UHN Boards of Directors (Part I)
Meeting in Public

Fri 09 May 2025, 12:30 - 15:00

Boardroom, Kettering General Hospital

Agenda

12:30 - 12:30
0 min

1. Welcome, apologies and declarations of interest

Andrew Moore

1. UHN Boards Part I Agenda 090525 (1).pdf (2 pages)

12:30 - 12:35
5 min

2. Minutes of the previous meeting held on 4 April 2025 and Action Log

Decision *Andrew Moore*

2.1 040425 Draft Minutes UHN Public Part I Board of Directors meeting.pdf (10 pages)
2.2 Board Action Log Updated 040425 Part I Boards.pdf (1 pages)

12:35 - 12:40
5 min

3. Chair's report (verbal)

Information *Andrew Moore*

12:40 - 12:45
5 min

4. UHN Chief Executive's Report

Information *Laura Churchward*

4. CEO update public board report May 2025 final.pdf (3 pages)

12:45 - 13:30
45 min

5. Integrated Performance Report (IPR) and Board Committee Chairs' reports

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

5. UHN IPR May 2025.pdf (3 pages)
5. March 2025 Integrated Performance Report.pdf (67 pages)
5.0 Group Upward Reporting to UHN 090525 Boards (1).pdf (9 pages)

13:30 - 13:40
10 min

6. Northampton General Hospital (NGH) CQC Urgent and Emergency Care (UEC) Inspection: Section of Section 29 Notice

Assurance *Julie Hogg*

6. UHN CQC UEC Report v3 May 25.pdf (6 pages)

13:40 - 13:50
10 min

7. Maternity Perinatal Dashboards

Assurance *Julie Hogg*

7. UHN Perinatal Scorecards Report Apr 2025 (Mar 2025 Data).pdf (7 pages)
7. Appendix 1 - KGH Perinatal Scorecard April 2025 (March data).pdf (16 pages)
7. Appendix 2 - NGH Perinatal Scorecard April 2025 (March Data).pdf (22 pages)

7.1. KGH Maternity Support Programme: Latest Position

Information *Julie Hogg*

- 7.1 KGH Maternity Support Programme Update.pdf (2 pages)

13:50 - 14:10
20 min

8. Freedom to Speak Up (FTSU) Quarterly Report

Assurance *FTSU Guardians*

- 8. Cover Sheet UHN Boards May 2025.pdf (2 pages)
- 8. FTSU 2024-25 Q4 Report.pdf (15 pages)

14:10 - 14:30
20 min

9. Children's and Young People's Services at KGH: Patient Safety Culture Review (to follow on 6 May 2025)

Receive *Julie Hogg*

14:30 - 14:40
10 min

10. UHN Risk Management Strategy

Decision *Richard Apps*

- 10. Cover Sheet Draft Risk Management Strategy Board 09-05-25.pdf (2 pages)
- 10. UHN Draft Risk Management Strategy 22-04-25.pdf (11 pages)

14:40 - 14:50
10 min

11. Board Assurance Framework (BAF)

Assurance *Richard Apps*

- 11. BAF Boards cover paper MAY25.pdf (2 pages)
- 11. Appendix A_Group BAF_170425.pdf (16 pages)
- 11. Appendix B_ Corporate risks aligned to BAF risks @ April25.pdf (2 pages)

14:50 - 14:55
5 min

12. Integrated Leadership Team (ILT) Terms of Reference

Decision *Richard Apps*

- 12. ILT Terms of Reference cover.pdf (1 pages)
- 12. Appendix ILT ToR April 2025.pdf (5 pages)

14:55 - 14:55
0 min

13. Report on the use of the NGH Trust Seal

Information *Richard Apps*

- 13. UHN Cover Sheet NGH Trust Seal 090525.pdf (1 pages)

14:55 - 15:00
5 min

14. Questions from the public

15:00 - 15:00
0 min

15. 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)

Meeting	Boards of Directors (Part I) Meeting in Public
Date & Time	Friday 9 May 2025, 12:30-15:00
Location	Boardroom, Kettering 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	Chair	12:30	-	Verbal
2	Minutes of the Previous Meeting held on 4 April 2025 and Action Log	Chair	12:30	Decision Receive	Attached Attached
3	Chair's report	Chair	12:35	Information	Verbal
4	UHN Chief Executive's Report	Chief Executive Officer	12:40	Information	Attached
Operations					
5	Integrated Performance Report (IPR) and Board Committee Chairs' Reports	Chief Executive, Executive Directors and Committee Chairs	12:45	Assurance	Attached
6	Northampton General Hospital (NGH) CQC Urgent and Emergency Care (UEC) Inspection – Receipt of Section 29 Notice	Chief Nurse	13:30	Assurance	Attached

7	UHN Perinatal Scorecards 7.1 KGH Maternity Support Programme: Latest Position	Chief Nurse	13:40	Assurance Receive	Attached Attached
People and Culture					
8	Freedom to Speak Up (FTSU) Quarterly Report	FTSU Guardians	13:50	Assurance	Attached
9	Children's and Young People's Services at KGH: Patient Safety Culture Review	Chief Nurse	14:10	Receive	To follow
Governance					
10	Risk Management Strategy	Director of Corporate and Legal Affairs	14:30	Decision	Attached
11	Board Assurance Framework	Director of Corporate and Legal Affairs	14:40	Assurance	Attached
12	Integrated Leadership Team Terms of Reference	Director of Corporate and Legal Affairs	14:50	Decision	Attached
13	Use of the NGH Trust Seal	Director of Corporate and Legal Affairs	14:55	Note	Attached
14	Questions from the Public	Chair	14:55	Information	Verbal
15	Any Other Business and close	Chair	15:00	Information	Verbal

Minutes of the Meeting

Meeting	Boards of Directors of the University Hospitals of Northamptonshire NHS Group (UHN) comprising Northampton General Hospital (NGH) and Kettering General Hospital (KGH) (Part I) Meeting together in Public
Date & Time	4 April 2025, 09:30-12:45
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
	Sarah Noonan	Chief Operating Officer
	Suzie O'Neill	Director of Communications and Engagement
	Trevor Shipman	Vice-Chair and Non-Executive Director
	Sarah Stansfield	Interim 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
	Charlotte Cooper	Equality, Diversity and Inclusion Engagement Officer (Item 2)
	Helen Essex	Director of Corporate Governance and Company Secretary, University College London Hospitals

		NHS Foundation Trust
	Christine Hardy	Co-Chair of the Diversity and Wellbeing Support Network (Item 2)
	Ilene Machiva	Director of Midwifery
	Richard May	Company Secretary

Item	Discussion	Action Owner
1	**Welcome, Apologies and Declarations of Interest** The Chair welcomed colleagues and guests to the meeting. There were no apologies for absence or declarations of interest relating to specific agenda items.	
2	**Staff Story – Disability, Accessibility, Wellbeing and Neuroinclusion Network (DAWN)** The Boards welcomed colleagues from the DAWN network who outlined its role to promote disability equality with the trusts, including a video in which Luke Sullivan, NGH Freedom to Speak Up, described his life and work experiences as an autistic person, and the challenges he faced and overcame on a daily basis in order to build effective working relationships and successfully fulfil his role. The Boards also heard the testimony of Fahad Siddiqui, Systems Support Specialist, describing the difficulties he had experienced obtaining reasonable adjustments to make selection interview questions available in advance. The Boards thanked contributors for their courage and openness in describing their experiences and, noting that disability discrimination persisted (as reflected in key national employment indicators), committed to empowering managers to build trusting relationships based on dialogue and mutual understanding with their team members to identify reasonable adjustments which, in many cases, were cheap and simple to implement. Autistic colleagues, and those with other neurodiverse characteristics, often had skills, interests and personal qualities which, if made the most of, had the potential to improve individual and organisational performance. The Chief People Officer undertook to progress arrangements to make interview questions available to all candidates in advance, in direct response to the feedback received, and to explore other adjustments suggested such as immediate interview feedback and the use of online rather than in-person interviews to reduce stress and anxiety.	
3	**Minutes of the last meeting held on 7 February 2025 and Action Log** The Minutes of the meeting of the Boards of Directors of Kettering General Hospital (KGH) and Northampton General Hospital (NGH) held on 7 February 2025, were approved as a correct record. The Boards noted the action log, upon which all actions were marked as all closed or not yet due.	

4	**Chair's Report** The Chair addressed the boards in the first week of a new financial year in which there must be determination to meet challenging financial targets whilst maintaining safe patient care; an early priority was to prepare and agree full finance and operational plans for delivery, with strong oversight mechanisms in place led by Board Committees. Other key priorities for the trust were to improve staff engagement, achieve targets for patient waits for elective and non-elective care, and progress digital transformation through the new digital strategy (see item 8 below) and NGH electronic patient record. The group would be operating in a national context of uncertainty brought about by the recent announcement of the abolition of NHS England and substantial reductions in Integrated Care Board staffing.	
4.1	**UHN Chief Executive's report** The Boards received and noted the UHN Chief Executive's report. In addition to the written report, the UHN Chief Executive confirmed that the new divisional leadership structure formally took effect on 1 April 2025 following consultation and recruitment; the aligned structure provided a solid basis from which to maintain and enhance collaboration and deliver challenging financial and operational goals. The Boards extended their thanks to colleagues who would be leaving the organisations following the restructure for their contributions in previous roles. The trusts had held well-attended listening events to brief colleagues on recent national changes and to hear staff suggestions for efficiencies; these would continue. The UHN CEO was committed to communicating the group's financial and workforce reduction target openly and transparently. The Boards were advised that the Director of Corporate and Legal Affairs, Richard Apps, would be leaving the trusts on 31 May 2025, extending their congratulations to Richard for his new role and thanking Richard for him work to develop group working arrangements within UHN.	
5.	**Integrated Performance Report (IPR) and Board Committee Summaries** The Boards received the IPR and Board Committee summaries and were advised that a refreshed IPR would be available at the next meeting following a redevelopment and improvement project led by the Director of Continuous Improvement. Executive leads drew the Boards' attention to the following matters: *Quality* - Friends and Family Test scores had deteriorated across Urgent and Emergency Care (UEC) pathways (related to the recent CQC inspection at NGH – see agenda item 6 below), though	

	scores had improved in inpatient areas; - There was a notable reduction in C.difficile infections across UHN, with only four reported cases. Improvement reflected the positive impact of ongoing infection prevention and control measures being implemented across the group; - Complaints response performance had improved at NGH but significant further work was required. The Boards sought further assurance regarding the deliverability of the improvement plan within existing resources and were advised that, whilst recovery would not be quick, new divisional leadership, the utilisation of new technology and close oversight by the Quality and Safety Committee should enable improvements to be implemented and sustained. The Quality and Safety Committee was also receiving reports identifying learning from complaints. *Operations* - Ambulance handovers continued to decrease during February at both trusts; - The number of 'stranded' and 'super stranded' patients spending over 7 and 21 days in hospital respectively increased at KGH during February; the trust continued to work with internal and external partners to address these issues; - Unappointed follow-ups continued to show an upward trend, partly due to capacity issues within KGH clinics. The Boards expressed concern at continuing doubts regarding the quality and validity of performance data and received assurances that the Federated Data Platform and new IPR would address these issues, and that partners across the local health system would use a common definition and metric to define patients in the hospitals with reasons to reside. In response to a question, the Chief Operating Officer indicated confidence that the withdrawal of Waiting List Initiatives would have minimal impacts on outpatient activity; there were variations by specialty and procedure for some day case and inpatient activity, however. The Boards noted that clear responsibilities and accountabilities for each local health system partner were required to effectively manage activity and care volume during 2025-26. *Finance* - The year-end projection was a deficit of £30m compared to the revised plan submission, taking into account the receipt of £15m additional 'surge' funding from the Northamptonshire Integrated Care Board in Month 12 (March 2025). The Boards noted the consequences of not achieving the year-end target, which would include higher borrowing costs, increased scrutiny and reporting requirements, increased challenges to the delivery of the 2025-26 plan and the need to repay the deficit to the NICB; - The year-end capital projection was yet to be finalised following focussed and ongoing work to ensure full commitments.	

People

- Bank and agency usage was reducing but remained above national targets; divisions had submitted reduction plans, overtime approvals had ceased without accompanying justification through quality impact assessment, and the trusts were subject to a temporary pause on all recruitment. The Boards anticipated some reduction in bank and agency following the withdrawal of temporary winter capacity whilst reiterating the need for fully scoped and costed reduction plans for 2025-26;
- A wellness campaign was planned in anticipation of the 2025-26 winter period, including new arrangements for 'flu vaccination;
- The Boards welcomed the launch of a new system for filling medical shifts which gave rise to efficiency savings and would enhance collaboration with the University Hospitals of Leicester NHS Trust

Following executives' presentations and discussion, the Chair identified the following key areas for ongoing focus:

1. Reason to reside: adoption of common metrics for use by the local health system (Operational Performance Committee)
2. Learning from complaints (Quality and Safety Committee)
3. Clarify responsibilities and accountabilities for determining volume of care projections with NICB colleagues (Operational Performance Committee)
4. Robust projections for bank and agency reductions during 2025-26 (Finance and Investment and People Committees).

Committee Chairs drew the following items to the Boards' attention:

Operational Performance Committee

- Endorsement of One Digital Strategy 2025-2028 (see item 8 below)
- Limited assurance arising from risk to delivery from the current high vacancy rate in the Health Intelligence Team and difficulty in recruiting individuals with the required skills sets (Integrated Leadership Team had subsequently approved recruitment to key roles);
- The Committee was strongly assured in respect of planned care performance and was maintaining a strong focus on urgent and emergency care.

Finance and Investment Committee

- The Committee indicated limited assurance regarding the delivery of the 2025-26 financial plan due to unidentified cost improvement plan targets required to deliver the agreed year-end deficit;
- The Committee approved a business case to NHS England for the appointment of a strategic delivery partner to support the achievement of the 2025-26 plan;

	- The Boards received assurance that measures were in place to ensure timely delivery and monitoring (through the new IPR) of the 2025-26 capital plans, which would be submitted to the next meetings for endorsement. *Quality and Safety Committee* - The Committee indicated 'No assurance' regarding Autism Spectrum Disorder assessments in response to evidence that some children were waiting up to 110 weeks due to the unavailability of assessors and decommissioning issues within community paediatrics. The Director of Strategy advised that the county's Health and Wellbeing Boards recognized the issues and had prioritized the development of remedial options within the next month; all partners had accepted the need for detailed review of community paediatric services, which was underway; - The Committee indicated 'limited' assurance regarding Oral Maxillofacial Surgery Services which remained extremely fragile due to consultant roles to which recruitment was challenging. *People Committee* - The Committee indicated limited assurance regarding workforce financial sustainability and requested the development of a robust and deliverable plan for consideration at its forthcoming strategy workshop in April 2025; - While UHN's absence figures were in line with regional and national data, the committee expressed concern around the high level of stress-related absence, requesting closer analysis of the trusts' current data and how it was used. *Audit Committees* The Committees received an update on the plans in play to enhance the UHN's ability to meet the external audit requirements and timelines for this year-end. It was acknowledged that the auditors had noted a significant improvement since last year, and this was welcomed by the Committees, but that risks remained in the plans, most significantly at KGH, where the timetable was currently slightly behind awaiting the arrival of two further agency staff members into the finance team. The Boards requested an update on the restructuring of the finance team at the next meeting. The Committees endorsed changed to Standing Financial Instructions, Schemes of Delegation and Standing Orders: see item 11 below.	**SS** **SS**
6.	**Northampton General Hospital (NGH) CQC Urgent and Emergency Care (UEC): Inspection and Action Plan** The Boards considered a report describing the recent unannounced CQC inspection of UEC and medical services at NGH, which took place on 18 February 2025. The visit took place during a particularly busy	

	period for the hospital, with high patient demand, extended stays in the Emergency Department and delays in ambulance handovers. The CQC recognised the compassion, commitment and professionalism of staff but also identified a number of concerns, requesting urgent actions in the following areas: - The potential risk of harm to patients in the Emergency Department; - Hospital flow issues affecting the timeliness of care; - Ensuring the privacy and dignity of patients, particularly where Temporary Escalation Spaces are in use. The Trust acted quickly following the inspection, taking immediate and short-term actions to improve safety, patient experience, and flow through the hospital. These included reviewing how and where patients are cared for in high-demand areas and enhancing senior clinical oversight in key areas of the hospital. The final CQC report was awaited and would be received by the Boards following publication. The Boards indicated assurance in respect of immediate actions and improvements and reiterated the group's commitment to improving patient flow and quality of care across UEC pathways, in collaboration with local health system partners and the CQC. In doing so, the Boards noted cultural issues around colleagues feeling reluctant to speak up and an unwillingness to embrace change, which had arisen in other areas, particularly children's and young people's services at KGH. It was important for the trusts to recognize that addressing patient flow to reduce corridor care and UEC overcrowding required 'whole-hospital' solutions. Furthermore, learning must be implemented quickly in preparation for the next winter period.	
7.	**UHN Perinatal Quality Surveillance Scorecard – Highlight Report** The Boards welcomed the Director of Midwifery to present the perinatal quality surveillance scorecards, noting significant exceptions as specified. The return of services to the KGH Rockingham Wing from the Sir Thomas Moore Ward on 27 March 2025 was particularly welcome. The Boards noted that NGH's compliance against maternity incentive scheme safety action 1 (approved at the February 2025 meeting) had not been validated; the Trust intended to appeal this position. 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.	
7.1	**KGH Maternity Support Programme (MSSP): Latest Position** The Boards considered a report setting out progress with the MSSP and Maternity Improvement Advisor's feedback to the service. Areas of positive feedback around engagement and access, and areas of concern, particularly regarding the medical workforce difficulties in recruiting to senior roles to enable new triage pathways to be implemented, were specified in the report. The Boards further noted	

	concerns regarding the capacity of the maternity and neonatal voices partnership to provide input due to funding concerns. A diagnostic report was awaited, from which recommendations and actions could be determined. The Boards of Directors noted the latest position.	
8.	**One Digital Strategy 2025-2028** The Chief Digital Information Officer (CDIO) presented a report recommending approval, following endorsement by the Operational Performance Committee, of the One Digital Strategy 2025-2028. The strategy provided a framework for digital and data transformation across both Trusts, focusing on getting the basics right, putting users first, enabling transformation, embracing emerging technology, unifying data, leveraging strategic partnerships, and creating and embedding one digital to deliver better care and outcomes for patients and improving staff experience. The Boards welcomed the strategy and the patient and staff-centred approaches set out within it. In response to a question, the CDIO expressed confidence that recent investment in equipment, faster call responses and higher first-time call resolutions suggested that the digital service was making progress towards getting the basics right. The Boards emphasised the importance of continuing engagement to seek end user feedback in order to assess implementation (including engagement with, and access by, medical students as part of their training), and considered that the introduction to the document should acknowledge the group's current lack of digital maturity and strategic direction. The group invested heavily in its digital service, and the strategy provided the opportunity for more focussed investment on the highest priorities to derive business benefits. Subject to the above change, the Boards **approved** the One Digital Strategy 2025-2028.	
9.	**2024 National Staff Survey – Results and Priorities** The Boards received headline results from the 2024 national Staff Survey and proposed next steps, in a report prepared and presented by the Chief People Officer. KGH overall results had improved slightly compared to the 2023 survey, but remained poor compared to national results. NGH overall results showed slight deterioration, remaining within the average range nationally. Executive Directors had been requested to prepare, agree and deliver focussed local action plans to address consistent and recurring areas of concern relating to racial discrimination, tiredness and burnout, inappropriate behaviours, poor team dynamics, colleagues not feeling valued or recognized. The People Committee Chair advised that the Committee indicated 'limited' assurance following discussion at its last meeting; whilst	

	encouraged by the early planning interventions, there were concerns regarding staff voices being heard and meaningful improvements demonstrated to colleagues. The Boards expressed disappointment at the results and the lack of progress demonstrated in response to actions put in place following the 2023 survey; in particular, it was apparent that the group's approach to eliminating racial discrimination was ineffective and required review. The Boards acknowledged that the new divisional structure provided the opportunity for stability and renewed leadership and commitment by all layers of management led by the Boards. Following discussion, the Boards: 1. Noted the feedback from UHN colleagues and recognized that there is much improvement required; 2. Noted the engagement plan to share the results of the survey across UHN; 3. Noted the corporate priorities across UHN and the plans to develop local plans in divisions/directorates/departments; 4. Noted accountability for performance against improvement plans will be reviewed in monthly assurance meetings, with the work against corporate priorities being overseen by Deputy Chief People Officer and Communications and Engagement Director, and 5. Indicated assurance in respect of the trust's response as evidenced by points (1)-(4) above.	
10.	**Nursing and Midwifery Establishment** The Boards considered a report setting out the outcomes of the six-monthly establishment reviews for Nursing and Midwifery, **approving** the recommended establishments set out in the appendices to the report. In doing so, the Boards endorsed the Chief Nurse and Medical Director's recommendation that there was good compliance with Developing Workforce Standards and that staffing was safe, effective and sustainable in the context of the trusts' run rates and pressure to reduce temporary staffing spend.	
11.	**UHN Schemes of Delegation and Standing Financial Instructions, and NGH Standing Orders** Following endorsement by the Audit Committees: (1) The Boards of Directors **approved** aligned UHN Schemes of Delegation and Standing Financial Instructions as set out in Appendices A-B to the report; (2) The **NGH Board of Directors approved** revised Standing Orders as set out in Appendix C to the report. **(3)** The Board of Directors requested the Chief Finance Officer and Director of Corporate and Legal Affairs work with the Integrated Leadership Team to take the necessary steps to ensure the appropriate publication, communication and dissemination of, and compliance with, these documents.	

12.	**Use of the Trusts' Seals** The NGH Board noted the use of the Trust Seal in respect of the Deed of Variation between NGH and the Maggie Keswick Jencks Cancer Caring Centres Trust on 13 February 2025, affixed by the Director of Corporate and Legal Affairs in the presence of the Director of Estates, Facilities and Sustainability. The KGH Board noted the use of the Trust Seal in respect of the Sub-station lease to ESP (power infrastructure provider) at the Corby Community Diagnostic Centre on 4 March 2025, affixed by the Group Company Secretary in the presence of the Director of Strategy.	
13.	**Questions from the Public** None	
14.	**Any other business and close** There was no other business.	

