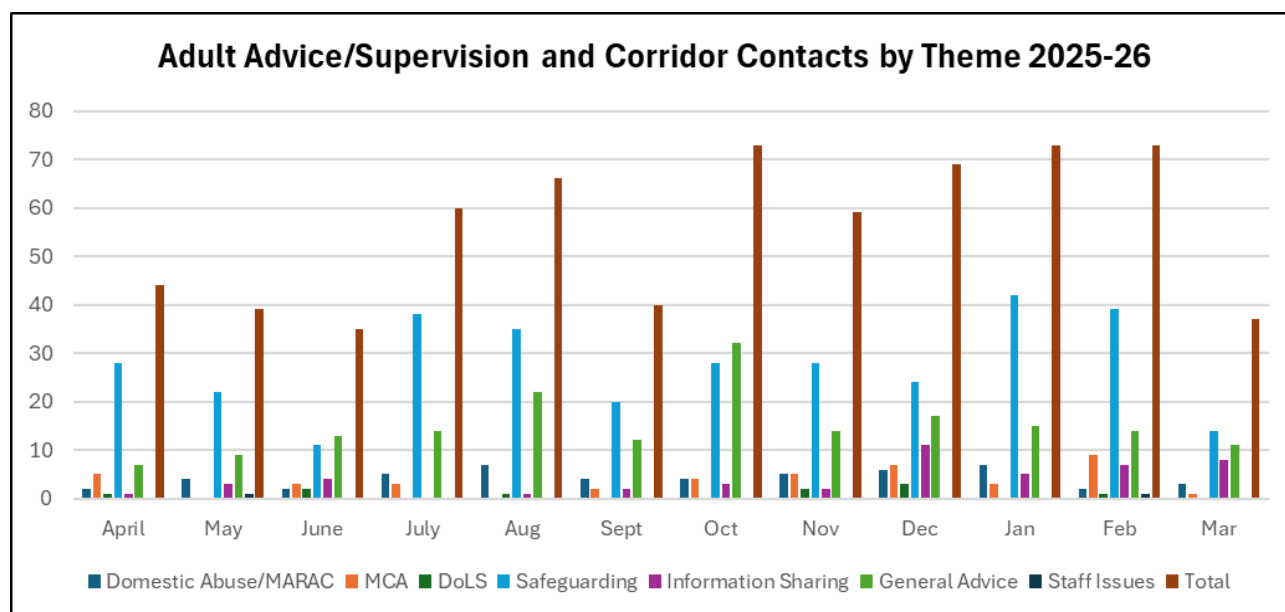
- 477 Urgent Extensions were requested.
- 1260 Standard Authorisations were requested with just 1 was approved by the Local Authorities following escalation by the Trust safeguarding team, a conversion rate of 0.07%.
- Our team undertook 1699 individual patient reviews for patients who lacked capacity to consent to remain in hospital for their care and care arrangements. This allows for additional assurance in respect of compliance with the Mental Capacity Act



6.3 Adult Safeguarding Advice/Supervision and Corridor Contacts

The team dealt with and responded to 668 formally logged advice calls/contacts over the year. These contacts are managed in line with the Trust Adult Safeguarding Supervision Framework Level 2 provision. Individual nurses within the Adult Safeguarding team access monthly 1:1 line management/safeguarding supervision along with peer supervision on a 6 weekly basis although

this has been suspended temporarily due to team vacancies and the need for safeguarding clinical cover across the Trust. The Head of Adult Safeguarding accesses external supervision



6.4 Safeguarding Adult Reviews and Domestic Homicide Reviews

The Trust continues to respond to and engage with the respective Adult Safeguarding Partnership Boards Safeguarding Adult and Domestic Homicide Reviews as required. The Head of Adult Safeguarding represents the Trust at the Domestic Homicide Oversight Review Panel.

Any immediate actions or learning for the Trust is proactively identified at initial scoping and reported through the Safeguarding Operational Group before an update being provided at the Safeguarding Assurance Committee for assurance. Training is amended to reflect any training actions identified at this preliminary stage of the reviews, with Trust training being adapted to ensure learning is fully incorporated.

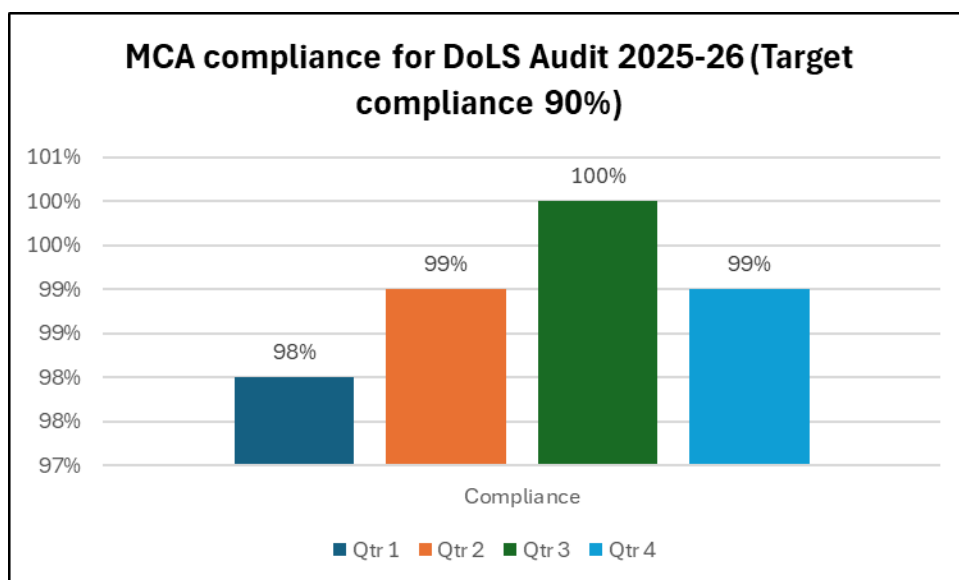
7.0 Safeguarding Audits

7.1 Safeguarding Adults Audits

Mental Capacity Act (MCA)/Deprivation of Liberty Safeguard (DoLS) Compliance Audit

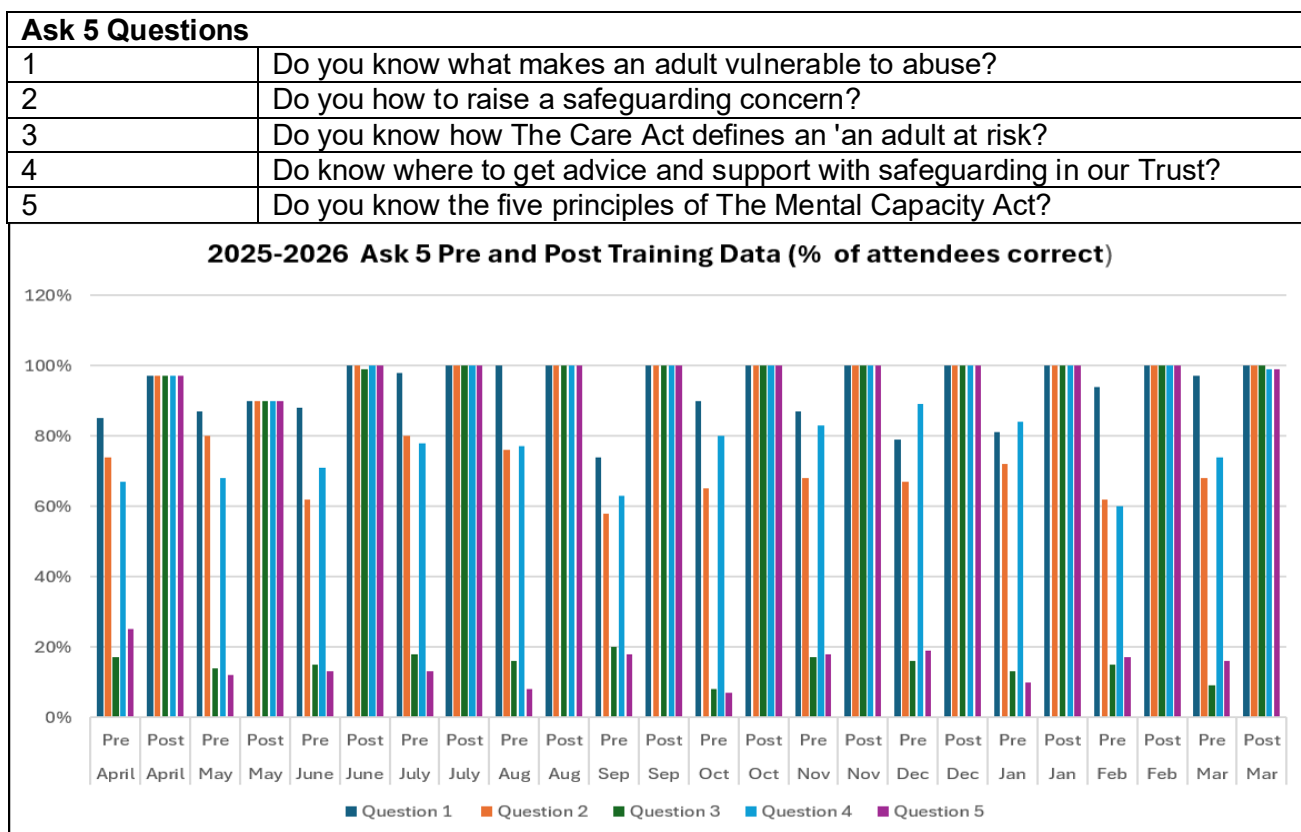
The team undertake a quarterly MCA compliance review in respect of DoLS. Our MCA audit measures the compliance of Mental Capacity Assessments in relation to DoLS and has remained consistently above the Trust compliance target of 90%.

This is possible due to a comprehensive recording system in place. Compliance is measured against a Trust target of 90% with an average yearly compliance of 99%.



ASK 5 Audit

An ASK 5 audit has been incorporated into the face-to-face training sessions utilising Mentimeter at both the start and end of each face-to-face session effective from April 2025. The Ask 5 Audit measures pre and post training knowledge and consistently identifies that our Trust face to face training offer is effective. This is further evidenced by the types and numbers of contacts and concerns raised by staff across the Trust, along with an understanding of responsibilities in respect of the Mental Capacity Act



Missing Person Audit

The Missing Persons Audit provides assurance that the Missing Person Policy is embedded within the Trust. It was identified in October 2025 that this would become an annual summary report, reportable through the Joint Safeguarding, LD and MH Operational meetings, with the next audit becoming due Q2 2026-27

7.2 Safeguarding Children Audits

Audits undertaken by the Children's Safeguarding team are outlined below:

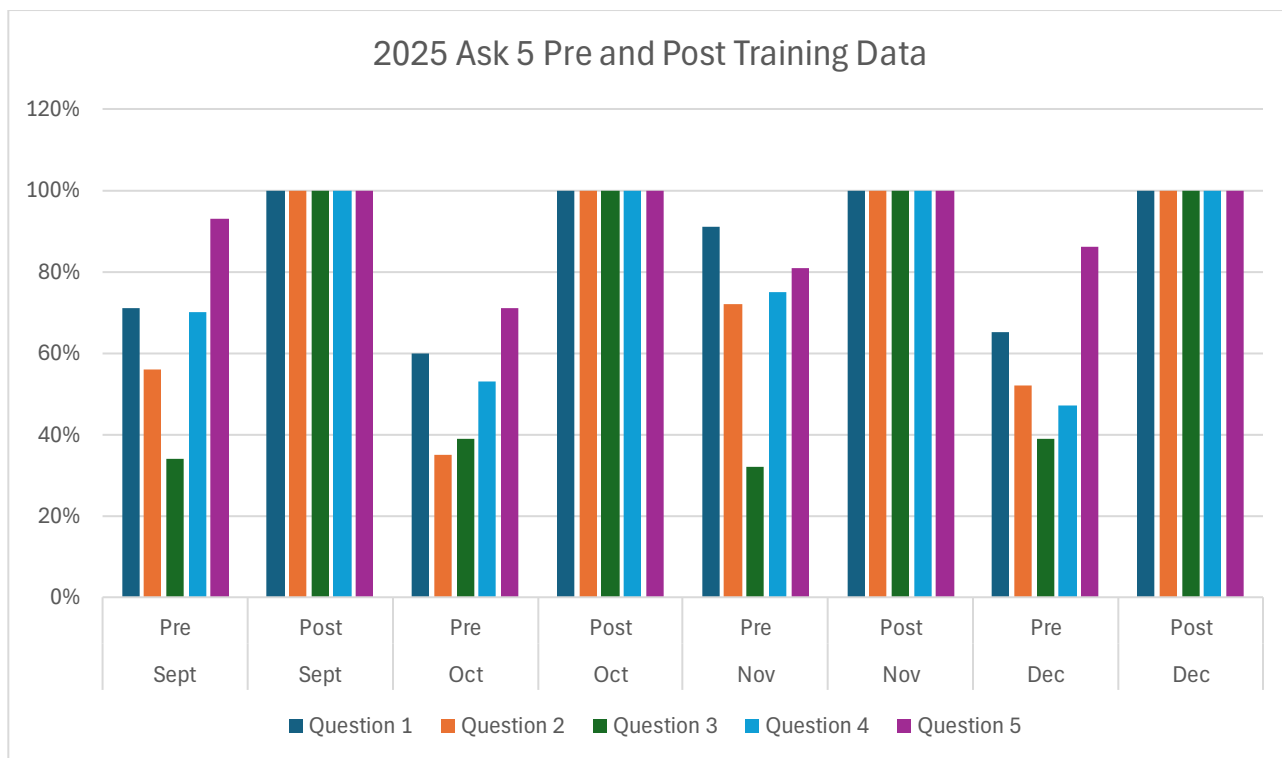
Audit Title	Lead	Completion Date	Presented to	Key Findings and Actions
Audit of Safeguarding Referrals	Children's Safeguarding Specialist Nurse	Completed March 2026	Presented to the April 2026 Operational Meeting	Overall the audit showed there were good levels of compliance. This will continue to be monitored to ensure ongoing compliance.
Audit of Dog Bite cases	Children's Safeguarding Specialist Nurse	Completed March 2026	Will be presented to the April 2026 Operational Meeting	SOP is being followed. In most cases the dog is known to the family and very few children are requiring admission to the ward for treatment.

Ask 5 Audit

The Ask 5 questions are asked of staff pre and post training. Results show that the staff are understanding their responsibilities in relation to safeguarding in relation to children. This provides assurance to the Trust and the ICB that training is appropriate and staff awareness and competency is raised.

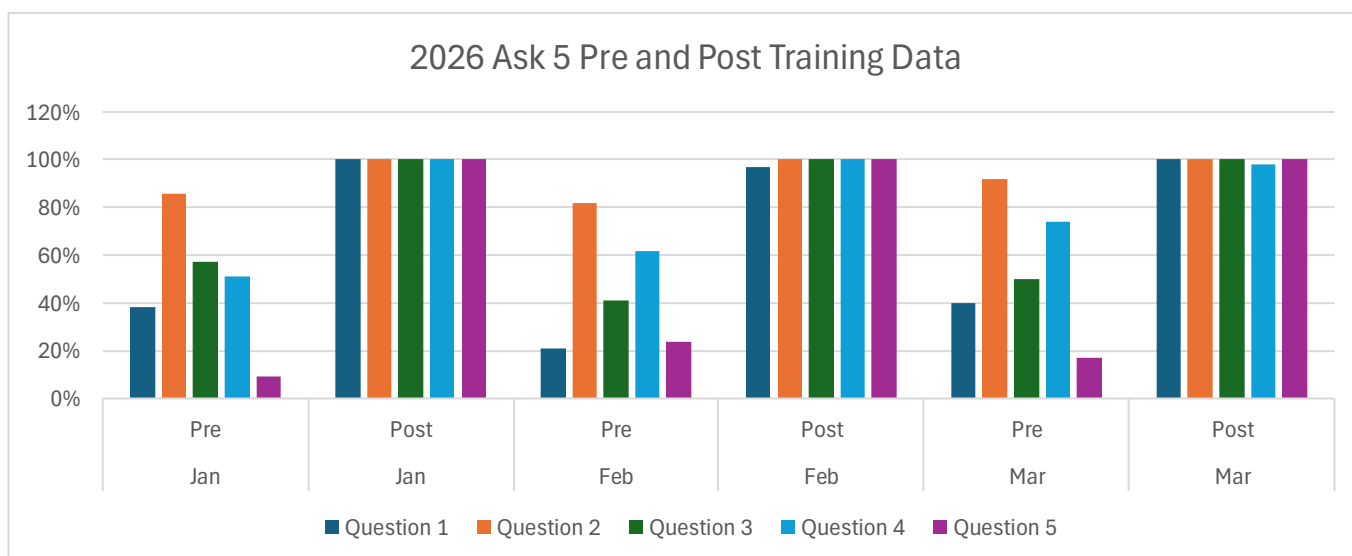
Questions

Ask 5 Questions	
1	Do you feel confident you could spot the signs of sexual exploitation?
2	Do you feel confident you could spot the signs of criminal exploitation?
3	Do you know where to find the CSE checklist?
4	Do you know where to find the Multiagency Referral Forms (MARFs)
5	Do you know how to contact the safeguarding team at SaTH?



Ask 5 for Children's Safeguarding training was commenced in September 2025, in 2026 the subject changed to Physical Harm.

Ask 5 Questions	
1.	Do you know what NAI stands for?
2.	Do you know how to contact the safeguarding team at SaTH?
3.	Do you know how to make a referral to Children's Social Care?
4.	Do you know where to find the MARAC referral form?
5.	Do you know what HIDVA stands for?



8.0 Governance and Assurance Arrangements

In respect of governance a monthly Joint Safeguarding, Mental Health & Learning Disability Operational Group (SOG) is attended by the Divisions with representation from the ICB chaired by the Director of Nursing (acute)/Deputy Chief Nurse. The Joint Safeguarding Operational Group reports into the Safeguarding Assurance Committee chaired by the Group Chief Nursing Officer which meets quarterly.

The Adult Safeguarding Work plan along with the Trust Safeguarding Assurance Tool and a Training Needs Analysis are regularly reviewed as standing agenda items within the Trust Adult Safeguarding Operational Group meetings. The Risk Register is reviewed quarterly, and safeguarding themes and trends are reported on a monthly basis with an additional quarterly formal review being undertaken jointly with the ICB Head of Adult Safeguarding.

The Adult Safeguarding team are represented and contribute to a number of Trust internal governance processes including.

- Rapid Review meetings
- Divisional Clinical Governance meetings
- HR liaison meetings
- Safe Medicine Group
- Divisional Management Group meetings

External to the Adult Safeguarding Team continue to represent the Trust at a number of sub-groups, these play a central role in providing the respective Shropshire, Telford & Wrekin Safeguarding Partnership Boards with evidenced assurance that safeguarding systems across the partnerships are sound and effective. The subgroups also work to identify and highlight areas which require improvement.

An external independent review of the Safeguarding team's activity and functions was held in September 2025 with a number of recommendations being made to promote team cohesion with an action plan which is in the process of being finalised.

The subgroups attended by the Trust during the year were:

Team	Telford and Wrekin Partnership Board	Shropshire Partnership Board
Adults	Safeguarding Adult Review Panel	Adult Statutory Case Review Group Meeting
	Adult Review, Learning and Training Subgroup	Adult Quality, Assurance and Performance Subgroup
	Prevent partnership Board.	Domestic Homicide Review Recommendation Meetings
	Domestic Homicide Decision Making Meetings	Domestic Homicide Decision Making Meetings
	Safeguarding Adult Review Panel Decision Making meetings.	Safeguarding Adult Review Panel Decision Making meetings.
	Domestic Homicide Oversight Panel x 1 MCA & DoLS Multi-Agency Operational group x 1 Right Care Right Person group	

Children/ Maternity	Partnership Development Group	Safeguarding Children Training Pool
	Rapid Reviews	
	CSPR Sub-Group	Quality and Performance Group
	CSE Panel (weekly)	Domestic Abuse Strategic Priority Group
	MARAC (monthly)	MARAC (Monthly)
	Child Death Reviews	Compass Steering Group
	Neglect Sub-Group	Neglect Sub-Group
	Telford Safeguarding Children's Board	Early Help & Prevention Partnership Board.
	Family First Partnership Meetings	CSPR Sub-Group
		Shropshire Safeguarding Children's Board

There are now more meetings for both Telford & Wrekin and Shropshire under the remit of Family First Partnership Programmes (FFPP), these are being held on a regular basis until the launch of the FFPP in April 2026

The Children and Maternity Safeguarding teams are represented and also contribute to several Trust internal governance processes including.

- Paediatric, Maternity and Emergency Department Clinical Governance meetings
- HR Decision Making Group Meetings

Externally, the respective team leads are members of various Safeguarding Partnership sub-groups. The subgroups play a central role in providing the respective Telford and Wrekin and Shropshire Safeguarding Partnership Boards with evidenced assurance that safeguarding systems across the partnerships are sound and effective. The subgroups also work to identify and highlight areas which require improvement.

9.0 Key Priorities Moving Forward

The Safeguarding team's key priorities for 2026/2027 include:

- The Safeguarding teams continue to work with the Divisions to achieve the required training compliance with increased team visibility throughout the Trust to support staff in meeting their safeguarding responsibilities. This remains a key target area.
- Providing shadowing opportunities and study opportunities for safeguarding champions across the Trust
- To continue to work with partner agencies to develop the Action Plan following the IITCSE report
- Joint Action planning and review of training formats and content in line with the respective current Intercollegiate Roles and Competencies for Safeguarding Children and Adults and the proposed NHSE national training (to be launched autumn 2027)

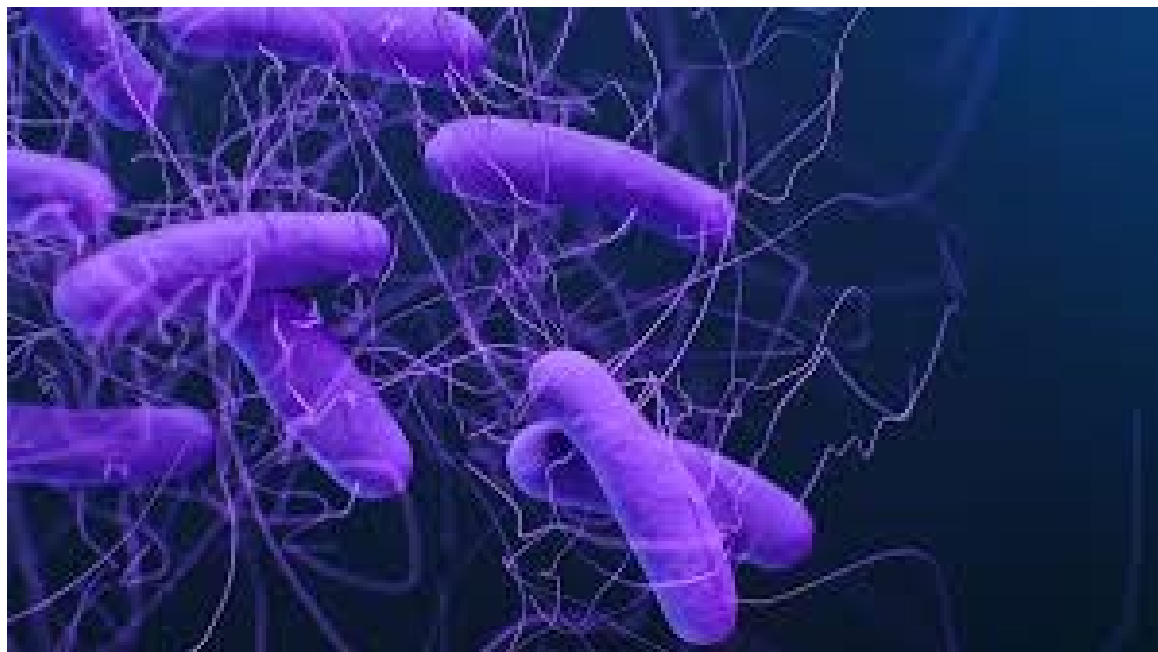
- Development of online SSU Adult Safeguarding programme to supplement offer to provide alternative to face to face should it be required due to trainer absence.
- Head of Adult Safeguarding to develop a Patient Sexual Safety policy
- To identify and complete actions arising from the external Safeguarding service review.
- To arrange the Safeguarding Conference for 2027, provisional date of 17 March 2027 identified
- To work with partner agencies to embed the new government reforms: Families First Partnership Programme.

