# UHN Boards of Directors (Part II)
# Meeting in Public

*Fri 27 June 2025, 12:30 - 15:00*

**William Wilson Room, Cripps Postgraduate Centre, Northampton General Hospital**

## Agenda

**12:30 - 12:30**
0 min

### 1. Welcome, apologies and declarations of interest

*Andrew Moore*

1. UHN Public Boards Part II Agenda 270625 (1).pdf (2 pages)

**12:30 - 13:00**
30 min

### 2. Patient Story - Research and Innovation

*Presentation and Discussion* *Hemant Nemade*

**13:00 - 13:00**
0 min

### 3. Minutes of the previous meeting held on 9 May 2025 and Action Log

*Decision* *Andrew Moore*

3.1 090525 Draft Minutes UHN Public Board of Directors meeting.pdf (9 pages)
3.2 Board Action Log Updated 090525 Part I Boards.pdf (1 pages)

**13:00 - 13:05**
5 min

### 4. Vice-Chair's report (verbal)

*Information* *Trevor Shipman*

**13:05 - 13:10**
5 min

### 5. UHN Chief Executive's Report

*Information* *Laura Churchward*

5. CEO update public board report June 2025.V01.pdf (4 pages)

**13:10 - 13:40**
30 min

### 6. Integrated Performance Report (IPR - to follow) and Board Committee Chairs' reports

*Assurance* *Laura Churchward / Becky Taylor / Executive Leads / Board Committee Chairs*

6.0 Group Upward Reporting to UHN 270625 Boards (2).pdf (11 pages)

**13:40 - 14:10**
30 min

### 7. Northampton General Hospital (NGH) CQC Urgent and Emergency Care (UEC) Inspection section 29 warning notice – delivery of action plan

*Assurance* *Julie Hogg*

BREAK 14:00-14:10

7. Board directors June CQC action plan.pdf (8 pages)

**14:10 - 14:25**
15 min

### 8. UHN Perinatal Scorecards Highlight Report (April and May 2025 Data)

*Assurance* *Julie Hogg*

8. Board of Directors_UHN Perinatal Scorecards_APRIL 2025_MAY 2025.pdf (3 pages)
9. Appendix 1 - KGH Perinatal Scorecard April 2025.pdf (15 pages)

- 9. Appendix 2 - NGH Perinatal Scorecard April 2025.pdf (22 pages)
- 9. Appendix 3 - KGH Perinatal Scorecard May 2025.pdf (16 pages)
- 9. Appendix 4 - NGH Perinatal Scorecard May 2025.pdf (22 pages)

**14:25 - 14:40**
15 min

## 9. Children and Young People (CYP) Improvement Plan Analysis and update on Patient Safety Cultural Review status against recommendations

*Assurance* *Julie Hogg*

- 9. Children and Young People (CYP) Improvement Plan AnalysisJune25.pdf (9 pages)

**14:40 - 14:55**
15 min

## 10. Race, Ethnicity and Cultural Heritage (REACH) Network Tackling Racism Paper

*Decision* *Paula Kirkpatrick*

- 10. Racism at UHN review paper June 2025.pdf (9 pages)

**14:55 - 14:55**
0 min

## 11. Northamptonshire Healthcare Charitable Fund – appointment of Alternate Trustee

*Decision* *Richard May*

- 11. UHN Cover Sheet NHCF Trustee appointments.pdf (2 pages)

**14:55 - 14:55**
0 min

## 12. Report on the use of the KGH Trust Seal

*Information* *Richard May*

- 12. UHN Cover Sheet KGH Trust Seal 270625.pdf (1 pages)

**14:55 - 15:00**
5 min

## 13. Questions from the public

**15:00 - 15:00**
0 min

## 14. Any other business and close

# University Hospitals of Northamptonshire NHS Group (UHN): Meeting in Public of the Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH) and Northampton General Hospital NHS Trust (NGH)

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| Meeting | Boards of Directors (Part II) Meeting in Public |
| Date & Time | 27 June 2025, 12:30-15:00 |
| Location | William Wilson Room, Cripps Postgraduate Centre, Northampton General Hospital |

| Purpose and Ambition | | | | | |
|---|---|---|---|---|---|
| The Boards are accountable to the public and stakeholders; to formulate the Trusts' strategies; ensure accountability; and to shape the culture of the organisations. The Boards delegate authority to Board Committees to discharge their duties effectively and these committees escalate items to the Boards, where Board oversight, decision making and direction is required. | | | | | |
| Item | Description | Lead | Time | Purpose | P/V/Pr |
| 1 | Welcome, Apologies and Declarations of Interest | Vice-Chair | 12:30 | - | Verbal |
| 2 | Patient Story: Research and Innovation | Medical Director | 12:30 | Presentation | Pr. |
| 3 | Minutes of the Previous Meeting held on 9 May 2025 and Action Log | Vice-Chair | 13:00 | Decision<br>Receive | Attached<br>Attached |
| 4 | Vice-Chair's report | Vice-Chair | 13:00 | Information | Verbal |
| 5 | UHN Chief Executive's Report | UHN CEO | 13:05 | Information | Attached |
| Operations | | | | | |
| 6 | Integrated Performance Report (IPR) (to follow) and Board Committee Chairs' Reports (attached) | Chief Executive, Executive Directors and Committee Chairs | 13:10 | Assurance | Attached |
| 7 | Northampton General Hospital (NGH) CQC Urgent and Emergency Care (UEC) Inspection section 29 warning notice – delivery of action plan | Chief Nurse | 13:40 | Assurance | Attached |

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| | BREAK | | 14:00 | | |
| 8 | UHN Perinatal Scorecard Highlight Report (April and May 2025 Data) | Chief Nurse | 14:10 | Assurance | Attached |
| 9 | Children and Young People (CYP) Improvement Plan Analysis and update on Patient Safety Cultural Review status against recommendations | Chief Nurse | 14:25 | Assurance | Attached |
| People and Culture | | | | | |
| 10 | Race, Ethnicity and Cultural Heritage (REACH) Network Tackling Racism Paper | Chief People Officer | 14:45 | Assurance | Attached |
| Governance | | | | | |
| 11 | Northamptonshire Healthcare Charitable Fund – appointment of Alternate Trustee | Company Secretary | 14:55 | Decision | Attached |
| 12 | Use of the KGH Trust Seal | Company Secretary | 14:55 | Information | Attached |
| 13 | Questions from the Public | Chair | 14:55 | - | - |
| 14 | Any Other Business and close | Chair | 15:00 | - | - |

# Minutes of the Meeting

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| Meeting | Boards of Directors of the University Hospitals of Northamptonshire NHS Group (UHN) comprising Northampton General Hospital (NGH) and Kettering General Hospital (KGH) Meeting together in Public |
| Date & Time | 9 May 2025, 12:30-14:30 |
| Location | Boardroom, Kettering General Hospital |

| Purpose and Ambition |
|---|
| The Boards are accountable to the public, stakeholders and KGH Council of Governors to formulate the UHN Group's strategy, ensure accountability and shape the culture of the group. The Boards delegate authority to Committees to discharge their duties effectively and these committees escalate items to the Boards where decision making, assurance and direction is required. |

| Attendance | Name and Title | |
|---|---|---|
| **Present** | | |
| | Andrew Moore | Trusts' Chair |
| | Richard Mitchell | Chief Executive, UHN/UHL |
| | Laura Churchward | Chief Executive, UHN |
| | Richard Apps | Director of Corporate and Legal Affairs |
| | Alice Cooper | Non-Executive Director |
| | Stuart Finn | Director of Estates, Facilities and Sustainability |
| | Simon Gay | Non-Executive Director |
| | Polly Grimmett | Director of Strategy |
| | Julie Hogg | Chief Nurse |
| | Jill Houghton | Non-Executive Director |
| | Denise Kirkham | Non-Executive Director |
| | Paula Kirkpatrick | Chief People Officer |
| | Will Monaghan | Chief Digital Information Officer |
| | Hemant Nemade | Medical Director |
| | Suzie O'Neill | Director of Communications and Engagement |
| | Trevor Shipman | Vice-Chair and Non-Executive Director |
| | Sarah Stansfield | Chief Finance Officer |
| | Caroline Stevens | Non-Executive Director |
| | Becky Taylor | Director of Continuous Improvement |
| | Damien Venkatasamy | Non-Executive Director |
| | Chris Welsh | Non-Executive Director |
| **In Attendance** | | |
| | Simon Baylis | KGH Lead Governor |
| | Ilene Machiva | Director of Midwifery |
| | Richard May | Company Secretary |
| | Jane Sanjeevi | Freedom to Speak Up Guardian (Item 8) |
| **Apology for absence** | | |
| | Sarah Noonan | Chief Operating Officer |

| Item | Discussion | Action Owner |
|---|---|---|
| 1 | **Welcome, Apologies and Declarations of Interest**<br><br>The Chair welcomed colleagues to the meeting and noted apologies for absence as listed above. There were no declarations of interest relating to specific agenda items. | |
| 2 | **Minutes of the last meeting held on 4 April 2025 and Action Log**<br><br>The Minutes of the meeting of the Boards of Directors of Kettering General Hospital (KGH) and Northampton General Hospital (NGH) held on 4 April 2025, were approved as a correct record.<br><br>The Boards noted the action log, actions on which were closed or not yet due. | |
| 4 | **Chair's Report**<br><br>The Chair reported outcomes from a recent meeting with the supplier for NGH's Electronic Patient Record and spoke about the need for the group to develop its understanding of digital systems and corresponding changes to process, structure, skills and capabilities required to realize maximum business benefits in terms of efficiency, productivity, service quality and job satisfaction.<br><br>In driving change, the trusts must not neglect the basics of quality business as usual delivery; the new Integrated Performance Report (see item 5 below) would enable enhanced scrutiny of performance and outcomes, prior to 'golden' performance measures being identified to sustain focus on key financial, operational, activity, quality and safety targets.<br><br>The Chair offered his congratulations to newly-elected councillors in North and West Northamptonshire following the Local Elections which took place on 2 May 2025, and looked forward to working collaboratively to address common challenges.<br><br>The Chair drew attention to recent high-profile cyber attacks in the retail sector and substation fire affecting Heathrow Airport; he requested specific communications reminding staff of the importance of, and need to take personal responsibility for, data security, and assurance on the trusts' cyber security arrangements. | **SON**<br><br>**WM** |
| 4.1 | **UHN Chief Executive's report**<br><br>The UHN Chief Executive drew Boards' attention to her written report and to the following specific matters:<br><br>- Concerted work by finance teams to prepare year-end accounting data and deliver a year-end capital position which showed a small variance from plan (see item 5 below);<br>- The reopening of Maple Ward in Rockingham Wing (KGH), which provided a better environment for patient care and | |

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| | enabled the Thomas Moore Ward to be repurposed as a Discharge Lounge;<br>- Stakeholder engagement was ongoing following the decision to relocate mortuary services to a new facility at Northampton; funeral directors had raised specific concerns regarding the increased distance required to travel from the north and east of the county.<br><br>The Boards noted the report. | |
| 5. | **Integrated Performance Report (IPR) and Board Committee Summaries**<br><br>The Director of Continuous Improvement presented an updated IPR which had been subject to significant redevelopment to review and improve the format and set out performance against a revised suite of key metrics agreed by committees. Metrics were aligned to CQC domains, and the report included additional information to provide an integrated assessment of the group's activity, finance, workforce and service quality. Boards members welcomed the new IPR and looked forward to its ongoing development, thanking colleagues across the organisations, and particularly those in the Health Intelligence Team, for their work to achieve the current position.<br><br>Executive Leads drew the Boards' attention to significant items:<br><br>*Care, Effective and Safe Domains*<br><br>- Significant improvement in Friends and Family Test satisfaction scores in both A&E departments, with 84% of patients at KGH and 79% at NGH reporting satisfaction with care received;<br>- Complaints response performance had reduced at KGH following the reallocation of resources to NGH, whose performance had improved; the provisional position showed that KGH responded to all complaints on time, whilst significant improvement was still required at NGH;<br>- Infection prevention control metrics remained stable at both trusts despite ongoing operational pressures. Both sites had exceeded their 2024-25 trajectories for C-Difficile infections, and a task and finish group had been established for the local health system to drive further improvements through a co-ordinated approach to prevention, early detection and management;<br>- There was an increase in diabetes management incidents; an Insulin Oversight Group was in place to drive improvements in insulin safety, and a Nutrition Group was being developed at KGH to oversee incidents assessed as 'moderate and above' harm.<br><br>*Responsive Domain*<br><br>- Performance against the four-hour A&E target was a cause for concern at NGH; this would be addressed following the launch of the release to respond initiative and the expansion of the streaming hub;<br>- Average handover times in March 2025 were 28 minutes (KGH) | |

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| | and 45 minutes (NGH); this represents improved performance;<br>- Non-elective average length of hospital stay had increased following the closure of the Spinneyfield escalation capacity; work with divisions continued to address this;<br>- Projected 52-week positions were met at 31 March 2025, putting the trusts in a good position to meet 2025-26 targets for patients waiting over 52 weeks to represent no more than 1% of overall waiting lists by year-end;<br>- Cancer Faster Diagnosis Standard performance remained consistently strong and was regularly the highest in the region. There would be an operational focus on the 62-day cancer treatment target, as several patients had been treated shortly before the end of this period.<br><br>In response to a question, the Boards were advised that work continued to improve the accuracy and consistency of performance data regarding the percentage of inpatients with 'reason to reside' within the hospitals.<br><br>*Well-Led*<br><br>- The trusts had submitted draft annual accounts to NHS England within the deadline of 25 April 2025;<br>- The forecast year-end position at Month 11 (28 February 2025) was a £29.98m residual deficit across UHN; the year-end position remained provisional and was subject to external audit;<br>- Business as usual capital showed an underspend of £206k against a £36.8m programme at year end; the nationally-funded programme was underspent by around £3m due to delays in the Community Diagnostic Centre programme;<br>- The closing cash balance at year end was £7.3m which was within tolerance; cash drawdown for the first quarter of 2025-26 had been approved as part of the annual plan submission to NHS England;<br>- Month 12 (March 2025) showed the first reduction in total whole-time equivalent workforce (WTE) for KGH, during which a 46% reduction in agency usage had been achieved. Total WTE at NGH had increased due to bank support for annual leave;<br>- Vacancy rates were above target in both Trusts due to the recent recruitment freeze for non-clinical positions and significant reductions in clinical recruitment; similarly, the decision to slow recruitment had increased time to hire;<br>- Budget holders had been requested to review 2025-26 establishments in order to agree an updated vacancy position by 30 June 2025;<br>- KGH achieved the lowest sickness absence mate in the Midlands Region (4.3%) and had been asked to showcase its performance to regional HR Directors<br>- The Boards noted that non-Bank engagements now required executive director approval.<br><br>In response to questions, executive directors identified examples of strong and effective collaboration: | |

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| | *Within UHN (KGH and NGH)*<br><br>- Alignment of infection prevention control (IPC) policies and procedures and the opportunity to share good practice in terms of IPC education;<br>- UHN Learning from Deaths Group in place driving sustained improvement at KGH;<br>- Aligned Datix incident reporting system and closer working between nursing and medical teams;<br>- Collaboration between finance teams assisting timely accounts submission and enabling a more consistent approach.<br><br>*UHN and the University Hospitals of Leicester NHS Trust (UHL)*<br><br>- Alignment of job planning via the Locum's Nest platform;<br>- Sharing and comparing planning assumptions and the identification of shared opportunities to increase automation and deliver workforce reduction plans.<br><br>*Committee Summaries*<br><br>The Boards noted the Committee summaries set out in the report. Committee Chairs drew the following exceptions to the Boards' attention:<br><br>- Assurance level for urgent and emergency care performance increased from 'limited' to 'reasonable' for the reasons specified in the report (Operational Performance Committee);<br>- Freedom to Speak Up Guardians' reports received (People Committee, see item 8 below)<br>- Limited assurance items relating to the Perinatal service (Quality and Safety Committee (see item 7 below);<br>- Limited assurance regarding progress with the delivery of the annual internal audit plan due to many outstanding recommendations and cases in which implementation dates had been deferred; executive leads were requested to provide targeted focus on these recommendations and would be invited to Audit Committees regarding specific exceptions (Audit Committees);<br>- Limited assurance continuing to be indicatied regarding the trusts' financial position, acknowledging positive directions of travel in the context of additional grip and control measures implemented and identified cost improvements for 2025-26 (Finance and Investment Committee). | |
| 6. | **Northampton General Hospital (NGH) CQC Urgent and Emergency Care (UEC): Inspection and Action Plan**<br><br>The Boards considered a report notifying the receipt of warning notice for urgent and emergency care under Section 29A of the Health and Social Care Act, highlighting where urgent improvements were required to address the potential of harm to patients in the emergency department, patient flow through the hospital and the privacy and dignity of patients. The Trust had made immediate changes (summarised in the report) and developed a detailed action plan | |

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| | focussing on key points raised within the feedback, which was subject to regular monitoring and oversight by the Quality and Safety Committee. Receipt of the warning notice was being communicated in advance of the publication of the CQC final report following notification in recent NICB public papers.<br><br>The Boards noted the latest position and supported the accompanying open letter to stakeholders (enclosed as an appendix to the report), receiving assurances regarding staff ownership of changes, the closure of escalation spaces, improvements to patient flow across the hospital and engagement mechanisms in place to ensure the staff voice informed and drove improvements. | |
| 7. | **UHN Perinatal Quality Surveillance Scorecards – Highlight Report**<br><br>The Boards welcomed the Director of Midwifery to present the trusts' Perinatal Quality Surveillance Scorecards, bringing the following significant exceptions to the Boards' attention:<br><br>• The antenatal scanning review was complete, with recommendations made to improve training, policies, digital infrastructure and quality assurance. The Quality and Safety Committee would oversee implementation of the recommendations;<br>• The cessation of funding for Maternity Tobacco Dependency Advisor roles, which impacted the provision of smoking cessation services in maternity and potentially affected compliance with Maternity Incentive Scheme requirements;<br>• The implementation of the Badgernet system at both hospitals due to issues with providing licences for clinicians to access System C; negotiations continued with the supplier to identify a resolution;<br>• NGH had no Obstetric Clinical Director and consequently no Obstetric Maternity Safety Champion; recruitment was underway to this key position.<br><br>The Boards were advised that the KGH Local Neonatal Unit Level 2 status would be restored on 14 May 2025, subject to Northamptonshire Integrated Care Board approval.<br><br>The Boards noted the report, indicating assurance in respect of the identification and investigation of, and learning from, maternity patient safety incidents and compliance against national key safety indicators. In doing so, the Boards requested the inclusion of a summary scorecard in future reports to enable 'at a glance' assessments of safety and performance. | **JH** |
| 7.1 | **KGH Maternity Support Programme (MSSP): Latest Position**<br><br>The Boards considered a report setting out progress with the MSSP and Maternity Improvement Advisor's feedback to the service. Following site visits and a stakeholder event to discuss the draft diagnostic report, areas of escalation had been identified, and subsequently resolved, regarding the expiry of seconded Midwifery senior leadership and | |

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| | specialist midwife roles, for which recruitment was underway for an intrapartum matron and backfilling arrangements for specialist midwives extended for six months, and the removal of a second Senior House Doctor from April 2025: short term mitigation measures had been approved by the Medical Director to provide Locum cover whilst substantive recruitment took place.<br><br>The Boards extended their thanks and best wishes to the Director of Midwifery who was attending her last meeting before leaving UHN for a new role, and their congratulations following her receipt of the Chief Midwifery Officer's Silver Award.<br><br>The Boards of Directors noted the latest position. | |
| 8. | **Freedom to Speak Up (FTSU) Report for January to March 2025 (Quarter 4)**<br><br>The Boards welcomed the FTSU Guardian to present the quarterly report summarising highlights and exceptions from FTSU activity for January to March 2025. The Boards indicated their continuing concern regarding reports of incivility, bullying, harassment and discrimination, and requested additional assurance from the People Committee regarding the robustness of plans and initiatives to address this, which included a review of the Rethinking Racism programme and development of a performance dashboard for organisational development and inclusion.<br><br>There was evidence from the national Staff Survey of a greater reluctance by colleagues to speak up compared to other trusts; this could be addressed through demonstrable evidence and case studies that staff were listened to and that concerns were acted upon appropriately.<br><br>The work of FTSU ambassadors within departments was acknowledged as being of great value in providing local points of contact, though competing operational pressures sometimes resulted in a lack of protected time to fulfil this role effectively.<br><br>The Director of Corporate and Legal Affairs drew the Boards' attention to a recent report from the National Guardian's office focussing on measures to improve FTSU awareness and participation by international colleagues, including promotion of FTSU in overseas recruitment and measures to raise cultural competency and awareness amongst colleagues; the trusts planned to use national training materials to support delivery of these objectives locally.<br><br>The Boards noted the latest position and were advised that the Director of Continuous Improvement would be designated as the executive FTSU lead following the departure of the Director of Corporate and Legal Affairs. Additionally, the Boards extended their thanks to the KGH FTSU Guardian Susan Clennett, who was relinquishing the role she had undertaken, in addition to her substantive role as Deputy Director of Integrated Governance, since 2016. | **PK** |

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| 9. | **Children's and Young People's Services (CYP) Patient Safety Cultural Review at Kettering General Hospital (KGH)**<br><br>The Boards considered a report setting out the findings and recommendations following an external patient safety culture review, undertaken by Ibex Gale, within the Children's Emergency Department, Paediatric Assessment Unit and Skylark Ward at Kettering General Hospital between November 2024 and February 2025. The review was commissioned in response to concerns from colleagues, parents and patients regarding the quality of care delivered, and the professionalism of colleagues, within these areas.<br><br>The review identified key themes which were potential barriers to the cultivation and maintenance of a positive patient safety culture as they had the potential to have negative impacts on the culture, operational, effectiveness and safety of the services provided: these related to workforce issues, service demand, leadership and a lack of collaborative working. Specifically, staff did not feel properly supported, engaged and psychologically safe to deliver safe, compassionate and effective patient care.<br><br>The Trust fully accepted the report's findings and was in the process of embedding all recommendations into a comprehensive action plan to address immediate priorities and longer-term cultural and operational improvements; an open letter had been issued to patients and families, with engagement events planned to explore how their views could shape and monitor service delivery. Achieving cultural change required greater team work, civility, compassion and respect, aligned to the Group's Values.<br><br>Following the discussion, the Boards:<br><br>(1) Received the report;<br>(2) Indicated support for the progression of recommendations as specified in the Appendix to the report, and<br>(3) Delegated oversight to the Quality and Safety Committee to ensure delivery of the recommendations and triangulation with findings and actions from other internal and external review. | |
| 10. | **Risk management Strategy**<br><br>The Boards considered a report recommending the adoption of an updated Risk Management Strategy which reflected group strategy and set clear objectives for the development of risk management systems (including a single digital risk management tool), enabled improved ownership and integration of key risks by Boards, Committees and responsible executive directors as well as further alignment of risk registers at operational and corporate risk register levels. The draft strategy had been reviewed and recommended for approval by Audit Committees, which would maintain oversight of its implementation.<br><br>The Boards noted that UHL had recently undertaken a similar exercise and hoped that relevant learning could be shared between the Trusts. | |

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| | The Boards **APPROVED** the UHN Risk Management Strategy as set out in the appendix. | |
| 11. | **Board Assurance Framework (BAF)**<br><br>The Boards received the latest version of the BAF and a summary of updates following the quarterly review by committee and responsible executive leads. Following the adoption of the updated Risk Management Strategy (see item 10 above), work would proceed to align the BAF to new corporate objectives and associated risk appetite, and to further embed the BAF as a live and impactful resource providing a valuable source of assurance and enabler for service improvement. Guidance on best practice for how the BAF should be used would be prepared as part of strategy implementation.<br><br>The Boards discussed the impact of the highest-scoring risk, which related to the trusts' financial position and which, when materialising, detrimentally impacted UHN's ability to deliver its objectives for patient care and the staff experience.<br><br>The Boards noted the latest position, indicating their assurance in respect of the proactive management of key risks, and looked forward to new iterations of the BAF which addressed the points raised during the discussion. | |
| 12. | **Integrated Leadership Team (ILT) Terms of Reference**<br><br>The Boards considered and **APPROVED** changes to ILT Terms of Reference as set out in the report and appendix, subject to clarification of references to 'deputy' and 'vice chair'. | |
| 13. | **Use of the Trusts' Seals**<br><br>The NGH Board noted the use of the Trust Seal in respect of a Car Parking Lease with St Andrew's Healthcare on 28 April 2025, affixed by the Director of Corporate and Legal Affairs in the presence of the Director of Estates, Facilities and Sustainability. | |
| 14. | **Questions from the Public**<br><br>None | |
| 15. | **Any other business and close**<br><br>The Boards of Directors extended their thanks and best wishes to the Director of Corporate and Legal Affairs, who was attending his last meeting before leaving the trusts for a new role. | |

# Action Log

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| Meeting | Boards of Directors (Part II) Meeting in Public |
| Date & Time | Updated following 9 May 2025 meeting |

| Minute Ref. | Action | Owner | Due Date | Progress | Status |
|---|---|---|---|---|---|
| Feb 25<br>5 | The Director of Continuous Improvement undertook to explore how peer group benchmarking could be reflected as part of in-year performance monitoring. | BT | June 25 | Benchmarking information is included in the new Integrated Performance Report at agenda item 5 | CLOSE |
| Apr 25<br>5i | Presentation of 2025-26 Capital Plan to Boards | SS | Aug 25 | Capital Plan to be submitted to Finance and Investment Committee and Boards. | OPEN |
| May 25<br>4i | (i) Issue communications reminding staff of the importance of, and need to take personal responsibility for, data security;<br>(ii) assurance on the trusts' cyber security arrangements. | SON<br>WM | June 25 | (i) Director of Communications and Engagement to confirm completion<br>(ii) Report on Agenda | OPEN |
| May 25<br>7 | Peritnatal dashboards: inclusion of a high level scorecard in future reports to enable 'at a glance' assessments of safety and performance. | JH | Aug 25 | The dashboards at agenda item 9 contain 'at a glance' summaries. A consolidated UHN scorecard is under development | OPEN |
| May 25<br>8 | Boards requested additional assurance regarding the robustness of plans and initiatives to address discrimination | PK | June 25 | Report on agenda | CLOSE |

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University Hospitals of Northamptonshire
NHS Group

## Cover sheet

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| Meeting | Boards of Directors of Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) (Part I) Meeting together in Public |
| Date | 27 June 2025 |
| Agenda item | 5 |
| Title | Chief Executive's report |
| Presenter | Laura Churchward - UHN Chief Executive (CEO) |
| Author | Laura Churchward - UHN CEO and UHN Executive Team |

| This paper is for | | | |
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| ☐ Decision | ☐Discussion | ✓ Note | ☐Assurance |
| To formally receive and discuss a report and approve its recommendations OR a particular course of action. | To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it | For the intelligence of the Board without the in-depth discussion as above | To reassure the Board that controls and assurances are in place |

| Executive Summary |
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| This report provides an update from the UHN CEO, summarising key points from May / June 2025. |
| **Appendices** |
| None |
| **Risk and assurance** |
| Information report – no direct implications. |
| **Financial Impact** |
| There is no financial impact |
| **Legal implications/regulatory requirements** |
| There is no legal impact |
| **Equality Impact Assessment** |
| Information report – neutral |

**Welcome**

Thank you to all the staff who have contributed to our listening events in June in response to our staff survey results and to all those who continue to welcome me – and other executives – into their clinical and non-clinical services. I continue to be impressed by the openness and honesty of the many teams I have met with.

**Estate Developments**

Our Community Diagnostic Centre (CDC) in Corby was completed in June 2025 as part of NHS England's national programme to help tackle health inequalities and reduce waiting lists across the NHS. Like the Kings Heath Centre in Northampton, it will offer advanced diagnostic services seven days a week from 8 am to 8 pm. The centre will conduct over 90,000 scans annually, including MRI's, CT's, Echocardiography, Ultrasound, Phlebotomy and more. For the first time in this county, an early dementia diagnosis pathway will be available for some of our hardest to reach communities. Thank you to everyone who has worked on the project thus far – I look forward to seeing it in action.

We have also secured an additional £8m in capital funding to undertake safety improvements work to our buildings at Kettering and Northampton, improving our electric and power supplies, fire protection and nurse call bell systems.

**UHN collaboration**

There have now been over 1,000 patient transfers between NGH and KGH to support reductions in waiting times for patients, highlighting the real benefit in the ongoing work to bring the two hospitals closer together.

**Electronic Patient Record (EPR)**

We are on track for our Tranche 1 EPR go-live at NGH on 28 June 2025. This represents a significant milestone in our digital transformation journey, with clinical teams prepared and technical readiness confirmed. The implementation will improve clinical workflows and patient safety through better integrated care records.

**Ambient AI Scribe Trials**

Our ambient AI scribe trials are now live at both NGH and KGH. Early feedback from clinicians is positive, with the technology demonstrating its potential to reduce administrative burden and allow

more time for direct patient care. We are capturing learning from these pilots to inform wider rollout.

**Corporate Services Automation**

Our first corporate service automations have gone live, marking the beginning of our broader automation programme. These initial implementations are already showing time savings and improved accuracy in routine administrative processes.

**Mortuary Service**

The County Mortuary project is progressing on schedule, with a provisional opening date of 1 November 2025. Engagement with key stakeholders has taken place, to ensure the service is developed in a way that reflects community needs and expectations. This has included a meeting with the local MP for Kettering and separate engagement sessions with Funeral Directors from across the county to gather feedback on how they would like the service to be delivered. In addition, wider consultation is underway with KGH Governors, Healthwatch, Northamptonshire Carers, and other organisations representing the views of the bereaved, to ensure their insights are considered in shaping the service model.

**Workforce**

We continue to safely right-size our workforce to meet our financial targets. Reducing our reliance on bank and agency use is our primary focus.  In response to the national requirement for Trusts to reduce corporate costs, we continue to hold most admin and clerical vacancies unless essential for service. We have now closed our Mutually Agreed Resignation Scheme (MARS) which was open to colleagues who are not involved in direct clinical care. A verbal update will be given at the meeting in relation to this.

**Supporting a safe working environment**

As part of our work to make UHN the best place to work, and listening to the voice of our colleagues, “Report and Support” has been launched in conjunction with our partners at UHL. This provides an independent route for colleagues to report unwanted behaviours in the workplace and to receive support for their wellbeing and to address the issue.

**Mandatory training**

We have aligned to the national framework for mandatory training which means our training is fully

transferrable across the NHS and will reduce the frequency with which some mandatory training has to be refreshed. There will still be some local requirements, but we hope this will be of benefit to staff across the whole system.

**CQC Inspection**

Following the CQC inspection at NGH and the Section 29A Warning Notice issued on 21 March 2025, the Trust has developed a 100-point action plan focused on patient safety in the Emergency Department, improving hospital flow, and protecting privacy and dignity. The plan has been co-designed with external partners including GIRFT (Getting it Right First Time) and NHSE (NHS England) and is reviewed bi-weekly.

Key improvements include a new assessment hub, face-to-face ambulance handovers, closure of corridor escalation areas, enhanced nursing oversight, and strengthened discharge processes. We have made good progress against all areas of significant concern and now await the final CQC report.

**Spinneyfield Closure**

We have now closed the ground floor of Spinneyfield, which has served as our community provision since August 2024. This has been a significant undertaking, and I want to thank all the staff who have been involved. Northamptonshire Healthcare NHS Foundation Trust has taken over ownership of the facility, with further beds being opened in October 2025 as part of the system winter plan.

**Laura Churchward**

**UHN Chief Executive Officer**

# BOARD COMMITTEE SUMMARIES

University Hospitals of Northamptonshire Boards of Directors Meeting: 27 June 2025

AGENDA ITEM 5

People: 23 May 2025

Quality and Safety: 28 May and 20 June 2025

Finance and Investment: 27 May 2025

Operational Performance: 29 May 2025

Audit: 25 June 2025

(June meetings comprised informal workshops – see slide 10)

| People Committee<br>Reports to the Boards of Directors | Date of reporting group's meeting: 23 May 2025 (1 of 2) | | |
|---|---|---|---|
| **Reporting: Denise Kirkham** | | | |
| **Agenda Item** | **Description and summary discussion** | **Decision / Actions and timeframe** | **Assurance level *** |
| Temporary Staffing | The Committee considered a report setting out the latest temporary staffing position and oversight of measures to improve workforce controls. The Month 1 position (30 April 2025) showed a reduction of 115 and 69 Agency positions compared to the planned position. The Committee recognised the work and 'green shoots' are being seen. However further embedding is required. | -: | Limited |
| Supporting and Managing Attendance | The Committee considered a report providing assurance regarding the processes in place and approaches taken to support colleagues to maintain their health at work and thus sustain attendance whilst reducing unavailability. There has been a reduction in overall sickness absence across UHN since the launch of the launch of the wellbeing policy in October 2024 and sickness rates are below the regional average. The committee were assured that strong processes are in place. Further work is required on stress- related absence. | | Substantial |
| Racism Deep Dive | The Committee considered a report providing an overview of progress within the Tackling Racism workstream, including feedback data gathered from REACH Staff Network members following the publication of the 2024 Staff Survey results. This is an area of concern for the Committee and requires consistent Boards' focus.<br>Whilst a number of initiatives are in place and changes have been made to the Rethinking Racism programme as a result of feedback, only Limited assurance was assessed. | On Boards' agenda | Limited |
| Safe Staffing Report – Nursing, Midwifery and Allied Health Professionals | The Committee considered a report providing an overview of safe staffing metrics. This was a strong report providing reasonable assurance to the Committee. The introduction of the Collaborative Bank will be a key enabler moving forward. | - | Reasonable |

| People Committee<br>Reports to the Boards of Directors | Date of reporting group's meeting: 23 May 2025 (2 of 2) | | |
|---|---|---|---|
| **Reporting: Denise Kirkham** | | | |
| **Agenda Item** | **Description and summary discussion** | **Decision / Actions and timeframe** | **Assurance level *** |
| Joint Midwifery Workforce Report | The Committee considered a report providing an overview of midwifery staffing capacity for the period November 2024 to April 2025, noting additional updates following consideration by the Perinatal Assurance Committee at its recent meeting. Whilst the report was clear, the overall view is that some risks remain including pastoral support and concerns around retention | -: | Limited |

| UHN Finance and Investment Committee<br>Upward Report to Boards of Directors | Date of reporting group's meeting:<br><br>27 May 2025 | | |
|---|---|---|---|
| **Reporting Group Chair: Damien Venkatasamy** | | | |
| **Agenda Item** | **Description and summary discussion** | **Decision / Actions and timeframe** | **Assurance level *** |
| Finance Report Month 1 | The committee:<br>1. Received the financial position to Month 1 which was ahead of plan for delivery.<br>2. Noted the likely cash pressures during Quarter 2 until efficiency schemes begin to reduce the expenditure run rate from Quarter 3 onwards.<br>3. Noted the ongoing external audit of the 2024/25 accounts. | (3) For Boards decision 27/6/25 | Reasonable |
| Deloitte Financial Review and action plan | The committee received the final report from Deloitte and associated action plan and was assured of the implementation of the recommendations from this. | On Boards' agenda | Reasonable |
| Workforce Update | The committee reviewed the workforce update and took assurance from the oversight and controls in place regarding workforce growth and the use of temporary staffing. The committee welcomed the early signs of positive progress in this area. | - | Reasonable |
| Efficiencies update for 2025/26 | The committee:<br>1. Received a Month 1 update on the delivery of the 2025/26 efficiency programme which was above plan for Month 1.<br>2. Noted the total efficiency requirement across UHN for 25/26.<br>3. Noted the plan for the delivery of the efficiency programme which would be phased and weighted on Quarters 3 and 4, and the risks associated with this.<br>The Boards will need to consider options for addressing any potential shortfall against the organisation's CIP (Cost Improvement Programme) target. The committee suggests these discussions take place at an early stage to enable timely and effective decision making.<br><br>The committee confirms limited assurance in relation to this item as while there is an efficiencies plan, much of this is at very early stages. | - | Limited |
| Rockingham Rebuild options | The committee received an update on the actions underway and the planned approach to secure funding for the continuation of the Rockingham Wing extension. The update also covered the option appraisal process to identify the most effective solution for eradicating RAAC. | - | n/a |

| UHN Quality and Safety Committee<br>Upward Report to Board of Directors | Date of reporting group's meeting: 28th May 2025<br>(1 of 2) | | |
|---|---|---|---|
| **Reporting Non-Executive Director: Chris Welsh (Chair)** | | | |
| **Agenda Item** | **Description and summary discussion**<br><br>**The committee:** | **Decision / Actions and timeframe** | **Assurance level *** |
| Subgroup reports | 1. Received upward reports from the Nursing Midwifery & AHP Committee, Health and Safety Committee, Risk Management Committee and Patient Safety Committee.<br>2. Noted items of limited assurance from these groups and the actions being taken in relation to these.<br>3. Noted that the Health and Safety Committee had received annual reports for KGH and NGH Health and Safety, KGH Medical Devices, NGH Clinical Engineering and KGH and NGH Fire reports.<br>4. Was assured that issues relating to fetal scanning were being addressed. | - | Reasonable |
| UHN Perinatal scorecard highlight report | 1. Noted the perinatal quality surveillance metrics and plans to continue improvement across the service.<br>2. Noted the progress made with the NGH medical rota.<br>3. Welcomed the redesignation of KGH's neonatal unit to Level 2. | - | Reasonable |
| UHN Perinatal Assurance Committee highlight report | Received an update and confirmed reasonable assurance from the Perinatal Assurance Committee which had reviewed the perinatal surveillance framework, progress against perinatal key indicators and areas requiring intervention within the perinatal services. | On agenda | Reasonable |
| NGH Paediatric Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) service update | 1. Received an update on the measures being implemented to address issues with the ASD/ADHD assessment services for Northamptonshire children.<br>2. Confirmed reasonable assurance regarding the short-term actions being taken, with the allocation of additional funding. | | Reasonable |
| | Due to the significant gap between service demand and capacity, the committee can only provide limited assurance on the longer term at this time. A coordinated, system-wide approach is required to develop sustainable solutions for the medium and long term. | | Limited |

| UHN Quality and Safety Committee in Common<br>Upward Report to Board of Directors | Date of reporting group's meeting: 28th May 2025<br>(2 of 2) |
|---|---|