Action Log

Meeting	Boards of Directors (Part I) Meeting in Public
Date & Time	Updated following 4 April 2025 meeting

Minute Ref.	Action	Owner	Due Date	Progress	Status
Oct 24 8ii	Initial submission of future year winter plan	SN	May 25	On 9 May Part II agenda	CLOSE
Feb 25 5	The Director of Continuous Improvement undertook to explore how peer group benchmarking could be reflected as part of in-year performance monitoring.	BT	May 25		NOT YET DUE
Apr 25 5i	Presentation of 2025-26 Capital Plan to Boards	SS	June 25		NOT YET DUE
Apr 25 5ii	The Boards requested an update on the restructuring of the finance team at the next meeting	SS	May 25	The formal work on the finance restructure commenced in early April. A new operating model for the function has now been agreed and the next stage is to work through job roles. This is anticipated to be completed by the end of May - with a case for change being produced over June. Consultation and change activity will run over July and August with a new structure anticipated to be implemented by the end of Q2.	CLOSE

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NHS
University Hospitals of Northamptonshire
NHS Group

Cover sheet

Meeting	UHN Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	9 May 2025
Agenda item	4

Title	Chief Executive's report (CEO)
Presenter	Laura Churchward - UHN CEO
Authors	Chief Executive and Executive Team

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

Executive Summary
This report is an update from the UHN CEO, summarising key points from April 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

I would like to start by thanking all staff who have contributed to the listening events we have held over the last six weeks and to all those who continue to welcome me – and other executives – into their clinical services. I have been really impressed by the openness and honesty many have shown me.

Financial Position 24/25

I am pleased to report that the draft accounts were submitted to NHS England in line with the national timetable. UHN achieved our predicted forecast position, with a final deficit outturn of £29.90m (£12.90m KGH, £17.00m NGH.) This position remains subject to external audit and should continue to be considered draft until this process is completed. The outturn position represents a significant achievement, as several risks remained within the forecast that have been successfully mitigated by our teams. I would like to sincerely thank all our finance colleagues who are working on closing the year-end position. I know that the workload has been intense.

Capital

Significant capital expenditure was completed across the Trusts in March, as programme leads worked to achieve the forecasts that had previously been agreed. As a result, outturn gross capital expenditure for 24/25 was £65.40m (£33.32m KGH, £32.09m NGH) which is broadly in line with our plan. We continue to make improvements in our capital management across UHN.

Planned position 2025/26

The final planned position for UHN for 2025/26 is a deficit of **£75.0m**. This contains a Cost Improvement Programme requirement of **£85.5m**, which is the equivalent of 8.6% of our expenditure. The financial recovery programme will continue to be assessed, to ensure there are no impacts on patient safety.

Mortuary Service

We continue to engage with our colleagues and stakeholders around plans to change the delivery of mortuary services across Northamptonshire. The plans mean that those who die in our care will be moved from our smaller hospital mortuaries to the new County Mortuary, which is being built by West Northamptonshire Council (on behalf of both Northamptonshire Councils.) This will give bereaved families better access to earlier viewing of their loved ones, if they wish to. We will continue to engage with wider stakeholders on this work.

Women and Babies at KGH

We were delighted to be able to open Maple Ward in April 2025 for women and babies at Kettering. From the beginning of April this means our antenatal and postnatal patients are cared for together in a fully refurbished and bright ward environment. We continue our plans to build an extension to the Rockingham Wing to deliver the desired estate for our bereaved families as part of the Twinkling Stars appeal and to provide a new neonatal unit.

Spinneyfield

In November 2024 we opened 30 community beds in Spinneyfield as additional community capacity. We have now successfully closed the beds over the summer, as planned. Alongside this change we have repurposed the Thomas Moore Ward as an extended discharge lounge at KGH. The old discharge lounge has closed as a result.

Improving Together Awards

The Improving Together Awards took place in April, celebrating some innovative projects that are making a real difference to our patients' lives. The projects have helped improve patients' recovery, reduced the time they spend in our hospitals and improved our sustainability and productivity. I want to thank those colleagues for making a difference.

Focal Therapy

On Friday 28th April I had the pleasure of thanking the supporters of Northamptonshire Health Charity's appeal who have raised £450,000 for a new focal therapy service for prostate cancer. The evening was a great success, attended by guests including the Lord Lieutenant and local MPs. This will be the first focal therapy service available on the NHS in the Midlands. Donations are funding advanced equipment including a High Intensity Focused Ultrasound (HIFU) machine, cryotherapy, Nanoknife, and MRI fusion biopsy technology.

My thanks go to all those who supported the appeal, especially Maurice Thompson, whose vision inspired the campaign. Thanks to their generosity, we've now reached our initial fundraising goal, with efforts continuing to expand the service even further. More information is available at https://nhcharity.co.uk/focal. This appeal is a powerful example of how working in partnership with our charity can help deliver life-changing advances in care, beyond what NHS funding alone can provide. The first patient is expected to receive treatment in early June.

Laura Churchward, UHN CEO

Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	9th May 2025
Agenda item	5

Title	Integrated Performance Report (IPR)
Facilitator	Laura Churchward, UHN Chief Executive
Author	Becky Taylor, Director of Continuous Improvement

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

Group priority				
☒ Patient	☒ Quality	☒ Systems & Partnerships	☒ Sustainability	☒ People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
The Integrated Performance Report (IPR) provides an overview of both KGH and NGH's performance.	The IPR is produced on a monthly basis and is presented at public Boards on a bi-monthly basis. The IPR was considered by the Integrated Leadership Team (ILT) on 6th May, and by non-executive directors ahead of Board. Its development has been overseen by the Operational Performance Committee.

Executive Summary

The Integrated Performance Report (IPR) for the May 2025 Boards is enclosed, which reports on March 2025 performance. Executive Leads will draw the Boards'

attention to significant exceptions within the Caring, Safe, Effective, Responsive, Well-Led and Use of Resources domains.

There has been significant redevelopment of the report in the last quarter of 24/25, and the report for the period of March 2025 incorporates the revised suite of metrics and revised format. The same set of data and metrics will be included in the new Accountability and Continuous Improvement Framework, which will form the dataset for the Divisional Accountability Meetings from April performance, with summaries of divisional performance reported to Boards from June 2025.

During the February committee cycle, Board Committees approved a refreshed set of metrics for reporting and a refreshed format. Feedback was received that has been incorporated into the final format of the IPR, including:

- Providing benchmarking data and national comparator information where this is available
- Ensuring that there are more detailed data to aid understanding of where issues are where this makes sense
- Making sure the definitions of metrics are clear

In the refreshed IPR format and process, there is now incorporated in the report:

- Best practice Statistical Process Control (SPC) interpretation on the advice and guidance from the Insightful Board Framework and the national Making Data Count team;
- Clearer narrative focussed on action, continuing to be signed off by Executive Owners;
- Data quality flags to provide assurance on the quality of data being provided and clear actions to improve data quality where required;
- Metrics have been aligned to the national standard data definitions, where one is available. Where this is not the case, this is now clear in the data quality narrative;
- A move to exception reporting for metrics so not all metrics have detailed narrative each month, allowing focussed discussion on the areas that need it most. Latest performance for all metrics is still available reported in domain summaries;
- Addition of detailed workforce, activity and financial tables to provide increased oversight and assurance on performance in these areas; and
- A guide to interpreting SPC charts and a glossary of terms has been added to aid understanding.

A monthly programme group for the Accountability and Continuous Improvement framework, of which the IPR is the part that is reported to Boards, has been established in order to continuously improve the IPR and deliver a programme of continued improvement in our data, reporting and narrative throughout the organisation. Feedback from Boards, Board Committees, ILT and Divisional Accountability Meetings will be considered and acted on by that forum.

The process to develop the IPR metrics now draws for many metrics on the new data warehouse. A rolling programme to continue to move metrics from manual to automated in the warehouse will continue throughout 2025.

There are six metrics approved by committees that are not represented in the IPR, which are outlined below, with target dates for inclusion.

Metric	Committee	Issue	Target date for inclusion
Sepsis six bundle compliance	Quality and Safety Committee	This is currently manual data capture through spot audit. To improve this metric, it requires the full implementation of e-observations and electronic prescribing.	Post NGH Electronic Patient Record go-live
VTE risk assessments	Quality and Safety Committee	The data requires manual collation of historic data points in both Trusts, which will be completed for the next IPR.	May 2025
Underlying run-rate	Finance and Investment Committee	The finance team is developing a process to be able to produce this in the right time frame for the IPR on a monthly basis.	Jul 2025
Distance from financial plan (year to date)	Finance and Investment Committee	Will be included from the start of the new financial year for the new financial year plan.	May 2025
Distance from capital plan (year to date)	Finance and Investment Committee	Will be included from when the capital plan is signed off for 25/26.	
30 day readmission rate	Quality and Safety Committee	The metric requires configuring in the data warehouse to be accurate to the national definition.	Sep 2025

The Boards are asked to take assurance from the refreshed IPR on performance and provide any feedback for the continued improvement of the report.

Appendices

Integrated Performance Report, reporting period March 2025
Board Committees summaries from April 2025 meetings.

Risk and assurance

The appendices provide key controls and assurances to inform the effective management of strategic risks, set out in the Group Board Assurance Framework.

Financial Impact

No direct implications relating to this assurance report.

Legal implications/regulatory requirements

No direct implications relating to this assurance report.

Equality Impact Assessment

Neutral

Dedicated to excellence

NHS
University Hospitals of Northamptonshire
NHS Group

Integrated Performance Report

Kettering General Hospital NHS Foundation Trust
Northampton General Hospital NHS Trust

Reporting March 2025 performance in 9th May 2025 Board

Contents

Introduction

- This month's performance report provides detail of the March 2025 performance for Kettering General Hospital NHS Foundation Trust (KGH) and Northampton General Hospital NHS Trust (NGH) as reported at the University Hospitals of Northamptonshire (UHN) Board meeting.
- In February 2025 an updated format for the Integrated Performance Report (IPR) was agreed to align performance reporting to the CQC domains. The format that follows in this report now includes a single narrative summary slide for each of the CQC domains, forming an executive summary of good news, areas of concern and improvement plans.
- In line with NHS guidance and best practice, we use statistical process control (SPC) charts to help interpret our performance data. Each domain has a slide outlining the key metrics using the SPC chart icons. More detail on metrics which are shown as 'worsening' or 'failing' are included in the report, providing detailed narrative and corrective improvement actions. A guide to interpreting SPC charts is included at the end of the report.
- Information on delivery of activity compared to plan and financial statements are now included in the IPR.
- The IPR format and metrics are used within UHN to with our clinical and corporate divisions, using our Accountability and Continuous Improvement Framework (ACIF) to hold leaders to account for their performance. Each metric in the IPR is weighted and dependent on performance, a score for each CQC domain is given to divisions based on their performance.
- The Accountability and Continuous Improvement Framework will be reported at divisional level a month in arrears in the Board IPR report from the July 2025 Board meeting.

Our Caring and Effective domain executive summary

	Good news	Areas of concern	Improvement plans in place
Patient experience	• Following a period of lower scores, Friends and Family Test satisfaction has significantly improved in both A&E departments, with 84% of patients at KGH and 79% at NGH now reporting they are satisfied with the care they received. • Continue to have high scores for patient experience in outpatients (97% KGH, 94% NGH) and inpatient (95% KGH, 93% NGH) areas. • Reduction in overdue complaints cases (those older than 60 days).	• We are currently not meeting the 90% standard for complaint response times, with performance in Northampton particularly low at 44%	• The Patient Experience Team is leading a deep-dive into ward areas with lower Friends and Family Test response rates, encouraging greater participation and promoting the use of paper copies in A&E. • A recovery plan for complaints performance at NGH is in place and starting to show early signs of improvement. • Additional focus has been placed on managing in-month complaints, with cross-cover arrangements between complaints case officers now supporting divisions more effectively. • A Trust-wide initiative is underway to reduce length of stay, aiming to ease bed pressures and minimise single sex breaches.
Mortality	• Mortality remains below or as expected across the range of mortality measures for both KGH and NGH	• Perinatal mortality remains 5% greater than expected at KGH and within 5% for NGH.	• Changes to coding to adapt to the new methodology to be put in place. • Divisional improvement plan in place to address known service gaps impacting on COPD mortality. • Development of the perinatal safety improvement programme

Our Safe domain executive summary

NHS University Hospitals of Northamptonshire NHS Group

	Good news	Areas of concern	Improvement plans in place
Infection prevention control	• Despite ongoing operational pressures, Infection Prevention metrics across both organisations remain stable, highlighting the resilience of frontline teams and their continued focus on patient safety. • There have also been no new MRSA bacteraemia cases reported this month, maintaining strong performance in reducing healthcare-associated infections.	• Both sites have exceeded their 24/25 trajectories for C. difficile infections. Despite this, KGH has achieved a notable improvement over the past six months, with the mean number of infections reducing from 19.4 to 17.1, reflecting positive progress in infection control practices.	• A system-wide C. difficile task and finish group has been established to drive further improvements through a coordinated approach to prevention, early detection, and management. • UHN spring campaign on hand hygiene to celebrate World Hand Hygiene Day on 5th May • IV to oral antibiotic QI project has commenced on named wards on each site
Incidents	• Positive feedback has been received from HM Coroner in response to the Prevention of Future Deaths (PFD) report on insulin management, recognising the robustness of the actions taken. • There has also been an increase in reported incidents relating to diabetes management. This is seen as a positive indicator of an improving reporting culture, with staff demonstrating greater awareness and a shared commitment to enhancing compliance with insulin management practices.	• Recent data has shown an increase in incidents involving serious or moderate harm at Kettering General Hospital. However, this rise is attributed to changes in the process for validating incidents of moderate and above harm. As the new validation process is embedded, the numbers reported are expected to adjust accordingly. This specifically relates to incidents of falls resulting in serious or moderate harm.	• An Insulin Oversight Group is now in place to drive improvements in insulin safety. • Nervecentre is being deployed to support safer insulin management. • A new Nutrition Group is being developed at KGH to oversee moderate and above harm incidents. • Quality governance alignment across UHN continues to ensure stronger, consistent oversight.
Safe care	• Care hours per patient day are continuing to improve, aligning well with peer performance and reflecting greater efficiency in care delivery.	• The higher care hours per patient day resulting from a higher ratio of healthcare assistants to beds may not be beneficial and can be associated with increased patient mortality and length of stay.	• Continued roll out of Enhanced Therapeutic Observation of Care (ETOC) guidelines on wards. • Agency reduction plan continues to progress.

Our Responsive domain executive summary

	Good news	Areas of concern	Improvement plans in place
Urgent and emergency care	• Extensive feedback received from colleagues on winter learning and winter planning is underway with an intention to develop winter plan 25/26 by end Q1. • Improvement in 4 hour A&E performance at KGH - now achieving the 78% target at 80.2% • Frailty SDEC (3 spaces) and Sir Thomas Moore discharge lounge (14 spaces) are both now operational at KGH. • Improvement in average handover time for ambulances in March in KGH.	• 12 hour performance and overcrowding within both Emergency Departments. • 4 hour Type 1 A&E performance – particularly for NGH. • Ambulance handover performance at both sites. • High bed occupancy and the use of temporary escalation space / escalation beds. • Increase in the proportion of the bed-base occupied by stranded and super-stranded patients in KGH.	• Divisional length of stay speciality and ward level plans to achieve a 1 day reduction in NGH and 0.5 day reduction in KGH being finalised by end of April. • 4 hour A&E performance recovery plans are in progress at both sites. • UEC priority workstreams are in place supported by NHSE and GIRFT. • Medical Consultant engagement event on UEC planned for 2nd May.
Elective	• Delivered ahead of plan on 52 weeks as at the end of March 2025. This puts us in a good position going into 2025/26. • Kettering achieved the target of average cases per theatre list in March 25.	• Risk of delivery in light of financial decisions which may be made during 25/26. • RTT performance improvement is likely to come later in the year due to the need to focus on the long waits position, in particular the remaining 65 week waits.	• The new operational structure will enable a reduction in variation of waiting times between sites. • Triumvirate meetings on outpatient clinic utilisation opportunity are in diaries for the beginning of May.
Cancer	• Cancer Faster Diagnosis Standard performance has been consistently good and is regularly the highest in the region.		• There will be an operational focus on Cancer 62 day targets, as a number of patients are treated within a few days of their breach date. This will be driven through 6:4:2 meetings.

Our Well-Led domain executive summary

	Good news	Areas of concern	Improvement plans in place
Workforce financial sustainability	• M12 shows first reduction in total WTE at KGH • 46% agency reduction during 24/25	• Vacancy rate is above target in both Trusts. Recrutment freeze of non-clinical and significant reduction of clinical recruitment will mean vacancy rates remain above target • Time to Hire adversely impacted by the decision to slow recruitment. • Growth in total workforce and agency and bank use are not reducing fast enough	• Establishments need to be reviewed to reflect budget 25/26 position and all closed vacancies to be removed from establishment to more accurately reflect the vacancy position. • Clarity required on which vacancies can proceed through recruitment – requires clinical and operational “red lines” to be defined • Recruitment freeze and vacancy controls. • Nursing and Medical bank and agency reduction plans
Culture and safety	• Turnover shows consistent improvement during 24/25 • KGH appraisal rates consistently above target • Both Trusts are achieving mandatory training compliance targets. • Our volunteers continue to support us with 6,790 hours volunteered in March 25.	• Appraisal rates at NGH remain below target	• Targeted interventions with groups with low uptake. Review of reporting methodology to ensure consistent with KGH

Our Use of Resources domain executive summary

	Good news	Areas of concern	Improvement plans in place
Finance	• The year end forecast position has been delivered by both NGH and KGH with an £81k upside. • The forecast year-end position at Month 11 was a £29.98m residual deficit (£12.95m KGH, £17.04m NGH) across UHN. • The draft accounts were submitted to NHS England in line with the national timetable and confirm that UHN have delivered a final outturn of £29.90m (£12.90m KGH, £17.00m NGH).	• The final planned position for UHN for 2025/26 is a deficit of £75.0m. This contains a CIP requirement of £85.5m, which is 8.6% of expenditure and will be required to de delivered in cash in full to deliver the planned position.	• Work continues at pace on identification of further schemes – with 71% of the programme currently identified. The programme will continue to be impact assessed to ensure no impacts on patient safety. • UHN is currently undertaking a procurement process for a Strategic Delivery partner to support financial recovery over the course of 2025/26.
Productivity and efficiency	• Acute implied productivity, which measures since 19/20 the growth in costs vs the growth in activity, has shown significant improvement through 24/25, with both KGH and NGH in the third quartile nationally at -8.8% and -8.4%, respectively, against a national median of -10.7%. • Across UHN, £39.6m of efficiencies have been delivered against a target of £41.5m, representing 95% delivery	• High growth in bank and substantive pay, clinical consumable spend and drugs are driving low productivity, with key areas of focus on non-elective length of stay, temporary staffing and corporate as key drivers. • A large proportion of the efficiencies delivered have been delivered non-recurrently (70% NGH, 34% KGH), adding to the financial challenge for 25/26	• Efficiency programme for 25/26 to be fully identified by end of May 25 • Weekly reporting on temporary staffing spend overseen by Chief Nursing Officer and Medical Director • Strengthened accountability and oversight for efficiency delivery through new Accountability and Continuous Improvement Framework

Our Caring domain metrics

	P	?	F	No target
H / L				
		• Friends and Family Test – A&E • Friends and Family Test – Outpatients • Friends and Family Test – Inpatients • Single sex breaches	• Complaints response performance – KGH	• Overdue complaints
H / L		• Complaints response performance - NGH		

Caring

NHS University Hospitals of Northamptonshire NHS Group

Patient experience

Metric	Target	Latest Month	Kettering General Hospital Measure	Variation	Assurance	Kettering General Hospital Mean	Northampton General Hospital Measure	Variation	Assurance	Northampton General Hospital Mean	Data Quality Indicators
Friends and family test – A&E	80%	Mar-25	84.0%			77.9%	79.2%			78.2%	S T P
Friends and family test – inpatients	95%	Mar-25	95.0%			93.4%	93.4%			93.6%	S T P
Friends and family test – outpatients	95%	Mar-25	97.0%			96.4%	93.6%			93.9%	S T P
Complaints response performance	95%	Mar-25	67%			62%	44.0%			56.6%	S T P
Overdue complaints	0	Mar-25	14			16	19			32	S T P
Single sex breaches	0	Mar-25	4			5	14			13	S T P

Data quality assessment

Single sex breaches is currently a manual data field. It is planned to develop this as an automated feed by Sept 25. Only six months of manual data is available.

SPC indicator key

Worsening	Improving	No change
Below target	Above target	Inconsistent in whether target achieved

Data quality indicator key

S Sign off & review	T Timely & complete	P Process & system

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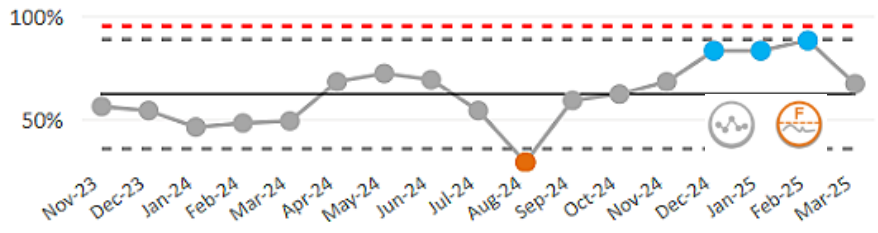
Complaints response performance

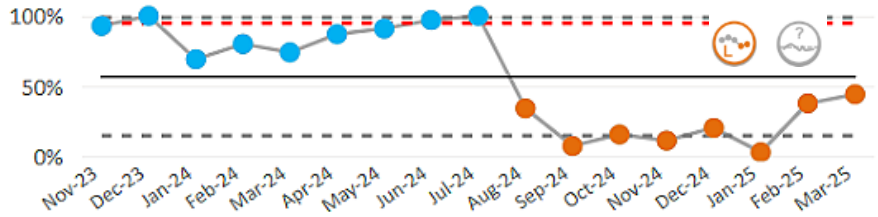
The percentage of complaints responded to within the agreed timescale of 60 days.

NHS University Hospitals of Northamptonshire NHS Group

Complaints response performance - Kettering



Complaints response performance - Northampton



Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	95%	67%	62%
Northampton General	95%	44%	57%

Understanding the performance

- Northampton has experienced a decline in complaints response performance since August 2024, with the current mean performance at 56%.
- After a period of improvement, Kettering's complaints response performance has stabilised within its historic range, with expected monthly values fluctuating between 35% and 88%.

