Boards in Common Paper H

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:	11 June 2026					
Title:	5.2 (Paper H) **Kettering General Hospital (KGH) MatNeoIST Summary Report May 2026**					
Report presented by:	Julie Hogg, Group Chief Nurse Danni Burnett, Group Director of Midwifery and Deputy Chief Nurse					
Report written by:	Danni Burnett, Group Director of Midwifery and Deputy Chief Nurse					
Action – this paper is for:	Decision/Approval		KGH Assurance	X	KGH Update	X
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	*Includes Exception Reporting* from NHS England Midlands and LNR Integrated Care Board facilitated Improvement Oversight and Assurance Group (IAOG) May 2026					

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

The report provides assurance that maternity improvement at KGH is progressing and that key risks are being actively managed. These include governance and regulatory recovery, workforce capacity, triage and fetal monitoring, pathway delays, data quality and delivery of the improvement programme. It also identifies the areas that still need close oversight, particularly workforce resilience, evidence maturity and embedding improvements into routine practice.

Impact assessment

The report supports assurance against MatNeoIST requirements and highlights the main operational risks that still need active management. It also identifies workforce and capacity pressures with potential financial impact, and confirms that equity, service-user voice and community access remain part of the improvement focus.

Appendices

Appendix 1: NHS England MIA exception report.

Glossary

This glossary explains terms and acronyms used in this KGH maternity report.

Glossary	Meaning
Ward-to-board reporting	The route by which risks, concerns and performance information are escalated from frontline services to governance groups and Boards.
Bellwether metric	A key measure used to show whether improvement is translating into safer, more reliable care.

Evidence maturity	The extent to which reported progress is supported by repeat audit, validated data and clear proof of sustained improvement.
Regulatory recovery	The actions and evidence needed to respond to external concerns and demonstrate sustained improvement to regulators.
Business as usual (BAU)	The point at which improvement actions are no longer temporary or project-based and have become routine everyday practice.

Acronyms

Acronym	Meaning
BAU	Business as usual
BSOTS	Birmingham Symptom Specific Obstetric Triage System
CQC	Care Quality Commission
CTG	Cardiotocography
EDI	Equality, Diversity and Inclusion
FFT	Friends and Family Test
FDP	Federated Data Platform
IOAG	Improvement Oversight and Assurance Group
IOL	Induction of labour
MIA	Maternity Improvement Advisor
MIS	Maternity Incentive Scheme
MNVP	Maternity and Neonatal Voices Partnership
OPEL	Operational Pressures Escalation Level
PQOM	Perinatal Quality Oversight Model
PSIP	Perinatal Safety Improvement Programme
QI	Quality Improvement
RCOG	Royal College of Obstetricians and Gynaecologists
PSIRF	Patient Safety Incident Response Framework
MatNeoIST	Maternity and Neonatal Improvement Support Team

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST AND UNIVERSITY HOSPITALS OF NORTHAMPTONSHIRE GROUP

BOARDS OF DIRECTORS

11 JUNE 2026

NHS ENGLAND MatNeoIST SUMMARY REPORT - KETTERING GENERAL HOSPITAL

PURPOSE OF THE REPORT

This report provides the Boards of UHL and UHN with an update on progress within Kettering General Hospital maternity services against the NHS England MatNeoIST programme. It summarises the improvements achieved during May 2026, outlines the current assurance position across governance, safety, workforce, culture and service-user experience, and highlights the areas of residual risk and priority focus requiring continued executive and Board oversight.

RECOMMENDATION

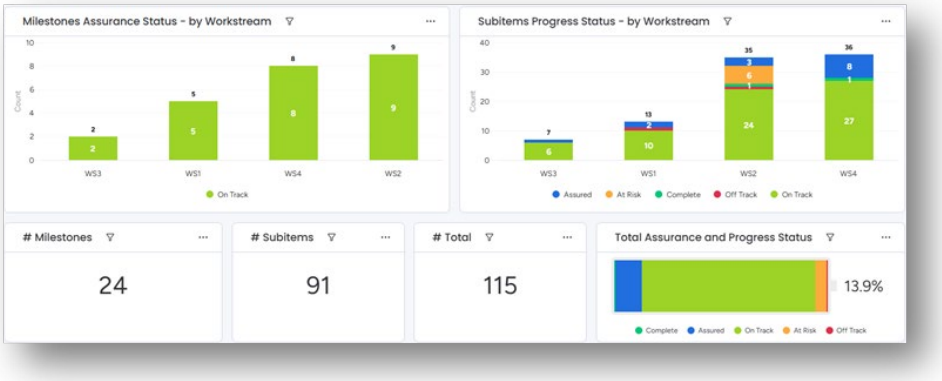
The KGH Board of Directors is asked to **note and indicate assurance regarding** the improving trajectory at KGH maternity services, including strengthened governance, oversight and delivery against key improvement actions, while recognising the areas of residual risk that continue to require focused attention. In particular, Boards are invited to support ongoing oversight of workforce resilience, evidence maturity, data quality and the embedding of improvements into business-as-usual practice to sustain progress and support continued regulatory recovery.

