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UHL/UHN Boards in Common Paper H

Meeting	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	9 April 2026
Title	KGH Maternity and Neonatal Intensive Support Team (MatNeoIST) Programme (Item 3.2 Paper H)
Presenters	Julie Hogg, Chief Nurse Danni Burnett, UHN Interim Director of Midwifery
Author	Danni Burnett, UHN Interim Director of Midwifery

Action: this paper is for		
☐ Decision *(indicate, UHL, UHL, KGH or NGH as required)*	√ Assurance (KGH)	☐ Update

Which Group Priorities does this link to?		
√ Transform Patient Care	√ Strengthen our Culture	☐ Deliver our financial plan

Where has this report has been discussed previously?
NHS England and Northamptonshire ICB Improvement Oversight & Assurance Group (IOAG) 18 November 2025, 17 December 2025, and 15 January 2026, 5 March 2026
Does the report provide assurance or mitigate any significant risks? If yes, please detail which
UHN11 Improved clinical outcomes, experience and effectiveness *UHL BAF risk reference*
Appendix
Appendix 1: MatNeoIST Monthly Report (February 2026) (enclosed below)
Impact assessment
Financial: Potential for increased/changes to workforce and equipment. Failure to achieve our CNST incentive reduction (>£200k). Possible support available through NHS England funding vis LMS work streams. *Legal:* Risk of the safety of maternity services being called into question and the aligned financial and reputational risk *Equality:* This is applicable to all staff within Northamptonshire LMNS and all women accessing care within the LMNS.

Executive Summary

Maternity services at KGH continue to demonstrate clear, observable and sustained improvement, with positive movement across safety, governance, workforce and cultural indicators. The service is now operating within a far more mature, reliable and transparent improvement architecture, with strengthened oversight from divisional, corporate and system-level partners.

The implementation of the Perinatal Safety Improvement Programme (PSIP) alongside a high-quality bi-weekly SitRep has created a single, coherent regulatory recovery framework, aligning PSIP, CQC actions, and MatNeoIST milestones and improving Board visibility, grip and pace. These mechanisms ensure that risks are proactively identified, mitigated and escalated through a strengthened governance line of sight.

All PSIP workstreams are embedding. There is clear evidence of improved clinical governance, strengthened workforce resilience and early cultural recovery. Continued focus on estates, documentation, policy governance and specialist workforce capacity will be critical to securing sustained improvement and delivering regulatory exit.

Recommendations

For the **KGH** Board of Directors to:

1. Take assurance that effective governance, controls and escalation arrangements are in place to oversee maternity and neonatal safety improvement.
2. Note the transition to NHS England MatNeoIST intensive support, providing enhanced external challenge, executive-level oversight and alignment with national expectations.
3. Acknowledge remaining risks, particularly in relation to cultural maturity, documentation quality and sustainability of improvements, and confirm that these are actively monitored with clear mitigation.
4. Confirm continued Board focus on sustaining improvement, evidencing impact and maintaining pace.

Kettering General Hospital (KGH) Maternity Improvement Progress Report: Perinatal Safety Improvement Programme (PSIP) and NHS England MatNeoIST

Reporting period: February 2026 – March 2026

EXECUTIVE SUMMARY

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Key Improvements (demonstrated this reporting period):

- Clinical safety indicators:
    - Consultant attendance: 88%
    - BSOTS triage: 73% seen within 15 minutes; 80–95% compliance across 1-hour/4-hour markers
    - Neonatal resuscitaire checks: 92–98%
    - Theatre medicines safety: 100% compliance
- Service-user experience improving: 100% compliance with consent/communication standards (January audit) and FFT comments referencing improved information-giving and autonomy.
- Workforce stability: All midwifery vacancies filled; mandatory training sustained at 92–96%; strengthened senior medical presence.
- Culture indicators improving: Increased *speaking up* engagement, leadership visibility, civility training uptake, and psychological-safety feedback.