Board of Directors' Meeting in Common – 8 October 2026

Agenda item	Board Information Pack Item 05		
Report Title	SaTH Infection Prevention & Control Annual Report 2025/26		
Executive Lead	Martina Morris, Group Chief Nursing Officer		
Report Author	Infection Prevention & Control Team		
Prior Consultation:	CQC Domain:		Link to (SATH) BAF id(s)
Infection Prevention Control Operational Group, 11 August 2026 Infection Prevention Control Assurance Committee, 17 August 2026	Safe	√	
	Effective	√	
	Caring	√	(SaTH) Risk Register id(s):
	Responsive	√	
	Well Led	√	
Executive Summary	The Infection Prevention and Control (IPC) Annual Report covers the period from 1 April 2025 to 31 March 2026 and has been produced in accordance with the Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Infection (updated 2022). The report outlines the Trust position against the ten Code of Practice criteria used by the Care Quality Commission to assess compliance with IPC and cleanliness requirements, including surveillance, the care environment and cleaning, workforce compliance, policies and procedures, and laboratory provision. Assure: The Trust has maintained a comprehensive IPC programme underpinned by established governance arrangements, surveillance systems, audit processes and assurance reporting. Compliance with the Health and Social Care Act 2008 Code of Practice has been monitored through the IPC Operational Group and IPC Assurance Committee, with no areas assessed as non-compliant against the IPC Board Assurance Framework during 2025/26. Advise: The IPC Team has continued to provide specialist advice to clinical and non-clinical services on infection prevention, outbreak management, healthcare-associated infections, antimicrobial stewardship, environmental cleanliness, decontamination and workforce compliance. This has supported the development of improvement programmes and preparation for emerging Group-wide IPC governance arrangements. Alert: Whilst compliance with IPC standards has been maintained, ongoing challenges remain in relation to healthcare-associated infection performance, mandatory training compliance, environmental cleanliness and elements of the healthcare environment. These areas require continued organisational focus, divisional ownership and oversight through established governance processes to support sustained improvement.		
Recommendations	The Boards are asked to note the SaTH Infection Prevention & Control Annual Report 2025/26		
Appendices	Appendix 1: Infection Prevention & Control Annual Report 2025/26		

Infection Prevention and Control Annual Report

Draft 2025/26



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Infection Prevention and Control Annual Report 2025/26

Executive summary

This Infection Prevention and Control (IPC) Annual Report covers the period 1 April 2025 to 31 March 2026 and is produced in accordance with the Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Infection (updated 2022). The report provides assurance against the ten Code of Practice criteria used by the Care Quality Commission to assess compliance with IPC and cleanliness requirements, including surveillance, the care environment and cleaning, workforce compliance, policies and procedures, and laboratory provision.

The most significant IPC issue during the year was the continued increase in *Clostridioides difficile* infection, with 132 cases attributed to the Trust against a trajectory of 98. This reflects a wider national trend, but remains a concern locally. In response, the Trust's *C. difficile* Reduction Action Plan was reviewed and strengthened during the year, with monthly oversight through IPCOG and focus on antimicrobial stewardship, environmental cleanliness, early recognition, isolation, treatment and ward-level practice.

The Trust also exceeded a number of other nationally set HCAI trajectories, including *E. coli*, *Klebsiella* and MRSA bacteraemia, while MSSA bacteraemia remained a significant area of review despite no national target being set. Surveillance and case reviews identified repeated learning themes relating to antimicrobial prescribing, urinary catheter care, invasive device management, blood culture documentation, environmental cleanliness and timely isolation.

This position has occurred within a context of sustained operational pressure, including prolonged Emergency Department stays, corridor care, escalation of medical and surgical activity, high hospital occupancy, limited isolation capacity and increasing patient complexity. These pressures affect the reliability of IPC practice and increase the challenge of achieving national HCAI ambitions.

Measles, pertussis and diphtheria have also increased nationally and regionally, reflecting declining vaccination uptake and placing further demand on front door services, isolation facilities and IPC resources. Despite these challenges, IPC remains a core patient safety priority, with continued focus on surveillance, assurance, outbreak management and targeted improvement to reduce avoidable infection risk across the Trust

During 2025/26 the Trust continued to experience significant operational pressure which affected the ability to consistently deliver all aspects of safe IPC practice. Key risks included high hospital occupancy, prolonged Emergency Department stays, corridor care, increased patient complexity, limited isolation capacity and continued escalation of medical and surgical activity. These pressures increased the challenge of achieving national HCAI trajectories and maintaining reliable IPC practice across all clinical areas.

Key IPC risks during the year included:

- Continued increase in *Clostridioides difficile* infection, with Trust apportioned cases exceeding the national trajectory.
- Ongoing pressure on isolation capacity, particularly during periods of increased respiratory infection, diarrhoea, outbreak activity and emerging infection risk.
- Competing priorities between patient flow and IPC requirements, including the time required for effective cleaning, decontamination, isolation and safe bed turnaround.
- Gram-negative bacteraemia, particularly *E. coli* and *Klebsiella*, with urinary sources and catheter-associated infection remaining important themes.
- Staphylococcal bacteraemia, with repeated learning linked to invasive device care, wound management, blood culture documentation and timely decolonisation.
- Sustained environmental cleanliness and decontamination risks, including commode cleanliness, equipment storage, waste management and assurance of cleaning standards.
- National and regional increases in measles, pertussis and diphtheria, placing additional pressure on front door services, isolation facilities and IPC resources.
- Continued IPC oversight of new build, ventilation, water safety, decontamination and estates-related risks.

Clostridioides difficile

The Trust trajectory for *C. difficile* infection in 2025/26 was no more than 98 cases. The year-end figure was 132 Trust-apportioned cases, compared with 112 in 2024/25. This represents a continued increase and remains the most significant IPC challenge for the Trust. The *C. difficile* Reduction Action Plan was reviewed and strengthened during the year, with monthly oversight through IPCOG. Key areas of focus included antimicrobial stewardship, environmental cleanliness, timely recognition and isolation, treatment, patient hand hygiene and ward-level IPC practice.

Methicillin-resistant *Staphylococcus aureus* bacteraemia

The Trust target for MRSA bacteraemia remains zero. During 2025/26, the Trust reported five MRSA bacteraemia cases. Reviews identified themes including incomplete screening, delayed decolonisation, invasive device documentation, wound-related sources and blood culture collection practice. Two cases were agreed to be contaminants.

Methicillin-susceptible *Staphylococcus aureus* bacteraemia

There were 51 Trust-apportioned MSSA bacteraemia cases in 2025/26, compared with 61 in 2024/25. There is no nationally set target for MSSA bacteraemia, but these infections remain clinically significant. Learning themes included peripheral cannula and long-line care, VIP scoring, wound management, urinary catheter-associated infection and blood culture documentation.

***Escherichia coli* bacteraemia**

There were 172 Trust-apportioned *E. coli* bacteraemia cases in 2025/26, against a trajectory of 146. This is an increase from 159 cases in 2024/25. Urinary sources, including catheter-associated infection, remained the most significant avoidable risk factor. Reducing *E. coli* bacteraemia will require continued focus on catheter care, timely review of catheter need, prompt removal where clinically appropriate, hydration, diagnosis of urinary infection and cross-system working with community partners.

***Klebsiella* bacteraemia**

There were 54 Trust-apportioned *Klebsiella* bacteraemia cases in 2025/26, against a trajectory of 36. This is an increase from 48 cases in 2024/25 and continues the rising trend seen over recent years. Source attribution indicates that urinary, respiratory, biliary and intra-abdominal sources contributed to the overall burden.

***Pseudomonas aeruginosa* bacteraemia**

There were 18 Trust-apportioned *Pseudomonas aeruginosa* bacteraemia cases in 2025/26, compared with 19 in 2024/25. The Trust remained close to the trajectory of 16 cases. Continued focus is required on urinary catheter care, device-related infection prevention, antimicrobial stewardship and management of infection risk in immunocompromised patients.

Audit and assurance

The IPC audit programme continued during 2025/26, with activity focused on outbreak areas, high-risk wards and areas where IPC concerns were identified. Key audit and assurance activity included Quality Ward Walks, hand hygiene audits, commode audits, isolation audits, loose stool audit, waste management audits, cleanliness monitoring and exemplar audits.

Findings were used to support local improvement actions and provide assurance through IPCOG, divisional governance and Trust reporting routes.

Influenza

This year's rollout of the SaTH staff flu vaccination programme commenced from 1 September 2025 for pregnant colleagues and those staff about to become immunocompromised. The main programme ran in line with national direction from 1 October 2025 to 31 March 2026. During which time 16 Peer vaccinators, 4 bank nurses and the vaccination Clinical Nurse Specialist vaccinated 54% of staff (3541). This is a 5% increase in uptake from the previous years programme (3450). Out of the 234 trusts within England, SaTH sits within the top 20% . The vast majority of the vaccinations were administered as per national direction during October and November, in time for antibody levels to rise before the Christmas and New Year break and usual infection rate peak.



SECTION 2 – ABBREVIATIONS

AMR	Anti-Microbial Resistance
ASG	Antimicrobial Stewardship Group
CCG	Clinical commissioning groups
<i>C difficile</i>	<i>Clostridoides difficile</i>
CDI	<i>Clostridoides difficile</i> infection
CAP	Community Acquired Pneumonia
COHA	Community onset, healthcare associated
COVID-19	Coronavirus disease 2019
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Payment Framework
DH	Department of Health
DIPC	Director of Infection Prevention & Control
DivDoN	Divisional Director of Nursing
E coli	Escherichia coli
ESBL	Extended Spectrum Beta Lactamase
ESCMID	European Society of Clinical Microbiology and Infectious Diseases
GDH Ag	Glutamate dehydrogenase antigen of <i>C. difficile</i>
GRE	Glycopeptide Resistant Enterococcus
GP	General Practitioner
HAP	Hospital Acquired Pneumonia
HCAI	Health Care Associated Infection
HOHA	Hospital onset, Healthcare associated
IDSA	Infectious Diseases Society of America
IM&T	Information & Technology
IPC	Infection Prevention & Control
IPCAC	Infection Prevention & Control Assurance Committee
IPCOG	Infection Prevention & Control Operational Group
IPCN	Infection Prevention & Control Nurse
IPCT	Infection Prevention & Control Team
MGNB	Multi Resistant Gram-Negative Bacilli
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Meticillin Resistant <i>staphylococcus aureus</i>
NHSE	NHS England
MSSA	Meticillin Susceptible <i>staphylococcus aureus</i>
PCR	Polymerase Chain Reaction

PFI	Private Fund Initiative
PLACE	Patient-led assessments of the Care environment
PPE	Personal Protective Equipment
RAG	Red, amber, green
RCA	Root Cause Analysis
SaTH	Shrewsbury & Telford Hospitals
SSI	Surgical Site Infection
STW ICB	Shropshire Telford & Wrekin Integrated Care Board
UKHSA	United Kingdom Health Security Agency
VNTR	Variable number tandem repeat (a form of DNA typing)

SECTION 3 – INTRODUCTION

The Trust recognises that the effective prevention and control of healthcare-associated infections (HCAIs) is integral to the delivery of safe, high-quality care. The consistent application of infection prevention and control measures in everyday practice is essential to protect patients, staff and visitors. Strong leadership, supported by clear governance, management and organisational arrangements, is critical to maintaining high standards of infection prevention and control.

This report outlines how the Trust meets its statutory obligations under the Health and Social Care Act 2008 Code of Practice on the prevention and control of healthcare-associated infections (updated 2022) and its associated guidance.

The Trust remains committed to strengthening infection prevention practices and, in line with the Code of Practice, this commitment is underpinned by two key principles: a focus on continuous improvement in the quality of care and the delivery of services that place patients at the centre of decision-making. Compliance with the Act is assessed against the ten Code of Practice criteria, which are detailed in the sections that follow.

Criterion	Detail
Criterion 1	There are systems to monitor the prevention and control of infection. These systems use risk assessments & consider the susceptibility of service users and any risks that their environment and other users may pose to them
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance
Criterion 4	Provide suitable accurate information on infectious to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
Criterion 5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
Criterion 6	Systems 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.
Criterion 7	Provide or secure adequate isolation facilities
Criterion 8	Secure adequate access to laboratory support as appropriate
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections

Criterion 10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection
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Criterion 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.

1.1 Infection Prevention Team

The Infection Prevention and Control Team (IPC) provide guidance and assistance to wards and departments.

At the Shrewsbury and Telford Hospital NHS Trust (SaTH), Chief Nurse who is the Director of Infection Prevention and Control (DIPC) holds overall accountability for the IPC Team, which is overseen by the Deputy Chief Nurse (Deputy DIPC) and Lead Nurse in Infection Prevention and Control.

The organisational structure for Infection Prevention and Control within the Trust is detailed in Appendix 2. Additionally, a Consultant Microbiologist works within the IPC team as the Infection Prevention and Control Doctor (IPCD) for 2 PAs.

1.2 External reviews

NHSE

In April 2025 an NHS England (NHSE) visit was undertaken providing independent assurance of the Trust's Infection Prevention and Control arrangements. The visit confirmed strong governance, effective leadership, and established monitoring processes. Areas for improvement were clearly identified and have been incorporated into existing action plans, with progress aligned to key programmes including C. difficile reduction.

1.3 Committee Structures and Assurance Processes

Infection Prevention and Control Operational Group (IPCOG):

The IPCOG meets monthly and is chaired by the Deputy Chief Nurse. It includes members from the Divisional Teams, Estates, Facilities, and the Integrated Care Board (ICB). This group is crucial for monitoring the organisation's Infection Prevention and Control (IPC) performance, including external objectives and compliance. Each division must report monthly on their IPC performance and key actions.

Reporting Structure:

IPCOG reports quarterly to the Infection Prevention and Control Assurance Committee (IPCAC) and IPCAC reports quarterly to the Quality and Safety Committee. Monthly performance on healthcare-associated infections (HCAIs) is included in the Trust Integrated Performance Report, which is presented to the Quality Operational Committee, Quality and Safety Assurance Committee, and Trust Board.

Quarterly IPC Update

A quarterly IPC Update report, which includes the IPC Board Assurance Framework (BAF), is presented to the Trust Board by the Chief Nurse.

IPC Service

The IPC service operates through a structured annual programme that provides expert advice, audits, teaching, education, surveillance, and policy development and review. It also offers support to staff, patients, and visitors. The main goal of the annual programme is to maintain and improve IPC standards, addressing both national and local priorities. The annual programme is approved by the IPC Assurance Committee.

Trust Board

The Code of Practice mandates that the Trust Board collectively acknowledges its responsibilities for Infection Prevention and Control (IPC). The Chief Executive holds overall accountability for infection control at the Trust, while the role of Director of Infection Prevention and Control (DIPC) is fulfilled by the Chief Nurse. The DIPC provides detailed updates on IPC matters at Trust Board meetings.

Quality & Safety Assurance Committee

The Quality & Safety Assurance Committee (QSAC) is a sub-committee of the Trust Board, responsible for managing organisational quality risks. The QSAC reviews high-level performance data related to infection prevention and control, monitors compliance with statutory obligations, and oversees the management of risks associated with infection prevention and control. QSAC ensures that processes are in place for patient safety and continuous monitoring and improvement in infection prevention. It receives quarterly assurance from the IPC Assurance Committee that effective policies and systems are in place.

Antimicrobial Stewardship Group

The Antimicrobial Stewardship Group (AMG) is a multidisciplinary team responsible for overseeing antimicrobial stewardship within the Trust and reporting to the Drug and Therapeutics Committee. The AMG is now well established, after a period of absence, and is working on a programme of audit and intervention where there are deemed deficiencies in antimicrobial prescribing within the Trust. The areas of intervention that the group has prioritised are:

- 72 Hr antibiotic review after initiation. This is in line with the national document Start Smart then Focus. This requirement is for consistent antibiotic review with documentation to refine what is often very broad-spectrum antibiotic treatment initiated when the patient presents with sepsis.
- Focus on pneumonias, Community Acquired Pneumonia (CAP) and Hospital Acquired Pneumonia (HAP) and aspiration pneumonias where prescribing is often outside trust antimicrobial guidelines.
- Changes to the treatment and management of CDI to move towards ESCMID and IDSA recommendations.
- Audit of use of broad-spectrum antibiotics, especially Tazocin and Meropenem, with a focus on control and reduction in inappropriate prescribing.

Decontamination Meetings

The primary purpose of a decontamination meeting within the Trust is to ensure the effective and safe sterilisation and decontamination of medical instruments and equipment as well as environmental decontamination. This meeting is crucial for maintaining high standards of infection prevention and control and patient safety.

Water Safety Group

The Water Safety group is a sub-group of IPC Assurance Committee; the Water Safety Group meets quarterly. It is chaired by the Deputy Chief Nurse/Deputy DIPC with Divisional and multi-disciplinary representation.

Ventilation Safety Group.

This group has not been meeting regularly however does meet for extraordinary meetings in response to incidents/concerns. This has been escalated to the Deputy Chief Estates, Facilities and MES Officer.

Infection Prevention and Control Committees

The Infection Prevention and Control Operational Group (IPCOG), reports into the Infection Prevention and Control Assurance Committee (IPCAC). The following papers/updates are received to the IPCOG:

Monthly	Quarterly
COVID Update	IPC Board Assurance Framework Update
IPC Monthly Report	HCAI Self-Assessment Update
IPC Policy Updates	IPC Strategy Assurance Framework
Divisional Update Reports	Antimicrobial Stewardship Report
Facilities Update (Cleanliness Monitoring)	Specific Area Action Plans (If relevant)
Decontamination Update	Water Safety Group AAAA Report
Estates Update	Decontamination Group AAAA Report
Health and Safety Update (FFP3)	Health and Safety (Sharps and Splashes)
	Re-established: Ventilation Safety Group.
Risk Register	Annually
Flu Plan	Previous year IPC Annual Programme
PHE Update	Next IPC Annual Programme for Approval
Bimonthly	IPC Annual Report
Occupational Health Update	

The following papers/updates are received by the Infection Prevention and Control Assurance Committee:

Quarterly	
Antimicrobial Stewardship Report	IPC Board Assurance
Health Act Self-Assessment Update	Estates Report
Decontamination Update	IPC Current Incidents Report

IPC Operational Group AAAA Report	IPC Risk Register and New Risks
Facilities Update	
IPC Annual Report	

Groups and Meetings attended by the Infection Prevention Team

Weekly or More Frequently	Monthly
Divisional Medicine Safety Huddles	IPC Operational Group
Outbreak meetings	Housekeepers meetings
	Integrated Care System (ICS) IPC
	Devices, Products and Gases Committee
	Nursing, Midwifery, AHP & Facilities
As Required	Quarterly
Cohorting Meetings	Water Safety Group
Decision Making Group (Staff return)	Decontamination Group
C diff / MSSA / E. coli RCA Review Meetings	IPC Assurance Committee
Measles/whooping cough/TB	IPC Link Nurse

1.4 Infection Surveillance (including external targets)

All organisms of IPC significance are monitored by the IPC team. The IPC Team use an automated surveillance system (ICNET).

1.5 Healthcare associated infections (HCAIs)

Clostridioides difficile

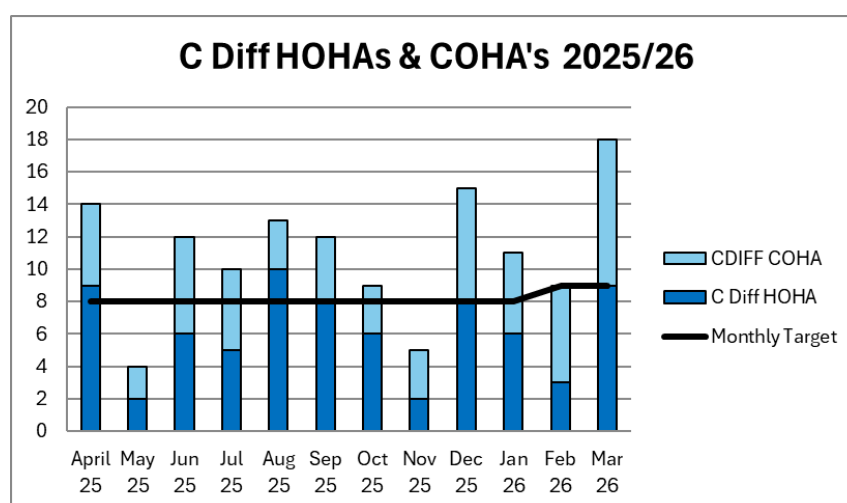
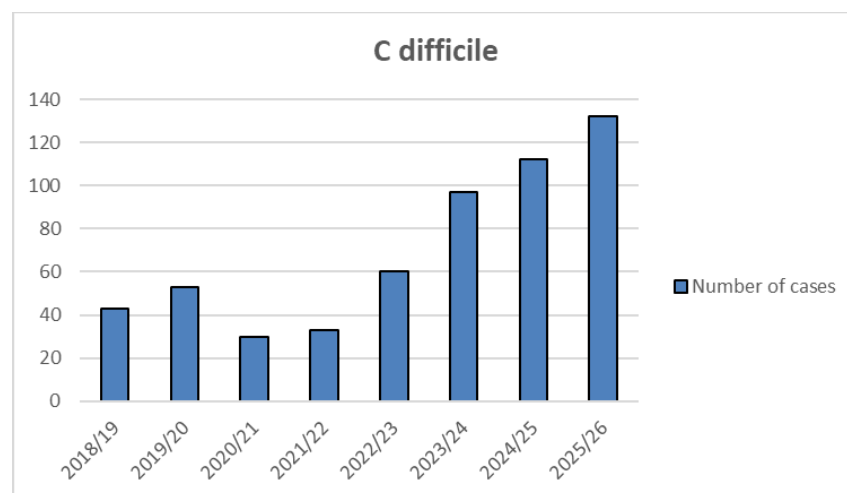
Clostridioides difficile (C.difficile) is a bacterium found in the gut which can cause diarrhoea after antibiotics. It can rarely cause a severe and life-threatening inflammation of the gut called pseudo-membranous colitis. It forms resistant spores that persist in the hospital environment which require very effective cleaning and disinfection to prevent transmission to other patients

There are a number of risk factors for patients developing C.diff Infection (see below) but it is nearly always preceded by some antibiotic treatment. Although most antibiotics have been implicated, broad-spectrum agents such as cephalosporins, quinolones, Tazocin, carbapenems (e.g., Meropenem) are most likely to cause it as they wipe out the “normal flora”

of the gut which usually holds C difficile in check.. As Tazocin is so widely used as workhorse broad spectrum antibiotic in the trust it is most commonly implicated as a causative agent.

Risk factors for developing CDI.

- Age >65. (? Should this be lower eg >55 years).
- Hospitalisation and previous /multiple hospitalisation.
- Antibiotics – multiple courses/ broad spectrum.
- Inflammatory bowel disease.
- Chronic immunosuppression. Malignancy Drug therapy. Alcoholism.
- Post chemo diarrhoea (within 2 weeks of chemo).
- Haematological malignancy – with or without chemotherapy.
- Proton pump inhibitors, eg Omeprazole etc. (now available over the counter)
- IPC issues: Ward overcrowding, poor IPC practice and lack of prompt isolation.



The C difficile target for SaTH in 2025-26 was to have no more than 98 cases overall and Trust apportioned cases in patients over the age of 2 years. By the end of the financial year we had

exceeded the target with 132 cases. This data is in line with an upward trend since 2022.

HOHA C. diff rate per 100,000 bed days			
Year	SaTH	West Midlands	England
2020/21	10	15.9	17.5
2021/22	8.3	17.1	18.2
2022/23	20.4	20.5	21.8
2023/24	26.1	25.3	22.9
2024/25	27.4	28.0	25.7
2025/26	25.75	22.1	

The trend for increases in rates of CDI is universal amongst most acute trusts regionally and across the country, with the exception of London hospitals (which may be explained by younger demographic). Why this is happening is difficult to explain but it may be as simple as a consequence of more intense medicine, with greater throughput, being performed as the NHS attempts to catch up with the backlog of the Covid years. It cannot be attributed to a return of a more virulent form of C.diff, and most cases of increased incidence in our hospital wards do not appear to be cases of classic cross- infection or outbreaks.

Inappropriate antibiotic related: 114 cases reviewed, 40 where antibiotic prescribing considered inappropriate.

Yet again in 2025-26 we have exceeded our given target. The funnel plots below show that we are consistently above the line, although we just about avoid being a statistical outlier.

Code for funnel plots: SATH = RXW. RWH (as a comparator trust) = RL4.

Issues identified from case reviews:

Many of our CDI cases appear to present as late or co-terminal events in patients who are extremely frail and often have significant multiple co-morbidities such as carcinomatosis, on chemotherapy or biologic agents. These patients by the nature of their underlying disease and being prone to infection require multiple courses of broad-spectrum antibiotics. This seems to be a trend, shifting away from the more usual medical in-patient.

- Late submission of specimen and diagnosis, leading to delay in isolation and treatment.
- Failure to obtain stool specimen in ED has led to some cases being erroneously attributed to acute trust. In addition leading to delay in diagnosis.
- Repeat testing sometimes required if ongoing diarrhoeal disease.

