Board of Directors' Meeting in Common – 14 May 2026

Supporting Information to SCHT Integrated Performance Report – Agenda item 014/26a

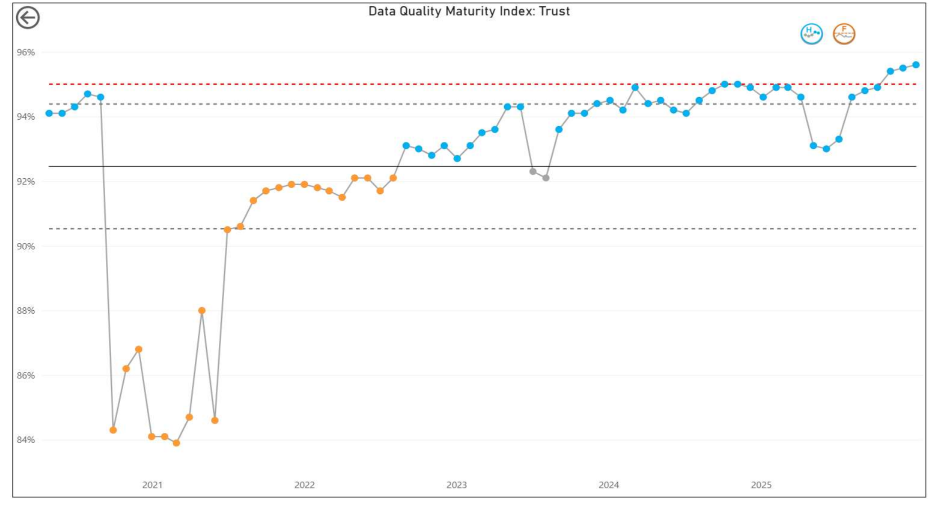
Exception Report - Action Plan

Data Quality Maturity Index

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
DQMI	%	94.6%	94.8%	94.9%	95.4%	95.5%	95.6%	95.6%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

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



Reason for performance gap:	
	The target for DQMI is 95% and December has seen continued improvement ahead of the planned trajectory and we have met the target with an achievement of 95.6%. The Plan had been to achieve the 95% target by the end of quarter 4 and all individual action plans align to this deadline. The improvement is testament to the actions plans that have been developed and the work that has gone into achieving the improving position. The requirement now is to ensure the achievement is maintained in future months and continues to require monitoring of key elements within the indicators. The main elements impacting this metric are compliance with accurately recording ethnicity, spoken language, MIU chief complaint, MIU acuity, MIU discharge and Clinical Coding. Ongoing education efforts emphasise the importance and relevance of these metrics with dedicated areas to target focusing heavily on data capture, clinical coding and MIU. Informatics have supported services in understanding areas that require improvement and the impact to DQMI . There is an ongoing risk to meeting DQMI requirements, especially for recording ethnicity, because primary care no longer provides proformas that previously supplied this vital information for input into RiO following Industrial Action. The below action plans are however designed to mitigate this as much as possible.

		Start Date	End Date	Status	Outcome
	Oversight of improvement plan: Through Data Quality Sub-Group and Divisional Performance Meetings progress is systematically tracked to assess the effectiveness of the education plan against the trajectory to achieve 95% by January and proactively mitigate risks as they arise, focusing interventions towards specific teams requiring additional support.	Aug-25	Jan-26	Off Track	**April 26 Update** There has been a slight increase to 95.6% for December. Further work to continue with new Teams Leads at Ludlow and Bridgnorth to embed processes. New RiO reports have been developed for Teams to go in and view their own ethnicity and spoken language figures between information report timetables ensuring ownership at team level. **March 26 Update** Recovery to target has continued to be achieved in November at 95.5%. December may show a small dip, due to early sight of ECDS data showing a deterioration in Acuity and Chief Complaint levels at Ludlow MIU, but improvement in other areas is anticipated to offset this until targeted actions at Ludlow lead to improvement in performance. **February 26 Update** Recovery to target has been achieved in October at 95.4%. There will be a likely small dip from this position in November, December and January, as early sight of ECDS data shows a small deterioration in Acuity and Chief Complaint recording levels, but still in advance of previous levels seen up to September 2025. Further targeted action required in relation to this area and others, as per below individual action updates
	Area 1 - Clinical Coding: Stabilisation of clinical coding workforce	Nov-25	Jan-26	Complete	**April 26 Update** Agency coding commenced w/c 30.03.26. Weekly data will be collated to evaluate impact and overall position **March 26 Update** Laptops have been delivered, access, etc, being finalised and then plan will be implemented **February 26 Update** Everything is in place to go live waiting delivery of Laptops for the new staff. Once laptops complete the project will commence .
	Targeted approach to clinical coding to provide change in KPI performance	Oct-25	Jan-26	Off Track	**April 26 Update** Agency coding commenced w/c 30.03.26 and they are working on most recent uncoded episodes. Weekly data will be collated to evaluate impact and overall position **March 26 Update** Laptops have been delivered, access, etc, being finalised and then plan will be implemented and 3rd party will begin with most recent uncoded episodes **February 26 Update** Awaiting start date for 3rd party staff and delivery of equipment as per action above. Once this starts, the approach will be in line with this action.

Action Plan					
	Area 2 - Ethnicity: Community Hospital Outpatients Appt Letter currently contains Ethnicity question to patients, which should be populated into RiO at appt check in. Spoken Language will be added to the letter as well, through contact with Rio Configuration Team and message will be re-enforced to reception staff and linking HCA's into process, to check letter when patient arrives at appt and ensure Rio is updated	Oct-25	Feb-26	Off Track	**April 26 Update** Improvements of 10% at Bridgnorth and 17% at Ludlow, but deterioration of 10% at Whitchurch, in March 26. Compliance remains not consistent across services. Now SCHT is part of the group model, operational leads will link with SATH colleagues to understand if they have any plans that are supporting their recordng ethnicity that could be transferrable. **March 26 Update** Performance continues to be up and down, so CSM will pick this back up with service leads, through recovery plans and revised approach **February 26 Update** Improvement has been mixed with an improvement in B'North but a reduction in Ludlow. Further work and focus is required to ensure recovery across both areas. The admin team now has staff returning from sickness which will help improve this position.
	MSST to implement a trajectory to recover to 90% by February 2026, to continue recent improvement of 10% over last 12 months, including drilling down to organisational level across SaTH and RJAH to assess education and learning requirement across all that impact upon MSST.	Oct-25	Feb-26	Off Track	**April 26 Update** Performance continues to fluctuate, deterioration of 3% in March 26. However the revised approach is being developed for implementation. **March 26 Update** Performance continues to be up and down, so CSM will pick this back up with service leads, through recovery plans and revised approach **February 26 Update** Further Improvement of 3% seen. Work is underway to split the data by organisation to allow for a more targeted approach.
	Diabetes Nursing - Reviewed admin processes, with support from planned care and identified additional admin capacity was required, being recruited to and expected trajectory of 90% by April	Oct-25	Apr-26	On Track	**April 26 Update** There has been a slight decrease in valid ethnicity reporting, recovery plan drafted and to be implemented and enacted for recovery in 1/12. Noted there are a high number of patients recorded as declined to state within this service so a deep dive has been scheduled to explore this fully and align required actions to improve. **March 26 Update** CSM has re-contacted service lead to ask for a recovery plan **February 26 Update** CSM working with Diabetes Clinical Lead and Admin. Plan is to hold improvment day to clear any backlog and look at process to maintain improvment moving forward.
	Pulmonary Rehab - Targeted workshop has taken place and demonstrable impact seen in last month improvement from 54% to 67%. Trajectory to continue improvement to 90% by April 26	Oct-25	Apr-26	On Track	**April 26 Update** New admin started 07/04/26, minimal change from last month but this has been added to admin induction to recover and make business as usual. **March 26 Update** CSM has re-contacted service lead to ask for a recovery plan **February 26 Update** Interviews taking place 11th February, improvement has commenced (circa 10%) and so this will continue to be embedded into process with new Admin post once in place

	Action	Start	Due	Status	Update
	Admiral Nurses Telford - Showing decline in performance on Ethnicity recording month on month. Trajectory to improve performance back to 90% position by Apr-26	Nov-25	Apr-26	On Track	**April 26 Update** Improvement noted. no admin specifically in post for this service and interim arrangement through SPR along with clinical vacancy. Team to link with Shropshire to Team to share good practice and mirror process across both teams for consistency and ongoing improvement. **March 26 Update** CSM has re-contacted service lead to ask for a recovery plan **February 26 Update** Performance remains at 82%, CSM working with service to mitigate current admin gaps causing the impact.
	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	**April 26 Update** Products planned for demonstration and digital team working through planned implimentation with current capacity levels **March 26 Update** Two products identified by digital team for Ops to demo over next 4-6 weeks **February 26 Update** Digital working with ops to schedule launch on work plan alongside all other transformation project
	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	On Track	**April 26 Update** Reports continue to be shared at performance meetings and teams encouraged to improve recording processes. DAART position steady at 70%, further improvement required also in Virtual Ward as currently at 73% **March 26 Update** Performance has improved in DAART by 10% on last month, to 71%, so still further improvement required, other areas remain fairly static and so repeat message will be cascaded through Divisional Performance Meeiting around Ethnicity and Spoken Language **February 26 Update** Performance remains static, with some services performing well but others remain similar to previous months. We have agreed through DQ Subgroup and Clinical Information leads to alter the "Not Known" option in Rio to "Not Asked" from mid-January and this will be specifically monitored and staff questioned as to why they feel unable to ask the question if this option is being selected
	SAIS Immuniations	Apr-26	Jun-26	On Track	**New Action** Noticed a decrease in ethnicity performance in February. Will explore e-consent forms and possible transfer of data to demographics on RiO to fully mitigate.
	School Nursing Shropshire & Telford - Ethnicity Improvement has failed to continue and so target work required to embed the plan	Jan-26	Apr-26	On Track	**April 26 Update** Reveiw the front end reports by staff and identify trends to be discussed with individual supervision **March 26 Update** Commissioned a service review for Shropshire School Nursing, which will then move to Dudley and Telford. Ethnicity and Spoken Language will be included as part of the review. **February 26 Update** Staffing sicknes currently impacting the improvement plan in these services. 0-19 lead now supporting to recover and comms plan in place to re-iterate importance of asking the question

	Area 3 - MIU: Ludlow MIU - Triage Issue to be urgently solved Staff misunderstanding that using the triage field in Rio to add Acuity and Chief Complaint is populating the Triage timestamp that feeds the 15 minute Triage assessment KPI.	Jan-26	Apr-26	On Track	**April 26 Update** Ludlow Team Lead position currently with recruitment. Further new starters coming in over the following 2 months. Training and embedding of need and purpose sessions will be held face to face within 2 weeks of start dates. Inidividual practitioners will be approached with assistance from Information colleagues and reporting. **March 26 Update** Whitchurch team lead to provide support 2 days a week to Ludlow, part of which is the priority to directly address the triage issue and recording with individuals who are not recording to levels expected. There has been some improvement to 40% populated in February and therefore we have extended the action deadline to April, to allow the impact of the above to be seen **February 26 Update** Rio Config have confirmed that populating the Acuity and Chief Complaint does not timestamp the Triage date and this has been cascaded to staff and requirement to populate instructed. There are still some areas of challenges, with January performance at 26% (8% in December) so further targeted meetings to take place with CSM to understand where and why some staff are not recording this and to remind them of their requirement to keep an accurate clinical record
	Bridgnorth MIU - Acuity and Chief Complaint recording requires further improvement due to slight deterioration in performance	Mar-26	Apr-26	On Track	**April 26 Update** Team Lead still with recruitment. Once in place, training to be provided within 2 weeks of start date. **New Action** New Team Lead interviews set for late March and Whitchurch team lead will therefore support once team lead is in place and in advance, in same way as at Ludlow, to link with individuals who are not recording to levels expected. Current performance is at 64%
	Area 4 - Unoutcomed Appointments Health Visiting and School Nursing unoutomed appointments are showing at a higher level than desired and this has a potential impact upon performance against Core Contact KPI's (i.e. New Birth Visits)	Mar-26	Jun-26	On Track	**April 26 Update** Meeting arranged to discuss reporting options with Information colleagues **New Action** Benchmarking across all 3 services will be undertaken and areas of poor performance will be encouraged to link through shared learning and a recovery plan put in place

Author	Alastair Campbell/Helen Cooper/Wendy Hallows/Sam Townsend/Sarah Robinson/Edliz Kelly/Jade Thomas/Sally Stubbs	**Date**	13/04/2026	
Accountable Officer Approval	Claire Horsfield	**Date**	24/04/2026	

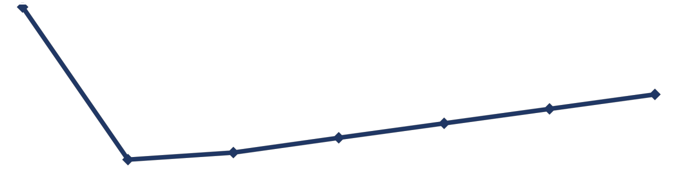
Exception Report - Action Plan

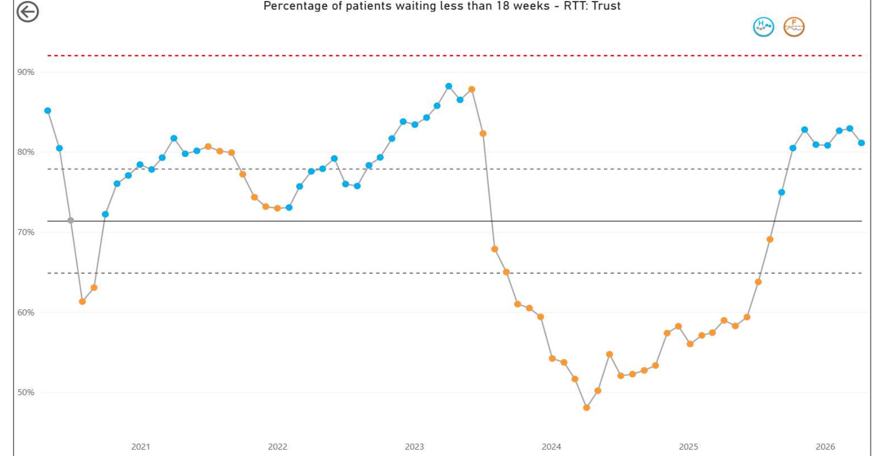
Percentage of Patients waiting less than 18 weeks - RTT

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

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
RTT Incomplete Pathways	%	82.77%	80.90%	80.81%	82.64%	82.92%	81.11*%	81.11*%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
%	92.0%	81.5%	82.0%	83.0%	84.0%	85.0%	86.0%





Reason for performance gap:

RTT performance for the organisation was at 58.97% in March 25 with a 22.14% improvement seen across the past 12 months. Whilst the profile of the RTT waiting list continues to improve March-26 has shown a deterioration in performance with a drop of 1.8%, this is mainly seen within the MSST service (due to volume of backlog patients) and to a lesser extent Dental and Ludlow outpatients. Overall results do however remain substantially ahead of the national pathway for achieving 65% RTT compliance by March 2026 and 92% by March 2029. Trajectory has been revised appreciating there are complex actions below and across multiple providers, 92% in 2026-27 is the aim and the trajectory will need further review once some of the actions are completed.

Whilst improvement has continued in bringing down the profile of the RTT waits, the overall position has started to slow. Community Hospital Outpatients has been struggling due to sickness and longstanding challenges with capacity. There has been significant focus on improving this position with improved links with partner organisations such as SATH to support recovery. The below highlights performance across all Community Hospital sites.

•Bridgnorth: 58.8% for February and has impoved to an unvalidated position of 67% in March.
•Ludlow: 69.81% for February and has impoved to an unvalidated position of 67.89% in March.
•Whitchurch: 58.11% for February and has impoved to an unvalidated position of 68.14% in March.

Key agreed actions in partnership with SaTH to support continued recovery in Community outpatients include:
•Joint Patient Tracking Lists (PTLs)
•Job planning and standardisation of clinic templates
•Targeted additional interventions for ENT, respiratory, and gynaecology over all wait lists

Service transformation in APCS and Dental is ongoing; APCS saw an improvement in performance from 45.95% in February to 49.3% in March. Dental has dropped from 66.94% in February to 61.41%, however there has been agreement with SATH to support increasing and ringfencing theatre list at PRH.

Ongoing recovery across all RTT pathways is supported by monthly data validation, performance dashboards, and regular review meetings. SCHT leads will now start to attend the SATH PTL to ensure equity of access. The aim continues to be to work towards acheiving 92% and work is underway to review the current position against the trajectories to provide a clear route to 92%.

Action Plan		Start Date	End Date	Status	Comments
	Transformation of clinical pathways for MSST, including focus on community appointment days (CAD), superclinics and blitz clinics.	Feb-26	Jun-26	On Track	**April 26 Update** Internal SCHT operational meeting now implemented to help support traction on implementation of the new pathways with particular focus on community appointment days. **March 26 Update** Continue to work up a CAD day at Euston House but no confirmed date at present. **New Action** SCHT taking the lead on implementation of a CAD day at Euston House, with the aim of May 26. Review of potential superclinics but with radiology support on the day.
	Focus on MSST level 2 to support increased activity with review of templates across SCHT, then SATH and finally RJAH with the aim to improve clinic utilisation and increased activity to drive down recovery.	Feb-26	May-26	On Track	**April 26 Update** Internal SCHT operational meeting now implemented to help support traction on supporting improving utilisation. SCHT templates have been reviewed, next step is to make changes to increase number of new appointments. Additionally a large number of SMS have been sent to patients to supporting increaseing the booking horizon. **March 26 Update** Data pulled together that shows potential for 25% increase in new activity. Working on revising templates across SCHT and SATH. **New Action** New/FU data provided by informatics supporting a review of clinic templates to support improved productivity and increased activity.
	MSST Service reviewing and implementing new ways of working with booking of capacity inlcuding use of Dr Doctor, increasing booking horizons and ensuring correct rules with booking order.	Apr-26	Jun-26	On Track	**New Action** Focus on ensuring correct rules followed throughout booking process to ensure better utilisation imporved data quality
	Workforce Managmeent - Working with finance to review annual turnover and the potential to over recurit to ensure fill capacity throughout the year	Apr-26	Jun-26	On Track	**New Action** Regular reduction in capacity available due to number of vacancies carried throughout year.
	GPwPER recruitment within APCS to support both Gynae and ENT	Dec-25	Jun-26	On Track	**April 26 Update** Still awaiting start date for Gynae GPwER. GPwER ENT interviews were succuesfull with one candidate accepting the role and another to be over recruited to support the longer term transformational plan and recovery of backlog. **March 26 Update** Awaiting start date for Gynae GPwER. ENT GPwER in recruitment process. **February 26 Update** Successful interview of Gynae GPwPER so awaiting recruitment process to complete and ENT out to advert currently.

	Action	Start	Due	Status	Update
	Further roll out of T-PRO across community outpatients	Dec-25	Mar-26	Complete	**April 26 Update** All consultants now have a licence and access via mobile devices. Action complete. **March 26 Update** Ongoing implementation across all specialities dependant on when consultants are scheduled to attend clinic. **February 26 Update** This has now started and is being rolled across all consultants in community outpatient providing greater oversight to operational team
	Review of options to support improving APCS with potential short term support and long term aim involving the system wide transformation project.	Feb-26	Apr-26	On Track	**April 26 Update** Overtime planned throughout April/May to support and this has now commenced in April. **March 26 Update** Overtime now planned for April/May to support recovery. Longer term, the transformation project continues to progress with potential for over-recruitment in APCS ENT to support current recovery but pre-empt shift in demand. **New Action** Options to improve activity with review of clinic templates, review of waiting list and review of potential locum options. Longer term plan to continue to work on system wide ENT transformation project.
	Agree sustainable and consistent Dental theatre provision via SATH.	Feb-26	Apr-26	On Track	**April 26 Update** Meeting has taken place with SATH and agreement to work together to ensure equity of access to theatre provision to support the longest waiting patients. SATH have agreed to support improving list efficiency and consistency of lists. **New Action** Feb meeting took place with initial support from SATH to review current situation and provide additional support.

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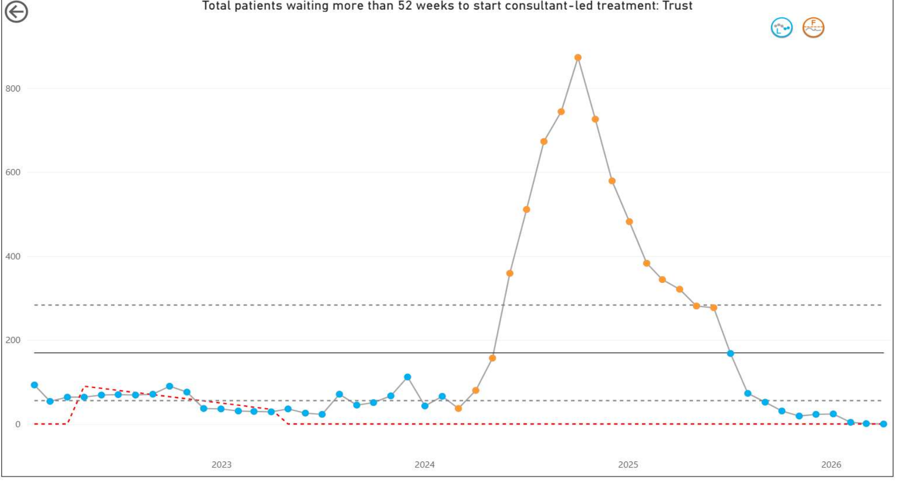
Exception Report - Action Plan

Total patients waiting more than 52 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 52 weeks

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
RTT 52+ week waits	Number	19	23	24	4	1	0*	0*
	Target	0	0	0	0	0	0	0

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



Reason for performance gap:	The position for 52 weeks in March is zero with very low risk of 52 week breaches for April. The main risk associated with this sits within the APCS service, community outpatients and Dental but plans are in place for all to prevent any further 52 week breaches.				
		Start Date	**End Date**	**Status**	**Outcome**
	GPwPER recruitment within APCS to support both Gynae and ENT	Dec-25	Jun-26	On Track	**April 26 Update** Still awaiting start date for Gynae GPwER. GPwER ENT interviews were succuesfull with one candidate accepting the role and another to be over recruited to support the longer term transformational plan and recovery of backlog. **March 26 Update** Awaiting start date for Gynae GPwER. ENT GPwER in recruitment process. **February 26 Update** Successful interview of Gynae GPwPER so awaiting recruitment process to complete and ENT out to advert currently.

	Action	Start	Due	Status	Update
Action Plan	Further roll out of T-PRO across community outpatients	Dec-25	Mar-26	Complete	**April 26 Update** All consultants now have a licence and access via mobile devices. Action complete. **March 26 Update** Ongoing implementation across all specialities dependant on when consultants are scheduled to attend clinic. **February 26 Update** This has now started and is being rolled across all consultants in community outpatient providing greater oversight to operational team
	Review of options to support improving APCS with potential short term support and long term aim involving the system wide transformation project.	Feb-26	Apr-26	On Track	**April 26 Update** Overtime planned throughout April/May to support and this has now commenced in April. **March 26 Update** Overtime now planned for April/May to support recovery. Longer term, the transformation project continues to progress with potential for over-recruitment in APCS ENT to support current recovery but pre-empt shift in demand. **New Action** Options to improve activity with review of clinic templates, review of waiting list and review of potential locum options. Longer term plan to continue to work on system wide ENT transformation project.
	Agree sustainable and consistent Dental theatre provision via SATH.	Feb-26	Apr-26	On Track	**April 26 Update** Meeting has taken place with SATH and agreement to work together to ensure equity of access to theatre provision to support the longest waiting patients. SATH have agreed to support improving list efficiency and consistency of lists. **New Action** Feb meeting took place with initial support from SATH to review current situation and provide additional support.

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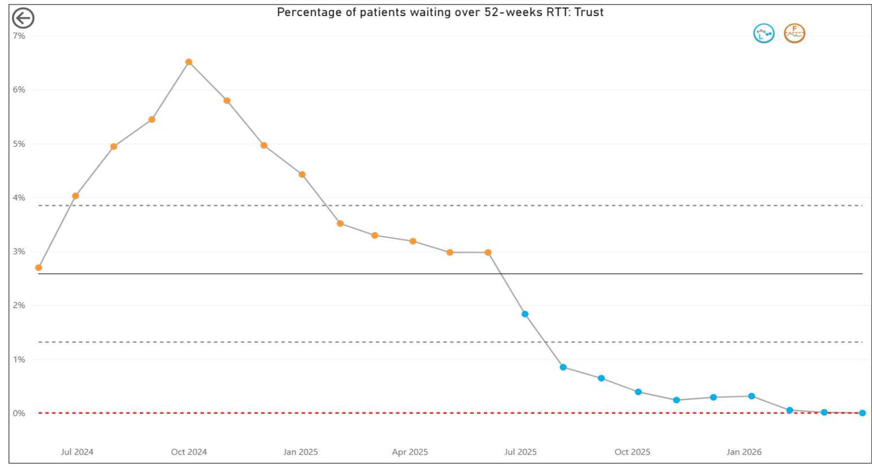
Exception Report - Action Plan

Percentage of Patients waiting over 52 weeks - RTT

As at the end of the month, the percentage of patients that are still waiting for treatment and are over 52 weeks

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Percentage of Patients waiting over 52 weeks - RTT	%	0.24%	0.29%	0.31%	0.05%	0.01%	0.00%*	0.00%*
	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
%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%



Reason for performance gap:

The position for 52 weeks in March is zero with very low risk of 52 week breaches for April. The main risk associated with this sits within the APCS service, community outpatients and Dental but plans are in place for all to prevent any further 52 week breaches.

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	Agree sustainable and consistent Dental theatre provision via SATH.	Feb-26	Apr-26	On Track	**April 26 Update** Meeting has taken place with SATH and agreement to work together to ensure equity of access to theatre provision to support the longest waiting patients. SATH have agreed to support improving list efficiency and consistency of lists. **New Action** Feb meeting took place with initial support from SATH to review current situation and provide additional support.

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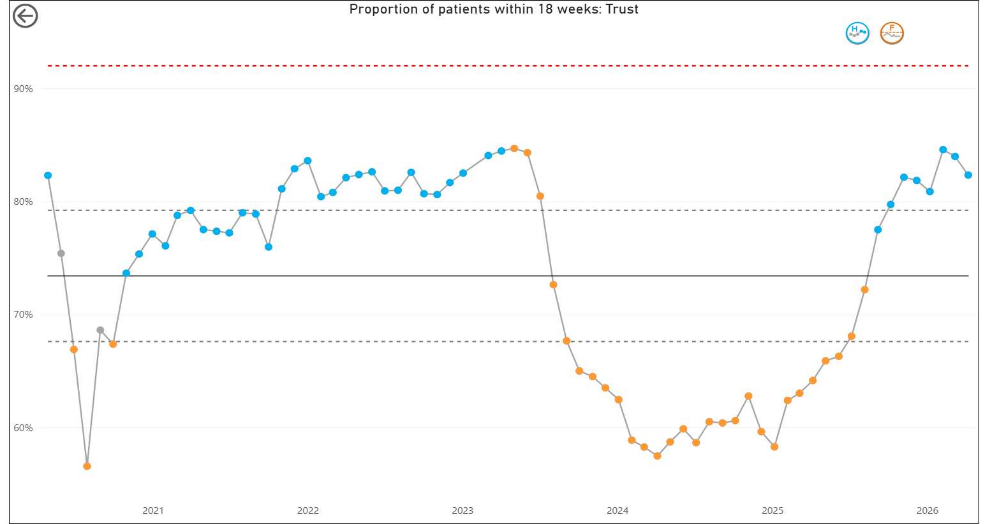
Exception Report - Action Plan

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	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Proportion of patients within 18 weeks	%	82.14%	81.85%	80.87%	84.58%	83.98%	82.33%	82.33%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
%	84.5%	82.0%	82.0%	83.0%	84.0%	85.0%	86.0%	87.0%



Reason for performance gap:	Performance experienced an improvement of nearly 4% in January but has since dropped by 0.6% in February and a further 1.65% in March which has led to the KPI dropping below the trajectory. March's performance has been impacted due to a reduction in activity overall which aligned to balancing annual leave across services with some unplanned sickness challeneges in the MSST level 2 and 3 and also Podiatry. Improvment plan in place to adress and stablise workforce. Trajectory has been updated to reflect the trajectory submitted in the Operational Plan for 2026-27. Key Services Impacting Performance •CDC (Children's Development Centre) •Diabetes •Dental •Community Paediatrics •Children's Speech and Language •MSST (Musculoskeletal Services Shropshire and Telford) •Pulmonary Rehabilitation •Podiatry Revised recovery trajectories have been established for each, and progress is being closely monitored through action plan workshops and local performance meetings. Every service, including both RTT (Referral to Treatment) and non-RTT reportable areas, has a robust, aligned recovery plan to ensure equitable provision. While restoring the 18-week referral to treatment target remains a key objective, priority is consistently given to clinically urgent and long-waiting patients, in line with national guidelines, with particular emphasis on MSST due to the large patient cohort. The stability of the service has improved following the transfer of Tems, supported by targeted waiting list initiatives and comprehensive demand and capacity modelling. Progress has been particularly achieved, through targeted improvements at level 3 within MSST, resulting in more patients being seen within the 18-week timeframe. The recovery strategy to realign with the trajectory, will now broaden to include level 2 to further reduce waiting lists and enhance overall service delivery, driving further improvements in the coming months. Speech and Language Therapy: Ongoing improvements have continued, with early intervention and revalidation initiatives reducing the number of children waiting over 52 weeks to zero as of January and maintained in February/March. For CDC and Comm Paeds core focus to recover is through the Coral House Estates reconfiguration which will support the maximising of clinic space to increase clinics as part of recovery. Diabetes performance for March was 65.12% with 0 patients above 52 weeks Pulmonary Rehab are a small team with several vacancies across registered, non-registered and admin. Performance for March was 66.09% with 2 patients waiting over 52 weeks, both of which have now been seen. Dental has continued to face challenges with consistent theatre provision across in SATH but progress has started to be made on this which should enable greater consistency in access to capacity required to sustain recovery. Podiatry's performance has started to dip due challenges with sickness within the team. There is some recruitment being proposed to bolster the administrative provisison which will support improvement in data quality and clinic utilisation alongside supportiung staff who are off sick to return to work once able to do so. There are other services that contribute to not meeting this target, including Adult Physio, APCS, Bridgnorth Hospital - Day Surgery Unit, Care Transfer Hub, Children in Care, Community Neuro Rehabilitation Team, Continence Specialist Nursing, Long Covid Service, Paediatric Physiotherapy, School Age Immunisation Service, Wheelchair Services, Community Outpatients

		Start Date	End Date	Status	Outcome
	Due to additional external Local Authority funding the CDC subcontracting initiative has been extended. A further 20 appointments have been procured to be delivered by end of Jan 2026.	Nov-25	Feb-26	Off Track	**April 26 Update** A further 10 appointments were procured, the company did not have capacity to commence mid March however are working with SCHT to schedule in over next 6-8 weeks. **March 26 Update** Further subcontracting arrangements have now been agreed. Appointments being allocated to build capacity. Additional appointments will aim to commence from mid March. **February 26 Update** Service are exploring extending the offer beyond the 20 appointments with the current procured providers.
	Transformation of clinical pathways for MSST, including focus on community appointment days (CAD), superclinics and blitz clinics.	Feb-26	Jun-26	On Track	**April 26 Update** Internal SCHT operational meeting now implemented to help support traction on implementation of the new pathways with particular focus on community appointment days. **March 26 Update** Continue to work up a CAD day at Euston House but no confirmed date at present. **New Action** SCHT taking the lead on implementation of a CAD day at Euston House, with the aim of May 26. Review of potential superclinics but with radiology support on the day.
	Focus on MSST level 2 to support increased activity with review of templates across SCHT, then SATH and finally RJAH with the aim to improve clinic utilisation and increased activity to drive down recovery.	Feb-26	May-26	On Track	**April 26 Update** Internal SCHT operational meeting now implemented to help support traction on supporting improving utilisation. SCHT templates have been reviewed, next step is to make changes to increase number of new appointments. Additionally a large number of SMS have been sent to patients to supporting increaseing the booking horizon. **March 26 Update** Data pulled together that shows potential for 25% increase in new activity. Working on revising templates across SCHT and SATH. **New Action** New/FU data provided by informatics supporting a review of clinic templates to support improved productivity and increased activity.
	MSST Service reviewing and implementing new ways of working with booking of capacity inlcuding use of Dr Doctor, increasing booking horizons and ensuring correct rules with booking order.	Apr-26	Jun-26	On Track	**New Action** Focus on ensuring correct rules followed throughout booking process to ensure better utilisation imporved data quality
	Workforce Managmeent - Working with finance to review annual turnover and the potential to over recurit to ensure fill capacity throughout the year	Apr-26	Jun-26	On Track	**New Action** Regular reduction in capacity available due to number of vacancies carried throughout year.

