

Boards in Common Paper F

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:	8 May 2026					
Title:	4.1 KGH Maternity and Neonatal Intensive Support Team (MatNeolST) Programme					
Report presented by:	Julie Hogg, Chief Nurse Danni Burnett, Director of Midwifery					
Report written by:	Danni Burnett, Director of Midwifery					
Action – this paper is for:	Decision/Approval		KGH Assurance	X	Update	
Which Group Priorities does this link to	Transform patient care	X	Strengthen our culture	X	Deliver our financial plan	X
Where this report has been discussed previously	NHS England and LNR ICB facilitated Improvement Oversight & Assurance Group (IOAG): most recent meeting 22 April 2026					

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

UHN11 Transforming Patient Care (positive safety culture)
UHN12 Culture of compassionate responsive and inclusive care

Impact assessment

Financial:

The maternity safety improvement programme supports efficient use of resources through strengthened governance, data-driven decision-making and reduced avoidable harm. Improved safety, workforce stability and control reduce the risk of costly adverse events, litigation, premium staffing and regulatory intervention, supporting sustainable service delivery. Overall, continued improvement represents good value for money and contributes positively to the Trust's financial sustainability.

Legal and regulatory

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Equalities

Assurance through the Perinatal Assurance Committee (PAC) actively embeds Equality, Diversity and Inclusion by promoting inclusive practice, monitoring disparities in outcomes and supporting culturally competent maternity care across services.

**Kettering General Hospital (KGH) Maternity Improvement Progress Report: Perinatal Safety
Improvement Programme (PSIP) and NHS England MatNeolST
March 2026 – April 2026**

EXECUTIVE SUMMARY

Maternity services at KGH continue to demonstrate clear, observable and sustained improvement, with increasing evidence that services are now operating within control across safety, governance, workforce and culture. Immediate patient-safety risks identified have been mitigated, core controls are embedded, and the service is now functioning within a more mature, transparent and reliable improvement architecture, supported by strengthened oversight at divisional, corporate and system level.

The implementation of the Perinatal Safety Improvement Programme (PSIP), underpinned by a high-quality, bi-weekly SitRep and Bellwether metrics, has created a single, coherent regulatory recovery framework. This aligns PSIP, CQC actions, MatNeolST milestones and wider national requirements (including PSIRF, Ockenden and MIS), significantly improving Board visibility, grip and pace. Risks are now identified earlier, escalated appropriately and actively managed through a clear ward-to-board governance line of sight.

All PSIP workstreams are now embedding. There is strong evidence of improved clinical governance, stabilising workforce resilience and early but sustained cultural recovery. While the overall trajectory is positive, continued focus remains required on front-door triage responsiveness, specialist workforce capacity, estates and documentation reliability, and data quality, to ensure improvements are demonstrably sustained and to support regulatory exit.

KEY IMPROVEMENTS DEMONSTRATED THIS REPORTING PERIOD

Clinical safety and reliability

- Consultant attendance: 88–89% overall compliance, with 98% compliance where consultant or suitably competent senior presence is required.
- BSOTS triage:
 - 73–77% of women assessed within 15 minutes (initial assessment)
 - 80–85% compliance at 1 hour (Yellow/Orange)
 - 90–95% compliance sustained at 4 hours (Green)
- Neonatal resuscitaire safety checks: 92–98% both AM/PM, within control limits.
- Theatre medicines safety: 100% compliance, with timely rectification of any isolated gaps.

Service-user experience

- Consent and communication: 100% compliance in March/January audits.
- FFT feedback consistently references improved information-giving, involvement in decision-making and respect for autonomy.

- No evidence of inequity in consent processes; interpreter provision timely and appropriate. However further work required to explore differential care across demographics

Workforce stability

- All funded midwifery vacancies filled.
- Mandatory training sustained at 92–96%.
- Enhanced senior medical presence and strengthening consultant job planning.
- Shift fill consistently 90–100%, with breaches contained within control limits.

