Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group - UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together (Public)					
Date of the meeting:	9 April 2026					
Title:	3.1 (Paper G) Perinatal Report and Dashboards					
Report presented by:	Julie Hogg, Group Chief Nurse (UHL & UHN) & Deputy Chief Executive (UHL) Danni Burnett, Director of Midwifery and Deputy Chief Nurse (UHL) & Interim Director of Midwifery (UHN)					
Report written by:	Danni Burnett, Director of Midwifery and Deputy Chief Nurse (UHL) & Interim Director of Midwifery (UHN) Karradene Aird, Interim Head of Midwifery (UHL) Angela Boyce, Head of Perinatal Governance & Quality Improvement (UHN)					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	X
Where this report has been discussed previously	UHL Womens & Children's CMG and UHN Family Health Divisional Governance / UHL Perinatal Assurance Committee (PAC) / UHN PAC (March 2026)					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which

Current UHL Clinical Management Group (CMG) and UHN Family Health Care Group risks indicate challenges around workforce and culture, please read this report alongside corporate risks to consider any additional actions and mitigations.

Impact Assessment

Finance: UHL is on track and expected to recover its full NHS Resolution's Maternity Incentive Scheme (MIS) for Year 7. UHN is on track and expected to recover its full NHS Resolution's Maternity Incentive Scheme (MIS) for Year 7 for NGH however not KGH.

Legal/regulatory: The Trusts must continue to comply with all CQC regulatory requirements which is requiring timely, evidenced improvement and ongoing engagement with the regulator. In addition to meeting statutory obligations for Duty of Candour UHL and UHN must fulfil national patient-safety reporting duties, including timely referrals to the Maternity and Newborn Safety Investigations (MNSI) programme and adherence to the Patient Safety Incident Response Framework (PSIRF). For NHS Resolution's Maternity Incentive Scheme, the Boards must ensure full, accurate declarations including disclosure of relevant external regulatory findings supported by appropriate governance and Boards' approval. Failure to sustain safe staffing, training compliance, escalation processes and adherence to clinical standards may increase legal exposure through claims, inquests or enforcement actions

Equality: UHN and UHL PAC has given due consideration to the potential equality and health-inequality implications. In particular, PAC reflected on the importance of ensuring sustained improvements to culture and inclusivity across the service. Actions are being taken to ensure personalised risk assessment, communication, and midwifery competency frameworks support equitable access and safe care for all women and birthing people. No adverse impacts have been identified at this stage, and equality considerations will continue to be embedded and monitored through established perinatal governance and EDI oversight mechanisms as the work progresses.

Appendices

Perinatal dashboards for UHL (G2) and UHN (G3)

Executive Summary

The Perinatal Report provides a consolidated overview of perinatal quality, safety, performance, workforce and experience across UHL, KGH and NGH (UHN). The overall system position remains stable and improving, with strong assurance against core maternity and neonatal standards, no service diversions, and a maturing safety and reporting culture. UHL continues to show sustained improvement in key outcomes and avoidable term admissions, while KGH and NGH maintain expected performance with targeted oversight in areas such as neonatal mortality variation (KGH) and operational flow (NGH).

Workforce resilience is strengthening across all sites—UHL now has 0% midwifery vacancy, NGH has a significant pipeline of new starters, and KGH staffing trajectories are improving. Safety-culture indicators show clear positive movement, particularly through increased safety-champion activity across UHN.

Operational performance is robust, with stable escalation status across all Trusts. Experience remains positive, with consistently high FFT satisfaction and strengthened community engagement, especially at UHL. Quality outcomes, while generally stable, continue to show variation in preterm birth, early booking, smoking in pregnancy and IOL timeliness; these are being addressed through targeted PSIP actions and strengthened governance.

Recommendation

The Boards are asked to note and indicate assurance in respect of the consolidated position, acknowledge key risks, and support continued oversight of data quality, workforce sustainability and cultural improvement.

Specifically:

1. UHL and UHN Boards to **support** ongoing work to stabilise data quality, improve interoperabili and ensure credible, trend data across all three organisations.
2. UHL and UHN Boards to **note** ongoing recruitment and retention efforts, cross-site leadership alignment, consultant workforce planning, and targeted investment in specialist roles to secure sustainable service delivery.
3. UHL and UHN Boards to **note** PAC's intention to oversee equity-focused improvement and early-access interventions through PSIP
4. UHN Board to **note** the development of a single, strengthened, Northamptonshire Homebirth Service, ensuring reopening criteria, training, competencies and governance are fully met befo reinstatement.
5. UHL and UHN Boards to **support** the accelerated delivery of PSIP quality improvement initiatives, strengthening responsiveness and effectiveness across elective pathways and triag
6. UHL and UHN Boards to **note** delivery and integration of national programmes to support alignment of the Maternal Care Bundle (MCB), Saving Babies' Lives, Ockenden requirements, and MIS Year 8 within PSIP governance

UHL & UHN PERINATAL REPORT (MARCH 2026)

The purpose of this paper is to provide the Boards with a consolidated, system-wide overview of perinatal quality, safety, performance, workforce and experience across University Hospitals of Leicester (UHL) and University Hospitals of Northamptonshire (KGH and NGH). It brings together intelligence from the latest PAC Chair's Highlight Reports, Perinatal Scorecards and key assurance papers to give the Board clear line-of-sight on current performance, areas of improvement, outstanding risks, and the maturity of the Perinatal Safety Improvement Programme (PSIP) across the system.

1. PERINATAL SERVICES SUMMARY

Across perinatal services, the overall safety picture remains stable and improving, with strong assurance in core maternity and neonatal standards, robust reporting cultures and maturing digital infrastructure. Despite continued pressures in workforce and estates, all three organisations have maintained resilient operational performance, with no service suspensions, diversions or unsafe escalation outcomes. Our PSIP is increasingly acting as the unifying framework for consistent improvement in variation, workforce sustainability, data maturity and equity.

Across UHN and UHL, clinical outcomes remain within expected variation. UHL continues to demonstrate progressive improvement in perinatal safety indicators, including reductions in Obstetric Anal Sphincter Injury (OASI)[i], postpartum haemorrhage and avoidable term admissions (ATAIN).

Across all organisations, no new systemic safety risks have been identified through MOSS (Maternity Outcomes Signal System), Perinatal Mortality Review Tool (PMRT) or Patient Safety Investigation (PSII) processes, although KGH continues to require targeted oversight for neonatal mortality trends and fetal surveillance, and UHL is undertaking more detailed analysis of emerging preterm-birth variation.

2. PERINATAL SURVEILLANCE & ASSURANCE HIGHLIGHTS

PAC members received several papers as part of ensuring robust perinatal surveillance, highlighting areas of progress and risks to delivery of the key national and regional drivers for change and improvement:

a) Workforce & Culture

Workforce pressures remain a defining challenge, but overall indicators are improving. UHL is currently the strongest-performing site with 0% midwifery vacancies and improving neonatal staffing. KGH and NGH both report robust recruitment pipelines, including >12 whole-time equivalent (WTE) midwives commencing at NGH by September, and improved midwifery and

neonatal staffing trajectories at KGH. Medical workforce resilience continues to require focus, with NGH reliant on a locum obstetrician until June and UHL holding several consultant vacancies.

Culture is strengthening across UHN: safety-champion reporting has grown from 18 actions (2024) to 63 (2025), with most actions closed—demonstrating enhanced psychological safety, earlier escalation and maturing learning behaviours.

b) Performance

No sites reported whole service diversion or critical incidents linked to capacity over the most recent reporting period.

- UHL saw improved OPEL (operational performance escalation) stability through February with low numbers of red-flag events and sustained timely MAU triage performance.
- NGH maintained OPEL 1 throughout February with no escalations, though variation persists in Induction of Labour (IOL) flow and triage timeliness.
- KGH performed more consistently than NGH in time-critical obstetric metrics, although the temporary homebirth pause has added operational and governance demands.

Screening and immunisation programmes remained stable across the system, with persistent variation in RSV (Respiratory Syncytial Virus), pertussis and equity-related access. BadgerNet Electronic Patient Record (EPR) rollout has improved tracking and reporting, although sites remain at different stages of digital maturity.

c) Experience & Engagement

Experience remains consistently positive across UHN, particularly regarding staff compassion and intrapartum care. NHS Friends and Family Test (FFT) satisfaction remains high (97–100%), though response rates are more variable due to demographic factors and EPR transition.

Patient experience data demonstrated a mixed picture at UHL. Maternity complaints reduced to their lowest level since August 2025, with no complaints received in neonatal services. Positive feedback continues to be received for the Single Point of Contact model, community midwifery and intrapartum care. Targeted improvement work within the Maternity Assessment Unit (MAU) and postnatal services is ongoing. A notable system strength is UHL's community engagement, delivering almost 20 events against a target of five, significantly improving equity of access and population reach.

Communication, waiting times and the postnatal environment remain the principal themes, with targeted PSIP actions underway across UHN and UHL.

d) Quality & Outcomes

Across UHL, KGH and NGH, there is evidence of stable and improving perinatal outcomes however variation persists. It is well-recognised and supported by targeted improvement programmes within the Perinatal Safety Improvement Programme (PSIP) with oversight by PAC:

Perineal Trauma / Intrapartum Injury	Instrumental birth, shoulder dystocia, and intrapartum complication rates remain within expected limits across UHL and UHN. **UHL continues to show sustained reductions in perineal trauma**, supported by strengthened PPHS pathways, warm compress guidance, and full compliance with OASI referral processes. **UHN performance remains within expected variation**; fluctuations are linked to small numbers.
Postpartum Haemorrhage (PPH)	**UHL continues to improve**, and **UHN remains stable** across both sites.
Preterm Birth	**UHL remains an area of special cause variation**; a deep dive is planned for May 2026. Early evidence suggests links to clinical complexity rather than pathway failures. UHN shows expected month to month variation; KGH shows greater fluctuation due to low numbers. System improving risk identification via enhanced surveillance and the *"Period Late, Tell Us by 8"* campaign.
Access: Early Booking (<10 weeks)	**73%** of UHL women book early, though **Black African/Black Caribbean women are 1.6 times more likely to book late**. **NGH performs strongly; KGH shows variation** linked to deprivation. New equalities dashboards (local + national) are driving targeted outreach and PSIP actions.
Smoking in Pregnancy	UHL performs **better than the 6% target**. NGH meets target. KGH remains variable and a priority for joint work with public health partners.
Avoidable Term Admissions (ATAIN)	UHL remains within national standards (5.8% for 2024/25), with a **44% reduction in hypoglycaemia admissions**. Thermal regulation is the next improvement focus. UHN remains within expected limits with no outlier concerns.
Neonatal Mortality	**UHL unvalidated data reports the lowest levels in a decade (2025)**. NGH stable. **KGH and UHL remain under enhanced**

	monitoring with system level work on wider determinants. An **LLR Infant Mortality System Meeting** has occurred during this reporting period - well attended, bringing together all key stakeholders from UHL, CDOP, Public Health, Primary Care and MBRRACE. CDOP and Public Health delivered excellent presentations outlining Leicester's infant mortality position, followed by open and constructive discussion. A series of workshops generated collective ideas for reducing infant mortality. Public Health are now collating the outputs and establishing a stakeholder group to take forward the agreed actions.
Incident Reporting & Learning	Reporting remains high across all three sites, reflecting strong safety culture and early escalation. No new MOSS alerts at UHN; one Level1 alert at UHL with no avoidable harm. PSII, MNSI, and PMRT processes remain within required timescales, with UHN strengthening cross site governance.

Please refer to **Appendix 1 for a site-specific summary**, and Appendix 2, 3, 4, and 5 for the relevant Perinatal Scorecards and PAC Chair Highlight Reports.

3. ADDITIONAL PERINATAL HIGHLIGHTS

PAC received progress reports on the implementation of the actions in relation to the Perinatal Safety Improvement Programme (PSIP) and wider perinatal assurance:

KGH MatNeoIST Improvement Programme: The PSIP programme has established a coherent regulatory-recovery framework that is delivering clearer oversight, faster escalation and stronger Board assurance as the vehicle for improvement as part of KGH and the MatNeoIST programme. Improvements through the milestone monitoring have been consistently high for consultant labour-ward presence, BSOTS (Birmingham triage system) performance, neonatal equipment and theatre-medicines safety, alongside early positive cultural gains in psychological safety, leadership visibility, civility and speaking-up, with remaining work on estates, documentation, specialist workforce and pathway embedding still required but overall demonstrating increasing maturity, reliability and clear progress toward regulatory recovery and eventual MatNeoIST exit.

UHL Complaints: The maternity complaints deep-dive showed that a temporary rise in complaints was linked to operational pressure rather than declining quality, with timely reporting improving, themes remaining consistent (communication, compassion and delays), no evidence of inequity or

unsafe care, and clear actions already in place to strengthen responsiveness and patient experience.

Director of Midwifery Highlight Report: outlines significant national, regional and local developments shaping maternity and neonatal services, including preparations for the CQC Maternity Survey, early findings from the interim Amos report, and implementation planning for the new Maternal Care Bundle, alongside important population insights from the National Perinatal Health Inequalities Dashboard which will inform targeted improvements; the report highlights ongoing escalation of the Perinatal Pelvic Health Service, progress with reconciling workforce data following regional scrutiny, and an update on the NHS England Perinatal Heatmap. PAC were briefed on the implementation of the new cross-site Midwifery Management of Change to strengthen leadership and governance at UHN plus the emerging strategic planning through the UHN/UHL Group Clinical Strategy.

4. PERIANTAL SURVEILLANCE & ASSURANCE FOR ESCALATION

PAC was assured that each service continues to operate safely and effectively, with strong assurance in core maternity and neonatal standards. The predominant challenges relate to variation, data maturity, workforce sustainability, and equity, all of which are being managed through strengthened governance, PSIP oversight, and targeted local actions.

- Variation in perinatal outcomes and operational metrics, particularly triage and Induction of Labour (IOL) timeliness
- Data maturity challenges associated with BadgerNet rollout across UHL and UHN.
- Homebirth governance at KGH with the recent pause to due inability to safety staff. UHL and NGH model are assured but national guidance updates pending.
- Fetal medicine / Sonography / Diabetes capacity constraints across all sites, requiring estate and digital investment (CRIS® replacement, BadgerNet imaging integration). Work being prioritised as part of the Group Clinical Strategy.
- Equity in access with late bookings and socioeconomic and ethnicity-linked variation remain visible across UHL and UHN.

The Boards are invited to note this consolidated narrative and endorse the ongoing UHL & UHN focus on harmonising pathways, strengthening digital maturity, and addressing operational variation across the three organisations.

5. RECOMMENDATIONS

7. UHL and UHN Boards to **support** ongoing work to stabilise data quality, improve interoperability and ensure credible, trend data across all three organisations.

8. UHL and UHN Boards to **note** ongoing recruitment and retention efforts, cross-site leadership alignment, consultant workforce planning, and targeted investment in specialist roles to secure sustainable service delivery.
9. UHL and UHN Boards to **note** PAC's intention to oversee equity-focused improvement and early-access interventions through PSIP
10. UHN Board to **note** the development of a single, strengthened, Northamptonshire Homebirth Service, ensuring reopening criteria, training, competencies and governance are fully met before reinstatement.
11. UHL and UHN Boards to **support** the accelerated delivery of PSIP quality improvement initiatives, strengthening responsiveness and effectiveness across elective pathways and triage
12. UHL and UHN Boards to **note** delivery and integration of national programmes to support alignment of the Maternal Care Bundle (MCB), Saving Babies' Lives, Ockenden requirements, and MIS Year 8 within PSIP governance

University Hospitals Leicester (UHL)	• UHL continues to demonstrate a strengthening safety trajectory, with Q3 data confirming reductions in OASI, PPH, and term neonatal admissions, and 100% Duty of Candour compliance. • The first MOSS Level 1 alert was fully reviewed with no avoidable harm, no service quality concerns identified. February scorecard data showed stability, with Apgar<7 and preterm birth requiring ongoing analysis but no emerging systemic risk. Sepsis management remains highly reliable (98% antibiotics within 1 hour) and assessment of unwell postnatal women continues to meet national standards. • Midwifery vacancies have reduced to zero, with improved sickness absence and progress in neonatal-nursing recruitment. Consultant obstetric recruitment is underway with additional pipeline activity in junior medical workforce expansion. Cultural and engagement indicators are improving. • Operational pressures earlier in the period did not translate into adverse outcomes. February saw improved escalations, sustained MAU timeliness, and stable IOL and caesarean section metrics. No service suspensions or significant risks were identified. • Complaints have stabilised at low levels, with positive intrapartum and community feedback. Themes remain centred on communication and waiting times. Community engagement reached record levels, demonstrating improved reach across diverse groups. • UHN's asylum-seeking women's project achieved 80% antenatal and 60% postnatal continuity, recognised as a top three national Core20PLUS5 programme. • UHL continues to embed immunisation prompts through digital platforms and multi-agency partnership working: RSV uptake remains a concern, with early implementation challenges linked to administrative gaps and booking processes. Uptake is improving following recruitment of administrative support and expansion of community follow-up. Pertussis vaccination shows steady performance with common-cause variation around a stable mean and no significant deterioration. Flu vaccination continues to follow expected seasonal patterns, with robust forward planning for 2026–27 vaccine ordering. BCG uptake remains below target, though collaborative work across NHSE, LPT and CHIS is underway to improve coverage and reconcile movers in/out of area. • UHL maintains full MIS Year 7 compliance, strong Perinatal Safety Improvement Programme (PSIP) progress, positive Ockenden trajectories, and maturing digital safety systems. • Risks relate to fetal medicine estates, data quality, and MAU capacity, all actively managed through governance channels.

Kettering General Hospital (KGH)	• KGH continues to provide safe, stable maternity and neonatal services, though areas requiring targeted oversight persist, particularly neonatal mortality trends and fetal surveillance quality. An external thematic review of cooled babies described generally strong escalation and CTG practices, though targeted actions are underway to strengthen variation across all cases. • Ongoing PSII cases are progressing appropriately, with no MOSS and 1 SPEN[ii] signals reported (Q3). • National Neonatal Audit Programme (NNAP) 2024 results were strong, with excellent performance in magnesium sulphate use, deferred cord clamping, admission temperature, and parental consultation • Workforce stability continues to improve, supported by cultural-development programmes and strengthened senior leadership. Midwifery vacancies remain but are reducing, and neonatal staffing is progressing well. Consultant workforce planning is underway to ensure sustainable leadership. • KGH performs consistently across time-critical categories such as Category 1/2 caesarean and IOL flow. • The homebirth service was paused as a precaution following national PFD learning, with a robust recovery plan and strengthened governance in place. • FFT promoter rates remain high (approaching 100%). Experience insight themes include communication, discharge delays and clarity of plans of care. Improvement projects are underway to address these concerns. • KGH's immunisation activity in February shows steady performance across pertussis, RSV, flu and neonatal BCG programmes, with clear documentation of accepted/declined vaccinations. The site continues to deliver its antenatal immunisation activity consistently, with no safety concerns raised. • While seven MIS Safety Actions were achieved, three (1, 4, 5) did not fully meet the required evidence standard, impacting CNST incentive recovery. Action plans are in place and monitored through PSIP and PAC.
Northampton General Hospital (NGH)	• NGH continues to demonstrate strong clinical outcomes with exceptional NNAP performance, particularly with zero bloodstream infections, high-quality stabilisation at birth, and strong parental-consultation standards. • Workforce pressures increased due to repurposing of Band 3 roles, but significant recruitment is in progress (over 12 WTE scheduled to join between March and September). Obstetric and anaesthetic staffing remain areas for ongoing focus, with reliance on locum cover until summer 2026. • NGH maintained OPEL 1 throughout February but displays the greatest operational variation across the system, particularly in triage performance, IOL median waits and Category 1–2 response times. BadgerNet rollout is contributing to some data instability. Targeted recovery work is active and supported by regional PSIP alignment.

	• NGH exceeded FFT response targets (26%) with sustained high satisfaction (97–100%). Communication and discharge delays remain consistent themes. New discharge-education videos are now deployed Trust-wide. • NGH's antenatal immunisation uptake is the strongest across the system, supported by three community clinics that have improved accessibility and reduced pressure on hospital settings: Pertussis 62.3%, RSV 89.7%. Strong alignment with flu vaccination pathways, with detailed month-by-month tracking. NGH's community-based model is reportedly improving BCG uptake and overcoming estate constraints affecting hospital delivery. • NGH fully met all MIS Year 7 requirements. CQC must/should actions are largely complete, though medicines management and ward-security actions remain open and are progressing to plan.