Action Plan					
	GPwPER recruitment within APCS to support both Gynae and ENT	Dec-25	Jun-26	On Track	**April 26 Update** Still awaiting start date for Gynae GPwER. GPwER ENT interviews were succuesfull with one candidate accepting the role and another to be over recruited to support the longer term transformational plan and recovery of backlog. **March 26 Update** Awaiting start date for Gynae GPwER. ENT GPwER in recruitment process. **February 26 Update** Successful interview of Gynae GPwPER so awaiting recruitment process to complete and ENT out to advert currently.
	Diabetes Nursing - Reviewed admin processes, with support from planned care and identified additional admin capacity was required, being recruited to and expected trajectory of 90% by April	Oct-25	Apr-26	On Track	**April 26 Update** The group Diatetic appointments have been successful which is demonstrated through the reduction in overall numbers waiting to be seen. This now needs to be implemented within the nursing element of the service. Continue to explore digital solutions for admin efficiencies. **March 26 Update** Piloting group contacts for both dietician and nursing appointments. Also exploring digital solutions through Synertec for communications, to help release admin capacity for other work **February 26 Update** Further improvment works undertaken on admin process, review of processes in line with access policy. Review being undertaken to establish if group contacts would be beneficial.
	Diabetes Nursing - recruitment of clinical vacancies	Nov-25	Mar-26	Off Track	**April 26 Update** Awaiting start date for fixed term contract at Band 6. **March 26 Update** 0.7 WTE Band 6 has started in post, current 0.6 WTE recruitment still in process and will be increased to 1 WTE with fixed term contract monies to support performance **February 26 Update** 0.8 WTE Band 6 starts w/c 16th Feb. 0.6 WTE awaiting start date
	Pulmonary rehab. workforce review underway and recruit to admin vacancy to support clinic utilisation.	Dec-25	Feb-26	Off Track	**April 26 Update** Admin is now in post as of 13th April. Awaiting banding panel for band 5 Physiotherapist. Band 3/4 rebanding process under way. **March 26 Update** Admin post recruited to, awaiting start date. Workforce review complete, band 5 Job Description submitted to banding panel. Band 4 Job Description submitted to DCM for review. **February 26 Update** Post has been advertised externally with interviews taking place 11th February. Service lead linking with Lead AHP and conducted a workforce review including job descriptions for technicians. Vacancies for technician roles are going out to advert following recent approval at VRF

	Action	Start	Due	Status	Update
	Community Paediatrics Job planning - Group session planned for January to support continued improvement.	Jan-26	Feb-26	Closed	**April 26 Update** No further update, suggest closing action down as not directly linked to improving performance as 1st round of Job plans all complete. Expectation next round would invovle wider group model support. **March 26 Update** No further progress made yet but further communication with SATH re next steps. Likely to be post April once group model is embedded. **February 26 Update** Group session complete; identified some areas that require further understanding and input. Next step - seek support from SaTH. Risk of non-implementation by April 2026
	Children's Speech and Language Therapy to develop new ways of working	Feb-26	Jun-26	On Track	**April 26 Update** We continue to embed the new clinical pathways and onboard new staff. **March 26 Update** New clinical pathways for different cohorts of CYP requiring interventions have commenced. Onboarding of new staff continues. Training has been identified to facilitate SLT's being able to work across clinical pathways. **New Action** Following the successful recruitment, the service are reviewing new ways of working to streamline processes
	Further roll out of T-PRO across community outpatients	Dec-25	Mar-26	Complete	**April 26 Update** All consultants now have a licence and access via mobile devices. Action complete. **March 26 Update** Ongoing implementation across all specialities dependant on when consultants are scheduled to attend clinic. **February 26 Update** This has now started and is being rolled across all consultants in community outpatient providing greater oversight to operational team
	Review of options to support improving APCS with potential short term support and long term aim involving the system wide transformation project.	Feb-26	Apr-26	On Track	**April 26 Update** Overtime planned throughout April/May to support and this has now commenced in April. **March 26 Update** Overtime now planned for April/May to support recovery. Longer term, the transformation project continues to progress with potential for over-recruitment in APCS ENT to support current recovery but pre-empt shift in demand. **New Action** Options to improve activity with review of clinic templates, review of waiting list and review of potential locum options. Longer term plan to continue to work on system wide ENT transformation project.

	Action	Start	End	Status	Update
	Agree sustainable and consistent Dental theatre provision via SATH.	Feb-26	Apr-26	On Track	**April 26 Update** Meeting has taken place with SATH and agreement to work together to ensure equity of access to theatre provision to support the longest waiting patients. SATH have agreed to support improving list efficiency and consistency of lists. **New Action** Feb meeting took place with initial support from SATH to review current situation and provide additional support.
	Podiatry workforce recuritment, immediate support with longer term review planned to ensure standardisation of admin structure/oversight across Planned Care services.	Apr-26	Jun-26	On Track	**New Action** Recruit to vacant administrative roles to support improvement in clinic utilisation and data quality and release additional clinical capacity that supporting some admin tasks currently.

Author	Alastair Campbell/Helen Cooper/Gemma McIver/Sally Stubbs	**Date**	13/04/2026	
Accountable Officer Approval	Claire Horsfield	**Date**	24/04/2026	

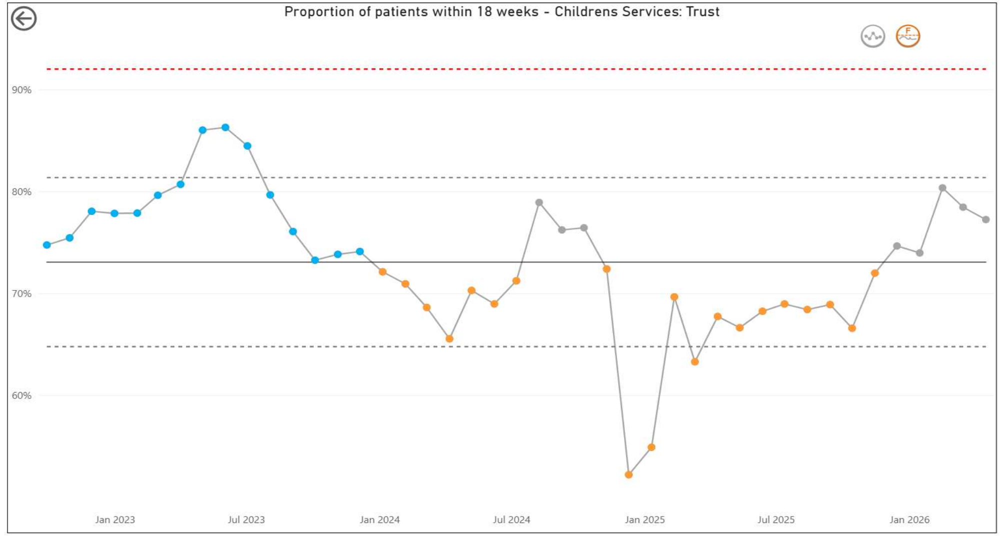
Exception Report - Action Plan

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	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Proportion of patients within 18 weeks - Children's Services	%	71.98%	74.64%	73.95%	80.35%	78.45%	77.23%	77.23%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

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



Reason for performance gap:

Performance has dropped by 1.22% in March but remains ahead of trajectory. Trajectory has been updated to reflect the trajectory submitted in the Operational Plan for 2026-27.

Key Services Impacting Performance
- CDC (Children's Development Centre)
- Dental
- Community Paediatrics
- Children's Speech and Language

Revised recovery trajectories have been established for each, and progress is being closely monitored through action plan workshops and local performance meetings. Every service, including both RTT (Referral to Treatment) and non-RTT reportable areas, has a robust, aligned recovery plan to ensure equitable provision.

Speech and Language Therapy: Ongoing improvements have continued, with early intervention and revalidation initiatives reducing the number of children waiting over 52 weeks to zero as of January and maintained in February/March.

For CDC and Comm Paeds core focus to recover is through the Coral House Estates reconfiguration which will support the maximising of clinic space to increase clinics as part of recovery.

Dental has continued to face challenges with consistent theatre provision across in SATH but progress has started to be made on this which should enable greater consistency in access to capacity required to sustain recovery.

There are other services that contribute to not meeting this target, including Children in Care, Paediatric Physiotherapy, School Age Immunisation Service, Wheelchair Services.

Action Plan		Start Date	End Date	Status	Outcome
	Due to additional external Local Authority funding the CDC subcontracting initiative has been extended. A further 20 appointments have been procured to be delivered by end of Jan 2026.	Nov-25	Feb-26	Off Track	**April 26 Update** A further 10 appointments were procured, the company did not have capacity to commence mid March however are working with SCHT to schedule in over next 6-8 weeks. **March 26 Update** Further subcontracting arrangements have now been agreed. Appointments being allocated to build capacity. Additional appointments will commence from mid March. **February 26 Update** Service are exploring extending the offer beyond the 20 appointments with the current procured providers.
	Community Paediatrics Job planning - Group session planned for January to support continued improvement.	Jan-26	Feb-26	Closed	**April 26 Update** No further update, suggest closing action down as not directly linked to improving performance as 1st round of Job plans all complete. Expectation next round would invovle wider group model support. **March 26 Update** No further progress made yet but further communication with SATH re next steps. Likely to be post April once group model is embedded. **February 26 Update** Group session complete; identified some areas that require further understanding and input. Next step - seek support from SaTH. Risk of non-implementation by April 2026
	Children's Speech and Language Therapy to develop new ways of working	Feb-26	Jun-26	On Track	**April 26 Update** We continue to embed the new clinical pathways and onboard new staff. **March 26 Update** New clinical pathways for different cohorts of CYP requiring interventions have commenced. Onboarding of new staff continues. Training has been identified to facilitate SLT's being able to work across clinical pathways. **New Action** Following the successful recruitment, the service are reviewing new ways of working to streamline processes
	Agree sustainable and consistent Dental theatre provision via SATH.	Feb-26	Apr-26	On Track	**April 26 Update** Meeting has taken place with SATH and agreement to work together to ensure equity of access to theatre provision to support the longest waiting patients. SATH have agreed to support improving list efficiency and consistency of lists. **New Action** Feb meeting took place with initial support from SATH to review current situation and provide additional support.

Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	13/04/2026
Accountable Officer Approval	Claire Horsfield		24/04/2026

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	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Percentage of patients waiting over 52-weeks for community services	%	0.46%	0.35%	0.05%	0.06%	0.05%	0.05%	0.05%
	Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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

Reason for performance gap:

There has been consistent and significant improvement in reducing 52 weeks over a sustained period, this month recovery hasnt continued to improve and is no longer meeing the trajectory.

Of the 4 patients at 52 weeks, plans are in place for the remaining patients to be seen in April

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.

<table>
<tr><td rowspan="3">Action Plan</td><td></td><td>Start Date</td><td>End Date</td><td>Status</td><td>Outcome</td></tr>
<tr><td>Pulmonary rehab. workforce review underway and recruit to admin vacancy to support clinic utilisation.</td><td>Dec-25</td><td>Feb-26</td><td>Off Track</td><td>April 26 Update
Admin is now in post as of 7th April. Awaiting banding panel for band 5 Physiotherapist. Band 3/4 rebanding process under way.

March 26 Update
Admin post recruited to, awaiting start date. Workforce review complete, band 5 Job Description submitted to banding panel. Band 4 Job Description submitted to DCM for review.

February 26 Update
Post has been advertised externally with interviews taking place 11th February. Service lead linking with Lead AHP and conducted a workforce review including job descriptions for technicians. Vacancies for technician roles are going out to advert following recent approval at VRF</td></tr>
<tr><td>Support Service Leads to ensure waiting list validation is conducted in line with wait profile improvements e.g. as we move the targets to 40 weeks</td><td>Feb-26</td><td>Jun-26</td><td>On Track</td><td>April 26 Update
New KPI for 30/40 weeks were approved at Board. This shows the profile is moving and this will support further reduction in waits

March 26 Update
Mesure review is reccommending new KPIs at 30 weeks and 40 weeks. Reporting will support operational leads in reviewing waits against the new KPI

New Action
Targets for high waits will be reduced to support a movement back to performance within 18 weeks. Raising awareness through arenas such as weekly huddles and performance meetings to ensure services regularly validate the wait position. Validation meeting in diaries prior to formal submission to ensure accuracy and senior oversight for escalation.</td></tr>
<tr><td>Author</td><td>Alastair Campbell/Helen Cooper/Gemma McIver/Sally Stubbs</td><td>Date</td><td>13/04/2026</td><td rowspan="2" colspan="2"></td></tr>
<tr><td>Accountable Officer Approval</td><td>Claire Horsfield</td><td></td><td>24/04/2026</td></tr>
</table>

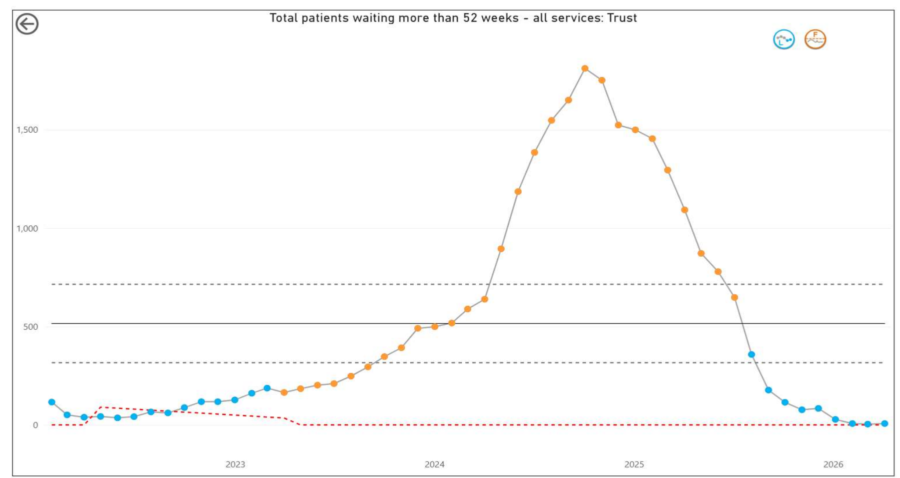
Exception Report - Action Plan

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	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
52+ Week waits - All services	Number	77	84	28	7	4	7	7
	Target	0	0	0	0	0	0	0

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Number	2	0	0	0	0	0	0	0



Reason for performance gap:	There has been consistent and significant improvement in reducing 52 weeks over a sustained period, this month recovery hasnt continued to improve and is no longer meeing the trajectory. Of the 7 patients at 52 weeks, plans are in place for the remaining patients to be seen in April For the Adults services there will be an increased focus on validation, data quality and PTL tracking to ensure any data quality issues are highlighted and updated prior to census at month end.

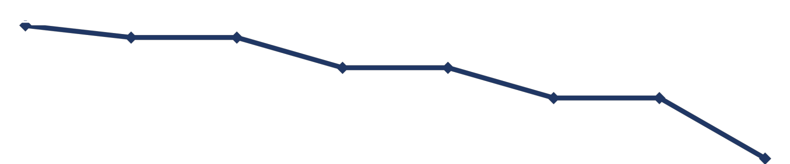
Action Plan		Start Date	End Date	Status	Outcome
	Pulmonary rehab. workforce review underway and recruit to admin vacancy to support clinic utilisation.	Dec-25	Feb-26	Off Track	**April 26 Update** Admin is now in post as of 7th April. Awaiting banding panel for band 5 Physiotherapist. Band 3/4 rebanding process under way. **March 26 Update** Admin post recruited to, awaiting start date. Workforce review complete, band 5 Job Description submitted to banding panel. Band 4 Job Description submitted to DCM for review. **February 26 Update** Post has been advertised externally with interviews taking place 11th February. Service lead linking with Lead AHP and conducted a workforce review including job descriptions for technicians. Vacancies for technician roles are going out to advert following recent approval at VRF
	Support Service Leads to ensure waiting list validation is conducted in line with wait profile improvements e.g. as we move the targets to 40 weeks	Feb-26	Jun-26	On Track	**April 26 Update** New KPI for 30/40 weeks were approved at Board. This shows the profile is moving and this will support further reduction in waits **March 26 Update** Mesure review is reccommending new KPIs at 30 weeks and 40 weeks. Reporting will support operational leads in reviewing waits against the new KPI **New Action** Targets for high waits will be reduced to support a movement back to performance within 18 weeks. Raising awareness through arenas such as weekly huddles and performance meetings to ensure services regularly validate the wait position. Validation meeting in diaries prior to formal submission to ensure accuracy and senior oversight for escalation.
Author	Alastair Campbell/Helen Cooper/Gemma McIver/Sally Stubbs	**Date**	13/04/2026		
Accountable Officer Approval	Claire Horsfield		24/04/2026		

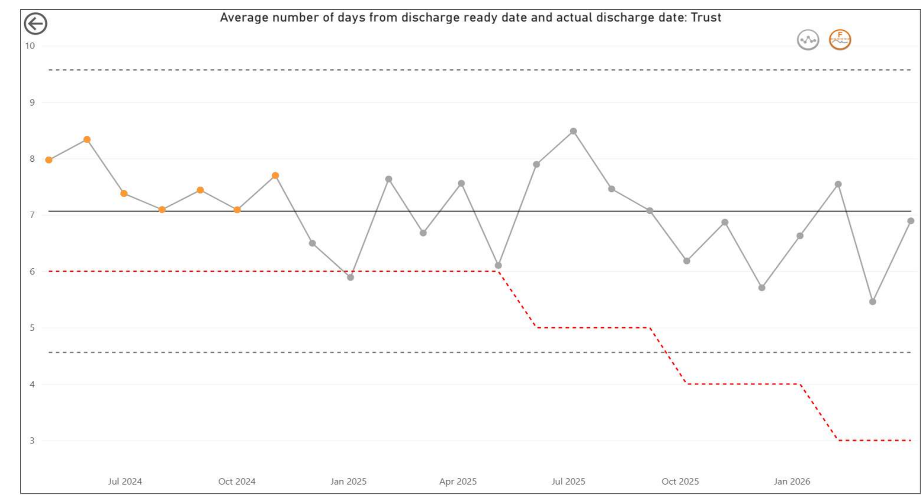
Exception Report - Action Plan

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

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Average number of days from discharge ready date and actual discharge date	Number	6.9	5.7	6.6	7.5	5.5	6.9	6.9
	Target	4.0	4.0	4.0	3.0	3.0	3.0	3.0

Trajectory	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
%	6.20	6.00	6.00	5.50	5.50	5.00	5.00	4.00





Reason for performance gap:	
	NCTR performance is currently below target but in February 26 the performance was in line with the expected improvement trajectory. Unfortunately this performance was not sustained due to a Norovirus outbreak which impacted upon overall patient flow and increased length of stay. There has also been an increase in patients admitted to Community hospital Pathway 2 beds with high levels of social complexity. Pathway 3 availability is limited resulting in more patients with NCTR remaining in hospital beds while a placement is found. The improvement plan is making progress and is being managed by a dedicated task and finish group, with support from the wider system. Oversight of this workstream is provided by the UEC Delivery Group as part of the complex discharge improvement plan. Continued progress depends significantly on engagement from local authorities and ensuring that suitable patients are admitted to community hospitals. A major risk to sustaining improvement, especially during winter, is the national rise in Flu and Covid cases. This could increase the risk of patient deconditioning and require more intensive care following discharge, leading to additional delays and longer length of stay. To address this, enhanced infection prevention and control (IPC) measures have been introduced, including daily IPC support, mandatory red mask use, and consolidating ‘red to green’ and ‘no criteria to reside’ meetings into a single daily meeting. This change is designed to free up clinical therapy time and provide more focused rehabilitation support on wards, fostering a stronger rehabilitation culture and minimising unnecessary internal delays.

<table>
<tr><th rowspan="3">Action Plan</th><th></th><th>Start Date</th><th>End Date</th><th>Status</th><th>Outcome</th></tr>
<tr><td>Following a shift in profile from pathway 3 to pathway 2 an audit of pathway 2 patients is being completed to review their outcomes. This will enable a greater understanding of the types of patients who achieve the best outcomes on pathway 2.</td><td>Nov-25</td><td>Apr-26</td><td>Complete</td><td>April 26 Update
Pathway 2 audit completed by Care transfer Hub lead Therapist October-December 25- full report presented to CTH lead. Improvement initiatives and service delivery actions are being added to the CTH Service delivery plan and STW system transformation program pillar 3- discharge transformation and capacity release for 26/27 submission week of 21/4/26 system sign off

March 26 Update
Data demonstrates that Pathway 3 demand has reduced however length of stay waiting pathway 3 has increased. Detail to be shared with local authority and scope for how a discharge to assess model for pathway 3 could be established.

February 26 Update
Outcomes of data currently being reviewed and findings will now pull into a system owned improvment plan overseen via UEC Delivery Group.</td></tr>
<tr><td>Condense the NCTR daily oversight calls at ward level to once a day to reduce duplication, align RIO oversight and release time back to care for therapy staff</td><td>Dec-25</td><td>Apr-26</td><td>On Track</td><td>April 26 Update
Creation of standard operatng procedure for NCTR to standardise practices and release efficiencies across all inpatient units. Adults Operational Lead and Clinical Services Manager now co-chair daily NCTR call.

March 26 Update
Form went live on 4th March. Initial feedback is positive and new front end report is in place for the daily oversight calls. Action remains open to monitor impact

February 26 Update
Rio form has been developed and has been tested by the service. Go live for new process 4th March</td></tr>
<tr><th>Author</th><td>Sam Townsend / Sarah Robinson / Sally Stubbs / Gemma McIver</td><th>Date</th><td colspan="2">13/04/2026</td><td rowspan="2"></td></tr>
<tr><th>Accountable Officer Approval</th><td>Claire Horsfield</td><td></td><td colspan="2">24/04/2026</td></tr>
</table>

Appendix 1

Quality and Safety Committee - SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Quality & Safety Committee	Patient Safety	Category 3 Pressure Ulcers	2026-03-31		2	0	2	2	0	2	
Quality & Safety Committee	Patient Safety	Category 4 Pressure Ulcers	2026-03-31		4	0	4	4	0	4	
Quality & Safety Committee	Effectiveness and experience of care	Complaints - (Open) % within response timescales	2026-03-31		100.00%	95.00%	5.00%	92.03%	95.00%	-2.97%	
Quality & Safety Committee	Effectiveness and experience of care	CQC Conditions or Warning Notices	2026-03-31		0	0	0	0	0	0	
Quality & Safety Committee	Patient Safety	Deaths - unexpected	2026-03-31		1	0	1	1	0	1	
Quality & Safety Committee	Patient Safety	Falls per 1000 Occupied Bed Days	2026-03-31		5.73	4.00	1.73	5.73	4.00	1.73	
Quality & Safety Committee	Patient Safety	Medication Incidents with Moderate Harm	2026-03-31		0	0	0	17	0	17	
Quality & Safety Committee	Patient Safety	NHS Staff Survey - raising concerns sub-score	2026-03-31		6.83	7.08	-0.25	6.83	7.08	-0.25	
Quality & Safety Committee	Patient Safety	Patient Safety Incident Investigations	2026-03-31		1	0	1	11	0	11	
Quality & Safety Committee	Patient Safety	Rates of Healthcare Associated Infection (C-Difficile)	2026-03-31		275.00%	100.00%	175.00%	275.00%	100.00%	175.00%	
Quality & Safety Committee	Patient Safety	Rates of Healthcare Associated Infection (E-Coli)	2026-03-31		0.00%	100.00%	-100.0...	0.00%	100.00%	-100.0...	
Quality & Safety Committee	Patient Safety	Rates of Healthcare Associated Infection (MRSA)	2026-03-31		0	0	0	0	0	0	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2026-02-28		104%	95%	9%	104%	95%	9%	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2026-02-28		103%	95%	8%	103%	95%	8%	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Day	2026-02-28		104%	95%	9%	104%	95%	9%	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Night	2026-02-28		105%	95%	10%	105%	95%	10%	

APPENDIX 2

Exception Report - Action Plan

Clostidium difficile infection rate

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

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD (Rolling 12 months)
Clostidium difficile infection rate	Number	13	11	10	8	10	11	11
	Target	4	4	4	4	4	4	4

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

Narrative/Description:

There has been two cases of C-Difficile reported in March, one at Whitchurch Community Hospital and one at Ludlow Community Hospital.
The rolling 12 months total now stands at 11 and there have been 11 cases YTD against an annual threshold of 4. A Post Infection Review/After Action Review is completed for each case with many patients having been on multiple courses of antibiotics for other infections identified as the most probable cause, individual feedback is given to prescribers and they are encouraged to attend the case reviews. Quarterly thematic reviews will continue for 26/27 to identify improvements in systems and processes required with actions monitored below and via the IPC Improvement plan. Ribotyping is requested in all cases. A rolling deep clean programme is in place across all Community Hospital sites.

The eleven cases YTD for 2025/26 are:
April: Ward 36 x 2 and Ludlow x 1
May: Ludlow x 1
July: Whitchurch x 1
August: Ludlow x 1
December: Whitchurch x 1
February 2026: Whitchurch x 2
March 2026: Whitchurch x 1 Ludlow x 1

n Plan

	Start Date	End Date	Status	Outcome
Create visual aids (videos or posters) on how to clean key pieces of equipment (i.e. beds)	Jun-25	~~01/08/2025~~ April-26	In progress	On recent audit over 10 types of bed in use across all 4 sites. Locality Clinical Managers working to standardise to one type of bed so video on how to clean can be produced.
Introduce disinfectant decontamination processes following identification of patients with diarrhoea as undiagnosed patients and carriers may excrete the organism into the environment.	Aug-25	Sep-25	Complete	What Cleaning Product' Posters produced
SIGHT or alternative posters capturing need for timely stool sample collection displayed in all inpatient community hospital sluices	Sep-25	~~01/10/2025~~ November 2025	Complete	Poster has been shared across all 4 inpatient Community Hospitals

Actio	Use of AAR template/poster to disseminate and embed learning across Community Hospitals	Sep-25	~~01/12/2025~~ April 2026	In progress	Draft document has been circulated for comment
	Extend HCAI/Outbreak meeting to Medical staff to ensure timely feedback of antibiotic stewardship and to ensure regular clinical reviews/assessments of patients with CDiff carrier status	Sep-25	Oct-25	Complete	
	Fidaxomycin for CDI relapse cases to be added to Trust Antibiotic guidelines	Aug-25	Sep-25	Complete	
	E-learning module to raise awareness of identification, assessment and treatment of CDI	Sep-25	Mar-26	Complete	E-learning modeule identified by IPEAT. Link circulated to all Ward Managers, Deputy Ward Managers and Medical staff for Community Hospitals by DDIPC
	Review implementation of bedspace cleaning checklist	Sep-25	Dec-25	Complete	Via IPC QAA
	Ensure Housekeeper roles and responsibilities are mapped to daily/weekly/monthly and are consistent across all sites to support with environmental decontamination	Sep-25	May-26	In progress	
Author	IPC team	**Date**	16/04/2026		
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	**Date**	16/04/2026		

Exception Report - Action Plan

Deaths - Unexpected

Deaths - Unexpected

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Latest Month
Deaths - unexpected	Number	2	0	2	1	2	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

Narrative/Description:

In accordance with the Trust's Learning from Deaths Policy, all deaths that are unexpected are required to be added to the Trust's Incident Reporting System and a Learning from Death Review Completed. There was 1 unexpected death recorded in March. This related to a self inflicated Death of a Patient in Custody at HMP Stoke Heath. The incident was presented at Patient Safety Incident Panel and a full patient safety incident investigation has been comissioned by way of a learning response. The Governance Team continue to monitor all deaths recorded at point of triage so that appropriate consideration through PSIP where indicated in accordance with Trust Policy and Procedure.

		Start Date	End Date	Status	Outcome
Action Plan	Request Benchmarking data for similar Community Trusts	Oct-25	Apr-26	In Progress	Will be in Q4 Learning from Deaths report. To review whether benchmarking data can be extended to Virtual Wards.
	Virtual Ward deep dive for QSC to include review of deteriorating patient/escalation and safety netting	Oct-25	Feb-26	Complete	VW deep dive includes 6 clinical case reviews

Author	Amy Fairweather - Governance Manager - Patient Safety and Risk Management	**Date**	15/04/2026
Accountable Officer Approval	Dr Mahadeva Ganesh	**Date**	16/04/2026

Exception Report - Action Plan

Category 4 Pressure Ulcers

The number of Category 4 Pressure Ulcers developed in service

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

Trajectory	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Number	1	1	1	1	1	1	1

Narrative/Description:

In March 2026 there were 4 Category 4 pressure ulcer reported in-service. Themes associated with these reported pressure ulcers were complex co-morbidities and approaching end of life, the teams are also experiencing issues with patient concordance with equipment and repositioning, ADDER and Self-neglect framework being utilised to support issues. The Tissue Viability Team continues to support the IDT through monthly caseload review meetings and a consistent presence on community hospital wards to assist staff with classification. The TV team are also seeing an increase in referrals from community teams due to complexity to wounds this resulting in deterioration, support is being given daily via Triage and telemedicine advice. Following discussion with regional TV Nurse network, local community teams are also seeing increases in pressure ulcer numbers and deterioration and wider thematic review to be planned as a region to establish themes and actions to support.

Action Plan

Action	Start Date	End Date	Status	Outcome
Further PURPOSE T sessions planned for 2026 to support clinical teams	Jan-26	Dec-26	In Progress	
Monthly caseload meetings with IDT teams to support complex cases and pressure ulcers	May-25	Dec-25	Complete	This is ongoing throughout the year
Documentation update for community nurses re-introducing aSSKINg into notes (this comes as an action from PSII)	Oct-25	Apr-26	In Progress	Slight delays due to capacity within TV lead role and also community teams
TV sessions added to Core Clinical Skills week throughout 2026 - am - Pressure ulcer prevention and management, PM - Wound assessment/recognising the deteriorating wound	Jan-26	Dec-26	In Progress	
Liaise with Medequip as community equipment provider to increase stock of specialist equipment and add Community Nursing generic email addresses on order forms to lessen the risk of delays in equipment orders.	Feb-26	Apr-26	In Progress	

Author	Jodie Jordan - Tissue Viability Service Lead	**Date**	16/04/2026
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	**Date**	17/04/2026

Exception Report - Action Plan

Category 3 Pressure Ulcers

The number of Category 3 Pressure Ulcers developed in service

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

Trajectory	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Number	1	1	1	1	1	1	1

Narrative/Description:

There were 2 Category 3 pressure ulcers reported in-service in March 2026, issues around complexity of patients and concordance which is resulting in wound deterioration . The Tissue Viability team continue to support community teams and wards with education and caseload management

Action Plan

Action	Start Date	End Date	Status	Outcome
PURPOSE T sessions for clinical staff to attend in 2026	Jan-26	Dec-26	In Progress	
Monthly caseload meetings with IDT teams to support complex cases and pressure ulcers	May-25	Dec-25	Complete	This is ongoing throughout the year
TV sessions added to Core Clinical Skills Week for 2026 - AM - PU classification and PM - wound assessment and recognising the deteriorating wound	Feb-26	Dec-26	In Progress	

Author	Jodie Jordan - Tissue Viability Service Lead	**Date**	16/04/2026
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	**Date**	17/04/2026

Exception Report - Action Plan

Falls per 1000 occupied bed days

Falls per 1000 occupied bed days

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Latest Month
Falls per 1000 OBDs	Number	3.60	6.10	7.69	4.64	9.30	5.30	5.30
	Target	4	4	4	4	4	4	4

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Number	4.00	4.00	4.00	4.00	4.00	4.00	4.00

Narrative/Description:

In March 2026 there were 13 inpatient falls reported within our Inpatient Community Hospital wards, this is a decrease of 7 falls from our last monthly report (February 2026 = 21 reported falls, note: last month repored as 20 however, an additional fall for LCH ward was reported in March 2026 but it occured in February 2026). This equates to a Trust rate of 5.3 per 1000 Occupied Bed Days (OBDs) which, has decreased from 9.3 falls per 1000 OBD's last month however, it remains above our Trust target of 4.0 falls per 1000 OBD's. The range of falls per 1000 OBD's is BNCH 6.7 (previous month 5.9); LCH ward 5.3 (previous month 9.7); BCCH ward 4.7 (previous month 21.7) and WCH 4.7 (previous month 5.9). Two wards had patients who fell multiple times - BCCH and BNCH both had 1 patient that fell twice in the month of March 2026. It is is to be noted that the overall Trust rate and all 4 sites have reduced their falls per 1000 OBD's and in the first week of March 2026 we launched Ramblegard digital falls sensors across all wards; BCCH have seen the largest impact of this roll out with their number of falls and falls per 1000 OBD's.

Quarter 4 summary: For Quarter 4 of 2025/6 BCCH ward varied in falls per 1000 OBD's from 21.6 in February, 4.7 in March and 2.5 in January - their Q4 average rate was 9.2 falls per 1000 OBD's; BNCH ward varied in falls per 1000 OBD's with 6.7 in March, 5.9 in February and 3.9 in January - their Q4 average rate was 5.4 falls per 1000 OBD's; LCH ward varied in falls per 1000 OBD's from 9.7 in February, 5.3 in March,and 0 in January - their Q4 average was 5.0 falls per 1000 OBD's, the nearest achieved to the the Trust KPI target of 4.0; WCH ward varied in their falls per 1000 OBD's from 10.7 in January, February 5.9 and March 4.7 - their Q4 average was 7.2 falls per 1000 OBD's.
Overall Trust summary: The majority of falls in March were classified as found on floor 5/14, 36% (previous month 30%) and the category Fall from bed / chair / trolley has reduced to 3/14 21% contiuing downward trend from last month. It is to be noted that BCCH ward and BNCH ward had no falls from bed in March 2026. The majority of falls were classified as no or low physical harm, 92% (12/13) which, has improved from 76% last month. There were no moderate physical harms. There is one serious harm, a fall on WCH ward that has lead to a hip fracture, this will be reportable to National Audit of Inpatient Falls (NAIF) and it has been identified for a full Patient Safety Incient Investigation (PSII). In March the majority of falls were recorded as no to low psychological harm, 92% (12/13) , which is an improvement from 82% last month and there was only one severe psychological harm which was the fall leading to a fracture on WCH ward. This month 62% of falls were unwitnessed which is a slight increase from 60% last month. The majority of our falls occur during the day 9/13, 69% however, WCH and BNCH wards are flagging as an outlier as 50% of their falls 2/4 occur at night. Of the 13 falls 3 ambulances were called to our inpatient wards, resulting in 2 being sent to an acute hospital, this is 6 less conveyances than last month.To be highlighted the severe fall at WCH was discussed at PSIP on 08/04/2026, a summary of actions are:Health & Safety team contacted to confirm if RIDDOR reportable; Health Hero and WMAS to be included in learning response; Patient's first fall to also be included in learning response and PSII confirmed.