What are the issues impacting performance?

- The increasing number and complexity of complaints are placing additional pressure on the team, affecting overall performance.
- In Northampton, staffing capacity issues and vacant posts are creating particular challenges in managing complaints within expected timeframes.
- In Kettering, delays are linked to a number of complaints awaiting investigation within divisions, especially in Surgery.

What SMART actions are being taken to improve?

- A recovery plan has been in place at Northampton since mid-February and is already showing positive results. Key actions include:
- Recruitment to vacant posts
- Dedicated management time, with two days per week now protected for preparing complaint responses.
- Additional support from the PALS Manager and administrator to manage the generic complaints mailbox.
- Cross-cover arrangements in place, with case handlers providing additional support to the Surgery division.

Risks

- Staffing shortages risk undermining the success of the recovery plan.
- Role changes to support the backlog may lead to staff burnout and reduced support for other services.
- Public reputation may be impacted if complaints response performance does not improve.

Our Effective domain metrics

University Hospitals of Northamptonshire NHS Group

	P	?	F	No target
H / L	• HSMR - KGH	• SMR - KGH	• SHMI - KGH	
H / L	• SHMI – NGH • HSMR – NGH • SMR - NGH			

Effective

NHS University Hospitals of Northamptonshire NHS Group

Mortality

Metric	Target	Latest Month	Kettering General Hospital: Measure	Variation	Assurance	Mean	Northampton General Hospital: Measure	Variation	Assurance	Mean	Data Quality Indicators
Summary Hospital-Level Mortality Indicator	100	Mar-25	99			104	94			90.7	S T P
Hospital Standardised Mortality Ratio	100	Mar-25	89			95.3	100			93.9	S T P
Standardised Mortality Ratio	100	Mar-25	91			97.2	96			93.4	S T P

Data quality assessment

No data quality issues identified.

SPC indicator key

Worsening	Improving	No change
Below target	Above target	Inconsistent in whether target achieved

Data quality indicator key

S	T	P
Sign off & review	Timely & complete	Process & system

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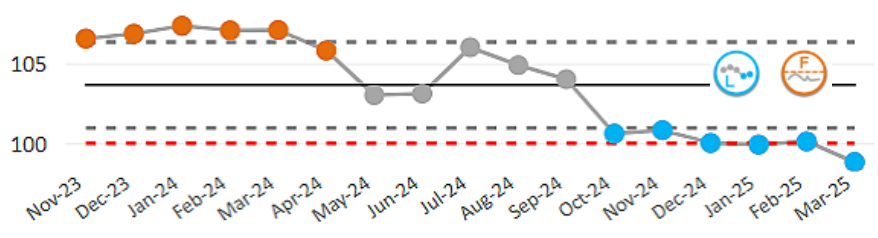
Summary Hospital-Level Mortality Indicator (SHMI)

NHS University Hospitals of Northamptonshire NHS Group

The ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures based on demographics.

SHMI - Kettering



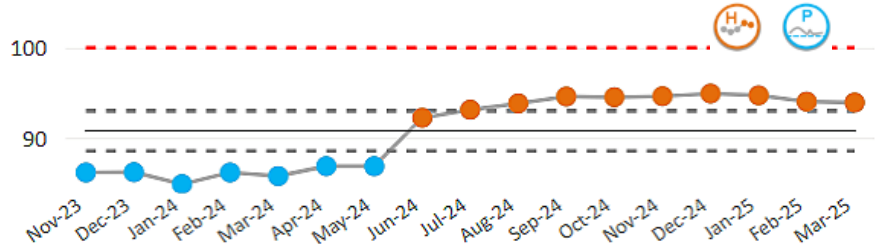
Understanding the performance

- Kettering is undergoing a period of sustained improvement and is now below expected mortality at 98.8.
- Northampton is undergoing a period of deterioration from a previously very positive position but is still below the expected mortality at 93.9.

What are the issues impacting performance?

- Due to changes in methodology, mortality data will be reviewed for next months' IPR to determine if thresholds have been met to recalculate control limits

SHMI - Northampton



What SMART actions are being taken to improve?

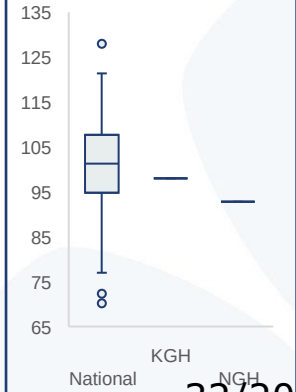
- Divisional improvement plan in place to address known service gaps impacting on COPD mortality
- Review thresholds for recalculating control limits

Risks

- Not applicable, mortality is within expected range.

National comparator

SHMI
(Dec-23 - Nov-24)



Data Quality Indicators
S T P

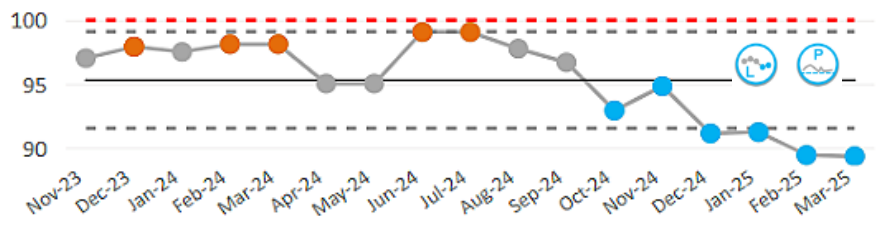
Trust	Target	Latest Month	Mean
Kettering General	100	99	104
Northampton General	100	94	90.7

Hospital Standardised Mortality Ratio (HSMR)

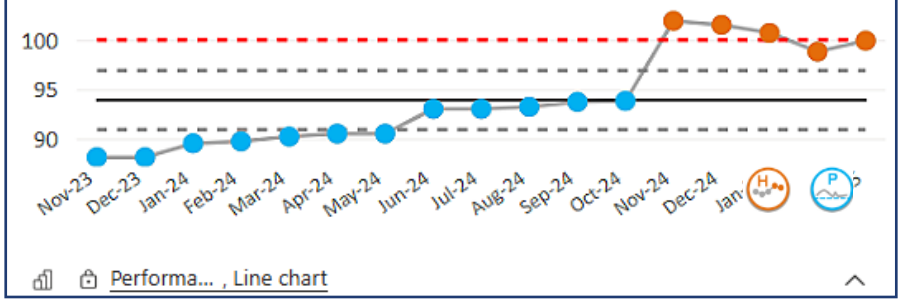
University Hospitals of Northamptonshire NHS Group

The overall rate of deaths within the NHS trust each hospital belongs to. Rates are given as better, worse, or as expected compared to the national average, which is represented as 100 on the scale.

HSMR - Kettering



HSMR - Northampton



Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	100	89	95.3
Northampton General	100	100	93.9

Understanding the performance

- Kettering is undergoing a period of sustained improvement and is consistently expected to be below the expected range for mortality.
- Northampton is undergoing a period of deterioration from a previously very positive position but is still within the expected range for mortality at 100.

What are the issues impacting performance?

- NGH HSMR increased following implementation of the new HSMR+ methodology. We anticipate HSMR will gradually decrease over the next 12 months as changes to our clinical coding processes (to adapt to the new methodology) start to be reflected in the data
- Due to changes in methodology, mortality data will be reviewed for next months' IPR to determine if thresholds have been met to recalculate control limits

What SMART actions are being taken to improve?

- On-going project within the Clinical Coding service to increase comorbidity capture will align with the changes associated with the HSMR+ methodology
- Divisional improvement plan in place to address known service gaps impacting on COPD mortality
- Review thresholds for recalculating control limits

Risks

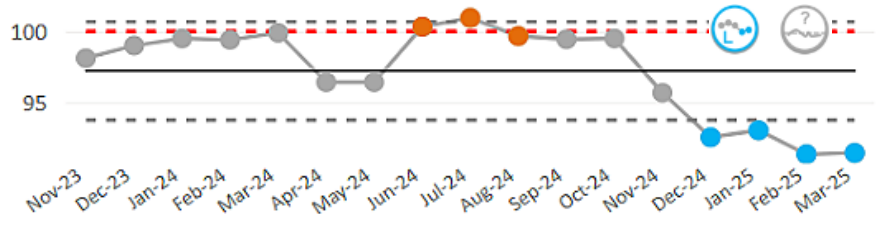
- Not applicable, mortality is within expected range.

Standardised Mortality Ratio (SMR)

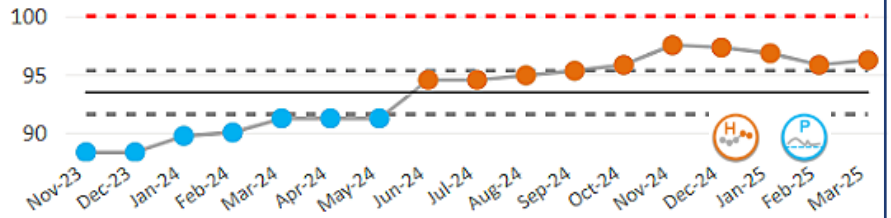
The overall rate of deaths within the population. Rates are given as better, worse, or as expected compared to the national average, which is represented as 100 on the scale.

University Hospitals of Northamptonshire NHS Group

SMR - Kettering



SMR - Northampton



Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	100	91	97.2
Northampton General	100	96	93.4

Understanding the performance

- Kettering is undergoing a period of sustained improvement and is consistently expected to be below the expected range for mortality.
- Northampton is undergoing a period of deterioration from a previously very positive position but is still below the expected range for mortality at 96.

What are the issues impacting performance?

- Due to changes in methodology, mortality data will be reviewed for next months' IPR to determine if thresholds have been met to recalculate control limits

What SMART actions are being taken to improve?

- Divisional improvement plan in place to address known service gaps impacting on COPD mortality
- Review thresholds for recalculating control limits

Risks

- Not applicable, mortality is within expected range.

Our Safe domain metrics

	P	?	F	No target
H / L		• Number of C. Diff infections - KGH		
		• MRSA • MSSA • Number of C. Diff infections - NGH	• Care hours per patient day	• Serious or moderate harms – NGH • Serious or moderate harms (falls) – NGH • Serious or moderate harms (pressure ulcers)
H / L			• Never event incidence	• Serious or moderate harms – KGH • Serious or moderate harms (falls) – KGH

Safe

University Hospitals of Northamptonshire NHS Group

Infection prevention control

Metric	Target	Latest Month	Kettering General Hospital Measure	Variation	Assurance	Mean	Northampton General Hospital Measure	Variation	Assurance	Mean	Data Quality Indicators
MRSA	0	Mar-25	0			0.2	0			0.4	S T P
MSSA	0	Mar-25	2			1	3			1.7	S T P
Clostridium difficile	KGH: 22.4 NGH: 31.5	Mar-25	17.1			19.4	31.2			41.8	S T P

Data quality assessment

No data quality issues identified.

Incidents and safe care

Metric	Target	Latest Month	Kettering General Hospital Measure	Variation	Assurance	Mean	Northampton General Hospital Measure	Variation	Assurance	Mean	Data Quality Indicators
Serious or moderate harms		Mar-25	1.49			0.44	1.87			1.02	S T P
Serious or moderate harms – falls		Mar-25									S T P
Serious or moderate harms – pressure ulcers		Mar-25									S T P
Never event incidence	0	Mar-25	1			0.24	0			0.36	S T P
Care hours per patient day	Between 8 and 9	Mar-25 (KGH) Feb-25 (NGH)	9.2			9.3	9.5			9.7	S T P

Data quality assessment

No data quality issues identified.

SPC indicator key

Worsening	Improving	No change
Below target	Above target	Inconsistent in whether target achieved

Data quality indicator key

S Sign off & review	T Timely & complete	P Process & system

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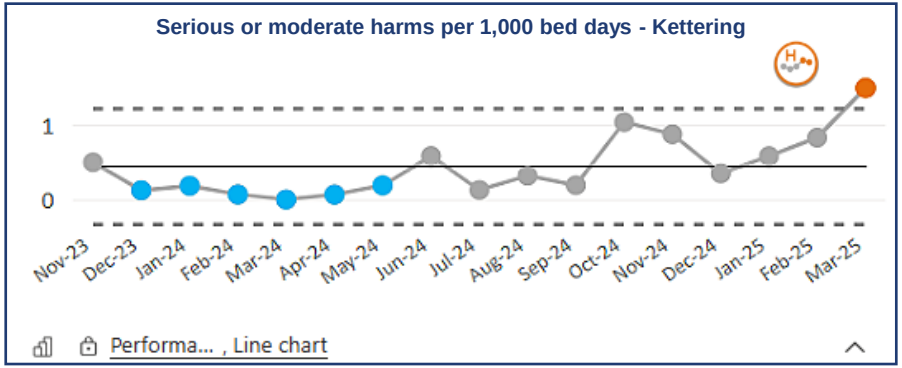
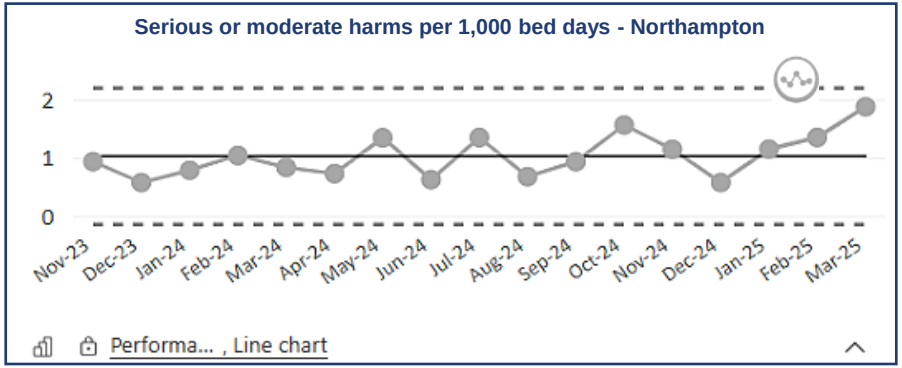
Serious or moderate harms

The number of serious or moderate harms patients have experienced per 1,000 bed-days.





Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	-	1.49	0.44
Northampton General	-	1.87	1.02

Understanding the performance

- Recent data has shown an increase in incidents involving serious or moderate harm at Kettering General Hospital. However, this rise is attributed to changes in the process for validating incidents of moderate and above harm.
- Northampton continues to show no significant variation in the number of serious or moderate harm incidents.

What are the issues impacting performance?

- Key patient safety events include issues related to insulin administration and diabetes management.
- Nutrition and acute kidney injury (AKI) management have also been identified as contributory factors.
- VTE incidents were noted in March; however, this coincided with a strengthened harm review process led by the Thrombosis Committee.

What SMART actions are being taken to improve?

- An Insulin Oversight Group is now in place to drive improvements in insulin safety.
- Nervecentre is being deployed to support safer insulin management.
- A new Nutrition Group is being developed at KGH to oversee moderate and above harm incidents.
- Quality governance alignment across UHN continues to ensure stronger, consistent oversight.

Risks

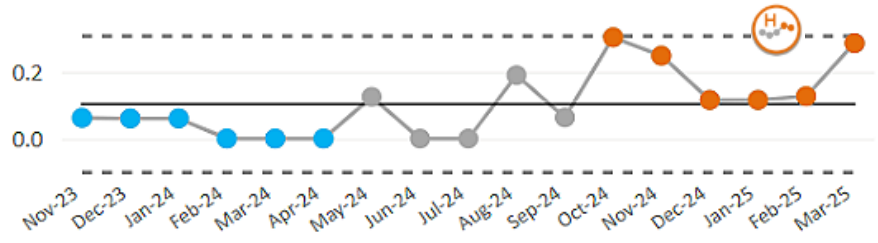
- There is a risk that delays or inconsistencies in aligning processes with the Patient Safety Incident Response Framework (PSIRP) could impact the quality, timeliness, and effectiveness of patient safety investigations.
- There is a risk that colleagues may not feel safe or supported to report incidents, leading to potential under-reporting of harm and missed opportunities for learning and improvement.

Serious or moderate harms - falls

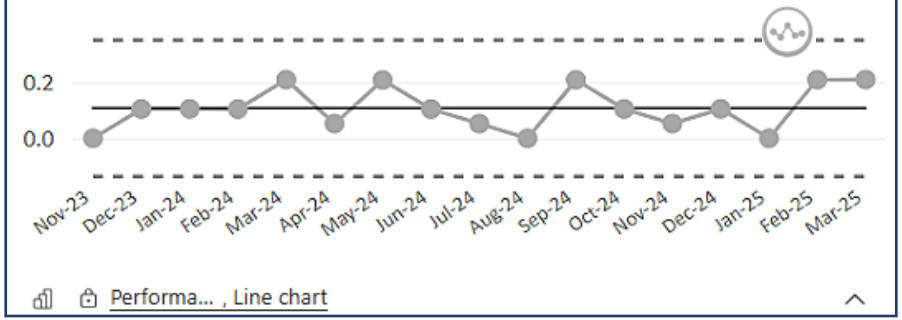
The number of falls resulting in serious or moderate harms per 1,000 bed-days.

NHS University Hospitals of Northamptonshire NHS Group

Serious or moderate harms from falls per 1,000 bed days - Kettering



Serious or moderate harms from falls per 1,000 bed days - Northampton



Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	-	0.29	0.10
Northampton General	-	0.21	0.11

Understanding the performance

- At KGH, there has been a noticeable increase in the number of falls resulting in serious or moderate harm, with the expected range now between 0 and 0.31 incidents per 1,000 bed days.
- AT NGH, the number of serious or moderate harms from falls has remained stable, with performance staying within the expected range of 0 to 0.35 incidents per 1,000 bed days.

What are the issues impacting performance?

- The increase in falls at Kettering has been influenced by higher patient activity over the winter period and the opening of Spinneyfields, where the patient cohort and increased use of side rooms have contributed to greater risk.

What SMART actions are being taken to improve?

- A visit to Spinneyfields by falls specialists from KGH, NGH, and NHFT led to the introduction of targeted measures to address the specific risks identified at the site.
- Ongoing monitoring and shared learning are being cascaded through governance structures and the Nursing, Midwifery, and AHP Committee.
- Risk mitigation measures are now in place across both hospitals to support patient safety and reduce falls.

Risks

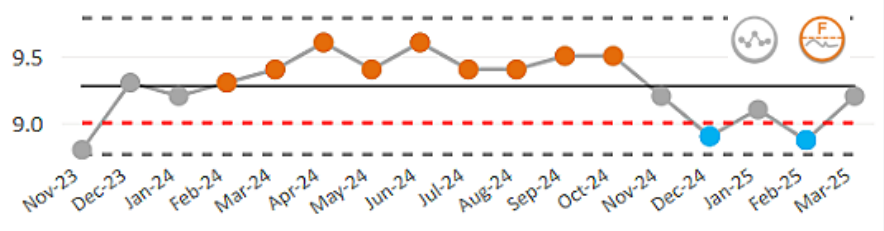
- Higher patient acuity and frailty increasing risk.
- Environmental challenges, including side rooms and ward layouts.
- Staffing shortages affecting supervision and response times.
- Inconsistent application of falls prevention measures.
- Increased patient activity during peak periods.
- Training gaps reducing staff confidence in prevention strategies.
- Patient non-compliance with safety advice.

Care hours per patient day

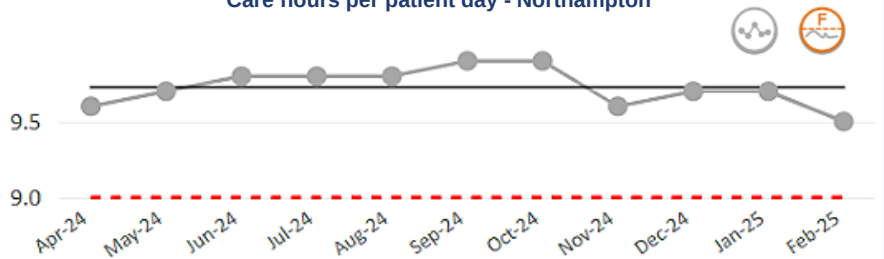
The number of hours of registered and unregistered nursing staff on the wards per patient on the wards.

NHS University Hospitals of Northamptonshire NHS Group

Care hours per patient day - Kettering



Care hours per patient day - Northampton



Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	Between 8 and 9	9.2	9.3
Northampton General		9.5	9.7

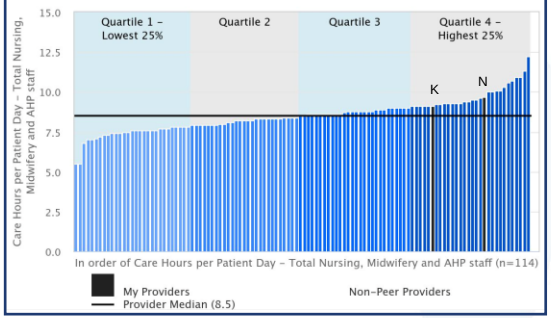
Understanding the performance

- Both sites are showing no significant variation in the number of care hours per patient day (CHPPD).
- Both sites are above the target range and remain in the top quartile nationally.

What SMART actions are being taken to improve?

- Ensuring the appropriateness of workforce deployment, specifically noting the following:
  - Temporary staffing usage (bank and agency).
  - Enhanced Therapeutic Observation of Care (ETOC).
  - Adherence to evidence based staffing.

National comparator



What are the issues impacting performance?

- Gaps in understanding around workforce planning among colleagues may lead to decisions that do not fully align with best practice, contributing to increased care hours per patient day (CHPPD).
- Several wards at KGH, are adversely impacting CHPPD due to the "small ward" phenomenon, where staffing requirements remain high despite lower patient numbers.

Risks

- A higher ratio of Healthcare Assistants (HCAs) to beds may be linked to increased patient mortality and longer length of stay (Griffiths et al., 2016; 2018).
- Increased supervisory demands on Ward Leaders and Nurses in Charge.
- Financial risks from uncontrolled workforce deployment.