- Fidaxomicin still not cleared for funding as first-line treatment by ICB.
- Deficiencies in basic IPC practice such as hand washing and glove use.

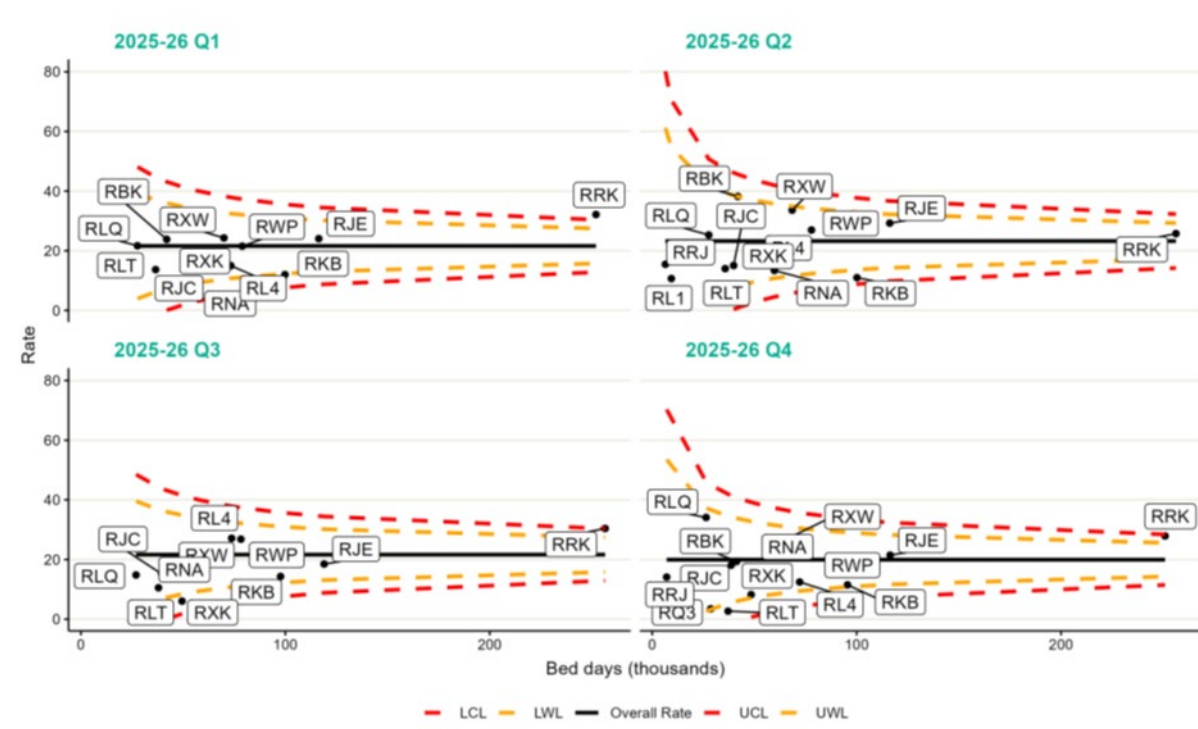
Additional questions that have arisen from wider discussions:

Efficiency of Tristel as the primary disinfectant. There is some question about the ability of a two in one detergent and disinfectant to remove all soiling which would allow the disinfectant to decontaminate the ward environment – undertaking literature search to look into this issue.

Efficiency of cleaning in ward areas. If there are gaps in the cleaning this needs to be addressed.

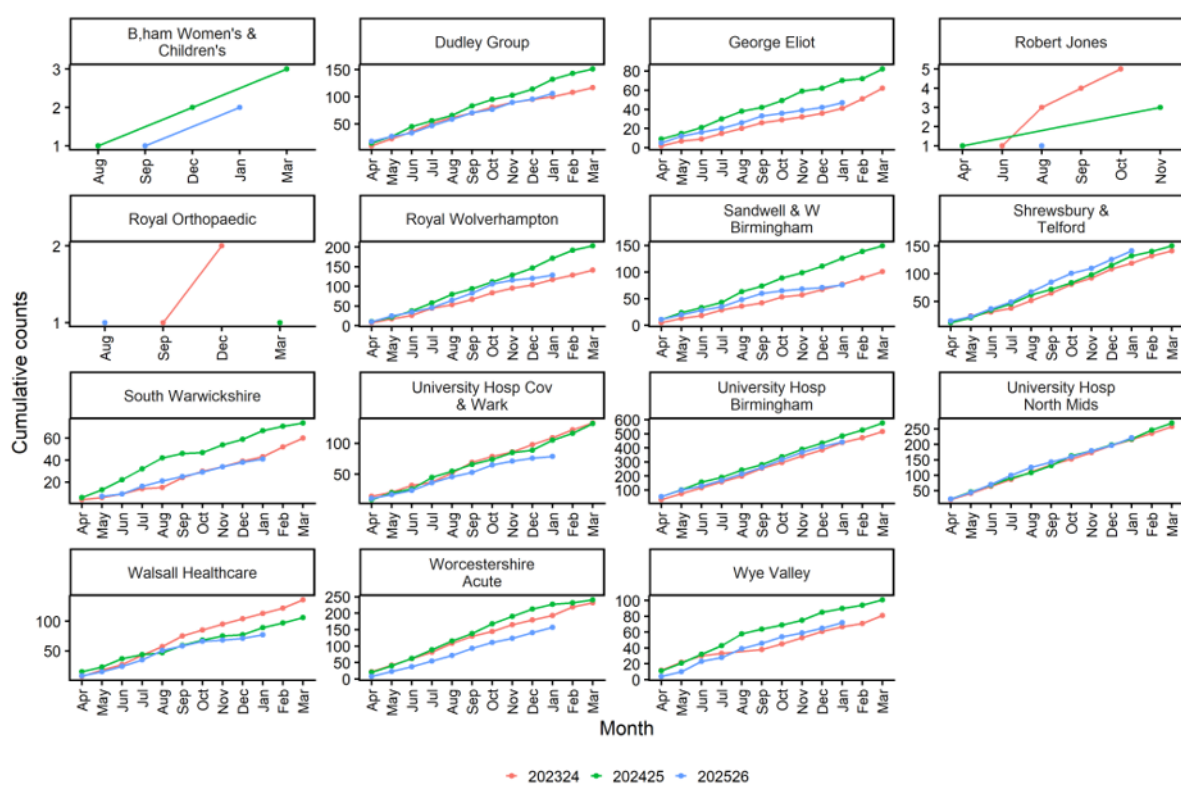
- User of ATPase to detect organic matter.
- Use of fluorescent markers to detect uncleaned surfaces.
- Consider dedicated bed decontamination facility.

Request for analysis of mortality rate: We have noticed a trend of CDI. being diagnosed a co-terminal event in patients who are extremely sick. These are often in very old and frail patients, and/or patients with carcinomatosis, on chemotherapy or Biologics. We looked at the death certificates to calculate the attributable mortality rather than the gross mortality (ie where C. diff was written in part 1 of death certificate). Attributable CDI mortality: 6.8% This is not exceptional and well bellow the threshold for concern of 15%.



C.difficile

Cumulative reports of all *C.difficile* by FY from Apr-2023 to Jan-2026, West Midlands



The Trust's C. difficile Reduction Action Plan was comprehensively reviewed and updated during 2025/26 following feedback from NHS England and the Integrated Care Board (ICB). The revised plan has also been benchmarked against action plans from other NHS organisations to ensure alignment with best practice and incorporates 44 actions across five key themes:

- Improving Infection Prevention and Control (IPC) practices and procedures
- Environmental cleanliness and decontamination
- Antimicrobial stewardship
- Management of patients with C. difficile infection and diarrhoea
- Trust-wide communication and engagement

Progress against the action plan is monitored through the Infection Prevention and Control Operational Group (IPCOG) on a monthly basis, providing oversight, challenge and assurance that actions remain on track.

Key areas of progress during the year include:

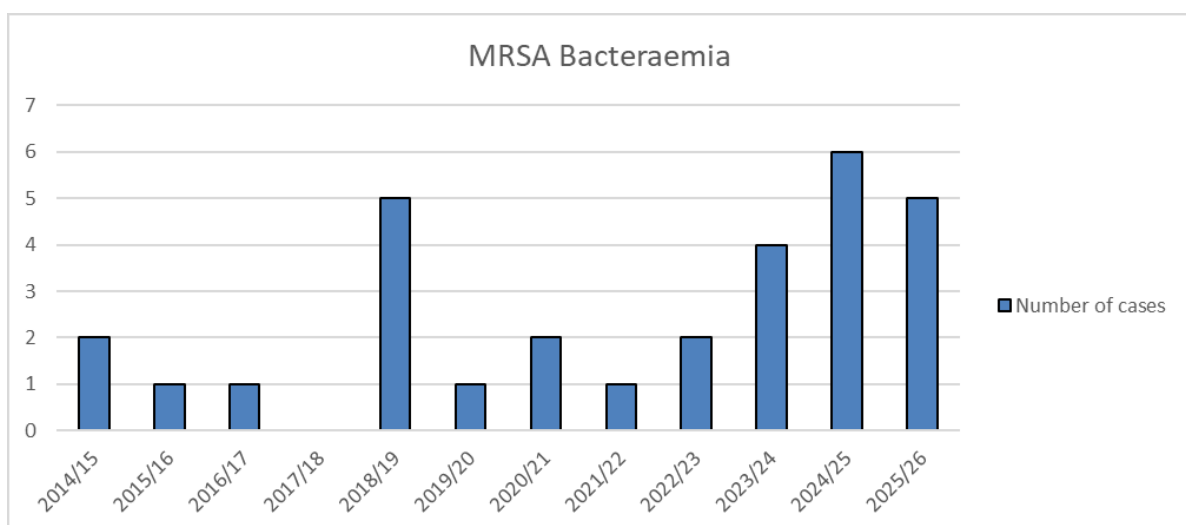
- Development and implementation of a targeted deep-clean programme focused on reducing the environmental burden of C. difficile spores in high-risk clinical areas.

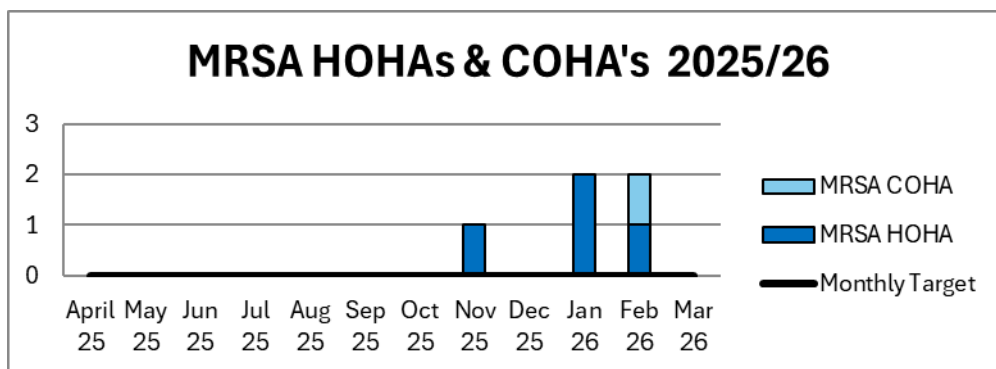
- Introduction of an alternative first-line treatment regimen for patients with *C. difficile* infection, aimed at reducing recurrence rates and subsequent environmental contamination.
- Implementation of a RAG-rated ward assessment tool to identify areas at increased risk of transmission, supported by an escalation framework and tailored improvement actions.
- Enhanced focus on inpatient care practices that influence transmission risk, including reducing inappropriate commode use, promoting patient hand hygiene before meals, and improving access to hand hygiene facilities in high-throughput clinical areas.
- Strengthened antimicrobial stewardship arrangements through closer review of prescribing practices and targeted interventions in high-risk areas.
- Improved oversight and learning through thematic reviews of healthcare-associated cases and targeted ward support.

The action plan has strengthened the Trust's approach to reducing transmission risk and improving the management of patients with *C. difficile*. Whilst challenges remain in achieving the national objectives, the plan provides a robust framework for sustained improvement, with progress monitored through established governance arrangements and reported regularly to IPCOG and relevant Trust committees.

MRSA Bacteraemia

The Trust Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia target is zero. In 2025-26 the trust had 5 cases.





MRSA cases- synopsis

Case 1. November 25. Patient admitted following prolonged treatment and surgery in Switzerland, with known MRSA history both overseas and at SaTH. Admitted directly to a side room and screened positive in nose and abdominal wound. Decolonisation was delayed by one week and subsequently refused. Burn wounds were also MRSA positive. The case was agreed to be unavoidable. Classed as HOHA.

Case 2. January 26. Patient admitted via ED on 26 December 2025. Admission MRSA nose screen was negative, but a later sacral skin tear screened MRSA positive. Documentation gaps were identified for cannula insertion/removal and blood culture collection, and skin preparation practice did not follow expected chlorhexidine/alcohol use. The case was agreed to be a contaminant. Classed as HOHA.

Case 3. January 26. Patient admitted following paracentesis on 30 December 2025. Admission nose screen was MRSA positive, but the paracentesis site was not screened. Blood cultures were taken when pyrexial and influenza positive; documentation did not identify who took the cultures. The case was agreed to be a contaminant. Classed as HOHA.

Case 4. February 26. Patient previously admitted for anaemia and UTI, with a catheter inserted for convenience. Following discharge, the catheter was changed by district nurses in the community. The patient was readmitted with haematuria and pyrexia; blood cultures were MRSA positive. No urine specimen was taken, and MRSA screening was not completed on readmission. The case was agreed likely related to catheter change in the community. Classed as COHA.

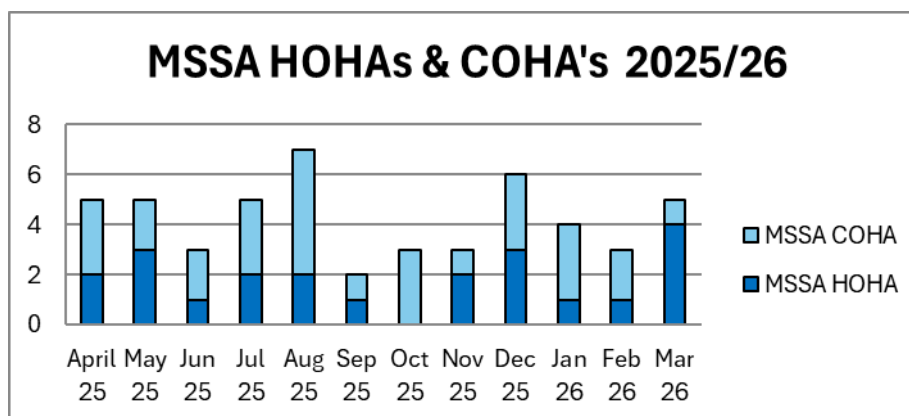
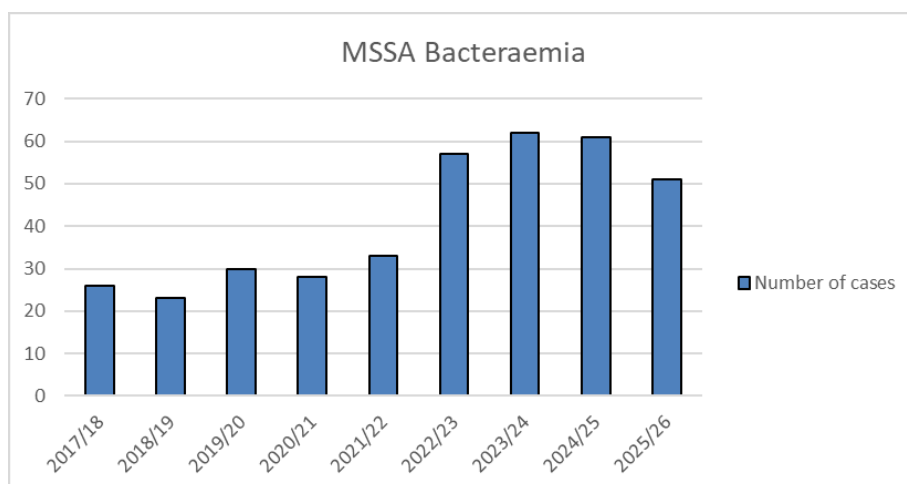
Case 5. February 26. Patient admitted to ED following a fall with fractured toe and possible leg wounds. The patient was likely colonised on admission, but MRSA screening was not undertaken in ED. The likely portal of entry was the leg wound or broken toe. Classed as HOHA.

MSSA Bacteraemia

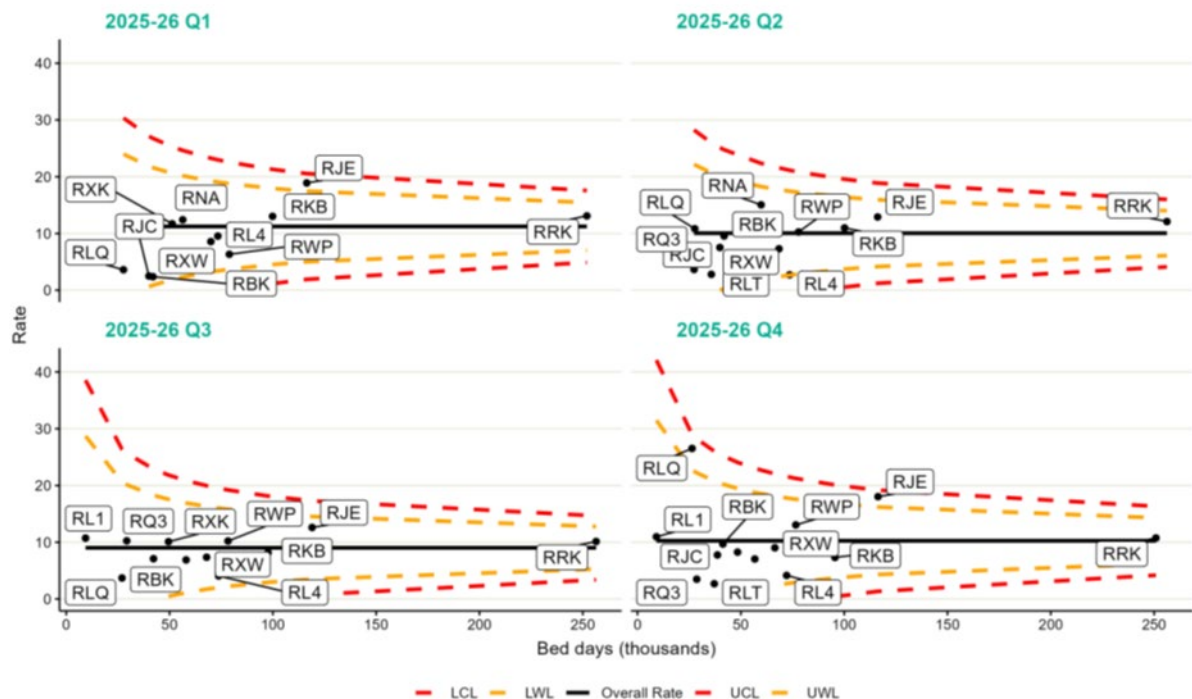
MSSA (Methicillin sensitive *Staphylococcus aureus*) is the much commoner Flucloxacillin sensitive version of *Staphylococcus aureus*.

There were 51 cases apportioned to SaTH in 2025/26 compared with 61 in 2024-25. Of these 8 were associated with potentially healthcare-related or device associated sources. Although numbers of MSSA bacteraemia's has dropped somewhat compares to the previous 3 years it is still at worryingly high rate. Some of these cases are related to the nature of the patient, prosthetic devises, wound infections etc. However, there are some elements that are IPC related:

- Venflon and long line care. – removal at earliest appropriate opportunity.
- Urinary catheter-associated. This reinforces the importance of robust catheter care, regular review of catheter necessity, and prompt removal where clinically appropriate.
- Failure to provide accurate VIP scores and act when appropriate.
- Poor documentation in notes for clinicians taking blood-cultures



Funnel plots comparing with other regional trusts show SATH (RXW) in a reasonable position and consistently below the line.



Gram Negative Blood Stream Infections

We are required to monitor blood stream infections (or bacteraemia) for three Gram negative bacteria - E coli, Klebsiella and Pseudomonas. These are less amenable to IPC measures as they are often related to UTIs, urinary tract catheterisation or immunocompromising factors.

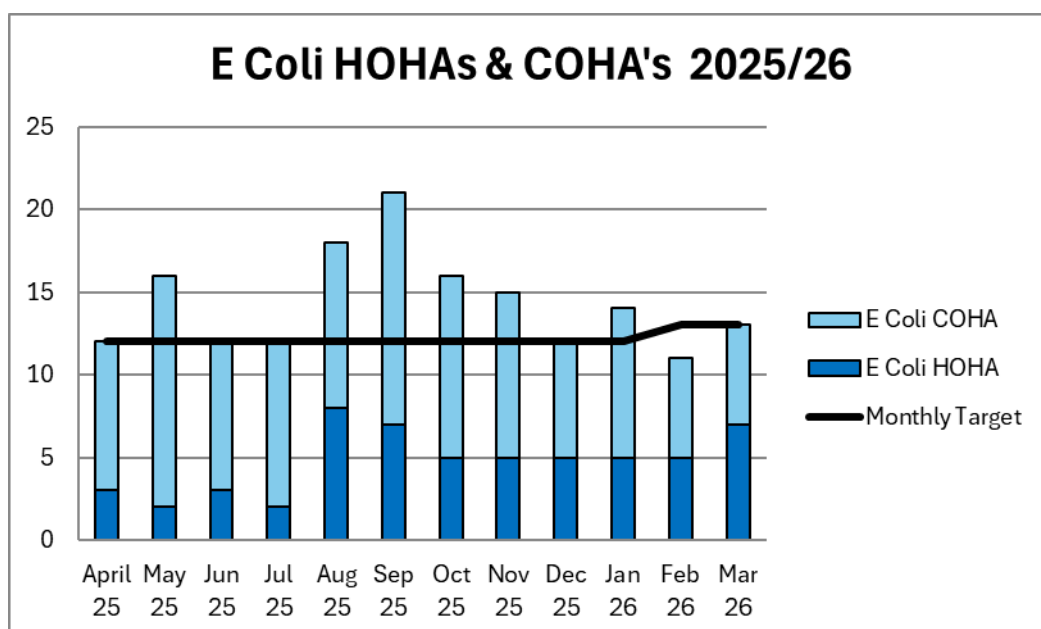
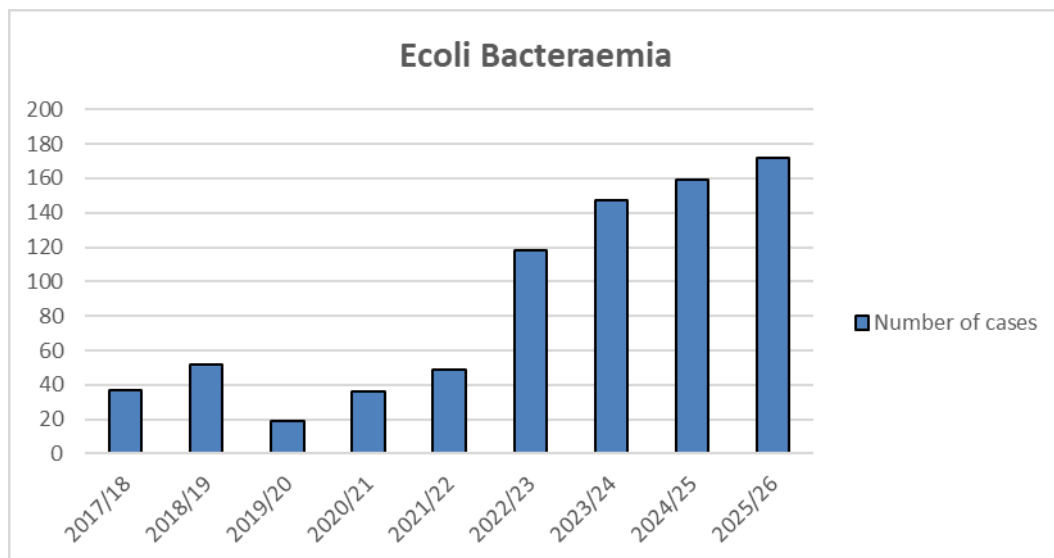
E coli

E. coli is a common commensal of the human colonic flora. If it escapes from the gut, it may become the cause of bacteraemia and sepsis, the most common causes or sources include the urinary tract, intra-abdominal/biliary sepsis and hospital acquired pneumonia. Severe immunosuppression may allow direct translocation from the gut into the bloodstream, many cases are associated with the instrumentation of the urinary tract including insertion and maintenance of urinary catheters.