The reduction of falls aim is linked to the wider ETOC programme and improvement plan which has oversight at Patient Safety Committee (PSC). The Quarterly falls thematic review is due in May to PSC.

Action	Start Date	End Date	Status	Outcome
Digital falls equipment - ramblegard pilot at Bridgnorth and Whitchurch community hospital	Jan-25	Jan-26	Completed	**March Update:** Ramblegard bed and chair sensors delivered to all inpatient wards week commencing 2/3/2026- 5 units at LCH ward; 4 units each at BNCH and WCH ward and 3 units at BCCH ward. Outcomes and impact of the sensors will be tracked through the monthly and quarterly falls reports and a QI project to review the implementation of the sensors.

Action Plan	**Dementia friendly environment standardisation QI project** - Phase 1) Ludlow Phase 2) Bishop's Castle Phase 3) Bridgnorth Phase 4) Whitchurch 5) MIU's	Jun-25	Jun-26	In Progress	**March update:** Site visits have occurred to secure a quote for multiple sites for the work to go ahead as 3 out of 4 wards have secured funding to support this QI project renovations. SCHT MIU's that have flagged they would like to work with the project group to review their patient areas from a dementia friendly perspective so potential to combine WCH MIU with inpatient ward site visit. Further funding agreed at Charitable Funds Committee to support this workstream **April update** - Ludlow installation due to take place in May, funding for other sites all presented and awaiting for decision
	Moderate falls learning - Improve pro-active learning from moderate falls within inpatient wards Phase 1) Bishop's Castle Ward 2) Whitchurch	Sep-25	Apr-26	In progress	**April Update:** Clinical Quality Lead has established capacity to do a weekly datix review of falls rather than monthly process to support more timely connection with the wards. Governance team to alert Clinical Quality Lead to any falls with moderate harm and are exploring a Quality Dashboard. Clinical Lead for quality attends weekly governance triage of Datix meetings. Clinical Lead for Quality prepared for PSIP a timeline report for a fracture on BNCH ward to support PSRIF culture of reflections and learning that occured on 11/3/2026 following a datix submitted in Feburary 2026. Clinical Lead for Quality is supporting Patient Safety Team and Clinical Governance team with chasing of quality of falls datix re: missing information, lesson learnt updates and updates re: 999 calls and conveyance to Acute Hospital. Clinical Lead for Quality attended WCH ward on 14/4 to meet LCM, Ward Manager and registered nurses to review falls assessment and care planning, provide NAIF 2025 summary, 25/26 falls trend sumnmary and review bed rails asssesment and processes.
	Falls under-reporting audit - as per RCP Guidance within NAIF	Oct-25	Jan-26	Completed	**March update:** Falls under-reporting audit report to be presented by Sarah Venn (Clinical Lead for Quality) on behalf of Hayley Grice (Clinical Lead for Quality) at Divisional Governance meeting 17/2/2026 prior to the following PSC meeting. Await Divisional and PSC feedback on shared actions.
	NICE guidance - SCHT endorse the most recent NICE falls guidance (April 2025) that all inpatients are classed as high risk of falls due to their inpatient needs therefore, there is an expectation to improve implementation of a multifactoral falls assessments for all inpatients which, will require an MDT approach.	Sep-25	Jul-26	in progress	**April Update:** The recent falls survey of clinical staff (Nursing and AHP) confidence and competence one theme within the survey was: the current falls training offer has had feedback it is insufficient, with staff requesting more training on falls, dementia, FRAX, continence, dizziness and MUST. We have scoped with SaTH the Bedside Mobility Assesment tool (BMAT) after they attended our falls meeting and the RIO team have now built this within RIO for us to pilot with the UCR teams - Rapid Response and Virtual Wards in due course. We have on-going meetings with the UCR Team Leads as we see that part of the falls pathway as an area to pilot a new approach to falls screening and assessment, we would aim to pilot this by July 2026. Clinical Lead for Quality has met with the education team on 10/4 to feedback on the falls training feedback from the survey.
	Hydration QI project - Now launched as of 3/11/25 across all wards. First audit due first week of December 2025 with initial results to be presented	Nov-25	Feb-26	Completed	**March update:** Re-audit sharing of results with ward staff postponed as Quality presence at Ward Manager meeting cancelled. SCHT Trust engaging with Nutrition and Hydration week, week commencing 16/3/2026 with Executive visits planned in across Community Hospital and Community services bases; themes per day; Quality, Education and IPEAT visits as well as SLT stand at WCH site and ABBOT rep visits.

	Anti-slip Hospital Socks - evidence for and against hospital anti-slip socks shared with Director of Nursing, Deputy Director of Nursing and Head of Quality on 10/12/2025 who are supportive of a QI project to cease use of hospital anti-slip socks across all inpatient wards. Deadline for roll out 1/4/2026 however, due to lack of source of funding and time for a sustainable QI plan his has been extended to October 2026.	Nov-25	Oct-26	In progress	**March Update**: Jayne Carter, Locality Clinical Manager has been identified as Project Lead and the QI team will facilitate and support this project with a phased approach with an aim of a hard stop from 1.4.2026. WCH have already sought to reduce stock ordering and promotion of own shoes as early adopters. We have identified key stakeholders from Nursing and Therapy teams with Therapy representatives from WCH; Care Transfer Hub (CTH) and BNCH and Nursing reps from LCH identified. We await Therapy reps from BCCH and LCH and Nursing reps from WCH, BNCH and BCCH to be identified. Potential QI funding grant source identified from The RCN Foundation Quality Improvement Project, deadline 6/4/2026. **April update** - RCN QI grant application submitted, however, not shortlisted, discussions with LCM's and podiatry over supply of new footwear.New project implementation date full roll out October 2026.
	New confusion datix category and alignment to NEWS2 scores- Within the Q2 PSC Falls Quarterly thematic review it was highlighted that 41% of falls (21 patients) had new confusion category selected within the datix submission. NEWS2 audit QI work has not identified such high levels of new confusion thus, the QI team are interested to correlate NEWS 2 charts to falls datix for specific patients regarding documentation of new confusion to deep dive this finding and share any learning.	Dec-25	Mar-26	Completed	**March update:** on-going reporting area for quarterly thematic review.
	Falls Community service(s) and falls assessment scoping - both Clinical Lead for Quality, Hayley Grice and Sarah Venn met 5/12/2025 to process map our current community services offer for falls across multiple services and identified the need for a full service review within SCHT as highlighted by the NICE guidance benchmarking that has flagged gaps in our current offer.	Dec-25	Dec-26	in progress	**March update**: The community service process map produced on 5/12/2025 has been shared with Head o Quality. We have been scoping data as it appears a large proportion of patients with falls access our Urgent Community Response (UCR) teams- Rapid Response and Virtual Ward. It is clear we do not have internally a clear falls pathway once someone is identified as at risk of falls or post-fall. In alignment set out in the latest NICE guidance for falls it is recommended that we consider a pro-active and preventation approach to falls that encompasses all services and we would recommend it is timely to commence a full service review to internally outline our falls pathway. This will require a Phased QI approach with stakeholder engagement and we have identified UCR as the first services to be reviewed with our support and we have commenced engagement with them and have a follow up meeting on 26/1/2026. Clinical Lead for Quality has mapped the current falls service offer across SCHT and shared with Lorna Watkins, Strategy Development Manager NHS Shropshire, Telford & Wrekin ICB and we continue to engage with the ICB Falls Steering group that will meet monthly. We met with UCR Team lead reps 26/2/2026 and continue to meet reguarly.
	PSC new requested action around reporting of timelines of actions taken - i.e. post falls assessment	Feb-26	Apr-26	in progress	**April update:** Clinical Lead for Quality has completed two detailed feedbacks to MDT representatives of 2 SCHT wards (LCH and BCCH), AHP, Nursing and Medical teams as well as Quality and Governance teams, regarding 2 submissions to NAIF for the 2025 audit that have been submitted to date. Comprehensive written feedback has been provided on areas of good practice and opportunities for improvement covering: Multi-factorial Assessment to Assessment to optimise Safe Activity (MASA) – reviewing vision screen; lying and standing BP screen; medication review; delirium screening; mobility screen and continence screen; Post-fall management and Post-fall review. Good practice included: timely Pharmacy reviews; nursing care planning and neurological observations post-fall. There are improvement themes for both inpatient wards regarding: use of RIO documentation rather than paper copy of forms uploaded; lying and standing BP measurements which highlights the priority for e-obs digital solution; the need for the roll out of 4AT delirium screen which, we have piloted with falls task and finish group members and are now ready to launch and timeliness of medical reviews and provision of analgesia post-fall.

	National Audit of Inpatient Falls (NAIF)	Dec-25	Mar-26	Completed	**March update:** Clinical Lead for Quality has triaged and so far forJAN-DEC 2025 they have reviewed 135 falls Datix; 3 reportable to NAIF falls identified and 2 submitted on the webtool to date (both fractured neck of femur); 2 head injuries CT scans requested from SaTH and they have now been ruled out as not applicable to the NAIF reporting criteria. 1 head injury is also to be submitted that meets the new NAIF reporting critieria. The NAIF facilities audit was completed 10/3/2026 with support of Governance Manager – Clinical Effectiveness Lead and all NAIF submissions are on track to be completed before deadline of 31/3/2026. **April update** : 2025 Audit submitted in time. To date so far there are 3 confirmed submissions and 1 possible submission for the 2026 audit: 2 for WCH ward for February 2026, 1 potential for LCH ward and 1 for WCH ward for March 2026.

Author	Hayley Grice - Clinical Lead for Quality	**Date**	17/04/2026	
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	**Date**	17/04/2026	

Exception Report - Action Plan

Medication Incidents with Moderate Harm

Number of internal medication incidents per month resulting in moderate harm

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Medication Incidents with Moderate Harm	Number	0	3	2	4	4	0	17
	Target	0	0	0	0	0	0	0

Trajectory	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Number	1	1	1	1	1	1	1

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 March 2026.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	MSO to liaise with education team regarding re-implementation of insulin documentation booklet	Sep-24	May-26	In Progress	Meeting held with Diabetes Specialist Nursing team. Agreed that best course of action was to set up a Diabetes intranet page with links to all relevant resources and guidance that would have been in insulin booklet. JMW / SH to contact GP to set this up. South west community team using something, round table discussion required to ensure standardisation, consider review of incidents ? if declined in south west as a result of using booklet. 10.03.26 - meeting taken place with JMW information requested from Datix to understand number of incidents relating to each community team, further information then requested from informatics to understand capacity and demand figures vs number of incidents. Once received will review areas of high incidents and meet with team leads to discuss further. 09.04.26 - all data now received and being analysed
	Review and update of inpatient medicines administration chart	Apr-25	Jul-26	In Progress	SW leading on review of document, multiple changes being made and different professionals involved in review, therefore, deadline extended to July 2026 for approval at Patient Safety Committee
	Discuss mechanism for feeding back concerns re: delays to palliative and end of life patients care out of hours with Health Heros	Feb-26	Feb-26	Complete	DDON met with Health Heros Associate Director of Quality on 12.02.26
Author	Clare Walgrove - Head of Quality Pam Simmons - Interim Medicines Safety Officer	**Date**	09/04/2026		
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	**Date**	17/04/2026		

Exception Report - Action Plan

Patient Safety Incident Investigations (PSII)

The number of Patient Safety Incident Investigations reported each month

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Patient Safety Incident Investigations	Number	0	0	0	0	2	1	11
	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

Patient Safety Incident Investigations: Trust

Narrative/Description:

There were 1 PSII declared for March relating to Whitchurch Community Hospital. This investigation will review the arrangements following the Patient's discharge and to seek to address concerns raised by the Patient's family. An Investigator has been appointed and information gathering has commenced. The Governance team continue to review and support in those investigations commissioned over previous months to seek to ensure 6 month timeframe for completion.

Action Plan	Start Date	End Date	Status	Outcome
The governance team has a process in place to triage incidents on a regular basis. This	Sep-24	Dec-26	In Progress	
The governance team is reviewing all processes and policies to ensure that they are PSIRF	Sept	Dec-26	In Progress	

Author	Amy Fairweather - Patient Safety Officer	**Date**	15/04/2026
Accountable Officer Approval	Shelley Ramtuhul, Director of Governance	**Date**	17/04/2026

Exception Report - Action Plan

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

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

KPI Description	Latest 6 months	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	YTD
Safer Staffing	%	94.0%	85.0%	88.0%	111.0%	111.0%	104.0%	104.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Narrative/Description:

Bishops Castle - 97%
Bridgnorth -99%
Ludlow - 105% 5% - due to supervisory shifts
Whitchurch - 114% 14% - over due to TES beds being opened

When staff are on supervisory shifts they are not included in the establishment numbers but due to their shifts being recorded on E-Roster this pulls through on the monthly safer staffing reports.
TES beds closed at Whitchurch on the 13.04.2026 and so staffing was reduced to met the requirement of 25 beds not 29

Action Plan

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

Author	Tracie Black, Associate Director of Workforce Education and Professional Standards	**Date**	10/04/2026
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community		17/04/2026

Exception Report - Action Plan

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

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

KPI Description	Latest 6 months	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	YTD
Safer Staffing	%	99.0%	88.0%	87.5%	107.0%	112.0%	105.0%	105.0%
	Target	95.0%	95.0%	95%%	95%%	95%%	95%%	95.0%

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Narrative/Description :

Bishops Castle - 102% on review of the rota there are no shifts that are over on RN.
Bridgnorth - 102% 2% due staff on supervisory shifts
Ludlow - 111% 11% due to over established on nights, these shifts were established staff on duty
Whitchurch - 104% 4% overestablished RN

When staff are on supervisory shifts they are not included in the establishment numbers but due to their shifts being recorded on E-Roster this pulls through on the monthly safer staffing reports.

Action Plan

Action	Start Date	End Date	Status	Outcome
Bi-annual safer staffing review to review establishements against SNCT data sets and whether any changes are required	Jan-25	Jun-25	Complete	
National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	
Further education with the Ward Managers around the health roster and adding additional shifts	Feb-25	Apr-25	Completed and ongoing	Check and challenge meeting to address this action. weekly data now being received to monitor additional shift code so any discreptencies can be discussed with relevant teams
ICB Peer review of staffing fill rates	Apr-25	Jun-25	Complete	
Review RN to HCSW ratios for 26/27 as cost pressures	Dec-25	Mar-26	Completed	cost pressure in the 2026/2027 plan for 7.50WTE HCA ageed and recruitment to posts underway
Work with E-Roster team to review whether supervisory shifts can be removed from monthly safer staffing reports	Feb-26	Apr-26	In Progress	

Author	Tracie Black, Associate Director of Workforce Education and Professional Standards	**Date**	05/04/2026
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community		17/04/2026

Exception Report - Action Plan

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

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

KPI Description	Latest 6 months	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	YTD
Safer Staffing	%	110.0%	104.0%	92.0%	112.0%	117.0%	104.0%	104.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Narrative/Description :

Bishops Castle - 88% during this month there were 2 RN on supervisory shift and safer staffing maintained -
Bridgnorth - 110% 10% overestablished
Ludlow - 104% 4% for Cohorting and 1to 1 nursing
Whitchurch - 105% 5% overestablished

Action Plan

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

Author	Tracie Black, Associate Director of Workforce Education and Professional Standards	**Date**	10.04.2026
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community		17/04/2026

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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	YTD
Safer Staffing	%	109.0%	94.0%	86.0%	109.0%	115.0%	103.0%	103.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Aug-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Narrative/Description:

Bishops Castle - 102%	2% due to RN on supervised practice
Bridgnorth - 109%	9% due to over establishment from RRU closure
Ludlow - 101%	1% due to 1:1cohorting pattients
Whitchurch - 101%	1% due to 1:1 cohorting patients

Action Plan

Action	Start Date	End Date	Status	Outcome
Daily review of patients requiring enhanced supervision at the Red/Amber staffing meeting to ensure parity across all inpatient areas with agreed maximum levels.	Jan-25	Feb-25	Complete	SOP in place
National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	
Review of Enhanced Supervison 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 witl 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**	09/04/2026
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community		17/04/2026

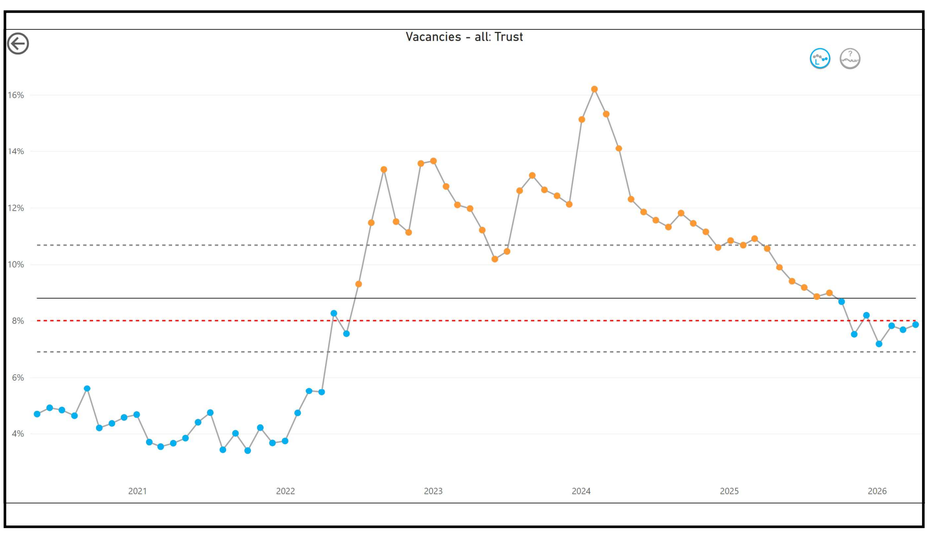
Appendix 1
People Committee – SPC Summary
Month 12 (March) 2025/2026 Performance

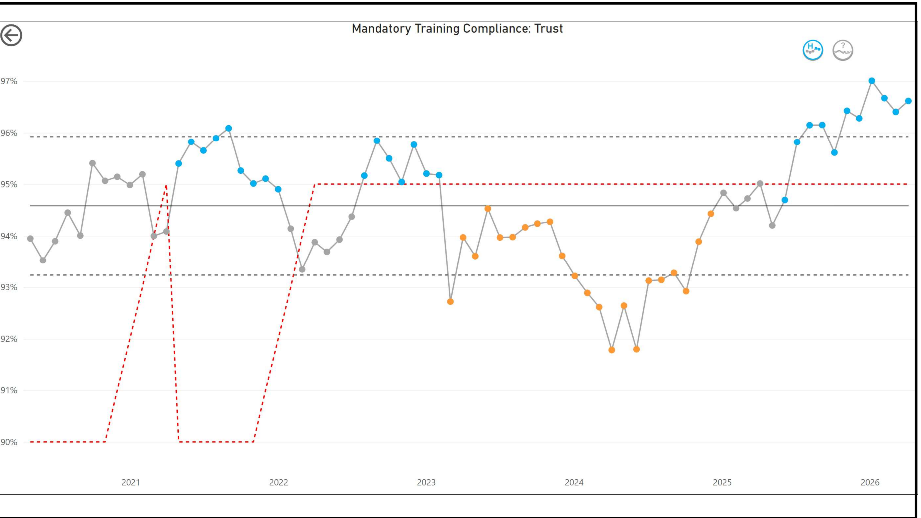
Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People Committee	People and Workforce	Appraisal Rates	2026-03-31		87.37%	90.00%	-2.63%	88.40%	90.00%	-1.60%	
People Committee	People and Workforce	Mandatory Training Compliance	2026-03-31		96.62%	95.00%	1.62%	96.62%	95.00%	1.62%	
People Committee	People and Workforce	National Education and Training Survey overall satisfaction score	2024-12-31		88.06%	90.00%	-1.94%	88.06%	90.00%	-1.94%	
People Committee	People and Workforce	Net Staff in Post Change	2026-03-31		0.14	0.00	0.14	1.40	0.00	1.40	
People Committee	People and Workforce	NHS staff survey engagement theme score	2026-03-31		7.2	7.2	0.0	7.2	7.2	0.0	
People Committee	People and Workforce	Proportion of temporary staff	2026-03-31		3.6%	3.4%	0.2%	3.3%	3.4%	-0.1%	
People Committee	People and Workforce	Sickness Absence Rate	2026-03-31		5.73%	4.75%	0.98%	5.73%	4.75%	0.98%	
People Committee	People and Workforce	Total shifts exceeding NHSI capped rate	2026-03-31		86	0	86	135	0	135	
People Committee	People and Workforce	Total shifts on a non-framework agreement	2026-03-31		0	0	0	1	0	1	
People Committee	People and Workforce	Vacancies - all	2026-03-31		7.86%	8.00%	-0.14%	8.43%	8.00%	0.43%	

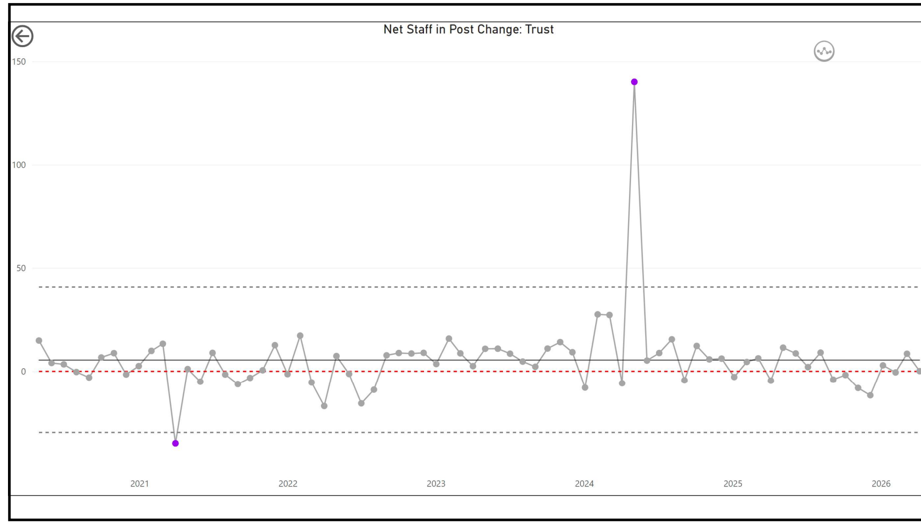
Appendix 2
People Committee
Month 12 (March) 2025/2026 Performance

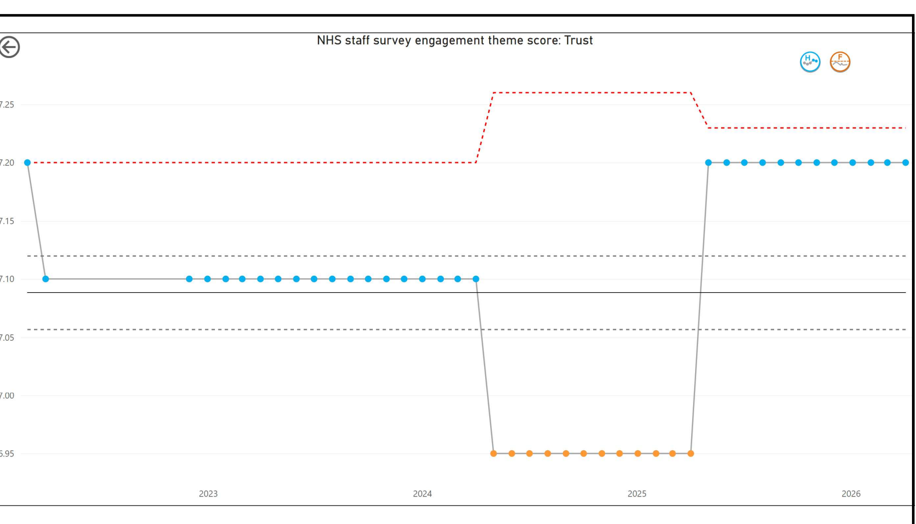
Variation	Assurance: P (pass)	Assurance: ? (hit or miss)	Assurance: F (fail)	Assurance: none
H (improving, blue)	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER. This process is not capable and will FAIL the target without process redesign.	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER. Assurance cannot be given as there is no target.
L (improving, blue)	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. This process is not capable and will FAIL the target without process redesign.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. Assurance cannot be given as there is no target.
Common cause (grey)	Common cause variation, NO SIGNIFICANT CHANGE. This process is capable and will consistently PASS the target if nothing changes.	Common cause variation, NO SIGNIFICANT CHANGE. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Common cause variation, NO SIGNIFICANT CHANGE. This process is not capable and will FAIL the target without process redesign.	Common cause variation, NO SIGNIFICANT CHANGE. Assurance cannot be given as there is no target.
H (concerning, orange)	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER. This process is not capable and will FAIL the target without process redesign.	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER. Assurance cannot be given as there is no target.
L (concerning, orange)	Special cause variation of a CONCERNING nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of a CONCERNING nature where the measure is significantly LOWER. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of a CONCERNING nature where the measure is significantly LOWER. This process is not capable and will FAIL the target without process redesign.	Special cause variation of a CONCERNING nature where the measure is significantly LOWER. Assurance cannot be given as there is no target.
Up arrow (purple)				Special cause variation of an increasing nature where UP is not necessarily improving or concerning. Assurance cannot be given as there is no target.
Down arrow (purple)				Special cause variation of an increasing nature where DOWN is not necessarily improving or concerning. Assurance cannot be given as there is no target.
None				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

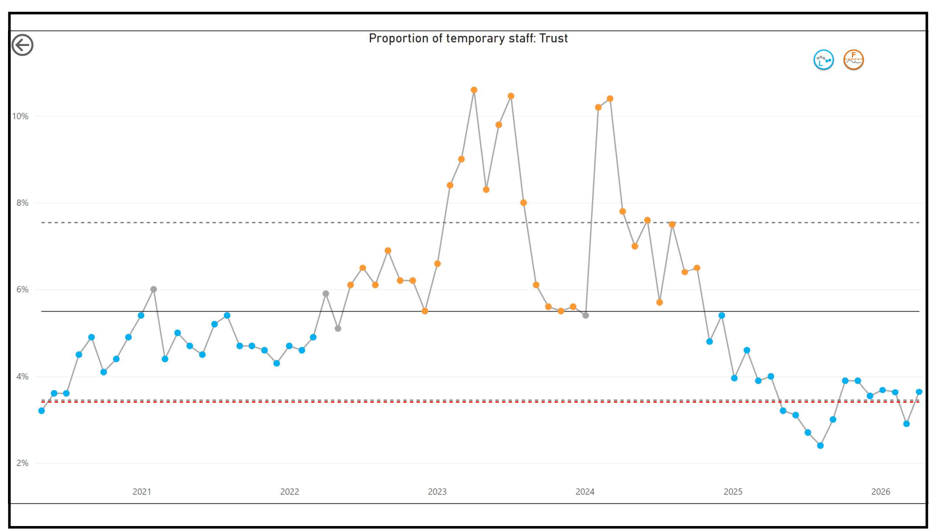
APPENDIX 3

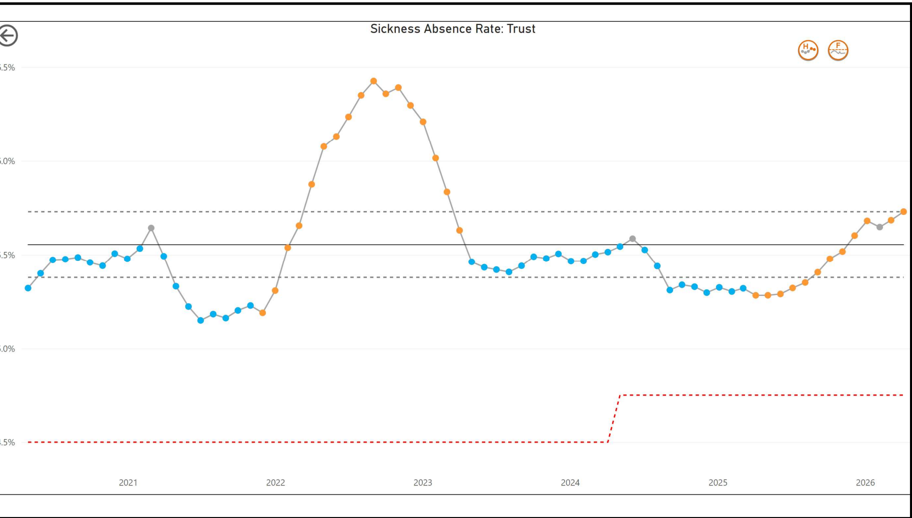


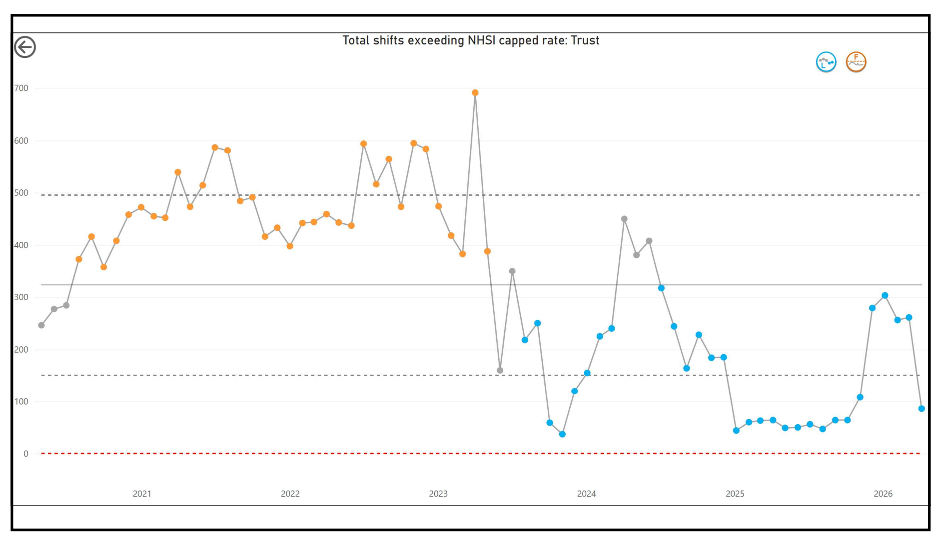


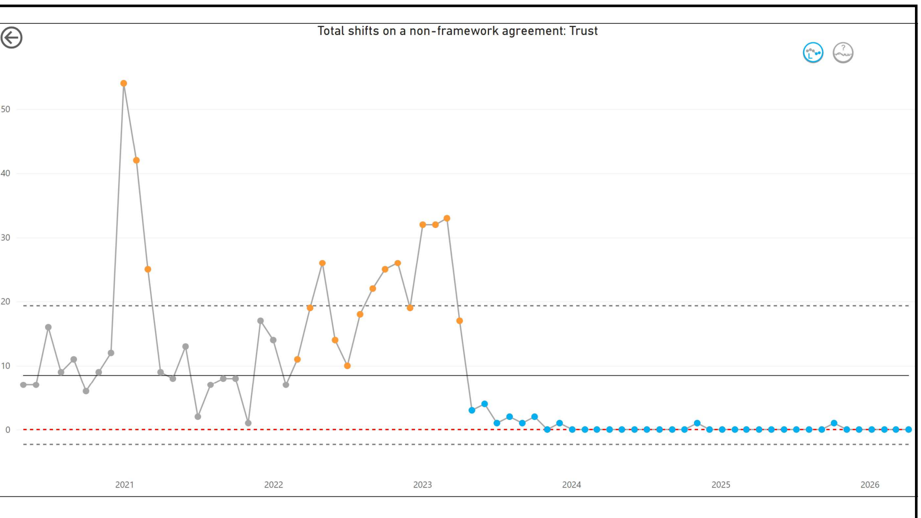


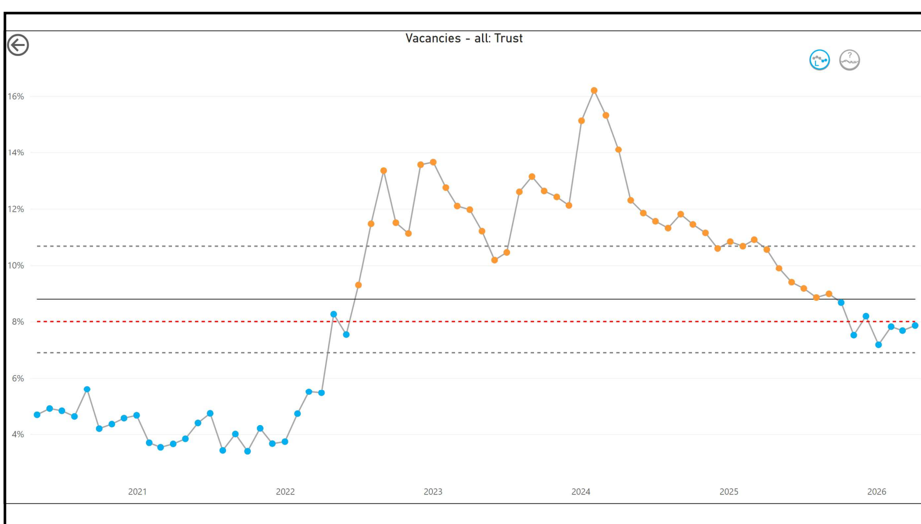



Proportion of temporary staff: Trust
10%
8%
6%
4%
2%
2021
2022
2023
2024
2025
2026


Sickness Absence Rate: Trust
6.5%
6.0%
5.5%
5.0%
4.5%
2021
2022
2023
2024
2025
2026


Total shifts exceeding NHSI capped rate: Trust
700
600
500
400
300
200
100
0
2021
2022
2023
2024
2025
2026


Total shifts on a non-framework agreement: Trust
50
40
30
20
10
0
2021
2022
2023
2024
2025
2026


Vacancies - all: Trust
16%
14%
12%
10%
8%
6%
4%
2021
2022
2023
2024
2025
2026

APPENDIX 4

Exception Report - Action Plan

Sickness Rate

Percentage of staff absent over a rolling 12-month period

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Sickness Rate	%	5.52%	5.60%	5.68%	5.65%	5.68%	5.73%	5.73%
	Target	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

Trajectory	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
%	5.30%	5.30%	5.30%	5.20%	5.10%	5.10%	5.00%

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	307	383	11,562.07	34.3
S12 Other musculoskeletal problems	125	150	3,136.74	9.3
S13 Cold, Cough, Flu - Influenza	655	825	2,992.81	8.9
S25 Gastrointestinal problems	469	610	2,796.53	8.3
S98 Other known causes - not elsewhere classified	174	202	2,728.67	8.1
S28 Injury, fracture	57	58	1,568.52	4.7
S11 Back Problems	79	92	1,461.31	4.3
S26 Genitourinary & gynaecological disorders	102	117	1,296.91	3.8
S17 Benign and malignant tumours, cancers	17	18	1,140.92	3.4
S30 Pregnancy related disorders	42	99	828.84	2.5

Org L6	Absence FTE	Available FTE	Absence FTE %
825 Dudley CYP&F Management Services	159.60	584.00	27.33%
825 Children's Continence Service	99.77	520.17	19.18%
825 Ludlow Outpatient Service	106.77	569.40	18.75%
825 Workforce Systems Service	158.00	942.00	16.77%
825 Telford & Wrekin Paediatric Physiotherapy Team (DO NOT USE)	49.00	303.60	16.14%
825 Whitchurch Hospital Inpatients Service	2,093.43	13,618.54	15.37%
825 Outpatients Admin Service	301.00	2,228.67	13.51%
825 Enhanced Care Home Service	510.52	3,781.86	13.50%
825 Service Delivery Group - Adult Community Services Management Service	262.00	2,087.00	12.55%
825 Stoke Heath YOI Service	943.10	7,781.13	12.12%

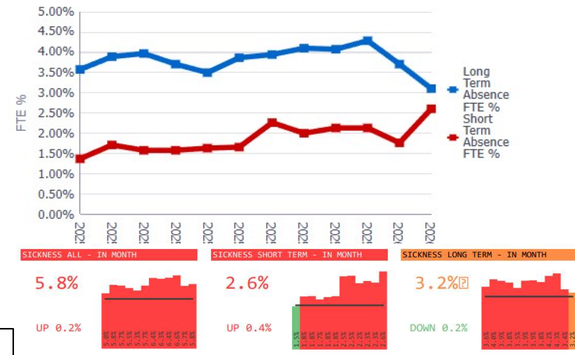
Reason for performance gap:

Since March 2025 the rate continues to remain above target and we have seen very slight increases month on month, however, in January 2026 we saw a slight decrease with slight increases in February and March. The main drivers continue to be stress, anxiety and depression conditions. We continue to see a reduction in long term absence and an increase in short term absence with other MSK being the second highest reason for absence and cold cough flu as the third highest reason. In terms of long term absence cases we have seen a slight increase but they remain the lowest number of cases we have seen for a number of months. Support around health and wellbeing, resilience and flexibility are critical to support reduction in absence levels and are being implemented by the People Team. The People Team are continuing to promote the importance of the wellbeing with a monthly health & wellbeing newsletter. At present there is no assurance that short term absence (which has increased) is being managed in line with the Managing Attendance Policy. The People Team are now sending out trigger reports for short term absence to managers with guidance on the triggers and next steps. This is a key action area for our teams to monitor compliance and provide support to managers in maintaining compliance with our policy.