The overall trajectory indicates increasing maturity and reliability, with clear evidence that KGH is progressing towards sustained regulatory recovery and MatNeoIST exit.

1. Perinatal Safety Improvement Programme (PSIP) Oversight and Governance

A single, integrated PSIP governance structure is now fully operational, ensuring direct line of sight from frontline improvement activity through to the Board. This is supported by a network of cross-site specialist forums (i.e. IPC, Digital, Harm-Free Care, Fundamentals of Care) which provide real-time intelligence, expert validation and early risk detection.

Key enhancements to governance include:

- Weekly divisional/directorate senior leadership oversight
- Monthly IAOG scrutiny and exception reporting
- Weekly CQC exception reporting to Executives
- Full alignment of PSIP, CQC, national policy and strategic sustainability planning
- An Executive-led Perinatal Assurance Committee (PAC) as the formal Board-delegated oversight body

This layered approach provides the Board with triangulated assurance, reduces duplication, and ensures risk is actively managed using a three-lines-of-defence model.

KGH formally transitioned from MSSP to Intensive MatNeoIST Support on 1 January 2026. This introduces:

- A 12-month period of intensive, executive-led support
- Dedicated midwifery and obstetric Maternity Improvement Advisors (MIAs)
- Access to national expertise (neonatal, QI, equity, workforce, PMA)
- A focus on co-delivery rather than performance management

Monthly NHS England executive meetings now form the primary assurance mechanism for the improvement programme, with attendance from KGH executives, clinical leadership, Maternity Voice partnerships and regional teams. The monthly MatNeoIST report is shared in Appendix 1. MIAs also attend Trust Board as required, ensuring direct Board visibility of progress, risks and required actions.

Outputs from these meetings are integrated into PAC, Divisional Governance and specialist forums—providing aligned, multi-layered oversight and preventing fragmentation historically seen in maternity improvement programmes.

Evolving MatNeoIST bellwether metrics will further enhance oversight as data maturity improves through BadgerNet implementation.

Board assurance: Governance is now functioning cohesively, with risks actively managed, actions tracked, and assurance strengthened through integrated reporting and executive leadership visibility.

2. MatNeoIST Progress

The MatNeoIST programme continues to progress, with strong clinical engagement and clear ownership across all workstreams. Several deadline extensions are now required, and the newly created PSIP Board (reporting directly into PAC) will be asked to approve (week beginning 30 March 2026). The primary issue has been capacity, rather than a lack of progress or commitment. Over recent months, a significant proportion of clinical leadership time has necessarily been directed toward delivering the CQC response plan, resulting in slower-than-planned mobilisation of certain MatNeoIST strands.
Despite these operational pressures, several key components of the programme are now underway or already embedded, including:

- The Induction of Labour (IOL) Quality Improvement Group,
- Strengthened Diabetes improvement work, supported regionally,

- Consultant job planning to strengthen medical workforce resilience,
- Pathway mapping for Elective Lower Segment Caesarean Section (ELCS), and
- Continued progress in implementing BSOTS (Birmingham Symptom-Specific Obstetric Triage System).

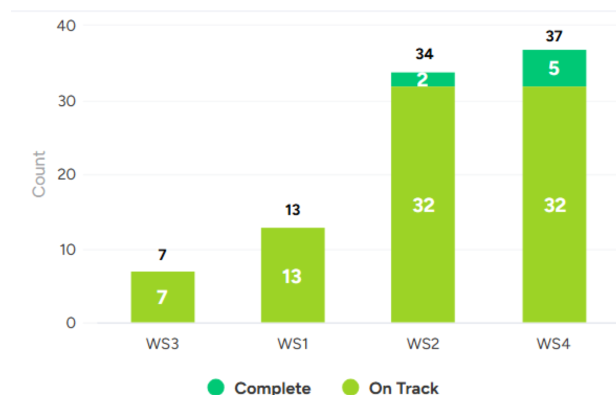
Revised Milestones and Workstream Extensions