E. coli Bacteraemia:

The total cases attributed to the Trust for the financial year 2025/26 was 172 (against a target of 146) compared to last financial year (2024/25) where there was a total of 159 cases. This figure is significantly above our nationally set target. The ability of healthcare services to limit

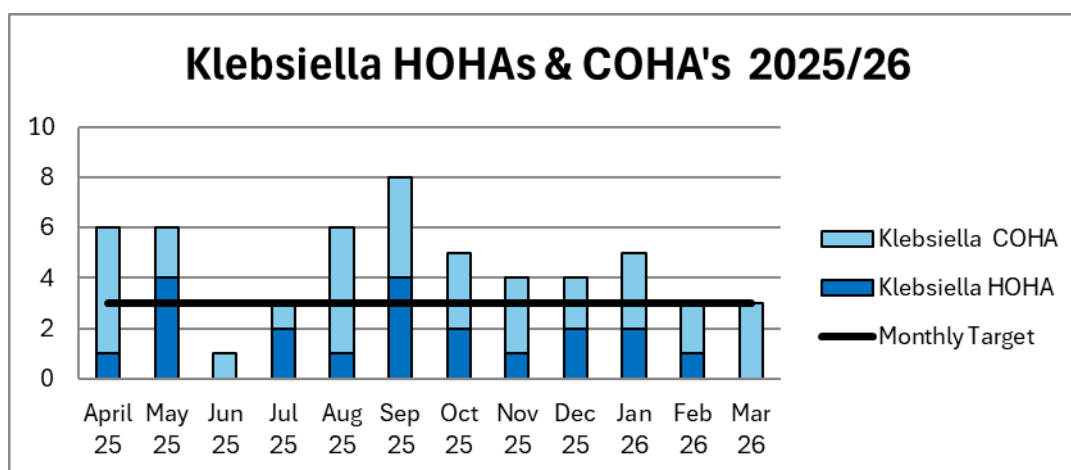
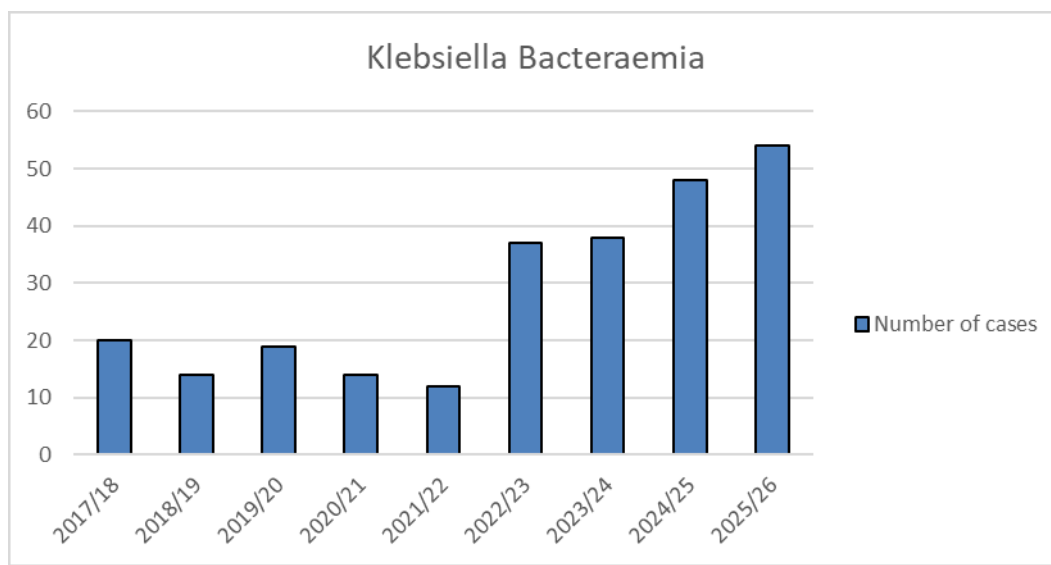
E.coli bacteraemia is strictly limited as many causative factors are endogenous to the patient and largely outside the control of the IPC Team. Urinary catheterisation is the commonest avoidable risk factor and requires a program of monitoring patients for ongoing utility of medium to long term catheters. Two third of cases are COHA cases, and many of these will be related to long term catheterisation. A proportion of E. coli bacteraemia's originate in hospital acquired LRTIs and measures aimed at risk reduction, such as mouth hygiene programmes, may pay dividends.



The graph shows E coli bacteraemia cases. Please note the attribution rules changed in 2019/20 to include patients who had been in hospital in the last 28 days as well as those who had been in hospital for 2 days or more when the sample was collected.

Klebsiella

Klebsiella, like E coli, is part of our normal flora and causes similar infections, particularly UTI, but also pneumonia in patients with damaged lungs. However, it is more resistant to antibiotics than E. coli and infections are more commonly found to be healthcare acquired. In 2025/26 there were 54 against a target of 36 Trust apportioned Klebsiella bacteraemia so we have exceeded that target and seen a significant rise in cases over the last 4 years.

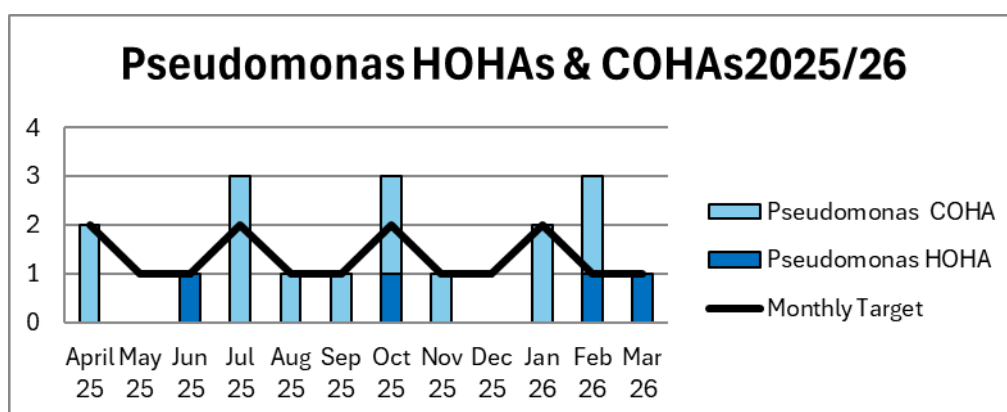
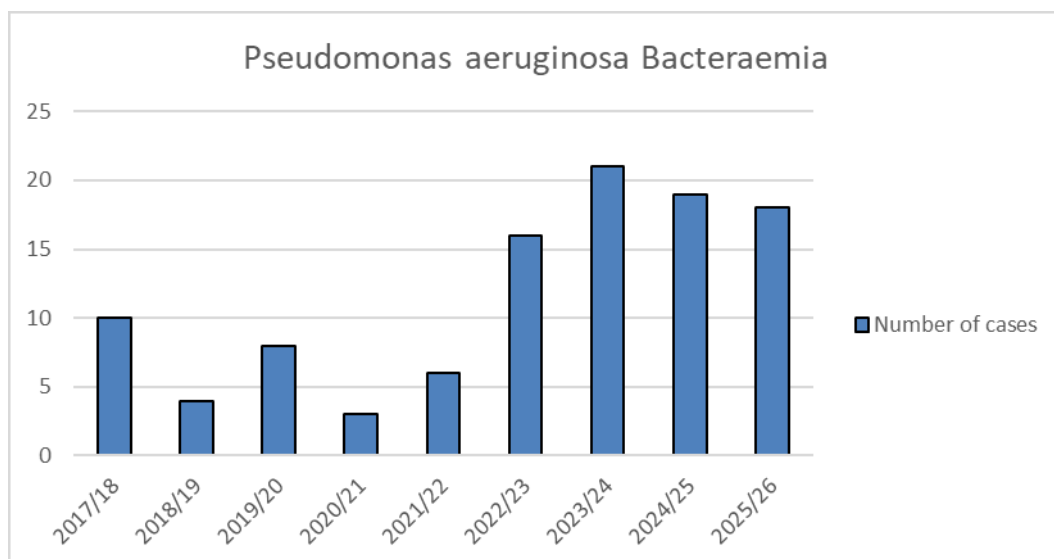


The graph shows Klebsiella bacteraemia cases. Please note the attribution rules changed in 2019/20 to include patients who had been in hospital in the last 28 days as well as those who had been in hospital for 2 days or more when the sample was collected.

Pseudomonas aeruginosa

Pseudomonas aeruginosa, unlike *E coli* or *Klebsiella*, is an environmental organism and not part of our normal flora. It is naturally highly resistant to antibiotics and is considered an opportunistic pathogen. This means it is unlikely to cause infection in healthy people but can take advantage of situations where the patient is debilitated by illness or immunosuppression and can also be selected by use of broad-spectrum antibiotic use. One of the major problems with this organism is creeping increases in resistance leading to difficulties in treating some infections and requiring higher doses of anti-pseudomonal antibiotics.

In 2025/26 there were 18 cases of Trust apportioned *Pseudomonas aeruginosa* compared with 19 cases in 2024/25, and we have met our target of 19 or less cases for the year.



The graph shows *Pseudomonas* bacteraemia cases. Please note the attribution rules changed in 2019/20 to include patients who had been in hospital in the last 28 days as well as those who had been in hospital for 2 days or more when the sample was collected.

Overall Summary of Performance

Source attribution of Trust-apportioned bloodstream infections, 2025/26

The table below summarises the recorded source attribution for Trust-apportioned bloodstream infections during 2025/26. It demonstrates that urinary sources remain the largest contributor to Gram-negative bacteraemia, while skin and soft tissue sources were the most frequently identified source for staphylococcal bacteraemia.

Bacteraemias, by source of infection

Source	E.coli	Klebsiella	Pseudomonas	All GNB	MSSA	MRSA	All Staphs
Biliary	23	4	0	27	2	0	2
Bone/joint	1	1	0	2	8	0	8
Endocarditis	0	0	0	0	2	0	2
Intra abdominal	18	6	0	24	0	0	0
IV access	0	1	1	2	1	0	1
Neutropaenic sepsis	11	4	5	20	0	0	0
Other medical device	0	1	2	3	3	0	3
Respiratory	3	7	2	12	1	0	1
Skin/Soft tissue	5	2	2	9	16	2	18
Urinary (catheter)	40	14	2	56	4	1	5
Urinary (no catheter)	61	13	3	77	1	0	1
Unknown	10	1	1	12	13	0	13
Contaminant	0	0	0	0	0	2	2
Total	172	54	18	244	51	5	56

Key themes from this source attribution include the continued prominence of urinary sources for Gram-negative bloodstream infection, particularly catheter-associated infection, and the contribution of skin, soft tissue and device-related sources to staphylococcal bacteraemia. These findings support ongoing focus on urinary catheter care, peripheral and central line care, wound management, documentation of device checks, and timely source control.

HOHA – Hospital Onset Healthcare Associated. Cases where the positive sample was taken on, or after day 2 of admission and therefore assumed to be acquired during current admission.

COHA – Community Onset Healthcare Associated. Cases where the patient was admitted with the infection but has been an inpatient at the Trust in the previous 28 days.

Fungi

Screening for *Candidozyma auris* has been introduced in augmented care areas and for patients returning from healthcare facilities abroad. This screening programme is now fully active. *Candidozyma auris* is a multidrug-resistant yeast that can colonise patients and persist in clinical environments. Early identification supports timely IPC countermeasures and is in line with national guidance.

Potential isolates of *Trichophyton indotineae*, a highly pathogenic dermatophyte associated with terbinafine resistance, are being referred for species identification and antifungal susceptibility testing.

1.6 Audit Programme to Ensure Key Policies are Implemented.

There is an extensive IPC audit plan across both sites. To ensure consistent compliance with evidence practice, and national and Trust policies, the audits are conducted as a minimum on an annual basis, by both the clinical areas and the IPC team. To ensure the audit tools used by the IPC team can capture changes in guidance, the IPC team consistently revises the audit template.

Audit results and completion of the actions arising from the audits are reviewed at the IPC Operational group, and through the Divisional Quality meetings, and are reported to the Board via these meetings. All outbreak audits are also analysed during the post infection reviews.

The IPC team aims to visit each clinical area at least every 3 months, although this visit may not include the completion of an audit, and areas with identified issues are visited more frequently, depending on the level of compliance.

During 2025/6, as in the previous year, the IPC programme of audit focused on responding to Periods of Increased Incidence (PII) and outbreaks, as well as on areas where IPC concerns have been raised.

Audit / assurance activity	Lead	Frequency	Reporting route	Key findings / assurance
Hand hygiene audits	Matrons	Monthly	Divisional quality reviews	Completed through the IPC Quality Ward Walk audit tool.

				Ward managers and matrons review IPC practice monthly.
Quality Ward Walks	IPC team / Matrons	Weekly, monthly or quarterly according to risk	Divisions, DIPC outbreak meetings and IPCOG	Routine QWWs are completed every 3–4 months. Areas below 90% receive monthly reviews. Weekly audits are undertaken in outbreak areas.
Exemplar audits	Corporate Nursing Quality Team with IPC input	Three-monthly	Ward manager, Matron, Divisional Director of Nursing and divisional quality meetings	Multidisciplinary reviews of clinical standards, patient safety and improvement requirements.
Commode audit	IPC team	Annual	IPCOG and clinical/divisional leads	All inpatient commodes reviewed. Issues included incorrect storage, damaged commodes, lack of clean labelling and macerator problems.
Isolation audit	IPC team	Annual	IPCOG and clinical/divisional leads	Side room availability does not consistently align with patient need. Limited en-suite provision and some doors left open without documented rationale were identified.
Loose stool audit	IPC team	Point prevalence audit	Clinical and divisional leads	Audit at RSH identified gaps in ward awareness of patients with loose stool when compared with SQL reporting.
Waste management pre-acceptance audit	Independent Safety Services Ltd	Annual / rolling programme	IPCOG, Assurance, Facilities and Estates	Issues included waste segregation, security of disposal holds, locked waste bins, timely removal of clinical waste, container cleanliness and Sharpsmart documentation.
Sharps audit	Sharpsmart company	Monthly	IPCOG, Assurance, Facilities and Estates	Review of returned Sharpsmart containers for assurance and safe practice.

Cleanliness monitoring audits	Facilities	Monthly	Divisions and NQM triangulation	Monthly cleanliness monitoring is reported through NQM, QWWs and the Facilities report to IPCOG.
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1.7 Infection Prevention and Control Quality Ward Walks

Quality ward walks (QWW) of clinical areas within the Trust, have been undertaken by the IPC team on a quarterly basis, or more frequently when areas fall below the expected standard of 90%. However, the areas that have outbreaks are monitored weekly and results are reported directly to the DIPC through the PII/outbreak assurance meetings.

The matron led IPC QWW had become a routine and integral part of the matron/ward relationship and has continued throughout 2024/25 with some areas conducting peer audits.

For routine QWW's the IPC team use a proforma tool (housed on the Gather tool on the Trust's intranet page) based on 42 key points, which provide an in depth and rounded audit of a ward/department, focusing on several areas including hand hygiene and PPE, cleaning and decontamination, estates and waste management, invasive devices, and isolation. Credits for Cleaning scores are also used to provide a triangulated approach to the status of a clinical area in any point and time. The Ward's rolling action plan associated with these findings is a "live" hyperlinked document that the leads for the ward/department can use to input corrective actions and plans to prevent recurrence as well as monitoring notes where required.

In the 2025-26 period the IPC team have completed:

- 94 quality walks between April 2025 and March 2026 recorded on Gather.
- In addition to this, the IPC team conducted visits to all areas with periods of increased incidence (PII) of C.diff, Norovirus, ESBL to look at specific elements of practice
- The IPC team supports Exemplar assessments in clinical areas

2958 Sanitary Equipment Audits were completed between April 2025 and March 2026 by all staff groups.

- 97.5% of these were commode audits
- Most elements of the audit scored over 98% on average

- The exception was the use of a green 'I am clean' label which was in use 93% of the time on average.

1.9 Audits of Hand Hygiene Practice

Hand Hygiene audits continue to be completed on the electronic audit and reporting system, Gather.

Below are the compliance figures from audits completed in the whole of 2025/26. There has been an improvement in score by staff group and in clinical specialities.

Hand Hygiene Compliance

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Nurse	100.0%	99.2%	99.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	100.0%
Doctor	97.5%	98.1%	97.9%	97.5%	93.9%	95.3%	97.3%	98.4%	96.6%	90.4%	100.0%	97.4%
HCS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.2%	100.0%	100.0%
Other	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%	100.0%

2025/26

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Medical	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.3%	95.6%	88.2%	100.0%	94.9%
Surgery	100.0%	100.0%	100.0%	100.0%	97.3%	100.0%	100.0%	86.5%	100.0%	100.0%	100.0%	99.2%
Oncology / Haematology	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	82.5%	100.0%	89.6%	100.0%	100.0%
Musculoskeletal	100.0%	92.6%	95.0%	100.0%	100.0%	94.6%	97.5%	98.9%	98.2%	98.2%	100.0%	98.3%
Head & Neck / Ophthalmology	97.2%	100.0%	100.0%	97.4%	97.8%	100.0%	100.0%	100.0%	100.0%	94.2%	100.0%	100.0%
Patient Access	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Theatres, Anaes & Critical Care	100.0%	100.0%	100.0%	N/A	94.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Women's & Children's	95.7%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	100.0%	85.5%
Diagnostics	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

In 2025-26 the Trust Hand Hygiene Policy stipulated that all staff should have their hand hygiene technique assessed within one month of starting their employment and reviewed every three years. It is the responsibility of the Ward Manager, the individual staff member, and the IPC link nurses to ensure these assessments are carried out.

The overall compliance rate for 2025/26 is 87% and includes all staff groups within the Trust. This is the same as the reported result for 2024/5 but is still lower than that for 2022/23 of 94%.

The results listed in the table below show compliance by staff group. There has been a general trend of increase in compliance although the Healthcare Scientist Group compliance percentage has decreased.

Staff Group	Compliance
Add Prof Scientific and Technical	84%

Additional Clinical Services	94%
Administrative and Clerical	82%
Allied Health Professionals	85%
Estates and Ancillary	95%
Healthcare Scientists	71%
Medical and Dental	51%
Nursing and Midwifery Registered	92%
Students	100%
Grand Total	84%
Division	Compliance
Clinical Support Services	80%
Medicine and Emergency	84%
Surgery Anaesthetics % Cancer	92%
Women & Children	88%
Corporate	92%
Total	87%

Criterion 2:

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

2.1 Cleanliness Team

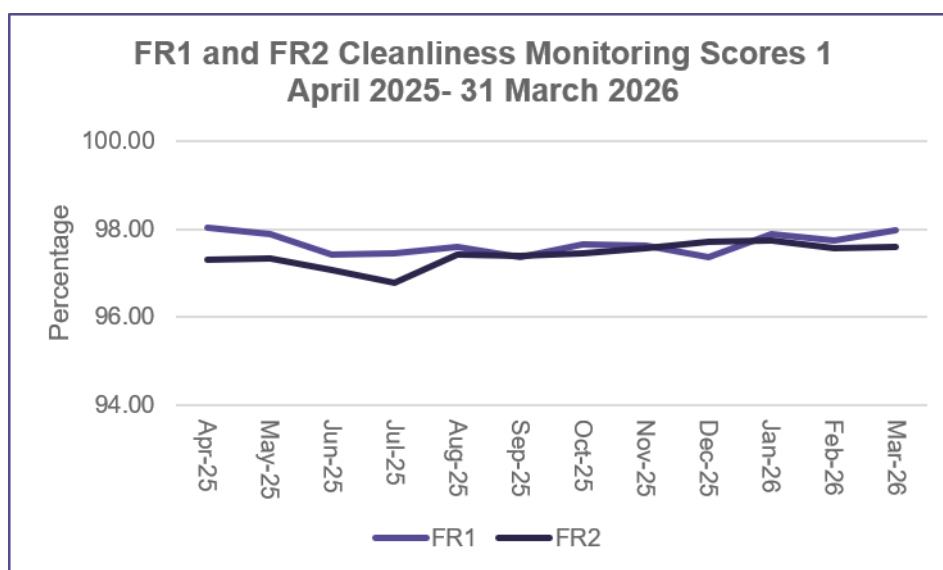
The Cleanliness Team provides a 24/7 service to the Trust in accordance with the National Standards of Healthcare Cleanliness. Cleanliness Technicians are trained and adhere to, robust method statements and IPC Protocols.

National Standards of Healthcare Cleanliness

The National Standards of Healthcare Cleanliness (2025) has been adhered to by the Trust and is monitored by an independent team using fmfirst Cleaning Audit Software.

The Cleanliness Management team also carry out audits which review their responsibilities for all areas, logging the fails and providing the cleanliness technician with corrective actions and deadlines dependant on risk areas. Cleanliness standards in clinical areas are split into Functional Risk 1 (FR1) and Functional Risk 2 (FR2) categories.

FR1 areas are higher risk areas and are expected to meet a 98% compliance – this standard has on average been slightly underachieved with an average score of 97.67% for the year. General wards and clinical departments are FR2 and expected to meet 95% compliance which they have consistently met with an average score of 97.41% for the year. The areas of non-compliance are fed back to the responsible team to action.



Monitoring Processes for In-House Cleaning

The Trust Monitoring Team carry out visible checks of all elements of cleanliness using the Micad Audit software to record the results. The system then generates a report showing the percentage score that the area has achieved and any corrective actions required which is then automatically sent to the Ward/Area Manager, Estates and Cleanliness Teams for action.

Matrons and Ward Managers are encouraged to join the audits. The results of the audits are reported monthly to IPC Operational Group and exceptions presented at IPC Assurance Committee.

The Senior Cleanliness Manager or Site Cleanliness Managers participate in any outbreak or periods of increased incidents (PII) meetings when issues are identified on site as well as joining Exemplar Audits.

The Cleanliness Management Team carry out twice monthly audits. The first audit is to check cleanliness responsibility elements on all areas and feedback to Cleanliness Technicians any corrective actions needed. The next audit takes place one week later to ensure all actions are complete. This is currently recorded on paper.

Decontamination

Decontamination is carried out in infected rooms/bays as required, using Hydrogen Peroxide or Ultraviolet Light Systems, in accordance with the Cleanliness Team RAG Poster. The Team also carries out a programme of proactive decontamination of bathrooms and toilets as well as any other areas requested of them.

Terminal Cleans

All terminal cleans at the Trust are requested via the internal bleep system during. Hydrogen Peroxide decontamination of side rooms is requested as per the Cleanliness Team RAG poster.

Radiator Cleaning

The Trust has a planned programme of radiator cover removal to allow for cleaning. It has also been agreed that radiator covers are removed, and radiators cleaned after any outbreak of infection.

Criterion 3:

Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

3.1 Antimicrobial Stewardship (AMS)

The Trust antimicrobial stewardship group (AMG) membership includes representatives from pharmacy, microbiology, nursing, and medical staff. This group manages policy with regard to antimicrobial stewardship, formulates policy with regard to antimicrobial stewardship and responds to concerns in this area. The group feeds back actions and concerns via the Drug and Therapeutic committee and reports into the Infection Prevention and Control Operational Group and through to the IPC Assurance Committee.

The AMG has been meeting regularly to discuss antimicrobial matters and formulating a workplan for moving forward. Clinical engagement remains a challenge and forms part of improvement work. Following publication of the Call-to-Action letter, the group presented to the Trust Board highlighting the key areas of focus for the upcoming year is

- 48-72 hour review of antimicrobial prescriptions
- Intravenous oral switch
- Reduction in delayed identification of HCAs

The pharmacy team continue to engage in antimicrobial stewardship activities and antimicrobial stewardship actions are communicated through direct contact. There are continue challenges this year relating to issues with data upload for admissions and bed days which has impacted on the ability to provide meaningful reports on antimicrobial consumption. National targets are expected to change to remove this denominator which will impact on the ability to meet the national targets requiring additional explanation of results. Collaboration across the system continues with partner providers including Shropshire Community Health Trust, the UKHSA and Shropshire, Telford and Wrekin ICS to improve antimicrobial stewardship practices across the system. The Integrated Care System has its own Antimicrobial Stewardship Strategy and Oversight Group with contributions from local healthcare providers and future efforts for a local health economy wide approach to antimicrobial stewardship.

The group undertakes the following actions.

- Production of the antibiotic guidelines publishing them on the Eolas app
- Yearly update of the antibiotic guidelines or more frequently as necessary

- A rolling Antimicrobial Audit Programme in line with Start Smart then Focus has been in place across the Trust for a number of years.
- Review of guidelines and issue of temporary alternative guidance when certain key antibiotics are unavailable due to global and national shortages.
- The Antimicrobial Guideline App (Eolas) is in use for all desktop and mobile devices, this continues to be popular with prescribers, facilitating easy access of antimicrobial guidelines at the point of prescribing. The Antimicrobial policy for both Adults and Paediatrics are available via the app.