[i] An OASI is an obstetric anal sphincter injury that can occur during vaginal birth, also referred to as severe perineal tearing or third- and fourth-degree
[ii] (SPEN) Submit a Perinatal Event Notification is a one-stop service designed for reporting specific perinatal safety events to NHS Resolution

University Hospitals of Leicester NHS Trust

Perinatal Quality Assurance Scorecard

February 2026

Data presented in this scorecard is sourced from Badgernet following the Trust's transition to a new Electronic Patient Record system. Data quality assurance and validation are ongoing as part of this transition. The figures shown represent the best available data at the time of reporting and may be subject to minor revision as validation continues.

CONTENTS

University Hospitals of Leicester NHS Trust

SUMMARY

Activity reduced in February 2025, with fewer OPEL escalations and low numbers of midwifery red flags, and MAU triage consistently met BSOTS standards. Maternity complaints fell to their lowest level since August 2025, although communication continues to be a recurring theme, and FFT response and promoter rates remained below national averages despite positive feedback for SPOC, community midwifery and intrapartum care. Key improvement areas include MAU waiting times and postnatal experience. No new PSIIs were commissioned, one case was escalated to MNSI and one final report was received with a single recommendation; two moderate-harm incidents occurred and learning has been triangulated through the perinatal improvement programme. Clinical indicators were largely stable, with favourable smoking and stillbirth rates but increased Apgar <7 and preterm birth rates. Workforce measures improved, including reduced sickness, ongoing recruitment across all staff groups, and progress with neonatal and obstetric consultant appointments, and MIS Safety Action 8 compliance remained strong as preparations continue for the 2026/27 education programme.

Clinical Quality and Safety

No new Patient Safety Incident Investigations (PSIIs) were commissioned in February. One case was referred to the Maternity and Neonatal Safety Investigation (MNSI) programme and accepted for national investigation, and one final MNSI report was received with a single safety recommendation and no safety prompts. Two moderate-harm incidents were reported across maternity and neonatal services. Learning continues to be reviewed and triangulated through the Perinatal Safety Improvement Programme to inform ongoing safety improvement.

Outcomes

Clinical quality indicators across antenatal, intrapartum and neonatal care remained broadly stable during February, with the majority of measures demonstrating common cause variation. Smoking at both booking and delivery continued to perform favourably against target. Intrapartum outcomes, including third- and fourth-degree tears, postpartum haemorrhage ≥1500ml and breastfeeding at discharge, remained stable, providing assurance of consistent performance. An increase was observed in Apgar scores <7 at 5 minutes and in preterm births, with preterm birth continuing to demonstrate special cause variation, largely associated with clinical complexity and iatrogenic factors. Stillbirth rates remained low and stable, with no emerging upward trend.

Workforce

Active recruitment continues across Midwifery and Neonatal Nursing to address outstanding vacancies. Sickness absence improved in month across nursing and midwifery. Midwifery vacancies remain low and neonatal nursing vacancies have begun to reduce with a further pipeline of 6 wte nurses recruited. Turnover rates remain low compared to the Trust and national average. Recruitment to neonatal consultant posts is now complete with all posts now filled and one consultant obstetrician has been recruited following interview. Further recruitment is pending to continue to strengthen medical workforce resilience. Increased establishment for junior medical workforce has now been agreed and recruitment is underway to fill these posts.

Training and Compliance

Compliance across all three MIS Safety Action 8 targeted training areas remained stable during February, with performance sustained above the internal benchmark of 80%. This reflects consistent delivery of core safety and quality training. Priorities remain strengthening training coordination and governance alignment, while the Maternity and Neonatal Education teams continue development of the 2026/27 Education Programme, due to launch in April 2026.

Operational and Capacity

Activity reduced during February, with a corresponding improvement in OPEL Level 2 and 3 escalations. A small number of OPEL Level 4 episodes were recorded, with no associated safety incidents. Induction of labour and caesarean section rates remained stable. Red Flags reduced and remained low for the month (n=5). Performance within Maternity Assessment Unit remained timely, with an average triage time of 10 minutes; 79% of women were triaged within 15 minutes and 95% within 30 minutes, consistent with BSOTS national recommendations.

Experience

Maternity complaints reduced this month and lowest since August 2025 (n=9), with no complaints received in Neonatal Services. No clear themes this month however communication remains a concern. FFT response and promotor rates below national average however accurate monthly totals impacted by Badgernet launch and addition of 3 new surveys. Positive feedback noted for Single Point of Contact, community midwifery and intrapartum care with focus needed on wait times in Maternity Assessment Unit and postnatal ward environment. Successful Meet the Experts event held this month at LGH with >100 attendees. Free parking (up to 7 days) now offered to support bereaved families.

FEBRUARY 2026 AT A GLANCE

AVERAGES PER DAY

BOOKINGS **32**

BIRTHS **27**

BABIES BORN

757

PREV. 12 MONTH AV. 800

BIRTH LOCATION

LRI	ST MARY'S
451	**0**
LGH	**HOME**
288	**18**

3RD & 4TH DEGREE TEARS

1.9%

Jan 2.5% ▼

BLOOD LOSS >1,500MLS

3.1%

Jan 2.9% ▲

367 GIRLS

384 BOYS

PREV. 12 MONTH AVERAGE
383 GIRLS, 413 BOYS

FULL TERM BABIES ADMITTED TO NNU

5.3%

Jan 5.7% ▼

INDUCTION OF LABOUR (IOL)

29.3% PREV. 12 MONTHS – 30.8%

344 CAESAREAN SECTIONS

	JAN	PREV 12 MTH. AV.
ELECTIVE	123 (16.4%)	143 (18.0%)
EMERGENCY	221 (29.5%)	221 (27.8%)

SETS OF TWINS

15

SETS OF TRIPLETS

0

ASSISTED BIRTHS

82

VENTOUSE	FORCEPS
26	**56**

PREV. 12 MONTH AV.

VENTOUSE	FORCEPS
31	**61**

BREASTFEEDING INITIATION

74.5%

PREV. 12 MONTHS – 67.3% ▲

NHS

FEBRUARY 2025 AT A GLANCE

93%

MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

Exc Med. Staff starting >1st Jul 25

January- 92%

100%

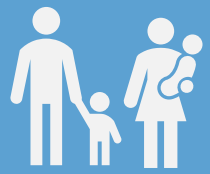
YEAR 7 MATERNITY INCENTIVE SCHEME 10 SAFETY ACTIONS

1

MNSI REPORTABLE CASES & REFERRED

January - 1

11.5%



January 16.9%

MATERNITY FRIENDS & FAMILY TEST (RESPONSE RATE)

89%

January 84.4%

MATERNITY FRIENDS & FAMILY TEST (PROMOTER RATE)

VACANCY RATE

MIDWIVES January –void	1.0%
CONSULTANT OBSTETRICIAN	5 WTE
NEONATAL NURSES	8.0%
NEONATOLOGISTS	8.1%

2 MODERATE INCIDENTS

January - 3

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)

89%

January– 89%

0 PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

January - 0

0 CORONER'S REGULATION 28

January - 0

MINIMUM SAFE STAFFING MET (MATERNITY YTD)

Data not available

September– 93.9%

1:1 CARE IN LABOUR **100%**

January- 100%

NHS

IN FOCUS – Clinical Quality Surveillance

Data sourced from Badgernet. Validation is ongoing following EPR transition.

University Hospitals of Leicester NHS Trust

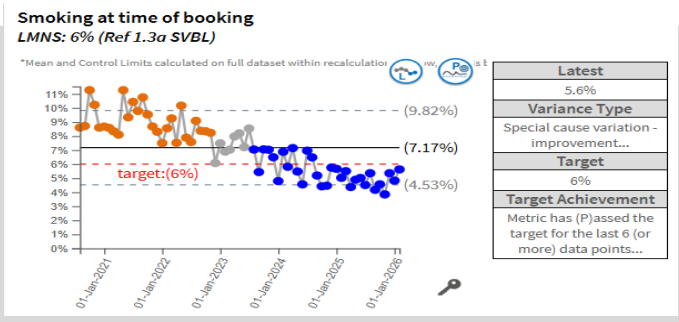
Summary

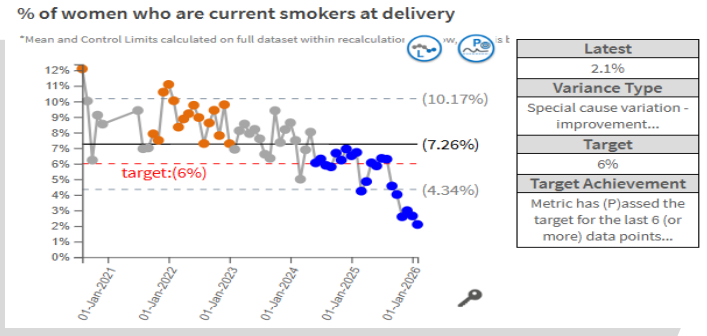
CQIMs continue to demonstrate common cause variation (see slide 16). A reduction has been observed in both postpartum haemorrhage and third- and fourth-degree tears. There has been a slight increase in stillbirths and preterm births during this period, with the former remaining within common cause variation. Smoking prevalence at both booking and delivery remains consistently low. Encouragingly, breastfeeding initiation continues to show a positive upward trend. In addition, the proportion of women with a BMI >35 at booking has decreased.

Smokers at Booking & Delivery

Smoking indicators continue to demonstrate sustained improvement. Smoking at booking remains consistently below the 6% target, with the latest data confirming the target has been maintained for a prolonged period. Smoking at delivery has also reduced further, showing special cause improvement and indicating a genuine shift in performance rather than random variation.

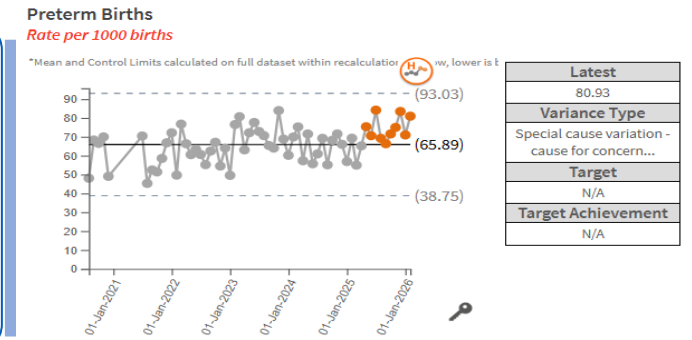
Focus now moves to maintaining these gains by supporting women to remain smoke-free throughout pregnancy and strengthening follow-up through smoking cessation services to reduce relapse prior to delivery.

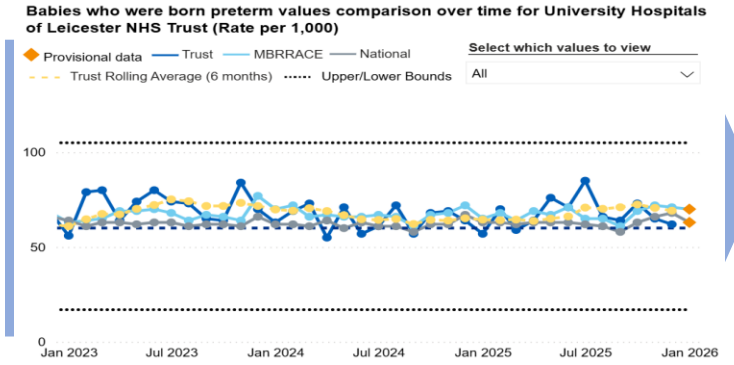




Preterm Births

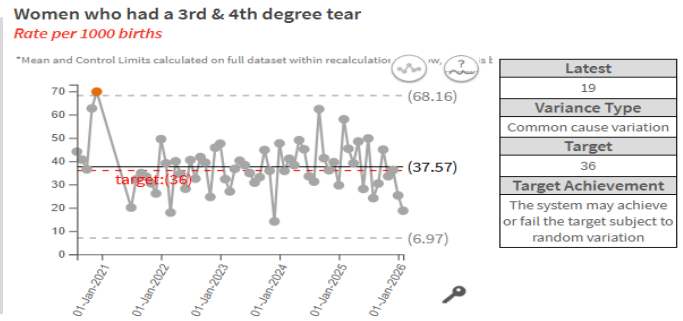
Preterm births increased slightly to 80.93 per 1,000 births, remaining above the process mean with ongoing special cause variation. Cases continue to be largely iatrogenic and associated with complex maternal conditions. This work is being actively triangulated with the neonatal mortality system review, recognising the inter-relationship between preterm birth and neonatal outcomes, to strengthen system-wide learning and assurance. Improvements in timely treatment have been maintained, alongside a continued focus on prevention through education, early assessment and prioritisation within the Preterm Prevention Clinic.

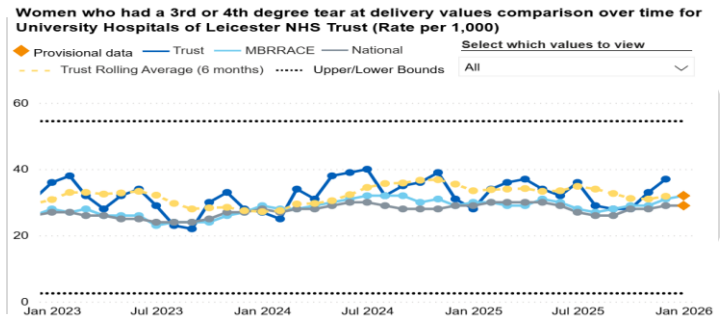




3rd and 4th degree tears

The 3rd and 4th degree tear rate has reduced significantly and remains below the target, with variation consistent with common cause performance. Preventative work continues, including the introduction of warm compress equipment in line with evidence-based practice. The Perinatal Pelvic Health Service (PPHS) continues patient education through the Leicester Maternity Matters podcast and maintains a 100% referral rate for OASI via EPR failsafe processes. Women experiencing OASI are contacted by physiotherapy within 5 days, and the new community-based midwifery/physiotherapy clinic is now supporting follow-up care.





EQUITY AND POPULATION

Data sourced from Badgernet. Validation is ongoing following EPR transition.

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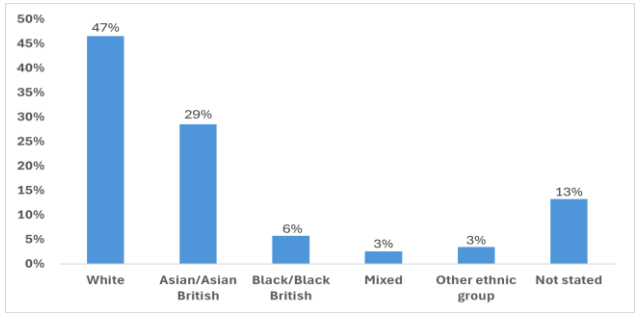
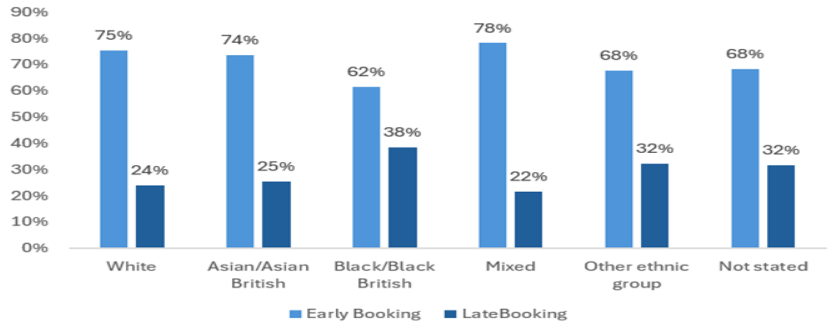
Ethnic profile and variations

Population profile at booking



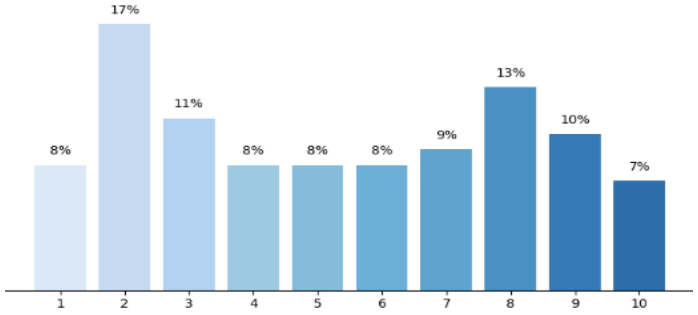
Variation in booking times

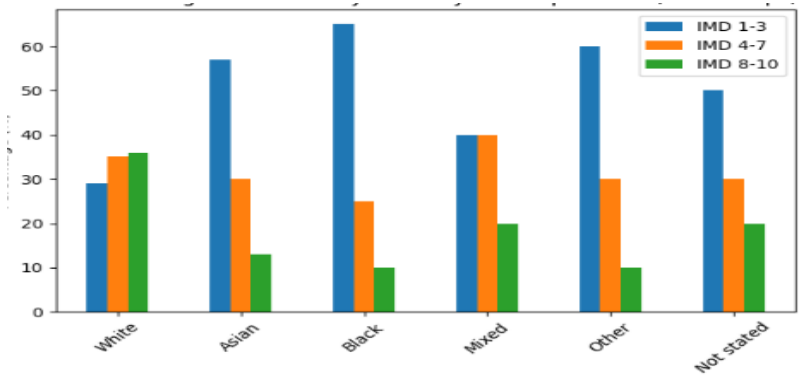


Commentary

During the reporting period, 73% of women booked by 10 weeks, with 27% booking at 11 weeks or later. While overall early access remains strong, persistent variation is evident when analysed by ethnicity. Black African/Black Caribbean women represent 6% of total bookings but have the highest proportion of late bookings (38%), meaning they are approximately 1.6 times more likely to book late than White women (38% vs 24%). In contrast, late booking rates among White (24%) and Asian/Asian British women (25%) are closer to, or below, the overall position. Mixed ethnicity women continue to demonstrate the most favourable booking profile, with the highest early booking rate (78%) and the lowest proportion of late bookings (22%). These patterns reinforce the importance of targeted, culturally responsive approaches to improve timely access for groups experiencing disproportionate delay.

Deprivation



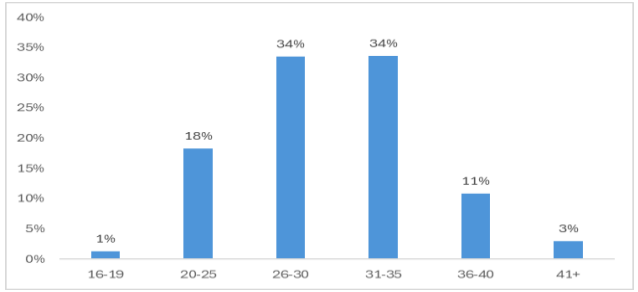


Commentary (Late bookings by deprivation)

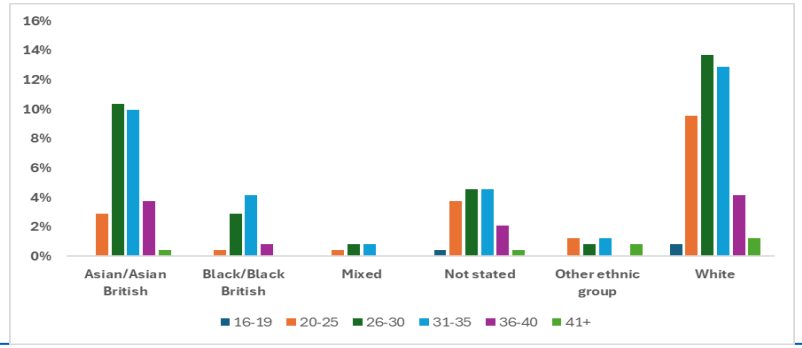
The observed deprivation gradient in late booking, particularly for Black/Black British women living in IMD deciles 1–3, is significant because early access to antenatal care is a key protective factor for identifying and managing clinical and social risk. This insight aligns with other areas of focus, including the ongoing special cause variation seen in preterm birth rates and the system review of neonatal mortality, reinforcing the importance of addressing upstream access and equity as part of a whole-pathway approach to safety and outcomes. It also mirrors themes emerging from patient experience and community engagement work, where barriers to access and navigation are more pronounced for women living in deprivation. In response, current workstreams focused on health equity, early engagement and community partnership are being prioritised towards the most affected populations and geographies, with continued monitoring through the PQRM.

