

# STW ICS Board - Appendices

MEETING  
29 June 2022 14:00

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## **Interim ICB CEO Designate update**

- Appendix A STW QSRM Feedback Letter
- Appendix B – ROS
- Appendix 1 TWIPP Annual report (draft 1) Dashboard
- Appendix 2 SHIPP Annual report (draft 1)
- Slides - Pledge 3 Population Health Management and Outcome Framework

Agenda item 29-06.008

QSRM Feedback Letter

Agenda item 29-06.008

Sent via email

From the office of Fran Steele  
Director of Strategic Transformation, North Midlands

**Neil McKay**  
ICB Independent Chair Designate  
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31 May 2022

Dear Neil,

### **Quarterly System Review Meeting – 18 May 2022**

Thank you to you and system colleagues for attending the Quarterly System Review Meeting (QSRM) on 18<sup>th</sup> May, chaired by Dale Bywater, Regional Director, and for providing a comprehensive slide pack to support the agenda.

#### **1. Overview**

The purpose of the meeting was to review the current areas of focus across the system and to discuss the key challenges the system is facing. The recent challenges of the COVID-19 waves of infection were acknowledged, including the impact to services largely due to staff absence across the system. Your commitment in responding to the difficult challenges over the last few months is recognised and appreciated.

We congratulated you on several positive features of the system's work in previous months including

- some good appointments to the ICB leadership team with significant potential as you move forward to the next phase
- real progress being made with the Strategic outline Case of the HTP with a much clearer articulation of how to deliver the clinical model within the £312m financial envelope
- continued access to support for families impacted by Ockenden through the arrangements in place with MPFT and continuing to make sure your own workforce has access to support
- system working to deliver the Covid vaccination programme including nomination for an award in recognition of the approach to health inequalities
- some genuine system working during times of increased operational pressures in the hospital setting, a clear example being RJaH staff forming part of SaTH workforce rotas at times of intense need. Also, the close working with your Local Authorities, with active representation and support around the discharge agenda in particular
- reaching out for support in areas requiring particular attention – Primary Care being a key example where you are seeking to optimise the support available through both the regional team and the national offer

However, despite the context remains incredibly challenging some of what we want to explore further with you today

- finance – your draft plan was the 2<sup>nd</sup> worst in the Country based on %. We know you have made subsequent improvements but undoubtedly the national escalation focus will remain
- urgent care and ambulance handover delays – whilst you have experienced some calmer days recently the level of heightened concern remains particularly as the ongoing pressures continue to impact your ability to convert ward areas back to elective use.
- elective care – your initial plan submission suggested you could still have patients waiting over 104ww right through to the end of March 2023 which is clearly unacceptable. We know you recognise this issue and are considering how to mitigate and will resubmit your plan on the back of those considerations
- diagnostics capacity challenges and seeking to optimise the use of private providers
- quality
  - continued focus on fully implementing the Ockenden improvement plan
  - IPC issues at RJaH but a real step forward in terms of your recovery plan being in place alongside a full time Improvement Director, Jacqueline Barnes.
- workforce– whilst you have made some progress on reducing vacancies you undoubtedly have a significant recruitment and retention challenge so as a system need to be clear what will best help to ensure this happens.

## 2. Finance

It was noted that whilst there is an expectation of additional funding being made available nationally to support unavoidable costs it was recognised this will not close the systems' financial gap and that STW needs to continue to seek improvements. We noted that the work you are progressing has already reduced the planned deficit from £73m to £38m. You also outlined further action the system is taking including senior engagement through the DoFs group and a weekly briefing to the CEOs Group.

You raised concerns regarding the cessation of the Hospital Discharge Programme (HDP) funding and the detrimental impact it will likely have on effective hospital discharge processes, particularly in terms of the block purchase of care home beds and the availability of enablement hours. However, you also emphasised that work continues to seek to mitigate these risks.

We reflected that whilst some good progress on finance has been achieved to date there was more potential savings opportunities to be explored and that Adrian Roberts from the national NHSE&I team would continue to work with and support the system.

Having acknowledged the good progress being made on the HTP programme all agreed the importance of meeting upcoming timescales so that key decision points can be serviced.

**Action QSRM20220518-1 NHSEI and System call to be arranged to discuss HDP cessation of funding and potential mitigations**

**Action QSRM20220518-2 System to confirm actions to identify potential further savings**

### 3. Urgent Care

We acknowledged the context in which the system has been operating; high inpatient Covid numbers, staff sickness levels and impact on community and care home capacity. However there remains a significant risk in terms of patient safety and quality associated with delays in the urgent care pathway. The areas we discussed were:

- Both the number and length of ambulance handover delays remains extremely challenging, whilst acknowledging that more recently numbers have reduced. We noted that the system will be arranging roundtable summits with WMAS to agree actions to address this key concern.
- You have arranged for the CCG's Quality Lead to visit SaTH to understand ambulance handover delays issues from a quality perspective
- A UEC Improvement Plan has been developed by the system
- Medical beds remain on escalation into elective areas. De-escalation is currently planned to commence after the Jubilee bank holiday and these areas become fully operational as elective beds wef 13 June.

**Action QSRM20220518-3 System to hold roundtable summit(s) with WMAS to address ambulance handover delays and confirm actions**

**Action QSRM20220518-4 System to ensure de-escalation of elective areas and ensure they are operational for electives by 13 June**

### 4. Elective care

#### 4.1 104ww

The system made good progress in achieving a reduction in patients waiting over 104 weeks for their care by the end of March 2022. However, there remains significant concerns regarding the forward plans for both 104ww and 78ww throughout 2022/23. You are currently working towards a final figure for the end of Q1 (June 2022) of 93 patients for the system overall however everyone recognised this was much higher than was hoped.

The current plan position of having 107\*104ww by end of March 2023 was recognised as not being acceptable. Your current plan also suggests there will be 508\*78ww of which is currently the highest number in the region despite STW being the smallest ICS in terms of population. You are clearly continuing to review this number with a key focus on creating more resilience in your elective capacity with delivery of your elective Hub programme being a key element. However you highlighted the risk that should a full OBC be required to support the investment then time delays could be added. You requested that region provide support to this and other initiatives to ensure that waits are addressed, it was agreed that a meeting of senior colleagues would be convened.

**Action QSRM20220518-5 A meeting is to be convened to address elective waits between region and the system to explore further actions that would help mitigate current risks**

## 4.2 Cancer

We recognised that the cancer element of your 22/23 plan is compliant but registered concerns that the reduction of the 62-day backlog will be a significant challenge. It was also noted that whilst you believe there would be an improvement in the FDS performance it is unlikely to achieve 75% by end of March 2023 but the planned volumes are still sufficient to support the cancer recovery projections.

## 4.3 Diagnostics

CT, MRI and NOUS are key constraints for the system. In response you are seeking to put in place a new contract with an ultrasound provider and are focusing on improving access to CT together with running endoscopy lists 7 days per week. However, the MRI service continues to struggle with a radiographer workforce shortfall and an intense recruitment focus continues.

You highlighted a particular concern in relation to the attractiveness of independent sector employment for MRI radiographers and that radiographer availability is also a potential risk for the operation of the Telford CDC. Following discussion, we agreed to consider if there is further support region can provide to help alleviate these issues, recognising this is not an easy issue to resolve. We also confirmed that there is a Midlands regional recruitment and retention programme in development that we will ensure you are directly linked in to

**Action QSRM20220518-6 Region to provide further information on the recruitment and retention approach for radiographers that is in development**

**Action QSRM20220518-7 System to review activity plan especially for elective 104ww and 78ww, cancer performance and diagnostic recovery, in advance of the expected reopening of annual plan submissions in June.**

## 5. Maternity and Clinical Quality

### 5.1 Maternity

We confirmed that the first Ockenden report actions are now green which is clearly a positive. You emphasised that an analysis of the second and final Ockenden report has been conducted by SaTH and you believe there are 68 actions for local learning and 15 essential themes (which have a total of 92 required actions). You stated that the CCG would not be able to confirm system assurance due to timescales and schedule of Governing Body meetings however, there is a process in place to handover responsibility to the ICB wef 01 July 2022. You asked for support to the system for family and staff psychological support, the financial risk of £400K currently sits with the system for a contract with MPFT as provider. We asked for further detail to enable us to pursue this matter further

**Action QSRM20220518-8 System (MPFT) to provide further details of the psychological support arrangements for NHSEI region to seek an update on potential funding options**

## 5.2 RJAH IPC concerns and SOF3 rating

You articulated the level of focus in both the trust and across the system towards resolving the IPC concerns and the ambitions you have to achieve the associated exit criteria. You gave us detail on several initiatives you have instigated including NED Oversight, review of capacity and capability of your IPC team, estates improvements and NHSE/CCG quality reviews. There is an overarching Improvement plan which has been presented to your Trust Board and we are aware that your Chair is actively and personally involved. You have also commissioned a governance review by the GGI – Good Governance Institute.

## 5. Workforce

We questioned the lack of Chief People Officer in the ICB's proposed structure. You explained that the system currently has HRD gaps and that the ICB is developing a proposal for a system wide approach to HR. Your intention is to appoint a CPO eventually but, in the meantime, Simon Whitehouse and Stacey Keegan would hold joint responsibility for the agenda. We asked for confirmation by email on the current arrangements. We were also informed that the ICB is keen to explore shared services options across the system.

We reflected that there is much good work on the workforce approach in the system, but you face a major challenge in building clinical capacity. The system does not have a strong record in delivery of step change improvements in workforce numbers. We had the opportunity to discuss some potential options but are convinced that a major risk remains with overall workforce numbers. However you believe your current system workforce plan and approach is strong but recognise that some key risks remain that you will continue to seek to mitigate

**Action QSRM20220518-9 System to confirm current arrangements for senior responsibility and accountability for HR/CPO**

## 6. Summary and Next Steps

In conclusion we would like to thank you and your system colleagues for a helpful and informative discussion. We are mindful you have been operating under a difficult set of circumstances but that the system continues to work well together. We are keen to understand ongoing progress and we will continue to work with you to support improvement where possible.

Yours sincerely



Fran Steele, Director of Strategic Transformation, NHSE&I

cc:

Simon Whitehouse, ICS Interim CEO Designate

Dale Bywater, Regional Director, NHSE/I

Steven Redfern Assistant Director Strategic Transformation, North Midlands, NHSE/I

Jacqueline Barnes, Improvement Director, NHSE&I



## Appendix B - ROS

Agenda item 29-06.008

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

Introduction to the Readiness to Operate Statement (ROS) Checklist V4

**IMPORTANT - THIS CHECKLIST SHOULD ONLY BE USED ONCE YOU HAVE READ THE ICS ESTABLISHMENT GUIDANCE ENTITLED: 'ICB READINESS TO OPERATE STATEMENT (ROS) AND CHECKLIST' AND THE CONTENT OF THIS TAB.**

The ROS checklist has been co-produced by NHS England and NHS Improvement teams, including the legal team, Integrated Care Systems (ICs) and other stakeholders. It was published via FutureNHS on 18 August 2021. It has been released as appendix B of the guidance document and also as a working Excel document with RAG rating drop-down options to enable systems to self-assess. The Excel document was revised and re-published on 14 October 2021 (V2) to take account of feedback that the RAG ratings needed to include options for 'not started' and 'completed', on 3 November 2021 (V3) to remove 'not started' and provide a 'N/A' option for prompt 3.8 and again on 2 March 2022 to reflect the change in the target date for ICB establishment.

The ROS checklist is a national tool for regional implementation. It indicates that arrangements should be 'in line with relevant guidance' and thus sets a national minimum standard where applicable. However, it does not specify the level or type of evidence required, nor in detail the assessment process to be adopted. Within parameters, there is flexibility, and regional teams have determined and documented their approaches to assessment, with differentiation between ICs where appropriate to take account of local circumstances.

The ROS checklist is the key mechanism for reporting and assuring progress towards ICB establishment. System colleagues can download the checklist to undertake a self-assessment, RAG rating their current and projected (June 2022) positions against the different elements, and supplying a supporting commentary. Individual system self-assessments should be submitted to regional teams.

In June 2022 (see ICB Establishment Timeline for dates) each designate ICB chief executive and their relevant NHS England & NHS Improvement regional director will be asked to co-sign a 'Readiness to Operate Statement' (ROS). This will be a high-level statement to confirm that:

- all legally required and operationally critical elements are in place ready for the establishment of the Integrated Care Board (ICB) as a statutory body on 1 July 2022; and
- arrangements are in place for the ICB to fulfil its role within the wider ICS, including establishing the Integrated Care Partnership (ICP) with the relevant local authority/ies.

Once completed in June 2022, the checklist should be appended to the signed ROS.

The ROS checklist will be the key mechanism for reporting and assuring progress towards ICB establishment.

There will be a joint assessment of progress against each element of the checklist between all systems and the relevant NHS England and NHS Improvement regional team. Assessments at the end of Q2 and Q3 have been completed, and the assessment for Q4 2021/22 will take place in March / April.

There will be a final assessment and each ICB's ROS will need to be signed off in June 2022.

Precise dates for submission of the ROS assessments are all outlined in the ICB Establishment Timeline.

Tab 2 includes the full checklist and the key points to note are as follows:

- column B provides an optional hierarchy allowing presentation as a high level summary (ie 12 core areas) or with all supporting elements
- the date of completion should be included at line 6 and as outlined above, and assessments at Q2, Q3, Q4 2021/22, with a final submission in June (noting that no projected position will be required for the final submission)
- column F seeks a current RAG rating based on the descriptions on the drop down list
- column G seeks a projected RAG rating based on the description on the drop down list
- column H provides a commentary column

Guidance in relation to the subjects covered in the ROS checklist is / will be available on the dedicated workspace for ICS Guidance on the FuturesNHS Platform: <https://future.nhs.uk/ICSGuidance/grouphome> on the FutureNHS Collaboration Platform

Version Control

The final draft of the ROS Checklist is contained in the guidance document and this working version is accessible via the Hub. Changes are not anticipated but if deemed necessary, strict version control will be applied. The version number and date of issue will be included below and any changes clearly identified

Current version number

Date of current version

V4  
3/2/2022

Comments Regarding Versions Released

V1 was released on 18.08.21

V2 was released on 14.10.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log

V3 was released on 03.12.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log

V4 was released on 02.03.22 - most changes relate to the change in date for ICB establishment and a change in the narrative re prompt 9.1 - see changes in the version control log

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT  
**Readiness to Operate Statement (ROS) Checklist - to prepare for legal establishment on 1 July 2022**

**Please refer to the ROS Guidance before using this checklist**  
Guidance in relation to the subjects covered in the ROS checklist is / will be available on the dedicated workspace for ICS Guidance on the FuturesNHS Platform:

Name of ICB:	Shropshire, Telford and Wrekin ICS
Date:	10-Jun-22
Completed by:	Nicky O'Connor
Contact details:	

Hierarchy	Ref	Description
High Level Summary	1	<b>Integrated care partnership (ICP): Initial ICP arrangements and principles agreed</b>
V4	Supporting elements	1.1 Initial Integrated Care Partnership (ICP) arrangements agreed, including principles for operation from 1 July 2022, in line with relevant guidance
High Level Summary	2	<b>Integrated care board (ICB): Designate appointments to the Board of the ICB made and Board quorate in line with relevant guidance</b>
Supporting elements	2.1	Designate Chair appointed and ready to take up post on 1 April 2022
Supporting elements	2.2	Designate Chief Executive appointed and ready to take up post on 1 April 2022
Supporting elements	2.3	Designate Non-Executive Directors (minimum of two) appointed and ready to take up post on 1 April 2022
V4	Supporting elements	2.4 Designate Partner members appointed and ready to take up post [timing dependent on the Partner Member Regulations]
Supporting elements	2.5	Other designate appointments made and postholders ready to take up post on 1 April 2022 (minimum additional Executive roles: finance; medical; nursing) to ensure quoracy of the ICB Board, according to its Constitution
High Level Summary	3	<b>System development plan, ICB constitution and governance arrangements: System Development Plan, ICB constitution and governance arrangements in place</b>
Supporting elements	3.1	System development plan (SDP) in place indicating how the ICB will work with its partners in the ICP from April 2022 to meet the needs of the population, with a focus on reducing health inequalities
V4	Supporting elements	3.2 ICB Constitution, including the Standing Orders and agreed ICB name, approved by NHS England before 1 July 2022, ready to be adopted on 1 July 2022 - in line with relevant guidance
V4	Supporting elements	3.3 ICB Scheme of Reservation and Delegation (SoRD) prepared and ready to be adopted on 1 July 2022
V4	Supporting elements	3.4 ICB Standing Financial Instructions (SFIs) prepared and ready to be adopted on 1 July 2022
V4	Supporting elements	3.5 ICB Governance Handbook (setting out the governance arrangements) prepared and ready to be adopted on 1 July 2022
V4	Supporting elements	3.6 ICB functions and decision map prepared and ready to be adopted on 1 July 2022 - including (where applicable) place boundaries, place-based leadership, and place-based governance arrangements (e.g. with Health and Wellbeing Boards); delegations (where appropriate); and any supra-ICB governance arrangements
V4	Supporting elements	3.7 Any joint commissioning arrangements for 2022/23 (including joint committees with local authorities, trusts / foundation trusts, other ICBs and NHS England and NHS Improvement) documented, ready to take effect on 1 July 2022
V4	Supporting elements	3.8 Schedules of delegation to be in place for 1 July 2023 where the ICB has agreed with NHS England and NHS Improvement to assume delegated responsibility for NHSEI commissioning functions in line with relevant guidance [For clarification purposes this relates to Pharmacy, Optometry and Dental commissioning function only]
V4	Supporting elements	3.9 Standards of business conduct policy prepared and ready to be adopted on 1 July 2022
V4	Supporting elements	3.10 Conflicts of interest policy prepared and ready to be adopted on 1 July 2022
Supporting elements	3.11	Essential policies identified through risk assessment (eg commissioning [eg IVF commissioning], safeguarding, HR) and prepared
High Level Summary	4	<b>Provider partnerships: Provider partnership arrangements agreed</b>
V4	Supporting elements	4.1 Provider partnership arrangements which will apply from 1 July 2022 agreed in line with relevant guidance. These include provider collaboratives, primary care networks and other collaborative arrangements
High Level Summary	5	<b>People and culture: People function ready for operation</b>
Supporting elements	5.1	Governance and delivery arrangements for people function agreed and ready for operation as set out in line with relevant guidance, and workforce and organisational development priorities identified in the system development plan
High Level Summary	6	<b>Quality, safety and EPRR: Quality, safety and EPRR systems and functions ready for operation</b>
V4	Supporting elements	6.1 Quality and safety systems and function ready to take effect from 1 July 2022, including implementation of System Quality Groups in line with the National Quality Board's guidance
V4	Supporting elements	6.2 EPRR responsibilities clear and systems and function ready to operate from 1 July 2022 in line with relevant guidance
High Level Summary	7	<b>Clinical and care professional leadership: Model / arrangements prepared</b>
Supporting elements	7.1	ICB leadership model / arrangements prepared in line with relevant guidance
High Level Summary	8	<b>Working with people and communities: Public involvement and engagement strategy / policy</b>
Supporting elements	8.1	ICB public involvement and engagement strategy / policy prepared in line with relevant guidance
High Level Summary	9	<b>NHS oversight and ways of working: NHS oversight and ways of working between NHS England and NHS Improvement regional team and ICB</b>
V4	Supporting elements	9.1 Arrangements for NHS oversight and the MOU to describe the agreed ways of working between the NHS England and NHS Improvement regional team and the ICB prepared, ready to take effect from 1 July 2022
High Level Summary	10	<b>Finance and planning: Planning for 2022/23 developed in line with national requirements and finance function and systems ready for operation</b>
Supporting elements	10.1	Planning for 2022/23 has been carried out in line with relevant guidance
V4	Supporting elements	10.2 Activities as outlined in the NHS SBS finance / ledger reconfiguration programme plan as due by 1 July 2022 have been delivered e.g. new bank account in place for the ICB, ICB able to make payments for goods and services, finance function ready to operate, etc.
Supporting elements	10.3	Plan for ESR changes in place (if using IBM for a technical merge of ESR systems, technical slot booked)
High Level Summary	11	<b>Data, digital and information governance: Systems ready to operate and information governance activities on target</b>
V4	Supporting elements	11.1 Activities outlined in the Organisation Data Service (ODS) reconfiguration toolkit as due by 1 July 2022 have been delivered
V4	Supporting elements	11.2 Activities outlined in the Information governance / data security and protection toolkit (DPST) (e.g. Caldicott Guardian, Information Asset Owner, Senior Information Risk Owner, records retention, etc.) as due by 1 July 2022 have been delivered
High Level Summary	12	<b>Transition from CCGs to ICBs: Equalities duties complied with, due diligence of people and property complete, consultation completed in line with TUPE requirements / COSoP guidance, staffing and property lists prepared and first day arrangements confirmed</b>
Supporting elements	12.1	Equalities duties
Supporting elements	12.1.1	Evidence of compliance with the Public Sector Equalities Duty, and wider equalities duties, in the transfer and establishment process
Supporting elements	12.2	People transfer
Supporting elements	12.2.1	Consultation completed in line with TUPE requirements / COSoP guidance and staff list shared by sending CCG(s) to receiving ICB(s) (designate Chief Executive) - in line with relevant guidance (HR Framework and Due Diligence Guidance [tab 2.2 of the Due Diligence Checklist])
Supporting elements	12.2.2	CCG(s) staff due diligence completed and written assurance provided by the CCG's AO to the ICB's designate CE, with a copy to NHSE's RD (where the AO and CE are the same person the written assurance should be provided to the NHSE RD) - in line with relevant guidance (HR Framework and Due Diligence Guidance [tab 2.2 of the Due Diligence Checklist])
Supporting elements	12.3	Property transfer
Supporting elements	12.3.1	CCG(s) due diligence completed on all property (assets and liabilities, including contracts e.g. with CSUs) in line with guidance; and written assurance provided by the CCG's AO to the ICB's designate CE, with a copy to NHSE's RD (where the AO and CE are the same person the written assurance should be provided to the NHSE RD). List of property and liabilities from sending CCG(s) to receiving ICB(s) produced - in line with relevant guidance (Due Diligence Guidance)
Supporting elements	12.4	First day arrangements
Supporting elements	12.4.1	Appropriate arrangements made in relation to NHS Resolution schemes (Clinical Negligence Scheme for Trusts, Liabilities to Third Parties Scheme and the Property Expenses Scheme) to provide indemnity in line with NHS Resolution guidance (when available)
Supporting elements	12.4.2	First ICB Board meeting to note / approve (as appropriate): Constitution, governance handbook, appointments, key strategies, policies and delegation arrangements (covering both joint commissioning and formal delegations)
Supporting elements	12.4.3	First day communications plan in place
Supporting elements	12.4.4	ICB website in place

