Boards in Common Paper I

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:	**Perinatal Report** (including **Perinatal Assurance Committee Highlight Reports** and the latest **Perinatal Scorecards**)					
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		Assurance	X	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	N/A					

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

The report provides assurance that perinatal (maternity and neonatal) services are subject to regular oversight and that key risks are being actively managed across UHL and UHN. This includes governance and Board reporting, workforce pressures, variation in clinical outcomes, operational flow, mortality review, data quality and equity. It also highlights areas requiring continued attention, including preterm birth, low Apgar scores, smoking in pregnancy, specialist capacity, ARM delays, digital maturity and the phased restoration of the KGH homebirth service. The report should be read alongside corporate risk registers to consider any further actions or mitigations required.

Impact assessment

From a legal perspective, the report mitigates regulatory, contractual and litigation risk by evidencing strengthened governance, clearer Board oversight, formal escalation routes and delivery of learning in response to MIS Year 8, CQC, PMRT, MNSI and wider maternity safety requirements. From a financial perspective, while no immediate additional cost arises directly from the report, it highlights material risks linked to workforce gaps, pathway capacity, theatre and scanning demand, neonatal activity, digital maturity and operational inefficiency, and provides assurance that these are being managed through clearer oversight, prioritisation and coordinated improvement. From an equity perspective, the report identifies ongoing risks relating to variation in outcomes, experience and access across ethnicity, deprivation, smoking in pregnancy and early booking, and provides assurance that these are being addressed through scorecard surveillance, equity-focused PSIP work, targeted pathways and wider maternity race equity and anti-discrimination actions.

Appendices

Appendix 1 Perinatal Report (Site Specific Summary)
Appendix 2 UHN PAC Chairs Highlight Report (May 2026)
Appendix 3 UHL PAC Chairs Highlight Report (May 2026)
Appendix 4 UHN Perinatal Scorecard (March 2026 Full Scorecard / April 2026 Summary Scorecard)

Appendix 5 UHL Perinatal Scorecard (March 2026 Full Scorecard / April 2026 Summary Scorecard)

Glossary

The following glossary and acronym guide is included to support readability and consistent interpretation of terms used throughout this report and its appendices.

Glossary	Meaning
Ward-to-Board assurance	A clear reporting route showing how risks, concerns and performance information are identified in clinical services and escalated through governance structures to Trust Boards.
Unwarranted variation	Differences in outcomes, experience or processes that cannot be explained by population need or case mix alone and may indicate improvement opportunities.
Case mix	The complexity, acuity and characteristics of the women and babies cared for by a service, which can influence outcomes and demand.
Care bundle	A set of evidence-based actions which, when delivered consistently together, improve the reliability and quality of care.
Deep-dive review	A focused review of an issue, outcome or service area to better understand causes, themes and required actions.

Acronyms

Acronym	Meaning
PAC	Perinatal Assurance Committee
PSIP	Perinatal Safety Improvement Programme
MIS	Maternity Incentive Scheme
PMRT	Perinatal Mortality Review Tool
MNSI	Maternity and Newborn Safety Investigations
FFT	Friends and Family Test
OPEL	Operational Pressures Escalation Level
ARM	Artificial Rupture of Membranes
MAU	Maternity Assessment Unit
ATAIN	Avoiding Term Admissions Into Neonatal units
EPR	Electronic Patient Record
FDP	Federated Data Platform
ODN	Operational Delivery Network
PPH	Postpartum Haemorrhage
OASI	Obstetric Anal Sphincter Injury
CTG	Cardiotocography
NNAP	National Neonatal Audit Programme
SPEN	Strategic Executive Information System for patient safety event notification
MatNeoIST	Maternity and Neonatal Improvement Support Team
MatNeoPREM	Maternity and Neonatal Patient Reported Experience Measure

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

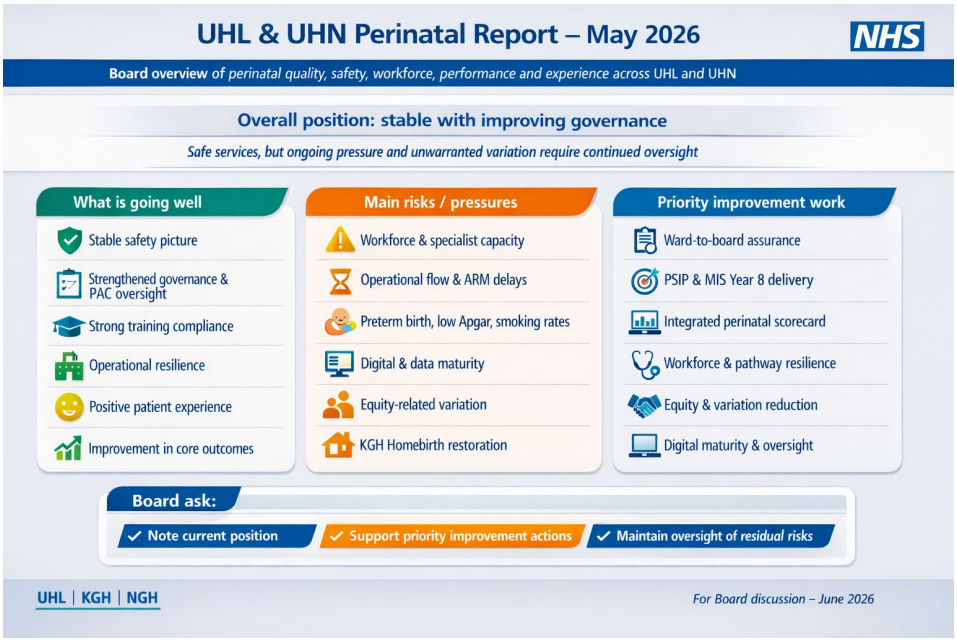
BOARD OF DIRECTORS

11 JUNE 2026

UHL & UHN PERINATAL REPORT

PURPOSE OF THE REPORT

The purpose of this paper is to provide the Board 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 Perinatal Assurance Committee (PAC) highlight reports, perinatal scorecards and the Group Director of Midwifery report to provide a clear line of sight on current performance, areas of improvement, principal risks and the maturity of the Perinatal Safety Improvement Programme (PSIP) across the group. Appendix 1 provides the current site-specific summary, Appendices 2 and 3 are the PAC Highlight Reports, and Appendices 4 and 5 set out the latest UHL and UHN perinatal surveillance scorecards which underpin the narrative and assurance set out in this report.



RECOMMENDATION

The Boards are asked to **note** the current perinatal position across UHL and UHN and the detailed recommendations set out in section 5 of this report, including the continued

strengthening of governance and assurance arrangements, development of integrated ward-to-Board reporting, and delivery of priority improvement work across workforce, operational flow, equity, digital maturity and reduction in unwarranted variation.

1. PERINATAL SERVICES SUMMARY

Across UHL and UHN, the overall perinatal safety picture remains stable, with evidence of continued improvement in a number of priority areas. Services have remained operationally resilient despite ongoing workforce, capacity and estate pressures, and there is no evidence of systemic safety failure.

Governance has continued to strengthen through PAC, PSIP and closer alignment of oversight arrangements across the group. Board reporting arrangements are being strengthened and made more explicit through the proposed Perinatal Assurance and Accountability Framework. The framework sets out that detailed perinatal assurance will continue through PAC, reporting into Quality Committees, with bi-monthly escalation through a Perinatal Report and Perinatal Quality Surveillance Scorecard to the joint Board arrangements. It also reflects the intention for PAC and the Perinatal Safety Champions arrangements to combine, bringing greater coherence between oversight, challenge, engagement and escalation. Further consideration is being given to the future alignment of PSIP arrangements in a way that reinforces organisational focus and accountability within each Trust, while strengthening opportunities for shared learning and coordinated delivery across the group. In parallel, work is progressing toward a more integrated perinatal scorecard through use of the Federated Data Platform, creating opportunities for more consistent reporting, improved comparability across organisations, earlier identification of unwarranted variation, reduced duplication in data production, and a clearer, more reliable line of assurance from ward to Board across UHL and UHN. A core set of perinatal metrics will also be reflected through the Integrated Performance Report to strengthen routine Board visibility of workforce, safety, experience and outcomes.

Clinical performance remains mixed but generally improving. At UHL during April there was stable operational flow, with a strong triage performance, 100% one-to-one care maintained in labour, reductions in major haemorrhage and severe perineal trauma, and a further reduction in full-term neonatal admissions. Some indicators remain under enhanced review, particularly Apgar scores below 7 at 5 minutes and preterm birth, but these continue to sit within a wider context of improving intrapartum and neonatal outcomes. UHL also continues to show early delivery against MIS Year 8 and Saving Babies' Lives requirements, with all six core safety actions currently on track.

At UHN, April presents a mixed but improving position. No PSIIs were commissioned, moderate harm remained low, and governance grip has strengthened, evidenced by improved oversight of incidents and a significant reduction in overdue actions. Operational performance remained largely stable, though intermittent periods of OPEL 2 escalation and ongoing red flag activity continue to highlight pressure in the delivery of time-critical care. Training compliance remains strong across both sites, but workforce capacity remains a key constraint, particularly in midwifery and neonatal services, despite active recruitment and improving turnover trends. The site-level summary position supporting this summary is set out in Appendix 1 and in the latest UHL and UHN perinatal scorecards at Appendices 4 and 5.

2. PERINATAL SURVEILLANCE HIGHLIGHTS

a. Workforce and Culture

Workforce remains one of the most important risks across UHL and UHN, although the overall trajectory is improving. At UHL, midwifery vacancies remain low, sickness absence continues to reduce, neonatal consultant recruitment has been completed, and further recruitment is underway to strengthen medical resilience. In April, however, obstetric consultant and neonatal vacancies remained material, although early improvement in fill rates and recruitment pipelines is evident. At UHN, vacancy rates remain higher, particularly within KGH and within neonatal services overall, with April midwifery vacancy at 10.7% across UHN and neonatal vacancy at 9.6%. Active recruitment and retention work is ongoing, alongside improved workforce planning and establishment review.

Cultural improvement also continues to strengthen. UHL and UHN perinatal senior leadership team have participated in an externally commissioned restorative justice programme, and there remains a focus on embedding PSIP culture work, plus increasing leadership coherence across UHL and UHN. Within UHN, incident oversight, action management and learning dissemination have improved materially, and KGH continues to show progress through MatNeoIST and strengthened governance disciplines. PAC continues to receive positive assurance regarding psychological safety, leadership visibility and increasingly mature escalation behaviours, though these remain areas requiring sustained attention.

b. Operational Performance and Flow

Across the system, operational performance remains resilient. UHL has maintained strong triage performance, with 97.5% of women triaged within 30 minutes in April, and no evidence that increased red-flag activity compromised safe care or one-to-one support in labour. The

main operational constraint remains prolonged time from decision to perform ARM, which remains at 20 hours and continues to require focused improvement. At UHN, operational performance remained stable overall in April, with the service at OPEL 1 for most of the month but periods of OPEL 2 escalation, together with 202 red flag events, confirming ongoing operational fragility even where overt service disruption has been avoided.

The KGH homebirth service remains a specific area of operational and governance focus. The temporary pause continues to be managed through a controlled restoration plan, with individualised care plans in place and relaunch dependent on completion of all safety-critical actions and governance sign-off. This remains appropriately controlled but requires continued Board oversight.

c. Experience and Engagement

Experience remains broadly positive across all organisations, with consistent feedback regarding compassionate staff and good intrapartum care. UHL continues to receive positive feedback for the Single Point of Contact model, community midwifery and labour care, while breastfeeding initiation and maternal bonding improvements remain strengths. At the same time, UHL experience data continues to show recurring themes around communication, consent, staff attitude, waiting times and the postnatal ward environment, including cleanliness, space and temperature. FFT response rates reduced slightly in April and promoter rates also dipped modestly, although overall experience remains positive.

At UHN, experience remains positive overall, with strong promoter scores, particularly at KGH. However, response rates remain below target, and feedback highlights car parking, communication, continuity, and delays in triage and analgesia as the main themes. NGH triage satisfaction in March demonstrated a clear localised pressure point, and KGH continues to focus on medicines rounds and compliance to reduce delays in pain relief. Across the group, communication, waiting times, ward environment and postnatal experience remain the principal areas requiring focused improvement.

d. Quality and Outcomes

UHL and UHN continue to demonstrate stable and improving outcomes across many core indicators, although variation persists and some indicators require enhanced oversight.

At UHL, data shows improvement in severe perineal trauma, major haemorrhage and full-term neonatal admissions, with breastfeeding initiation remaining strong and above the 12-month average. Smoking at booking and delivery continues to perform favourably against target. The

Preterm Prevention Service remains a key tertiary referral centre with expanded clinic capacity and strong multidisciplinary oversight but rising regional referrals and national guidance are increasing pressure on elective theatre capacity and funding pathways. Mitigations are in place, including additional capacity planning, reimbursement work and exploration of a local transabdominal cerclage service. Assurance is strengthening through PeriPREM, with better governance, improved data quality and a more mature quality improvement infrastructure. Although overall optimisation remains below the national average, performance in magnesium sulphate and steroids is strong, and targeted work on early expressed breast milk and normothermia is showing early recovery. Emerging data suggests a shift away from the most extreme gestations toward later gestational groups, consistent with the impact of prevention and optimisation activity. As a tertiary centre, UHL continues to manage a higher-acuity case mix, and further work is underway to better understand referral patterns and underlying drivers. Operational and digital constraints remain, but targeted actions are in place through service redesign and EPR optimisation. Overall, PAC noted improving assurance, with clear actions in place to address residual risks and support further improvement in outcomes for preterm babies. UHL also continues to demonstrate strong ATAIN performance and reduced avoidable term admissions, although thermal regulation and respiratory causes remain areas for continued neonatal focus.

At UHN, data shows improvement in postpartum haemorrhage and severe perineal trauma, while breastfeeding initiation remains above target. However, low Apgar scores, preterm birth and smoking at booking remain above expected thresholds and continue to show unwarranted variation between sites, particularly at KGH. These issues are being addressed through PSIP workstreams, strengthened surveillance, preterm prevention work, targeted smoking cessation interventions and local quality improvement activity. The data also reinforces the importance of continued focus on pathway reliability, data quality and reducing variation in prevention and escalation.

Equity remains a central theme across the group. Discussions through PAC combined with the UHL and UHN scorecards, highlights persistent inequalities relating to ethnicity, deprivation, smoking in pregnancy, early booking and access. UHL continues to identify disparity in perineal trauma outcomes among Asian women and late-booking patterns among Black women, while UHN continues to show variation associated with deprivation, ethnicity and smoking at booking. Work is progressing to ensure clear triangulated through local and national dashboards and are informing PSIP, community outreach, and maternity race equity planning. Both UHL and UHN are now onboarded to the Perinatal Equity and Anti-Discrimination programme (PEADP) facilitated by the Race Health Observatory (RHO).

3. ADDITIONAL PERINATAL HIGHLIGHTS

There is a rapidly evolving national and regional context, with a clear shift from review to action. MIS Year 8, MatNeoPREM, the National Perinatal Health Inequalities Dashboard, the interim AMOS report, the National Maternity and Neonatal Taskforce and the Maternal Care Bundle all reinforce the requirement for stronger Board oversight, outcome-focused assurance and reduced unwarranted variation. Locally, this is being addressed through PAC, PSIP, strengthened regional perinatal oversight and further alignment of governance across UHL and UHN.

The latest NHS England regional perinatal heatmap demonstrates improvement across all three sites, with reductions in scores for Leicester, Northampton and Kettering, indicating a positive trajectory within the context of continued enhanced surveillance. The UHL and UHN Group Clinical Strategy work also continues to progress, with initial pathway priorities including fetal medicine, sonography, diabetes, reconfiguration, governance alignment and digital integration.

At UHL, further positive assurance is provided by ongoing work on fetal medicine, ATAIN, digital programmes, maternal care bundle readiness and Maternity Assessment Unit (MAU) flow. PAC also noted that perinatal mortality activity remains subject to robust oversight (see Learning from Deaths Report). Governance remains strong through integrated multidisciplinary PMRT review, peer benchmarking and effective system collaboration. Delivery of learning is evident, with 38 actions closed and most remaining actions on track. External scrutiny, including review with a comparator tertiary centre and alignment with regional ODN oversight, provides added assurance on the quality and consistency of review processes. Themes such as aspirin prescribing and antenatal corticosteroid administration are informing targeted quality improvement, supported by stronger triangulation across PMRT, MNSI and Early Notification processes in line with MIS Year 8. PAC therefore noted good assurance on comparative performance, governance, delivery of learning and system collaboration, while requesting an update on the outstanding actions from last year's annual review.

At UHN, perinatal mortality oversight remains robust through multidisciplinary review, incident triangulation and strengthened committee governance. Services remain operationally stable overall, with no evidence of systemic safety failure; however, variation in neonatal mortality at KGH continues to require close scrutiny and is not yet fully explained by population factors alone. Assurance is strengthening through PSIP, MatNeoIST and improved thematic review of incidents, actions and learning, with greater visibility of risk and clearer governance grip

across both sites. PAC noted maturing oversight, stronger action tracking and a more coordinated approach to escalation and improvement, while recognising the need for continued focus on unwarranted variation, pathway reliability and understanding the drivers of neonatal outcomes.

At UHN, significant progress has been made in reducing overdue actions, strengthening incident oversight, and improving governance coherence through PSIP and MatNeoIST. Both trusts continue to develop their response to MIS Year 8, with governance, oversight, culture and assurance now being brought together more explicitly through the developing group framework.

4. PERINATAL SURVEILLANCE AND ASSURANCE FOR ESCALATION

PAC remains assured that services continue to operate safely and effectively, with strong assurance in core maternity and neonatal standards. The Board is asked to read this section alongside Appendices 2 and 3, which provide insights into the evidence and discussion at the latest PACs. However, a number of issues continue to require Board visibility and targeted action:

- variation in key perinatal outcomes, particularly preterm birth, low Apgar scores and smoking in pregnancy across UHN, and preterm birth and Apgar variation at UHL;
- operational fragility in time-critical care pathways, particularly ARM delays, red flag events, and aspects of triage and elective flow;
- workforce sustainability, particularly obstetric, neonatal and specialist capacity across both trusts;
- data maturity and ongoing validation challenges associated with BadgerNet and digital integration;
- equity-related variation in access, experience and outcomes;
- specialist pathway demand and fragility, particularly fetal medicine, sonography, diabetes and neonatal capacity (all captured within the Group Clinical Strategy priorities);
- the ongoing restoration of the KGH homebirth service and associated governance requirements.

The Board is invited to note this updated consolidated narrative and endorse the continued group focus on strengthening assurance, reducing variation, improving digital maturity and supporting delivery of PSIP and MIS Year 8 priorities across UHL and UHN.

5. OVERALL RECOMMENDATIONS

- UHL and UHN Boards to **note** the current perinatal position across the group, including improving governance, operational resilience and core safety indicators.
- UHL and UHN Boards to **note** that UHL Quality Committee and UHN Quality & Safety Committee have approved the implementation of the Group Perinatal Assurance and Accountability Framework, including progression toward combined PAC and Perinatal Safety Champions arrangements to strengthen coherence of oversight, challenge, engagement and escalation.
- UHL and UHN Boards to **support** further consideration of PSIP alignment in a way that maintains clear organisational focus and accountability within each Trust, while maximising opportunities for shared learning, coordinated delivery and reduction in unwarranted variation across the group.
- UHL and UHN Boards to **support** development of a more integrated perinatal scorecard through the Federated Data Platform, alongside inclusion of a core set of perinatal metrics within the Integrated Performance Report, to improve comparability, reduce duplication, strengthen early identification of variation and provide a clearer routine line of assurance from ward to Board.
- UHL and UHN Boards to **note** the ongoing workforce and specialist capacity risks and support continued delivery of priority improvement work across preterm birth, fetal monitoring, smoking in pregnancy, operational flow, equity and digital maturity.
- UHN Board to **note** the continued phased restoration of the KGH homebirth service, subject to completion of all safety-critical actions and governance approval, and for both Boards to remain sighted on those residual risks requiring continued group oversight through PAC and the wider assurance framework.

University Hospitals Leicester (UHL)	• April activity remained high at 784 births, with stable operational flow, 97.5% triaged within 30 minutes, 100% one-to-one care in labour and no evidence that red-flag activity compromised safe care. • Clinical indicators improved month on month, with severe perineal trauma reducing from 3.7% to 3.3%, major haemorrhage from 3.6% to 2.4%, and full-term neonatal admissions from 5.3% to 4.9%. Breastfeeding initiation remained strong at 77.4%, above the 12-month average. • Preterm birth and Apgar scores below 7 at 5 minutes remain under enhanced review. Preterm birth continues above the process mean and reflects case-mix complexity, including tertiary referrals, fetal medicine activity and specialist preterm pathways; a deep-dive audit is also underway on Apgar variation. • Workforce pressures are beginning to stabilise. Midwifery vacancy remains low at 2.7%, sickness absence has reduced, and recruitment progress is evident across neonatal and obstetric roles, although consultant obstetric and neonatal vacancy remain material. • Experience remains broadly positive, with FFT response at 13.2% and promoter rate 89.6% in April. Complaints and feedback continue to highlight communication, consent, waiting times and postnatal ward environment as the principal areas for improvement. • Training compliance remains strong, with MDT simulation at 96% and NLS at 90% in April, and all six MIS Year 8 core safety actions on track. • RSV uptake has improved, while BCG remains below target and data quality assurance continues following the EPR transition to BadgerNet.
Kettering General Hospital (KGH)	• KGH continues to provide safe and stable maternity and neonatal services, but outcome variation remains a key area for oversight, particularly in preterm birth, low Apgar scores, smoking in pregnancy and neonatal mortality. • April data shows improvement in severe perineal trauma to 0% and postpartum haemorrhage to 3.1%, but preterm birth and smoking at booking remain above target and more variable than at NGH. KGH also contributes disproportionately to UHN variation in low Apgar scores. • Governance and oversight are strengthening through PSIP, MatNeoIST and improved incident action tracking. KGH is now reporting delivery against all six MIS Year 8 safety actions, though workforce and governance assurance remain less mature than at NGH.

	• Workforce remains pressured, with April midwifery vacancy at 8.3%, neonatal nurse vacancy at 7.25% and consultant obstetric vacancy at 1 WTE. Recruitment and workforce planning continue to support safe staffing resilience. • The homebirth service remains paused following national Prevention of Future Deaths learning, with a controlled restoration plan in place and relaunch dependent on completion of all safety-critical actions and governance approval. • Patient experience remains positive, with FFT satisfaction at 97% and strong promoter performance, though response rates remain below target. Feedback themes include communication, discharge, analgesia and clarity of care plans.
Northampton General Hospital (NGH)	• NGH continues to demonstrate a broadly positive and more stable position, with strong training compliance, positive patient experience and more consistent clinical performance than KGH across several indicators. • Although UHN-wide variation persists in preterm birth, low Apgar scores and postpartum haemorrhage, NGH generally shows less volatility than KGH and remains closer to target in several surveillance measures. • Operational performance remains largely stable, but NGH continues to experience pressure in triage, discharge and flow. • Workforce pressure has increased due to establishment and rota changes, with April midwifery vacancy at 12.5% and active recruitment underway. • Patient experience is a relative strength, with higher FFT response and satisfaction than KGH; NGH achieved 97.2% overall satisfaction in April, though triage, discharge delays and communication remain areas for improvement. • NGH also demonstrates a strong antenatal immunisation model supported by community clinic delivery, improving accessibility, sustaining uptake and reducing pressure on hospital-based services. • Governance remains strong, with full delivery of MIS Year 7 requirements, all six MIS Year 8 safety actions now in progress, and continued contribution to UHN-wide PSIP and improvement priorities.

APPENDIX TWO – UHN PAC Chairs Highlight Report

UHN PERINATAL ASSURANCE COMMITTEE (PAC) MAY 2026 CHAIRS HIGHLIGHT QUADRANT	
UHN PAC on 20 May 2026 reviewed quality, safety and performance across maternity and neonatal services, alongside the governance arrangements needed to sustain improvement and strengthen assurance across the Group. Overall, services remained operationally stable in March 2026, with the risk profile at OPEL 1, robust incident reporting and governance processes in place, no evidence of systemic safety failure, and no MNSI referrals. One Patient Safety Incident Investigation (PSII) was commissioned during the period. PAC received assurance through a range of indicators, including positive training compliance, patient feedback, Duty of Candour compliance, maintaining 1:1 care in labour, and service continuity. Progress continues through the Perinatal Safety Improvement Programme (PSIP), MatNeoIST delivery, digital development, and strengthened governance arrangements, including proposals for a Group Perinatal Assurance and Accountability Framework to improve consistency, oversight and escalation across UHN and UHL. However, PAC also recognised a number of areas requiring continued focus. These include persistent variation in key outcomes such as severe postpartum haemorrhage, low APGAR scores, preterm birth and neonatal mortality at KGH; workforce and estate pressures; gaps in the current Perinatal Pelvic Health Service model; and the need to strengthen pathway reliability, equity, and data capability. The temporary pause to the KGH homebirth service remains appropriately controlled, with relaunch planned for July 2026 subject to completion of all safety-critical actions and governance sign-off. Overall PAC concluded that there is positive assurance and improving governance grip across perinatal services, with credible improvement plans in place to address unwarranted variation, strengthen regulatory compliance, and improve outcomes for women, babies and families. PAC recommends that the UHN Board receive and note this report as evidence of an established and maturing approach to perinatal oversight, with clear management of risk and targeted action in those areas requiring further improvement.	
Matters of Concern or Key Risks to Escalate	**Major Actions Commissioned / Work Underway**
• Variation in outcomes remains a key concern, particularly sustained elevated neonatal mortality at KGH, which is not yet fully explained by population factors. • Inconsistency in CTG interpretation and escalation behaviours continues to present clinical risk, with cultural and communication factors influencing reliability. • Workforce pressures remain across key roles, including anaesthetic leadership, establishment requirements and administrative support.	• Development of a UHN-UHL Assurance and Accountability Framework to strengthen governance, reporting and escalation. • Delivery of the Perinatal Safety Improvement Programme to coordinate action across key safety priorities. • Targeted improvement work is underway on fetal monitoring, escalation, workforce resilience and equity. • MIS Year 8 delivery is being used to align investment and improvement activity to priority risks. • Digital transformation work, including CTG digitisation, neonatal EPR and enhanced data capability, is progressing to improve oversight.