Culture and leadership

- Improved leadership visibility and multidisciplinary engagement.
- Increased Freedom to Speak Up activity with high resolution rates.
- Strong uptake of civility and respect interventions and OD-led coaching.
- Early evidence of improving psychological safety and reduced formal employee-relations activity.

Board Assurance: The cumulative evidence demonstrates increasing maturity and reliability, with maternity services progressing toward sustained regulatory recovery and MatNeoIST exit, subject to continued embedding and assurance over time.

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

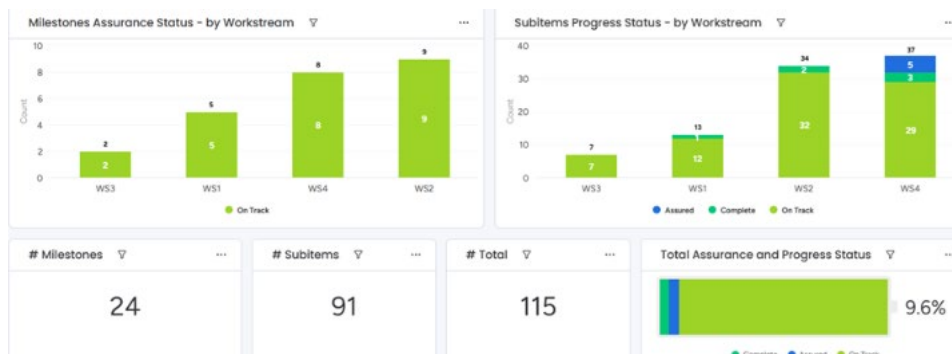
A single, integrated PSIP governance model remains fully operational, maintaining a clear ward-to-board line of sight supported by cross-site specialist forums. Routine executive, divisional and IOAG oversight continues through exception-based reporting, with PSIP, CQC and MatNeoIST actions fully aligned under the Executive-led Perinatal Assurance Committee (PAC). This three-lines-of-defence approach has reduced duplication and strengthened the quality and timeliness of assurance.

Monthly NHS England executive assurance meetings provide external oversight, with outputs embedded into PAC and divisional governance, ensuring aligned and non-fragmented delivery. **Appendix A** indicates that progress is being made across the agreed improvement actions, with clear priorities identified following recent site visits and implementation plans in place. Some short-term milestones have required agreed extensions due to workforce capacity, leadership and perinatal governance complexity, all of which are escalated and being addressed with executive oversight.

2. MatNeoIST Progress

The MatNeoIST programme continues to demonstrate forward momentum despite the scale and concurrency of change. Delivery has advanced overall (+7% month-on-month), with seven milestones achieved this period and the majority of remaining milestones either on track or

progressing within tolerance. As discussed at the executive assurance meeting a small number of milestones are in transition.



Progress is increasingly output-focused rather than process-driven, with tangible movement across priority areas including elective LCS pathwys, induction of labour, diabetes care, equity oversight and bereavement support. Governance grip and executive ownership have strengthened further, supporting improved pace across multiple workstreams. Where milestones have moved closer to tolerance, this reflects the breadth and interconnectedness of delivery, rather than loss of engagement, and recovery against revised monthly trajectories is already evident.

The programme remains clinically led and actively managed, with continued support from regional and national partners, including MIAs, adding value to both the quality and sustainability of delivery.

Board Assurance: Overall, assurance continues to improve as interim arrangements are converted into embedded practice and evidence maturity increases.

3. Culture & Organisational Development (OD)

A substantive culture reset is underway as part of PSIP, addressing historic concerns relating to behaviours, psychological safety and supervision.

Key indicators following the range of interventions demonstrate:

- Improved escalation behaviours
- Strengthened psychological safety
- Increased recognition and positive feedback
- Reduced reliance on formal employee-relations processes

Residual risks remain around sickness absence, screening/immunisation and fetal medicine capacity, requiring continued wellbeing focus and specialist workforce investment.

Board Assurance: Cultural trajectory is positive and improving, though sustained leadership visibility and targeted support remain essential for full embedding.