RAG Rating October 2021	RAG Rating December 2021	RAG Rating March 2022	Final RAG Rating May 2022	Final RAG Rating at June 2022	Comments
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	On target for delivery by 1 July (only to be used in exceptional circumstances)	Arrangements will be further evolved once ICP is established;
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	On target for delivery by 1 July (only to be used in exceptional circumstances)	Governance handbook submitted
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	
Completed	Completed	Completed	Completed	Completed	
Not on target, significant concerns	Progress made, minor concerns	Completed	Completed	Completed	
Changed to green	On target, no concerns	Completed	Completed	Completed	
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	The joint nomination process for Trust, LA and GP Partner Members has been completed. GP members will be appointed in advance of July 1 in line with establishment timelines
Progress made, minor concerns	On target, no concerns	On target, no concerns	Completed	Delivery is at risk but mitigation plan in place for delivery by 1 July	national steer that all systems with an outstanding pay case for an exec role should be rated as amber
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	Completed	Completed	
On target, no concerns	On target, no concerns	On target, no concerns	Completed	Completed	
Progress made, minor concerns	On target, no concerns	On target, no concerns	Completed	Completed	
Changed to green	On target, no concerns	On target, no concerns	Completed	Completed	As requested in feedback on 20 May submission: final amendments have been made and SORD has been included in this submission as part of the governance handbook
Changed to green	On target, no concerns	On target, no concerns	Completed	Completed	As requested in feedback on 20 May submission: Final ICB Standing Financial Instructions (SFIs) are attached
Changed to green	On target, no concerns	On target, no concerns	Completed	Completed	As requested in feedback on 20 May submission: amendments have been made and a copy of the ICB governance handbook
Changed to amber	On target, no concerns	On target, no concerns	Completed	Completed	As requested in feedback on 20 May submission: An updated version of the functions and decisions map has been included in the Governance handbook
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	Confirmed in feedback on 20 May submission: no further evidence is required
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	NA
Changed to green	On target, no concerns	On target, no concerns	Completed	Completed	A standards of business conduct policy has been drafted as part of the governance handbook included in the evidence supporting this submission
Changed to green	On target, no concerns	On target, no concerns	Completed	Completed	A conflicts of interest policy has been drafted as part of the governance handbook included in the evidence supporting this submission.
Changed to green	On target, no concerns	On target, no concerns	Completed	Completed	Policy review has been carried out and revised CCG policies will be formally adopted by the ICB on date of establishment. A masterlist of policies is attached
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	Confirmed in feedback on 20 May submission: no further evidence is required
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	Delivery is at risk but mitigation plan in place for delivery by 1 July	Completed	
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	Delivery is at risk but mitigation plan in place for delivery by 1 July	Completed	Evidence against Governance and delivery arrangements for people function included - updated people plan - excerpt from System Development plan on "people and culture" - communication from Chief Executive on appointment/resourcing the people function
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	Delivery is at risk but mitigation plan in place for delivery by 1 July	Delivery is at risk but mitigation plan in place for delivery by 1 July	Confirmed in feedback on 20 May submission: no further evidence is required
Changed to red	Progress made, minor concerns	Progress made, minor concerns	Delivery is at risk but mitigation plan in place for delivery by 1 July	Completed	
Progress made, minor concerns	On target, no concerns	Progress made, minor concerns	Delivery is at risk but mitigation plan in place for delivery by 1 July	Delivery is at risk but mitigation plan in place for delivery by 1 July	Simon Whitehouse will take the lead ICB executive role for EPRR; an updated work plan and assurance template were submitted to NHSE/I on 31 May 2022; further work between the ICS and NHSE/I is ongoing in order to complete this action; a copy of the assurance template and workplan is included
Progress made, minor concerns	Progress made, minor concerns	Not on target, significant concerns	Delivery is at risk but mitigation plan in place for delivery by 1 July	On target for delivery by 1 July (only to be used in exceptional circumstances)	
Changed to red	Progress made, minor concerns	Not on target, significant concerns	Delivery is at risk but mitigation plan in place for delivery by 1 July	On target for delivery by 1 July (only to be used in exceptional circumstances)	CPL framework provided on 15 June
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	A final version of the people and communities strategy is attached
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	On target for delivery by 1 July (only to be used in exceptional circumstances)	national position has now been confirmed that all systems should be green for oversight MoU to reflect that national template not out and conversations ongoing.
Progress made, minor concerns	On target, no concerns	Not on target, significant concerns	Delivery is not achievable by 1 July	On target for delivery by 1 July (only to be used in exceptional circumstances)	
Progress made, minor concerns	On target, no concerns	On target, no concerns	Delivery is at risk but mitigation plan in place for delivery by 1 July	Delivery is at risk but mitigation plan in place for delivery by 1 July	amber based on current financial position.
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	On target for delivery by 1 July (only to be used in exceptional circumstances)	Confirmed in feedback on 20 May submission: no further evidence is required however ledgers cannot be transferred until 1 July
Progress made, minor concerns	On target, no concerns	On target, no concerns	Completed	Completed	Confirmed in feedback on 20 May submission: no further evidence is required
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	Completed	Completed	Confirmed in feedback on 20 May submission: no further evidence is required
Progress made, minor concerns	Progress made, minor concerns	Completed	Completed	Completed	Confirmed in feedback on 20 May submission: no further evidence is required
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	Completed	Completed	Confirmed in feedback on 20 May submission: no further evidence is required
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	Completed	Completed	
Changed to green	On target, no concerns	On target, no concerns	Completed	Completed	As requested in feedback on 20 May submission: a signed version of the EHA is attached
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	As requested in feedback on 20 May submission: a signed final consultation document as well as confirmation on staff level 4 transfer are attached
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	Confirmation of the written assurance provided by the CCG's AO to the ICB's designate CE as well as an assurance report are attached
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	As requested in feedback on 20 May submission: A reviewed version, addressing any amber and red rated issues was included in the communication between CCG AO to ICB Chief Executive. The most recent Due Diligence checklist (further amended) has been included
No possible to start	Progress made, minor concerns	On target, no concerns	On target for delivery by 1 July (only to be used in exceptional circumstances)	Completed	Confirmed in feedback on 20 May submission: no further evidence is required
No possible to start	Progress made, minor concerns	On target, no concerns	Completed	Completed	Confirmed in feedback on 20 May submission: no further evidence is required
No possible to start	On target, no concerns	On target, no concerns	Completed	Completed	Running order of inaugural meeting on 1 July is included
No possible to start	On target, no concerns	On target, no concerns	Completed	Completed	Confirmed in feedback on 20 May submission: no further evidence is required
No possible to start	On target, no concerns	On target, no concerns	Completed	Completed	Confirmed in feedback on 20 May submission: no further evidence is required

## RAG Rating Guidance

### RAG RATING FOR ALL LINES EXCLUDING 3.8

**Current RAG rating (minimum requirement: 31 October 2021, 31 December 2021, 14 February 2022 and final in March 2022)**

<b>R</b>	Not on target, significant concerns
<b>A</b>	Progress made, minor concerns
<b>G</b>	On target, no concerns
<b>C</b>	Completed

**V2 V3** To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.

**Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22)**

<b>R</b>	Delivery by June 2022 is not achievable
<b>A</b>	Delivery by June 2022 is at risk but mitigation plan in place
<b>G</b>	On target for delivery by June 2022
<b>C</b>	Completed

### RAG RATING FOR LINE 3.8 ONLY

**Current RAG rating (minimum requirement: 31 October 2021, 31 December 2021, 14 February 2022 and final in March 2022)**

<b>R</b>	Not on target, significant concerns
<b>A</b>	Progress made, minor concerns
<b>G</b>	On target, no concerns
<b>NA</b>	Not applicable - applies to 3.8 only
<b>C</b>	Completed

**V2 V3** To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.

**Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22)**

<b>R</b>	Delivery by March 2022 is not achievable
<b>A</b>	Delivery by March 2022 is at risk but mitigation plan in place
<b>G</b>	On target for delivery by March 2022
<b>NA</b>	Not applicable - applies to 3.8 only
<b>C</b>	Completed

VERSION CONTROL - LOG OF CHANGES

Date of Change	Version Change	Tab	Ref	Original Drafting	Revised Drafting	Comment Regarding Change
Version 1 released 18 August 2021						
Version 2 released 14 October 2021 - Changes shown below						
10/14/2021	V2	Introduction	Line 19	N/a	Comments Regarding Versions Released V1 was released on 18.08.21 V2 was released on 14.10.21 - no changes have been made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log	Added to provide confirmation of all versions released
10/14/2021	V2	ROS checklist	Current RAG rating	Current RAG rating (minimum requirement: Q2, Q3 2021/22, mid-February 2022 and final in March 2022) R - Not in place, not started or position unknown A - Progress made G - Completed and in place	Current RAG rating (minimum requirement: Q2, Q3 2021/22, mid-February 2022 and final in March 2022) R - Not on target, significant concerns A - Progress made, minor concerns G - On target, no concerns NS - Not possible to start C - Completed To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.	Change to RAG rating options
10/14/2021	V2	ROS checklist	Projected RAG rating	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable or significant risk to delivery A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022 C - Completed	Change to RAG rating options
Version 3 released 3 December 2021 - Changes shown below						
12/3/2021	V3	Introduction	Line 19	Comments Regarding Versions Released V1 was released on 18.08.21 V2 was released on 14.10.21 - no changes have been made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log	Comments Regarding Versions Released V1 was released on 18.08.21 V2 was released on 14.10.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log V3 was released on 03.12.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log	Updated to reflect version control
12/3/2021	V3	ROS checklist	Current RAG rating	Current RAG rating (minimum requirement: Q2, Q3 2021/22, mid-February 2022 and final in March 2022) R - Not on target, significant concerns A - Progress made, minor concerns G - On target, no concerns NS - Not possible to start C - Completed To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.	Current RAG rating (minimum requirement: 31 October 2021, 31 December 2021, 14 February 2022 and final in March 2022) R - Not on target, significant concerns A - Progress made, minor concerns G - On target, no concerns NA - Not applicable - applies to 3.8 only C - Completed To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.	Change to RAG rating options. Not possible start has now been removed as work will now have started for all areas of the ROS. N/A option introduced for prompt 3.8 only.
12/3/2021	V3	ROS checklist	Projected RAG rating	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable or significant risk to delivery A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022 NA - Not applicable - applies to 3.8 only C - Completed	Change to RAG rating options. N/A option introduced for prompt 3.8 only.
Version 4 was prepared on 16 February 2022 (approved by the C&TSG) but not released and updated again on 2 March 2022 - Changes shown below						
2/16/2022	V4 16.02.22	Introduction	Line 7	The ROS checklist has been co-produced by NHS England and NHS Improvement teams, including the legal team, Integrated Care Systems (ICSs) and other stakeholders.	The ROS checklist has been co-produced by NHS England and NHS Improvement teams, including the legal team, Integrated Care Systems (ICSs) and other stakeholders. It was published via FutureNHS on 18 August 2021. It has been released as appendix B of the guidance document and also as a working Excel document with RAG rating drop-down options to enable systems to self-assess. The Excel document was revised and re-published on 14 October 2021 (V2) to take account of feedback that the RAG ratings needed to include options for 'not started' and 'completed', on 3 November 2021 (V3) to remove 'not started' and provide a 'N/A' option for prompt 3.8 and again on 16 February 2022 to reflect the change in the target date for ICB establishment.  The ROS checklist is a national tool for regional implementation. It indicates that arrangements should be 'in line with relevant guidance' and thus sets a national minimum standard where applicable. However, it does not specify the level or type of evidence required, nor in detail the assessment process to be adopted. Within parameters, there is flexibility, and regional teams have determined and documented their approaches to assessment, with differentiation between ICSs where appropriate to take account of local circumstances.  The ROS checklist is the key mechanism for reporting and assuring progress towards ICB establishment. System colleagues can download the checklist to undertake a self-assessment, RAG rating their current and projected (June 2022) positions against the different elements, and supplying a supporting commentary. Individual system self-assessments should be submitted to regional teams.	Extended description
2/16/2022	V4 16.02.22	Introduction	Line 8	In March 2022 (exact date TBC) each ICB chief executive designate and their relevant NHS England & NHS Improvement regional director will be asked to co-sign a 'Readiness to Operate Statement' (ROS). This will be a high-level statement to confirm that: • all legally required and operationally critical elements are in place ready for the establishment of the Integrated Care Board (ICB) as a statutory body on 1 April 2022; and • arrangements are in place for the ICB to fulfil its role within the wider ICS, including establishing the Integrated Care Partnership (ICP) with the relevant local authority/ies. Once completed in March 2022, the checklist should be appended to the signed ROS.	In June 2022 (see ICB Establishment Timeline for dates) each designate ICB chief executive and their relevant NHS England & NHS Improvement regional director will be asked to co-sign a 'Readiness to Operate Statement' (ROS). This will be a high-level statement to confirm that: • all legally required and operationally critical elements are in place ready for the establishment of the Integrated Care Board (ICB) as a statutory body on 1 July 2022; and • arrangements are in place for the ICB to fulfil its role within the wider ICS, including establishing the Integrated Care Partnership (ICP) with the relevant local authority/ies. Once completed in June 2022, the checklist should be appended to the signed ROS.	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	Introduction	Line 9	The ROS checklist will be the key mechanism for reporting and assuring progress towards ICB establishment. There will be a joint review of progress against each element of the checklist between all systems and the relevant NHS England and NHS Improvement regional team at the end of Q2 and Q3 2021/22. ICSs will be asked to share their checklist with the regional team at these points, alongside their updated system development plans. There will be a final progress review in mid-February 2022 and each ICB's ROS will need to be signed off in March 2022 (deadline date to be confirmed).	The ROS checklist will be the key mechanism for reporting and assuring progress towards ICB establishment. There will be a joint assessment of progress against each element of the checklist between all systems and the relevant NHS England and NHS Improvement regional team. Assessments at the end of Q2 and Q3 have been completed, and the assessment for Q4 2021/22 will take place in March / April. There will be a final assessment and each ICB's ROS will need to be signed off in June 2022. Precise dates for submission of the ROS assessments are all outlined in the ICB Establishment Timeline.	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	Introduction	Line 10	Tab 2 includes the full checklist and the key points to note are as follows: • column B provides an optional hierarchy allowing presentation as a high level summary (ie 12 core areas) or with all supporting elements • the date of completion should be included at line 8 and as outlined above, it is expected that an assessment will be completed at Q2, Q3 2021/22, mid-February 2022, with a final submission in March (noting that no projected position will be required for the final submission) • column F seeks a current RAG rating based on the descriptions on the drop down list. • column G seeks a projected RAG rating based on the description on the drop down list. • column H provides a commentary column.	Tab 2 includes the full checklist and the key points to note are as follows: • column B provides an optional hierarchy allowing presentation as a high level summary (ie 12 core areas) or with all supporting elements • the date of completion should be included at line 8 and as outlined above, and assessments at Q2, Q3, Q4 2021/22, with a final submission in June (noting that no projected position will be required for the final submission) • column F seeks a current RAG rating based on the descriptions on the drop down list • column G seeks a projected RAG rating based on the description on the drop down list • column H provides a commentary column	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	ROS checklist	Cell G10	Projected RAG Rating at March 2022	Projected RAG Rating at June 2022	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	ROS checklist	1.1, 3.2-3.10 incl, 4.1, 6.1, 6.2, 10.2, 11.1, 11.2	Date previously referred to 1 April 2022	Date now refers to 1 July 2022	Changed date to respond to the new target date of 1 July 2022 - for all prompts shown [note line 24 below which later included prompt 9.1]
2/16/2022	V4 16.02.22	ROS checklist	3.8	Schedules of delegation to be in place for 1 July 2022 where the ICB has agreed with NHS England and NHS Improvement to assume delegated responsibility for NHSEI commissioning functions in line with relevant guidance	Schedules of delegation to be in place for 1 July 2022 where the ICB has agreed with NHS England and NHS Improvement to assume delegated responsibility for NHSEI commissioning functions in line with relevant guidance [For clarification purposes this relates to Pharmacy, Optometry and Dental commissioning function only]	Clarified that this prompt relates to POD services only

## Appendix 1 TWIPP Annual Report

Agenda item 29-06.008

## Telford & Wrekin Integrated Place Partnership (TWIPP)

### Update for Integrated Care Board – Draft TWIPP Dashboard

<b>Date of Report:</b>	15 <sup>th</sup> June 2022
<b>Purpose of Report:</b>	To provide an update on the Telford & Wrekin Integrated Place Partnership dashboard.
<b>Author(s):</b>	Helen Potter, Insight Manager, Telford & Wrekin Council Sarah Downes, Integration Programme Manager (Telford and Wrekin), Telford & Wrekin Council
<b>Sign off:</b>	Please note that it has not been possible to present this report to TWIPP ahead of the ICB as the next meeting is not until 30 June.  Signed off by Sarah Dillon, Director of Adult Social Care, Telford & Wrekin Council

## 1. Context

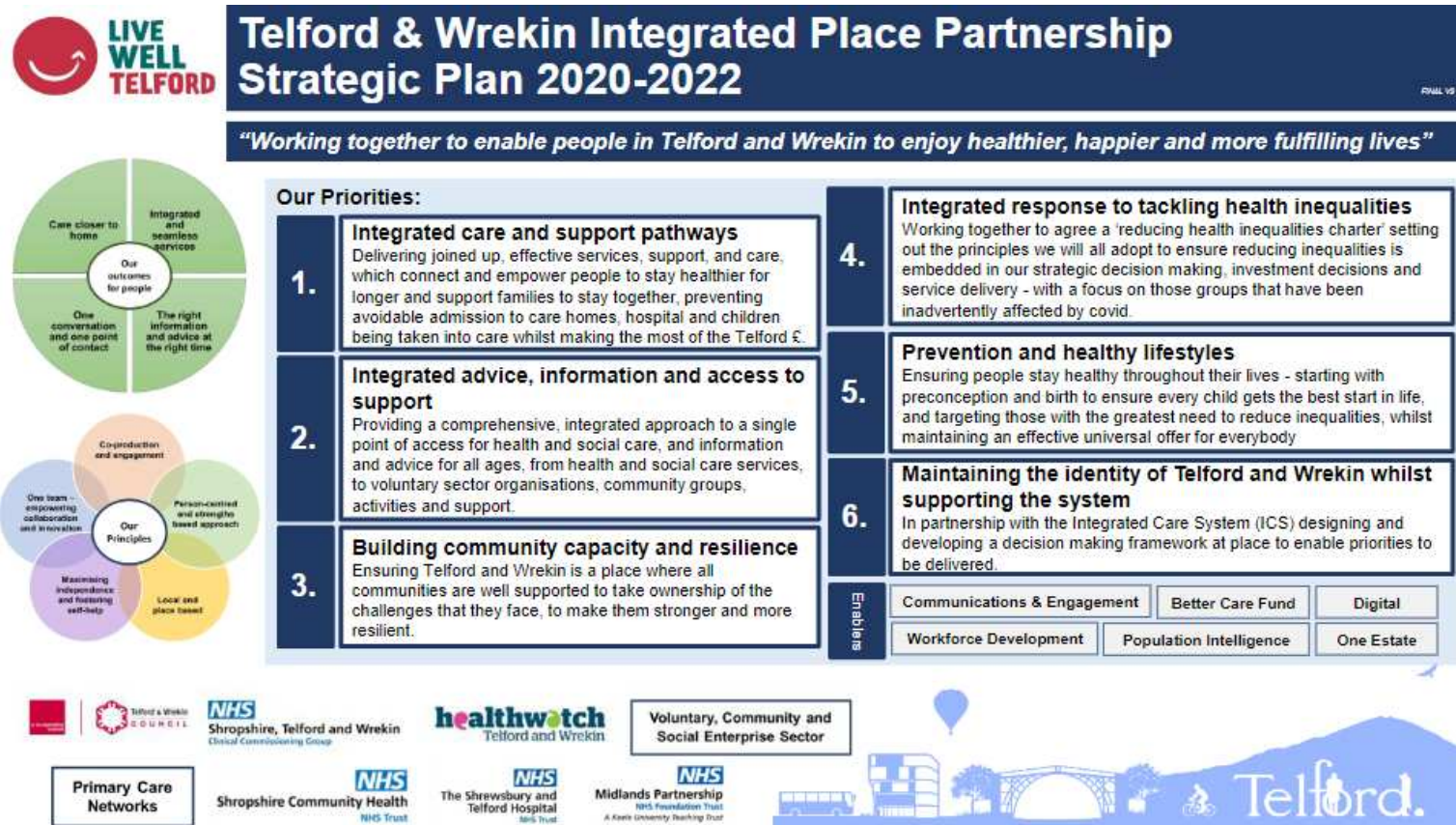
The Telford & Wrekin Integrated Place Partnership (TWIPP) was set up in 2019 and has continued to evolve to meet the needs of residents. The purpose of TWIPP is to drive the delivery of community centred health and care integration, with a key focus upon place-based proactive prevention, seamless services and all age support in Telford and Wrekin.

The TWIPP is a formal partnership board that is accountable to the Telford & Wrekin Health and Wellbeing Board and the Shropshire and Telford & Wrekin Integrated Care Board.

The Partnership's programme is a complex set of activities bringing together all aspects of community centred approaches under the same strategic vision and principles of working to achieve the outcomes for people in Telford and Wrekin. To provide a



framework for delivery of a strategic plan for the programme is in place. The current TWIPP's priorities and associated deliverables are outlined in the following two images.







## Telford & Wrekin Integrated Place Partnership Deliverables for 2021/22

### Integrated Care and Support Pathways

- Roll out of Primary Care Multi-Disciplinary Team (MDTs), case management, risk stratification and Care Home MDTs
- Roll out of Health and Social Care Rapid Response Team
- Continued development of Integrated Discharge Hub including clear linkages to other parts of the system, enablement pathways and length of stay.
- Living with and Beyond Cancer Programme
- Implement the Blue Light project
- Involvement in the hospital transformation work to ensure it is place based and meets needs of residents (linked to Community and Place Based Programme)
- Place based approach to Mental Health including the role of TW VSCE
- Development and Implementation of a Telford & Wrekin Learning Disability Strategy
- Implementation of the Hertfordshire Family Safeguarding Model (CYP)
- Exploring new models of care for diabetes and respiratory pathways
- Development of a telehealth option to deliver care for long term conditions

### Prevention and Healthy Lifestyles

- NHS Diabetes Prevention Programme
- Delivery of whole system approach to reduce obesity
- Delivery of national service specifications for PCNs, including development of the social prescribing role in PCNs
- Improving self-care for post exacerbation respiratory care

Blue wording – health delivery only

### Integrated advice, information and access to support

- Development of a Single Point of Access for health and social care
- Health and Social Care Live Well Hubs in the community
- Ongoing promotion of Live Well Telford
- Establishment of an Independent Living Centre/Smart House

### Building Community Capacity

- Increased volunteering capacity within the community








### Integrated response to health inequalities

- Identify the priority areas of health and social care inequality in Telford and Wrekin, especially those who have inadvertently been affected by Covid
- Develop and agree a 'reducing health inequalities charter'

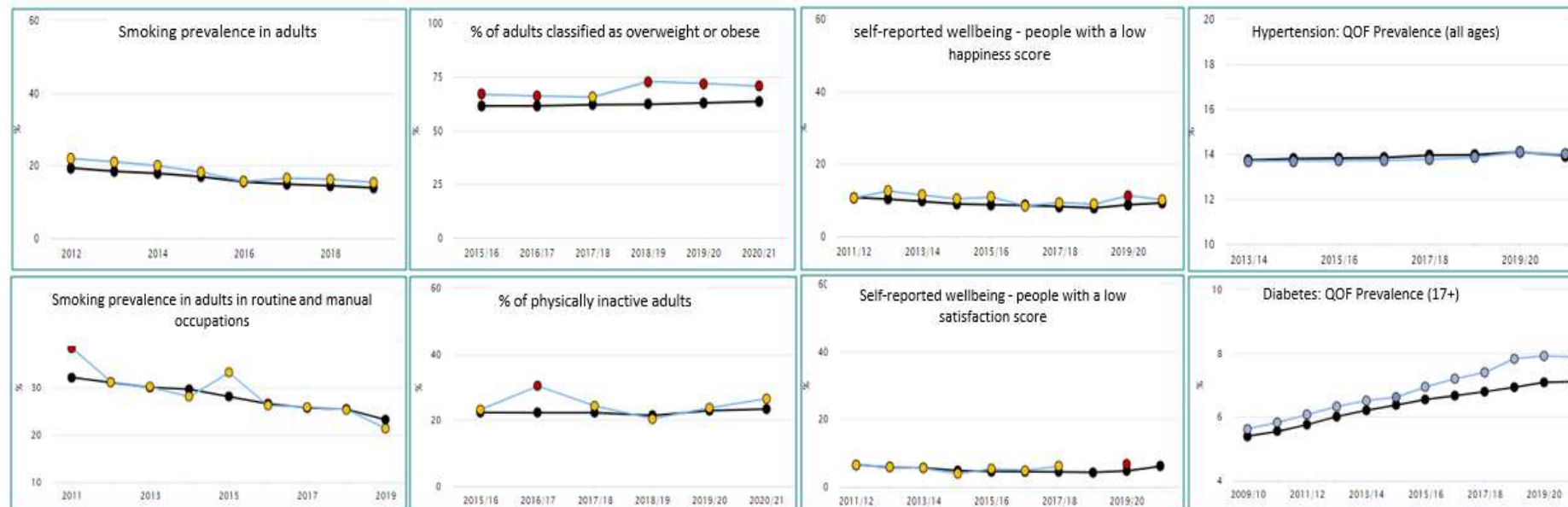
### Maintaining the identity of Telford and Wrekin whilst supporting the system

- Work with the ICS and all organisations to identify what delegated decision making can be done at TWIPP
- Implementation and further development of the BCF Pooled Budget
- Identify the most effective way of organising ourselves at 'Place'
- Development of new integrated estates/extra care facilities

## 2. TWIPP Dashboard

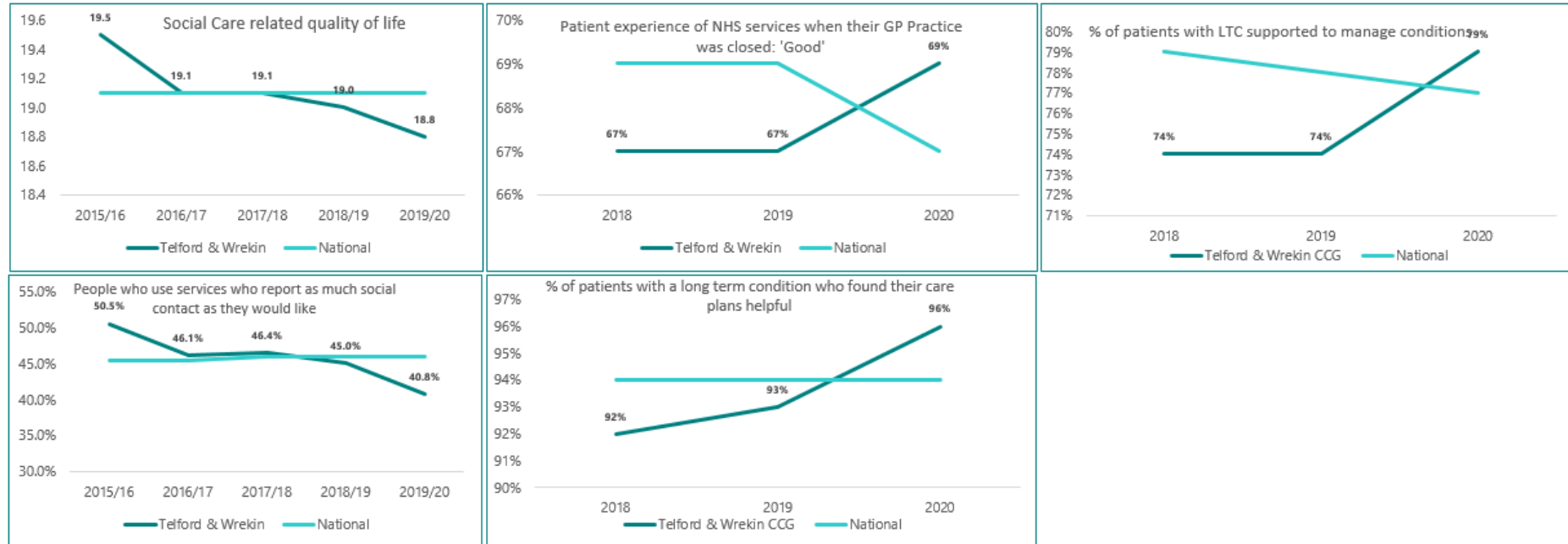
Variation				Assurance		
						
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values		Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