• The current Perinatal Pelvic Health Service model remains fragmented, with inequitable access, incomplete pathways and insufficient commissioning support. • Digital and data limitations, particularly within BadgerNet, continue to constrain timely audit, triangulation and real-time oversight. • Homebirth relaunch remains dependent on completion of staffing, governance and policy requirements. • The neonatal estate at NGH continues to present an infrastructure risk requiring longer-term investment.	• The homebirth recovery plan continues against defined milestones, with relaunch dependent on completion of safety-critical actions. • Further work has been commissioned to define the required PPHS model and quantify commissioner-related gaps and costs.
Positive Assurance to Provide	**Decisions Made**
• The overall safety profile remains stable, with effective escalation processes and no major service disruption. • Governance arrangements continue to strengthen, with greater alignment, visibility and oversight of risk and performance. • MatNeoIST delivery remains broadly on track, supported by external assurance of progress. • The neonatal workforce position at NGH remains comparatively strong, with good recruitment and improving capability. • Quality improvement and learning systems continue to mature, with clearer thematic insight and action tracking. • Peer review outcomes for neonatal services remain positive, including sustained level 2 status at KGH. • The homebirth recovery programme is progressing well, with the majority of actions on track. • There is emerging evidence of cultural improvement where multidisciplinary working and leadership integration are strongest.	• Support was given to progression toward a joint UHN-UHL PAC model and continued development of the assurance framework. • The Committee endorsed the MIS Year 8 funding approach, with refinement of investment priorities delegated through the division. • Agreement was reached to progress PPHS work, clarify requirements and escalate commissioning gaps. • The Committee confirmed that homebirth relaunch remains conditional on completion of safety-critical actions. • Support was given to progress the NGH neonatal estate investment case. • Further assurance on CTG and escalation improvement work will be brought back through the Committee.

APPENDIX THREE – UHL PAC Chairs Highlight Report

UHL PERINATAL ASSURANCE COMMITTEE (PAC) MAY 2026 CHAIRS HIGHLIGHT QUADRANT	
UHL PAC on 6 May 2026 was provided assurance that perinatal safety and quality remain stable despite sustained service pressure, with low harm profiles, strong escalation processes and continued delivery against national standards. PAC noted good evidence of progress in triage performance, workforce stabilisation, incident learning, digital delivery and key improvement programmes, including MIS Year 8, maternal care bundle implementation and targeted work to reduce avoidable neonatal admissions. Positive assurance was also drawn from robust mortality and safety governance, improving workforce indicators, strong compliance with Saving Babies' Lives and Ockenden actions, and early gains in equity-focused improvement. However, PAC highlighted ongoing capacity and sustainability risks requiring continued Board oversight, particularly in maternity scanning, neonatal demand, workforce availability, elective and preterm pathway capacity, MAU flow and digital resource. In response, the Committee endorsed progression of a full business case for antenatal scanning capacity, requested further review of theatre and neonatal capacity requirements, supported continued development of the fetal medicine model and maternity assessment improvements, and asked to remain sighted on delivery of outstanding assurance actions and system-wide risks.	
Matters of Concern or Key Risks to Escalate	**Major Actions Commissioned / Work Underway**
Perinatal Safety Report Qtr. 4: Q4 safety performance remained stable despite sustained pressure, with 2,334 births and 682 incidents reported, reflecting improved reporting rather than increased harm. Harm remained low, with 97% of incidents graded no or minor harm and moderate harm incidents reduced to 13. No PSIIs were commissioned; three cases were referred to MNSI, with two accepted. Reviews confirmed strong clinical care, including 49/50 PPH cases appropriately escalated and 100% compliance with the OASI care bundle. Mortality and safety surveillance remained robust, with no evidence of avoidable harm. Avoidable neonatal admissions were stable at 5.9%, complaints reduced to 37, and improvement work continued on medicines, restorative practice and equity, including a 12.2% reduction in late booking among Black women. PAC received good assurance that risks are understood and improvement remains focused on system reliability.	**Group Director of Midwifery Update:** PAC noted the national shift from review to action, with greater emphasis on Board accountability, outcomes-based assurance and reducing unwarranted variation through MIS Year 8 and wider national policy. UHL and UHN are responding through closer collaboration, aligned governance and delivery of the Perinatal Safety Improvement Programme, including a proposed Group perinatal governance model to strengthen oversight, shared learning and early risk identification. National developments, including MatNeoPREM, the Perinatal Health Inequalities Dashboard, the AMOS interim report and the National Maternity and Neonatal Taskforce, reinforce the need for stronger Board oversight of safety, experience, culture and equity. UHL is an early adopter of PREM implementation. Early MBRRACE review shows ongoing outcome variation, with neonatal and extended perinatal mortality at UHL above peer averages; further analysis is underway. Equity remains a core priority through PSIP, improved analytics and development of a maternity race

Preterm Prevention Service: The service continues as a key tertiary referral centre with strong multidisciplinary oversight, but rising regional demand for specialist cerclage is increasing pressure on elective theatre capacity and funding. Mitigations include securing additional capacity, improving reimbursement and exploring a local transabdominal cerclage service. Assurance is strengthening through PeriPREM, better governance, improved data quality and maturing improvement infrastructure. While overall optimisation remains below the national average, performance in magnesium sulphate and steroids is strong, and improvement work in early expressed breast milk and normothermia is showing early recovery. Emerging data suggests fewer births at the most extreme gestations, indicating early impact of prevention and optimisation work. PAC noted improving assurance, with clear actions in place to address residual operational, digital and pathway risks. **Perinatal Mortality Update- MBRRACE:** MBRRACE 2024 data shows stillbirth rates comparable with peers, with 55 stillbirths reported (44 corrected) and local data stable over the last 12 months. Corrected neonatal deaths reduced to 22, and there were no term intrapartum stillbirths in the most recent quarter, providing assurance of intrapartum safety. Governance remains strong through multidisciplinary PMRT review, peer benchmarking and system collaboration, with 38 actions closed and most others on track. Themes such as aspirin prescribing and antenatal corticosteroid administration are informing targeted improvement. PAC received good assurance on comparative performance, governance and delivery of learning, and requested an update on outstanding actions from last year's annual review. **Neonatal Nursing & Midwifery Bi-annual Workforce Update:** Workforce performance remained broadly stable despite sustained pressure. Neonatal occupancy is around 90% against a recommended 80%, creating ongoing pressure on staffing and flow, compounded by workforce	equity action plan. Regional oversight indicates continued improvement across all sites, providing cautious assurance within a context of sustained workforce, capacity and cultural pressures. **Perinatal Scorecards:** PAC noted stable service delivery in March despite ongoing pressure, with lower escalation, no impact on safe staffing or one-to-one care, and strong triage performance, with most women assessed within 15 minutes and 96% within 30 minutes. ARM waits reduced from 23 to 20 hours but remain under review. No PSIIs were commissioned, and MNSI and moderate harm reviews identified no new significant harm themes. Clinical outcomes were broadly stable, with favourable smoking and stillbirth rates; variation in Apgar <7 and preterm birth is being reviewed. Workforce resilience continues to improve, patient experience remains positive despite a slight rise in complaints, and MIS Year 8 and Saving Babies' Lives compliance remain strong. Operational flow showed early improvement, with ARM waiting times reduced from 23 to 20 hours, although this remains an area of focus. No PSIIs were commissioned, with MNSI activity and moderate harm review providing assurance of effective oversight and no new significant harm themes. Targeted learning in fetal monitoring, preterm risk and escalation continues to inform improvement. Clinical outcomes remained broadly stable, with favourable smoking and stillbirth rates and maintained intrapartum outcomes; increases in Apgar <7 and preterm birth reflect case mix and are under active review. Equity variation persists, with targeted action progressing through PSIP. Workforce indicators continue to strengthen, supporting service resilience, while patient experience improved overall despite a slight increase in complaints, with actions in place. MIS Year 8 and Saving Babies' Lives compliance remain strong, providing assurance of delivery against national standards, with ongoing focus on data quality.

unavailability of 27–37%. Mitigations include a 3.4 WTE uplift, active recruitment and investment in training. Midwifery indicators remain positive, with vacancy rates reduced to 2.6%, 40 midwives appointed across Q3 and Q4, and no agency usage since October 2024. One-to-one care in labour and supernumerary coordinator standards remain strong, though pressures persist from high unavailability, bank reliance and acuity variation. Targeted actions include an early Birthrate Plus review, ongoing acuity validation, twice-daily staffing oversight and a proposal to increase funded midwifery headroom from 23% to 28%. **Maternity Services Scan Capacity Paper:** Demand for maternity ultrasound significantly exceeds funded capacity, with over 44,000 scans delivered annually and an estimated requirement of 434–540 hours per week against a baseline of 352. Compliance is currently maintained through premium-rate staffing, overtime and Saturday services, but this is financially and operationally unsustainable. The gap presents clear risks to timely care, workforce sustainability and delivery of national standards, including MIS Year 8. PAC noted that sustainable resolution will require substantive investment and service redesign, and requested progression of a phased full business case.	**ATAIN:** PAC received assurance of sustained improvement, with UHL remaining below the 6% national target for term admissions and a 31% reduction in avoidable admissions. Improvements in hypoglycaemia, hypothermia and jaundice have been sustained through targeted quality improvement. Respiratory distress is now the main driver of admissions and is a priority for further review, alongside fetal monitoring and infant feeding. Robust data validation and case review remain in place to support ongoing learning and improvement. **Fetal Medicine Peer Review – Progress Update:** PAC noted that Fetal Medicine continues to operate as a high-volume tertiary service, with around 80% of referrals now seen at Leicester Royal Infirmary, supporting a more consistent single-site model. Good progress has been made against peer review actions across leadership, workforce, pathways and governance, with stronger MDT working and improved oversight through BadgerNet. Service redesign is progressing through plans for a dedicated Fetal Medicine Unit to address capacity and flow. Workforce and administrative pressures remain, but mitigations are in place through recruitment, role development and strengthened regional collaboration. Overall assurance is improving, supported by a clear phased approach to a more sustainable service model. Service redesign is progressing through a pragmatic estate solution to establish a dedicated Fetal Medicine Unit, addressing key constraints in scan capacity and fragmented working, whilst improving patient flow and experience. Workforce and capacity risks remain, including consultant gaps and administrative pressures; however, these are actively mitigated through recruitment, role development and progression of a coordinator function to improve flow and utilisation. Strong system collaboration continues across the region to align referral pathways and improve access. Overall, PAC noted improving assurance through delivery of peer review actions, strengthened

	governance and a clear, phased approach to service redesign, supporting a more sustainable model for a growing tertiary service. **Digital Programmes – Maternity and Neonatal:** PAC noted continued progress in digital delivery, with BadgerNet utilisation above 90% and strong registration and consent rates, improving digital engagement and data capture. Neonatal integration has been delayed appropriately to maintain safe implementation amid capacity pressures. Priorities now focus on CTG integration, neonatal observations and location tracking to strengthen real-time oversight. Progress remains constrained by digital and workforce capacity, and continued focus is needed on resource, training and optimisation to maximise safety and efficiency benefits. Key priorities include CTG integration and optimisation of neonatal observations and location tracking to strengthen clinical oversight and real-time visibility, although progress is constrained by digital and workforce capacity. PAC noted that digital capability is increasingly supporting service delivery and improvement. However, continued focus is required on resource, training and optimisation to ensure consistent use and maximise safety and efficiency benefits.
Positive Assurance to Provide	**Decisions Made**
Maternity Incentive Scheme (MIS) – Year 8 and Maternity Care Bundles Update: PAC noted that MIS Year 8 and the Maternal Care Bundle represent a significant shift to outcomes-focused assurance, with over 177 safety actions requiring clear oversight, accountability and governance. A RACI framework is being developed to support delivery and PAC visibility. Initial gap analysis shows variation in implementation rather than absence of policy, with key risks relating to workforce capacity, digital limitations and protected clinical time. Strong foundations are in place through existing antenatal infrastructure and the Trust's role in hosting the Maternal Medicine Network, but delivery will require coordinated system input and improved real-time data.	PAC endorsed progression of antenatal scanning capacity work to a full business case due to significant gap between demand and capacity. PAC noted the increasing demand of elective pathways and requested a review of theatre capacity requirements for elective and preterm services. PAC noted continued progress against CQC must/should actions and agreed to remain sighted on a small number of outstanding evidence-dependent items.

Enhanced Continuity of Carer: PAC noted progress through the Bowling Green Street pilot and targeted recruitment focused on populations experiencing deprivation and ethnic inequality. Early delivery is strengthening the foundation for a more personalised and equitable model, though further work is needed to expand and embed continuity caseloads. **Maternity Assessment Unit (MAU) Update / Neonatal Staff Wellbeing and Aftercare Programme:** PAC noted improved MAU performance, with sustained BSOTS compliance and over 90% assessed within 30 minutes despite a 14% rise in attendances. Progress has been supported by training, greater workforce confidence, CQC delivery and continued development of telephone triage. Work continues toward a single point of contact to improve oversight and flow. Ongoing risks relate to rising demand and medical workforce gaps, with recruitment and interim mitigations in place. **Perinatal Safety Champions Update:** PAC received assurance of strengthened Safety Champion activity, with regular walkarounds, expanding virtual engagement and improved visibility across maternity and neonatal services. Thirty-two safety actions were identified in Q4, up from 24 last year, reflecting improved psychological safety and confidence to raise concerns. Sixteen actions remain open, all progressing, with none overdue or requiring escalation. PAC noted continued progress across engagement, regulatory assurance and perinatal programme delivery. Compliance remains high across Ockenden, CQC and MIS programmes. Key risks relate to delivery of the single point of contact, fetal medicine estates, workforce sustainability and culture under sustained pressure. PAC asked to remain sighted on fetal medicine estates, MIS Year 8 readiness and maternity care bundle delivery. • **First Ockenden report:** 99% compliance (up from 98%) with the **Final Ockenden report:** improved response by 3%	PAC supported progress of the fetal medicine group restructuring as a subgroup within the wider clinical strategy governance framework PAC noted that neonatal capacity pressures require further strategic review under group clinical strategy, including potential expansion of cot capacity and redistribution across sites. PAC noted the need to progress maternity assessment unit improvements, including single point of contact model and continued compliance with triage standards, with further assurance regarding medical workforce requirements.

• **Empowering Voices:** 98% compliance, up 10% (7 actions remaining) • **Section 29A action plan:** maintained • **CQC Must / Should Do Action Plan:** maintained, with a small number of evidence-dependent actions in progress • **MIS Year 7:** 100% compliance achieved • **Saving Babies' Lives Care Bundle:** 98% compliance	

NHS
University Hospitals of Northamptonshire

Perinatal Quality Surveillance Scorecard

March 2026

CONTENTS

SUMMARY March 2026

University Hospitals of Northamptonshire

The month in review:

During March 2026, maternity and neonatal services across University Hospitals of Northamptonshire continued to operate safely within an overall stable risk profile. Operational pressures were maintained at OPEL 1 throughout the month, with effective escalation and mitigation arrangements in place, providing assurance that capacity and acuity risks were proactively managed without adverse impact on patient safety. Red flag events were identified and monitored through established escalation and operational processes, with no resulting service disruption. Clinical quality and safety risks remain under active surveillance. Incident reporting is timely and transparent, with one Patient Safety Incident Investigation commissioned and no Maternity and Newborn Safety Investigation referrals during the month. Targeted clinical surveillance has identified episodic variation in key outcome measures, including severe postpartum haemorrhage, low APGAR scores and preterm birth. Mitigating controls include strengthened multidisciplinary review, evidence-based care bundles and enhanced escalation pathways, providing assurance that emerging risks are recognised and addressed. Workforce and training risks continue to be managed through active recruitment, retention initiatives and strong overall compliance with mandatory and safety-critical training. Anaesthetic training compliance requires ongoing focus and is subject to targeted action. Following a Prevention of Future Deaths-informed service review, the KGH homebirth service was temporarily paused; a controlled restoration plan, with individualised care plans and clear oversight, provides assurance of safe reintroduction by the end of May.

Training compliance:
Training compliance across maternity services at Northampton General Hospital and Kettering General Hospital remains strong, supporting delivery of the Perinatal Safety Improvement Programme (PSIP). High attendance is consistently achieved for key safety-critical training, including maternity emergencies, neonatal life support and fetal monitoring, with most staff groups meeting or exceeding local targets. This provides assurance that multidisciplinary teams are well prepared to recognise and manage perinatal risk. Focused work is underway to improve lower compliance within the anaesthetic staffing group, including protecting training time and improving access to sessions, to ensure consistent training standards and sustained improvement across all professional groups.

Clinical Quality and Safety:
Clinical quality and safety performance within maternity services remains closely monitored across University Hospitals of Northamptonshire. In March one Patient Safety Incident Investigation was commissioned, with no cases referred to the Maternity and Newborn Safety Investigation programme. Incident reporting remains robust, with the majority relating to medication and staffing themes and no immediate systemic concerns identified. Perinatal mortality events have been reported in line with national requirements and are subject to appropriate review. There were no MOSS alerts. Governance and oversight continue to be strengthened through multidisciplinary reviews, action planning and shared learning across both trusts, supporting ongoing improvement and assurance of safe, high-quality maternity and neonatal care.

Patient experience:
Patient experience across maternity services remains positive, with consistently high Friends and Family Test promoter scores at both sites. Current priorities focus on increasing response rates to ensure feedback is representative, particularly at NGH. Action is being taken to address themes identified through complaints and feedback, including waiting times, communication and ward environment. Matron-led oversight and service-level actions are in place, with shared learning across both trusts. Ongoing monitoring and targeted improvement activity support continued enhancement of patient experience and provide assurance around responsive, person-centred maternity care.

Outcomes:
Targeted clinical quality surveillance highlights areas where variation is clinically significant or suggests potential special cause or data quality issues, requiring enhanced oversight. Key areas include severe postpartum haemorrhage, low APGAR scores at five minutes and preterm birth rates. While variation remains episodic, recent trends indicate emerging risks. Actions focus on strengthening multidisciplinary review, early recognition and escalation, and consistent use of evidence-based care bundles. Preterm birth indicators will be included in the 2026/27 perinatal scorecard to support ongoing oversight, shared learning and improvement..

Operational & Capacity:
Maternity services across UHN remained stable throughout March 2026, maintaining OPEL 1 with no significant escalation. Operational pressures were proactively managed, with delays or cancellations appropriately mitigated and no adverse impact on safety. Red flag events were monitored closely and did not result in service disruption. Following a service review informed by the national Prevention of Future Deaths report, the KGH homebirth service was temporarily paused; a comprehensive restoration plan is in place, individualised care plans have been agreed for all booked women, and relaunch is anticipated before the end of May. Ongoing workforce, acuity and capacity monitoring continues to support safe, responsive service delivery across both sites.

Workforce:
The maternity workforce continues to experience recruitment and retention pressures, with registered midwifery vacancy rates remaining higher at KGH compared with NGH and the Trust average. Neonatal nurse vacancies are present across both sites but remain relatively stable, while non-registered midwifery vacancies are lower and provide some mitigation to overall workforce pressures. Active recruitment and retention initiatives are underway, supported by workforce planning for 2026/27. The 12-month rolling leaver rate remains stable, indicating early impact of retention measures, although sustained focus is required to reduce vacancy levels and maintain safe staffing across both sites.

March 2026 UHN AT A GLANCE

AVERAGES PER DAY

BOOKINGS	BIRTHS
25	20.3

BABIES BORN

609

PREV. MONTH Feb - 519

BIRTH LOCATION

KGH (Labour Ward)	OOA	HOME
268	10	2
NGH (Labour Ward)	BIRTH CENTRE	HOME
230	16	8

3RD & 4TH DEGREE TEARS

1.28%

March 1.0%

3.1%

BLOOD LOSS >1,500MLS

March 5.1%

278 GIRLS / 320 BOYS

4.45%

March 3.7%

FULL TERM BABIES ADMITTED TO NNU

INDUCTION OF LABOUR (IOL)

27.4%

March 26.6%

49.3%

CAESAREAN SECTIONS

March 48.8%

	March	PREV 12 MTH. AV.
ELECTIVE	127 (21.1%)	59 (22.7%)
EMERGENCY	170 (28.2%)	81 (29.36%)

SETS OF TWINS

8

SETS OF TRIPLETS

0

ASSISTED BIRTHS

8.3%

VENTOUSE	FORCEPS
3.2%	5.1%

BREASTFEEDING INITIATION

83.6%

PREV. 12 MONTHS – 79.4%

NHS

March 2026 AT GLANCE

AVERAGES PER DAY

	BOOKINGS	BIRTHS
KGH	11.7	9.0
NGH	12	10

BABIES BORN

UHN 609
KGH 280
NGH 329
PREV. MONTH UHN 519

BIRTH LOCATION

	KGH (Labour Ward)	OOA	HOME
	268	10	2
	NGH (Labour Ward)	BIRTH CENTRE	HOME
	230	16	8

3RD & 4TH DEGREE TEARS

KGH 1.07%
March 0.9% ▲
NGH 1.9%
March 3.4% ▲

BLOOD LOSS >1,500MLS

KGH 4.64%
March 5.7% ▼
NGH 5.8%
March 4.1% ▲

GIRLS

KGH 129
NGH 149

BOYS

KGH 144
NGH 176

FULL TERM BABIES ADMITTED TO NNU

KGH 2.9%
NGH 2.1%

UHN CAESAREAN SECTIONS

48.8%
KGH 53.2%
NGH 48.6%

			PREV 12 MTH. AV.
ELECTIVE	KGH	57 (21.0%)	55 (23.47%)
	NGH	70 (21.4%)	78 (22.8%)
EMERGENCY	KGH	81 (29.8%)	78 29.6%
	NGH	89 (27.2%)	90 (26.3%)

INDUCTION OF LABOUR (IOL)

KGH 25% PREV. 12 MONTHS – 30.4%
NGH 23.5% PREV. 12 MONTHS – 25.7%

SETS OF TWINS

KGH 8
NGH 4

SETS OF TRIPLETS

KGH 0
NGH 0

ASSISTED BIRTHS

KGH 27
NGH 23

	VENTOUSE	FORCEPS
	KGH 11	KGH 16
	NGH 8	NGH 15
PREV. 12 MONTH AV.		
	KGH 8	KGH 14
	NGH 4	NGH 24

BREASTFEEDING INITIATION

KGH 76.1%
NGH 91.2%

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

NHS

March 2026 UHN AT A GLANCE

93.1%
MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)
98% Feb

YEAR 7 MATERNITY INCENTIVE SCHEME SAFETY ACTIONS
KGH 7 SAFETY ACTIONS
NGH 10 SAFETY ACTIONS

1
MNSI REPORTABLE CASES & REFERRED
1 Feb

MATERNITY FRIENDS & FAMILY TEST
(SATISFACTION %)
95.5%

VACANCY RATE
(February DATA)

MIDWIVES	9.68%
CONSULTANT OBSTETRICIAN	0 WTE
NEONATAL NURSES	5.61%
NEONATOLOGISTS	0 WTE

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)
95%
97% Feb

3 MODERATE INCIDENTS
5 Feb

MINIMUM SAFE STAFFING MET (LABOUR WARD ONLY)
78.5%
82.5% Feb

1 PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)
0 Feb

0 CORONER'S REGULATION 28
0 Feb

1:1 CARE IN LABOUR 99%
100% Feb

NHS

March 2026 AT A GLANCE

KGH 90.33%
NGH 95.8%
MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

YEAR 7 MATERNITY INCENTIVE SCHEME SAFETY ACTIONS
KGH 7 SAFETY ACTIONS
NGH 10 SAFETY ACTIONS

KGH 0
NGH 0
MNSI REPORTABLE CASES & REFERRED
Feb 1

MATERNITY FRIENDS & FAMILY TEST (SATISFACTION %)
KGH 99%
NGH 92%

VACANCY RATE

MIDWIVES	KGH 12.43% NGH 6.58 %
CONSULTANT OBSTETRICIAN	KGH 0% NGH 0%
NEONATAL NURSES	KGH 7.25% NGH 5.62 %
NEONATOLOGISTS	KGH 0 WTE NGH 0 WTE

KGH 3
NGH 0
MODERATE INCIDENTS

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)
KGH 96%
NGH 94%

KGH 1
NGH 0
PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

KGH 0
NGH 0
CORONER'S REGULATION 28

MINIMUM SAFE STAFFING MET (LABOUR WARD ONLY)
KGH 73%
NGH 84%

1:1 CARE IN LABOUR
KGH 100%
NGH 99%

NHS

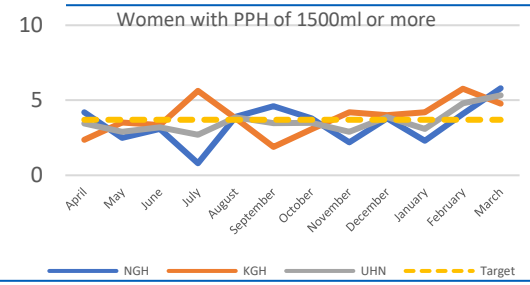
IN FOCUS – UHN Clinical Quality Surveillance

University Hospitals of Northamptonshire

Summary

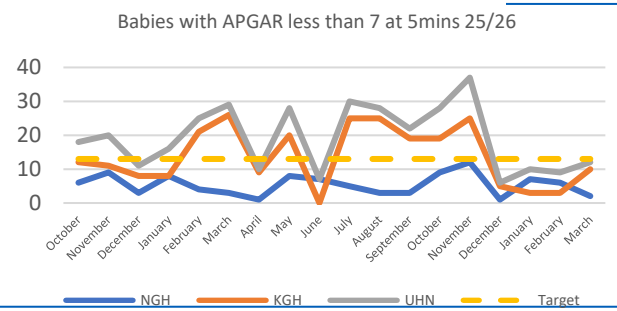
Clinical quality surveillance across University Hospitals of Northamptonshire highlights key maternity indicators where variation is either clinically significant or suggests potential special cause or data quality issues. Areas of focus include severe postpartum haemorrhage, low APGAR scores at five minutes and preterm birth rates. While variation is largely episodic, recent trends indicate emerging risks that require ongoing oversight. Targeted actions are underway, including strengthened multidisciplinary review, improved early recognition and escalation, and consistent application of evidence-based care bundles. These measures support early identification of risk, shared learning across sites and continued improvement in maternal and neonatal outcomes.