Basic audits of prescribing are undertaken on a monthly basis and fed back to IPCOG and Clinical Governance Meetings. More detailed audits and direct prescriber feedback are not able to be undertaken due to lack of electronic prescribing within the Trust. Regular monitoring of prescribing at ward level continues and pharmacist antibiotic related interventions are reviewed each month. Updated methods for audits are underway and form part of the AMG workplan including development of a dashboard of results to enable timely feedback to clinical areas. Engagement with clinical teams has introduced the development of more detailed audits of specific areas including community acquired pneumonia, piperacillin/tazobactam and meropenem prescribing.

The Pharmacy Antimicrobial Team structure continues to be reviewed, and work is underway to assess the current workforce need in line with national recommendations from NHSE and GIRFT and the growing OPAT service. This work will enable additional support within the trust for antimicrobial stewardship activities.

The Antimicrobial Pharmacist continues to undertake FY1 junior doctor teaching in August/September for the new intake and attends medical and surgical clinical governance meetings to communicate information where necessary. The AMG aims to review Antimicrobial education provision and develop a plan to ensure a more robust antimicrobial stewardship teaching programme.

The work of the Sepsis Nursing team is established with the deteriorating patient team and since restarting the AMG meetings has been working closely with the group to support the workplan for improving antimicrobial stewardship and sepsis management.

As in previous years, there have been challenges as a result of ongoing shortages of various antimicrobials during the year due to manufacturer's supply problems. These continue to be managed by the pharmacy team with alerts sent out detailing appropriate actions/alternatives.

The AMG, Microbiology and Pharmacy Departments work collectively to ensure that alternative agents are available for patients in a timely manner.

The Shropshire Outpatient Parenteral Antimicrobial Therapy (OPAT) Service continues to support the administration of intravenous antimicrobials in the outpatient setting. The service has identified opportunity for growth and development and has submitted a business case for expansion. This work will continue to enhance antimicrobial stewardship and assist patient flow through early discharge and admission avoidance in line with the wider NHS plan of bringing care closer to home.

Criterion 4:

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

4.1 Communication Programme

Communications have continued to be a priority for the Infection Prevention and Control team in 2025/26. The IPC team have communicated all changes in national or local guidance, changes to SaTH IPC policies, and lessons learnt following outbreaks and root cause analysis.

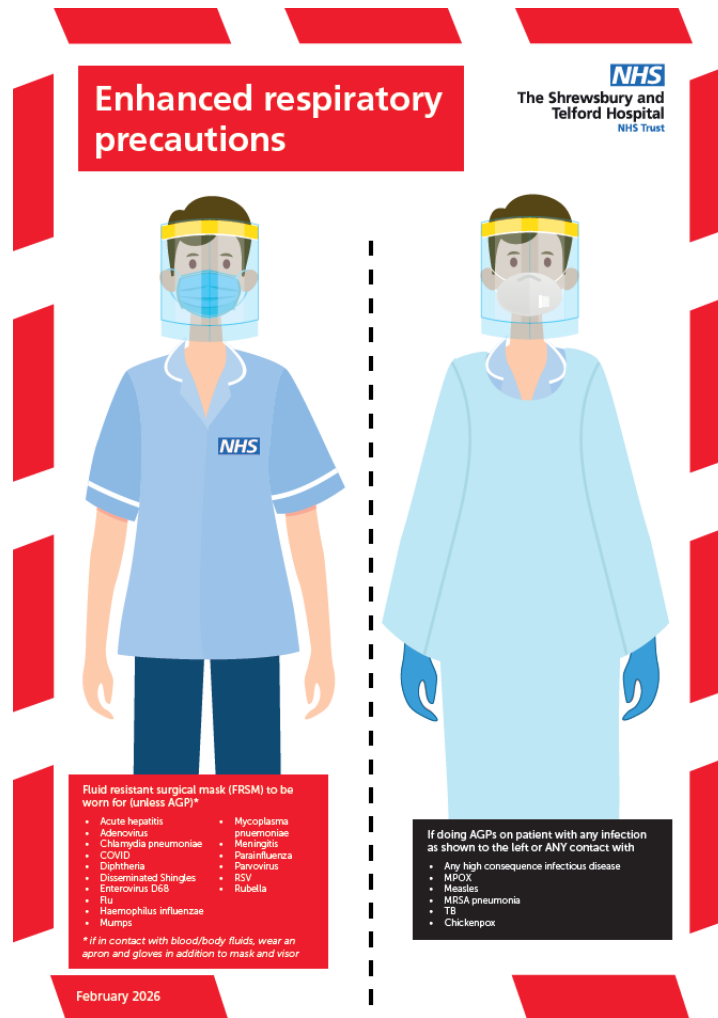
The information has been shared through the presentations at Chief Nurses monthly meetings, short teaching sessions on wards, updating content of mandatory teaching sessions, and the creation of posters and process flow-charts and comms messages titled 'Colleagues alert' sent by email and saved on intranet. The team have worked closely with the communications team to ensure that this has happened in a timely manner.



In the past 12 months the IPC and Communications Teams have worked together to:

- To update patient information leaflets for common infections
- To share COVID and Measles updates including policy change/SOP development
- Shared IPC improvement news and lessons learned following outbreak investigations.
- Shared findings from in depth analysis of C diff cases
- Update the Trust website and intranet.
- Issue media statements during outbreaks.
- Support the annual flu vaccination campaign.
- To create posters to share the changes across the Trust.

COVID, Flu and RSV PPE poster



Nursing, Midwifery, AHP & Facilities meetings

The IPC team have a permanent section in the agenda for a meeting for Nursing, Midwifery, AHP & Facilities. Presentation with updates on all changes, lessons learnt from outbreaks and RCAs are discussed and shared with all attendees.

Patient hand hygiene

Patients should be assisted to clean their hands after they have used the toilet and before they eat, as a minimum.

PDI who provide our wipes will be delivering training on both sites from today

Individual hand wipes are available to order for meal times and the ordering details have been sent to matrons.

C.diff

Year to date we have had 56 cases of C. diff against a limit of 98

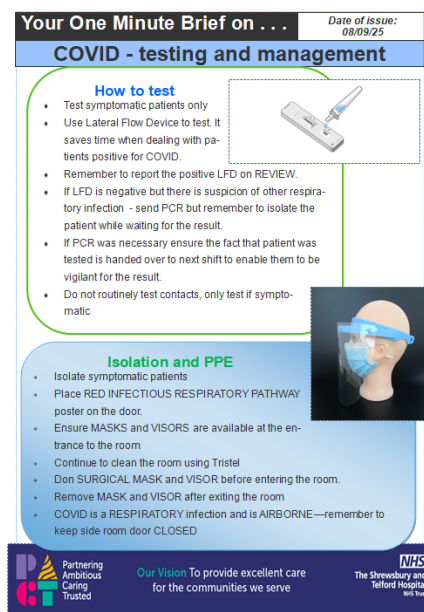
By this time last year (2024) we had 43 cases

By this time in 2023 we had 37 cases

By this time in 2022 we had 29 cases

One Minute Briefs

The IPC team have created and published a One Minute Brief on COVID – testing and Management in preparation to winter period.

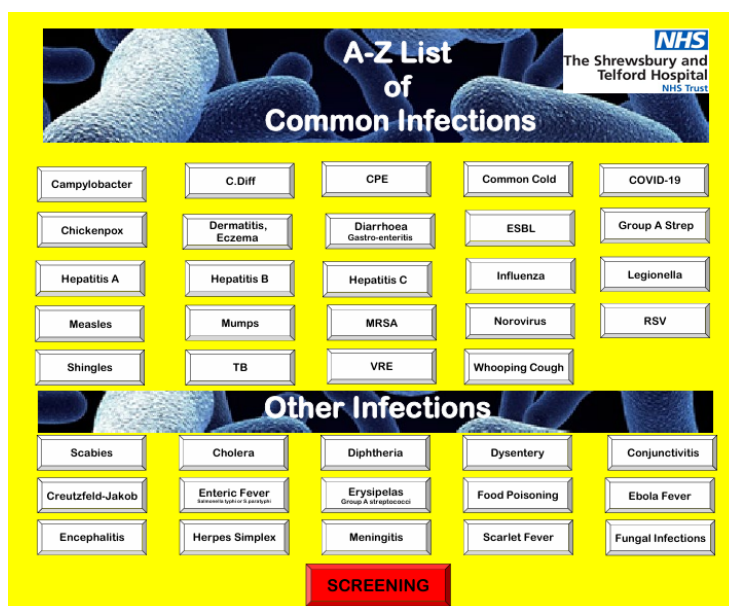


4.2 Trust Website and Information Leaflets

The Infection Prevention section on the Trust's website also promotes the IPC information.

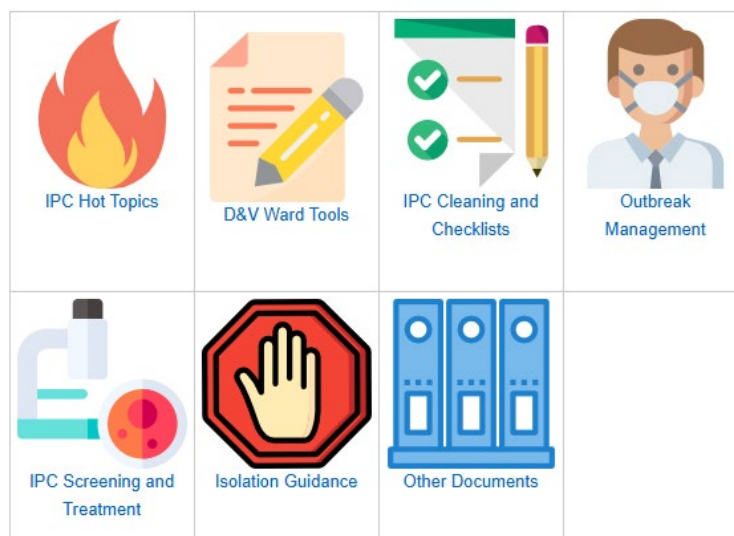
The page consists of information on general IPC issues and guidance. It includes sections on:

- A – Z of common infections



- Link nurse
- Hand Hygiene

- Policies and guidance on various infections and processes,
- IPC Forms, Documentation and Posters



There are a range of IPC patient and visitors' leaflets available

Criterion 5:

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Infection Prevention Nurses are alerted of daily laboratory alert organisms.

The Trust has a policy for screening both elective and emergency patients for MRSA and a system is in place for monitoring compliance.

5.1 ICNET/ CareFlow

ICNET imports results in real time from the laboratory system. The IPC team then manually adds patient alerts onto the CareFlow system as the required integration between the systems has not been completed.

These alerts are available to be seen in CareFlow, Patient Flow and Clinical Portal. The Patient Flow boards on the wards show patient alerts as a Red, Amber or Blue bell symbol, these are shown in priority order, red bells taking ultimate priority. IPC alerts are Amber bells and as, unfortunately, the Flow boards are only able to show one patient alert bell at a time, often IPC alerts are not as visible as they were on PSAG. Therefore, staff are trained in checking alerts, and the IPC alerts are available to see separately on the ward managers dashboard.

There is a plan and progress being made on integration of ICNET and CareFlow in 2026/27 which would provide improved ability to contact trace in the event of an outbreak or exposure incident and also reduce the amount of repetition in applying Infection Prevention and Control Alerts to CareFlow to minimise the risk of transcription errors from manual processes.

5.2 Surgical Site Infection Surveillance Service (SSISS)

Surgical Site Infection Surveillance Scheme (SSISS)

Surgical site infection (SSI) is a healthcare-associated infection in which a wound infection occurs following a surgical procedure. A National Surveillance System was established in England in 1997 by Public Health England (PHE), which has now transferred its health protection functions into UK Health Security Agency (UKHSA). The Surgical Site Surveillance Service (SSISS) surveillance monitors categories of surgical procedures that are relatively common or associated with relatively high risk of infection. The use of standardised definitions

and monitoring systems enable the SSISS national centre to provide high quality comparative data, which is shared between hospitals.

Mandatory surveillance of SSI was introduced in 2004, requiring each Trust to undertake surveillance for at least one orthopaedic surgical category for one quarter in a financial year. The categories include total hip replacement, total knee replacement, repair of neck of femur, and reduction of long bone fracture. In addition to the orthopaedic surgery surveillance, there are 14 other categories which may be monitored. At SaTH these are selected through a 3-year surveillance programme which can be adjusted in response to concerns identified within a clinical area

The Surveillance Nurse is responsible for collecting evidence of surgical site wound infections which develop during a patient's hospital stay and following discharge. The surveillance period continues for 30 days postoperatively or, up to one year if an implant was inserted.

The Gynaecology ward staff collect continuous surveillance in abdominal hysterectomy including post discharge.

All identified SSI cases are assessed through a formal patient review process. This includes evaluation of microbiology results, patient readmissions, and follow-up outpatient appointments. Definitions for superficial, deep, and organ/space infections are provided within the SSISS guidelines issued by UKHSA. The review process ensures robust identification of SSIs and helps to highlight opportunities for improvement in clinical practice. Due to the relatively low number of surgeries performed in some categories, a single infection may result in rates exceeding the national benchmark. For this reason, data trends are generally reviewed over the previous four quarters in which surveillance participation occurred. The following table summarises the SSI results.

Summary of Surveillance Carried out at SaTH 2025-26 per quarter.

	Quarter	No. of Cases	Inpatient Readmission Infections (%)	National infection Rate	% Last 4 quarters	No. Eligible for post discharge review	Post Discharge infections
Neck of Femur RSH	1	114	2 (1.8%)	0.8%	1.8%	113	2
Neck of Femur RSH	2	106	0 (0%)	0.8%	1.6%	103	0
Neck of Femur RSH	3	110	1 (0.9%)	0.8%	1.2%	106	1
Neck of Femur RSH	4	126	0 (0%)	0.8%	0.7%	125	0

Neck of Femur PRH	1	71	0 (0%)	0.8%	1.5%	68	0
Neck of Femur PRH	2	69	1 (1.4%)	0.8%	1%	67	0
Neck of Femur PRH	3	72	0 (0%)	0.8%	0.7%	70	0
Neck of Femur PRH	4	78	0 (0%)	0.8%	0.3%	76	0
Abdominal Hysterectomy	1	62	0 (0%)	0.8%	0%	62	1
Abdominal Hysterectomy	2	63	0 (0%)	0.8%	0%	63	2
Abdominal Hysterectomy	3	83	2 (2.4%)	0.8%	0.7%	83	3
Abdominal Hysterectomy	4	53	1(1.9%)	0.8%	1.1%	53	2
Elective THR	1	46	1 (2.2%)	0.3%	0.5%	46	0
Elective THR	2	40	0 (0%)	0.3%	0.6%	40	1
Elective TKR	1	35	0 (0%)	0.2%	0%	35	0
Elective TKR	2	54	0 (0%)	0.2%	0%	54	0
Large Bowel	3	108	4 (3.7%)	7.5%	5.5%	100	6
Long Bone RSH	4	63	0 (0%)	1.0%	1.4%	63	0
Long Bone PRH	4	92	1(1.1%)	1.0%	0.3%	92	1

Abdominal Hysterectomy

The Gynaecology staff collect this data. During Quarters 3 (2 infections; 2.4%) & Quarter 4 (1 infection; 1.9%) a review was carried out. The main operator was the same on 2 occasions. All 3 were readmitted with an intra-abdominal organ space infection following a CTAP scan. Due to small numbers, we look back over the last 4 quarters - we have had 261 operations with 3 infections. Our infection rate is 1.1% compared to the national rate of 0.8%.

Total Hip Replacement (THR)

We reviewed THR for two quarters, during Quarter 1 we had one infection in 46 operations giving an infection rate of 2.2% which was above the national rate of 0.3%, however, looking back over the previous 4 quarters our infection rate was 0.5%. Following Quarter 2 THR & TKR surgery was transferred to RJAH due to Ward 5 (PRH) having a new air handling unit installed. This service returned to SaTH in March 2026.

PRH Long bone surgery

Long bone surgery was reviewed during quarter 4; there was 1 infection in 92 operations giving an infection rate of 1.1%. The national infection rate is 1%. Over the last 4 quarters in which we participated our infection rate is 0.3%.

RSH Long bone surgery

During Quarter 4 we had no inpatient/readmission infections; over the last 4 quarters in which we participated our infection rate is 1.4% compared to the national rate of 1%.

Repair of Fracture Neck of Femur (NOF)

Continuous surveillance was carried out for 12 months across both sites. 'Reviews' were carried out on infected surgical wounds in the form of data collection & documentation by the Infection Control Surveillance Nurse which was then reviewed by a Consultant Microbiologist, and the relevant Orthopaedic consultant.

a) PRH

We had one infection during Quarter 2 which gave us an infection rate of 1.4%. Over the last 4 Quarters our infection rate is 0.3% which now compares well to the national rate of 0.8%.

b) RSH

RSH started with an infection rate of 1.8% in Quarter 1 (2 cases out of 114). However, it steadily improved, dropping to 0% in Quarter 2, 0.9% in Quarter 3 (1 case), and 0% in Quarter 4. Its rolling 4-Quarter average successfully decreased from 1.8% down to the national benchmark of 0.8% by Quarter 4.

Over the last 4 quarters we had 3 infections in 456 operations which gives us an overall infection rate of 0.6%. Which has progressively decreased over the previous 4 quarters.

Among the 3 infected cases with SSI, all 3 were readmitted with a surgical wound infection. All were deep/organ space infections, all required further interventions and returned to theatre for wound washout and debridement. All patients had an ASA score of 3, two had BMIs under 30 & one over 30. All were operated in theatre 5. The same registrar was the main operator on two occasions. Swab cultures showed no concerning pattern of isolation.

All had the same dressing post theatre, 2 had absorbable sutures and one had clips.

All patients had one or more co-morbidities, including dementia, frailty, osteoporosis, AF, CKD, asthma, sensorimotor neuropathy.

Following concerns regarding a high infection rate in patients with neck of femur fractures, a comprehensive investigation was undertaken.

At RSH, remedial work within the operating theatres has commenced, including the replacement of ceiling tiles. The air handling unit has been fitted with new gel seals and filters, and plans are in place to replace the existing unit. Microbiological air sampling has been conducted, with results confirming no concerns.

Estates teams have also completed improvement works on Ward 32 (RSH), resulting in an enhanced clinical environment.

The surgical antibiotic prophylaxis hospital guidelines have been reviewed and remain unchanged. Compliance to this programme is satisfactory.

The Surgical Division will undertake the One Together Audit to identify opportunities for improvement throughout the patient's care pathway.

Regular multidisciplinary meetings involving the Clinical Director, senior nursing staff, Infection Prevention and Control (IPC) team, consultants, and microbiology colleagues have been established to provide ongoing oversight and progress updates.

We will continue to monitor NOFs across the trust for the next year and investigate any infected wounds through a wound "Review".

5.3 Managing Outbreaks of Infection - Responses to Incidents and Outbreaks

The IPC Team coordinates the management of outbreaks, periods of increased incidence and incidents.

The IPC team monitors all alert organisms to identify trends and potential links between cases based on their location and time frame. If links are identified, a Period of Increased Incidence (PII) investigation is commenced and a meeting to discuss potential cases is held within 3 working days wherever possible. Since August 2021, the ICNET system alerts the IPC team of PIIs and allow the IPC nurses to carry out rapid investigations and if required, trigger an outbreak management process.

In 2025/26 29 non-COVID/Flu or Norovirus PIIs were identified and investigated as potential outbreaks, following typing only 7 were confirmed as outbreaks.

In 2025/26 35 COVID outbreaks were identified and managed, this number is similar to 36 COVID outbreaks in 2024/25. There were also 12 flu outbreaks (5 in a previous year).

All outbreaks are discussed for the purpose of shared learning and service development through divisional governance meetings. Recurring themes from these investigations are disseminated through the IPC operational and assurance committees. Lessons learnt are shared with the trust and disseminated through communications.

Action plans that are put in place by the ward manager and/or matron are monitored by the IPC team for compliance, once compliance has been demonstrated the action plans are signed off by the lead nurse or Infection Prevention and Control and the Matron or Head of Nursing for the area.

If further PIIs are linked to the same area, previous action plans are revisited.

COVID 19, Flu and Norovirus

PRH					
Ward	Month/Year	Date first case	Number of pts	Number of staff	Total involved
Ward 6 - Covid	June 2025	24.05.25	4	0	4
Ward 7 - Covid	June 2025	11.06.25	8	0	8
Ward 9 - Covid	August 2025	20.08.2025	8	0	8
Ward 7 - Covid	August 2025	26.08.2025	2	0	2
MEW - Covid	September 2025	16.09.2025	3	0	3
Ward 7 - Covid	September 2025	25.09.2025	2	0	2
Ward 4 - Covid	September 2025	25.09.2025	2	0	2
Ward 17 - Covid	September 2025	16.09.2025	2	0	2
Ward 8 - Covid	October 2025	07.10.2025	2	0	2
Ward 9 - Covid	October 2025	07.10.2025	2	0	2
Ward 9 - Covid	December 2025	03.12.2025	6	0	6
Ward 10 - Covid	December 2025	08.12.2025	2	0	2
Ward 11 - Covid	December 2025	04.12.2025	3	0	3
Ward 6 - Covid	December 2025	10.12.2025	8	0	8
Ward 9 - Flu	December 2025	18.12.2025	3	0	3
Ward 10 - Flu	December 2025	13.12.2025	2	0	2
Ward 6 - Flu	January 2026	14.01.2026	8	0	8
Ward 9 - RSV	January 2026	14.01.2026	4	0	4
Ward 7 - Covid	January 2026	26.01.2026	4	0	4
Ward 9 - Flu	February 2026	04.02.2026	2	0	2
Ward 11 - Flu	January 2026	12.01.2026	2	0	2
Ward 9- Flu	February 2026	04.02.2026	2	0	2

RSH					
Ward	Month/Year	Date first case	Number of pts	Number of staff	Total involved
Ward 23. - Covid	April 2025	20.04.25	8	1	9
Ward 25 - Covid	April 2025	27.03.25	3	0	3
Ward 27– Covid	April 2025	21.04.25	3	0	3
Ward 26 - Norovirus	May 2025	12.05.25	4	0	4
Ward 28 - Covid	June 2025	10.06.25	7	0	7
Ward 23 - Covid	June 2025	09.06.25	2	0	2
Ward 27 - Covid	July 2025	21.07.25	4	0	4
Ward 28 - Covid	July 2025	26.07.25	2	0	2
Ward 22SS - Covid	August 2025	13.08.25	2	0	2
Ward 23 - Covid	August 2025	25.08.2025	2	0	2
Ward 24 - Flu	October 2025	22.10.2025	11	0	11
Ward 26 - Flu	October 2025	22.10.2025	10	4	14
Ward 24 - Covid	November 2025	25.11.2025	4	0	4
Ward 25 - Covid	November 2025	06.11.2025	7	0	7
Ward 23 - Covid	December 2025	03.12.2025	4	0	4
Ward 35 - Flu	November 2025	03.11.2025	2	0	2
Ward 25 - Covid	November 2025	21.10.2025	3	0	3
Ward 23 - Covid	December 2025	03.12.2025	5	0	5
Ward 26 - Covid	December 2025	09.12.2025	2	0	2
Ward 22SS - Flu	December 2025	14.12.25	2	0	2
Ward 24- Covid	December 2025	24.12.25	2	0	2
Ward 24 – Covid 2	December 2025	13.12.2025	2	0	2
Ward 27 - Covid	December 2025	03.12.2025	7	0	7
Ward 28 - Flu	December 2025	27.12.2025	3	0	3
Ward 27 - Covid	January 2026	03.01.2026	6	0	6
Ward 26 - Covid	February 2026	13.02.2026	2	0	2
Ward 26 - Flu	February 2026	19.02.2026	7	0	7

Other Organisms

PRH					
Ward	Month	Organism	No. of cases	Typing results	Outcome
Ward 9	April 2025	C Diff	2	1 st case 113 2 nd case 005	PII

Ward 10	April 2025	C diff	3	1 st case 020 2 nd case 020 3 rd case 005	Outbreak
Ward 11	April 2025	C diff	2	1 st case 021 2 nd case 005	PII
PRH MEW	April 2025	C diff	2	1 st case 015 2 nd case 002	PII
Ward 7	July 2025	C Diff	4	1 st case 013 2 nd case 050 3 rd case 020 4 th case 126	PII
Ward 23 NNU	September 2025	MRSA	6	Typing of all cases unique	PII
Ward 10	October 2025	C Diff	2	1 st case 015 2 nd case 003	PII
Ward 9	December 2025	Scabies	9 staff	Patient was an index case. 9 staff developed symptoms after contact with the patient	Outbreak
Ward 23NNU	December 2025	ESBL Klebsiella / E Coli	5	1 st case RSHR00KP-1 2 nd case RSHR00KP- 1 3 rd case unique 4 th case 5-SNP (baby) 5 th case 5-SNP (mother) 6 th case unique 7 th case the same as case 9 (tween 1) 8 th case unique 9 th case the same as case 7 (tween 2).	Outbreak
Ward 7	January 2026	C Diff	2	1 st case 254 2 nd case 054	PII
Ward 11	January 2026	MRSA	3	Unique	PII
RSH					
Ward	Month	Organism	No. of cases	Typing results	Outcome
Ward 32	April 2025	C diff	2	1 st case 078 2 nd case 015	PII
Ward 37	April 2025	C diff	4	1 st case 078 2 nd case 087 3 rd case 002	PII

				4 th case 154	
Ward 28	June 2025	C diff	6	1 st case 014 2 nd case 054 3 rd case 002 4 th case 078 5 th case 002 6 th case 126	Outbreak
Ward 24	July 2025	CPE	2	1 st case ST 893 2 nd case ST 323	PII
SITU	August 2025	Pseudomonas	6	All typing unique	PII
Ward 23	August 2025	C diff	2	1 st case 015 2 nd case 003	PII
Ward 32	August 2025	C diff	2	1 st case 1169 2 nd case 002	PII
Ward 26	September 2025	C diff	2	1 st case 005 2 nd case 054	PII
Acute floor (AMA, AMU and 22SS at RSH	September 2025	C diff	5	1 st case 011 2 nd case 054 3 rd case 005 4 th case 020 5 th case 002	PII
Ward 27	September 2025	C Diff	3	1 st case 005 2 nd case 014 3 rd case 103	PII
Ward 32, 23 and 37 at RSH	November 2025	VRE	7	1 st case RSH00EC-44 2 nd case RSH00EC-44 3 rd case RSHR00EC-44 4 th case RSHR00EC-44 5 th case ST:807 6 th case RSHR00EC-44 7 th case RSHR00EC-44	Outbreak
Ward 27	December 2025	C diff	3	1 st case 002 2 nd case 002 3 rd case 015	Outbreak
Ward 28	January 2026	C Diff	3	1 st case 005 2 nd case 046 3 rd case 002	PII
Ward 25	February 2026	C Diff	2	1 st case 015 2 nd case 015	Outbreak
Ward 26	March 2026	C Diff	2	1 st case 002	PII

				2 nd case 070	
Ward 26	March 2026	ESBL	2	unique	PII
Ward 27	March 2026	C Diff	4	1 st case 015 2 nd case 026 3 rd case 050 4 th case 002	PII
Ward 37	March 2026	C Diff	3	1 st case 005 2 nd case 014 3 rd case 020	PII

MRSA PII on Ward 23 NNU

During the reporting period, a period of increased incidence of MRSA was identified on Ward 23 Neonatal Unit. The incident was managed in line with Trust infection prevention and control processes, with oversight from the IPC team and the relevant clinical teams.