1. SUMMARY

Since transition into the MatNeoIST programme in January 2026, KGH maternity services have made measurable progress in safety, governance, culture and oversight. All 24 parent milestones are on track and overall assurance improving.

Progress this period includes stronger ward-to-board reporting, improved governance grip, continued delivery of key safety actions and improving reliability across a number of bellwether metrics. Strongest assurance is currently seen in governance delivery, BSOTS

documentation, antenatal CTG classification, consultant job planning, QI action delivery and service-user feedback, with detailed exception reporting set out in Appendix One.



Residual risk remains concentrated in workforce capacity, triage medical cover, fetal monitoring compliance, evidence maturity, data quality and embedding improvements into routine practice. Executive focus should therefore remain on sustaining delivery pace, strengthening evidence and maintaining workforce resilience.

2. KEY IMPROVEMENTS DEMONSTRATED THIS REPORTING PERIOD

Key improvements this period are most evident in governance delivery, safety oversight, workforce structure, service-user engagement and culture. Assurance has strengthened not only because actions have progressed, but because a greater proportion of work is now supported by clearer governance, routine monitoring and more reliable reporting.

Clinical safety and reliability

- PQOM ward-to-board reporting delivered: 100% (target 95%).
- BSOTS usage and documentation compliance: 99% (target 90%).
- Antenatal CTG classification completed: 100% (target 95%).
- Neonatal resuscitaire and medicines safety controls continue to provide good assurance, with no evidence of systemic safety failure.

Service-user experience

- FFT satisfaction remains high at 97%, providing positive evidence of stable experience, although still marginally below the local ambition of 100%.
- MNVP collaborative assessment is complete, with a new strategic lead appointed to strengthen co-production and structured engagement.

Workforce stability

- Consultant establishment has improved to 14.8 WTE, with 13.8 WTE in post and additional locum arrangements in progress.
- Turnover remains favourable at 4.39% against a 6.5% target.
- Perinatal Safety Champion roles have been recruited, strengthening frontline ownership of safety and ward-to-board reporting.

Culture and leadership

- A behavioural and culture framework is being progressed alongside civility, psychological safety and leadership development work.
- Governance deep-dive work and additional Quality and Safety capacity are strengthening leadership coherence and oversight.

Board Assurance: The cumulative evidence demonstrates improving maturity and grip, with KGH maternity services progressing toward more sustained regulatory recovery and MatNeoIST exit, subject to continued embedding, validated evidence and workforce resilience.

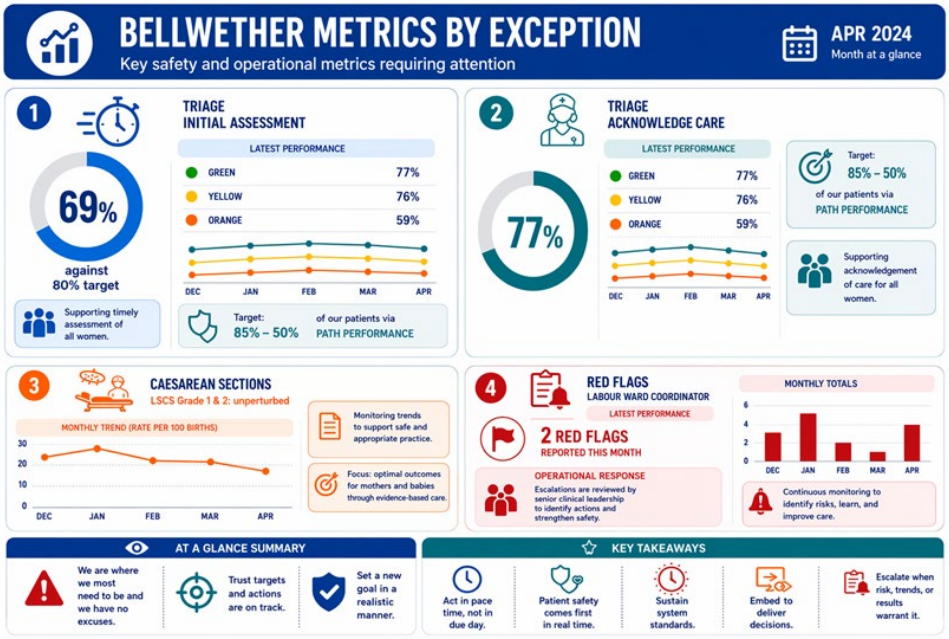
3. BELLWETHER METRICS AND MONITORING FOR IMPACT