Our Responsive domain metrics

	P	?	F	No target
H / L		• A&E 4 hour performance - KGH • 52 week waits as a percentage of the waiting list – KGH	• 52 week waits as a percentage of the waiting list – NGH • RTT performance	• Size of RTT waiting list
	• Cancer Faster Diagnosis Standard - NGH	• Time to initial assessment • Bed utilisation – NGH • Patients with no reason to reside - NGH • Cancer Faster Diagnosis Standard – KGH • 31-day Cancer Standard • 62-day Cancer Standard • Outpatient appointments per Consultant WTE	• A&E 4 hour performance – NGH • Ambulance handovers within 45 minutes • 12 hour waits in A&E – NGH • Bed utilisation – KGH • Patients with no reason to reside – KGH • Wait for first appointment less than 18 weeks • Theatre utilisation • Average cases per list • Patients with a 7+ day length of stay - NGH • Patients with a 21+ day length of stay – NGH	• Non-elective length of stay - NGH
H / L			• Patients with a 7+ day length of stay - KGH • Patients with a 21+ day length of stay – KGH	• Non-elective length of stay - KGH

Responsive – Urgent and Emergency Care

NHS University Hospitals of Northamptonshire NHS Group

Urgent and Emergency Care and Flow

Metric	Target	Latest Month	Kettering General Hospital				Northampton General Hospital				Data Quality Indicators
			Measure	Variation	Assurance	Mean	Measure	Variation	Assurance	Mean	
A&E 4 hour performance	78%	Mar-25	80.2%			73.3%	65.8%			68.3%	S T P
Average ambulance handover time	0%	Mar-25	45			44	45			63	S T P
Time to initial assessment	15	Mar-25	15.4			16.5	11.8			16.6	S T P
12 hour waits in A&E	0%	Mar-25	4.6%				5.0%			6.3%	S T P
Bed utilisation	92%	Mar-25	98.6%			98.3%	91.8%			90.3%	S T P
Non-elective length of stay	Target to be set for May	Mar-25	16.0			13.4	15.1			15.8	S T P
Patients with a reason to reside	80%	Mar-25	56%			59%	71%			66%	S T P
Patients with a 7+ day length of stay	42%	Mar-25	57%			54%	58%			58%	S T P
Patients with a 21+ day length of stay	12%	Mar-25	23%			19%	23%			24%	S T P

Data quality assessment

KGH didn't submit 12 hr breaches until March 25. The metric is being built which will generate historic data. This will be completed for May 25 IPR.

Ambulance handover currently is only 6 months of data. More historic data will be added for May 25 IPR.

Issues with iBox data provision during Oct 24 and Feb 25 mean the metric for Patients with a reason to reside are inaccurate for those months. A review is ongoing for KGH to ensure all future reported values match the agreed definition.

Validation that length of stay matches the Model Hospital definition is underway.

Note on targets

Many metrics in the Responsive domain have an improvement trajectory through the year. The target listed for each metric represents the target at March 2026.

SPC indicator key

Worsening	Improving	No change
Below target	Above target	Inconsistent in whether target achieved

Data quality indicator key

S	T	P
Sign off & review	Timely & complete	Process & system

Dedicated to excellence

Responsive – Cancer and Elective

University Hospitals of Northamptonshire NHS Group

Cancer

Metric	Target	Latest Month	Kettering General Hospital: Measure	Variation	Assurance	Mean	Northampton General Hospital: Measure	Variation	Assurance	Mean	Data Quality Indicators
Cancer Faster Diagnosis Standard	80%	Feb-25	85.7%			84.3%	88.6%			86.3%	S T P
31-day wait to start treatment	96%	Feb-25	99.4%			94.9%	92.2%			92.4%	S T P
62-day wait for first treatment	75%	Feb-25	76.0%			66.8%	64.5%			67.1%	S T P

Data quality assessment

No data quality issues identified.

Elective Care

Metric	Target	Latest Month	Kettering General Hospital: Measure	Variation	Assurance	Mean	Northampton General Hospital: Measure	Variation	Assurance	Mean	Data Quality Indicators
52 week waits as a percentage of the waiting list	1%	Mar-25	0.81%			1.31%	1.83%			2.72%	S T P
Wait for first appointment less than 18 weeks	72%	Mar-25	70.4%			67.4%	66.4%			66.4%	S T P
RTT performance	70%	Mar-25	66.4%			64.0%	61.9%			60.6%	S T P
Size of RTT waiting list	-	Mar-25	25,698			27,789	41,421			42,859	S T P

Data quality assessment

No data quality issues identified.

Dedicated to excellence

Note on targets

Many metrics in the Responsive domain have an improvement trajectory through the year. The target listed for each metric represents the target at March 2026.

SPC indicator key

Worsening	Improving	No change
Below target	Above target	Inconsistent in whether target achieved

Data quality indicator key

S Sign off & review	T Timely & complete	P Process & system

Responsive – Productivity

University Hospitals of Northamptonshire NHS Group

Productivity

Metric	Target	Latest Month	Kettering General Hospital: Measure	Variation	Assurance	Mean	Northampton General Hospital: Measure	Variation	Assurance	Mean	Data Quality Indicators
Theatre utilisation	85%	Mar-25	82.2%		F	78.7%	77.6%		F	78.0%	S T P
Average cases per list	2.5	Mar-25	2.57		F	2.37	2.13		F	2.23	S T P
Outpatient appointments per consultant WTE	116	Mar-25	126		?	129	139		?	150	S T P

Data quality assessment

No data quality issues identified.

Data quality assessment

No data quality issues identified.

SPC indicator key

L H Worsening	H L Improving	No change
F Below target	P Above target	? Inconsistent in whether target achieved

Data quality indicator key

S	T	P
Sign off & review	Timely & complete	Process & system

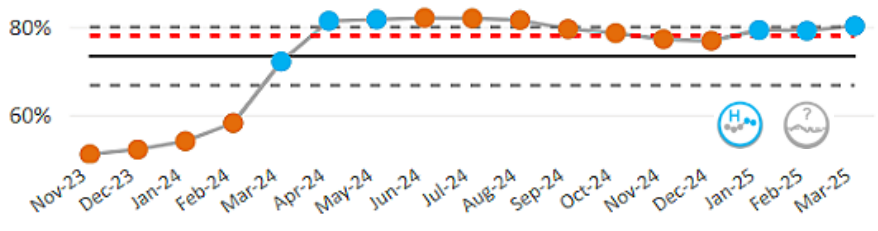
Dedicated to excellence

A&E 4-hour performance

The percentage of patients who attend our Accident & Emergency departments who leave the department either by being discharged, transferred or admitted within 4 hours of their arrival.

NHS University Hospitals of Northamptonshire NHS Group

A&E 4 hour performance - Kettering



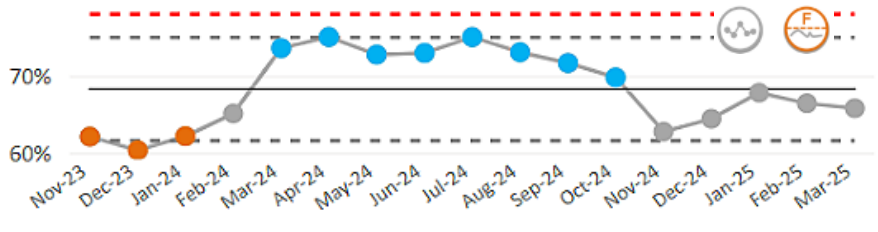
Understanding the performance

- There has been a positive improvement in 4 hour A&E performance in Kettering, with KGH now achieving the 78% target at 80.2%. The variation in performance expect to range between 67 and 80%.
- There has been a reduction in performance for NGH in part due to counting and coding change in Nov (~5%) and part due to true performance reduction of a similar 5%.

What are the issues impacting performance?

- Exit block for admitted flow impacting ED clinical space to review patients.
- Consistency of Type 3 performance at NGH.

A&E 4 hour performance - Northampton



What SMART actions are being taken to improve?

4hr Recovery Plans in place in both hospitals to:

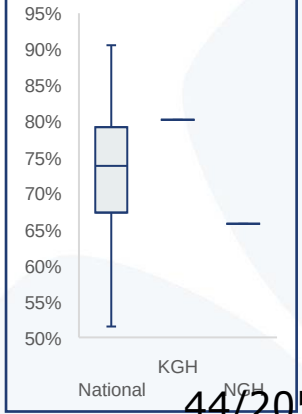
- Agree internal standards for all non-admitted performance.
- Roll out of ED IPS.
- Agree and deliver minors 4hr performance.
- Implementation of new initial assessment screening tool to make early decisions to reduce time to initial assessment (NGH).

Risks

- Continued high demand for A&E.
- Workforce and reliance on temporary staffing.

National comparator

A&E 4 hour performance (Mar-25)



Data Quality Indicators
S T P

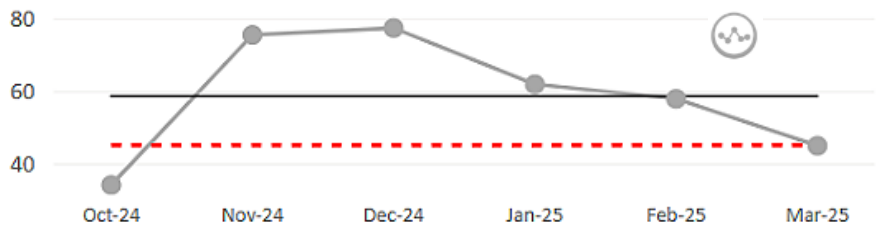
Trust	Target	Latest Month	Mean
Kettering General	78%	80.2%	73.3%
Northampton General	78%	65.8%	68.3%

Average ambulance handover time

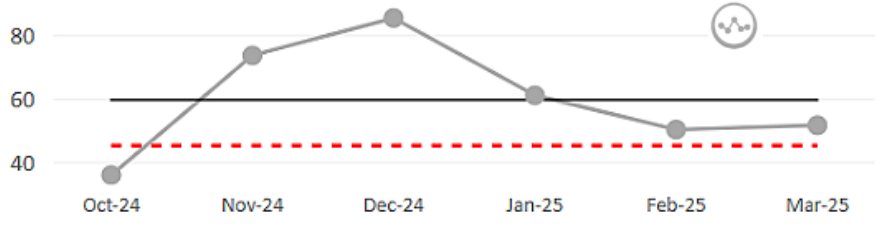
The average time from when an ambulance arrives at our Emergency Department to when the handover from ambulance staff to our clinicians is longer than 45 minutes.

University Hospitals of Northamptonshire NHS Group

Average ambulance handover time - Kettering



Average ambulance handover time - Northampton



Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	45	44	55
Northampton General	45	63	59

Understanding the performance

- KGH have improved handover performance since November with latest position in March demonstrating compliance against the 45min plan.
- NGH whist have improved since December have experienced challenging days during March and whilst in line with trajectory is currently at 63mins against 45min target.

What are the issues impacting performance?

- Capacity within the Emergency Department (ED) and flow through inpatient beds.
- 12 hour performance and admitted patient delays.

What SMART actions are being taken to improve?

- Extended Same Day Emergency Care (SDEC) hours to decompress the ED and provide straight to SDEC access to EMAS.
- UEC priority workstreams to improve length of stay across UHN including internal flow and discharge group.
- Divisional length of stay plans at ward level with overall plan of a 1 day (NGH) and 0.5 day (KGH) with full benefit by October.

Risks

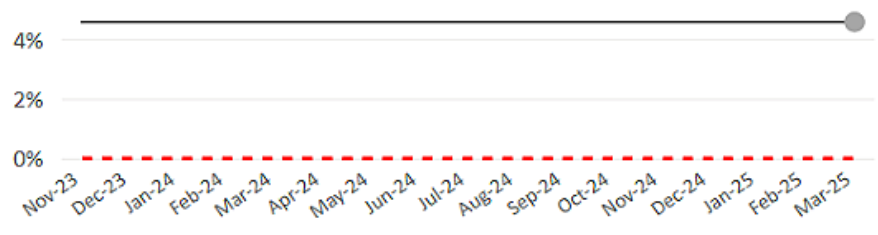
- There is no reduction in LoS to improve ED flow and overcrowding.
- Ongoing handover delays impacting patient care and safety both within the Trust and Community.
- Ongoing use of temporary escalation space, escalation beds and temporary staffing.

12 hour waits in A&E

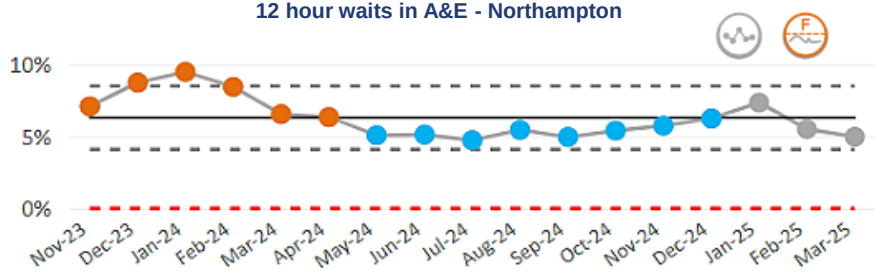
The percentage of patients who have waited more than 12 hours in our Emergency Departments before being discharged, admitted or transferred.

University Hospitals of Northamptonshire NHS Group

12 hour waits in A&E - Kettering



12 hour waits in A&E - Northampton



Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	0%	4.6%	
Northampton General	0%	5.0%	6.3%

Understanding the performance

- Kettering has not reported 12 hour waits until March, impacting on ability to analyse performance. This will be rectified for the May IPR.
- After a period of improvement between May and December, there has been no significant change in Northampton performance since January 25. The variation can expect to range between 4.1 and 8.5%.

What are the issues impacting performance?

- 12hr waits within the ED are impacted by speciality response times to expedite discharge from ED alongside time waiting for admission following DTA.

What SMART actions are being taken to improve?

- Release to respond – rapid flow of patients to move into ward areas against key triggers to reduce delays in beds being ready on wards.
- Divisional LoS actions at ward level to reduce LoS and improve 12hr performance within the ED.

Risks

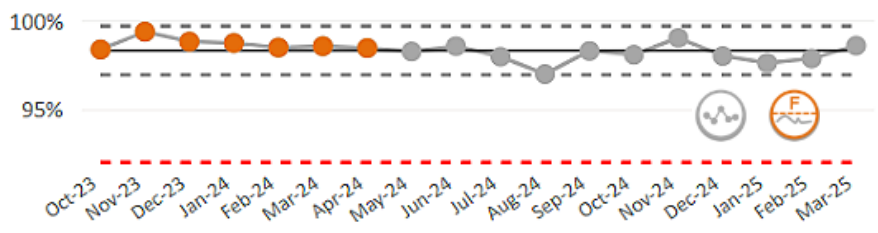
- Delay in speciality response times into the ED impacting decisions and patient care.
- No reduction in NEL LoS impacting flow from the ED and 12hr waiting times.

Bed utilisation

The average percentage of our available general acute beds which are occupied by patients at midnight each day.

University Hospitals of Northamptonshire NHS Group

Bed utilisation - Kettering



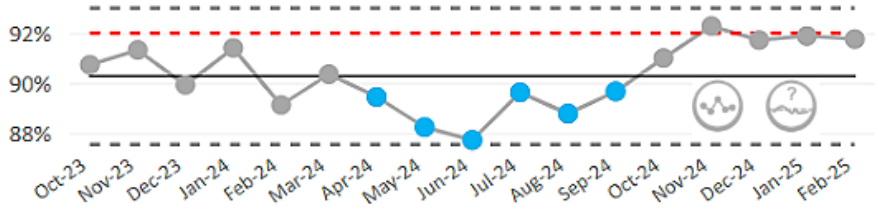
Understanding the performance

- There has been no significant change in bed occupancy in Kettering for a year, with the expected range between 96 and 99% occupancy.
- After a period of improvement in the summer, there has been no significant change to bed occupancy in Northampton since October, with the expected range between 87 and 93%.

What are the issues impacting performance?

- Non-elective LoS position with a longer length of stay than average.

Bed utilisation - Northampton



What SMART actions are being taken to improve?

- Admission avoidance in use of extended hours within SDEC.
- UHN review of Virtual Ward including Cardiology VW at NGH from Q2.
- Length of stay improvement plans being developing by divisional teams at ward level.

Risks

- Ongoing bed occupancy of 99% impacting flow and ED overcrowding.
- Ongoing use of temporary escalation space resulting in additional temporary staffing and cost.

Data Quality Indicators
S T P

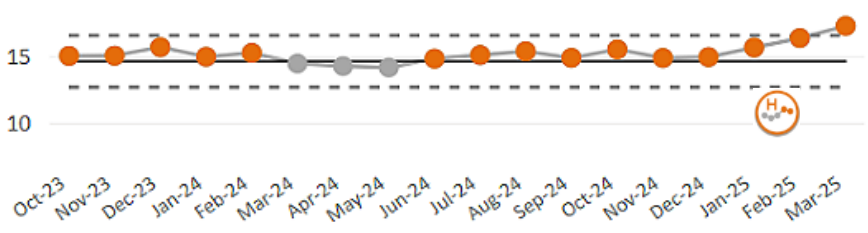
Trust	Target	Latest Month	Mean
Kettering General	92%	98.6%	98.3%
Northampton General	92%	91.8%	90.3%

Non-elective length of stay

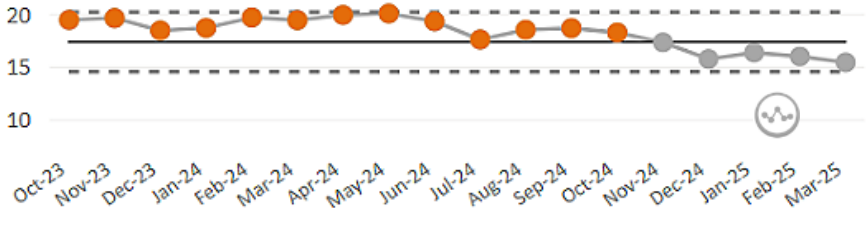
The average length of stay for patients who have been admitted as a non-elective or emergency stay for patients, not including patients who stayed for less than 24 hours.

University Hospitals of Northamptonshire NHS Group

Non-elective length of stay - Kettering



Non-elective length of stay - Northampton



Understanding the performance

- Kettering length of stay has been increasing over the past six months.
- After a period of deterioration, Northampton length of stay has been showing no significant variation for the past five months.

What are the issues impacting performance?

- Length of stay increases in Kettering is likely to be impacted by the opening of Spinneyfields.

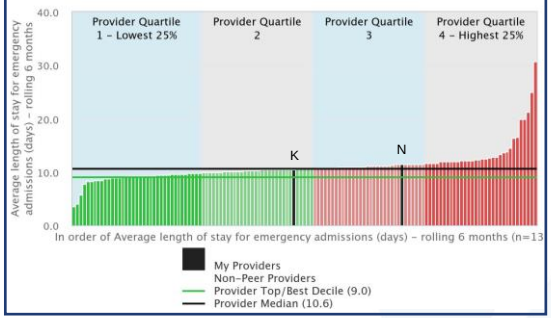
What SMART actions are being taken to improve?

- Inpatient flow group focusing on AMU delivery, internal professional standards and diagnostics.
- Discharge group standardising complex discharge workstreams across UHN to reduce delays from patients being MFFD to discharge.
- Divisional LoS work at ward level to reduce delays and improve patient experience.

Risks

- Partner support in placement of patients who require supported discharge.

National comparator



Data Quality Indicators
S T P

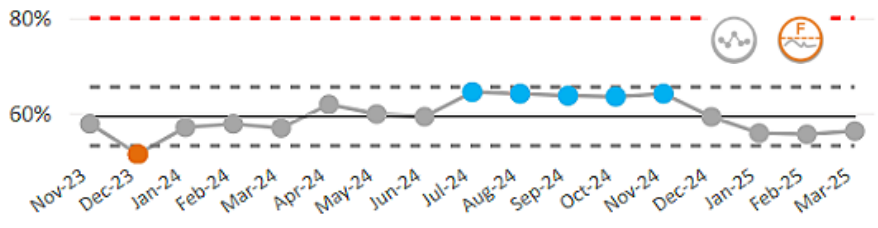
Trust	Target	Latest Month	Mean
Kettering General	-	16.0	13.4
Northampton General	-	15.1	15.8

Patients with a reason to reside

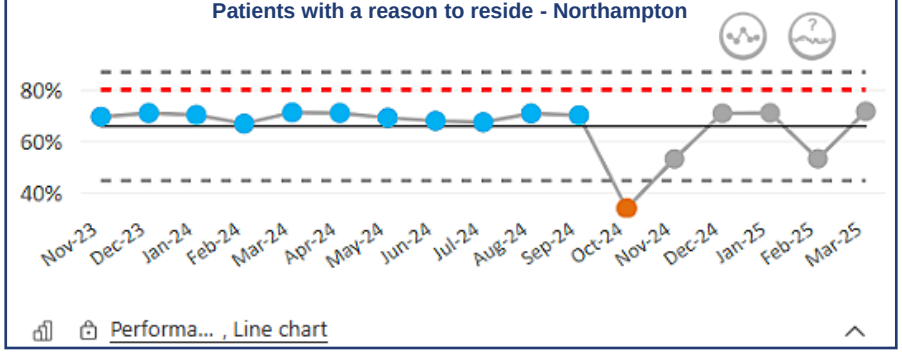
The percentage of patients in a hospital bed who do meet the national reason to reside criteria, meaning they have a medical reason to be residing in a hospital bed.

University Hospitals of Northamptonshire NHS Group

Patients with a reason to reside - Kettering



Patients with a reason to reside - Northampton



Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	80%	56%	59%
Northampton General	80%	71%	66%

Understanding the performance

- After a period of improvement in the autumn, there has been no significant change in the proportion of patients with a reason to reside since December 24, with an expected range of between 53 and 65% at Kettering, and an expected range of between 44 and 86% in Northampton..
- Northampton control limits are impacted by poor data quality in Oct-24 and Feb-25, which extend the range.

What are the issues impacting performance?

- Delays in patients being accepted to care homes and cut off times.
- Dementia and delirium bed capacity.
- Stroke rehab capacity.
- Kettering calculation currently includes beds which are not General Acute beds and this required updating.

What SMART actions are being taken to improve?

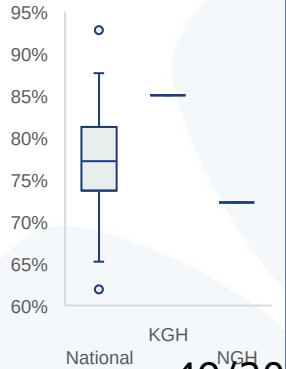
- Standardisation of transfer of care (TOC) form across UHN to improve quality of referrals and standardise process of patients requiring supported discharge.
- Trusted assessor model being reviewed to support patients placements into NHFT beds / care homes to reduce assessment delays.
- Update the KGH metric to only include General Acute beds.