Age of parent

Population profile at booking



Variation in booking times



Commentary (Late bookings by age of parent)

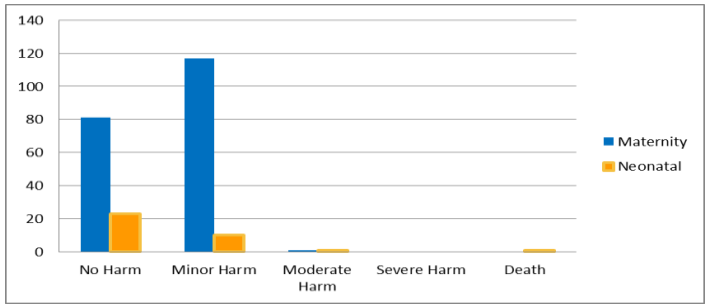
Late booking is concentrated within the 26–30 and 31–35 age groups, accounting for around two-thirds of all late bookings and reflecting the underlying maternity population. This indicates that delayed access is not driven by younger age or teenage pregnancy, but by wider system and access barriers affecting women of typical childbearing age. As such, improvement activity is focused on reducing structural and navigation barriers to early booking, rather than age-specific interventions, and aligns with wider equity and early-access workstreams.

CLINICAL QUALITY AND SAFETY

University Hospitals of Leicester NHS Trust

Incidents and Events

Incidents



MNSI cases	Current month	Prior month
Referred	1	1
Accepted	1	1

PSII cases	Current month	Prior month
Commissioned	0	0

What the data is telling us

- **0 Patient Safety Incident Investigations** (PSII) commissioned
- **1 Case referred** to Maternity and Newborn Safety Investigation (MNSI): Case accepted for external review
- **2 Moderate Incidents** reported: 1 within Maternity Services: Unexpected admission to the Neonatal unit, case referred to Maternity and Newborn Safety Investigation (MNSI) following therapeutic cooling. 1 within Neonatal Services: Complication of treatment following the insertion of an umbilical vein catheter
- **4 Stillbirths recorded** during February (25+4-30+3 week's gestation)
- **3 Early Neonatal Deaths** (33+3-36+1 week's gestation
- **Themes:** Consanguinity

What we need to focus on

Clinical Safety and Risk Management
Strengthening the accuracy of cardiotocograph (CTG) interpretation to support the early identification of fetal compromise, ensuring prompt obstetric assessment and timely intervention, alongside effective neonatal resuscitation and escalation at birth

Practice and Technical Skills
Strengthening procedural safety by ensuring competent insertion technique with consistent monitoring in place to identify and manage complications promptly

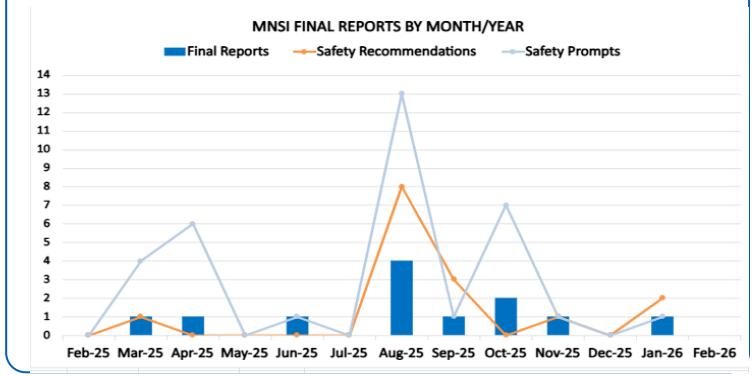
Perinatal Mortality
Perinatal Mortality Learning highlights the need for strengthened system support for very early preterm birth, including improved coordination between clinical care and social support to reduce postnatal risk and promote safe practices such as safe sleeping.

What is going well

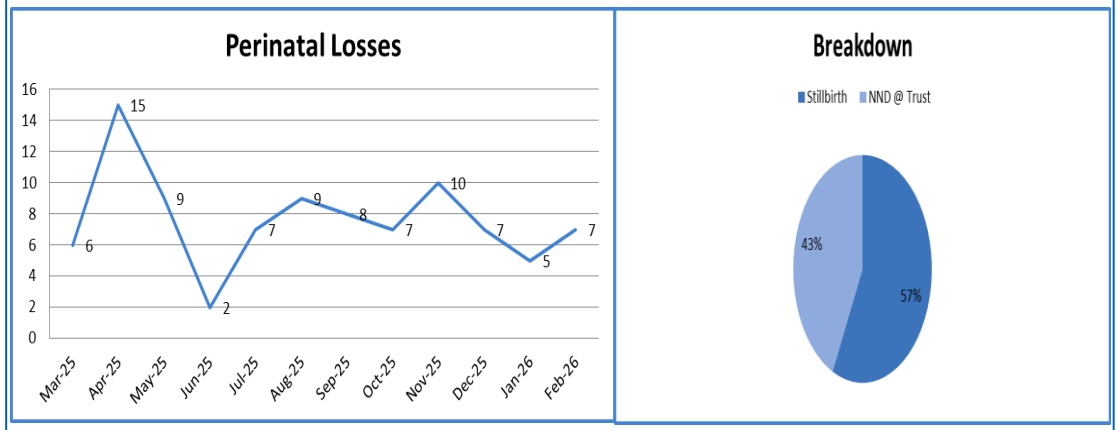
Perineal Trauma
3rd and 4th degree perineal trauma rates have significantly reduced and continue to remain consistently below the agreed target indicating sustained improvement rather than random fluctuation.
On-going preventative initiatives are supporting progress in-line with evidence based National Guidance

Postpartum Haemorrhage
The rate of women experiencing postpartum haemorrhage (PPH) of 1500 ml or more has remained stable over the reporting period, This stability provides assurance that current processes for identifying, managing, and escalating PPH remain effective. On-going monitoring continues to be essential

MNSI Referrals



Perinatal Mortality



CQC Maternity Rating

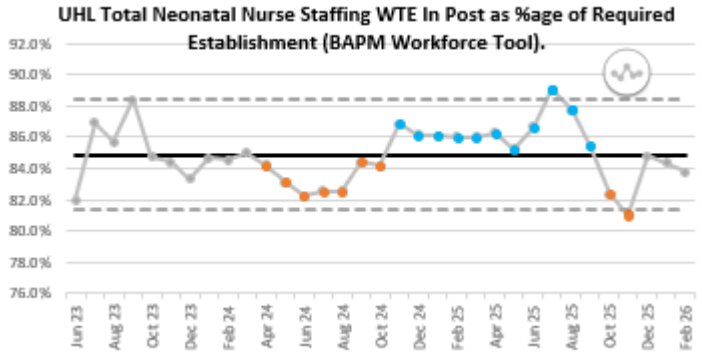
	LRI	LGH	StM
Are services safe?	●	●	●
Are services effective?	●	●	●
Are services caring?	●	●	●
Are services responsive?	●	●	●
Are services well-led	●	●	●
Overall	●	●	●

★ Outstanding ● Good
● Requires Improvement ● Inadequate

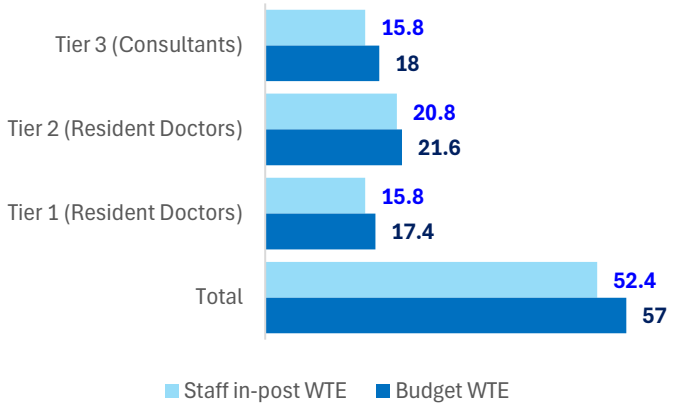
WORKFORCE - Overview

University Hospitals of Leicester NHS Trust

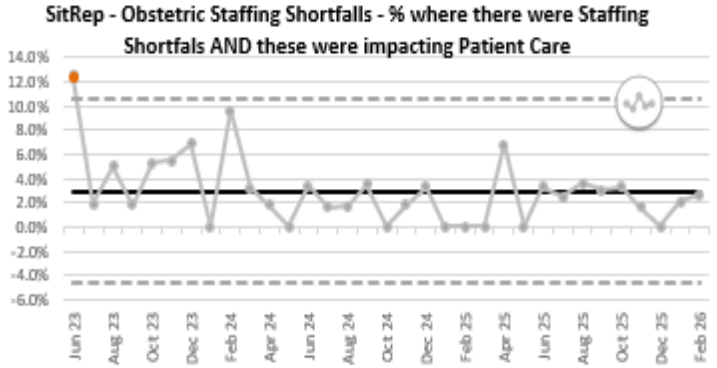
Workforce

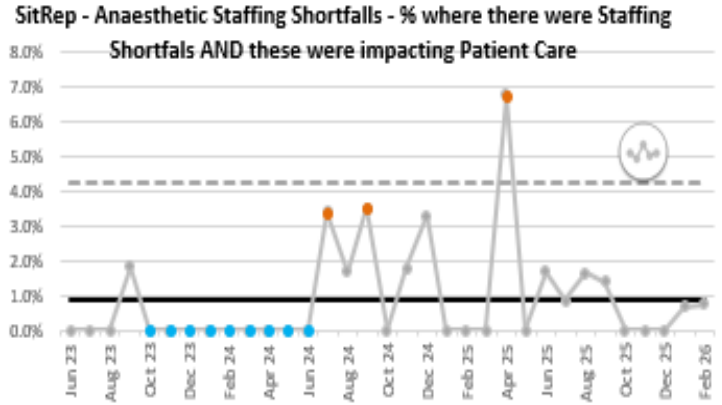


Neonatal Medical Workforce - Dec 2024

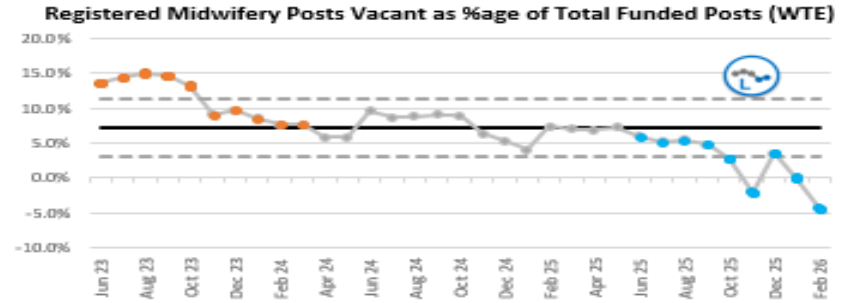


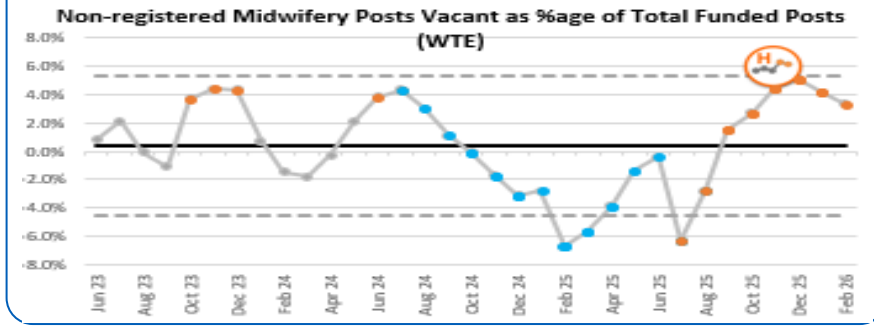
Shortfalls



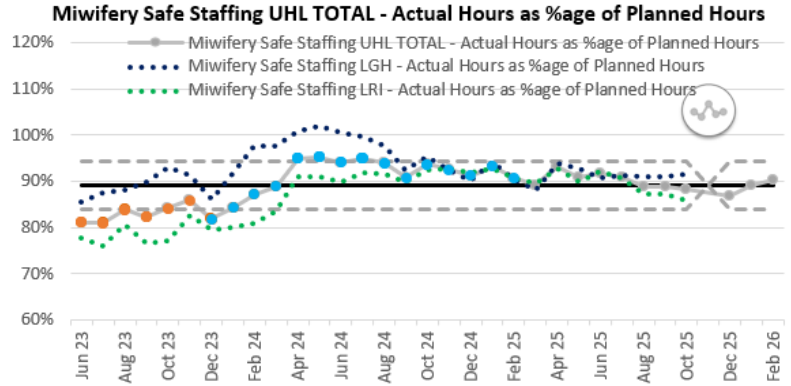


Vacancies





Safe Staffing

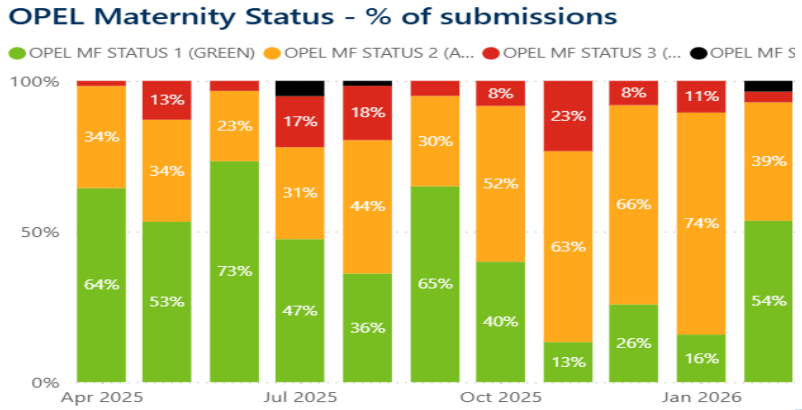


OPERATIONAL AND CAPACITY

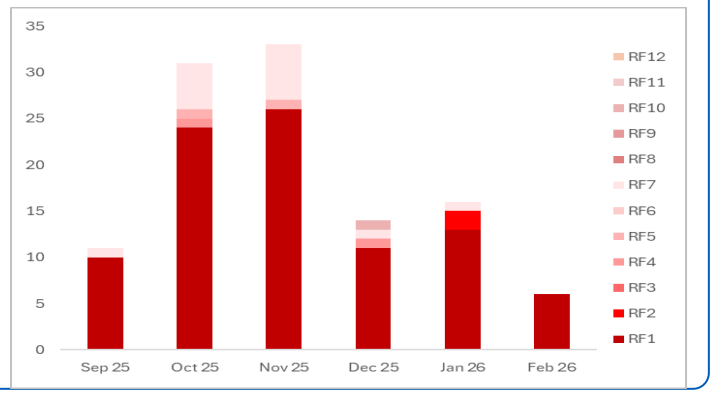
University Hospitals of Leicester NHS Trust

Key Information

Operational Pressures Escalation Levels



Midwifery Red Flag Events



Efficiency and Timeliness

Average time from attendance to triage

10 mins

% Seen within 30 Mins

95%

Avg. time from ARM decision to perform

23 hours

Seen within 15 Mins

79%

Average volume of calls to triage (antenatal)

4,777

Average call response time for triage

2 Mins 2secs

Average talk time for triage

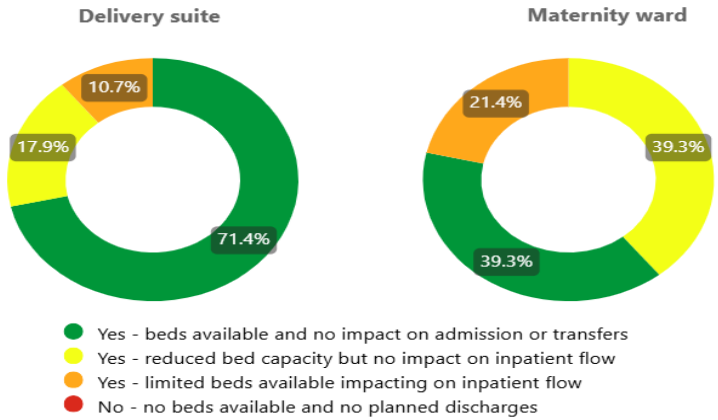
3 Mins 26secs

Categorised on admission (triage within target)

1710

(94%)

Bed Capacity



What the data is telling us

- Activity levels reduced during February with the OPEL Level 2 and 3 escalations improving in line with this. There was a small amount of level 4 OPEL acuity, but no safety incidents related to these episodes .
- Induction of labour and Caesarean section rates reamined stable.
- Red Flags were significantly reduced in month stable in month (5) with no reported incidents where the coordinator did not maintain supernumerary status or inability to provide one to one care in labour.
- Average triage times were 10 mins, with 79% of patients triaged within 15 minutes of arrival and 95% within 30 mins indicating prompt assessment of patients in line with BSOTS national recommendations.
- The average time for women to wait for an ARM from decision to perfom was 23 hours.

What we need to focus on

- Review impact of LGH Maternity Day Assessment Unit (MDAU) and optimisation of capacity to support Maternity Assessment Unit
- Bed capacity and demand modelling
- Review of elective pathway and demand
- Transition into the Single Point of Contact from Telephone Triage
- Progress consultant recruitment and succession planning.
- Strengthen sickness management through proactive monitoring, early intervention, and targeted support to reduce avoidable absence.
- Reducing time from decision to perform ARM.