KGH is now using the Integrated Performance Report within the Federated Data Platform to support more transparent, trend-based ward-to-board reporting. Bellwether metrics are aligned to MatNeoIST milestones and reviewed through Statistical Process Control, providing a clearer view of variation, trajectory and areas requiring management attention.

This is strengthening oversight, helping distinguish true performance concerns from data or recording artefact, and enabling more targeted improvement activity.

Current bellwether reporting shows strongest assurance in ward-to-board reporting, QI delivery, consultant job plans, BSOTS documentation and antenatal CTG classification, with FFT remaining stable and positive.

By exception, bellwether metrics continue to indicate improving operational control overall, with the main issues relating to flow, demand, data quality and documentation rather than evidence of sustained safety failure.



Most women continue to be assessed within 60 minutes in triage, although timeliness reduces predictably during high-pressure periods and medical review remains the main pathway constraint. Red flag episodes affecting Labour Ward Coordinator supernumerary status were managed safely through escalation and did not represent a sustained loss of oversight. Reported induction delays over 24 hours and a number of apparent caesarean delay exceptions were not confirmed on case review and were largely attributable to data artefact, classification or recording issues rather than decision-making quality.

Fresh Eyes reporting is not yet sufficiently reliable to provide assurance on its own therefore other sources of evidence support oversight, but further work is needed to strengthen confidence in this measure.

High-level actions are in place through QI, PSIP and MatNeoIST to strengthen triage medical review, improve escalation and OPEL reliability, finalise the IOL prioritisation and escalation process, improve documentation and coding accuracy, embed fetal monitoring training and audit, and improve the usability and reliability of digital reporting.

Board Assurance: Bellwether reporting is increasingly useful and credible, but some measures still require refinement and stronger validation before they can provide fully mature routine assurance.

4. PRIORITIES & AREAS FOR FOCUS

The next phase of delivery is focused on sustaining improvement, embedding evidence and strengthening resilience in the areas that remain most at risk. Priorities for May to July 2026 are set out below.

- → Workforce and culture, including behavioural framework, civility training, safety champions and strengthened professional leadership.
- → Equality, equity and inclusion, including response to the EDI deep dive and stronger integration of equity into service design and oversight.
- → Clinical pathway improvement, particularly fetal monitoring, escalation, induction of labour, elective caesarean section and diabetes in pregnancy.
- → Community service response model, neonatal MatNeoIST milestones and continued restoration of the homebirth service.
- → Further development of bellwether metrics, evidence standards and ward-to-board assurance to support sustained business-as-usual oversight.
- → Finalisation of Neonatal Milestones and supporting Bellwether Metrics

5. OVERALL BOARD ASSURANCE SUMMARY

KGH maternity services continue to demonstrate credible progress across governance, safety, workforce and culture. Oversight is stronger, immediate risks are better controlled, and the overall trajectory remains positive. However, sustained assurance still depends on repeat audit, stronger evidence maturity, continued data quality improvement and workforce resilience. Board attention should therefore remain on sustainability, embedding and delivery of the remaining recovery actions. Detailed exception reporting relevant to this assurance position is included in Appendix One.

Appendix One – MatNeoIST MIA Exception 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:	10th, 13th, 17th, 18th, 24th, 25th – March 2026

Report date:	March 2026 update (reported in April Exec Meeting)		
Level of support:	Intensive		
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