### Primary Prevention:



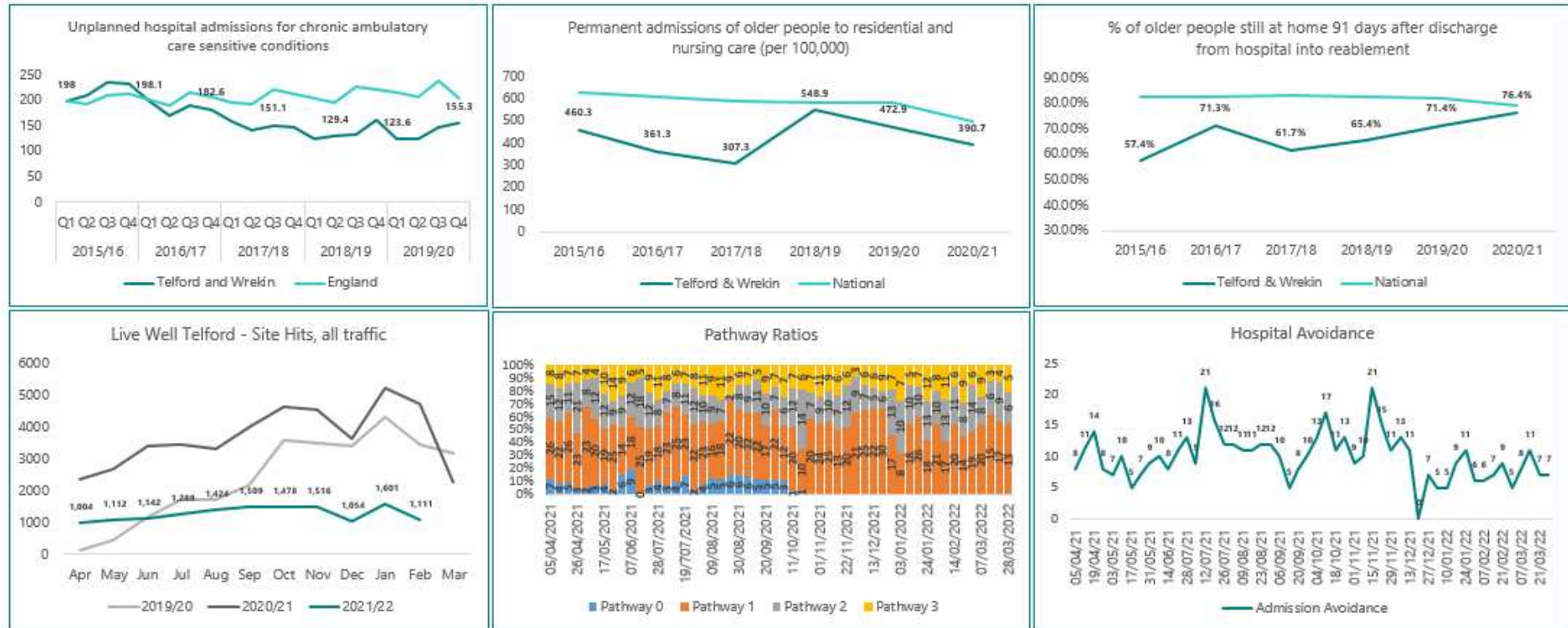
- The number of adult smokers (15.4%), including the number of smokers in routine and manual occupations (21.4%) are decreasing and similar to England rates.
- 70.6% of adults are classified as overweight or obese, significantly higher than England average. Around 26.5% of adults are physically inactive, similar to the England rate.
- The self reported scores of the residents of Telford & Wrekin for happiness is similar to the England average, and worse than the England average for satisfaction.
- 14% of the population have hypertension and 7.9% diabetes.

## People's Experiences of Place Based Integrated Care



- People receiving social care services in Telford and Wrekin report a lower related quality of life than national (18.8 T&W, 19.1 England) and a smaller proportion report having as much social contact as they would like (40.8% T&W, 45.9% T&W)
- Patient reported experience of out of hours GP services increased in 2020 to 69%, above the national rate (67%).
- Patients with long term conditions who found their care plans helpful increased to 96% (England 94%) and 79% felt supported to manage their conditions (England 77%)

## Place Based metrics



- At the end of 2019/20 the rate of unplanned admissions for chronic ambulatory care sensitive conditions was 155.3, lower than the England rate of 202.6
- Telford & Wrekin has a lower rate of admissions for older people to residential and nursing care (T&W 390.7 per 100,000, National 498.2)
- 76.4% of older people are still at home 91 days after discharge from hospital into reablement services

## Social Care Provider CQC Assessment



## 3. TWIPP Dashboard Key Points

- Good performance of continued reductions in the number of people being admitted to permanent residential and nursing home care is being sustained. This means that local people continue to be supported to live in their own homes independently for longer.

- Good performance supporting those people on the enablement pathway to remain in their own homes for longer. The measure at 91 days shows that there continues to be an increase in the numbers who have had enablement and then go on to remain in their own home.
- Maintained performance for Admission Avoidance, a key work stream of TWIPP, which shows further system wide collaboration needs continued focus. The importance of the Local Care Programme and in particular the Proactive Prevention work stream in order to review allocation of resources to have the most impact.
- Maintained performance is evidenced for the discharge pathway ratios of 1, 2 and 3 with planned work underway across the system via the Discharge Alliance.
- CQC metrics demonstrate good performance across our provider market in terms of CQC registered care provision at a time when the care market is particularly challenged in terms of workforce and sufficiency. The Council is currently consulting with providers on the Fair Cost of Care and will report to TWIPP upon completion.
- It should be noted that the social care quality of life which is a national indicator is currently under review with a new metric due shortly.
- The numbers of adult smokers are decreasing and similar to England rates. We have seen a continued downward trend in smoking prevalence. Smoking prevalence amongst routine and manual workers is for the first time below the national average.
- The percentages of adults are classified as overweight or obese, significantly higher than the England average. The percentage of adults that are physically inactive is similar to the England rate. Supporting people to achieve a healthy weight remains a key public health issue locally.



- The Healthy Lifestyle Service provided by Telford and Wrekin Council has capacity to support 2500 people through a 12 week programme each year so the team is now working hard to re-engage with residents and partners to increase referrals. Examples include targeted work with IAPT; the Diabetes Specialist Team at SaTH; the Hospital and Community Respiratory team, GP's; social prescribing link workers and the cancer pathway. Referrals to the service from GP's remain low.
- In March this year, the Government announced new funding for the current financial year for local authorities to help people achieve a healthier weight. The funding has been used to recruit 6 additional Healthy Lifestyle Advisors on a fixed term contract until 30th June 2022. This will provide capacity to support an additional 1344 people during this time.
- The self-reported scores of people from Telford & Wrekin around their happiness and satisfaction are both worse than the England average.
- Live Well Telford is our TWIPP online directory of services. There is a comprehensive programme of awareness raising and communications which continues to be a priority across the system and in our TW Place.
- Many of the health indicators are now at a Shropshire, Telford and Wrekin level rather than only Telford and Wrekin (as they were pre 2020). This will require some work to ensure that the data shared is Telford and Wrekin only so that TWIPP can understand what is happening in the local area, rather than the potential for it being skewed by including Shropshire.

## 4. Next Steps

The TWIPP strategic plan is due to be refreshed over the next 6 months (alongside the Telford and Wrekin Health and Wellbeing Strategy), following a period of engagement and co-production with residents, staff and organisations. This is timely as it will enable TWIPP to reflect and build on the:

- Excellent integration work already undertaken,
- Existing pooled budgets,

- Looking at all opportunities to pool and integrated resources to deliver at place for our residents,
- Changing needs of residents post pandemic,
- Increasing health inequalities,
- Wider determinants of health and impact on our outcomes,
- Need to include to a greater extent the children and young people's agenda,
- Priorities and challenges of all TWIPP members,
- Integration white paper, and subsequent changing health landscape as it moves into a formal Integrated Care Board and associated governance.

As part of this review TWIPP will also be reviewing its outcomes framework/dashboard to ensure that it reflects the new priorities and enables members to ensure progress is being made.

TWIPP is currently part of the NHS ICS Place Development Programme (PDP) which runs until middle of August 2022. The programme is working with TWIPP members to deliver the best possible population health outcomes in Telford and Wrekin through four modules. This work will help shape and accelerate the next steps of TWIPP, including its dashboard.

Key upcoming dates:

- **June/July 2022** - Priority refresh
- **July/August 2022** - Terms of Reference update – including governance, delegated authority and membership
- **August to October 2022** - Co-production of a new TWIPP strategic plan and associated outcomes framework

For more information on TWIPP please refer to <https://livewell.telford.gov.uk/Information/TWIPP> for more information.

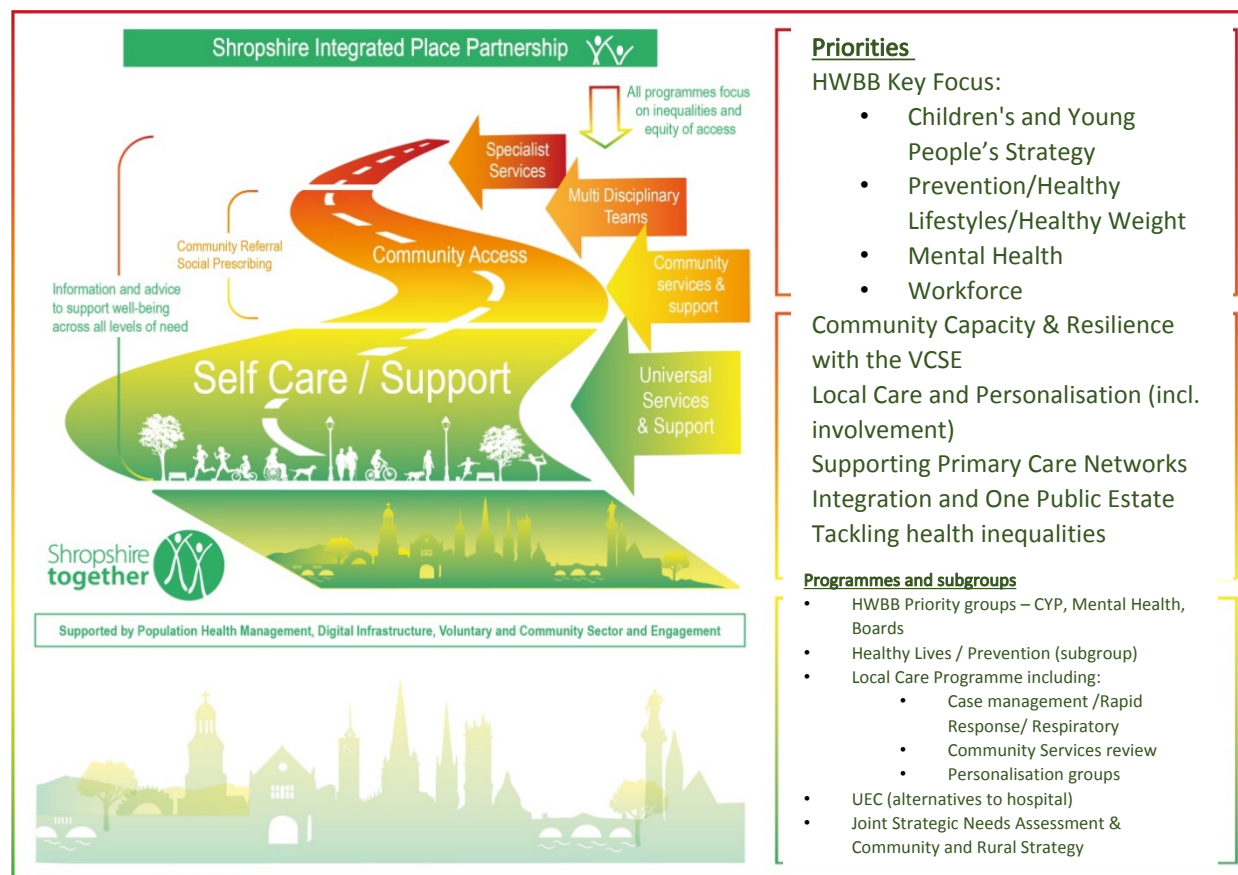


## Appendix 2 – SHIPP Annual Report

Agenda item 29-06.008

## Shropshire Integrated Place Partnership - SHIPP

### Agreed SHIPP priorities



A variety of data sources has been used for this draft report – see appendix 1. It is envisaged that this list will change and grow with the report to reflect the best available sources in terms of data quality, availability, flexibility and ease of use.

A very brief methodology is included in appendix 2. The backing data used to generate the charts is available on request.

Position statement – Presently the SHIPP report is in a draft format. This draft is in the early stages of development, with further discussion and use. It is envisaged the SHIPP report will evolve into a versatile and useful mature document to picture position. It is noted that further development is required for this document to accurately and succinctly measure progress towards attainment of the key priorities highlighted within the agreed SHIPP priorities framework.

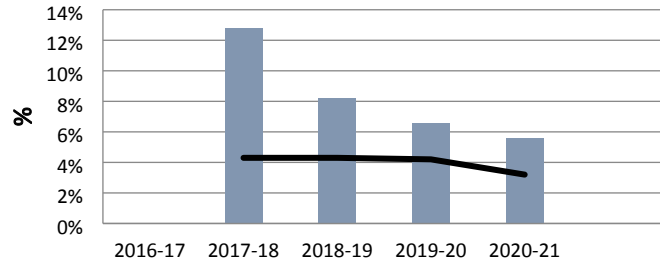
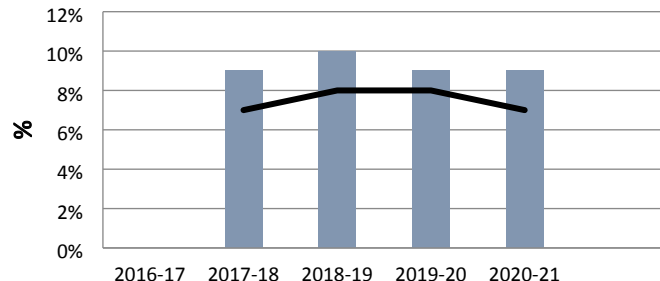
Particular issues facing the Shropshire population – Whilst the UK as a whole has an ageing population, Shropshire’s population is experiencing a slightly higher level of ageing. This phenomenon is slightly more evident in the south and individual pockets of the ceremonial county. There is a noticeable rural population present in Shropshire which brings its own challenges of an uneven population density distribution and an associated uneven resource distribution. A third factor is the impact of out of area service provision and demand. Whilst all LAs experience this factor to some degree, Shropshire has the additional impact of being a border LA to Wales and the West Midlands conurbation. These two regions offer challenges of system integration in the case of Wales and resource/demand implications of a major urbanised area for the West Midlands; it is often more convenient for residents to seek assistance OOA because of geography or availability/choice offered by OOA resources.

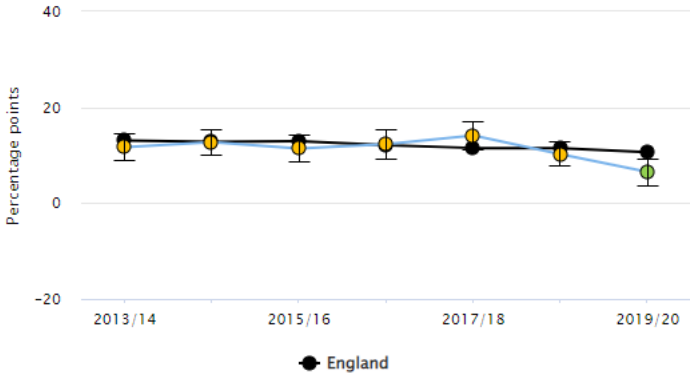
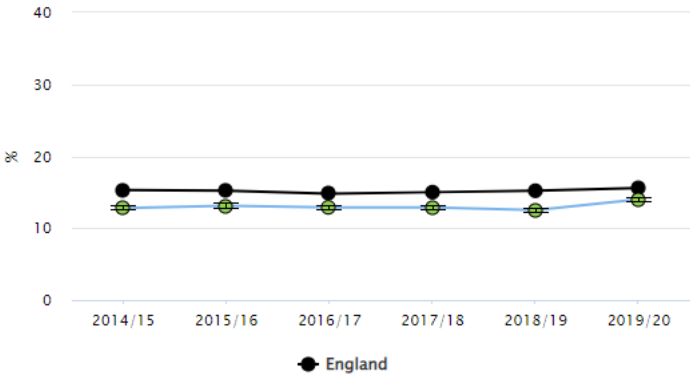
Whilst there are few defined targets available for the SHIPP metrics at present. It is hoped to develop some meaningful benchmarking to similar peer organisations and similar metrics to show the relative performance of Shropshire in the service areas prioritised in the SHIPP arena. This benchmarking methodology can be firmed up once the SHIPP metric selection is more defined. The benchmarking process will naturally develop as the report becomes more established and mature.

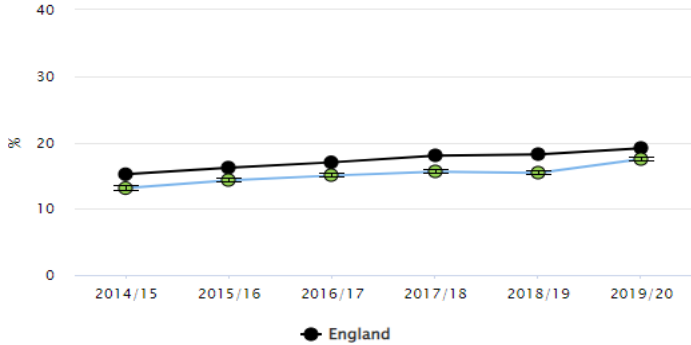
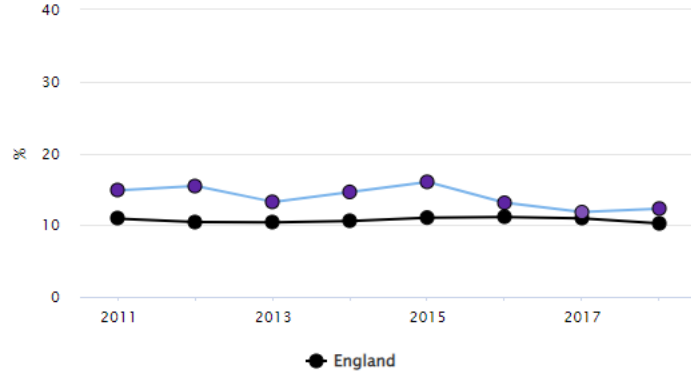
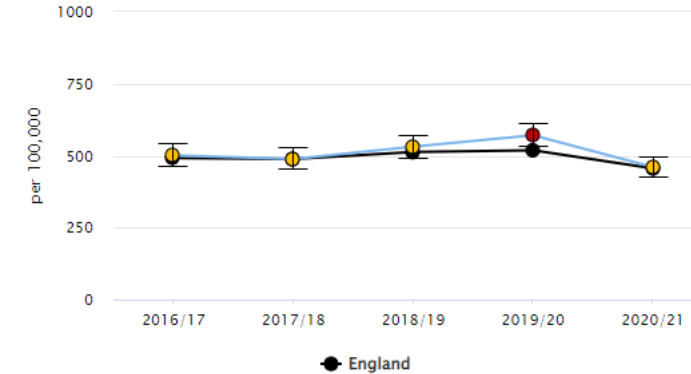
Workforce	Local progress measures	Frequency of reporting	Inclusion in ICS Quality and Performance
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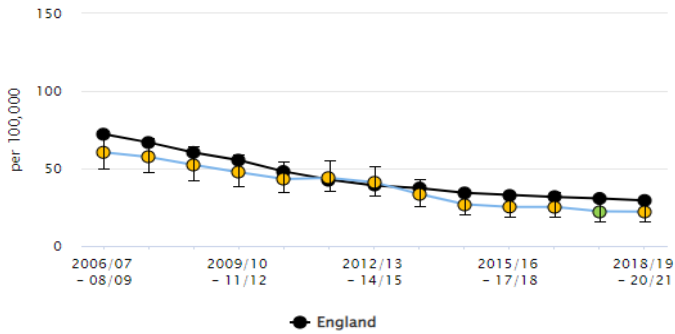
Wider Determinants																
B05 16-17 year olds not in education employment or training (NEET) whose activity is not known <b>This OHID/PHOF measure for HWBB and HI plan metrics</b>	<p>DoE - proportion of 16 and 17 year olds who were not in education, employment or training (NEET), or their activity was not known (Shropshire LA)</p> <table><thead><tr><th>Year</th><th>% of 16 &amp; 17 year olds NEET</th></tr></thead><tbody><tr><td>2016-17</td><td>10.30%</td></tr><tr><td>2017-18</td><td>8.70%</td></tr><tr><td>2018-19</td><td>4.40%</td></tr><tr><td>2019-20</td><td>7.20%</td></tr><tr><td>2020-21</td><td>10.30%</td></tr></tbody></table>	Year	% of 16 & 17 year olds NEET	2016-17	10.30%	2017-18	8.70%	2018-19	4.40%	2019-20	7.20%	2020-21	10.30%	Need to develop		
Year	% of 16 & 17 year olds NEET															
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B05 16-17 year olds not in education employment or training (NEET) whose activity is not known <b>This is OHID/PHOF measure for HWBB and HI metrics</b>  Shropshire in green and red points. Values lower than the England average value, are seen as more preferable. Whiskers are set as 95% confidence limits	PHE (Child and Maternal Health, Young people section). 16-17 year olds not in education employment or training (NEET) whose activity is not known															

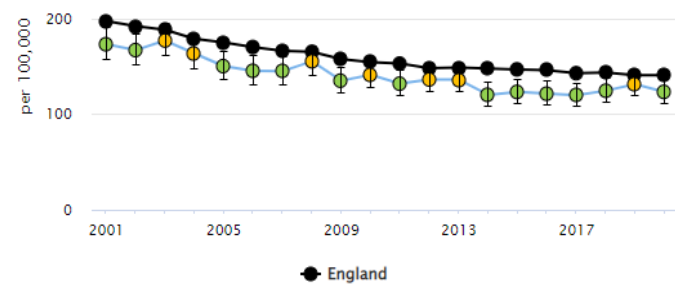
	<p>● England</p>			
<p>Average weekly earnings</p> <p>Values lower than the Great Britain and West Midlands values could be seen as less preferable</p> <p>ONS data as a measure for HWBB metrics</p>	<p>Workplace Earnings, 2008-2017</p> <p>£ gross per week</p> <p>Shropshire West Midlands Great Britain</p> <p>Source: Annual Survey of Hours and Earnings, 2017, © Crown Copyright, 2017</p>			
<p>Percentage Unemployment Rate – All people – Economically active – Unemployed Shropshire (Model based), ONS based metric</p> <p>In HI plan - <a href="#">Levelling Up the United Kingdom: missions and metrics Technical Annex</a> (<a href="#">publishing.service.gov.uk</a>); through the adoption of the Economic Growth Strategy with Wellbeing and Health embedded as core value, this measure is being looked alongside the</p> <p>Improving overall employment rate/average earnings</p> <ul style="list-style-type: none"> <li>• Average life satisfaction rating</li> <li>• Average feeling that things done in life are worthwhile</li> <li>• Average happiness rating</li> <li>• Average anxiety rating</li> </ul>	<p>Great Britain West Midlands Shropshire</p>			