Risks

- Partners support across ICB / NHFT / LA in reduction of time from MFFD to discharge.

National comparator

Patients meeting the criteria to reside (Dec-24)

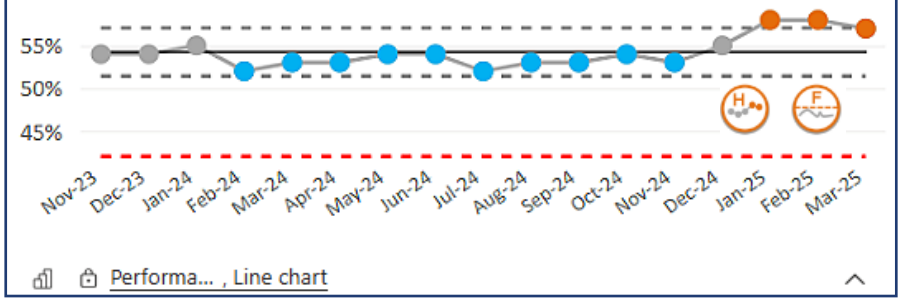


Patients with length of stay greater than 7 days

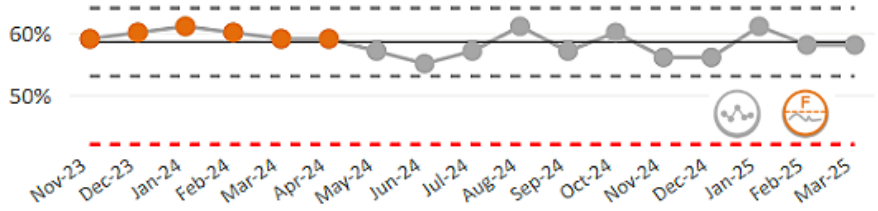
The percentage of general acute hospital beds occupied by patients who have been in hospital for more than 7 days.

University Hospitals of Northamptonshire NHS Group

Percentage of patients with a length of stay more than 7 days - Kettering



Percentage of patients with a length of stay more than 7 days - Northampton



Understanding the performance

- There has been a concerning increase in the number of patients in beds for more than 7 days in Kettering, with the latest figures at 57%, the top of the expected range.
- There has been no significant change in Northampton, with the expected range between 53 and 64% of beds occupied by patients who have been in beds for more than 7 days.

What are the issues impacting performance?

- Medical / Surgical outliers impacting delays in decision making.
- No Frailty SDEC at NGH.

What SMART actions are being taken to improve?

- Extended hours for SDEC capacity.
- Frailty SDEC at both acute sites.
- Use of STMoore as short stay unit / discharge lounge.
- Review of AMU and short stay patient flow.
- Boardround structures, discharge planning and decision making.
- Adherence to Internal professional standards.

Risks

- Consistency and resource of weekend / bank holiday medical staffing provision across the 7day service.
- Diagnostic delays due to demand.

Data Quality Indicators
S T P

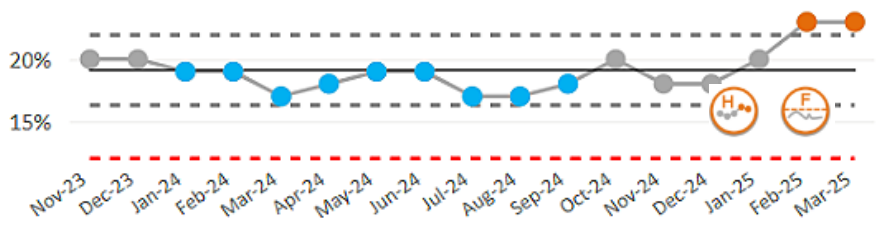
Trust	Target	Latest Month	Mean
Kettering General	42%	57%	54%
Northampton General	42%	58%	58%

Patients with length of stay greater than 21 days

The percentage of general acute hospital beds occupied by patients who have been in hospital for more than 21 days.

NHS University Hospitals of Northamptonshire NHS Group

Percentage of patients with a length of stay more than 21 days - Kettering



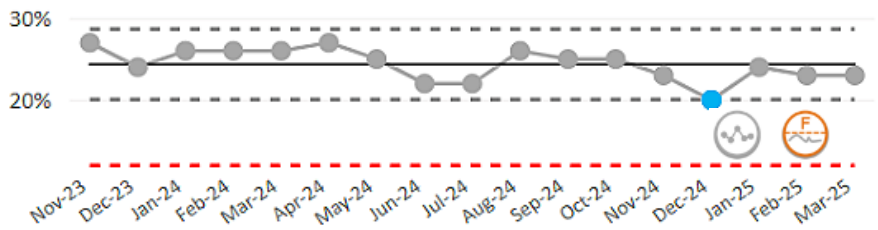
Understanding the performance

- There has been a concerning increase in the number of patients in beds for more than 21 days in Kettering, with the latest figures at 23%, above the expected range of 16 to 22%.
- After an improved December, there has been no significant change in Northampton, with the expected range between 20 and 28% of beds occupied by patients who have been in beds for more than 21 days.

What are the issues impacting performance?

- Delays in patients being accepted to care homes and cut off times.
- Dementia and delirium bed capacity.
- Stroke rehab capacity.

Percentage of patients with a length of stay more than 21 days - Northampton



What SMART actions are being taken to improve?

- Standardisation of transfer of care (TOC) form across UHN to improve quality of referrals and standardise process of patients requiring supported discharge.
- Trusted assessor model being reviewed to support patients placements into NHFT beds / care homes to reduce assessment delays.

Risks

- Partners support across ICB / NHFT / LA in reduction of time from MFFD to discharge.

Data Quality Indicators
S T P

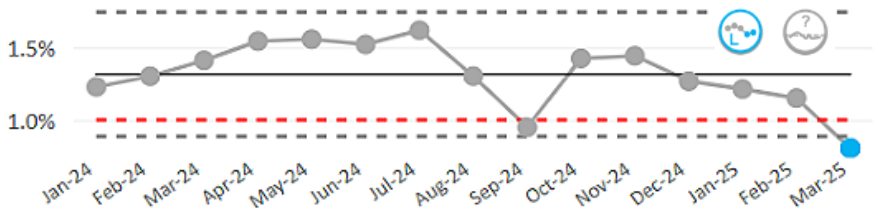
Trust	Target	Latest Month	Mean
Kettering General	12%	23%	19%
Northampton General	12%	23%	24%

52 week waits as a percentage of the waiting list

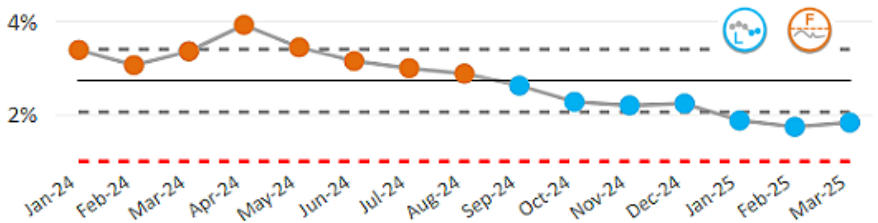
The percentage of patients who have been waiting on our planned care waiting list for 52 weeks or more

University Hospitals of Northamptonshire NHS Group

52 week waits as a percentage of the waiting list - Kettering



52 week waits as a percentage of the waiting list - Northampton



Understanding the performance

- Kettering has seen a significant improvement in 52 week performance, and is achieving the target of 1% of the waiting list, at 0.8%. The expected range is between 0.9 and 1.7%.
- Northampton has seen sustained improvement in 52 week performance since September 24, with the expected range between 2 and 3.4%.

What are the issues impacting performance?

- Upper GI and Lower Limb at NGH remain the risk specialties for the long waits position (both 65 weeks and 52 weeks).

What SMART actions are being taken to improve?

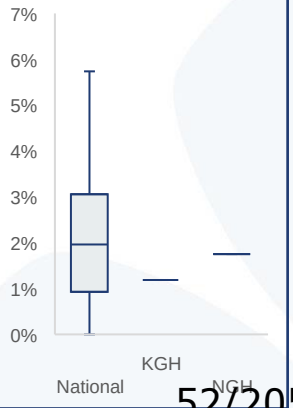
- Targeted Inter-Provider Transfers between sites are taking place to balance the long waits position against available capacity, this should support a continued reduction in the 52-week position.
- General Surgery are sending 20 patients a week from NGH to KGH and T&O are scoping an appropriate cohort for transfer.

Risks

- As the size of the waiting list reduces, there is a proportionate decrease in the 52-week target, so we will need to monitor these targets in tandem and offset the planned validation work on the waiting list with a corresponding focus on 52 weeks.

National comparator

52 week as % of waiting list (Feb-25)



Data Quality Indicators
S T P

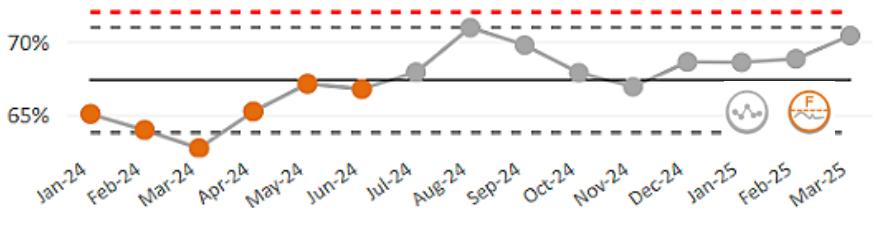
Trust	Target	Latest Month	Mean
Kettering General	1%	0.81%	1.31%
Northampton General	1%	1.83%	2.72%

Wait for first appointment less than 18 weeks

The percentage of patients who have their first appointment within 18 weeks of referral of all the planned care referrals we receive

University Hospitals of Northamptonshire NHS Group

Percentage of patients waiting less than 18 weeks for an appointment - Kettering



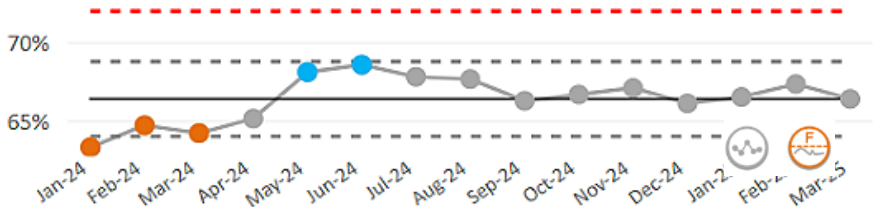
Understanding the performance

- There has not been a significant change in performance in either Trust since June 24.
- The expected range for Kettering is between 64 and 71%.
- The expected range for Northampton is between 64 and 78%.

What are the issues impacting performance?

- This is a new target for 2025/26. In contrast to the long waits targets, some of the medical specialties (in particular dermatology and cardiology) have a large contribution to the overall 18 week position.

Percentage of patients waiting less than 18 weeks for an appointment - Northampton



What SMART actions are being taken to improve?

- Specialties will be asked to:
  - Look at their first to follow up ratio and how we can adapt clinic templates to see more first appointments
  - Reduce follow ups through PIFU
  - Increase remote monitoring
  - Implement pathway changes.

Risks

- There is a risk in the volume of overdue non-RTT follow up appointments. A focus on first appointments will necessarily mean less capacity for this cohort. We will develop a validation and discharge approach for this cohort to mitigate the risk.

Data Quality Indicators
S T P

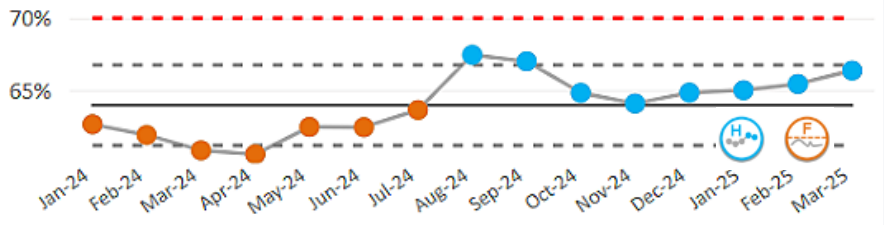
Trust	Target	Latest Month	Mean
Kettering General	72%	70.4%	67.4%
Northampton General	72%	66.4%	66.4%

Referral to Treatment performance

The number of patients who are referred urgently for suspected cancer and receive a diagnosis or have cancer ruled out within 28 days

NHS University Hospitals of Northamptonshire NHS Group

RTT performance - Kettering



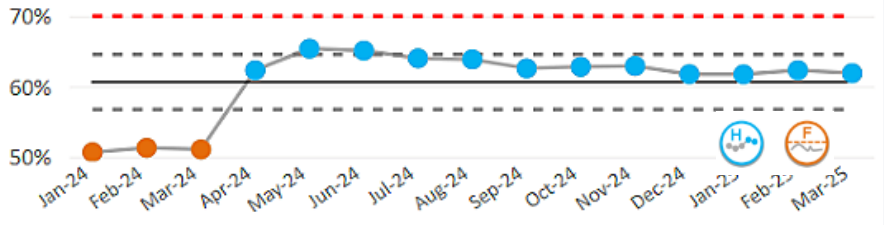
Understanding the performance

- There has been a sustained improvement in RTT performance in both Trusts in the last year.
- The expected range for Kettering is 61 to 67%, and the expected range for Northampton is 57 to 65%.

What are the issues impacting performance?

- This is a new target for 2025/26. In contrast to the long waits targets, some of the medical specialties (in particular dermatology and cardiology) have a large contribution to the overall 18 week position.

RTT performance - Northampton



What SMART actions are being taken to improve?

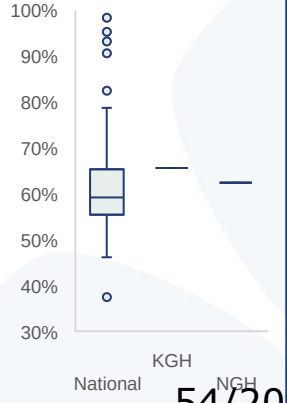
- Transfers are taking place to balance the waiting list clearance time (the number of months at current capacity levels that it would take to clear the waiting list) across the two sites. In particular there is a focus in Cardiology to balance the RTT position across NGH and KGH, which should support a performance improvement.

Risks

- It is difficult to model RTT performance, although waiting list size and the balance between capacity and demand is the best indicator. As the overall waiting list reduces, RTT performance should improve.

National comparator

RTT performance (Feb-25)



Data Quality Indicators
S T P

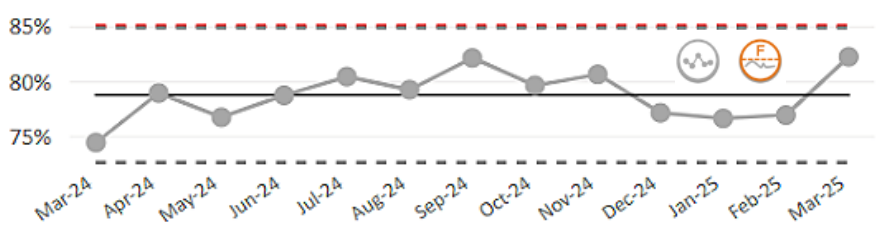
Trust	Target	Latest Month	Mean
Kettering General	70%	66.4%	64.0%
Northampton General	70%	61.9%	60.6%

Theatre utilisation

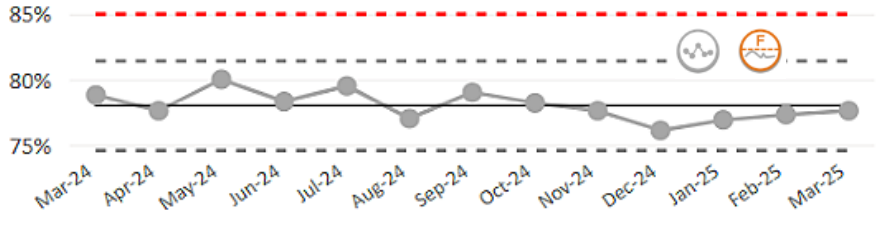
The percentage of the available time in our elective theatre sessions which is spent operating on patients.

University Hospitals of Northamptonshire NHS Group

Theatre utilisation - Kettering



Theatre utilisation - Northampton



Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	85%	82.2%	78.7%
Northampton General	85%	77.6%	78.0%

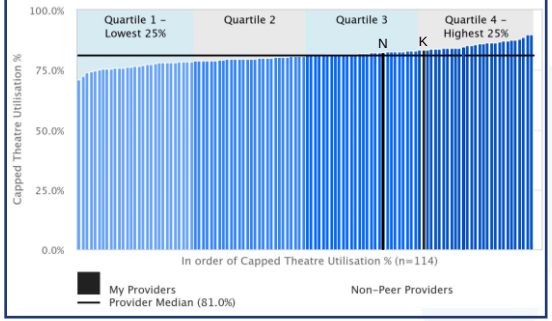
Understanding the performance

- There has been no significant change in theatre utilisation in either Trust in the past year.
- Kettering theatre performance can be expected to be between 73 and 85%, with this months' value at 82.2%
- Northampton theatre performance can be expected to be between 75 and 81%, with this months' value at 78%.

What SMART actions are being taken to improve?

- Consistency of practice across sites being driven with the new UHN single division for Surgery.
- Further embedding of the Theatre dashboard usage will support improvement.

National comparator



What are the issues impacting performance?

- There remain a significant number of cancellations on the day for avoidable reasons and a productivity target has been set based on this for 2025/26.

Risks

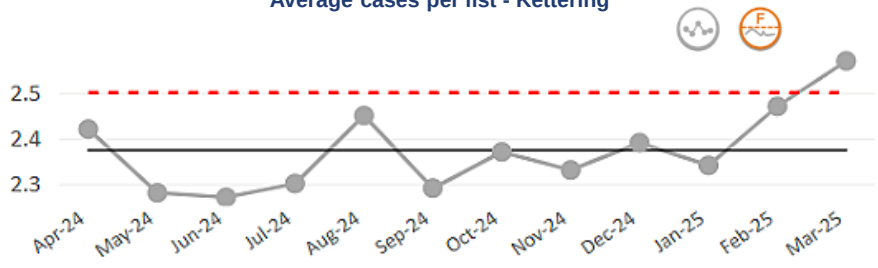
- Good quality peri-operative care is a key interdependency with this metric. In addition, reducing the time to first appointment in specialties, giving more time to plan in Surgery dates will support this to be better managed.

Average cases per list

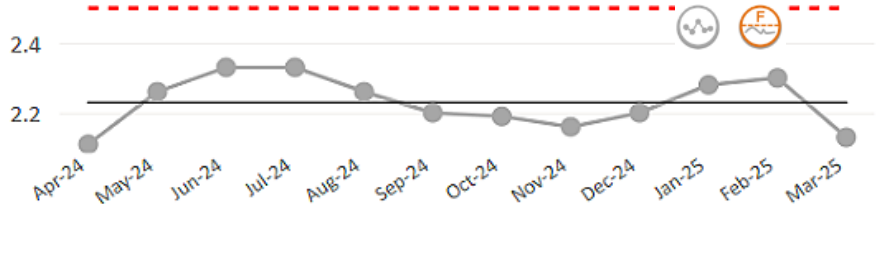
The average number of cases per operating theatre list, normalised to a 4-hour operating list.

University Hospitals of Northamptonshire NHS Group

Average cases per list - Kettering



Average cases per list - Northampton



Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	2.5	2.57	2.37
Northampton General	2.5	2.13	2.23

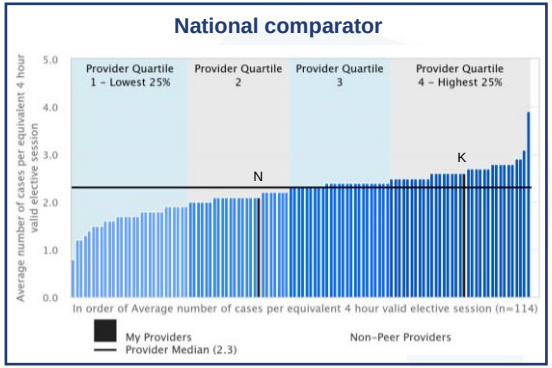
Understanding the performance

- There has been no significant change in average cases per list in either Trust in the past year. Kettering achieved the target in March with a value of 2.57.
- The average in Kettering is 2.4, and in Northampton is 2.2. There is a case mix difference between the two Trusts which may account for some of the difference

What SMART actions are being taken to improve?

- HVLC (high volume, low complexity) lists being piloted in KGH, and if successful will be rolled out to further specialties.
- As late starts in Theatres are reduced, this creates time on lists for an additional case. T&O at NGH are now in a position to list an additional case on a number of lists and will do so from April.

National comparator



What are the issues impacting performance?

- Complexity of cases directly impacts on the number of cases per list. In addition, in some specialties where there is use of the Independent Sector for simpler cases, this impacts on the overall complexity of the work done at UHN.

Risks

- There is a key interdependency with Theatre Utilisation and case per list.

24/25 Activity and 25/26 Plan

		Kettering General Hospital			Northampton General Hospital			University Hospitals of Northamptonshire Group		
		24/25 Final out-turn	25/26 Plan	Change in activity from 24/25 to 25/26	24/25 Final out-turn	25/26 Plan	Change in activity from 24/25 to 25/26	24/25 Final out-turn	25/26 Plan	Change in activity from 24/25 to 25/26
Outpatients	Total outpatient appointments (including non-consultant-led)	400,166	389,715	-3%	583,822	557,941	-4%	983,988	947,656	-4%
	First outpatient appointments (consultant-led)	113,994	122,111	7%	149,673	160,190	7%	263,667	282,301	7%
	Follow up outpatient appointments (consultant-led)	238,673	218,924	-8%	351,328	306,666	-13%	590,001	525,590	-11%
	Outpatient procedures (consultant-led)	93,490	88,062	-6%	138,173	127,769	-8%	231,663	215,831	-7%
Elective	Elective overnight spells	3,807	3,557	-7%	4,853	4,890	1%	8,660	8,447	-2%
	Day case spells	45,736	41,763	-9%	53,735	53,551	0%	99,471	95,314	-4%
UEC	Type 1 A&E attendances	119,938	119,938	0%	116,108	115,493	-1%	236,046	235,431	0%
	Same day emergency care	0	14,302	-	8,695	17,786	105%	8,695	32,088	269%
	Zero-day non-elective spells	17,851	7,199	-60%	22,562	13,886	-38%	40,413	21,085	-48%
	Overnight non-elective spells	24,204	24,204	0%	23,162	23,162	0%	47,366	47,366	0%

Understanding the position

- The activity plan for 25/26 assumes a reduction in activity in most points of delivery, with the exception of first outpatient appointments and same day emergency care. This is due to the assumption of the removal of premium activity.