The following areas in which timeline extensions are proposed:

- Workstream 1: MNVP workplan and collaborative assessment
- Workstream 2: Community review, obstetric leadership/capacity, workforce strategy development, OPEL/escalation framework, and the EDI deep dive
- Workstream 3: Governance and board effectiveness, and further embedding of PSIRF
- Workstream 4: IOL and ELCS pathway milestones

Workstream 4 additionally proposes the establishment of a dedicated ELCS Task & Finish Group, mirroring the existing structures for IOL, Diabetes, and the Triage group, to accelerate progress and ensure clinical ownership of pathway redesign.

With the new extensions all actions (115 actions) will be on track for delivery:



Overall Programme Position

All MatNeoIST milestones remain aligned to the updated timelines, which have now been formally approved and supersede previous MSSP expectations. These milestones span 3-, 6- and 12-month horizons, giving the programme a clear recovery trajectory and enabling strengthened national oversight.

Although operational stretch is recognised due to the number of concurrent improvement programmes, it is important to note that:

- Milestones are fully mapped into governance routes
- Clinically led, multidisciplinary teams hold delivery ownership
- Delivery pace, engagement, and intent remain high

Next Phase of Delivery

The forthcoming phase of MatNeoIST implementation will provide tangible evidence of:

- increasing cultural maturity,
- greater workforce resilience,
- strengthened and embedded clinical governance, and
- demonstrable improvements across priority pathways, including elective LSCS, community provision, equity, maternity IQI, and strategic workforce planning.

The programme remains on a positive trajectory, and the requested extensions reflect a pragmatic and transparent approach to ensuring high-quality, sustainable delivery.

3. Culture & Organisational Development (Culture & OD)

As part of PSIP a significant culture reset is underway, addressing known issues including inconsistent behaviours, strained psychological safety, and variable supervisory structures.

Progress includes:

- High leadership visibility
- Civility and Respect interventions
- OD-led coaching
- “How Was Your Shift” real-time feedback
- Strong FTSU engagement and early resolution trends
- Mandatory training at 92–96%

Early indicators show:

- Improved escalation behaviours
- Strengthened psychological safety
- Increased recognition awards
- Less formal employee-relations activity

However, risk hotspots remain in sickness, screening/immunisation, and fetal medicine capacity. Sustained investment in wellbeing, supervision and retention will be essential.

Board assurance: Culture trajectory is positive, but full embedding will require continued leadership visibility, behavioural consistency and targeted support for specialist teams.

4. Bellwether Metrics & Monitoring for Impact

A developing 59-metric Bellwether dashboard provides triangulated insight across governance, pathways, workforce, fetal monitoring, triage, elective/emergency pathways, culture, and service-user voice. Approximately two-thirds of metrics now have trend data, with remaining gaps linked to diabetes pathways, MNVP workplan, and developing QI projects.

The latest clinical, governance, workforce and cultural performance metrics provide a high level of assurance that maternity services continue to progress towards sustained safety and regulatory compliance. Evidence presented through routine audit, triangulated intelligence, and PSIP-aligned oversight demonstrates that core safety processes are increasingly reliable and embedded across the service.

Clinical safety indicators remain strong. Consultant labour-ward presence is consistently achieved at 88–89%, and significant improvement has been sustained in BSOTS triage performance, with Yellow/Orange (1-hour) compliance increasing from 45–50% to 80–85% and Green (4-hour) performance maintained at 90–95%. Neonatal resuscitaire checks remain within control limits (AM 92%, PM 98%), and theatre medicines-safety audits continue to demonstrate 100% compliance, with any isolated lapses promptly rectified. These metrics indicate a stable and well-governed clinical environment with effective risk controls in place.