<p>Unemployment rate those with Learning Disability</p> <p>ASCOF 1E – Proportion of adults with learning disabilities in paid employment, proposed</p> <p>In HI plan - <a href="#">Wider Determinants of Health - Data - OHID (phe.org.uk)</a></p> <p>B08B Gap in the employment rate between those with a learning disability and the overall employment rate</p>	<p>ASCOF 1E – Proportion of adults with learning disabilities in paid employment</p> <p>ASCOF - 1E Proportion of adults with learning disabilities in paid employment</p> <p>■ Shrops ASCOF - 1E    — Regional ASCOF 1E</p>  <table><caption>ASCOF - 1E Proportion of adults with learning disabilities in paid employment</caption><thead><tr><th>Year</th><th>Shrops ASCOF - 1E (%)</th><th>Regional ASCOF 1E (%)</th></tr></thead><tbody><tr><td>2016-17</td><td>0</td><td>4.5</td></tr><tr><td>2017-18</td><td>13.0</td><td>4.5</td></tr><tr><td>2018-19</td><td>8.5</td><td>4.5</td></tr><tr><td>2019-20</td><td>7.0</td><td>4.5</td></tr><tr><td>2020-21</td><td>6.0</td><td>3.5</td></tr></tbody></table>	Year	Shrops ASCOF - 1E (%)	Regional ASCOF 1E (%)	2016-17	0	4.5	2017-18	13.0	4.5	2018-19	8.5	4.5	2019-20	7.0	4.5	2020-21	6.0	3.5			
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<p>Unemployment rate those with mental illness</p> <p>In HI plan - <a href="#">Wider Determinants of Health - Data - OHID (phe.org.uk)</a></p> <p>B08C Gap in the employment rate between those who are in contact with secondary mental health services and the overall employment rate</p>	<p>ASCOF 1F – Proportion of adults in contact with secondary Mental Health services in paid employment</p> <p>ASCOF - 1F Proportion of adults in contact with secondary care Mental Health in paid employment</p> <p>■ Shrops ASCOF - 1F    — Regional ASCOF 1F</p>  <table><caption>ASCOF - 1F Proportion of adults in contact with secondary care Mental Health in paid employment</caption><thead><tr><th>Year</th><th>Shrops ASCOF - 1F (%)</th><th>Regional ASCOF 1F (%)</th></tr></thead><tbody><tr><td>2016-17</td><td>0</td><td>7.5</td></tr><tr><td>2017-18</td><td>9.5</td><td>7.5</td></tr><tr><td>2018-19</td><td>10.5</td><td>8.5</td></tr><tr><td>2019-20</td><td>9.5</td><td>8.5</td></tr><tr><td>2020-21</td><td>9.5</td><td>7.5</td></tr></tbody></table>	Year	Shrops ASCOF - 1F (%)	Regional ASCOF 1F (%)	2016-17	0	7.5	2017-18	9.5	7.5	2018-19	10.5	8.5	2019-20	9.5	8.5	2020-21	9.5	7.5			
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<p>Unemployment rate those with mental illness / LD?</p> <p>Repeat of above?</p> <p>B08a Gap in employment with those with a long term health condition and overall employment rate</p> <p>Using same measure in HI Plan <a href="#">Public Health Outcomes Framework - Data - OHID (phe.org.uk)</a></p> <p>Shropshire in yellow and green points. Percentages</p>	<p>PHOF - B08a Gap in employment with those with a long term health condition and overall employment rate</p>																					

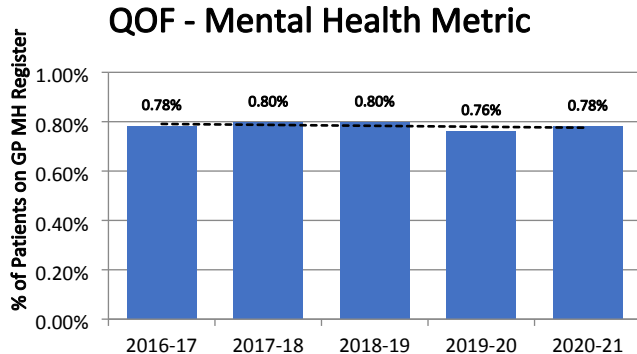
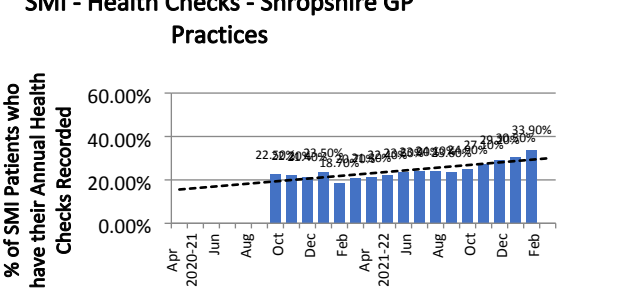
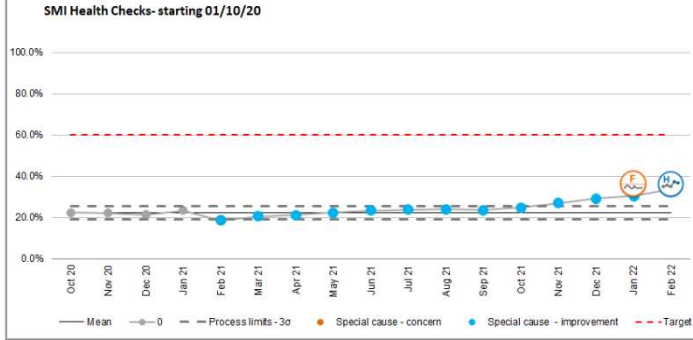
<p>lower than the England average value, are seen as more preferable. Whiskers are set as 95% confidence limits</p>			
<p>Not measuring in either plan, but important &amp; looks OK as a measure <i>In work poverty rate</i></p> <p><i>Alternative - PHOF – B01b – Children in absolute low income families (under 16s)</i> <i>Suitable?</i></p> <p>Shropshire in green points. Percentages lower than the England average value, are seen as preferable. Whiskers are set as 95% confidence limits</p>	<p>PHOF – B01b – Children in absolute low income families (under 16s)</p> 		
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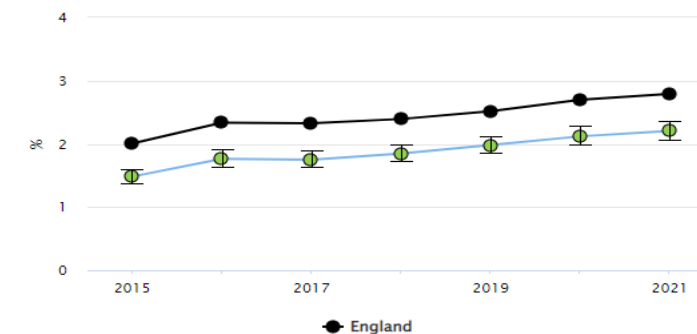
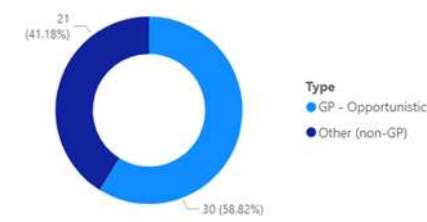
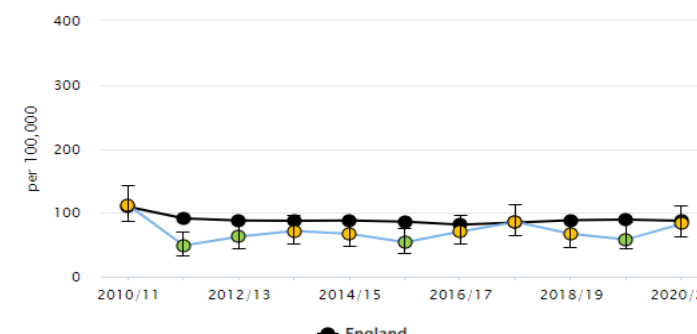
	 <p>Line graph showing In work poverty rate for England from 2014/15 to 2019/20. The rate is relatively stable, starting around 15% and ending around 18%.</p>			
<p><i>In work poverty rate</i></p> <p>Not measuring in either plan, but important &amp; looks OK as a measure</p> <p><i>Alternative - PHOF – B17 Fuel poverty, low income high cost methodology</i></p> <p><i>Suitable?</i></p> <p>Shropshire in purple points. Percentages higher than the England average are seen as less preferable.</p>	<p>PHOF – B17 Fuel poverty, low income high cost methodology</p>  <p>Line graph showing PHOF – B17 Fuel poverty, low income high cost methodology for England from 2011 to 2017. Shropshire is represented by purple points, which are generally higher than the England average (black line).</p>			
<p><i>Right section? Implementation of Alcohol Care Team</i></p> <p>PHOF - C21 Admission episodes for alcohol related conditions (revised parameters) – <i>suitable?</i></p> <p>Shropshire in red and yellow points. Standardised values lower than the England average value, are seen as preferable. Whiskers are set as 95% confidence limits</p>	<p>PHOF - C21 Admission episodes for alcohol related conditions (revised parameters)</p>  <p>Line graph showing PHOF - C21 Admission episodes for alcohol related conditions (revised parameters) for England from 2016/17 to 2020/21. Shropshire is represented by red and yellow points, which are generally lower than the England average (black line).</p>	Implementation of Alcohol Care Team		

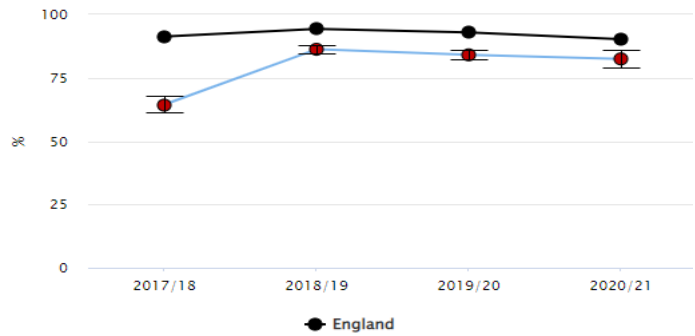
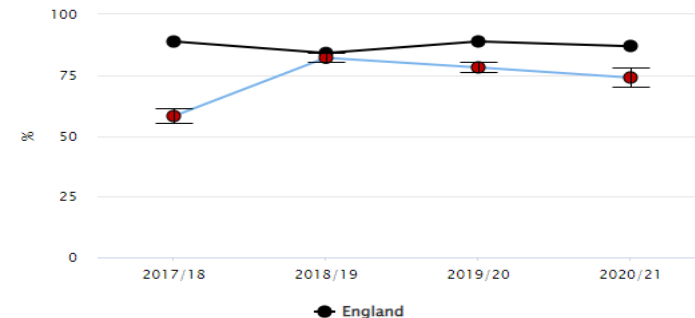
<p><i>Implementation of Alcohol Care Team</i></p> <p><i>Suitable metric?</i></p> <p>Shropshire in green and yellow points. Standardised values lower than the England average value, are seen as preferable. Whiskers are set as 95% confidence limits</p>	<p>PHOF – PHE (Child and Maternal Health, school age children supplementary indicators). Admissions for alcohol specific conditions (under 18s)</p> 		
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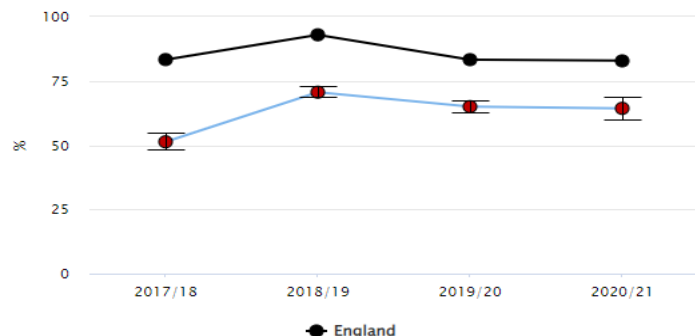
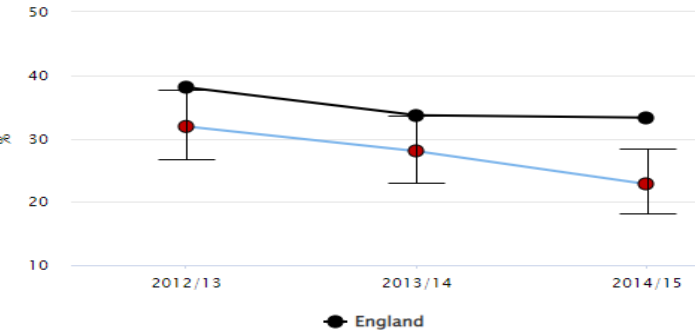
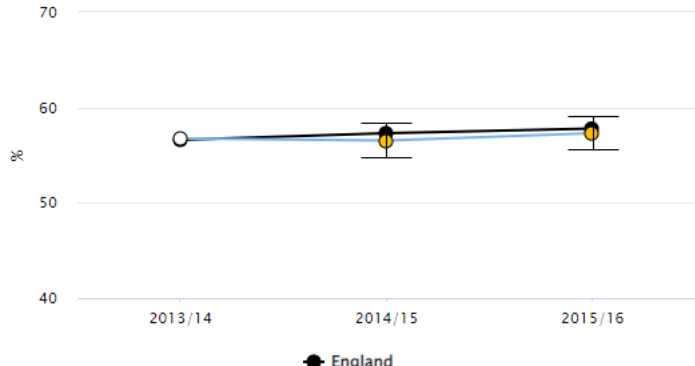
Mental Health	Local progress measures	Frequency of reporting	Inclusion in ICS Quality and Performance
<p><b>E09b Excess under 75 mortality rate in adults with Severe Mental Illness (SMI) – no data in source (PHE Fingertips)</b></p> <p><i>Alternative - All causes mortality for under 75's considered preventable (2019 1-year range variant); standardised rate per 100,000</i></p> <p>Shropshire in green and yellow points. Values lower than the England average value, are seen as preferable. Whiskers are set as 95% confidence limits</p>	<p>E03 – Under 75 mortality seen as preventable (2019 variant, 1 year range) Value per 100,000 population</p> 		

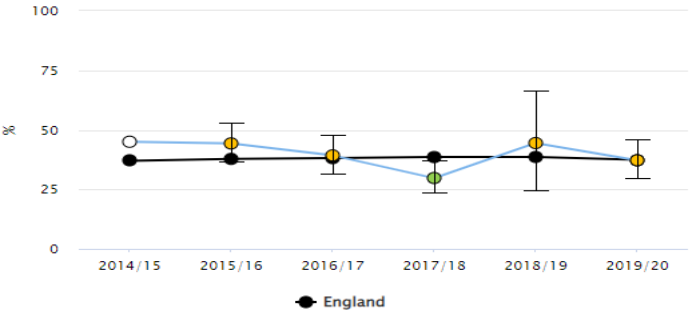
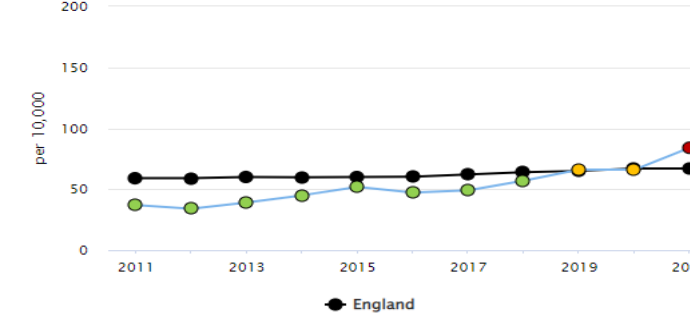


<p><b>Extra alternative metric - Mental Health Register -</b></p> <p>Using Table 21 from the yearly QOF reports: Recorded disease prevalence, achievements and exceptions, mental health and neurology group, mental health, 2018-19, CCG level. For NHS Shropshire CCG patients.</p> <p><b>Drop QOF measures?</b></p> <p><i>Please note: 2020-21 value is derived from the former NHS Shropshire CCG GP Practice list.</i></p> <p><i>Develop this further to include comparison from elsewhere</i></p>	<p><b>QOF - Mental Health Metric</b></p>  <table><tr><th>Year</th><th>% of Patients on GP MH Register</th></tr><tr><td>2016-17</td><td>0.78%</td></tr><tr><td>2017-18</td><td>0.80%</td></tr><tr><td>2018-19</td><td>0.80%</td></tr><tr><td>2019-20</td><td>0.76%</td></tr><tr><td>2020-21</td><td>0.78%</td></tr></table>	Year	% of Patients on GP MH Register	2016-17	0.78%	2017-18	0.80%	2018-19	0.80%	2019-20	0.76%	2020-21	0.78%	<p>What support is offered when they are on the register. Do people receive health checks, reviews, how many access secondary services, readmissions.</p>															
Year	% of Patients on GP MH Register																												
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2020-21	0.78%																												
<p>This is also included in the Health Inequalities plan</p> <p><i>% of those on SMI register receiving annual health check</i></p> <p><i>Metric collection ongoing. National target is for 60% of patients on GP SMI registers to have received physical health check in the last year</i></p> <p><i>Please note: data is on a Shropshire GP Practice level</i></p>	<p><b>SMI - Health Checks - Shropshire GP Practices</b></p>  <table><tr><th>Month</th><th>% of SMI Patients who have their Annual Health Checks Recorded</th></tr><tr><td>Apr 2020-21</td><td>22.50%</td></tr><tr><td>Jun</td><td>22.50%</td></tr><tr><td>Aug</td><td>22.50%</td></tr><tr><td>Oct</td><td>22.50%</td></tr><tr><td>Dec</td><td>22.50%</td></tr><tr><td>Feb</td><td>15.70%</td></tr><tr><td>Apr 2021-22</td><td>22.50%</td></tr><tr><td>Jun</td><td>22.50%</td></tr><tr><td>Aug</td><td>22.50%</td></tr><tr><td>Oct</td><td>22.50%</td></tr><tr><td>Dec</td><td>22.50%</td></tr><tr><td>Feb</td><td>33.90%</td></tr></table>	Month	% of SMI Patients who have their Annual Health Checks Recorded	Apr 2020-21	22.50%	Jun	22.50%	Aug	22.50%	Oct	22.50%	Dec	22.50%	Feb	15.70%	Apr 2021-22	22.50%	Jun	22.50%	Aug	22.50%	Oct	22.50%	Dec	22.50%	Feb	33.90%	<p>Also consider cancer rates; those with SMI are more likely to die from long term health conditions and cancer (incl. Respiratory and CVD)</p>	
Month	% of SMI Patients who have their Annual Health Checks Recorded																												
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Dec	22.50%																												
Feb	33.90%																												
<p><i>SMI – Health checks complete. Data values as above in SPC chart format.</i></p> <p><i>National target = 60% (red dotted line)</i></p>	<p><b>SMI Health Checks- starting 01/10/20</b></p>  <p>Legend: Mean, 0, Process limits -3σ, Special cause - concern, Special cause - improvement, Target</p>	<p>Embed personal improvement scores within the Community Transformation programme</p> <p>Gather qualitative data to understand experience, including case studies (Population Health Rhiannon)</p> <p>Enable data</p>																											
	<p>Common Mental Disorders</p>	<p>Bereavement pathway</p> <p>Together All</p>																											

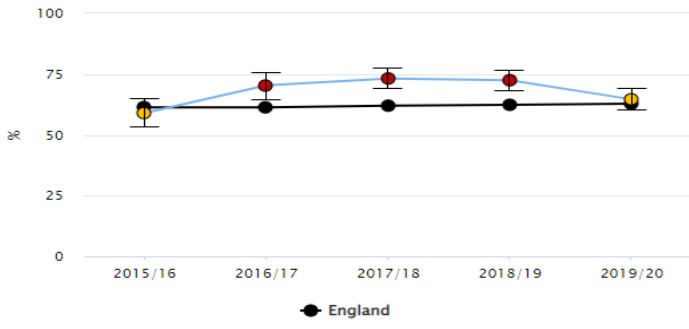
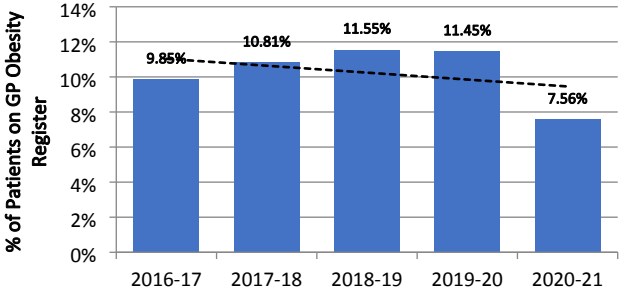
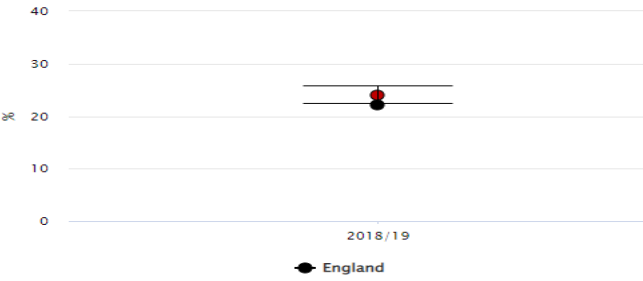
		Those accessing community support (Samaritans, MHS)		
		Workfore training		
<p>School pupils with social, emotional and mental health needs, % of pupils with social, emotional and mental health needs</p> <p>Shropshire in green points. Percentages lower than the England average, are seen as more preferable. Whiskers are set as 95% confidence limits</p>	<p>PHE (Child and Maternal Health, school age children supplementary indicators). School pupils with social, emotional and mental health needs, % of pupils with social, emotional and mental health needs</p> 	<p>Referrals by Type</p>  <p>Number of children accessing Social Prescribing Service (SW Shropshire)</p>		
<p>Number of children and young people accessing Tier 4 crisis beds</p> <p>Shropshire in green and yellow points. Percentages lower than the England average, are seen as more preferable. Whiskers are set as 95% confidence limits</p> <p>Include A&amp;E attendance as self harm</p>	<p>PHOF – (Child and Maternal Health, healthcare use). Hospital admissions for Mental Health conditions (under 18 years old)</p> 	<p>Number of Shropshire schools accessing national 'Senior mental health lead training' programme</p> <p>Delivery of CYP Social Prescribing</p>		
Children and Young People		Local progress measures	Frequency of reporting	Inclusion in ICS Quality and Performance

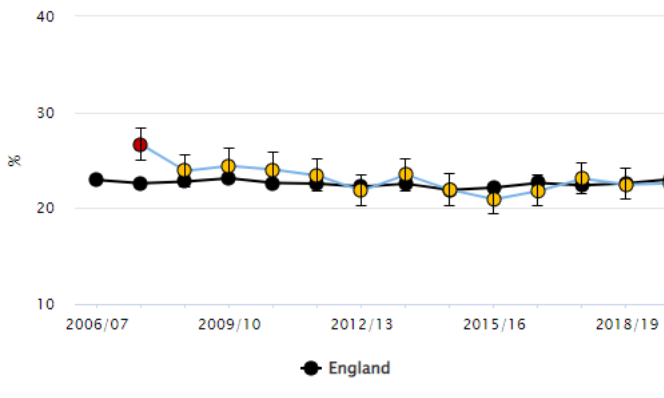
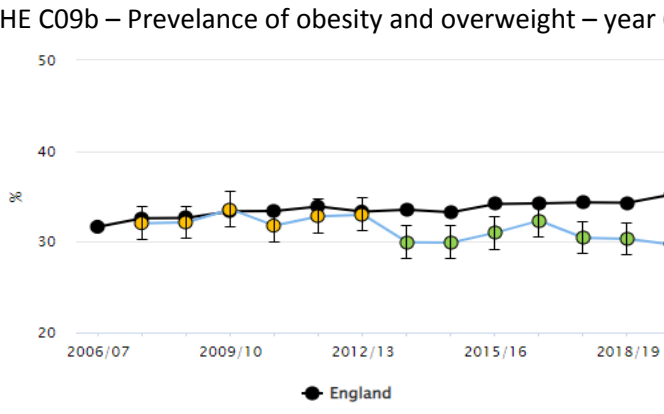
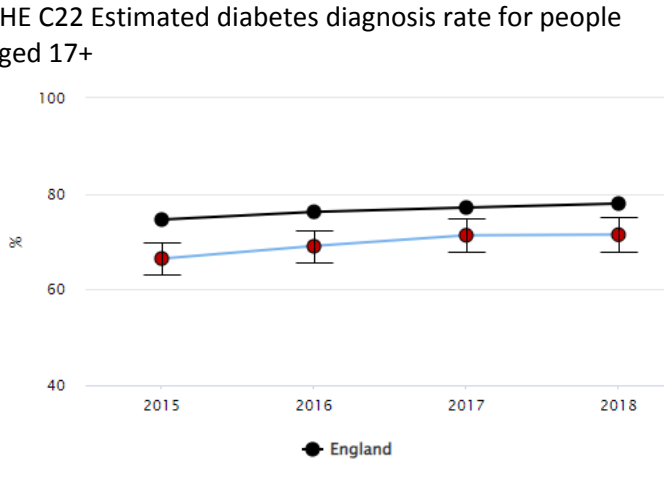
<p>C03c Child development. % achieving the expected level in personal-social skills at 2 - 2 1/2 years</p> <p>Shropshire in red points. Percentages lower than the England average, are seen as less preferable. Whiskers are set as 95% confidence limits</p>	<p>PHE (Child and Maternal Health, Early Years section). Child development. % achieving the expected level in personal-social skills at 2 - 2 1/2 years</p>  <table><tr><th>Year</th><th>England (%)</th><th>Shropshire (%)</th></tr><tr><td>2017/18</td><td>~92</td><td>~65</td></tr><tr><td>2018/19</td><td>~95</td><td>~85</td></tr><tr><td>2019/20</td><td>~93</td><td>~83</td></tr><tr><td>2020/21</td><td>~90</td><td>~82</td></tr></table>	Year	England (%)	Shropshire (%)	2017/18	~92	~65	2018/19	~95	~85	2019/20	~93	~83	2020/21	~90	~82	<p>Implementation of enhanced Early Help Workforce</p> <p>Number of parents supported by Family Nurse Partnership</p>		
Year	England (%)	Shropshire (%)																	
2017/18	~92	~65																	
2018/19	~95	~85																	
2019/20	~93	~83																	
2020/21	~90	~82																	
<p>C03b Child development. % achieving the expected level in communication skills at 2 - 2 1/2 years</p> <p>Shropshire in red points. Percentages lower than the England average, are seen as less preferable. Whiskers are set as 95% confidence limits</p>	<p>PHE (Child and Maternal Health, Early Years section). Child development. % achieving the expected level in communication skills at 2 - 2 1/2 years</p>  <table><tr><th>Year</th><th>England (%)</th><th>Shropshire (%)</th></tr><tr><td>2017/18</td><td>~88</td><td>~58</td></tr><tr><td>2018/19</td><td>~85</td><td>~82</td></tr><tr><td>2019/20</td><td>~88</td><td>~78</td></tr><tr><td>2020/21</td><td>~87</td><td>~75</td></tr></table>	Year	England (%)	Shropshire (%)	2017/18	~88	~58	2018/19	~85	~82	2019/20	~88	~78	2020/21	~87	~75			
Year	England (%)	Shropshire (%)																	
2017/18	~88	~58																	
2018/19	~85	~82																	
2019/20	~88	~78																	
2020/21	~87	~75																	
<p>C08a Child development. % achieving a good level of development at 2 - 2 1/2 years</p> <p>Shropshire in red points. Percentages lower than the England average, are seen as less preferable. Whiskers are set as 95% confidence limits</p>	<p>PHE (Child and Maternal Health, Early Years section). Child development. % achieving a good level of development at 2 - 2 1/2 years</p>																		