What are the issues impacting the position?

- A significant reduction in the volume of work done at premium costs through WLIs, insourcing and outsourcing.
- An increase in outpatient first appointments through focussed productivity improvement.

What SMART actions are being taken to improve?

- Data will be shared with Divisional Triumvirates on the outpatient productivity opportunity, to support delivery plans.

Risks

- Clinical support for the focus on first appointments and the change in practice around follow up appointments will be key to delivery.

Our Well-Led domain metrics

	P	?	F	No target
H / L		• Turnover rate – NGH • Appraisal completion rate - KGH	• Vacancy rate • Turnover rate - KGH	• Number of volunteering hours – KGH
	• Mandatory training compliance	• Time to hire – NGH • Sickness and absence rate	• Appraisal completion rate - NGH	• Number of volunteering hours - NGH
H / L		• Time to hire - KGH	• Whole-time equivalent workforce	

Well-Led

NHS University Hospitals of Northamptonshire NHS Group

Culture and safety

Metric	Target	Latest Month	Kettering General Hospital				Northampton General Hospital				Data Quality Indicators
			Measure	Variation	Assurance	Mean	Measure	Variation	Assurance	Mean	
Turnover rate	6.5%	Mar-25	5.8%			7.2%	5.3%			6.2%	S T P
Sickness and absence rate	5%	Mar-25	4.3%			4.9%	4.9%			5.2%	S T P
Mandatory training compliance	85%	Mar-25	91.7%			91.9%	89.2%			89.2%	S T P
Appraisal completion rate	85%	Mar-25	85.6%			85.1%	80.0%			78.6%	S T P
Employee relations formal cases		Mar-15	13			13.7	23			20.5	S T P
Number of volunteering hours	-	Mar-25	2,979			2,615	3,991			3,873	S T P

Data quality assessment

There is NGH appraisal completion data which is under-reporting performance and will be corrected (including historical data) for the May 25 report.

SPC indicator key

Worsening	Improving	No change
Below target	Above target	Inconsistent in whether target achieved

Data quality indicator key

S Sign off & review	T Timely & complete	P Process & system

Dedicated to excellence

Well-Led

University Hospitals of Northamptonshire NHS Group

Workforce financial sustainability

Metric	Target	Latest Month	Kettering General Hospital: Measure	Variation	Assurance	Mean	Northampton General Hospital: Measure	Variation	Assurance	Mean	Data Quality Indicators
Vacancy rate	8%	Mar-25	9.3%			11.4%	8.4%			10.2%	S T P
Time to hire	70	Mar-25	77			64	98			87	S T P
Contracted whole-time equivalent (WTE)	-	Mar-25	5,228			5,115	6,807			6,502	S T P
Bank spend as a percentage of total pay	8.0%	Mar-25	11.5%			11.54%	12.0%			13.56%	S T P
Agency spend as a percentage of total pay	3.2%	Mar-25	3.0%			4.2%	4.1%			5.8%	S T P

Data quality assessment

Time to hire data for process steps has only been collected consistently across UHN for 3 months, meaning it is not possible to provide historical data.

SPC indicator key

Worsening	Improving	No change
Below target	Above target	Inconsistent in whether target achieved

Data quality indicator key

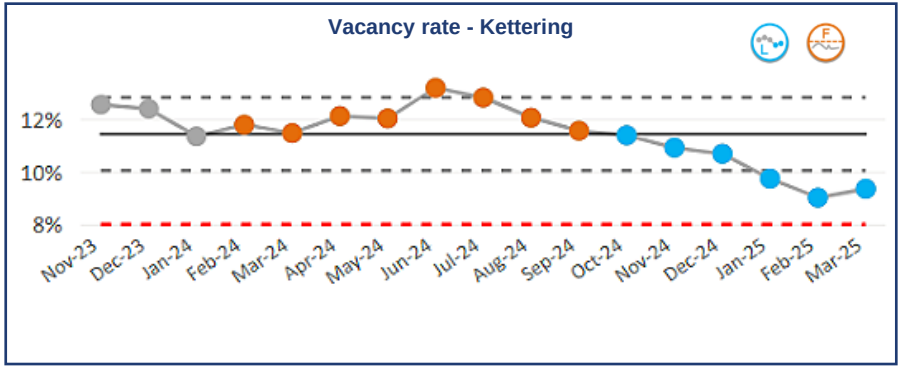
S: Sign off & review	T: Timely & complete	P: Process & system

Dedicated to excellence

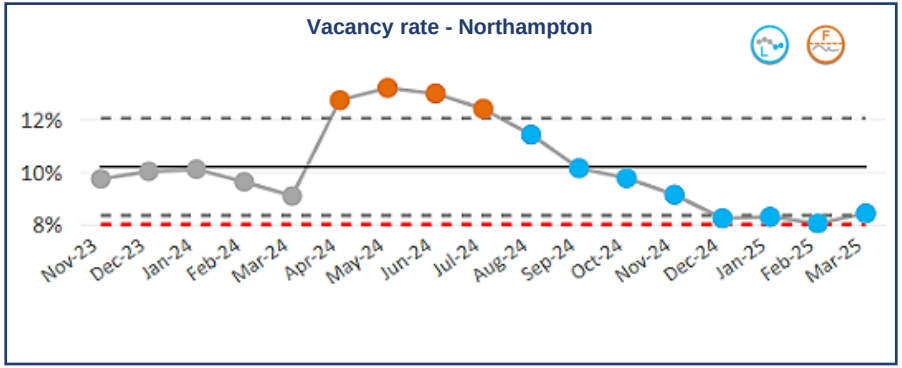
Vacancy rate

The percentage of established posts which are currently vacant.

University Hospitals of Northamptonshire NHS Group



Metric	Target	Latest Month	Measure KGH	Measure NGH
Additional clinical services	8%	Mar-25	10.50%	7.00%
Allied health professionals	8%	Mar-25	5.61%	8.89%
Healthcare scientists	8%	Mar-25	9.74%	9.62%
Administrative and clerical	8%	Mar-25	9.68%	10.16%
Nursing and midwifery registered	8%	Mar-25	8.61%	8.31%
Medical and dental	8%	Mar-25	3.99%	5.49%
Additional professional, scientific and technical	8%	Mar-25	17.17%	14.97%
Estates and ancillary	8%	Mar-25	16.77%	9.81%



Understanding the performance

- The vacancy rate is significantly improving in both Trusts, although both are above target.
- Estates and ancillary, additional professional, scientific and technical have the highest vacancy rates.

What are the issues impacting performance?

- Enhanced VCP controls and delays/approval required for start dates is impacting on the ability to reduce vacancy rate
- National/Local workforce shortages in some staff groups are causing higher vacancy rates in some areas
- Identifying vacancies that will continue to be recruited to

What SMART actions are being taken to improve?

- Targeted work with each division to review their workforce efficiency plans and identify the roles that can continue in the recruitment process

Risks

- Continued enhanced vacancy control processes
- Continued National/Local workforce shortages in some staff groups
- Removal of vacancies following the divisional review of workforce efficiency plans

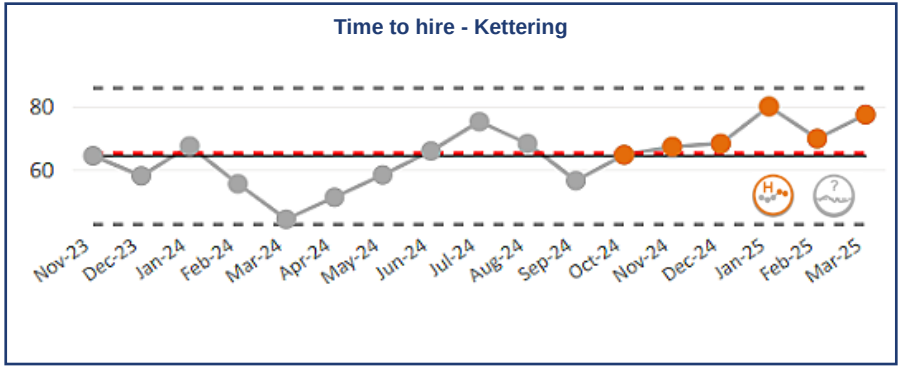
Data Quality Indicators

S T P

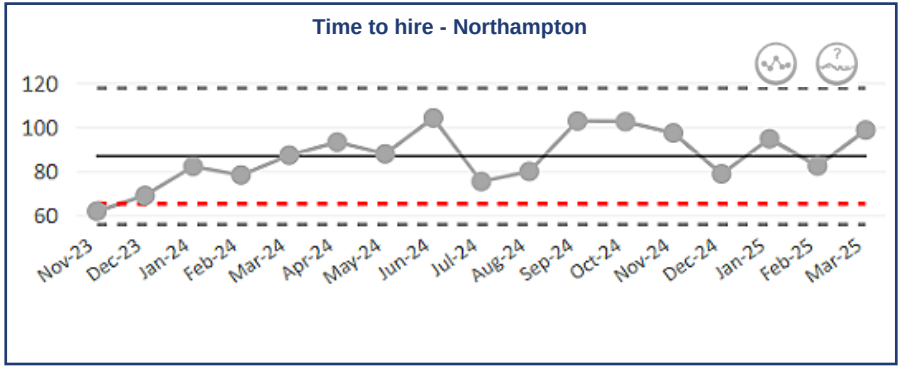
Time to hire

The average number of days between when a post is submitted onto the system for approval to recruit until the colleague starts in role.

University Hospitals of Northamptonshire NHS Group



Metric	Target	Latest Month	Measure KGH	Measure NGH
Total time to hire	**70**	**Mar-25**	**77**	**98**
Approval	Targets under development	Mar-25	15	19
Shortlist		Mar-25	11	9
Advert to checks ok		Mar-25	49	69
Offer to checks ok		Mar-25	26	31
Checks ok to start		Mar-25	22	17
Advert to start		Mar-25	77	98



Understanding the performance

- Time to hire is showing concerning deterioration in Kettering since October 24.
- Northampton has an expected range of 55 to 117 days, with Kettering between 42 and 86 days.

What are the issues impacting performance?

- The time to hire figure has started to be negatively impacted leading to an increase due to enhanced VCP requirements, approval being needed for start dates and delaying start dates until April/May despite a reduction in volume of recruitment activity since October

What SMART actions are being taken to improve?

- Targeted work with each division to review their workforce efficiency plans and identify the roles that can continue in the recruitment process
- New SOPs have been developed for the Recruitment Teams with stretch KPIs and communications to each divisions in regarding a joint SLA in respect of recruitment KPIs will be launched shortly

Risks

- Continued enhanced vacancy control processes
- Ongoing delays from divisional recruiting managers and challenges in obtaining pre-employment checks required by NHS Employers Standards from external sources e.g. DBS, references from external organisations, candidates not providing documentation/information

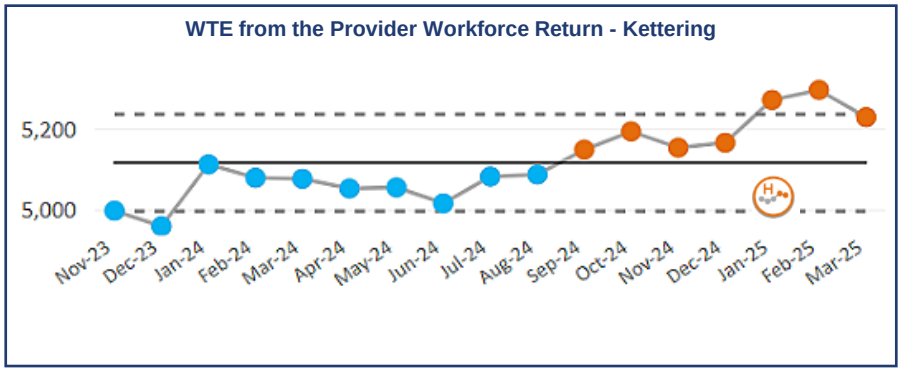
Data Quality Indicators

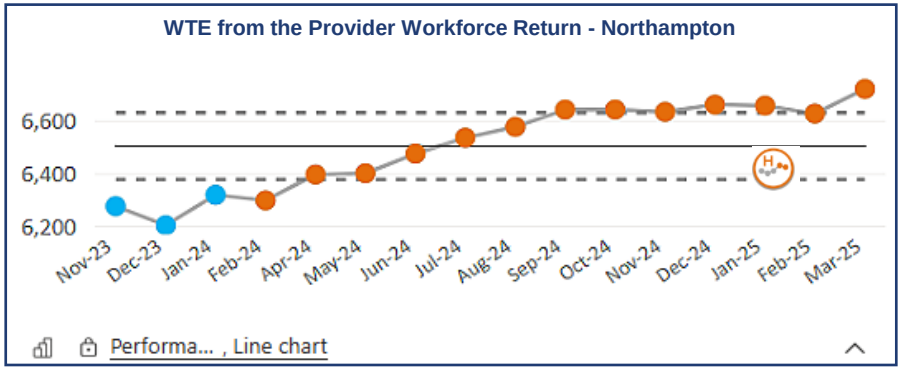
S T P

Whole-time equivalent workforce

The number of whole-time equivalent workforce used in the Trust.

University Hospitals of Northamptonshire NHS Group





Metric	Latest Month	Apr-24	Mar-25	Apr-24	Mar-25
		KGH		NGH	
Total WTE	**Mar-25**	**5,052**	**5,228**	**6,472**	**6,807**
Substantive WTE	Mar-25	4,434	4,662	5,556	5,928
Bank WTE	Mar-25	511	486	657	761
Agency WTE	Mar-25	107	80	259	118

Understanding the performance

- Both hospitals have seen a sustained, significant increase in workforce numbers over the past 18 months.
- Since end of April 2024, workforce has increased by 511 WTE (176 in KGH, 335 in NGH).

What are the issues impacting performance?

- In the last year, despite a reduction in the use of agency and in bank in KGH, there has been an increase in substantive WTEs,
- The financial position requires us to reduce WTE by 781 in 25/26.

What SMART actions are being taken to improve?

- Budgeted establishment targets for reduction have been issued to divisions
- Divisions are working to identify areas in which WTE can be reduced in a way to meet the target with support from the People team.

Risks

- Timely identification of workforce reduction plans
- Impact on service delivery

Data Quality Indicators

Detailed workforce numbers

		Kettering General Hospital			Northampton General Hospital			University Hospitals of Northamptonshire Group		
		Apr-24	Mar-25	Change in WTE during FY 24/25	Apr-24	Mar-25	Change in WTE during FY 24/25	Apr-24	Mar-25	Change in WTE during FY 24/25
Total		**5,149**	**5,330**	**4%**	**6,473**	**6,808**	**5%**	**11,609**	**12,127**	**4%**
Substantive		4,520	4,752	5%	5,556	5,928	7%	10,064	10,670	6%
Bank		519	497	-4%	657	761	16%	1,176	1,258	7%
Agency		110	81	-26%	259	118	-54%	369	199	-46%
Substantive	Registered Nursing and Midwifery	1,464	1,551	6%	1,745	1,828	5%	3,209	3,379	5%
	Infrastructure support	1,220	1,244	2%	1,403	1,449	3%	2,623	2,693	3%
	Support to Clinical Staff	944	968	3%	1,143	1,279	12%	2,088	2,247	8%
	Medical and Dental	529	601	14%	727	800	10%	1,255	1,401	12%
	Registered/ Qualified Scientific, Therapeutic and Technical	355	383	8%	534	567	6%	889	949	7%
Bank	Registered Nursing and Midwifery	150	183	22%	211	260	23%	361	443	23%
	Infrastructure support	73	74	1%	158	142	-10%	231	216	-6%
	Support to Clinical Staff	191	148	-22%	197	257	30%	388	405	4%
	Medical and Dental	87	72	-18%	82	86	5%	169	158	-7%
	Registered/ Qualified Scientific, Therapeutic and Technical	17	20	18%	10	16	68%	27	37	36%
Agency	Registered Nursing and Midwifery	80	46	-42%	57	53	-6%	137	100	-27%
	Infrastructure support	1	1	0%	11	0	-100%	12	1	-91%
	Support to Clinical Staff	1	1	-41%	105	0	-100%	106	1	-99%
	Medical and Dental	23	20	-15%	66	38	-43%	89	57	-36%
	Registered/ Qualified Scientific, Therapeutic and Technical	5	14	192%	20	27	33%	25	40	63%

Understanding the position

- There has been an increase of 4% in total WTE, despite a 46% decrease in agency WTE worked.
- The largest increases have been in substantive registered nursing, medical and dental, and support to clinical staff.

What are the issues impacting the position?

- The financial position requires us to reduce WTE by 781

What SMART actions are being taken to improve?

- Weekly workforce reports on nursing bank and agency spend in place with oversight from CNO. Work being undertaken to replicate this for medical spend.
- Enhanced workforce controls in place with increased scrutiny on workforce.
- Efficiency schemes being developed to achieve workforce reduction targets.

Risks

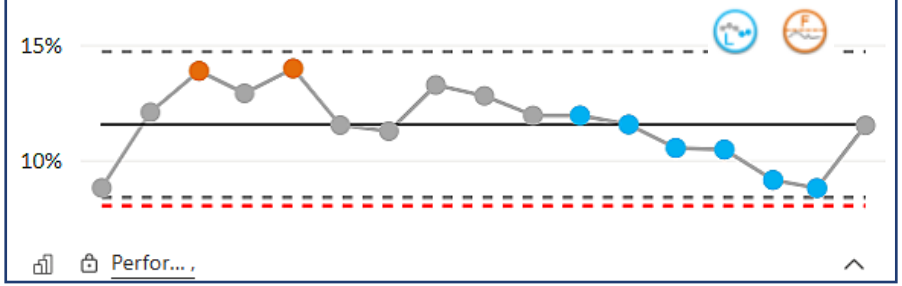
- Timely identification of workforce reduction plans
- Impact on service delivery

Bank spend as a percentage of total pay

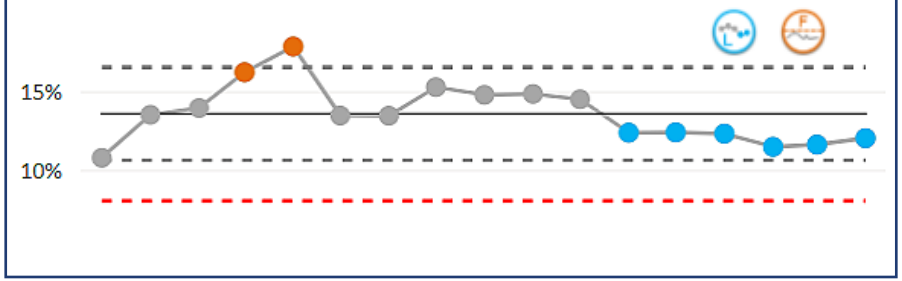
The amount of money spent on bank workers as a proportion of total spend on pay.

NHS University Hospitals of Northamptonshire NHS Group

Bank spend as a % of total pay - Kettering



Bank spend as a % of total pay - Northampton



Metric	Latest Month	Var	Measure KGH	Var	Measure NGH
Overall	**Mar-25**		**11.5%**		**12.0%**
Medical	Mar-25		15.0%		14.0%
Nursing	Mar-25		13.1%		14.0%
Scientific, Therapeutic and Technical	Mar-25		4.0%		2.8%
Non-clinical	Mar-25		5.3%		7.2%
Support to Clinical Staff	Mar-25		11.2%		15.7%

Understanding the performance

- Both Kettering and Northampton are showing a sustained reduction in the proportion of pay spend on bank staff in the last six months.
- Managerial and admin in both Trusts, and Medical and Other clinical staff in NGH have seen particular improvement.

What are the issues impacting performance?

- Continued high usage of bank spend.
- Clinical areas utilising high bank spend to support elective activity and increased operational pressure on the UEC pathway and beds.
- In KGH, there has not been a corresponding increase in worked WTE for bank, so the large increase in percentage of pay spend on bank is related to financial adjustments and accruals.

What SMART actions are being taken to improve?

- Weekly workforce reports on nursing bank spend in place with oversight from CNO. Work being undertaken to replicate this for medical spend.
- Enhanced controls in place for temporary staffing spend.
- Focussed work on specialties and areas with high bank spend.

Risks

- There is a risk that continued high demand on the UEC pathway results in the need for escalation spaces that will impact on temporary staffing spend.
- In some areas, reducing bank spend would impact on service delivery.

Data Quality Indicators

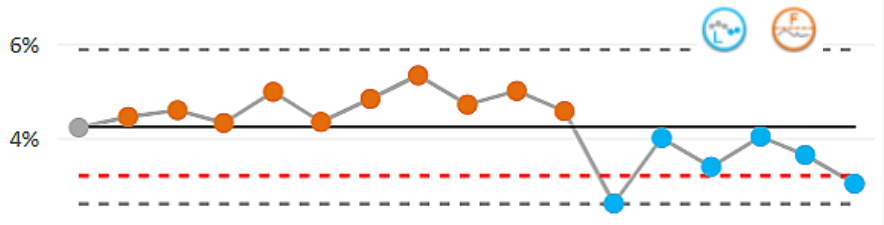
S T P

Agency spend as a percentage of total pay

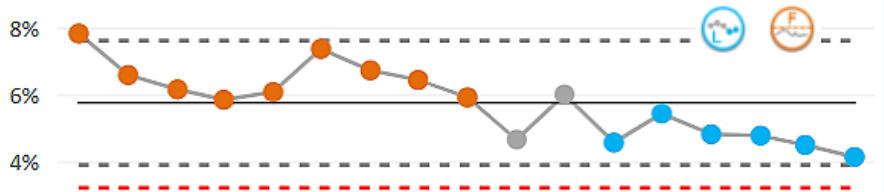
The amount of money spent on agency workers as a proportion of total spend on pay.

University Hospitals of Northamptonshire NHS Group

Agency spend as a % of total pay - Kettering



Agency spend as a % of total pay - Northampton



Metric	Latest Month	Var	KGH Measure	Var	NGH Measure
Overall	**Mar-25**		**3.0%**		**4.1%**
Medical	Mar-25		5.3%		7.8%
Nursing	Mar-25		3.8%		3.5%
Scientific, Therapeutic and Technical	Mar-25		2.7%		6.0%
Non-clinical	Mar-25		1.8%		0.8%
Support to Clinical Staff	Mar-25		0.0%		0.0%

Understanding the performance

- Both Kettering and Northampton are showing a sustained reduction in the proportion of pay spend on agency staff in the last six months.
- Nursing and Other clinical staff in both Trusts and Medical in NGH have seen particular improvement.