Action	Start Date	End Date	Status	Outcome
Conduct an absence masterclass for Bridgnorth Hospital and the South East Community Nursing team, incorporating an audit of absence management practices in accordance with Trust policy. Review the audit results and deliver tailored sessions based on the identified findings. If successful evaluate rolling out to all areas of the Trust.	Apr-26	Jun-26	On track	To confirm adherence to Trust policy and deliver tailored support to Team Leaders and Clinical Services Managers
Operational leads to receive the annual leave report on a monthly basis to review and ensure annual leave recorded and being taken	Mar-26	Mar-27	On track	To ensure all staff take time away from work to rest and recuperate
Explore digital solutions to support Line Managers in timely management of attendance in line with the Managing Attendance policy. This inlcudes a review of eroster to establish absence management capabilities and other digital solutions	May-26	Jul-26	On track	To provide Line Managers with tools to support the timely management of absence
Planned care - Clinical Services Managers to review the absences with Team Leaders and ensure absences are being managed/supported appropriately. Stoke Heath reviewing processes for absence management ensuring consistency of absence management and support	Feb-26	May-26	On track	To better understand the detail behind absences and what bespoke support needs to be put in place.
Implement HWB Action plan	May-25	Mar-26	Completed	Ensure appropriate HWB support is implemented for staff

Action Plan					
	A deep dive into MSK absences has highlighted that the main causes for MSK absences relate to neck, shoulder and back pain. Work with the MSK Physio team to develop appropriate videos around prevention with the MSK team initially focussing on these common absence reasons. Launch the Myrecovery app which covers advice, exercise etc for staff experiencing MSK issues instead of developing videos this will be rolled out in the next 3 months. The comms plan will include general communications, targeted comms for staff experiencing MSK issues and those staff absent due to MSK issues, Occupational Health will also raise awareness in appointments and when referring to fast track physio	Feb-25	May-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 Division -. Short term 1.93%, Long term 4.83%. Operational Lead will check to ensure those absences categorised as unknown is most appropriate category and ensure communications have been shared in relation to support available and the importance of absence management/support to Team Leaders. This date has been extended due support Operational changes in structure.	Feb-26	May-26	On Track	Provide staff with appropriate support
	Adults Services Overall sickness is down from 6.9% in February to 6.79% in March. Operationa	Apr-26	May-26	On track	Ensure avsence
	CYP Shropshire absence rate is 3.6 % which is under target (1.35% short term 2.25% long term) Continue to oversee management of short term absence to gain assurance this is being managed appropriately and in line with the Managing Attendance Policy.	Jan-26	May-26	On track	Increase the uptake of flu vaccinations to protect staff and ensure absence is managed appropriately ensuring staff have the appropriate support in place
	Dudley 0-19 & Stoke Heath Prison - Work with the OD team to provide input into culture which will include reviewing the relevant staff survey results for both teams .	Mar-26	Dec-26	On track	Create a positive working environment as a supportive and positive workplace can reduce stress and improve job satisfaction, lowering the risk of sickness absence.
	HWB Workshop to understand the offers and what is in place across the Group, working together to develop a collective plan of what can be done as Group	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	May-26	On track	Create a positive working environment as a supportive and positive workplace can reduce stress and improve job satisfaction, lowering the risk of sickness absence.
	Review the health and wellbeing responses, including any free-text comments, from the National Staff Survey. Update the local HWB survey accordingly and distribute it to gain further insights into the national staff survey responses, as well as to inform the HWB action plan for 2026-27.	Feb-26	May-26	On track	Tailor interventions to meet the actual needs of teams, ultimately fostering a healthier, more supportive workplace environment where everyone can thrive.
	Undertake a regular flexible campaign to raise awareness of flexible working and the benefits of flexible working	Nov-25	Dec-26	On track	Flexibility can help employees balance work and personal commitments, reducing stress and the likelihood of sickness absence.
	Conduct a health and wellbeing survey to gain a clear understanding of employees' perspectives on health and wellbeing (HWB) initiatives. This survey aims to identify the types of HWB initiatives employees would like to see introduced, assess employees' awareness of the HWB initiatives that are currently available within the Trust, and gather information on which initiatives employees have accessed to date. The findings will help evaluate engagement and utilisation of existing HWB resources and support the development of the 2026-27 HWB action plan	Mar-26	May-26	On track	Tailor interventions to meet the actual needs of teams, ultimately fostering a healthier, more supportive workplace environment where everyone can thrive.
	Undertake a deep dive of all absences to establish any themes looking at age profiles, gender, job role etc, once completed work with hot spot teams to ensure provide support	Jan-26	Apr-26	Completed	To understand if there are any underlying themes etc for absences
	Deliver the actions identified in the deep dive of all absences and provide relevant support	Apr-26	Jun-26	On track	
	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**	01/05/2026
Accountable Officer Approval	Rhia Boyode	**Date**	01/05/2026



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	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Shifts	Number	108	279	303	256	261	114	
	Target	0	0	0	0	0	0	0

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
%	114	105	105	105	100	100	100

		Start Date	End Date	Status	Outcome
Reason for performance gap:	We have not yet been advised by NHSE of a date for price cap compliance or the new rates for medical and dental staff however 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, Stoke Heath Prison. Recruitment to the consultant role in UEC has been unsuccessful and an options appraisal is being undertaken, this may impact on the planned medical roles within UEC. UEC Speciality Dr JD still with the Royal College for approval. GPwER jd with Medical Director for finalisation.				
Action Plan	Grow our bank and implement the use of centralised bank to support reduction in agency usage. Resourcing team to work with operational managers and recruitment team to plan recruitment events and rolling bank adverts to be held over the next 12 months.	Apr-25	Mar-26	On Track	**13/11/25:** **Event 16/5/25** *Shrewsbury* : 25 offers - 14 started, 5 withdrawn, 6 waiting completion supernumary shifts/training **Event 26/6/25** *Ludlow* 13 offers - 8 started, 4 withdrawn, 1 waiting completion of supernumary shifts/training **Event 29/7/25** *Whitchurch* - 21 offers - 7 started, 5 withdrawn, 9 waiting completion supernumary shifts/training **Events 3/10 & 24/10** *Shrewsbury:* 18 offers - 7 awaiting completion supernumary shifts/training, 11 in pre-employment checks **Event 2/1/2026** scheduled to take place at Mount McKinley **13/1/26** Event Cancelled due to adverse weather. Rearranging for 23 or 30/1/26 (Subject to ops availability for interview panels) **10/02/2026** Ops unable to support on the dates - all interviews now being undertaken by Ops on **18/2/26** Offers were made to 2 individuals. **10/03/2026** 1 applicant is undergoing pre-employment checks and the other is ready to start. **07/04/2025** Recruitment Lead is arranging a meeting to discuss a rolling bank advert with Operational Lead for adults division
	Expansion of UEC: medical staffing reviewed requirement for Consultant, Speciality Dr and GP.	Oct-25	May-26	On Track	**13/11/25.** New Consultant JD with the Royal College for approval prior to being able to advertise. Resourcing are supporting Ops managers with writing a Speciality Dr jd and a GPwER jd. Speciality Dr jd will also require Royal College Approval. **23/12/25** Consultant jd comments from RC requires jd to be updated and resubmitting. Spec Dr JD drafted and awaiting form completion by ops to go to Royal College for approval. Both jds with ops and Medical Director for further work **13/1/26** Consultant job approval from RC received 14/1/26 - kitemark application in process (approx 1 day for return expected latest 16/1/26). Scoping out dates for March and panel members for the AAC process. Speciality Dr jd to be completed by Ops by 16 Jan 2026 for submission to Royal College w/b 19/1/26. Revised date set due to length of time for Consultant recruitment. **16/02/2026** Spec Dr jd with Royal College **3/2/26** - expected 3 week turnaround. Consultant role advertised with a provisional date set of 8 April for AAC panel (interview) - awaiting confirmation of a Royal College representative attendance. RC requested DSA agreement to be signed - with IG team. **16/3/26** Data sharing agreement with Royal College. RC advised delay in Speciality Dr Jd approval due to staff shortages. Estimated approval: 6/4/26. GPwER jd with medical director for finalisation. Confirmation of RC representative for consultant interviews received. **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.
	Reduction in the use of medical agency staff	Dec-25	Mar-26	On Track	Where vacancies are the cause work with managers on reviewing jds and adverts as appropriate to the post. Long Covid: review the requirement and if a fixed term contract is appropriate as funding dependent. Virtual Ward & IFD - part of the UEC expansion - priortise vacancies in these areas (on going work with jds also taking place). Paeds - this is to cover LTS (HR involved) and waiting lists. Stoke Heath - GPwER has been offered a post - recruitment to priortise the onboarding. **16/2/26** Long Covid - working on appointing to the bank with ops presenting to VRF panel 12/2/26. Virtual Ward & IFD - vacancies are managed and recruitment commenced for some roles. UEC budgets to be finalised for the next financial year for confirmation of establishment figures. Stoke Heath - GP has been offered and being progressed. **10/03/2026** GP Pre-employment checks completed, awaiting confirmation of a start date. **13/4/26** Start date for Stoke GP 1/5/26. UEC: 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.
	A review to be undertaken of the medical staffing agency in use	Apr-26	May-26	On Track	Agree plans with relevant ops leads to reduce/remove the agency medical staffing in their areas

Author	Gina Billington	**Date**	01/05/2026
Accountable Officer Approval	Rhia Boyode	**Date**	01/05/2026

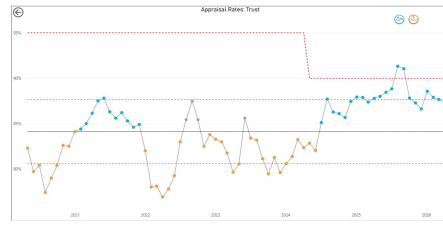
Exception Report - Action Plan

Appraisal Rates

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

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Appraisals	%	87.28%	86.61%	88.56%	87.89%	87.66%	87.37%	88.40%
	Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Trajectory	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
%	87.80%	88.50%	89.30%	90.00%	90.00%	90.00%	90.00%



Reason for performance gap:

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

Action Plan

Action	Start Date	End Date	Status	Outcome
The Line Managers of the 19 people recorded incorrectly on ESR will be contacted by the Associate Director of Professional Standards to ensure this is rectified by the end of January	Jan-26	Mar-26	Completed	To ensure that all appraisals that have taken place are recorded and counted within the appraisal compliance rate
Adults Community Services Division; Compliance rate has increased to 86.8% with 80 non-compliant, Non-compliant hotspots include, 7 in South East, 14 in North, 10 in Whitchurch. Operational Lead to send a monthly email to team leads to review compliance and evidence a plan	Jan-26	May-26	On track	To ensure that all appraisals that are non-compliant are undertaken
Adult Community Services Division - Check and challenge with the Service Lead for Team Leaders. Review appraisal recording to ensure they are recorded as performance appraisal. 109 appraisals are coming out of compliance over the course of the next 3 months.	Mar-25	Apr-26	On Track	To ensure teams with low compliance are supported to increase their compliance rates and senior oversight is in place
Urgent care 81.86% Virtual Ward, UCR and MIU Hot spot teams. Across the Division there are 2 recorded incorrectly 3 individuals who are non compliant are working their notice. Operational Lead to review list of individuals who have not had an appraisal whilst in the organisation and those outstanding to ensure compliance	Jan-26	May-26	On track	To ensure teams with low compliance are supported to increase their compliance rates and senior oversight is in place
Look at 30 60 90 day compliance and raise awareness of the conversation tools available	Apr-26	Jun-26	On track	To ensure individuals are receiving the relevant support when they commence with the organisation
Planned Care Division recovery plan in place. Dental also have 10 outstanding appraisals. Operational Lead is following up all outstanding appraisals to ensure completion. 1 appraisal recorded incorrectly to be followed up by the Operational Lead	Apr-26	May-26	On track	To ensure teams with low compliance are supported to increase their compliance rates and senior oversight is in place
Urgent & Emergency Care Division - SDG Manager implementing an escalation process. The escalation process will start with the Clinical Services Manager confirming a date when appraisals require completion, if not completed by this date escalation to the Services Delivery Manager who will make contact directly with the Line Manager. . Service Lead will get all Team Leaders to check how appraisals have been recorded as a performance appraisal to ensure they are within the correct parameters. Monthly newsletter to Division to include importance of appraisals and ensuring individuals also take ownership of ensuring their appraisal is completed in time alongside the Team Leader. (This approach and any communications will be shared with other Divisions). This has been delayed due to operational structure changes	Aug-25	May-26	On Track	Appraisals complete and both staff and Line Managers are reminded of the importance of appraisals. Foster a culture of accountability for staff and Line Managers.
Moving forward ensure all pre booked appraisal dates are populated in ESR to enable a report to be generated from ESR of appraisal data to enable senior oversight and oversight at Performance Workshop of a monthly basis	Nov-25	Mar-27	On track	To ensure senior oversight of appraisals providing assurance that appraisals are booked in advance
Shropshire CYP & Dudley CYP. Operational Lead to review all non-compliant appraisals and have discussions with Line Managers to provide support to complete. Hot spot team will Divisional Manager will follow up. No appraisals are recorded incorrectly.	Jan-26	Mar-27	On track	To ensure all appraisals are recorded correctly and non-compliance appraisals completed

Author	Fiona MacPherson	Date	01/05/2026
Accountable Officer Approval	Rhia Boyode	Date	01/05/2026

SDGs and Divisions	Assignment Count	Reviews Completed	Reviews Completed %	
825 Digital Division	43	43	100.00	⇔
825 Finance, Strategy and Estates Division	31	31	100.00	↑
825 Governance Division	20	15	75.00	↓
825 Infection Prevention and Control Division	4	4	100.00	⇔
825 Medical Division	4	3	75.00	⇔
825 Medicines Management Division	16	14	87.50	↓
825 Nursing and Quality Division	11	11	100.00	⇔
825 Nursing and Workforce Management Division	5	5	100.00	⇔
825 Operations Directorate Management Division	10	9	90.00	↓
825 People and OD Division	29	25	86.21	↑
825 Safeguarding Division	12	12	100.00	⇔
825 Service Delivery Group - Adult Community Services Division	606	526	86.80	↑
825 Service Delivery Group - CYP&F Dudley Services Division	137	129	94.16	↓
825 Service Delivery Group - CYP&F Shropshire Services Division	344	307	89.24	↓
825 Service Delivery Group - Planned Care Division	206	174	84.47	↓
825 Service Delivery Group - Urgent Care Division	208	164	78.85	↓
825 Trust Board Division	9	9	100.00	⇔

Previous month	Assignment Count	Reviews Completed	Reviews Completed %
825 Digital Division	44	44	100.00
825 Finance, Strategy and Estates Division	31	30	96.77
825 Governance Division	17	14	82.35
825 Infection Prevention and Control Division	4	4	100.00
825 Medical Division	4	3	75.00
825 Medicines Management Division	17	15	88.24
825 Nursing and Quality Division	10	10	100.00
825 Nursing and Workforce Management Division	5	5	100.00
825 Operations Directorate Management Division	10	10	100.00
825 People and OD Division	27	23	85.19
825 Safeguarding Division	12	12	100.00
825 Service Delivery Group - Adult Community Services Division	597	503	84.25
825 Service Delivery Group - CYP&F Dudley Services Division	135	128	94.81
825 Service Delivery Group - CYP&F Shropshire Services Division	349	318	91.12
825 Service Delivery Group - Planned Care Division	209	186	89.00
825 Service Delivery Group - Urgent Care Division	214	171	79.91
825 Trust Board Division	9	9	100.00

Division	Team (hotspot areaas are teams with 10 or more staff members with compliance of less than 81%)	Appraisals Required	Appraisals In-Date	% Compliance
Adult Community Services Division	825 Community Therapies Central Service	15	12	80.00
Adult Community Services Division	825 Whitchurch Hospital Inpatients Service	39	29	74.36
Adult Community Services Division	825 North Shropshire Community Nursing Service	54	40	74.07
Adult Community Services Division	825 South East Shropshire Community Nursing Service	26	19	73.08
Adult Community Services Division	825 Specialist Nursing Diabetes Adults Service	10	8	80.00
CYP&F Shropshire Services Division	825 Wheelchair Service	11	5	45.45
Planned Care Division	825 Dentistry Service	50	40	80.00
Urgent Care Division	825 Care Transfer Hub Service	21	17	80.95
Urgent Care Division	825 MIU Service	25	18	72.00
Urgent Care Division	825 Urgent Community Response Service	41	31	75.61
Urgent Care Division	825 Virtual Wards Service	55	40	72.73

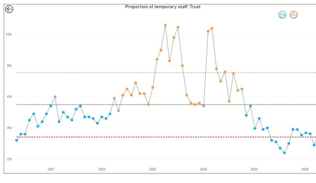
Exception Report - Action Plan

Proportion of temporary staff

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

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Prop Temporary staff	%	3.9%	3.5%	3.7%	3.6%	2.9%	3.6%	3.3%
	Target	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
%	3.60%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%



Reason for performance gap:	UEC medical staffing recruitment : Recruitment to the consultant role in UEC has been unsuccessful and an options appraisal is being undertaken, this may impact on the planned medical roles within UEC. UEC Speciality Dr JD still with the Royal College for approval. GPwER jd with Medical Director for finalisation. Community Peads have Locum consultant covering LTS and waiting lists work. HMP Stoke are using a GP to cover a vacancy (recruited to post). To support the costs reduction of our temporary workforce we will be focusing on both volume reductions and price of agency. Price Cap for agency: we are compliant wih the the West Midlands Region Price Rate card for medical and dental staff .

Action Plan

Action	Start Date	End Date	Status	Outcome
UEC Consultant: Advert closed - not able to shortlist - UEC to review options of recruitment with medical director and director of ops. JD has been reviewed - may need Royal College approval. Revised target set.	Apr-25	Mar-26	On Track	Medical Director/Ops review complete and an agreed solution for this post. **22/08/25** JD reviewed and new job pack in draft. **15/9/25** Ongoing work is underway regarding the medical provision/skill mix. **14/9/25:** Ops continuing to review - support from resourcing has been offered.**15/10/25** Ops working on updating the jd and reviewing the medical offer. **13/11/25.** Medical Director/Ops review complete and an agreed solution for this post. New Consultant JD with the Royal College for approval prior to being able to advertise. Resourcing are supporting Ops managers with the writing a Speciality Dr jd and a GPwER jd. Speciality Dr jd will also require Royal College Approval. **23/12/25** Consultant jd comments from RC requires jd to be updated and resubmitted. Spec Dr JD drafted and awaiting form completion by ops to go to Royal College for approval. Both jds with ops and Medical Director for further work. GPwER jd drafted.**13/01/2026** Consultant job approval from RC received 14/1/26 - kitemark application in process (approx 1 day for return expected latest 16/1/26). Scoping out dates for March and panel members for the AAC process. Speciality Dr jd to be completed by Ops by 16 Jan 2026 for submission to Royal College w/b 19/1/26. **16/02/2026** Spec Dr jd with Royal College 3/2/26 - expected 3 week turnaround. Consultant role advertised with a provisional date set of 8 April for AAC panel (interview) - awaiting confirmation of a Royal College representative attendance. RC requested DSA agreement to be signed - with IG team.**16/03/2026** Data sharing agreement with Royal College. RC advised delay in Speciality Dr Jd approval due to staff shortages. Estimated approval: 6/4/26. Confirmation of RC representative for consultant interviews received. **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.
Prison: GP Vacancy - using a locum. Resourcing support to jd writing.	Nov-25	Mar-26	Closed	JD advertised. Recruitment underway - interviews 14/1/26. Offer made to individual and recruitment is progressing. **10/03/2026** Pre-employment checks completed, awaiting confirmation of a start date. Revised date. **13/4/26** Start date of GP 1/5/26
Maximise the availability of our workforce through monitoring and improving roster practices. Comms sent to roster approvers regarding use of roster to send unavailable shifts to bank/agency 11/3/25. Programme of continuous improvement workshops in place for roster approvers. Check and Challenge meetings in place with teams to review KPIs and roster efficiencies.	Mar-25	Mar-26	On Track	Improve assignments where the duty's grade type doesn't match the person's qualification / grade. Limited, improvement from current 2.2% to 1%. - Net Hours Balance %. The % contracted hours left unused. Currently at 5.08%, potential to reduce to align with system average 3%. - Roster Approval Lead Time currently 59 days - Additional Duty %. % of assigned duties that are in addition to the budgeted demand move from current 6.7% to 3%. **15/9/25** Roster Approval Lead Time currently 59 days. Work is ongoing with further teams being implemented onto the roster system in a phased approach until March 2026. **14/10/25** % contracted hours left unused 5.36%, % additional duties 3.19%, Roster Approval Lead Time partial 54 days – Full 49 days **13/11/25** Currently 89 teams are live on e-roster with a further 21 teams scheduled up to 31/3/26. Roster approval lead time - full approval = 54 days, Partial approval 59 days. % contract hours unused 2%, % hours additional duties 6%. **23/12/25** Currently 91 teams are live on e-roster with a further 22 teams now scheduled up to 31/3/26. Roster approval lead time - full approval = 53 days, Partial approval 61 days. % contract hours unused 2.06%, % hours additional duties 7%. **13/1/26** Currently 103 teams are live on e-roster with a further 19 teams now scheduled up to 31/3/26. Roster approval lead time - Full approval = 61 days, Partial approval 56 days. % contract hours unused 3.90%, (Adjusted to account for 8 records where individual is not actively rostered) % hours additional duties 6.22% **16/2/26** Currently 103 teams are live on e-roster with a further 19 teams now scheduled up to 31/3/26. Roster approval lead time - Full approval = 58 days, Partial approval 64 days. % contract hours unused 3.01%, % hours additional duties 3.44%. The increase in days for approval indicates that rosters are being published earlier. **16/3/26** 112 Teams live with a further 10 planned to go live 01-04-2026. Roster approval lead time: Full Approval = 47 Days- Reduction. Partial Approval = 52 Days - reduction. % Contract hours unused 3.22%, additional duties 2.48%. **14-04-2026** 120 teams now live Roster approval lead time: Full Approval = 51- increase by 4 days Partial Approval = 57 Days - increase by 5 days Contract hours unused 2.62% reduction of 0.60% Additional duties 3.61% increase of 1.13%
Grow our bank and implement the use of centralised bank to support reduction in agency usage and relieve pressure on teams where covering sickness absence . Resourcing team to work with operational managers and recruitment team to plan recruitment events and rolling bank adverts to be held over the next 12 months. First event planned for May 16th.	Apr-25	Mar-26	On Track	**Event 16/5/25** *Shrewsbury* : 25 offers - 14 started, 5 withdrawn, 6 waiting completion supernumary shifts/training **Event 26/6/25** *Ludlow* 13 offers - 8 started, 4 withdrawn, 1 waiting completion of supernumary shifts/training **Event 29/7/25** *Whitchurch* - 21 offers - 7 started, 5 withdrawn, 9 waiting completion supernumary shifts/training **Events 3/10 & 24/10** *Shrewsbury:* 18 offers - 7 awaiting completion supernumary shifts/training, 11 in pre-employment checks **Event 2/1/2026** scheduled to take place at Mount McKinley. **13/01/26** Event cancelled due to adverse weather. Rearranging for 30/1/26 (Subject to ops availability for interview panels) **16/2/26** unable to rearrange event however ops are able to interview all applicants on 18/2. 2 offers have been made. **10/03/2026** 1 applicant is undergoing pre-employment checks and the other is ready to start. Plans to look at a plan for rolloing adverts across the year for bank HCA adverts. If a process is agreed we will look to do the same for other roles. **07/04/2025** Recruitment Lead is arranging a meeting to discuss a rolling bank advert with Operational Lead for adults division.
Roll out e-roster to all clinical staff and non-clinical bank workers. New revised end date.	Sep-25	Jun-26	On-track	Improved staff productivity and reduction of agency usage. Increased goverance and reporting of bank and agency bookings across the Trust. **13/11/25**: Implementation plan in place: 89 teams on e-roster with 21 teams planned for implementation until March 2026 - 3 outstanding teams for April implementation. **23.12.25** Implementation plan in place: 91 teams on e-roster with 22 teams planned for implementation until March 2026 - 3 teams planned for April implementation with further scoping and planning to utilise licences in progress for Q1and Q2 2026/27 **13/1/26** Implementation plan in place: 103 teams on e-roster with 19 teams planned for implementation until March 2026 - 1 teams planned for April 2026 implementation with further scoping and planning to utilise licences in progress for Q1and Q2 2026/27. **16/3/26** 112 Teams live with a further 10 planned for go live 01-04-2026 with 3 Teams now planned for April
Deep dive into the reasons for booking temporary staffing	Oct-25	May-26	On Track	To ensure managers use the correct reason for booking temporary staffing using the roster system to improve the reporting of booking reasons that in turn will enable the resourcing team and ops senior managers to identify any trends with staffing productivity. Meeting arranged 1/4/26 Revised date set **30/4/26:** Meeting with Associate Director for Workforce, Education & Professional Standards to agree reasons for booking.
Weekly reports to managers to review outstanding shift requests	Apr-26	May-26	On Track	To improve the efficiency of shift fill rates.
Develop manager training and guidance on the use of booking reasons for bank and agency.	Apr-26	Jun-26	On Track	Managers use the correct booking reasons on the system and improves the reporting data
Review of the bank and agency approval request form, booking and cancellation reasons	Apr-26	Jun-26	On Track	Update the form to include reasons from the e-roster system and lock the relevant field in the form so only the correct reason can be selected. Reduce the number of reasons for booking/cancelling and streamline the request and approval process.
E-roster team rolling out a 12 month training plan	Apr-26	Jun-26	On Track	Improve the use of e-roster by managers ensuring efficient use of substantive staff and reduce the need to bank or agency

Author	Gina Billington	**Date**	01/05/2026
Accountable Officer Approval	Rhia Boyode	**Date**	01/05/2026

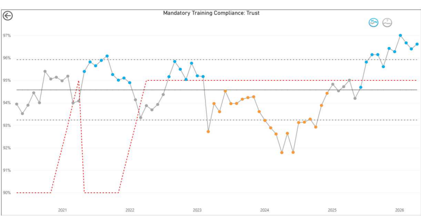
Exception Report - Action Plan

Mandatory Training Compliance

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

KPI Description	Latest 6 months	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Mandatory Training	%	96.42%	96.28%	97.01%	96.67%	96.40%	96.62%	96.62%
	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	Oct-26
%	97.10%	97.10%	97.60%	97.60%	98.10%	98.10%	98.60%



TOPIC	February		March	Variance
Conflict Resolution (England)	98.7%	▼	98.6%	-0.05%
Corporate Induction|	97.5%	▲	98.1%	0.57%
Equality, Diversity and Human Rights	99.0%	▼	99.0%	-0.05%
Fire Safety - 2 Years|	99.6%	▲	99.7%	0.05%
Fire Safety - High Risk	92.8%	▼	92.4%	-0.41%
Fraud Awareness	98.1%	▲	98.3%	0.18%
Health, Safety and Welfare	98.4%	▲	98.8%	0.34%
Infection Prevention and Control - Level 1	97.8%	▲	98.1%	0.24%
Infection Prevention and Control - Level 2	95.7%	▼	95.6%	-0.16%
Information Governance and Data Security	97.9%	▼	96.8%	-1.12%
Moving and Handling - Level 1	98.0%	▼	97.8%	-0.20%
Moving and Handling - Level 2	87.8%	▲	90.1%	2.38%
Oliver McGowan Mandatory Elearning	88.0%	▼	87.5%	-0.49%
Patient Safety - Level 1	99.5%	▲	99.8%	0.27%
Patient Safety - Level 2	98.5%	▲	98.8%	0.27%
Preventing Radicalisation - Prevent Awareness	97.9%	▲	98.1%	0.13%
Resuscitation - Level 2 - Adult Basic Life Support	91.8%	▲	92.3%	0.48%
Resuscitation - Level 2 - Paediatric Basic Life Support	91.8%	▲	92.2%	0.37%
Resuscitation - Level 3 - Adult Immediate Life Support	80.3%	▲	86.0%	5.68%
Resuscitation - Level 3 - Paediatric Immediate Life Support	79.9%	▲	86.0%	6.03%
Safeguarding Adults - Level 1	97.4%	▲	97.9%	0.52%
Safeguarding Adults - Level 2	98.7%	▲	99.0%	0.27%
Safeguarding Adults Level 3	93.5%	▲	94.7%	1.20%
Safeguarding Children - Level 1	97.1%	▲	97.2%	0.13%
Safeguarding Children - Level 2	95.2%	▲	95.4%	0.21%
Safeguarding Children - Level 3	96.3%	▼	95.7%	-0.59%
Safeguarding Children - Level 4	100.0%	▼	85.7%	-14.29%

Reason for performance gap:

Corporate Updates – In March, compliance rates experienced increase of 0.22%, reaching 96.62%, which is a welcomed change after 2 months of decreases. Over the course of the month, compliance decreased across 9 topics, with reductions ranging from 0.05% (Conflict Resolution) to -14.29% for Safeguarding Children - Level 4, however the unusually large drop is due to 1 person being non-compliant but because there is such a small group 1 person has bigger than usual impact
Conversely, compliance improved in 18 topics, a significate improvement compared with the previous month. Increases range from 0.05% (Fire Safety eLearning) up to 6.03% (Resuscitation - Level 3 - Paediatric Immediate Life Support).