Postpartum Haemorrhage



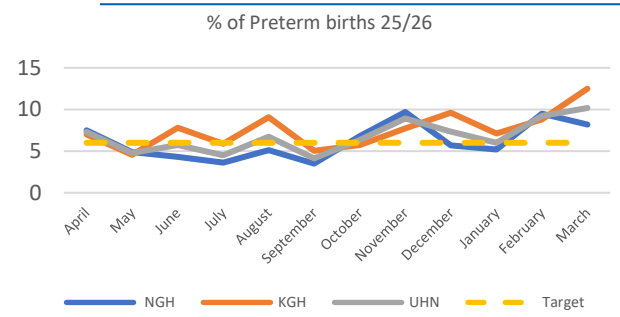
This chart shows monthly trends in women experiencing severe postpartum haemorrhage (PPH ≥1500ml) NGH, KGH, and the combined UHN position. Rates fluctuate at both trusts, with intermittent peaks above the target rather than a sustained upward trend, suggesting episodic variation rather than systemic deterioration. Major Obstetric Haemorrhage PPH is a key Perinatal Safety Improvement Programme indicator due to its association with maternal morbidity. Monitoring supports early identification of emerging risk and targeted improvement action. At NGH, all PPH cases are reviewed through a multidisciplinary incident review group to identify contributory factors and learning. Both KGH and NGH are participating in the OBI-UK (Obstetric Bleeding Study UK) care bundle, aimed at improving early recognition of bleeding and standardising treatment to reduce harm and improve maternal safety.

APGARs less 7 @ 5mins



Monthly performance in babies with an APGAR score of less than 7 at five minutes shows variation across NGH, KGH and the combined UHN position, against a target of fewer than 13 per 1,000 births. Both sites experience intermittent months above the target rather than a sustained upward trend. KGH demonstrates greater volatility, with more pronounced month-to-month fluctuations and several peak values above the threshold. NGH demonstrates a more stable pattern, remaining largely below or close to the target. Ongoing monitoring continues to distinguish random variation from emerging risk. Improvement actions focus on multidisciplinary review of low APGAR cases, strengthening intrapartum fetal monitoring and decision-making, and maintaining staff competence in newborn assessment and resuscitation to support safe and consistent care.

% of Preterm Births

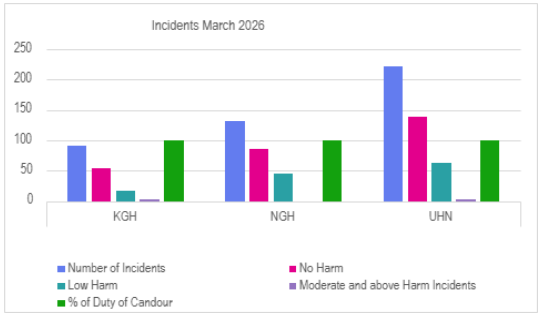


Monthly monitoring of preterm birth rates across NGH, KGH, and the combined UHN position demonstrates variation over the year, with performance initially fluctuating at or below the target. From late autumn onwards, a sustained upward trend is evident, most notably at KGH, with NGH also showing a gradual increase. The combined Trust position reflects this rise, suggesting a developing system-wide issue rather than isolated site variation. Preterm birth is a key contributor to neonatal mortality & morbidity and length of stay, making this trend a priority for review. Improvement actions include MDT review of recent preterm births, strengthening antenatal risk assessment and escalation for high-risk women, and consistent application of preterm prevention care bundles. Preterm indicators will be incorporated into the 2026/27 perinatal scorecard to support ongoing oversight and improvement and monitored via PSIP.

CLINICAL QUALITY AND SAFETY

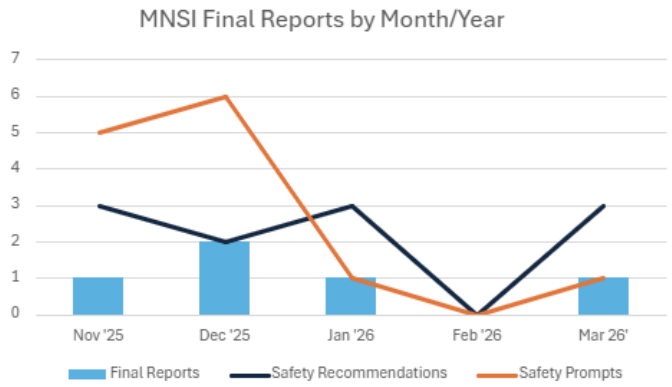
University Hospitals of Northamptonshire

Incidents and Events



MNSI Cases	Current Month	Prior Month
Referred	0	1
Accepted	0	1
On Going	3	2

PSII Cases	Current Month	Prior Month
Commission	1	0



What the data is telling us

- In March **1 Patient Safety Incident Investigation (PSII)** was commissioned at Kettering General Hospital following a neonatal medication error.
- **No cases were referred to the Maternity and Newborn Safety Investigation (MNSI)** programme. **One final investigation report** was received, resulting in **one safety prompt** and **three safety recommendations**.
- A total of **222 Datix** incidents were reported across maternity and neonatal services, with themes primarily relating to **medication incidents** and staffing pressures associated with **transitional care**.
- **Three** incidents were graded as **moderate harm**, with no immediate systemic concerns identified.
- **Two early neonatal deaths (**21–34 weeks' gestation**), one late neonatal death** (>34 weeks), **two stillbirths, and one maternal death.** All deaths have been reported via SPEN, and reviews are being undertaken in line with national guidance.

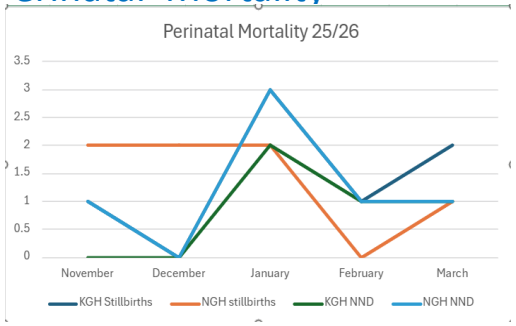
What we need to focus on

There are currently **12 active action plans (10 at KGH and 2 at NGH),** comprising a total of 153 actions. Of these, 75 actions are overdue, with the majority (74) relating to KGH. A strengthened, collaborative UHN approach is now in place to support recovery and ensure shared oversight.
Both UHN Perinatal Safety Matrons are reviewing outstanding actions and Datix themes to improve visibility, coordination and consistency across trusts. Weekly multidisciplinary meetings have been introduced with a clear objective to reduce the number of overdue actions. In addition, a programme of deep-dive review of governance processes is planned during April and May to ensure more cohesive working, clear accountability and effective shared learning across both sites.

What is going well

- A recent focused review of postpartum haemorrhage (PPH) at Northampton General Hospital identified no recurring themes or trends, providing assurance on current practice.
- Recruitment to additional administrative posts is underway to strengthen perinatal safety and governance support.
- A pan-site Perinatal Safety Newsletter will launch in April to support shared learning across both trusts.
- All After Action Reviews are up to date, with associated action plans in development to embed learning and support ongoing improvement.

Perinatal Mortality



	MOSS Signals	SPEN Referrals
KGH	0	2
NGH	0	1

Five incidents are attributable to SPEN; however, only two are reflected in March reporting. The remaining incidents occurred at the end of March and were notified to SPEN in early April, and will therefore be included in April's reporting. All incidents were reported within the required national reporting timeframes.

CQC Maternity Rating

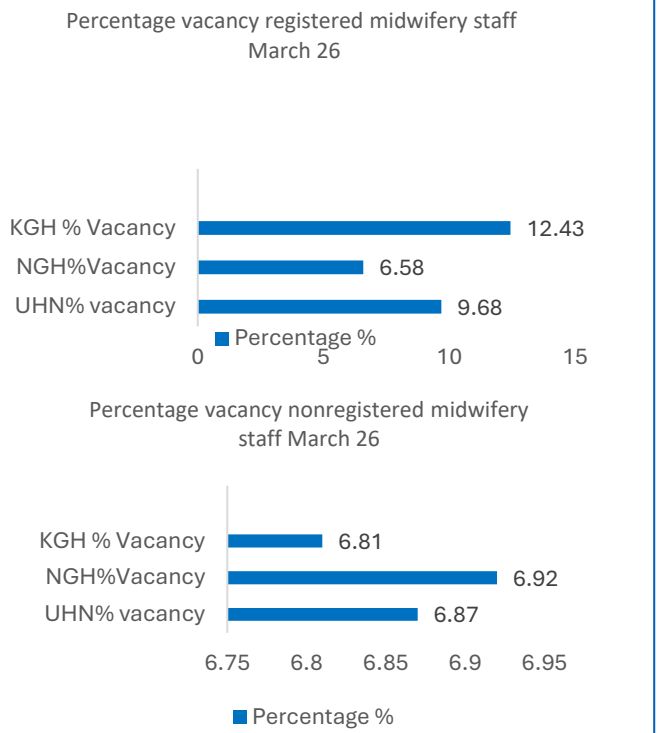
	KGH	NGH
Are services safe?	●	●
Are services effective?	●	●
Are services caring?	●	●
Are services responsive?	●	●
Are services well-led?	●	●
Overall	●	●

★ Outstanding ● Good
● Requires Improvement ● Inadequate

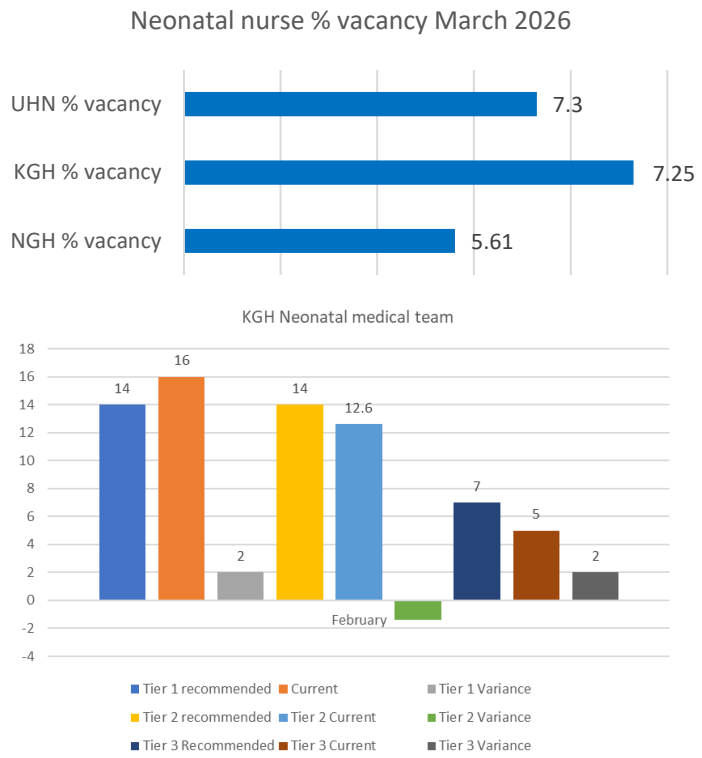
WORKFORCE - Maternity

University Hospitals of Northamptonshire

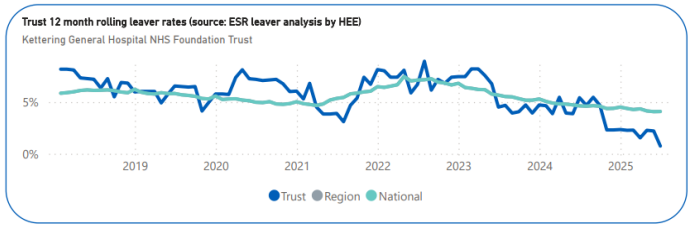
Midwifery vacancy

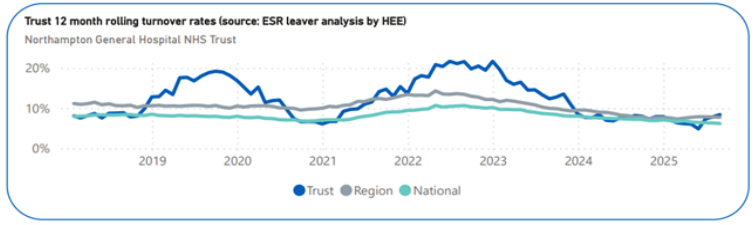


Neonatal vacancy



UHN 12 month rolling leaver rate





What the data is telling us

The maternity workforce continues to experience recruitment and retention pressures, with registered midwifery vacancy rates remaining higher at KGH compared with NGH and the Trust average.

Neonatal nurse vacancies are present across both sites but remain comparatively stable. Non-registered midwifery vacancies are lower and consistent, offering some mitigation to overall workforce gaps

A programme of active recruitment is underway across all registered posts, supported by robust retention initiatives, including wellbeing and pastoral support. Position statements for 2026/27 have been developed to support workforce sustainability, with particular focus on addressing MSW vacancies and continued recruitment of newly qualified midwives at NGH.

The 12-month rolling leaver rate shows relative stability, indicating that retention measures are having a positive impact, although ongoing focus is required to reduce vacancy pressure and maintain safe staffing levels across both sites.

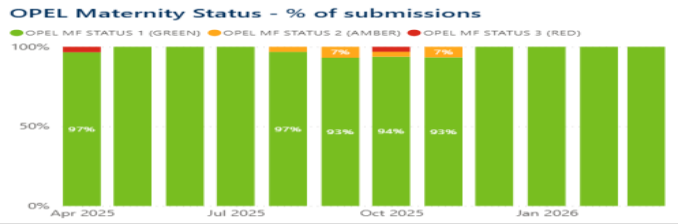
OPERATIONAL AND CAPACITY

University Hospitals of Northamptonshire

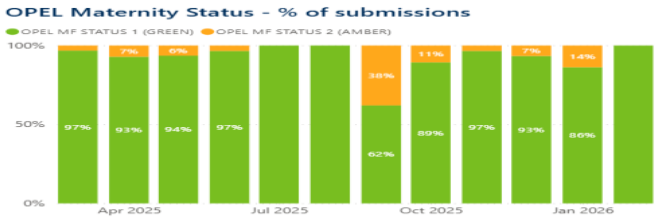
Key Information

Operational Pressures Escalation Levels

Kettering General Hospital

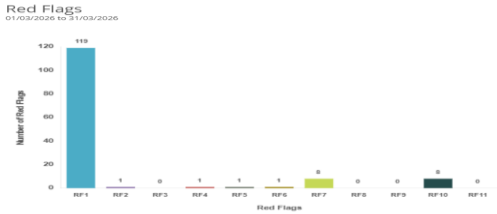


Northampton General Hospital



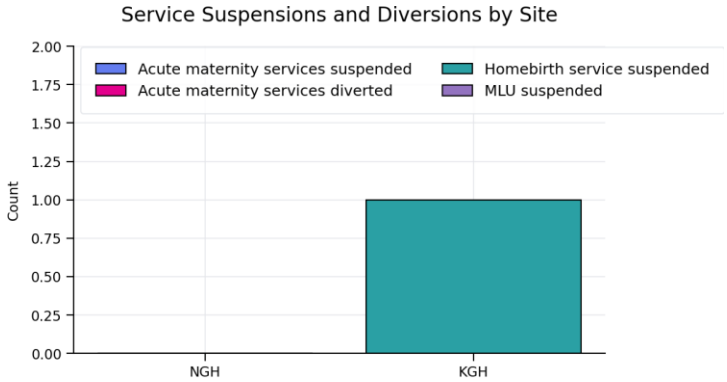
Midwifery Red Flag Events

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 operational pressures, remaining at OPEL 1 throughout March '26 with no significant escalation. Red flag events were reported at both sites, primarily relating to delays or cancellations of critical activity, none of which resulted in service disruption. Following a service review informed by the national Prevention of Future Deaths report, the KGH homebirth service was temporarily paused (24th February); a restoration plan is underway, individualised plans are in place for all booked women, extension of service by end of May to Kettering area.

What we need to focus on

Recruitment activity continues across maternity services, alongside close monitoring of capacity to maintain safe staffing levels, manage fluctuations in demand, and minimise red flags. Early escalation processes remain effective through established Trust pathways, supporting timely identification and management of emerging risk. At NGH, work is ongoing to improve Birthrate Plus compliance, strengthening the Trust's evidence-based approach to maternity workforce planning and ensuring staffing models remain aligned to activity and acuity. Birthrate Plus review is now due at NGH, Planning meetings start in May 2026

What is going well

Operational pressures continued across both NGH and KGH during March; however, services remained resilient and well managed. Operational leadership was further strengthened through the introduction of UHN neonatal safety huddles, enhancing oversight, coordination, and escalation across maternity and neonatal services .Delays and cancellations continued to be closely monitored and safely managed, with appropriate clinical prioritisation and no adverse impact on service continuity. Overall, maternity services maintained safe operational delivery despite ongoing system pressures. Homebirth restoration plan is underway with actions being completed on time to support safe

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	MAR
Prompt Midwives	**99%**	**99%**	**99%**	**96%**
Prompt Doctors Cons	**100%**	**100%**	**100%**	**92%**
Prompt Doctors Reg	**100%**	**100%**	**100%**	**100%**
Prompt Anaesc Cons	**100%**	**100%**	**100%**	**71%**
Prompt Anaes Reg	**100%**	**100%**	**100%**	**88%**
Prompt MSW	**98%**	**100%**	**100%**	**95%**

PROMPT	Dec	Jan	Feb	Mar
All Staff	98%	97%	97%	98%
Anaesthetists	97%	89%	83%	79%
Obstetric Consultants	92%	100%	100%	100%
Obstetric Doctors	97%	87%	95%	100%
Midwives	98%	100%	99%	99%
Maternity Support Workers	99%	97%	99%	99%

Module 6: Neonatal Basic Life Support:

	Dec-25	JAN	FEB	MAR
NLS Midwives	**99%**	**99%**	**99%**	**96%**
NLS MSW	**98%**	**100%**	**100%**	**95%**

NBLS/NLS	Dec	Jan	Feb	Mar
Midwives	97%	97%	96%	94%
Maternity Support Workers	97%	97%	94%	91%

Element 4: Fetal monitoring and surveillance:

	Dec-25	JAN	FEB	MAR
CTG Day Midwives	**100%**	**99%**	**100%**	**96%**
CTG Day Consultants	**100%**	**100%**	**100%**	**92%**
CTG Day Reg	**100%**	**100%**	**100%**	**100%**

Fetal Monitoring	Mar
All Staff	96%
Obstetric Consultants	100%
Obstetric Doctors	91%
Midwives	98%

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. PROMPT attendance is high across all clinical groups—including obstetric, 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 and restoration of training compliance in this staff group.

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 both sites requires 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.

A gap analysis is underway to benchmark current training against requirements of Maternity Incentive Scheme Year 8.

What is going well

Training compliance remains strong across maternity services at both Northampton General Hospital and Kettering General Hospital, supporting the aims of the Perinatal Safety Improvement Programme (PSIP).

High attendance is consistently achieved across key safety-critical training, including maternity emergencies, neonatal life support and fetal monitoring, with most staff groups meeting or exceeding local targets.

This reflects sustained staff engagement and effective coordination of training delivery. Strong compliance provides assurance that multidisciplinary teams are equipped with the skills required to identify, escalate and manage perinatal risk, contributing to improved maternal and neonatal safety and supporting continued reduction in preventable harm in line with PSIP priorities.

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 7UHN submitted MIS Year 7 CNST declarations for both Trusts. NGH achieved all ten Safety Actions, providing strong assurance of compliance. At KGH, Safety Actions 1, 4 and 5 were not fully met, reflecting gaps in evidencing consistent embedding rather than safety concerns. Targeted improvement work is underway to strengthen governance, workforce assurance and audit methodologies. MIS Year 8 was published in March and introduces a reduced set of six Safety Actions with a stronger focus on impact and outcomes rather than processes, with a greater reliance on local Board level accountability. Implementation planning is in progress, providing a clear framework to support improved compliance and assurance 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	Mar-26	YTD	Trend
Maternity KGH	3	3	1	1	14	→
Neonatal KGH	0	0	0	0	0	
Maternity NGH	10	10	0	0	28	→
Neonatal NGH	0	0	0	0	0	

Friends and Family Test (FFT)

Kettering General Hospital

	Target	National	Jan-26	Feb-26	Mar-26	YTD
FFT % Responses	20%	13%	12%	13%	13%	**13%**
FFT % Promoters	96%	93%	98%	99%	99%	**99%**

Northampton General Hospital

	Target	National	Jan-26	Feb-26	Mar-26	YTD
FFT % Responses	25%	13%	19%	26%	13%	**23%**
FFT % Promoters	96%	93%	96%	97%	92%	**96%**

KGH: My preferences have been listened to and respected throughout my care, I have always been able to speak to someone when needed and all my questions were answered. Parking at the hospital is a nightmare.

Excellent service. Extremely knowledgeable and willing to share and offer advice. Appointments available when needed. Support needed at the right time. Advertise the Anya app more.

NGH: Fantastic care & attention throughout my time here. The midwives & support workers have been amazing; I cannot sing their praises enough. This is my 2nd child but 1st time in Northampton, this was by far a better experience & at a time I truly will relish in my memories. You guys are amazing & truly wish more expectant mothers knew & considered this ward (condition permitting). Thank you for everything you've done & for making a big difference in my birth story.

What the data is telling us

NGH: FFT response rates fell in March (147 responses; 13%), contributing to a lower overall satisfaction score of 92%. Notwithstanding this, feedback continues to evidence highly compassionate and professional care from midwifery and support staff, despite operational pressures and long waits.

KGH: FFT results continue to indicate a strong and consistent patient experience. The year-to-date promoter score remains at 99%, exceeding both the local target (96%) and national benchmark (93%). The response rate is 13% year to date, below the 20% local target but aligned to the national average and stable over time. The priority is therefore to improve participation so that feedback is more representative, while sustaining current performance.

What we need to focus on

NGH: Triage reported 0% satisfaction in March, based on four comments received on a single day, indicating a localised pressure point rather than a sustained trend. The main themes remain staffing capacity, communication, waiting times in triage and for medication, facilities, and consistency of information. Action is in progress, including exploration of ward self-administration to align with KGH.

KGH: Delays in analgesia remain the principal concern, although the volume of related feedback has reduced following improvement actions. A structured drug round was introduced in January, with audit activity commencing in March. Compliance was 52% in March, with weaker performance mainly on night shifts. Further improvement is required and will be driven through strengthened daily oversight, routine review of audit findings by ward and matrons, real-time feedback to teams, and clearer accountability for compliance across all shifts.

SPOTLIGHT ON…

University Hospitals of Northamptonshire

What is going on?

Earlier access to maternity care

University Hospitals of Northamptonshire is introducing a new early booking campaign, **"Period Late, Tell Us by 8 (Weeks)",** to encourage people to contact maternity services as early as possible in pregnancy. Early contact helps ensure timely appointments, important health checks and access to the right support, helping to promote healthier pregnancies and better outcomes for parents and babies.

Communications

The Communications team will be supporting the recording of a tour of the maternity unit at Kettering General Hospital on 28 April 2026. Filming will take place across all clinical areas, including the community hub attached to the hospital. Staff are welcome to say hello to the team during the recording. A similar recording is planned at Northampton General Hospital on 12 May 2026.

What is going on?

Creating supportive environments

A sensory audit supported by the Autism Network is scheduled to take place at Kettering General Hospital on 20 April 2026. A similar audit was completed earlier this year at Northampton General Hospital, providing a foundation for shared learning. A service improvement planning meeting has been arranged for 21 April 2026 to review findings from both sites and agree next steps.

Improving accessibility and inclusion

A new University Hospitals of Northamptonshire translation service was launched on 1 April 2026, providing improved access to interpretation services. Word360/Workski is now in place for telephone translation, alongside Sign Solutions for British Sign Language interpretation, supporting more inclusive and accessible care for patients and families.