4. Bellwether Metrics & Monitoring for Impact

The developing Bellwether framework is now providing meaningful, triangulated assurance on whether improvement activity is translating into safer and more reliable care. Trend data is available for the majority of measures, with increasing stability across core safety, governance, workforce and cultural domains. Remaining gaps relate to a small number of pathway-specific measures (notably diabetes and MNVP activity) that are still maturing through active QI delivery rather than representing control failures.

The latest Bellwether intelligence demonstrates that maternity services remain stable and improving overall, with no evidence of emerging or unmanaged risk. Clinical safety indicators are holding within control limits, governance arrangements are operating effectively with closed-loop assurance, and cultural indicators continue to show positive movement. Importantly, these trends have been maintained during periods of sustained operational pressure, indicating increasing system resilience rather than reliance on short-term mitigation.

Variation that remains visible within the dashboard is controlled and explainable, most often relating to documentation timing or data capture as digital systems embed, rather than gaps in clinical practice or escalation. This is supported by exception-based deep dives (for example in triage, fetal monitoring and consent), which consistently demonstrate functioning safety behaviours, appropriate escalation and learning.

Board Assurance: The Bellwether metrics now provide credible, routine assurance that improvements are embedding and being sustained. While data quality and pathway-level maturity remain active areas of focus, the overall position reflects a service operating within control, with high confidence in direction of travel and no indicators of systemic deterioration.

5. Overall Board Assurance Summary

KGH maternity services are demonstrating measurable, sustained and credible improvement across all core domains. While further embedding is required in targeted areas, the current trajectory supported by strengthened governance, PSIP discipline and MatNeoIST alignment, provides the Board with a high degree of confidence that services are moving toward regulatory recovery, sustained assurance and the delivery of safe, high-quality maternity care.

6. Recommendation

The KGH Board is asked to **note and indicate assurance regarding** the positive trajectory, endorse continued focus on sustainability, and support targeted actions to secure long-term assurance and safe, high-quality maternity services.

Appendix A – MatNeoIST Monthly Report

Maternity and Neonatal Improvement Support Team

Monthly Update Report

Trust name:	Kettering General Hospital (University Hospitals of Northamptonshire Trust)	Report date:	March 2026 update (reported in April Exec Meeting)	
MIA(s):	Sarah Latham, Emily Brace – Midwifery MIAs Sabeena Panicker, Sonji Clarke – Obstetric MIAs Elizabeth Pilling, Elizabeth Langham – Neonatal MIAs	Level of support:	Intensive	
Site visits in past month:	10 th , 13 th , 17 th , 18 th , 24 th , 25 th – March 2026	Support start date:	January 2026	Support end date: January 2027

Achievements and progress of milestones

- Progress continues in relation to the milestones
- Neonatal improvement advisors came on site visit on 18th March – potential areas of focus for neonatal milestones to include workforce, perinatal governance and Transitional Care
- Community review completed by MIA awaiting final comments from community matron
- Actions ongoing regarding plan to reinstate Homebirth Service, comprehensive implementation plan in place. EQIA completed by Trust and shared with Regional Chief Midwife
- Plan to implement cross site 7 day a week Bereavement Service cover by end of April
- PSIP board established and due to commence in April
- EDI deep dive – focus groups now completed, report expected by end of May. MIA has requested Wendy Olayiwola to share initial feedback and any immediate recommendations with DoM, CN and CD ahead of the full report

Escalations

Minor slippage in relation to some of the 3 month milestones escalated to Exec as follows.

Governance and Board Effectiveness – UHN perinatal governance deep dive scheduled to take place in April and May – 2 month extension requested and agreed

Obs Leadership and Capacity – job planning ongoing, scoping of workforce capacity – 2 month extension requested and agreed

Service User Voice – MNVP collaborative assessment benchmarking now taking place in April – 1 month extension requested and agreed

Workforce Planning – work ongoing by DoM and senior midwifery leadership team in relation specialist Mw review and maternity support worker competency framework. Cross site escalation framework being devised – request for 2 month extension requested and agreed

Escalation for Exec oversight in relation to operational/obstetric input and support for clinical pathways – see action log