What is going well

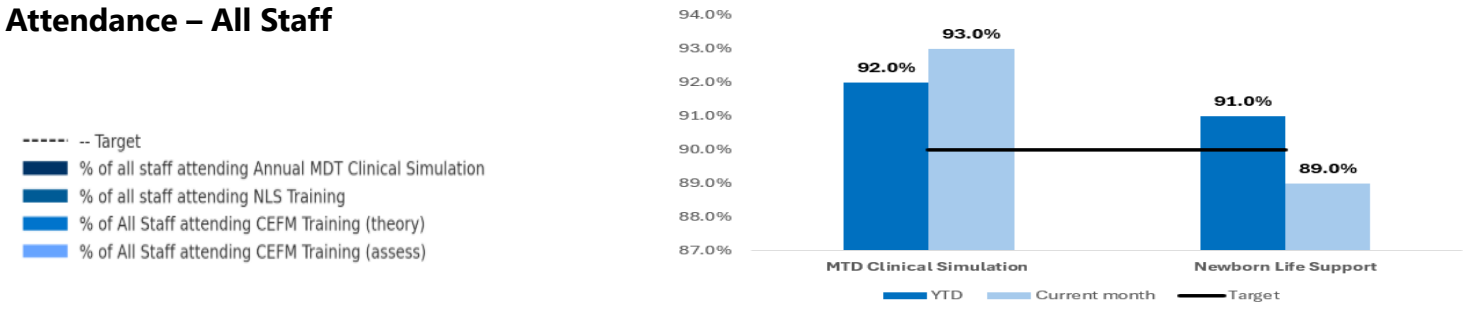
- Enhanced triage performance, reflecting more efficient patient assessment and flow
- Supporting the long-term sustainability of specialist services through ongoing succession planning, and workforce development
- Sustained trajectory to increase the Qualified in Speciality (QIS) neonatal nursing workforce
- Positive recruitment and reduced vacancies of Midwives and Neonatal Nurses
- Oversight of red flags and Matron validation of Birthrate plus acuity scoring

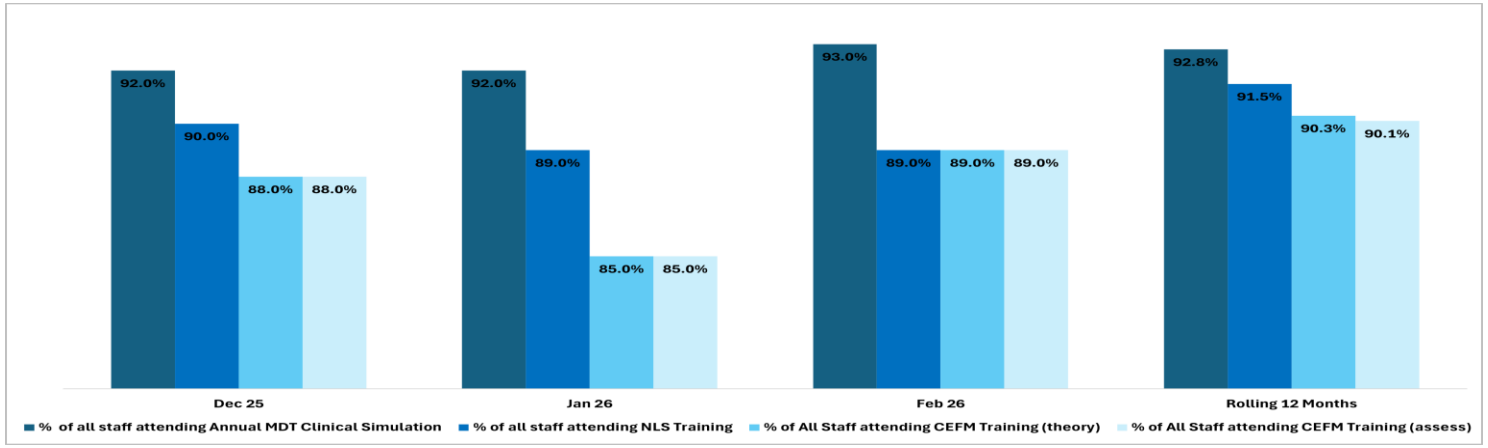
TRAINING AND COMPLIANCE

University Hospitals of Leicester NHS Trust

Training compliance

Attendance – All Staff





Key Performance Indicator	Target	Dec-25	Jan-25	Feb-26	Rolling 12 months
% of all staff attending Annual MDT Clinical Simulation	**90%**	92.0%	92.0%	93.0%	**92.8%**
% of all staff attending NLS Training	**90%**	90.0%	89.0%	89.0%	**91.5%**
% of all staff attending CEFM Training (theory)	**90%**	88.0%	85.0%	89.0%	**90.3%**
% of all staff attending CEFM Training (assess)	**90%**	88.0%	85.0%	89.0%	**90.1%**

What the data is telling us

- In February as predicted we have seen no further decline in compliance across our three MIS Safety Action 8 areas of targeted training. With compliance in all areas remaining above our internal benchmark of 80%
- In March we predict there may be a slight fall in compliance, as we draw to close our 25/26 Training Calendar at the end of the month. Thus, within March the number of study days that link to the compliance reduces.

What we need to focus on

- Moving into Q4, the Maternity Education Team will continue to prioritise actions aligned with safety, compliance, and quality improvement. Our Key initiatives focusing on sustaining high standards in maternity care through improved staff training coordination, enhanced clinical governance collaboration, and proactive efforts to reduce avoidable harm.
- The Maternity and Neonatal Education teams will move into the next stages of Education Programme Development for the 26/27 training year, due to start in April 2026.
- 1.0 WTE Education and Practice Development Midwife remains vacant with a in internal Job advert going live in February.
- Continued partnership work with PSIP team around postpartum haemorrhage management.

What is going well

- MIS Year 7 SA8 achieved
- Consistency in training compliance across all areas, with close oversight and early preventative action taken and communicated where required.
- 26/27 Training Needs Analysis launched for line managers and due for submission 1st April 2026.
- Joint Neonatal and Maternity Insitu Skill Drill Completed

SAFETY ACTIONS

University Hospitals of Leicester NHS Trust

Maternity Improvement Scheme

MIS Safety Action – Year 7	MIS Standards	Status
1. Use of Perinatal Mortality Review Tool	6	Achieved
2. Submitting data to the Maternity Services Data Set	2	Achieved
3. Transitional Care and Avoiding Term Admissions to Neonatal Unit	4	Achieved
4. Clinical workforce planning	10	Achieved
5. Midwifery workforce planning	6	Achieved
6. Saving Babies Lives Care Bundle	6	Achieved
7. Listening to women, parents, and families	5	Achieved
8. Multidisciplinary training	3	Achieved
9. Ward to Board assurance	9	Achieved
10. MNSI and Early Notification Scheme Reporting	9	Achieved

Summary

Year 7 of the scheme

All requirements of the Year 7 Maternity Incentive Scheme (MIS), have been completed and the Trust has achieved all 10 Safety Actions and the associated 95 individual standards, in accordance with the MIS Guidance issued by NHS Resolution.

Confirmation from NHS Resolution of safe receipt of Declaration form received.

Year 8 of the scheme launch date 2 April 2026

Year 8 of the Maternity Incentive Scheme (MIS) will introduce major changes to make the programme clearer, more outcome-focused, and better aligned with national learning on maternity safety. It will replace detailed requirements with six core safety actions, highlighting 'what good looks like', allowing NHS Trusts greater local flexibility, while requiring Boards to demonstrate strong governance, safety assurance, service-user involvement, and clear evidence of improvement.

Full publication and confirmation of changes due for release 31st March 2026

Saving Babies Lives

Element	Interventions Fully Implemented (Self-Assessment) Q2		Interventions Fully Implemented (LMNS Validated) Q2		NHS Resolution MIS
Smoking in Pregnancy	Fully	100%	Partly	100%	CNST Met
Fetal Growth Restriction	Partly	95%	Partly	95%	CNST Met
Reduced Foetal Movements	Fully	100%	Fully	100%	CNST Met
Fetal Monitoring in Labour	Fully	100%	Fully	100%	CNST Met
Preterm Birth	Fully	100%	Partly	96%	CNST Met
Diabetes	Fully	100%	Fully	100%	CNST Met
All Elements	Partly	99%	Partly	97%	CNST Met

Summary

Submission 8 (Q2 25/26) 97% implemented

Element 2 95% implemented. Lab now confirmed ability for on-site testing and plan for PlGF roll out by March 2026 and Consultant Lead in place.

Element 5 96% implemented. Action plan update- Badger Net now live. New App built by Neonatal Data Analyst and MDT plan in place for accurate data submissions and tracking via App.

Submission 9 (Q3 25/26) Retrospective review due April 2026

EXPERIENCE FEEDBACK

University Hospitals of Leicester NHS Trust

Patient Experience

Complaints and Concerns	Dec-25	Jan-26	Feb-26	25 / 26 YTD
Maternity	10	13	9	111
Neonatal	2	0	0	7

Friends and Family Test (FFT)	Target	National	Dec-25	Jan-26	Feb-26	25 / 26 YTD
Maternity FFT % Responses	25%	13%	11.9%	16.9%	11.5%	13%
Maternity FFT % of Promoters	96%	93%	92.3%	88.4%	89%	92.7%

Footfall data is 6 month average , due to move to BadgerNet for reporting, accurate monthly totals not currently available

Birth Reflections	Dec-25	Jan-26	Feb-26	25 / 26 YTD
Number of appointments	19	31	31	81
% attended within 12 months of birth	68.4%	77.4%	80.6%	76.5%

Compliments

"Every staff member was so kind and compassionate and there was always somebody available to help"

Ward 30 LGH

"The triage was smooth and the doctor was attentive"

Maternity Assessment Unit LRI

What the data is telling us (Complaints)

- 2 complaints this month relate to care received in 2021 and 2022
- No complaints received related to recent care in MAU. Complaints relate to varying wards/departments
- No clear complaint themes this month however 3 complaints relate to staff attitude/communication (2 x support staff, 1 x medical staff) - similar noted from Birth Reflections Service
- FFT concerns remain about cleanliness of postnatal wards (score = 87%) and communication regarding wait time on MAU (score = 54%)
- Single Point of Contact data available this month; 30 completed surveys with 29 rating either 'good' or 'very good' experience
- Lowest response rates in community midwifery
- No poor promotor rates for community midwifery and labour and birth
- Areas for improvement include; induction of labour delays, temperature of rooms and waits for doctors on MAU
- Birth reflections themes include: patient involvement in plans of care/communication, staff attitude, consent (assisted birth and vaginal examinations) and delays in care

What are we working on?

- Implementation of Self-Administration of Medications
- Change to obstetric cover on Maternity Assessment Unit out of hours (weekend)
- Re-launch of QR codes in MAU at triage to inform women of triage system
- Mandatory consent training for all staff from April 2026 with a focus on vaginal examinations and assisted births

What we need to focus on

- Using text messaging to send full FFT surveys at 3 stages of maternity journey to increase response rates
- Link with Avoiding Term Admissions to Neonatal Unit group to introduce room thermometers to monitor temperatures on postnatal wards
- Progress Fundamentals of Care review across postnatal wards

SPOTLIGHT ON…Meet the Expert Community Event

When?
February
2026

University Hospitals of Leicester NHS Trust

Following the success of its inaugural launch, the maternity ‘Meet the Expert’ community event returned for a second time, with engagement continuing to grow and nearly 150 women and families in attendance. Held in the antenatal clinic at Leicester General Hospital, the event provided an accessible and welcoming space for families to connect directly with maternity and partner services, helping them better understand the care available throughout pregnancy and supporting informed choice, early engagement and continuity.

A wide range of services were represented—including Smoking Cessation, Public Health, Pelvic Health, Birth Reflections, Birth Centres, the Home Birth Team, Fetal Monitoring, the MNVP, Janam app, Infant Feeding and Immunisations

This provided families the opportunity to speak with professionals from across the pathway in one place. Crucially, the event supports wider system aims by addressing known barriers to access, navigation and engagement, particularly for women who may face disadvantage or delayed entry into care.

APPENDICES

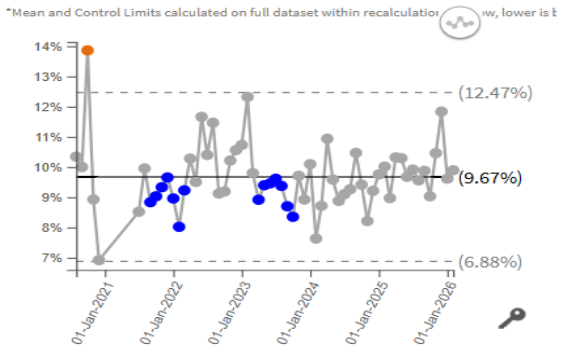
TRENDS: CLINICAL QUALITY SURVEILLANCE

Data sourced from Badgernet. Validation is ongoing following EPR transition.

NHS University Hospitals of Leicester NHS Trust

Antenatal

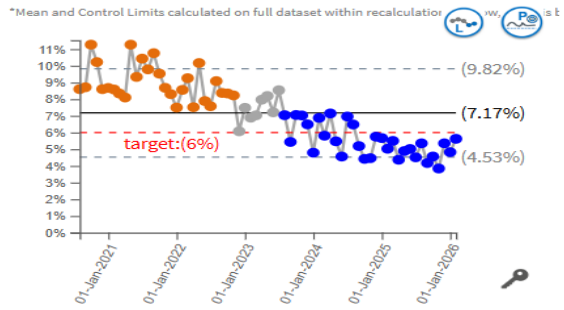
BMI at Booking >35



Latest
9.9%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

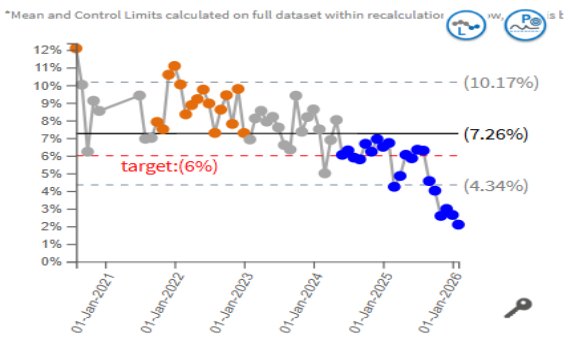
Smoking at time of booking

LMNS: 6% (Ref 1.3a SVBL)



Latest
5.6%
Variance Type
Special cause variation - improvement...
Target
6%
Target Achievement
Metric has (P)assed the target for the last 6 (or more) data points...

% of women who are current smokers at delivery

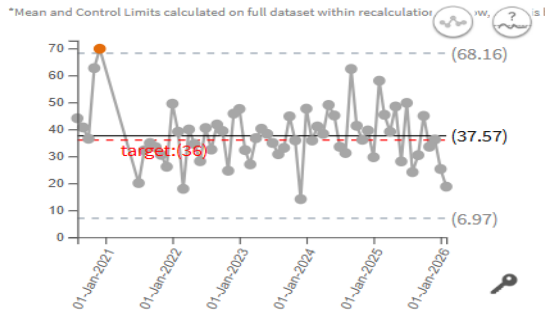


Latest
2.1%
Variance Type
Special cause variation - improvement...
Target
6%
Target Achievement
Metric has (P)assed the target for the last 6 (or more) data points...

Intrapartum

Women who had a 3rd & 4th degree tear

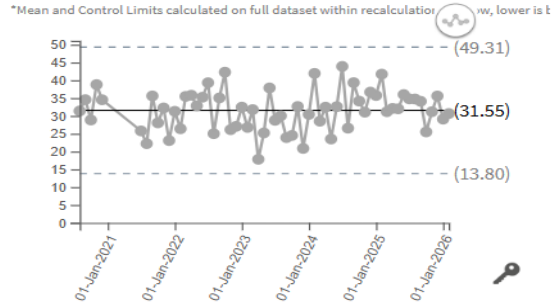
Rate per 1000 births



Latest
19
Variance Type
Common cause variation
Target
36
Target Achievement
The system may achieve or fail the target subject to random variation

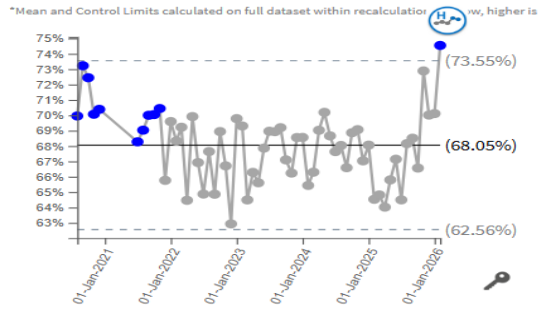
Women with PPH of 1500ml or more

Rate per 1000 births



Latest
31
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

BREASTFEEDING

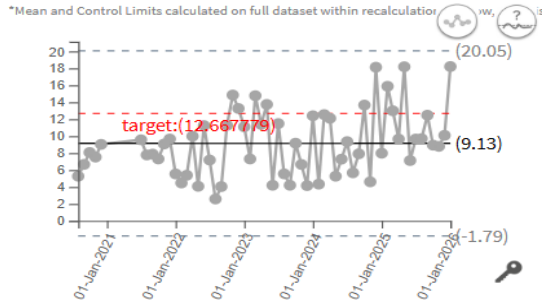


Latest
74.5%
Variance Type
Special cause variation - improvement...
Target
N/A
Target Achievement
N/A

Outcomes

Babies with Apgar @5mins less than 7

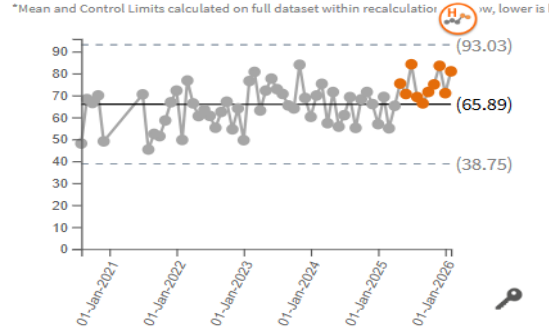
Rate per 1000 births



Latest
18
Variance Type
Common cause variation
Target
12.667779
Target Achievement
The system may achieve or fail the target subject to random variation

Preterm Births

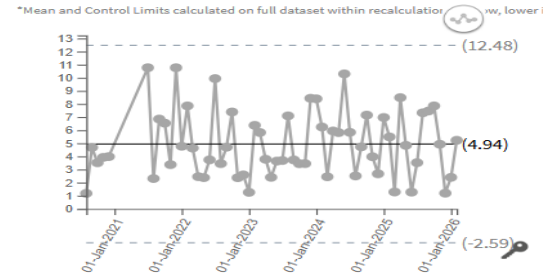
Rate per 1000 births



Latest
80.93
Variance Type
Special cause variation - cause for concern...
Target
N/A
Target Achievement
N/A

Stillbirths

Rate per 1000 births



Latest
5
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

THE HEADLINES – Key Delivery Insights

Data sourced from Badgernet. Validation is ongoing following EPR transition.

NHS University Hospitals of Leicester NHS Trust

Total Births (in month)

757

12 mnth avg.= 800

Preterm Births (in month)

82

Prev. month = 71

Stillbirths (in month)

4

Prev. month = 2

Born Before Arrival (in month)

6

Prev. month = 4

Homebirth (in month)

18

Prev. month = 18

Sickness Rates
UHL Women's Services- Dec 2025

Data is reported with a standard two-month reporting lag

5.88%

Monthly Sickness Absence

6.14%

Year-to-Date (Cumulative)

Safe Staffing (UHL Total)

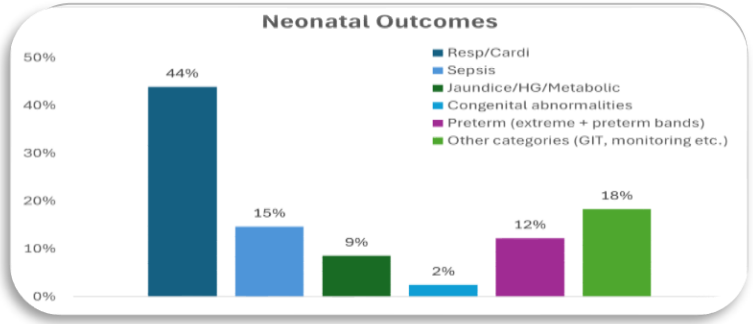
Monthly actual staff hours as a percentage of planned staff hours

90.2%

Prev. month.= 89.2%

Feb '26	WTE	%
Actual Vacancy	5	1.2%
Felt Vacancy	43.61	11.6%

Outcomes

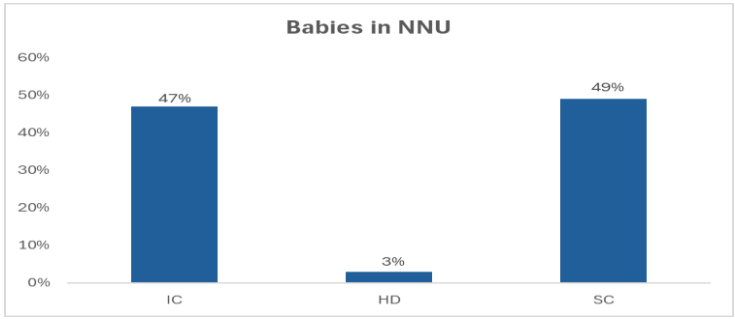


Skin to Skin < 1hr (full-term w/o complication)

57%

Prev. month = 59.6%

National Avg = 74.2%



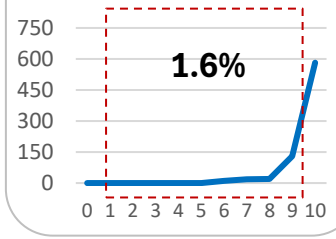
NNU ATAIN Rate (full-term babies)

5.3%

0.4% from prev. month

National Avg = 6%

Apgar < 7 at 5 mins



Maternal Wellbeing

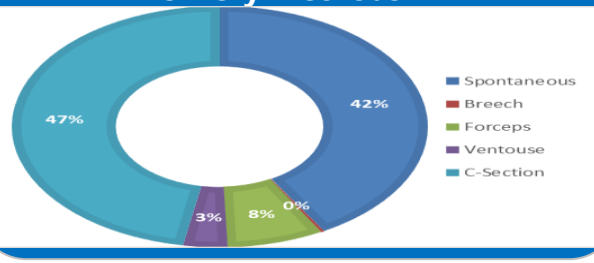
Vaginal Birth Rate in month (natural / total)

53.6%

Prev. month = 51.5%

National Avg = 42%

Delivery Methods



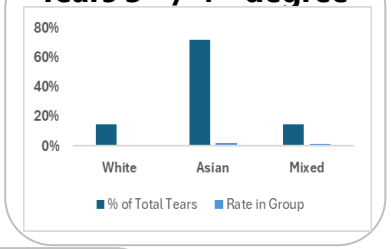
One-One Care in Labour

100%

10 % from prev. month

National Avg = 51%

Tears 3rd / 4th degree



Blood Loss >1.5ltr

	% of Tot. PPH	% Rate in Group
White	48.0%	3.5%
Asian	36.0%	3.7%
Black	8.0%	3.9%
Mixed	8.0%	2.9%
Other	0	0

THE HEADLINES – Perinatal Journey

Data sourced from Badgernet. Validation is ongoing following EPR transition.