**Reporting Non-Executive Director: Chris Welsh (Chair)**

| Agenda Item | Description and summary discussion<br><br>**The committee:** | Decision / Actions and timeframe | Assurance level * |
|---|---|---|---|
| UHN Joint Annual Review: Safeguarding Section 42 Investigations | Received substantial assurance regarding adult safeguarding activity and arrangements in relation to Section 42 investigations relating to the Trust. | - | Substantial |
| Urgent and Emergency Care Standards | Received reasonable assurance on the quality and safety aspects of urgent and emergency care standards, noting improvements in ambulance handover, a reduction in the use of temporary escalation spaces at both sites and significant improvements in the emergency department waiting area at NGH. | - | Reasonable |
| UHN Patient Experience Group Q4 report (complaints, PALS and Patient Experience) | 1. Received reasonable assurance from the report detailing complaints and PALS activity at KGH and NGH.<br>2. Noted proactive efforts of the Patient Experience and Engagement teams in gathering feedback from patients and carers and in driving improvements through the 'You said, we did' model.<br>3. Noted the key themes emerging across patient experience, complaints and PALS and acknowledged the importance of ongoing monitoring and responsiveness to patient feedback. | - | Reasonable |
| UHN Mortality and Morbidity Quarterly report | Received reasonable assurance from the quarterly mortality and morbidity report and acknowledged the extensive work underway to align processes. | - | Reasonable |
| Quarterly Quality Impact Assessment Update | 1. Received substantial assurance from the report which provided oversight of the quality impact assessment process of efficiency schemes.<br>2. Was assured that decisions being taken on efficiency schemes are assessed for their impact on quality. | - | Substantial |
| External inspection and assurance | 1. Was informed of the temporary suspension of UKAS (United Kingdom Accreditation Service) accreditation for histopathology and cellular pathology services following an inspection of NGH pathology services.<br>2. Noted that an action plan is being developed to address the recommendations and support the reinstatement of accreditation. | - | n/a |

| UHN Quality and Safety Committee in Common<br>Upward Report to Board of Directors | Date of reporting group's meeting: 20 June 2025<br>(2 of 2) | | |
|---|---|---|---|
| **Reporting Non-Executive Director: Chris Welsh (Chair)** | | | |
| **Agenda Item** | **Description and summary discussion**<br><br>**The committee:** | **Decision / Actions and timeframe** | **Assurance level *** |
| Quality Report/Account 2024-25 | The Committee approved the combined UHN Quality Report/Account for 2024-25 | Approved | N/a |

| UHN Operational Performance Committee<br>Upward Report to Board of Directors | Date of reporting group's meeting: 29th May 2025 | | |
|---|---|---|---|
| **Reporting Non-Executive Director: Trevor Shipman (Chair)** | | | |
| **Agenda Item** | **Description and summary discussion**<br><br>**The committee:** | **Decision / Actions and timeframe** | **Assurance level *** |
| Subgroup upward reports | 1. Received the Digital Department's upward report which provided highlights from the Operation and Service Delivery Board, Transformation Delivery Board and Data Security and Cyber Security, Clinical Safety and Risk Group.<br>2. Noted an update on preparations for the go-live of the new Electronic Patient Record (EPR) system and received assurance that the required training targets would be reached in time for go-live.<br>3. Will receive an update on cyber security in the autumn. | Cyber security report on Boards' agenda | Reasonable |
| Integrated Performance Report (IPR) | 1. Received a verbal update and had a detailed discussion about the IPR production process and the issues associated with this which had meant the IPR was unavailable for the committee's meeting.<br>2. Although the committee could only confirm its limited assurance as the IPR was unavailable for the meeting, the committee acknowledges the huge amount of work that has been undertaken to progress the IPR. | - | Limited |
| Operational performance | Acknowledged that achieving the national target of eliminating 65-week waiters by the end of June is not feasible. Contributing factors were discussed, including capacity constraints and operational challenges. However, early benefits of the new UHN operational structure are beginning to emerge. Additionally, an agreement has been reached to resume the transfer of patients to the independent sector following a previous pause, which is expected to support further progress. | - | n/a |
| 2025/26 Strategic Priorities and Deliverables | Approved the deliverables that have been allocated to the committee for oversight. | - | Reasonable |
| Federated Data Platform update | Received an update on the progress of the UHN Federated Data Platform programme, noting the organisation is an incubator site for the FDP programme with three of the available national products implemented and a fourth scheduled for go-live in June. | - | Reasonable |
| Clinical and operational productivity | Received an update on the productivity improvement programme for 2025/26 aimed at enhancing productivity across planned and urgent and emergency care. | - | Reasonable |

| KGH/NGH Audit Committees (meeting together)<br>Upward Report to Boards of Directors | Date of reporting group's meeting: 25 June 2025 | | |
|---|---|---|---|
| **Reporting Chair: Alice Cooper** | | | |
| **Agenda Item** | **Description and summary discussion** | **Decision / Actions and timeframe** | **Assurance level *** |
| Year-end reports | The Committee will consider the External Auditor's Reports, Audit Findings Reports, Letters of Representation, Annual Reports and Accounts at its 25 June 2025 meeting. Its recommendations will be reported to the Boards. | For Boards' awareness and approval before submission to NHS England by 30 June 2025 | N/a |
| Internal Audit Progress Report | To follow 25 June 2025 meeting | - | Tbc |
| Anti-Crime Annual Report | To follow 25 June 2025 meeting | - | Tbc |
| Board Assurance Framework | To follow 25 June 2025 meeting | - | Tbc |
| Financial Governance Reports | To follow 25 June 2025 meeting | - | Tbc |
| NHS England follow up review of group governance | To follow 25 June 2025 meeting | On agenda | Tbc |

| Informal Committee workshops: June 2025 | Quality and Safety Committee: 20 June 2025<br>Finance and Investment Committee: 24 June 2025<br>Operational Performance Committee: 24 June 2025<br>People Committee: 26 June 2025 | | |
|---|---|---|---|
| **Agenda Item** | **Description and summary discussion** | **Decision / Actions and timeframe** | **Assurance level *** |
| - | The Committees will hold informal workshops to review governance arrangements. Chairs will be invited to provide brief feedback on key themes emerging from these meetings; formal recommendations in respect of the Committees' Terms of Reference will follow to the August 2025 meeting | 1 August 2025 Boards | - |

*The Committee will indicate the level of assurance it is able to provide to the Boards of Directors using the following definitions:

| | |
|---|---|
| Substantial Assurance | There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback) |
| Reasonable Assurance | There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance. |
| Limited Assurance | There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed |
| No Assurance | Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing |

# Cover sheet

| | |
|---|---|
| Meeting | Boards of Directors of Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) (Part I) Meeting together in Public |
| Date | 27 June 2025 |
| Agenda item | 7 |

| | |
|---|---|
| Title | NGH CQC inspection of Urgent and Emergency Care (UEC) section 29a Warning Notice Action Plan delivery |
| Presenter | Julie Hogg, Group Chief Nurse |
| Authors | Jo Smith - Director of Nursing<br>Simon Nicholson – Deputy Chief Operating Officer for Unplanned care |

| This paper is for | | | |
|---|---|---|---|
| ☐ Decision | ☐Discussion | ☐Note | √ Assurance |
| To formally receive and discuss a report and approve its recommendations OR a particular course of action. | To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it | For the intelligence of the Board without the in-depth discussion as above | To reassure the Board that controls and assurances are in place |

| Reason for consideration | Previous consideration |
|---|---|
| To inform the Boards Directors of the updated position of the CQC action plan following the receipt of the section 29a Warning notice for Urgent and Emergency Care. | Weekly UEC Oversight Meeting chaired by Medical Director<br>UEC Steering Group<br>ICB Quality Committee<br>Boards of Directors April and May 2025 |

## Executive Summary

On 18 February 2025, the CQC conducted an unannounced two-day inspection of Northampton General Hospital as part of a national review of pressurised services. The visit occurred during a particularly challenging period marked by high demand, delays in patient flow and ambulance handovers, and the use of Temporary Escalation Spaces. While the inspectors recognised the compassion and teamwork of staff, especially in the Emergency Department, they also raised concerns regarding aspects of urgent and emergency care and hospital-wide flow. Consequently, the Trust received a Section 29A

Warning Notice on 21 March and responded with a 100-point action plan to address the issues.

This paper describes the work undertaken to date with partners to address the concerns raised and demonstrates the improvements made. We await the final report and continue to update the CQC on our progress.

The Boards of Directors are asked to:

1. Indicate assurance regarding the actions taken and the improvements made following the inspection, and
2. Note that the full report is yet to be received by NGH.

## Appendices

Appendix 1 Summary dashboard of action plan

## Risk and assurance

UHN02 - Failure to deliver the UHN Clinical Strategy and clinical collaboration may. result in some areas of clinical and financial unsustainability.
UHN03 - Deterioration in patient outcomes and experience as a result of unwarranted variation in the provision of patient care
UHN04 - Failure of the Integrated Care Board (ICB) to deliver transformed care will. result in an impact on the quality of service provided across the Group.

## Financial impact

No direct implications arising from this report and recommendations.

## Legal implications/regulatory requirements

The Care Quality Commission (CQC) regulates all health and social care services. in England.

## Equality Impact Assessment

The implementation of improvement plan actions will give rise to positive impacts. for patients with protected equality characteristics, particularly relating to age and disability

# Paper

## Situation

On 18th February 2025 the Care Quality Commission (CQC) conducted a two-day unannounced inspection at Northampton General Hospital to assess the quality of care provided across our Urgent and Emergency (UEC) and medical services (including older people's services). The inspection formed part of its national review of pressurised services across England.

Despite these challenges, the CQC inspectors noted the compassion and dedication of our staff, particularly those working in the Emergency Department. They recognised the caring approach taken by our teams and the strong collaboration between inpatient services. However, the inspection team also raised concerns regarding elements of care. within the urgent and emergency care pathway and the ongoing challenges with patient flow across the hospital.

As a result, the Trust received a Section 29A Warning Notice from the CQC on 21st March 2025. This paper describes the work undertaken to date with partners to address the concerns raised and demonstrates the improvements made.

We remain proud of the dedication shown by our teams, and we are committed to. learning, improving, and ensuring every patient receives safe, high-quality care.

## Background

Northampton General Hospital Urgent & Emergency Services were last inspected. by the CQC in October 2019 and received a rating of Good. Medical services (including older people's services) were last inspected in October 2019 and received a rating of Requires Improvement.

Overall, the current overall rating for the Trust is Requires Improvement.

## Assessment

The section 29a warning notice focused on 3 areas of concern which required feedback to the CQC by a preset timeframe for.

1. Reducing Potential of harm to patients in the emergency department.
2. Improving Hospital flow.
3. Improving Privacy and dignity of patients.

In response to this we formulated an extensive 100-point action plan that encompassed the three key areas requiring improvement. This plan has been shared with the CQC, NICB and regional colleagues. Oversight is provided at the biweekly UEC CQC oversight group to ensure effective progression of improvement. It has also been shared and in part co-created by external experts from the regional team and the getting it right first-time support team.

We have made good progress with the completion of our agreed actions and the present position is as follows:

- 88 % green rated (completed with clear evidence to meet the action)
- 11% amber rated (in progress and on track to meet the action by planned date)

- 1% red rated (off track to meet the action by the planned date).

The red rated action is implementation of the Trusted Assessor model; this is not within our own sphere of influence and is reliant on external agencies to provide a deliverable solution. The inability to progress this action has been escalated internally and externally. The UHN Medical Director requested an urgent action for the NICB to provide a finalised plan as a matter of urgency at the most recent UEC CQC Oversight group. We are hopeful that this action will soon be on track.

See appendix 1 for a dashboard summary of the action plan.

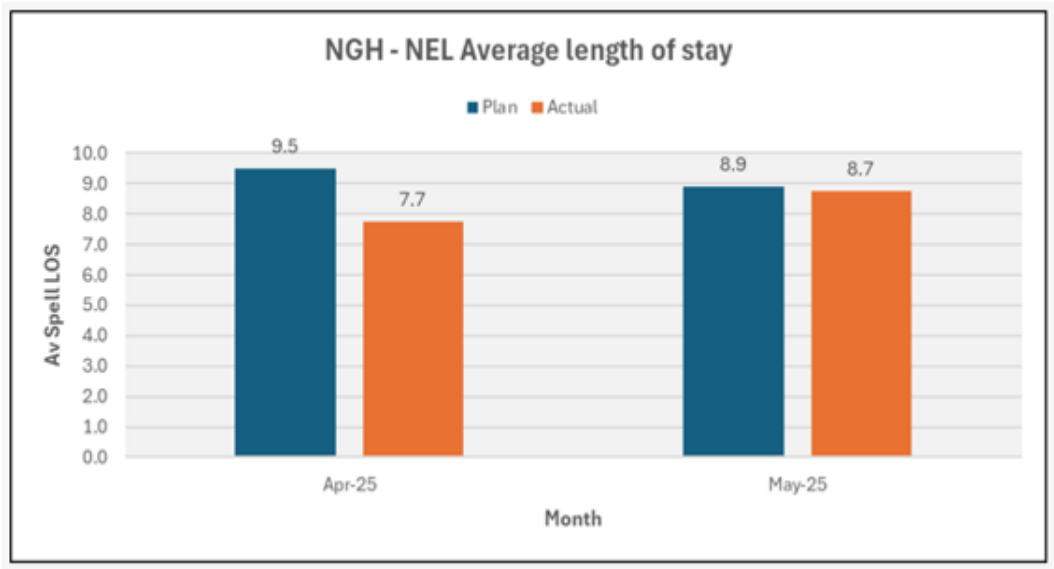
Key improvements delivered to date in the Emergency Department (ED) are as follows:

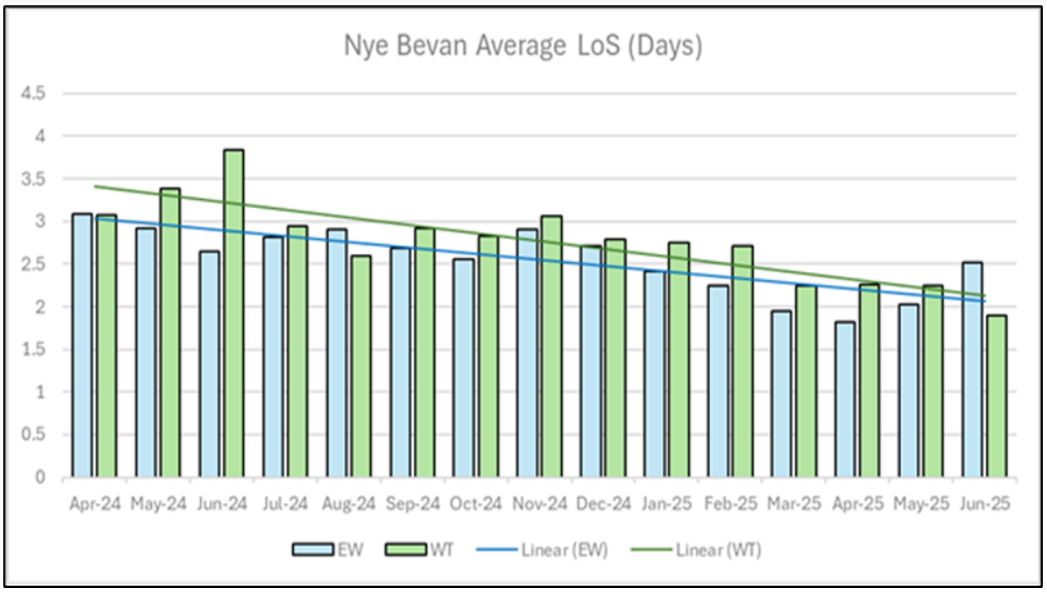
- Initial assessment process changes in ED with ambulatory patients being seen in the new assessment hub and those arriving by ambulance now receiving a face-to-face handover in ED.
- Chair based model adaptions resulting in a different model of care being provided in ED (fit to sit) and Temporary escalation spaces being closed in the corridors.
- Continued care focusing on Pressure ulcer prevention and management leading to a peer review process led by our specialist Tissue viability team and a weekly ED pressure ulcer validation meeting. Review of pressure relieving strategies and operationalisation of the Purpose T risk assessment tool in ED.
- Increased safety oversight by senior nursing teams and 2 hourly safety huddles with the Nurse in charge, Clinician in charge and the operational team.
- Strategy for sustaining improvements by formulating improved communication strategies and opportunities for the teams to escalate concerns and ideas for improvements. Medical and Nursing audit schedules formulated with identified clinical leads.
- Peer review processes across UHN and UHL formulated with the first peer visits completed in June. Formulation of ED development group across UHN looking into harm reviews and learning from patient delays in ED.
- Promotion of privacy and dignity by closing temporary escalation spaces in resus and COA corridor.
- Closure of the ambulance pod immediately after the CQC visit with the area now being redesigned and extended.
- Fundamentals of care programme is being finalised for implementation which will focus on the core components of patient care e.g. continence care, pain management, privacy and dignity, nutrition and hydration. This programme will be lead and embedded by the band 7 Nursing team who are on duty 24 hours a day.
- Leadership programme commencing focusing on improving quality and confidence of our future leaders in the UEC programme.
- Formation of a Regional Emergency Medicine committee across UHN and UHL, focusing on long stay reviews and associated care delivery.
- Supporting external peer review visits across the region focusing on the UEC pathways. Also promoting and facilitating, positive engagement with external reviews and clinical experts for UEC.
- Formation of a safe forum for staff to have a voice and escalate concerns about patient care delivery.

Key improvements delivered to date to improve flow through the organisation are as follows:

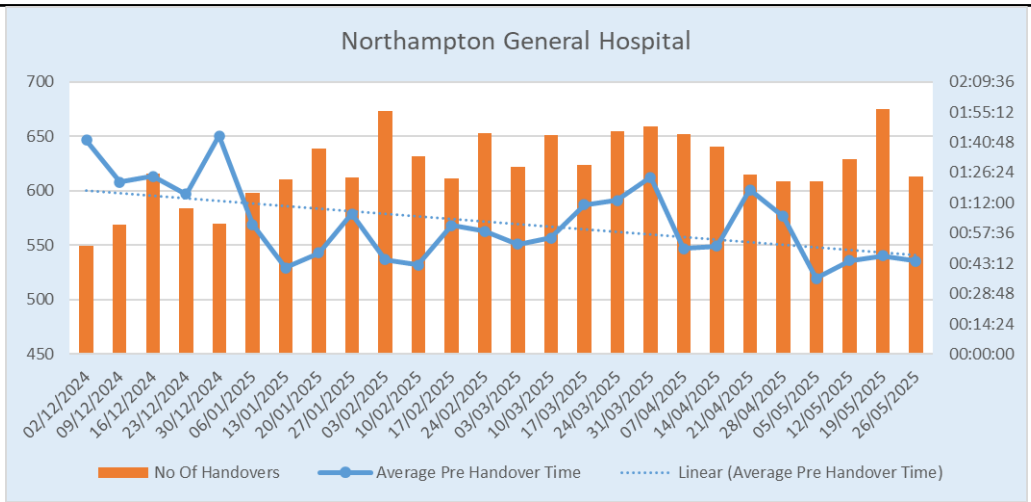
- Admitted patient flow focused work on the assessment areas ensuring that the clinical area is being used effectively. The Acute Medical Nye Bevan Ward have

implemented several key changes resulting in a reduction in Length of stay – May 2025 Esther White Ward now at 2 days compared to 2.92 in May 2024 and Walter Tull Ward 2.25 in May 2025 compared to 3.38 in May 2024. See bar charts below of improved Length of stays.

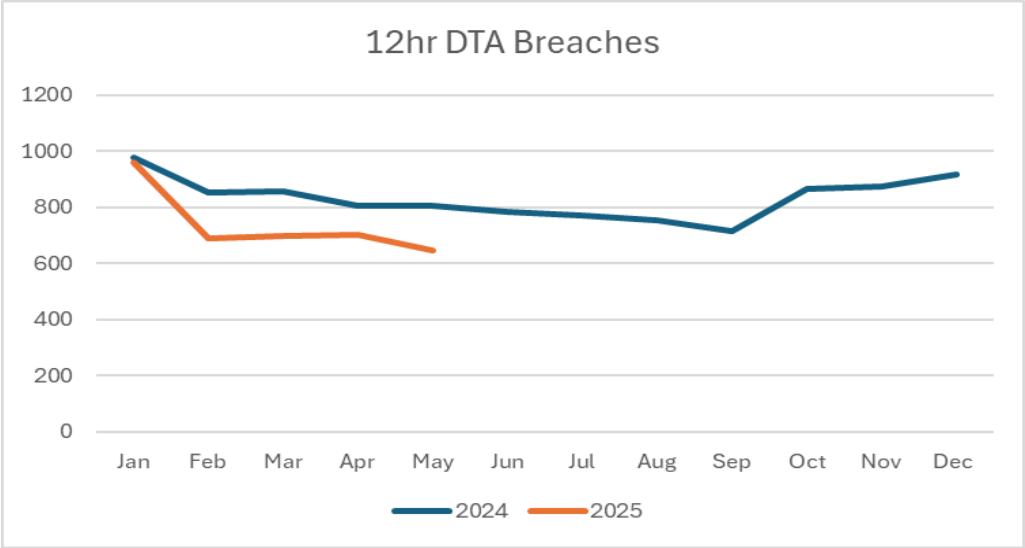



- Expansion of Same Day Emergency Care (SDEC) hours has continued post winter to provide admission avoidance and reduce overcrowding within the Emergency Department opening, with capacity 8am till 2am
- Release to respond initiative to improve category 2 ambulance responses was initiated in the Trust to ensure we are compliant with 45-minute handover times for ambulance offloads. See bar chart below of improved handover times.




- The total number patients waiting over 12hrs in ED is also showing signs of improvement with NGH being recognised as amongst one of the most improved organisations by NHSE, 2% improvement across 24/25 compared to 23/24.
- There has been a reduction in 12hr Discharge to assess breaches in ED since January 2025. May 2025 demonstrates a 20% improvement in the number of 12hr breaches compared to May 2024. It is also important to note as of 12th May patients in Clinical Observation Area (COA) particularly those patients awaiting Mental Health placement are also now continuing to be recorded on the clock and will impact the May 2025 onwards position, however, this improves oversight and escalation of these complex patients across the system of any delays. See graph below.




- Complex Discharge Work continues with partners to reduce the number of Medically Fit for Discharge patients. As of 28th April, a standardised Transfer of Care (TOC) form has been in place across UHN improving quality of referrals across NGH and KGH. Twice daily discharge hubs have also now been in place from 28th April to minimise delays for supported discharge alongside daily escalation and grip of any internal TOC delays across the 7day service to ensure delays at minimised.
- Base Ward improvements with a new UHN SOP implementation and focused board round work supported by NHSEI. Base ward length of stay has focused on board round structure to improve MDT decision making, robust discharge planning

and early decision making to expedite earlier patient flow. 4 wards were identified with increased length of stay as a focused test for change with senior support.

- A Trust wide Board round Standard Operating Procedure developed and in place since April, supported by Clinical and Divisional Directors to support working towards standardisation of board round structure and clinical decision making.
- In response to the requirement to improve Category 2 ambulance response through releasing crews by reducing ambulance handover delays, triggers have been agreed to support rapid flow of patients from the ED into Acute assessment areas and base ward areas. At the trigger of FitStop being at capacity patients are risk assessed and move into Assessment area Temporary escalation spaces with associated flow into Base Wards against definite and potential discharges. Implemented since 6th May demonstrates a step change in handover performance from around 60 minutes average to delivery against the 45-minute average handover standard. During the week commencing 26th May, average handover time for Northamptonshire was 36 minutes, the fourth consecutive week delivering inside the operating plan for Q1.

We remain fully committed to working in partnership with system partners and the CQC to deliver a high-quality, patient-centred urgent care pathway. Our leadership team is driving this agenda with urgency and transparency to ensure that all patients receive the standard of care they deserve. There has been significant initial improvement in the care delivery in our UEC and across the Trust, and we are committed to sustain and continue to develop these services.

We await the final report and continue to update the CQC on our progress.

## Recommendations

The Boards of Directors are asked to:

3. Indicate assurance regarding the actions taken and the improvements made following the inspection, and
4. Note that the full report is yet to be received by NGH.

**Appendix 1. Summary dashboard of action plan.**

# Summary dashboard of action plan.

NHS University Hospitals of Northamptonshire NHS Group

| Theme / Workstream | Description | B | G | A | R | NS | Total | Completion Rate |
|---|---|---|---|---|---|---|---|---|
| **Theme** | **Safety - Potential of harm to patients in ED** | **0** | **56** | **5** | **1** | **0** | **62** | 0% |
| Workstreams | Pressure Ulcers | 0 | 13 | 2 | 0 | 0 | 15 | 0% |
| | Initial Assessment on arrival to ED | 0 | 6 | 1 | 0 | 0 | 7 | 0% |
| | ED clinical space utilisation | 0 | 20 | 1 | 0 | 0 | 21 | 0% |
| | Culture | 0 | 13 | 0 | 0 | 0 | 13 | 0% |
| | Governance Processes | 0 | 4 | 1 | 1 | 0 | 6 | 0% |
| **Theme** | **Flow** | **0** | **27** | **4** | **0** | **0** | **31** | **0%** |
| Workstreams | Daily rhythm & oversight | 0 | 11 | 0 | 0 | 0 | 11 | 0% |
| | Escalation | 0 | 3 | 2 | 0 | 0 | 5 | 0% |
| | Temporary Escalation Space (TES) outside ED Footprint | 0 | 2 | 0 | 0 | 0 | 2 | 0% |
| | On Call | 0 | 2 | 0 | 0 | 0 | 2 | 0% |
| | Engagement | 0 | 3 | 0 | 0 | 0 | 3 | 0% |
| | Digital Enablers | 0 | 0 | 2 | 0 | 0 | 2 | 0% |
| | ICB / Regional / National Support | 0 | 3 | 0 | 0 | 0 | 3 | 0% |
| | Length of Stay Improvement (Not due to be delivered in line with 12th June timeline) | 0 | 3 | 0 | 0 | 0 | 3 | 0% |
| **Theme** | **Privacy and Dignity (Theme)** | **0** | **5** | **2** | **0** | **0** | **7** | **0%** |
| Workstreams | Privacy and Dignity | 0 | 3 | 2 | 0 | 0 | 5 | 0% |
| | Respect | 0 | 2 | 0 | 0 | 0 | 2 | 0% |
| | **Overall Completion Rate (Count of Tasks by Status)** | **0** | **88** | **11** | **1** | **0** | **100** | |
| | **Overall Completion Rate (%Tasks by Status)** | **0%** | **88%** | **11%** | **1%** | **0%** | **100%** | |

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| Key | |
|---|---|
| | Success Criteria achieved and signed off |
| | Completes with clear evidence to meet the action |
| | In progress and on track to meet the action by the planned date |
| | Off track to meet the action by the planned date. |
| | Not yet commenced/due |

| Cover Sheet | |
|---|---|
| Meeting | Boards of Directors of Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) (Part II) Meeting together in Public |
| Date | Friday 27 June 2025 |
| Agenda item | 8 |

| | |
|---|---|
| Title | UHN Perinatal Scorecard Highlight Report (April and May 2025 Data) |
| Presenters | Julie Hogg - UHN Chief Nurse |
| Authors | Danni Burnett – Interim UHN Director of Midwifery |

| This paper is for | | | |
|---|---|---|---|
| ☐ Approval | ☐ Discussion | ☐ Note | **X Assurance** |
| To formally receive and discuss a report and approve its recommendations OR a particular course of action | To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it | For the intelligence of the Board without the in-depth discussion as above | **To reassure the Board that controls and assurances are in place** |

| Reason for Consideration | Previous consideration |
|---|---|
| To brief the Boards on the key discussions arising from the meeting of the UHN Perinatal Assurance Committee (PAC) on Wednesday 21 May 2025 (April data discussed) and O&G Governance Meetings on Friday 20 June 2025 (May data discussed).<br><br>The Boards of Directors are asked to receive and note the report and to indicate assurance that:<br>1. The identification investigation and learning from all maternity patient safety incidents is being managed effectively,<br>2. Maternity services are achieving good compliance against the national maternity key safety indicators, and<br>3. Ongoing scrutiny, oversight and assurance will be provided by the Perinatal Assurance Committee. | Obs & Gynae Governance Meetings<br><br>UHN Perinatal Assurance Committee |

## Executive Summary

The scorecards are produced in line with the Perinatal Quality Surveillance Model designed by NHS England to support sharing safety intelligence Board to Frontline / Frontline to Board. They include five areas of focus, and the minimum dataset as described within the Maternity Incentive Scheme (MIS):

1. Safety
2. Workforce
3. Training
4. Experience
5. Outcomes

The bi-monthly UHN Perinatal Assurance Committee (PAC) was held on 21 May 2025. PAC is attended by the Board Executive Safety Champion, the NED safety champion, and the perinatal services safety champions, with representation from Divisional teams and system / regional partners. The Heads of Midwifery presented the individual Perinatal Scorecards for NGH and KGH, acknowledging the intention to work towards one single scorecard across the group. May 2025 Data was presented at KGH O&G Governance Meeting and NGH Risk & Governance Meeting, both held on 20 June 2025.

**SUMMARY**

April and May 2025 saw areas of continued improvements across maternity and neonatal services. Despite intermittent staffing and operational pressures, there was consistent delivery of 1:1 care during labour across both sites. Through tactical management the episodes of red flags for delayed activity, specifically the induction of labour (IOL) pathway, were managed. It is acknowledged that more work is required to address delays and improve experience across this pathway. A group Quality Improvement for IOL has been established. Maple Ward at the KGH site is now open with post LSCS (Lower Segment Caesarean Section) activity on Labour ward significantly reduced, positive feedback and experiences reported by the staff.

Recruitment and retention remains strong. Midwifery recruitment is going well with a strong pipeline of new recruits from local universities. A recent business case to align KGH with the BirthRate Plus® recommendations has been approved and action is being to be taken to progress this through the recruitment channels. Whilst the felt vacancy at NGH is high there has been daily oversight of safe staffing levels with no concerns flagged. It is anticipated that there will be further improvement with 8wte midwives joining between March – May. At KGH recruitment continues to take place in neonates with registered nurses with current QIS (Qualified in Specialisms) compliance for the British Association of Perinatal Medicine at 74.7%. There are also improvements in Tier 3 medical workforce. There are minimal vacancies within neonates at NGH with recruitment retention and sickness all staying stable however further work is underway to understand QIS trajectories.

During April & May, there were two externally reported cases to the Maternity and Newborn Safety Investigation (MNSI) team. Both cases related to care at KGH (one intrapartum stillbirth and one cooled baby). Rapid Reviews have been conducted. Three MNSI reports have been completed with 3 Safety Recommendations relating to fetal monitoring and escalation. Learning identified as part of these investigations are informing service improvements. Currently there are five MNSI, one Patient Safety Incident Investigations (PSII), and two ongoing Serious Incidents (SI) in progress. Duty of Candour has taken place and investigations are underway, with no immediate safety concerns to flag. The number of complaints and concerns remains stable with information sharing, involvement, and communication featuring as the main think. The *Listen to Me* campaign has been launched at KGH and there is further work to develop video and digital solutions across both sites.

All clinical quality indicators and measures are being developed to work towards the group 'making data count' to drive improvements. Postpartum haemorrhage has been highlighted in the NGH scored as an indicator which appears to be on the increase. In recent months, NGH have been part of the OBSUK PPH study. This includes implementing a care bundle focusing on risk assessment and accurate reporting. It is believed that the rates have increased due to improved oversight and reporting. Close surveillance will continue with the aim for the impact of this care bundle to be reported on in future reports.

Positive progress is being made with fully embedding the Saving Babies Lives Care Bundle across both sites, with additional work to strengthen and support the in-reach tobacco dependency advisors / service.

In response to the implementation of the ten Safety Actions for Year 6 of the NHS Resolution Maternity Incentive Scheme (MIS) KGH achieved 6 and NGH 9. Whilst this is disappointing, the Division is confident that the areas for improvement are fully recognised with plans in place to work towards full compliance for Year 7. KGH has replicated the NGH approach to oversight and monitoring of the evidence and, as a group, there is full commitment to ensure safe, high-quality maternity care for all. Continuing to develop a strong relationship with the Northamptonshire Maternity and Neonatal Voices Partnership is going to be key to driving forward the improvements.

The ambition for Q2 is to work towards developing a group Perinatal Scorecard with the aim to align intelligence and insights across KGH and NGH. This will also include full development of CQIMs.

**Recommendations**

The Boards of Directors are asked to receive and note the report and to indicate assurance that:

1. The identification investigation and learning from all maternity patient safety incidents is being managed effectively,
2. Maternity services are achieving good compliance against the national maternity key safety indicators, and
3. Ongoing scrutiny, oversight and assurance will be provided by the Perinatal Assurance Committee.

| Appendices |
|---|
| Appendix 1: UHN Perinatal Scorecard (KGH – Apr 2025 Data)<br>Appendix 2: UHN Perinatal Scorecard (NGH – Apr 2025 Data)<br>Appendix 3: UHN Perinatal Scorecard (KGH – May 2025 Data)<br>Appendix 4: UHN Perinatal Scorecard (NGH – May 2025 Data) |
| Risk and assurance |
| Non delivery of National and Local recommendations and improvements in maternity care which compromises our Trust strategic objectives and may result in increased claims, poor patient outcomes/ experience and Trust reputation. |
| Financial Impact |
| Potential for increased/changes to workforce and equipment. Failure to achieve our CNST incentive reduction (>£200k). Possible support available through NHS England funding vis LMS work streams. |
| Legal implications/regulatory requirements |
| Risk to Board oversight of maternity services in line with the Perinatal Quality Surveillance Tool and the requirements of the Maternity Incentive Scheme |
| Equality Impact Assessment |
| This is applicable to all staff within Northamptonshire Local Maternity and Neonatal System (LMNS), and all women accessing care within the LMNS. |

NHS
University Hospitals of Northamptonshire
NHS Group

# KGH Perinatal Quality Assurance Scorecard

May 2025

Dedicated to excellence

April 2025 Dataset

# CONTENTS


Overall Summary


Workforce


Safety


Patient Experience


Staff Feedback


Training


Progress against MIS


Hot Topics

# 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.

# APRIL 2025 AT A GLANCE

## AVERAGES PER DAY

| BOOKINGS | BIRTHS |
|---|---|
| 11 | 11 |

## BABIES BORN

332

PREV. 12 MONTH AV. 250

## BIRTH LOCATION

| KGH | HOME |
|---|---|
| 227 | 5 |

## 3RD & 4TH DEGREE TEARS

0.4%

March - 1.8% ▼

## 3%

BLOOD LOSS >1,500MLS

March - 23.1% ▼

## 119 GIRLS

## 116 BOYS

PREV. 12 MONTH AVERAGE
122 GIRLS, 128 BOYS

## 0.9%

March 5.3% ▼

## FULL TERM BABIES ADMITTED TO NNU

## 116

CAESAREAN SECTIONS 35%

| | MARCH | PREV 12 MTH. AV. |
|---|---|---|
| ELECTIVE | 40 | 55 |
| EMERGENCY | 76 | 69 |

## INDUCTION OF LABOUR (IOL)

23.5% PREV. 12 MONTHS – 30.8%

## SETS OF TWINS

3

## SETS OF TRIPLETS

0

## ASSISTED BIRTHS

20

| VENTOUSE | FORCEPS |
|---|---|
| 4 | 16 |

PREV. 12 MONTH AV.

| VENTOUSE | FORCEPS |
|---|---|
| 12 | 11 |

## BREASTFEEDING INITIATION

76%

PREV. 12 MONTHS – 73.2 % ▲

# PERINATAL QUALITY SCORECARD SUMMARY

## Overview

In April, there were 332 babies born across the service which is an increase of over 100 when compared to March. Activity remained green throughout the month however there was a decrease in the number of times acuity was met and and increase in the number of red flags which are delayed ARMs. Despite the operational challenges there was no escalations to community April.

1:1 care during labour was maintained throughout April and continues to be an area of success for KGH.

In April we saw the opening of our new antenatal and postnatal ward 'Maple'. Feedback has been positive relating to the new environment.

The diagnostic work with MSSP is ongoing with a draft report expected in April '25.

The interim triage plans are in place and feedback from staff and women is positive overall. Challenges

## Quality & Safety

Total of 117 incidents reported in April which is an increase in numbers compared to 98 in March which equates to a 16% increase in total number of incidents.

One Patient Safety Incident Investigations (PSII) has been reported and 2 cases were referred to MNSI.

3 after action reviews (AARs) are to be arranged following review of cases at weekly round table.

1 draft MNSI report received and awaiting factual accuracy process.

There were 2 perinatal losses reported in April all have been reported as per Maternity Incentive Scheme Criteria.

### CQC Maternity Overall Ratings

| Maternity CQC rating (Last Inspected Feb 2019 & Oct 2023 Safe and well-led only) | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| | | | | | | |

## Training

The education team continue to work hard to deliver mandatory training requirements. Training compliance has started off well for year 7, focus needed for obstetric anaesthetic compliance. Actions in place to monitor compliance for Year 7.

## Experience

Positive feedback received around the launch of the listening to me campaign. Whilst there is still work to do, more women are reporting feeling heard. Women have reported good care across all aspects of the maternity service and have fed back work is needed to improve timely communication, particularly around delays with induction of labour.
There has been a reduction noted in April around staff attitude and behaviours. Ongoing quality improvement work continues, with plans in place to bring back partners staying overnight and align with NGH policy.

## Workforce

Positive work around midwifery recruitment and retention continues. Good pipeline in place with students from local universities. Business case in progress for uplift of midwifery establishment, likely to be in place in May/June '25. Speciality trainee feedback received for 2024 with some positive feedback, ranking KGH 15th in UK.
Recruitment continues to take place in neonates with registered nurses and improvements noted in tier 3 medical workforce. QIS training meets BAPM standard at 74.7%.