Key actions included enhanced surveillance, reinforcement of standard infection prevention precautions, review of environmental cleaning standards, and ongoing communication with the ward team. The situation was monitored through appropriate governance routes until assurance was achieved that transmission risk had been reduced.

ESBL Klebsiella and E Coli outbreak ward 23 Neonatal Unit (NNU)

During 2025/26, an outbreak of ESBL-producing Klebsiella and E. coli was identified on Ward 23 Neonatal Unit. This was managed as a significant infection prevention and control incident due to the vulnerability of the neonatal population and the potential for transmission within a high-risk clinical environment.

The outbreak response was coordinated through established Trust outbreak management arrangements, with involvement from the Infection Prevention and Control team, microbiology, neonatal clinical teams, cleanliness services and relevant operational leads. Control measures included enhanced surveillance, review of patient placement and cohorting arrangements, reinforcement of hand hygiene and standard infection prevention precautions, and targeted communication with staff working in the unit.

Environmental cleanliness and equipment decontamination were key areas of focus throughout the response. Additional assurance was supported through the use of ATP monitoring, which provided a rapid indication of cleaning effectiveness and helped identify areas where further

cleaning or immediate feedback was required. The findings supported targeted actions and provided additional assurance through the outbreak management process.

The incident was monitored until there was sufficient assurance that transmission risk had been reduced and that appropriate IPC controls were embedded within the unit. Learning from the outbreak has informed ongoing work to strengthen environmental assurance, decontamination practice and outbreak preparedness in high-risk clinical areas.

ATP swabs results

ATP swabs were completed twice in October during
An investigation of MRSA PII.

3rd round of swabs was completed in December.

- Improvement on: ultrasound scanner, IV pumps, lamp in the bedspace.
- Improvement but still work to be done on:
Ophthalmoscope, incubator, lamp in clean bed space, purple tray
- Increase in contamination on: Sterilising microwave and breast pump in the storeroom.

Equipment/surface	Score 29/12/2025	Score 15/10/2025	Score 07/10/2025
Ultrasound scanner	No data	6	85
Screen of the monitor in clean bed space on ITU	No data	9	No data
IV pump screen in clean bed space on ITU	4	16	No data
Ophthalmoscope	23	54	42
Incubators in clean bed spaces in ITU – touch points	32	95 /99	57
Lamp above empty bed space – touched frequently when assessing a baby	22	103	No data
Sterilising microwave	48	No data	26
Purple tray	11	No data	23
Clean breast pump	29	No data	9
Weighing scale	9	No data	No data
Baby bath	0	No data	No data

<10 – good
10-20 concern
>30 – dirty

VRE outbreak at Surgery wards

During 2025, a period of increased incidence of Vancomycin Resistant Enterococci (VRE) was identified across the Surgical Division, initially involving 13 patients. Typing confirmed that this represented two separate outbreaks involving different strain types, EC-46 and EC-44. Outbreak meetings were held at the time to coordinate the investigation, review transmission risks and agree appropriate infection prevention and control measures. Following the initial investigation, retrospective samples from the preceding six months, together with prospective samples from surgical wards at RSH, were submitted for typing to support further assessment of potential transmission. Typing results identified six samples with the same RSH R00EC-44 type, including the four original EC-44 cases that had already been investigated. Point prevalence screening was subsequently undertaken across Wards 23, 32 and 37, identifying a further 14 VRE-positive results from rectal swabs, with two of these also associated with one positive urine sample. The findings supported continued surveillance, targeted screening and reinforcement of IPC measures across the affected surgical ward areas.

Criterion 6:

Systems 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.

At the Trust, Infection Prevention responsibilities and expectations are included in all job descriptions. All clinical staff must complete regular IPC training at Level 1 &/or 2 depending on staff group. In addition, the IPC team provides bespoke training for different groups. Training is also provided as part of the Ward Readiness Programme for new HCAs. There are leaflets for contractors explaining their responsibilities (recently updated March 2024) and external work must be signed off by the IPC team with Estates to ensure appropriate cross infection measures are in place, such as, dust control.

6.1 Staff Training & Education

Face to face statutory training sessions continued throughout 2025-6 and include the FY1 inductions. However, due to large number of staff members with outstanding statutory training the IPC module can still be completed via online learning (LMS).

The table below shows the average compliance by staff group for all levels of IPC training and Hand Hygiene competence as of end of April 2026.

Staff Group	Hand Hygiene	Infection Prevention and Control – Level 1	Infection Prevention and Control – Level 2 (Medics)	Infection Prevention and Control – Level 2 (non-medics)	PPE: Donning and Doffing
Add Prof Scientific and Technic	84.05%	96.77%	100%	97.90%	81.82%
Additional Clinical Services	93.69%	95.65%		90.80%	95.14%
Administrative and Clerical	81.82%	94.59%		88.89%	90.91%
Allied Health Professionals	84.82%	95.56%		92.76%	87.06%
Estates and Ancillary	94.92%	95.35%		100%	86.55%
Healthcare Scientists	71.43%	97.94%		94.29%	100%
Medical and Dental	50.78%	84.21%	76.11%		49.13
Nursing and Midwifery Registered	92.29%	100%	94.55%	91.45%	91.58%
Students	100%			100%	100%
Grand Total	83.76%	95%	90.22	94.5%	86.91%

Those areas who fall below the trust target of 95% compliance with any area of mandatory training, should be managed within the division as per the respective policy. Doctors' mandatory training in IPC has been delivered by the IPC team with two sessions per month.

The IPC team continue to complete quality ward walks and take part in exemplar assessments to identify lack in knowledge within staff groups and takes these opportunities to deliver educational material in short sessions. The continued increasing prevalence of c diff cases has led to a continuation of Improved hand hygiene assessor training and provision of face-to-face education both within departments and planned education sessions (nursing and medical teams) continue to be delivered to address basic Infection Prevention education.

SureWash – hand hygiene training system trial

In a continuation of interventions to improve compliance with hand hygiene training and knowledge the IPC team arranged a trial of the SureWash system. Charitable funds were used to fund the trial.

The aim of the trial was to ascertain if the system is suitable to deliver education and assessment of hand hygiene unsupervised in clinical areas.

The trial took place through May and June 2025, on wards 25 and 37 at the Royal Shrewsbury Hospital. The staff members were instructed how to use the machine and were informed of the purpose of the trial. Each person using the machine was asked to complete a feedback form.

The feedback was predominantly negative. Please see a graph below.



In addition to the scaled scores users were able to leave comments. The comments received were grouped into 4 themes.

- Staff trying to pass the machine test rather than performing good hand hygiene technique
- Not always detecting movements/hands
- Waste of money- poor use of money in the current financial situation
- Doesn't meet criteria for hand hygiene assessment

Due to the feedback received, as well as IPC team feedback and observed use, the team decided to end the trial. The system was deemed as not meeting its primary objective; reliable hand hygiene assessments and hand hygiene education.

6.2 Infection Prevention and Control Team/Team Development

One band 7 IPC specialist nurse continues an MSc in Infection Prevention & Control at the University of Dundee.

The other band 7 IPC specialist nurse has secured a place at the University of Essex to commence an MSc In Infection Prevention & Control in April 2026.

Criterion 7:

Provide or secure adequate isolation facilities

The availability of single rooms remains a key factor in effective infection prevention and control (IPC). According to Public Health England, the average proportion of single rooms available in NHS acute trusts in England in 2016/17 was 30.2%, with 20.7% being single rooms with ensuite facilities (this is the most recent available data on the proportion of single rooms in NHS acute Trusts).

At SaTH, we remain significantly below this national average. Currently:

- 20% of all inpatient beds are in single rooms
- This figure drops to 12% when side rooms in specialist areas in women's and children's, oncology/haematology and critical care are excluded
- 10% of all beds have en suite facilities, falling to 4% when specialist areas are excluded.

This shortfall significantly impacts our ability to isolate all patients who require it in accordance with national IPC guidelines. In cases where side room capacity is limited, a risk assessment tool is used to support consistent and effective decision-making around patient isolation. This tool is available Trust-wide and supports staff to prioritise isolation needs safely. The IPC team works closely with ward teams and Clinical Site Managers, including active participation in twice-daily bed meetings, to maximise the effective use of available side rooms through informed risk assessments.

To mitigate limited side room availability, the Trust continues to utilise Redirooms (mobile, HEPA-filtered, "pop-up" isolation units) that can be deployed in standard bed spaces. The Trust now has 33 Redirooms. These units are used daily across the Trust to support isolation for infectious conditions beyond COVID-19, especially in wards where structural isolation is limited. Each bay can generally accommodate one Rediroom, though a small number of bays at PRH are unable to accommodate them due to space constraints.

In addition to Redirooms, the Trust also benefits from the use of Bioquell isolation pods, comprising:

- 4 pods in RSH ITU
- 2 pods in PRH ITU
- 4 pods on Ward 24 (Respiratory), RSH

We now have a total of 30 mobile air purification units in active use across our sites:

- 19 units at RSH

- 11 units at PRH

These air purification systems are routinely deployed in outbreak scenarios to help control and contain the spread of infection, enhancing both patient and staff safety.

Criterion 8

Secure adequate access to laboratory support as appropriate.

Laboratory services for SaTH are provided from purpose-built pathology laboratories at both Royal Shrewsbury Hospital and Princess Royal Hospital. The Microbiology Laboratory has full Clinical Pathology Accreditation (CPA).

The Microbiology consultant team has no current consultant vacancies. This supports regular ITU ward rounds, improved in-person cover at PRH, and weekly hospital rounds for patients with *C. difficile* infection.

Criterion 9:

Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections.

The IPC team has a rolling programme that highlights policies that require updating each year so that they are in line with the annual reviews and overarching Trust Governance policy. This policy outlines the requirement for the responsibility, auditing, and monitoring of IPC policies to provide assurance that they are being adhered to and are compliant with changes. Both policy and manual are available for staff to view on the Trust intranet.

The IPC team ensure the patient and staff information leaflets are also amended in line with the policy updates and are available on the Trust internet. In addition, policies are updated prior to review date if national guidance changes to ensure the Trust is in line with those amendments.

In 2025/26 the team reviewed and updated the following IPC policies:

- Candidozyma auris
- ESBL
- Group B Strep
- Head and Body Lice
- High Consequence Infectious Diseases
- MRSA
- Patient Placement and Isolation
- Pseudomonas aeruginosa
- Seasonal Respiratory Infections
- TB
- Water Safety Policy in conjunction with Estates

An Infection Prevention & Control A-Z of Common Infections is available on the trust's intranet which has been updated to reflect the amendments to the policies highlighted above. This significantly enhances the quick location of key infection prevention guidance by our front-line staff regarding common infections and has been promoted as part of the IPC face to face training.

Criterion 10:

Providers have a system in place to manage the occupational health needs of staff in relation to infection.

The Trust has a contract with Optima Health, an occupational health and wellbeing company in the UK and Ireland. Optima Health is contracted to carry out:

- Pre-placement health screening to check if new starters are fit for their role
- Health surveillance monitoring for staff exposed to specific risks e.g. sharps and blood/body fluid, respiratory hazards, noise, hazardous substances
- Occupational exposure management e.g. needlestick injury follow-up, bloodborne virus testing and post-exposure prophylaxis pathways
- Immunisation programmes e.g. hepatitis B, MMR, varicella, measles, pertussis, 70 vaccinator hours to support the internally run seasonal flu vaccination programme, as well as blood tests and immunity screening and contact tracing
- Management referrals to provide clinical assessments for staff to maintain their capability at work and give advice on e.g. reasonable adjustments, return to work plans and capability assessments
- Employee assistant programme (EAP) to offer confidential support on anything that a member of staff feels concerned about at work or home. This can range from family relationship issues, financial or legal worries to concerns at work. Short-term counselling, stress or trauma support can be put in place to support employees.

The occupational health contract is currently out for tender to align with the timing of the end of the current contract. The new contract will encompass the delivery as outlined above.

10.1 Safer Sharps Directive

The Trust requires that where possible, safer sharps are used in preference to unguarded sharps and all sharps are disposed of in dedicated SharpSmart bins which are widely available. Wheeled bins are to be taken to the point of the procedure to prevent unnecessarily walking with dirty sharps.

Sharps incidents and near misses are reported through Datix which are then investigated by the H&S Team to ensure that staff receive the appropriate follow-up care, are reminded of safer sharps features where appropriate and opportunities for improvement to work practices are taken. These are collectively reported to the IPC Operational Group and HSSF Committee.

Incidents reported	Totals
Dirty sharps injuries	132
Blood/ body fluids contact with eyes/nose/mouth/ broken skin	35
Inappropriate disposal of sharps not leading to injury	27
Clean sharps injury	28
Totals	222

There were 4 RIDDOR-reportable dangerous occurrences involving potential occupational exposures to blood-borne viruses. None of these were subject to HSE investigation or enforcement action.

Three were sharps injuries and one a splash incident, as listed below. Post-exposure protocols were followed in each case and no occupational infections resulted.

- Blood sampling, source patient positive for Hepatitis C – two incidents.
- Blood sampling, source patient positive for HIV – one incident.
- Flushing a cannula, source patient positive for HIV, could not exclude possibility of presence of blood in fluid – one incident.

Of the three sharps injuries reported, two involved butterfly needles/ safety blood collection sets, and one a cannula introducer needle. Two were caused by discarded sharps left on hard surfaces prior to disposal via sharps bin, and one by a falling walking stick making a staff member flinch.

Throughout the year standard insulin needles remained a common feature of other sharps injuries and wards were reminded that patients self-administering medications must be risk assessed and have sharps bins to hand via Datix report follow-ups.

The IPC priorities for 2026/27 will focus on the areas where we continue to see the greatest risk and repeated learning: C. difficile, antimicrobial prescribing, urinary catheter-associated infection, device-related infection, environmental cleanliness and timely recognition and isolation of patients with infection. Key areas of focus will include:

- Delivering and monitoring the updated C. difficile Reduction Action Plan, with continued focus on timely diagnosis, isolation, treatment, cleaning, patient hand hygiene and antimicrobial stewardship.
- Strengthening antimicrobial stewardship, including 72-hour antibiotic review, reduction in inappropriate broad-spectrum antibiotic use, and targeted feedback from C. difficile and bacteraemia reviews.
- Reducing urinary catheter-associated and Gram-negative bloodstream infections through improved catheter care, regular review of catheter necessity, prompt removal where clinically appropriate, and strengthened cross-system working with community partners.
- Improving device-related infection prevention, including peripheral cannula, central line and long-line care, VIP scoring, documentation of device checks and timely removal of invasive devices.
- Maintaining focus on environmental cleanliness and decontamination, including commode cleanliness, equipment storage, cleaning assurance, waste management and targeted deep-clean programmes in high-risk areas.
- Embedding screening and preparedness for emerging infection risks, including Candidozyma auris, returnees from healthcare facilities abroad, and national/regional increases in measles, pertussis and diphtheria.
- Strengthening ward-level IPC assurance and culture through Quality Ward Walks, outbreak audits, thematic reviews, IPC link practitioners, and clear feedback to clinical teams.
- Maintaining IPC oversight of water, ventilation, decontamination, estates and new build risks, ensuring IPC input is embedded early in service changes, refurbishments and infrastructure planning.
- Supporting staff to balance patient flow and safe IPC practice, recognising the need for adequate cleaning time, appropriate isolation use and safe management of beds, mattresses and equipment.

SECTION 6: CONCLUSION

During 2025/26, the Trust continued to experience significant operational pressures which affected the ability to consistently deliver all elements of safe IPC practice. High occupancy, prolonged Emergency Department stays, limited isolation capacity, increased patient complexity and sustained demand across services all contributed to increased infection risk.

The Trust exceeded a number of nationally set HCAI trajectories during the year, most notably for *C. difficile*, *E. coli* and *Klebsiella* bacteraemia. MRSA bacteraemia also remained above the zero-tolerance target. Case reviews and surveillance identified repeated learning themes relating to antimicrobial prescribing, timely recognition and isolation of patients with diarrhoea or infection, environmental cleanliness, urinary catheter care, invasive device management, blood culture documentation and ward-level IPC practice.

Despite these challenges, IPC governance and assurance arrangements remained in place throughout the year. The IPC Team continued to provide specialist advice, outbreak support, surveillance, audit, education, policy review and case review. The *C. difficile* Reduction Action Plan was reviewed and strengthened during the year, with progress monitored through IPCOG and wider Trust governance routes.

The priorities for 2026/27 will focus on the areas where the Trust continues to see the greatest risk and repeated learning: reducing *C. difficile*, strengthening antimicrobial stewardship, improving urinary catheter and invasive device care, supporting environmental cleanliness and decontamination, improving early recognition and isolation of patients with infection, and maintaining preparedness for emerging infection risks.

Infection prevention and control remains a core patient safety priority. The IPC Team will continue to support services to reduce avoidable infection risk, but delivery of sustained improvement will require consistent Trust-wide ownership of IPC standards at ward, divisional and organisational level.

SECTION 7: REFERENCE

Department of Health: The Health and Social Care Act 2008 (Revised Dec 2022): Code of Practice on the prevention and control of infections and related guidance.

<https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance>

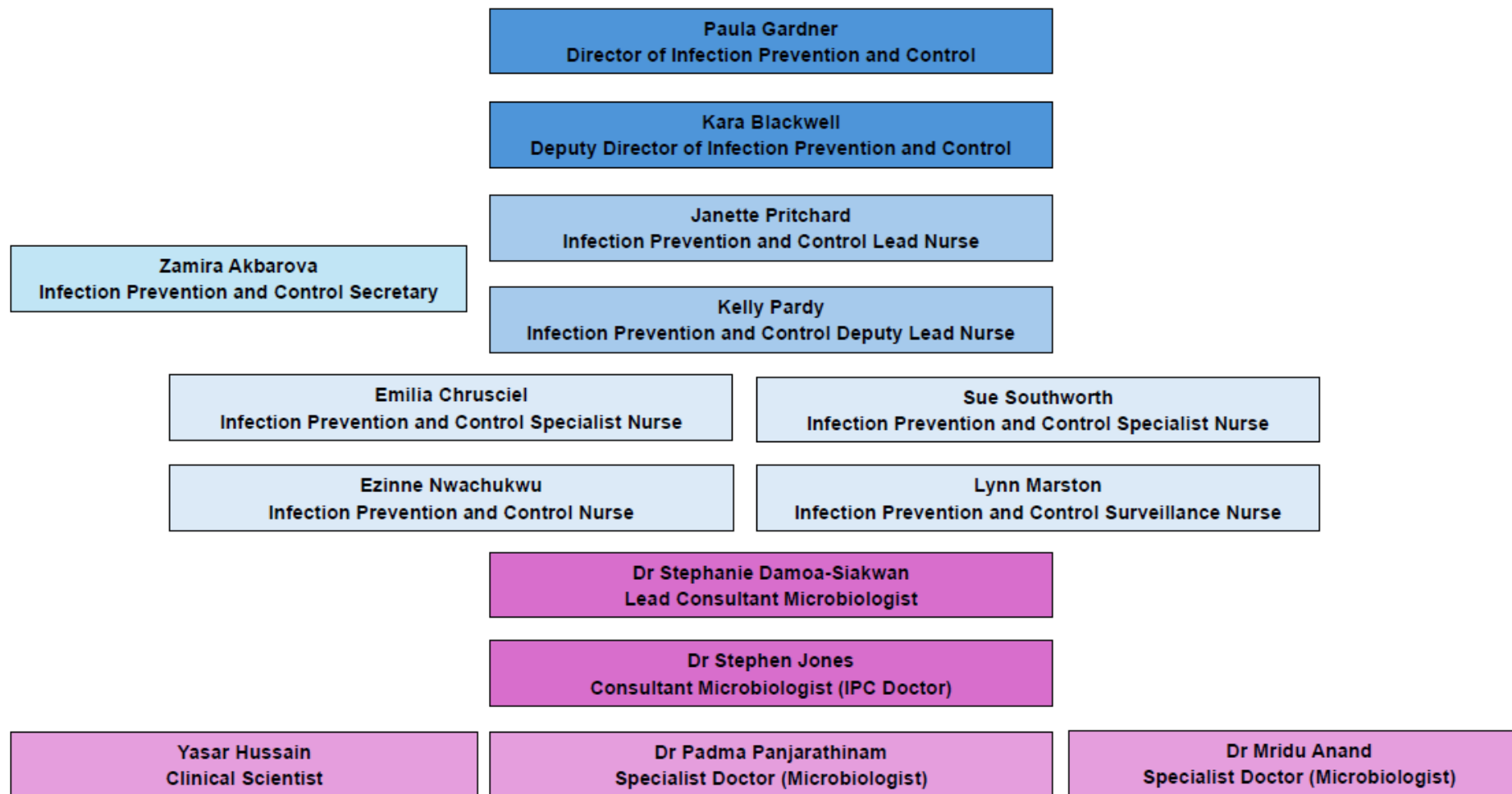
Department of Health: Improving outcomes and supporting transparency

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545605/PHOF_Part_2.pdf

Infection Prevention Society Audit tools. <http://www.ips.uk.net/professional-practice/quality-improvement-tools/quality-improvement-tools/>

Appendix 1 Infection Prevention and Control Structure

Infection Prevention and Control Team 2025/2026



Boards of Directors' Meeting in Common: 8 October 2026

Agenda Item	Board Information Pack Item 06		
Report Title	SaTH Annual Security Report (2025-26)		
Executive Lead	Ned Hobbs Group Chief Operating Officer and Deputy Chief Executive (SaTH)		
Report Author	Jon Simpson, Trust Security Manager (SaTH)		
Prior Consultation:	CQC Domain:		Link to (SATH) BAF id(s)
Audit & Risk Assurance Committee (ARAC), 7/9/26	Safe	√	BAF1, BAF2, BAF3, BAF 8
	Effective	√	
	Caring	√	(SaTH) Risk Register id(s):
	Responsive	√	ID1349
	Well Led	√	
Executive Summary	In accordance with the provisions of the NHS England (NHSE) Violence Prevention & Reduction Standard (VPRS) (2024), Nice Guidance (NG) 10 (short-term management in mental health, health and community settings 2015), The Mental Health Units (Use of Force) Act (2018), Emergency Preparedness & Resilience Response Standard No 21 (Lock Down), The Terrorism (Protection of Premises) Act (2025) and the Health & Safety at Work Act (1974), Providers are required to have in place and maintain security management arrangements in their organisations ¹ . The attached annual security report provides information on reported security incidents, security team activity and other security management work across the Trust in 2025-26.		
Recommendation	The Board is asked to take assurance from the report.		
Appendices:	Appendix 1: SaTH Annual Security Report (2025-26)		

¹ The following sites are provided with varying levels of support:
Community Diagnostic Centre (CDC) & RENAL Unit at Hollinswood House, Telford.
Corporate Services offices at Douglas Court, Shrewsbury Business Park & William Farr House (NHS) site, Shrewsbury.
Embryology & Fertility Services at Severn Fields Health Village, Shrewsbury.
Medical Records & Procurement warehousing operations at the Sentinel and Atcham Business Parks, Shrewsbury.
Midwife Led Unit's (MLU) at Bridgnorth, Ludlow and Whitchurch community hospitals and Robert Jones & Agnes Hunt (RJA) Orthopaedic Hospital.
The Princess Royal Hospital (PRH) Telford.
The Royal Shrewsbury Hospital (RSH).
Sterilisation & Decontamination Services Unit, Queensway Business Park, Telford.
Therapy Services at William Farr House (NHS) site, Shrewsbury.