Governance arrangements provide further assurance. Approximately 90% of actions arising from the 2024 CQC inspection have been completed, supported by strengthened closed-loop assurance mechanisms, comprehensive audit logging, independent oversight via PSIP, and routine triangulation of incidents, complaints and performance data. This reflects a maturing governance system with clear line-of-sight from frontline practice to executive and Board-level oversight.

Cultural indicators show early but sustained positive movement. The latest pulse survey reports strong awareness of safety processes, improving leadership visibility and escalation behaviours, and rising Freedom to Speak Up activity with high closure rates. Formal employee-relations activity remains low, indicating issues are increasingly resolved proactively and informally. These trends demonstrate progressive strengthening of psychological safety and team communication, though continued attention is required to ensure consistency across all clinical areas.

Workforce and training data further reinforce service stability. Mandatory training is progressing towards the ≥90% target, Enhanced Maternal Care competencies embedding, and midwifery shift-fill remains consistently between 90–100%. Supernumerary labour-ward coordinator breaches remain within control limits and are effectively mitigated. Midwife-to-birth ratios continue to align with Birthrate Plus® benchmarks, and recruitment actions are underway to deliver a fully dedicated 24/7 registrar presence for triage and FHU.

Pathway and documentation improvements, most notably full adoption of BSOTS, high antenatal escalation documentation (100%), strong risk-assessment and CTG accuracy, and stable induction-of-labour intervals. This provides further assurance that safety-critical processes are reliable and consistently applied. All key clinical policies are in-date or formally extended, and a new Duty of Candour policy has been approved.

Board Assurance: Key metrics demonstrate that maternity services are operating within a strengthened safety, culture and governance framework. While further work remains to fully embed improvements and address residual variation, the evidence provides the Board with a high degree of confidence in the direction of travel, the reliability of current safety processes, and the organisation's continued commitment to delivering safe, high-quality care and meeting regulatory expectations.

5. Overall Board Assurance Summary

KGH is demonstrating measurable and sustained improvement across all core domains. While further embedding is required the current trajectory, supported by strengthened governance and MatNeoIST alignment, provides the Board with a high degree of confidence that KGH is progressing towards regulatory recovery and sustainable, high-quality maternity care.

Appendix 1 – MatNeoIST Monthly Report

Maternity and Neonatal Improvement Support Team

Monthly Update Report

Trust name:	Kettering General Hospital (University Hospitals of Northamptonshire Trust)
MIA(s):	Sarah Latham, Emily Brace – Midwifery MIAs Sabeena Panicker, Sonji Clarke – Obstetric MIAs Elizabeth Pilling, Elizabeth Langham – Neonatal MIAs
Site visits in past month:	2nd, 3rd, 4th, 16 th, 17th, 23rd, 24th - Feb

Report date:	Feb 2026		
Level of support:	Intensive		
Support start date:	January 2026	**Support end date:**	January 2027

Achievements and progress of milestones

- Milestones – positive progress in relation to all milestones. Some minor slippage in relation to IOL, ELCS, governance benchmarking, revised timeframes in place with the view to be on track by end of Q1.
- EDI deep dive undertaken, lead by Wendy Olayiwola, National Maternity Lead for Equity NHSE, final group sessions to take place in mid March.
- Trust focused work in relation to culture ongoing – staff wide training in relation to civility with use of innovative ‘lived experience’ staff videos
- Triage / BSOTS has made excellent progress and is exceeding 3 month milestone (inclusive of governance arrangements)
- Homebirth service review for KGH and NGH undertaken by MIAs
- Neonatal NIAs in place and will be on site in March
- Community review complete (report in development)

Escalations

- Trust review of Homebirth Service, inclusive of benchmarking and Quality Impact Assessment – decision to temporarily pause the Homebirth service for 3 months at KGH. Briefing paper, comms and comprehensive action plan to restore service
- Strengthening legal teams interface relating to birth outside of guidance pathway
- Emerging Obs consultant gap due to upcoming mat leave – out to recruit locum cover, potential challenge in relation to covering leadership roles for Triage, People and Culture.