Overall summary

# WORKFORCE (MATERNITY)

### What is the data telling us?

- Awaiting outcome of Business case for additional 9.56WTE midwives
- Usage of bank staff has improved slightly and will further improve once move back into Rockingham Wing
- Use of bank will continue due to interim triage area and helpline while awaiting business case outcome
- Consistent weekly consultant hours on Labour ward to support patient safety
- Speciality trainee feedback received for 2024 with some positive feedback, ranking KGH 15th in UK

### What is going well?

- Retention remains stable
- Staff continue to be supported to work in their area of choice following feedback which has improved retention
- Vacancy rate continues to decrease along with felt vacancy rate
- Overall satisfaction of trainees has increased

### What do we need to focus on?

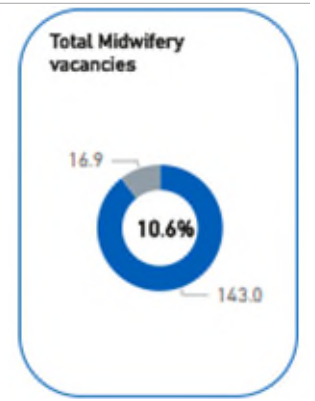
- Advertising for remaining vacancy
- Continue to support development opportunities and succession plan
- Reducing our Bank spend/usage

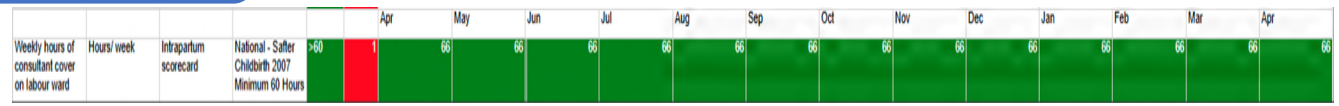
**Maternity Workforce Programme - Midwifery workforce**

| Midwifery headline figures | Establishment | Midwives SIP | Midwife Vacancy FTE | Vacancy rate |
|---|---|---|---|---|
| Registered Midwives in trust (WTE/KPI tab) | 164.9 | 148.0 | 16.9 | 10.3% |
| Midwives in maternity services (Maternity tab) | 159.9 | 143.0 | 16.9 | 10.6% |

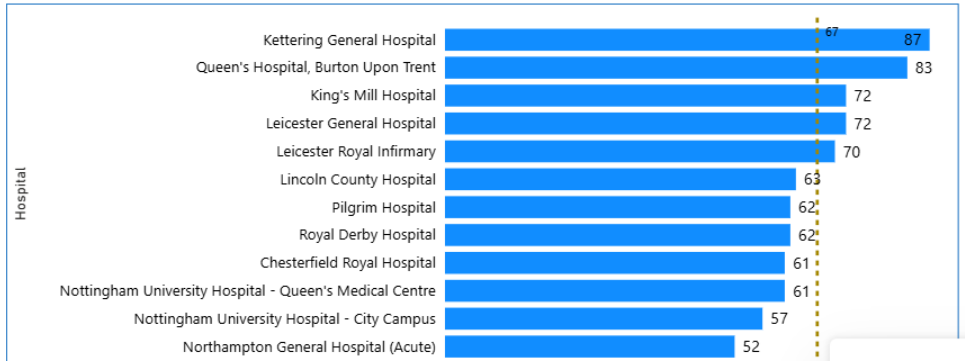
| Midwifery demand (BR+vs.funded establishment) | BR+ demand | Establishment gap | Vacancy gap |
|---|---|---|---|
| | 150.6 | 9.3 | -7.6 |

Remaining WTE Midwives recruited to —BR+ recommends uplift of 9.56WTE


| Post Specialty | Trust / Board | Indicator | 2019 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|
| Obstetrics and gynaecology | Kettering General Hospital NHS Foundation | Overall Satisfaction | 76.86 | 81.67 | 75.42 | 84.23 |
| Obstetrics and gynaecology | Kettering General Hospital NHS Foundation | Clinical Supervision | 92.14 | 87.64 | 89.09 | 90.48 |
| Obstetrics and gynaecology | Kettering General Hospital NHS Foundation | Clinical Supervision out of hours | 90.91 | 88.02 | 86.11 | 87.12 |




| 6.1.4 I have had appropriate supervision & support whilst on labour ward – outside of normal working hours | Row Labels | Chesterfield Ro | Kettering Ger |
|---|---|---|---|
| | 1. Strongly agree | 1 | 1 |
| | 2. Agree | 4 | 4 |
| | 3. Neither agree nor disagree | 1 | |
| | 4. Disagree | | |
| | 5. Strongly disagree | | |
| | (blank) | | |
| | Grand Total | 6 | 5 |

### Where do we want to be?

- **Reinstate 2nd continuity of care team / Improved staff satisfaction and engagement evidenced through the staff survey results / Increase In baseline establishment to ensure safe staffing of new triage department**

# WORKFORCE (NEONATOLOGY)

### What is the data telling us?

- Timely recruitment taking place into leadership roles
- Current nursing vacancy rate 9.5WTE, improvement since March 2025
- Significant improvement in Tier 3 medical workforce

### What is going well?

- Currently 74.7% QIS compliant, which is above the 70% BAPM compliance recommendation.
- Only 1WTE Neonatal Consultant gap to be BAPM compliant. Business case submitted for 7th Consultant.

### What do we need to focus on?

- Recruiting into Band 6 nursing vacancies – plan to go out to advert by the end of May 2025.
- Approval of business case for 7th Neonatal Consultant.

## Where do we want to be?

- Ensure staffing levels and QIS trained nurse levels for the unit remain compliant with BAPM standards.
- Recruit into nursing workforce gaps over the next 6 months.
- Approval of the business case for the 7th Neonatal Consultant to become BAPM compliant at Tier 3 level. Then monitor and maintain medical workforce levels.

## Nursing Workforce

| Position | Budgeted Establishment | In Post | Vacancy | Pipeline |
|---|---|---|---|---|
| Band 8a | 1.00 | 1.00 | 0.00 | |
| Band 7 | 5.08 | 5.10 | 0.30 | 0.30 WTE hours went out to advert, now closed and shortlisting taking place. |
| Band 6 | 19.78 | 13.21 | 6.57 | Jobs to be approved at Hospital Vacancy Panel on 13th May 2025 then out to advert. |
| Band 5 | 14.63 | 8.68 | 3.17 | 3 x Band 5s started beginning of April 2025. 1 x 0.17WTE started 21st April and 1 x 1WTE starting 14th May 2025. Resulting in vacancy gap of 2.17WTE ultimately. |
| Band 4 | 6.39 | 6.39 | 0.00 | 2 WTE Band 4s continuing on RN conversion course. 1 NA successfully completed course awaiting NMC pin. |
| Band 3 – NSW | 5.37 | 5.91 | -0.54 | 2 WTE on RN conversation course and 1 on NA conversion. |
| Band 3 - Admin | 1.00 | 1.00 | 0.00 | |
| **TOTAL** | 53.25 | 41.29 | 9.5 | |

## Medical Workforce

**Current position:**

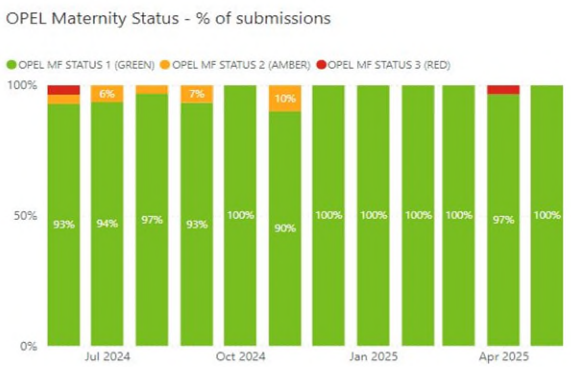
- Tier 1 Compliant – 14WTE in post. No vacancies.
- Tier 2 Compliant – 14WTE in post . No vacancies.
- Tier 3 Non-compliant – Separated rota from Paediatrics, currently 5WTE substantive Neonatal Consultants and 1 Locum Consultant. Business case submitted for 7th Consultant to be BAPM compliant.
- Compliant in having Neonatal Consultant designated lead as per BAPM.

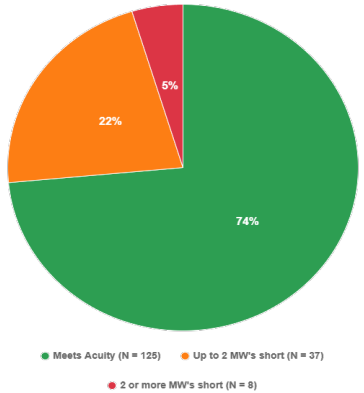
**Current Neonatal Consultant Recruitment Plan:**

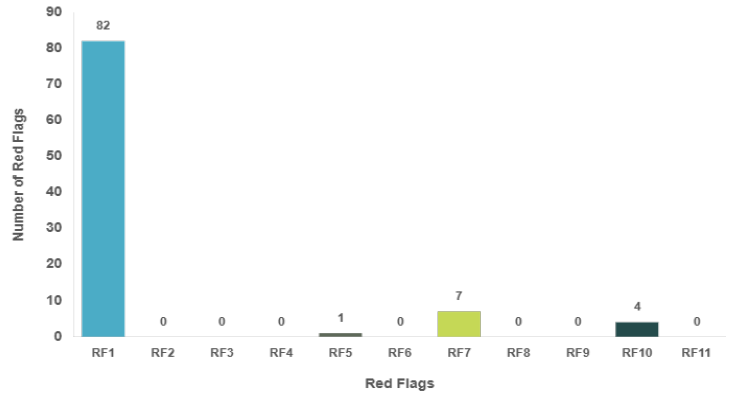
Post 1 - Substantive Consultant – recruited, commenced 7th April 2025.
Post 2 - Locum Consultant – recruited, started 28th April 2025.

We will continue long line bank staffing to support the rota gaps if required.

# OVERALL MATERNITY OPERATIONAL ACTIVITY




**Maternity Red Flags – LW**

Apr 25 - 94
Mar 25 - 34
Feb 25 - 69

Total Q4 24/25 - 203
Total Q3 24/25 - 324
Total Q2 24/25 - 335

| One to One care in labour 24/25 | October | November | December | January | February | March | April |
|---|---|---|---|---|---|---|---|
| % of women receiving 1:1 care in labour | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

| Supernumerary status of DSC - 24/25 | October | November | December | January | February | March | April |
|---|---|---|---|---|---|---|---|
| No of occasions DSC was NOT supernumerary | 1 | 8 | 3 | 6 | 2 | 0 | 4 |

## What is the data telling us?

- Slight deterioration of number of occasions met acuity in April when compared to March
- Increase in number of red flags for delays in ARM
- Delay in launching triage continuing to impact flow.

## What is going well?

- All women continue to receive 1:1 care in labour
- No escalation to community
- Maple now open, post LSCS activity on Labour ward significantly reduced.

## What do we need to focus on?

- IOL – QI project to be commenced – reviewing methods for IOL in line with NGH
- Consideration of co-location of FHU and Triage to limit obstetric staffing risk.

## Where do we want to be?

**Maintain safe staffing levels / Maintain 1:1 care / sustain improvement of supernumerary status of the Labour Ward Coordinator / Consistent reporting within the Birthrate plus acuity tool across the service / Reduce the number of delayed ARMs within the service**

# SAFETY INCIDENT REPORTING

| Perinatal Mortality Data | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Monthly perinatal losses | Total Number of Losses reported to MBRRACE | Number of losses reported to MBRRACE within 7 days | Perinatal Surveillance completed within 1 month | Number that meet PMRT criteria and 72hr review completed | Parents informed and questions/ concerns noted | PMRT completed by MDT team and comply with CNST submission requirements | Breakdown of perinatal losses | | | |
| | | | | | | | | | Late Fetal Loss >22/40 | Stillbirths | NND born and died at KGH | NND (born KGH, transferred and died at other Trust) |
| Q2 2025 | JUNE | | 2 | 2 | 2 | 2 | 2/100% | 0/100% | 0 | 2 | 0 | 0 |
| | MAY | | | | | | | | | | | |
| | APRIL | 2 | | | | | | | | | | |
| Q1 2025 | MARCH | 3 | 5 | 5 | 5 | 2 | 5/100% | 5/100% | 1 | 4 | 0 | 3 |
| | FEBRUARY | 3 | | | | | | | | | | |
| | JANUARY | 2 | | | | | | | | | | |
| Q4 2024 | DECEMBER | 1 | 2 | 2 | 2 | 2 (1 external) | 2/100% | 1/100% | 1 | 1 | 0 | 2 |
| | NOVEMBER | 3 | | | | | | | | | | |
| | OCTOBER | 0 | | | | | | | | | | |
| Q3 2024 | SEPTEMBER | 8 | 3 | 3 | 4 | 3 | 2/100% | 2/100% | 0 | 1 | 1 | 0 |
| | AUGUST | 5 | | | | | | | | | | |
| | JULY | 0 | | | | | | | | | | |

| April 2025 |
|---|
| 2 cases met MNSI criteria |
| 0 MNSI Safety Recommendations |
| 0 Non MNSI Serious Incidents |
| 0 Never Events |
| 1 Severe Incident |
| 1 Moderate Incidents |
| 3 After Action Review |
| 0 Coroner Reg 28 |

## What is the data telling us?

- 24 Clinical care and treatment – 8 delayed treatment or diagnosis 5 of which relate to delayed ARM all reported as no harm. 8 failure to follow policy no themes and trends identified within this area
- 19 Medication incidents 10 in relation to administration, 5 prescription errors, 2 storage 1 failure to follow policy and 1 in relation to time critical medication being delayed – y
- 14 Obstetric Incidents within is a lower number of incidents that usually reported within this category
- 13 Medical records incidents 10 in relation to missing or incorrect information within the medical records or medical records not completed.

## What is going well?

- Incident review meetings are now in place to review and close outstanding datix.
- Monthly medicine safety meeting established to look at themes and trends and review actions that are require to enhance medication safety across the speciality

## What do we need to focus on?

- Timely arrangements and completion of AAR's – these should be completed within 1 month of incident

| PSII |
|---|
| 2025/2349 – Management of babies with seizures and low blood sugars – Rediscussed at IRG in April and uplifted to PSII to be able to identify robust actions to prevent a reoccurrence of a similar incident |
| **MNSI's** |
| 2025/2348 – Term baby born in poor condition, transferred for cooling – MNSI have accepted investigation – declared as PSII –AAR to be undertaken to identify immediate actions to prevent reoccurrence<br>2025/2378 – Term still birth – MNSI investigation – early learning regarding completion and escalation of CTG |
| **AAR's** |
| 3 AAR's to be arranged<br>Terbutaline Medication Error<br>Cooling Baby<br>Neonatal Death |

## Where do we want to be?

**Reduction in number of cooled babies / timely review of incidents at Round Table / AAR's to be arranged promptly**

# MATERNITY AND NEONATAL EXPERIENCE

| Complaints & Concerns | Jan-25 | Feb-25 | Mar-25 | April-25 | 2024 |
|---|---|---|---|---|---|
| Maternity Complaints | 2 | 2 | 2 | 3 | 17 |
| Maternity Pals | 3 | 3 | 6 | 5 | 44 |

| Family & Friends Test (FFT) | UHN Target | National | Feb-25 | Mar-25 | Apr-25 | 2024-25 YTD |
|---|---|---|---|---|---|---|
| Maternity Friends & Family % of Responses | 20% | 13% | 168 | 82 FFT cards given to staff | 211 | 2191 collected |
| Maternity Friends & Family % of Promoters | 96% | 93% | | | | |

**Improvement Work following service user feedback**

- Listen to Me Campaign
- Consent training for all staff
- Bespoke work with Motherhood Group
  - Community listening event
  - Bespoke staff training pro-gramme
- Commence UHN IOL QI work
- Introduction of drug rounds
- Order placed for partner recliner chairs for new ward

"I felt cared for and listened to... it made all the difference"

Together, we can ensure a safe, responsive, and positive birth experience.

Ask a member of staff about the 'Listen to Me' campaign for more information.

**Listen to Me**

We want to hear your voice

## What is the data telling us?

Feedback throughout April includes:

- More timely updates for women
- Did not always feel listed to by Dr's during impatient admission, felt dismissed
- Lack of continuity in community setting
- Did not feel listened to by midwife
- A phoneline to ring when appointments need to be changed

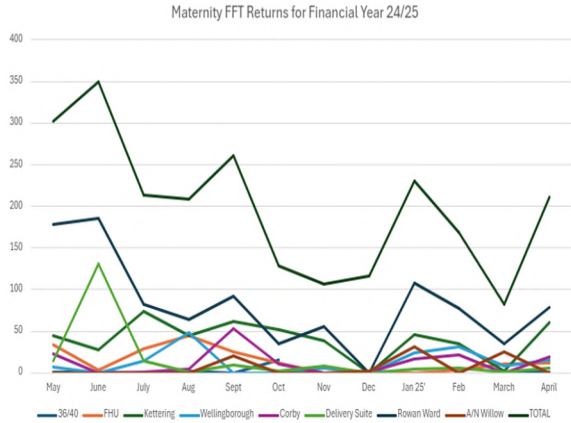
## What is going well?

- Women are reporting an improvement in feeling listened to.
- LTM relaunch April well received.
- Positive response to Motherhood group feedback session - actions to follow.
- Newly recruited MNVP NNU Champion recruited.
- Kind and caring staff thanked in all clinical areas.

## What do we need to focus on?

- Improving FFT collections
- Focus on CQC maternity survey 24/25 Action Plan:

1. Supporting partners to stay overnight.
2. Supporting with infant feeding especially nights & weekends.
3. Offering & evidencing choice of where to have your baby.
4. Offering & evidencing opportunity to ask questions about birth & labour.
5. Was your discharge delayed?




## Where do we want to be?

**Provide compassionate, caring and individualised care where women and birthing people feel supported and informed / Actions and improvements related to patient feedback and are acted upon promptly and sustained / Collaborative working to enable responsive service improvements .**

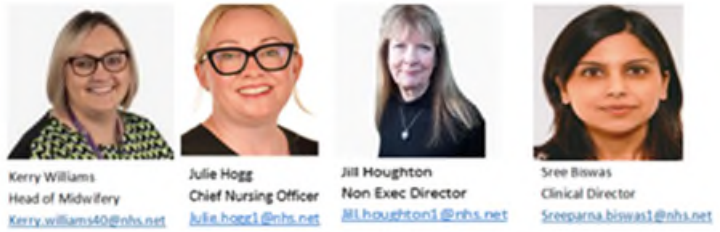
# MATERNITY AND NEONATAL FEEDBACK (STAFF)

## What is going well?

- More learning opportunities provided (LEO Course)
- Continuing Staff Forum
- Increased capacity on Labour Ward following opening of Maple Ward
- Positive feedback about Maple environment

## What do we need to focus on?

- Compassionate Leadership
- Listening to staff
- Team working
- Ongoing work with OD




| **Date of Walkaround :** 23rd April 2025 | **SC Name:** Jill Houghton |
|---|---|
| **Location:** KGH Maternity Rockingham Wing | **No. of Staff** : Midwives, MSWs, medics |

| Staff Feedback | Plan |
|---|---|
| Reorganisation of the caesarean section team | Inpatient matron to understand staff concerns and support with improvements |
| Fragile morale amongst workforce | Work ongoing with OD, dates to be circulated in May |
| Improved patient flow following Maple Ward move | Continue to observe adequate flow through department |
| Ongoing concerns from specific departments regarding change to hours of work | Matron to meet with team to discuss plans |

## Where do we want to be?

**Empathic, culturally sensitive, and compassionate workforce to the benefit of families and staff / Improved staff experience**

# WORKFORCE: TRAINING SUMMARY

### What is the data telling us?

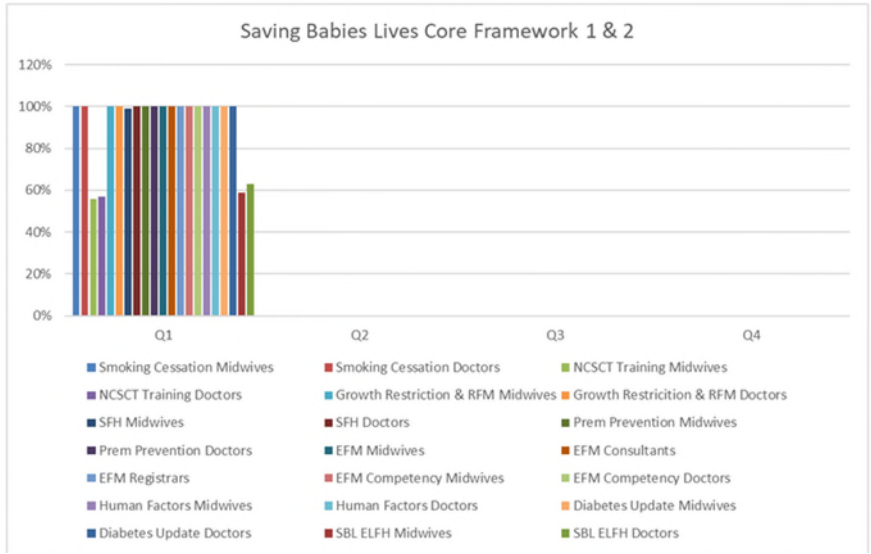
**May 2025**
**Framework Criteria 1&2**
**SBL - Smoking Cessation, SFH, RFM, GROW & PREM Prevention**
Midwives **99%**
Obs Doctors **97%**
**EFM Competency Assessment & Human Factors**
Midwives **100%**
Obs Doctors **97%**
**Framework Criteria 3**
Midwives **98%**
Obs Doctors **97%**
Anesthetists **100%**
**Framework Criteria 4**
Midwives **99%**
Obs Doctors **97%**
**Framework Criteria 5**
**Management of Labour & Perineal Trauma OASI**
Midwives **99%**
Obs Doctors **97%**
**Epidural, Critical Care, Enhanced Recovery**
Midwives **98%**
Obs Doctors **97%**
**Framework Criteria 6, 7 & 8**
Midwives **98%**
Obs Doctors **97%**

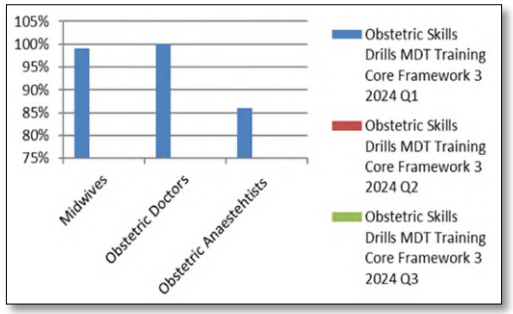
### What is going well?

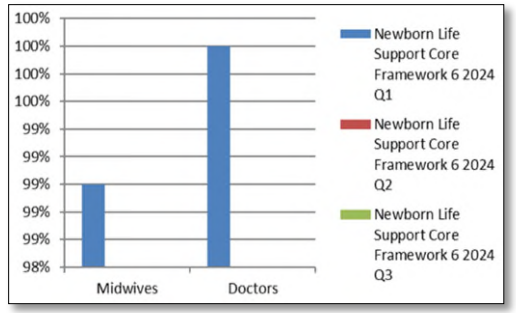
- Protected training continues monthly for staff
- Overall training compliance is above the targeted 95% in all areas
- Good engagement with MDT facilitators
- Good engagement from the MNVP in training to get patients perspectives
- Additional training as an MDT on PeriPrem & Motherhood group on enhanced cultural awareness and inclusivity
- Bereavement study day planned for May 2025

### What do we need to focus on?

- Achieving CNST element 8 this financial year
- Ensuring rotational Obstetric Doctors complete CPD training prior to November for CNST
- Ensuring Anesthetists remain compliant by November for CNST




## Where do we want to be?

**>95% compliant in mandatory training by the end of the year / Enhance staff knowledge, skills and confidence to provide safe evidence based and compassionate maternity care. / Create a culture of continuous learning**

# MATERNITY INCENTIVE SCHEME (MIS) PROGRESS

| MIS Safety Action | MIS Standards | Status |
|---|---|---|
| 1: Use of Perinatal Mortality Review Tool | 6 | 100% complete |
| 2: Submitting data to the Maternity Services Data Set | 2 | 100% complete |
| 3: Transitional Care and Avoiding Term Admissions to Neonatal Unit | 4 | not achieved |
| 4. Clinical workforce planning | 10 | not achieved |
| 5. Midwifery workforce planning | 6 | 100% complete |
| 6. Saving Babies Lives Care Bundle | 6 | 100% complete |
| 7. Listening to women, parents and families | 5 | not achieved |
| 8. Multidisciplinary training | 3 | not achieved |
| 9. Ward to Board assurance | 9 | 100% complete |
| 10. MNSI and Early Notification Scheme reporting | 9 | 100% complete |

***Year 6 Results by Exception***

Kettering General Hospital has declared compliance with six out of the ten safety actions. KGH will declare partial compliance for the following safety actions:

•**Safety Action 3:** The current provision of transitional care services at KGH do no meet the BAPM recommended standard. Action plan being developed. A requirement to have a QI project to be registered within six months of MIS year 6 was not met.

•**Safety Action 4:** Obstetric consultant attendance to labour audit was completed, but did not measure all the requirements as outlined in the RCOG guidance for the measure to give assurance of compliance.

•**Safety Action 7:** KGH is not able to demonstrate co-production of the CQC women's survey with service users.

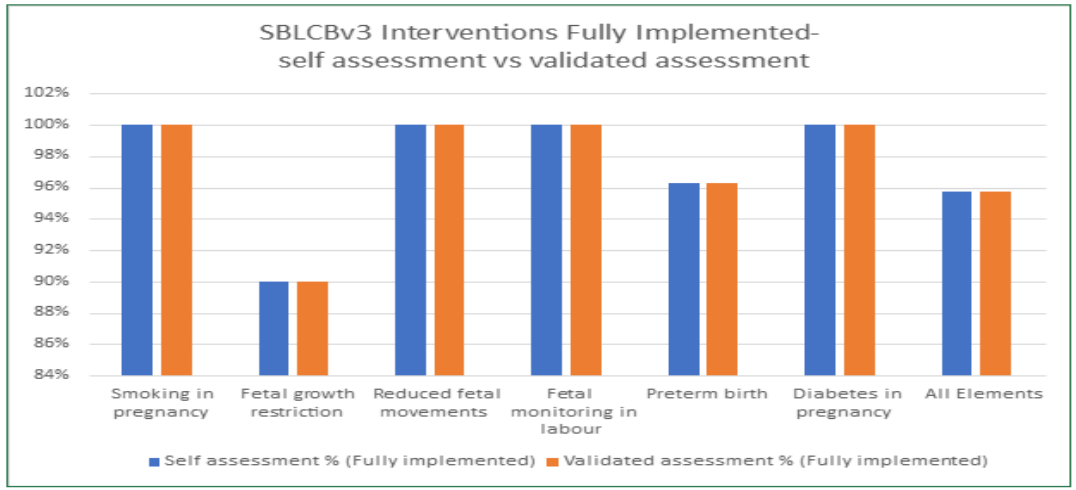
•**Safety Action 8:** Training compliance for obstetric and anaesthetic medical staff did not meet the 90% minimum standard during the reporting period.

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

# SAFETY: SAVING BABIES LIVES CARE BUNDLE v3

## Implementation Progress

| Intervention Elements | Description | Element Progress Status (Self assessment) | % of Interventions Fully Implemented (Self assessment) | Element Progress Status (LMNS Validated) | % of Interventions Fully Implemented (LMNS Validated) | NHS Resolution Maternity Incentive Scheme |
|---|---|---|---|---|---|---|
| Element 1 | Smoking in pregnancy | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 2 | Fetal growth restriction | Partially implemented | 90% | Partially implemented | 90% | CNST Met |
| Element 3 | Reduced fetal movements | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 4 | Fetal monitoring in labour | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 5 | Preterm birth | Partially implemented | 96% | Partially implemented | 96% | CNST Met |
| Element 6 | Diabetes | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| All Elements | TOTAL | Partially implemented | 96% | Partially implemented | 96% | CNST Met |




Summary

**As we have now been seen as a high performing organisation many of our compliance % has been increased.**

**Element 1**- Percentage of those engaged with the tobacco dependence treatment who set a quit date in March 2025 and achieved their 4 week quit: remains at 100% - this may be attributed to the new incentive scheme established by the MDTA team. However, the amount of women in April who were able to engage with the smoking cessation team has dropped by 40.9% due to the one remaining MDTA unable to contact all those referred. This is due to her full caseload. (MDTA team is down by the equivalent of 2 people). Kettering smoking cessation team has also had a pause imposed on the Incentive Scheme due to the lack of MDTAs as one MDTA cannot fulfil the contractual obligations to the women which would result in women not being paid for their successful progress in the scheme. The scheme **can** recommence if numbers in team **increase**. Failure to meet the service due to lack MTDA posts is being added to the risk register at the next Risk Meeting.

**Element 2**- 82% of FGR cases <3rd centile were detected antenatally. **100%** of fetuses with an EFW **<3rd centile** on ultrasound at 36 weeks were **delivered before 37+6** weeks gestation, 33% of SGA cases 3rd-10th centile were detected antenatally**77%** of fetuses with an EFW **3rd-10th centile** on ultrasound at 36 weeks were **delivered by 39+6** weeks gestation

**Element 3**- In April 2025, of the 125 births, IOL was offered before 39 weeks for 1 patient due to RFM and maternal anxiety; IOL was offered prior to 39 weeks to 0.4% due to reduced FMs alone. All other IOL's had an additional indication for IOL or were past 39 weeks when IOL was offered due to RFM alone.

**Element 4** – 30 sets of notes audited. Method of fetal monitoring – 24 CTG cases and 3 IIA cases. 3 cases of IIA which transferred to CTG in labour.
83% had a Start of Labour checklist to exclude Chronic hypoxia completed. This is a significant increase from last month. 87% had fresh eyes/ears sticker completed every hour. This is a significant increase from last month. 83% of fresh eyes stickers had a 2nd signature to evidence a peer review. This is an increase from last month.

**Element 5- Data not reported this month will be included in June 2025**

**Element 6-** We are still unable to see 100% of our women face to face due to the numbers and the lack of clinic capacity.

# HOT TOPIC –

## Move to Maple Ward



### Staff feedback prior to the move was sought

- Environment change to 1 ward
- All new bedside setup, recliner and overbed cots
- 29 beds total
- 8 AN, 20 PN and 1 side room
- Continue with allocating AN and PN area
- MWs to only care for 1 cohort
- Staffing model increased to include MW for LSCS as well as MIC (3 month trial)
- 6 MWs 3 MSW – Day
- 4 MWs 2 MSW + 1 Flex MW - Night

### Work to focus and continue

- MSW forum planned to identify how they would like their role to be structured
- Move of MSW lead to ward environment
- Recommence Shared Decision Council
- Continue with regular feedback meetings
- Liaise with NGH re partners charter for overnight stay
- TC Lead to support new TC bay and ways of working
- Staff QR feedback code
- Additional patient QR feedback – ward specific

NHS
University Hospitals of Northamptonshire
NHS Group

# NGH Perinatal Quality Assurance Scorecard

## May 2025

April 2025 Dataset

Dedicated to excellence

# CONTENTS


Overall Summary


Workforce


Safety


Patient Experience


Staff Feedback


Training


Progress against MIS


Hot Topics

# 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.

# APRIL 2025 AT A GLANCE

## AVERAGES PER DAY

| BOOKINGS | BIRTHS |
|---|---|
| 13 | 11 |

## BABIES BORN

336

PREV. 12 MONTH AV. 323

## BIRTH LOCATION

NGH (Labour Ward) 312

| BIRTH CENTRE | HOME |
|---|---|
| 10 | 5 |

## 3RD & 4TH DEGREE TEARS

1.9%

MARCH - 2.9% ▼

## 4.2%

BLOOD LOSS >1,500MLS

MARCH - 3.2% ▲

## 153 GIRLS / 181 BOYS

PREV. 12 MONTH AVERAGE
146 GIRLS, 170 BOYS

## 4.2%

MARCH 4.3% ▼

FULL TERM BABIES ADMITTED TO NNU

## 172 CAESAREAN SECTIONS 51%

| | APRIL | PREV 12 MTH. AV. |
|---|---|---|
| ELECTIVE | 78 (23.4%) | 73 (23.0%) |
| EMERGENCY | 94 (28.1%) | 102 (32.0%) |

## INDUCTION OF LABOUR (IOL)

23.4%

PREV. 12 MONTHS –25.8%

## SETS OF TWINS

1

## SETS OF TRIPLETS

0

## ASSISTED BIRTHS

28

| VENTOUSE | FORCEPS |
|---|---|
| 12 | 24 |

PREV. 12 MONTH AV.

| VENTOUSE | FORCEPS |
|---|---|
| 7 | 18 |

## BREASTFEEDING INITIATION

85.0%

PREV. 12 MONTHS –78.6% ▲

# APRIL 2025 AT A GLANCE

**96%**

MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

MARCH - 96%

YEAR 6 MATERNITY INCENTIVE SCHEME 9 SAFETY ACTIONS

**0**

MNSI REPORTABLE CASES & REFERRED

MARCH - 0

MATERNITY FRIENDS & FAMILY TEST (SATISFACTION %)

**97.9%**

MARCH 96.5% ▲

VACANCY RATE (MARCH DATA)

| | |
|---|---|
| MIDWIVES (FEB– 6.12% ▼) | 5.58% |
| CONSULTANT OBSTETRICIAN | 1.0 WTE |
| NEONATAL NURSES | 0.6% |
| NEONATOLOGISTS | 0 WTE |

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)

**90%**

MARCH – 96% ▼

**0** MODERATE INCIDENTS

MARCH - 1

MINIMUM SAFE STAFFING MET (LABOUR WARD ONLY)

**91%**

MARCH – 87%% ▲

**0** PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

MARCH – 0

**0** CORONER'S REGULATION 28

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

MARCH – 99.6% ▲

NHS

# PERINATAL QUALITY SCORECARD SUMMARY

## Overview

In April there were 336 babies born across the service, which was again higher than the monthly average. 51% of total births were caesarean sections.

There were 48 red flags – which was lower than the previous month. High acuity resulted in 39 occasions where there was a delay or cancellation of critical activity.

Staffing met acuity 91% of the time in April and there was a shortage of up to two midwives for 9% of the time.

## Quality & Safety

0 (zero) Patient Safety Incident Investigations (PSII) have been reported. There were 3 moderate harm of which two were downgraded to low or no harm. The other moderate harm is still being reviewed with support from IRG. Two AAR's were undertaken and the actions are complete.

## Training

- PROMPT overall compliance – 96%
- Newborn life support (NBLS/NLS) - 90%
- Fetal Monitoring overall compliance - 100%
- Community PROMPTS planned for April in community hubs
- Working on a robust data base to ensure all bank staff are up to date with training and compliance for oversight
- Attendance for Obstetric Drs still remains an issue for PROMPT and Specialities day. This continues to be escalated

**CQC Maternity Overall Ratings**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Maternity CQC (Last Inspected Nov 2022) | | | | | | |

## Outcomes

All CQiM Metrics remain within standard cause variation. The percentage of women who booking at 10 weeks continues to be above 75% for the last 6 months. Close surveillance continues for PPH and 3rd/4th degree tears, which are reviewed through MIRF. No trends or themes have been identified on review.

## Experience

in April we had 195 responses which is a response rate of 17% April's overall satisfaction was 97.9%. 'Birth' achieved 94.6% but only received 37 feedbacks, which was only 11% of the total births. Dissatisfaction was at 1.5%. There were two Maternity complaints and one for Neonates.

## Workforce

A sustained reduction on vacancies seen month on month with a steady recruitment pipeline for Midwives. The felt vacancy rate for March 2025 was 15.75% for Midwives and 17.75% for MSWs. 2 WTE band 5 Midwives commenced in post in March 2025, with 6.92 WTE plan to start in May 2025. Trajectory in place to illustrate progress in year 2025/2026.

Minimal vacancies within neonates with recruitment retention and sickness all staying stable.

# WORKFORCE (MATERNITY)

| | JAN 2024 | | FEB 2025 | | MAR 2025 | |
|---|---|---|---|---|---|---|
| | Midwife | MSW | Midwife | MSW | Midwife | MSW |
| Funded Establishment* | 202.07 WTE | | 202.07 WTE | | 202.07 WTE | |
| Funded Establishment | 195.35 WTE | 68.74 WTE | 195.35 WTE | 68.74 WTE | 196.35 WTE | 68.74 WTE |
| Vacancy WTE | 15.32 WTE | 1.45 WTE | 11.95 WTE | 3.28 WTE | 10.96 WTE | 4.65 WTE |
| Vacancy Rate | 7.84% | 2.11% | 6.12 % | 4.84% | 5.58% | 6.76% |
| LTS WTE | 8.3 WTE | 1.9 WTE | 3.93 WTE | 3.56 WTE | 8.20 WTE | 2.83 WTE |
| Maternity Leave WTE | 11.8 WTE | 3.6 WTE | 11.2 WTE | 3.6 WTE | 11.77 WTE | 2.61 WTE |
| **Felt Vacancy Rate** | **18.13%** | **10.11%** | **13.86%** | **15.19%** | **15.75%** | **17.75%** |

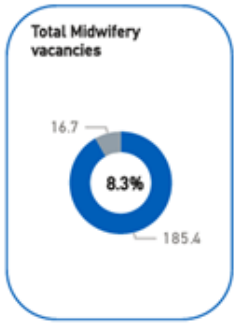
* Number includes 5.72 WTE Registered General Nurses

**January 2025 Data**

**Maternity Workforce Programme - Midwifery workforce**

| Midwifery headline figures | Establishment | Midwives SIP | Midwife Vacancy FTE | Vacancy rate |
|---|---|---|---|---|
| Registered Midwives in trust (WTE/KPI tab) | 202.1 | 185.4 | 16.7 | 8.3% |
| Midwives in maternity services (Maternity tab) | 202.1 | 185.4 | 16.7 | 8.3% |

| Midwifery demand (BR+vs.funded establishment) | BR+ demand | Establishment gap | Vacancy gap |
|---|---|---|---|
| | 197.4 | 4.6 | -12.0 |


## What is the data telling us?

- A sustained reduction on vacancies seen month on month with a steady recruitment pipeline for Midwives

## What is going well?

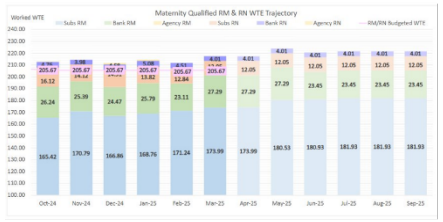
- 2 WTE band 5 Midwives commenced in post in March 2025
- 6.92 WTE plan to start in May 2025
- Trajectory in place to illustrate progress in year 2025/2026
- We have a total of 23 preceptorship Midwives in the Trust

## What do we need to focus on?

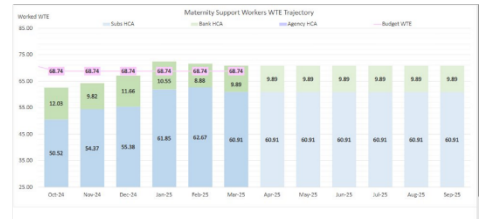
- 2 Midwives Resignations - relocation
- 1 MSW Resignation – studying as a student Midwife

## Workforce Trajectories

**Midwives**



**MSWs**



## Where do we want to be?

**Reviewing continuity of care pathway / Respond to staff survey results with meaningful output to improve satisfaction /**

**Sustain and continue to improve retention rates for the pipeline staff expected / Maintain low levels of Long and Short-term sickness absence**

# WORKFORCE (NEONATOLOGY)

| | JAN 2025 | | FEB 2025 | | MAR 2025 | |
|---|---|---|---|---|---|---|
| | Registered | HCA | Registered | HCA | Registered | HCA |
| Funded Establishment | 47.69 WTE | 8.32 WTE | 47.69 WTE | 8.32 WTE | 47.69 WTE | 8.32 WTE |
| Vacancy WTE | 0.22 WTE | 0.05 WTE | 0.53 WTE | 0.05 WTE | 0.53 WTE | 0.05 WTE |
| Vacancy Rate | 0.46% | 0.6% | 1.11 % | 0.6% | 1.11 % | 0.6% |
| LTS WTE | 2.0 WTE | 0.00 WTE | 2.0 WTE | 0.00 WTE | 2.0 WTE | 0.00 WTE |
| Maternity Leave WTE | 4.03 WTE | 0.00 WTE | 3.03 WTE | 0.00 WTE | 3.03 WTE | 0.00 WTE |
| Felt Vacancy Rate | 10.67% | 0.6 % | 11.65% | 0.6 % | 11.65% | 0.6 % |

| | Q1 WTE | Q2 WTE | Q3 WTE | Q4 WTE |
|---|---|---|---|---|
| New Starters | 0.61 | 0 | 3 | 1 |
| Leavers | 0 | 2.84 | 0 | 0 |
| Net Gain / Loss | 0.61 | -2.84 | 3 | 1 |
| Turnover | 0% | 5% | 0% | 0% |
| Maternity Leave (WTE) in quarter | 3.76 | 3.77 | 4.6 | 4.6 |
| Sickness days (WTE) in quarter | 6.29 | 6.65 | 4.59 | 2.16 |
| Bank Usage (WTE) in quarter | 3.4 | 5.4 | 4.3 | 7.3 |
| Agency Usage (WTE) in quarter | 0.00 | 0.00 | 0.00 | 0.0 |

## What is the data telling us?

- Minimal vacancies within neonates

## What is going well?

- Recruitment and retention stable
- Sickness is staying stable

## What do we need to focus on?

- Reducing bank usage as able

## NGH Neonatal Medical Staffing – As at 29 April 2025 (including Action Plan)

NHS University Hospitals of Northamptonshire NHS Group

- **Tier 1 (SHO)**
  - Fully BAPM compliant ✓ dedicated tier 1 doctor for neonatal service available 24/7, but many are GP trainees
  - One Nurse currently undertaking ANNP training in Southampton, to join tier 1 in 2025
- **Tier 2 (Registrar)**
  - As per local activity, BAPM standard = dedicated tier 2 doctor for neonatal service 24/7
  - Requires 15 WTE tier 2 rota
  - NGH Business Case secured in 2022 to uplift tier 2 staffing from 10 to 15 WTE
  - Challenges recruiting sufficient new tier 2 doctors in last 18 months: applicants ✓ but most abroad, VISA problems
  - Current Plan
    - 3 internal ANNPs promoted to tier 2 in May 2024 (their backfill on tier 1 rota has been recruited)
    - Further tier 2 interviews and appointments are in progress; rota may be replete by Spring 2025
    - In the interim, tier 2 is being supported by internal locum coverage and occasional external locum
    - The current approach affords the Neonatal Service a dedicated tier 2 doctor on almost all (but not every) shift
- **Tier 3 (Consultant)**
  - Fully BAPM compliant ✓ current establishment is 7 WTE = BAPM standard for LNU

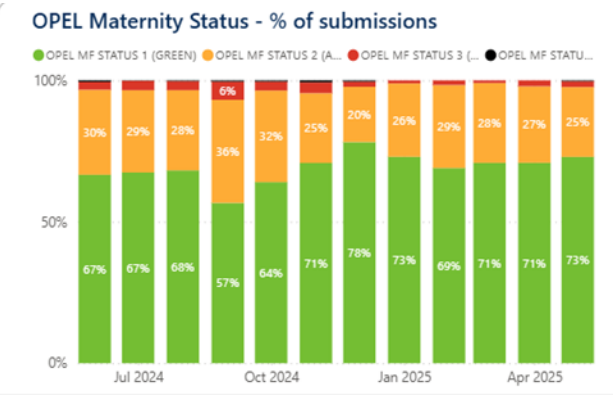
## Where do we want to be?