University Hospitals of Leicester NHS Trust

Total Bookings

907

Last month = 1,078

Triage Attend.

1,927

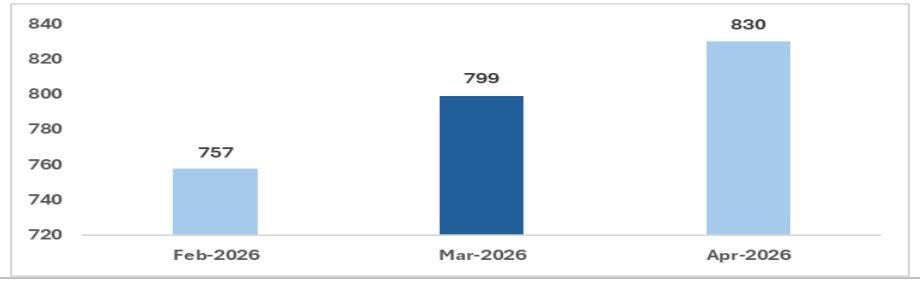
Last month = 2,164

Triaged within 15 minutes

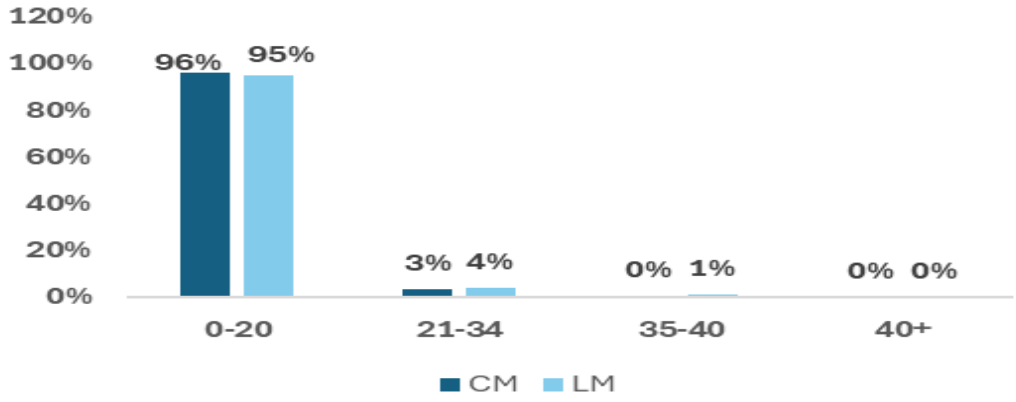
79.0%

Last month = 70.2%

Expected Deliveries (by gestational age)



Comparison of Bookings by Gestational Age (Current Month vs Last Month)



Antenatal Wellbeing

Missed apps. In community
(#all missed appointments)

837

Last month = 911

Screening Uptake
(tests declined / tests offered)

97.9%

National Avg ~ 97.5%

Risk identified at booking

Risk	% of bookings
Smoking	5.6%
BMI>35	11.6%
Alcohol/Drugs	3.1%
Mental Health	25.5%

Postpartum Support

Maternal Readmissions
(count of readmissions in month)

204

Last month = 216

Breastfeeding Data

Journey	UHL Feb	UHL Prev.Month
Initiation Rate	74.5%	70.1%
Breastfeeding only @ 10 days	34.8%	22.5%
Breastfeeding only @ transfer to Health Visit.	39.6%	39.5%

NEONATAL OUTCOMES

University Hospitals of Leicester NHS Trust

Total Babies in Month

135

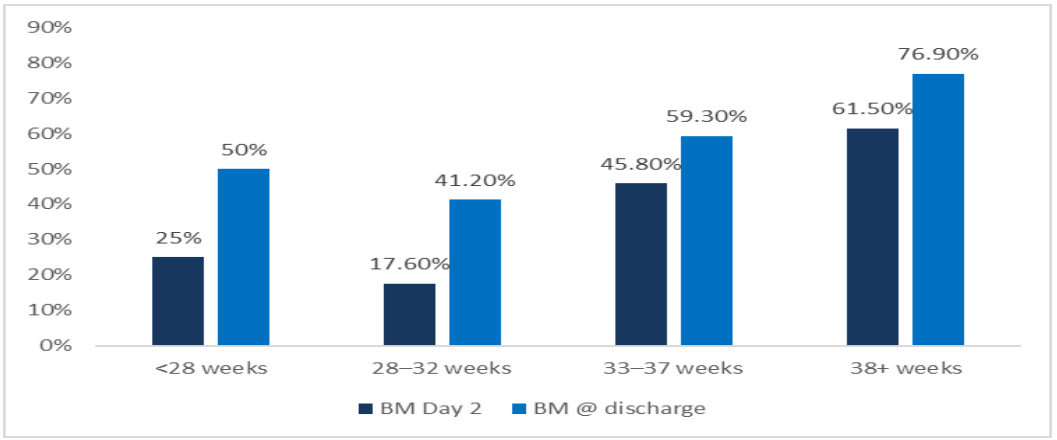
Total Admissions in Month

145

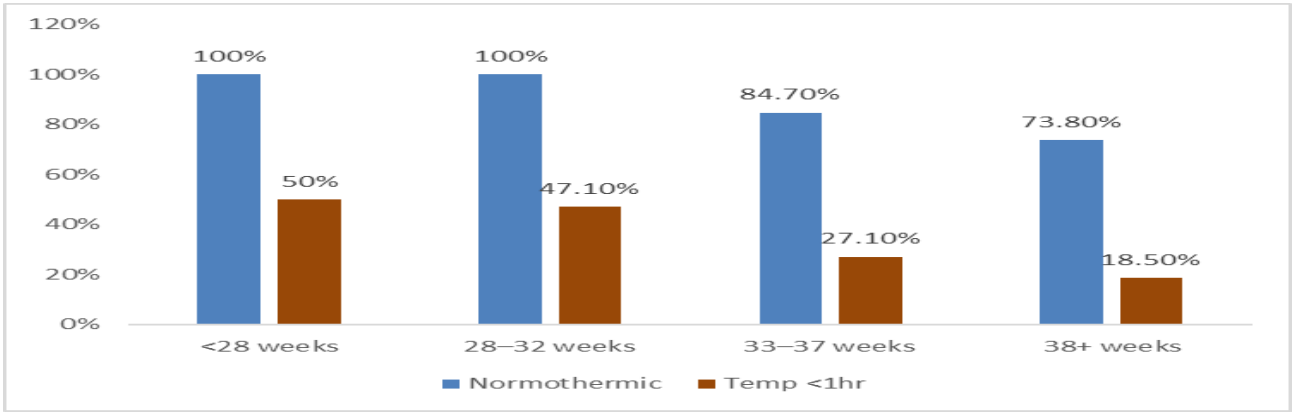
Summary

Neonatal outcomes demonstrate low mortality and morbidity with expected variation by gestation. Feeding outcomes improve consistently to discharge, while thermal care remains high across all groups, particularly in preterm infants.

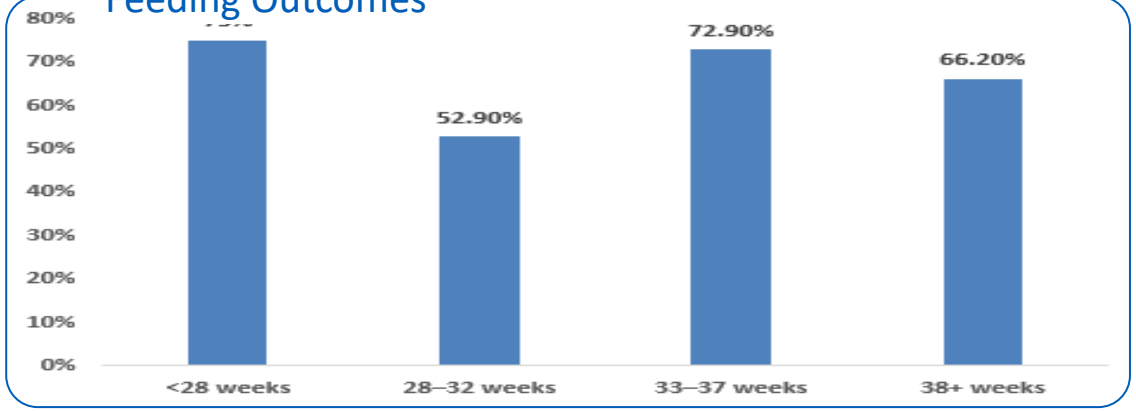
Feeding Outcomes



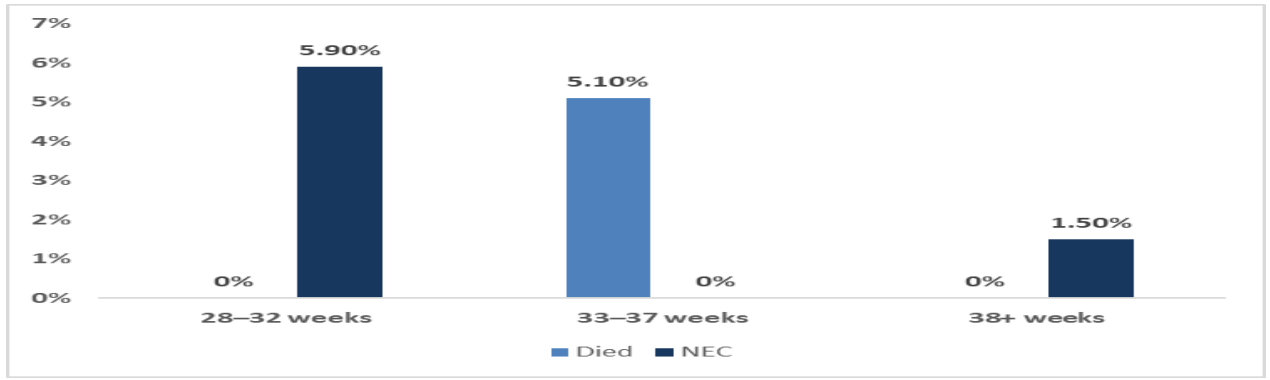
Thermal Care



Feeding Outcomes



Mortality and Morbidity



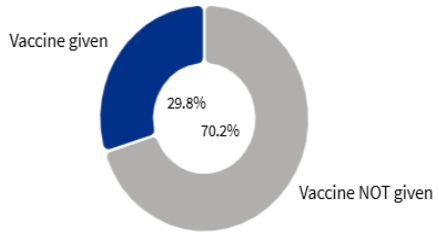
IMMUNISATION SUMMARY

University Hospitals of Leicester NHS Trust

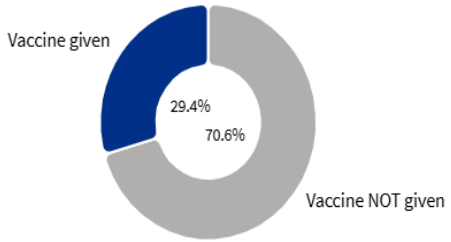
RSV Uptake

RSV uptake remains a concern across UHL Maternity. Although a booking service launched in February, early challenges and an administrative vacancy have limited its success. Recruitment is now complete, and we expect improvements in booking, as well as follow-up for DNAs and declines in the community. Staff and public education continues, with VIP Nurses attending April's parent education sessions to further promote uptake. NHSE have reduced the touch points with UHL following the action plan as they are assured with current actions.

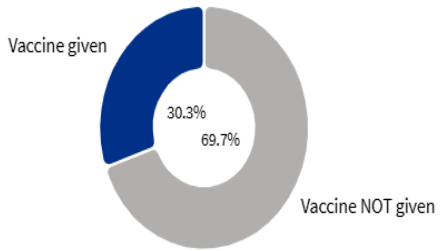
Uptake of RSV Vaccination - UHL Total
Given/Not given



Uptake of RSV Vaccination - LRI
Given/Not given



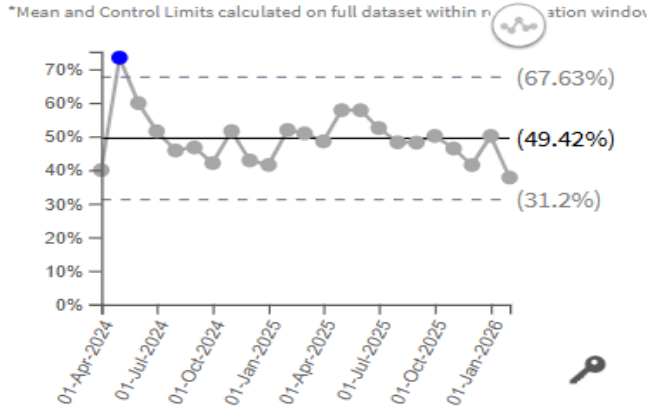
Uptake of RSV Vaccination - LGH
Given/Not given



Pertussis Uptake

Uptake of pertussis vaccination for UHL demonstrates common cause variation, with performance fluctuating around a stable mean. No special cause signals are observed within the reporting period, indicating a consistent underlying process. The latest data point remains within expected control limits. Continued monitoring of vaccination is recommended

% Uptake of Pertussis Vaccination for UHL TOTAL

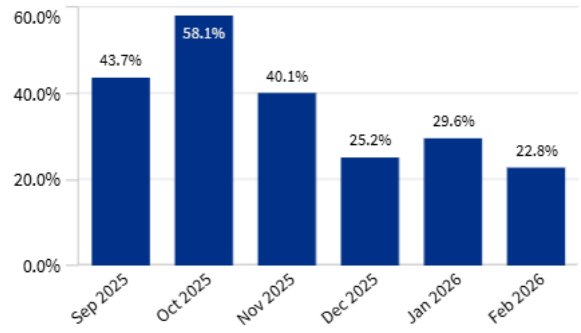


Latest
37.7%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Flu Vaccination

The pattern remains consistent with a seasonal vaccination programme, where demand is typically highest at the start of the winter campaign. Uptake will continue to be monitored across the remainder of the season, with ongoing emphasis on opportunistic vaccination. Plan are already underway for 2026-27 flu season i.e. ordering of vaccinations and PGD's.

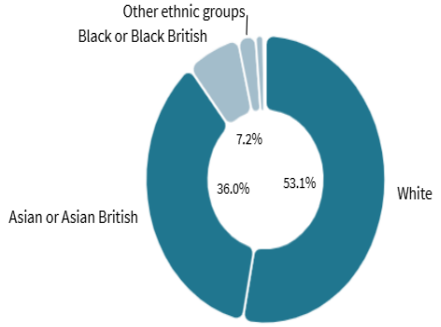
% Uptake of FLU Immunization



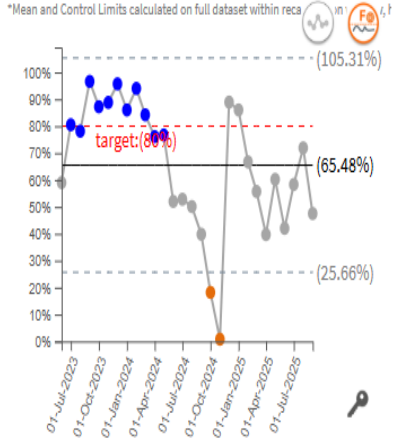
Insights

BCG vaccine uptake remains below target, with the current pattern reflecting common cause variation. Work is also underway to support the movers in and out of UHL in collaboration with NHSE, LPT and CHIS

Ethnic Group of those who received the Pertussis Vaccine (UHL)
Reporting Period: Feb-2026 to Feb-2026



Of those eligible (number 1b) the percentage of BCG vaccinations given ≤ 28 days (with appropriate SCID screening outcome) KPI=80% (i.e. coverage)



Latest
47.5%
Variance Type
Common cause variation
Target
80%
Target Achievement
Metric has (F)ailed the target for the last 6 (or more) data points...

INTERPRETING DATA

Throughout this series of slides, we display data that shows you how we are performing in the current month and across time.
We primarily do this through single data points on the 'At a Glance' slides and Statistic Process Control (SPC) charts.
On this slide, we describe **single data points.**

A single data point is indicative of a single month only.

These values should not be interpreted in isolation, even if they seem especially high or low in comparison to previous months. In this situation, the SPC chart (covered on the next slide) will help us understand whether a particular value represents a significant change.

The arrow indicator (where present) shows you how the value compares to the value for that same measure in the previous month, and whether that value is better than last month's (green) or worse than last month's (red).

Sometimes a measure will appear both as a single data point and an SPC chart within these slides. You may notice that the numbers do not align for the same month for that same measure. Good spot! This is because we may calculate a measure differently, depending on what we are trying to measure.

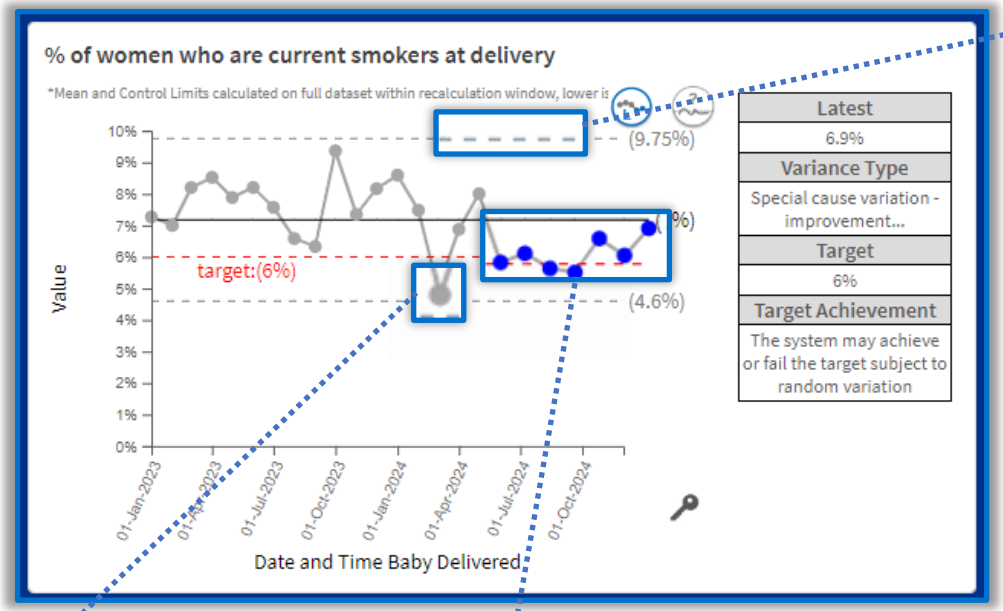
Single data points
these reflect local calculations. They will not exclude specific populations, unless there is a specific reason to do so.

SPC charts
these will be calculated in line with standard national calculations so that we can compare ourselves meaningfully to other Trusts. These calculations may exclude certain categories of people.

INTERPRETING DATA

Throughout this series of slides, we display data that shows you how we are performing in the current month and across time. We primarily do this through single data points on the 'At a Glance' slides and Statistic Process Control (SPC) charts. In this slide, we describe **SPC charts.**

SPC charts are widely used across the NHS to measure changes in data over time.
There is **strong evidence** that these provide a **better basis for decision making** versus isolated data points.



An SPC chart has **three reference lines** that allow you to interpret variation in the data. The **central reference line** shows the average (sometimes the median). The **upper and lower reference lines** show the process limits. These limits are defined by the variability in the data itself. Roughly 99% of the values should fall inside process limits. Sometimes there is also a **target line** – this shows the target that we are aiming to achieve for a given measure.

Common cause variation: a single value that looks abnormally high or low, but remains within process limits, is due to **common cause variation**. This means that it is not statistically significant as an isolated value and can be explained by usual variance in the system.