It is important to note that High Risk Fire fell by 0.41% and there missed the target of 95% by the end of March 2025. There are no training dates taking place in April, however there is more training taking place in May. Managers have been emailed where staff are non-compliant or due to expire prior to the end of May to try and reach this target in the coming months.
Resus Level 2 has seen another increase of just under 0.5% in compliance but it is still below the target of 95%. There are dates in various locations in April, compliance will continued to be monitored. Since the topic has been targeted, we have seen monthly increases in compliance, so action is being taken. More work needs to be done with regards to the 3 month notification of expiry.
Resus Level 3 as predicted also did not reach the 95% target. However, there was significant improvement in compliance where it increased by over 5%. Managers have been emailed where staff are non-compliant or due to expire prior to the end of May to try and reach this target in the coming months.

DNA
High Risk Fire – 11 (8 – Ludlow. 3 - Oswestry). Spaces not used 81 (Ludlow – 34. Oswestry – 47)
Resus Level 2 – 15
Resus Level 3 – 6
Moving and Handling Level 2 – 9. Spaces not used 18. There were 2 sessions cancelled due to lack of bookings.
Corporate Induction – 6. Spaces not used 18

Action Plan

Action	Start Date	End Date	Status	Outcome
Hotspot - Compliance Overview - Ops Teams to focus efforts on improving compliance rates for **Resuscitation Training**. The ESR Learning Management Team have identified gaps in these topics and provided managers with a detailed breakdown of non-compliance to support targeted interventions. These emails encourage managers to prioritise and allocate time for their staff to complete mandatory training	Mar-25	Mar-26	On Track	Resus Level 2 Adult - Nov 2025 - Target 84%. Actual 87% (+3%). Dec 2025 - Target 88%. Actual 91% (+3%). Jan 2026 Target 90%. Actual 91% (+1%). Feb 2026 Target 92%. Actual 92% (=0%). Mar 2026 Target 95%. Actual 92% (-3%). Resus Level 2 Paediatric - Nov 2025 - Target 84%. Actual 87% (+3%). Dec 2025 - Target 88%. Actual 91% (+3%). Jan 2026 – Target 90%. Actual 91% (+1%). Feb 2026 – Target 92%. Actual 92% (=0%). Mar 2026 Target 95%. Actual 92% (-3%). Resus Level 3 Adult - Nov 2025 - Target 73%. Actual 75% (+2%). Dec 2025 - 75%. Actual 73% (-2%). Jan 2026 – Target 80%. Actual 80% (=%). Feb 2026 – Target 90%. Actual 80% (-10%). Mar 2026 – Target 95%. Actual 86% (-9%). Resus Level 3 Paediatric - Nov 2025 - Target 84%. Actual 75% (+2%). Dec 2025 - 75%. Actual 73% (-2%). Jan 2026 – Target 80%. Actual 80% (=%). - Feb 2026 – Target 90%. Actual 80% (-10%). Mar 2026 – Target 95%. Actual 86% (-9%). During February there was 15 DNA's for Resus Level 2 and 6 DNA's for Resus Level 3. We cannot monitor the attendance for the Resus Level 2 and Level 3 training, as there is not the need to book their place through ESR and can turn up to the training. However where staff are booked through ESR, if they don't attend, we have followed the DNA as per any other topic. Resus Level 3, managers have been emailed where they have staff who are non-compliant or due to expire within the next 3 months. More planning needs to be done with regard to those who are due to expire. We can see that around 50% of staff who are non-compliant or due to expire in the next 3 months are booked onto a future training date.
Hotspot - Compliance Overview - ESRLMS to focus efforts on improving compliance rates for **High Risk Fire**. The Associate Director of Estates has attended Mandatory Training Group with proposal that High Risk Fire is replaced with Fire Warden Training.	Apr-25	Mar-26	On Track	High Risk Fire Trajectory - Oct 2025 - Target 75%. Actual 77%. (+2%). Nov 2025 Target 77%. Actual 78% (+1%), Dec 2025 - Target 82%. Actual 84% (+2%). Jan 2026 – Target 89%. Actual 90% (+1%). Feb 2026 - Target 91%. Actual 93 (+2%). Mar 2026 - Target 95%. Actual 92% (-3%). Mar 2026 - 95%. In February, we hosted a total of 6 training sessions: 3 in Ludlow and 3 in Oswestry. There were 11 people who did not attend their scheduled training (8 – Ludlow. 3 - Oswestry). The utilisation of available spaces warrants attention. Overall, 81 spaces were not utilised across all locations, 34 within Ludlow and 47 within Oswestry. Like with Resus Level 3 staff and managers are not booking in training when receiving the 3 month notification, we can see just under 40% of staff who are non-compliant and due within the next 3 months are booked onto a future date.
Hotspot - Compliance Overview - ESRLM to focus on improving compliance where there has been a continuation of non-compliance.	Oct-25	Apr-26	Completed	ESRLM reported on staff who have been non-compliant for 3 months or longer or have never completed the training. This report has been sent to the Associate Director for Workforce, Education & Professional Standards and the Deputy Workforce Operations Director (Interim)) Further investigation will be done on a number of people who are non-compliant for multiple topics and which topics have high rate of continued non-compliance.

Author	Catherine Morris	**Date**	01/05/2026
Accountable Officer Approval	Rhia Boyode	**Date**	01/05/2026

Agenda Item 016/26 Appendix 1

Public Participation Report
(October 2025 - March 2026)

Julia Clarke – Director of Public Participation

Shrewsbury and Telford Hospital NHS Trust

The agreed alliance between Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospital NHS Trust

VOLUNTEERS

VOLUNTEERS
Current position

- We currently have **214** active volunteers at the Trust, who over the past 6 months have contributed over 12,000 volunteering hours
- **Volunteer Team –** During the past 6 months there have been changes within the volunteer team. We have a new Volunteer Service Manager (Eve Simmonds-Jones) and a Volunteer Facilitator (Nicci Smith).
- We are also currently recruiting for a Band 5 to fill a vacant position.
- **Volunteer Coffee and Catch Up – Evening Sessions.** The first evening sessions have been held at RSH and PRH and the feedback from volunteers were that these are useful to hold every six months (in addition to the monthly coffee and chat sessions)
- **Our processing time for new volunteers is, on average, 3.2 weeks** which includes all recruitment checks (references, DBS, Occupational Health clearance) and mandatory training.
- Five year Volunteer Strategy 2026-2030 finalised after extensive consultation with public, staff and volunteers

VOLUNTEER

NHS
Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

VOLUNTEERS
Duke of Edinburgh's Award

SaTH successfully applied to the Duke of Edinburgh's Award scheme to become an Approved Activity Provider for volunteering. This will support more young people access volunteering opportunities at SaTH as part of their award.

Eve Simmonds-Jones, Volunteer Services Manager, and Nicci Smith, Volunteer Facilitator, were invited to attend an Approved Activity Provider (AAP) Event for the Duke of Edinburgh at the HSBC Building in Birmingham on the 3rd February. As the only AAP from the NHS in attendance, it was a great opportunity to share the opportunities we offer young people and we already have some young volunteers join us as part of this scheme.

Volunteer Driver and RSH Buggy Service

Volunteer Driver Service Update

250+	18	7
Journeys per month	Operational volunteer drivers in March	New volunteer drivers in progress

Our Volunteer Driver Service has continued to build and increase the number of patients they help and support. We have received enquiries from the Ophthalmology department along with DAART to see how we might be able to assist their patients and clinics. Drivers also offer a delivery service for medications, equipment and discharge letters to allow them to get home quicker and also provides a “settling in” service to check patients have drinks, electricity and heating with a working phone before leaving them. Conversations are planned with Shropshire Community Trust and our non-emergency patient transport provider to look at extending this service and we are aiming to achieve 300 journeys per month

RSH Patient Transport Buggy Service

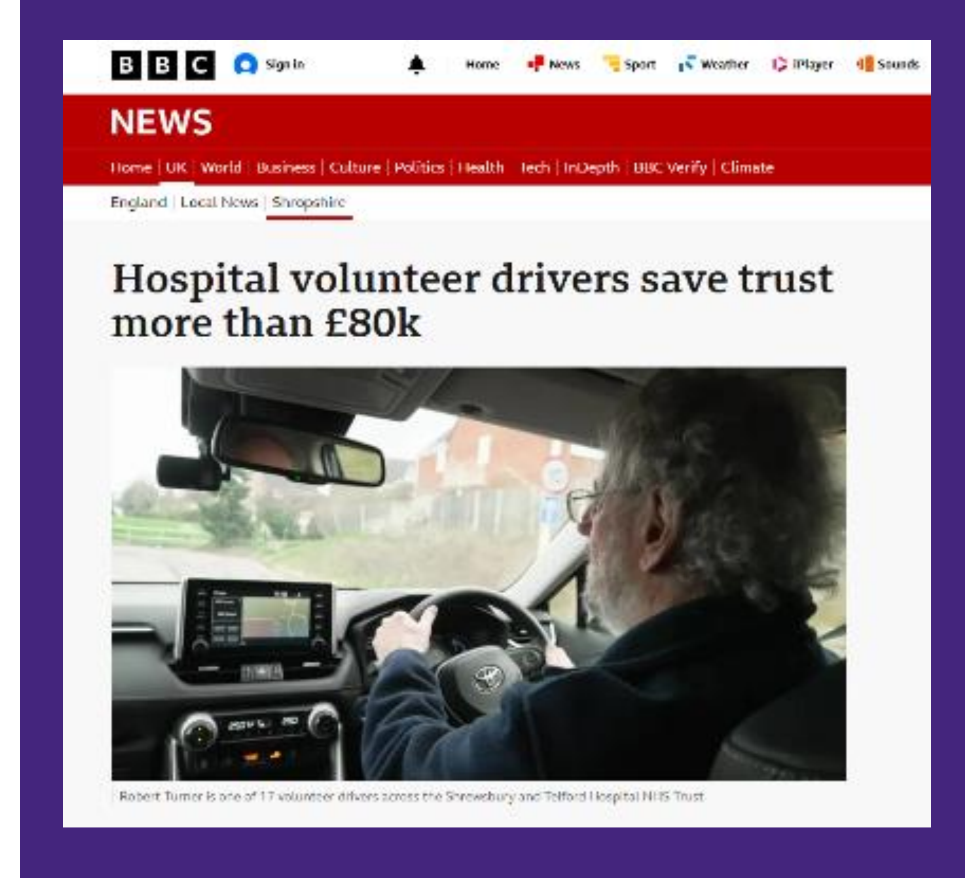
We have now trained **8** volunteers to drive our Patient Transport Buggy at the Royal Shrewsbury Hospital, with **3** new volunteers currently in progress enabling us to run a full driver rota getting patients to outpatient clinics from the Treatment Centre entrance.

VOLUNTEER DRIVERS

Our Volunteer Driver Service was featured throughout the day on Tuesday 24th March across the full range of BBC Media Channels; television, radio and online article, with televised reports on the breakfast, evening and late edition of Midlands Today.

The report focused on a renal patient, Jane Lewis, who is a regular patient for our volunteer drivers, and the story focused on the huge difference our volunteer drivers make in providing a safe and comfortable transport option with a 98% record of taking patients within 30 minutes.

In addition, Helpforce highlighted keys areas of the 6-month pilot report to emphasise the impact to our patients and services, and to encourage other NHS Trusts to implement the service.


BBC Sign in Home News Sport Weather iPlayer Sounds

NEWS

Home | UK | World | Business | Culture | Politics | Health | Tech | InDepth | BBC Verify | Climate

England | Local News | Shropshire

Hospital volunteer drivers save trust more than £80k

Robert Turner is one of 17 volunteer drivers across the Shrewsbury and Telford Hospital NHS Trust

VOLUNTEERS
Helpforce partnership

Our Volunteer to Career programme was featured by Helpforce who won the Health Service Journal (HSJ) Award for ‘Staffing Solution of the Year’ in March 2026. Julia Clarke, Director of Public Participation, was in attendance as SaTH was showcased from one of the 70-plus partners involved in Volunteer to Career, nationally:

“We are absolutely delighted to see Helpforce recognised at the HSJ Partnership Awards. With their support, our volunteering service has focused on strengthening our workforce, supporting our staff, improving patient experience and opening doors for people from all backgrounds to join the NHS.”

Julia and Hannah Morris, Head of Public Participation, were also invited to attend a reception in the House of Commons on 5th February 2026 where Helpforce brought together distinguished speakers and guests to explore how the healthcare and VCSE

sectors, as well as policymakers and funders, can play their full role in transforming the impact of volunteers.

Helpforce also launched and presented their landmark report, 'Reimagining Healthcare Volunteering’ which prominently featured the volunteering services we currently offer, along with referencing the impact and success of our Volunteer Driver Service.

We are discussing piloting neighbourhood volunteering schemes with Helpforce in line with the 10Year NHS Plan

VOLUNTEER

VOLUNTEERS

Volunteer welfare

Our first Volunteer Wellbeing Session took place on Tuesday 27th January, led by Catherine O'Callaghan from SaTH's Psychological Services Department. The session was very well received, and further sessions have been set up throughout the year with a mix of themed Wellbeing Sessions to focus on skills our volunteers can develop and use in both their volunteering and everyday life, along with structured Care Space Sessions where they can share experiences and learn from each other with the support and guidance of the Psychological Services Team

The Volunteer Team have also started making regular visits to our volunteers on shift, including volunteers Daisy and Nicky who greet our patients and visitors at the Ward Block Entrance at RSH, and Susan who welcomes our patients and visitors at the Women and Children's Atrium at PRH.

These visits, along with our Wellbeing Calls have been really well received by our volunteers and they allow us to check-in with volunteers and staff teams to offer support, reassurance and an opportunity to identify and potential issues so that they can be addressed quickly.

SHREWSBURY AND TELFORD HOSPITAL CHARITY

SATH CHARITY

NHS
Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

- Income for the 6 months September 2025 – February 2026 was £223,801 compared to £210,604 in the same period last year.
- Expenditure for the same period was £196,574 compared to £188,854 in 2024/25.

- During October 2025 – March 2026 SaTH Charity had:
  - **891** monetary donation entries registered on the charity database.
  - **4** donations were legacies and **18** donations were 'In Memory' donations from funeral services.

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

- Nicola Brockley is the Charity's Fundraising Manager supported by Emily Hughes the Fundraising Apprentice

SaTH CHARITY Supporters

Donors

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

Fundraisers

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

Donors	
Number of Donations	Total
1	1219
2 to 4	258
5 and above	11

Fundraisers	
Number of Fundraising Pages	Total
1	102
2 and above	38

SATH CHARITY
Supporting our patients (1)

Xray Specimen Window £15,000

There are two theatres at the Royal Shrewsbury Hospital, both capable of stereotactic guided breast biopsies. However, only one room could x-ray the specimen. Being able to x-ray the specimen is very important as it is a visual aid to show the correct area has been sampled. A second x-ray window was requested to increase capacity, improve the patient journey and reduce the number of insufficient biopsies requested and speed up time to diagnosis

Pupilometers for Critical Care- £7,000

Thanks to generous donations, Shrewsbury and Telford Hospital Charity have been to be able to purchase two pupillometers one for each Critical Care Unit at Royal Shrewsbury Hospital and Princess Royal Hospital, each costing £3,500.

The pupillometers helps assess patients by accurately measuring pupil size and reaction. This is especially useful when reactions are slow or hard to see, providing a more accurate result – making it a valuable tool for Critical Care.

SATH CHARITY
Supporting our patients (2)

RAF Shawbury Fly Santa to the Hospital

Santa swapped his sleigh for a RAF Shawbury helicopter when he flew in to visit the Children's Ward at the Princess Royal Hospital in Telford just before Christmas. Excited patients and staff greeted the Juno helicopter as it touched down with its special visitor aboard.

Christmas can be a really challenging time for patients, especially for children and their families whilst receiving treatment in hospital during the festive period, so Shrewsbury and Telford Hospital Charity and RAF Shawbury helped Santa deliver gifts to patients on the Children's Ward and also visited parents on the Neonatal Unit.

SATH CHARITY

Supporting our staff – Small Things Big Difference Fund

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

- Over **1350** members of staff are now playing the staff lottery. Half the income is paid out in prizes each month and the remaining income goes into the Small Things Big Difference Fund for staff requests.
- Between Oct-March there were **179** requests for support from SaTH Charity, **71** of which were for the Small Things/Big Difference Fund totalling £14,489 and included outdoor benches for staff breaks, coffee machines and microwaves for staff rooms

Impact Statement

"Sometimes it really is the small things that make a big difference. The Elective Hub at PRH team shared feedback about their working environment including something very simple: having a toaster and a microwave that actually worked. We contacted the SaTH "Small Things Make a Big Difference" Fund and applied on the team's behalf and the items were approved.

"This is a great example of how speaking up and sharing feedback leads to positive change, and how listening to our teams really does matter. It also highlights the incredible role SaTH Charities play in supporting our staff and helping to make day-to-day working life that little bit better. Thank you to the team for being open and engaged, and to SaTH Charities for your continued support."

SATH CHARITY
Celebrating our fundraisers (1)

Integrated Health Partners (IHP)

We are incredibly grateful to companies Integrated Health Partners (IHP), Dalkia, JCS, Longworth and O&B who joined together to raise an amazing £14,000 for Children's Services at SaTH. The different companies worked together as a team to raise a monumental amount for our newly launched campaign to raise money to build a sensory room and Sky Garden for the new children's ward, as part of our Hospitals Transformation Programme

Charity Concert- Jackfield Brass Band

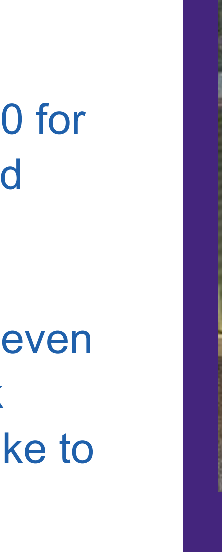
A magical evening of music was held in November with the Jackfield Brass Band and Haberdasher's Abraham Darby Jazz Band to raise funds for the Women & Children HTP appeal, which has now raised over £20,000 for the development of a Children's play garden and a sensory room in the new building at RSH, with Group CEO Jo Williams picking up the baton to lead the band for one of the tunes!

SATH CHARITY
Celebrating our fundraisers (2)

Red Lion Caersws

Customers at The Red Lion, Caersws have raised an incredible £7,125 in support of the Shrewsbury and Telford Hospital Charity. The money will go towards the HTP Critical Care and Oncology Garden – a new outdoor space for patients and their families.

The fundraising total was achieved through a series of fun and creative community activities, including food stalls, "money in a jar," "spud in a bucket," freshly prepared baps, and other lively events hosted at the pub. The generosity and enthusiasm of customers and supporters turned small change and community spirit into a significant donation for local hospital services.



Henrietta's Squat Challenge £2,235

Superstar Henrietta raised 1490% more than her goal of £150 for her squat challenge. The challenge start on 20th February and ended 20th March where she did her final 100 squats in her school, joined by some of her friends. Henrietta's story has captured the attention of lots of enthusiastic supporters, and even BBC Radio Shropshire; she was invited onto the show to talk about her challenge and the positive impact she wants to make to the patients staying on the Neonatal Unit.

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

SATH CHARITY
Working in partnership with NHS Charities Together
Staff Menopause service

In August we were notified that our bid of £48,965 to NHS Charities Together to fund a staff menopause service had been successful.

The clinic is a self-referral system with various stages of the support provided starting with access to recordings on general menopause information to provide awareness and understanding, followed by a Group Consultation / 1:1 s led by SaTH's Consultant Specialist, Dr Jo Ritchie.

The first clinic took place on 17 October and since that time dozens of SaTH staff have self-referred. In March it was agreed that the service could be extended to staff at Shropshire Community Trust from 1 April 2026

Impact Statement:

"I found the session very informative and felt very comfortable discussing my own symptoms and found it reassuring listening to others who suffered with the same or similar symptoms - I have recommended the session to a colleague."

"I think the session was great we were given a lot of information, and we were able to share our experiences in a safe environment

SATH Charity – working with local partners

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Shrewsbury Severn Rotary Critical Care and Oncology Garden

- A focus group was held with Shrewsbury Severn Rotary club in December, to consider the plans to landscape the critical care outdoor terrace.
- Former patients, families, as well as staff members, contributed to the conversation.
- Award winning garden designer, Mike Russell, also attended and has agreed to design a garden for this important space that will be capable of having two beds and plenty of seating for patients, families, and members of staff.
- Plans will be shared with public and staff for further feedback.

Lingen Davies Sunflower Appeal - Cancer Centre PRH

- Lingen Davies launched their appeal for the £5million Sunflower Appeal, that will develop a Cancer treatment unit in Princess Royal Hospital, scheduled to open in 2029.
- Combined with the existing services in the Royal Shrewsbury Hospital, this development will double chemotherapy capacity across our region.
- There are numerous ways to support the Sunflower Appeal including volunteering, hosting a fundraiser, making an 'in memory' donation, attending a Lingen Davies event, or simply helping to spread the word.

Respiratory Centre PRH

Clinical space in Princess Royal Hospital provides an opportunity to develop a Respiratory Day Unit – with support from charitable funding. Discussions are underway with the League of Friends of Shrewsbury and Telford Hospital about this aspiration.

Our vision is to:

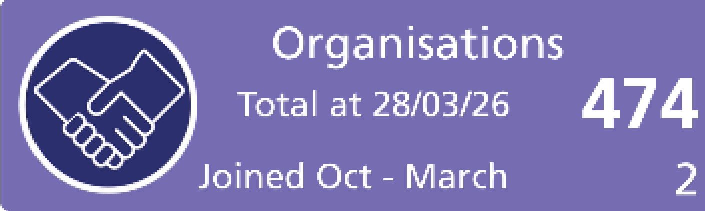
- Consolidate our respiratory specialists in one centre that will **serve our entire region**
- Provider **faster diagnostics and treatment** for respiratory conditions
- **Utilise existing, high-quality clinical space** in the current PRH W&C centre, which will be available once clinical moves have taken place as part of HTP

COMMUNITY ENGAGEMENT

COMMUNITY ENGAGEMENT

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

- The Community Engagement team (Kate Ballinger and Aaron Hyslop) arrange a a series of community events where the public across Shropshire, Telford & Wrekin and Powys are invited to join us virtually to find out more about their hospitals, which includes:
  - **Monthly newsletter update –** An email update to our 5000+ members and 400+ organisations
  - **Monthly Hospital Update (previously Community Cascade)** – this is a public session delivered once a month by the Director of Public Participation and focuses on current hospital news, public participation update and provides a Q&A opportunity. The presentations are available on our website
  - **About Health Events**– There is an ongoing series of one hour Teams health events delivered by health professionals for staff and the public on topics including the menopause, HTP, chaplaincy and other requested topics. The sessions are recorded and available on the website, with an opportunity for Q&As.
- The Hospitals Transformation Programme remains the main theme of feedback received by the Community Engagement team and we continue to work closely with HTP colleagues to support ongoing engagement.
- Five year Community Engagement Strategy 2026-2030 finalised after extensive consultation with public, staff and partners



COMMUNITY ENGAGEMENT
Hospital events

We hold monthly **Hospital Update** sessions on the last Wednesday of each month (apart from December!) Attendance at these events is generally around 20 members of the public. They are one hour long delivered by the Director of Public Participation and there is an opportunity to ask questions. They cover hospital news and the latest on how to get involved with SaTH. The presentation is shared on the #GetInvolved page of our website after the event.

Our regular **About Health** events, which are 60-minute sessions looking at particular topics of interest, delivered by clinicians/service leads with an opportunity to ask questions. These are recorded and the videos shared online after the event.

In Q3&4 we have covered:

- Hospitals Transformation Programme (x2)
- Menopause – Dr Jo Ritchie
- Patient Portal – Digital team
- Diabetes Footcare: Your questions answered – Nicky Beard, Podiatry Lead
- Cardiovascular disease and prevention – Dr Jayan Makesh
- Health & Wellbeing for People living with Cancer – multi-disciplinary team

Community Engagement

Dementia | Diabetes | Respiratory | Cardiovascular

All priority areas benefit from sharing these 4 key messages and we are visiting community groups where evidence shows an increased risk of these conditions, and sharing information/signposting to local services:

- ✓ Drink (alcohol) in moderation
- ✓ Eat a balanced diet
- ✓ Exercise more
- ✓ Don't Smoke

We are working closely with partners to maximise effectiveness and will be having discussions around closer working relationships with Shropshire Community Trust colleagues, which is one of our strategic objectives.

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

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

Respiratory
We are working with system partners to focus on outreach being taken to community settings for vulnerable groups (addiction, autism, gypsy/traveller communities)

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

COMMUNITY ENGAGEMENT
Seldom Heard communities (Core 20Plus5)

NHS
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Between October 2025 and April 2026, the Engagement Team delivered a programme of community, public and stakeholder engagement across Shropshire, Telford & Wrekin and Powys, combining face-to-face outreach with online engagement. Where possible, our team works collaboratively with multi-agency partners to increase trust and reach.

Alongside the key messages outlined on the previous slide, conversations focus on Hospitals Transformation Programme (HTP) updates, listening to community concerns, and building relationships with seldom-heard groups including:

- Inclusion Health Groups, including Gypsy, Roma and Traveller communities
- People with sensory impairments, including Deaf, Deafblind, Hard of Hearing and visually impaired people
- People living with dementia and their carers
- Rural and agricultural communities, including farming populations
- People experiencing digital exclusion or with limited access to online services
- People with long-term health conditions, including diabetes, cardiovascular disease, cancer and sight loss
- Older people, including those experiencing social isolation or frailty
- Unpaid carers, including carers of people with long-term conditions or dementia
- Armed Forces community, including veterans and their families
- STW Cancer Champions network

COMMUNITY ENGAGEMENT

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

You may remember the Patient Transport Desk as you entered Princess Royal Hospital…

This became the new Transforming Princess Royal Hospital Hub, pictured here at its launch
The hub gives us a space to talk with people who are using our services

Members of the Public Participation team (*Community Engagement, Volunteer and Charity teams*) are available in the hub Monday – Friday between 09:00 and 16:30

Since opening, we have engaged with thousands of people, more than 60% of whom were patients of the Trust.

COMMUNITY ENGAGEMENT

Hospitals Transformation Programme (HTP)

The Public Participation Team has been supporting HTP to engage with our local communities around the Hospitals Transformation Programme since 2023. The team organises a number of events including:

- **Quarterly focus groups** aligned to our clinical workstreams. We hold the focus groups every three months, and members can either attend in person or via MS Teams. Focus groups were held in early December 2025 and March 2026. The next focus group is 2 June 2026
- We have also held a series of specialised focus groups based upon the feedback we received from our quarterly focus group members and local communities. In December 2025 we held a HTP focus group for the Critical Care and Oncology Garden to draw up designs, with a further meeting planned in the Spring. There is also a Focus Group being planned for seating options.
- **Presentations, Q&As and action logs** from our focus groups are published in the public domain and can be found here with the Q&As from the focus groups : HTP Focus Groups – SaTH
- There is also a regular newsletter issued Hospitals Transformation Programme - Information Leaflet - 2026 by The Shrewsbury and Telford Hospital NHS Trust - Issuu
- **Quarterly *About Health HTP* events** have been delivered using MS Teams in October and January and the next About Health event is on the evening of **Tuesday 28 April 2026 at 6.30pm.** All About Health events are recorded and available on the website

Moving to EXCELLENCE

HTP Together

COMMUNITY ENGAGEMENT

NHS
Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Hospitals Transformation Programme (HTP)

- 01/10/25 – Bridgnorth Befriending Group, presentation
- 02/10/25 – Telford Visually Impaired Group, presentation
- 03/10/25 – Lydham Friday Market, drop-in
- 09/10/25 – The Wakes, Oakengates, drop-in
- 13/10/25 – Leadership Conference, presentation
- 14/10/25 – Newtown Health & Wellbeing day, drop-in
- 23/10/25 – RSH Neighbours, drop-in
- 23/10/25 – Rotary Club of Ironbridge, presentation
- 04/11/25 – Telford COG, Strengthening Community and Voluntary Organisations, drop-in
- 02/12/25 – HTP Quarterly Focus Group
- 05/12/25 – HTP Critical Care & Oncology Terrace Focus Group

- 08/01/26 – Wellington Live Well Hub, drop-in
- 13/01/26 – Newport Library, drop-in
- 23/01/26 – Whitchurch Library, drop-in
- 27/01/26 – RSH Neighbours, drop-in
- 28/01/26 – Oswestry Library, drop-in
- 02/02/26 – Bridgnorth Library, drop-in
- 06/02/26 – Broseley Library, drop-in
- 11/02/26 – Ludlow Library, drop-in
- 26/02/26 – Friends of SaTH Executive Committee, presentation
- 24/02/26 – Newtown Library, drop-in
- 05/03/26 – HTP Quarterly Focus Group
- 06/03/26 – Donnington Community Hub, drop-in
- 12/03/26 – Madeley Library, drop-in
- 20/03/26 – Bishops Castle Library, drop-in
- 23/03/26 – Welshpool Library, drop-in

COMMUNITY ENGAGEMENT
Implementing Feedback from our communities

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Throughout the HTP programme with have engaged and worked with our communities – they have had a direct impact into the programme and design of new healthcare facilities

Some examples of the feedback and changes from our focus groups are below and the full list of all actions taken can be found on our website

- Redesigned main entrance into the hospital – now with separate entrances for ED/UTC and main hospital
- Distinct, yellow toilet doors in the new building to aid patients or visitors with dementia or visual impairment
- Second bereavement suite added to W&C floors and one flexible room for use when required – this includes soundproofing of these rooms
- Providing a sensory room within W&C accommodation for children with learning disabilities and their families
- Dementia friendly clocks and signage within rooms and wards
- Two en-suite mental health rooms now incorporated within the Emergency Department
- Communal social space created for women to meet and chat when staying on the Maternity Unit (some for many weeks)
- Involvement (over 1600 responses) in naming convention and colour palette and clear colour differentiation between floors, walls and doors for those living with dementia and with additional visual needs

HTP Together

COMMUNITY ENGAGEMENT
Public Assurance Forum 3 November 2025

Shropshire, Telford and Wrekin Community and Hospitals
NHS Group

- The Public Assurance Forum (PAF) was established in 2021 to bring a public and community perspective to processes, decision making and wider engagement work at The Shrewsbury and Telford Hospital NHS Trust. The Forum provides constructive challenge and scrutiny of decisions from a patient and public perspective. They also share information back into their own organisations. PAF has a wide range of community and statutory sector organisations as members as well as representation from SaTH's Divisional Leadership Team.
- All papers are available on the Trust website Public Assurance Forum – SaTH
- The standing items include
  - updates from public members
  - updates from SaTH Divisions,
  - HTP report and review of draft presentation for next public About Health event,
  - HTP Engagement report (including fundraising).
  - Strategy and Partnerships report
  - Public Participation action plan report

Some of the other items discussed included:

- Park and ride scheme – Head of Facilities
- Modular wards – Chief Operating Officer
- Volunteer Driver Scheme – Volunteer Manager
- Patient Engagement Portal – Business Change Manager - Digital
- Review of draft Public Participation Public Board 6-monthly report before presentation to Board of Directors

COMMUNITY ENGAGEMENT
Public Assurance Forum 19 January 2026

- The standing items include:
  - Updates from public members
  - Updates from SaTH Divisions,
  - HTP report and review of draft presentation for next public About Health event,
  - HTP Engagement report (including fundraising).
  - Strategy and Partnerships report
  - Public Participation action plan report
- All papers are available on the Trust website Public Assurance Forum – SaTH
- In addition, some of the other items discussed included:
  - SaTH Medium Term Plan – Divisional Director of Operations
  - Group name and next steps – Chief Communications Officer
  - Community Engagement Strategy – Director of Public Participation
  - Helpforce Discharge Driver Report – Head of Public Participation

COMMUNITY ENGAGEMENT
Additional Engagement Routes

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

LOOKING FORWARD

PUBLIC PARTICPATION

Forward Look

- The Public Assurance Forum to meet quarterly and review its constitution when Foundation Trust guidance issued
  Continue to support staff with any future service changes engagement
- Support the HTP Engagement programme, including the quarterly focus group for the public and patients.
- Maximise opportunities for joint working with Shropshire Community Trust
- Continue to support staff wellbeing through Charity Small Things Big Difference Fund
- Support fundraising for the Hospitals Transformation Programme
- Continue to grow and support our volunteers and the opportunities we provide to them
- Develop Volunteer schemes to address hospital priorities, NHS Plan and work closely with Shropshire Community Trust to maximise effectiveness

Areas of Focus

- Dementia
- Diabetes
- Respiratory
- Cardiovascular

Methods of Engagement

- **Online**
  Targeted messaging around prevention and management of conditions identified above with appropriate audiences
  Sharing hospital knowledge through **About Health** programme
  Sharing information from stakeholders through **#GetInvolved**

- **Partnership**
  Working with VCSA groups, representatives and forums.
  Building relationships with community leaders.
  Providing articles for community newsletters.
  Liaising with community advocates to ensure engagement is appropriate.
  Collaborative engagement with local authorities and other statutory bodies.