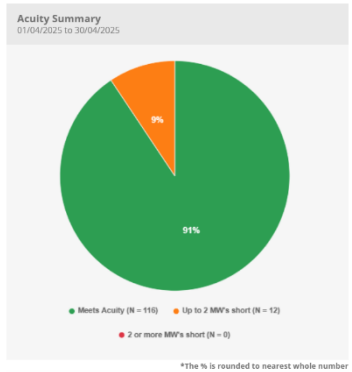
Staffing levels and QIS trained nurse levels for the unit to be compliant with BAPM standards /

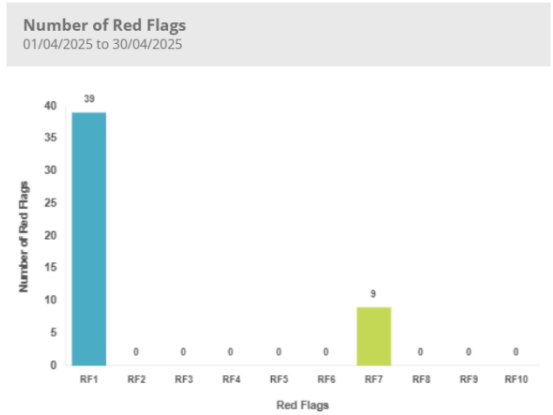
Recruit and train according to the trajectory plan for the nurses to achieve the compliance as required by BAPM

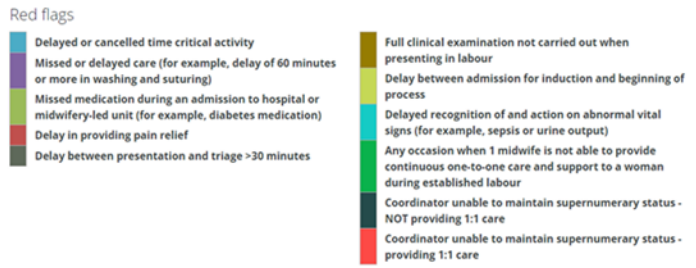
# OVERALL MATERNITY OPERATIONAL ACTIVITY

**Maternity Red Flags - LW**
February 2025– 59
March 2025 – 66
April 2025 - 48




| One-to-One Care in Labour | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 |
|---|---|---|---|---|
| % of women receiving 1:1 care in labour | 100% | 100% | 99.6% | 100% |

| Supernumerary Status of LWC | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 |
|---|---|---|---|---|
| No of occasions LWC was NOT Supernumerary | 0 | 0 | 0 | 0 |

## What is the data telling us?

- Reduction in Red Flags for April at 48
- High acuity has resulted in 39 occasions where there has been a delay or cancellation of critical activity. These relate to delays with transfers to Labour Ward to continue the process of induction of labour or timely completion of elective caesarean section
- Escalation process in place via Midwifery Manager on call in relation to mitigating these delays

## What do we need to focus on?

- The acuity app compliance rate for April sits at 71.11%, however the team are working towards a minimum of 85%

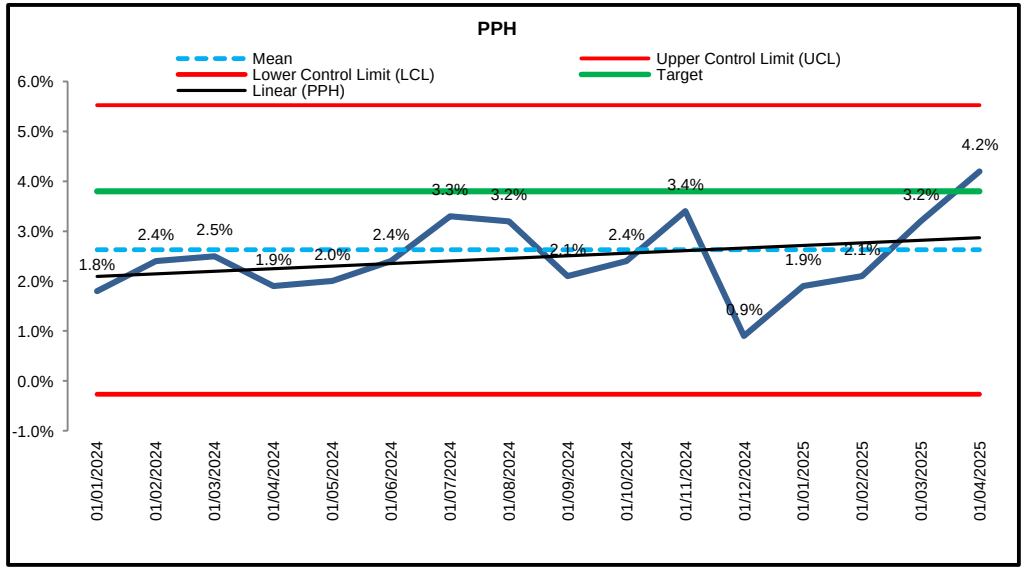
## What is going well?

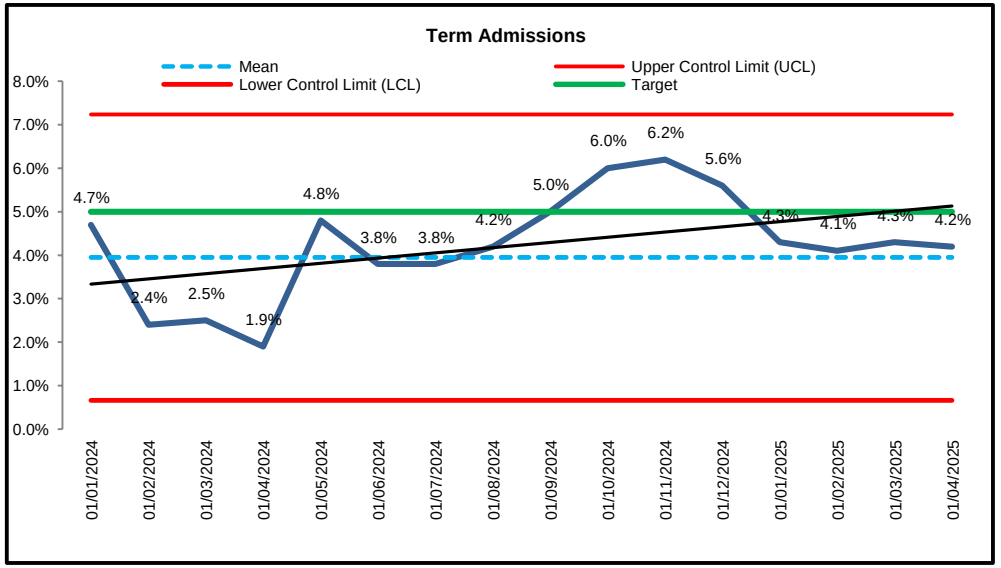
- Staffing met acuity 91% of the time in April. There was a shortage of up to two midwives for 9% of the time
- The percentage of women receiving 1:1 care in labour during April was 100% and there were no occasions where the LWC was not supernumerary

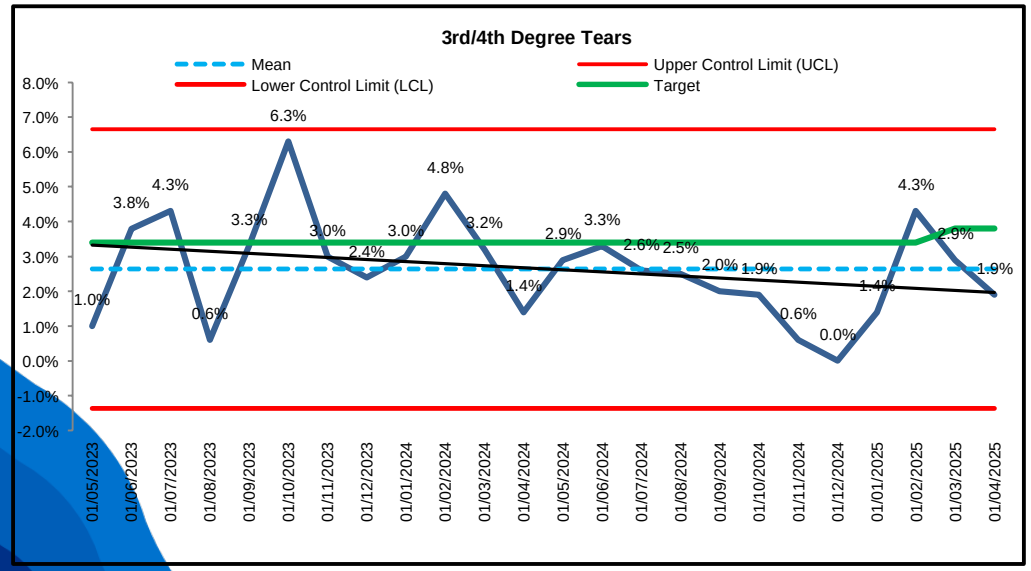
## Where do we want to be?

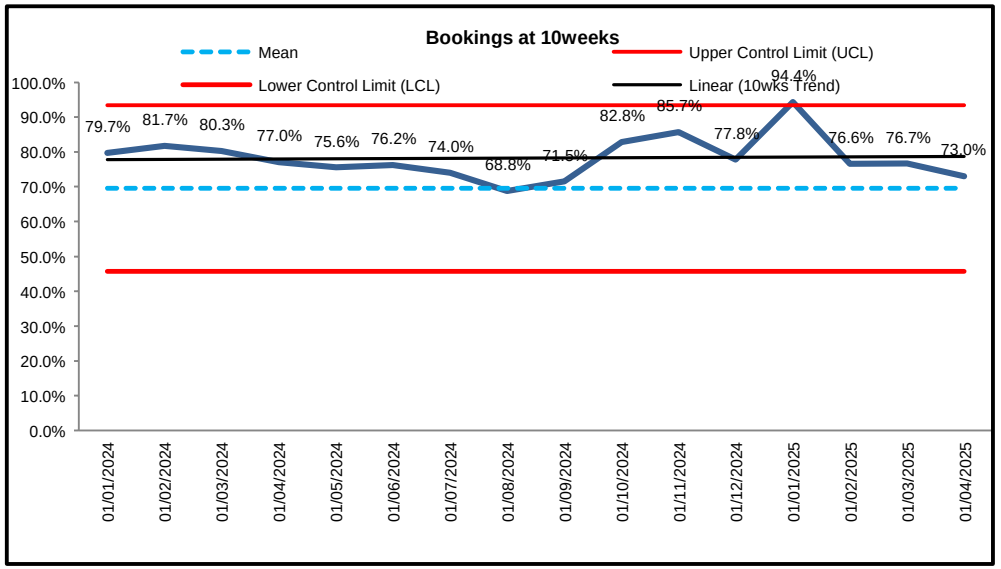
**Meet or Exceed 85% BirthRate Plus Compliance / Maintain safe staffing levels / Maintain 1:1 care in labour / Maintain Supernumerary Status of Labour Ward Co-Ordinator / Consistent reporting within the Birthrate plus acuity tool across the service / Reduce reliance on Bank**

# SAFETY: CLINICAL QUALITY SURVEILLANCE METRICS




## Summary

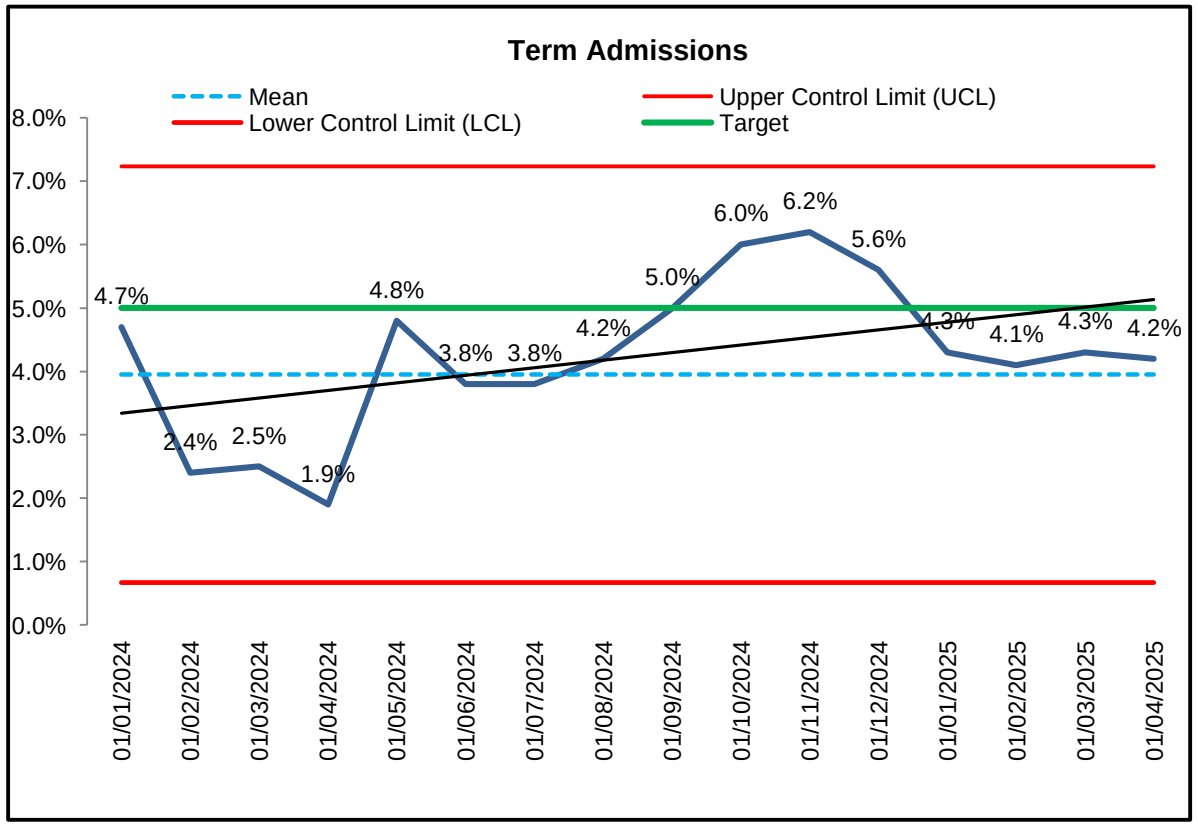
All CQiM Metrics remain within standard cause variation.

The percentage of women booking by 10 weeks continues to be above 75% for the last 6 months.

Close surveillance continues for PPH and 3rd/4th degree tears, which are reviewed through MIRF. No trends or themes have been identified on review.

# SAFETY: CLINICAL QUALITY SURVEILLANCE METRICS

## *Area of Focus: ATAIN*




### What is the data telling us?

The most recent data reflects a 4.2% admission rate into Neonatal Unit and remains within the expected range

The last 4 months shows that the percentage has decreased following 4 months above the target

Term admissions continue to be reviewed at MIRF and ATAIN, any learning identified is followed up accordingly

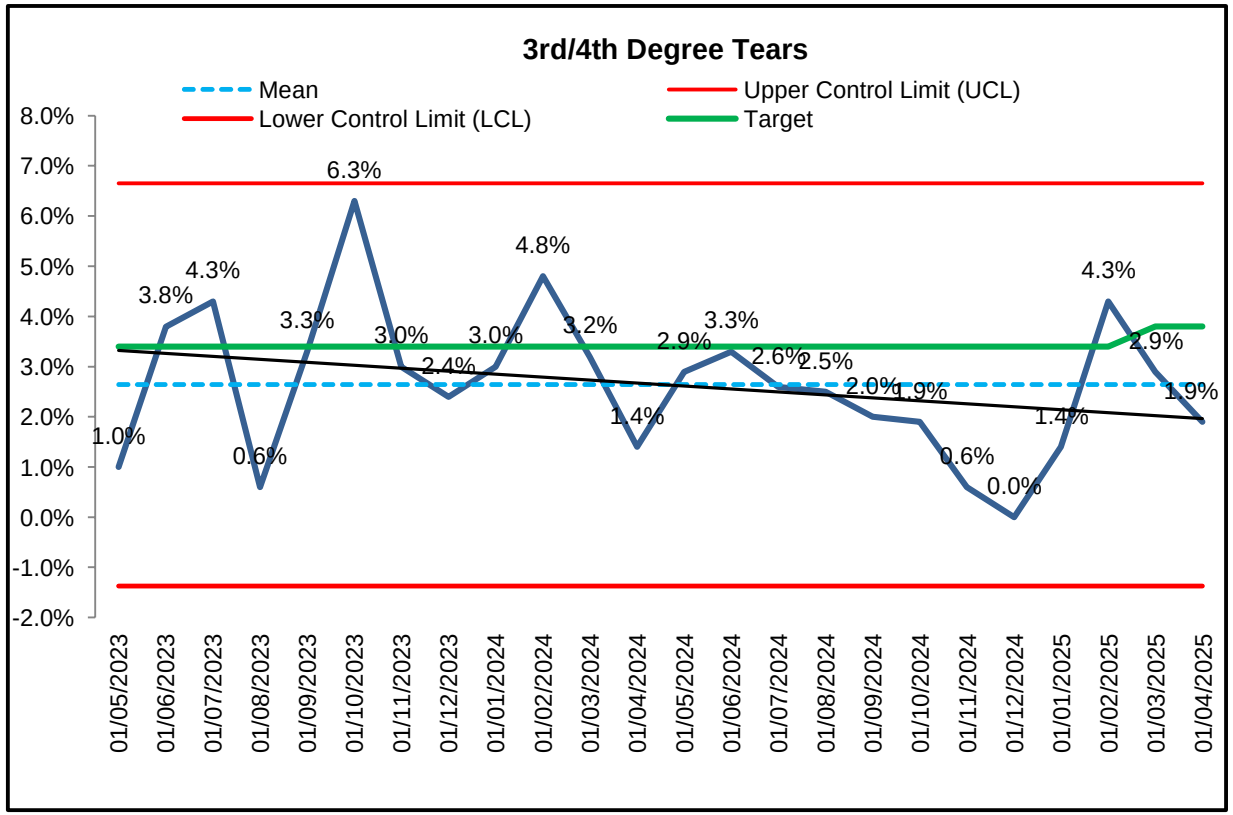
### What do we need to focus on?

Neonatal Hypoglycaemia action plan ongoing following an increase in term admissions not following the Hypoglycaemia pathway. The working group meets regularly to increase the compliance to the pathway and reduce Hypoglycaemia related admission to the neonatal unit.

Education and communication has been a focus for staff to follow the Hypoglycaemia pathway for babies who are at risk. Posters have been displayed and a new updated NEWTT chart has been embedded.

# SAFETY: CLINICAL QUALITY SURVEILLANCE METRICS

## *Area of Focus: Third-and-Fourth Degree Tears*




### What is the data telling us?

The recent percentage shows a decrease (1.9%) from the previous month (2.9%). There were 11 months from the last peak above target which suggests there are no trends/themes but it is an area that continues to be monitored

### What do we need to focus on?

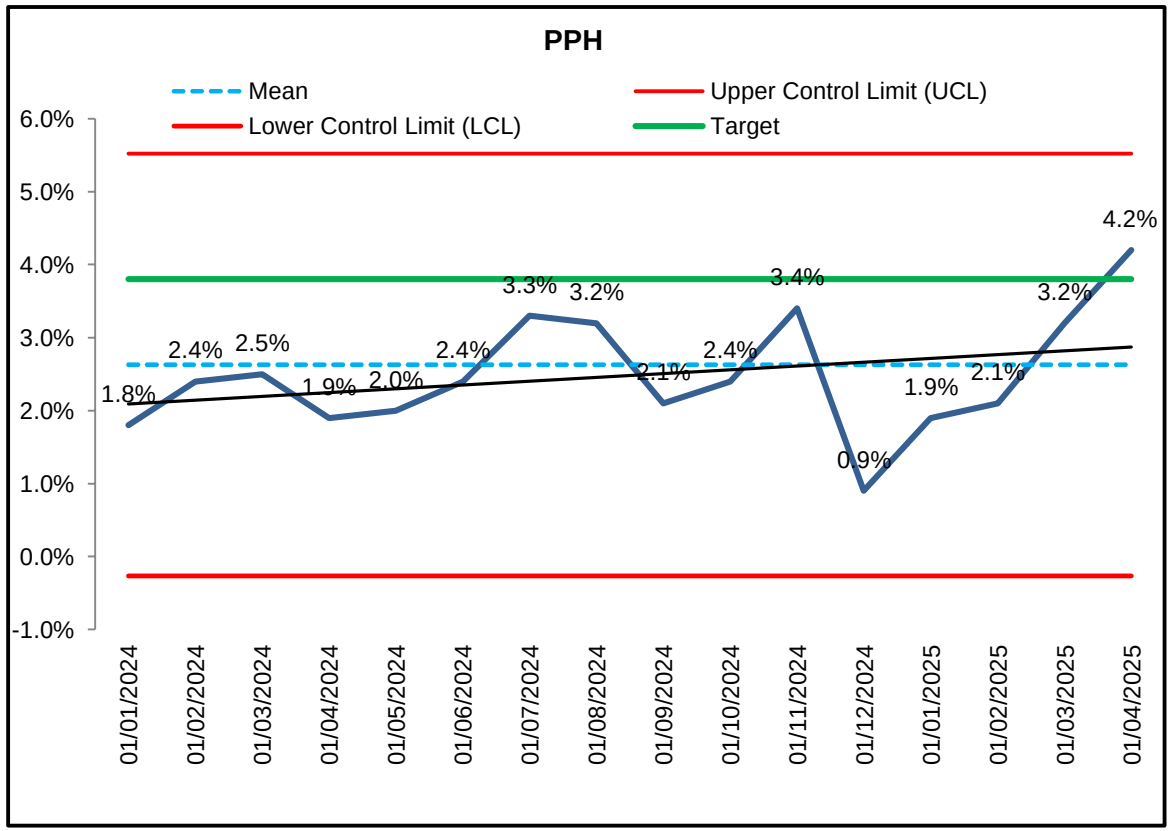
All 3rd/4th Degree tears will continue to be reviewed in MIRF, any learning identified will be actioned accordingly. There were no care omissions in the cases reviewed, however, incidental learning identified is the OASI bundle at delivery is not being followed consistently.

This is being followed up with the PD Team, Consultant Midwife and Risk Team who will work collaboratively to improve this practice which should reflect in reviews going forward.

Different methods of learning will be discussed at identified.

# SAFETY: CLINICAL QUALITY SURVEILLANCE METRICS

## *Area of Focus: PPH*




### What is the data telling us?

The recent percentage (4.2%) shows an increase in comparison to the last 3 months data. This is above the target and work is ongoing to bring this figure down.

### What do we need to focus on?

All PPH incidents are reviewed through MIRF and no trends or themes have been identified.

Although there haven't been any care omissions or themes identified from the reviews, it has been identified that documentation can be improved in terms of calculating the final blood loss if there was an APH or if cell salvage is used. This learning has been shared with staff for their awareness. There have been no concerns regarding the management of PPH

PPH management will continue to be monitored each month.

### Next Steps

We are currently participating in the OBSUK PPH project. The project aims to improve identification and management of PPHs.

The 4 elements are;

- Risk assessment for all admissions for delivery in all settings
- Cumulative real-time measurement of blood loss for ALL deliveries
- Escalation of multi-professional care to more senior staff at defined volumes of blood loss with appropriate medical intervention.
- Use of ROTEM for point-of-care testing of coagulation to guide blood product management

- Monthly audits carried out

- Commencing use of the ROTEM machine; more training coming soon and then the use of it will be rolled out.

- To use the OBS UK PPH proforma, but to continue to use our own risk assessment forms and cumulative measured blood loss forms.

# SAFETY INCIDENT REPORTING

| PERINATAL MORTALITY CASES | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Monthly Perinatal Losses | Total number of losses reported to MBRRACE | Number of losses reported to MBRRACE within 7 days | Perinatal Surveillance completed within 1 month | Number that meet PMRT criteria | Parents informed and questions/ concerns noted | PMRT completed by MDT and comply with CNST submission requirements | Late Fetal Loss >22/40 | Stillbirths | NND born and died at NGH | NND (born, NGH transferred and died at other Trust) |
| Q4 2024/25 | Jan-25 | 5 (1x NND delivered/ died OUH) | 4 | 4 | 4 (OUH Case) | 3 | 3 | 3 | 0 | 2 | 2 | 0 |
| | Feb-25 | 9 | 2 | 2 | 1 (1 case TOP surveillance not required) | 1 | 1 | 2 | 0 | 2 | 0 | 0 |
| | Mar-25 | 9 | 2 | 2 | 2 (1 case NND in LRI) | 2 | 2 | 2 | 1 | 1 | 0 | 1 |
| Q1 2025/26 | April-25 | 7 | 1 | 1 | 1 | 0 | N/A | 1 | 1 | 1 | 1 | 0 |

| APRIL 2025 |
|---|
| 0 cases met MNSI criteria |
| 0 MNSI Safety Recommendations |
| 0 Non MNSI Serious Incidents |
| 0 Never Events |
| 0 Moderate Incidents |
| 0 Coroner Reg 28 |
| 0 New Claims |
| 0 Closed Claims |

In April the NND weighed under 400g so wasn't reportable to MBRRACE and the stillbirth was a TOP so surveillance and PMRT not required

2 x AAR's

CAT 1 LSCS, Baby sent for cooling. MRI normal. Triage concerns with RAG rating and delay in CTG. (MI-040238)

**Actions:**

- BSOTS Training
- Triage staffing
- Education for gynae staff

CAT 2 LSCS FTP, Baby sent out to Coventry, Triage concerns over obstetric review and Pethidine px when not in established labour.

**Actions:**

- MW Reflection
- BSOTS training
- Maternity messages re: Pethidine

## PSII UPDATE

**Ongoing PSII**

0

**Completed PSII**

0

## AFTER ACTION REVIEW

0

## Where do we want to be?

**Full implementation of MNSI Safety Recommendations / Further reduction of perineal trauma incidents / Proactive incident reporting, encouraging the reporting of all incidents promptly to ensure early identification of potential risk**

# SAFETY INCIDENT REPORTING

### What is the data telling us?

- 0 (zero) Patient Safety Incident Investigations (PSII) have been reported.
- 3 moderate incidents reported but two downgraded to low and no harm.
- No themes have been identified through Perinatal Mortality Review Tool.
- There was a total of 7 perinatal losses, but no cases were reportable to MBRRACE. The 7 losses are 3 TOP's, 1 spontaneous loss and 2 IUDs, and 1 NND (16+4) all being non-registerable gestation.

### What is going well?

- NGH & KGH are working collaboratively on improving and streamlining our ATAIN and PMRT Meetings
- The Risk Team continues to work closely with specialty areas within Maternity to ensure all learning is disseminated to staff in a positive manner.

### What do we need to focus on?

- Continue training for OASI bundle in intrapartum care and highlight any further training/learning material that could potentially be used for staff.
- Ensure that reported incidents are graded in line with harm as per the Patient Safety Incident Response Framework.
- We need a focused piece of work on getting our Datix's investigated and closed in a timely manner. This should include training for new starters including the medical team.

# MATERNITY AND NEONATAL EXPERIENCE

| PALS Complaints & Complaints | Jan-25 | Feb-25 | Mar-25 | Apr-25 | 2024/25 YTD |
|---|---|---|---|---|---|
| Maternity | 4 | 5 | 4 | 2 | 35 |
| Neonatal | 0 | 0 | 0 | 1 | 1 |

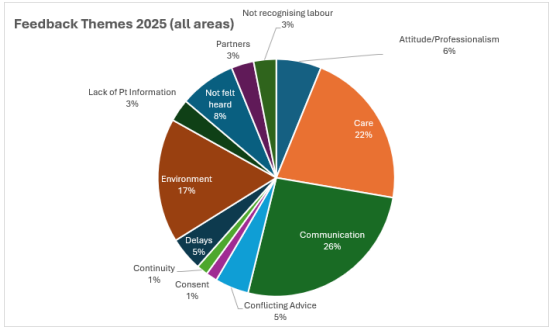
| Family & Friends Test (FFT) | Jan-25 | Feb-25 | Mar-25 | Apr-25 | 2024-25 YTD |
|---|---|---|---|---|---|
| Maternity FFT % Satisfaction Score | 97.0% | 97.2% | 96.5% | 97.9% | 95.8% |
| Maternity FFT Responses Received | 169 | 248 | 258 | 195 | 3,205 |

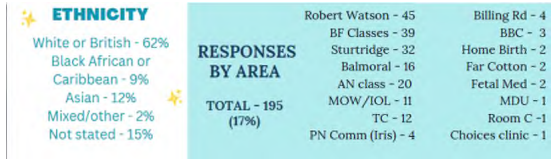
## What is the data telling us?

- in April we had 195 responses which is a response rate of 17%
- April's overall satisfaction was 97.9%
- 'Birth' achieved 94.6% but only received 37 feedbacks, which was only 11% of the total births

## What do we need to focus on?

- Dissatisfaction was 1.5%
- x1 'neither good nor bad' score
  - MOW – not recognising active labour.
- x1 'poor' score
  - Sturtridge – pt felt they were not given adequate information and forced in a LSCS.
- x2 'very poor' scores (MOW and RWW)
  - MOW - No comment left
  - RRW - related to the condition (peeling paint and mould) which has been escalated to the manager who has contacted estates




## Compliments

*"The care I received post C-section was faultless, all staff were kind, compassionate and attentive. Being expected to wait in the waiting room for a planned c section which was delayed was not the best experience, I was wearing my gown and ted stockings, had been nil by mouth for 12 hours by the time I went to theatre. So being sat in a room with people coming and going from outpatient appointments who are eating and drinking is not very nice. I explained to a member of staff I felt faint and a bed space was offered to me, where my blood pressure was checked, however I think this should be mandatory"*

*"From triage to theatre, I received outstanding care from everyone involved in my labour, especially Kerrie Bale my midwife who kept me informed in the loop, clearly spoke and supported my decisions and family. She was relentless in ensuring my daughter remained safe and calm whilst I was labouring. I couldn't fault the care and support me and my little family received, thank you"*

*"I had a really positive Labour experience following on from a pre term traumatic c section 6 years ago, I was looked after by such kind and supportive midwifes throughout my Labour and even when the emergency button was used the team of doctors who came in so quick made me feel at ease straight away, my daughter was born happy and healthy and myself was made to feel so special and I cant thank the whole of Labour ward for that"*

| Neonatal Parent Feedback | |
|---|---|
| **You said** | **We did** |
| One family had been there 2 months and were a bit disgruntled because they had been asked that morning whether they had breast fed yet and all sorts of questions they felt staff should know | Parents informed that the neonatal consultants do change on a Monday for their service week, and we will take on board how the change can be for the parents when they have had the same doctors for the previous week and built-up relationships |
| A family was busy with twins, great experience on Gosset but wanted to give feedback on RW another time | Will feedback to staff |
| A family were incandescent with how good all our services were. Everyone across the perinatal pathway had been brilliant - they didn't want to name staff on Gosset because said they were all amazing and always explained everything and supported when there were concerns | Will feedback to staff |

## Where do we want to be?

**Provide compassionate, caring and individualised care where women and birthing people feel supported and informed / Women and birthing people feel empowered to provide feedback and are given regular opportunities which are accessible for all / Actions and improvements related to patient feedback and are acted upon promptly and sustained**

# MATERNITY AND NEONATAL FEEDBACK (STAFF)

| NED Safety Champion Walkaround<br>Date: APRIL 2025<br>Location: NGH | SC Name: Jill Houghton<br>No. of Staff: |
|---|---|
| **Staff Feedback** | **Plan** |
| Labour Ward - keen to get on with new ambulatory IOL pathway (Foleys) - raised with me the staff room was very small (and hot yesterday) - one member of staff wondered if they could swap with the anaesthetists who had a better room not used by many or often. I knocked on the door but no one answered | Induction of labour work in progress led by Lorraine. We should hopefully be commencing staff training soon. Currently working through the governance. In terms of the staff room, we have explored swapping with the anaesthetists, and we have not been able to progress this. One of the main reasons I understand is that anaesthetists need somewhere to be able to rest while they are on LW, and the feeling was that none of the other rooms are appropriate |
| One patient attended ED at 25 weeks because she had fainted. Because she was a type 1 diabetic ED staff were convinced she had a hypo but her blood sugars were recorded on her phone and they tried to show this wasn't the case. They were in ED 7 hours and kept asking to be referred to triage - eventually they got there and triage were apparently amazing. Does this pathway need reviewing? | Pathway does need reviewing. Will share with team and see how best to progress. I believe a guideline is in place and pathway established following an SI. It may be a case of ensuring everyone is aware of the referral pathways when pregnant women present to A&E. Conversely we have done a lot of work around encouraging wider Trust Teams to accept pregnant women when they present with non pregnancy related illness. More work to be done. |
| Robert Watson - the heating had been on the previous day and the 3 sets of parents I spoke to were complaining about the heat - especially when the heating was on! | Escalated to Estates to turn off |
| PMA service - some concern about fixed term posts otherwise no feedback | Awaiting outcome of business cases. Totally understand the staff concerns |
| Balmoral - staff wondered if they could see low risk parents on the triage pathway - they are keen to do more deliveries on this unit. | Yes definitely. I believe this work is in progress |
| Safeguarding - I haven't spoken to this team (central) for a long while. They felt well supported but I gather long term sickness in the team is impacting on their workload and resilience | It's good to hear the team feel supported, processes in place to support the teams, despite the current challenges with sickness |


## What is going well?

- IOL Pathways progressing well
- Great teamwork managing high risk safeguarding caseloads

## What do we need to focus on?

- Liaising with ED and developing Medical Pathways
- Staff Survey results now available and action plans in development
- Direct access to Birth Centre following Triage

## Where do we want to be?

**Empathic, culturally sensitive, and compassionate workforce to the benefit of families and staff / Improved service user experience: families to receive high quality care which is personalized and inclusive / High care for all, with NGH being a great place to work; investing in the development of our staff and timely action on feedback.**

# WORKFORCE: TRAINING SUMMARY

**Module 3: Maternity emergencies and multiprofessional training:**

| | Dec 2024 | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 |
|---|---|---|---|---|---|
| Midwives | 97% | 97% | 97% | 99% | 99% |
| Consultants | 100% | 100% | 100% | 100% | 100% |
| Obstetric Doctors | 92% | 96% | 79% | 83% | 83% |
| Anaesthetists | 87% | 81% | 73% | 86% | 86% |
| MSW's | 95% | 95% | 100% | 99% | 99% |

**Module 6: Neonatal basic life support:**

| | Dec 2025 | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 |
|---|---|---|---|---|---|
| Midwives | | 97.5% | 95%* | 93% | 93% |
| MSW's | | | 90% | 88% | 88% |
| Neonatal Consultants | 100% | 100% | 100% | TBC | TBC |
| Neonatal Junior Doctors (who attend births) | 100% | No figures supplied | 100% | TBC | TBC |
| Neonatal Nurses (Band 5 and above QIS) | 100% | 100% | 100% | TBC | TBC |
| Advanced Neonatal Practitioners (ANNP) | 100% | 100% | 100% | TBC | TBC |

**Element 4: Fetal monitoring and surveillance:**

| | Dec 2024 | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 |
|---|---|---|---|---|---|
| Midwives | 96% | 96% | 92% | 95% | 100% |
| Consultants | 100% | 100% | 91% | 100% | 100% |
| Obstetric Doctors | 100% | 100% | 81% | 96% | 100% |

## What is the data telling us?

- PROMPT overall compliance – 96%
- Newborn life support (NBLS/NLS) overall compliance 90%
- Three additional dates have been set to target midwives and MSW's whose compliance has lapsed; email invites sent to all.
- Midwives with current NLS Provider status will undertake the local NLS update whilst attending NBLS training, where there is two NLS Instructors available.
- Fetal Monitoring overall compliance: 100%
- Safeguarding Adults/Childrens Level 3 – Due to reconfiguration with mandatory NGH General Trust figures there is no current break down for maternity only figures at present. This will hopefully be rectified in the next month or so

## What is going well?

- PD team have worked very hard to facilitate large numbers of attendees through PROMPT and maternity training weeks.
- Point of care tests running well in all areas and baby abduction drill well received/Pool evacuations on LW and Birth centre.
- Community PROMPTS planned for April in community hubs.
- Working on a robust data base to ensure all bank staff are up to date with training and compliance for oversight.