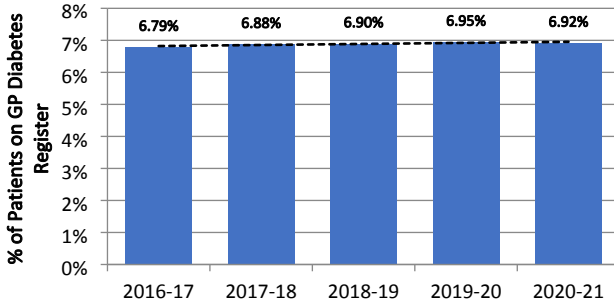
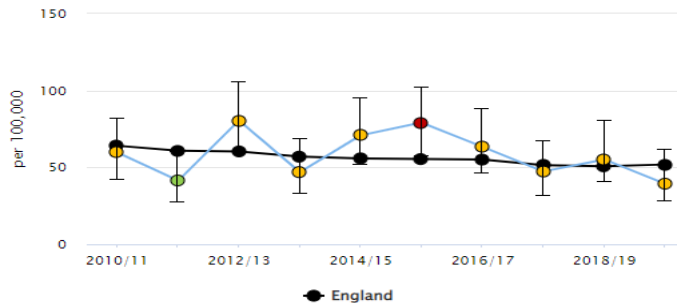
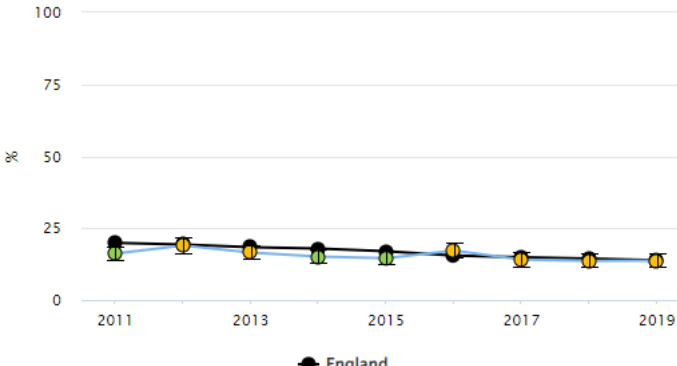
	 <table><caption>Estimated data for England vs Shropshire (2017/18 - 2020/21)</caption><thead><tr><th>Year</th><th>England (%)</th><th>Shropshire (%)</th></tr></thead><tbody><tr><td>2017/18</td><td>85</td><td>52</td></tr><tr><td>2018/19</td><td>92</td><td>70</td></tr><tr><td>2019/20</td><td>85</td><td>65</td></tr><tr><td>2020/21</td><td>85</td><td>65</td></tr></tbody></table>	Year	England (%)	Shropshire (%)	2017/18	85	52	2018/19	92	70	2019/20	85	65	2020/21	85	65			
Year	England (%)	Shropshire (%)																	
2017/18	85	52																	
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2019/20	85	65																	
2020/21	85	65																	
<p>Educational attainment FSM vs Non-FSM status</p> <p>Shropshire in red points. Percentages lower than the England average, are seen as less preferable. Whiskers are set as 95% confidence limits</p> <p>Need to find more recent data</p>	<p>PHE - GCSE achieved 5 A*-C including English and Maths with Free School Meal Status</p>  <table><caption>Estimated data for England vs Shropshire (2012/13 - 2014/15)</caption><thead><tr><th>Year</th><th>England (%)</th><th>Shropshire (%)</th></tr></thead><tbody><tr><td>2012/13</td><td>38</td><td>32</td></tr><tr><td>2013/14</td><td>34</td><td>28</td></tr><tr><td>2014/15</td><td>33</td><td>23</td></tr></tbody></table>	Year	England (%)	Shropshire (%)	2012/13	38	32	2013/14	34	28	2014/15	33	23						
Year	England (%)	Shropshire (%)																	
2012/13	38	32																	
2013/14	34	28																	
2014/15	33	23																	
<p>Educational attainment FSM vs Non-FSM status</p> <p>Caution: not strickly comparable with the above as this is 5 GCSEs vs 5 GCSEs including English and Maths</p> <p>Shropshire in yellow points. Percentages lower than the England average, are seen as less preferable. Whiskers are set as 95% confidence limits</p>	<p>PHE – Educational Attainment 5 or more GCSEs, % of all Children</p>  <table><caption>Estimated data for England vs Shropshire (2013/14 - 2015/16)</caption><thead><tr><th>Year</th><th>England (%)</th><th>Shropshire (%)</th></tr></thead><tbody><tr><td>2013/14</td><td>57</td><td>57</td></tr><tr><td>2014/15</td><td>57</td><td>56</td></tr><tr><td>2015/16</td><td>58</td><td>57</td></tr></tbody></table>	Year	England (%)	Shropshire (%)	2013/14	57	57	2014/15	57	56	2015/16	58	57						
Year	England (%)	Shropshire (%)																	
2013/14	57	57																	
2014/15	57	56																	
2015/16	58	57																	
% Children Looked After with annual health plan review	PHOF (Child and Maternal data –School age children supplementary indicators section). Percentage of looked after	What local measure could be used?																	

<p><b>Alternative, suitable?</b></p> <p>Shropshire data points are in green and yellow. Percentages lower than the England average, are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>children where their emotional wellbeing is a cause for concern</p> 			
<p><b>Children in Care</b></p> <p>Shropshire data points are in green, yellow and red. Percentages lower than the England average, are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHE (Child and Maternal data – child health profiles section) – Children in Care – crude rate per 10,000</p> 			

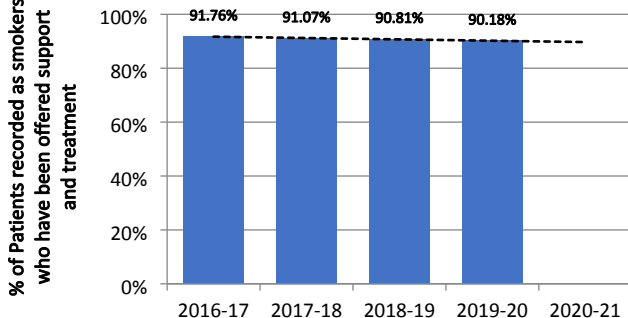
Healthy Weight and Physical Activity		Local progress measures	Frequency of reporting	Inclusion in ICS Quality and Performance
<p>C16 The percentage of adults who are overweight and obese</p> <p>The criteria for this metric is different to QOF GP Register (BMI 30 vs 35). Sample size is 1,118 from Active Lives Sport England survey</p> <p>Shropshire data points are in yellow and red. Percentages higher than the England average are seen</p>	<p>PHE C16 Percentage of adults (18+) classified as obese or overweight</p>			

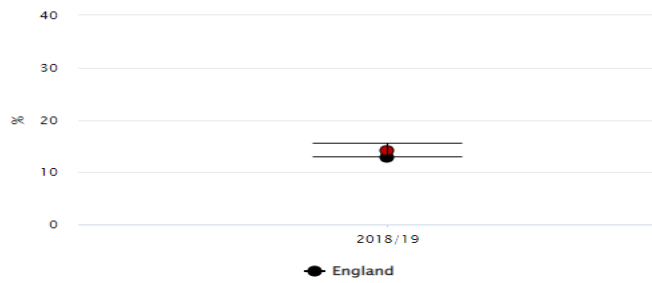
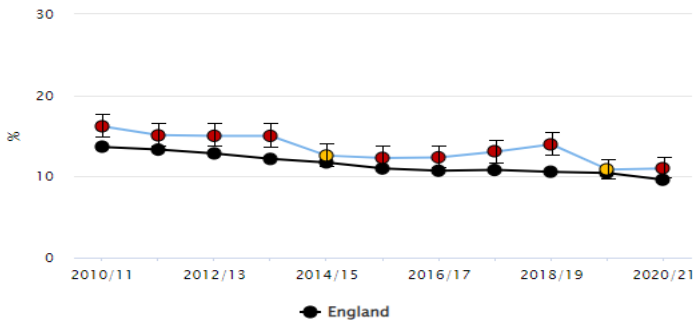
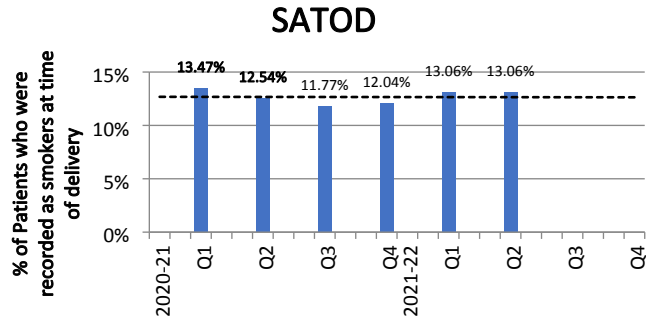
<p>as less preferable. Whiskers represent the 95% confidence limits</p>				
<p><b>Obesity</b></p> <p>Using Table 11 from yearly QOF reports: Recorded disease prevalence, achievements and exceptions, lifestyle group, obesity, 2018-19, CCG level. For NHS Shropshire CCG patients. <b>Drop QOF metrics?</b></p> <p><i>Please note: colleagues may disagree with the values reported. Metric reports those patients with a BMI of 35+ These values shown are the values reported in the QOF reports; 2020-21 value is derived from the former NHS Shropshire CCG GP Practice list – <b>Fingertips metric?</b></i></p>	<p><b>QOF - Obesity Metric</b></p> 	<p>34 GP practices accessing the NHS Digital Weight management programme Equates to offer open to 292,876</p>		
<p><b>C03a Obesity in early pregnancy</b></p> <p>Shropshire data point is in red. Percentages higher than the England average are seen as less preferable. Whiskers represent the 95% confidence limits</p>	<p>PHOF (Child and Maternal health, healthcare use section) – C03a Obesity in early pregnancy</p> 			
<p>Obesity and overweight - Reception and Year 6 NCMP (by deprivation)</p>	<p>PHE C09a – Prevalence of obesity and overweight – reception year</p>			

<p>By deprivation not available in PHE Fingertips source</p> <p>Shropshire data points are in yellow and red. Percentages higher than the England average are seen as less preferable. Whiskers represent the 95% confidence limits</p>			
<p>Obesity and overweight - Reception and Year 6 NCMP (by deprivation)</p> <p>By deprivation not available in PHE Fingertips source</p> <p>Shropshire data points are in yellow and green. Percentages lower than the England average, are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHE C09b – Prevalence of obesity and overweight – year 6</p> 		
<p>C22 Estimated diabetes diagnosis rate for people aged 17+</p> <p>Shropshire data points are in red. Percentages lower than the England average, are seen as less preferable. Whiskers represent the 95% confidence limits</p>	<p>PHE C22 Estimated diabetes diagnosis rate for people aged 17+</p> 		

<div>Diabetes rate</div> <div>Using Table 15 from QOF yearly reports: Recorded disease prevalence, achievements and exceptions, high dependency and other long term conditions group, diabetes mellitus, 2018-19, CCG level. For NHS Shropshire CCG patients. – drop QOF metric? Fingertips metric?</div> <div>Please note: it is noted on Aristotle results from Pandemic years may be inaccurate and comparisons may be invalid. 2020-21 value is derived from the former NHS Shropshire CCG GP Practice list.</div>	<div>QOF - Diabetes Metric</div> <div><table><thead><tr><th>Year</th><th>% of Patients on GP Diabetes Register</th></tr></thead><tbody><tr><td>2016-17</td><td>6.79%</td></tr><tr><td>2017-18</td><td>6.88%</td></tr><tr><td>2018-19</td><td>6.90%</td></tr><tr><td>2019-20</td><td>6.95%</td></tr><tr><td>2020-21</td><td>6.92%</td></tr></tbody></table></div>	Year	% of Patients on GP Diabetes Register	2016-17	6.79%	2017-18	6.88%	2018-19	6.90%	2019-20	6.95%	2020-21	6.92%			
Year	% of Patients on GP Diabetes Register															
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<div>Diabetes rate</div> <div>Alternative metric, Suitable? PHOF (Child and Maternal health, healthcare use section) – Admissions for diabetes for Chilren and young people aged under 19</div> <div>Shropshire data points are green, yellow and red. Standardised rates higher than the England average, are seen as less preferable. Whiskers represent the 95% confidence limits</div>	<div>PHOF (Child and Maternal health, healthcare use section) – Admissions for diabetes for Chilren and young people aged under 19</div> <div></div>															
<div>Smoking Prevalence in adults (18+) – current smokers (2019 data)</div> <div>Shropshire data points are yellow and green. Percentages lower than the England average, are seen as more preferable. Whiskers represent the 95% confidence limits</div>	<div>C18 - Smoking Prevalence in adults (18+) - current smokers</div> <div></div>															

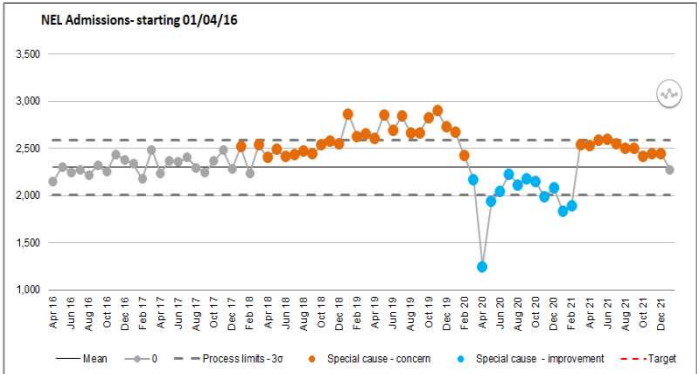
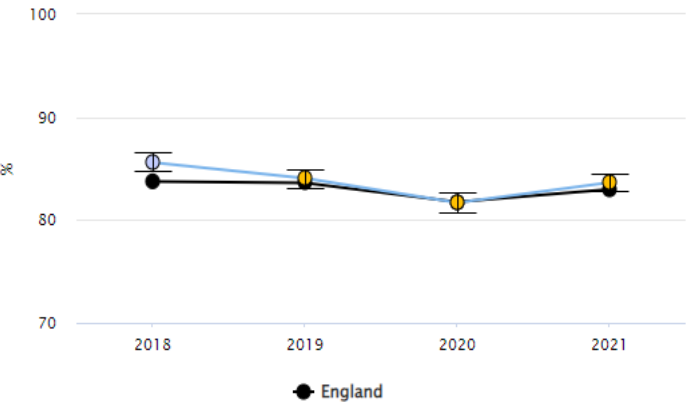


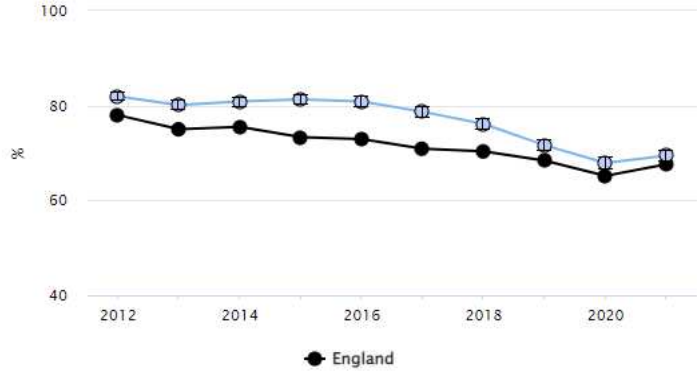
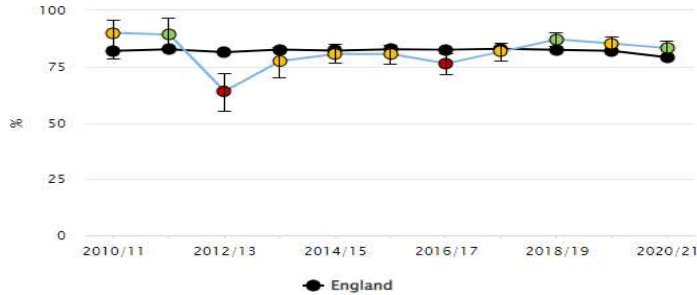
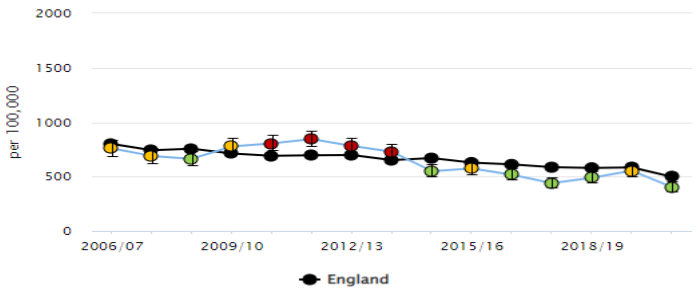
<p>Smoking rates</p> <p>Using QOF <i>SMOK4</i> metric – The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months. For NHS Shropshire CCG patients. – <b>Drop all QOF Smoking metrics?</b> <b>Fingertips metric?</b></p> <p><i>Please note: this metric is not reported in the 2020-21 QOF report.</i></p> <p>Three more ‘QOF smoking metrics’- <b>Drop QOF metrics?</b></p> <p>i) <i>The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months</i></p> <p>ii) <i>The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy</i></p> <p>iii) <i>The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months</i></p>	<p><b>QOF - Smoking 4 Metric</b></p>  <table><tr><th>Year</th><th>% of Patients recorded as smokers who have been offered support and treatment</th></tr><tr><td>2016-17</td><td>91.76%</td></tr><tr><td>2017-18</td><td>91.07%</td></tr><tr><td>2018-19</td><td>90.81%</td></tr><tr><td>2019-20</td><td>90.18%</td></tr><tr><td>2020-21</td><td></td></tr></table>	Year	% of Patients recorded as smokers who have been offered support and treatment	2016-17	91.76%	2017-18	91.07%	2018-19	90.81%	2019-20	90.18%	2020-21				
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<p>C03c Smoking in early pregnancy</p> <p>Shropshire is the red point. Percentages higher than the England average are seen as less preferable. Whiskers represent the 95% confidence limits</p>	<p>PHE (Child and Maternal data – Pregnancy and birth profiles section). Smoking in Early Pregnancy</p>															

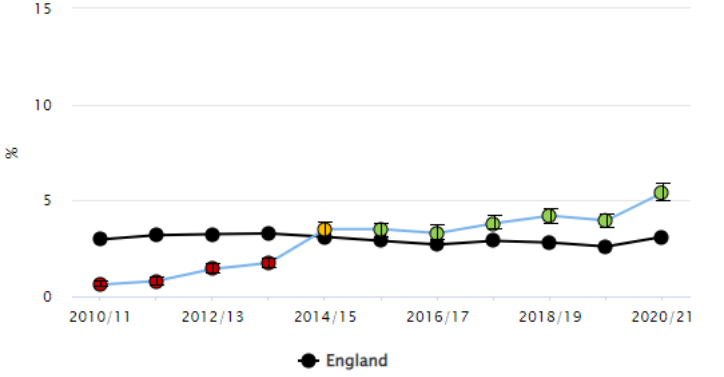
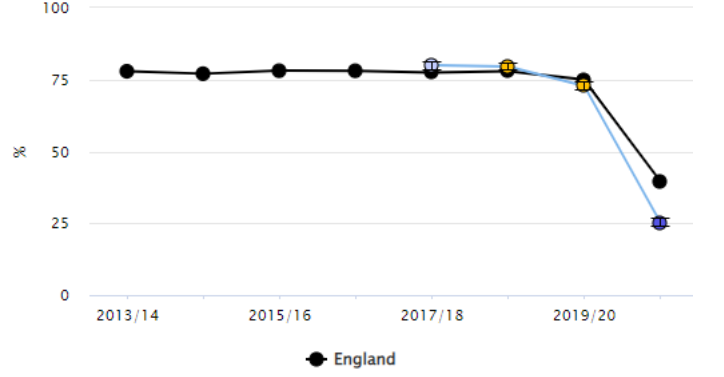
				
<p>C03c Smoking in early pregnancy trend data not available on PHOF (single data point, see above)</p> <p>SATOD ok as an alternative? To give a run of data</p> <p>Shropshire in red and yellow points. Percentages higher than the England average are seen as less preferable. Whiskers represent the 95% confidence limits</p>	<p>Public Health England – SATOD</p> 			
<p>SATOD – NHS Data. This data is at STW CCG geography. More historic data available is available for NHS Shropshire CCG – drop NHS SATOD? Fingertips metric?</p>	<p>SATOD</p> 			
<p>Numbers accessing new maternity smoking service</p> <p>4 ‘new’ data fields under formation/discussion within the SQL Warehouse environment. To confirm access and start date.</p> <p>Suitable alternatives?</p>	<p>4 metrics are in discussion for establishment in the CSU SQL Warehouse</p> <ol style="list-style-type: none"> <li>1. Number of people with a completed smoking status (any category) in the reporting month reported for all Admitted Patient Care - inpatient admissions</li> <li>2. Number of people with a completed smoking status (any category) in the reporting month reported for all maternity bookings</li> <li>3. Number of people with a completed smoking status</li> </ol>			

SaTH may have this information	(any category) in the reporting month reported for all first outpatient attendances 4. Number of people with a completed smoking status (any category) in the reporting month reported for all first community care contacts			
Local Care Programme		Local progress measures	Frequency of reporting	Inclusion in ICS Quality and Performance

<p>Admissions to hospital</p> <p>SUS data – all NEL admissions to all secondary providers for patients registered to a Shropshire CCG GP Practice. 2020-21 and 2021-22 using the same list of former Shropshire GP Practices to maintain consistency. 2021-22 Data is YTD to and including Jan-22.</p> <p>There is the ability to split this group of patients by a number of factors eg LoS, Diagnosis/condition group (eg 5*LTC, diabetes, asthma), geography, age, ethnicity to a degree and deprivation to a degree. Acorn grouping and GP Practice taxonomy also.</p>	<p><b>NEL Admissions - Shropshire Patients</b></p>			
<p>PHE – E11 Emergency re-admission to hospital within 30 days of discharge</p> <p>Alternative, suitable?</p> <p>Shropshire in green points. Percentages lower than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p> <p>PHE Emergency admission metrics for self-harm, falls and unintentional + deliberate harm in children and young people are available</p>	<p>PHE – E11 Emergency re-admission to hospital within 30 days of discharge</p>			

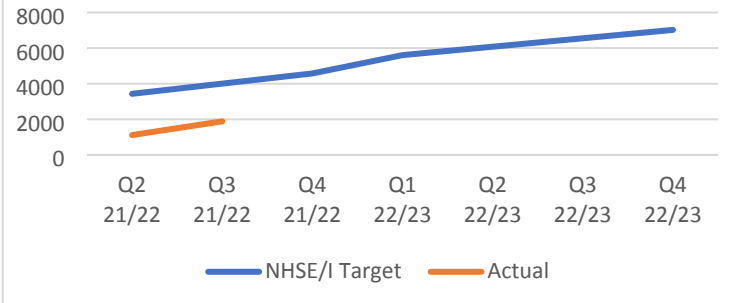
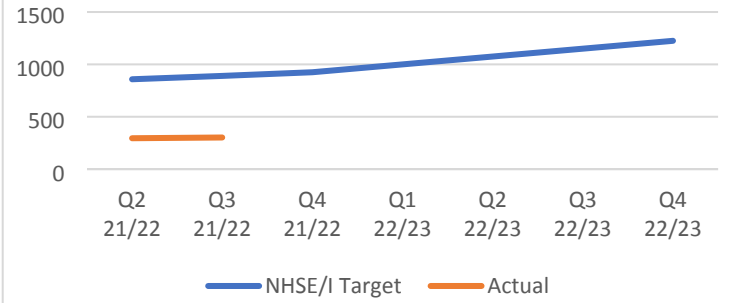
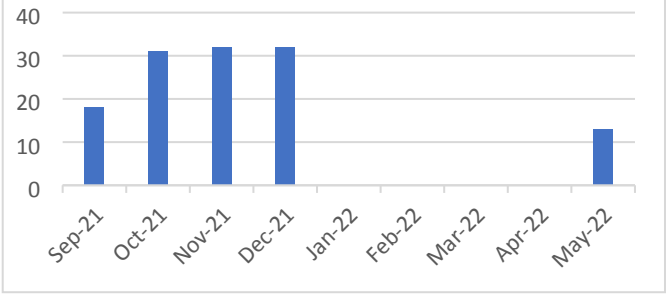
<p>SUS Data – all NEL admissions to all secondary providers for patients registered to a Shropshire CCG GP Practice – As an SPC chart – making data count format, (same data values as above chart).</p>				
<p>% increase in satisfaction of care provided</p> <p>Shropshire in yellow and blue points. Percentages higher than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHE – National General Practice Profiles. Percentage of people who have a positive experience of their GP Practice</p> 			
<p>% increase in satisfaction of care provided</p> <p>Shropshire in blue points. Percentages higher than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHE – National General Practice Profiles. Percentage satisfied with phone access</p>			

				
<p>% increase in the number of people supported in their own home</p> <p>Alternative, suitable?</p> <p>Shropshire in yellow, green and red points. Percentages higher than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHE - Percentage of people aged 65 or over who were still at home 91 days after discharge from hospital into re-ablement</p> 			
<p>Reduction in the number of permanent residential and nursing home placements</p> <p>Shropshire in yellow, green and red points. Percentages lower than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHE – Permanent admissions to residential and nursing care homes per 100,000 (aged 65+)</p> 			
Baseline % carers assessments	Source?			