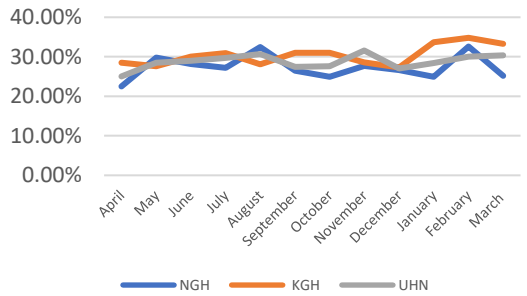
APPENDICES

TRENDS: – CLINICAL QUALITY SURVEILLANCE

University Hospitals of Northamptonshire

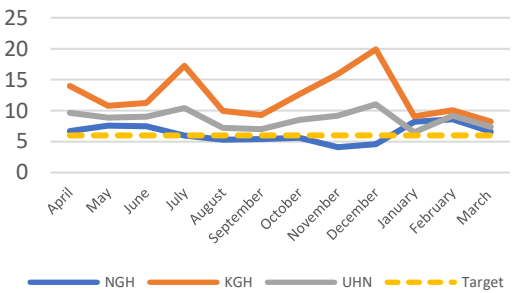
Antenatal

BMI 30 or more at time of booking



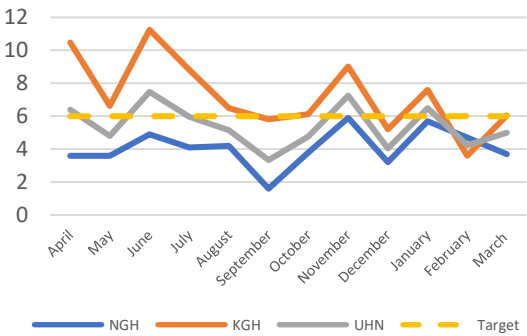
Latest
30.39% increase from 30.05%
Variation
N/A
Target achievement
N/A

% smokers at booking 25/26



Latest
7.35% deccrease from 9.19%
Target
6% SBLCB
Target achievement
Require additional data points to analyse

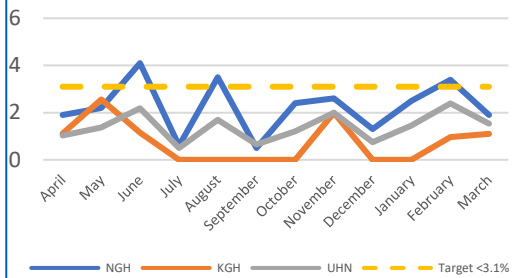
% current smokers at time of birth



Latest
5% increase from 4.24%
Target
6%
Target achievement
Require additional data points to analyse

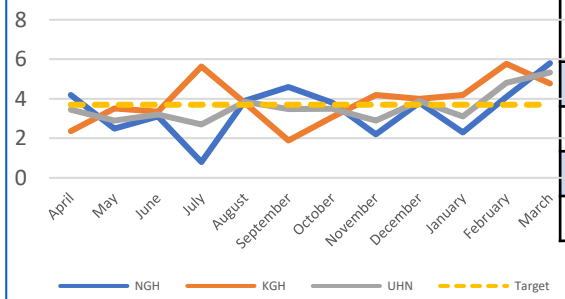
Intrapartum

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



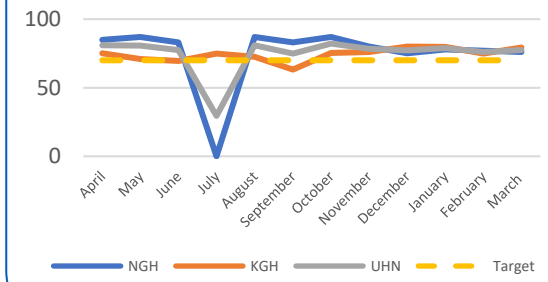
Latest
1.53% decrease from 2.39%
Target
3.1%
Target achievement
Require additional data points to analyse

Women with PPH of 1500ml or more



Latest
5.33% increase from 4.8%
Target 3.7%
N/A
Target achievement
N/A

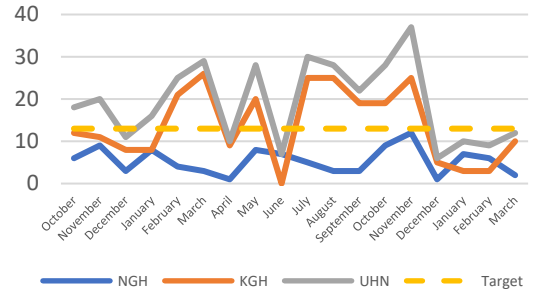
% Breastfeeding initiation 25/26



Latest
77.47% increase from 76.12%
Target 70%
No NGH data for July '25
Target achievement
Largely exceeding target

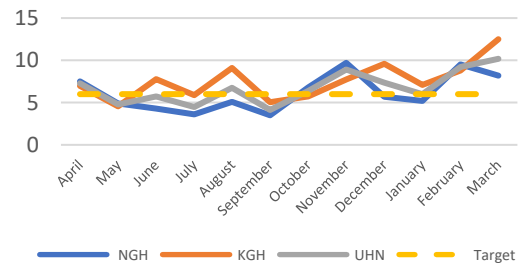
Outcomes

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



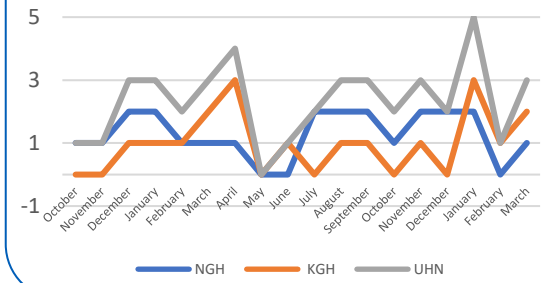
Latest
12 increase from 9 19.7/1000 births higher than target
Target 13/1000 births
N/A
Target achievement
Require additional data points to analyse

% of Preterm births 25/26



Latest
10.18% of total births increase from 9.21%
Target
6% SBLCB
Target achievement
Require additional data points to analyse

Stillbirth 25/26



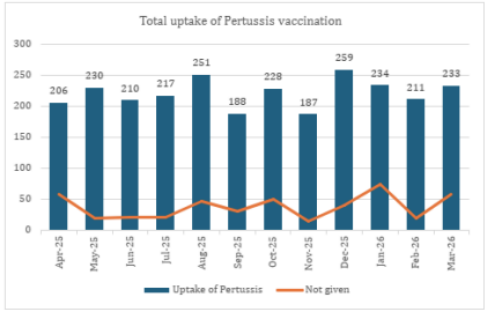
Latest
4.9 per 1000 births - UHN
Target
N/A
Target achievement
N/A

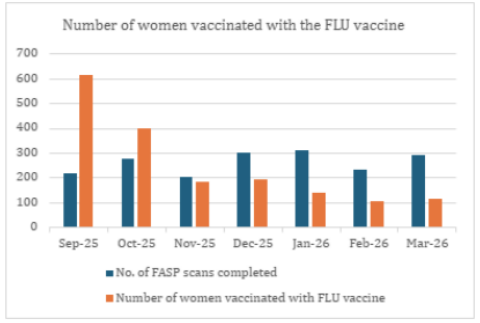
IMMUNISATION SUMMARY

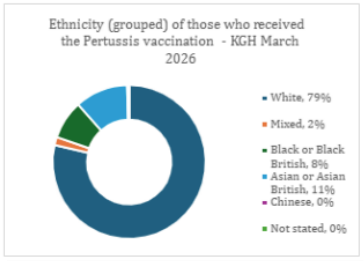
University Hospitals of Northamptonshire

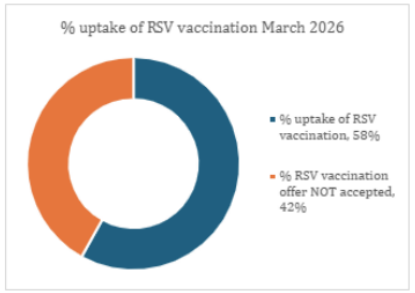
Kettering General Hospital

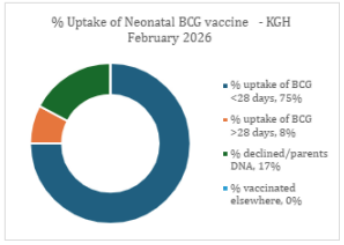
Immunisation Summary Antenatal Pertussis, RSV, FLU & Neonatal BCG Immunisations – MARCH 2026

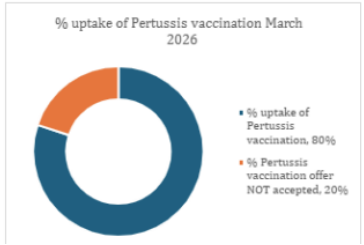


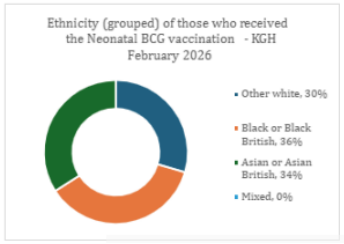




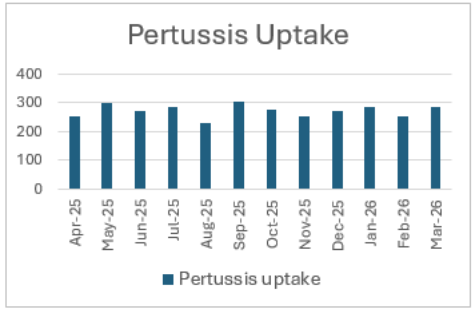


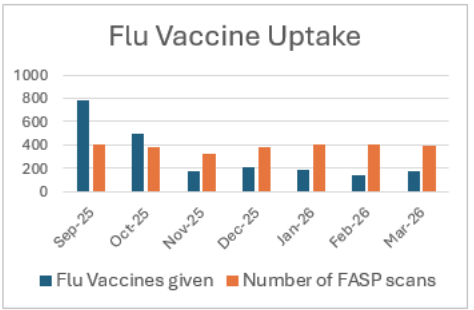


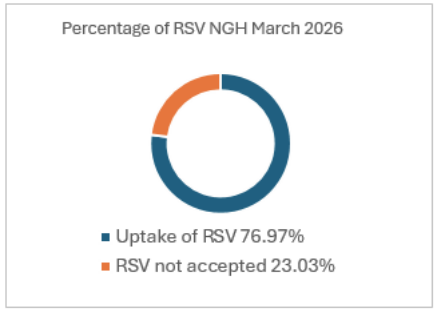


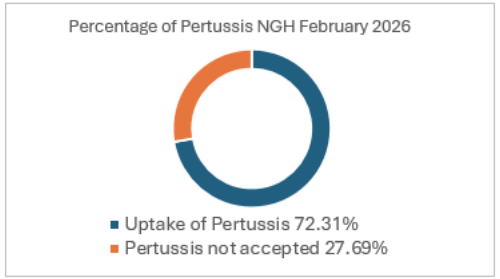


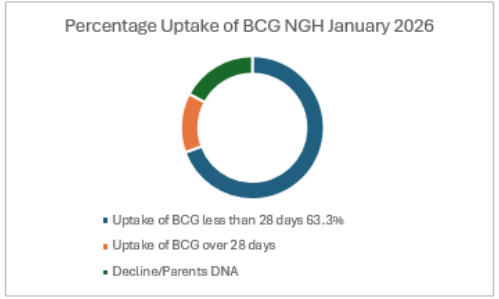
Northampton General Hospital











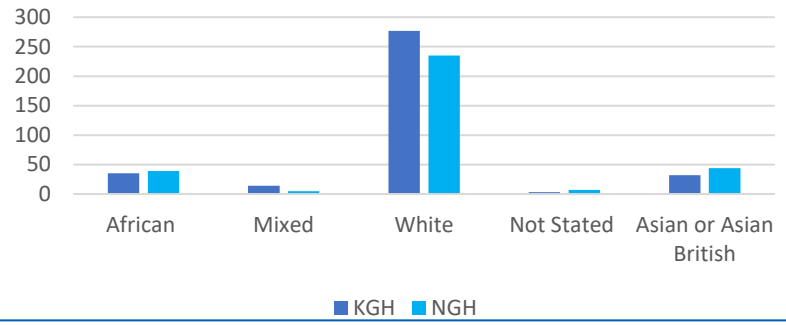
Kettering General Hospital demonstrates stable antenatal and neonatal immunisation uptake across pertussis, RSV, influenza and BCG programmes, with consistent delivery within hospital settings. Northampton General Hospital shows strong uptake supported by community clinic delivery, improving accessibility, sustaining maternal and neonatal vaccination rates, and reducing pressure on acute hospital services.

EQUITY AND POPULATION

University Hospitals of Northamptonshire

Ethnic profile and variations

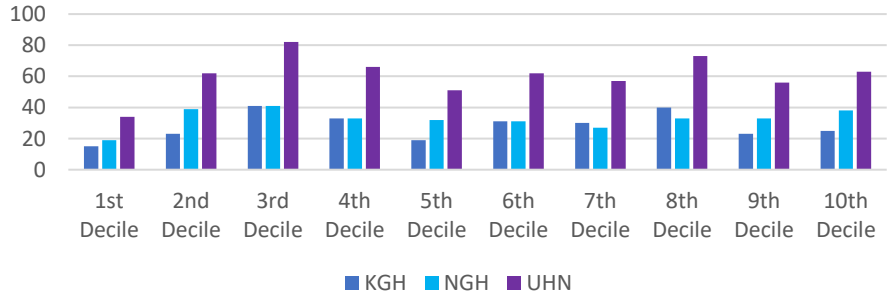
Population profile at booking



The booking population differs between trusts. At KGH, approximately 78% White, 10% African, 10% Asian or Asian British, and 3% Mixed. At NGH, around 71% White, 12% African, 11% Asian or Asian British, 3% Mixed, with a small proportion not stated. NGH therefore serves a more ethnically diverse population than KGH. Monitoring this distribution is important to identify potential inequalities, tailor maternity services appropriately, and support equitable perinatal outcomes across Northamptonshire.

Deprivation

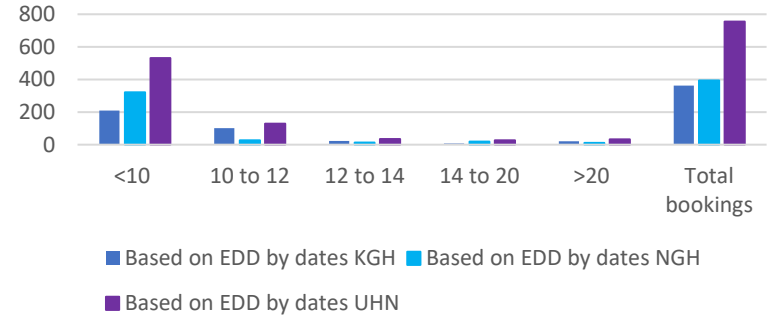
Population profile at birth



KGH shows a relatively even distribution across deprivation deciles, with the highest counts in the 3rd and 8th deciles. NGH demonstrates higher overall activity, peaking in the 3rd, 6th and 8th deciles, indicating greater concentration in mid-to-higher deprivation groups. UHN, combining both trusts, reflects these shared peaks, suggesting deprivation-related gradients across Northamptonshire and the importance of interpreting patterns by individual trust as well as in aggregate.

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. 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 and care planning across UHN a new campaign has been launched **– 'Period Late Tell Us By 8'**

GLOSSARY OF TERMS

University Hospitals of Northamptonshire

Glossary

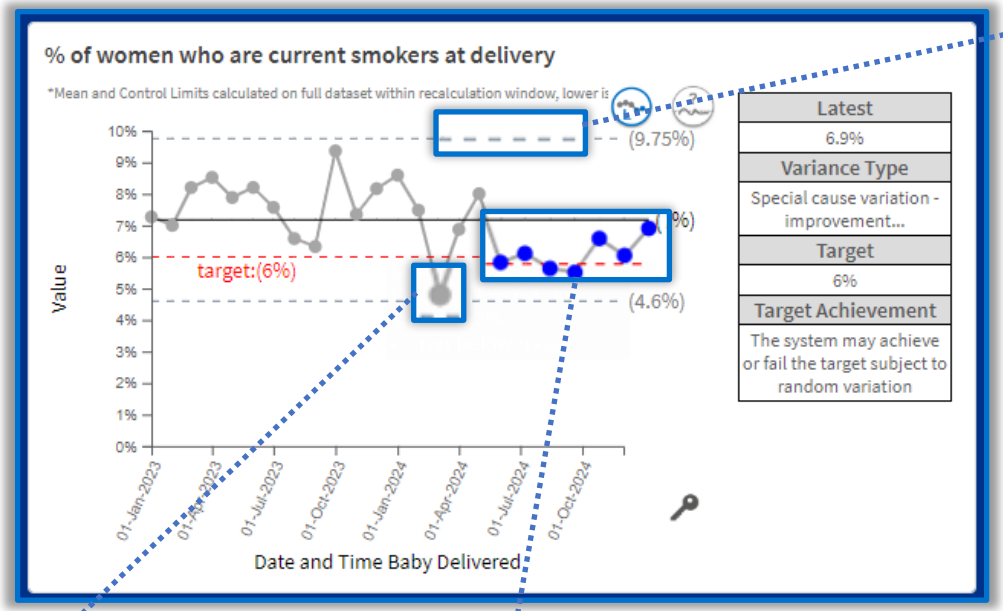
In February, there were 716 babies born across the service, which was below the monthly average and notably lower than January, partly due to the shorter month. Irrespective of the decrease in number of babies born, activity remained high noted in our amber and red OPEL status, along with higher acuity 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**

NHS
University Hospitals of Northamptonshire

Perinatal Quality Surveillance Scorecard

April 2026

SUMMARY April 2026

University Hospitals of Northamptonshire

The month in review:

Overall, April 2026 reflects a mixed but steadily improving position across UHN, with continued progress in several key areas alongside ongoing pressures. Training compliance remains strong, and patient experience is generally positive, particularly at NGH, although variability in feedback response rates and challenges within triage highlight areas requiring further improvement. Clinical quality and safety indicators demonstrate low levels of harm and strengthened governance processes, with improved oversight and a reduction in overdue actions. However, some variation in outcomes and recurring incident themes require sustained focus. Operational performance has remained largely stable, although red flag events continue to highlight risks in the delivery of time-critical care. Workforce capacity remains a key constraint, with vacancy levels impacting resilience despite active recruitment and establishment changes. A coordinated programme of improvement is in place, with progress being closely monitored through the PSIP programme to ensure learning is embedded, variation is reduced, and measurable improvements in safety, quality, and experience are delivered across both sites.

Training compliance:
Training compliance remains consistently strong across UHN, with the majority of areas achieving or exceeding the 90% target, particularly in midwifery, neonatal life support, and fetal monitoring. However, there is variation in obstetric doctor compliance, with some areas below target, reflecting workforce changes and rota pressures. Targeted actions are in place to improve compliance, including focused training delivery and strengthened alignment across sites. Overall, UHN is on track to meet Maternity Incentive Scheme requirements, with continued emphasis on sustaining high compliance and addressing areas of variation. A mid-year assessment of training compliance is planned for July 2026 as per the updated MIS year 8 guidance to support sustainable training compliance across the MDT

Clinical Quality and Safety:
Clinical quality and safety performance presents a mixed but improving position across UHN, with no PSII investigations commissioned in April and low levels of moderate harm incidents identified. Two MNSI cases remain under review, with no new referrals this month. Themes from incidents continue to centre on medication and documentation. Perinatal mortality and stillbirth rates remain variable, requiring ongoing monitoring. Positively, governance processes have strengthened, evidenced by a significant reduction in overdue actions and improved oversight of incident management. Focus remains on reducing overdue incidents, strengthening learning dissemination, and ensuring timely investigation and action to drive sustained improvements in safety and quality through the PSIP programme.

Patient experience:
Patient experience presents a mixed picture across UHN, with strong satisfaction scores but variable engagement in feedback collection. NGH continues to demonstrate high FFT response and promoter rates, achieving 97.2% overall satisfaction and nearing the 20% response target. In contrast, KGH response rates remain below target, limiting the reliability of insight despite positive promoter scores. Themes from complaints and feedback highlight car parking issues, continuity of care, and delays in triage, with the latter reflected in low satisfaction scores for NGH triage services. Focus remains on improving FFT collection rates, addressing key themes, and strengthening the use of feedback to drive measurable improvements in patient experience.

Outcomes:
Overall, clinical quality surveillance shows mixed performance, with areas of improvement alongside ongoing risks. Early indicators highlight rising BMI and smoking at booking, while smoking at birth remains stable. Intrapartum measures show improvement in severe perineal trauma, and a recent reduction in postpartum haemorrhage in April, although performance requires continued monitoring. Outcome measures indicate elevated rates of low Apgar scores and preterm birth, while breastfeeding initiation remains above target despite a slight decline. Data quality issues persist, and focus remains on targeted improvement, reducing variation, and strengthening data completeness.

Operational & Capacity:
Operational performance across UHN remains stable overall, with the service operating at OPEL 1 for the majority of April (78%), indicating a generally manageable level of pressure. However, there are periods of escalation to OPEL 2 (22%), reflecting intermittent capacity challenges. A total of 202 midwifery red flag events were reported, with key themes relating to delays and cancellations of time-critical care, highlighting ongoing operational risks. Positively, no in-utero transfers for extreme preterm births were recorded and strengthened workforce oversight is supporting improved situational awareness. Focus remains on improving workforce capacity, reducing red flag events, and strengthening oversight of time-critical care delivery to ensure safe and sustainable service provision.

Workforce:
The workforce position across UHN highlights ongoing capacity challenges within both midwifery and neonatal services, with vacancy rates of approximately 10–12%. Increased establishment at NGH has contributed to a rise in recorded vacancies, alongside pressures in non-registered staffing. Neonatal nurse vacancy remains at 9.6% overall. Actions are underway to strengthen the obstetric consultant workforce, including substantive recruitment and reduced reliance on locum at KGH. Workforce stability shows early signs of improvement, with turnover rates declining toward regional levels. Continued focus is required on recruitment, retention, and workforce planning to stabilise staffing and support safe, sustainable service delivery.

April 2026 UHN

AVERAGES PER DAY

BOOKINGS	BIRTHS
25	23

BABIES BORN

610

PREV. MONTH April 609

BIRTH LOCATION

	KGH (Labour Ward)	OOA	HOME
	251	5	0
	NGH (Labour Ward)	BIRTH CENTRE	HOME
	308	21	8

3RD & 4TH DEGREE TEARS

1.4%

March 1.3%

2.7%

BLOOD LOSS >1,500MLS

March 3.1%

tbc GIRLS / tbc BOYS

6.1%

March 4.45%

FULL TERM BABIES ADMITTED TO NNU

INDUCTION OF LABOUR (IOL)

23.5%

March 27.4%

45.2%

CAESAREAN SECTIONS

March 49.3%

		PREV 12 MTH. AV.
ELECTIVE	106 (15.1%)	59 (22.7%)
EMERGENCY	195 (27.8%)	81 (29.4%)

SETS OF TWINS

8

SETS OF TRIPLETS

0

ASSISTED BIRTHS

61

VENTOUSE	FORCEPS
24	37

PREV. 12 MONTH AV.

VENTOUSE	FORCEPS
3.2%	5.1%

BREASTFEEDING INITIATION

84.7%

PREV. 12 MONTHS – 79.4%

NHS

April 2026 AT GLANCE

AVERAGES PER DAY

	BOOKINGS	BIRTHS
KGH	11.6	8.6
NGH	13.4	11.8

BABIES BORN

UHN 610
KGH 256
NGH 354
PREV. MONTH UHN 609

BIRTH LOCATION

	KGH (Labour Ward)	OOA	HOME
	245	11	0
	NGH (Labour Ward)	BIRTH CENTRE	HOME
	313	21	8

3RD & 4TH DEGREE TEARS

KGH 0%
March 1.07%
NGH 1.1%
March 1.9%

BLOOD LOSS >1,500MLS

KGH 3.1%
March 4.64%
NGH 3.1%
March 5.8%

GIRLS

KGH 106
NGH 170

BOYS

KGH 149
NGH 169

FULL TERM BABIES ADMITTED TO NNU

KGH 2.2%
NGH 4.6%

UHN CAESAREAN SECTIONS

45.2%
KGH 55.9%
NGH 49.2%

		PREV 12 MTH. AV.	
ELECTIVE	KGH	51 (19.9%)	55 (23.5%)
	NGH	55 (15.5%)	78 (22.8%)
EMERGENCY	KGH	87 (34.0%)	178 (29.6%)
	NGH	108 (30.5%)	90 (26.3%)

INDUCTION OF LABOUR (IOL)

KGH 32.4% PREV. 12 MONTHS – 30.4%
NGH 23.2% PREV. 12 MONTHS – 24.0%

SETS OF TWINS

KGH 4
NGH 4

SETS OF TRIPLETS

KGH 0
NGH 0

ASSISTED BIRTHS

KGH 37
NGH 24

	VENTOUSE	FORCEPS
	KGH 18	KGH 19
	NGH 6	NGH 18
PREV. 12 MONTH AV.		
	KGH 8	KGH 14
	NGH 4	NGH 24

BREASTFEEDING INITIATION

KGH 76.1%
NGH 91.2%

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

NHS

April 2026 UHN AT A GLANCE

95%

MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

93.1% March

YEAR 8 PROGRESS MATERNITY INCENTIVE SCHEME SAFETY ACTIONS

KGH 6 SAFETY ACTIONS

NGH 6SAFETY ACTIONS

0

MNSI REPORTABLE CASES & REFERRED

1 March

MATERNITY FRIENDS & FAMILY TEST (SATISFACTION %)

97%

VACANCY RATE (APRIL DATA)

MIDWIVES	10.7%
CONSULTANT OBSTETRICIAN	1 WTE
NEONATAL NURSES	9.6%
NEONATOLOGISTS	0 WTE

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)

94%

95% March

12 MODERATE INCIDENTS

3 March

MINIMUM SAFE STAFFING MET (LABOUR WARD ONLY)

80%

78.5% March

0 PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

1 March

0 CORONER'S REGULATION 28

0 March

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

99% March

NHS

April 2026 AT A GLANCE

KGH 90.8%
NGH 97%
MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

YEAR 8 MATERNITY INCENTIVE SCHEME
6 SAFETY ACTIONS
KGH 6 SAFETY ACTIONS
NGH 6 SAFETY ACTIONS

KGH 0
NGH 0
MNSI REPORTABLE CASES & REFERRED
March 1

MATERNITY FRIENDS & FAMILY TEST
(SATISFACTION %)
KGH 97%
NGH 97%

VACANCY RATE

MIDWIVES	KGH 8.3% NGH 12.5%
CONSULTANT OBSTETRICIAN	KGH 1 WTE NGH 0 WTE
NEONATAL NURSES	KGH 7.25 % NGH 4.3 %
NEONATOLOGISTS	KGH 0 WTE NGH 0 WTE

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)
KGH 95%
NGH 94%

KGH 5
NGH 7
MODERATE INCIDENTS

MINIMUM SAFE STAFFING MET (LABOUR WARD ONLY)
KGH 77%
NGH 82 %

KGH 0
NGH 0
PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

KGH 0
NGH 0
CORONER'S REGULATION 28

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

NHS

IN FOCUS – UHN Clinical Quality Surveillance

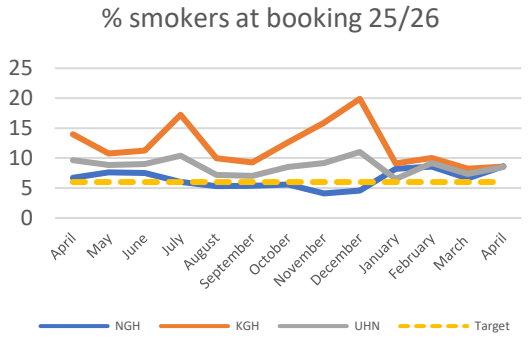
University Hospitals of Northamptonshire

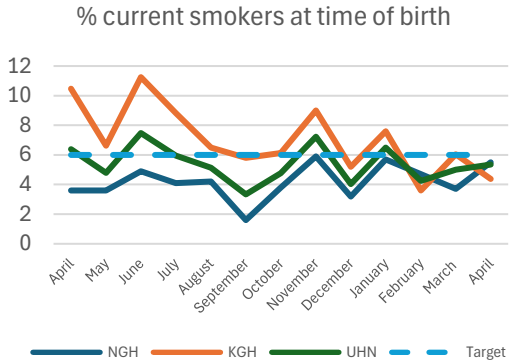
Summary

The overall picture shows smoking in pregnancy and preterm birth both running above the 6% target for much of the period and showing meaningful variation between sites. Some indicators are moving in the right direction and there are signs that focused interventions can work, including smoking rates improving by birth and some intrapartum measures performing better than target, but gains are not yet consistent enough to shift the wider risk profile.

Smoking in Pregnancy

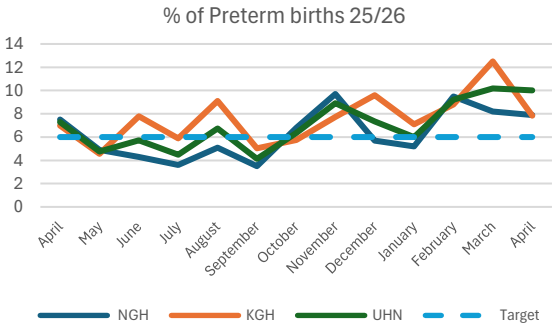
Smoking in pregnancy remains above the 6% target at booking, with a rising trend to around 9% and significant variation across sites, particularly higher and more volatile performance at KGH. While rates reduce to around target by birth, demonstrating some effectiveness of cessation support, improvement is inconsistent and insufficient to offset higher booking prevalence. This represents a risk to maternal and neonatal outcomes which requires action. Priority actions include strengthening early identification and opt-out referral pathways, reducing unwarranted variation through standardised practice, and targeting high-risk populations to improve quit rates and sustain reductions across the pregnancy pathway. A key to this is increasing collaborative partnerships with Public Health partners and MNVP to better understand the barriers women face and shaping interventions that are more accessible and effective in supporting behaviour change.