What are the issues impacting performance?

- Continued high usage of agency spend.
- Clinical areas utilising high agency spend to support elective activity and increased operational pressure on the UEC pathway and beds.
- High reliance on medical agency in fragile services and to support elective recovery.

What SMART actions are being taken to improve?

- Weekly workforce reports on nursing agency spend in place with oversight from CNO. Work being undertaken to replicate this for medical spend.
- Enhanced controls in place for temporary staffing spend.
- Focussed work on specialties and areas with high agency spend.

Risks

- There is a risk that continued high demand on the UEC pathway results in the need for escalation spaces that will impact on temporary staffing spend.
- In some areas, reducing bank spend would impact on service delivery.

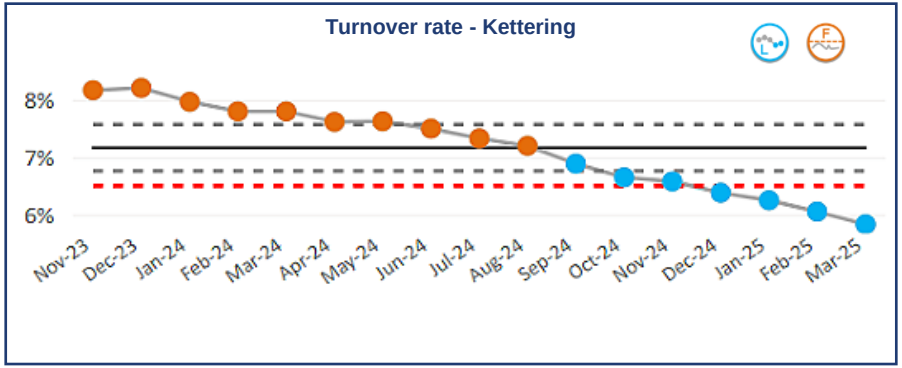
Data Quality Indicators

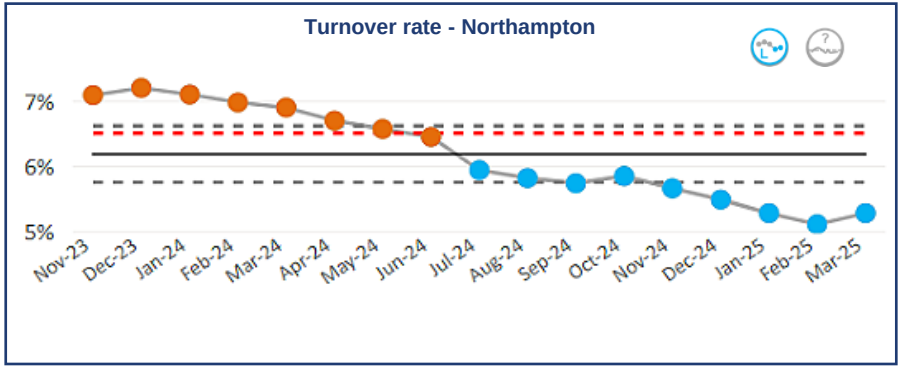
S T P

Turnover rate

The percentage of colleagues who have left their position over the previous 12 months.

NHS University Hospitals of Northamptonshire NHS Group





Metric	Target	Latest Month	Measure KGH	Measure NGH
Additional clinical services	6.5%	Mar-25	6.43%	2.89%
Allied health professionals	6.5%	Mar-25	5.82%	5.69%
Healthcare scientists	6.5%	Mar-25	6.77%	8.59%
Administrative and clerical	6.5%	Mar-25	7.38%	8.44%
Nursing and midwifery registered	6.5%	Mar-25	3.82%	4.29%
Medical and dental	6.5%	Mar-25	2.88%	3.79%
Additional professional, scientific and technical	6.5%	Mar-25	6.10%	6.78%
Estates and ancillary	6.5%	Mar-25	11.78%	6.49%

Understanding the performance

- The turnover rate is significantly improving in both Trusts, with both currently below target.
- The highest turnover is in Estates & Ancillary and Healthcare Scientists.

What are the issues impacting performance?

- The NHS is undergoing large-scale change within a challenging financial and operational landscape
- UHN Mutually Agreed Resignation Scheme and potential impacts on turnover rate
- NSS results show that racial discrimination; feeling tired, burnt out and frustrated and not feeling valued are their main concerns.

What SMART actions are being taken to improve?

- Continue coordinating FAQs from UHN Listening Events and targeted communication outcomes across UHN
- Ensure risks associated with the MARS scheme do not impact business critical roles and potential impacts on remaining staff
- Continue developing localised action plans to address NSS results

Risks

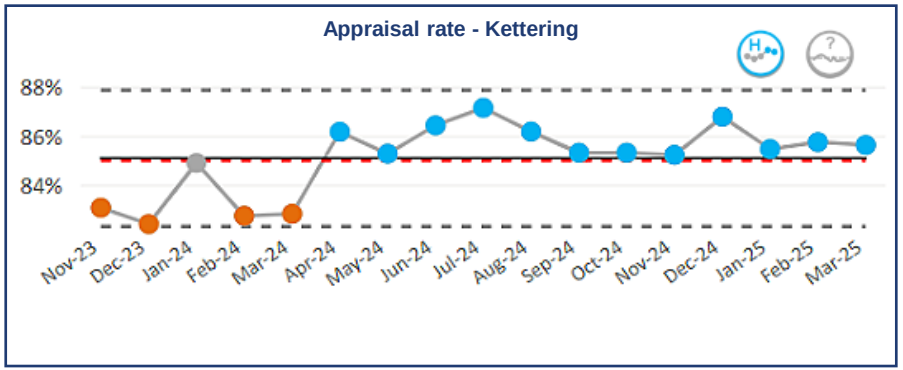
- Messaging of NHS financial challenges causing workforce to seek other employment they consider to be more secure
- Implementation delays developing localised action plans due to operational pressures

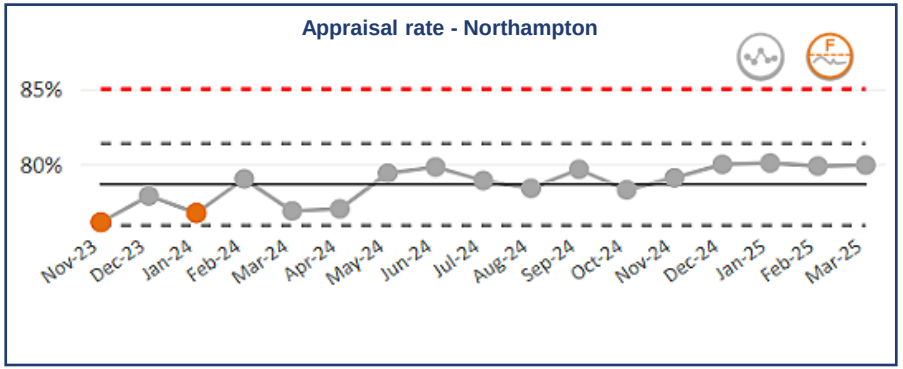
Data Quality Indicators

S T P

Appraisal rate

The percentage of colleagues who have had an appraisal in the last 12 months.





Metric	Target	Latest Month	Measure KGH	Measure NGH
Additional clinical services	85%	Mar-25	81.41%	86.37%
Allied health professionals	85%	Mar-25	89.37%	83.88%
Healthcare scientists	85%	Mar-25	80.77%	63.31%
Administrative and clerical	85%	Mar-25	81.09%	72.66%
Nursing and midwifery registered	85%	Mar-25	88.08%	82.21%
Medical and dental	85%	Mar-25	91.41%	-
Additional professional, scientific and technical	85%	Mar-25	81.41%	79.62%
Estates and ancillary	85%	Mar-25	86.74%	75.55%

Understanding the performance

- Kettering is showing significant improvement and has achieved the target for 12 months.
- Northampton is showing no significant improvement, with an expected range of 76 to 81%.

What are the issues impacting performance?

- Staff turnover and vacancies have impacted continuity and the ability to schedule appraisals.
- Competing clinical priorities often result in limited time for completing non-clinical tasks such as appraisals.
- Variation in management oversight and accountability also contributes to inconsistencies.
- Reporting parameters will align from April reporting in line with National recommendation.

What SMART actions are being taken to improve?

S: Targeted communication and support to departments below 80%, with a focus on Healthcare Scientists at NGH.
M: Monthly tracking and feedback to teams on performance v target.
A: Ongoing training refreshers and alignment of reporting parameters.
R: Aligning appraisals with personal development and service delivery goals to increase engagement.

Risks

- High Clinical workloads may continue to deprioritise appraisals
- Ongoing workforce instability (sickness/ recruitment delays, can derail reviews

Data Quality Indicators

S T P

Our Use of Resources domain metrics

University Hospitals of Northamptonshire NHS Group

	P	?	F	No target
H / L			• Acute implied productivity - NGH	
		• CIP delivery	• Acute implied productivity - KGH	
H / L				

Use of Resources

NHS University Hospitals of Northamptonshire NHS Group

Finance

Metric	Target	Latest Month	Kettering General Hospital: Measure	Variation	Assurance	Mean	Northampton General Hospital: Measure	Variation	Assurance	Mean	Data Quality Indicators
Surplus / deficit (in-month)	To be set as per 25/26 plan	Mar-25	£5.6m			(£0.34m)	£4.5m			(£1.03m)	S T P
Cash balance	-	Mar-25	£5.3m			£5.3m	£2.0m			£4.9m	S T P

Data quality assessment

No data quality issues identified.

Productivity and efficiency

Metric	Target	Latest Month	Kettering General Hospital: Measure	Variation	Assurance	Mean	Northampton General Hospital: Measure	Variation	Assurance	Mean	Data Quality Indicators
Acute implied productivity	0%	Dec-24	-8.6%			-8.8%	-7.6%			-8.4%	S T P
Cost improvement plan delivery	100%	Mar-25	90%			92%	100%			106%	S T P

Data quality assessment

There has been a change in the NHSE definition of acute implied productivity implemented from 1st April. This includes the most recent measure, which will only be provided monthly from 1st April. Model Hospital data has been used which is up-to-date until Dec-24.

SPC indicator key

Worsening	Improving	No change
Below target	Above target	Inconsistent in whether target achieved

Data quality indicator key

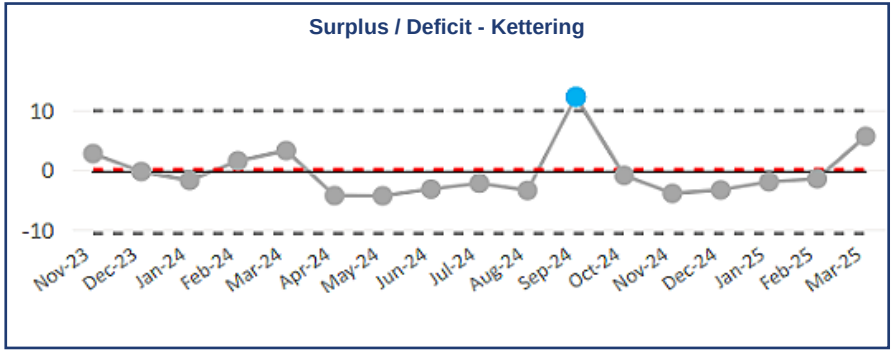
S	T	P
Sign off & review	Timely & complete	Process & system

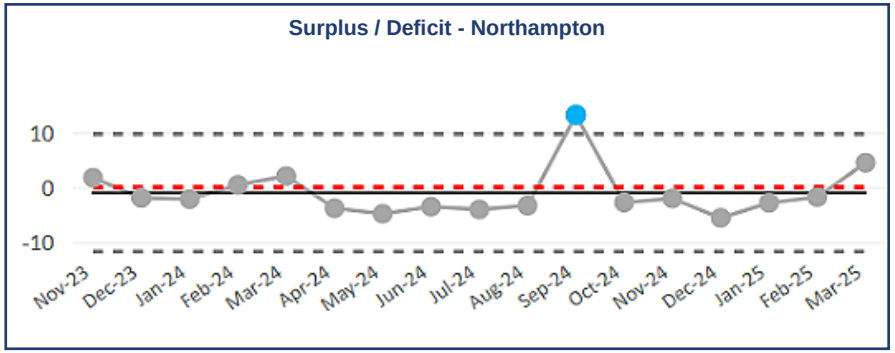
Dedicated to excellence

Surplus / deficit

Monthly financial position – total income vs total expenditure.

University Hospitals of Northamptonshire NHS Group





Performa... , Line chart

Data Quality Indicators
S T P

Trust	Target	Latest Month	Mean
Kettering General	To be set as per 25/26 plan	£5.6m	(£0.34m)
Northampton General		£4.5m	(£1.03m)

Understanding the performance

The forecast year-end position at Month 11 was a £29.98m residual deficit (£12.95m KGH, £17.04m NGH) across UHN. The draft accounts were submitted to NHS England in line with the national timetable and confirm that UHN have delivered a final outturn of £29.90m (£12.90m KGH, £17.00m NGH).

What are the issues impacting performance?

Income recovery has exceeded planned levels for ERF and variable activity – the position also contains surge funding made available in the latter months of 2025/26.

Expenditure has been impacted by UEC pressures over the winter months, cover for vacancies and sickness across the Trust, HCA re-banding pressures and unfunded inflation.

What SMART actions are being taken to improve?

Actions to improve are now focussed on efficiency planning for 2025/26. Work continues at pace on identification of CIP and efficiency schemes and control measures around workforce. The programme will continue to be impact assessed to ensure no impacts on patient safety. UHN is currently undertaking a procurement process for a Strategic Delivery partner to support financial recovery over the course of 2025/26.

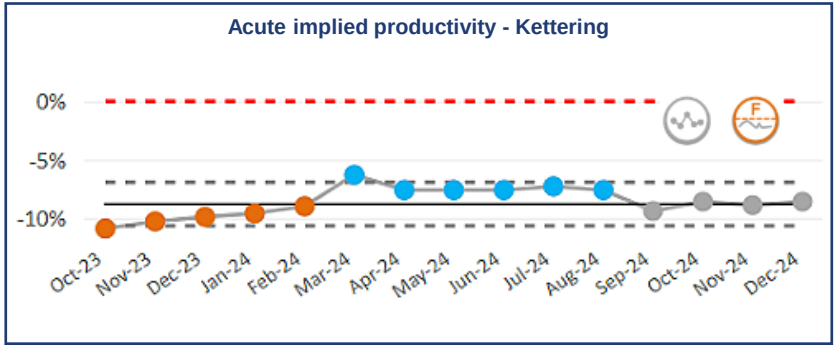
Risks

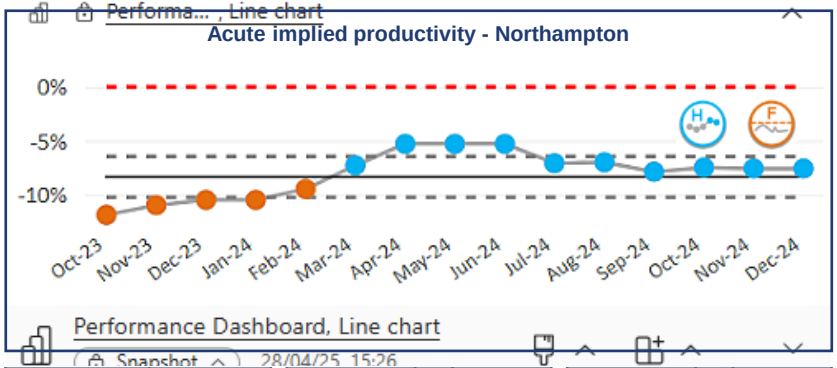
The final Month 12 position remains subject to external audit and should continue to be considered draft until this process is completed.

Acute implied productivity

Implied productivity of the organisation, using the NHS England data which calculates change in productivity since 19/20 as a function of growth in costs compared to growth in activity.

University Hospitals of Northamptonshire NHS Group





Metric	Latest Month	KGH Measure	KGH Var.	KGH Mean	NGH Measure	NGH Var.	NGH Mean
Activity growth	Dec-24	15.7%		13.5%	16.9%		13.5%
Cost growth	Dec-24	26.6%		24.5%	26.5%		23.8%

Understanding the performance

- There has been a significant improvement in acute productivity in Northampton in the last year. Following a period of improvement, Kettering is showing no significant change. The expected range is between -6.5 and -10%.
- Both Trusts are in the second highest quartile nationally.

Data Quality Indicators

S T P

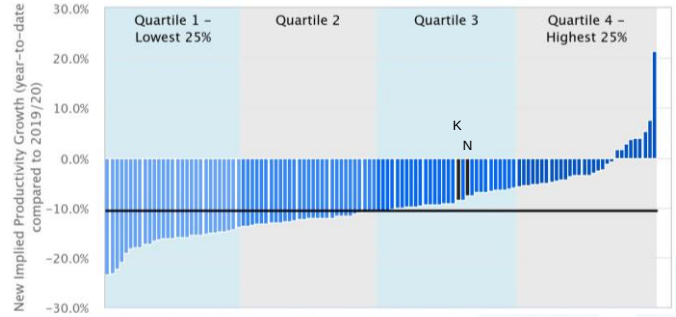
What are the issues impacting performance?

- Cost growth is being driven by increased substantive and bank pay costs, and clinical consumables and drug non-pay costs
- Kettering has had a lower growth in elective activity (2.3% vs 10.9%) which drives lower activity growth.
- Main productivity drivers by care setting are non-elective length of stay, temporary staffing and corporate.

What SMART actions are being taken to improve?

- Workforce controls strengthened for temporary staffing and efficiency plans aiming to reduce bank by 32%.
- Length of stay improvement plans under development
- Working groups established to reduce clinical consumables, pathology and radiology ordering.
- Medicines management workstream aiming to reduce drug costs through biosimilars.
- Corporate productivity programme developed.

National comparison



Risks

- Reducing non-elective length of stay may not realise cash savings.
- Limitations on premium capacity may limit activity delivery.

Income and Expenditure

NHS University Hospitals of Northamptonshire NHS Group

Month 1-12 Position	UHN Position			KGH Position			NGH Position		
	Plan £m	Actual £m	Actual £m	Plan £m	Actual £m	Actual £m	Plan £m	Actual £m	Actual £m
Income (Pre deficit funding)	919.45	980.56	61.11	408.25	432.28	24.04	511.20	548.27	37.08
Pay	(670.12)	(727.93)	(57.81)	(296.34)	(322.71)	(26.36)	(373.78)	(405.23)	(31.45)
Non Pay	(305.40)	(352.93)	(47.53)	(141.50)	(159.58)	(18.08)	(163.91)	(193.35)	(29.44)
NHSE Adjustments	1.08	15.40	14.32	0.39	7.91	7.51	0.68	7.49	6.81
Surplus/(Deficit)	**(55.00)**	**(84.90)**	**(29.90)**	**(29.20)**	**(42.09)**	**(12.89)**	**(25.80)**	**(42.81)**	**(17.01)**
Deficit Funding Received	55.00	55.00	0.00	29.20	29.20	0.00	25.80	25.80	0.00
Revised Surplus/(Deficit)	**0.00**	**(29.90)**	**(29.90)**	**(0.00)**	**(12.89)**	**(12.89)**	**0.00**	**(17.01)**	**(17.01)**

Understanding the position

The forecast year-end position at Month 11 was a £29.98m residual deficit (£12.95m KGH, £17.04m NGH) across UHN. The draft accounts were submitted to NHS England in line with the national timetable and confirm that UHN have delivered a final outturn of £29.90m (£12.90m KGH, £17.00m NGH). The position remains subject to external audit and should continue to be considered draft until this process is completed.

What are the issues impacting the position?

Income recovery has exceeded planned levels for ERF and variable activity – the position also contains surge funding made available in the latter months of 2025/26.

Expenditure has been impacted by UEC pressures over the winter months, cover for vacancies and sickness across the Trust, HCA re-banding pressures and unfunded inflation.

What SMART actions are being taken to improve?

Actions to improve are now focussed on efficiency planning for 2025/26. Work continues at pace on identification of CIP and efficiency schemes and control measures around workforce. The programme will continue to be impact assessed to ensure no impacts on patient safety. UHN is currently undertaking a procurement process for a Strategic Delivery partner to support financial recovery over the course of 2025/26.

Risks

The outturn position represents a significant achievement as a number of risks remained within the forecast that have been successfully mitigated, bolstered by strong income performance in March and the achievement of a number of additional grip and control measures.

Summary Balance Sheet - KGH

University Hospitals of Northamptonshire NHS Group

TRUST SUMMARY BALANCE SHEET MONTH 12 2024/25	Balance at 31-Mar-24	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement (in month)	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	190,873	190,873	190,873	0	190,873	0
IN YEAR REVALUATIONS	0			0		0
IN YEAR MOVEMENTS	0	23,558	27,486	3,928	27,486	27,486
LESS DEPRECIATION	0	(13,964)	(15,256)	(1,292)	(15,256)	(15,256)
NET BOOK VALUE	190,873	200,467	203,103	2,636	203,103	12,230
NON CURRENT RECEIVABLES	956	1,061	1,238	177	1,238	282
CURRENT ASSETS						
INVENTORIES	6,208	6,582	6,795	213	6,795	587
TRADE & OTHER RECEIVABLES	8,530	10,816	12,423	1,607	12,423	3,893
CASH	5,057	9,167	5,261	(3,906)	5,261	204
TOTAL CURRENT ASSETS	19,795	26,565	24,479	(2,086)	24,479	4,684
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	27,926	40,691	30,966	(9,725)	30,966	3,040
LEASE PAYABLE under 1 year	1,498	0	1,460	1,460	1,460	(38)
DHSC LOANS	1,508	768	768	0	768	(740)
PROVISIONS under 1 year	1,519	337	1,935	1,598	1,935	416
TOTAL CURRENT LIABILITIES	32,451	41,796	35,129	(6,667)	35,129	2,678
NET CURRENT ASSETS / (LIABILITIES)	(12,656)	(15,231)	(10,650)	4,581	(10,650)	2,006
TOTAL ASSETS LESS CURRENT LIABILITIES	179,173	186,297	193,691	7,394	193,691	14,518
NON CURRENT LIABILITIES						
LEASE PAYABLE over 1 year	4,887	5,783	4,739	(1,044)	4,739	(148)
LOANS over 1 year	760	0	0	0	0	(760)
PROVISIONS over 1 year	609	548	560	12	560	(49)
NON CURRENT LIABILITIES	6,256	6,331	5,299	(1,032)	5,299	(957)
TOTAL ASSETS EMPLOYED	172,917	179,966	188,392	8,426	188,392	15,475
FINANCED BY						
PDC CAPITAL	278,136	302,829	312,800	9,971	312,800	34,664
REVALUATION RESERVE	40,875	40,875	41,267	392	41,267	392
I & E ACCOUNT	(146,094)	(163,738)	(165,675)	(1,937)	(165,675)	(19,581)
FINANCING TOTAL	172,917	179,966	188,392	8,426	188,392	15,475

Non-Current Assets

Capital expenditure in the month was £8,524k

Depreciation and in year movements include the impact of right of use assets.