## What do we need to focus on?

- Large number of attendees and room booking facilities have been a challenge this quarter
- Obstetric doctors and anaesthetic team attendance at PROMPT has been in the red and amber zones – escalated to appropriate leads.
- Anaesthetic attendance has increased to 83%
- Obstetric challenges with lack of rota co-ordinator for obstetrics.
- Attendance for Obstetric Drs still remains an issue for PROMPT and Specialities day. This continues to be escalated

## Where do we want to be?

**>95% compliant in mandatory training by the end of the year / Outcomes to improve through seeing a reduction in perineal trauma and significant blood loss / Enhance staff knowledge, skills and confidence to provide safe evidence based and compassionate maternity care. / Create a culture of continuous learning / Using simulation, refine maternity staffs existing expertise and skill to identify and manage obstetric emergencies in a timely manner to reduce poor outcomes for mothers/ birthing people and infants**

# MATERNITY INCENTIVE SCHEME (MIS) PROGRESS

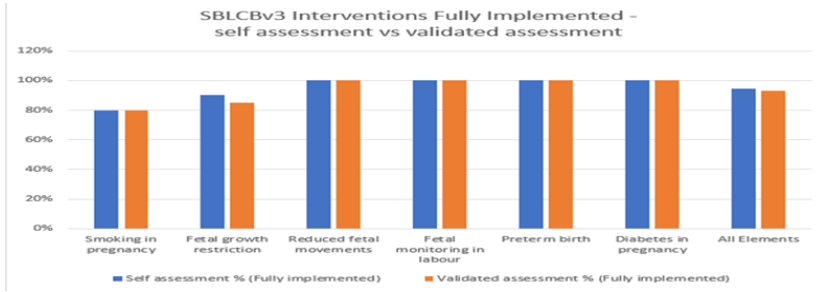
***SUMMARY***

| MIS Safety Action – Year 6 | MIS Standards | Status |
|---|---|---|
| 1: Use of Perinatal Mortality Review Tool | 6 | NOT ACHIEVED |
| 2: Submitting data to the Maternity Services Data Set | 2 | 100% complete |
| 3: Transitional Care and Avoiding Term Admissions to Neonatal Unit | 4 | 100% complete |
| 4. Clinical workforce planning | 20 | 100% complete |
| 5. Midwifery workforce planning | 6 | 100% complete |
| 6. Saving Babies Lives Care Bundle | 6 | 100% complete |
| 7. Listening to women, parents and families | 7 | 100% complete |
| 8. Multidisciplinary training | 17 | 100% complete |
| 9. Ward to Board assurance | 9 | 100% complete |
| 10. MNSI and Early Notification Scheme reporting | 8 | 100% complete |

| MIS Safety Action – Year 7 | MIS Standards | Status |
|---|---|---|
| 1: Use of Perinatal Mortality Review Tool | 6 | On Track |
| 2: Submitting data to the Maternity Services Data Set | 2 | On Track |
| 3: Transitional Care and Avoiding Term Admissions to Neonatal Unit | 4 | On Track |
| 4. Clinical workforce planning | 20 | On Track |
| 5. Midwifery workforce planning | 6 | On Track |
| 6. Saving Babies Lives Care Bundle | 6 | On Track |
| 7. Listening to women, parents and families | 7 | On Track |
| 8. Multidisciplinary training | 17 | On Track |
| 9. Ward to Board assurance | 9 | On Track |
| 10. MNSI and Early Notification Scheme reporting | 8 | On Track |


**Full MIS year 7 document and accompanying resources were published on 2 April 2025**

# SAFETY: SAVING BABIES LIVES CARE BUNDLE v3




- **Four Elements at 100% compliance - Two Elements remain partially compliant at 80% and 85%**
- **CNST – met across all six Elements of SBLCB**

**Implementation Progress**

| Intervention Elements | Description | Element Progress Status (Self assessment) | % of Interventions Fully Implemented (Self assessment) | Element Progress Status (LMNS Validated) | % of Interventions Fully Implemented (LMNS Validated) | NHS Resolution Maternity Incentive Scheme |
|---|---|---|---|---|---|---|
| Element 1 | Smoking in pregnancy | Partially implemented | 80% | Partially implemented | 80% | CNST Met |
| Element 2 | Fetal growth restriction | Partially implemented | 90% | Partially implemented | 85% | CNST Met |
| Element 3 | Reduced fetal movements | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 4 | Fetal monitoring in labour | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 5 | Preterm birth | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 6 | Diabetes | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| All Elements | TOTAL | Partially implemented | 94% | Partially implemented | 93% | CNST Met |

All Elements of the care bundle are fully compliant with CNST

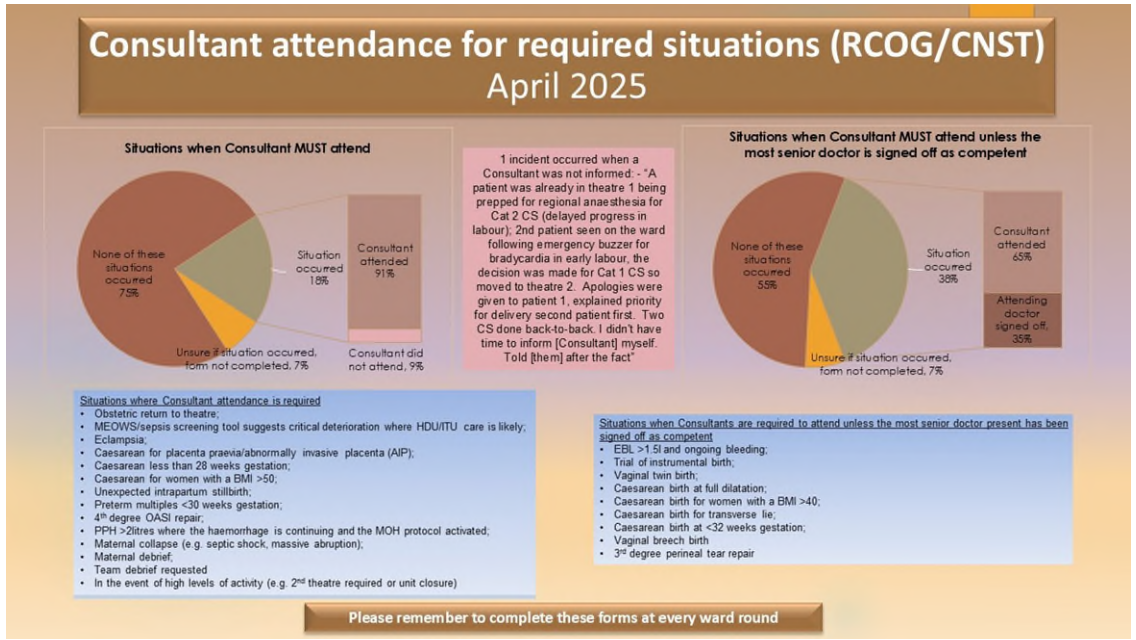
Four out of the six elements of the care bundle are fully implemented

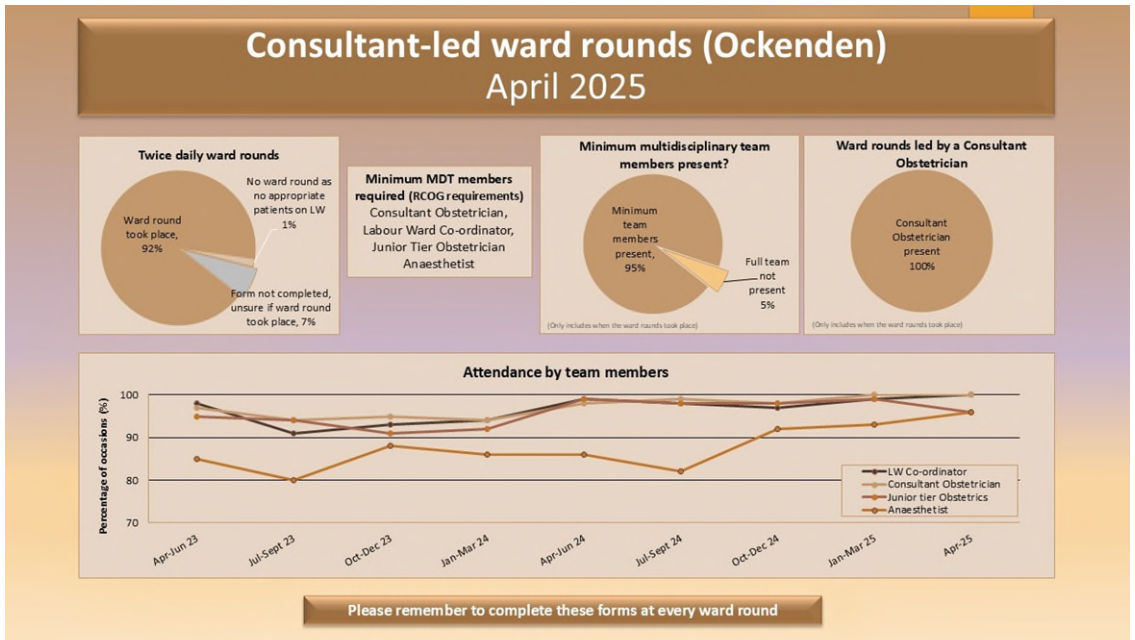
Two out of the six need little adjustments in preparation for Quarter 4

Next LMNS Review – June 2025

| What do we need to focus on | Actions |
|---|---|
| **Element 1 - Smoking cessation**<br>The Maternity In house smoke free service has been in place and fully functional for just over a year. The Maternity Tobacco Dependency Advisors have been caseload holding and working directly with pregnant families to support them to achieve a smoke free household.<br>The results are now starting to see real results in the steady decline in smoking at booking and delivery rates. This is a fantastic achievement. However, due to lack of funding for the post of MTDA we may start to see reversal in progress | Lack of job security for MTDA documented on risk register, for action by all stakeholders |
| Preterm Birth Prevention<br>All components of the care bundle re-Element 5 fully implemented and continuous review of clinical practice on going | Preterm Birth Optimisation protocol discussed monthly at staff mandatory study day and Launch of New PERIPrem Video (Patient information video) |

# SAFETY: Consultant Attendance for Required Situations (RCOG/CNST)



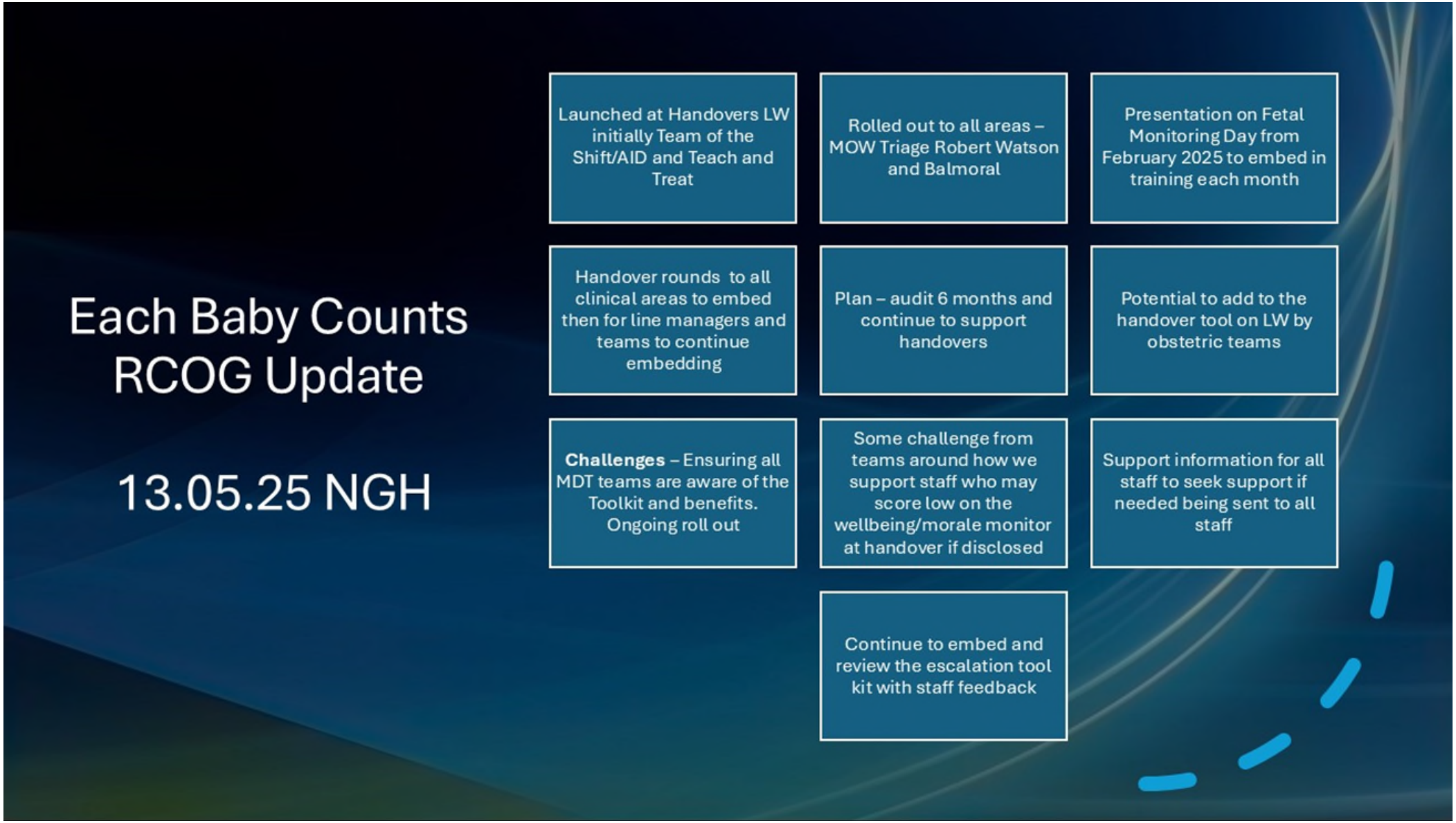

### What is the data telling us?

- 56/60 forms were completed = 93%

### What do we need to focus on?

- 1 incident occurred when a Consultant was not informed. Mitigating circumstances of two caesarean sections done back-to-back with no time to inform Consultant and was done after the fact

# HOT TOPIC – Each Baby Counts RCOG Update



NHS
University Hospitals of Northamptonshire
NHS Group

# KGH Perinatal Quality Assurance Scorecard

June 2025

May 2025 Dataset

Dedicated to excellence

# CONTENTS


Overall Summary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# 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.

# MAY 2025 AT A GLANCE

## AVERAGES PER DAY

| BOOKINGS | BIRTHS |
|---|---|
| 10 | 7.9 |

## BABIES BORN

245

PREV. 12 MONTH AV. 250

## BIRTH LOCATION

| KGH | HOME |
|---|---|
| 242 | 3 |

## 3RD & 4TH DEGREE TEARS

1.2%

April - 0.4% ▲

## 3.3%

BLOOD LOSS >1,500MLS

April - 3% ▲

## 120 GIRLS / 125 BOYS

PREV. 12 MONTH AVERAGE
122 GIRLS, 128 BOYS

## 1.6%

February 0.9% ▲

FULL TERM BABIES ADMITTED TO NNU

## INDUCTION OF LABOUR (IOL)

35.3%

PREV. 12 MONTHS – 30.4%

## 143 CAESAREAN SECTIONS

| | MARCH | PREV 12 MTH. AV. |
|---|---|---|
| ELECTIVE | 58 | 55 |
| EMERGENCY | 85 | 69 |

## SETS OF TWINS

4

## SETS OF TRIPLETS

0

## ASSISTED BIRTHS

19

| VENTOUSE | FORCEPS |
|---|---|
| 8 | 11 |

PREV. 12 MONTH AV.

| VENTOUSE | FORCEPS |
|---|---|
| 12 | 11 |

## BREASTFEEDING INITIATION

69%

PREV. 12 MONTHS – 73.2% ▼

NHS

# PERINATAL QUALITY SCORECARD SUMMARY

## Overview

There were 245 babies born in May across the service with operational activity remaining OPEL green throughout the month; an improved position compared to the previous month. The number of reportable red flags declined however Induction of Labour and Delays in Ongoing Care continue to be the flags regularly reported. 1:1 care in labour was maintained.
Triage pathways are the hot topic of the month with focus on utilising data to inform improvements whilst the service is transitioning within the estate. Triage within 15mins remains at or above 90% compliant.

Progress continues on the implementation of the Saving Babies Lives Care Bundle & Year 7 MIS

## Quality & Safety

There was a total of 113 datix incidents reported which remains static compared to April. There was one moderate harm related to perineal trauma.
The highest reporting themes include clinical care/treatment, and medication errors. Learning is to be included within the improvement programme of work. There were no PSII declared, no cases referred to MNSI, and no after-action review (AARs) initiated or completed. Two completed MNSI reports have been received, and action plan meetings have taken place.

## Training

Practice development team continue to deliver training programme to support achievement of MIS year 7 requirements which are on target to achieve. Additional focus within the team to support medicines competency training for midwives.
Additional planned work includes community emergency drill day and live skills drills following move to Maple Ward.

## Experience

May data shows a positive position for Kettering with 3 consecutive months where FFT feedback scores are higher then UHN target and the national average. More women reporting feeling happy with their care and where improvements are needed. Matrons are undertaking targeted work including structured drug arounds to support regular analgesia administration and the launch of partners staying over night from June 2025.

There were no complaints received in May and no reports of poor staff attitude or behavior for the second consecutive month.

## Workforce

Improved position with midwifery recruitment and reduction in turnover as well as felt vacancy rate. Establishment increase of 9.56 WTE has been supported in line with recent Birthrate plus ® review, active recruitment underway to fill vacancies. NHSE funding to support midwifery shortened programme continuing in 2025. Planned recruitment in place to increase number of obstetric doctors to support launching of BSOTS in line with CQC action plan. BAPM compliance for neonatal nurse staffing remains god, further focused work required to improve vacancy rate amongst neonatal nurses and neonatal consultant post.

**CQC Maternity Overall Ratings**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Maternity CQC rating (Last Inspected Feb 2019 & Oct 2023 Safe and well-led only)** | | | | | | |

Overall summary

# WORKFORCE (MATERNITY)

## What is the data telling us?

- Vacancy rate decreasing with 2 Registered Midwives joining KGH in May
- Attrition rates are improving with 1 midwife leaving the organisation in past 6 months
- Medical workforce remains static although there is an ongoing advert to increase the workforce identified for Triage
- Speciality trainee feedback received for 2024 with positive feedback – KGH ranking 15th in UK

## What is going well?

- Retention remains stable with 100% of NQM since 2022 still holding posts at KGH
- All Band 5 midwives successfully completing competencies and transition into B6 posts
- Additional 9.56 wte as per uplift in establishment now out to advert
- Funding continues for 2025 for shortened programme
- Vacancy rate continues to decrease along with felt vacancy rate
- Overall satisfaction of obstetric trainees has increased (see indicator 12 and 6.1.4)

## What do we need to focus on?

- Supporting staff through periods of sickness to improve the felt vacancy
- Recruit substantively reducing the number of staff currently on secondments within the service – which will further reduce our reliance on temporary workforce
- Ongoing pastoral support and retention strategies

## Maternity Workforce Programme - Midwifery workforce

| Midwifery headline figures | Establishment | Midwives SIP | Midwife Vacancy FTE | Vacancy rate |
|---|---|---|---|---|
| Registered Midwives in trust (WTE/KPI tab) | 164.9 | 148.0 | 16.9 | 10.3% |
| Midwives in maternity services (Maternity tab) | 159.9 | 143.0 | 16.9 | 10.6% |

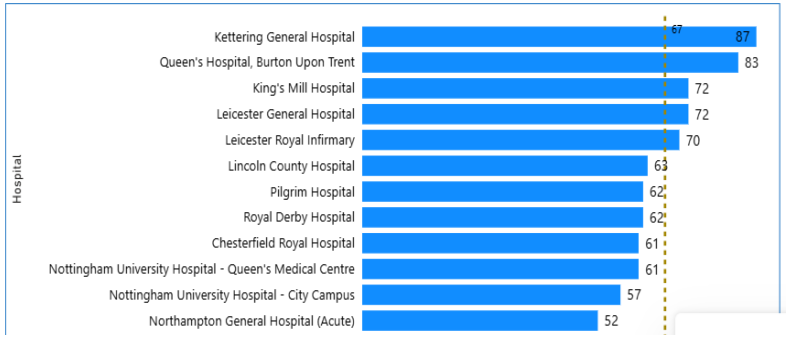
| Midwifery demand (BR+vs.funded establishment) | BR+ demand | Establishment gap | Vacancy gap |
|---|---|---|---|
| | 150.6 | 9.3 | -7.6 |

Increased establishment of 9.56 WTE in line with BR+ recommendation

| | Kettering | | Community | | Screening & Imms | |
|---|---|---|---|---|---|---|
| May-25 | Midwife (B5-B7) | MSW/B4 | Midwife (B5-B7) | MSW/B4 | Midwife (B5-B7) | MSW/B4 |
| **Funded Establishment wte** | **85.80** | **23.32** | **37.68** | **8.60** | **6.77** | **1.80** |
| Vacancy Wte (excluding triage uplift) | 0.22 | 3.75 | 1.95 | 0.08 | 0.00 | 0.00 |
| Vacancy Rate | 0.25% | 16% | 5.2% | 1% | 0% | 0% |
| Maternity Leave Wte | 2.55 | 0.99 | 0 | 0.00 | 0.00 | 0.00 |
| Seconded with no back fill | 1.6 | 0.8 | 0 | 0.00 | 0.00 | 0.00 |
| LTS Wte | 2.56 | 1.28 | 0.59 | 0.00 | 0.00 | 0.00 |
| Felt Vacancy Rate | 6.90% | 29.2% | 6.7% | 1% | 0% | 0% |

| Post Specialty | Trust / Board | Indicator | 2019 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|
| Obstetrics and gynaecology | Kettering General Hospital NHS Foundation | Overall Satisfaction | 76.86 | 81.67 | 75.42 | 84.23 |
| Obstetrics and gynaecology | Kettering General Hospital NHS Foundation | Clinical Supervision | 92.14 | 87.64 | 89.09 | 90.48 |
| Obstetrics and gynaecology | Kettering General Hospital NHS Foundation | Clinical Supervision out of hours | 90.91 | 88.02 | 86.11 | 87.12 |

Indicator 12: Overall recommendation




## Where do we want to be?

- **Reinstate 2nd continuity of care team / Improved staff satisfaction and engagement evidenced through the staff survey results / Increase In baseline establishment to ensure safe staffing of new triage department**

# WORKFORCE (NEONATOLOGY)

### What is the data telling us?

- Current nursing vacancy rate 9.5WTE with clear recruitment plan in place.
- Significant improvement in Tier 3 medical workforce.

### What is going well?

- Currently 74.7% QIS compliant, which is above the 70% BAPM compliance recommendation.
- 1WTE Neonatal Consultant gap to be BAPM compliant. Business case submitted for 7th Consultant.

### What do we need to focus on?

- Recruiting into Band 6 nursing vacancies – 6 applicants shortlisted, interviews scheduled for 26th June 2025.
- Approval of business case for 7th Neonatal Consultant.

## Where do we want to be?

- Ensure staffing levels and QIS trained nurse levels for the unit remain compliant with BAPM standards.
- Recruit into nursing workforce gaps over the next 6 months.
- Approval of the business case for the 7th Neonatal Consultant to become BAPM compliant at Tier 3 level. Then monitor and maintain medical workforce levels.

## Nursing Workforce

| Position | Budgeted Establishment | In Post | Vacancy | Pipeline |
|---|---|---|---|---|
| Band 8a | 1.00 | 1.00 | 0.00 | |
| Band 7 | 5.08 | 4.80 | 0.28 | Band 7 Clinical Sister increasing her hours by 0.28 in June |
| Band 6 | 19.78 | 13.20 | 6.57 | Interviews 26th June. 6 Applicants 3x internal, 3x external |
| Band 5 | 14.63 | 13.21 | 1.42 | 1x NA now received Pin number. 1x NSW qualifies end of June resulting in a vacancy gap of 0.5 WTE |
| Band 4 | 6.39 | 5.47 | 0.92 | |
| Band 3-NSW | 5.37 | 4.91 | 0.46 | 1x NSW in band 5 numbers, 2x qualifying end of June 2025- 1 leaving 1x converting to band 5. NSW job on TRAC |
| Band 3- Admin | 1.00 | 1.00 | 0.00 | |
| **Total** | 53.25 | 43.60 | 9.65 | |

## Medical Workforce

**Current position:**

- Tier 1 Compliant – 14WTE in post. No vacancies.
- Tier 2 Compliant – 14WTE in post . No vacancies.
- Tier 3 Non-compliant – Separated rota from Paediatrics, currently 5WTE substantive Neonatal Consultants and 1 Locum Consultant. Business case submitted for 7th Consultant to be BAPM compliant.
- Compliant in having Neonatal Consultant designated lead as per BAPM.

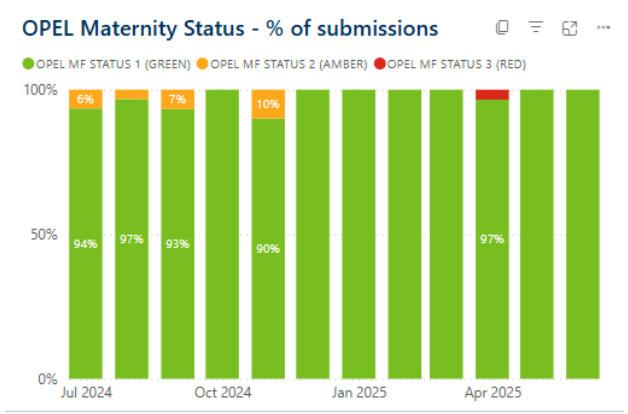
**Current Neonatal Consultant Recruitment Plan:**

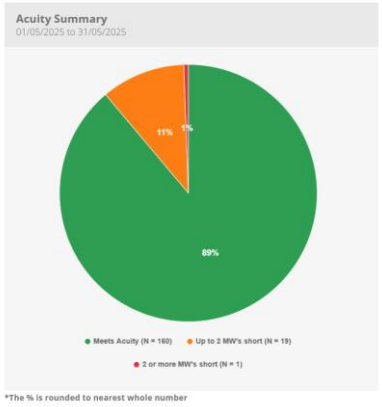
Post 1 - Substantive Consultant – recruited, commenced 7th April 2025.
Post 2 - Locum Consultant – recruited, started 28th April 2025.

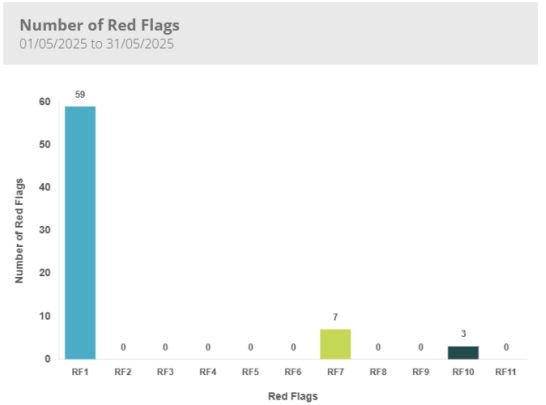
We will continue long line bank staffing to support the rota gaps if required.

**Adoption of the Clinical Reference Group (CRG) workforce tool to support incremental workforce expansion to reach a capacity of 48 cots / Staffing levels and QIS trained nurse levels for the unit to be compliant with BAPM standards / Recruit and train according to the trajectory plan for the nurses to achieve the compliancy as required by BAPM / Over the next 6 months recruit into the vacant consultant posts to meet full establishment for the planned 18-person rota.**

# OVERALL MATERNITY OPERATIONAL ACTIVITY




| One to One care in labour 24/25 | November | December | January | February | March | April | May |
|---|---|---|---|---|---|---|---|
| % of women receiving 1:1 care in labour | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

| Supernumerary status of DSC - 24/25 | November | December | January | February | March | April | May |
|---|---|---|---|---|---|---|---|
| No of occasions DSC was NOT supernumerary | 8 | 3 | 6 | 0 | 0 | 4 | 3 |

**Maternity Red Flags**

**Labour Ward**

May 25 – 69

Apr 25 - 94

Mar 25 - 34

Total Q1 25/26 - 163

Total Q4 24/25 - 203

Total Q3 24/25 - 324

Total Q2 24/25 - 335

<u>May</u>

n59 Delayed or cancelled time critical activity

n7 Delay between admission for IOL and beginning of process.

n3 Co-Ordinator unable to maintain supernumerary status

### What is the data telling us?

- Red flags for delayed or cancelled time critical activity consistent due to continued delays in Artificial Rupture of Membranes (ARM)
- Improved operational position when compared to April
- Number of times acuity met also improved when compared to April

### What do we need to focus on?

- Although 1:1 care provided in labour 100% of the time there remains reportable episodes reported by coordinators not being supernumerary
- Targeted work regarding supernumerary status to ensure reporting reflects holistic oversight lost and escalation has not been achieved.

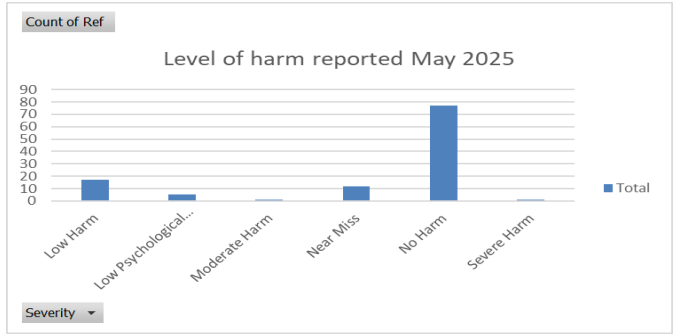
### What is going well?

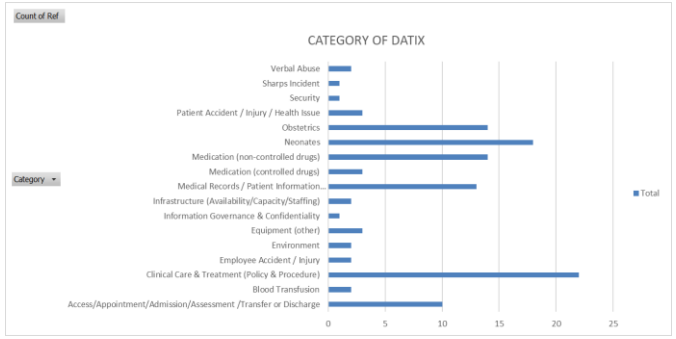
- 1:1 care in labour maintained 100% of the time.
- Improved staffing levels- new staffing model continues to positively support staffing/acuity overnight and minimal escalation to community.

**Where do we want to be?** **Maintain safe staffing levels / Maintain 1:1 care / sustain improvement of supernumerary status of the Labour Ward Coordinator / Consistent reporting within the Birthrate plus acuity tool across the service / Reduce the number of delayed ARMs within the service**

# SAFETY INCIDENT REPORTING

| Perinatal Mortality Data | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Monthly Perinatal Losses | Total Number of losses reported to MBRACE | Number of losses reported to MBRACE within 7 days | Perinatal Surveilance completed within 1 month | Number that meet PMRT criteria and 72hr review completed | Parents informed and questions/concerns noted. | PMRT completed by MDT team and comply with CNST submission requirements | Breakdown of perinatal losses | | | |
| | | | | | | | | | Late Fetal Loss >22/40 | Still Births | NND born and Died at KGH | NND (born KGH, transferred and died at other trust |
| Q2 2025 | June | | 2 | 2 | 2 | 2 | 2/100% | 2/100% | 1 | 2 | 0 | 0 |
| | May | 5 | | | | | | | | | | |
| | April | 4 | | | | | | | | | | |
| Q1 2025 | March | 3 | 5 | 5 | 5 | 2 | 5/100% | 5/100% | 1 | 4 | 0 | 3 |
| | February | 3 | | | | | | | | | | |
| | January | 2 | | | | | | | | | | |
| Q4 2024 | December | 1 | 2 | 2 | 2 | 2(1 external) | 2/100% | 1/100% | 1 | 1 | 0 | 2 |
| | November | 3 | | | | | | | | | | |
| | October | 0 | | | | | | | | | | |
| Q3 2024 | September | 8 | 3 | 3 | 4 | 3 | 2/100% | 2/100% | 0 | 1 | 1 | 0 |
| | August | 5 | | | | | | | | | | |
| | July | 0 | | | | | | | | | | |




| May2025 |
|---|
| 0 cases met MNSI criteria |
| 3 MNSI Safety Recommendations |
| 0 Non MNSI Serious Incidents |
| 0 Never Events |
| 1 Severe Incident |
| 0 Moderate Incidents |
| 0 After Action Review |
| 0 Coroner Reg 28 |

## PSII

2025/2349 – Management of the newborn with seizures and low blood sugars – investigation underway

## MNSI's

None declared in May

2 Final MNSI reports back in May with 3 safety recommendations in relation to CTG interpretation, escalation and neonatal resus - action plan meetings taken place

Three ongoing MNSI cases continue

## AAR's

0 New AARs declared in month
2 AAR's to be arranged
Terbutaline Medication Error
Cooling Baby

## What is the data telling us?

- 113 incidents report in May 2025. 77 No Harm, 12 near Miss, 1 moderate harm, 5 low psychological Harm and 17 Low Harm
- The highest category for Datix was Clinical care and Treatment (22) with medication non controlled drugs (18),Controlled medication and Obstetric incidents (14).

## What is going well?

- 0 cases referred in May to MNSI
- 2 completed MNSI report has been received and action plan to be agreed.

## What do we need to focus on?

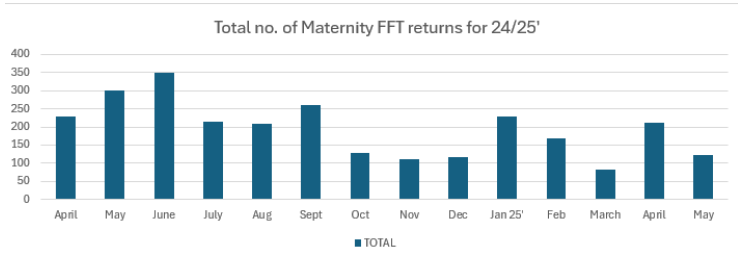
**AARs** should be scheduled promptly and documented more swiftly than has been the case to date. Efforts are also needed to **reduce the number of overdue Datix reports**, as this figure is rising—largely due to consultant workload and competing priorities.

## Where do we want to be?

**Reduction in number of overdue incidents / timely review of AAR's / Reduction is Medication incidents**

# MATERNITY AND NEONATAL EXPERIENCE

| Complaints & Concerns | March-25 | April-245 | May-25 | 2024/25 YTD |
|---|---|---|---|---|
| Maternity Complaints | 2 | 3 | 0 | 17 |
| Maternity Pals | 6 | 45 | 3 | 44 |




"I felt cared for and listened to... it made all the difference"

Together, we can ensure a safe, responsive, and positive birth experience.

Ask a member of staff about the 'Listen to Me' campaign for more information.

Listen to Me

We want to hear your voice

| Family & Friends Test (FFT) | UHN Target | National | March-25 | April-25 | May-25 | 2024-25 YTD |
|---|---|---|---|---|---|---|
| Maternity Friends & Family % of Responses | **20%** | **13%** | **82** | 211 | **123** | **2191 collected** |
| Maternity Friends & Family % of Promoters | **96%** | **93%** | **98%** | **99%** | **99%** | |

## What is the data telling us?

Areas for Improvement include:

- Need to update Delivery Rooms – ward manager to purchase wall stickers and Boards in process of being updated.
- Rooms are hot – fans purchased.
- Length of time to discharge – ongoing work. maternity discharge survey live –ends July 1st –results to follow.
- Partners staying overnight – June 2025 introduction, recliners ordered

## What is going well?

- FFT positive responses – great comments and over 98% satisfaction rate in all areas.
- One O'Clock Wonder – Maple Ward huddle of positivity launched June.
- No complaints this month.
- Launching Partners staying overnight on the back of service user feedback.

## What do we need to focus on?

- Improving FFT Collections – comms shared with staff.
- Appreciative Enquiry – 2 exciting initiatives to be launched:
- Wonderwall – wall of names of staff mentioned positively in FFT's devised and shared.
- Super7 – 7 positive feedback comments chosen by a different staff member per month.
- Continued focus on CQC Action Plan

**Improvement Work following service user feedback**

- Listen to Me Campaign
- Consent training for all staff
- Bespoke work with Motherhood Group
  - Community listening event
  - Bespoke staff training pro-gramme
- Commence UHN IOL QI work
- Introduction of drug rounds
- Order placed for partner recliner chairs for new ward

## Where do we want to be?

**Provide compassionate, caring and individualised care where women and birthing people feel supported and informed / Actions and improvements related to patient feedback and are acted upon promptly and sustained**

# MATERNITY AND NEONATAL FEEDBACK (STAFF)

## What is going well?

- Support from colleagues on shifts
- Staffing has improved
- Great feedback from staff attending LEO Course
- Fantastic UHN Celebration Day for International Day of the Midwife
- Positive feedback from ward staff
- Launch of divisional feedback Friday newsletter
- Staff social events organized by PMA team
- LNU reinstated as Level 2

## What do we need to focus on?

- Repeating culture survey to assess progress against previous years actions
- Staff appreciation – launch of recognition scheme within division
- Senior leaders undertaking walk arounds and checking in with staff
- Improved cross area working and understanding of challenges
- Work with LNU staff to support increase in number of babies in line with BAPM staff to baby ratio


| **Date of Walkaround : 22nd** May 2025 | **SC Name:** Jill Houghton |
|---|---|
| **Location:** KGH Maternity Rockingham Wing | **No. of Staff** : Midwives, MSWs, medics |

| Staff Feedback | Plan |
|---|---|
| Improved handover process | Inpatient matron working with ward manager to improve and standardise handovers on maple ward |
| Lack of you said we did posters in clinical areas | Matrons to work with admin support to ensure updated in line with monthly newsletter |
| Staff unaware of Real Birth Company plans | Update to be included in June's staff forum |
| NNU staff raised concern around facetime being removed from Ipads | Working with IT to reinstate |

## Where do we want to be?

**Empathic, culturally sensitive, and compassionate workforce to the benefit of families and staff / Improved staff experience**

Staff feedback

# WORKFORCE: TRAINING SUMMARY

### What is the data telling us?

**June 2025 – May dataset**

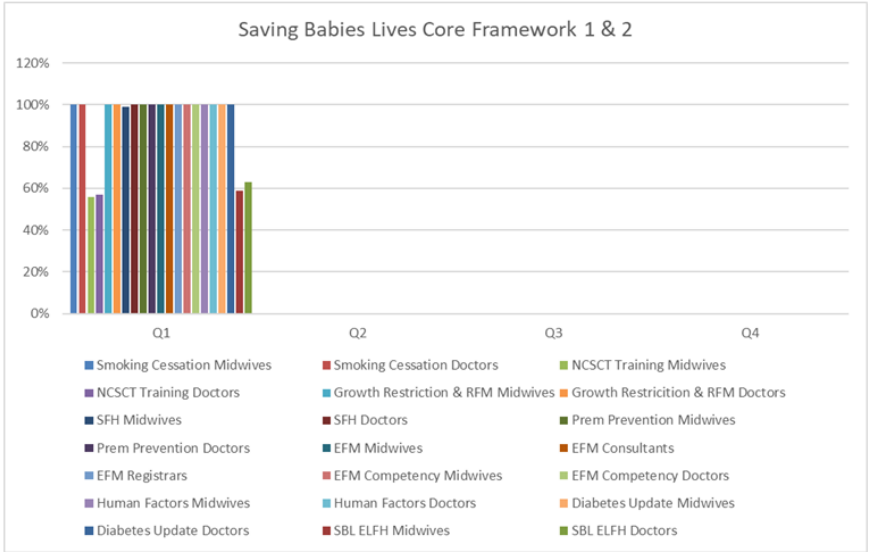
Framework Criteria 1&2
SBL - Smoking Cessation, SFH, RFM, GROW & PREM Prevention
Midwives 99%
Obs Doctors 97%
EFM Competency Assessment & Human Factors
Midwives 100%
Obs Doctors 97%
Framework Criteria 3
Midwives 98%
Obs Doctors 97%
Anesthetists 100%
Framework Criteria 4
Midwives 99%
Obs Doctors 97%
Framework Criteria 5
Management of Labour & Perineal Trauma OASI
Midwives 99%
Obs Doctors 97%
Epidural, Critical Care, Enhanced Recovery
Midwives 98%
Obs Doctors 97%
Framework Criteria 6, 7 & 8
Midwives 98%
Obs Doctors 97%

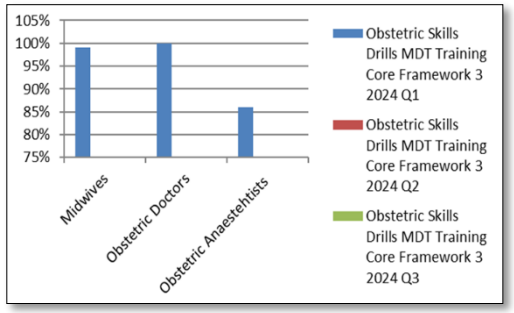
### What is going well?