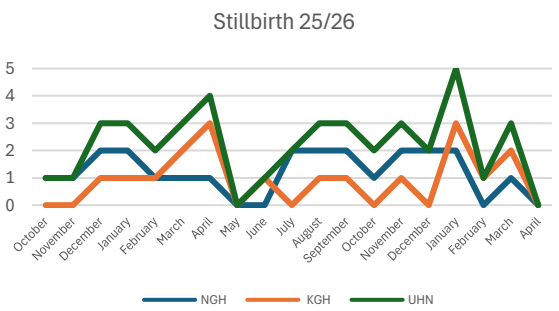
Preterm Births

Preterm birth rates remain above the 6% target across both sites, averaging around 8–9% with peaks up to 13%. The pattern is sustained rather than episodic, with deterioration noted in recent months. Variation is evident between sites, with higher fluctuation at KGH, suggesting inconsistent delivery of prevention pathways. This represents an ongoing risk to neonatal outcomes and demand on perinatal services. Improvement will focus on strengthening the preterm prevention pathway, targeting high-risk groups earlier, and reducing variation through standardised practice. Partnership with MNVP will help ensure women receive clear, consistent information about preterm birth and can access timely and appropriate support. This will be monitored through PSIP workstream 1 to ensure an effective, sustainable reduction in preterm birth.



Stillbirths

Stillbirth numbers remain low overall but show ongoing month-to-month variation, with intermittent spikes across all sites. While no sustained upward trend is evident, this reflects the unpredictability of a rare but high-impact outcome and reinforces the need for continued focus on prevention. Reducing smoking in pregnancy and strengthening preterm birth prevention pathways will be key contributors to improving outcomes. Every case is subject to robust review, with learning embedded into day-to-day practice through the PSIP programme, applying a culturally competent lens to support equitable care. When stillbirth does occur, ensuring families receive high-quality, compassionate bereavement care remains a priority alongside ongoing improvement.

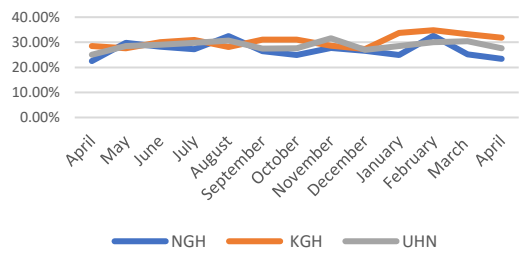


TRENDS: – CLINICAL QUALITY SURVEILLANCE

University Hospitals of Northamptonshire

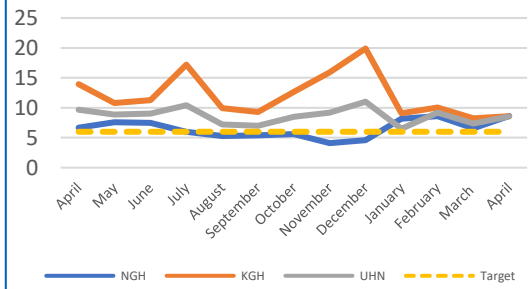
Antenatal

BMI 30 or more at time of booking



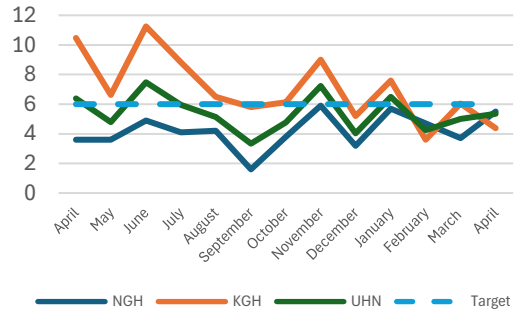
Latest
28.09 % decrease from 30.39%
Variation
No NGH data so UHN value artificially lower
Target achievement
N/A

% smokers at booking 25/26



Latest
8.62% increase from 7.35%
Target
6% SBLCB
Target achievement
Require additional data points to analyse

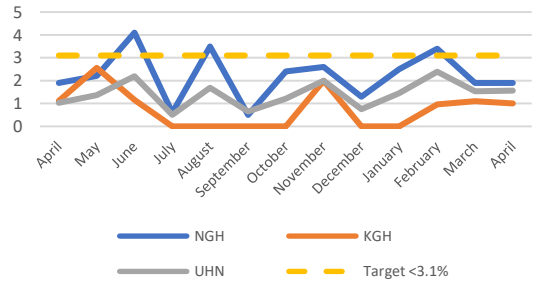
% current smokers at time of birth



Latest
5% no change from previous month 5%
Target
6%
Target achievement
Require additional data points to analyse

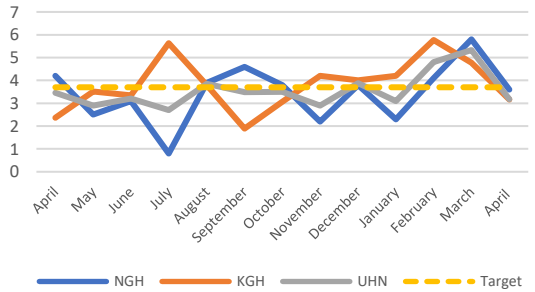
Intrapartum

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



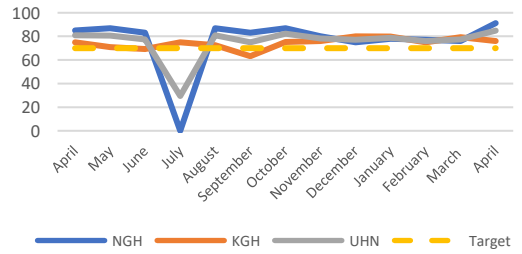
Latest
1.6% no change from previous month
Target
3.1%
Target achievement
Require additional data points to analyse

Women with PPH of 1500ml or more



Latest
3.18% decrease from 5.33%
Target 3.7%
N/A
Target achievement
N/A

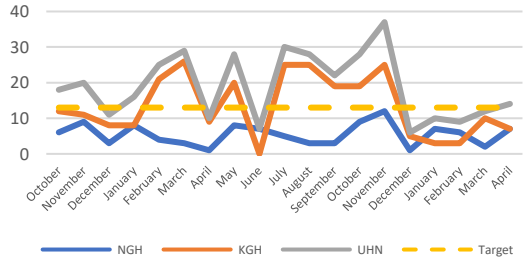
% Breastfeeding initiation 25/26



Latest
84.86% increase from 77.47%
Target 70%
No NGH data for July
Target achievement
Require additional data points to analyse

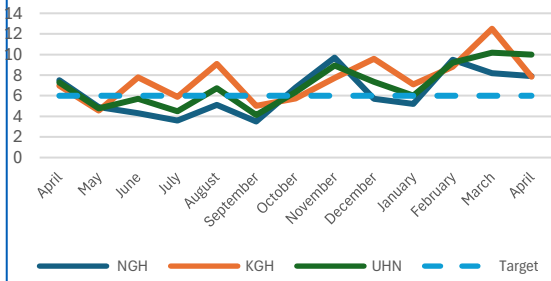
Outcomes

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



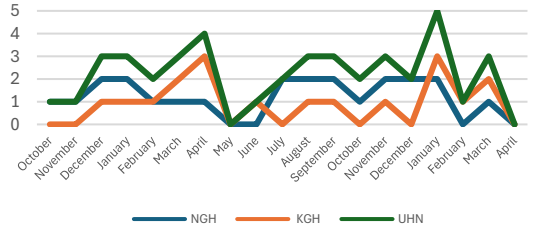
Latest
14
Target 13
N/A
Target achievement
Require additional data points to analyse

% 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

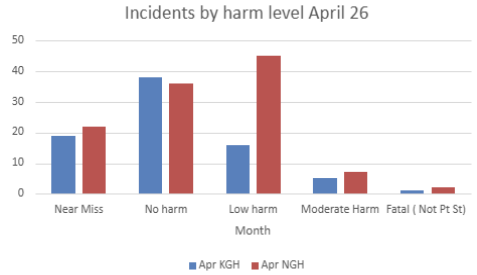


Latest
5.83 per 1000 births – UHN April-April 25-26
Target
N/A
Target achievement
N/A

CLINICAL QUALITY AND SAFETY

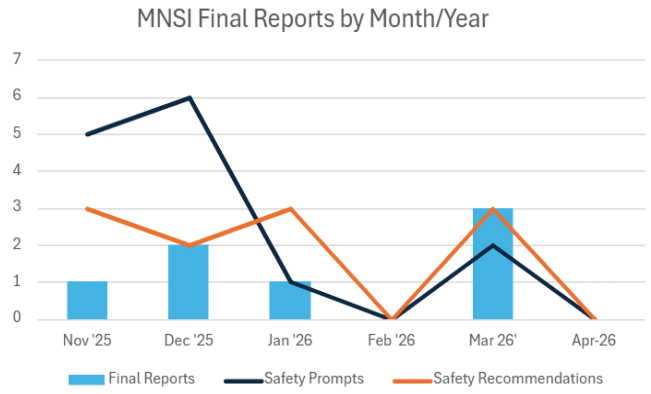
University Hospitals of Northamptonshire

Incidents and Events



MNSI Cases	Current Month	Prior Month
Referred	0	0
Accepted	0	0
On going	2	2

PSII Cases	Current Month	Prior Month
Commissioned	0	3



What the data is telling us

- In April 0 **Patient Safety Incident Investigation (PSII)** across UHN .
- **No cases were referred to the Maternity and Newborn Safety Investigation (MNSI)** programme. N**o final reports were received. There are 2 ongoing MNSI cases at KGH, with the first of these reports expected in June**
- A total of 191 **Datix** incidents were reported across maternity and neonatal services, with themes primarily relating to **medication incidents**, MOH documentation
- **Three** incidents were graded as **moderate harm**, with no immediate systemic concerns identified.
- **Two early neonatal deaths (**21–34 weeks' gestation**), one late neonatal death** (>34 weeks), **two stillbirths, and one maternal death.** All deaths have been reported via SPEN, and reviews are being undertaken in line with national guidance.

What we need to focus on

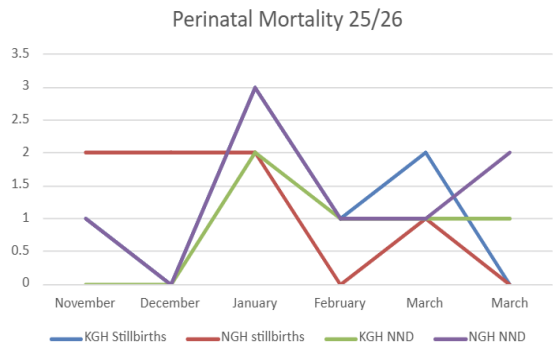
Overdue Datix incidents continue to increase despite escalation to Matrons and Team Leads regarding required timeframes and expectations for timely closure. A comprehensive review will be undertaken to identify recurring themes and trends within outstanding incidents, with consideration given to incorporating these into the PSIP programme. This will support improved oversight, ensure themes and learning are appropriately identified, and enable targeted actions to be implemented and monitored through governance processes.

A strengthened approach to the dissemination of learning from incidents will be implemented to ensure key themes, outcomes, and identified improvements are consistently communicated across teams. Learning will be shared through governance meetings, team briefings, safety huddles, and targeted communications to support organisational learning, improve practice, and reduce the risk of recurrence.

What is going well

- In April KGH focused on Action plans.
- KGH has instigated Action Review meetings which is well attend by the Safety improvement team, consultant and divisional governance.
- All After Action Reviews are up to date, with associated action plans in development to embed learning and support ongoing improvement.
- A significant reduction in overdue actions has been achieved, with numbers decreasing from 76 in the previous reporting period to 20 this month, representing a 74% reduction. This reflects strengthened oversight, improved monitoring processes, and increased accountability for the timely completion of actions.

Perinatal Mortality



	Moss Signals	SPEN Referrals
KGH	0	3
NGH	0	2

5 incidents were reported on SPEN in April- 2 incidents were report in March score card as they occurred the last day of March and reported on the 1st April to SPEN. There was no MOSS signals in April. A MOSS Critical Safety Test is planned for June 2026 for both sites.

CQC Maternity Rating

	2023 KGH	2024 NGH
Are services safe?	Requires Improvement	Requires Improvement
Are services effective?	Requires Improvement	Good
Are services caring?	Good	Good
Are services responsive?	Requires Improvement	Good
Are services well-led?	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement

★ Outstanding ● Good
● Requires Improvement ● Inadequate

NHS
University Hospitals of Leicester
NHS Trust

Perinatal Quality Assurance Scorecard

March 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

University Hospitals of Leicester NHS Trust

Overall performance in March 2026 remained stable, with most indicators providing assurance and targeted improvement work focused on a small number of operational and experience priorities. Operationally, activity reduced slightly, OPEL escalations were fewer, Red Flag incidents remained low, and MAU triage continued to meet BSOTS standards. Experience measures improved, with stronger FFT response and promoter rates and positive feedback for SPOC, community midwifery and intrapartum care, while MAU waiting times and postnatal experience remain the principal areas for improvement. From a safety perspective, no new PSIIs were commissioned; one case was escalated to the national MNSI programme, one final report was received with a single recommendation, and learning from ten moderate-harm incidents is being triangulated through the perinatal improvement programme. Clinical outcomes were broadly stable, with favourable smoking and stillbirth rates, although rates of Apgar <7 and preterm birth remain under close review. Workforce indicators continued to strengthen, with reduced sickness absence, active recruitment across staff groups and progress in neonatal and obstetric consultant appointments, while compliance with MIS Safety Action 8 remained strong and work continues to prepare the 2026/27 education programme.

Clinical Quality and Safety

No Patient Safety Incident Investigations (PSIIs) were commissioned in March. One case was referred to the Maternity and Neonatal Safety Investigation (MNSI) programme but did not meet the threshold for national investigation. One final MNSI report was received during the period. Ten moderate-harm incidents were reported in maternity services, although two were duplicates. Learning continues to be reviewed and triangulated through the Perinatal Safety Improvement Programme to support ongoing safety improvement.

Outcomes

Clinical quality indicators across antenatal, intrapartum and neonatal care remained broadly stable in February, with most measures showing common cause variation. Smoking at 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. Apgar scores <7 at 5 minutes and preterm births increased; preterm birth continues to show special cause variation, largely reflecting 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 remaining vacancies. Midwifery sickness absence has continued to reduce. Midwifery vacancy levels remain low, and neonatal nursing vacancies are reducing, supported by a further recruitment pipeline of 6 WTE nurses. Staff turnover remains below both Trust and national averages. Recruitment to neonatal consultant posts has been completed, with all posts filled, and one consultant obstetrician has been successfully appointed following interview. Further recruitment is planned to strengthen medical workforce resilience. An increased junior medical workforce establishment has been approved, and recruitment to these posts is underway.

Training and Compliance

Compliance increased across two of the three MIS Safety Action 8 training areas, with all areas remaining above the 80% internal benchmark. A small, expected reduction in Newborn Life Support compliance followed completion of the 2025/26 training calendar. The 2026/27 Training Needs Analysis has been submitted for review and prioritisation. Partnership work with the PSIP team on PPH management continues, and individual case reviews for ATAIN remain in place.

Successful internal appointment to the Education and Practice Development Midwife role further supports service improvement.

Operational and Capacity

Activity levels remained stable in March, with equal numbers of OPEL Level 1 and Level 2 escalations and no OPEL Level 3 or 4 incidents. Red Flag incidents increased slightly from February; however, there were no occasions where the coordinator was unable to maintain supernumerary status or where one-to-one care in labour could not be provided. Average triage time was 9 minutes, with 83.55% of women triaged within 15 minutes of arrival and 96% within 30 minutes.

The average time from decision to perform artificial rupture of membranes (ARM) to procedure was 20 hours, representing a slight improvement on the previous month.

Experience

Maternity complaints increased by 3 this month, with 2 complaints received for neonatal services. Staff attitude was the main theme, with FFT feedback also highlighting concerns about the postnatal ward environment. Both response and promoter rates improved this month, with repsonse rate above national target.

The CQC survey launched for Neonates this month, and UHL is actively involved in conversations with NHSE programme for development of a Patient Reported Experience Measure. Maternity has also secured funding for over-the-bed cots on postnatal wards to improve maternal bonding and reduce dropped baby risk.

MARCH 2026 AT A GLANCE

AVERAGES PER DAY

BOOKINGS	BIRTHS
33	25

BABIES BORN

753

PREV. 12 MONTH AV. 802

BIRTH LOCATION

LRI **439**

LGH	HOME
297	17

3RD & 4TH DEGREE TEARS

3.7%

Feb 1.9% ▲

3.6%

BLOOD LOSS >1,500MLS

Feb 3.1% ▲

359 GIRLS

391 BOYS

PREV. 12 MONTH AVERAGE
384 GIRLS, 415 BOYS

5.4%

Feb 5.3% ▲

FULL TERM BABIES ADMITTED TO NNU

INDUCTION OF LABOUR (IOL)

28.9% PREV. 12 MONTHS – 30.5%

357 CAESAREAN SECTIONS

	March	PREV 12 MTH. AV.
ELECTIVE	130 (17.2%)	142 (17.9%)
EMERGENCY	227 (30.1%)	222 (27.9%)

SETS OF TWINS

12

SETS OF TRIPLETS

0

ASSISTED BIRTHS

79

VENTOUSE	FORCEPS
21	58

PREV. 12 MONTH AV.

VENTOUSE	FORCEPS
31	62

BREASTFEEDING INITIATION

78.9%

PREV. 12 MONTHS – 68.1% ▲

NHS

MARCH 2025 AT A GLANCE

92.4%

MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

Exc Med. Staff starting >1st Jul 25

February- 93%

100%

YEAR 7 MATERNITY INCENTIVE SCHEME 10 SAFETY ACTIONS

1

MNSI REPORTABLE CASES & REFERRED

February - 1

13.9%

February 11.5%

MATERNITY FRIENDS & FAMILY TEST (RESPONSE RATE)

VACANCY RATE

MIDWIVES	2.7%
CONSULTANT OBSTETRICIAN	4 WTE
NEONATAL NURSES	8.0%
NEONATOLOGISTS	8.1%

90.6%

February 89%

MATERNITY FRIENDS & FAMILY TEST (PROMOTER RATE)

10 MODERATE INCIDENTS

February - 2

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)

90.9%

February– 89%

MINIMUM SAFE STAFFING MET (MATERNITY YTD)

Data not available

September– 93.9%

0 PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

February - 0

0 CORONER'S REGULATION 28

February - 0

1:1 CARE IN LABOUR 100%

February- 100%

NHS

IN FOCUS – Clinical Quality Surveillance

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

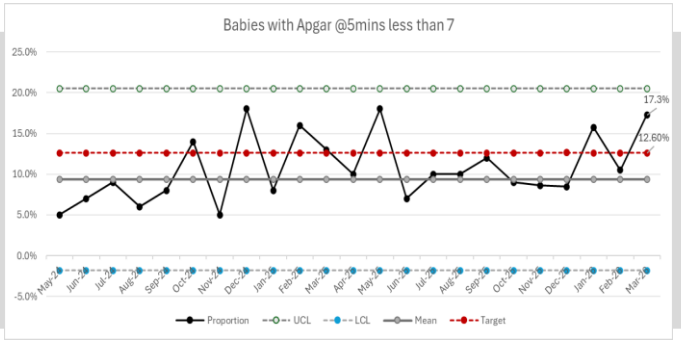
University Hospitals of Leicester NHS Trust

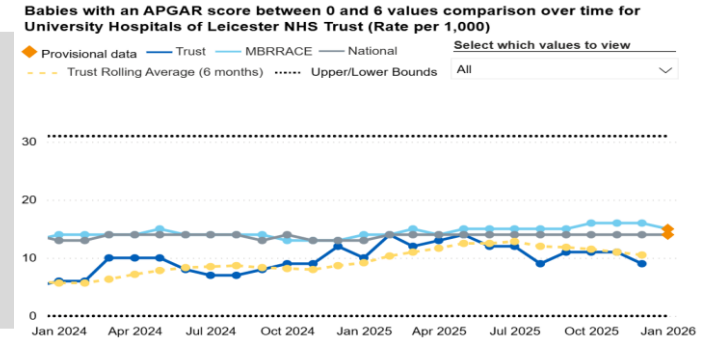
Summary

CQIMs continue to demonstrate common cause variation (see slide 16). An increase has been observed in Apgar less than 7 at five minutes. 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 and postpartum haemorrhage have also increased but remain within common cause variation.

Babies with Apgar @5 mins less than 7

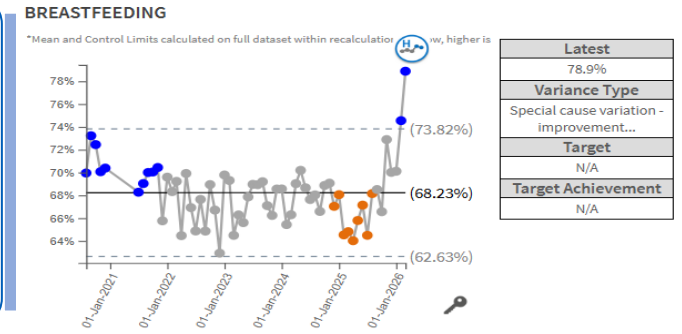
Recent analysis at UHL has identified an increase in the proportion of babies with an Apgar score of less than 7 at 5 minutes. This sits alongside a sustained upward trend in overall Apgar scores, which is now meeting criteria for special cause variation. Whilst the upward trend is noted, UHL performance remains below both the national and MBRRACE-UK averages. In addition, term admissions to the neonatal unit continue to sit below the national average; however, further work is required to fully understand the contributory factors and to ensure appropriate interpretation. In response, a targeted deep-dive audit has been commissioned to explore underlying drivers, assess the consistency and reliability of Apgar scoring practice, and provide assurance that recorded outcomes accurately reflect clinical care and system performance.



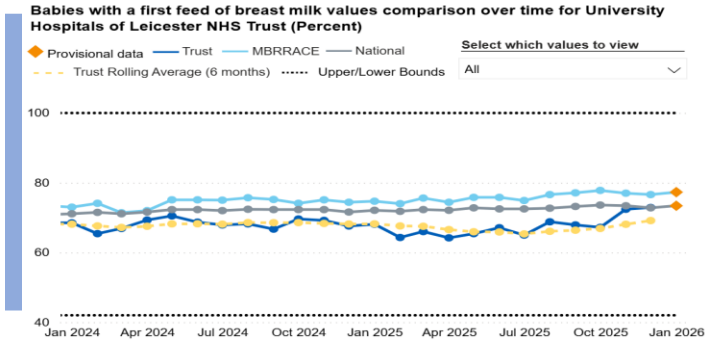


Breastfeeding Initiation

Breastfeeding initiation has shown recent improvement, increasing to 78.9% and exceeding the historical mean. This represents special cause variation and indicates a genuine shift in performance rather than random fluctuation. This improvement is likely supported by strengthened ward-based support, including increased peer supporter presence, enhanced antenatal preparation through *Bumps to Babies* and *Getting to Know Your Baby* sessions, and improved infrastructure such as colostrum freezers. Consistent staff messaging and increased parent engagement through *Meet the Expert* sessions have further supported early feeding confidence, alongside external influences on feeding choices. Focus now moves to sustaining this improvement through continued support, education, and engagement across the pathway

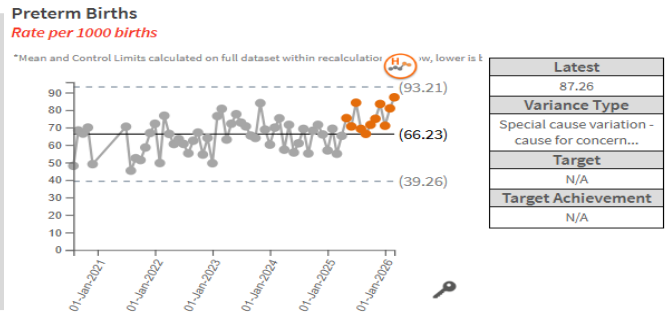


Latest
78.9%
Variance Type
Special cause variation - improvement...
Target
N/A
Target Achievement
N/A

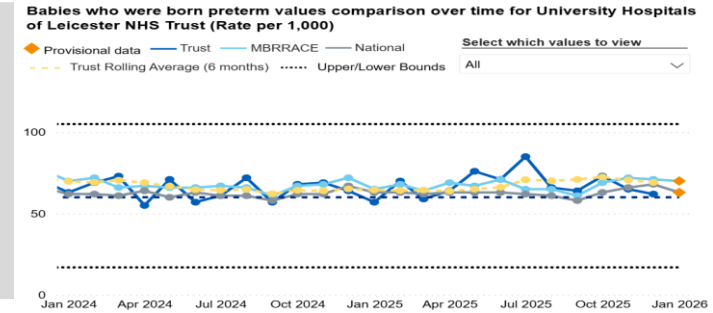


Preterm births

The preterm birth rate increased compared to February and remains above the process mean, with ongoing special cause variation.
The underlying drivers remain consistent, with a significant proportion of preterm births being iatrogenic and linked to complex maternal and fetal conditions. The increase also reflects improved regional referral pathways into specialist services at UHL, including preterm birth clinics, fetal medicine, and tertiary neonatal care. There has been a rise in referrals from other units, including for specialist procedures such as Shirodker cerclage.
As a result, UHL continues to manage a higher proportion of complex cases, contributing to the observed increase. Ongoing actions include continued staff education, strengthened referral pathways, and improved information sharing.



Latest
87.26
Variance Type
Special cause variation - cause for concern...
Target
N/A
Target Achievement
N/A

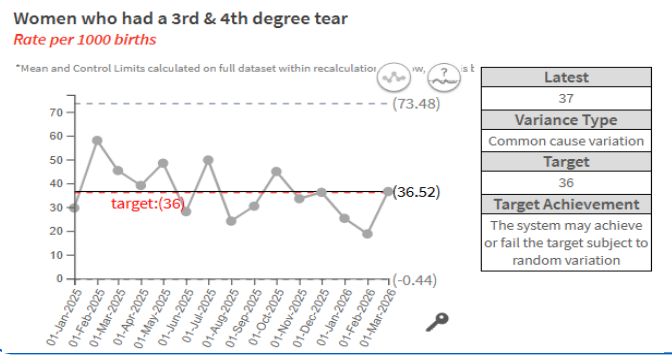


EQUITY AND POPULATION

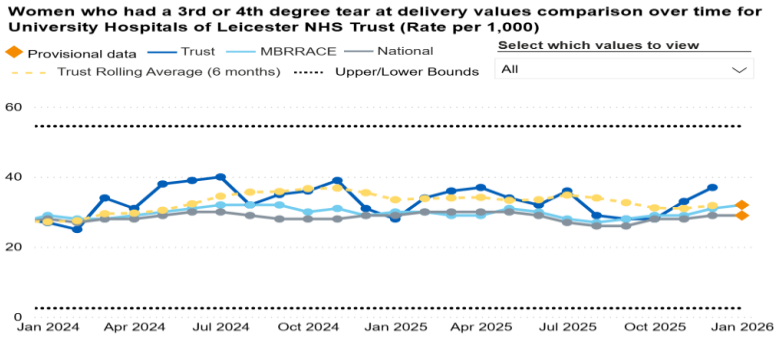
Data sourced from Badgernet. Validation is ongoing following EPR transition.