Special cause variation: this represents a value or trend that is likely to be **statistically significant** and therefore **not due to normal variation**. In our slides, these will be highlighted in **blue**. There are 4 different kinds of special cause variation:

1. **6 or more consecutive points above or below the mean line**
2. **A single data point outside the control limits**
3. **6 or more consecutive points increasing or decreasing**
4. **2 out of 3 consecutive points close to the process limit**

GLOSSARY OF TERMS

University Hospitals of Leicester NHS Trust

Glossary

Term	Abbreviation
Induction of Labour	IoL
Hypoxic-Ischemic Encephalopathy	HIE
Hospital Readmission	HRA
Postpartum Haemorrhage	PPH
Intensive Care Unit	ICU
Severe Maternal Morbidity	SMM
Leicester General Hospital	LGH
Leicester Royal Infirmary	LRI
Gestational Diabetes Mellitus	GDM
Hyperemesis Gravidarum	HG

Appendix G3

NHS
University Hospitals of Northamptonshire

Perinatal Quality Assurance Scorecard

March 2026 (February 2026 data)

CONTENTS

SUMMARY February 2026

University Hospitals of Northamptonshire

The month in review

UHN maternity services remained safe and stable throughout February, with clinical quality indicators, outcomes and operational performance all within expected ranges and no significant safety concerns identified. Workforce and operational pressures persist however strong recruitment pipelines, sustained training compliance and improved governance alignment continue to strengthen service resilience. Patient experience is positive overall, though response rates and communication-related feedback highlight areas for continued focus, while targeted improvement work across smoking, preterm birth, triage, IOL flow and CNST/MIS requirements is progressing well through the Perinatal Single Improvement Programme (PSIP). Vaccination uptake remains steady across both sites, with NGH showing strong RSV and pertussis acceptance supported by expanded community clinics, and KGH maintaining consistent antenatal immunisation activity, ensuring continued protection for mothers and newborns.

Training compliance:
Training across NGH and KGH remains consistently strong, with the majority of modules achieving near-complete (approaching 100%) attendance. PROMPT and CTG training are firmly embedded in practice, providing robust assurance of safe, coordinated multidisciplinary care. Neonatal life support compliance continues to be high, reflecting sustained focus on critical clinical skills. Variability in anaesthetic attendance at NGH persists due to rota and release-time constraints, and targeted work is ongoing to address this. Overall, the evidence demonstrates strong engagement with safety-critical training and provides solid assurance against CNST requirements and national standards.

Clinical Quality and Safety
Clinical quality indicators across UHN remain stable, supported by active and reliable incident reporting. No Maternity Outcomes Signal System (MOSS) MNSI alerts were identified during the reporting period, and PMRT reviews continue to be completed within expected national timeframes. Perinatal mortality demonstrates normal month-to-month variation with no concerning trends emerging. Ongoing work to align governance processes across NGH and KGH is strengthening consistency, standardising reporting, and improving data quality. The introduction of Perinatal Quality and Safety Matrons is already enhancing clinical oversight, promoting cross-site learning, and providing increased assurance around safety and continuous improvement.

Patient experience across UHN remains positive, with strong engagement in the Friends & Family Test. Complaints remain low, and initiatives such as Family & Friends Friday are improving visibility and feedback, while language, communication and discharge information continue to be key themes highlighted by service users. Staff feedback also emphasises the need for clearer communication and updates on improvement work, and ongoing actions are focused on strengthening consistency, cultural awareness and real-time responsiveness across both sites.

Outcomes: Clinical outcomes in February were stable across maternity services. Most measures remained close to expected levels. Smoking rates and high BMI at booking continue to vary and will be monitored. Key indicators during labour, such as perineal trauma, major blood loss and breastfeeding, stay within expected ranges, despite normal month-to-month changes. Outcomes like APGAR scores, preterm birth and stillbirth also show typical variation with no signs of deterioration. Regular monthly monitoring ensures any concerns are identified early and acted on.

Operational & Capacity:
Operational performance across UHN remained stable throughout February. NGH maintained OPEL 1 with no escalation, and KGH experienced no significant increases in pressure, demonstrating effective capacity management across both sites. Red-flag events were recorded at each site primarily linked to delays and activity pressures. Homebirth services at KGH were temporarily paused due to staffing pressures, and one in-utero transfer for an extreme preterm case took place; however, there were no suspensions of acute maternity services at either site. Continued focus on maintaining safe staffing, strengthening escalation processes and improving Birthrate Plus compliance remains essential to ensuring resilient, evidence-based workforce planning.

Workforce:
Workforce pressures remain across UHN, with vacancies increasing at NGH following the repurposing of Band 3 funding, though recruitment progress and pipeline for midwifery and neonatal roles remains strong. KGH continues to manage a smaller midwifery vacancy gap with a confirmed recruitment pipeline, while medical workforce gaps persist and are being addressed through locum recruitment and plans to convert posts to substantive roles. Consultant job planning and a demand-and-capacity review are underway to ensure sustainable consultant presence, safe staffing and alignment of service needs across both sites.

February 2026 UHN AT A GLANCE

AVERAGES PER DAY

BOOKINGS	BIRTHS
12	18

BABIES BORN

519

PREV. MONTH
Jan - 598

BIRTH LOCATION

KGH (Labour Ward)	OOA	HOME
193	15	6
NGH (Labour Ward)	BIRTH CENTRE	HOME
227	17	8

3RD & 4TH DEGREE TEARS

2.37%

Jan 1.6%

4.76%

BLOOD LOSS >1,500MLS

Jan 3.88%

251 GIRLS / 264 BOYS

4.45%

January 3.7%

FULL TERM BABIES ADMITTED TO NNU

INDUCTION OF LABOUR (IOL)

26.6%

Jan 30.65%

51.35%

CAESAREAN SECTIONS

Jan 41.03%

	AUGUST	PREV 12 MTH. AV.
ELECTIVE	118 (24.5%)	59 (22.7%)
EMERGENCY	136 (24.5%)	81 (29.36%)

SETS OF TWINS

15

SETS OF TRIPLETS

0

ASSISTED BIRTHS

9.1%

VENTOUSE	FORCEPS
2.34%	4.81%

BREASTFEEDING INITIATION

79%

PREV. 12 MONTHS – 79.4%

NHS

February 2026 AT GLANCE

AVERAGES PER DAY

	BOOKINGS	BIRTHS
KGH	10	8
NGH	12	10

BABIES BORN

UHN 519
KGH 214
NGH 305
PREV. MONTH UHN 598

BIRTH LOCATION

	KGH (Labour Ward)	OOA	HOME
	193	15	6
	NGH (Labour Ward)	BIRTH CENTRE	HOME
	227	17	8

3RD & 4TH DEGREE TEARS

KGH 0.9%
Jan 0.4% ▲
NGH 3.4%
Jan 2.5% ▲

BLOOD LOSS >1,500MLS

KGH 5.7%
Jan 4% ▲
NGH 4.1%
Jan 2.3% ▲

GIRLS

KGH 93
NGH 158

BOYS

KGH 119
NGH 145

FULL TERM BABIES ADMITTED TO NNU

KGH 3.7%
NGH 5.2%

UHN CAESAREAN SECTIONS

51.35%
KGH 54.7%
NGH 49.0%

			PREV 12 MTH. AV.
ELECTIVE	KGH	51 (24.5%)	55 (23.47%)
	NGH	67 (22.6%)	64 (22.2%)
EMERGENCY	KGH	58 (27.9%)	78 29.6%
	NGH	78 (26.3%)	84 (29.2%)

INDUCTION OF LABOUR (IOL)

KGH 37% PREV. 12 MONTHS – 30.4%
NGH 26.7% PREV. 12 MONTHS – 24.0%

SETS OF TWINS

KGH 6
NGH 9

SETS OF TRIPLETS

KGH 0
NGH 0

ASSISTED BIRTHS

KGH 18
NGH 29

	VENTOUSE	FORCEPS
	KGH 12	KGH 6
	NGH 10	NGH 19
PREV. 12 MONTH AV.		
	KGH 8	KGH 14
	NGH 4	NGH 24

BREASTFEEDING INITIATION

KGH 74.9%
NGH 77%

PREV. 12 MONTHS
KGH – 73.2%
NGH – 84.0%

NHS

Month 2026 UHN AT A GLANCE

98%

MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

98% Jan

YEAR 7 PROGRESS MATERNITY INCENTIVE SCHEME SAFETY ACTIONS

KGH 7 SAFETY ACTIONS

NGH 10 SAFETY ACTIONS

1

MNSI REPORTABLE CASES & REFERRED

2 Jan

MATERNITY FRIENDS & FAMILY TEST (SATISFACTION %)

95.5%

VACANCY RATE (February DATA)

MIDWIVES	8.4%
CONSULTANT OBSTETRICIAN	0 WTE
NEONATAL NURSES	7.3%
NEONATOLOGISTS	0 WTE

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)

97%

97% Jan

5 MODERATE INCIDENTS

13 Jan

MINIMUM SAFE STAFFING MET (LABOUR WARD ONLY)

82.5%

88.4% Jan

0 PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

0 Jan

0 CORONER'S REGULATION 28

0 Jan

1:1 CARE IN LABOUR **100%**

100% Jan

NHS

Month 2026 AT A GLANCE

KGH 99%
NGH 97%
MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

YEAR 6 MATERNITY INCENTIVE SCHEME
9 SAFETY ACTIONS
KGH 6 SAFETY ACTIONS
NGH 9 SAFETY ACTIONS

KGH 1
NGH 0
MNSI REPORTABLE CASES & REFERRED
November

MATERNITY FRIENDS & FAMILY TEST
(SATISFACTION %)
KGH 95%
NGH 96%

VACANCY RATE

MIDWIVES	KGH 7.95% NGH 8.68 %
CONSULTANT OBSTETRICIAN	KGH 0 % NGH 0 %
NEONATAL NURSES	KGH 9.3% NGH 5.61 %
NEONATOLOGISTS	KGH 0 WTE NGH 0 WTE

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)
KGH 99%
NGH 96%

KGH 2
NGH 3
MODERATE INCIDENTS

KGH 0
NGH 0
PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

KGH 0
NGH 0
CORONER'S REGULATION 28

MINIMUM SAFE STAFFING MET (LABOUR WARD ONLY)
KGH 79%
NGH 86%

1:1 CARE IN LABOUR
KGH 100 %
NGH 100 %

NHS

IN FOCUS – UHN Clinical Quality Surveillance

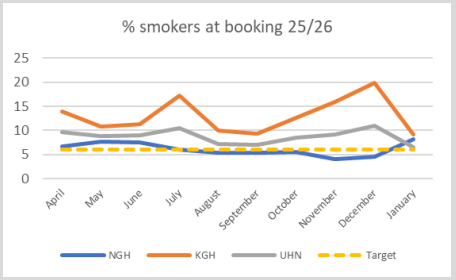
University Hospitals of Northamptonshire

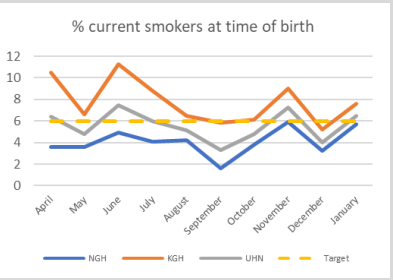
Summary

Overall clinical quality across UHN remains stable, with most antenatal, intrapartum and outcome measures showing expected month-to-month variation and no sustained deterioration. NGH generally performs close to target across indicators, while KGH contributes more variation, particularly in smoking rates, APGAR scores and preterm birth, although patterns largely reflect small numbers and high-impact single cases. Intrapartum measures such as PPH, perineal trauma and breastfeeding initiation stay within normal ranges, and outcomes including stillbirth and preterm birth remain broadly aligned with national expectations. Rising BMI at booking and persistent smoking variation indicate areas requiring continued focus, alongside strengthening intrapartum surveillance, early-pregnancy risk assessment and cross-site standardisation. Ongoing monitoring through the Perinatal Single Improvement Programme will ensure emerging trends are identified early and addressed consistently across both sites.

Smoking in Pregnancy

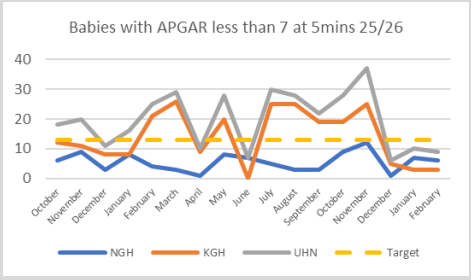
NGH continues to perform close to the smoking-reduction target, with consistently low rates at both booking and birth. KGH's rates remain significantly higher throughout the year, with several peak months that drive the overall UHN figures above target; as a result, UHN's combined trajectory closely mirrors KGH's trend. Improvement actions include strengthening pre-conception cessation work with public health partners, reviewing cross-site interventions to identify effective and transferable practice, implementing standardised UHN-wide monitoring and shared learning, and working with the MNVP to enhance communication campaigns and promote available support.





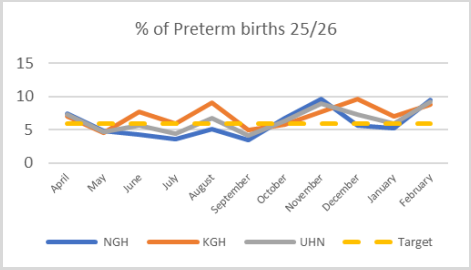
APGARs less 7 @ 5mins

NGH remains relatively stable and consistently below the target threshold, with only minor month-to-month variation. In contrast, KGH demonstrates greater fluctuation with several clear peaks, particularly in March, May and October, suggesting performance is influenced by small numbers and single high-impact cases, as well as periods of increased acuity or variation in intrapartum and immediate newborn care. To address this, key improvement actions include strengthening intrapartum surveillance and escalation pathways, enhancing consistency in fetal monitoring skills, expanding simulation-based newborn resuscitation training, and improving cross-site learning with standardised data definitions and recording. Progress will be monitored through the PSIP to ensure variation is reduced and practice becomes more consistent across both hospitals.



% of Preterm Births

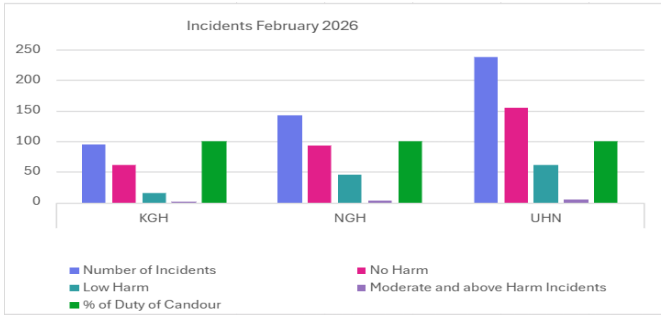
Rates across UHN fluctuate around the national 6% target, with most months sitting close to or slightly above the threshold. NGH remains relatively stable with modest variation, while KGH shows slightly greater fluctuation with intermittent peaks. The combined UHN rate reflects this pattern and remains within a moderate range, showing normal statistical variation rather than a sustained upward trend. However, repeated months above target highlight opportunities to strengthen prevention and early risk identification. UHN is enhancing early-pregnancy risk assessment and launching a system-wide "Period Late, Tell Us By 8" campaign to support earlier booking, enabling timely identification of women at higher risk of preterm birth and ensuring consistent access to preterm birth prevention and optimisation – Deep Dive to be presented at the next PAC meeting



CLINICAL QUALITY AND SAFETY

University Hospitals of Northamptonshire

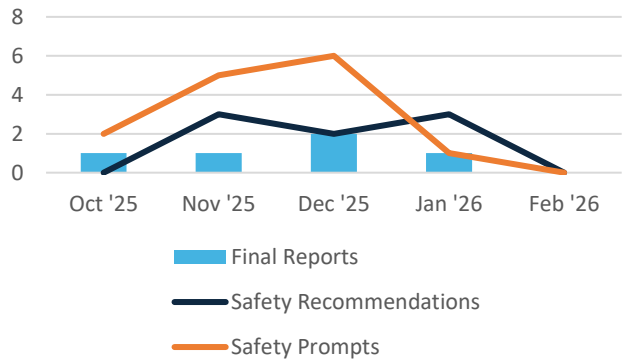
Incidents and Events



MNSI Cases	Current Month	Prior Month
Referred	1	1
Accepted	1	0

PSII Cases	Current Month	Prior Month
Commissioned	0	0

MNSI Final Reports by Month/Year



What the data is telling us

- **0 Patient Safety Incident Investigations** (PSII) commissioned
- **1 Case referred** to maternity and Newborn Safety Investigation (MNSI): Cases accepted
- **238 Datix's** reported. Themes related to medication incidents and staffing due to transitional care. **5 Moderate Incidents** with no immediate cause for concern.
- **2 Early Neonatal Deaths** (21-36 week's gestation) and **2 Stillbirth Births**. Spontaneous pre-viable labour and care provided outside of the UK identified as a themes.

What we need to focus on

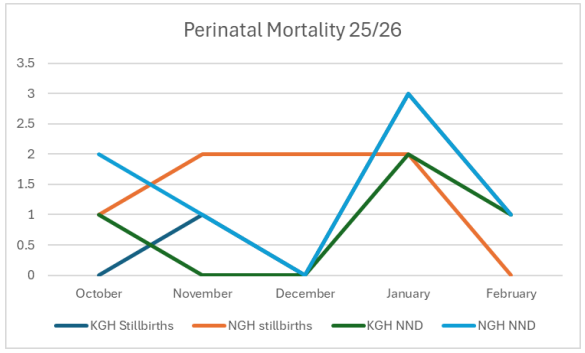
Postpartum Hemorrhage:
NGH are undertaking a deep dive into PPH as numbers have increased, this is currently attributed to more accurate measuring and reporting however further analysis required

Clinical Quality and Safety: Ongoing work to strength governance alignment across NGH and KGH to ensure standardised reporting and improve data quality. Workshops beginning in April 2026

What is going well

Perinatal Safety Improvement Programme (PSIP) continues to progress at pace. The workstreams, Listening to and working with women and families, Growing, retaining and supporting our workforce, Developing and sustaining a culture of safety, learning and support and standards and structures that underpin safer, more equitable & personalised care are becoming well embedded. With good representation across the MDT and sites.