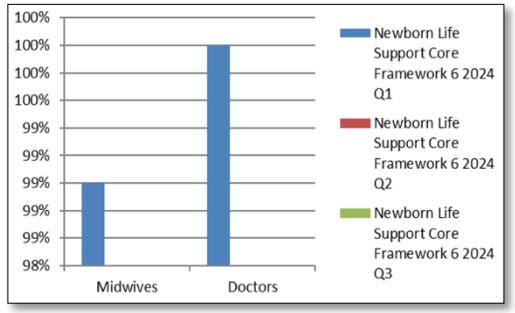
- Protected training continues monthly for all members of the MDT.
- Overall training compliance is above the targeted 95% in all areas
- Good engagement with MDT facilitators continues
- Bereavement study day completed in May

### What do we need to focus on?

- Achieving CNST element 8 this financial year
- Ensuring rotational Obstetric Doctors complete CPD training prior to November for CNST
- Ensuring Anesthetists remain compliant by November for CNST
- Update on Quarter 2 graphs following CPD week on 16th June




## Where do we want to be?

**>95% compliant in mandatory training by the end of the year / Outcomes to improve through seeing a reduction in perineal trauma and significant blood loss / Enhance staff knowledge, skills and confidence to provide safe evidence based and compassionate maternity care. / Create a culture of continuous learning / Using simulation, refine maternity staffs existing expertise and skill to identify and manage obstetric emergencies in a timely manner to reduce poor outcomes for mothers/ birthing people and infants**

# MATERNITY INCENTIVE SCHEME (MIS) PROGRESS

***SUMMARY***

| MIS Safety Action | MIS Standards | Status |
|---|---|---|
| 1: Use of Perinatal Mortality Review Tool | 6 | 100% complete |
| 2: Submitting data to the Maternity Services Data Set | 2 | 100% complete |
| 3: Transitional Care and Avoiding Term Admissions to Neonatal Unit | 4 | not achieved |
| 4. Clinical workforce planning | 10 | not achieved |
| 5. Midwifery workforce planning | 6 | 100% complete |
| 6. Saving Babies Lives Care Bundle | 6 | 100% complete |
| 7. Listening to women, parents and families | 5 | not achieved |
| 8. Multidisciplinary training | 3 | not achieved |
| 9. Ward to Board assurance | 9 | 100% complete |
| 10. MNSI and Early Notification Scheme reporting | 9 | 100% complete |

***Year 6 Results by Exception***

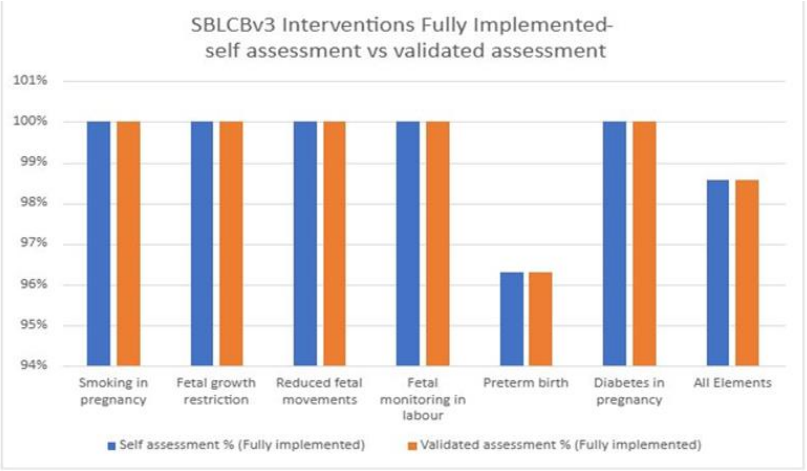
Kettering General Hospital has declared compliance with six out of the ten safety actions. KGH will declare partial compliance for the following safety actions:

- **Safety Action 3:** The current provision of transitional care services at KGH do no meet the BAPM recommended standard. Action plan being developed. A requirement to have a QI project to be registered within six months of MIS year 6 was not met.
- **Safety Action 4:** Obstetric consultant attendance to labour audit was completed, but did not measure all the requirements as outlined in the RCOG guidance for the measure to give assurance of compliance.
- **Safety Action 7:** KGH is not able to demonstrate co-production of the CQC women's survey with service users.
- **Safety Action 8:** Training compliance for obstetric and anaesthetic medical staff did not meet the 90% minimum standard during the reporting period.

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

# SAFETY: SAVING BABIES LIVES CARE BUNDLE v3 May 2025

| Intervention Elements | Description | Element Progress Status (Self assessment) | % of Interventions Fully Implemented (Self assessment) | Element Progress Status (LMNS Validated) | % of Interventions Fully Implemented (LMNS Validated) | NHS Resolution Maternity Incentive Scheme |
|---|---|---|---|---|---|---|
| Element 1 | Smoking in pregnancy | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 2 | Fetal growth restriction | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 3 | Reduced fetal movements | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 4 | Fetal monitoring in labour | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 5 | Preterm birth | Partially implemented | 96% | Partially implemented | 96% | CNST Met |
| Element 6 | Diabetes | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| All Elements | TOTAL | Partially implemented | 99% | Partially implemented | 99% | CNST Met |




**Element 1 – Smoking Cessation**
In April, the service reduced to one Midwife Dedicated to Tobacco Addiction (MDTA), resulting in no referrals to the in-house stop smoking service during that period. This is likely to impact compliance in the next quarter, and the service anticipates a *partial compliance* rating for this element.

**Element 2 – Risk Assessment and Surveillance of Fetal Growth Restriction**
The service is now *fully compliant* with this element. It is now possible to measure the identification of Fetal Growth Restriction (FGR) at 36 weeks and appropriately plan for induction of labour (IOL).

**Element 3 – Raising Awareness of Reduced Fetal Movement (RFM)**
There has been *no change* in compliance status for this element during the current reporting period.

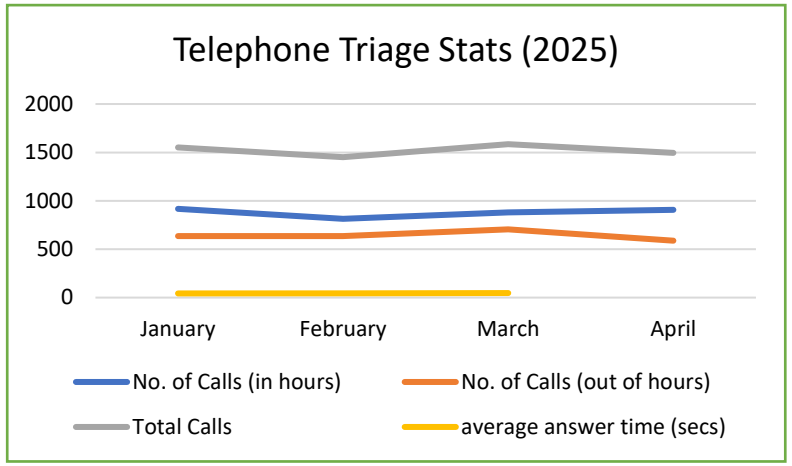
**Element 4 – Effective Fetal Monitoring During Labour**
In May, there were *zero reported cases* of intrapartum stillbirths, early neonatal deaths, or severe brain injuries where failures in intrapartum monitoring were identified as contributory factors. This is a positive indicator of effective practice in this area.

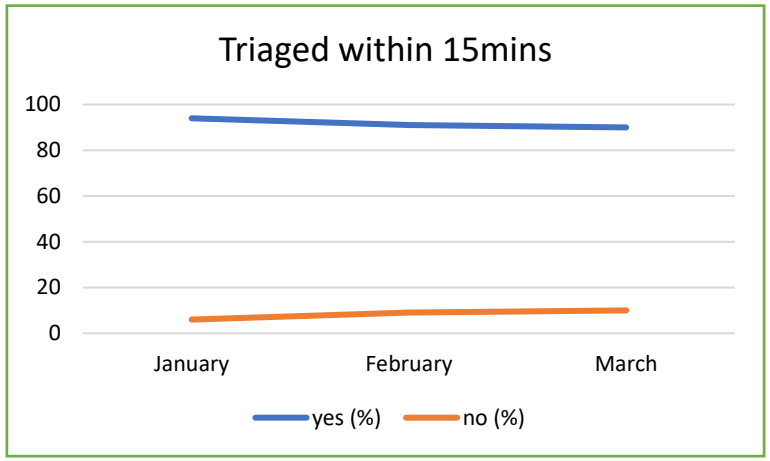
**Element 5 – Preterm Birth Prevention**
This element remains *partially compliant*, due to the current inability to audit women who attend with symptoms of threatened preterm labour. It is anticipated that the forthcoming implementation of the triage service and introduction of BadgerNet will enable improvements in data collection and compliance.

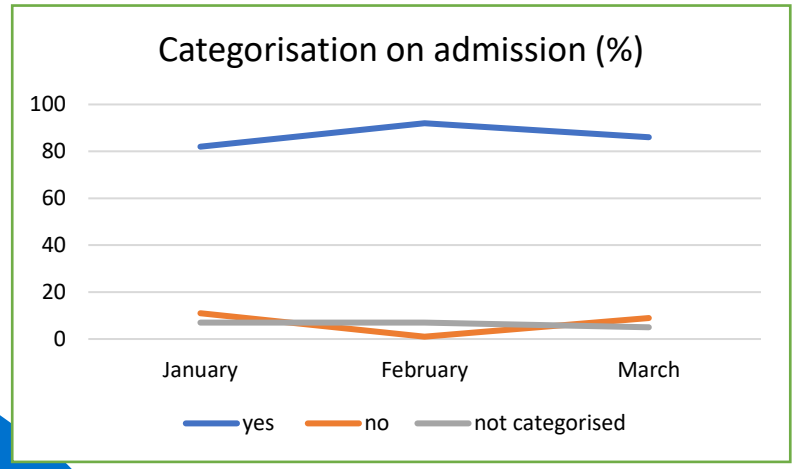
**Element 6 – Management of Women with Pre-existing Diabetes in Pregnancy**
There has been *no change* in compliance status for this element during this period.

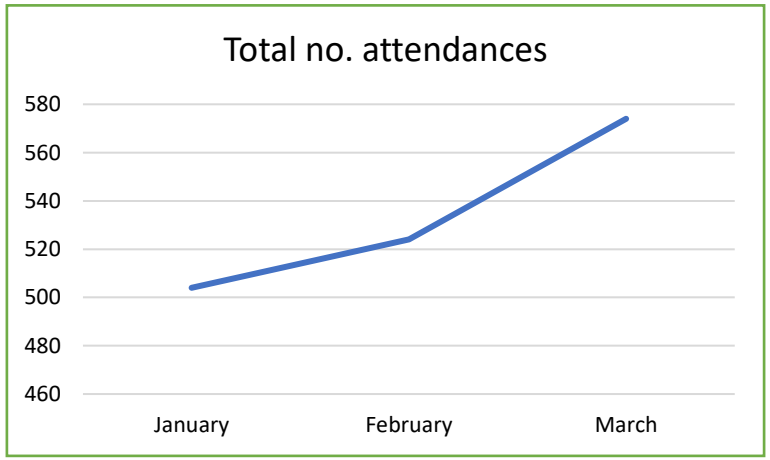
**SBLCBv3 Update**
The SBLCBv3 guidance has been updated to *Version 3.2* as of June 2025. Notably, the implementation tool has been revised accordingly. Services are advised to review the updated guidance and adapt implementation plans to ensure alignment.

# HOT TOPIC – Triage Update



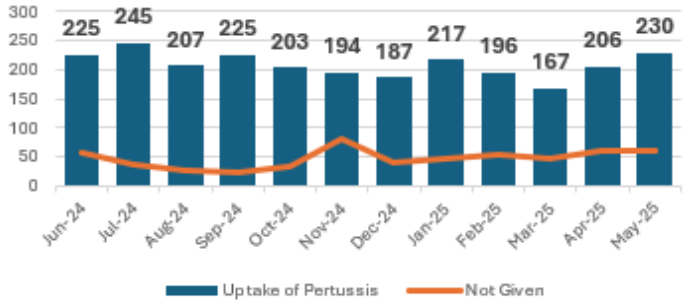




## Summary

- Interim triage relocated and launched
- Process is going well to date with positive feedback from women and staff
- Total number of telephone calls remain static over a 4-month period
- Less calls received out of hours compared to in hours, however numbers not too dissimilar
- Increase in number of attendances seen between Jan-Mar ’25
- Previous data was not collected so unable to determine if this is an expected number of admissions
- Triaged within 15mins remains at or above 90% compliant
- Additional work required around correct categorisation to remain consistently above 90% compliance

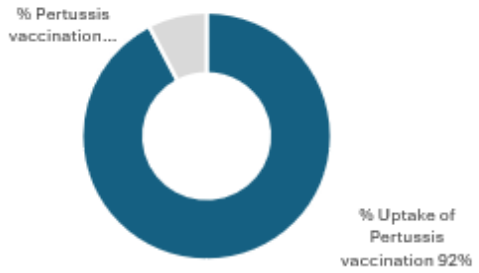
# IMMUNISATION SUMMARY: Antenatal Pertussis, RSV, Flu & Neonatal BCG (MAY 25 data)

Total Uptake of Pertussis vaccination

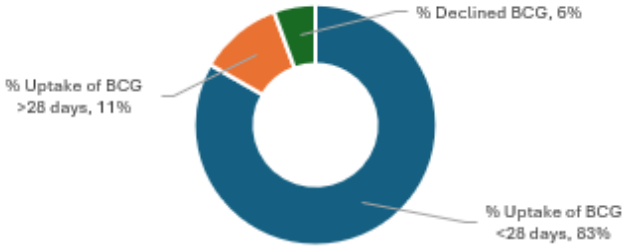



% Uptake of RSV vaccination - KGH May 25

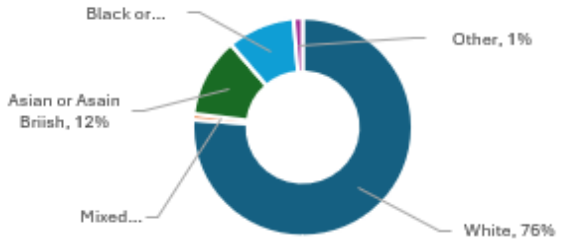

Uptake of Pertussis vaccination - KGH May 25




% Uptake of BCG Vaccination - KGH April 2025




Ethnicity (Grouped) of those who received the Pertussis vaccination - KGH May 25




Ethnicity (Grouped) of those who received the BCG Vaccine


*Proportion of women offered RSV vaccination who were vaccinated by the Trust's maternity service in the reporting period in comparison to the number of 1st FASP scans carried out

# NGH Perinatal Quality Assurance Scorecard

## June 2025

May 2025 Dataset

# CONTENTS


Overall Summary


Workforce


Safety


Patient Experience


Staff Feedback


Training


Progress against MIS


Hot Topics

# 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.

# MAY 2025 AT A GLANCE

## AVERAGES PER DAY

| BOOKINGS | BIRTHS |
|---|---|
| 11 | 11 |

## BABIES BORN

369

PREV. 12 MONTH AV. 357

## BIRTH LOCATION

NGH (Labour Ward) 325

| BIRTH CENTRE | HOME |
|---|---|
| 17 | 5 |

## 3RD & 4TH DEGREE TEARS

2.2%

APRIL - 1.9% ▲

## 2.5%

BLOOD LOSS >1,500MLS

APRIL - 4.2% ▼

## 185 GIRLS / 184 BOYS

PREV. 12 MONTH AVERAGE
181 GIRLS, 176 BOYS

## 4.9%

APRIL 4.2% ▲

FULL TERM BABIES ADMITTED TO NNU

## INDUCTION OF LABOUR (IOL)

24.7%

PREV. 12 MONTHS –22.8%

## 179 CAESAREAN SECTIONS 49.0%

| | MAY | PREV 12 MTH. AV. |
|---|---|---|
| ELECTIVE | 77 (21.1%) | 73 (20.6%) |
| EMERGENCY | 102 (27.9%) | 110 (30.9%) |

## SETS OF TWINS 5

## SETS OF TRIPLETS 1

## ASSISTED BIRTHS 29

| VENTOUSE | FORCEPS |
|---|---|
| 14 | 34 |

PREV. 12 MONTH AV.

| VENTOUSE | FORCEPS |
|---|---|
| 9 | 26 |

## BREASTFEEDING INITIATION

87.0%

PREV. 12 MONTHS –83.9% ▲

# MAY 2025 AT A GLANCE

**92%**

MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

APRIL - 96% ▼

YEAR 6 MATERNITY INCENTIVE SCHEME 9 SAFETY ACTIONS

**0**

MNSI REPORTABLE CASES & REFERRED

APRIL- 0

MATERNITY FRIENDS & FAMILY TEST (SATISFACTION %)

**94.3%**

APRIL 97.9% ▼

VACANCY RATE (APRIL DATA)

MIDWIVES **12.69%**

MAR– 10.96 % ▲

CONSULTANT OBSTETRICIAN 1.0 WTE

NEONATAL NURSES **3.2%**

NEONATOLOGISTS **0 WTE**

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)

**93%**

APRIL – 90% ▲

**0** MODERATE INCIDENTS

APRIL - 1

MINIMUM SAFE STAFFING MET (LABOUR WARD ONLY)

**87%**

APRIL – 91% ▼

**0** PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

APRIL – 0

**0** CORONER'S REGULATION 28

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

APRIL – 100%

NHS

# PERINATAL QUALITY SCORECARD SUMMARY

## Overview

In May there was 369 babies born across the service, higher than the monthly average.

94 Red Flags were reported with delay or cancellation of critical or elective activity the leading cause. This is likely a correlation minimum safe staffing levels dropping from 91% in April to 87% in May. These flags primarily relate to delays with transfers to Labour Ward to continue the process of induction of labour or timely completion of elective caesarean section. Escalation processes are in place.

Triage within 15minutes in the month was achieved for 92.5% of cases and 100% in 30minutes representing minimal delays in initial assessment. Work is ongoing to improve discharges and flow through the unit.

## Quality & Safety

0 (zero) Patient Safety Incident Investigations (PSII) have been reported. There were 5 moderate harm incidents reported with 2 downgraded and 2 further cases expected to be decreased following initial fact-finding post Incident Review Group.

## Outcomes

All CQiM Metrics remain within standard cause variation. The percentage of women who are booked by 10 weeks continues to be above 75% for the last 6 months. Close surveillance continues for PPH and 3rd/4th degree tears, which are reviewed through MIRF. No trends or themes have been identified on review.

## Training

- PROMPT overall compliance across all staff groups is 92%
- Newborn life support (NBLS/NLS) overall compliance is 93%
- Safeguarding compliance: Adults Level 3 - 92.09% Childrens Level 3 - 85.61%

## Experience

Overall Maternity satisfaction rate for May was 94.3%. Total response rate just below target (20%) at 18%, staff reminded to encourage all patients to complete the FFT for all areas of care. 'Birth' satisfaction dropped to 79.4%, however only 34 responses were received out of a potential 365 (9%).

## Workforce

- Midwifery vacancies increase in Month 1 to 12.69 WTE owing to resignation and a decrease in hours
- Reduction to 6.82 WTE in Month 2 due to new starters
- Trajectory in place to illustrate progress in year 2025/2026
- 5.9 WTE starting in May 2025
- 2.0 WTE Midwives starting between June and July
- interviews scheduled for a further 3.0 WTE Band 5 Midwives

| CQC Maternity Overall Ratings | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Maternity CQC (Last Inspected Nov 2022) | | | | | | |

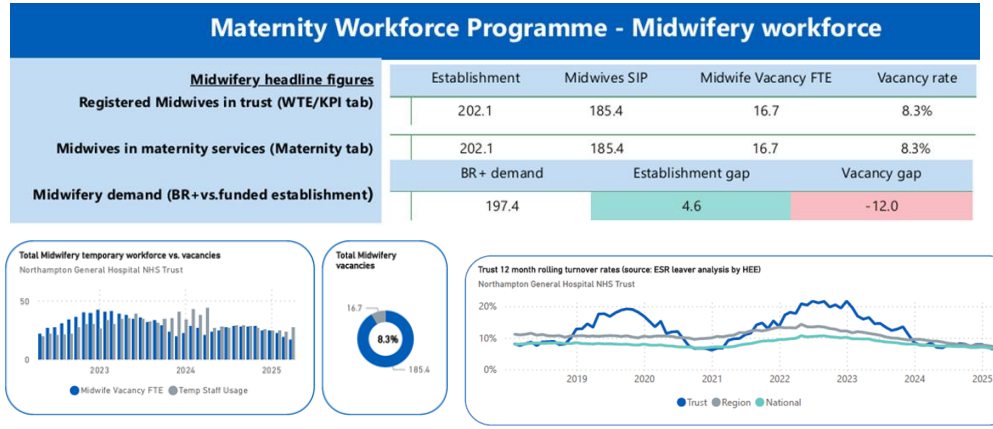
Overall summary

# WORKFORCE (MATERNITY)

| | MAR 2024 | | APR 2025 | | MAY 2025 | |
|---|---|---|---|---|---|---|
| | **Midwife** | **MSW** | **Midwife** | **MSW** | **Midwife** | **MSW** |
| Funded Establishment* | 202.07 WTE | | 202.16 WTE | | 202.16 WTE | |
| Funded Establishment | 196.35 WTE | 68.74 WTE | 196.44 WTE | 65.94 WTE | 196.44 WTE | 65.94 WTE |
| Vacancy WTE | 10.96 WTE | 4.65 WTE | 12.69 WTE | 4.87 WTE | 6.82 WTE | 5.28 WTE |
| Vacancy Rate | 5.58% | 6.76% | 6.46% | 7.39% | 3.47% | 8.00% |
| LTS WTE | 8.20 WTE | 2.83 WTE | 10.41 WTE | 2.03 WTE | 9.13 WTE | 2.21 WTE |
| Maternity Leave WTE | 11.77 WTE | 2.61 WTE | 12.16 WTE | 2.61 WTE | 11.16 WTE | 2.61 WTE |
| **Felt Vacancy Rate** | **15.75%** | **17.75%** | **17.95%** | **14.42%** | **13.80%** | **15.32%** |

* Number includes 5.72 WTE Registered General Nurses – figures updated accordingly

**January 2025 Data**




## What is the data telling us?

- Midwifery vacancies increase in Month 1 to 12.69 WTE owing to resignation and a decrease in hours.
- Reduction to 6.82 WTE in Month 2 due to new starters
- Trajectory in place to illustrate progress in year 2025/2026

## What is going well?

- 5.9 WTE starting in May 2025
- 2.0 WTE MW starting between June and July
- Interviews scheduled for 3.0 band 5 MWS

## What do we need to focus on?

Leavers
- 2 Midwives resignations due to relocation
- 2 more upcoming Midwife leavers

## OBSTETRICS STAFFING UPDATE

- 10.9 WTE currently in position (Funded for 11.9 WTE, 10.9 WTE Substantive Consultants + 2.2 WTE Locum Consultant)
- 8.9 WTE Consultant able to undertake full clinical duties
- 1 WTE Consultant with Special Interest in College Tutor role - due to commence in August 2025

## OBSTETRIC ONGOING WORK:

- Review fetal medicine service including lead role and number of fetal medicine clinics following scan review
- Working to reduce locum use as new consultant commences in post

## Where do we want to be?

**Reviewing continuity of care pathway / Respond to staff survey results with meaningful output to improve satisfaction /**
**Sustain and continue to improve retention rates for the pipeline staff expected / Maintain low levels of Long and Short-term sickness absence**

# WORKFORCE (NEONATOLOGY)

| | FEB 2025 | | MAR 2025 | | APR 2025 | |
|---|---|---|---|---|---|---|
| | Registered | HCA | Registered | HCA | Registered | HCA |
| Funded Establishment | 47.69 WTE | 8.32 WTE | 47.69 WTE | 8.32 | 47.70 WTE | 8.32 WTE |
| Vacancy WTE | 0.53 WTE | 0.05 WTE | 1.53 WTE | 0.05 Wte | 1.54 WTE | 0.05 WTE |
| Vacancy Rate | 1.11 % | 0.6% | 3.2% | 0.6% | 3.2% | 0.6% |
| LTS WTE | 2.0 WTE | 0.00 WTE | 1.0 WTE | 0.00 WTE | 1.0 WTE | 0.00 WTE |
| Maternity Leave WTE | 3.03 WTE | 0.00 WTE | 3.03 WTE | 0.00 WTE | 3.03 WTE | 0.00 WTE |
| Felt Vacancy Rate | 11.65% | 0.6 % | 11.65% | 0.6 % | 11.66% | 0.6% |

| | Q1 WTE | Q2 WTE | Q3 WTE | Q4 WTE |
|---|---|---|---|---|
| New Starters | 0.61 | 0 | 3 | 1 |
| Leavers | 0 | 2.84 | 0 | 0 |
| Net Gain / Loss | 0.61 | -2.84 | 3 | 1 |
| Turnover | 0% | 5% | 0% | 0% |
| Maternity Leave (WTE) in quarter | 3.76 | 3.77 | 4.6 | 4.6 |
| Sickness days (WTE) in quarter | 6.29 | 6.65 | 4.59 | 2.16 |
| Bank Usage (WTE) in quarter | 3.4 | 5.4 | 4.3 | 7.3 |
| Agency Usage (WTE) in quarter | 0.00 | 0.00 | 0.00 | 0.0 |

## What is the data telling us?

Minimal vacancies within neonates within all staffing groups

## What is going well?

Recruitment and retention stable, advert for Band 5 is on TRAC

Sickness is stable with support in place

## What do we need to focus on?

- Reducing bank usage as able
- AHP Gaps

## NGH Neonatal Medical Staffing – As at 29 April 2025 (including Action Plan)

- **Tier 1 (SHO)**
  - Fully BAPM compliant ✓ dedicated tier 1 doctor for neonatal service available 24/7, but many are GP trainees
  - One Nurse currently undertaking ANNP training in Southampton, to join tier 1 in 2025
- **Tier 2 (Registrar)**
  - As per local activity, BAPM standard = dedicated tier 2 doctor for neonatal service 24/7
  - Requires 15 WTE tier 2 rota
  - NGH Business Case secured in 2022 to uplift tier 2 staffing from 10 to 15 WTE
  - Challenges recruiting sufficient new tier 2 doctors in last 18 months: applicants ✓ but most abroad, VISA problems
  - Current Plan
    - 3 internal ANNPs promoted to tier 2 in May 2024 (their backfill on tier 1 rota has been recruited)
    - Further tier 2 interviews and appointments are in progress; rota may be replete by Spring 2025
    - In the interim, tier 2 is being supported by internal locum coverage and occasional external locum
    - The current approach affords the Neonatal Service a dedicated tier 2 doctor on almost all (but not every) shift
- **Tier 3 (Consultant)**
  - Fully BAPM compliant ✓ current establishment is 7 WTE = BAPM standard for LNU

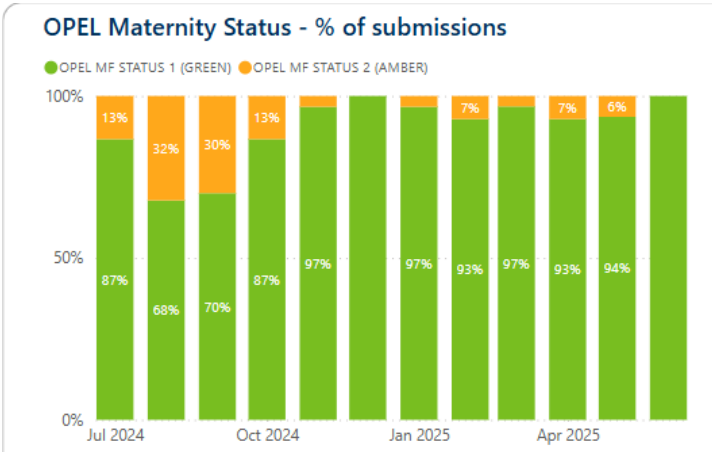
**Where do we want to be?**

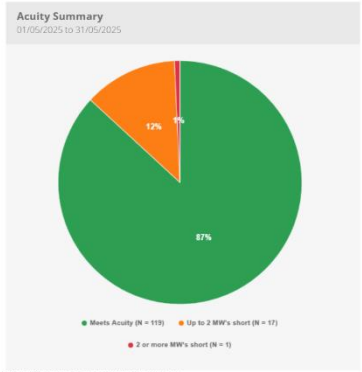
**Staffing levels and QIS trained nurse levels for the unit to be compliant with BAPM standards /**

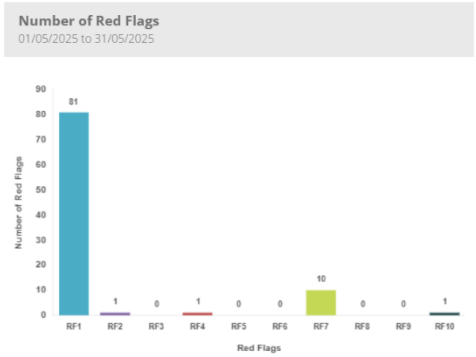
**Recruit and train according to the trajectory plan for the nurses to achieve the compliance as required by BAPM**

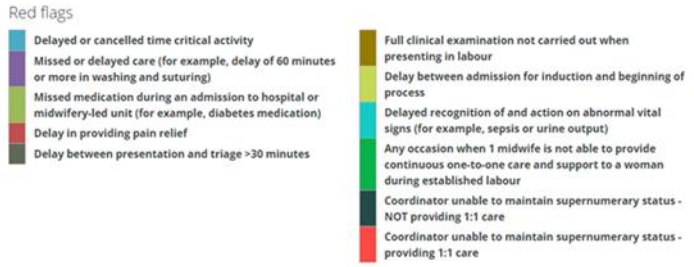
# OVERALL MATERNITY OPERATIONAL ACTIVITY

**Maternity Red Flags - LW**
March 2025 – 66
April 2025 – 48
May 2025 - 94




| One-to-One Care in Labour | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 | May 2025 |
|---|---|---|---|---|---|
| % of women receiving 1:1 care in labour | 100% | 100% | 99.6% | 100% | 100% |

| Supernumerary Status of LWC | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 | May 2025 |
|---|---|---|---|---|---|
| No of occasions LWC was NOT Supernumerary | 0 | 0 | 0 | 0 | 1 |

## What is the data telling us?

- Monthly reportable Red Flags 94
- High acuity has resulted in 81 occasions where there has been a delay or cancellation of critical activity. These relate to delays with transfers to Labour Ward to continue the process of induction of labour or timely completion of elective caesarean section. Escalation process in place via Midwifery Manager on call in relation to mitigating these delays
- LWC was not supernumerary for around 20 minutes due to a labourer coming in and precipitate labour

## What do we need to focus on?

The acuity app compliance rate for May sits at 73.66%

Elective Pathways – review of capacity and demand, experience

## What is going well?

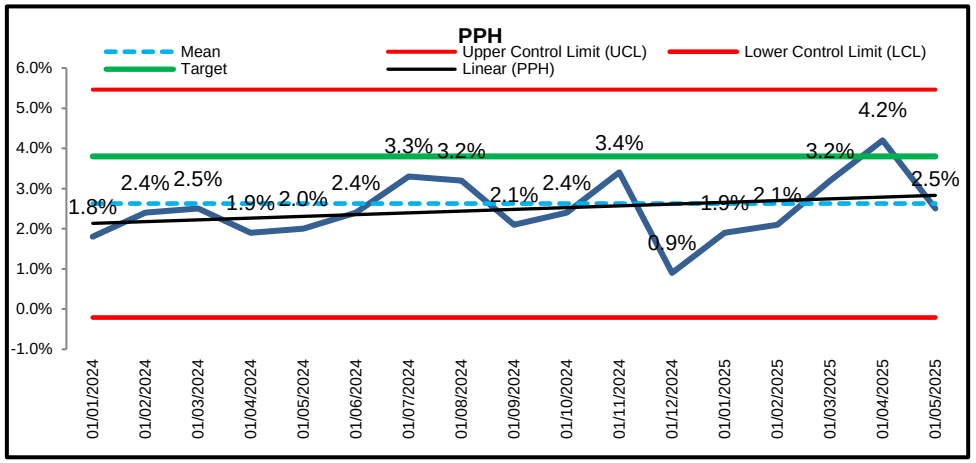
Staffing met acuity 87%% of the time in May

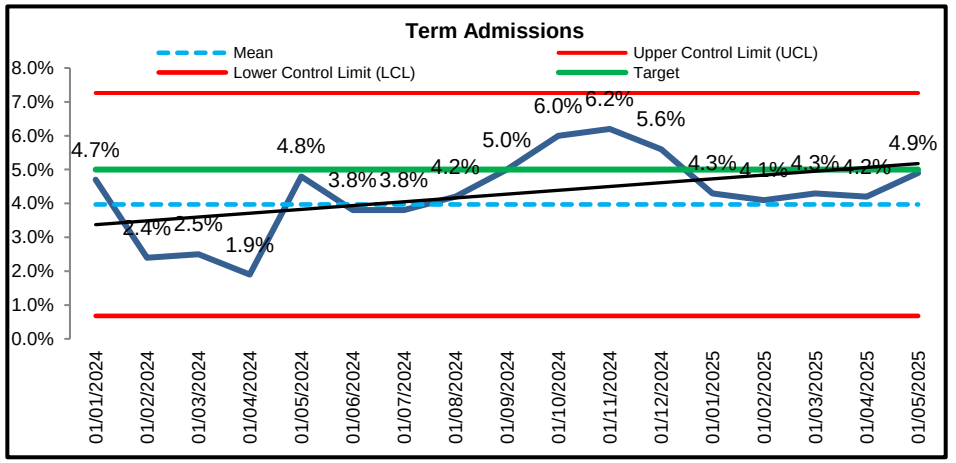
The percentage of women receiving 1:1 care in labour during May was 100%

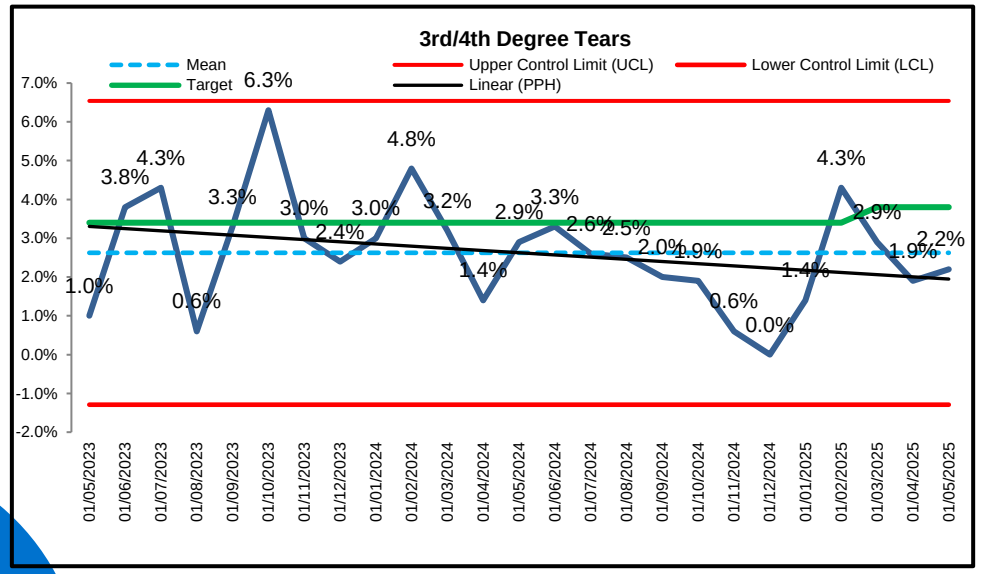
## Where do we want to be?