<p>% increase in the number of carers assessment</p> <p>Alternative, suitable?</p> <p>Shropshire in yellow, green and red points. Percentages higher than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHE - Percentage of people aged 65 and over who were offered reablement services following discharge from hospital</p> 		
<p>% increase in the number of carers assessment</p> <p>Alternative, suitable?</p> <p>Shropshire in yellow and blue points. Percentages lower than the England averages are seen as less preferable. Whiskers represent the 95% confidence limits</p>	<p>PHE – Dementia care plan has been reviewed in the last 12 months</p> 		
<p>Collabortaion with Partners – Primary, Acute, Social Care, Voluntary and Community Sector</p> <p>Useful metric to support? 2011 data source is from the census, extra data point this year with release of 2021 census?</p> <p>Shropshire in yellow points. Percentages higher</p>	<p>PHOF – Unpaid carers</p>		

<p>than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>				
<p><b>Experience better health and care</b></p> <p><b>Alternative, suitable?</b></p> <p><b>May fit better in the satisfaction section?</b></p> <p>Shropshire in yellow and green points. Percentages higher than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHE – Percentage of adult social care users satisfied with care and support services, aged 65+</p>			

Personalisation Programme	Local progress measures	Frequency of reporting	Inclusion in ICS Quality and Performance
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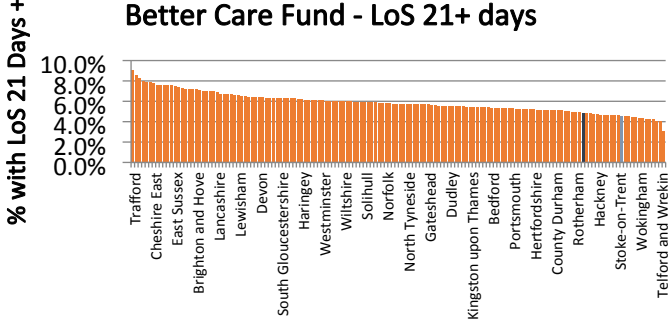
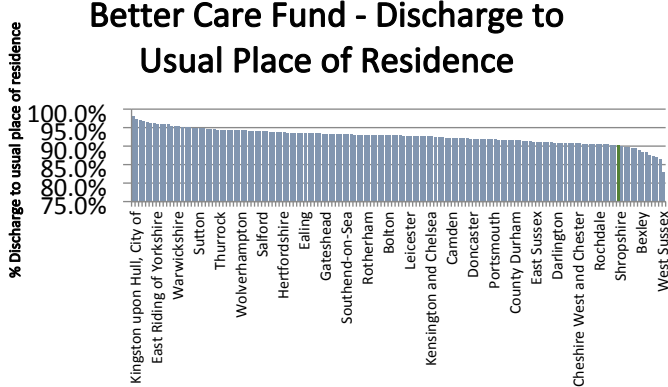
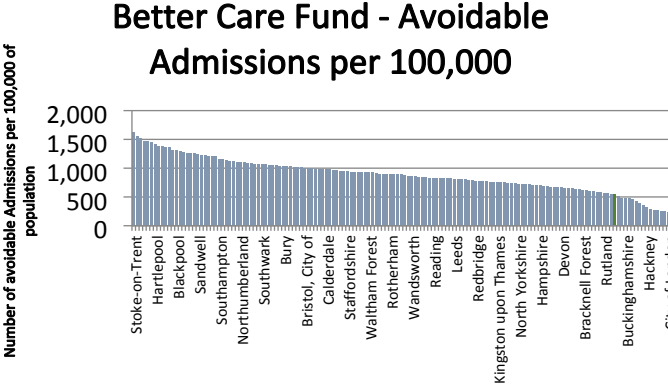
<p>Increase the number of Social Prescribing referrals</p>	<p>Social Prescribing Referrals against NHSE/I Targets</p>  <p>(Source NS)</p>			
<p>Increase the number of Personal Health Budget allocations</p>	<p>Personal Health Budgets performance against NHSE/I Targets</p>  <p>(Source NS)</p>			
<p>Trained Staff in Motivational Interviewing – 120 staff trained  Source: Training Hub Records  Further training planned Q1 2022/23</p>	<p>Motivational Interviewing Training</p>  <p>(Source NS)</p>	<p>Staff trained in Health coaching = 32</p> <p>Staff trained in PCI accredited free Personalised Care Training = 54</p>		
<p>Number of Personalised Care Plans in place –</p>		<p>Local project tracking</p>		

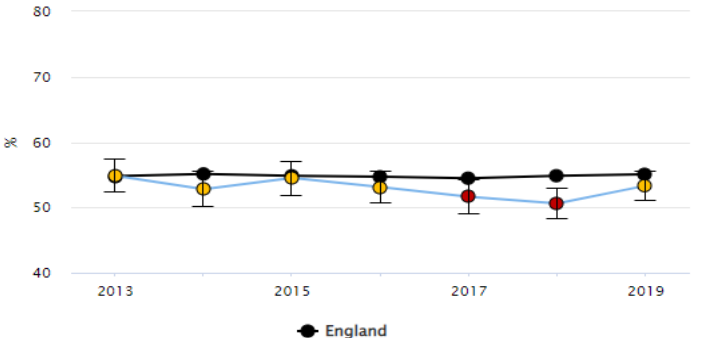
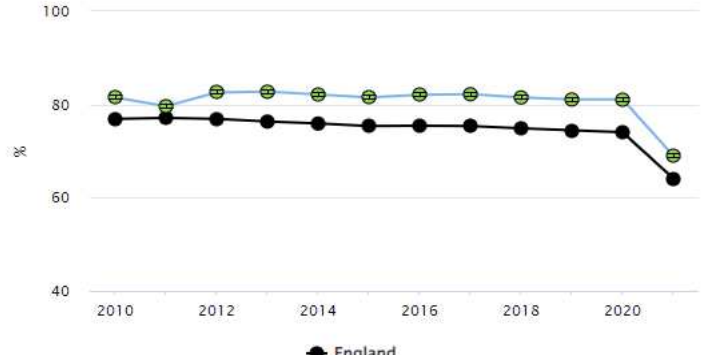


<p>Asthma – 500 <i>Source to confirm – present data from SHIPP draft document</i></p> <p>Number of Personalised Care Plans in place – CYP with complex MH needs – 20 Children</p> <p>No PCSP MH</p> <p>NS – PODs and PACs, beginning Q2/Q3 next year</p>		in 22/23		

Better Care Fund Programme	Local progress measures	Frequency of reporting	Inclusion in ICS Quality and Performance
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<p>Decrease the Better Care Fund LoS</p> <p>14+ days LoS chart – Shropshire LA highlighted in orange at 9.9% (lower % is seen as preferable / better)</p>	<p><b>Better Care Fund - LoS 14+ days</b></p> <table><thead><tr><th>Local Authority</th><th>% with LoS 14+ days</th></tr></thead><tbody><tr><td>Trafford</td><td>15.0%</td></tr><tr><td>Blackpool</td><td>14.0%</td></tr><tr><td>Isle of Wight</td><td>13.0%</td></tr><tr><td>Cambridgeshire</td><td>12.0%</td></tr><tr><td>Buckinghamshire</td><td>11.0%</td></tr><tr><td>Staffordshire</td><td>10.0%</td></tr><tr><td>Manchester</td><td>9.9%</td></tr><tr><td>Lincolnshire</td><td>9.0%</td></tr><tr><td>Redcar and Cleveland</td><td>8.0%</td></tr><tr><td>Merton</td><td>7.0%</td></tr><tr><td>North East Lincolnshire</td><td>6.0%</td></tr><tr><td>East Riding of Yorkshire</td><td>5.0%</td></tr><tr><td>Dorset</td><td>4.0%</td></tr><tr><td>Lambeth</td><td>3.0%</td></tr><tr><td>Brent</td><td>2.0%</td></tr><tr><td>Central Bedfordshire</td><td>1.0%</td></tr><tr><td>Sandwell</td><td>1.0%</td></tr><tr><td>Essex</td><td>1.0%</td></tr><tr><td>Waltham Forest</td><td>1.0%</td></tr><tr><td>Islington</td><td>1.0%</td></tr><tr><td>Derbyshire</td><td>1.0%</td></tr><tr><td>Coventry</td><td>1.0%</td></tr><tr><td>North Lincolnshire</td><td>1.0%</td></tr><tr><td>Luton</td><td>1.0%</td></tr><tr><td>Southend-on-Sea</td><td>1.0%</td></tr><tr><td>Tower Hamlets</td><td>1.0%</td></tr></tbody></table>	Local Authority	% with LoS 14+ days	Trafford	15.0%	Blackpool	14.0%	Isle of Wight	13.0%	Cambridgeshire	12.0%	Buckinghamshire	11.0%	Staffordshire	10.0%	Manchester	9.9%	Lincolnshire	9.0%	Redcar and Cleveland	8.0%	Merton	7.0%	North East Lincolnshire	6.0%	East Riding of Yorkshire	5.0%	Dorset	4.0%	Lambeth	3.0%	Brent	2.0%	Central Bedfordshire	1.0%	Sandwell	1.0%	Essex	1.0%	Waltham Forest	1.0%	Islington	1.0%	Derbyshire	1.0%	Coventry	1.0%	North Lincolnshire	1.0%	Luton	1.0%	Southend-on-Sea	1.0%	Tower Hamlets	1.0%			
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<p>Better Care Fund – Patients discharged to usual place of residence</p> <p>Shropshire LA highlighted in orange at 90.3% (higher is seen as preferable/better)</p>	<p><b>Better Care Fund - Discharge to Usual Place of Residence</b></p>  <p>% Discharge to usual place of residence</p>			
<p>Better Care Fund – Avoidable Admissions rated per 100,000 of population</p> <p>Shropshire LA highlighted in orange at 544; (Higher avoidable admissions are seen as preferable/better)</p>	<p><b>Better Care Fund - Avoidable Admissions per 100,000</b></p>  <p>Number of avoidable Admissions per 100,000 of population</p>			

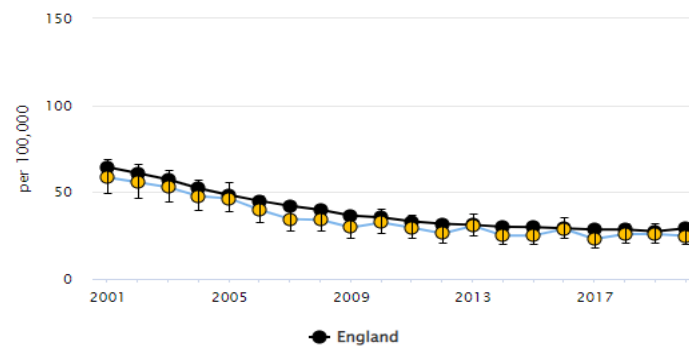
Cancer	Local progress measures	Frequency of reporting	Inclusion in ICS Quality and Performance
<p>Early diagnosis and treatment for cancer C23 – Percentage of cancers diagnosed at stages 1 + 2</p> <p>Shropshire in red and yellow points. Percentages lower than the England averages are seen as less preferable. Whiskers represent the 95% confidence limits</p>	<p>PHOF – C23 – Percentage of cancers diagnosed at stages 1 + 2</p> 		
<p>C24a Cancer Screening Coverage – Breast Cancer</p> <p>Shropshire in green points. Percentages higher than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHOF - C24a Cancer Screening Coverage – Breast Cancer</p> 		
<p>C24b Cancer Screening Coverage – Cervical Cancer (25-49 year olds)</p> <p>Shropshire in green points. Percentages higher than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHOF - C24b Cancer Screening Coverage – Cervical Cancer (25-49 year olds)</p>		

<p>C24c Cancer Screening Coverage – Cervical Cancer (50-64 year olds)</p> <p>Shropshire in green and yellow points. Percentages higher than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHOF - C24c Cancer Screening Coverage – Cervical Cancer (50-64 year olds)</p>			
<p>C24d Cancer Screening Coverage – Bowel Cancer</p> <p>Shropshire in green points. Percentages higher than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHOF - C24d Cancer Screening Coverage – Bowel Cancer</p>			
<p>E05a – Under 75 mortality rate from Cancer</p> <p>Shropshire in green and yellow points. Standardised rate lower than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHOF – E05a – Under 75 mortality rate from Cancer</p>			

<p>E05b Under 75 Mortality rate from Cancer considered preventable (2019 definition, 1 year range)</p> <p>Shropshire in green and yellow points. Standardised rate lower than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>PHOF - E05b Under 75 Mortality rate from Cancer considered preventable (2019 definition, 1 year range)</p>			

## CVD

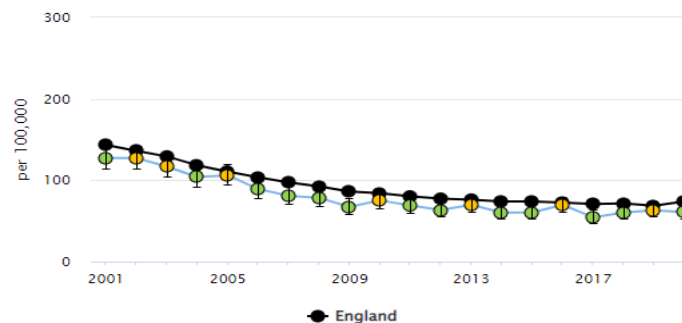
<p>Early diagnosis and treatment for cardiovascular disease</p> <p>Suitable alternative?</p> <p>E04b – Under 75 mortality rate from Cardiovascular diseases seen as preventable (2019 definition, 1 year range)</p> <p>Shropshire in yellow points. Standardised rate lower than the England averages are seen as more preferable. Whiskers represent the 95% confidence limits</p>	<p>Source?</p> <p>PHOF - E04b – Under 75 mortality rate from Cardiovascular diseases seen as preventable (2019 definition, 1 year range)</p>			
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E04a – Under 75 mortality rate from all Cardiovascular diseases (1 year range)

Shropshire in green and yellow points.  
Standardised rate lower than the England averages are seen as more preferable.  
Whiskers represent the 95% confidence limits

PHOF – E04a – Under 75 mortality rate from all Cardiovascular diseases (1 year range)



## Appendices

Appendix 1 – Information Sources	
Public Health Fingertips	<a href="https://fingertips.phe.org.uk/profile/health-profiles/">https://fingertips.phe.org.uk/profile/health-profiles/</a>
Public Health Outcomes Framework	<a href="https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data">https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data</a>
Quality Outcomes Framework – drop as a source?	<a href="https://digital.nhs.uk/data-and-information/publications/statistical/qu">https://digital.nhs.uk/data-and-information/publications/statistical/qu</a>
Shropshire LA – average weekly earning	<a href="https://www.shropshire.gov.uk/media/8824/earnings-information-sheet-2017.pdf">https://www.shropshire.gov.uk/media/8824/earnings-information-sheet-2017.pdf</a>
Office for National Statistics	<a href="https://www.nomisweb.co.uk/reports/lmp/la/1946157170/report.aspx?town=shropshire#tabempunemp">https://www.nomisweb.co.uk/reports/lmp/la/1946157170/report.aspx?town=shropshire#tabempunemp</a>
ONS – Unemployment all people	<a href="https://www.nomisweb.co.uk/reports/lmp/la/1946157170/subreports/ea_time_series/report.aspx?">https://www.nomisweb.co.uk/reports/lmp/la/1946157170/subreports/ea_time_series/report.aspx?</a>
Department for Education	<a href="https://www.gov.uk/government/publications/neet-and-participation-local-authority-figures">https://www.gov.uk/government/publications/neet-and-participation-local-authority-figures</a>
NHS Data	SUS Analyst Global SQL Warehouse
NHS Data	Internal Health Checks recorded for Mental Health Patients internal CCG report
NHS Data	Aristotle Information Portal
NHS Data - SATOD	<a href="https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england">https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england</a>
Better Care Fund	<a href="https://www.england.nhs.uk/publication/better-care-fund-end-of-year-report-2020-21/">https://www.england.nhs.uk/publication/better-care-fund-end-of-year-report-2020-21/</a>
NHS England – Friends and Family Test – drop as a source?	<a href="https://www.england.nhs.uk/fft/friends-and-family-test-data/">https://www.england.nhs.uk/fft/friends-and-family-test-data/</a>
ASCOF	<a href="https://app.powerbi.com/view?r=eyJrljoiMGM5OGRIOTAtY2QxYy00YzAxLWEyZWEtNjI3ZWVmOTE2OWI4IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTlTY3Mzc0OGU2MjllMlslmMiOjh9">https://app.powerbi.com/view?r=eyJrljoiMGM5OGRIOTAtY2QxYy00YzAxLWEyZWEtNjI3ZWVmOTE2OWI4IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTlTY3Mzc0OGU2MjllMlslmMiOjh9</a>

Appendix 2 - Methodology	
i)	Source of information defined
a.	Primary information sources are OHID/Public Health England Fingertips and OHID/Public Health Outcomes Framework. If there is no data is available on either of these two sources an alternative source has been searched for
b.	Some suggested metrics are yet to have a suitable source identified. These are left in red in the draft document; as are metrics with queries against them
ii)	Time period, geography and availability of historical of data is identified from the source
a.	Any queries are recorded in red in the draft document to seek clarification at a later date
iii)	A suitable chart is copied from OHID/PHE website source or generated using excel and copied across. Any metrics where a run of data of more than 16 points is available also has an SPC chart generated
iv)	Comments from the sources relating to data quality etc are noted
v)	Any pertinent points are noted on potential issues which may influence the metric's use

Pledge 3 – Population Health Management and  
Outcome Framework – Slides  
Agenda item 29-06.010





**Shropshire, Telford & Wrekin**  
Integrated Care System

# ICS Population Health Programme Board

High Level Delivery Plan  
March 2022 refresh

# Definitions

- ◆ **Population health** is an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies.

*A vision for population health, King's Fund*

- ◆ **Population Health Management (PHM)** is how we use historical and current data about people's health and how they are using health and care services to design new proactive models of care which will improve health and wellbeing today as well as in 20 years' time.
  - ◆ This acts as an **enabler** to allow us to tailor services to the needs of people in each area, improve people's health, prevent illnesses, and make better use of public resources.

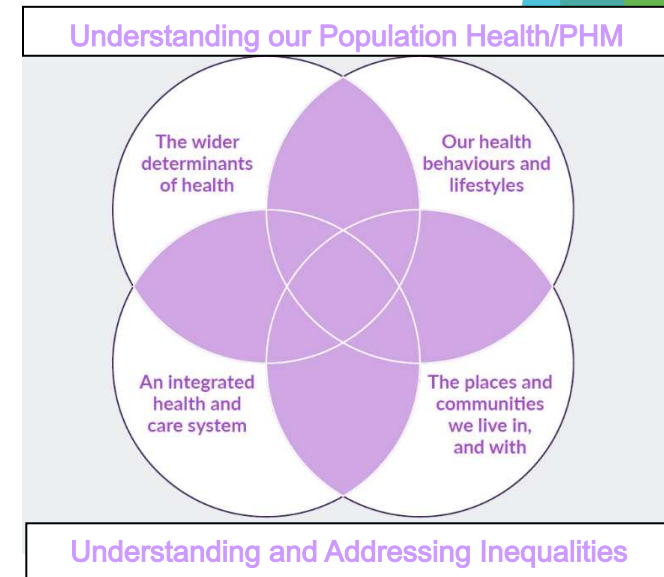
It involves the crucial role of communities and local people, the NHS and other public services including councils, schools, housing associations and social services working together to join up services for people by sharing information, resources and goals.



# Background

## May 2021 – Paper to CEO's Drawing it all together, a clear vision for Population Health

- ◆ **Systematically** use our intelligence on Population Health & Health Inequalities
- ◆ Agree priorities for **Population Health at Place & System** level – through the ICS and the HWBs
- ◆ Use a **Placed based approach** to improve health & wellbeing and **reduce health inequalities** through our Integrated Care Partnerships (SHIP and TWIP)
- ◆ Take a **preventative approach** across all system-wide programmes for example promotion of MECC approaches.
- ◆ Monitor **outcomes at Place and System** level, reporting to the **ICS** and **HWBs** with **Scrutiny Oversight** by Local Authority committees.