- **Involvement**
  Internal
  Working with divisions to develop meaningful engagement with target communities.
  Working collaboratively with the SaTH internal Health Inequalities group (***Accelerated Preventative Programme workstream)** to ensure a "whole of SaTH" approach to engaging our seldom heard communities.
  External
  Increase opportunities for the public to take part in SaTH involvement activity by identifying and mitigating barriers to involvement, developing new methods of involvement as required.

SaTH Community Engagement Action Plan 2025/2026 Agenda Item 016/26 APPENDIX 2

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

Strategic Aims

To contribute to delivery of the Public Participation Plan, namely:

1. **INCLUSION:** To increase the number and diversity of people involved with SaTH, ensuring that they are provided with meaningful and timely involvement opportunities
2. **RESPONSIVE:** Build greater public confidence, trust and understanding by listening and being responsive to our local communities
3 **DECISION-MAKING:** To introduce a public and community perspective to decision making and wider work at SaTH, including, recruitment, strategic planning, training and service development and delivery
4 **GET INVOLVED:** Ensure our communities feel better informed and able to Get Involved if they choose too. Develop a range of involvement opportunities that are rewarding, meaningful and enable individuals from a diverse range of backgrounds to get involved.
5 **COMMUNICATION:** SaTH will communicate with our communities directly to ensure they are kept informed and update about what is going on at the hospitals (making use of digital communications)
6 **OUR STAFF:** Enabled our staff to have the skills and confidence to engage with our communities

Desired Outcomes

- Make every contact count, and identify and find ways to engage with those communities who may have barriers to engage with us
- Key barriers to engagement identified & mitigation in place
- Regular meetings/networks in place to keep in contact with stakeholders
- Increase in incoming enquires and active and ongoing engagement from stakeholders
- Increase in both group & individual membership (Target 10% over the year)

Key Risks / Benefits	L	C	LxC	Mitigated L&C
Fail to deliver the Public Participation Plan, resulting lack of confidence of our communities	2	4	8	A detailed Action Plan and yearly plan on a page will be drawn up and submitted quarterly to the Public Assurance Forum (PAF)
Fail to deliver our statutory duties (S242) to engage with the public	3	4	12	Continue to support our Divisions to ensure they meet their statutory duties. Update PAF on engagement relating to service changes
Failure to continue to involve communities during the building stage of HTP could result in challenge	2	5	10	Full programme until 2028 and ongoing attendance/events planned until 2028

Q1 — April—May—June 2025

1. Recruit to Engagement vacancies
2. Work with SaTH Health Inequalities group to identify key audiences for thematic engagement.
3. Create a diary of engagement events/invites and share internally to enable collaborative engagement
4. Attend community events and meetings to engage local population and share messaging for key priorities/promote involvement opportunities
5. Deliver About Health events
6. Provide support for Hospitals Transformation Programme
7. Work with divisions to ensure they meet their Section 242 duties.

Q2 — Jul-Aug-Sep-2025

1. Recruit to Engagement vacancies
2. Create plan for Public Participation strategy development including community survey and workshop events.
3. Visit 2 priority community groups
4. Attend community events and meetings to engage local population and share messaging for key priorities/promote involvement opportunities
5. Deliver About Health events
6. Explore alternatives to CLEAR email platform—(greater functionality/lower cost)
7. Provide support for Hospitals Transformation Programme
8. Work with divisions to ensure they meet their Section 242 duties.

Q3 — Oct—Nov—Dec-2025

1. Recruit to Engagement vacancies
2. Carry out mid-point review of collaborative engagement and revisit plans for Q3 & Q4.
3. Progress Public Participation Strategy engagement.
4. Visit 2 priority community groups
5. Attend community events and meetings to engage local population and share messaging for key priorities/promote involvement opportunities
6. Deliver About Health events
7. Provide support for Hospitals Transformation Programme
8. Work with divisions to ensure they meet their Section 242 duties.
9. Explore alternatives to CLEAR email platform—(greater functionality/lower cost)

Q4 — Jan—Feb—March-2026

1. Recruit to Engagement vacancies
2. Review social media outcomes and develop standard protocols for ongoing use.
3. Visit 2 priority community groups
4. Attend community events and meetings to engage local population and share messaging for key priorities/promote involvement opportunities
5. Deliver About Health events
6. Provide support for Hospitals Transformation Programme
7. Work with divisions to ensure they meet their Section 242 duties.

General Notes

Outcomes—Q2

1. The team has successfully recruited to one of the vacant posts. The 0,6wte vacancy will be advertised in April 2026
2. ShropComm attended focus group and updated on Neighbourhood plans.
3. Surveys and focus groups carried out for Community Engagement and Volunteering strategies.
4. Ongoing programme of visits, and prioritised attendance at Community Connectors meetings across Shropshire/Telford & Wrekin to share information
5. Delivered 3 About Health events: Health & Wellbeing for People living with Cancer, HTP, Cardiovascular disease prevention
6. Continued support for Hospitals Transformation Programme.through focus groups and presentations
7. Supported Pre-Op move to Sentinel Park with focus group

SaTH Charity Development & Action Plan April 2025-26

V4 31/03/2026

Stakeholder Groups

A. Public (incl. patients)
Appealing to the public is important to achieve our core objectives of raising funds, community engagement and creating a platform to recognise care received.

B. Local Business and Organisations
SaTH provides health care for the workers of local businesses, many will have employees who either or their family are patients at SaTH. Supporting SaTH Charity is likely to be popular with employees. SaTH Charity is keen to engage, encouraging fundraising and their support.

C. Staff
The Charity recognises SaTH staff as its key asset and is focussed on supporting their wellbeing to aid wellbeing and retention. Staff can influence patients to be supporters and are also valuable fundraisers.

D. Existing charitable organisations providing support
SaTH Charity must not be seen as a threat but as a complimentary partner to other charities. Engagement with our ICB partners is an opportunity.

E. Volunteers
They might develop into active fundraisers. Volunteers give time which is comparable to giving money and aligns to supporting SaTH. Volunteers can raise the profile of the charity.

Charity Team
The SaTH Charity Team sits within the Public Participation Team, aligning it with engagement and volunteering.

Finance support is based at The Shrewsbury Business Park under the management of Vicky Hall, Senior Accountant Charitable Funds.

Strategic Aims

- We will build strong, dynamic relationships with local businesses, national organisations, and community groups to amplify our reach and resources. By working together, we can achieve greater impact, fund ambitious projects, and inspire collective pride in our hospitals.
- We will grow our income to enhance patient care and staff wellbeing, ensuring the funds raised makes a meaningful difference. At the same time, we are committed to investing responsibly, safeguarding resources to maintain financial stability and sustain our impact over the long term.
- We will create user-friendly and inclusive donation experiences that inspire generosity. From digital platforms to visible on-site opportunities, we'll ensure that everyone in our community can easily contribute and see the tangible impact of their support.
- We will launch a joint appeal to inspire community support, funding advanced medical equipment and creating uplifting environments that redefine care for patients and staff. By enhancing the patient journey and celebrating staff dedication, we will make the charity integral to the hospitals' transformation.
- We will support and develop our fund advisors, staff, and internal teams to maximize their potential. By providing training, tools, and guidance, we will align charitable efforts with the Trust's priorities and deliver exceptional outcomes together.

Desired Outcomes

- To increase charitable income, raised or left by legacy to SaTH Charity by 5% year on year based on a rolling 3 year average.
- Increase the visibility of SaTH Charity as the Trust's Hospital Charity locally, measured by increased engagement through social media and supporters and fundraising
- Develop partnership working with corporate organisations in county to maximise relationships with business sector
- Enhancing community involvement with SaTH through positive media opportunities engagement events and fundraising activity.

Key Risks / Benefits	L	C	LxC	Mitigation
5. Fundraising income falls below target of 3yr rolling average +5%	2	4	8	Activity targets and reports monitored through CFC to identify any variance and take action
6. Success of the HTP Appeal	2	3	6	Clear strategic plan to be develop with actions and activity targets and reports monitored through CFC to identify any variance and take action
8. SATH Charity team capacity & succession planning	2	3	6	Annual review to CFC of team function and comparison with NHS CT data. Secure fixed term funding for Charity Comms and engagement post.

Q1 — April – May – June

- Introduce digital donation pilot (TapDonate). Initially working with Fracture Clinic at PRH
- Engage with Fund Advisors and partners to implement new SaTH Charity Policy and online request form
- Develop HTP fundraising strategy working with HTP (and Lingen Davies for Cancer Centre).
- Submit paper to CFC for additional Charity resource to support HTP fundraising
- Review branding of SaTH Charity (to also include consideration for HTP appeal)
- Plan and promote annual charity fundraising events (Football Tournament, SaTH Charity Thank You Campaign, Shrewsbury Half Marathon and Jackfield Brass Band Charity Concert).
- Develop the relationship with our fundraisers to include: regular development of positive news and engagement and Quarterly Supporters newsletter
- Work on branding awareness at new PRH Main reception HTP/Charity hub

Q2 — July — August — Sep

- Submit draft copy of the Annual Report for review by CFC.
- Work with HTP and other stakeholders to develop a plan for HTP appeal. Work with the HTP team to make HTP experts available to support fundraising activities
- Reach out to "corporate" HTP support eg Rotary, Foundations
- Work closely with the Trust's Communication team to promote SaTH Charity with external and internal audiences
- Awareness campaign on Staff Lottery Sign Ups and summer promotion of Small Things Fund
- Submit draft copy of the Annual Report for review by Auditors.
- Deliver SaTH Charity Thank You Campaign on NHS Birthday
- Develop the relationship with our fundraisers to include: regular development of positive news and engagement and Quarterly Supporters newsletter

Q3 — Oct — Nov — Dec

- Explore and develop partnership working to create opportunities to support major appeals for HTP
- Ensure fundraising priorities and divisional charity expenditure plans are aligned to Trust's strategic priorities
- Deliver key milestones for HTP appeal plans.
- Awareness campaign on Staff Lottery Sign Ups
- Promotion of 'Small Change Big Difference' Scheme
- Deliver SaTH Charity Concert
- Develop the relationship with our fundraisers to include: regular development of positive news and engagement and Quarterly Supporters newsletter

Q4 — Jan — Feb – March

- Deliver key milestones for HTP appeal plans.
- Provide guidance and training for fund advisors and staff on donor stewardship and fundraising activities
- Analyse investments in clinical equipment, the hospital environment and enhanced service delivery based on divisional annual plans to ensure we are meeting the objectives of the charity.
- Develop the relationship with our fundraisers to include: regular development of positive news and engagement and Quarterly Supporters newsletter

General Notes — Progress against Q4

- HTP Appeal plans are ongoing. We are working closely with the Rotary Team who are fundraising for the Critical Care and Oncology Garden. The designs for this have been received and costs should be available soon. Focus groups are planned for the Children's Services Garden and fundraising is ongoing. Friends of SaTH intend to launch their campaign for the Respiratory Centre in 2026-2027
- A request for divisional plans for 2026/2027 has been circulated by the Chief Operating Officer . These are due to be brought to the CFC meeting 6th May.2026. Meetings have taken place with Divisional leads in Medicine, W&C, Pathology, oncology and CriticalCare to discuss stewardship and fundraising in relationship to HTP
- The quarterly Charity newsletter has been paused due to staff capacity. However social media has been utilised to engage with our audience and the Facebook page (where the majority of our engagement comes from) has grown almost 50% since September 2025 (719 followers to 1050 follows). Regular charity information has also been shared with over 5000 members n the monthly #GetInvolved Newsletter

SaTH Volunteer Development & Action Plan
April 2025 to March 2026

V1 17/03/2025

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Stakeholder Groups

A. Volunteers
Volunteers provide additional capacity to support staff, patients and visitors through a combination of tasks that would not otherwise be fulfilled. Improving the patient journey, outcomes and staff wellbeing.

B. Staff
This is a key group that should be aware of SaTH Volunteers to help and support the Trust to achieve the agreed desired outcomes.

C. Public
Engagement with the public is key to ensure the number of Volunteers is maintained to meet the needs of the Trust. Volunteering provides a step into engaging with the Trust and supporting SaTH Charity

D. Schools, Organisations and Local Business.
Provides candidates for our young Volunteers Schemes. Groups and Organisations support with corporate volunteer days.

E. Other Volunteer Organisations.
Maintain relationships with other volunteer organisations such as LoF, Lingen Davies, British Red Cross, RVS etc.

Programme
The Volunteer Team is based in William Farr House at RSH and provides support across both hospital sites.

Strategic Aims

- To improve the patient journey through a vibrant and effective volunteer programme. To ease pressures on staff and support their wellbeing.
- Widen the reach and further develop the Volunteer to Career Programme (VtC), including targeted programme for specific groups e.g. Veterans and Families
- Develop our discharge volunteer programme (volunteer drivers and telephone support services) and measure the impact of the project for our services and volunteers
- Develop and implement a 5 year volunteer strategy
- To work towards maintaining the required number of volunteers to meet the demand from the areas supported by the volunteer service.
- To hold quarterly volunteer focus groups to engage with our volunteer cohorts
- Support our staff to effectively manage and support our volunteers while on placement.

Desired Outcomes

- To increase the number of active volunteers and target recruitment to the areas within the Trust which has the highest need
- Ensure those who have completed the recruitment process have meaningful and regular placements.
- To deliver a successful discharge programme and continue to develop our VtC programme

Key Risks / Benefits	L	C	LxC	Mitigation
Hight turnover of volunteers creates capacity issues within the volunteer management team	4	1	4	Ensure robust recruitment process are in place, including structured interview. Those who do not meet the requirements to volunteers are, where possible, offered alternatives e.e.g work experience. Provide ongoing support through welfare calls and catch ups
The risk of providing adequate training prior to commencement with the Trust.	2	3	6	Strict on-boarding process to ensure that volunteers understand where they can work and how to mitigate risk through their training
Required Volunteer Recruitment to meet Trust need	2	3	6	All volunteer checks are done through the central Volunteer Dept. following an agreed protocol and the Manager has extensive experience of recruitment and Trust Policy. A recruitment focus is in place.

Q1	Q2	Q3	Q4	General Notes
April – May – June	**July — August — Sep**	**Oct — Nov — Dec**	**Jan — Feb – March**	**Progress against Q4**
• New members of the volunteer team to start in post and have an induction period • Progress with the Volunteer to Career Programme in Midwifery and Veterans and families (cohort 5 to start in June) • Develop Discharge Volunteers programme action plan and start the implementation of the discharge driver role and the discharge support phone calls • Deliver Volunteers' Week celebration event June 2025 • Coordinate monthly coffee and cake catch up with volunteers • Review the feedback from the 2025 volunteer survey and develop an action plan • Targeted recruitment of volunteers for areas where there is the most need for the Trust eg waiting list validation	• Develop with the input from volunteers and staff, a draft of the 5 year Strategy for volunteering and annual plan on a page • Launch 2025/6 September Youth Volunteer Programme • Review and update website content and social media exposure • Review Better Impact content (files, templates etc.) to ensure it is current. • Organise 2x Focus Group on selected area • Monthly coffee and cake catch up with volunteers • Review the discharge programme and outcomes. • Plan implementation of discharge programme as business as usual • Plan Cohort 6 of the VtC programme	• Interviewing, processing and training for the new cohort of Youth Programme volunteers • Plan and send volunteers annual survey • Contribute to Trust Volunteers awards process • Ensure volunteers are included in staff Christmas celebration • Monthly coffee and cake catch up with volunteers • Organise 2 x Focus Group on selected area • Engage with schools and colleges with on and off site presentations regarding volunteering • Review VtC programme Cohort 6	• Volunteer annual survey to go out to all volunteers • Develop a plan on a page for 2026/2027 • Plan Volunteers' Week 2026 • Review Better Impact as our management platform and implement updates • Organise 2 x Focus Group on selected area • Review current approach to Youth Programme Organise monthly coffee and cake catch up with volunteers • Active database and volunteer role review	• A Survey for the five year strategy was sent and received a good response which informed new initiatives—for example, Wellbeing Calls and Sessions. • The Wroxeter Hotel has been booked and Invitations sent to Volunteers and Executives. Certificates and badges are in process along with a presentation for Julia Clarke. • We have had a thorough review and audit of Better Impact data and functions, along with how we record volunteer information to ensure accuracy and efficiency. • We held an online meeting in January to share the findings of our volunteer driver service and gain feedback, along with evening Coffee and Catch up sessions planned to gather more general feedback from volunteers. • Cohort 6 of VtC is underway, with Cohort 7 planned for later in the year. DofE is ongoing • Monthly Coffee and Catch ups are now being held each month and a survey has been sent to all volunteers to gather feedback about how they would like these to look going forward. • Young Volunteers to be recruited through targeted schemes eg Duke of Edinburgh Award • We have reviewed all Volunteers roles with 18 roles prioritised and the remaining roles to be assessed once priority role rota are

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

Moving to Excellence

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

Our Moving to Excellence Ambition

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

Task ID	**Task** *The tasks you need to complete to produce the deliverables*	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**BRAG Progress Status**
Deliverable: 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 reviewed in March to April 2026 and are due to be considered at the May HTPAC meeting, ahead of approval by Board of Directors.	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
	• Committee workplans showing alignment • Minutes confirming review discussions. • Any revised Terms of Reference approved by Board committees.					
SaTH 4.1.15	Deliver and oversee the HTP Improvement Plan, ensuring governance, assurance and reporting via the HTP Assurance Committee. Evidence will include: • HTP Assurance Committee papers (agendas, minutes, slide packs) confirming regular reporting and oversight. • Quarterly HTP progress reports submitted through the Assurance Committee and escalated to QPC/STW Board as required. • Updated HTP Improvement Plan tracker showing progress, risks, mitigations, and RAG status. • Assurance Committee Key Issues Reports highlighting progress, risks, and decisions. • Evidence of internal governance routing, including CE meeting oversight and relevant Board Assurance Committee alignment • Integrated programme dashboards demonstrating progress against milestones and key interdependencies. • Correspondence or briefing notes provided to system partners (e.g.,	Matthew Neal	Already started	31/03/2027		

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
	ICS, NHSE) demonstrating ongoing assurance. • Updated Terms of Reference or governance flow diagrams where relevant, showing the HTP Assurance Committee's role in oversight.					
Deliverable: 4.2: Establish the new Group Model						
SaTH 4.2.7a	To recruit and appoint the Group leadership team and Group Non-Executive Directors. (Was previously Task ID 4.2.10) **Evidence will include:** • Remuneration Committee papers confirming process and timelines. • Job descriptions and adverts • Announcement or communication confirming appointments	Group Chair /Group CEO	01/09/2025	30/09/2026	In progress. Remuneration Committees to consider process and timeline. Plans in place to begin recruitment.	
SaTH 4.2.7b	Agree and embed joint membership of Board Committees and update NED portfolios to ensure clear alignment with roles and responsibilities, supporting effective oversight and assurance. (Was previously Task ID 4.2.7) **Evidence will include:** • A short note or minutes showing how membership was agreed. • The criteria used (e.g., alignment with portfolios, balance of workload) • The final membership list • The updated Terms of Reference showing the membership.	Anna Milanec	01/09/2025	31/12/2027 (pending confirmation of appointment of group members)	The Group Transition Committee (joint with ShropCom) held its initial shadow meeting in July 2025 to review and agree the Terms of Reference, ahead of its formal establishment in August 2025. Agenda, minutes and full meeting packs have been submitted. SaTH's existing Terms of Reference template continues to be used to ensure consistency.	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
	• The minutes confirming approval of the Terms of Reference (and therefore the membership). • Group Transition Committee papers (agenda, minutes, packs)					
SaTH 4.2.8	Further develop and embed the workings of the Group People and OD Committee as the first joint committee to unify workforce strategy, culture, and talent development. **Evidence will include:** • Minutes and papers from first and second joint committees (24 Nov 2025, 26 Jan 2026) • Forward plan (final version) • Updated ToR when approved	Deborah Bryce / Anna Milanec	01/09/2025	31/05/2026	The first Group People and OD committee in common meeting was held on 24 November 2025, with a further meeting held on 26 January 2026. Consideration to be given as to what items are for information and what are for decision. Forward plan being finalised and being considered with the Chief People Officer on 06 May 2026, along with the 01 June 2026 People Committee agenda.	
SaTH 4.2.9	Implement an Accountability and Governance Group Framework for setting out shared principles, objectives, and ways of working of the two providers working together (SaTH and ShropCom). **Evidence will include:** • Trust Board in Common minutes (23/09/2025) • Group Transition Committee ToR (approved Aug/Sept 2025) • Meeting packs submitted • Framework document (final PDF)	Anna Milanec	01/09/2025	31/03/2027	Trust Board in Common held between SaTH and SCHT 23/09/2025. Group Transition Committee is in place with Terms of Reference approved by the Board in public on 11 September 2025 (in private: August 2025). Meeting papers submitted as evidence.	
4.2.13	• Develop and implement the Freedom to Speak Up (FTSU) group model.	Anna Milanec	01/04/2026	31/12/2026	Freedom to Speak Up (FTSU) is already recognised as an essential component of the emerging Group governance framework. FTSU arrangements. The Group Transition Committee documentation confirms	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
	• Promote the FTSU group model through consistent communications so that all staff receive clear and aligned messaging. **Evidence will include:** • Draft and final FTSU model/approach • Communications plan and staff messages • Screenshots/newsletters confirming roll-out. • Minutes from FTSU steering or oversight groups. • Updated FTSU policy (when ready)	Jenny Fullard			that FTSU arrangements are in place across the organisations, including the FTSU Vision and Strategy, the FTSU policy and training in place. These elements are referenced alongside the wider governance and cultural development work required for the new Group Model, demonstrating that FTSU is being treated as a core part of the future Group governance structure.	
4.2.14	Take forward the recommendations from the December 2025 NHSE Freedom to Speak Up (FTSU) report and track delivery through 2026/27. **Evidence will include:** • NHSE FTSU review report • Action plan with status updates • Evidence folder (for recommendations) • Quarterly progress update to relevant committee and the Board.	Anna Milanec	01/12/2025	31/03/2027	• In progress	
4.2.15	Further to the review of the SFI's/ Standing Orders/ SoRD at both organisations during 2025, align SaTH and ShropCom Standing Financial Instruction's, Standing Orders and Scheme of Reservation and Delegation.	Anna Milanec Deborah Bryce	01/04/2026	31/03/2027	• In progress	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
	Evidence will include: • Baseline comparison document • Agreed aligned versions (draft & final) • Confirmation of approval in minutes (Audit & Risk or Board)					
Deliverable: 4.3: To ensure the Group identifies and manages risks effectively						
4.3.6	Develop a Group Risk Management Policy and Risk Management Strategy, including an agreed risk appetite statement for SaTH and ShropCom. **Evidence will include:** • Draft and final Risk Management Policy • Draft and final Strategy • Jointly agreed Risk Appetite Statement • Minutes from Audit & Risk or Board confirming approval.	Anna Milanec	01/04/2026	01/01/2027	Work to develop a Group Risk Management Policy, Risk Management Strategy and shared risk appetite statement for SaTH and ShropCom is scheduled for consideration.	

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

Appendix 2: SaTH Integrated Improvement Plan (SIIP): Workforce and Leadership Plan 2026/27.

Moving to Excellence

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

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Our Moving to Excellence Ambition

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

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
Deliverable: The outputs that you need to produce to demonstrate delivery of exit criteria	**Deliverable Metric 2.1: SaTH workforce planning completed ready for 2027/28 sign off by the Trust Board**					
SaTH 2.1.26	E-Rostering implementation – medical workforce. **Evidence will include:** • Medical E-Roster rollout complete based on programme outline • Completion report with % rollout by specialty Compliance dashboards (job plan linked / rostering KPIs)	Laura Carlyon	01/08/2025	31/03/2027	• 95% of resident doctors are now in place with e-roster. Activity Manager module purchased and preparations underway for consultant rotas.	
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 – completion by end of May	.
SaTH 2.1.29	Continued work on job planning embedding as part of workforce planning to support productivity and efficiency. **Evidence will include:** • Workforce plan document completed and including job planning elements. • % consultants with approved job plan • Job plan compliance dashboard	Simon Balderstone	1/2/2026	30/09/2026	• Job planning programme for 26/27 launched	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
	• Governance minutes from Strategic People Group monitoring					
SaTH 2.1.30	Staff engagement strategy to be developed and implemented to support preparations for HTP/development of a group model. **Evidence will include:** • Staff engagement strategy finalised • Board minutes confirming approval of the strategy • Engagement plan and communication materials Summary of staff feedback	Sabeena Khanna	1/2/2026	31/03/2027	• HTP workforce engagement activity, including emphasis on early engagement, communication and confidence-building with staff at an HTP workforce workshop held in February 2026.	
SaTH 2.1.31	Manage the workforce changes required for the Hospitals Transformation Programme (HTP), including staff consultation, trade union engagement, workforce impact assessment, and meaningful staff involvement to ensure the 2027/28 workforce plan is complete, affordable, and ready for Trust Board sign-off. **Evidence will include:** • HTP workforce impact assessments • Trade Union engagement logs • Consultation timeline • Workforce modelling for new clinical model Equality impact documentation	Sabeena Khanna	01/04/2026	31/03/2027	• Working with the PMO support team to develop workforce HTP timescales and these will be added to the Master Programme.	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
2.1.32	Continue to support transformation of services, system alignment and collaboration with STW (Shropshire, Telford and Wrekin) to align to system plans **Evidence will include:** • Evidence of participation in STW system transformation groups, programme boards, or working groups • Records of joint planning sessions and alignment of organisational plans with STW system priorities • Progress updates on shared transformation projects and delivery milestones • Workforce and leadership involvement in system-wide development or transformation activities • Improvements in service pathways or outcomes linked to system-wide transformation work • Regular reporting through internal governance routes on progress, risks, and impact Communication and engagement materials demonstrating staff and partner involvement in system transformation	Ned Hobbs Nigel Lee	1/2/2026	31/03/2027	• The Trust continues to actively support service transformation and system alignment through sustained collaboration with STW partners. This includes engagement in STW system governance and transformation forums, alignment of HTP, UEC and workforce activity to STW system plans, and contribution to shared services and system improvement programmes. Progress is monitored through SIIP and system assurance frameworks.	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
SaTH 2.1.33	Sickness absence management support programme developed with clear milestones for delivery. Evidence will include: • Programme outline developed and implemented. • Reduction in long-term sickness trend • Manager sickness training delivery • Health & Wellbeing interventions IPR reports	Nick Dowd	1/2/2026	31/03/2027	• Programme is being developed	
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	.
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	TG/ RA/ SF	01/9/2026	31/03/2027	The Trust is working with Higher Education Institutions to strengthen	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
	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				education pathways and develop new clinical and vocational roles, including ACP and apprenticeships. 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	
SaTH 2.2.8	Continue to deliver the cultural and leadership programmes required to support workforce transformation through a rolling framework, including leadership development, OD interventions, health and wellbeing (HWB) initiatives, staff survey actions, reward and recognition, People Pulse reporting and Group-wide communication and engagement plans **Evidence will include:** • Leadership development programme schedules and evaluations • OD intervention reports and outcomes • Health and well-being activity data • Staff Survey action plan progress • Reward and Recognition outputs • Quarterly People Pulse reports and improvements in scores	DT	01/04/2025	31/03/2027	Cultural transformation, focusing on group, Poppy's promise planning sessions for launch as a brand and movement for cultural change, plan being developed. Conversations have taken place with AQUA and Kind of Life. Group Leaders forum on 30th April 2026. Further planning meetings with AQUA in May 2026. Board development day 21st May 2026. Leadership Framework - programmes and masterclasses can be accessed by the Group.	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
	• Papers submitted to Strategic People Group / Group People Committee in Common • Approved Group communication and engagement plan Staff engagement materials & feedback					
SaTH 2.2.9	Continuing to deliver our Workforce Digital Programme including: • Deploy Manager Self-service. • Continuing to support Job Re-design/ Team Job Planning including different approaches to rostering, agile and flexible working. Further development and roll out of medical electronic rostering and dashboards to provide greater visibility of doctors working hours. **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	• 82% of all departments using new Manager Self-Service ESR, and 18% underway, giving greater autonomy for managers	

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, with delivery monitored via Board Assurance Committees and escalated to the Board of Directors through regular reporting. Ward-to-Board assurance is strengthened through PMO scrutiny, M2E transformation oversight, executive escalation routes and alignment with bi-monthly NHSE/PRM assurance processes.	Green
Deliverable: The outputs that you need to produce to demonstrate delivery of exit criteria	**Deliverable Metric 5.4: SaTH's contribution to a clear system culture and leadership improvement programme and evidence of a positive shift in staff experience through pulse survey/NHS staff survey.**					

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

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

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Appendix 3: SaTH Integrated Improvement Plan (SIIP): Finance Plan 2026/27.

Moving to Excellence

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

Our Moving to Excellence Ambition

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

Summary of the progress against delivery of the SaTH Finance Plan 2026/27

Deliverable(s) *The outputs that you need to produce to demonstrate delivery of exit criteria*	**Task** *The tasks you need to complete to produce the deliverables (*	**Task ID**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**BRAG**
SaTH has an agreed medium term 3–5-year financial plan (MTFP) in place that has been signed off by the Board and agreed with the ICS and NHS England.	2026/27 Annual refresh of MTFP and 5-year high level financial plan (including triangulation and cashflow).	SaTH 1.1.2	AW	Ongoing	30/09/2026	Annual refresh and triangulation complete in line with annual planning submission. Final plan to be submitted 12/02/2026 with realignment submission on 18/03/2026.	

Deliverable(s) *The outputs that you need to produce to demonstrate delivery of exit criteria*	**Task** *The tasks you need to complete to produce the deliverables (*	**Task ID**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**BRAG**
Triangulation exercise - financial plan to workforce, activity and performance plans; with evidence of testing and review against the HTP model. To be included with the MTFP for sign off. A further SaTH +5-year high level summary plan is required to align with HTP timescales and underlying financial balance for the system MTFP to include a summary of efficiencies linked to benchmarking opportunities.	Ongoing monitoring of underlying position against MTFP and HTP assumptions.	SaTH 1.1.3	AW	Ongoing	31/03/2027	Ongoing - monthly review of underlying position which is reported to FAC and Board.	
	SaTH Demand and capacity model aligned to system model.	SaTH 1.1.4	AW	Ongoing	31/01/2027	Refresh of HTP bed model being undertaken.	
	Cashflow requirements matched to MTFP modelled.	SaTH 1.1.5	AW	Ongoing	30/09/2026		
	Signed off LTFP 10-year high level financial plan - SaTH/ICS/NHSE Metric - Alignment with ICS/NHSE financial sustainability requirements.	SaTH 1.1.8	AW	Ongoing	31/01/2027	System long term plan – rolled over from 2025/26.	
2026/27 financial plans agreed and signed off by SaTH aligned to the ICS plans and NHS England Plans to include a fully developed Financial Improvement Plan (i.e. CIPs) with supporting PIDs linked to the benchmarking opportunities	2026/27 efficiency plan PIDs signed off by scheme leads and directors.	SaTH 1.2.1	AW	Ongoing	31/05/2026	Monitored through FRG, OPOG and PRM's.	
	2026/27 monthly review of activity plan aligned to performance and financial requirements based on development of D&C model and interventions.	SaTH 1.2.11	AW	Ongoing	31/03/2027	SLAM reporting to re-commence during Q1 of FY26/27 alongside Power Query reporting.	

Deliverable(s) *The outputs that you need to produce to demonstrate delivery of exit criteria*	**Task** *The tasks you need to complete to produce the deliverables (*	**Task ID**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**BRAG**
	In year monitoring of financial performance against plan, identifying escalation actions where needed (oversight through OPOG, FRG and Finance Assurance Committee).	SaTH 1.2.23	AW	Ongoing	31/03/2027	Monitored monthly through FRG and FAC. PAF to be implemented in FY26/27.	
	Monitor ongoing demand & capacity actuals against plan identifying escalation actions where needed (oversight through OPOG and Performance Assurance Committee).	SaTH 1.2.24	Ned Hobbs	Ongoing	31/03/2027	Monitored monthly through FRG and FAC. PAF to be implemented in FY26/27.	
Capital plans for 2026/27 signed off by SaTH aligned to system plans and NHSE	Support system delivery of 2026/27 CDEL - application of the Capital prioritisation framework in action in year. Performance monitoring through CPG and CPOG.	SaTH 1.3.8	AW	Ongoing	31/03/2027		
Independent review of 'grip & control' - identifying SaTHs' gaps	Delivery of individual organisational internal audit report recommendations and pro-active management in year (monthly review).	SaTH 1.4.6	AW	Ongoing	31/03/2027		

Deliverable(s) *The outputs that you need to produce to demonstrate delivery of exit criteria*	**Task** *The tasks you need to complete to produce the deliverables (*	**Task ID**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**BRAG**
Independent review of 'grip & control' - identifying SaTHs' gaps	Delivery of individual organisational external audit report recommendations.	SaTH 1.4.8	AW	Ongoing	31/03/2027		
	Individual organisational tracking of timely completion of external audit actions.	SaTH 1.4.9	AW	Ongoing	31/03/2027		
	Internal Audit findings for all finance related audits to be rated moderate or substantial.	SaTH 1.4.10	AW	Ongoing	31/03/2027		
	External audit for 2025/26 including VFM to be rated moderate or substantial.	SaTH 1.4.12	AW	Ongoing	30/09/2026		

BRAG Status
Completed and evidenced
On Track
At Risk
Off Track

Appendix 4: SaTH Integrated Improvement Plan (SIIP): UEC Plan 2026/27.