Perinatal Mortality



	MOSS Signal	SPEN referral
KGH	0	1
NGH	0	0

PMRT reviews include external panel member - no outstanding cases, all reviewed within correct time frames. SPEN Referral is in relation a Q3 MNSI case (baby transferred for cooling)

CQC Maternity Rating

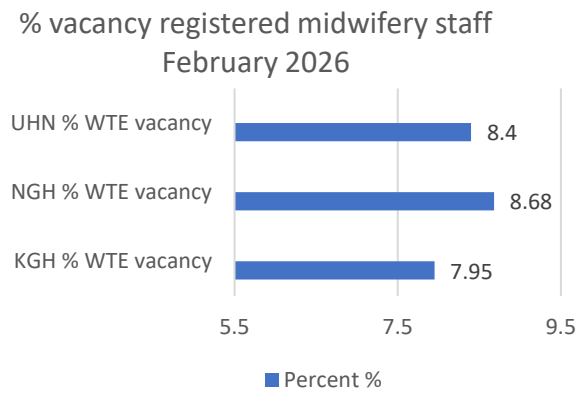
	KGH	NGH
Are services safe?	🟡	🟡
Are services effective?	🟡	🟢
Are services caring?	🟢	🟢
Are services responsive?	🟡	🟢
Are services well-led?	🟡	🟡
Overall	🟡	🟡

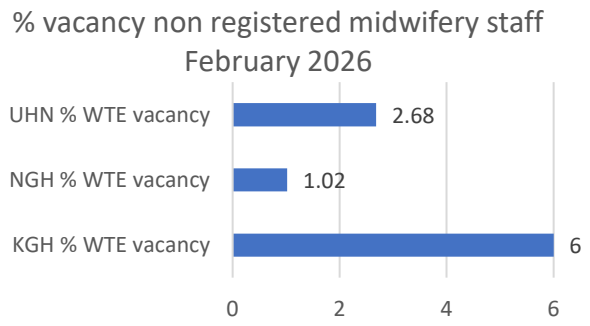
★ Outstanding 🟢 Good
🟡 Requires Improvement 🔴 Inadequate

WORKFORCE - Maternity

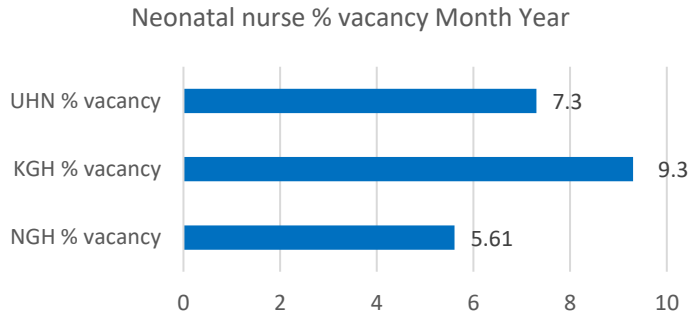
University Hospitals of Northamptonshire

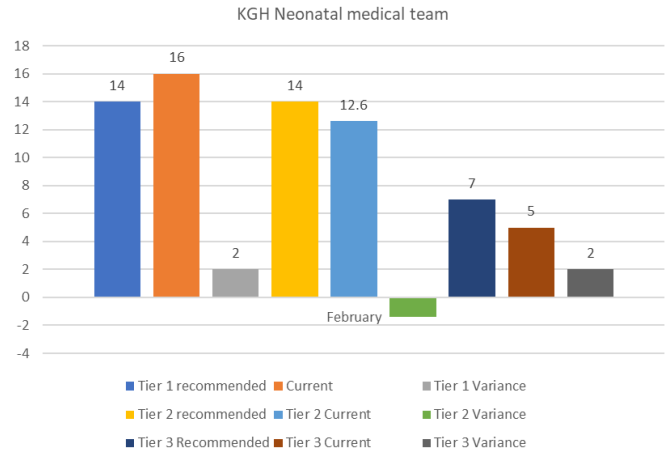
Midwifery vacancy



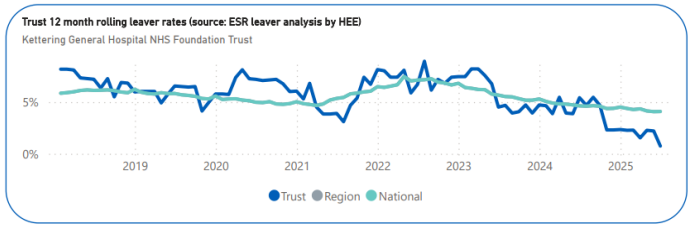


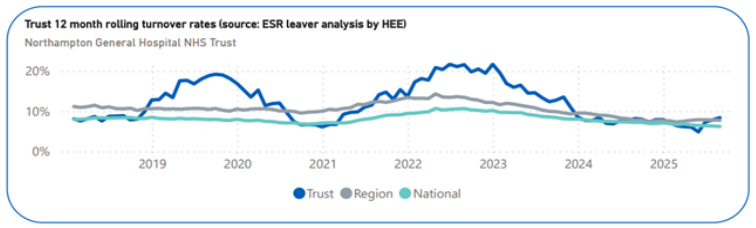
Neonatal vacancy





UHN 12 month rolling leaver rate





At NGH, vacancies have risen this month following the repurposing of Band 3 funding, although recruitment remains strong with 3.70 WTE midwives due to start in March and a further 8.81 WTE joining between April and September 2026. At KGH, the vacancy position stands at 7.95 WTE, supported by a healthy recruitment pipeline with appointed candidates and confirmed start dates. Neonatal nurse staffing continues to reduce across both sites month-on-month, but sustained recruitment activity is in place to address this.

Within the medical workforce, NGH currently relies on one agency locum obstetrician until June 2026. Recruitment is underway for two NHS locum posts on 12-month fixed-term contracts, with the agency locum being retained to maintain safe service cover until new staff are established in post. A business case will be developed to convert these roles into substantive positions, supporting long-term stability and reducing reliance on agency provision.

At KGH, obstetric consultant job planning continues with a focus on aligning clinical activity, supervision requirements and service needs. A comprehensive demand-and-capacity review is now required to identify current and emerging pressures and support the development of a sustainable consultant service model. This work will help ensure appropriate consultant presence, safe staffing levels and the resilience needed to meet current and future activity demands.

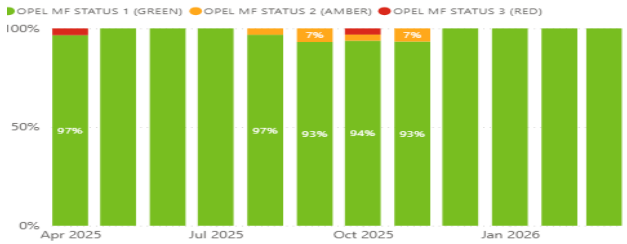
OPERATIONAL AND CAPACITY

University Hospitals of Northamptonshire

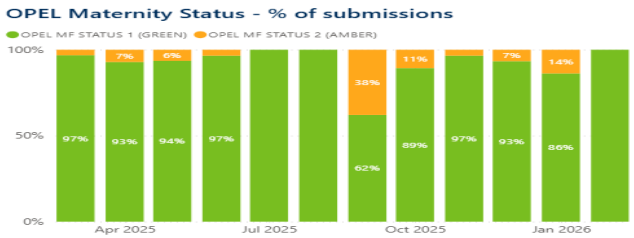
Key Information

Operational Pressures Escalation Levels

Kettering General Hospital

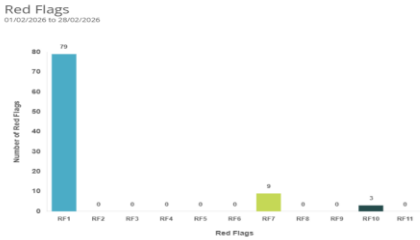


Northampton General Hospital

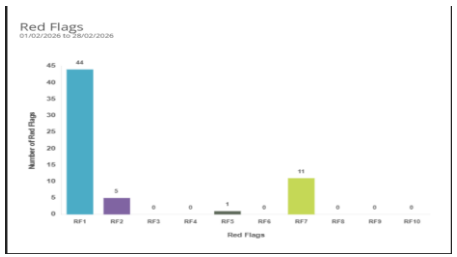


Midwifery Red Flag Events

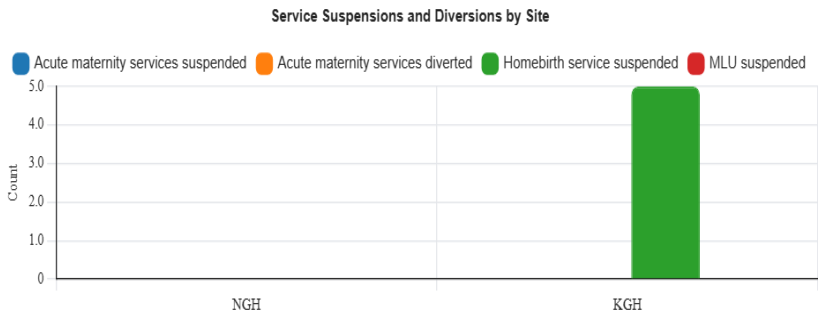
Kettering General Hospital



Northampton General Hospital



Performance Levels



In-Utero Transfers – extreme preterm births (Northamptonshire)

KGH 1

NGH 0

What the data is telling us

UHN maintained stable OPEL levels throughout February, with NGH remaining at OPEL 1 and KGH showing no significant escalation. Red flag events were recorded at both sites, mostly linked to delayed or cancelled critical activity, but without triggering service disruption. KGH homebirth services were pause on 24 February in response to a review of the service following the national PFD. An In-utero preterm transfer was undertaken supporting birth in the right place for gestation reflecting safe planning and good MDT working across the system.

What we need to focus on

Continue recruitment and close monitoring of maternity capacity to maintain safe staffing, manage demand surges and reduce red flags. Maintain early escalation through established pathways. At NGH, improve Birthrate Plus compliance to strengthen evidence-based workforce planning. The plan to restore Homebirth service at KGH involves immediate safety actions, strong governance, clear communication, workforce training, guideline review, and ongoing assurance to provide safe, sustainable, and personalised homebirth care for women across UHN.

What is going well

Operational performance across UHN remains strong, with no acute maternity service suspensions, diversions or unit closures reported at either NGH or KGH. Both sites maintained stable OPEL escalation levels throughout February, demonstrating effective capacity management despite activity pressures. Midwifery red flag events were monitored closely, with delays or cancellations managed safely and no associated service disruptions. In-utero transfers for extreme preterm births were recorded as zero across both hospitals, indicating stable clinical pathways and safe local management. Overall, maternity services continued to deliver consistent, resilient care with uninterrupted service availability. Individualised support for booked homebirths at KGH

TRAINING AND COMPLIANCE

University Hospitals of Northamptonshire

Training compliance

Attendance – All Staff

Kettering General Hospital

Northampton General Hospital

Module 3: Maternity emergencies and multiprofessional training:

	Dec-25	JAN	FEB
Prompt Midwives	99%	99%	99%
Prompt Doctors Cons	100%	100%	100%
Prompt Doctors Reg	100%	100%	100%
Prompt Anaesc Cons	100%	100%	100%
Prompt Anaes Reg	100%	100%	100%
Prompt MSW	98%	100%	100%

PROMPT	December	January	February
All Staff	98%	97%	97%
Anaesthetists	97%	89%	83%
Obstetric Consultants	92%	100%	100%
Obstetric Doctors	97%	87%	95%
Midwives	98%	100%	99%
Maternity Support Workers	99%	97%	99%

Module 6: Neonatal Basic Life Support:

	Dec-25	JAN	FEB
NLS Midwives	99%	99%	99%
NLS MSW	98%	100%	100%

NBLS/NLS	December	January	February
Midwives	97%	97%	96%
Maternity Support Workers	97%	97%	94%

Element 4: Fetal monitoring and surveillance:

	Dec-25	JAN	FEB
CTG Day Midwives	100%	99%	100%
CTG Day Consultants	100%	100%	100%
CTG Day Reg	100%	100%	100%

What the data is telling us

Training compliance remains consistently strong across both NGH and KGH, with the majority of modules achieving 95–100% attendance. NGH continues to perform above the 90% threshold and remains close to the 95% stretch target, providing strong assurance against CNST requirements. PROMPT attendance is high across all clinical groups—including obstetric, anaesthetic, midwifery and maternity support staff—demonstrating robust engagement with safety-critical training. While anaesthetic attendance shows a recent dip due to rota and release-time constraints, targeted coordination is already underway to ensure protected time for staff. Overall, the data provides clear evidence of sustained commitment to mandatory training and ongoing investment in safe, high-quality clinical practice.

What we need to focus on

Anaesthetic training compliance at NGH continues to require focused attention, with recent rota pressures and limited release time contributing to reduced attendance. Ensuring protected time for anaesthetic staff remains a priority to restore compliance levels.

Preparation for the next PROMPT cycle is underway, including updating training content and ensuring reliable attendance across all staff groups. Maintaining high compliance across all modules remains essential, with early variation—particularly in multidisciplinary sessions—being monitored closely. Improved coordination between training teams and service leads will help prevent missed sessions and secure consistent access to safety-critical learning across both sites.

What is going well

Training compliance across both NGH and KGH remains strong, with the majority of modules achieving 95–100% attendance. PROMPT training is well-embedded, with consistently high participation from midwives, obstetricians, anaesthetists and maternity support staff. Fetal monitoring (CTG) training shows 100% compliance across all staff groups. At NGH, local learning continues to be systematically embedded through Training Week and ongoing simulation programmes. Multidisciplinary engagement is strong, and recent clinical skills updates have supported safe practice. New starters and rotation planning are progressing well, helping maintain continuity of learning and strengthening overall training culture.

SAFETY GOVERNANCE ACTIONS

University Hospitals of Northamptonshire

Maternity Improvement Scheme

MIS Safety Action – Year 7	MIS Standards	KGH Status	NGH Status
1. Use of Perinatal Mortality Review Tool	6	Not Attained	Complete
2. Submitting data to the Maternity Services Data Set	2	Complete	Complete
3. Transitional Care and Avoiding Term Admissions to Neonatal Unit	4	Complete	Complete
4. Clinical workforce planning	10	Not Attained	Complete
5. Midwifery workforce planning	6	Not Attained	Complete
6. Saving Babies Lives Care Bundle	6	On Track	Complete
7. Listening to women, parents, and families	5	On Track	Complete
8. Multidisciplinary training	3	On Track	Complete
9. Ward to Board assurance	9	On Track	Complete
10. MNSI and Early Notification Scheme Reporting	9	On Track	Complete

Summary

Maternity Incentive Scheme for Trusts Year 7 UHN has submitted CNST declaration forms for both Trusts. NGH fully achieved all ten Safety Actions, providing strong assurance of compliance. At KGH, Safety Actions 1, 4 and 5 were not fully met for MIS Year 7, as the evidence submitted did not yet demonstrate consistent embedding of required standards. Specifically, one PMRT review closure fell slightly outside the expected timeframe, the frequency of labour ward coordinator supernumerary breaches—though low—did not sufficiently evidence robust mitigations, and the consultant attendance audit, while compliant, lacked a replicable and assured methodology. Targeted improvement work is already underway to strengthen governance, workforce planning and evidence-gathering processes, providing confidence that the outstanding requirements are being actively addressed and will be fully met in the next submission cycle.

Saving Babies Lives

Element	Interventions Fully Implemented (Self-Assessment)				Interventions Fully Implemented (LMNS Validated)				NHS Resolution MIS	
	KGH		NGH		KGH		NGH		KGH	NGH
Smoking in Pregnancy	Partly	90%	Fully	100%	Partly	90%	Partly	90%	CNST Met	CNST Met
Fetal Growth Restriction	Fully	100%	Fully	100%	Fully	100%	Fully	100%	CNST Met	CNST Met
Reduced Fetal Movements	Partly	50%	Fully	100%	Partly	50%	Fully	100%	CNST Met	CNST Met
Fetal Monitoring in Labour	Fully	100%	Fully	100%	Fully	100%	Fully	100%	CNST Met	CNST Met
Preterm Birth	Partly	96%	Fully	100%	Partly	96%	Fully	100%	CNST Met	CNST Met
Diabetes	Partly	83%	Fully	100%	Fully	83%	Partly	83%	CNST Met	CNST Met
All Elements	Partly	94%	Fully	100%	Partly	94%	Partly	97%	CNST Met	CNST Met

Summary

UHN has achieved full compliance with Safety Action 6 of the Maternity Incentive Scheme (MIS) Year 7, with both NGH and KGH completing two ICB-led quarterly reviews in 2025/26. NGH was assured at 97%, with ongoing improvement work focused on evidencing diabetes specialist leadership and increasing the proportion of smokers achieving a four-week quit date. At KGH, improvement initiatives include the introduction of a preterm birth signs-and-symptoms leaflet to support optimisation pathways; however, challenges with meeting scan referral times have affected full compliance. A UHN-wide quality-improvement programme focused on scanning has now been incorporated into PSIP to address this, strengthen referral processes, and ensure consistent delivery across both sites.

EXPERIENCE FEEDBACK

University Hospitals of Northamptonshire

Patient Experience

Complaints and Concerns

		Dec 25	Jan 26	Feb 26	YTD	Trend
Maternity	KGH	3	3	1	13	→
Neonatal	KGH					
Maternity	NGH	10	10	0	28	→
Neonatal	NGH	0	0	0	0	→

Friends and Family Test (FFT)

Kettering General Hospital

	Target	National	Dec-26	Jan-26	Feb-26	YTD
FFT % Responses	20%	13%	13%	10%	12%	**17%**
FFT % Promoters	96%	93%	99%	95%	98%	**99%**

Northampton General Hospital

	Target	National	Dec-25	Jan-26	Feb-26	YTD
FFT % Responses	25%	13%	25%	19%	26%	**23%**
FFT % Promoters	96%	93%	96%	96%	97%	**96%**

I had an amazing (very quick) birth on the labour ward in the birthing pool MW and St were both great with making me feel comfortable and respecting my wishes in my birth plan. They also gave me the confidence to listen to my own body and trusted when I was ready to push which felt really empowering and I'm really grateful for. I felt reassured throughout labour and after and the care I received from them both from start to finish was excellent. the student will be a fab midwife once you qualify and your words of encouragement throughout really got me through - thank you so much!!

The Doctor was very communitive, polite , and made sure we understand what was going on and what was going to happen next. 2. All staff welcoming + friendly- lovely attentive. Great facilities +comfortable appreciate being able to have politeness around. What could have be done better; Clear communication on delivery would waiting times/ plan of action for long wait times when busy.

What the data is telling us

- KGH has launched the 'Friends & Family Friday' initiative to increase routine feedback collection, aiming to capture views from every service user each Friday. Continued support from ward managers is essential to maintain momentum.
- Current Friends & Family Test (FFT) promoter scores stand at 98% for KGH and 97% for NGH.
- Complaints increased at both sites in February, with KGH reporting two cases and NGH three cases. Overall FFT response rates at KGH remain low at 12% (141).
- In February, NGH exceeded the 20% response-rate target, achieving 26% (272 responses). The 'Birth' area achieved 100% satisfaction for the second time, contributing to an overall satisfaction rate of 97.4%.
- At NGH, communication and use of language remain the most common themes highlighted by service users. Lower satisfaction persists within triage and postnatal wards, where targeted improvement work continues.

What we need to focus on

- Delays in discharge continues to be an area of dissatisfaction on the PN wards at NGH & KGH – discharge animations have now been approved via governance and are available for sharing which will hopefully speed up 'discharge talks' and support patients at home.
- The 'Motherhood group' has been contacted to explore staff training around black maternal health and cultures, with a focus around stigma, cultural differences, language and listening.
- Feedback rates continue to be a focus with regular sharing on social media. Work is being done with the digital team to add the FFT links to BadgerNet so that link can be sent directly to patients via badger notes. New links have been added to the NGH website to ensure the links are more accessible.

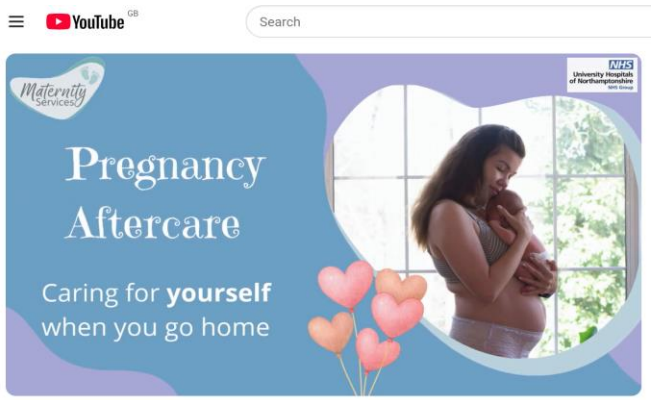
SPOTLIGHT ON…

University Hospitals of Northamptonshire

What is going on?

Two new patient-facing discharge animation videos are now available across both trusts, designed to support families in understanding key postnatal information before leaving the ward and again at home. Separate videos have been developed for maternal postnatal care and newborn care, created by the Patient Engagement Midwife in response to feedback highlighting delays in discharge and the need for clearer, more consistent information. These resources aim to ease pressure on ward teams by supporting the 'discharge talk' and ensuring patients receive accessible, standardised guidance. The videos can be accessed via the links below

Mother Discharge Video Subs
Baby Discharge Video



Pregnancy aftercare: Going home after giving birth

What is going on?

With the introduction of revised portfolio's for the UHN Senior Midwifery Team there are now Perinatal Quality Improvement Matrons working cross-site to provide dedicated leadership and collaboration on both ongoing and emerging QI programmes. Current QI priorities include:

- **Induction of Labour (IOL) Pathway** – supported by the NHSE Regional Perinatal Team, with task-and-finish groups in place to progress pathway redesign, strengthen consistency and address operational inefficiencies
- **Elective LSCS Pathway** – KGH has begun implementing a BadgerNet-based booking system, with actions from recent process-mapping now being taken forward. Longer-term plans include aligning the elective caesarean process across UHN and reviewing workforce models for the elective section team and enhanced recovery pathways
- **Medicines Management** – the next QI project to launch, with cross-site process mapping planned to identify variation, highlight system challenges and establish priority areas for improvement

Collectively, these programmes provide a structured and coordinated approach to perinatal improvement, ensuring both sites move toward more aligned, reliable and efficient pathways.