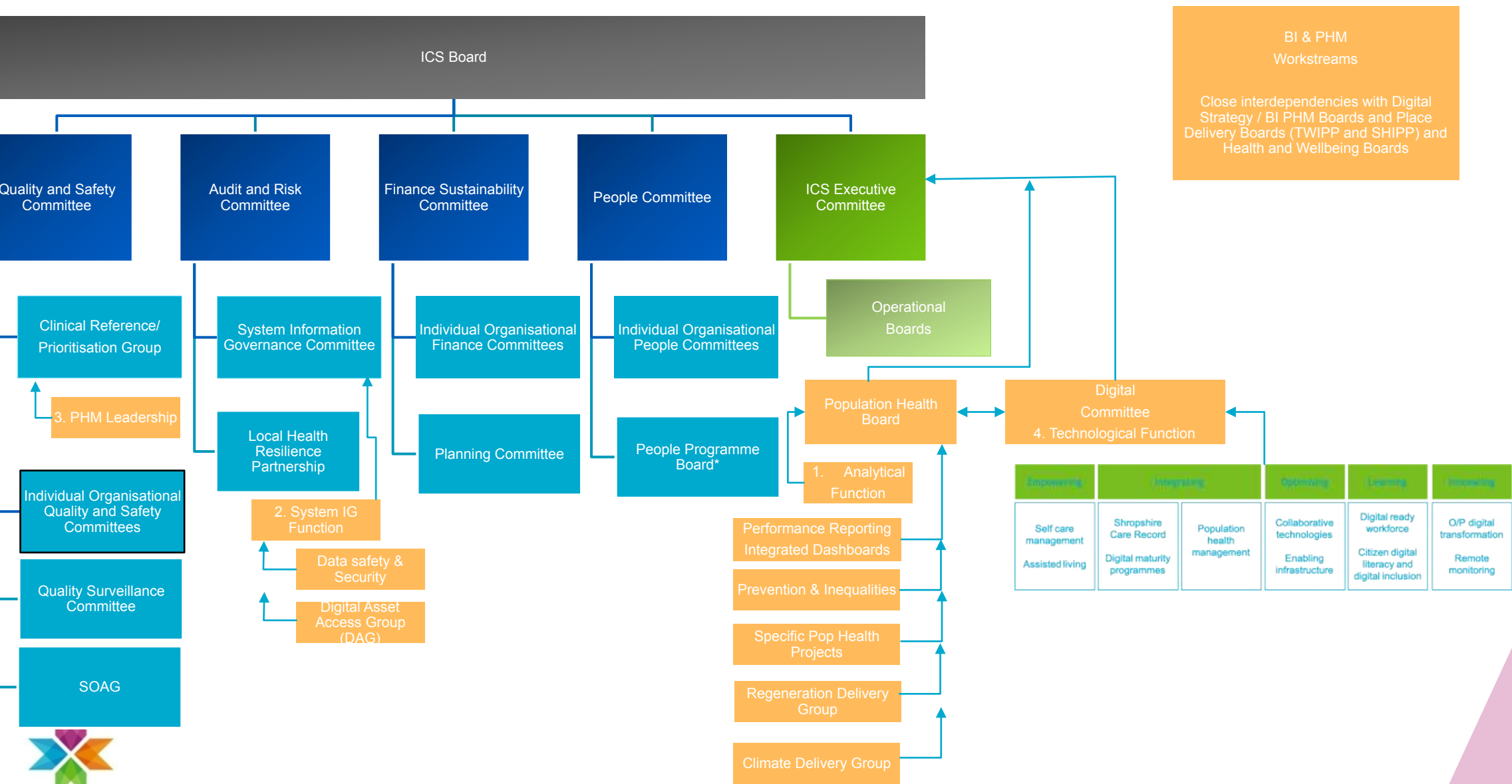
# Population Health Operational Board: Purpose

- ◆ Establish a system approach to **embedding** and leading Population Health approaches across all programmes of work
- ◆ Co-ordinate and lead delivery of **key programmes** of work which support delivery of a population health approach specifically;
  - ◆ **Population Health Management**: The aim is to use all data, evidence, insight in a systematic way to better understand, plan, deliver and ultimately improve our populations health and care whilst making best use of all available resources.
  - ◆ Tackling **inequalities**: See Plan plus develop **outcomes** framework
  - ◆ **Systemwide prevention** planning and delivery including weight management, alcohol, smoking and NHS England prevention programmes, framework to be developed by DPHs
  - ◆ Climate and Regeneration as key wider determinants of health to lead sub groups Assurance that **enabling** and the place as a delivery function are aligned to the Population Health board programme
- ◆ Enablers – there are a number of key enablers that support the delivery of the programme
  - ◆ Information Governance
  - ◆ Digital Technology
- ◆ Delivery at Place
  - ◆ Place – links to Childrens, see agreed framework in appendix, SHIP and TWIP plans for delivery



# Governance Overarching Structure Population Health ICS

(May 2021) Due to be updated in July 2022 with the establishment of the ICS. TWIP and SHIP report directly to the ICS Board



# A Population Health: Overarching Framework

System Function Development	Deliverables	SRO	Senior/Operational Lead	Team where delivery Sits	Clinical Lead where relevant	Start Date	Est Delivery Date	Comments and Updates (Feb 22)
1 Population Health Board development & Governance	Establish Population Health Programme Board, Governance, ToR, distributed leadership model	Andy Begley/Rachel Robinson	Jo Harding	Public Health Shropshire	RR/LN	June 21	July 21	Complete ToR to be reviewed and tightened to reflect new guidance July 22
2. Population Health Vision/Strategy	Develop a position statement to describe population health, its key components and the required programme of work <ul style="list-style-type: none"> <li>Our Population Summary</li> </ul>	Andy Begley	Liz Noakes/Rachel Robinson	Public Health teams	RR/LN	July 21	Sept 21	Complete Work required to refresh our population summary annually
3. Resources	Identify additional resources to support the delivery of programmes including training, grants across the system. <ul style="list-style-type: none"> <li>Population Health Management</li> <li>Inequalities and Prevention</li> </ul>	Rachel Robinson/Liz Noakes	Penny Bason/Helen Onions/Jo Harding	Public Health Teams	RR/LN/KE	June 21	On-going	Ongoing PHM fellow post x2 secured (Oct 21) Investment in Alcohol Care Teams Successful for Core 20 plus 5 (Jan 22)
4. Inequalities Framework & Implementation	Develop & Implement a System Integrated Framework for prevention & Inequalities to include wider determinants of health & care. To be aligned to equality and quality impact assessment work, also the wider health in all approach  Agree how this will be implemented at PLACE through SHIPP/TWIPP and HWB	Claire Parker/Zena Young/Edna Boampong/Liz Noakes/Rachel Robinson	Edna Boampong supported by Helen Onions/Berni Lee/Tracey Jones	Those priorities that are system wide or nationally mandated will be implemented through joint working  Those priorities that are specific to Place will be implemented through the appropriate PLACE based board.	JP	July 21  Jan 22	Nov21  Ongoing	Update required from EP – colleagues have input to the systemwide joint Equality, Health in All framework. Met 4 <sup>th</sup> March, moving forward  SHIPP and TWIPP delivery of programmes to focus on prevention and inequalities at place is ongoing. TOR are currently being reviewed
5. Develop a work programme for system population health issues	Develop a work programme for system <ul style="list-style-type: none"> <li>Agree deliverables, project leads and schedule of reporting</li> <li>Agree and establish a monitoring framework and KPIs</li> <li>Board Assurance Framework for monitoring key risks</li> </ul>	Rachel Robinson	Tbc previously Jo Harding	Across Place Boards, Public Health Teams, Climate and Regeneration Delivery Group	RR/LN	Sept 21	Feb 22	Need to establish a record of reporting to be brought to each Board and outcomes to link to KPI monitored by JG Delayed due to Omicron and loss of Programme support – needs to be covered in terms of gap



# B Population Health Management – enabling functions – delivered through existing system workstreams

System Function Development	Deliverables	SRO	Senior/ Operational Lead	Team where delivery Sits	Clinical Lead where relevant	Start Date	Est Delivery Date	Comments/Update Feb 22
1. System BI Analytical Function, systems and capacity	Establishing the "Engine Room" for system data analytics and BI	Sam Tilley Rebecca Gailmore	Jo Harding/tbc	System Analyst Network will evolve to fulfil System Analyst function and act as "Engine Room" for DSU	N/A		Oct 2021	Agreed 22 <sup>nd</sup> April 2021 BI & PHM workshop. No progression due to staff leaving and further COVID waves. System lead to be confirmed Conversation with AB/JG to move forward
	Reviewing existing skills mapping, refreshing, identifying gaps	Sam Tilley	Jo Harding/Craig Kynaston		N/A		Oct 2021	Initial Business Case to CE – Dec 2019 Capacity Mapping Sept 2019 Agreed at January Board to move forward with restarting the group
	Performance Dashboard capability (Dashboards for key programmes of work, linked to KPI's)	Julie Garside	David Ashford /Dave Whiting	System Performance Group	N/A			Update reports to Pop Health Board, delayed due to COVID
	Re-establish the steering group with an operational group of analysts, made up of two from each organisation	Sam Tilley	Craig Kynaston (interim)					Meetings took place in 2019 but ceased with the PHM academy and pandemic
	Establishing a local "decision support unit" or hub and spoke unit to deliver PHM approach and capacity across STW system	Sam Tilley	Craig Kynaston (interim)		tbc			Presentation from Gareth Wrench in October 2021. Links to reestablishment of steering group
	Determine Strategy and analytical lead for system	Sam Tilley	Craig Kynaston (interim)					Paper to Jan 2020 CEX group on additional resource, interim support (end March 2022) – long term support required and additional capacity
2. Framework/ Strategy	Develop a framework/strategy to enable understanding of data, evidence insight to support national, regional and local priorities	Sam Tilley	ICS Lead / Chief Analyst & Pop Health Board members	DSU & ICS Data Analysts Network	LN/RR	June 21	Dec 2021	
3. Population Health Management Work Programme 2021/2022	Develop a Population Health Management Programme of Work	Sam Tilley / Rachel Robinson	Craig Kynston/ Alex McKellen/ Helen Potter					Draft Programme of Work attached, to be updated via steering group/analysts routinely
	• 3a) Community Services PHM Approach	Patricia Davies	Helen Onions/Gordon Kochane	Led by Shrop Comm Intel Support from Las		May 21	Sept 21	Complete
	• 3b) Mental Health Capacity	Ben Hollands	Helen Onions/Gordon Kochane		Zafar Iqbal	July 21	Sept 22	Complete
	• 3c) Population Health Management in PCNs	PCN Clinical Directors	? Steve Ellis	All PCNs linked into the PC Team at the CCG and Public Health Teams within the LAS				Requirement on PCNS to develop a PHM approach is being supported by the CCG and Las aligned to current HWB priorities
	• 3d) Population Health Fellow (SMI and Healthy Lifestyle)		Helen Onions/Penny Bason	Links to PCNs and supported by LA teams	Kevin Eardly	Sept 21	Sept 22	Successful bid and recruitment of two population health fellows appointed into STW to support work around SMI and healthy lifestyles
	• 3e) Pharmacy Needs Assessment	Liz Noakes/Rachel Robinson	Gordon Kochane/Helen Onions	Supported by LA Intel Teams	Lynn Devlin LPC	Sept 21	April 23	Joint Planning in progress. Questionnaire to be circulated to Pharmacies



# C Population Health – Systemwide Prevention systemwide including operational Planning & NHSEI Priorities

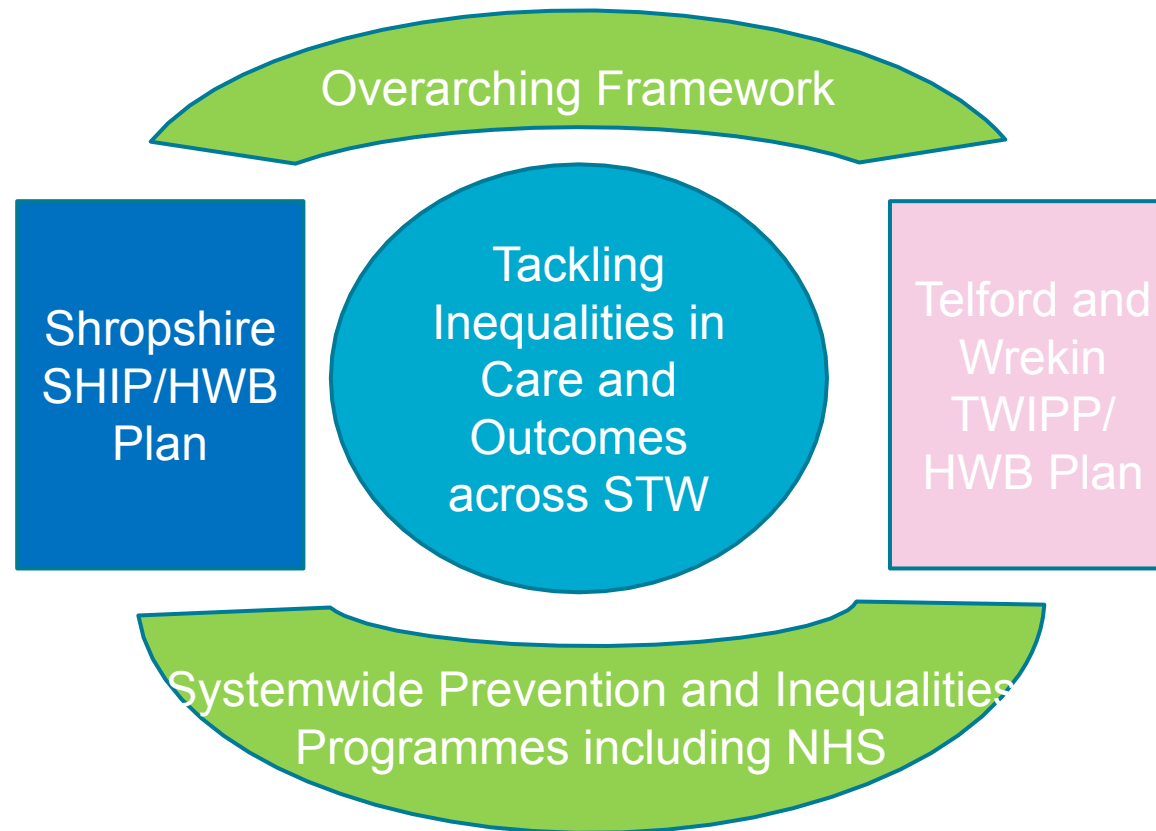
All the priorities below are what we expect the Population Health Board to oversee in terms of development & Implementation. This includes system wide strategies to address national & Local priorities, all of which need to be underpinned by data, evidence, insight and robust analysis of that in order to measure progress.

System priority	Deliverables	SRO	Senior/Operational Lead	Team where delivery Sits	Clinical Lead where relevant	Start Date	Est Delivery Date	Comments/Update Feb 22
1. Strategic Planning and oversight	<ul style="list-style-type: none"> <li>Establish STW Health Inequalities Plan and a Telford and Wrekin, Shropshire Council Plans</li> </ul>	Liz Noakes/Rachel Robinson/Claire Parker	Helen Onions/Berni Lee/Tracey Jones	CCG Partnerships team and LA Public Health Teams	Liz Noakes/Rachel Robinson	Sept 21	April 22	Reports are in progress and going through appropriate governance
	<ul style="list-style-type: none"> <li>Establish a steering group</li> </ul>					Nov 21	Ongoing	Established
	Establish a systemwide inequalities framework							See slide 6
	A demonstrable shift in the move to preventative approaches and services across health and social care to reduce demand	Andy Begley	Liz/Rachel					Language is there
Systemwide Prevention Programmes	NHS Tobacco Dependency <ul style="list-style-type: none"> <li>Treatment</li> <li>Systemwide approach</li> </ul>	Claire Parker	Tracey Jones/Emma Pira/BL/HO					
	Smoke Free Pregnancies – Healthy Pregnancy	Liz Noakes/Rachel Robinson	Helen Onions/Anne-Marie Speke/LMS	SATH/CCG SATH/LA		April 09	July 21	
	Excess Weight <ul style="list-style-type: none"> <li>Digital Weight Management</li> </ul>	Tracey Jones	Jenny Stevenson/Louise Mills/Berni Lee					NB Community Services delivered at place - see SHIPP & TWIPP
	<ul style="list-style-type: none"> <li>Digital Exclusion</li> </ul>	Julie Davies						
	Physical activity – system wide movement programme	Liz Noakes/Rachel Robinson	Louse Mills/ Berni Lee/ /Chris Child					Update at the January Board following CEX – need an action plan
	Alcohol Care Teams	Liz Noakes/Rachel Robinson	Ian Haughton/Tony Mercer Frances Sutherland	MPFT/We are With You/SATH	Kevin Eardley	May 21	March 23	Funding received to SATH from PHE and LA Support - update to future meeting
2. Systemwide Reduction in Healthcare Inequalities/ Core20Plus	Inequalities in Maternity Care <ul style="list-style-type: none"> <li>Continuity of Carer – BAME</li> </ul>	Louise Barnett	LMS/ Nick ODonald			April 09	July 21	Additional details of contacts required , outside reporting as high priority to LMS
	Serious Mental Illness and Complex Needs	Cathy Riley	Frances Sutherland/ Janet Gittens	MPFT/CCG/PC Public Health/		May 21	Sept 22	Update to be provided at next board, being picked up through Mental Health Board
	Inequalities in respiratory - Chronic Respiratory Disease, flu		Rebecca Gilmore					Need to target COPD patients in high levels of deprivation low uptake vaccine
	Early Cancer Diagnosis <ul style="list-style-type: none"> <li>Core20Plus5 Community Champions</li> </ul>	Julie Garside Liz Noakes/Rachel Robinson	Tracy Jones/Louise Mills/Penny Bason	LA/VCS				Funding secured from NHS E £60K in first wave to roll out the programme
	<ul style="list-style-type: none"> <li>Tackling inequalities in Vaccine uptake</li> </ul>	David Sidaway	Penny Bason/Helen Onions	Shrop Comm/LA outreach teams		Dec 21	Feb 22	Ongoing but focus due to Omicron. plans to continue with the programme post Feb for addressing healthcare inequalities
	<ul style="list-style-type: none"> <li>Inequalities in CVD risk focus on Hypertension (AF)</li> </ul>		Berni Lee/Anne Marie/ Emma Pyra					Links to PCNs and DES, population health fellow, Julie Garside mapping waiting lists (David – cancer group)
	<ul style="list-style-type: none"> <li>Access to services; inequalities <ul style="list-style-type: none"> <li>Access to Primary Care - Physical Health Checks in Primary Care</li> <li>Diagnostics</li> </ul> </li> </ul>	Clare Parker  Julie Garside Julie Garside	Steve Ellis/HO/AMS Emma Pyra					

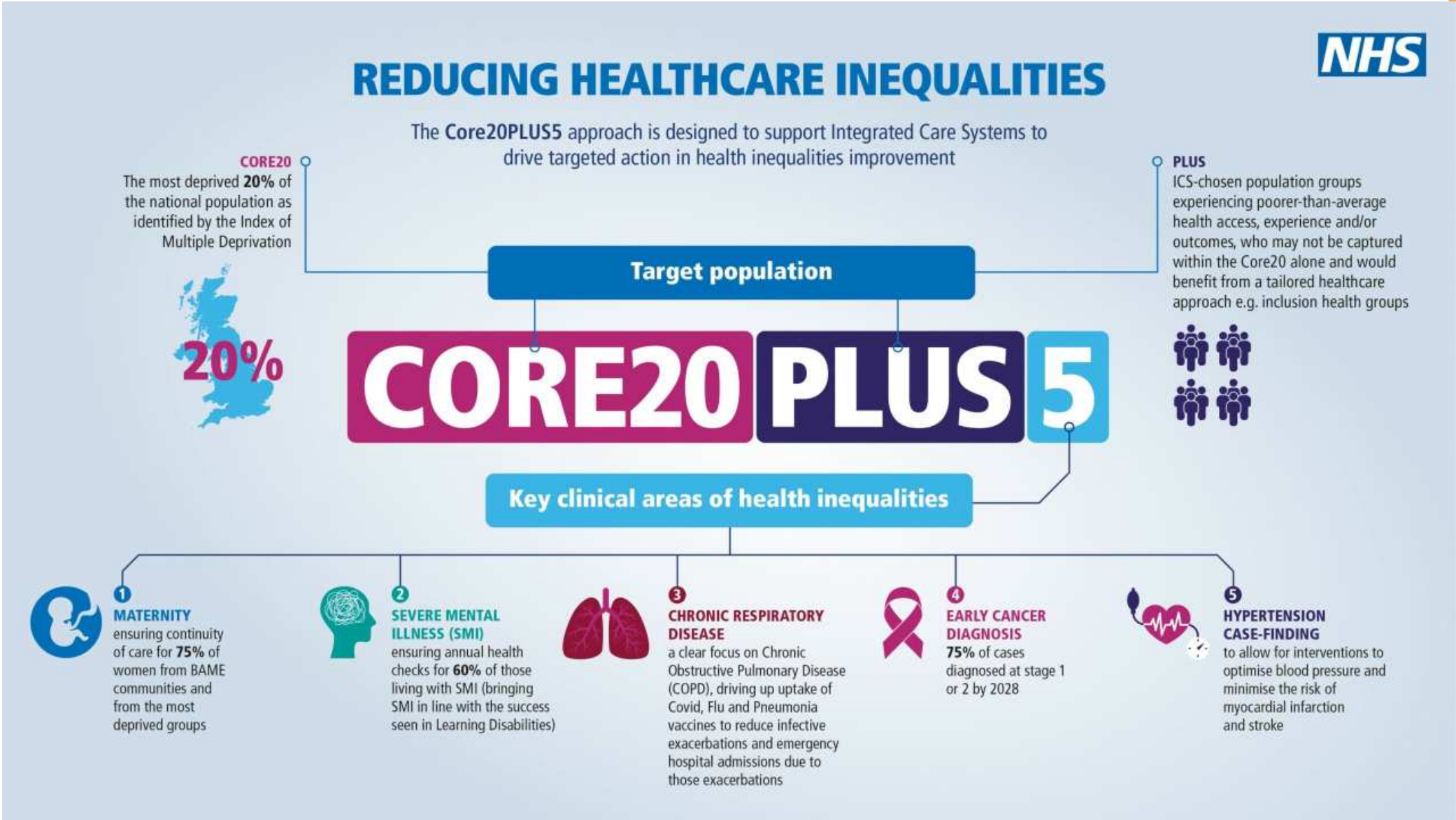


# Inequalities Plans

- ◆ Tackling Inequalities is embedded into prevention programmes and local programme
- ◆ The diagram shows the STW approach to planning and the mechanisms for delivery



# Core 20Plus5



# D Tackling Climate Change - tbc

System priority	Workstreams	SRO	Senior/Operational Lead	Team where delivery Sits	Clinical Lead where relevant	Start Date	Estimated Delivery Date	Comments and Updates (Feb 22)
Meeting the Challenge of Climate Change	Establish System wide Climate Change Working Group	Andy Begley/ David Sidaway	Adrian Cooper/ Felicity Mercer		-	16 <sup>th</sup> April	ongoing	Established
	Assess current position – organisations to share data, action plans, targets etc.							
	Develop STW system wide Strategy with clear deliverables to reduce carbon footprint							
	<ul style="list-style-type: none"> <li>Agree Shared vision &amp; targets to reduce Carbon Footprint across <i>Health and Social Care including commissioned services</i></li> <li>STP footprint data (or actions to collect data if not yet available)</li> <li>Action plan (joint projects) - timescales, carbon savings, lead organisation(s)</li> </ul>							
	Explore renewable energy options at RAJH in conjunction with SC	Stacey Keegan	Adrian Cooper	Simon Everett		June 21		
	Identify a 'Board-level' net zero lead with accountability	Andy Begley	Adrian Cooper	Across each organisation	N/A	Sept 21	Oct 21	Andy Begley identified as lead



# E Economic Regeneration - tbc

System priority	workstreams	SRO	Senior/ Operational Lead	Team where delivery Sits	Clinical Lead where relevant	Start Date	Estimated Delivery Date	Comments and Updates (Feb 22)
Maintaining a strong, growing economy, that directly addresses the inequalities in access and opportunity across communities – that strives to ‘level up’ – will deliver healthy, happy and economically productive communities, building resilience	<b>Recovering from economic impact of Covid pandemic</b>	Andy Begley				June 21		
	<b>Driving economic growth</b> <ul style="list-style-type: none"> <li>Accelerating Council infrastructure projects</li> <li>Investing to de-risk sites</li> <li>Bespoke support to investors to enable them to commit their funds to our sites, fast tracking them to the market</li> <li>Delivering a range of new employment sites, business parks and incubation space for start-up businesses</li> <li>Promoting our offer to the market creating new job opportunities, supply chain and spend in our local economies</li> </ul>		Jane Trethewey/ Tracey Darke/ Katherine Kynaston					
	<b>Investing in new homes, delivering stronger communities</b> <ul style="list-style-type: none"> <li>Driving our newbuild &amp; refurbishment housing programmes through Cornovii and Nuplace</li> </ul>							
	<b>Transformational Plans for Place</b> <ul style="list-style-type: none"> <li>STW Investment Plans</li> </ul>							
	<b>Employment &amp; Skills</b>							
	<b>Place Making</b> <ul style="list-style-type: none"> <li>New Economic Strategies reflecting economic changes &amp; opportunities</li> <li>Delivering new Local Plans, Neighbourhood Plans, and Supplementary Planning Documents to support the development of safe, healthy places</li> <li>Place Plans to capture locally focussed priorities vital to sustaining strong communities</li> <li>Delivering green infrastructures providing greater opportunities for walking and cycling, linking homes and employment sites and ensure access to green space</li> </ul>							
	<b>Digital Infrastructure</b> <ul style="list-style-type: none"> <li>Progressing the roll out of superfast broadband to deliver a full fibre infrastructure capable of supporting 5G</li> <li>Investing in digital infrastructure to meet the needs of businesses</li> <li>Driving up digital skills across our workforce</li> </ul>			This is delivered through System Digital Group and associated workstreams				
	<b>Attract investment</b> <ul style="list-style-type: none"> <li>Support digital and physical infrastructure</li> </ul>							

# Interdependencies/enablers

System priority	Deliverables/workstreams	SRO	Senior/Operational Lead	Team where delivery Sits
1. Interdependent Programmes	Local Care: Case Management, Rapid Response, and Hospital at Home			
	Community Services Review (PHM)	Patricia Davies		
	End of Life Review			
	One Public Estate			
	Early access to Information and Advice – Proactive and Prevention Offer	Jon Rowe	Sarah Dillon	
	Community Engagement, Coproduction	Edna Boampong		
	Early access to Information and Advice: Proactive & Prevention Offer	Jonathon Rowe	Sarah Dillon	
2. System IG Function	Establish System IG Group for oversight & Assurance	Jonathan Davis	System IG Group fulfil responsibility of System IG Group & will report back on progress	
	Data safety & security	Laura Clare & CSU		
	Data sharing arrangements	Laura Clare & CSU		
3. Professional Executive Leads	Systems and processes for prioritization, using all data, evidence, insight	Jane Povey	System Multi-professional Leadership Group will fulfil multi-professional leadership function in relation to population health	
	Multi-professional Leadership identification, wider stakeholder involvement across work programmes	Jane Povey		
5. System technological function  Digital Strategy themes & Associated deliverables	Empowering (Self Management, assisted Living)	tbc	SHIP & TWIP	
	Integrating (Shared Care Record, Digital Maturity)	Rebecca Gallimore	Digital Operational Group	
	Optimising (Collaboration, Enabling Infrastructure)	Rebecca Gallimore		
	Innovating (out-pt transformation, remote monitoring)	tbc		
	Learning (Digital ready Workforce, Digital Literacy & Inclusion)	Victoria Rankin	People	