Moving to Excellence

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

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Our Moving to Excellence Ambition

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

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
Deliverable: SaTH 3.1b: Delivery of the SaTH UEC Transformation Programme actions for the MEC Transformation Programme						
SaTH 3.1.1.1	Strengthen UTC workforce and recruit additional GP WTE, implement peak hour rota. **(Task 3.1.1.12 has merged with this task)**	Rebecca Houlston	01/10/2024	31/03/2027	**Evidence will include:** • Recruitment screenshots, • SPC demonstrating − Improvement in UTC utilisation to 25% and − 4-hour performance to 90% supporting overall ED 4-hour performance towards the local target of >65% by March 2027.	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)**	Zain Siddiqui	12/05/2024	28/02/2027	**Evidence will include:** • GP direct access specialty pathways, governance minutes, data on pathway usage.	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)**	Rebecca Race	01/07/2025	31/03/2027	A renewed Emergency Care Non-admitted working group has now launched with formalised agenda and specific focus on improving non-admitted performance metrics. This includes the wait time to see an ED clinician. To compliment this group, a dedicated dashboard has been launched and the group will review the data weekly.	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	Following a recent staff culture workshop which was held in response to the staff survey feedback, work has now been scoped to improve on themes of engagement, leadership and discrimination. This work will be carried out in collaboration with the Improvement Hub	At Risk

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
Deliverable: 3.1.2b: 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	**Evidence will include:** • SPC Charts demonstrating a reduction in 14 day / 21-day inpatient length of stay.	**On Track**
Deliverable: 3.1.4: Improved accuracy and completeness of ECDS data to enable reliable identification of alternative UEC opportunities.						
SaTH 3.1.4.3	Improving the data quality of ECDS to support identification of further alternative opportunities through monthly audit & feedback; publish a data quality dashboard **(Carried over from 2025/26)**	Rebecca Houlston	01/11/2024	31/03/2027	**Evidence will include:** • Monthly audits show measurable improvements in ECDS data completeness and accuracy, with a live data-quality dashboard in place to support ongoing monitoring.	**At Risk**
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	Sustained improved performance has continued and a digital solution has been found and rolled out to timestamp the streaming process.	**On Track**

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
SaTH 3.3.3	Implement escalation policy to further improve Mean ambulance handover time **(Carried over from 2025/26)**	Susanne Crossley	01/04/2025	31/03/2027	Mean ambulance handover time week commencing 20/04/2026 was 23.4 minutes. This metric has remained in special cause improvement for 9 weeks.	**On Track**
Deliverable 3.4: Delivery of the SaTH UEC Transformation Programme actions for the CSS Transformation Programme						
SaTH 3.4.1	Implement process to support interventions by physiotherapy/ occupational therapy earlier in the patient journey **(Carried over from 2025/26)**	Charlotte Jacks	01/07/2025	31/03/2027	The Therapy in-patient team in Medicine at RSH have combined their referrals with the intention of triaging referrals according to therapy needs and the best professional to assess and treat the patients as opposed to triaging OT and PT referrals individually which can lead to duplication and delays. The response time of referral to triage time has significantly improved since this has started. Performance has been showing special cause improvement for 8 weeks	**On Track**

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

SaTH 2026/27 Revised Undertakings – UEC

Section	Requirement/Action	Parties Involved	Key Focus/Emphasis	Reporting/Review
1.1	Ensure robust UEC improvement plan is in place	Licensee, NHS England, NHS England Midlands Region	Admitted, transferred or discharged within four hours, ambulance handovers; patients spending more than 12 hours in Emergency Department	SaTH are participating in the STW plan. The internal plan has been created with workstreams to support improvements in the process of launching. As a result of the ongoing work, April 2026 has shown good progression in 4 hour, 12 hour and ambulance handover performance
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 will 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 will remain under continuous review and will be updated in response to requirements with any changes being approved via the appropriate channels
1.4	Deliver UEC Plan and provide monthly report on	Licensee, NHSE		Reports submitted in writing,

	delivery of improvement priorities			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 are working closely with teams to develop the 2026/27 plan as well as continue the progress delivered to date
3.1-3.3	Licensee must attend appropriate NHSE meetings or conference calls	Licensee, NHSE		Provision of reports as requested by NHSE and attend monthly oversight and assurance meetings

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

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

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.

FIRST OCKENDEN REPORT ACTION PLAN

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

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

FIRST OCKENDEN REPORT ACTION PLAN

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

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

PROGRESS AS AT 10.03.2026

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

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

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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
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

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PROGRESS AS AT 10.03.2026

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.89	The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice'.	Y	10/12/20	31/01/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	30/09/23	12/09/23	H. Flavell	G. Dashputre	Monday.com
4.90	The Trust must ensure appropriately trained and appropriately senior/experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.	Y	10/12/20	31/03/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/03/22	31/03/22	10/05/22	H. Flavell	A. Lawrence	Monday.com
4.91	The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	31/03/22	10/05/22	H. Flavell	W. Parry-Smith	Monday.com

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FIRST OCKENDEN REPORT ACTION PLAN

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

FIRST OCKENDEN REPORT ACTION PLAN

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Immediate and Essential Action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard.													
2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Y	10/12/20	TBC	Evidenced and Assured	Completed	External dependent action on NHSEI. An exception report was presented and accepted at Apr-25's MNTAC changing the status of this action to "Off Track" as the MNISA who is in post cannot start working with families until the greenlight from NHSEI has been received. We currently have no information as to when that greenlight is expected. Progressing this action with NHSEI sits with the LMNS. All other evidence requirements for this action have been met and it will be proposed for "Delivered, Not yet Evidenced" as soon as NHSEI enable the MNISA to start their work with families. A new timeline for "Evidenced and Assured" will be proposed at the same time. This action was agreed as 'Delivered, Not Yet Evidenced' and back 'On Track' at Jun-25's MNTAC with a new assurance deadline of Dec-25 following of confirmation of NHSE's greenlight for the MNISA to start working with families. This action was greed as Evidenced and Assured at Jan-26's MNTAC.	10/06/25	31/12/25	13/01/26	P. Gardner	P. Gardner	
2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	Y	10/12/20	TBC	Evidenced and Assured	Completed	External dependent action on NHSEI. Linked to IEA 2.1. An exception report was presented and accepted at Apr-25's MNTAC changing the status of this action to "Off Track" as this action is dependant on IEA 2.1. Until progress can be made with the above action, realistic new timelines cannot be estimated. This action was agreed as 'Delivered, Not Yet Evidenced' and back 'On Track' at Jun-25's MNTAC with a new assurance deadline of Dec-25 following of confirmation of NHSE's greenlight for the MNISA to start working with families. This action was greed as Evidenced and Assured at Jan-26's MNTAC.	10/06/25	31/12/25	13/01/26	P. Gardner	P. Gardner	
2.3	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/05/21	30/04/21	08/06/21	H. Flavell	A. Lawrence	Monday.com
2.4	CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.	Y	10/12/20	TBC	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/03/24	TBC	11/06/24	H. Flavell	A. Lawrence	Monday.com

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

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

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

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FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital
NHS Trust

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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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FIRST OCKENDEN REPORT ACTION PLAN

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

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

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

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

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FINAL OCKENDEN REPORT ACTION PLAN

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

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

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

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

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

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

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

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

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

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Local Actions For Learning Theme 11: Diabetes Care													
14.32	The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.	Y	30/0322	30/11/23	Evidenced and Assured	Completed	This action was accepted as back 'on track' at Jul-24's MTAC as funding was allocated to the business case. This action is currently Off Track. Recuitment is underway to fill the vacancy necessary to run the diabetes clinic weekly with internal cover but no firm timeline is currently available. The clinic continues to run in the meantime and a locum is being engaged to provide cover with substantive recuitment is underway. This action was agreed as back 'On track' at Jun-25's MNTAC after confirmation of the appointment of a new endocrinologist to support the clinic was received. This action was greed as Evidenced and Assured at Jan-26's MNTAC.	13/09/22	28/02/25	13/01/26	P. Gardner	J. Atkinson	Monday.com

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

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

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

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

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

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The Shrewsbury and Telford Hospital
NHS Trust

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

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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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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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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	Delivered, Not Yet Evidenced	On Track	A deadline extension to Mar-26 was agreed at the Apr-25 MNTAC. Whilst the service has demonstrated good progress in improving the culture, the committee agreed it was too early in the cultural transformation journer to consider this action fully embedded.	10/10/23	31/03/26		P. Gardner	J. Atkinson	

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Local Actions For Learning Theme 23: Supporting Families After the Review is Published													
14.63	Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	14/02/23	J. Jones	H. Flavell	Monday.com
14.64	There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action is fully dependent on NHSEI, commissioners and Mental Health Trusts. Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffiecient evidence to allow for any status change according to the programme methodology. Suggestions of appropriate evidence were reviewed at Sep-25's MNTAC and communicated to the national teams.		TBC		J. Jones	P. Gardner	

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

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 1: Workforce planning And Sustainability The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented. We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.													
1.1	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	Y	30/03/22	31/05/25	Delivered, Not Yet Evidenced	On Track	This action was accepted as 'Delivered, Not Yet Evidenced' at Jul-25's MNTAC. An exception report was accepted at Oct-25's MNTAC adjusting this action's tiomeframe for assurance to Feb-27, aligning with the latest assurance date within the plan as this action will only be assured once all other actions within the trust's power have been fully embedded.	08/07/25	28/02/27		J. Jones	H. Flavell	Monday.com
1.2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	This action was accepted as Evidenced and Assured at Mar-25's MNTAC.	10/01/23	31/03/25	11/03/25	J. Jones	H. Flavell	Monday.com
1.3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/23	31/03/24	13/09/23	H. Flavell	C. McInnes	Monday.com
1.4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH	Y	30/03/22	TBC	Delivered, Not Yet Evidenced	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies (NHSE, RCOG, RCM and RCPCH) . Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffiecient evidence to allow for any status change according to the programme methodology. Suggestions of appropriate evidence were reviewed at Sep-25's MNTAC and communicated to the national teams. This action was agreed as Delivered not yet Evidenced at Mar-26's MNTAC following the publication of the Indepedent Review of birthrate+. This action however remains decsoped.	10/03/26	TBC		J. Jones	H. Flavell	Monday.com
1.5	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	31/08/23	09/05/23	H. Flavell	A. Lawrence	Monday.com

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FINAL OCKENDEN REPORT ACTION PLAN

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1.6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	28/04/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
1.7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	Y	30/03/22	TBC	Delivered, Not Yet Evidenced	Off Track (see exception report)	Action 'rescoped' at the Jan-24 MTAC; as the programme has been approved Nationally. An exception report was presented and accepted at May-24's MTAC setting the new deadline for Evidenced and Assured at May-25. This action is no longer 'At Risk'. This action is currently Off Track as a business case is necessary to adress new training requirement published as part of the national framework.	09/01/24	31/05/25		P. Gardner	A. Lawrence	Monday.com
1.8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
1.9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/06/23	31/03/24	12/09/23	H. Flavell	A. Lawrence	Monday.com
1.10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/07/23	31/03/24	14/12/23	H. Flavell	C. McInnes, A. Sizer, A. Lawrence	Monday.com

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

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

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

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FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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

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NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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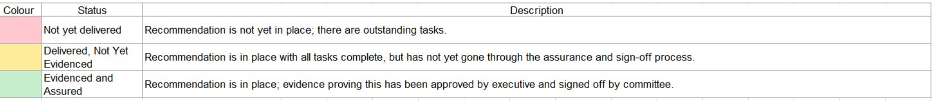
Immediate and Essential Action 6: Learning from Maternal deaths Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.													
6.1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies(Royal Colleges). Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffiecient evidence to allow for any status change according to the programme methodology. Suggestions of appropriate evidence were reviewed at Sep-25's MNTAC and communicated to the national teams.		TBC		J. Jones	H. Flavell	Monday.com
6.2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	J. Jones	H. Flavell	Monday.com
6.3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/01/23	31/08/23	09/05/23	H. Flavell	A. Sizer, A. Lawrence	Monday.com



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Immediate and Essential Action 7: Multidisciplinary Training Staff who work together must train together. Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training.													
7.1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/08/23	31/03/24	13/12/23	H. Flavell	C. McInnes	Monday.com
7.2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/05/22	30/09/22	15/06/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com
7.3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/07/23	31/03/24	09/01/24	H. Flavell	C. McInnes, A. Sizer, A. Lawrence	Monday.com
7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	A. Sizer	Monday.com
7.5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/05/22	30/09/22	15/06/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com
7.6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	09/08/22	31/01/23	09/08/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com
7.7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/03/24	13/12/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com

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Immediate and Essential Action 8: Complex Antenatal Care Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance. Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.													
8.1	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Y	30/03/22	30/04/25	Evidenced and Assured	Completed	This action was accepted as back 'on track' at Jul-24's MTAC as funding was allocated to the business case. An exception report was presented and accepted at Mar-25's MNTAC. New timelines for Delivered not yet Evidenced and Evidenced and Assured were set for Apr-25 and Oct-25 respectively. This action was agreed as 'Delivered, Not Yet Evidenced' at Jul-25's MNTAC. This action was greed as Evidenced and Assured at Jan-26's MNTAC.	08/07/25	31/10/25	14/01/26	P. Gardner	A.Sizer	Monday.com
8.2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com
8.3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com
8.4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	09/05/23	H. Flavell	A. Sizer	Monday.com
8.5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	08/08/23	H. Flavell	A. Sizer	Monday.com

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

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

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The Shrewsbury and Telford Hospital NHS Trust

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

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

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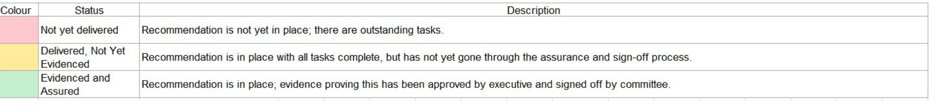
	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 12: Postnatal Care Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times.													
12.1	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/03/24	13/12/22	H. Flavell	A. Sizer	Monday.com
12.2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	On Track	This action was accepted as back 'on track' at Jul-24's MTAC as funding was allocated to the business case. An exception report was accepted at Mar-26's MNTAC, where a new timeline for Evidenced and Assured was set for Dec-26.	13/12/22	31/12/26		P. Gardner	A.Sizer	Monday.com
12.3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	On Track	This action was accepted as back 'on track' at Jul-24's MTAC as funding was allocated to the business case. An exception report was accepted at Jan-26's MNTAC, where a new timeline for Evidenced and Assured was set for Jul-26.	13/12/22	30/06/26		P. Gardner	A.Sizer	Monday.com
12.4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	14/02/23	H. Flavell	A. Sizer, A. Lawrence	Monday.com



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

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FINAL OCKENDEN REPORT ACTION PLAN

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

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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

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FINAL OCKENDEN REPORT ACTION PLAN

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

Colour	Status	Description
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	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
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Ockenden 1
Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	27	0	0	27
IEA	25	0	0	25
Total	52	0	0	52
Percentage		0%	0%	100%

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
LAFL	27	0	0	0	0	27	0
IEA	25	0	0	0	0	25	0
Total	52	0	0	0	0	52	0
Percentage		0%	0%	0%	0%	100%	0%

Counts

Counts

Ockenden 2

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	66	1	2	63
IEA	92	5	5	82
Total	158	6	7	145
Percentage		4%	4%	92%

Progress Status

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

Combined actions - Delivery status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	93	1	2	90
IEA	117	5	5	107
Total	210	6	7	197
Percentage		2.86%	3.33%	93.81%

Combined actions- Progress status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
LAFL	93	0	2	0	0	90	1
IEA	117	0	3	0	1	107	6

Counts

Total	210	0	5	0	1	197	7
Percentage		0.0%	2.4%	0.0%	0.5%	93.8%	3.3%

Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

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

Accountable Executive and Owner Index

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

PROGRESS AS AT 10.02.2026

APPENDIX TWO

Neonatal External Mortality Review Action Plan

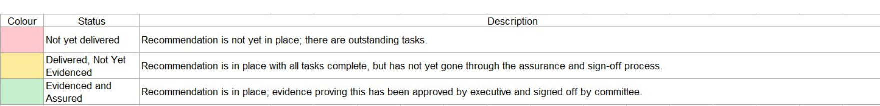
Ref	Action required	Delivery Status	Progress Status	Status Commentary (This Period)	Timeline set out in Report	Delivery Due Date (Amber)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
NEMR1/I_NEMR2	The service, an LNU, has retained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

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

Neonatal External Mortality Review Action Plan

NHS
The Shrewsbury and Telford Hospital NHS Trust

Ref	Action required	Delivery Status	Progress Status	Status Commentary (This Period)	Timeline set out in Report	Delivery Due Date (Amber)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
NEMR3d/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: d. The unit should review National Neonatal Audit Programme (NNAP) quality outcome trends, particularly bronchopulmonary dysplasia, brain injury, non-invasive ventilation rates, and create quality improvement projects to address any issues identified.	Delivered, Not Yet Evidenced	On Track	The clinical team have undertaken a review of NNAP data for 2022/23 and is in the process of reviewing the outcome of the 2023 data, evidence to demonstrate this will be presented to MNTAC in December 2023. Further evidence of any amended practice or dissemination of learning will be presented to MNTAC in due course to provide evidence of embedded practice. An exception report was presented and accepted at Mar-26's MNTAC follwoing delays in the implementation of Badgernet for neonates, changing the timframe for green tot Mar-27. Evidence Requirements for Delivery: NNAP review undertaken for latest available data through governance processes Evidence Requirements for Assurance: Robust Process in place for receiving and responding to national reports Evidence of QI projects delivered and audited Implementation of Badgernet EPR allowing better reporting	Immediate (0-3 months)	31/12/2024	10/12/2024	01/03/2027		Dr John Jones	CD's	Monday.com
NEMR4	The unit should develop a training programme on approaches to ventilation that reflect expectations in BAPM's Neonatal Airway Safety Standard, drawing on supporting training materials (for example, including for videolaryngoscopy).	Not Yet Delivered	On Track	Further to receipt of the final report, the clinical team have identified a series of actions required to demonstrate compliance with this recommendation. Current consultant staffing on the unit does not allow for a lead to be appointed until recruitment needs are met, which would be required to develop BAPM compliant training programme. An exception report was submitted to Jul-25's MNTAC and accepted, allowing for additional time while recruitment is underway. While a programme has not yet been developed that meets all requirements from the BAPM standard, training on airway safety continues to be delivered on the unit. Delivery and evidence dates were changed to Jan-26 and Apr-26 respectively. Evidence Requirements for Delivery: Training plan in line with BAPM Airway/ventilation standards (including cross speciality simulations) Training plan - competencies in place for members of the team Clinical Processes aligned with training plan Evidence Requirements for Assurance: Audits against standards in the training plan Training compliance from the LMS - 90% across all staff groups Rotas - all shifts have competent member of staff - Medical & Nursing	Short Term (0-6 months)	31/01/2026		30/04/2026		Dr John Jones	CD's	Monday.com
NEMR5/I_NEMR4	All neonatal nursing staff should be given protected time to attend mandatory training, equipment training and simulation sessions as a minimum. Simulation sessions should be regularly timetabled. To avoid nurses being pulled away from clinical duties, the trust could consider allocating one to two days over the year to complete mandatory training and attend multidisciplinary simulation training (like the approach taken in maternity services).	Evidenced and Assured	Completed	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. Evidence Requirements for Delivery: Training needs analysis Training plan for 2 day mandatory training Rosters and rotas demonstrating allocated time for training Evidence Requirements for Assurance: Education reports (3 months) demonstrating compliance against training.	Short Term (0-6 months)	31/10/2024	08/10/2024	31/10/2025	12/08/2025	Dr John Jones	CD's	Monday.com



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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
NEMR6a/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Education Lead	Evidenced and Assured	Completed	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. NEMR6a was agreed as "Evidenced and Assured" at Apr-25's MNTAC. Evidence Requirements for Delivery: Education Lead Job Description Education Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/03/2025	08/04/2025	31/08/2025	08/04/2025	Paula Gardner	Julie Plant	Monday.com
NEMR6b/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Governance Lead	Delivered, Not Yet Evidenced	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. This action was accepted as 'Delivered, Not Yet Evidenced' at Sep-25's MNTAC' Evidence Requirements for Delivery: Governance Lead Job Description Governance Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	30/08/2025		31/12/2025		Paula Gardner	Julie Plant	Monday.com
NEMR6c/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Family Integrated Care Lead	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. An exception report amneding the timframes to Aug-26 for amber and Feb-27 for green was agreed at mar-26' MNTAC to account for delays in the recruitment process. Evidence Requirements for Delivery: Family Integrated Care Lead Job Description Family Integrated Care Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/08/2026		28/02/2027		Paula Gardner	Julie Plant	Monday.com

Colour	Status	Description
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	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
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Neonatal External Mortality Review Action Plan

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NEMR6d/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Infant Feeding (BFI) Lead	Evidenced and Assured	Completed	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. NEMR6c was agreed as "Evidenced and Assured" at Apr-25's MNTAC. Evidence Requirements for Delivery: Infant Feeding Lead Job Description Infant Feeding Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/03/2025	08/04/2025	31/08/2025	08/04/2025	Paula Gardner	Julie Plant	Monday.com
NEMR6e/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Transitional Care Lead	Delivered, Not Yet Evidenced	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. Evidence Requirements for Delivery: Transitional Care Lead Job Description Transitional Care Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	30/09/2025	13/01/2026	31/01/2026		Paula Gardner	Julie Plant	Monday.com
NEMR6f/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Discharge Planning Lead	Delivered, Not Yet Evidenced	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. This action was agreed as Delivered, Not yet Evidenced at Jan-26's MNTAC Evidence Requirements for Delivery: Discharge Planning Lead Job Description Discharge Planning Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)		13/01/2026	31/07/2026		Paula Gardner	Julie Plant	Monday.com

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PROGRESS AS AT 10.02.2026

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
NEMR6g/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Safeguarding Lead	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. This action was agreed as 'Delivered, Not yet Evidenced' at Jul-25's MNTAC. Following the resignation of the member of staff holding the role, this action has reverted to Not Yet Delivered. The team presented an execption report with new timelines for recruitment bringing the new amber date to Jun-26 and green date to Nov-26. <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)	30/06/2026		30/11/2026		Paula Gardner	Julie Plant	Monday.com
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		Paula Gardner	Julie Plant	Monday.com
NEMR6i/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Breavement Lead	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. <u>Evidence Requirements for Delivery:</u> Bereavement Lead Job Description Bereavement Lead in post <u>Evidence Requirements for Assurance:</u> Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/03/2026		31/07/2026		Paula Gardner	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
NEMR7	There should be protected time for bereavement quality roles in the neonatal service to work alongside the bereavement midwives.	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including a dedicated bereavement lead post). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. An exception re[ort was presented and accepted at Feb-25's MNTAC adjusting the delivery and evidence timescales to Jan-26 and Apr-26 respectively to adhere to the current trajectory for recruitment. <u>Evidence Requirements for Delivery:</u> Backfill in place to cover for quality roles duties Bereavement lead in post <u>Evidence Requirements for Assurance:</u> Evidence of delivery withing the roles Roster demonstrating protected time - 3 months	Short Term (0-6 months)	31/01/2026		30/04/2026		Paula Gardner	Julie Plant	Monday.com
NEMR8/I_NEMR4	ANNPs should receive 20% protected time to ensure they complete all four pillars of advanced practice and must be able to access their allocated time to update their skills on a NICU.	Evidenced and Assured	Completed	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC with the addition of evidence of evaluation of the four pillars during appraisals. <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
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

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

PROGRESS AS AT 10.02.2026

APPENDIX TWO

Neonatal External Mortality Review Action Plan

The Shrewsbury and Telford Hospital NHS Trust

Ref	Action required	Delivery Status	Progress Status	Status Commentary (This Period)	Timeline set out in Report	Delivery Due Date (Amber)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
NEMR11	This review highlights the benefits realised with excellence in clinical leadership. The Trust should build on this with specific leadership development investment for medical and nursing leaders within the neonatal unit (eg Neonatal Clinical Lead, Clinical Director, Neonatal Matron). This could be executive coaching or specific leadership development programmes to include topics such as embedding psychological safety in teams, leadership succession planning etc.	Evidenced and Assured	Completed	The division has recently appointed a new clinical leadership team for the specialty. Two new CD's (job share) have commenced in post in September 2024, a new Ward Manager also commenced in post in September and a new Neonatal Matron has been appointed and will take up post in November 2024. Plans are in place to ensure each clinical leaders has an appropriate and bespoke personal development plan in place to equip them with the necessary leadership skills to succeed in their posts. Evidence of compliance with this will be presented to MNTAC in June 2025. This action was agreed as 'Delivered, Not yet Evidenced' at Jul-25's MNTAC. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC. Evidence Requirements for Delivery: Neonatal Leadership enrolled on SaTH leadership programmes Evidence Requirements for Assurance: Compliance with Leadership Programme Attendance of Clinical directors to quarterly CD meetings Measure of culture shift (staff survey, retention and recruitment)	Medium Term (6-12 months)	31/06/2025	08/07/2025	30/09/2025	14/10/2025	Dr John Jones & Paula Gardner	Dr Andrew Sizer & Julie Plant	Monday.com
NEMR12	The maternity service has had a new level of stability, following patterns of high turnover across all senior management roles, which has boosted recruitment (section 6.3.4). Trust leaders should facilitate learning from what has worked well in maternity and how this can be translated to neonatal consultant and nursing leadership development on an ongoing basis.	Evidenced and Assured	Completed	The divisional senior team responsible for maternity services in SaTH is also responsible for neonatal services. Consequently, learning from what has worked well in transforming maternity services has informed operational and clinical planning for the neonatal service. Fundamentally, a business case was submitted to the system by the division in March 2023 to seek funding for both clinical and governance roles to bring the service workforce establishment in line with BAPM best practice standards. The funding required has now been provided and recruitment to the identified roles is underway. In addition to this, the Maternity Transformation Programme has been expanded to incorporate delivery of this action plan, adopting the same improvement methodology which has proven to be successful for maternity service transformation. Evidence of compliance with this recommendation will be presented to MNTAC in June 2025. This action was agreed as 'Delivered, Not yet Evidenced' at Jul-25's MNTAC. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC. Evidence Requirements for Delivery: Integration of Neonates into MNTP Leadership and Specialist roles recruitment plans Evidence Requirements for Assurance: Staffing papers including recruitment and retention positions. Recruitment and retention measures	Medium Term (6-12 months)	31/06/2024	08/07/2025	30/09/2025	14/10/2025	Dr John Jones & Paula Gardner	Dr Andrew Sizer & Julie Plant	Monday.com
NEMR13	The PMRT process needs further development to become a useful mechanism for learning, including securing neonatal consultant as well as fetal medicine externality, protected time for neonatal nurse participation, and a clear mechanism for sharing learning with respect to the network. A network-wide approach may be needed to make best use of available resources and expertise, given the tension between a neonatal unit functioning with significant workforce gaps alongside a need of more from this same workforce in terms of PMRT attendance.	Evidenced and Assured	Completed	Actions have been identified by the clinical leadership team to deliver this recommendation. In addition to this, discussions will be held with network colleagues regarding the potential for developing a network wide approach. This action was agreed as 'Delivered, Not Yet Evidenced' at Feb-25's MNTAC. This action was brought to the committee for discussion at Jul-25's MNTAC where it was agree this action should be marked 'At Risk' due to the difficulty in securing externality for PMRTs. New timeframes (Mar-26) were agreed at Aug-25's MNTAC with the added requirement of complying with CNST SA1 Y7 for added assurance. This action was agreed as 'Evidencedand Assured ' at Feb-26's MNTAC. Evidence Requirements for Delivery: PMRT Business Case including PMRT resources PMRT ToRs inc. externality requirement Agendas and Minutes from Quarterly Network Mortality meetings Evidence Requirements for Assurance: Evidence of regular reporting of PMRTs and actions to the LMNS CNST year 7 - Safety action 1 compliance	Short Term (0-6 months)	31/01/2025	11/02/2025	31/03/2026	10/02/2026	Dr John Jones	CD's	Monday.com

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Neonatal External Mortality Review Action Plan

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NEMR14/I_NEMR1	Learning and actions from PMRT and incidents must be clearly documented and there must be a robust mechanism for feedback to the multidisciplinary team.	Evidenced and Assured	Completed	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. An exception report was accepted at Feb-25's MNTAC moving the evidence date to May-25 while the team continues to embed the PMRT processes and improves delivery of actions plans linked to PMRT. This action was agreed as 'Evidenced and Assured' at Jun-25's MNTAC Evidence Requirements for Delivery: ANNP mortality lead in post Monthly PMRT update template and schedule - Q2 through October Governance Quarterly joint mortality meetings (Shared with maternity) Section at governance meetings dedicated to the sharing of learning from PMRT Evidence Requirements for Assurance: Ongoing compliance with PMRT and incidents reporting including monitoring of actions Monthly Quality and Safety updates to LMNS and network Clinical gems, 3 minutes brief, learning from excellence examples	Short Term (0-6 months)	30/09/2024	08/10/2024	31/05/2025	10/06/2025	Dr John Jones	CD's	Monday.com
NEMR15	The service should ensure compliance with the medical and nursing standards as listed in BAPM Service and Quality Standards for Provision of Neonatal Care in the UK, November 2022.	Delivered, Not Yet Evidenced	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards. This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in June 2025 to allow time for recruitment into the new posts identified. This action was accepted as 'Delivered, Not Yet Evidenced' at Aug-25's MNTAC with new timeframes for green to jan-27. Evidence Requirements for Delivery: CNST SA4 compliance for Years 4, 5, 6 Refreshed QIS trajectory - Jun-25 Staffinf papers demonstration QIS cover on shifts Evidence Requirements for Assurance: CNST year 7 compliance QIS compliance reached	Short Term (0-6 months)	31/06/2025	12/08/2025	31/01/2027		Dr John Jones & Paula Gardner	Dr Andrew Sizer & Julie Plant	Monday.com
NEMR16	The neonatal service should review its 'golden hour' care practices for preterm infants and sick term infants born within the service, with a focus on implementing evidence-based care practices around resuscitation, stabilisation, surfactant administration and other supportive measures in the first few hours after birth.	Not Yet Delivered	On Track	A golden hour checklist has been produced and implemented within the department however it only accounted for preterm babies. A review is underway to include sick term babies as per the recommendation. To complete this work, the team requested additional time through an exception report which was accepted at Dec-24's MNTAC. This amended the deadlines to Jan-25 for amber and May-25 for green. This action has been agreed as 'Off Track' at feb-25's MNTAC. With no national guidance available for a golden hour checklist for term babies, the team has contacted the reviewers for more information. Guidance from the reviewers was received in May-25 and this action will now be brought to the Quality and safety Workstream of the LMNS for joint review and setting timeframes for implementation. This action was agreed back 'On Track' at Jul-25's MNTAC with new timeframes of Sep-25 for amber and Apr-26 for green. A further exception report was presented at Nov-25's MNTAC amending the timeframes to Mar-26 for amber and Jul-26 for Green as absences within the team has delayed the work required to implement this action. Evidence Requirements for Delivery: Amended guideline and checklist Evidence Requirements for Assurance: Audit of guideline and checklist implementation	Short Term (0-6 months)	31/03/2026		31/07/2026		Dr John Jones	Mr Andrew Sizer	Monday.com