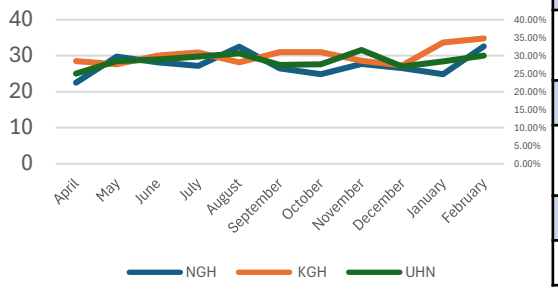
APPENDICES

TRENDS: – CLINICAL QUALITY SURVEILLANCE

University Hospitals of Northamptonshire

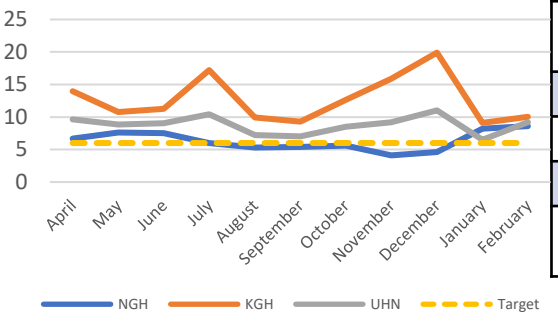
Antenatal

% BMI 30 or more at time of booking



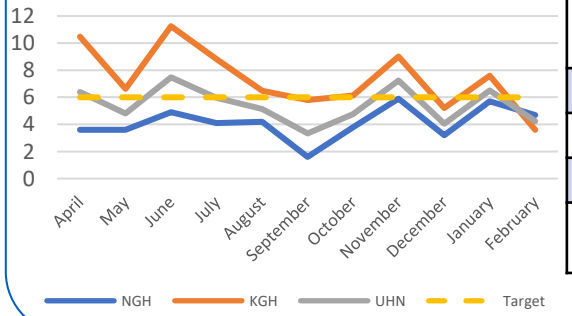
Latest
30.05% increase from 28%
Variation
No NGH data so UHN value artificially lower
Target achievement
N/A

% smokers at booking 25/26



Latest
9.214 % increase from 8.6%
Target
6% SBLCB
Target achievement
Require additional data points to analyse

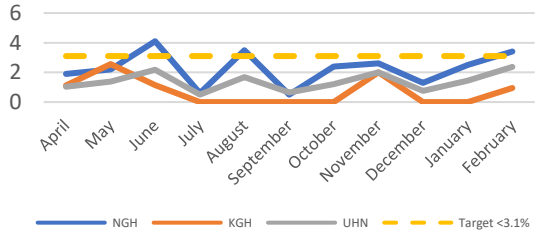
% current smokers at time of birth



Latest
4.24% decrease from 6.5%
Target
6%
Target achievement
Require additional data points to analyse

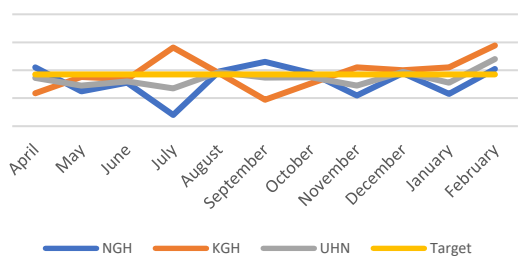
Intrapartum

% Women who experience a 3rd & 4th Degree Tear



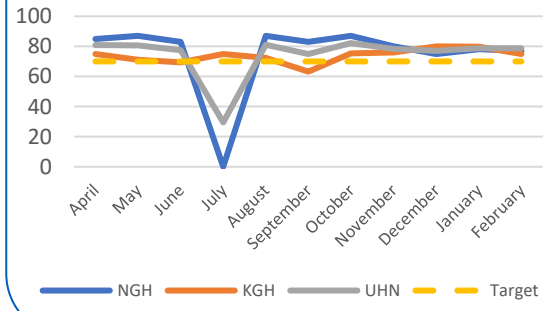
Latest
2.37% Increase from 1.45%
Target
3.1%
Target achievement
Require additional data points to analyse

% Women with PPH of 1500ml or more



Latest
4.8% increase from 3.1%
Target 3.7%
N/A
Target achievement
N/A

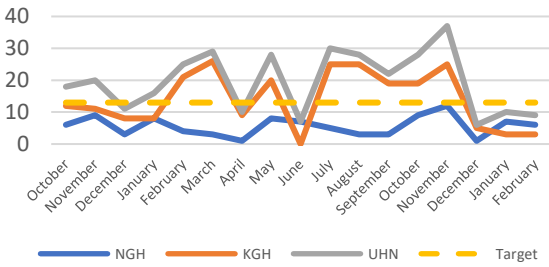
% Breastfeeding initiation 25/26



Latest
76.12% reduction from 78.76%
Target 70%
No NGH data for July
Target achievement
Require additional data points to analyse

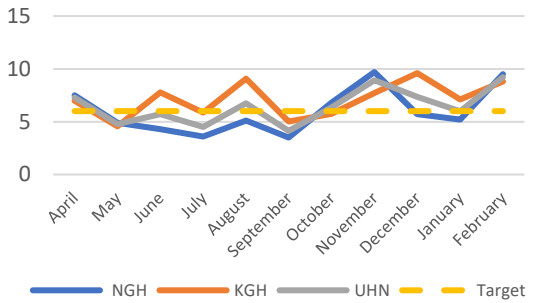
Outcomes

Babies with APGAR less than 7 at 5mins 25/26



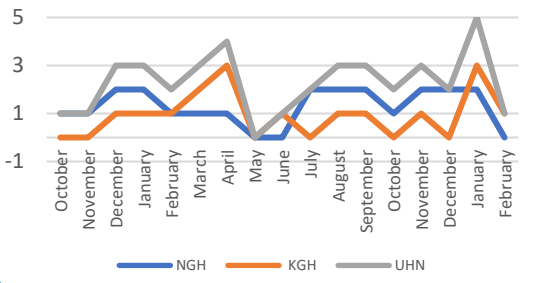
Latest
9 decrease from 10 . 17/1000 births higher than target
Target 13/1000 births
N/A
Target achievement
Require additional data points to analyse

% of Preterm births 25/26



Latest
8.92% of total births
Target
6% SBLCB
Target achievement
Require additional data points to analyse

Stillbirth 25/26



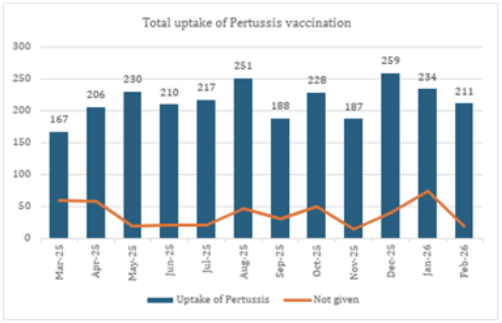
Latest
1.93 per 1000 births – UHN reduction from 5.36
Target
N/A
Target achievement
N/A

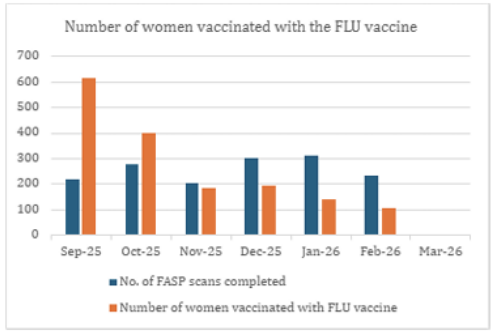
IMMUNISATION SUMMARY

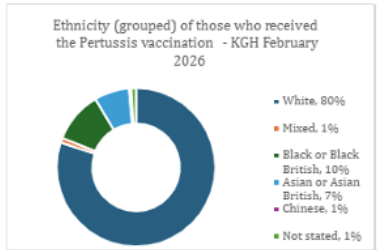
University Hospitals of Northamptonshire

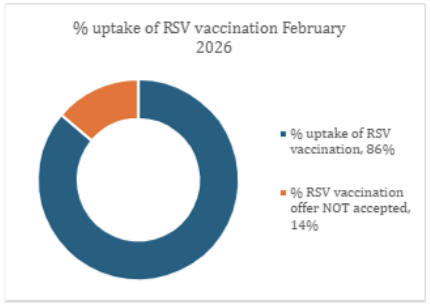
Kettering General Hospital

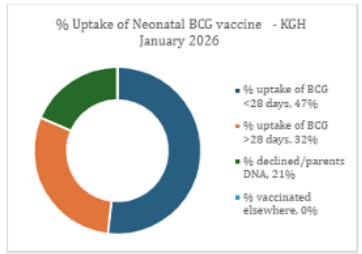
Immunisation Summary Antenatal Pertussis, RSV, FLU & Neonatal BCG Immunisations – FEBRUARY 2026

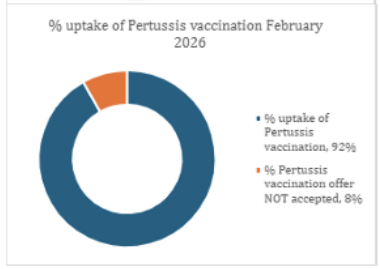


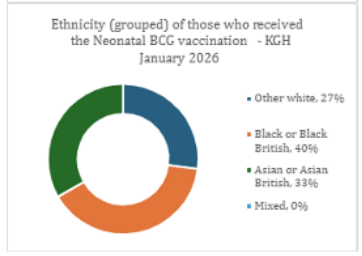






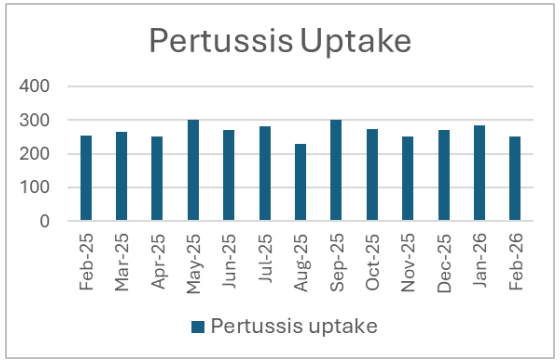


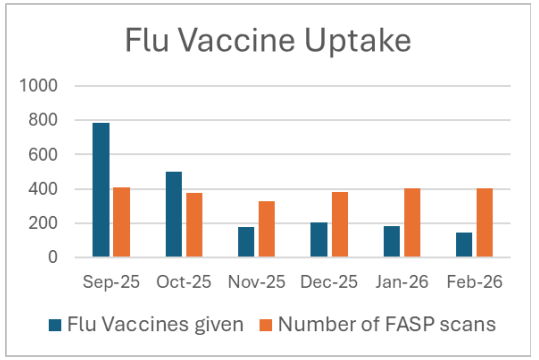




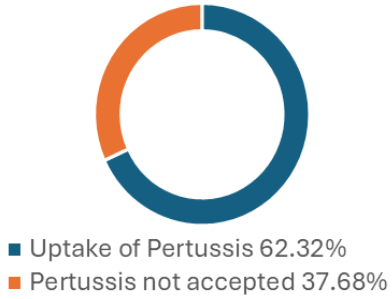
Northampton General Hospital

Immunisation Summary NGH February 2026

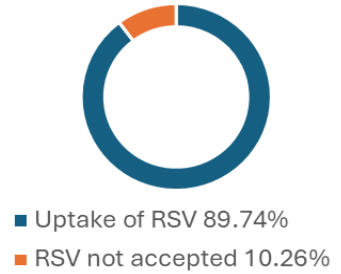




Percentage of Pertussis NGH February 2026



Percentage of RSV NGH December 2025



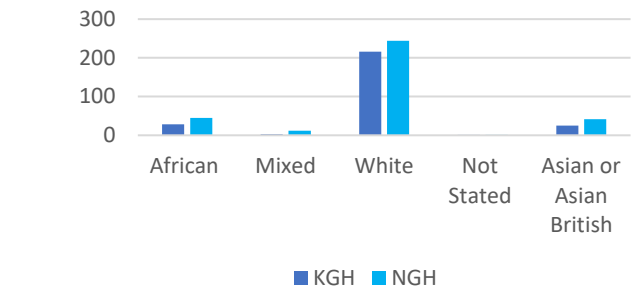
KGH reports steady antenatal immunisation activity, with February data showing uptake across pertussis, RSV, flu and neonatal BCG programmes, alongside visual breakdowns of accepted and declined vaccinations. NGH shows detailed February 2026 uptake trends for pertussis and flu, with pertussis acceptance at 62.32% and RSV acceptance at 89.74%. Flu vaccine volumes are tracked monthly against FASP scan numbers. NGH highlights improved accessibility through three community clinics, supporting higher maternal and BCG vaccination rates while reducing hospital burden and mitigating space and location challenges

EQUITY AND POPULATION

University Hospitals of Northamptonshire

Ethnic profile and variations

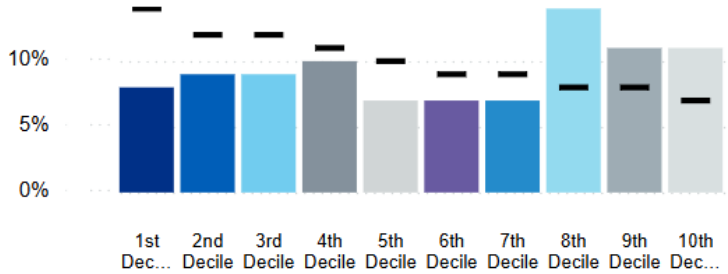
Population profile at booking



Across both sites, the vast majority of births occur within the White ethnic group, with NGH recording slightly higher numbers than KGH. Small numbers of births are recorded among African and Asian or Asian British families at both sites, with NGH again reporting marginally higher activity. Very low numbers appear in the Mixed category, and a small proportion of records are classified as Not Stated. The distribution reflects the population profile of the local maternity service, and the pattern is broadly similar across both hospitals, with no major disparities between sites except for overall activity volume.

Deprivation

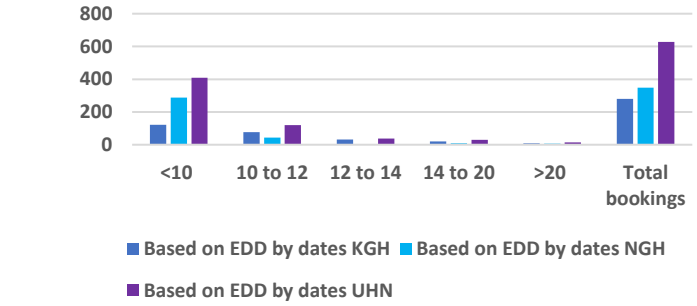
Population profile at birth



The chart shows the distribution of births across deprivation deciles, from the most deprived (1st decile) to the least deprived (10th decile). Births are spread across all deciles, but the pattern indicates no strong clustering at either extreme. The mid-range deciles (3rd–5th) show moderate representation, while the 8th decile displays a noticeable peak, suggesting a higher proportion of births from less deprived areas. The 1st and 2nd deciles also show steady contributions, indicating a continued presence of families from more deprived communities. Overall, the data suggests a mixed population with slightly higher birth activity in the less deprived deciles.

Gestational Age

Gestational age at booking



The chart shows the distribution of gestational age at booking across KGH, NGH and the combined UHN totals. Most women book before 10 weeks, with NGH showing the highest proportion of early bookings, followed by the combined UHN total. A smaller number of women book between 10–12 weeks and very few book after 12 weeks, with numbers declining further in the 14–20 week and >20-week categories. Total booking numbers are higher at NGH, reflected in the slightly larger bars across most gestational age groups. Overall, the data indicates that the majority of women access maternity care early in pregnancy, with relatively few late bookers across both sites. To further support early access to perinatal services across UHN a new campaign has been launched – **'Period Late Tell Us By 8'**

GLOSSARY OF TERMS

University Hospitals of Northamptonshire

Glossary

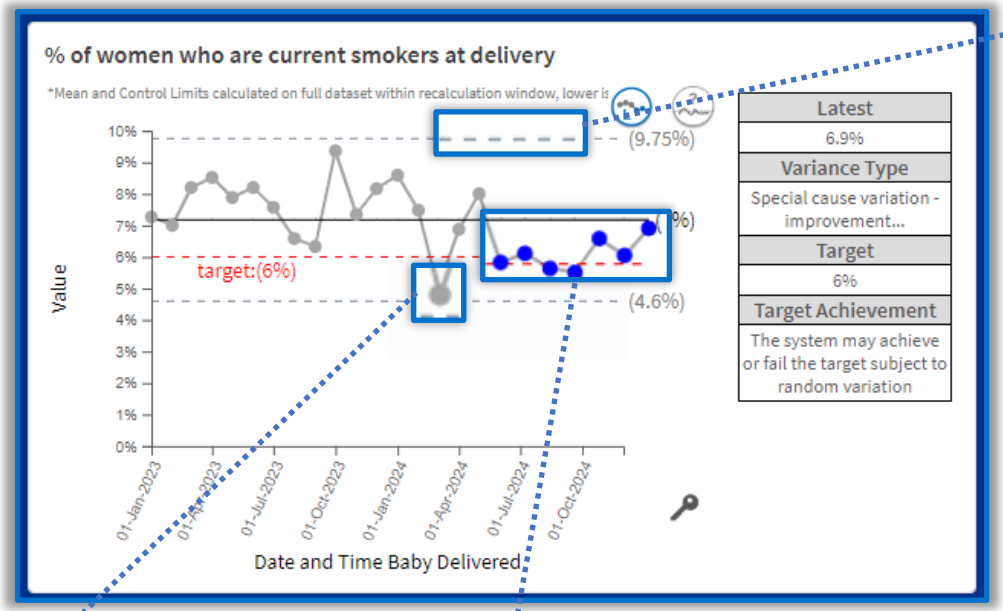
In February, there were 716 babies born across the service, which was below the monthly average and notably lower than January, partly due to the shorter month. Irrespective of the decrease in number of babies born, activity remained high noted in our amber and red OPEL status, along with higher acuity levels and a corresponding rise in reportable red flags. Tactical meetings ensured decisions were made to maintain 1:1 care during labour and ensure safe staffing levels. Staff were redeployed, and services were diverted as necessary with no impact or negative harm. Staffing gaps were primarily caused by high levels of sickness and unexpected absences. Induction of Labour (IOL) activity remained high, but there was a positive improvement in the time taken from decision-making to performing artificial rupture of membranes compared to previous month. Our latest position on the regional heatmap has improved significantly, now sitting at 34.3, down from 53.3. As a result of improvements within the service, ICB/Regional oversight has been stepped down, with ongoing monitoring through routine perinatal quality surveillance.

Term	Abbreviation
Induction of Labour	IoL
Hypoxic-Ischemic Encephalopathy	HIE
Hospital Readmission	HRA
Postpartum Haemorrhage	PPH
Intensive Care Unit	ICU
Severe Maternal Morbidity	SMM
Kettering General Hospital	KGH
Northampton General Hospital	NGH
Gestational Diabetes Mellitus	GDM
Hyperemesis Gravidarum	HG

INTERPRETING DATA

Throughout this series of slides, we display data that shows you how we are performing in the current month and across time. We primarily do this through single data points on the 'At a Glance' slides and Statistic Process Control (SPC) charts. In this slide, we describe **SPC charts.**

SPC charts are widely used across the NHS to measure changes in data over time.
There is **strong evidence** that these provide a **better basis for decision making** versus isolated data points.



An SPC chart has **three reference lines** that allow you to interpret variation in the data. The **central reference line** shows the average (sometimes the median). The **upper and lower reference lines** show the process limits. These limits are defined by the variability in the data itself. Roughly 99% of the values should fall inside process limits. Sometimes there is also a **target line** – this shows the target that we are aiming to achieve for a given measure.

Common cause variation: a single value that looks abnormally high or low, but remains within process limits, is due to **common cause variation**. This means that it is not statistically significant as an isolated value and can be explained by usual variance in the system.

Special cause variation: this represents a value or trend that is likely to be **statistically significant** and therefore **not due to normal variation**. In our slides, these will be highlighted in **blue**. There are 4 different kinds of special cause variation:

1. **6 or more consecutive points above or below the mean line**
2. **A single data point outside the control limits**
3. **6 or more consecutive points increasing or decreasing**
4. **2 out of 3 consecutive points close to the process limit**