Annual Security Report

2025-26

Foreword

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

I am the designated Board level Director responsible for security management matters. Day to day line management responsibility for the Trust Security Manager is undertaken by Susanne Crossley, Deputy Chief Operating Officer (DCOO).

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

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

Ned Hobbs

June 2026

Deputy Chief Executive and Group Chief Operating Officer

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1 Governance, Risk & Assurance

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

1.1 Security Arrangement Provision

In accordance with the provisions of the NHS England (NHSE) Violence Prevention & Reduction Standard (VPRS) (2024), Nice Guidance (NG) 10 (short-term management in mental health, health and community settings 2015), The Mental Health Units (Use of Force) Act (2018), Emergency Preparedness & Resilience Response Standard No 21 (Lock Down), The Terrorism (Protection of Premises) Act (2025) and the Health & Safety at Work Act (1974), Providers are required to have in place and maintain security management arrangements in their organisations¹.

1.2 Policy

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

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

In accordance with those schedules, SY01, SY03, SY04, SY05, SY07 were reviewed and republished during the reporting period, using national guidance and local protocols.

1.3 Security Risks

Security risks are managed in accordance with the Risk Policy and entered on to the Datix risk management system where they can be regularly reviewed. There is one (accepted/closed) security risk scoring more than fifteen concerning the inconsistent use of door access control systems (particularly swipe card access) across all areas of the Trust, especially in-patient wards² for which there is an ongoing Capital investment program (s2.12 refers).

1.4 Security Risk Assessment

When the Trust Violence & Aggression Prevention & Reduction policy is presented to Health Safety Security & Fire (HSSF) Committee (for ratification) and Policy Approval Group (PAG) (for approval) (following scheduled review or otherwise) submitted

¹ The following sites are provided with varying levels of support:

Community Diagnostic Centre (CDC) & RENAL Unit at Hollinswood House, Telford.
Corporate Services offices at Douglas Court, Shrewsbury Business Park & William Farr House (NHS) site, Shrewsbury.
Embryology & Fertility Services at Severn Fields Health Village, Shrewsbury.
Medical Records & Procurement warehousing operations at the Sentinel and Atcham Business Parks, Shrewsbury.
Midwife Led Unit's (MLU) at Bridgnorth, Ludlow, and Whitchurch Community hospitals and the Robert Jones & Agnes Hunt (RJA) Orthopaedic Hospital.
The Princess Royal Hospital (PRH) Telford.
The Royal Shrewsbury Hospital (RSH).
Sterilisation & Decontamination Services Unit, Queensway Business Park, Telford.
Therapy Services at William Farr House (NHS) site, Shrewsbury.

² Datix Risk Register id 312. 4-digit keypad pin code locks are on some entrances, but these systems are always subject to quite easy compromise/misuse and counter compromise action is time consuming and very disruptive. Use is awkward and clumsy when linked with or part of a patient or other manual handling task especially if doors do not open or close with electrical assistance, so doors get left open which has led to absconded/missing patient incidents. In the event of a known or immediate external threat all ward doors have the option to be secured manually and good physical security is provided to ward areas until an incident is over/stood down. This functionality is checked and evaluated every 3 months by security teams records held by the Security Manager.

documents include an evidence based self-assessment set against the NHSE VPRS (2024)³.

The Terrorism (Protection of Premises) Act (2025) places a legal duty on those responsible for certain publicly accessible locations to consider the threat from terrorism and implement appropriate and proportionate mitigation measures. Under the legislation the Trust's main sites will be included in the enhanced category of publicly operated buildings (meaning more than 800+ members of public expected on site per day). The legislation received Royal Assent on 3 April 2025, whilst premises are not legally required to comply with its specific duties until the implementation period concludes (expected in late 2027) initial risk assessment and gap analysis work has commenced to assess the Trust position in relation to all its sites, as well as understanding the legislative detail and how the appointed regulator will assess compliance with the Act.

Ongoing security needs/risk assessment advice and professional guidance was provided to Estates Capital Teams, other Project Management Offices (PMO) as well as Centres and department⁴ by the Trust Security Manager to support security improvements across all Trust sites. Some examples of the support provided, and the locations involved include:

- Clinical & Scientific Services:
 - (1) Pathology Services (RSH) CL3/2a Laboratory: Risk assessment advice on access control and CCTV (for staff safety/colleague monitoring).
 - (2) Pharmacy (PRH) Medical Gas store: Installation and configuration of intruder alarm, CCTV.
 - (3) Radiography Services (Hollinswood) House CDC: Intruder alarm system for modular MRI building.
- Estates & Facilities:
 - 1) Capital Lift refurbishment program: Guidance and agreement on installation of CCTV cameras.
 - 2) Car Parking Services: Deployment of Body Camera units to car parking staff due to increasing levels of aggression from service users.
 - 3) PRH main kitchen refurbishment: Risk assessment advice and support with access control and CCTV arrangements.
 - 4) Sustainability: Risk assessment advice and support with installation of CCTV on new solar panel farm at PRH.
 - 5) Waste & Water Systems: Development of organisational wide hazardous waste security plan⁵.
- Hospital Transformation Program (HTP):

Ongoing day to day involvement with development and implementation of security strategy and final decision for multiple staff and patient safety security systems including access control, CCTV, intruder/staff duress alarms, new-born security tagging detection systems, (patient) crisis rooms as well as counter terrorism and general crime prevention measures⁶ in the following areas.

³ Next scheduled policy review June 2026. Both the policy and VPRS self-assessment are subject to regular informal annual review by the Security Manager.

⁴ Auditing of departments for completion of self-assessed security risk assessments (Appendix D to SY01 Security Management policy [SaTH Intranet - Security Management in the Trust](#) and local lock down plans is included in the H&S element of the Exemplar Ward program.

⁵ In accordance with Department of Transport (DoT) guidance and [Agreement concerning the International Carriage of Dangerous Goods by Road \(ADR\)](#).

⁶ A Building Research Establishment Environmental Assessment Method (BREEAM) assessment uses recognised measures of performance, set against established benchmarks, to evaluate a building's specification, design, construction. This includes a Security Needs Analysis (SNA) which

- 1) RSH ED: Refurbishment/extension phases one to five.
 - 2) B31: New site security operating centre/CCTV monitoring facility.
 - 3) B60: Five floor new build and associated outdoor spaces.
- Medicine & Emergency Care (MEC):
 - 1) PRH AMU extension: Risk assessment advice and guidance on required patient safety systems installed in new extension.
 - 2) PRH ED Ambulance Receiving Area (ARA): Planning and installation of additional access control and CCTV systems.
 - 3) PRH ED Children & Young Persons Unit (CYPU): New door set/access control.
 - 4) PRH ED Mental Health (MH) assessment/Crisis Room): Access control, CCTV, staff, and patient safety alarm systems.
 - People & OD Directorate:
 - (1) Assistance with development of an organisational policy to see smoke free sites and how (uniformed) security teams will contribute to policy delivery.
 - Surgery Anaesthetic Critical Care and Cancer Services:
 - (1) Colorectal/Upper Gastroenterology, Intestinal Gastroenterology, Endoscopy: Advice on security arrangements and requirements for access control, patients' safety alarms, and CCTV for new modular ward building at RSH (Ward 38/39).
 - (2) Patient Access & Outpatient Nursing Support: Collaboration with existing site security provider/landlord, and installation of intruder alarm systems, staff safety systems, access control and CCTV at new medical records warehousing facility and Pre-Op Assessment Clinic, Sentinel Business Park (Shrewsbury).
 - Women & Children's Services:
 - (1) Women & Children Neo-Natal Unit (NNU) and Delivery Ward: Risk assessment advice and specialist contractor liaison for additional new-born security alarm detection systems (baby tagging) on PRH Delivery Suite and NNU and allied improvements to existing access control arrangements⁷.

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

- Lock Down; every month security team supervisors undertake audit and functionality tests of the emergency Lock Down plan for each of Emergency Departments (ED). This ensures that paper copies of Lock Down plans are in the place staff expect them to be should they need them, are the correct version and the instructions, systems and facilities referred to in each plan are correctly functioning. After the ED check security supervisors then complete a site wide check of the emergency Lock Down arrangements for each Ward and/or publicly accessible department/entrance at both main sites. Any service or maintenance issues identified are addressed and the check

has been completed and approved. The build is also being registered for 'Secured by Design' (SBD) accreditation. SBD is the official UK police security initiative that works to improve the security of buildings and their immediate surroundings to provide safe places to work and visit. Both initiatives will assist the Trust with meeting the requirements of The Terrorism (Protection of Premises) Act 2025, which places a legal duty on those responsible for certain publicly accessible locations to consider the threat from terrorism and implement appropriate and proportionate mitigation measures.

⁷ Installation work due to commence June 2026.

also gives security staff the opportunity to consult with clinical staff and highlight the procedure and mechanism for securing departments which are not regularly locked and secured because of operational constraints. The Trust Security Manager retains records on all these audits⁸.

- Infant/Newborn Security (s2.13 refers); every 3 months to prevent the undue removal of a baby from the hospital the Baby Tagging security systems are evaluated to ensure system operability and staff knowledge/reactions. Results of each test, undertaken by the Security and post-natal Ward Managers are fed back to W&C Senior Leadership Team (SLT). The Trust Security Manager retains records on all these audits. The benefit of this process has been noted in previous CQC Inspection⁹.

Committee Involvement.

- HSSF: A quarterly security report is presented to HSSF Committee which is attended by staff side Chairs, Union representatives and has Centre management representation. The report provides insight on progress with managing violence and aggression by service users (clinical as well as intentional/inexcusable aggression) including reports on sanction and redress and support to staff affected. In the fourth quarter, the annual security report is presented which gives feedback and a full account of all security management work in the reporting year¹⁰.
- Risk Management Committee: The Trust Security Manager joins monthly Risk Group meetings ensuring security management oversight and advice is available for all matters discussed or raised.
- Joint Safeguarding Mental Health & Learning Disabilities Operational Group: Chaired by the Deputy Chief Nurse, this ensures opportunity is given to discuss and focus on any security incidents issues or interventions with service users that have cause for additional interest, concern or general trend analysis as well as provide assurance and accountability on security team performance and training.
- Restrictive Interventions Meeting: Weekly review of all restrictive interventions (physical and chemical) by relevant multi-disciplinary specialists.
- Learning Disabilities & Autism Group: Chaired by the Trust Lead for Health Inequalities and Equality, Diversity and Inclusion, this ensures opportunity is given to discuss and focus on any security incidents issues or interventions with service users that have cause for additional interest, concern or general trend analysis as well as provide assurance and accountability on security team performance and training.
- Accommodation Control Working Group & Site Wide Trust Projects Coordination Group. Weekly review of change projects, including new builds, refurbishments, and department moves/transfers.

1.5 *Release of Information/Freedom of Information (FOI) requests*

Fifty-six releases of CCTV/Body Camera video footage were made in the report period.

- Thirty-two to police for preventing/detecting crime/prosecution of offenders.

⁸ Names of those clinical staff able to join these security huddles/on the spot briefings are noted. During the reporting period 1089 members of staff were briefed and engaged in these informal on the day face to face and on-location/specific work-space awareness briefings.

⁹ "Staff followed the baby abduction policy and undertook baby abduction drills. All babies were electronically tagged, and labels and tags were checked daily. Tags were removed as part of the discharge process. All staff were trained and aware of the baby tagging process." Source: CQC Inspection Report (Evidence Appendix) published 8 April 2020 page 392.

¹⁰ Once ratified the annual security report is presented to Audit Risk Assurance Committee (ARAC) and then Trust Board.

- Seventeen for internal investigation/fact find on site safety.
- Six for internal investigation/fact find regarding staff disciplinary matters.
- One following external/third party request (motor vehicle insurance claim)¹¹.

Information and/or advice was provided to the Trust FOI team on six other general FOI requests regarding security matters at the Trust.

¹¹ Footage is checked prior to release to ensure no third-party collateral intrusion/disclosure.

Security Incident Reporting & Safe Environment for Staff & Patients

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

- 2.1 Comparative figures for 2025-26 are shown in Table 1.

Table 1 - Security Incident Reporting¹²

ALL SECURITY INCIDENTS	2023/24	2024/25	2025/26
First quarter: Apr, May, Jun	333	461	607
Second quarter: Jul, Aug, Sep	262	360	666
Third quarter: Oct, Nov, Dec	399	604	715
Fourth quarter: Jan, Feb, Mar	609	521	681
Running Total	1603	1946	2669

- 2.2 Of the 2669 incidents 1627 occurred at the RSH, 1007 at PRH, twelve at Hollinswood House and the remainder at other satellite sites or out in the community. Most incidents concern aggressive service users. The sharp rises in incident numbers reflects high demand for security support on ever busier main sites but also well embedded awareness amongst work force on how to get support if matters escalate or risk is foreseen (s2.7 & s2.8 refer).

- 2.3 There was a total of 820 non-aggression security incidents, a breakdown is herewith:

- Other Security (754)¹³ Damage to Property (40)¹⁴
- Theft/alleged theft of Trust Property (9)¹⁵ and non-Trust Property (17)¹⁶

2.4 *Intentional/Inexcusable Violence & Aggression*

Figures for reported intentional/inexcusable violence and aggression incidents in 2025-26 are shown in Table 2. Intentional/inexcusable incidents ranged from acts of physical contact (however minor or inconsequential including spitting) to verbally threatening or intimidating behaviour and racial or other discriminatory/insulting behaviour. Intentional/inexcusable incidents are those incidents where the perpetrator *was not* deemed to have any

¹² Source Datix as of 18 May 2026. Numbers may change due late reporting, audit, or other data administration.

¹³ Including building/office/non-public areas found insecure, building alarm activations, suspicious behaviour, general concern re service user behaviour, undue interest in staff (harassment), nuisance phone calls, suspect packages or unattended bags and service users suspected to be or seen to be in possession of alcohol or other dangerous/illegal substances or knives bladed items (often carried for the purposes of self-harm or a misguided belief it was needed for self-defence and which needed removing to prevent injury to the patients whilst in our care and keep staff safe). In all twelve searches were reported that confirmed the presence of a knife or bladed item on or in possession of a patient. In line with our policy security staff have metal detector search wands available for use when searching patients, this equipment allows for more accurate searching of patients with less likelihood of harm to staff or opportunity for later use of the knife or blade ([patient search policy SY07](#)). Trespass includes unwelcome/unnecessary presence of relatives, rough sleepers, and/or intoxicated members of public in hospital grounds, public in staff only areas. Many concern patients refusing to leave after discharge (often demanding non entitled transport or medications) and result in a security intervention to see supervised removal from premises.

¹⁴ Majority concerned low level collision damage to private motor vehicles in hospital car parks or minor accidental damage to buildings/fixings, the majority of these caused by clinically confused or aggressive patients. Two concerned inexcusable damage to Trust property. One concerned the destruction of a CCTV camera in the ED by an inexcusably aggressive patient. In the other instance a patient discharged from the RSH ED subsequently caused damage to the RSH Ward entrance doors whilst trying to regain entry to premises during the silent hours. Both matters were reported to police resulting in appropriate resolution and outcome for the Trust.

¹⁵ All concerned small/low value items. Two did concern misappropriation of hospital drugs at the RSH. One on AMU involved a member of hospital staff and one on the Day Surgery Ward involved a patient. Both matters were escalated and dealt with appropriately.

¹⁶ Some incidents concerned alleged theft of unattended cash/personal items from staff and patients, a charity jar containing cash in League of Friends retail outlet, theft of bicycles (7) and theft of merchandise and goods from a retail outlet at the PRH (5) (previously agreed security improvements to the building housing the retail outlet were completed in May 2026 and are expected to provide significant mitigation out of hours when the majority of these thefts have occurred).

reasonable excuse for their behaviour e.g. an underlying medical condition or illness such as dementia, delirium, severe injury impairment, or toxic infection. Excess alcohol and/or drug misuse are not seen as mitigating circumstances for adverse behaviour, but as aggravating factors.

Table 2 – *Intentional/Inexcusable Violence & Aggression*¹⁷

INTENTIONAL/INEXCUSABLE VIOLENCE & AGGRESSION	2023/24	2024/25	2025/26
First quarter: Apr, May, Jun	29	50	44
Second quarter: Jul, Aug, Sep	52	45	62
Third quarter: Oct, Nov, Dec	56	47	48
Fourth quarter: Jan, Feb, Mar	40	59	53
Total	177	201	207

Of the reported 207 intentional/inexcusable violence and aggression incidents 104 occurred at the RSH, ninety-five occurred at PRH, three at William Farr House, four occurred at Hollinswood House and one occurred at a public car park in Telford town centre. Thirty-eight involved physical contact (however minor or inconsequential) of these twenty involved hospital staff.

2.5 *Non-intentional / Clinical Aggression*

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

Table 3 - *Non-intentional Clinical Violence & Aggression*¹⁸.

CLINICAL VIOLENCE & AGGRESSION	2023/24	2024/25	2025/26
First quarter: Apr, May, Jun	109	152	160
Second quarter: Jul, Aug, Sep	118	117	172
Third quarter: Oct, Nov, Dec	154	237	250
Fourth quarter: Jan, Feb, Mar	218	129	220
Total	559	635	802

Of the reported 802 non-intentional clinical aggression incidents 472 occurred at the RSH, 329 occurred at PRH and one occurred at Hollinswood House. 314 involved physical contact (however minor or inconsequential) of these 281 were on hospital staff.

2.6 *Immediate Response to Violence & Aggression*

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

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

Step 2 - Calling for emergency assistance from hospital Security Officers who provide

¹⁷ Source Datix as of 18 May 2026. Numbers may change due late reporting, audit, or other data administration.

¹⁸ Source Datix as of 18 May 2026. Numbers may change due late reporting, audit, or other data administration.

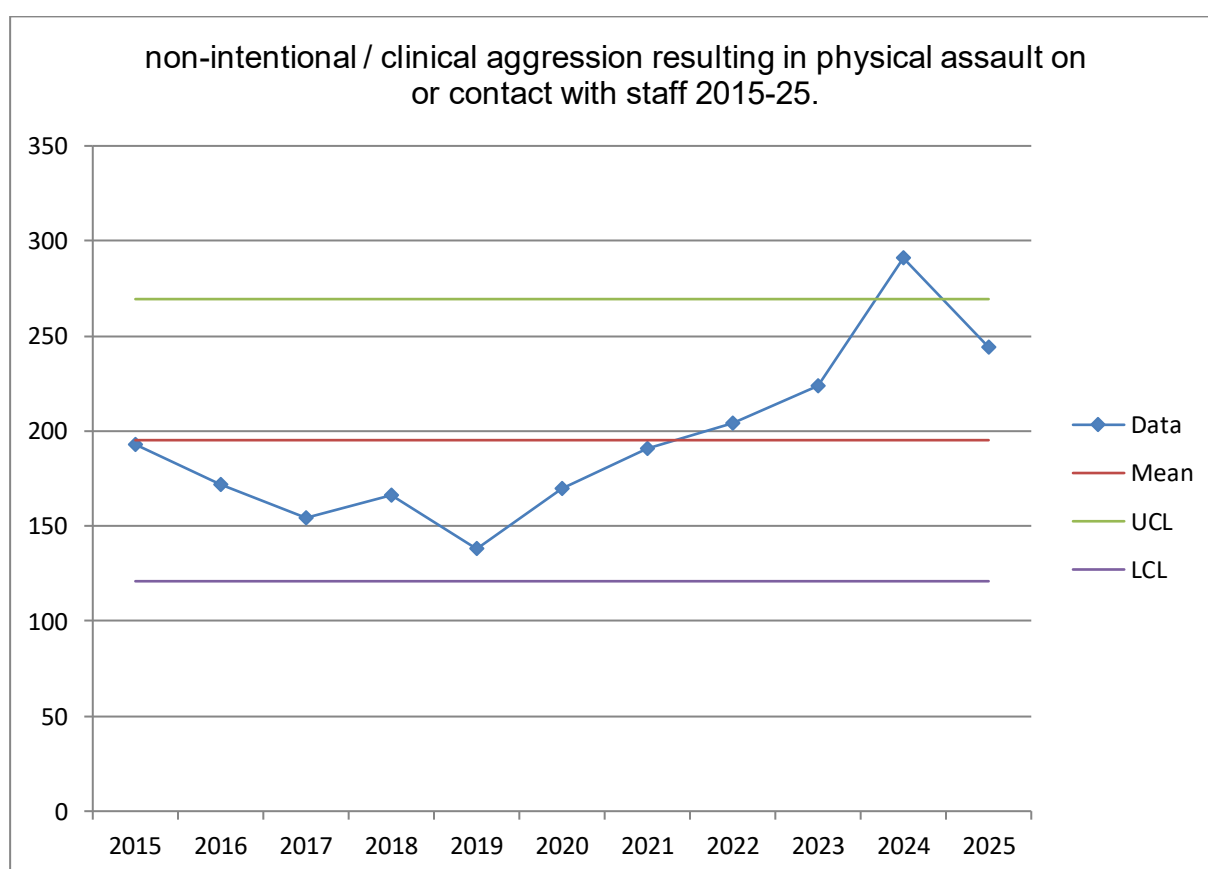
emergency response, are trained in de-escalation and safe handling/restraint (s3.2 refers) and support all staff facing threats of violence and aggression from service users, intentional or not as well as being backed up by an extensive CCTV network. All Security Officers carry body worn camera¹⁹.

Step 3 - Enlisting emergency assistance from the police.

2.7 Violence and Aggression Prevention and Reduction – Assessment of Strategies

Safe handling and restraint training for security staff (3.2 refers) and use of security staff as the principal resource within the Trust for the safe handling of aggressive service users (2.8 refers) started in 2014. Figure 1 shows that the number of incidents of *non-intentional clinical aggression* resulting in physical contact, harm or injury to staff reported each year since 2015 has for the most remained within upper control limit. The noted drop in the second half of 2024-25 onwards may well reflect recent security staffing increases.

Figure 1: Number of reported non-intentional/clinical aggression resulting in physical assault/contact, harm, or injury to staff between 1 January 2015 and 31 December 2025.



Aside from the incidents reported in Tables 2 and 3, there were a further 840 occasions where staff reported concern regarding potential for aggression from a patient²⁰. Through appropriate de-escalation and/or intervention, including where necessary security team contribution and/or rapid tranquilization, patient behaviour was controlled, and each occasion passed without further escalation, harm or injury demonstrating good incident prevention.

¹⁹ A statement on how the equipment is used and controlled is included within our published CCTV operating policy. Body Camera are not used when dealing with patients who lack capacity or may be in genuine crisis or ill-health.

²⁰ This may be through assessment of patients known to be in-crisis or at risk of self-harm whose behaviour is unpredictable, because of a patient needing a clinical or other intervention, but the patient is known for or will resist the intervention or will become agitated during the intervention and safe holding or restraint may be required for the safety of all concerned. Data source Datix as of 18 May 2026. Numbers may change due late reporting, audit, or other data administration.