University Hospitals of Leicester NHS Trust

Perineal Trauma (3rd/4th degree tears)



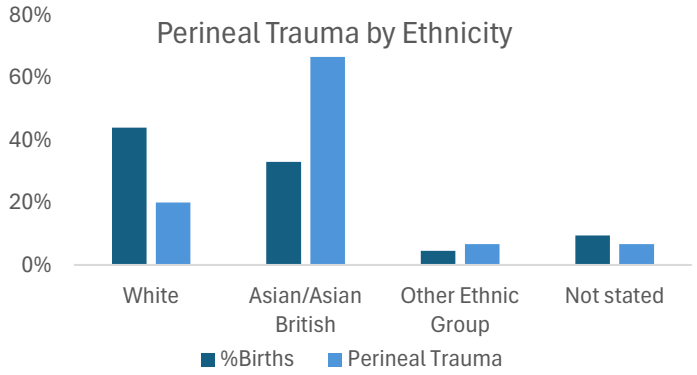
Latest
37
Variance Type
Common cause variation
Target
36
Target Achievement
The system may achieve or fail the target subject to random variation

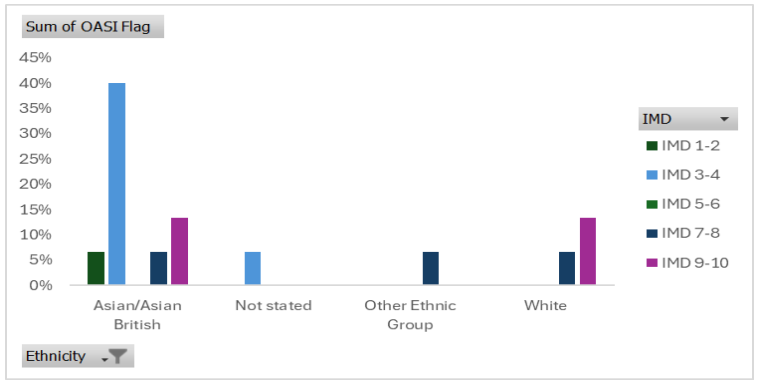


Commentary

Perineal trauma rates have fluctuated over recent months, with an increase in March.

All variation remains within control limits, indicating common cause variation with no evidence of a sustained shift in performance.

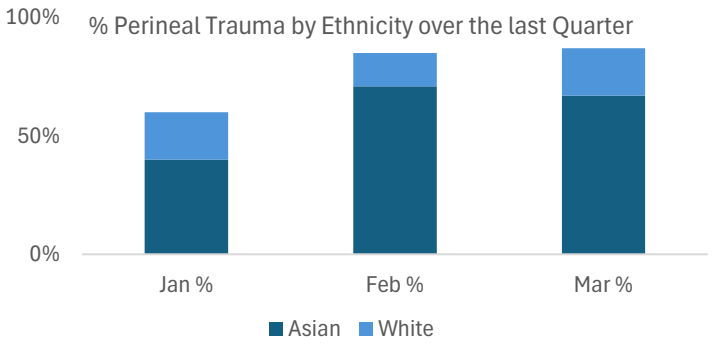


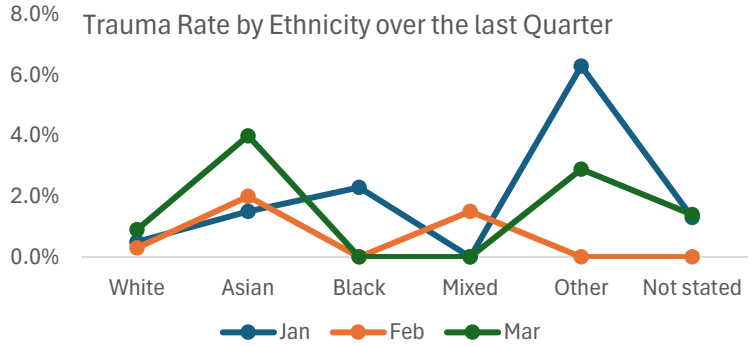


Commentary

Analysis by ethnicity shows a consistent pattern of variation. Asian women have the highest OASI rates reaching 4.0% in March compared to 0.9% in White women. They account for 33% of births but 67% of cases, indicating over representation.
Analysis by deprivation shows variation across IMD groups; however, no clear gradient is observed. A concentration of cases is seen among Asian women in IMD 3–4, likely reflecting underlying population distribution rather than increased risk. Other ethnic groups show variability, although interpretation is limited by small numbers.

Overall, this suggests a potential inequality in outcomes by ethnicity, with less consistent patterns by deprivation.





Commentary

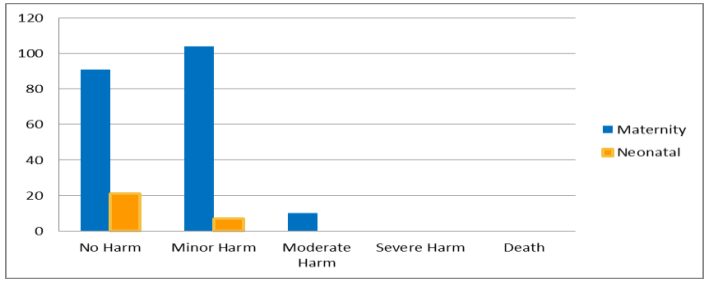
On going work is being actively managed through the Perinatal Safety Improvement Programme (PSIP), with continued engagement in national learning and action as this trend is recognised to be non-decreasing at a national level. Local analysis highlights a persistent ethnic disparity, with higher rates observed among Asian women; this is informing targeted review within existing PSIP workstreams to ensure equity-focused learning, appropriate escalation, and alignment with national safety actions.

CLINICAL QUALITY AND SAFETY

University Hospitals of Leicester NHS Trust

Incidents and Events

Incidents



MNSI cases	Current month	Prior month
Referred	1	1
Accepted	0	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 rejected for external review as no longer meeting criteria for investigation
- **10 Moderate Incidents** reported: two incidents rejected as duplicate, all incidents within Maternity Services: Intrauterine Fetal Death, Maternal deterioration, two cases of Major Obstetric Haemorrhage, missed opportunity of preterm birth prevention, two cases of perineal trauma
- **7 Stillbirths recorded** during March
- (24-41 week's gestation)
- **3 Early Neonatal Deaths** (16+3-39+3 week's gestation
- **Themes:** Triage for premature prevention care, fetal anomaly, gestational diabetes, two mothers were booked elsewhere

What we need to focus on

Earlier identification and prevention of preterm birth: Consistent recognition of pre-term risk factors, prompt referral to specialist preterm pathways

Fetal Monitoring: Cognitive bias and skill variability in CTG interpretation resulting in false reassurance and missed deterioration. Prompt escalation, responsive decision making, appropriate operational response

Major Obstetric Haemorrhage:
Continued timely recognition, response, and escalation

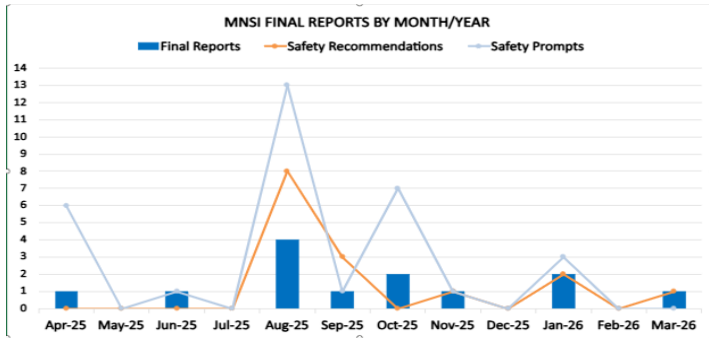
Perineal Trauma: Maintain current clinical practice and improvement initiatives

What is going well

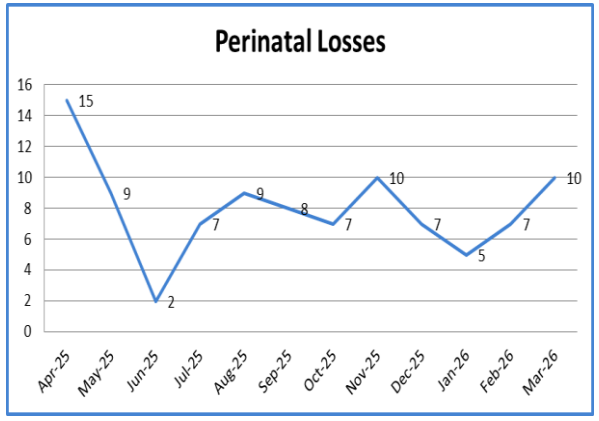
Perineal Trauma: Perineal trauma rates have shown month-to-month variability, with a noted increase in March. However, all data points remain within established control limits. As the variation is expected there is no immediate indication of increased risk however routine observation remains appropriate

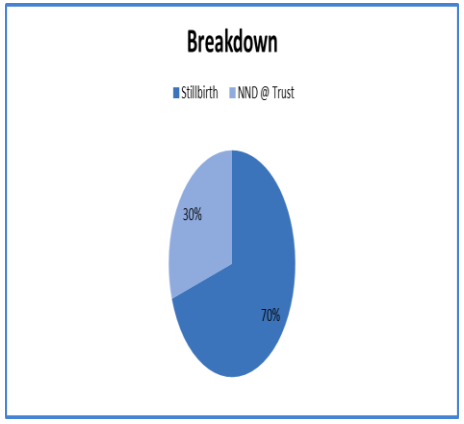
Postpartum Haemorrhage: Stability in the rates of postpartum haemorrhage suggest that current clinical pathways including identification, escalation, and treatment are broadly effective. Staff competence along with MDT working are likely maintained at an acceptable level with no signal of worsening harm evident over the reporting period

MNSI Referrals



Perinatal Mortality





CQC Maternity Rating

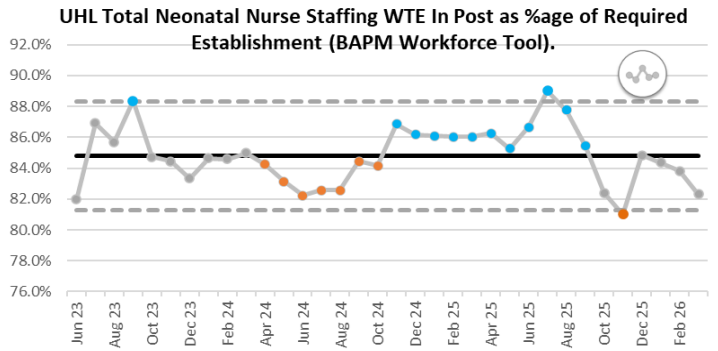
	LRI	LGH	StM
Are services safe?	Requires Improvement	Requires Improvement	Good
Are services effective?	Requires Improvement	Requires Improvement	Good
Are services caring?	Requires Improvement	Requires Improvement	Good
Are services responsive?	Requires Improvement	Requires Improvement	Good
Are services well-led	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good

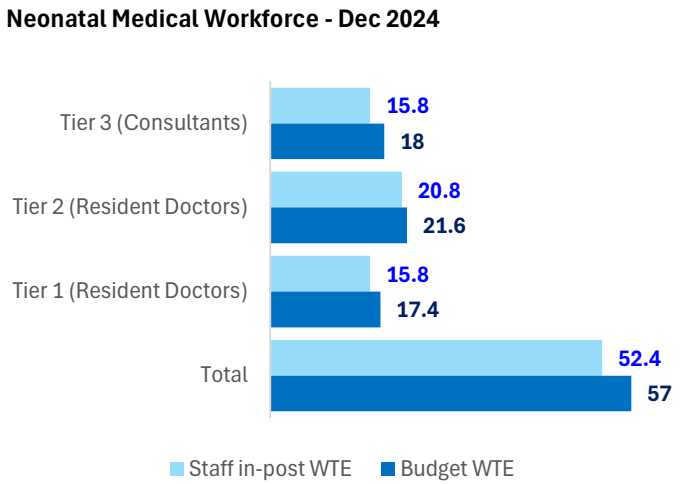
Outstanding · Good · Requires Improvement · Inadequate

WORKFORCE - Overview

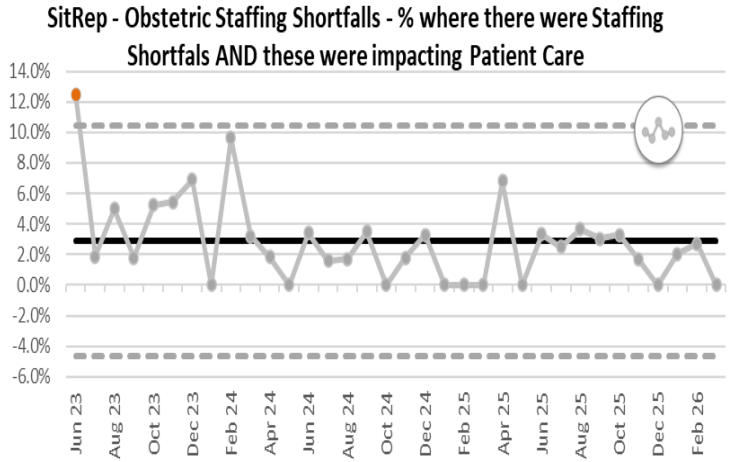
University Hospitals of Leicester NHS Trust

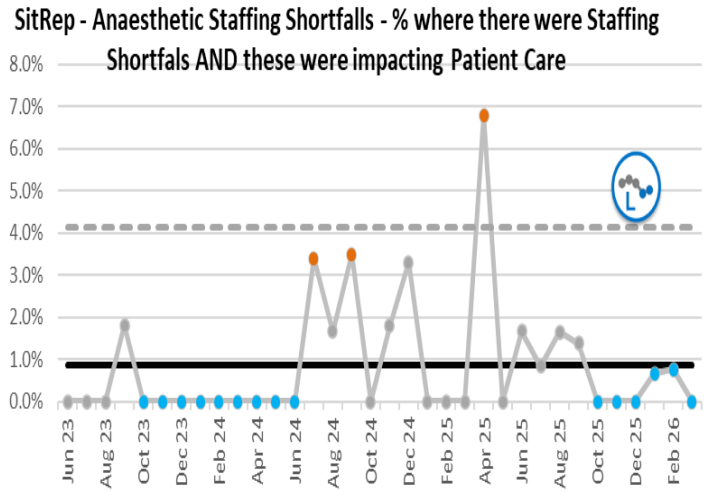
Workforce



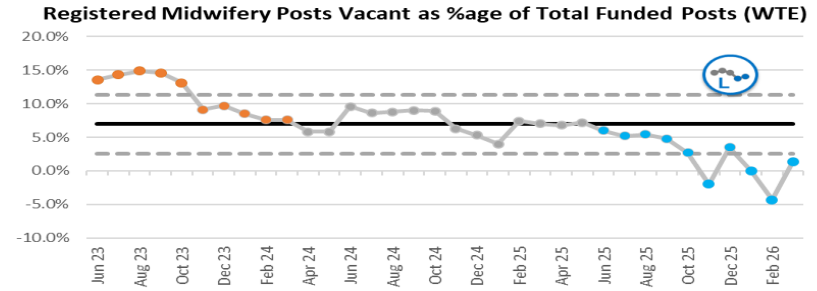


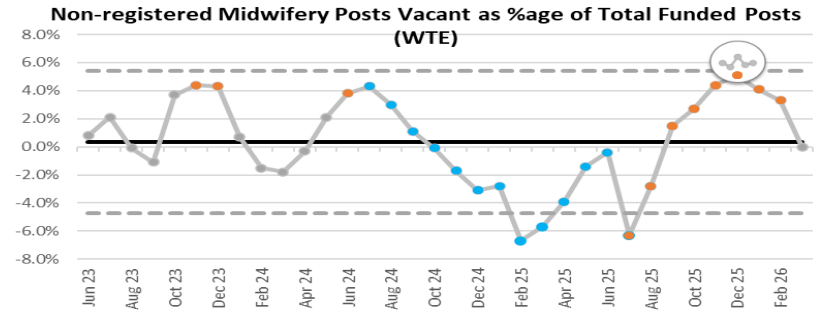
Shortfalls



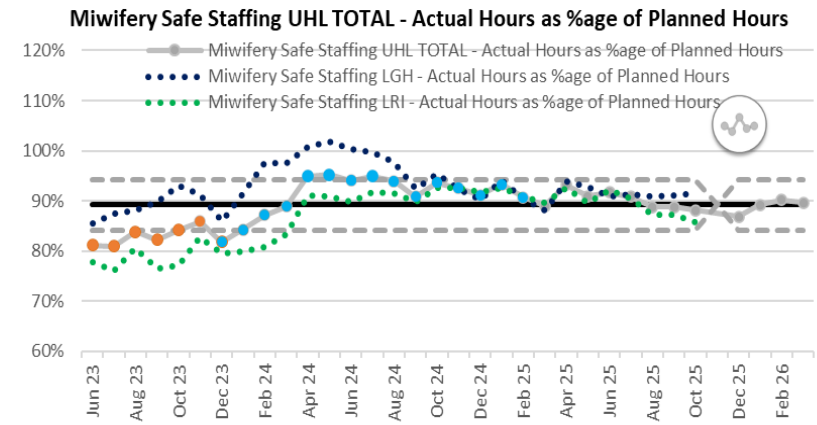


Vacancies





Safe Staffing

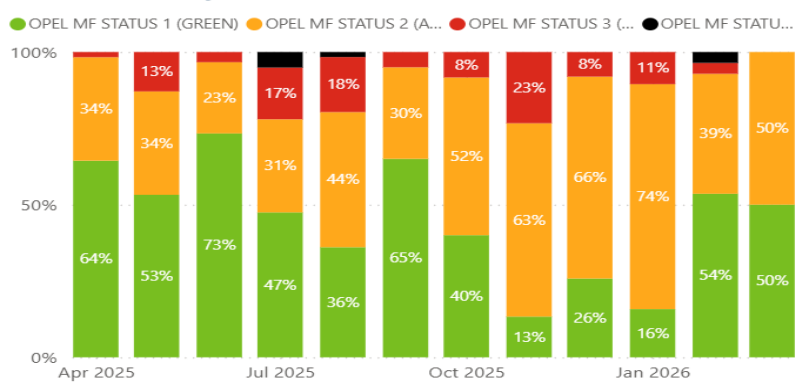


OPERATIONAL AND CAPACITY

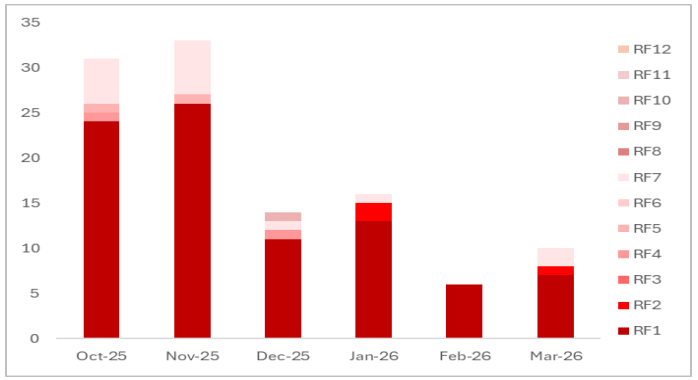
University Hospitals of Leicester NHS Trust

Key Information

Operational Pressures Escalation Levels



Midwifery Red Flag Events



Efficiency and Timeliness

Average time from attendance to triage

9 mins

% Seen within 30 Mins

96%

Avg. time from ARM decision to perform

20 hours

Last month = 23 hours

Maternal Request for CS during IOL

8.3%

Last month = 4.5%

Average volume of calls to triage

5,124

Last month = 4,777

Average call response time for triage

2mins 6 secs

Average talk time for triage

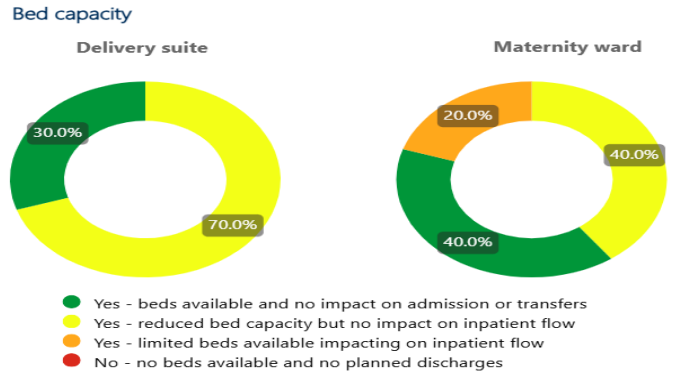
3mins 26secs

Categorised on admission (triage within target)

1,912

(94%)

Bed Capacity



What the data is telling us

- Activity levels remained stable in March, with equal numbers of OPEL Level 1 and Level 2 escalations and no OPEL Level 3 or 4 incidents.
- Induction of labour and caesarean section rates remained stable.
- Red Flag incidents increased slightly in February; however, there were no occasions where the coordinator was unable to maintain supernumerary status or where one-to-one care in labour could not be provided.
- Average triage time was 9 minutes, with 83.55% of women triaged within 15 minutes of arrival and 96% within 30 minutes, demonstrating timely assessment in line with BSOTS national recommendations.
- The average time from decision to perform artificial rupture of membranes (ARM) to procedure was 20 hours, representing a slight improvement on the previous month.

What we need to focus on

- Review impact of LGH Maternity Day Assessment Unit (MDAU) and optimisation of capacity to support Maternity Assessment Unit
- Review impact of creating maternity bay on ward 31 LGH
- 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.
- Reducing time from decision to perform ARM.

What is going well

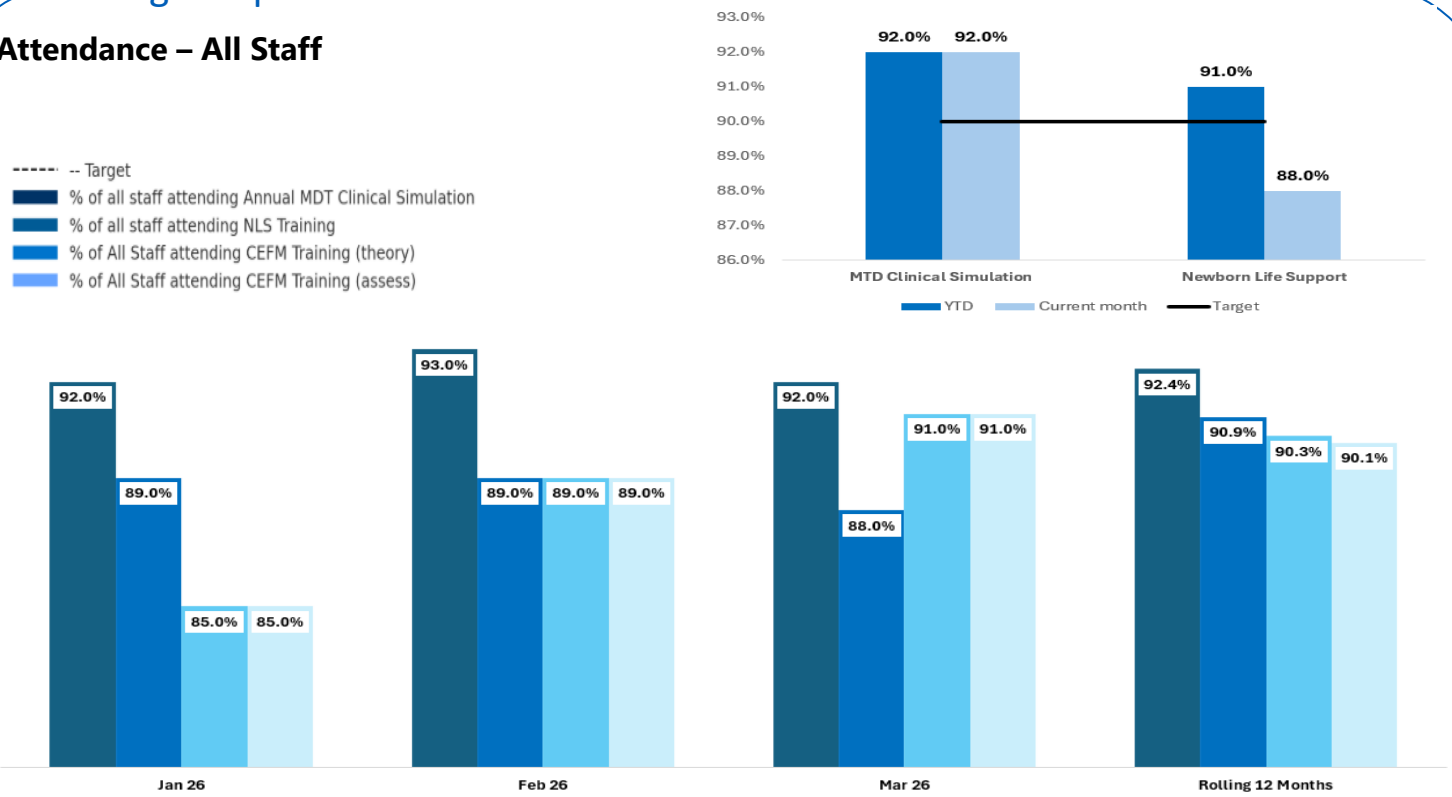
- Enhanced triage performance, reflecting more efficient patient assessment and flow
- Supporting the long-term sustainability of specialist services through ongoing succession planning, and workforce development
- Sustained trajectory to increase the Qualified in Speciality (QIS) neonatal nursing workforce
- 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	Jan-25	Feb-26	Mar-26	Rolling 12 months
% of all staff attending Annual MDT Clinical Simulation	**90%**	92.0%	93.0%	92%	**92.4%**
% of all staff attending NLS Training	**90%**	89.0%	89.0%	88%	**90.9%**
% of all staff attending CEFM Training (theory)	**90%**	85.0%	89.0%	91%	**90.3%**
% of all staff attending CEFM Training (assess)	**90%**	85.0%	89.0%	91%	**90.1%**

What the data is telling us

- March, has seen and increase in compliance across two of our three MIS Safety Action 8 areas of targeted training. With compliance in all areas remaining above our internal benchmark of 80%
- As predicted a slight drop in compliance is noted in Newborn Life Support, as we drew to a close our 25/26 Training Calendar. Thus, within March the number of study days that link to the compliance was reduced.