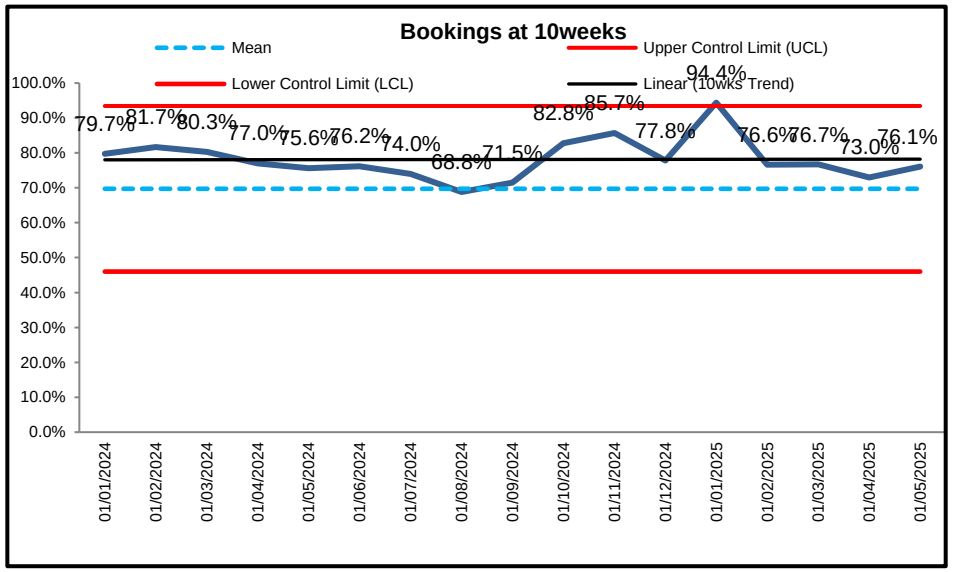
**Meet or Exceed 85% BirthRate Plus Compliance / Maintain safe staffing levels / Maintain 1:1 care in labour / Maintain Supernumerary Status of Labour Ward Co-Ordinator / Consistent reporting within the Birthrate plus acuity tool across the service / Reduce reliance on Bank**

# SAFETY: CLINICAL QUALITY SURVEILLANCE METRICS



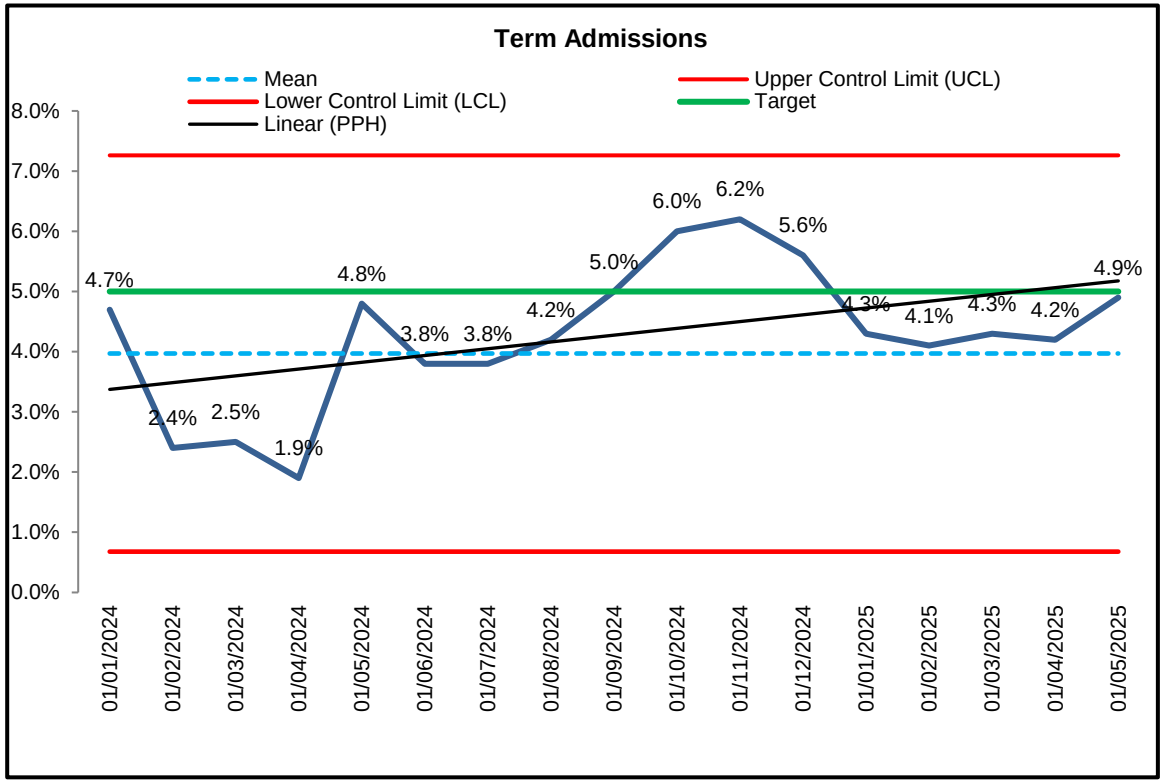




## Summary

CQiM Metrics remain within standard cause variation.

# SAFETY: CLINICAL QUALITY SURVEILLANCE METRICS

## *Area of Focus: ATAIN*




### What is the data telling us?

Continue to be below the national agreed average with a slight increase in month

ATAIN meeting continues monthly with a focus on the obstetric and neonatal care provided.

The obstetric ATAIN data for May tells us that all of the cases were unavoidable and appropriate.

### What do we need to focus on?

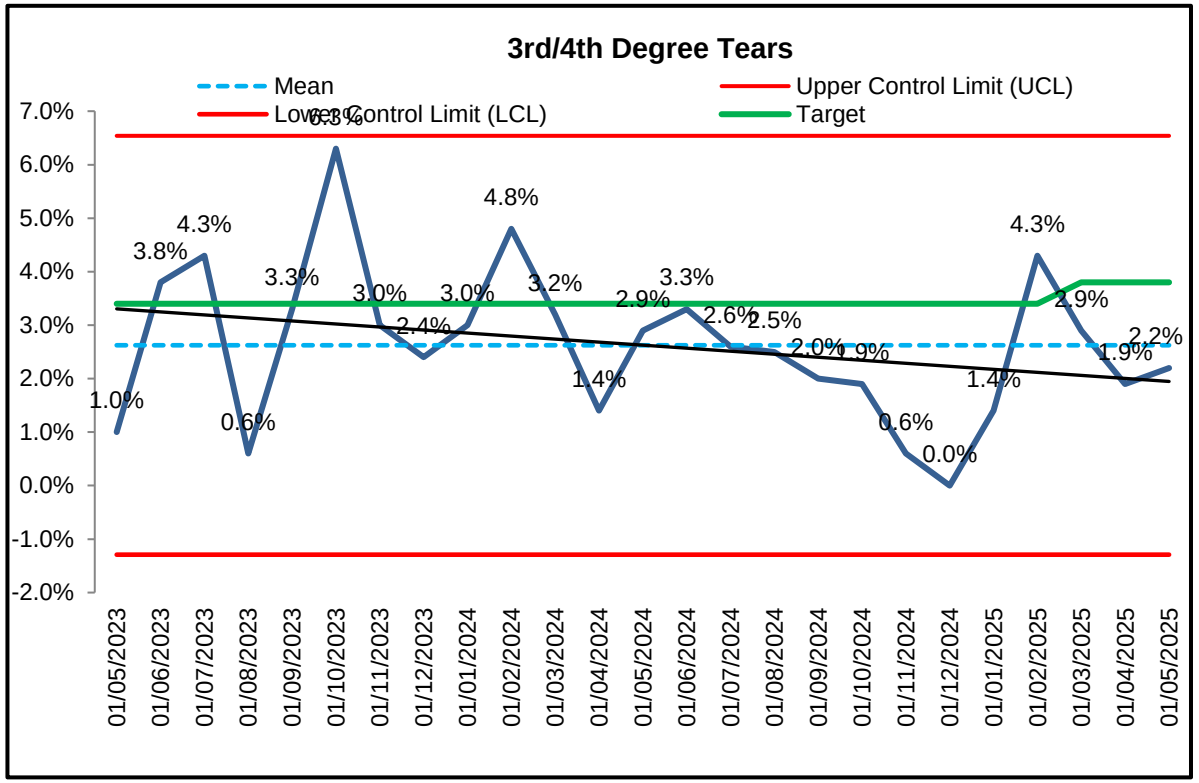
A meeting has been held between the KGH and NGH ATAIN teams to align eligibility requirements including a representative from the regional lead.

ATAIN meetings will continue, and the cases are thematically reviewed quarterly.

A QI project on Neonatal Hypoglycaemia continues to show improvements in the management of clinical care.

# SAFETY: CLINICAL QUALITY SURVEILLANCE METRICS

## *Area of Focus: Third-and-Fourth Degree Tears*




### What is the data telling us?

Continue to be below target for third and fourth degree tears (2.2%).

4 OASI cases reported in May (2 x 3b, 1 x 3a, 1 x 3c).

There were no obvious omissions in care. However incidental learning identified is the OASI bundle at delivery is not being followed consistently.

### What do we need to focus on?

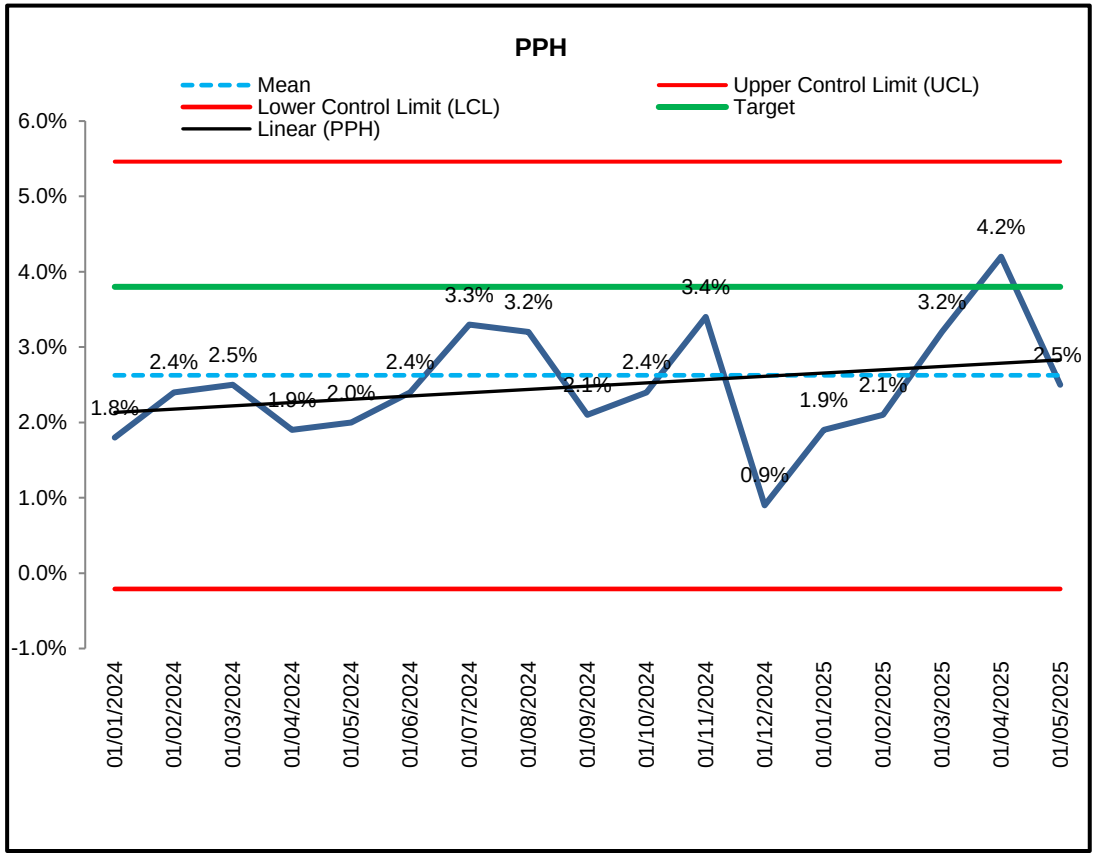
All 3rd/4th Degree tears will continue to be reviewed in MIRF, any learning identified will be actioned accordingly.

Practice development focusing on learning working collaboratively with the Consultant Midwife and Risk Team

Different methods of learning will be discussed as identified.

# SAFETY: CLINICAL QUALITY SURVEILLANCE METRICS

## *Area of Focus: PPH*




### What is the data telling us?

Following a peak in April of 4.2% the service has returned to below target for PPH at 2.5%

### What do we need to focus on?

No trends or themes have been identified.

No care omissions reported however learning identified that documentation can be improved.

There have been no concerns regarding the management of PPH

PPH management will continue to be monitored each month.

### Next Steps

Participating in the OBSUK PPH project aiming to improve identification and management of PPHs. The 4 elements are;

- Risk assessment for all admissions for delivery in all settings
- Cumulative real-time measurement of blood loss for ALL deliveries
- Escalation of multi-professional care to more senior staff at defined volumes of blood loss with appropriate medical intervention.
- Use of ROTEM for point-of-care testing of coagulation to guide blood product management

Monthly audits to be carried out. The use of the ROTEM machine has commenced and working well. Utilise risk assessment forms and cumulative measured blood loss recording

# SAFETY INCIDENT REPORTING

| PERINATAL MORTALITY CASES | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Monthly Perinatal Losses | Total number of losses reported to MBRRACE | Number of losses reported to MBRRACE within 7 days | Perinatal Surveillance completed within 1 month | Number that meet PMRT criteria | Parents informed and questions/ concerns noted | PMRT completed by MDT and comply with CNST submission requirements | Late Fetal Loss >22/40 | Stillbirths | NND born and died at NGH | NND (born, NGH transferred and died at other Trust) |
| Q4 2024/25 | Jan-25 | 5 (1x NND died OUH) | 4 | 4 | 4 (OUH Case) | 3 | 3 | 3 | 0 | 2 | 2 | 0 |
| | Feb-25 | 9 | 2 | 2 | 1 (1 case TOP surveillance not required) | 1 | 1 | 2 | 0 | 2 | 0 | 0 |
| | Mar-25 | 9 | 2 | 2 | 2 (1 case NND in LRI) | 2 | 2 | 2 | 1 | 1 | 0 | 1 |
| Q1 2025/26 | April-25 | 7 | 1 | 1 | 1 | 0 | N/A | 1 | 1 | 1 | 1 | 0 |
| | May-25 | 9 | 0 | 0 | 0 | 0 | N/A | 0 | 1 | 0 | 0 | 0 |

| MAY 2025 |
|---|
| 0 cases met MNSI criteria |
| 0 MNSI Safety Recommendations |
| 0 Non MNSI Serious Incidents |
| 0 Never Events |
| 0 Moderate Incidents |
| 0 Coroner Reg 28 |
| 2 New Claims |
| 0 Closed Claims |

## PSII UPDATE

**Ongoing PSII**
0

**Completed PSII**
0

## AFTER ACTION REVIEW

0

Where do we want to be? **Full implementation of MNSI Safety Recommendations / Further reduction of perineal trauma incidents / Proactive incident reporting, encouraging the reporting of all incidents promptly to ensure early identification of potential risk**

# SAFETY INCIDENT REPORTING

### What is the data telling us?

- 0 (zero) Patient Safety Incident Investigations (PSII) have been reported
- 5 moderate harm incidents reported but two downgraded to no harm and a further two to be discussed at IRG for downgrade
- No themes have been identified through Perinatal Mortality Review Tool
- There was a total of 9 perinatal losses, no cases were reportable to MBRRACE. The 9 losses are 4 TOP's, 3 spontaneous losses and 2 Intrauterine deaths all being non-registerable gestation
- 2 new claims in May 2025:
  - 40+4 weeks born by emergency section due to maternal pre-eclamptic toxemia (PET). Precipitate labour and baby born in poor condition with poor tone/thick meconium liquor (incident in Feb 2025)
  - Concerns regarding failure to recognise that fetal growth had tailed off with no follow up (incident in March 2017)

### What is going well?

- NGH & KGH are working collaboratively on improving and streamlining our ATAIN and PMRT Meetings
- The Risk Team continues to work closely with specialty areas within Maternity to ensure all learning is disseminated to staff in a supportive manner.

### What do we need to focus on?

- Continue training for OASI bundle in intrapartum care and highlight any further training/learning material that could potentially be used for staff.
- Ensure that reported incidents are graded in line with harm as per the Patient Safety Incident Response Framework.
- Targeted focus to support service leads on the investigation and closure of Datix in a responsive manner and within prescribed timescales
- Training for all new starters in Datix including medical colleagues

# MATERNITY AND NEONATAL EXPERIENCE

| PALS Complaints & Complaints | Apr-25 | May-25 | 2025-26 YTD |
|---|---|---|---|
| Maternity | 6 | 6 | 12 |
| Neonatal | 1 | 0 | 1 |

| Family & Friends Test (FFT) | Apr-25 | May-25 | 2025-26 YTD |
|---|---|---|---|
| Maternity FFT % Satisfaction Score | 97.9% | 94.3% | 96.1% |
| Maternity FFT Responses Received | 195 | 228 | 423 |

## What is the data telling us?

- Overall Maternity satisfaction rate for May was 94.3%
- Neonates are listening to parents and continue to perform well

## What do we need to focus on?

- Total response rate just below target at 18%
- Of the 9% of 'birth' rated satisfaction dropped to 79.4%
- 3 PALS / 3 Complaints
- Complaint Themes: Discrepancies in information given, lack of communication, no consistency in care, incorrect documentation

## Compliments

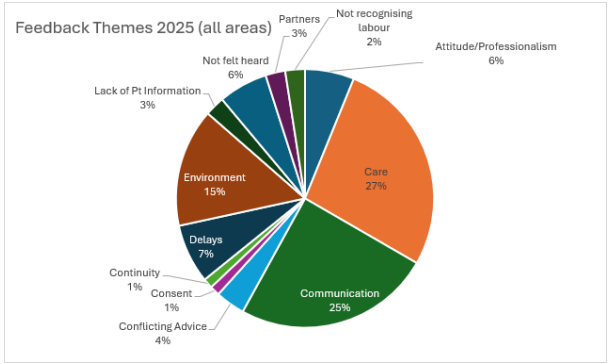
"As a fellow physician, the care given by the department has been excellent. Caring, patient and readily available to help. Consultant Ben was so kind, caring and empathetic approach. On the recovery ward, care given by midwife, MSW and nurse was absolutely amazing and compassionate"

"Every member of the team from food and drinks, cleaning and of course all the midwives were all fantastic!! Everyone went above and beyond and we had the best experience!"

"Midwives were absolutely fantastic, really calming and reassuring and I felt very safe and well looked after"

"The midwives that looked after me were amazing, great communication, very informative over what was happening and the choices I had. I felt very well looked after and was able to have a normal delivery even after some ups and downs in labour"

"We felt very cared for, the midwives were very thorough and attentive. As soon as I asked for help, they got it for me and made me as comfortable as they could"




**ETHNICITY**

White or British - 58%
Black African or Caribbean - 10%
Asian - 10%
Mixed/other - 9%
Not stated - 18%

**RESPONSES BY AREA**

TOTAL - 228 (18%)

Robert Watson - 53
AN class - 35
Sturtridge - 31
Balmoral - 24
BF Classes - 21
TC - 14
MOW/IOL - 12
MDU - 8
Screening -5
Far Cotton - 5

Billing Rd- 4
Central - 2
Iris - 2
BBC - 3
Fetal Med - 3
Room C - 2
Triage - 2
ANC - 1
Rural - 1

## Where do we want to be?

**Provide compassionate, caring and individualised care where women and birthing people feel supported and informed / Women and birthing people feel empowered to provide feedback and are given regular opportunities which are accessible for all / Actions and improvements related to patient feedback and are acted upon promptly and sustained**

# MATERNITY AND NEONATAL FEEDBACK (STAFF)

| Non Executive Safety Walkaround May 2025 (NGH) Staff Feedback | Plan / Actions |
|---|---|
| **Labour Ward:**<br>• Discussion with obstetrician and LW Co-ordinator regarding RCOG / EBC team working. Anaesthetists joining in more enthusiastically<br>• Use of Induction of Labour video discussed | • RCOG/EBC team of the shift continues to be embedded<br>• Induction of Labour video to be launched however further work to strengthen and refine |
| **Robert Watson:**<br>• Delays with Discharge video - staff frustrated in the delays to launch<br>• Student midwives enjoying their placements.<br>• Furniture still not available for the Garden<br>• No gel outside and immediately as you enter the area | • **Discharge video** presented at Maternity Clinical Effectiveness Group (MCEG). Animations to be included however support sought from the Communications Team.<br>• **Garden Furniture** Awaiting feedback from the Shared Decision Making Council. Charitable funds requested..<br>• **No Gel** escalated to ward manager to resolve plus escalation to the IPC team |
| **Balmoral:**<br>• Triage signposting to Balmoral is still not in place<br>• Paediatricians visiting Robert Watson Ward first which delays Balmoral discharges by hours<br>• TTOs are made up on Balmoral now but the staff thought this took them away from their patients and preferred it when pharmacy sent up the TTOs. | • Triage telephone midwife moving to Birth Centre to enable women being triaged over the phone and access directly to Birth Centre.<br>• Inpatient Matron and Ward Managers to communicate the need to prioritise discharges on Balmoral when appropriate at Board Round. |
| **Transitional Care:**<br>• Unit very busy with a newly qualified Midwife in charge, due to staffing issues | • Continue to support and ensure appropriate skill mix and staff allocation. Preceptorship package in place |
| **Gosset Ward:**<br>• Very excited about their Gold Award - again very busy but staff keen to tell me how much they loved working in the unit | • Continue to sustain gold award and ensure ongoing recognition for staff.<br>• Share learning across other areas |


**Where do we want to be? Empathic, culturally sensitive, and compassionate workforce to the benefit of families and staff / Improved service user experience: families to receive high quality care which is personalized and inclusive / High care for all, with NGH being a great place to work; investing in the development of our staff and timely action on feedback.**

# WORKFORCE: TRAINING SUMMARY

**Module 3: Maternity emergencies and multiprofessional training:**

| | Apr 2025 | May 2025 |
|---|---|---|
| Midwives | 99% | 96% |
| Consultants | 100% | 100% |
| Obstetric Doctors | 83% | 77% |
| Anaesthetists | 86% | 92% |
| MSW's | 99% | 95% |

**Module 6: Neonatal basic life support:**

| | Apr 2025 | May 2025 |
|---|---|---|
| Midwives | 93% | 92% |
| MSW's | 88% | 94% |
| Neonatal Consultants | Not Available | TBC |
| Neonatal Junior Doctors (who attend births) | Not Available | TBC |
| Neonatal Nurses (Band 5 and above QIS) | Not Available | TBC |
| Advanced Neonatal Practitioners (ANNP) | Not Available | TBC |

**Element 4: Fetal monitoring and surveillance:**

| | Apr 2025 | May 2025 |
|---|---|---|
| Midwives | 100% | 98% |
| Consultants | 100% | 100% |
| Obstetric Doctors | 100% | 100% |

**Cultural Competency Training**

This session has been rolled out as part of the Year Two agenda covering the Core Competency Framework requirements. This cover content including; UHN vision for EDI, discrimination, unconscious bias, health inequalities, LGBTQ+ content, BAME content, disability content, microaggression and tackling racism toolkits & more.

In 2025 172 staff members have attended the training across the maternity service, which is 46%. By the end of the year, the projected figures will be at least 98% attendance with 404 people planned/booked

### What is the data telling us?

- PROMPT overall compliance – 92%
- Newborn life support (NBLS/NLS) overall compliance 93%
- Safeguarding compliance:
  - Adults Level 3 - 92.09%
  - Childrens Level 3 - 85.61%

### What is going well?

- Consultants attendance continues at 100%

### What do we need to focus on?

- Attendance for Obstetric Doctors still remains an issue for PROMPT and Specialities day. This continues to be escalated

## Where do we want to be?

**>95% compliant in mandatory training by the end of the year / Outcomes to improve through seeing a reduction in perineal trauma and significant blood loss / Enhance staff knowledge, skills and confidence to provide safe evidence based and compassionate maternity care. / Create a culture of continuous learning / Using simulation, refine maternity staffs existing expertise and skill to identify and manage obstetric emergencies in a timely manner to reduce poor outcomes for mothers/ birthing people and infants**

# MATERNITY INCENTIVE SCHEME (MIS) PROGRESS

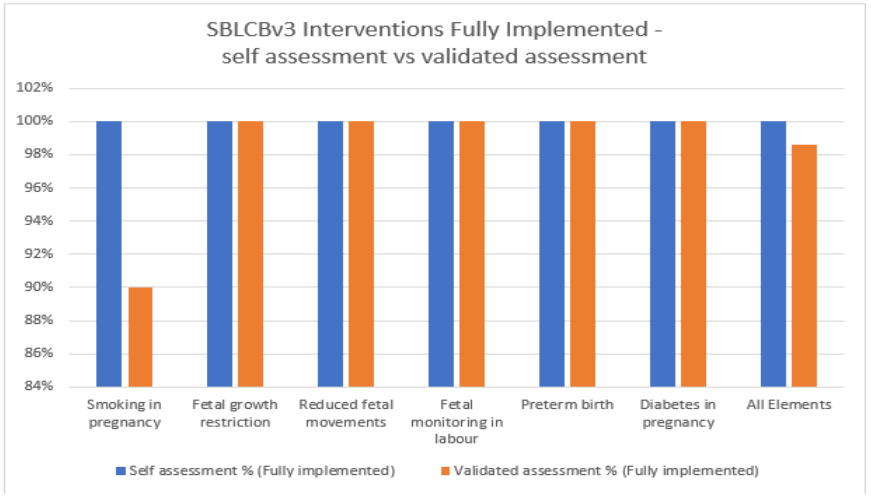
***SUMMARY***

| MIS Safety Action – Year 6 | MIS Standards | Status |
|---|---|---|
| 1: Use of Perinatal Mortality Review Tool | 6 | NOT ACHIEVED |
| 2: Submitting data to the Maternity Services Data Set | 2 | 100% complete |
| 3: Transitional Care and Avoiding Term Admissions to Neonatal Unit | 4 | 100% complete |
| 4. Clinical workforce planning | 20 | 100% complete |
| 5. Midwifery workforce planning | 6 | 100% complete |
| 6. Saving Babies Lives Care Bundle | 6 | 100% complete |
| 7. Listening to women, parents and families | 7 | 100% complete |
| 8. Multidisciplinary training | 17 | 100% complete |
| 9. Ward to Board assurance | 9 | 100% complete |
| 10. MNSI and Early Notification Scheme reporting | 8 | 100% complete |

| MIS Safety Action – Year 7 | MIS Standards | Status |
|---|---|---|
| 1: Use of Perinatal Mortality Review Tool | 6 | On Track |
| 2: Submitting data to the Maternity Services Data Set | 2 | On Track |
| 3: Transitional Care and Avoiding Term Admissions to Neonatal Unit | 4 | On Track |
| 4. Clinical workforce planning | 20 | On Track |
| 5. Midwifery workforce planning | 6 | On Track |
| 6. Saving Babies Lives Care Bundle | 6 | On Track |
| 7. Listening to women, parents and families | 7 | On Track |
| 8. Multidisciplinary training | 17 | On Track |
| 9. Ward to Board assurance | 9 | On Track |
| 10. MNSI and Early Notification Scheme reporting | 8 | On Track |


**Full MIS year 7 document and accompanying resources were published on 2 April 2025**

# SAFETY: SAVING BABIES LIVES CARE BUNDLE v3




**Implementation Progress**

| Intervention Elements | Description | Element Progress Status (Self assessment) | % of Interventions Fully Implemented (Self assessment) | Element Progress Status (LMNS Validated) | % of Interventions Fully Implemented (LMNS Validated) | NHS Resolution Maternity Incentive Scheme |
|---|---|---|---|---|---|---|
| Element 1 | Smoking in pregnancy | Fully implemented | 100% | Partially implemented | 90% | CNST Met |
| Element 2 | Fetal growth restriction | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 3 | Reduced fetal movements | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 4 | Fetal monitoring in labour | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 5 | Preterm birth | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 6 | Diabetes | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| All Elements | TOTAL | Fully implemented | 100% | Partially implemented | 99% | CNST Met |

All six Elements of the care bundle are fully compliant with CNST

NGH SBLCB V3 – 99% implemented across the total care bundle

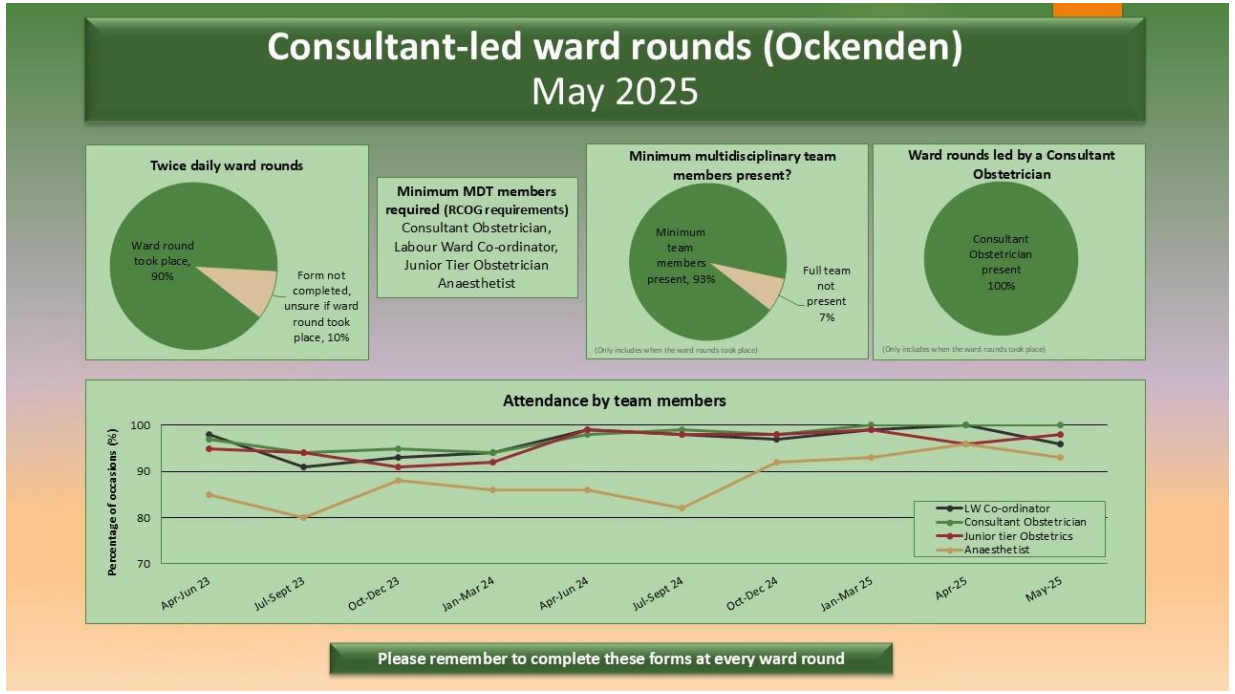
Five out of the six elements of the care bundle are fully implemented at 100%

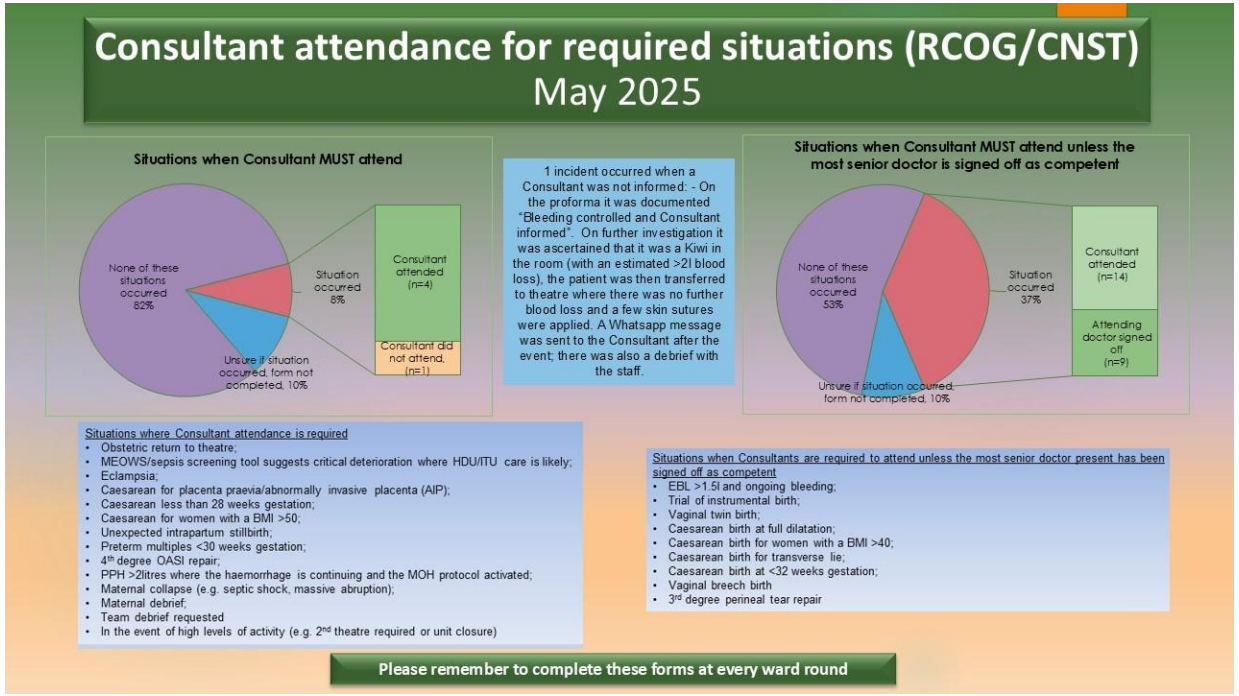
Element 1 smoking in pregnancy at 90% implemented, due to achieving less than the set trajectory for engagement with In –house Tobacco cessation Clinic

Next LMNS Review – August 2025

| What do we need to focus on | Actions |
|---|---|
| **Element 1 - Smoking cessation**<br>**Smoking cessation pathway**<br>Lack of job security for MTDA | Lack of job security for MTDA documented on risk register, for action by all stakeholders |
| Preterm Birth Prevention; focus required on preterm labour compliance with steroids<br><br>Fetal surveillance and risk assessment ; It is imperative all growth scans are inputted onto GROW 2.0 to ensure correct future care of the patient | Current review of monthly data and presentation of findings at next UHN Safety champions meeting<br><br>Email sent to staff as reminders |

# SAFETY: Consultant Attendance for Required Situations (RCOG/CNST)



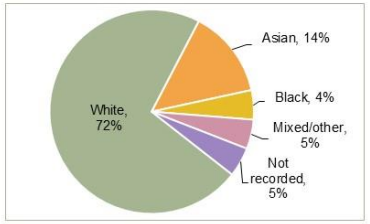



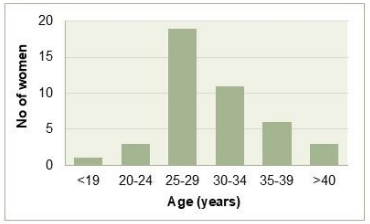
# HOT TOPIC – Triage Update

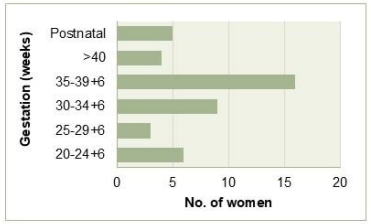
## The busiest day in the life of Maternity Triage during May 2025

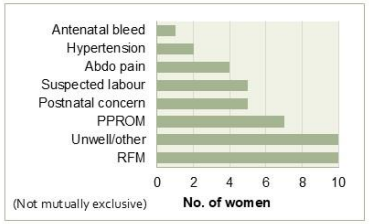
On the busiest day, 45 women attended
(2 did not have TAC cards filed in notes so were omitted from this analysis)

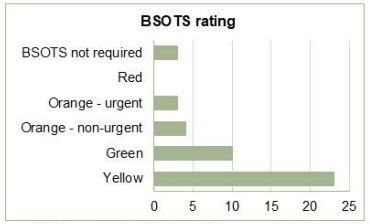
| | |
|---|---|
| Arrival to initial triage within 30 minutes (red-flag standard) | 100% |
| Arrival to initial triage within 15 minutes (gold standard) | 92.5% |
| Seen for ongoing treatment within appropriate time for BSOTS rating: - | |
| By midwife | 100% |
| By doctor | 78% |

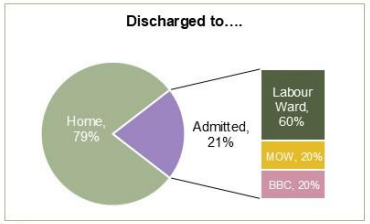



- 100% seen by the Midwife within appropriate time for BSOTS rating
- 78% seen by the Doctor within appropriate time for BSOTS rating
  - 1 orange non-urgent = 1hr 12 mins, should be seen within 1 hour
  - 2 yellow = 2 hrs 19 mins and 2 hrs 39 mins, should be seen within 2 hours
  - 2 lack of information on times

A huge thank you to the incredible **Triage Team** who worked across this 24-hour period - Precious Kufeji, Raz Akhtar, Bini Koshy, Hannah Stapleton, Kerrie Bale, Meg Knowles and Archana Patil

# Cover sheet

| | |
|---|---|
| Meeting | University Hospitals of Northamptonshire NHS Group (UHN): Boards of Directors of Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust (Part II) Meeting in Public |
| Date | 27 June 2025 |
| Agenda item | 9 |

| | |
|---|---|
| Title | Children and Young People (CYP) Improvement Plan Analysis and update on Ibex Gale cultural report status against recommendations |
| Presenter | Julie Hogg, Chief Nurse |
| Author | Ngozi David-West, Interim Deputy Director of Patient Safety, University Hospitals of Leicester NHS Trust (UHL) |

| This paper is for | | | |
|---|---|---|---|
| ☐ Decision | ✓Discussion | ☐ Note | ✓Assurance |
| To formally receive and discuss a report and approve its recommendations OR a particular course of action | To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it | For the intelligence of the Board without the in-depth discussion as above | To reassure the Board that controls and assurances are in place |

| Reason for consideration | Previous consideration |
|---|---|
| To provide the Boards with an update on progress against the CYP Improvement Plan, incorporating the actions arising from the independent Patient Safety Culture Review (PSCR). The paper summarises current delivery against identified actions, highlights key areas of assurance, and sets out next steps to support ongoing improvement in culture, leadership, safety and operational delivery within CYP services. | An update on the CYP Improvement Plan was received by the NICB Quality Committee on 17 June 2025. This is the first presentation of the combined update incorporating the PSCR recommendations. |

## Executive Summary

The Children and Young People (CYP) Improvement Plan continues to deliver meaningful progress across all workstreams, providing a clear, structured response to regulatory findings, independent reviews, and organisational priorities.

As of June 2025, over half of the actions (36 of 71) have been completed or formally signed off; of the remainder, 39% (28 of 71) are on track for timely delivery. A small number of actions (7 of 71) unfortunately remain behind trajectory, primarily relating to workforce development and finalisation of clinical policies. Robust recovery plans are in place for all outstanding actions, supported by established governance processes via bi-weekly oversight meetings to ensure appropriate mitigations are in place and a safe service is delivered, and twice-daily safety huddle which afford the opportunity to address any new and emerging issues in a timely manner.

**Key Headlines:**

- Leadership development and workforce competency training progressing through phased delivery, supported by clinical education leads.
- Clinical policy ratification for PED/PAU transfers and care of 16–17-year-olds under active review, with interim arrangements in place to support safe care delivery.
- Martha's Rule implementation initiated across CYP services, with national guidance awaited to inform full Emergency Department roll-out.
- Strengthened colleague engagement through listening events and phased involvement of patients and families.
- New clinical leadership team established, enhancing visibility, leadership presence and proactive cultural support.
- Governance processes embedded via AMaT system, ensuring transparent tracking, escalation, and shared learning.

**Key Areas of Focus:**

- Completion of outstanding clinical policy ratification and full embedding of competency frameworks.
- Continued delivery of leadership development programmes aligned to colleague accessibility and organisational priorities.
- Sustained winter planning preparations ahead of autumn 2025, including patient flow, escalation processes, and workforce flexibility.
- Ongoing alignment of Patient Safety Culture Review (PSCR) actions into core workstreams, with assurance integrated into divisional governance structures.