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

All reported security incidents from either hospital staff or the security teams are individually reviewed by the Trust Security Manager. This includes liaison with staff affected by more serious incident and/or their line management. The Group Chief Operating Officer/Deputy Chief Executive for SaTH acknowledges reported incidents of violence and aggression by writing to all members of staff who may have been physically injured, harmed or significantly affected by an incident, offering support through line management or occupational health/counselling services and advising of the Trust's response to incidents. During the reporting period 170 such letters were sent to staff²¹.

During the reporting period 31 alerts were added to patient electronic records for intentional/inexcusable acts of violence or aggression. This allows staff to be warned of the potential for adverse behaviour from the patient²². A warning letter, signed on behalf of the Group CEO by the Group Chief Operating Officer/Deputy Chief Executive (SaTH) is sent to the perpetrator of the adverse behaviour, is copied to the police and the victim via line management, advising that non-emergency treatment could be withdrawn if there are any further episodes and support for police action or civil action by the Trust²³. In the reporting period 57 warning/reminder/final warning letters and/or letters of concern were issued. Despite further attendances by some, many of whom are regular attendees, particularly at ED, only three of those persons receiving a letter in this period have come to further attention after the letter was issued. The use of formal correspondence can have a positive impact in addressing unreasonable behaviour, especially if escalated action such as criminal prosecution may not be possible or desired by victims/staff. In the reporting period the Trust also issued an exclusion notice to a very disruptive relative following unacceptable disruption and intimidation of staff on a medical ward at PRH²⁴.

The Trust supports all police and Court actions when taken and every effort is made to encourage staff to make complaints to police to allow rightful prosecution of offenders responsible for inexcusable violence and aggression towards staff as well as enable partnership working with police including provision of supporting CCTV, body camera recordings or other documentary evidence (1.5 refers)²⁵. Some examples of open on-going cases and/or reported outcomes reached during the reporting period are herewith:

- web280093 web283112: A male patient was charged to court for public order offences and threatening emergency service workers after he made threats on two separate occasions to stab staff. The first incident involved a male security officer assisting with the patient's supervised removal from the premises, the second involved a female nurse in

²¹ In line with the strategy outlined for dealing with violence and aggression a resulting outcome is that much adverse behaviour is diverted away from medical and nursing staff by the intervention of security staff before the behaviour escalates and so medical and nursing staff can avoid injury or unnecessary involvement; by virtue of their involvement security staff, based on their early involvement become responsible for reporting on the incident with medical/nursing staff being identified as witnesses as opposed to victims. This explains in some way the disparity between numbers of support letters issued to Trust/NHS staff and all reported incidents (Tables 2 and 3 refer).

²² A recommendation for an alert on a patient's CAREFLOW electronic personal record and the issue of a warning letter is made by the Trust Security Manager. However, prior to this action being undertaken the recommendation must be approved and supported by clinical colleagues; this ensures that patients who may have lacked capacity at the time of the incident and whose circumstances may not have been accurately reflected in the incident reporting process are not unnecessarily sanctioned.

²³ It should be noted that it is not always possible or appropriate to issue a warning regarding unacceptable behaviour because the individual may not have been identified or the circumstances of the individual deem it inappropriate.

²⁴ Datix id 307635 307019 306776 306741 306686 307128 305183 304673 304672 304423.

²⁵ It is recognised some staff may feel unable to make formal personal complaint to police about some matters, which is why Trust responses are important, so that it can be demonstrated that at the very least unacceptable behaviour is challenged.

ED Triage. The patient was a regular attendee at the RSH ED throughout the reporting period. Initial attendances required numerous low level security interventions and supervision. Notwithstanding effort by the Trust to accommodate his care needs, his behaviour, as this summary shows, still escalated, and resulted in unavoidable prosecution action. The Trust has responded to a number of incidents involving this patient in accordance with the provisions of the Trust Violence & Aggression Prevention and Reduction Policy. Organisational wide alerts and management plans have been produced to accommodate any future presentation by this individual at any of our premises.

- web287403: A female patient was charged to court for public order offences and threatening emergency service workers after making racially abusive remarks towards staff (nursing and security) and threats to harm. Body Camera footage was provided as evidence, and the individual was bailed not to attend the RSH (other than for emergency life threatening treatment). The Trust responded to the incident at the time in accordance with the provisions of the Trust Violence & Aggression Prevention and Reduction Policy.
- web294672: A male patient was charged with criminal damage after deliberately causing damage to a private motor vehicle at the RSH. He had earlier been discharged from the ED after other nuisance and inappropriate behaviour towards female staff. The Trust responded to the incident at the time in accordance with the provisions of the Trust Violence & Aggression Prevention and Reduction Policy.
- web285670: A male patient was charged and remanded into custody after being charged with public order offences and threatening emergency service workers for making racially abusive remarks towards staff (nursing and security) and threats to harm. Body Camera footage was provided as evidence. The Trust responded to the incident at the time in accordance with the provisions of the Trust Violence & Aggression Prevention and Reduction Policy which includes written offers of support to affected staff.
- web294517: A male patient was arrested on suspicion of causing criminal damage to hospital property. This followed reports of concern regarding his undue presence in the RSH ward block in the early hours following previous discharge from ED. A review of CCTV showed him damaging ward block entry doors by kicking until they gave way and gave him access. Whilst no permanent damage was caused, the doors were temporarily rendered in-operable creating a staff and patient safety security risk. The matter was subsequently resolved via a police officer brokered Community Resolution Order after the patient admitted the offence²⁶. The Trust responded to the incident at the time in accordance with the provisions of the Trust Violence & Aggression Prevention and Reduction Policy.

Notwithstanding the rises in numbers of reported security incidents involving aggression towards staff, the latest annual NHS Staff Survey suggested the number of Trust staff experiencing physical (Q13a) or non-physical (Q14a) abuse from patients, service users, relatives or other members of the public is still below the national average and very much below NHS Trusts with the worst experiences²⁷.

In addition, Table 4 below shows that despite increased numbers of intentional and clinical aggression incidents over the last 3 years (Tables 2 & 3 refer), the number of incidents resulting in moderate or severe harm/death to staff has not increased²⁸.

²⁶ A Community Resolution Order is a non-statutory, out-of-court disposal used to resolve minor offenses or anti-social behaviour without formal criminal justice proceedings. It requires an admission of guilt, focuses on restorative justice (apologies, compensation), and does not result in a formal criminal record. It is not a conviction. However, it is recorded on local police systems.

²⁷ NHS Staff Survey Bench Mark report 2024 (Shrewsbury & Telford Hospital NHS Trust) p62-63 [2025 NHS Staff Survey Benchmark Report](#).

²⁸ Source Datix as of 18 May 2026. Numbers may change due late reporting, audit, or other data administration. Does not include reports finally approved with the code 'concern re potential aggression' because as the title suggests these incidents were prevented in the first place.

Table 4 - Number of intentional and clinical aggression incidents resulting in no, low, moderate, or severe harm or death.

	2023-24	2024-25	2025-26
No/Low Harm	713	814	855
Moderate or	23	22	14
Severe Harm/Death	0	0	0
Total Incidents	736	836	869

Current strategies, in particular the consistent use of security teams to provide interventional support, has a positive impact in preventing and managing violent and aggressive behaviour by service users, including minimising as much as possible, physical harm or injury to staff.

The majority of incidents of intentional/inexcusable physical contact or aggression in both ED departments during the reporting period affected or were absorbed by security teams.

During the reporting period there were ten recorded incidents that required RIDDOR reporting in accordance with Health & Safety legislation. Of these eight involved non-intentional clinical aggression on in-patient wards and on review it can be seen the patient's aggression appears to have come without warning/could not be foreseen. The other two incidents involved complex patients in the PRH ED and resulted in injury to security officers²⁹.

2.8 Role of Security Officers

The Trust's staffed security guarding contract is key to being able to implement the provisions of several security policies and numerous other staff and patient safety policies³⁰. There are thirty-five named locally employed contract security staff across both main hospital sites supported by seven named relief staff who work locally on other MITIE contracts. Within the five on duty staff there is a named supervisor. In addition, the contract provides for a dedicated SaTH site security operations manager (Mon-Fri) who moves between each of the main sites as required providing increased oversight, assurance, and accountability for the work of security officers as well as supporting the Trust Security Manager with day-to-day operational security management issues across the main sites.

With any aggression incident security staff are called to help provide reassurance and assistance in seeing the safe closure of the incident or prevent further escalation, as well as providing pre- arranged preventative support to staff to stop a foreseeable incident

²⁹RIDDOR reporting for security staff is completed by their parent/employer company.

³⁰The security guarding contract is subject to regular multi quote competitive re-tender process by Shropshire Healthcare Procurement Services (SHPS). The Trust is currently in year 4 of a 4+2 (year) contract with MITIE Security Limited, who at the time of the last tender achieved the highest score across the combined Quality and Price evaluation, achieving a score of 89.11%. They were awarded a contract to provide uniformed emergency security services at the Trusts 2 main operating sites. The MITIE submission evidenced their front-line NHS experience with several large acute hospital Trusts (including SaTH) as well as strategic/national level involvement and engagement in development of healthcare security and forthcoming statutory and regulatory legislation affecting healthcare security. Existing core team locally employed security staff working at both hospital sites were retained and transferred to the new contract under TUPE thereby retaining the invaluable experience. MITIE are a Real Living Wage (RLW) employer, and the contract provides for hourly pay rates to staff that are above the RLW as well as the National Living Wage (NLW) rate, which further encourages retention of staff and knowledge.

escalation. Often staff may note a warning alert for aggression on a patient's electronic record, this triggers a request for security staff presence when they attend. All Security Officers carry body camera recording equipment³¹. Security Officers are licensed in accordance with the Private Security Industry Act (PSIA) by the Security Industry Association (SIA)³² for Door Supervisor duties. They are also trained to make physical interventions by way of safe holding/restraining those service users whose behaviour has escalated to the point that the safety of staff, the service user or others is endangered. To provide security staff with the skills and confidence to do this, specialist training is delivered over a one-week training course to security teams by accredited NHS training staff from the Midlands Partnership Foundation Trust (MPFT) (3.1 refers).

978 safe hold/restraint interventions were undertaken across both sites by security staff during the reporting year³³. All safe hold and restraints are recorded on Datix making them visible to Centre and Ward Management. Not all 'safe holds/restraints' were undertaken because of actual aggression towards staff. Some were undertaken due to concern about potential aggression due to:

- Concern by medical/nursing staff about safety for planned invasive procedure where the patients mental or physical state, whilst not aggressive, suggested that harm or injury to the patient or staff would have occurred had an intervention not been undertaken.
- A need to prevent patients in personal crisis from attempting/conducting self-harm.
- High risk confused and/or agitated patients who had or were attempting to leave the hospital buildings and/or their ward/bed spaces and refusing to return.

2.9 Other Duties

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

- Help with preventing or locating absconded/missing patients or patients in crisis deemed to be vulnerable and/or at high risk of self-harm or may/are intending to take flight (patient safety).
- Fire alarm activations and other fire incident related activity (fire safety incidents).
- Attendance at Air Ambulance arrival/departure (operational task).
- Emergency resuscitation team calls to victims in public areas of the hospitals to ensure resuscitation teams can work without disruption or oversight of victims and ensure safe passage for patient evacuation etc. (medical emergency task).
- Escort of General Office staff conducting cash transfer and filling/emptying of change machines and collection of valuables from night safes (cash security).

2.10 Closed Circuit Television (CCTV)

Each main hospital site has a dedicated CCTV camera control room which forms an operating base for Security Officers. Output from security cameras on our main hospital

³¹A statement on how the equipment is used and controlled is included within our published CCTV operating policy.

³²Unscheduled assurance visit completed by SIA Inspectorate on 8 March 2024 at the RSH site saw no adverse outcome/findings. Areas of attention included SIA license inspection and validation, right to work checks, confirmation (from the staff) they were in receipt of minim pay rates/National Living wage pay rate and were able to demonstrate a competent understanding of the duties and client expectation. Those staff spoken to by the Inspectorate included core team staff and additional relief staff providing specific ward support.

³³Source Datix as of 3 May 2026. Numbers may be subject to change due later reporting, audit, or other data administration.

sites is fed back to these camera control rooms³⁴. As well as addressing a wide range of security issues and requirements these facilities prove very helpful with the rapid investigation of patients, who have inadvertently or intentionally left hospital buildings.

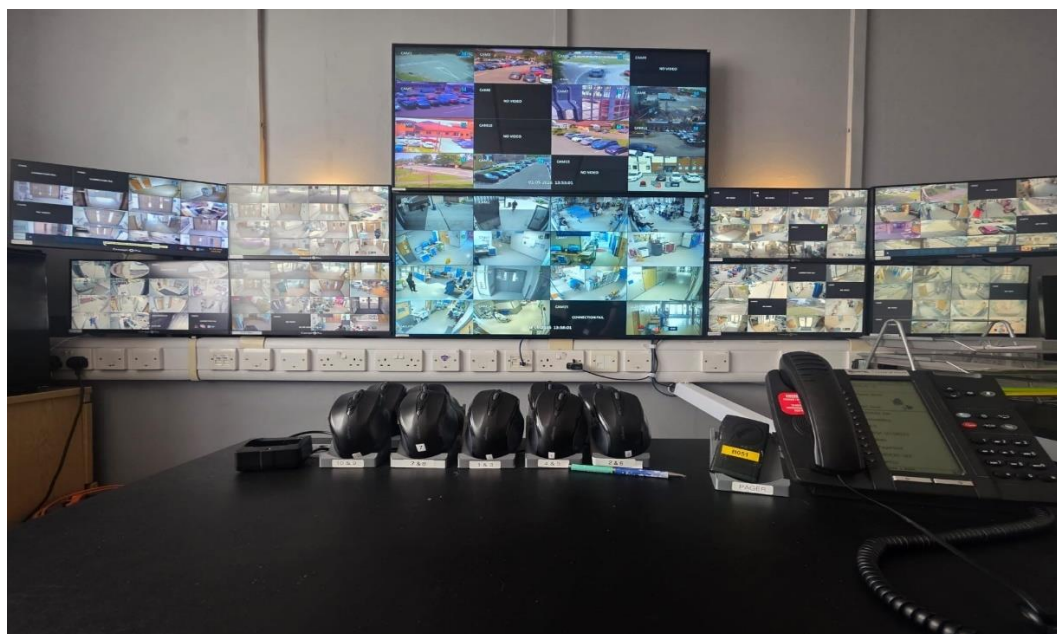
Images recorded on all systems are stored and controlled in accordance with our CCTV operating policy. There are over 150 camera at each of our main hospitals. In addition, cameras are present at our satellite sites including:

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

In the reporting year additional cameras have been installed to support a new two storey modular ward building at the RSH and the PRH ED Ambulance Receiving Area (ARA). Over a dozen other aged/obsolete camera at each site have been replaced in areas that support ED, Mortuary, Pharmacy and Estates operations amongst others. Further work is planned to install camera in new car parks at the PRH as well as replacing existing failing/obsolete camera in the hospital grounds. The arrival of a solar panel farm in one car park includes provision for new fit for purpose camera in this car park that are compatible with the solar panel farm environment following unavoidable removal of existing equipment. CCTV provision is also included in the Copthorne building new passenger lift installation and existing lift refurbishment programs.

At PRH a significant amount of work has been completed to see replacement of CCTV monitoring room recording and display equipment, some of which was either failing or becoming obsolete, image one refers.

Image 1 - new video wall in PRH CCTV camera monitoring room.



³⁴ Contract manager and all shift supervisors are licensed in accordance with the requirements of the Private Security Industry Act for Public Surveillance CCTV Monitoring.

CCTV provision has been included within the building schedule for the B60 element of the HTP at the RSH. To date, over twenty-five new digital Internet Protocol (IP) camera have been installed as part of the ED refurbishment element of the HTP at the RSH with more planned as further refurbishment and re-development of the RSH ED continues. The B31 element of the HTP at the RSH includes a new CCTV camera monitoring and security control room³⁵. This room will receive existing outputs from over 150 cameras at the RSH site, and in due course cameras in B60. Considerable effort and time has been given by security management and specialist contractors to realise and enable the switch over of the existing and complex (part digital/part analogue) CCTV network to the new B31 facility.

2.11 *Networked Swipe Card Door Access Control*

A security management business case to replace an increasingly unreliable and obsolete swipe card access control system used in several high-risk patient areas³⁶, several departments requiring high levels of assurance for accreditation and licensing purposes³⁷ and address concern around poor access control arrangements to and from in-patient areas and both ED³⁸ was given Capital funding in 2022³⁹. The replacement system (product name SALTO) is now being installed across the Trust.

Phase 1 of the main Capital funded program, has seen the new system delivered by the Capital Project team to Theatres, Pathology, Mortuary and Pharmacy at both sites as well as all clinical areas of the Copthorne building at the RSH.

Enabling work has been completed to see installation of the new system in the coming year in clinical areas currently occupied by Women & Children's (W&C) services at PRH as well as the new Trauma & Orthopaedic (T&O) Centre (Ward 31/32) at RSH with a view to further expansion into existing in-patient wards as capacity allows.

The same system is planned for installation in the B60 and B31 element of the HTP at RSH and has been/is being installed throughout the HTP refurbished/re-developed ED at the RSH.

The same new system has been included in recent years in other new build projects including the recently opened Elective Theatre HUB at PRH, CDC & Renal unit at Hollinswood House, Telford, and refurbished main kitchens, PRH. A modern cross site access control solution like this provides numerous financial and service user efficiencies/advantages, particularly so for those staff involved in cross site working.

2.12 *Baby Tagging*

This facility is in operation at the Shropshire Women and Children's Centre at the PRH on the Post-Natal Ward and the Wrekin Midwife Led Unit (MLU) at the PRH. Each new-born can have a tag fitted after delivery, image four refers. Should the infant then be taken towards a doorway, including a fire exit, the tag will alarm and send doors into Lock Down mode whilst discreetly alerting staff at the nurse base via a PC type console so they can investigate. If doors are physically forced, breached or someone manages to tail-gate out,

³⁵ The current facility is scheduled for (unavoidable) demolition as part of the RSH ED re-development in July 2026.

³⁶ In-patient Maternity, MLU & Paediatrics.

³⁷ Pharmacy, Pathology, Mortuary, Digital (Data Centres).

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

³⁹ Capital Planning Group (CPG) meeting minutes 16 Sep 22 (minute 2022.75).

the system will immediately alarm in a very loud and audible manner. In the Women & Children's Centre should the alarms at the doors fail, a second layer of sensors will activate in the main foyer and each external entrance to the building.

Image 4 – tag

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



As part of our security management assurance program, testing of the system and staff reactions are conducted every 3 months by Ward and Security Managers with feedback provided to senior management on the outcome from each test. A maintenance and support contract with the supplying company is in place to ensure system continuity and reliability. A 24/7 emergency telephone help line is included within the support element of the contract, so staff have constant access to specialist technical support. The same system is being installed in maternity and paediatric areas of the B60 new build element of the HTP at the RSH ready for when W&C services transfer from PRH.

2.13 Lone Working

The devices used by the Trust to support staff working alone/off site in the community or alone in hospital buildings (often out of hours) takes the form of either an identity badge holder worn around the neck or clipped to a belt/tunic or a key fob styled device, images 5 and 6 refer. Both include a panic alarm that can be discreetly activated, which automatically opens a line of communication (via roaming mobile phone signal) to a national Alarm Receiving Centre (ARC), thereby allowing situation assessment and immediate response/escalation, as well as recording of evidence.

Image 5 – identity badge holder device

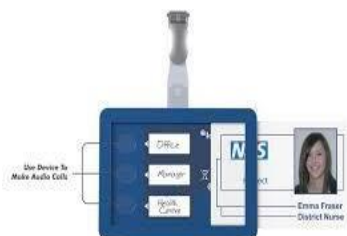


Image 6 – key fob style device



In very extreme instances ARC staff can directly provide information from the staff member's device including pre-recorded information on where the staff member is located, to the nearest police control room for those staff working out in the community or a satellite site and hospital security teams for those staff working at the PRH or RSH. There is a particular advantage for staff working out in the community in that police response is quicker because the information being received by them is from an accredited source as opposed to an anonymous cold call to police from public.

The device for staff working alone on the main sites (out of hours) has only recently been introduced following the retirement of older analogue radio pager devices due to switch off of VHF frequencies. Previously completed testing for signal quality of the new devices in user departments has been followed by a device switch over program led by the

Security Team Administration Officer. This has included significant liaison with the service provider, user departments, device distribution, and configuration as well as individual staff training. Although the switch over program only commenced in February 2026, progress has exceeded expectation in terms of devices issued and training delivered to ninety-one members of staff from across multiple disciplines.

Lone Worker devices are not risk eliminators, they are risk mitigation that complement other safe systems of work. Use of these was noted during the last CQC Inspection⁴⁰.

⁴⁰ Lone worker security devices had been provided for each community midwife." Source: CQC Inspection Report (Evidence Appendix) published 8 April 2020 page 429.

3 Training & Awareness

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

Security staff are the primary trained resource at the Trust for the safe handling and restraint of physically violent or aggressive patients. To provide security staff with the skills and confidence to do this, specialist DMI training is delivered by accredited NHS training staff from the MPFT. The training, which consists of a 5-day foundation course and annual refresher days thereafter, has been accredited by the British Institute for Learning & Development (BILD) and the Restraint Reduction Network (RRN). A syllabus ordinarily delivered to NHS Mental Health Professionals (MHP) working at MPFT is followed, but with additional bespoke content aimed at recognising the role of our security staff and the varied and different circumstances and settings experienced in a busy acute hospital environment. In the reporting period 35 security staff undertook either whole day annual refresher training or the initial 5-day foundation course (images 7-11 refer).

Images 7-11 showing security team members participating in annual 1-day DMI refresher training days held over 13-14 March 2026.



3.2 *Conflict Resolution Training (CRT)*

In the reporting period 2012 employees completed on-line national NHS CRT which equates to 95.07% compliance in terms of staff required to complete training⁴¹. Aggression from service users can be experienced face to face but also via telephone or social media, whilst on premises or off, and when on duty or off duty.

3.4 *Corporate Welcome*

An on-line voice over corporate welcome security information brief is available for all new staff starting at the Trust. This information brief is administered through the Trust's Learning Made Simple (LMS) on-line portal. During the reporting period 596 staff listened to this briefing (58.95% compliance)⁴².

⁴¹ Workforce Directorate dated 28 April 2026.

⁴² Workforce Directorate dated 28 April 2026.

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

This new statutory obligation places a legal duty on those responsible for certain publicly accessible locations to consider the threat from terrorism and implement appropriate and proportionate mitigation measures. It is expected that security awareness training for NHS staff will be seen as a corner stone of an organisations risk mitigation strategy. As part of the Trust response strategy from 1 December 2025 all staff have been asked to complete a 45-minute government on-line security awareness training assessment known as ACT (Action Counters Terrorism), followed by a short 10-minute voice over power point briefing by the Security Manager on local Lock Down arrangements and sign posting to related policies and procedures at the Trust⁴³. Both pieces of training are administered through the Trust's LMS on-line portal. During the period 1 December 2025 to 31 March 2026 5986 staff completed this training⁴⁴. Despite the training only being available from 1 December 2025 this figure shows a compliance of 77.84% with 100% compliance likely to be achieved in the next year.

Every month security team supervisors undertake audit and functionality tests of the emergency Lock Down plan for each of our Emergency Departments (ED) and each Ward and/or publicly accessible department/entrance at the main hospital sites. This includes 10 minute informal on-location face to face briefings to on-duty staff of all positions and professions, as an extra means of raising awareness and taking opportunity for staff to be refreshed on arrangements for their areas. During the reporting period 1089 members of staff were briefed in this manner⁴⁵.

3.6 *Lone Workers.*

In the reporting period 93 staff undertook training on how to use a Lone Worker device⁴⁶. Ninety-one of these were part of a specific switch over program to see introduction of a new digital device for those staff working alone on main hospital sites (often out of hours).

4 **Conclusion**

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

- Continue to provide specialist security risk assessment advice and guidance on security infrastructure and security resources for the HTP and other Capital investments or operational re-configurations.
- Continue to provide corporate security risk assessment advice, support, guidance to the Trust and all Centres and departments including change of lone worker device support for staff working on main hospital sites.
- Ensure that continued and credible professional uniformed 24/7 emergency security support remains available and at the disposal of all Centres and departments on our busiest sites including continued investment in the training of security teams to deal with conflict resolution and support clinical staff with aggressive service users.
- Continue to ensure clear messages are sent to perpetrators of unwelcome and anti-social behaviour to reinforce the Board's robust approach to abuse of staff and patients.

⁴³ HSSF 2023.160 dated 8 February 2024. SaTH Heads of Education Group Meeting dated 24 September 2025 (Papers 1 & 2).

⁴⁴ Workforce Directorate dated 28 April 2026.

⁴⁵ Data taken from Security Management records 5 May 2026.

⁴⁶ Data taken from lone worker administration portal 29 April 2026.

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