What we need to focus on

- As we move into Q1, the Maternity Education Team will maintain a strong focus on priorities that support safety, compliance, and quality improvement. Our key initiatives will centre on sustaining high standards of maternity care through more effective coordination of staff training, strengthened collaboration with clinical governance, and proactive actions to reduce avoidable harm.
- 26/27 Training Needs Analysis for Maternity and Neonatal services have been submitted and will be reviewed and prioritised due to service needs.
- Continued partnership work with the PSIP team around postpartum haemorrhage management and OASI bundle care.
- We continue to commit resources to our individual case reviews of term infants who are admitted to the Neonatal Unit to gain insight in trends and learning themes that can be identified and actioned.

What is going well

- Interviews held for 1.0 WTE Education and Practice Development Midwife and a candidate successfully recruited internally.
- Our Fetal Monitoring & Perinatal Education Lead facilitated a skill workshop within the clinical environment, focused on Fetal Scalp Electrode placement and management- to improve staff confidence.

SAFETY ACTIONS

University Hospitals of Leicester NHS Trust

Maternity Improvement Scheme

MIS Six Core Safety Actions – Year 8	MIS Standards	What Good Looks Like	Status
A. Workforce and Capacity	7	49	On Track
B. Training	5	33	On Track
C. Learning from Reviews and Investigations	6	36	On Track
D. Service User Voice, Experience and Equity	2	13	On Track
E. Care Bundles	3	22	On Track
F. Governance, Oversight and Culture	4	24	On Track

Summary

Year 8 of the scheme launched 2nd April 2026

Year 8 introduces a streamlined set of six core safety actions enabling Trusts to focus on the areas that have the greatest impact on outcomes for their population. The intention of this change is to support Trusts to concentrate on what matters most: securing the right workforce, learning from adverse events, improving clinical standards, strengthening culture, delivering better experiences for women, families and carers and supporting Trust flexibility while emphasising Board accountability and oversight.

Year 8 provides a bridge between the established MIS model and an approach that is more flexible, proportionate, focused on outcomes and developed around an agreed set of principles. Year 8 of the scheme affords organisations more flexibility and accountability for focusing on the priorities that are specific to their organisation and the families in which it serves, whilst working towards the implementation of 'what good looks like' for high performing Trusts.

Saving Babies Lives

Element	Interventions Fully Implemented (Self-Assessment) Q3		Interventions Fully Implemented (LMNS Validated) Q3		NHS Resolution MIS (Yr 8)
Smoking in Pregnancy	Fully	**100%**	Partly	**TBC**	On Track
Fetal Growth Restriction	Partly	**95%**	Partly	**TBC**	On Track
Reduced Fetal Movements	Fully	**100%**	Fully	**TBC**	On Track
Fetal Monitoring in Labour	Fully	**100%**	Fully	**TBC**	On Track
Preterm Birth	Fully	**100%**	Partly	**TBC**	On Track
Diabetes	Fully	**100%**	Fully	**TBC**	On Track
All Elements	Partly	**99%**	Partly	**TBC**	On Track

Summary

Submission 9 (Q3 25/26) 97% implemented April 2026- Await LMNS review

Element 2 95% implemented.
Lab now confirmed ability for on-site testing and plan for PlGF roll out however large annual cost involved, therefore for further review of options.

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. New data discrepancies since move to EPR (natural variation and expected), plan to wait to see data improvements over coming quarters

EXPERIENCE FEEDBACK

University Hospitals of Leicester NHS Trust

Patient Experience

Complaints and Concerns	Jan-26	Feb-26	Mar-26	25 / 26 YTD
Maternity	13	9	12	123
Neonatal	0	0	2	9

Friends and Family Test (FFT)	Target	National	Jan-26	Feb-26	Mar-26	25 / 26 YTD
Maternity FFT % Responses	25%	13%	16.9%	11.5%	13.9%	13.1%
Maternity FFT % of Promoters	96%	93%	88.4%	89%	90.6%	92.5%

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

Birth Reflections	Jan-26	Feb-26	Mar-26
Number of appointments	31	31	42
% attended within 12 months of birth	77.4%	80.6%	54%

Compliments

"All the staff were very welcoming and made sure I felt comfortable at all time"

Ward 5, LRI

"Friendly, supportive and informative staff. Everyone we met or had an interaction with were super supportive, detailed and kind. Nothing was pushed on us, we had options given to us and the support to choose"

Delivery Suite, LGH

What the data is telling us

FFT:

- Antenatal: 90.91% (very good or good) with 11 responses.
- Labour and Birth: 91.3% (very good or good) with 23 responses. Two poor experiences related to communication issues and delay in care
- Postnatal ward: 91.67% (very good or good) with 108 responses. Themes this month include; communication(3), staff attitude (3), environment (5) - reports of hot, cramped spaces particularly at LRI and cleanliness of bathrooms
- Postnatal community: 100% (very good or good) with 6 responses.
- There were 2 comments for community midwifery (homebirth team) about wanting more defined times for home visits

Complaints:

- 50% relate to care received in 2026
- 4 LGH, 7 LRI, 1 community (varying wards/departments)
- Themes include concerns relating to consent (2), staff attitude (4), environment (1), pain relief delays, basic care and not being listed to on the antenatal/postnatal wards

What are we working on?

- Request made to estates for full renovation of all patient bathrooms on antenatal/postnatal wards
- Mandatory consent training for all staff from April 2026 with a focus on vaginal examinations and assisted births
- Implementation of Self Administration of Medicines
- Shadowing shifts in community midwifery to find opportunities for service improvement in particular relating to individualised care planning for location of appointments

What we need to focus on

- Using service user voice within training to educate staff of feedback received
- Addressing poor patient experience directly with individuals involved in care
- Facilitating MNVP to complete regular 'Walk the Patch'
- Liasing with estates team to improve environment on wards particularly temperature control

SPOTLIGHT ON…PPHS Hindi and English Webinar

University Hospitals of Leicester NHS Trust

Topic: Constipation in pregnancy and after birth
When: Thursday 12th March 2026
Who for: English and Hindi speaking women
Delivered By: Perinatal Pelvic Health Team; Angie Doshani and Clare Crow

Pelvic floor health: Constipation during pregnancy and after birth

Constipation is a common but often underreported issue during pregnancy and the postnatal period, with potential impacts on pelvic floor health, recovery, and overall wellbeing. Local insight identified need to improve access to culturally and linguistically appropriate education, particularly for Hindi-speaking women who represent a considerable proportion of our service users. This initiative aimed to address health inequalities by providing inclusive, accessible support.

What we covered:

- Preventing and Managing Constipation
- Eating and Drinking Advice
- Positions and Techniques to Empty Bowels more Effectively
- Pelvic Floor Impact and When to Seek Support

Engagement: 37 Women
Targeted outreach via text messaging and wider dissemination through GPs.

Next Steps: To develop a 12-month rolling PPHS webinar programme and continue bilingual / accessible delivery.

When?

March 2026

APPENDICES

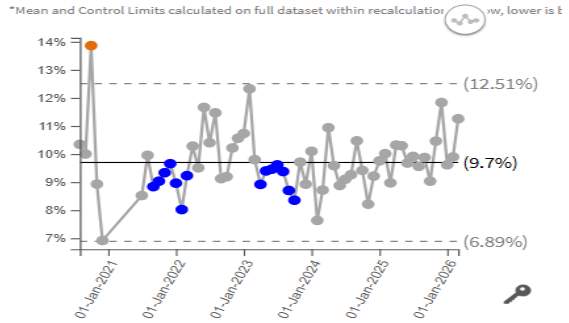
TRENDS: CLINICAL QUALITY SURVEILLANCE

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

NHS University Hospitals of Leicester NHS Trust

Antenatal

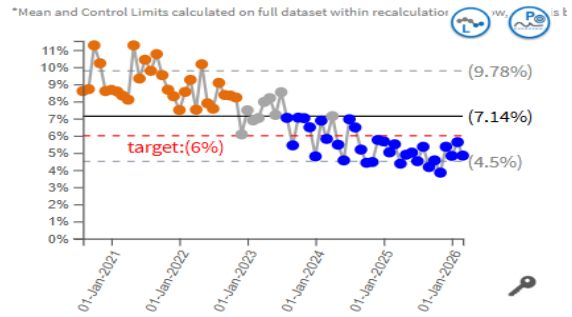
BMI at Booking >35



Latest
11.3%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

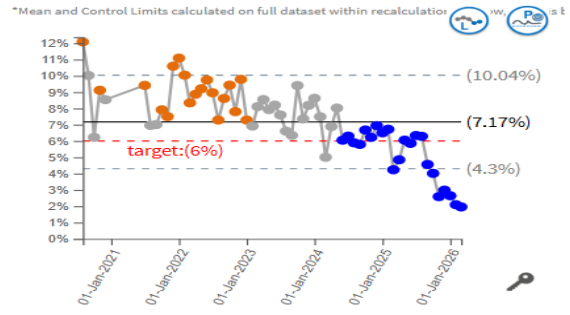
Smoking at time of booking

LMNS: 6% (Ref 1.3a SVBL)



Latest
4.8%
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

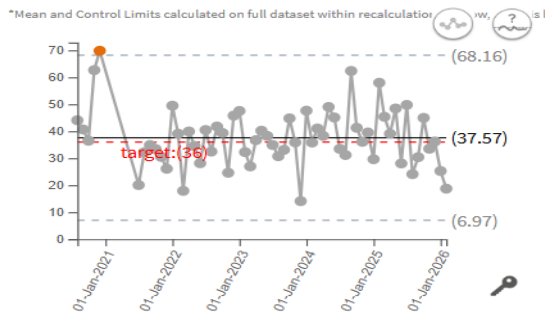


Latest
2.0%
Variance Type
Special cause variation - improvement...
Target
6%
Target Achievement
Metric has (P)assed the target for the last 6 (or more) data points...

Intrapartum

Women who had a 3rd & 4th degree tear

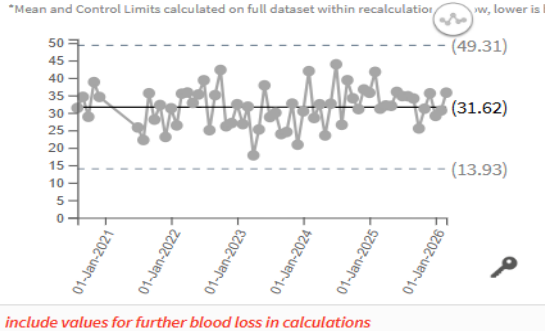
Rate per 1000 births



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

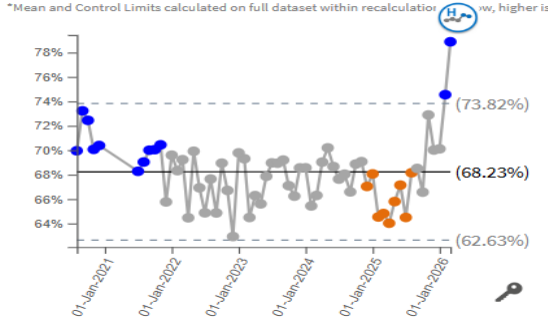
Rate per 1000 births



Latest
36
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

include values for further blood loss in calculations

BREASTFEEDING

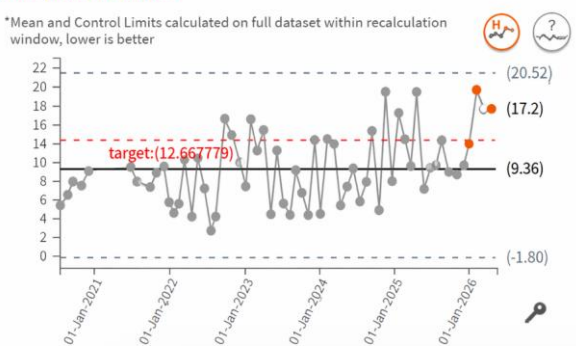


Latest
78.9%
Variance Type
Special cause variation - improvement...
Target
N/A
Target Achievement
N/A

Outcomes

Babies with Apgar @5mins less than 7

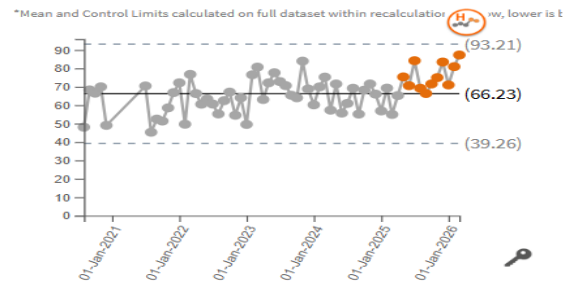
Rate per 1000 births



Latest
17.2
Variance Type
Special cause variation - cause for concern...
Target
12.667779
Target Achievement
The system may achieve or fail the target subject to random variation

Preterm Births

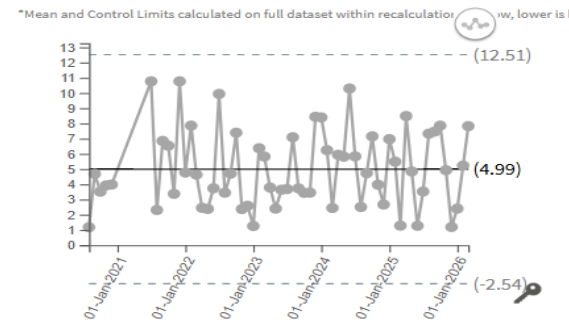
Rate per 1000 births



Latest
87.26
Variance Type
Special cause variation - cause for concern...
Target
N/A
Target Achievement
N/A

Stillbirths

Rate per 1000 births



Latest
8
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)
753
Prev. month= 757

Preterm Births (in month)
84
Prev. month = 82

Stillbirths (in month)
7
Prev. month = 4

Born Before Arrival (in month)
2
Prev. month = 6

Homebirth (in month)
17
Prev. month = 18

Sickness Rates

Data is reported with a standard two-month reporting lag

	Midwifery	Neonates
Monthly sickness absence (%)	5.9	7.14
Cummulative (%)	5.1	7.0

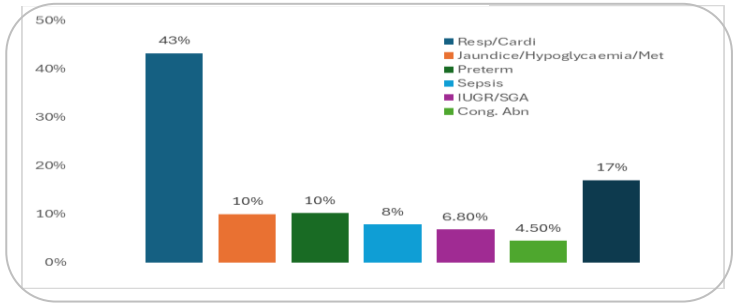
Safe Staffing

Monthly actual staff hours as a percentage of planned staff hours

Midwifery	Neonates
89.7% Prev month.90.2%	**79.0%** Prev month.79.1%

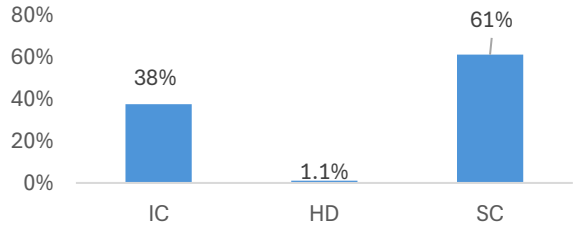
March 2026 (Midwifery Registered)	WTE	%
Actual Vacancy	11.8	2.7%
Unavailability Vacancy	25.22	18.8%

Neonatal Outcomes



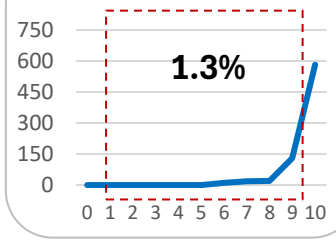
Skin to Skin < 1hr (full-term w/o complication)
61.9%
Prev. month = 57%
National Avg = 74.2%

Babies in NNU (all babies)



NNU ATAIN Rate (full-term babies)
5.4%
0.1% from prev. month
National Avg = 6%

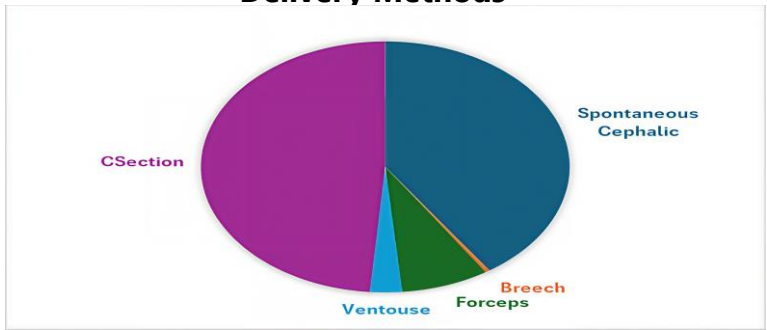
Apgar < 7 at 5 mins



Maternal Wellbeing

Vaginal Birth Rate in month (natural / total)
52%
Prev. month = 53.6%
National Avg = 42%

Delivery Methods

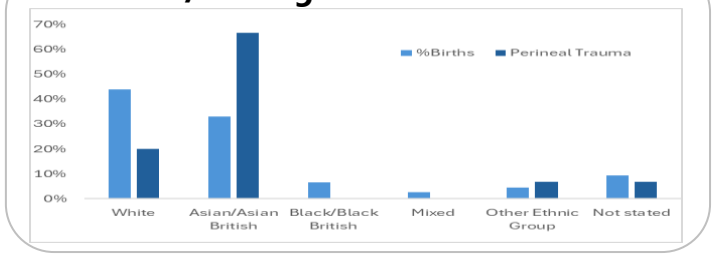


One-One Care in Labour
100%
same from prev. month
National Avg = 51%

Blood Loss >1.5ltr

	% of Tot. PPH	% in Group
White	44%	28%
Asian	33%	48%
Black	6%	8%
Not stated	9%	16%
Other	0	0

Tears 3rd / 4th degree



THE HEADLINES – Perinatal Journey

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

University Hospitals of Leicester NHS Trust

Total Bookings

1,014

Last month = 907

Triage Attend.

2,060

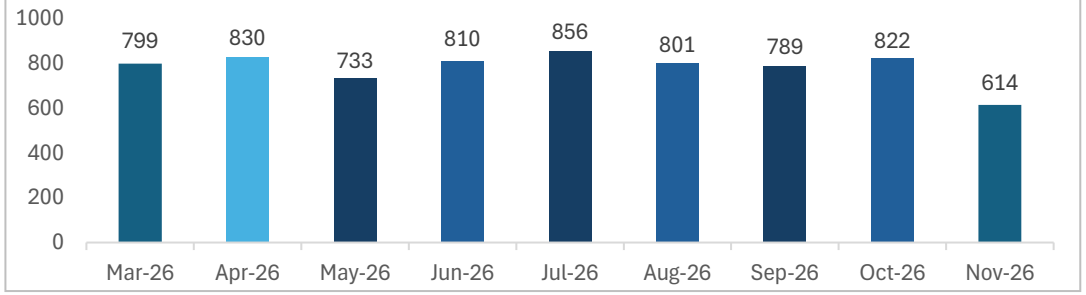
Last month = 1927

Triaged within 15 minutes

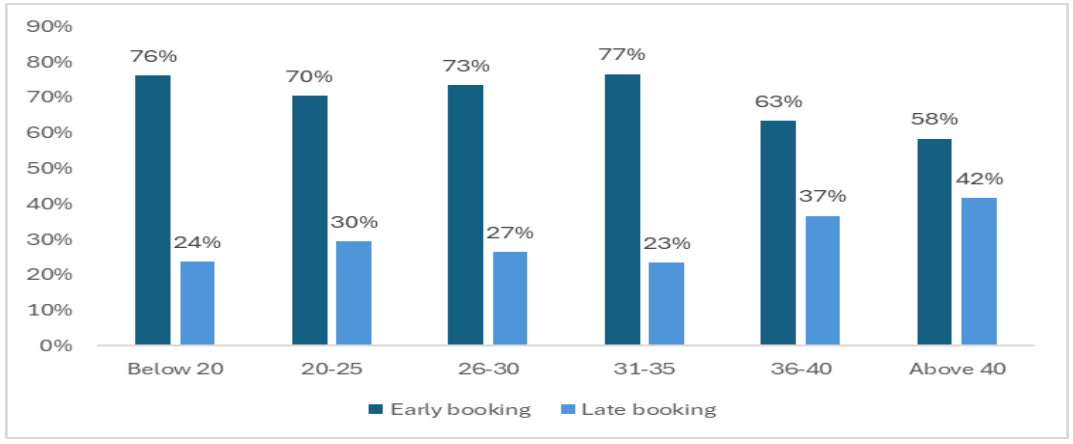
84%

Last month = 79%

Expected Deliveries



Comparison of Bookings by Age



Antenatal Wellbeing

Missed apps. In community
(#all missed appointments)

TBC

Last month = TBC

Screening Uptake
(tests declined / tests offered)

97.3%

National Avg ~ 97.9%

Risk identified at booking

Risk	% of bookings
Smoking	5.3%
BMI>35	10%
Alcohol/Drugs	2.3%
Mental Health	25.5%

Postpartum Support

Maternal Readmissions
(count of readmissions in month)

TBC

Last month = TBC

Breastfeeding Data

Journey	UHL March	UHL Prev.Month
Initiation Rate	78.9%	74.5%
Breastfeeding only @ 10 days	36.2%	34.8%
Breastfeeding only @ transfer to Health Visit.	42.2%	39.6%

THE HEADLINES – Peri Prem Bundle (February 2026)

6 of 8
metrics are on target

Care Standards (Process Measures)

	Actual	Target	Status
Antenatal Steroids Mothers receiving antenatal steroids	52%	40%	✓
Magnesium Sulphate Mothers receiving magnesium sulphate	100%	85%	✓
Intrapartum Antibiotics Mothers receiving intrapartum antibiotics	52%	85%	↓
Optimal Cord Management Benefited from optimal cord management	82%	68%	✓
Temperature Normothermic temperature (36.5-37.5c) within one hour of birth	66%	65%	✓

Summary

✓ 6 metrics on or above target
↓ 2 Metrics below target

Intrapartum Antibiotics- Dip/variation seen since EPR roll out, only 4 women for month of February affecting on overall percentage.
Caffeine -

Outcomes

Babies <34 weeks gestation born at the unit this month
18

	Actual	Target	Status
Babies born in the right place	100%	100%	✓
Caffeine within first 24 hours of life	47%	95%	↓
Early Breast Milk within 24 hours of birth	52%	25%	✓

Quality Improvement Updates

Antenatal Steroids- -Monthly data reviews via specialist App. Reviewed at Mortality & Morbidity meeting. Bi-weekly MDT case reviews.

Optimal Cord Management- Huddles & Cuddles project, Neonates Scrub, CPAP with intact cord stabilisation.

Temperature- Non-disposable thermometers now attached to all rescusitaires (LRI)

Early Breast Milk- Increase in breast pumps and improvements to feeding rooms.

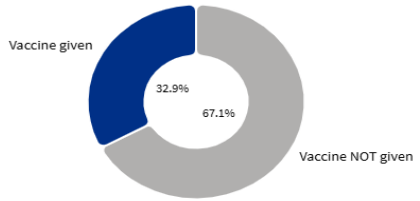
IMMUNISATION SUMMARY

University Hospitals of Leicester NHS Trust

RSV Uptake

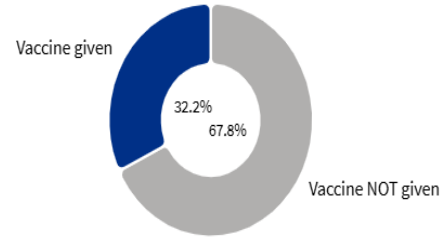
RSV uptake at both UHL sites have improved this month with each site seeing >30% uptake. This is still significantly below the 60% compliance target but an increase does provide assurance that the mitigations and actions from the ongoing NHSE deep dive are starting to have a positive effect for service users. Senior leaders in April are also attending a regional workshop to support improving vaccination uptake in Trusts which we hope will see another positive impact on UHL's compliance rate.

Uptake of RSV Vaccination - UHL Total
Given/Not given



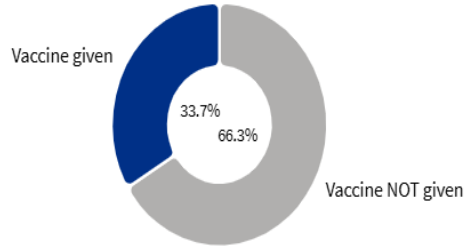
Reporting Period: Mar-2026 to Mar-2026

Uptake of RSV Vaccination - LRI
Given/Not given



Reporting Period: Mar-2026 to Mar-2026

Uptake of RSV Vaccination - LGH
Given/Not given

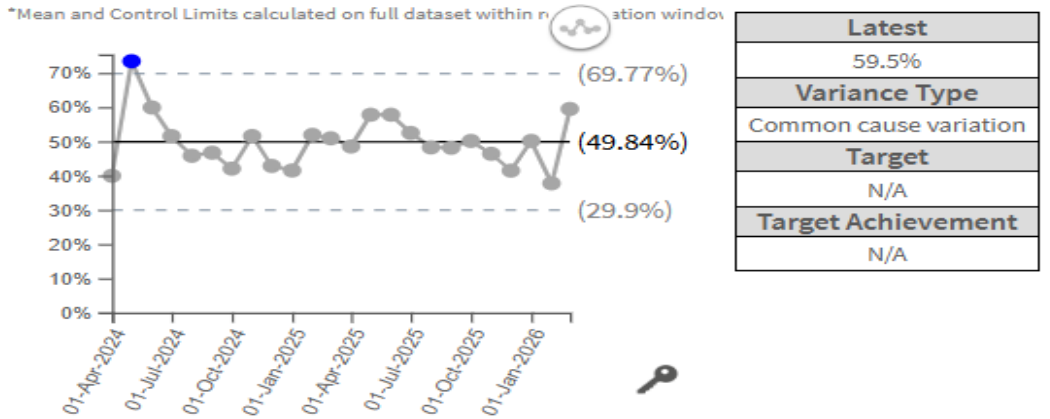


Reporting Period: Mar-2026 to Mar-2026

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

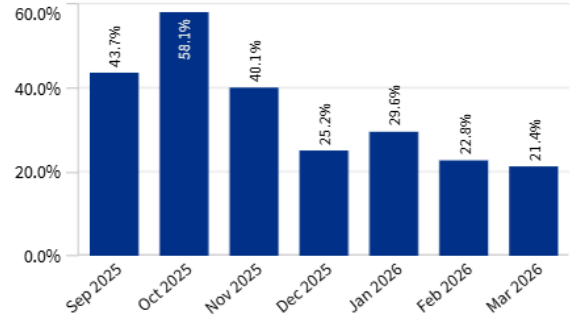


Latest
59.5%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Flu Vaccination

The pattern remains consistent with a seasonal vaccination programme, where demand is typically highest at the start of the winter campaign. Flu vaccination season has now ended and we are not expecting further uptake until September 2026.
Plans are already underway for 2026-27 flu season i.e. ordering of vaccinations and PGD's.