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NEMR17	The trust should expedite consideration of the business case for an electronic patient record to enhance the accurate recording of the clinical journey for babies admitted to the neonatal unit.	Delivered, Not Yet Evidenced	On Track	A business case for the implementation of an electronic patient record for the neonatal service has been produced and will be presented to the Women & Children's Divisional Committee in October 2024. Further to approval via divisional committee, the case will be submitted to Trust executives for review/ approval. This action was approved as "Delivered, Not Yet Evidenced" at Apr-25's MNTAC with the approval of the business case for Badgernet EPR. Revised timeframes were presented to enable this action to go back "On Track". An exception report was presented and accepted at Mar-26's MNTAC follwoing delays in the implementation, changing the timframe for green tot Mar-27. Evidence Requirements for Delivery: Approved business case NNU EPR Decision for implementation of NNU EPR Evidence Requirements for Assurance: Implementation of NNU EPR	Medium Term (6-12 months)	31/01/2025	08/04/2025	31/03/2027		Ned Hobbs	J.Atkinson	Monday.com
NEMR18	The trust should engage the network in discussions over having a robust 24/7 cot locator service for antenatal and acute postnatal transfers, and for a review to take place into NICU capacity. Consideration could be given to a digital solution that also incorporates maternal bed availability and to learn from exemplar networks with well-developed cot locator services.	Delivered, Not Yet Evidenced	Descoped (see exception report)	Initial discussions with the network regarding the outcome of the review and the associated network wide recommendations to be scheduled. Dates for implementation to be agreed with network colleagues. This action was agreed as 'Delivered, Not Yet Evidenced' at Feb-26's MNTAC with evidence of engagement with the network regarding the cot locator services. It was also agreed as descoped as it is not within the Trust power to secure a new and/or improved service. The team will continue to engage with the Network and is commited to implement any new system that is selcted by the network in future, at which time the action would be rescoped. Evidence Requirements for Delivery: Evidence of Engagement with network regarding cot locator provision (minutes and email exchanges) Evidence Requirements for Assurance:	Medium Term (6-12 months)	TBC	10/02/2026	TBC		Dr John Jones	Mr Andrew Sizer	Monday.com
NEMR19	The trust should engage the neonatal network in the findings of this review, and specifically: a. Questions raised by the review team over the functioning of the network, with the LNU at times left caring for extremely sick premature babies for longer than it ought to. b. The impact of instances when the NICU appeared reluctant to accept patients for transfer from the LNU (section 6.1.4) on the likelihood or readiness for staff at the LNU to make a referral, and on timely transfer. questions raised during interviews over whether escalation to NICUs happened sufficiently early and 'assertively enough' (section 6.2.2).	Evidenced and Assured	Completed	The team has continued to engage with the Network and to provide exception reports ensuring care continues to be delivered within pathway. The team will conduct a review of transfer cases and discuss the findings with the network to ensure transfers are happening appropriately. Those exception reports are regularly discussed at netwrok and LMNS meetings. This action was agreed as 'Delivered, Not yet Evidenced' at Jun-25 MNTAC. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC. Evidence Requirements for Delivery: Network exception reports - quarterly overview Evidence Requirements for Assurance: Review of Transfer cases Evidence of discussion with ODN - LMNS agenda and minutes	No Timeline Allocated	TBC	10/06/2025	31/10/2025	14/10/2025	Dr John Jones	Mr Andrew Sizer	Monday.com
NEMR20	The neonatal team should review the feedback provided on the 18 cases reviewed as an opportunity to consider learning for the whole MDT.	Not Yet Delivered	Off Track (see exception report)	Further to receipt of the final report, the clinical team have identified a series of actions required to demonstrate compliance with this recommendation. This action has been agreed as Off Track at jan-26's MNTAC as absence within the team has delayed the delivery of this work. The new Interim clinical director is conducting a review and an update will be presented at Feb-26's MNTAC.	Short Term (0-6 months)	30/09/2025		31/01/2026		Dr John Jones & Paula Gardner	Mr Andrew Sizer & Julie Plant	Monday.com

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

NHS
The Shrewsbury and Telford Hospital
NHS Trust

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.	Delivered, Not Yet Evidenced	On Track	Further to receipt of the final report, the clinical team have identified a series of actions required to demonstrate compliance with this recommendation. To note, additional capacity for clinical audit and quality improvement was incorporated into the aforementioned business case. This action was agreed as 'Delivered, Not Yet Evidenced' at Jun-25's MNTAC. An exception report was accepted at Nov-25's MNTAC, amending the Assurance date to Mar-26. Evidence Requirements for Delivery: Forward audit plan in place Quality Improvement plan in place Monthly dashboard with review of trends and themes Evidence Requirements for Assurance: Evidence of audits completed according to the Forward Audit Plan Evidence of QI projects delivery	Short Term (0-6 months)	31/05/2025	10/06/2025	31/10/2025		Dr John Jones & Paula Gardner	Mr Andrew Sizer & Julie Plant	Monday.com
NEMR22	The trust should consider sharing the conclusions of this review with families (in particular the parents of the babies whose cases were reviewed), and other service users.	Evidenced and Assured	Completed	The Committee agreed this action was fully evidenced and assured following the engagement with the families impacted in the report and the report's presentation at Public Board. Evidence Requirements for Assurance: - Report presented at Public Board and associated minutes - Evidence of meetings with families available due to confidentiality considerations.	Short Term (0-6 months)	31/12/2024	10/12/2024	31/03/2025	10/12/2024	Dr John Jones	Dr John Jones	Monday.com
NEMR23	The service must implement Family Integrated Care and regularly seek out family feedback and involvement in service improvements and redesign. This could be done by using network parent advisory groups, for example.	Not Yet Delivered	On Track	The clinical teams have identified a series of actions to fully deliver this recommendation. To note, a dedicated FIC' post was included within the aforementioned business case which has been approved. An exception report was accepted at Mar-26's MNTAC, amending the Delivery date to Oct-26 to allow for the recruitement of the FICare lead who will be essential to the embedding of this action. the assurance date has been removed and will be reallocated once the lead has had a chance to conduct a review of the service's position and devise an action plan. Evidence Requirements for Delivery: Patient Experience Group - Neonates Nurse Specialist in post MNVP surveys and meetings Local Parent Advisor 'Champion' Benchmark against BAPM PIC standard - Gap Analysis Evidence Requirements for Assurance: Evidence of Nurse Specialist delivering in role Compliance with BAPM OIC standards Evidence of deliverables from PEG meetings and survey findings	Medium Term (6-12 months)	31/10/2026				Paula Gardner	Julie Plant	Monday.com
NEMR24	This report should be shared with the trust board, which should have oversight of any action plan developed to address the recommendations.	Evidenced and Assured	Completed	The report and the associated action plan will be presented to the Trust Board in November 2024. This will be followed by regular reports on progress of delivery aligned with the assurance processes incorporated into the MNTAC process. This action was agreed as 'Delivered, Not Yet Evidenced' at Jan-25's MNTAC and as 'Evidenced and Assured' at Jun-25's MNTAC. Evidence Requirements for Delivery: Agenda and Minutes from Board BoD Neonatal Review appendix Evidence Requirements for Assurance: Evidence of progress being shared at agreed intervals - IMNR Nov-24/Jan/Mar/May-25)	Medium Term (6-12 months)	31/12/2024	14/01/25	31/05/25	10/06/25	Dr John Jones	J.Atkinson	Monday.com

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

Counts

NEMR

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
Actions	35	8	11	16
Total	35	8	11	16
Percentage		22.9%	31.4%	45.7%

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
Action	34	0	16	0	2	16	1
Total	34	0	16	0	2	16	1
Percentage		0.00%	47.06%	0.00%	5.88%	47.06%	2.9%

The Shrewsbury and Telford Hospital NHS Trust

Glossary and Index to the Neonatal Mortality Review Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

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

Accountable Executive and Owner Index

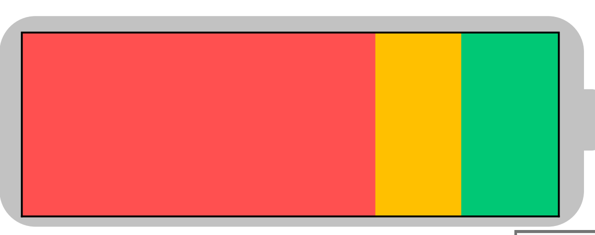
Name	Title and Role	Project Role
Paula Gardner	Executive Director of Nursing	Overall MNTP Executive Sponsor
John Jones	Executive Medical Director	Overall MNTP Executive co-sponsor
Andrew Sizer	Medical Director, Women & Children's Division	Senior Responsible Officer, MNTP and Accountable Action Owner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

APPENDIX 3

Phase 2 Updates

Phase 2 batteries – Post Mar-26 MNTAC

Overall Delivery



66% (161) Not Yet Delivered
16% (37) Delivered, Not Yet Evidenced
18% (44) Evidence & Assured

Overall Progress

18% (44) Complete
48% (116) On Track
3% (7) Descoped
1% (3) Off track
30% (72) 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	73% (22); 17% (5); 10% (3)	10% (3); 33% (10); 57% (17)
LMNS 3 Year Delivery Plan	21% (9); 39% (11); 39% (11)	39% (11); 46% (13); 4% (1); 11% (3)
Cultural Improvement Plan	92% (34); 5% (2); 3% (1)	3% (1); 49% (18); 48% (18)
CQC Neonates Action Plan	10% (1); 20% (2); 70% (7)	70% (7); 20% (2); 10% (1)
Neonatal External Mortality Review	23% (8); 31% (11); 46% (16)	46% (16); 46% (16); 3% (1); 5% (2)
Neonatal Unit Implementation Plan	91% (43%); 6% (3); 2% (1)	2% (1); 83% (39); 4% (2); 11% (5)
CQC National Review	25% (1); 50% (2); 25% (1)	25% (1); 75% (3)
Phase 2 Internal Actions	80% (4); 20% (1)	20% (1); 20% (1); 60% (3)

Not Yet Delivered | Delivered, not yet evidenced | Evidenced & Assured | Complete | On Track | At Risk | Descoped | Not Started | Off Track

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

Appendix 2 HCAI graphs

Table 1

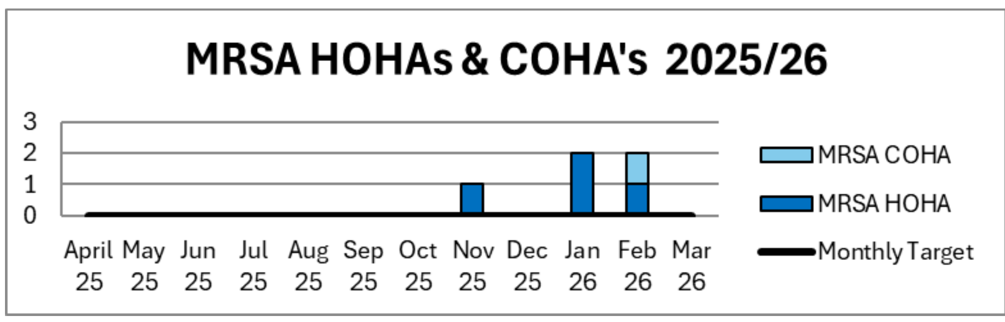
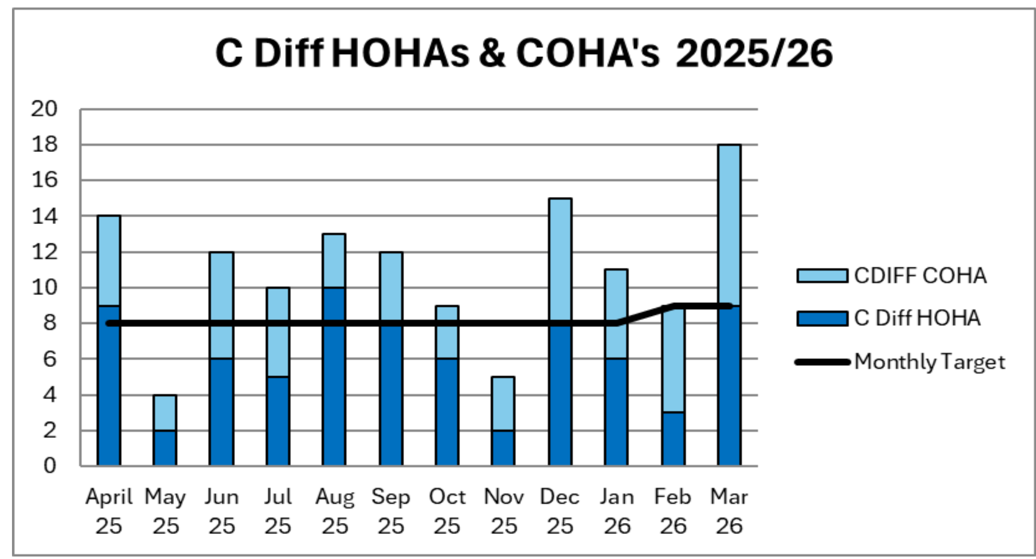


Table 2



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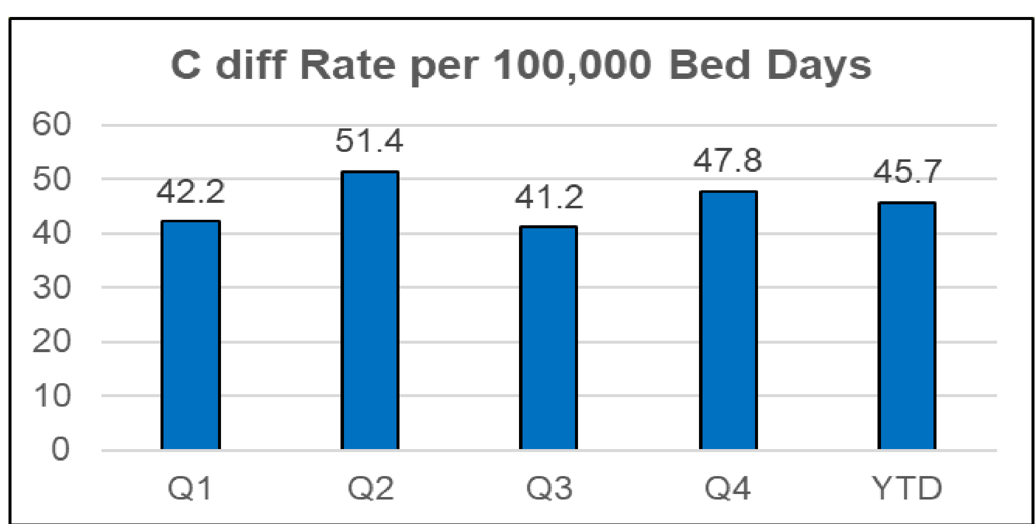

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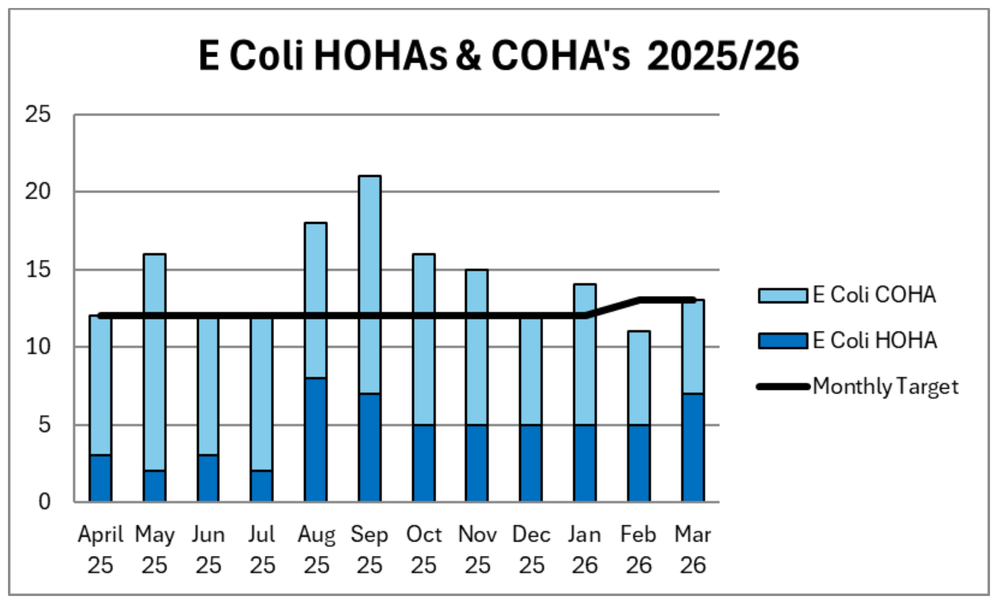

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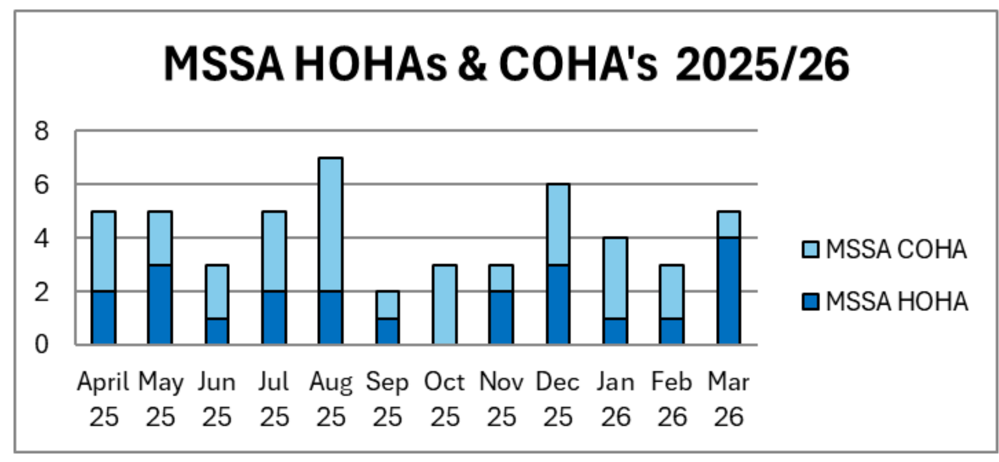

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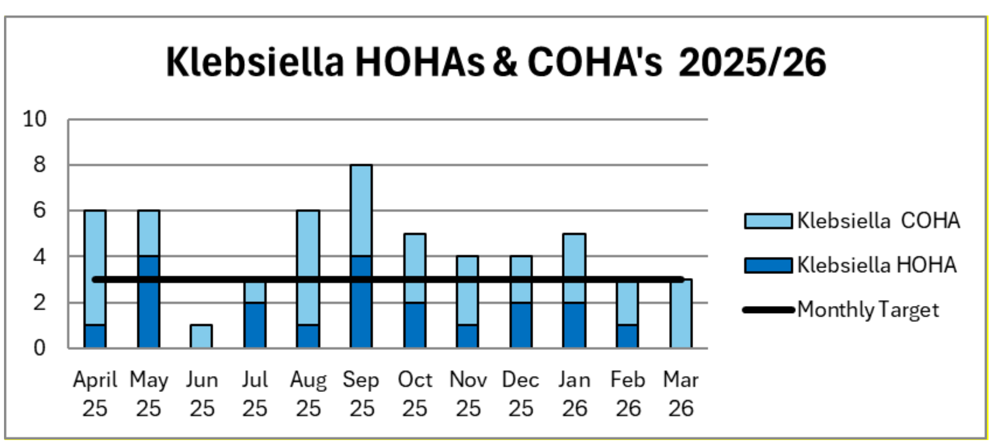

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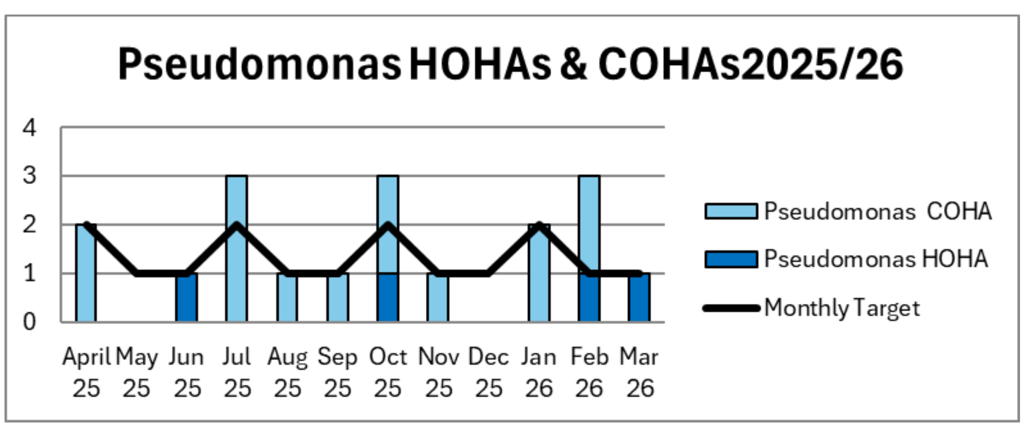


Appendix 3 – Health and Social Care Act 2008 self-assessment tool (Mar 26)

Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance					
Self Assessment Tool					
Shrewsbury and Telford Hospitals NHS Trust					
Criterion	**Statement of Compliance**	**Compliance Score**	**Score**		**Potential Score**
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibililty of service users and any risks that their environment an other users may pose to them.	95%	120		126
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	94%	76	*Decant facility and deep clean programme needed *MICAD Jjobs to be RAG rated	81
Criterion 3	Ensure appropriate antimicrobial use and stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance.	83%	20	1. Antimicrobial stewardship report to be realigned to the AMR national action plan. 2. Formalised education programme not in place/evidence of lack of adequate reviews or antimicrobial in line with start smart then focus. 3. Depleated pharmacy workforce.	24
Criterion 4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further health and social care support or nursing/ medical care in a timely fashion.	100%	66		66
Criterion 5	Ensure that people who have or at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.	100%	6		6
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.	100%	18		18
Criterion 7	Provide or secure adequate isolation facilities.	92%	11	low number of siderooms	12
Criterion 8	Secure adequate access to laboratory support as appropriate.	100%	15		15
Criterion 9	The service provider should have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.	98%	401	red element in relation to follow up of staff by occupational health as contact tracing is not included in the contract with Optima	408
Criterion 10	The registered provider will have a system or process in place to manage health and care worker health and wellbeing and organisational obligation to manage infection, prevention and control.	100%	48		48
Total Compliance		**97%**	**781**		**804**

Appendix 1: Exception Reports Q4

In Q4 a total of 65 exception reports were raised.

Exception Reports (ER) – Quarter 4	
Total number of exception reports received	**65**
Number relating to immediate patient safety issues	0
Number relating to hours of working	65
Number relating to pattern of work	0
Number relating to educational opportunities	0
Number relating to service support available to the doctor	0

The table below shows the number of exception reports carried over, raised, closed and outstanding for Q4. Please note this data excludes exception reports related to educational opportunities.

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Accident and emergency	0	11	11	0
Acute Medicine	0	2	2	0
Anaesthetics	0	1	1	0
General medicine	0	8	6	2
General surgery	0	2	1	1
Geriatric medicine	0	1	1	0
Haematology	0	2	1	1
Medical oncology	0	6	6	0
Obstetrics and gynaecology	0	14	14	1
Ophthalmology	0	9	9	0
Paediatrics	0	3	3	0
Trauma & Orthopaedic Surgery	0	6	6	0
Total	**0**	**70**	**66**	**4**

The below table provides a breakdown of the number of exception reports divided by medical grades for Q4.

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	15	12	3
FY2	0	7	6	1
CT1-2 / ST1-2	0	39	39	0
CT3+ / ST3-5	0	9	9	0
Total	**0**	**70**	**66**	**4**

Appendix 2: Locum Bookings by Department, Grade and Reason

Locum bookings (shifts) by department

Department	Filled by Agency	Filled by Bank	Unfilled
Acute Medicine	0	139	3
Anaesthetics	0	42	0
Cardiology (Medical)	0	30	0
Care of the Elderly	0	47	0
Emergency Medicine	0	272	3
Endocrinology and Diabetes	0	2	0
ENT	0	91	0
Gastroenterology	0	23	0
General Medicine	0	632	13
General Surgery	0	259	0
Neonatal Medicine	0	26	0
Obstetrics and Gynaecology	0	58	0
Oncology	0	69	0
Ophthalmology	0	17	0
Oral and Maxillofacial Surgery	0	81	0
Orthopaedic and Trauma Surgery	31	123	1
Paediatrics	0	114	0
Renal Medicine	0	77	0
Respiratory Medicine	0	6	0
Stroke Medicine	0	26	0
Urology	0	9	0
ITU	0	54	0
Grand Total	**31**	**2197**	**20**

Locum bookings (shifts) by grade

Grade	Filled by Agency	Filled by Bank	Unfilled
FY 1	0	26	0
FY 2	0	0	0
Core Trainee	0	1619	15
StR (ST3-8)	31	552	5
Grand Total	**31**	**2197**	**20**

Locum bookings (shifts) by reason

Reason	Filled by Agency	Filled by Bank	Unfilled
Compassionate / Special Leave	4	0	0
Extra Cover	0	2	0
Pregnancy / Maternity Leave	0	1	0
Sick	0	11	4
Vacancy	0	26	2
Winter Pressures	0	16	0
(blank)	0	1	0
Essential cover for short term sickness	0	554	9
Additional Agreed Activity	0	94	1
Cover above establishment	0	208	1
Essential cover during shadowing period	0	13	0
Special leave	0	23	0
Recognised funded vacancy	27	741	1
Essential cover due to Occupational Health adjustments	0	64	0
Essential cover for LTFT	0	24	0
Annual/Study/Professional Leave	0	2	0
Recurrently funded temporary staffing	0	148	0
Essential cover for long term sickness	0	221	1
Parental/Maternity/Paternity Leave	0	43	1
Essential cover during phased return	0	5	0
Grand Total	**31**	**2197**	**20**

Comments
A total of 2197 shifts were filled by bank staff and 31 by agency, with only 20 shifts remaining unfilled. The highest locum demand was in General Medicine (632 bank shifts), Emergency Medicine (272 bank), and General Surgery (259 bank shifts). while several specialties such as Endo & Diabetes and Respiratory Medicine show minimal usage

By grade, ST1-2/CT1-2 residents accounted for the majority of locum shifts (1619 bank and 0 agency), followed by ST3-8 residents (552 bank and 31 agency). The primary reasons for locum

bookings included vacancies (741 shifts), short term sickness cover (554), and long-term sickness (221). These figures reflect sustained pressure across key departments and highlight the importance of ongoing workforce planning to manage demand and reduce reliance on agency staffing.

SRO Update March 2026

ED2 Critical Path Overview

Report Date

2025				2026				2027				2028			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Section 1 – B31 Level 0 — October 25
- Section 2 – B31 Level 2 (AHU) — October 25
- Section 3 – B31 Level 2 — January 26
- Section 4 — February 26 — Moves 4 March 26
- Section 5 – Adult Wait Area / B31GF — June 26 — Moves 26 April 27
- Section 6 – Corridor — July 26
- Section 7 — October 26 — Moves 27 & 28 April 27
- Section 8 – PEADS & Reception — April 27 — Moves 27 & 28 April 27
- Section 9 – Corridor — June October 27
- Section 11 – ARA — October 27 — Moves 27 October 27
- Section 12 – ED Road — October 27
- Section 13 — Feb October 27
- Section 14 - Path — July 26
- Section 15 – Ambulance Bays — April 27
- Section 16 – ED Access — September 27

HOSPITALS
TRANSFORMATION
PROGRAMME

B60 Critical Path Overview

2025				2026				2027				2028			
Jan-March	April-June	July-Sept	Oct-Dec	Jan-March	Apr-June	July-Sept	Oct-Dec	Jan-March	Apr-June	July-Sept	Oct-Dec	Jan-March	Apr-June	July-Sept	Oct-Dec

Report Date

- Complete Construction (Main Build)
- Construction Completion (28 Feb)
- Install Group 2 Equipment
- Install & Test Group 3 Equipment& Digital (installation and set up)
- Clinical Pathways complete including, new Urgent Treatment Centre at PRH, Amb Conveyance Protocol, post 72 hour planned care
- Complete Fire, Security and Major Incident Plan Review of New Department
- OD and Culture Change impact reviewed, and Management of Change (MOC) process completed
- Review, Update and Communicate 'Hospital Full' Protocol
- SOPS updated and approved
- IPC Commissioning & Sign-off
- Tristel clean all areas
- Adult Inpatient moves
- **ED2 Completes review of Paediatric move plan (Dec 2027)**
- Paediatric moves
- Review, and monitor bed reductions against Demand and Capacity Model
- Update & Issue Security Cards
- Comms to inform of service changes
- B60 Planned Completion & Fully Operational (Aug 28)
- Getting the patient ready / transition process

Construction and Estates

Executive Lead :

Matthew Neal

Construction area

Welcome to the Royal Shrewsbury Hospital

The Shrewsbury and Telford Hospital NHS Trust

Key

Lift · Cafe · WC Toilet · Helipad · Staff Entrance · Parking Machine · Corridor · Multi-faith room · Pharmacy

Stairs · Bus · Food · Phone · Entrance · Disabled Parking · Public Car Park · Cycle Shelter

Level 1 (Outpatients Entrance Level) L1

Evolution Road

Entrance 3

Staff Only

Pathology Entrance (day time)

Copthorne Building

Entrance 0 Copthorne Building

Entrance 2 Treatment Centre Entrance

A&E

SAU Entrance

Outpatients Entrance CLOSED

Build Site

Emergency Department Entrance (24 hours) ONLY

Entrance 1 Ward Block Entrance

Renal Unit - Hummingbird (Diabetes) Entrance

Lingen Davies Centre Entrance

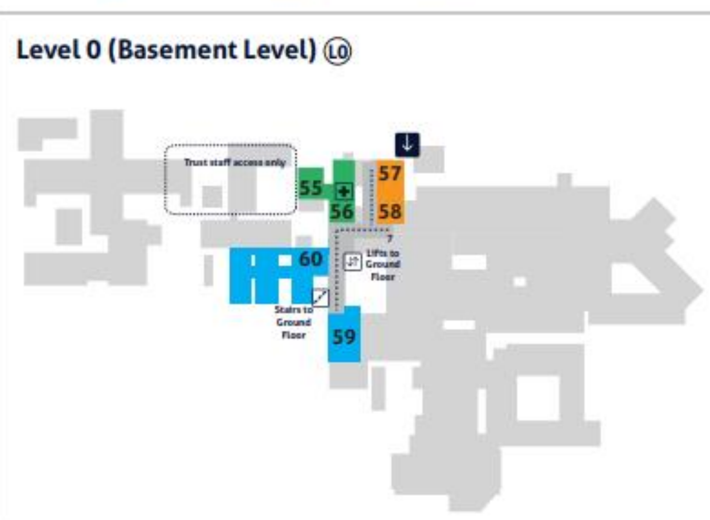
SaTH Education, Research & Improvement Institute (SERII) Entrance

Public Car Park

Mytton Oak Building

Hamar Centre and Macmillan Support Centre

Shropshire Education & Conference Centre (SECC)

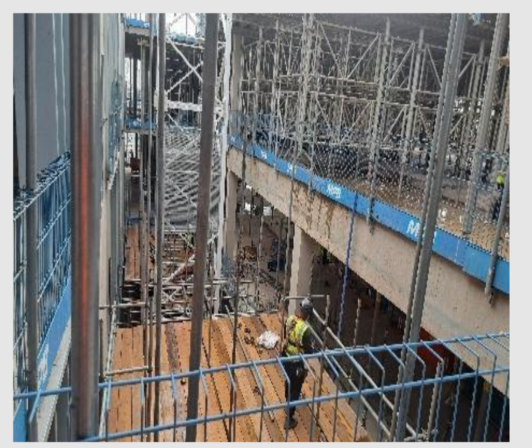


Latest Drone Image

HOSPITALS
TRANSFORMATION
PROGRAMME

Construction Progress

- The new build extension (Building 60) continues to remain on schedule.
- Installation of cladding, windows, internal partitions and the steel frame are progressing well.
- High voltage cabling installed under the road, connecting to a new sub-station.
- The next major milestone is on track for December 2026, when the envelope completes and the building becomes watertight.



Comms and Engagement

Executive Lead : Inese Robotham

Recent and upcoming engagement activity

- Bridgnorth Library drop-in – 2 February
- Broseley Library drop-in – 6 February
- SALC HTP update – 6 February
- Marden PPG update – 9 February
- Ludlow Library drop-in – 11 February
- LoF Executive Committee update – 16 February
- ShropComm Question Time update – 23 February
- Newtown Library drop-in – 24 February
- HTP focus group – 5 March
- Live Well Hub, Donnington – 6 March
- Madeley Library drop-in – 12 March

Upcoming

- Bishop's Castle Library drop-in – 20 March
- Welshpool Library drop-in – 23 March
- Wellington Library (Live Well Hub) – 23 April
- Public Assurance Forum – 27 April
- About Health event – 28 April
- Market Drayton Visual Impairment Club – 5 June

**please note – expected pre-election period to begin end of March 2026 in Wales. Exact dates TBC – engagement and communications activity to be impacted, avoiding sensitive and political use of information during this time*

Communications Update

- Collaboration continues with the Workforce Lead to support the work of Change Agents and to develop a broader internal campaign "HTP Together". The campaign will be a phased approach, aligned to different milestones within the workforce and operational programme. Outlined as follows:

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

- **Drop-ins across libraires underway** – with dates added following request of JHOSC
- **Quarterly focus groups and About Health events** scheduled and on track
- **New information booklet** now available in print and online – available here: Hospitals Transformation Programme - Information Leaflet - 2026 by The Shrewsbury and Telford Hospital NHS Trust - Issuu
- **Regular content through digital channels** and **local media** to inform audiences of our progress – sharing with system partners to amplify messaging
  - Focusing on system-wide Winter campaign for 2026/27 and agreeing messaging with partners to prepare for HTP clinical model. This includes promotion of UTCs, which has not been a feature of previous Winter Campaigns.
- A review has been undertaken of **engagement with Seldom Heard groups** to understand activity to date, lessons learnt. A report is being prepared following engagement with HTP Focus group to agree approach with these groups for the next 3-years.
- Supporting with a number of construction related activity including; ED modular building relocation and site roadworks

Recent coverage

- New emergency care facilities open in ongoing redevelopment project – SaTH

Communications Update – Social Value

Top headlines

- 37 education activities delivered – benefitting over 700 young people
- 22 community activities delivered – with over £13,500 being invested into Shropshire and Telford communities
- 3 DFN interns now into paid employment (
- 45 score in Considerate Constructions Scheme - 45 is the maximum score that can be achieved
- 576 apprentice weeks, 157 training weeks, and 77 work placement weeks provided

Recent activity includes:

- Shrewsbury College – Route 2 Careers event
- Telford College careers event
- Site visit with Shrewsbury Mens Shed – part of Build UK Open Doors
- 5 candidates from the first cohort from the Community Skills Centre are now in paid roles on site with supply chain – we will be sharing a case study on their progress in the coming months.