# Population Health Prevention and Inequalities- Delivery Shropshire Place (For Info)

\*\* Ref – 21/22 Operational Planning Priorities

System priority		** Ref	Deliverables	SRO	Senior / Operational Lead	Team where delivery Sits	Clinical Lead where relevant	Start Date	Estimated Delivery Date
Delivery of PHM approach from Person to System at Place	Shropshire Place	D2	Adoption and spread of PHM across <b>SHROPSHIRE INTEGRATED PLACE (SHIP) programmes, developing a framework to embedded all programmes are evidence bases (Utilizing refreshed JSNA)</b>	Tanya Miles	Penny Bason	HWB/SHIPP	RR	May 21	Ongoing
			Delivery of JSNA – Place Based, SEND, PNA	Rachel Robinson	Gordon/Alex McKellen	Public Health Led	RR	March 21	May 23
			<b>Specific interventions at Place :Tackling inequalities</b>	Rachel Robinson					
			Adverse Childhood Experiences	Tanya Miles	Anne Marie Speke	HWB			
			Workforce			Healthy Lives			
			Addressing Inequalities: Developing and Implementation of Health Inequalities Action Plan	Rachel Robinson	Berni Lee	Healthy Lives			
			Children and Young People	Tanya Miles/ Claire Parker		CYP Board/HWB			
			<b>Prevention/Healthy Lives</b>	Rachel Robinson					
			Healthy Lifestyles: Alcohol		Jayne Randall	Safeguarding Partnership			
			Air Quality		Kieron Smith	Task and Finish Group			
			Wider determinants of health: Health in all		Sue Lloyd	Public Health			
			Healthy Lifestyles: Healthy Weight and Physical Activity		Berni Lee	Healthy Lives			
			Complex Needs including Domestic Abuse, County Lines		Jayne Randall Penny Bason/Laura Fisher	Safeguarding Partnership			
			Social Prescribing	Rachel Robinson	Penny Bason	Healthy Lives			
			<b>Supporting Mental Health, LD &amp; A</b>	Cathy Riley/Rachel Robinson					
			suicide prevention		Gordon Kochane	Public Health			
			Mental Health - wellbeing support		Gordon Kochane	Public Health			
			Dementia			ASC			
			<b>PHM Wave 3 at PCN (SW Shropshire, Shrewsbury PCNs)</b>	Claire Parker	Jenny Stevenson	Primary Care CCF			70

# Population Health Prevention and Inequalities - Telford & Wrekin Place (For Info)

\*\* Ref – 21/22 Operational Planning Priorities

System priority		** Ref	Deliverables	SRO	Senior / Operational Lead	Team where delivery Sits	Clinical Lead where relevant	Start Date	Estimate d Delivery Date
Delivery of PHM approach from Person to System at Place	Telford & Wrekin Place	D2	Intelligence-led planning and delivery – using population health management approach (see HWB Strategy) JSNA refresh, including locality profiling	Liz Noakes	Helen Potter				
			Prevention (linked to NHS E priorities), including: <ul style="list-style-type: none"> <li>reducing alcohol consumption (e.g. ACT)</li> <li>Healthy weight &amp; physical activity</li> </ul>	Liz Noakes	Helen Onions/Louise Mills	ACT - Public Health with SaTH	ACT Kevin Eardley		
			Driving progress to address health inequalities (see HWB strategy) focus areas are: <ul style="list-style-type: none"> <li>Tackling the “wider determinants of health”</li> <li>Giving every child the best start in life</li> <li>Improving the lives of the most vulnerable, people with complex needs, and those at risk of abuse, neglect or exploitation</li> </ul>	Liz Noakes	Liz Noakes/ Helen Onions – HWB/TWIPP lead	Across LA Directors and various Teams		Inequalities Plan launch Sept 2021	
			Telford & Wrekin Inequalities Plan (HWB & TWIPP) Plan framework based on Marmot priorities <ul style="list-style-type: none"> <li>Employment - good work - standard of living</li> <li>Place and communities</li> <li>Prevention &amp; health lifestyles - link to NHS E requirements (overleaf)</li> <li>Best Start in Life – link to LMS</li> <li>Health &amp; social care integration – link to TWIPP work programme</li> <li>COVID-19 impact</li> </ul>						
			Supporting Mental Health LD & A	Cathy Riley	Frances Sutherland				



# Summary and recommendations from Feb review

## Summary

- ◆ Overall good progress or on track for:
  - ◆ Strategic actions
  - ◆ Climate group
  - ◆ Regeneration groups
  - ◆ Prevention and Inequalities: Vaccinations and inequalities planning, alcohol care teams funding and smoking in pregnancy services
  - ◆ Population Health Management Skills mapping and delivery of system work programme asks
- ◆ Further work is needed on elements of the Population Health Management Programme to:
  - ◆ Establishment of a strategic lead
  - ◆ Engine Room
  - ◆ Establish the steering group
  - ◆ Confirmation of analysts work programme with ICS
- ◆ Further work is needed on the inequalities and prevention work to:
  - ◆ Further scoping and confirmation of work streams, mapping of the correct individuals

## Recommendations

- ◆ Refocus the work of the board to lead on a smaller number of workstreams to be discussed in detail at the informal board (monthly) and reported by exception to the Population Health Board (Quarterly)
- ◆ Ask for the board to see sight of minutes of enabling workstreams to ensure alignment, items by exception only
- ◆ High level framework to be fully updated quarterly with updates on red areas to be brought to Board meetings for understanding of issues and areas to unlock/escalate
- ◆ Establish a workshop to focus on
  - ◆ Confirmation of key system priorities
  - ◆ Programme Support
  - ◆ Priorities for inequalities and prevention and leads
  - ◆ Mechanism for reporting





Ockenden Report  
Agenda item 29-06.009

**CONFIRMED POSITION AS AT 10.05.2022**  
**APPENDIX ONE - FIRST OCKENDEN REPORT ACTION PLAN (2020)**

**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
<b>Local Actions for Learning Theme 1: Maternity Care</b>													
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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>
4.55	All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will 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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
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**APPENDIX ONE - FIRST OCKENDEN REPORT ACTION PLAN (2020)**

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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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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
4.60	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	Hayley Flavell	Annemarie Lawrence	
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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>

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CONFIRMED POSITION AS AT 10.05.2022  
APPENDIX ONE - FIRST OCKENDEN REPORT ACTION PLAN (2020)



The Shrewsbury and  
Telford Hospital  
NHS Trust

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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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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
<b>Local Actions for Learning Theme 2: Maternal Deaths</b>													
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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>
4.73	Women with pre-existing medical comorbidities 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	Not Yet Delivered	On Track	External dependency (National/ regional) on the establishment of maternal medicine specialist centres. NHSEI have advised that the action is 'on track'		31/10/22		Hayley Flavell	Guy Calcott	
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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>

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<b>Local Actions for Learning Theme 3: Obstetric Anaesthesia</b>													
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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Vicki Robinson & Claire Eagleton	<a href="#">SaTH NHS SharePoint</a>
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	Delivered, Not Yet Evidenced	On Track	Action 'delivered, not yet evidenced' based on evidence of a guidelines update alert tracker, a nominated guidelines lead, and evidence of an audit plan. The action can become 'evidenced and assured' once the audit has been conducted. Exception report accepted at the May MTAC for new completion deadline of Oct-22.	07/12/21	30/10/22		Hayley Flavell	Annemarie Lawrence	
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	31/03/22	Delivered, Not Yet Evidenced	On Track	Action 'delivered, not yet evidenced'. For the action to become 'evidenced and assured', MTAC require governance approval of the guideline prior to upload and a minor change in wording. Exception report accepted at the May MTAC for new completion deadline of Dec22.	07/12/21	30/12/22		Hayley Flavell	Annemarie Lawrence	<a href="#">Link to SaTH Anaesthetics Document Library</a>

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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	31/03/22	Delivered, Not Yet Evidenced	On Track	Action 'delivered, not yet evidenced' based on evidence of partial completion of ACSA 189 standards audit, a nominated audit lead within anaesthesia and a co-produced bespoke Ockenden case notes audit tool which is currently being completed. Exception report accepted at the May MTAC for new completion deadline of Oct-22	07/12/21	30/10/22		Hayley Flavell	Annemarie Lawrence	
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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>

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
4.91	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	Hayley Flavell	Will ParrySmith	<a href="#">SaTH NHS SharePoint</a>

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LAFI 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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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 onsite, 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	Hayley Flavell	Vicki Robinson & Claire Eagleton	<a href="#">SaTH NHS SharePoint</a>
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	31/03/21	Delivered, Not Yet Evidenced	On Track	Action 'delivered, not yet evidenced' based on the job plans devised to enable neonatal consultants and ANNPs regular observational attachments at NICUs and the honorary HR contracts in place with BWH and UHNM. Exception report accepted at the May MTAC for new completion deadline of Oct-22.	03/02/22	30/10/22		Hayley Flavell	Vicki Robinson & Claire Eagleton	<a href="#">SaTH NHS SharePoint</a>

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# APPENDIX ONE - OCKENDEN REPORT ACTION PLAN

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

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
<b>Immediate and Essential Action 1: Enhanced Safety</b> 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	Delivered, Not Yet Evidenced	On Track	External dependency linked to LMNS. Action 'delivered. not yet evidenced' based on draft SOP produced in collaboration with LMNS. The action can become 'evidenced and assured' once the final SOP has been ratified through Maternity Governance. Exception report accepted with completion deadline for Jun-22 at the May MTAC.	08/03/22	28/06/22		Hayley Flavell	Annemarie Lawrence	
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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Hayley Flavell	<a href="#">SaTH NHS SharePoint</a>
1.4	An LMS cannot function as one maternity service only.	Y	10/12/20	30/04/22	Not Yet Delivered	Off Track (see exception report)	External dependency linked to LMNS. Action set as 'off track' in the May MTAC as the presented evidence was incomplete, therefore not meeting the April deadline. An exception report will be presented at the June MTAC with proposed new deadlines for the action to move back 'on track'.		30/04/22		Hayley Flavell	Hayley Flavell	
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	Hayley Flavell	Hayley Flavell	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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 2: Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

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APPENDIX ONE - OCKENDEN REPORT ACTION PLAN

2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Y	10/12/20	TBC	Not Yet Delivered	On Track	External dependent action 'on track'. NHSEI have advised that the National Maternity team are taking the options through the Infrastructure oversight group on the 4th May for a decision, once this has been made, they will communicate out to the system what the plans are and implementation timelines.		TBC		Hayley Flavell	Hayley Flavell	
2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	Y	10/12/20	TBC	Not Yet Delivered	On Track	External dependent action 'on track'. NHSEI have advised that the National Maternity team are taking the options through the Infrastructure oversight group on the 4th May for a decision, once this has been made, they will communicate out to the system what the plans are and implementation timelines.		TBC		Hayley Flavell	Hayley Flavell	
2.3	Each Trust Board must identify a nonexecutive 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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint - Maternity Safety Champions workspace</a>
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	Not Yet Delivered	On Track	External dependency linked to CQC. Action advised to be 'on track'. Conversations between NHSEI and CQC taking place regarding the change of inspections.		TBC		Hayley Flavell	Annemarie Lawrence	
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 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	30/10/20	07/12/21	Hayley Flavell	Will ParrySmith	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Hayley Flavell	<a href="#">SaTH NHS SharePoint</a>




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APPENDIX ONE - OCKENDEN REPORT ACTION PLAN

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<b>Immediate and Essential Action 4: Managing Complex Pregnancies</b> 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	29/10/21	04/11/21	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>
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	Not Yet Delivered	On Track	External dependency (National/ regional) on the establishment of maternal medicine specialist centres. NHSEI have advised that the action is 'on track'		30/10/22		Hayley Flavell	Guy Calcott	
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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>

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<b>Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy</b> 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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>

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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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Will ParrySmith	<a href="#">SaTH NHS SharePoint</a>
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	Hayley Flavell	Annemarie Lawrence	<a href="#">SaTH NHS SharePoint</a>

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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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>
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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	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>
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	22/04/2021	28/02/22	28/02/22	Hayley Flavell	Guy Calcott	<a href="#">SaTH NHS SharePoint</a>

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APPENDIX ONE - FINAL OCKENDEN REPORT ACTION PLAN (2022)



The Shrewsbury and

Telford Hospital  
NHS Trust

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

LAFI 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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established		TBC		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence	

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APPENDIX ONE - FINAL OCKENDEN REPORT ACTION PLAN (2022)



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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
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	31/05/23	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence	
14.9	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Y	30/03/22	31/07/22	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence	

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APPENDIX ONE - FINAL OCKENDEN REPORT ACTION PLAN (2022)



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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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence	
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	31/12/22	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence	

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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	30/11/23	Not Yet Delivered	Not Started			31/03/24		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	A. Lawrence	

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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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established		TBC		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence	
14.17	All staff involved in preparing complaint responses must receive training in complaints handling.	Y	30/03/22	31/12/22	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence	

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Local Actions For Learning Theme 5: Improving Audit Process													
14.18	There must be midwifery and obstetric coleads for audits.	Y	30/03/22	31/07/22	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence & M. Underwood	
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	Not Yet Delivered	Not Started			31/01/23		J. Jones	A. Lawrence & M. Underwood	
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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence	
14.21b	Matters arising from clinical incidents must contribute to the annual audit plan.	Y	30/03/22	30/11/23	Not Yet Delivered	Not Started			31/03/24		H. Flavell	A. Lawrence	

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Local Actions For Learning Theme 6: Improving Guidelines Process													

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14.22	There must be midwifery and obstetric coleads for developing guidelines.	Y	30/03/22	30/09/22	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence & M. Underwood	
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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence	

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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	31/07/22	Not Yet Delivered	On Track	Proposal to MTAC on 10th May 2022 to move this to Delivered Not Yet Evidenced was rejected. While some of the MTP work is presented to the Board every month, the progress against the whole MTP does not. Work has commenced to address this.		30/09/22		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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	C. McInnes	
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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence	

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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	30/11/23	Not Yet Delivered	Not Started			31/03/24		H. Flavell	A. Lawrence	

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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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence	
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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence	

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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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established		TBC		H. Flavell	M. Underwood	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established		TBC		H. Flavell	M. Underwood	

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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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	C. McInnes	

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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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence	

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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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	M. Underwood	
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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	M. Underwood	
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 SBAR to enable all staff to escalate and communicate their concerns.	Y	30/03/22	31/12/22	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence & C. McInnes	

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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	30/11/23	Not Yet Delivered	Not Started			31/03/24		H. Flavell	A. Lawrence	
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	30/11/23	Not Yet Delivered	Not Started			31/03/24		H. Flavell	A. Lawrence	

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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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence	
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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	30/11/23	Not Yet Delivered	Not Started			31/03/24		H. Flavell	C. McInnes	
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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence & M. Underwood	
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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	A. Lawrence, M. Underwood & C. McInnes	

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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	30/11/23	Not Yet Delivered	Not Started			31/03/24		H. Flavell	A. Lawrence & C. McInnes	
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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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	M. Underwood	
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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence, M. Underwood & C. McInnes	
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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrece & M. Underwood	

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Local Actions For Learning Theme 17: Specific to Midwifery-Led Units and Out-Of-Hospital Births													
14.47	Midwifery-led units must complete yearly operational risk assessments.	Y	30/03/22	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established		TBC		H. Flavell	A. Lawrence	
14.48	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Y	30/03/22	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established		TBC		H. Flavell	A. Lawrence	
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 outof-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.	Y	30/03/22	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established		TBC		H. Flavell	A. Lawrence	

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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	31/05/23	Not Yet Delivered	Not Started			31/08/23		H. Flavell	M. Underwood	

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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	30/09/22	Not Yet Delivered	Not Started			31/01/23		John Jones		
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	30/11/23	Not Yet Delivered	Not Started			31/03/24		H. Flavell	John 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	31/05/23	Not Yet Delivered	Not Started			31/08/23		H. Flavell	John 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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	John Jones	

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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	31/05/23	Not Yet Delivered	Not Started			31/08/23		H. Flavell	John Jones	

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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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	M. Underwood	
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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	C. McInnes	
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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	C. McInnes	
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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	C. McInnes	

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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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established		TBC		H. Flavell	M. Underwood	

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The Shrewsbury and

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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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	M. Underwood	
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Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
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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	30/03/22	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established		TBC		H. Flavell	C. McInnes	

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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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established		TBC		J. Jones	H. Flavell	
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	Not Started	Action pending further analysis before deadlines can be established		TBC		J. Jones	H. Flavell	

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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
<b>Immediate and Essential Action 1: Workforce planning And Sustainability</b> 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	TBC	Not Yet Delivered	Not Started	Action linked to external dependencies. Further analysis needed before deadlines can be established.		TBC		J. Jones	H. Flavell	
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	Not Yet Delivered	Not Started			31/03/24		J. Jones	H. Flavell	
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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	C. McInnes	
1.4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH	Y	30/03/22	TBC	Not Yet Delivered	Not Started	Action linked to external dependencies. Further analysis needed before deadlines can be established.		TBC		J. Jones	H. Flavell	
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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	A. Lawrence	

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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	31/05/23	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	A. Lawrence	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	C. McInnes, M. Underwood, A. Lawrence	
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	Not Started	Action linked to external dependencies. Further analysis needed before deadlines can be established.		TBC		J. Jones	H. Flavell	

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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.

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### APPENDIX ONE - FINAL OCKENDEN REPORT ACTION PLAN (2022)

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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	C. McInnes	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence	
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	31/05/23	Not Yet Delivered	Not Started			31/08/23		H. Flavell	M. Underwood	
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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence	

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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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	M. Underwood	

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<b>Immediate and Essential Action 3: Escalation and Accountability</b> 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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	
3.3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Y	30/03/22	31/07/22	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence	
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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	M. Underwood	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood, C. McInnes, A. Lawrence	

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<b>Immediate and Essential Action 4: Clinical Governance - Leadership</b> 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.													

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4.1	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Y	30/03/22	31/07/22	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence, C. McInnes, M. Underwood	
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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	C. McInnes	
4.3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Y	30/03/22	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		J. Jones	H. Flavell	
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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence	
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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence	
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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence, M. Underwood	
4.7	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Y	30/03/22	31/07/22	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence, M. Underwood	

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<b>Immediate and Essential Action 5: Clinical Governance - Incident Investigation and Complaints</b>													
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	A. Lawrence	

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5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan	Y	30/03/22	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood, A. Lawrence	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	A. Lawrence, M. Underwood	
5.4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Y	30/03/22	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood, A. Lawrence	
5.5	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	Y	30/03/22	31/12/22	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	A. Lawrence	
5.7	Complaints themes and trends must be monitored by the maternity governance team.	Y	30/03/22	31/07/22	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence	

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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	Not Started	Action linked to external dependencies. Further analysis needed before deadlines can be established.		TBC		J. Jones	H. Flavell	
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	TBC	Not Yet Delivered	Not Started	Action linked to external dependencies. Further analysis needed before deadlines can be established.		TBC		J. Jones	H. Flavell	
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	TBC	Not Yet Delivered	Not Started	Action linked to external dependencies. Further analysis needed before deadlines can be established.		TBC		H. Flavell	M. Underwood, A. Lawrence	

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<b>Immediate and Essential Action 7: Multidisciplinary Training</b> 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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	C. McInnes	
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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	C. McInnes, A. Lawrence, M. Underwood	
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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	C. McInnes, A. Lawrence, M. Underwood	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	
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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	C. McInnes, A. Lawrence, M. Underwood	
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	30/11/23	Not Yet Delivered	Not Started			31/03/24		H. Flavell	C. McInnes, A. Lawrence, M. Underwood	

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CONFIRMED POSITION AS AT 10.05.2022  
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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	Not Yet Delivered	Not Started			31/03/24		H. Flavell	C. McInnes, A. Lawrence, M. Underwood	
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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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	

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<b>Immediate and Essential Action 9: Preterm Birth</b> 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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	M. Underwood	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	
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	TBC	Not Yet Delivered	Not Started	Action linked to external dependencies. Further analysis needed before deadlines can be established.		TBC		H. Flavell	J. Jones	
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	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	

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<b>Immediate and Essential Action 10: Labour and Birth</b> 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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence, M. Underwood	

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10.2	Midwifery-led units must complete yearly operational risk assessments.	Y	30/03/22	30/09/22	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence	
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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence	
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	31/05/23	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence, M. Underwood	
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	31/05/23	Not Yet Delivered	Not Started			31/08/23		H. Flavell	A. Lawrence, M. Underwood	
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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	M. Underwood	

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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	TBC	Not Yet Delivered	Not Started	Further analysis required with colleagues from Anaesthetics Division before deadlines can be established.		TBC		H. Flavell	J. Jones	
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## CONFIRMED POSITION AS AT 10.05.2022

### APPENDIX ONE - FINAL OCKENDEN REPORT ACTION PLAN (2022)

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	TBC	Not Yet Delivered	Not Started	Further analysis required with colleagues from Anaesthetics Division before deadlines can be established.		TBC		H. Flavell	J. Jones	
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	TBC	Not Yet Delivered	Not Started	Further analysis required with colleagues from Anaesthetics Division before deadlines can be established.		TBC		H. Flavell	J. Jones	
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	Not Started	Further analysis required with colleagues from Anaesthetics Division before deadlines can be established.		TBC		H. Flavell	J. Jones	
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	TBC	Not Yet Delivered	Not Started	Further analysis required with colleagues from Anaesthetics Division before deadlines can be established.		TBC		H. Flavell	J. Jones	
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	TBC	Not Yet Delivered	Not Started	Further analysis required with colleagues from Anaesthetics Division before deadlines can be established.		TBC		H. Flavell	J. Jones	

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11.7	Obstetric anaesthesia staffing guidance to include:  The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.	Y	30/03/22	TBC	Not Yet Delivered	Not Started	Further analysis required with colleagues from Anaesthetics Division before deadlines can be established.		TBC		H. Flavell	J. Jones	
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	TBC	Not Yet Delivered	Not Started	Further analysis required with colleagues from Anaesthetics Division before deadlines can be established.		TBC		H. Flavell	J. Jones	

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<b>Immediate and Essential Action 12: Postnatal Care</b> 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 nonmaternity ward.	Y	30/03/22	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	
12.2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum	Y	30/03/22	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	
12.3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	Y	30/03/22	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood	
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	TBC	Not Yet Delivered	Not Started	Action pending further analysis before deadlines can be established.		TBC		H. Flavell	M. Underwood, C. McInnes	

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<b>Immediate and Essential Action 13: Bereavement Care</b> 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	Not Yet Delivered	Not Started			31/01/23		H. Flavell	A. Lawrence	
13.2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about postmortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of postmortem examinations.	Y	30/03/22	31/12/22	Not Yet Delivered	Not Started			30/04/23		H. Flavell	A. Lawrence	
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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence, M. Underwood	
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	Delivered, Not Yet Evidenced	On Track	Action already in place (Apr-22 gap analysis) - Action accepted as 'delivered, not yet evidenced' at May MTAC		30/09/22		H. Flavell	A. Lawrence, M. Underwood	

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<b>Immediate and Essential Action 14: Neonatal Care</b> 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	TBC	Not Yet Delivered	Not Started	Action linked to external dependencies. Further analysis needed before deadlines can be established.		TBC		J. Jones	H. Flavell	
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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	M. Underwood	

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# CONFIRMED POSITION AS AT 10.05.2022 APPENDIX ONE - FINAL OCKENDEN REPORT ACTION PLAN (2022)

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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	M. Underwood	
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	30/09/22	Not Yet Delivered	Not Started			31/01/23		J. Jones	H. Flavell	
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	30/09/22	Not Yet Delivered	Not Started			31/01/23		J. Jones	H. Flavell	
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	Not Yet Delivered	Not Started			31/08/23		H. Flavell	M. Underwood	

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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	Not Yet Delivered	Not Started			30/04/23		H. Flavell	M. Underwood	
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	30/11/23	Not Yet Delivered	Not Started			31/03/24		H. Flavell	C. McInnes, M. Underwood	

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<b>Immediate and Essential Action 15: Supporting Families</b> 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	TBC	Not Yet Delivered	Not Started	Action linked to external dependencies. Further analysis needed before deadlines can be established.		TBC		H. Flavell	C. McInnes	
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	TBC	Not Yet Delivered	Not Started	Action linked to external dependencies. Further analysis needed before deadlines can be established.		TBC		H. Flavell	C. McInnes	
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	TBC	Not Yet Delivered	Not Started	Action linked to external dependencies. Further analysis needed before deadlines can be established.		TBC		H. Flavell	C. McInnes	

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MATERNITY SERVICES - OCKENDEN REPORT ACTION PLAN

The Shrewsbury and  
Telford Hospital  
NHS Trust

Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

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

Accountable Executive and Owner Index

Name	Title and Role	Project Role
Hayley Flavell	Executive Director of Nursing	Overall MTP Executive Sponsor
John Jones	Executive Medical Director	Overall MTP Executive co-sponsor
Martyn Underwood	Medical Director, Women & Children's Division	Senior Responsible Officer, MTP and Accountable Action Owner
Guy Calcott	Obstetric Consultant	Lead: Clinical Quality and Choice Workstream
Vicki Robinson & Claire Eagleton	W&C HRBP / Deputy Director of Midwifery	Co-Leads: People and Culture Workstream
Annemarie Lawrence	Director of Midwifery	Lead: Risk and Governance Workstream and Maternity Improvement Plan and Accountable Action Owner
William Parry-Smith	Obstetric Consultant	Lead: Learning, Partnerships and Research Workstream
Mei-See Hon	Clinical Director, Obstetrics Director of Operations,	Lead: Communications and Engagement Workstream

Carol McInnes

Women & Children's Division

Accountable Action Owner