% Uptake of FLU Immunization

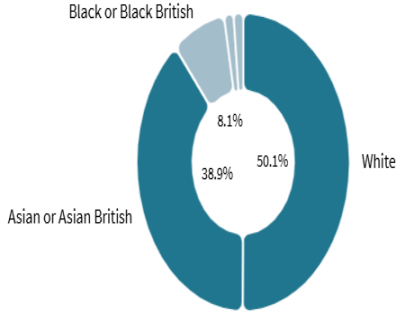


Reporting Period: Sep-2025 to Mar-2026

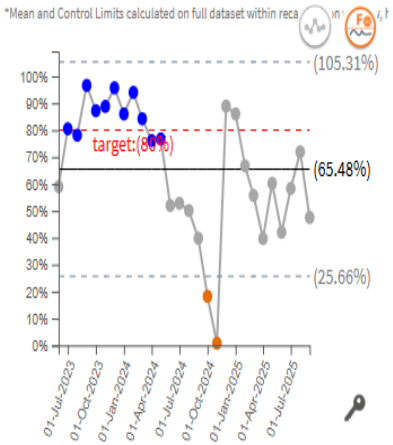
Insights

BCG vaccine uptake remains below target, with the current pattern reflecting common cause variation. Work is underway with regards to strengthening the staffing within the BCG team to ensure the UHL offer remains consistent.

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

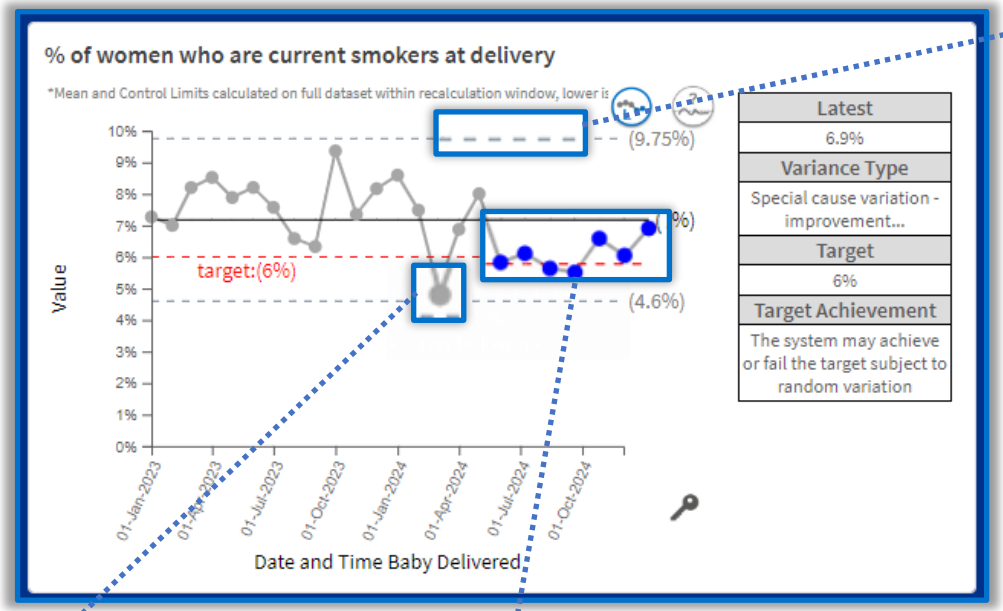
Single data points
these reflect local calculations. They will not exclude specific populations, unless there is a specific reason to do so.

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

NHS
University Hospitals of Leicester
NHS Trust

Perinatal Quality Assurance Scorecard

April 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.

INTRODUCTION

April activity remained high at 784 births, broadly in line with expected levels. Operational flow appears stable, with triage performance strong and no indication that increased red-flag activity has compromised safe care or one-to-one support in labour. The key operational constraint remains prolonged time from decision to perform ARM, which has shown only marginal improvement and remains a priority for action.

Workforce pressures persist but are beginning to stabilise. Vacancy levels across obstetric consultant and neonatal roles remain material; however, early improvement in fill rates and recruitment is evident, including preparation for incoming graduate nurses and midwives.

Clinical harm indicators improved month on month, with reductions in severe perineal trauma and major haemorrhage. Full-term neonatal admissions also declined and remain below the national average, indicating continued improvement in intrapartum care and immediate neonatal outcomes. Stillbirth numbers reduced this month but remain low-volume and should be interpreted cautiously. Induction and caesarean section rates remain above historic norms but have stabilised, consistent with an established response to a higher-acuity case mix rather than a worsening trend.

Neonatal indicators are largely within expected variation. Some Apgar measures continue to warrant closer review, but this sits alongside improving outcomes overall, including fewer neonatal admissions. Overall, the service appears to be managing complexity effectively while retaining focus on areas requiring further investigation.

Maternal wellbeing remains a relative strength. One-to-one care in labour continues at a consistently high level, and breastfeeding initiation has improved further, now performing above the 12-month average. The drop-off in continuation beyond the early postnatal period remains a concern and points to the need for stronger support after discharge. Vaccination performance for RSV has improved, while BCG performance has declined and requires targeted focus.

Population complexity continues to be a major driver of both activity and outcomes. A significant proportion of women are booking with risk factors such as mental health needs and higher BMI, reinforcing the high-acuity profile of the service. This is reflected in patterns such as iatrogenic preterm birth and continued reliance on intervention to manage risk safely.

APRIL 2026 AT A GLANCE

AVERAGES PER DAY

BOOKINGS **35**

BIRTHS **27**

BABIES BORN

784

PREV. 12 MONTH AV. 800

BIRTH LOCATION

LRI **415**

LGH **352**

HOME **17**

3RD & 4TH DEGREE TEARS

3.3%

March 3.7%

2.4%

BLOOD LOSS >1,500MLS

March 3.6%

383 GIRLS

396 BOYS

PREV. 12 MONTH AVERAGE
385 GIRLS, 413 BOYS

4.9%

March 5.3%

FULL TERM BABIES ADMITTED TO NNU

INDUCTION OF LABOUR (IOL)

34.0% PREV. 12 MONTHS – 30.1%

392 CAESAREAN SECTIONS

	March	PREV 12 MTH. AV.
ELECTIVE	146 (18.6%)	143 (18.0%)
EMERGENCY	246 (30.3%)	223 (28.1%)

SETS OF TWINS

10

SETS OF TRIPLETS

0

ASSISTED BIRTHS

82

VENTOUSE	FORCEPS
20	62

PREV. 12 MONTH AV.

VENTOUSE	FORCEPS
30	61

BREASTFEEDING INITIATION

77.4%

PREV. 12 MONTHS – 62.9%

NHS

APRIL 2025 AT A GLANCE

96%

MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

Exc Med. Staff starting >1st Jul 25

March- 92.4% ▲

100%

YEAR 7 MATERNITY INCENTIVE SCHEME 10 SAFETY ACTIONS

1

MNSI REPORTABLE CASES & REFERRED

March - 1

13.2%

March 13.9% ▼

MATERNITY FRIENDS & FAMILY TEST (RESPONSE RATE)

89.6%

March 90.6% ▼

MATERNITY FRIENDS & FAMILY TEST (PROMOTER RATE)

VACANCY RATE

MIDWIVES	-
CONSULTANT OBSTETRICIAN	7 WTE
NEONATAL NURSES	13%
NEONATOLOGISTS	8.1%

6 MODERATE INCIDENTS

March – 10 ▼

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)

90%

March– 90.9% ▼

1 PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

March - 0 ▲

0 CORONER'S REGULATION 28

March - 0 ◀ ▶

MINIMUM SAFE STAFFING MET (MATERNITY YTD)

Data not available

September– 93.9%

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

March 100% ▲

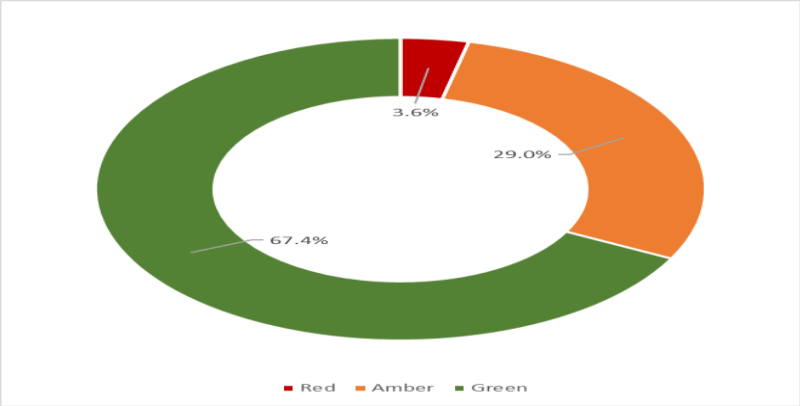
NHS

OPERATIONAL AND CAPACITY

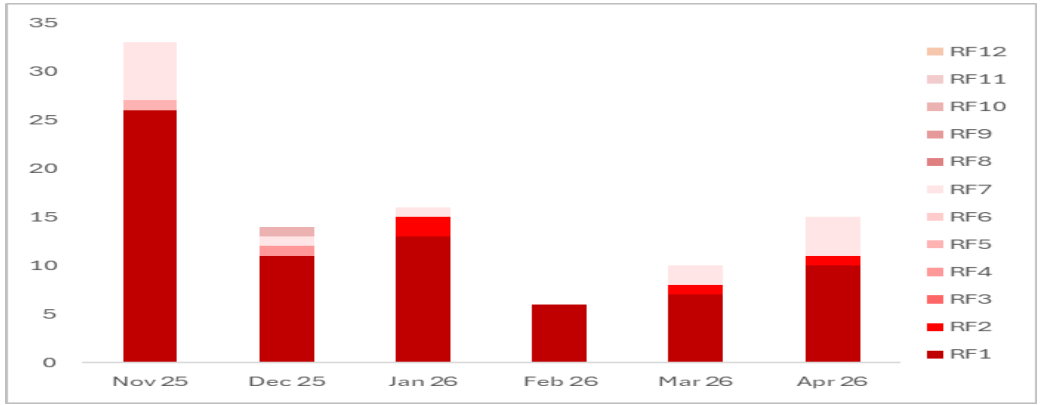
University Hospitals of Leicester NHS Trust

Key Information

Acuity by RAG Status



Midwifery Red Flag Events



Efficiency and Timeliness

Average time from attendance to triage
11 mins
Last month = 9 mins

% Seen within 30 Mins
97.5%
Last month = 96.5%

Average talk time for triage
3mins 6secs
Last month = 3mins 26secs

Avg. time from ARM decision to perform
20 hours
Last month = 20 hours

Maternal Request for CS during IOL
4.5%
Last month = 8.3%

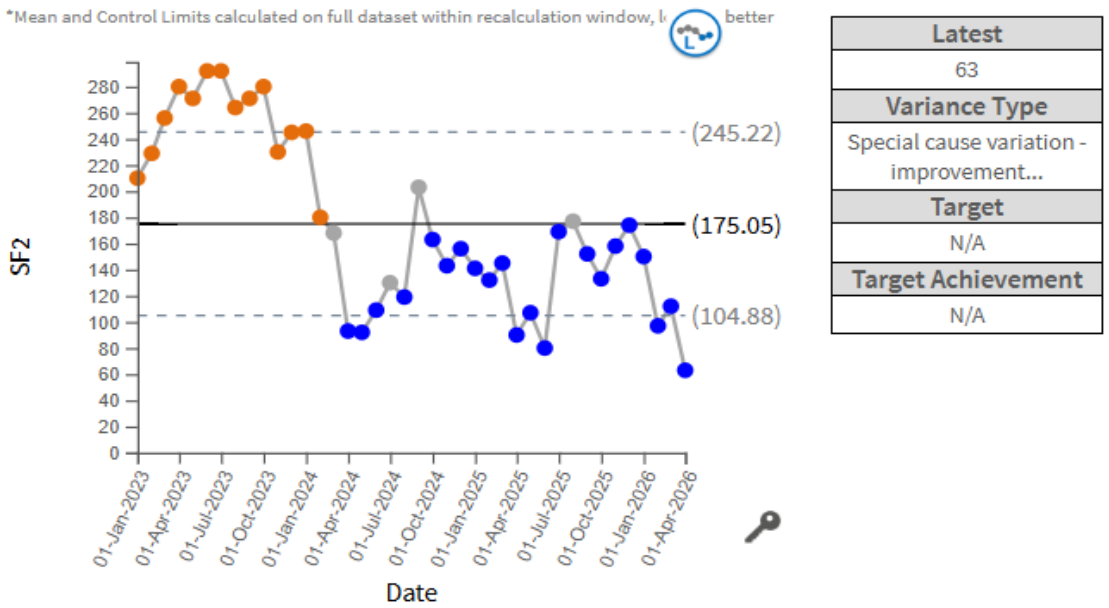
Categorised on admission (triage within target)
1,935
(94.3%)

Average volume of calls to triage
5,395
Last month = 5,124

Average call response time for triage
2mins 20secs
Last month = 2mins 6secs

Capacity

Unable to fill vacant shifts



Latest
63
Variance Type
Special cause variation - improvement...
Target
N/A
Target Achievement
N/A

IN FOCUS – Clinical Quality Surveillance

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

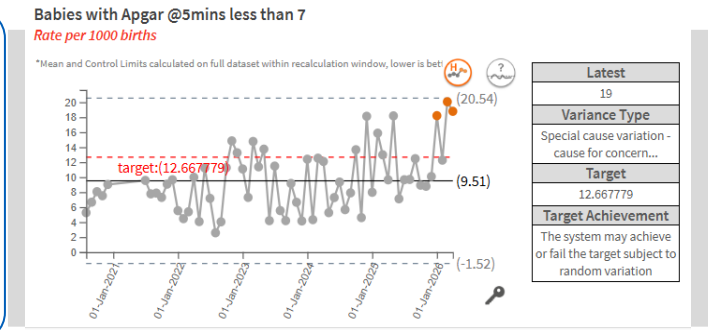
University Hospitals of Leicester NHS Trust

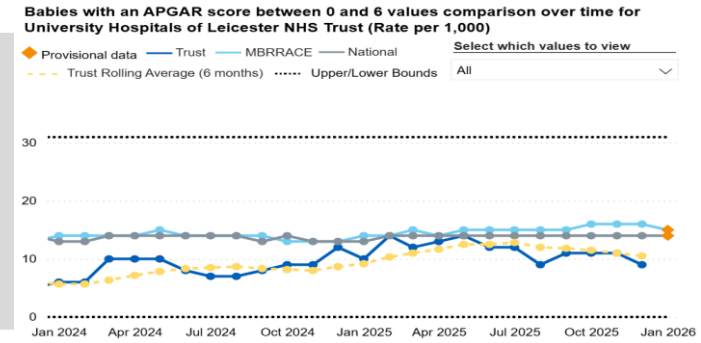
Summary

CQIMs continue to demonstrate common cause variation (see slide 16). An slight decrease has been observed in Apgar less than 7 at five minutes although it is still within special cause variation. There has been a decrease 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 and women with perineal tears have reduced slightly andremain within common cause variation.

Babies with Apgar @5 mins less than 7

Recent analysis at UHL has identified an increase in the proportion of babies with an Apgar score of less than 7 at 5 minutes of age. In parallel, overall Apgar scores demonstrate a sustained upward trend, now meeting criteria for special cause variation. Given these findings, a deep-dive audit is planned to further examine the underlying causes, assess the consistency of scoring practice, and ensure the reliability of recorded outcomes.

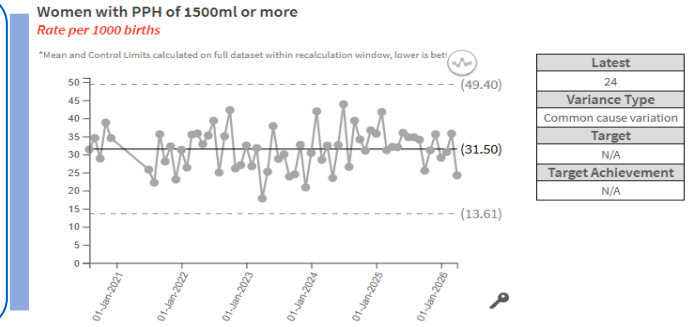


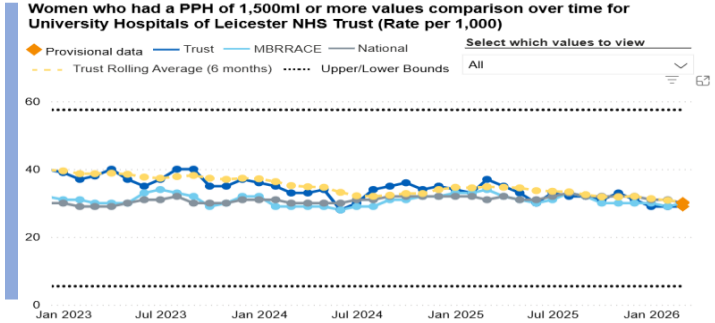


PPH of 1500 or more

PPH rates have stabilised over the course of 2025 has remained in common cause variation. Although monthly fluctuations continue, the latest PPH rate remains below the current mean and shows a reduction from the previous month.

Ongoing improvement work is still going through the PPH working group, OBS Cymru processes, measurement of blood loss, escalation pathways and documentation improvements in order to maintain this downward trend



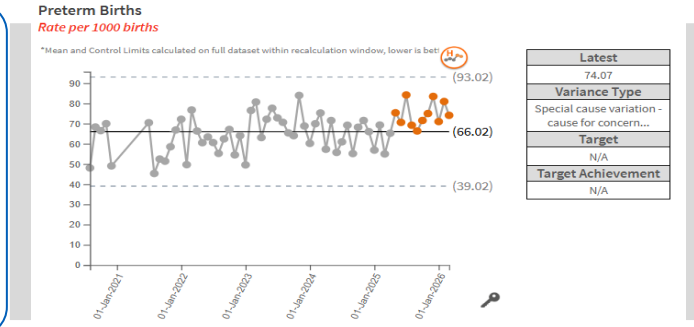


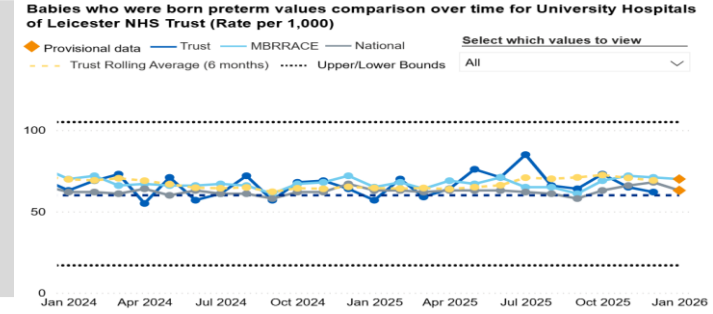
Preterm births

The preterm birth rate reduced in the reporting month but remains above the process mean, with ongoing special cause variation. The underlying drivers remain consistent, with a significant proportion of preterm births being iatrogenic and linked to complex maternal and fetal conditions.

The increase also reflects improved regional referral pathways into specialist services at UHL, including preterm birth clinics, fetal medicine, and tertiary neonatal care. There has been a rise in referrals from other units, including for specialist procedures such as Shirodker cerclage.

As a result, UHL continues to manage a higher proportion of complex cases, contributing to the observed increase. Ongoing actions include continued staff education, strengthened referral pathways, and improved information sharing.





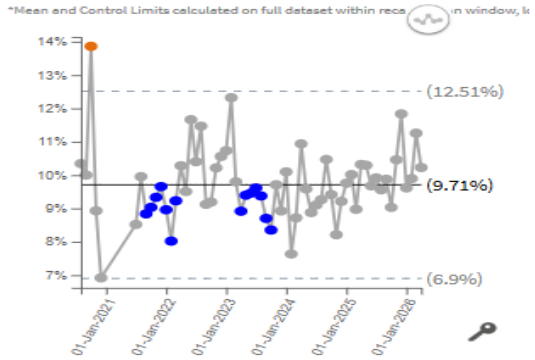
TRENDS: CLINICAL QUALITY SURVEILLANCE

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

NHS University Hospitals of Leicester NHS Trust

Antenatal

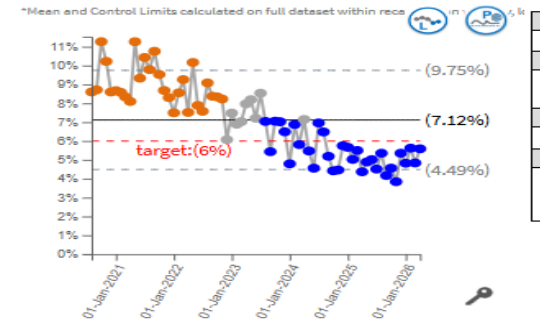
BMI at Booking >35



Latest
10.2%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

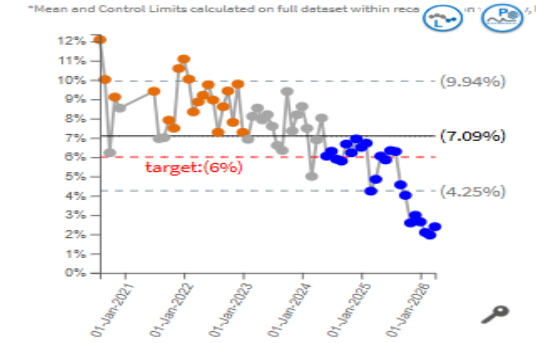
Smoking at time of booking

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

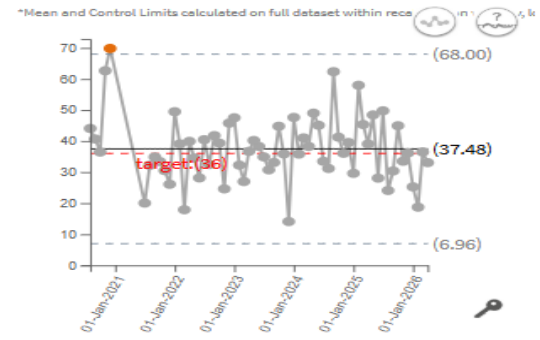


Latest
2.4%
Variance Type
Special cause variation - improvement...
Target
6%
Target Achievement
Metric has (P)assed the target for the last 6 (or more) data points...

Intrapartum

Women who had a 3rd & 4th degree tear

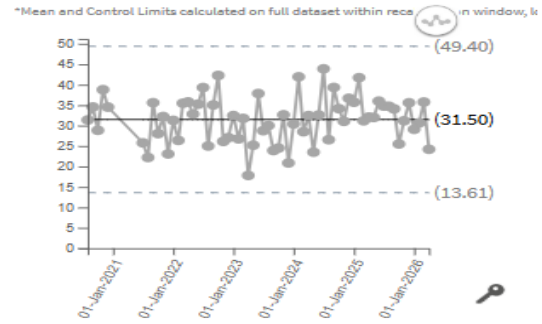
Rate per 1000 births



Latest
33
Variance Type
Common cause variation
Target
36
Target Achievement
The system may achieve or fail the target subject to random variation

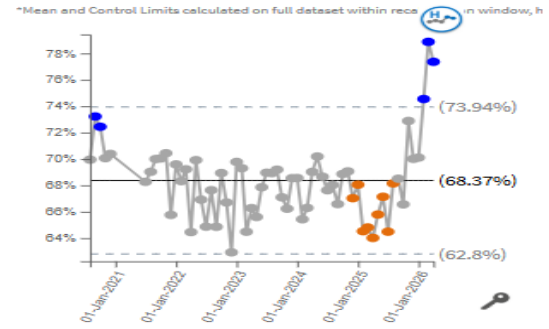
Women with PPH of 1500ml or more

Rate per 1000 births



Latest
24
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

BREASTFEEDING

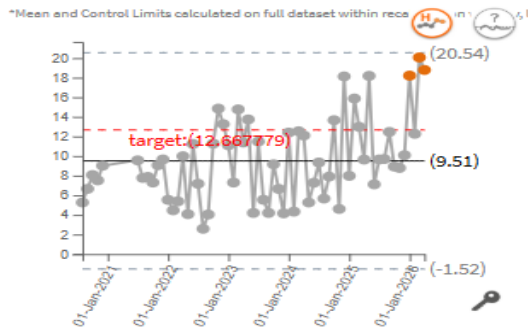


Latest
77.4%
Variance Type
Special cause variation - improvement...
Target
N/A
Target Achievement
N/A

Outcomes

Babies with Apgar @5mins less than 7

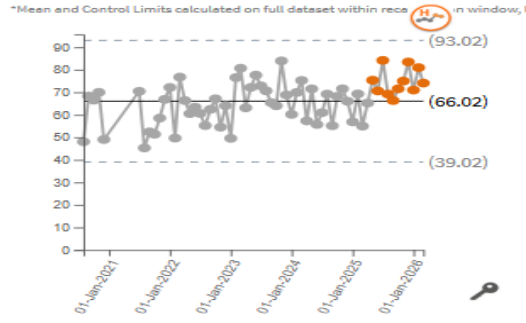
Rate per 1000 births



Latest
19
Variance Type
Special cause variation - cause for concern...
Target
12.667779
Target Achievement
The system may achieve or fail the target subject to random variation

Preterm Births

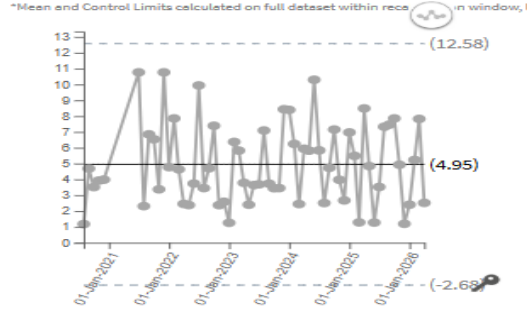
Rate per 1000 births



Latest
74.07
Variance Type
Special cause variation - cause for concern...
Target
N/A
Target Achievement
N/A

Stillbirths

Rate per 1000 births



Latest
3
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A