The CYP Improvement Plan remains underpinned by clear accountability, strong governance, and active risk management. The Trusts can be assured that while some actions remain in progress, we have appropriate mitigation and plans in place to ensure/secure delivery, sustain improvements, and maintain focus on delivering safe, effective care for children, young people, and their families.

The Boards are asked to:

1. Note the progress made to date in delivering the CYP Improvement Plan which is being overseen by the Quality and Safety Committee.
2. Support ongoing oversight and escalation of actions that remain off trajectory.
3. Endorse continued delivery through the established workstreams and governance framework.
4. To be assured that delayed actions have appropriate mitigation to deliver a safe service and a timeframe for completion

| Appendices |
| --- |
| None |
| **Risk and assurance** |
| **Risk Ref: 3012** – relating to insufficient nurse staffing to maintain safe 24/7 Paediatric ED cover.<br>**Risk Ref: 3016** – relating to insufficient middle-grade cover affecting timely paediatric care.<br>**Risk Ref: 4236** – relating to ED triage and flow delays impacting safe, timely care.<br>**Risk Ref: 4391** – relating to ongoing estates issues affecting clinical areas and requiring patient relocations to maintain safety.<br><br>Specific risks for the plans are described in Section (4) below. |
| **Financial Impact** |
| Plan is being delivered within existing resources, with ongoing financial requirements managed through routine planning; no material financial risks have been identified. |
| **Legal implications/regulatory requirements** |
| Plan supports the Trust's response to external regulatory requirements, including CQC findings, PFD reports, and independent safety reviews, ensuring continued compliance with statutory patient safety and governance duties. |
| **Equality Impact Assessment** |
| Plan promotes inclusive care by strengthening staff and family engagement, supporting equitable access to safe, high-quality services for all children and young people. No adverse equality impacts have been identified. |

# Paper

## Situation

The Children and Young People (CYP) Improvement Plan continues to address key areas identified through regulatory, external and internal reviews. Significant progress has been made across all workstreams, a small number of actions remain behind trajectory. Continued focus and oversight remains to ensure that remaining actions are delivered and that improvements are fully embedded to sustain safe, high-quality care and appropriate mitigation is in place to ensure safe, quality care is delivered to patients accessing the service.

## Background

The Children and Young People (CYP) Improvement Plan (IP) sets out a comprehensive programme of work to improve the safety, experience, and outcomes of care for children and young people at University Hospitals of Northamptonshire (UHN). The plan consolidates actions drawn from multiple sources, including Care Quality Commission (CQC) inspections, divisional leadership reviews, Prevention of Future Deaths (PFD) reports, and independent external reviews, most notably the Ibex Gale Patient Safety Culture Review (PSCR).

To support focused delivery and oversight, the plan is structured around seven thematic workstreams:

1. Leadership and Culture
2. Clinical Pathways and Guidance
3. Family Engagement and Communication
4. Safe Environment and Equipment
5. Governance, Incidents and Learning
6. Triage and Initial Assessment
7. Winter Planning and Escalation

Each action is assigned a role/named lead, delivery timeline, and supporting evidence requirements. Divisional teams have clear ownership of delivery, with progress monitored through established governance forums. The Trust's digital quality management platform (AMaT) system provides consistent and transparent tracking of all actions.

## Assessment

1. **Current CYP IP Progress by June 2025**

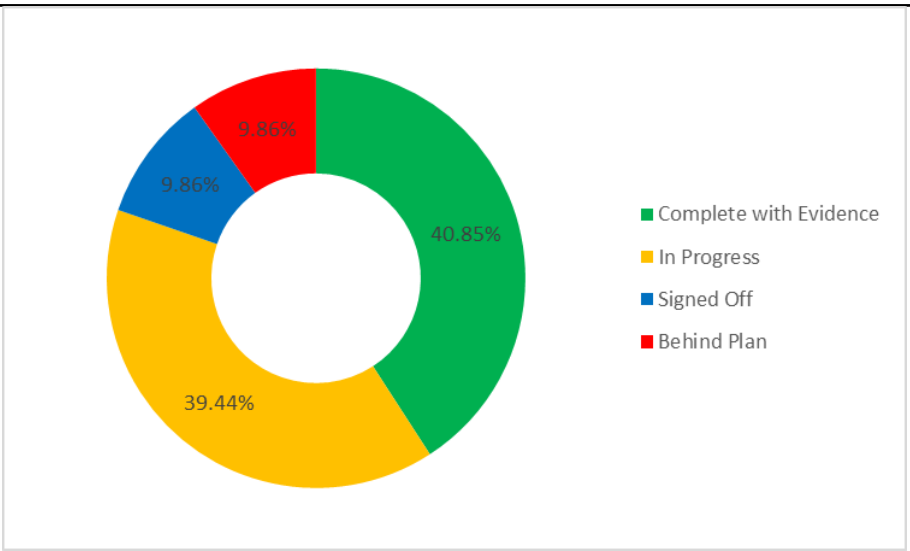



*Figure 1: Current CYP IP Status June 2025*

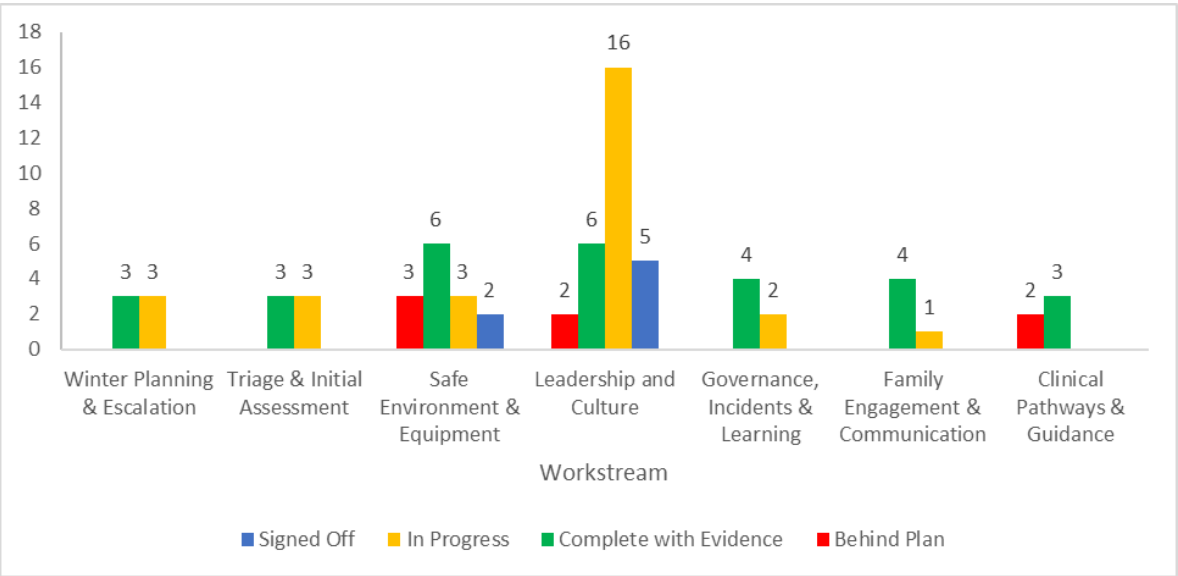
As at the time of writing the report:

- 51% (36 of 71) of CYP IP actions have been completed or formally signed off as meeting their success criteria.
- 39% (28 of 71) are progressing well and on track for delivery by planned due dates.
- 10% (7 of 71) are currently behind trajectory, largely related to workforce specialist competency development and clinical policy ratification (see Fig 1). Policies will be ratified during June 2025 governance meetings.

Recovery plans are in place for all delayed actions, with ongoing oversight through divisional governance and Trust-level assurance structures.

**2. CYP IP Workstream Headlines**

*Table 1: CYP IP Workstream Progress Summary by June 2024*



**Leadership and Culture**

- 38% (11 of 29) of actions have either been completed with supporting evidence or signed off; 7% (2 of 29) behind trajectory.
- Focus areas include leadership development programmes and alignment of nursing competencies with Royal College of Paediatrics and Child Health (RCPCH) standards.
- Leadership development is being made increasingly accessible across all staff groups, with phased delivery of competency training supported by clinical education leads.

**Clinical Pathways and Guidance**

- 60% (3 of 5) of actions completed, 40% (2 of 5) are behind plan.
- Delays relate to the ratification of the Paediatric Emergency Department (PED) / Paediatric Assessment Unit (PAU) transfer Standard Operating Procedure (SOP) and development of a policy to support the transition of care for 16–17-year-olds. Interim pathways are in place to minimise risk, and the Trust remains committed to ensuring these elements are finalised and embedded in a timely and robust manner. The respective policies/SOP will be ratified during June 2025 governance meeting.

**Family Engagement and Communication**

- 80% (4 of 5) of actions completed, 20% (1 of 5) is progressing well.
- The introduction of Martha's Rule has commenced within CYP services, with national guidance awaited to finalise implementation in Emergency Department settings.

**Safe Environment and Equipment**

- 57% (8 of 14) of actions have either been signed off or completed; 21% (3 of 14) on track; 21% (3 of 14) behind trajectory.
- The dependency on agency nurses is reducing as new colleagues join the team. All bank/agency Registered Nurses have attended a focused study day prior to being able to work across the CYP pathway this ensures they have the required core competencies to work in the area. Education leads continue to work with agencies to ensure colleagues have the required specialist competency to work within area i.e. non-invasive respiratory support. We have delivered a series of multidisciplinary simulation sessions with a long-term rolling programme that is cross division and encompasses the entire workforce. This forms the basis of a shared education strategy that will be signed off in August.

**Governance, Incidents and Learning**

- 83% (5 of 6) of actions either been signed off or completed with clear supporting evidence; 17% (1 of 6) is on track for timely delivery.
- Incident review and shared learning processes are embedded, with structured feedback loops in place to promote continuous learning across services.

**Triage and Initial Assessment**

- Half (3 of 6) of actions completed; half are (3 of 6) on track.

- Sustained improvements supported by targeted training and audit activity focused on early assessment and triage consistency.

**Winter Planning and Escalation**

- 50% (3 of 6) of actions completed; remaining actions progressing as planned.
- Divisional working groups are actively progressing key priorities, including patient flow, front-door streaming, staffing flexibility, and improved collaboration between site and ward teams. Which will feed into the ongoing organisational winter planning group.

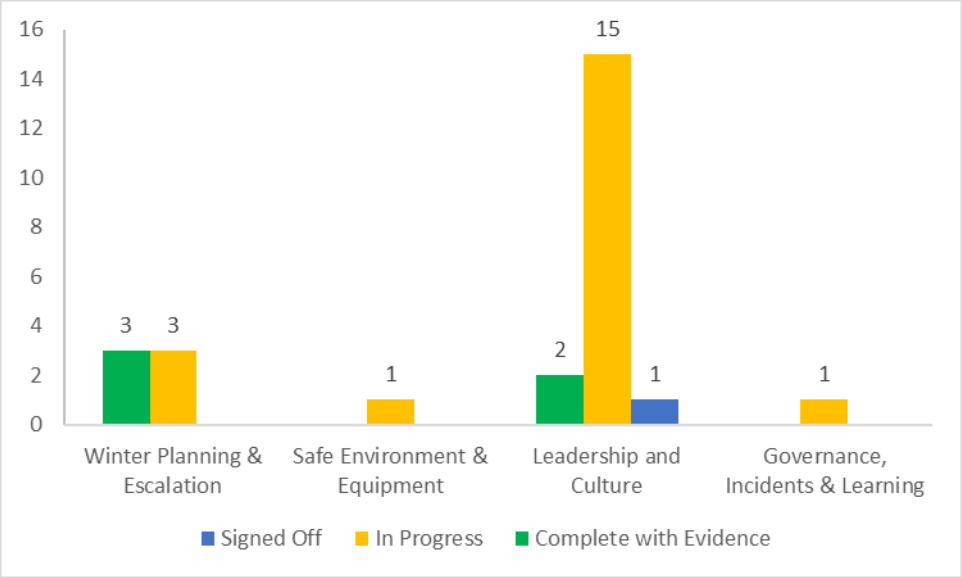
**3. Integration of Patient Safety Culture Review (PSCR)**

The independent Patient Safety Culture Review (PSCR), conducted by Ibex Gale in response to concerns raised in 2024, identified 55 recommended actions across workforce, leadership, collaboration, and service pressures. Over half of the issues highlighted were already recognised and being addressed through the CYP Improvement Plan, with 30 actions already embedded within existing workstreams. The remaining 26 new actions have been fully integrated into four active workstreams:

- Leadership and Culture
- Safe Environment and Equipment
- Governance, Incidents and Learning
- Winter Planning and Escalation.

Notably, the review has directly informed the establishment of a dedicated Winter Planning and Escalation workstream, further strengthening service readiness and operational resilience.

*Table 2: PSCR Action Progress by Workstream - June 2025*




**PSCR Action Progress - June 2025:**

As at the time of writing the report, 4% (1 of 26) of actions had been signed off, 19% (5 of 26) completed with evidence and approximately 77% (20 of 26) in progress (see Fig 2). All

actions are monitored through the CYP Improvement governance framework, with clear divisional ownership and accountability.

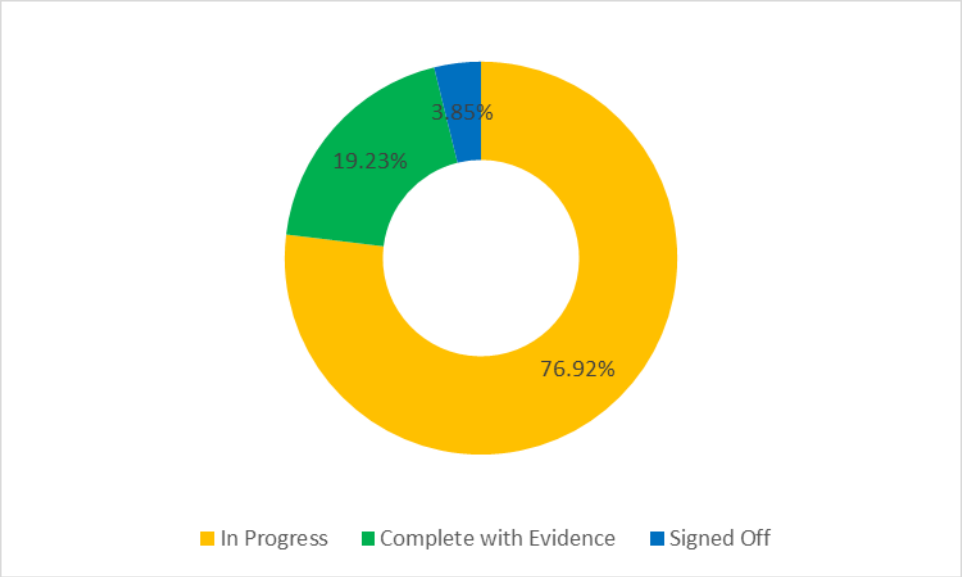



*Figure 2: PSCR Action Status by June 2025*

**PSCR Action Progress Key Headlines:**

- Six workforce listening events delivered; further sessions scheduled.
- Family engagement sessions commenced via a phased approach.
- New clinical leadership team in place, with enhanced visibility through regular walkabouts.

**PSCR Next Steps:**

- Complete integration of PSCR actions into workstream reporting cycles.
- Embed outcomes into divisional governance and clinical effectiveness reviews.
- Sustain workforce and family engagement, ensuring feedback drives service improvement.
- Evaluate the impact of winter planning preparations ahead of autumn 2025.

**4. Risks and Mitigations**

| Risk | Impact | Mitigation |
|---|---|---|
| Delay in clinical policy ratification (PED/PAU SOP, 16–17-year-old care) | Potential inconsistency in pathways | Interim processes in place; governance oversight maintained – completion June 2025 |
| Workforce development frameworks not fully embedded | Gaps in assurance on staff readiness | Ongoing phased roll-out supported by education leads; education leads working clinically by bedside nurses |
| Delays in leadership development programme delivery | Potential cultural and capability gaps | Ongoing accessibility work aligned to workforce needs |

| | | |
|---|---|---|
| Site-to-ward coordination during winter pressures | Potential flow and escalation challenges | Dedicated divisional working groups in place |

## Recommendations

The CYP Improvement Plan continues to demonstrate a clear, structured, and accountable approach to delivering necessary improvements. Strong progress is evident across all workstreams, with well-established governance providing oversight and early identification of risks.

While some actions remain behind trajectory, these are well understood, with recovery actions in place with appropriate mitigation to deliver a safe service. Use of the AMaT platform ensures transparency and consistency in monitoring delivery. The Trust remains fully committed to sustaining improvement, managing risks, and delivering safe, high-quality care for children, young people, and their families.

The Boards are asked to:

1. Note the progress made to date in delivering the CYP Improvement Plan which is being overseen by the Quality and Safety Committee.
2. Support ongoing oversight and escalation of actions that remain off trajectory.
3. Endorse continued delivery through the established workstreams and governance framework.
4. Be assured that delayed actions have appropriate mitigation to deliver a safe service and a timeframe for completion

# Cover sheet

| | |
|---|---|
| Meeting | University Hospitals of Northamptonshire NHS Group (UHN): Boards of Directors of Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust (Part II) Meeting in Public |
| Date | 27 June 2025 |
| Agenda item | 10 |
| Title | Race, Ethnicity and Cultural Heritage (REACH) Network Tackling Racism Paper |
| Presenter | Paula Kirkpatrick – Chief People Officer |
| Author | Tracey Robson – Deputy Chief People Officer |

**This paper is for**

| √ Decision | ☐Discussion | ☐Note | √ Assurance |
|---|---|---|---|
| To formally receive and discuss a report and approve its recommendations OR a particular course of action | To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it | For the intelligence of the Board without the in-depth discussion as above | To assure the Board that controls and assurances are in place |

| Reason for consideration | Previous consideration |
|---|---|
| Our REACH network raised concern on progress in addressing racism in the workplace. A rapid evidence review was conducted along with a listening event to identify improvement ideas. This paper provides an overview of progress to date, reassesses our current actions and identifies suggestions for improvement. | EDI Reports September 2024<br>National Staff Survey 2024 Results Roll Out Paper January 2025<br>Boards of Directors: Freedom to Speak Up discussion at May 2025 meeting |

## Executive Summary

In July 2023, the KGH and NGH Boards signed up to UHN being an anti-racist organisation. This is a commitment that means not just being anti-racist, but involves proactive efforts to address and dismantle systemic racism.

Between September 2023 – March 2025 significant work has been undertaken to address race-based discrimination at UHN. This report reminds Boards of the collaborative work and initiatives that have supported this agenda and in response to regional and national reports such as the NHSE Equality, Diversity & Inclusion Plan (June 2023).

We acknowledge that we are moving in the right direction, but more progress needs to be made. We have targeted inclusion programmes co-created with our REACH Network but we must constantly review and learn from what works and look at the evidence from other providers and organisations.

This report sets out where progress has been made and where there is more to do. The report recommends specific action for the Boards to take.

| Appendices |
| --- |
| Appendix 1: WRES (2022-2025), VARG (2022-2025) and staff survey data<br>Appendix 2: REACH Network Listening Event held on 14 May 2025 - Review NSS Result |
| **Risk and assurance** |
| BAF UHN 01: Challenges in our ability to attract, recruit, develop and retain colleagues means we are unable to deploy the right people to the right role at the right time resulting in potential detriment to patient care. |
| **Financial Impact** |
| Racism has adverse financial implications for recruitment, retention costs and everyday operational demands caused due to wellbeing of our colleagues (including long-term sickness). These recommendations offer sustainable, financially viable solutions that improve the experience of our workforce and our patient community |
| **Legal implications/regulatory requirements** |
| UHN has a statutory duty to respond to the Public Sector Equality Duty, ensuring we:<br>• foster good relations<br>• eliminate discrimination, harassment, and victimisation<br>• advance opportunities for individuals who share a protected characteristic (race, ethnicity & nationality for the purpose of this paper) |
| **Equality Impact Assessment** |
| This work focusses on the three general duties of the Equality Act 2010, with a specific emphasis on the protected characteristics around Race, the paper aims to highlight inequalities, gather soft intelligence and develop actions in response to reduce the disparity. The process established within UHN involves colleagues and stakeholders in discussion, action planning and assurance. |

## Situation

We have a number of sources of data available to us to assess changes in staff experience relating to race (detail in Appendix 1):

- Workforce Race Equality Standard (WRES) data
- Violence and Aggression Reduction Group (VARG) data
- National Staff Survey (NSS) data (some data from NSS feeds WRES)

The data tells us incidents involving colleagues are slightly declining overall, but cases related to ethnic discrimination are increasing and remain higher than the average. A review of WRES data (2022–2025) confirms these trends.

**WRES Data**
Indicator 5 - % of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This indicator has **improved slightly** at both Trusts but **remains high** at c.30% in both.

Indicator 6 - % of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months – has **seen improvement** over the last three years, **remains high** at 20% (NGH) and 27% (KGH).

Indicator 7 - % of BAME staff believing that the Trust provides equal opportunities for career progression or promotion – NGH has shown improvement over the last three years, KGH remains consistently low. **In both Trusts less than 50% of colleagues believe the Trust provides equal opportunities for progression**. (Encouragingly data from 2023-2025 indicates that 43% (out of total 351) of graduates of our aspiring and emerging leadership offer are REACH colleagues which is higher than their representation in the workforce.)

Indicator 8 - % of BAME staff experiencing discrimination at work from a manager/ team leader/other colleague – has **improved** at both Trusts but **still high** at 14% (NGH) and 18% (KGH).

Indicator 9 – % difference between Board membership and overall BAME workforce, KGH & NGH both show a **decline**, which is reflective of changes in Board membership.

**VARG Data**
Data from VARG between 2022-2025 depicts an increase in incidents reported via DATIX. NGH has encouraged colleagues to report all incidents that require an investigation by promoting the 'No Excuse For Abuse' campaign and this has seen an increase of nearly 100% in reported incidents. Staff to staff incidents tend to be cases of verbal abuse, with violence and aggression reported more in causes of patient/visitor to staff incidents.

**NSS Data**
Additionally, UHN Staff Survey data from 2020 – 2024 (Appendix 1) indicates that discrimination and bullying from the public, particularly based on ethnicity, remain a concern. *Q16 c On what grounds have you experienced discrimination - Ethnic background* has depicted a generally increasing trend for the last five years.

**The national position**
This local data trend is aligned to the findings of NHSE. On 13 March 2025, NHSE reported that 1 in 7 NHS staff (14.38%) experienced physical violence from patients, their relatives or other members of the public in 2024. The report reveals attacks on colleagues

has increased since 2023 (13.88%) and colleagues experiencing discrimination at work reached its highest level in 5 years (9.25%), with more than half (54.09%) saying the discrimination they received from patients and the public was based on their ethnic background.

**Local context**
Both KGH and NGH have been on a transformation programme since 2021, forming a group model first and then partnership with UHL. This transformation programme whilst creating a sustainable future for care delivery, has created uncertainty for some frontline care delivery colleagues following a number of leadership changes. These changes have been mirrored within Staff Networks as they merged to form single UHN networks supported by Exec Sponsors from January 2025.

*Overall summary – some improvements in a number of metrics have been noted, but there are still concerns in the following areas of BAME staff experience:*

- *Experiencing harassment, bullying or abuse from patients, relatives or the public*
- *Experiencing harassment, bullying or abuse from staff*
- *believing that the Trust provides equal opportunities for career progression or promotion*
- *experiencing discrimination at work from a manager/ team leader/other colleague*
- *difference between Board membership and overall BAME workforce*

## Background

As an organisation we have worked on several actions to drive improvement and enable our REACH colleagues to have a great working experience at UHN and address the concerning results we have consistently seen over the past three years.

**UHN Actions October 2023 - March 2025:**

- July 2023 – Boards declared their commitment to being anti-racist
- Between October and December 2023, we engaged with colleagues through listening events, ward walks and drop-in sessions to co-create UHN's Anti-Racist Statement alongside staff side representatives and networks. This work informed a set of stakeholder-driven recommendations, which continue to shape our efforts through the EDI Steering Group and action plans for WRES, WDES, Gender Pay Gap and Equality Delivery System (EDS).
- Reviewed our Tackling Racism workstream with Roger Kline who led development Sessions with our UHN Board, People Team and UHL peers.
- Piloted our own Rethinking Racism Education Programme for 9 months between June 2024-March 2025. Subsequently re modelled the programme after taking on feedback from our stakeholders to make it more accessible to front line colleagues and is now be a mandatory half day workshop for all people leaders.
- In support of inclusive conversations, developed toolkits and guidance documents, including REACH Allyship and Tackling Racism Toolkits, Microaggressions and Unconscious Bias training and cultural guidance on language, religious observances and leave.
- Revised the UHN Excellence Awards to improve diversity in nominations and judging.
- Launched a Buddying Support Group for Black male internationally educated colleagues to combat loneliness.

- Reinforced the Inclusive Recruitment Champion and Cultural Ambassador offers and strengthened collaboration with FTSU, Staff Side, Violence and Aggression Reduction Group, and International Shared Decision Making Councils to foster a safe, culturally competent environment where REACH colleagues feel supported and empowered to speak up.
- In response to the UK Civil Unrest, and building on the above efforts, UHN demonstrated exceptional response in co-designing an approach along with strong leadership from our Executive team. This approach earned UHN national recognition from Roger Kline and NHSE, placing UHN in the top three organisations providing exemplary support to REACH colleagues.
- June 2025 – we have commenced engagement with colleagues across UHN in developing our new Belonging Equity and Inclusion Strategy (replaces the former EDI strategy which has expired).

However, it remains that our results are not progressing at the pace we would like them to.

Our REACH network has challenged the organisation on its performance and we therefore undertook a rapid review with our REACH colleagues to enable us to understand what is and isn't working and develop further improvement actions.

## Assessment

REACH Network listening event was held in May to understand the everyday experiences of REACH colleagues and their feedback to help feedforward our support and improvement offer. 10% of UHN REACH Staff Network members were in attendance.

Three themes arose from the listening event –

1. Accountability and allyship
2. Lack of cultural competency amongst line managers
3. Talent development/representation of REACH colleagues in leadership roles

Detailed feedback of the above themes is presented in Appendix 2. Colleagues stated their experience would improve if we considered the below suggestions:

- Race education and cultural competency development should be a priority to help us improve the experiences of our colleagues and patients.
- Empower REACH colleagues to share their lived experiences with the Board and senior leaders in a manner that enables the leaders to critically review their personal and professional practices.
- Consider a Minority Groups Talent program for senior leadership as a key future talent source. REACH network has recommended targeted interventions should be embedded to develop REACH colleagues in roles where diverse representation is required.
- Embed a robust Freedom to Speak Up (FTSU) framework that encourages all UHN colleagues to raise concerns and issues in a psychologically safe space, with the knowledge that senior leadership fully embraces and understands the importance.

Across the NHS we rely on evidence-based practice to deliver patient care – work to improve staff experience should be no different. We have some evidence the work we have been doing has led to improvements:

- the Cultural Ambassadors programme has helped reduce cultural bias in formal processes and reduced the number of formal disciplinary cases
- inclusive Recruitment Champions (IRC) have helped improve diversity in recruitment and highlighted difficulties faced by applicants from minority groups.

The Boards' support and commitment towards listening to REACH colleague stories and experiences evidences the recognition of Tackling Racism as a corporate responsibility.

Before we commit to further new improvement actions, we should assess the evidence these actions are likely to lead to improvement and focus our attention on the actions with the strongest evidence base.

## Recommendations

Racism negatively impacts both patients and colleagues. By addressing racism and fostering inclusion, UHN can ensure a better experience for all. Implementing these recommendations shows that UHN listens to REACH colleagues and is committed to driving meaningful change. The Boards are therefore recommended:

1. To note the progress made in some areas of staff experience relating to race, but that work is still required in the areas of:
   - harassment, bullying or abuse from patients, relatives or the public
   - harassment, bullying or abuse from staff
   - providing equal opportunities for career progression or promotion
   - discrimination at work from a manager/ team leader/other colleague
   - difference between Board membership and overall BAME workforce

2. To support the identification of evidence-based improvement actions as part of the new Belonging Strategy, to address:
   - Race education and cultural competence
   - Talent programmes
   - Freedom to speak up and psychological safety to speak up

3. To restate their commitment to being anti-racist and that individual colleagues consider their personal improvement actions. All Board members are requested to sign up to the Reverse Mentoring programme and attend Rethinking Racism programme as a minimum commitment (in addition to personal EDI appraisal objective).

4. To invite a colleague(s) to share their personal story at a future meeting to coincide with the publication of the annual WRES and WDES reports.

5. To support the engagement, allyship and planned launch of the 'We Belong' Equity Inclusion Strategy (2025-2030)

**Appendix 1: UHN WRES, VARG and staff survey data**

| WRES Indicator | | NGH 22/23 | NGH 23/24 | NGH 24/25 | NGH trend | KGH 22/23 | KGH 23/24 | KGH 24/25 | KGH trend |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Percentage of **BAME staff** | 33% | 36% | 41% | +8% since 22/23 | 33% | 36% | 40% | +7% since 22/23 |
| 2 | Likelihood of **white applicants being appointed** from shortlisting across all posts compared to BAME applicants * | 0.90 | 0.93 | 0.53 | -0.37 since 22/23 White staff are marginally less likely to be appointed | 3.47 | 0.92 | 1.07 | - 2.4 across two years. Slight deterioration since 23/24 |
| 3 | Likelihood of **BAME staff entering formal disciplinary process** compared to white staff | 0.47 | 0.17 | 0.12 | -0.35 | 1.19 | 0.24 | 0.91 | -0.28 |
| 4 | Likelihood of **white staff accessing non-mandatory training** and CPD compared to BAME staff | 0.97 | 0.70 | 0.80 | -0.17 | 0.78 | 0.99 | 1.00 | +0.22 |
| 5 | Percentage of **BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public** - last 12 months | 32% | 30% | 30% | -2%, remains stubborn and high at 30% | 36% | 31% | 32% | -4% small increase on 23/24. Figure is high at 32% |
| 6 | Percentage of **BAME staff experiencing harassment, bullying or abuse from staff** in the last 12 months | 30% | 24% | 20% | -10% Improving but the figure is high | 34% | 31% | 27% | -7% Improving but the figure is high |
| 7 | % of **BAME staff believing the Trust provides equal opportunities for career progression or promotion** | 40% | 51% | 49% | +9% small deterioration from 23/24. Figure is low | 43% | 44% | 44% | +1% remains stubborn and low at 44% |
| 8 | Percentage of **BAME staff experiencing discrimination at work from a manager/team leader/other colleague** | 19% | 14% | 14% | -5% Improved but remains stubborn and high at 14% | 26% | 23% | 18% | -8% Improving but remains high at 18% |
| 9 | % Difference between **Board membership and BAME workforce** | -23% | -23% | -32% | -9% The Board is less representative | -28% | -27% | -31% | -3% The Board is less representative |

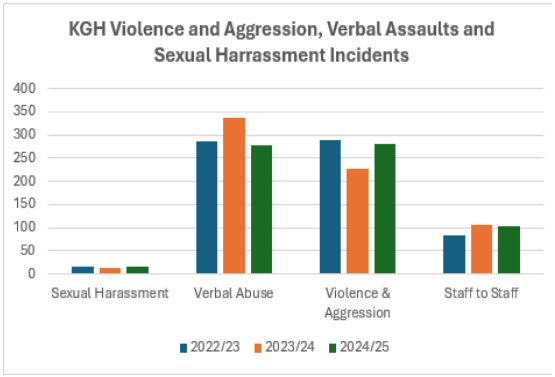
**'*** A figure of 1.0 means there is no greater likelihood of BAME or white colleagues seeing a positive outcome

**Violence and Aggression Reduction Group (VARG)**

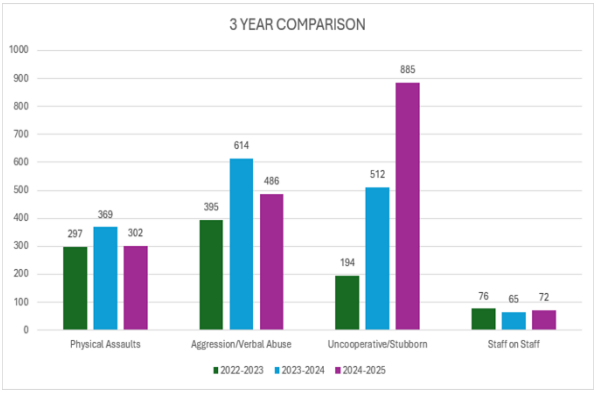
Data from VARG was reviewed to understand the details behind abuse incidents that are reported and help us shape our future actions. The table below provides an overview of incidents reported via DATIX. These may not necessarily have been raised as a complaint, but as an incident that needs to be reported and investigated. Since the launch of the 'No Excuse For Abuse' campaign in 2022, there has been an increase in reporting at NGH. The incident themes of Staff to Staff incidents are cases of Verbal Abuse, with Violence and Aggression reported more in causes of patient/visitor to staff incidents.

| Financial Year | KGH Total Incidents | NGH Total Incidents |
|---|---|---|
| 2022-23 | 590 | 962 |
| 2023-24 | 577 | 1560 |
| 2024-25 | 574 | 1745 |

**KGH VARG Data**




**NGH VARG Data**




We also reviewed the roles that REACH staff worked within, to help us review the VARG data in a holistic manner. ESR data states that despite 36% of our total workforce is REACH, most REACH colleagues are employed in starting positions – Bands 2 & 5 reflective of frontline care delivery positions where they are more likely to face discrimination.

**National Staff Survey data**

*Q16 c On what grounds have you experienced discrimination - Ethnic background* has depicted an increase annually.

| Organisation | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| KGH | 51.38% | 57.87% | 55.32% | 59.96% | 64.76% |
| NGH | 53.81% | 53.44% | 53.04% | 60.34% | 63.67% |
| *Benchmark Group - Median Result* | *44.63%* | *46.54%* | *48.69%* | *51.77%* | *56.16%* |
| *Benchmark Group - Best Result* | *20.18%* | *19.49%* | *19.69%* | *28.00%* | *31.53%* |
| *Benchmark Group - Worst Result* | *76.99%* | *71.86%* | *73.19%* | *77.24%* | *73.22%* |

**Appendix 2**

**REACH Network Listening Event to Review NSS Results (14 May 2025):**

A listening event was held to present data stated within this report to the REACH Network.

Allyship from a range of colleague support groups (listed below) attended the meeting to empower REACH colleagues to have a voice.

A facilitated appreciative inquiry was conducted and besides the ability to discuss in a safe space, colleagues were also provided with an anonymous tool to provide feedback. The main themes gathered from the responses were:

1. Accountability & Conflict Resolution
2. Cultural Competency Building of Line Managers
3. Talent Development/Representation of REACH Colleagues in Leadership Roles

| **Questions to REACH Network Members** | **Number of Responses** | **Accountability** | **Training** | **REACH Development** |
|---|---|---|---|---|
| Question 1 What is going well/or not as well? | 21 | 21 | 18 | 9 |
| Question 2 What is important to develop or continue? | 17 | 17 | 11 | 5 |
| Question 3 What does this look like in practice? | 9 | 9 | 7 | 6 |
| Question 4 What will make it possible? | 6 | 3 | 2 | 6 |
| Question 5 What else do we need to pay attention to? | 9 | 9 | 7 | 3 |
| **Grand Total** | **62** | **59** | **45** | **29** |

*"What's going well: Monitoring the data to see what we're doing well, and what needs improvement : A clear and concise strategy."*

*"We need more BAME senior and exec leaders who are visible actions of UHN in response to our race commitment"*

*"execs must see how work is REALLY allocated, surprise ward visits"*

*"What is going on in the 'outside' world - political climate, incidents occurring around the country and how this impacts on how people are feeling and interacting at work."*

*"Talent recognition, acceleration and improved diverse representation at ALL levels of leadership"*

# Cover sheet

| | |
|---|---|
| Meeting | Boards of Directors of Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) (Part I) Meeting together in Public |
| Date | 27 June 2025 |
| Agenda item | 11 |

| | |
|---|---|
| Title | Northamptonshire Health Charity (NHCF): Appointment of Alternate Trustee |
| Presenters | Richard May, Company Secretary |
| Author | Richard May, Company Secretary |

| This paper is for | | | |
|---|---|---|---|
| ☒ Decision | ☐ Discussion | ☐Note | ☐Assurance |
| To formally receive and discuss a report and determine its recommendations OR a particular course of action | To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it | For the intelligence of the Board without the in-depth discussion as above | To reassure the Board that controls and assurances are in place |

| Reason for consideration | Previous consideration |
|---|---|
| To fill a vacancy to an Alternate Trustee position following recent changes to the Boards' composition. | None |

## Executive Summary

The NHCF acts as trustee for the Trusts' charitable funds, following asset transfer by NGH and KGH in 2018 and 2021 respectively.

The NHCF charity Board of Trustees currently includes two nominated trustees from UHN – Laura Churchward and Jill Houghton. Trustees fulfil the Charity's duties through membership of the Board and sub-committees, which focus on enhancing the environments, patient pathways, and staff wellbeing and development across all the NHS Bodies.

The Trusts are entitled to appoint an Alternate Trustee to act in the Trustee(s) absence, a

role fulfilled by Richard Apps prior to his leaving the Trusts on 31 May 2025. The Boards are therefore recommended to **approve** the appointment of Suzie O'Neill (Director of Communications and Engagement) as Alternate Trustee of the Northamptonshire Health Charitable Fund to replace the Director of Corporate and Legal Affairs, with immediate effect, and until further notice.

## Appendix

None

## Risk and assurance

No direct implications

## Financial Impact

No direct implications

## Legal implications/regulatory requirements

As set out in above

## Equality Impact Assessment

Neutral

# Cover sheet

| | |
|---|---|
| Meeting | Boards of Directors of Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) (Part I) Meeting together in Public |
| Date | 27 June 2025 |
| Agenda item | 12 |

| | |
|---|---|
| Title | Use of the KGH Trust Seal |
| Presenter | Richard May, Company Secretary |
| Author | Richard May, Company Secretary |

| This paper is for | | | |
|---|---|---|---|
| ☐ Approval | ☐Discussion | ✓ Note | ☐Assurance |
| To formally receive and discuss a report and approve its recommendations OR a particular course of action | To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it | For the intelligence of the Board without the in-depth discussion as above | To reassure the Board that controls and assurances are in place |

| Reason for consideration | Previous consideration |
|---|---|
| The Trusts' procedures require uses of the Seals to be reported to the Boards of Directors. | None |

**Executive Summary**

The **KGH** Board of Directors is requested to note the use of the Trust Seal in respect of the Design and Build Contact for the Corby Community Diagnostic Centre on 17 June 2025, affixed by the Company Secretary in the presence of the UHN Chief Executive.

**Appendices**

None

**Risk and assurance**

None

**Financial Impact**

None

**Legal implications/regulatory requirements**

As specified in 'reason for consideration' section above.

**Equality Impact Assessment**

Neutral