As part of the annual accounts process, non-current asset values have been reviewed and revalued where appropriate. £7.3m of impairments have been recognised.

Current Assets

The cash balance is £5,261k, an in-month decrease of £3,906. Despite recent increases in receipts, cash management remains a concern and will be monitored to limit revenue and capital support in 2025/26.

Trade and other receivables have increased by £1,607k which includes NHS Debtors increase of £847k and an increase in VAT of £426k

Current Liabilities

Due to additional receipts in Q4 the Trust was in a position to pay creditors ahead of terms. This reduced trade creditors by £4,038k. Deferred Income reduced by £3,806k and there was a decrease in Capital accruals of £1,441.
Invoices are now paid on 30-day terms but are closely monitored to minimise BPPC breaches. The BPPC position has improved following the cash receipts in Q4. Expectation moving forward is the in-month BPPC position will hit target while the Trust can pay suppliers on time.
Provisions increased in M12 by £1,598k, made up of additional potential back pay relating to HCA Band 2/3 changes, HR provisions and management of change consequences.

Financing

YTD PDC Revenue Support - £14,250k.

YTD PDC Capital Support - £20,414k.

YTD I & E Deficit £19,581k, an in-month deficit of £1,937k

Summary Balance Sheet - NGH

University Hospitals of Northamptonshire NHS Group

TRUST SUMMARY BALANCE SHEET MONTH 12 2024/25	Balance at 31-Mar-24 £000	Current Month Opening Balance £000	Current Month Closing Balance £000	Current Month Movement £000	Forecast end of year Closing Balance £000	Forecast end of year Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	260,208	260,205	260,205	0	260,205	(3)
IN YEAR REVALUATIONS	0	(2,213)	(10,805)	(8,592)	(10,805)	(10,805)
IN YEAR MOVEMENTS	0	23,198	32,076	8,878	32,076	32,076
LESS DEPRECIATION	0	(17,051)	(18,415)	(1,364)	(18,415)	(18,415)
NET BOOK VALUE	**260,208**	**264,139**	**263,061**	**(1,078)**	**263,061**	**2,853**
CURRENT ASSETS						
INVENTORIES	7,724	8,638	9,137	499	9,137	1,413
TRADE & OTHER RECEIVABLES	18,304	20,720	21,814	1,094	21,814	3,510
CLINICIAN PENSION TAX FUNDING	628	628	628	0	628	0
CASH	1,842	7,093	2,012	(5,081)	2,012	170
TOTAL CURRENT ASSETS	**28,498**	**37,079**	**33,591**	**(3,488)**	**33,591**	**5,093**
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	38,725	49,094	41,335	(7,759)	41,335	2,610
FINANCE LEASE PAYABLE under 1 year	1,351	1,346	1,336	(10)	1,336	(15)
SHORT TERM LOANS	217	163	163	0	163	(54)
PROVISIONS under 1 year	2,450	1,345	3,612	2,267	3,612	1,162
TOTAL CURRENT LIABILITIES	**42,743**	**51,948**	**46,446**	**(5,502)**	**46,446**	**3,703**
NET CURRENT ASSETS / (LIABILITIES)	**(14,245)**	**(14,869)**	**(12,855)**	**2,014**	**(12,855)**	**1,390**
TOTAL ASSETS LESS CURRENT LIABILITIES	**245,963**	**249,270**	**250,206**	**936**	**250,206**	**4,243**
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	11,639	14,381	14,121	(260)	14,121	2,482
LOANS over 1 year	223	59	59	0	59	(164)
PROVISIONS over 1 year	1,208	1,208	768	(440)	768	(440)
NON CURRENT LIABILITIES	**13,070**	**15,648**	**14,948**	**(700)**	**14,948**	**1,878**
TOTAL ASSETS EMPLOYED	**232,893**	**233,622**	**235,258**	**1,636**	**235,258**	**2,365**
FINANCED BY						
PDC CAPITAL	295,633	319,191	322,348	3,157	322,348	26,715
REVALUATION RESERVE	60,334	60,333	60,399	66	60,399	65
I & E ACCOUNT	(123,074)	(145,902)	(147,489)	(1,587)	(147,489)	(24,415)
FINANCING TOTAL	**232,893**	**233,622**	**235,258**	**1,636**	**235,258**	**2,365**

Non-Current Assets

In year revaluation of (£8,592k), This is the net revaluation of the land and buildings (£7,276k) plus intangible asset impairments.

M12 Capital movements of £8,878k, includes specific scheme spend of (£2,484k) PDC Funded EPR and (£1,496k) purchase of the 2nd Surgical Robot. Estates spend totalled (£3,176k) including (£1,050k) Fire Safety works. MESC spend of (£521k). Digital BAU is (£441k), including (£254k) Network Refresh & (£186k) Hardware.

Current Assets

Inventories – £499k. Increases in Theatres including (£410k), Pacing (£398k) and Pharmacy (£37k) offset by decreases in Pathology (£195k) following the annual stock take exercise.

Trade and Other Receivables - £1,094k. Increases in NHS Income Accruals (£538k – net increase for excluded devices, ERF and additional funding), NHS Receivables (£1,214k- services provided to NHFT and KGH), VAT Debtor (£388k), PDC Dividend Receivable (£370k). Decreases in Non-NHS Other Receivables (£795k), Prepayments (£730k). There was an overall increase in provisions held for irrecoverable debt (£83k).

Cash – Decrease of £5,081k following larger than average Trade and Capital Creditors payments as well as £3,459k PDC Dividend payment.

Current Liabilities

Finance Lease Payable – £260k decrease. Nye Bevan lease repayment (£109k) . Right of use (ROU) assets monthly charge (239k).

Provisions - £404k – under/over 1 year adjustments

Financing

PDC Capital - £3,157k – Including CDC Phase 1 and 2 £1,615k and CIR – Fire Safety £1,406k

Revaluation Reserve - £66k, the sitewide valuation has resulted in an increase of £151k land and buildings and a (£85k) historic cost adjustment to equipment.

I & E Account - £1,587k - In-month deficit £1,672k. Retained Earnings - £85k historic cost adjustment to equipment.

Cash Flow - KGH

NHS University Hospitals of Northamptonshire NHS Group

MONTHLY CASHFLOW	ANNUAL TOTAL 2024/25 £000s	ACTUAL APR £000s	ACTUAL MAY £000s	ACTUAL JUN £000s	ACTUAL JUL £000s	ACTUAL AUG £000s	ACTUAL SEP £000s	ACTUAL OCT £000s	ACTUAL NOV £000s	ACTUAL DEC £000s	ACTUAL JAN £000s	ACTUAL FEB £000s	ACTUAL MAR £000s	FORECAST APR £000s	FORECAST MAY £000s	FORECAST JUN £000s
RECEIPTS																
Clinical Income	420,695	32,266	31,577	30,243	30,507	30,526	32,605	55,894	35,164	33,723	34,808	33,935	39,446	33,988	33,649	33,649
Health Education England	12,404	2,692	0	0	2,420	0	0	4,400	0	0	0	2,893	0	3,106	0	0
VAT	6,975	833	447	531	0	1,203	428	437	579	696	436	842	545	970	500	500
Other income	12,879	673	1,532	1,511	909	1,177	838	1,360	707	1,257	1,060	746	1,108	806	1,020	1,020
PDC - Capital	20,414	0	0	0	0	0	0	0	0	3,500	5,300	1,643	9,971	0	0	0
PDC - Revenue	14,250	0	0	3,750	0	5,000	5,500	0	0	0	0	0	0	0	0	0
Interest Receivable	1,253	123	106	110	93	81	72	80	130	146	110	101	102	132	85	85
TOTAL RECEIPTS	**488,870**	**36,587**	**33,663**	**36,146**	**33,928**	**37,987**	**39,443**	**62,170**	**36,580**	**39,322**	**41,713**	**40,160**	**51,171**	**39,001**	**35,254**	**35,254**
PAYMENTS																
Salaries and wages (incl agency)	303,971	20,653	24,114	23,871	23,788	24,322	23,890	28,362	28,812	27,356	26,686	25,808	26,310	25,322	26,060	25,310
Trade Creditors	134,869	9,006	12,754	10,489	8,099	11,229	10,128	14,526	10,962	10,944	10,940	10,284	15,508	5,705	10,490	10,640
NHS Resolution	13,532	1,353	1,353	1,353	1,353	1,353	1,353	1,353	1,353	1,353	1,353	0	0	1,418	1,418	1,418
Capital Expenditure	29,577	1,838	802	928	1,228	1,467	1,432	1,675	2,027	1,863	4,143	1,700	10,474	1,006	1,250	1,000
PDC Dividend	5,178	0	0	0	0	0	2,387	0	0	0	0	0	2,791	0	0	0
Repayment of DHSC loan (incl interest)	1,531	770	0	0	0	0	0	761	0	0	0	0	0	770	0	0
TOTAL PAYMENTS	**488,657**	**33,621**	**39,023**	**36,641**	**34,469**	**38,371**	**39,191**	**46,676**	**43,153**	**41,516**	**43,123**	**37,792**	**55,082**	**34,220**	**39,218**	**38,368**
Actual month balance	213	2,967	-5,361	-495	-541	-384	252	15,495	-6,574	-2,194	-1,409	2,368	-3,912	4,781	-3,964	-3,114
Cash in transit & Cash in hand adjustment	-9	-3	-22	26	38	-37	3	-23	-320	320	27	-23	5			
Balance brought forward	5,057	5,057	8,021	2,638	2,169	1,667	1,246	1,501	16,973	10,079	8,205	6,823	9,167	5,261	10,042	6,078
Balance carried forward	**5,261**	**8,021**	**2,638**	**2,169**	**1,667**	**1,246**	**1,501**	**16,973**	**10,079**	**8,205**	**6,823**	**9,167**	**5,261**	**10,042**	**6,078**	**2,964**

What are the issues impacting the position?

Closing cash balance in March was £5,261k, a decrease of £3,906k from February. The Trust received £17,881k deficit funding in October, which represented 7/12's of the year. The remaining deficit funding has been paid each month until the end of the year.

The Trust has managed its cash throughout the year which ultimately resulted in a lower than required creditor payment runs. The impact of this was seen with a fall in the BPPC position in September and October. With the additional cash provided, the Trust paid all suppliers up to their due date and will continue to do so while the cash position allows.

This cashflow includes Capital Income (PDC) and Expenditure profiles. The March Capital PDC funding was £9,971k. This represents a variation to the full draw down value of existing MOU's. Capital spend in March of £10,474k in March, which helped reduce the cash balance at year end.

The Trust continues to use 30 days payment terms. The Trust will monitor cash and adjust weekly payment runs accordingly.
The NHS resolution payments stop in January as these are paid over 10 months.

Cash Flow - NGH

NHS University Hospitals of Northamptonshire NHS Group

MONTHLY CASHFLOW	ANNUAL TOTAL 2024/25 £000	ACTUAL APR £000	MAY £000	JUN £000	JUL £000	AUG £000	SEP £000	OCT £000	NOV £000	DEC £000	JAN £000	FEB £000	MAR £000	FORECAST 25/26 APR £000s	MAY £000s	JUN £000s
RECEIPTS																
SLA Block Payments	510,455	37,946	38,432	36,914	37,268	37,788	43,076	64,831	41,693	40,339	41,715	40,463	49,990	42,012	41,689	41,689
Health Education Payments	16,520	3,505	0	0	3,134	0	0	5,667	0	0	0	4,213	0	4,143	0	0
Other NHS Income	18,618	1,189	763	3,948	1,304	1,179	2,030	3,200	667	767	1,760	927	883	1,800	2,200	850
VAT Claim	10,854	0	2,220	734	932	944	663	816	912	974	768	753	1,138	1,878	800	800
PP / Other	8,698	508	624	592	1,009	613	1,012	574	748	676	771	612	960	725	725	725
Salix Capital Grant	1,504	0	0	1,504	0	0	0	0	0	0	0	0	0	0	0	0
PDC - Capital	12,109	0	0	0	0	0	0	0	0	3,026	1,657	4,269	3,157	0	0	0
PDC - Revenue	14,606	2,581	3,616	1,500	909	1,000	5,000	0	0	0	0	0	0	0	0	3,500
Interest Receivable	1,337	135	109	104	91	105	87	84	141	160	118	105	98	110	105	105
TOTAL RECEIPTS	**594,702**	**45,864**	**45,764**	**45,297**	**44,648**	**41,630**	**51,868**	**75,173**	**44,161**	**45,940**	**46,790**	**51,342**	**56,226**	**50,667**	**45,519**	**47,669**
PAYMENTS																
Salaries and wages	366,183	25,317	28,892	28,519	28,501	29,736	28,551	34,292	35,322	32,893	32,699	30,773	30,687	30,769	31,350	30,800
Trade Creditors	166,901	9,171	16,036	12,502	11,934	12,667	15,644	18,144	12,393	13,333	13,827	13,265	17,985	13,000	12,500	13,000
NHS Creditors	29,042	2,626	2,795	2,509	2,325	1,970	2,547	3,237	2,366	2,731	3,159	623	2,154	2,696	2,946	2,696
Capital Expenditure	25,027	3,854	1,857	1,503	1,283	376	1,249	1,185	1,229	1,491	2,002	1,947	7,051	3,144	1,083	766
PDC Dividend	7,133	0	0	0	0	0	3,674	0	0	0	0	0	3,459	0	0	0
Repayment of PDC Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Salix loan	217	69	0	5	0	61	0	18	0	3	0	61	0	18	0	3
TOTAL PAYMENTS	**594,502**	**41,037**	**49,580**	**45,038**	**44,043**	**44,810**	**51,665**	**56,876**	**51,311**	**50,451**	**51,687**	**46,668**	**61,336**	**49,627**	**47,879**	**47,265**
Actual month balance	201	4,827	(3,815)	258	605	(3,180)	203	18,297	(7,150)	(4,511)	(4,897)	4,673	(5,109)	1,040	(2,359)	405
Cash in transit & in hand adjustment	(31)	79	(282)	51	142	(2)	19	(12)	(23)	4	2	(37)	28	(12)	0	0
Balance brought forward	1,842	1,842	6,748	2,651	2,960	3,707	525	747	19,031	11,858	7,352	2,457	7,093	2,012	3,040	681
Balance carried forward	**2,012**	**6,748**	**2,651**	**2,960**	**3,707**	**525**	**747**	**19,031**	**11,858**	**7,352**	**2,457**	**7,093**	**2,012**	**3,040**	**681**	**1,085**

What are the issues impacting the position?

Closing cash balance at the end of March was £2,012k, which was £1,988k less than forecast. Block payments for March included £8,500k Surge Funding from Northants ICB. This removed the requirement for PDC Revenue Support, the application for which was declined, on the basis of the additional funding received. £844k Cost and Volume and Devices funding from NHS England (Central Specialised Commissioning) was also received.

Other NHS Income forecast in April includes £1,000k 24/25 ERF and settlement of invoices raised in March to Northamptonshire Healthcare FT.

PDC Capital drawdowns in March totalled £3,157k. These were for CDC Phase 1 and 2 (£1,615k), Fire Safety (£1,406k), Cyber vPAN (£81k) and Cyber Honeypot (£55k)

VAT Reclaims for February and March, received in March and April reflect the value and volume of invoices processed.

It is still anticipated that Revenue Support will be required in quarter 1 25/26. Guidance relating to the application process is yet to be issued by NHS England.

Salaries in March continued to decrease as there were no further arrears payments or pay uplifts and bank shifts continued to decrease.

Trade and NHS Creditors in March reflect a larger volume of invoices, including a proportion of high value ones were received and authorised for payment than originally expected. A number of longstanding queries were also resolved.

Capital expenditure includes medical equipment delivered in March and end of scheme payments for Estates and Digital.

The PDC Dividend payment is based on the forecast at Month 9. The receivable carried forward (£370k) will reduce the payment made in September 2025.

Capital - KGH

University Hospitals of Northamptonshire NHS Group

Funding Sources	M12 £000's
Internally Generated Depreciation	14,744
Less Principle Repayment of Loan	(1,480)
Total BAU Funding	**13,264**
Borrowings - Right of Use Assets IFRS16	1,913
Total System Operational Capital	**15,177**
New Hospital Programme (NHP)	1,200
Community Diagnostic Centre (CDC)	10,500
Energy Centre & HV Infrastructure	3,636
Frontline Digitisation	1,445
RAAC Rockingham Way	4,626
Multi Storey Car Park	1,937
Estates - CIR Fire	260
Digital - Cyber ' honeypot'	20
Digital - Cyber vPAM	81
New Maternity Building	130
Total National Schemes	**23,835**
Donated Assets & Grants	0
Gross Capital	**39,012**
Exclude CFunds and Grant Income	**0**
Total - Funding	**39,012**

Capital Scheme	2024/25 Plan @ M12 £000's	M12 YTD Spend £000's	M12 Disposal £000's	M12 Spend - Disposals £000's	Spend Variance to allocation £000's
BAU Digital	2,909	3,515		3,515	(606)
BAU Medical Equipment	2,028	2,209	(137)	2,072	(44)
BAU Estates	5,210	4,309		4,309	901
RAAC Rockingham Way	4,626	4,940		4,940	(314)
Contingency	314			0	314
Total BAU CAPEX	**15,087**	**14,973**	**(137)**	**14,836**	**251**
ROU Assets	1,913	1,739		1,739	174
Total System Operational Capital	**17,000**	**16,712**	**(137)**	**16,575**	**425**
New Hospital Programme (NHP)	1,200	841		841	359
Community Diagnostic Centre (CDC)	10,500	8,339		8,339	2,161
Energy Centre & HV Infrastructure	3,636	4,160		4,160	(524)
Frontline Digitisation	1,445	1,445		1,445	0
Multi Storey Car Park	1,937	1,538		1,538	399
Estates - CIR - Fire	260	192		192	68
Digital - Cyber 'honeypot'	20	0		0	20
Digital - Cyber vPAM	81	88		88	(7)
Total National Schemes	**19,079**	**16,603**	**0**	**16,603**	**2,476**
Donated Assets & Grants	0	0		0	0
Gross Capital	**36,079**	**33,315**	**(137)**	**33,178**	**2,901**
Exclude CFunds and Grant Income	**0**	**0**	**0**	0	0
Total CRL	**36,079**	**33,315**	**(137)**	**33,178**	**2,901**

What are the issues impacting the position?

Total capital funding available of £39,012k. However, because of posting a deficit I&E plan the system allocation was reduced by 10% by NHSE, this has been applied to all provider capital allocations. In addition, UHN have agreed to a realignment of the system allocation to provide additional support in year to NHFT for their CYP scheme. The ICB had also reduced Right of Use lease funding to reflect overcommitments across the system.

The resultant revised funding of £36,079k comprises of three main elements; BAU capital £10,331k, Right of Use funding of £1,913k and non-BAU, national capital £23,835k for nine additional PDC centrally funded schemes.

Slippage against the BAU Estates schemes was largely mitigated, but the Trust finished the year with a £425k underspend against the System Capital allocation of £17,000k.

The underspend against nationally funded projects was more significant. The Corby CDC slippage from March 2025 completion to May 2025 being the most significant at £2,161k. This underspend and the NHP, including Multi Storey Car Park underspends, were communicated with NHSE and national leads. Energy Centre overspend in year recovers underspend in 23/24.

Capital - NGH

Funding Sources	M12 £000's
Internally Generated Depreciation	16,768
Internally Generated Depreciation - ROU Assets	2,553
Salix Repayment	(217)
Capital Element of leased assets	(3,324)
Cash Reserves	**(1,635)**
Total BAU Funding	**14,145**
Borrowings - Right of Use Assets IFRS16	5,686
Total System Operational Capital	**19,831**
Digital - EPR	7,628
Digital - Cyber ' honeypot'	55
Digital - Cyber vPAM	81
Estates - CDC Kings Heath	1,760
Estates - CDC, Ph2	1,179
Estates - CIR Fire	1,280
MESC - Aseptics Pharmacy	126
Total National Schemes	**12,109**
Donated Assets	292
Grant Funding - PSDS	330
Gross Capital	**32,562**
Exclude CFunds and Grant Income	**(622)**
Total - Funding	**31,940**

Capital Scheme	2024/25 Plan @ M12 £000's	M12 YTD Spend £000's	M12 Disposal £000's	M12 Spend - Disposals £000's	Spend Variance to allocation £000's
BAU Digital	2,251	2,185	(1)	2,184	67
BAU Medical Equipment	1,009	1,274	(2)	1,272	(263)
BAU Estates	4,626	4,821	0	4,821	(195)
Estates - UEC	1,000	891	0	891	109
Urgent Treatment Centre	0	227	0	227	(227)
Vacated Critical Care	653	47	0	47	606
Chest Clinic Works	2,824	2,740	0	2,740	84
Pharmacy Expansion	655	490	0	490	165
Winter Pressures - Bed Heads Nye Bevan	120	121	0	121	(1)
2nd Robot	1,007	1,496	0	1,496	(489)
Total BAU CAPEX	**14,145**	**14,292**	**(3)**	**14,289**	**(144)**
ROU Assets	5,686	5,769	(8)	5,761	(75)
Total System Operational Capital	**19,831**	**20,061**	**(11)**	**20,050**	**(219)**
Digital - EPR	7,628	7,628	0	7,628	0
Digital - Cyber 'honeypot'	55	36	0	36	19
Digital - Cyber vPAM	81	88	0	88	(7)
Estates - CDC, Kings Heath	1,760	1,760	0	1,760	0
Estates - CDC, Phase 2	1,179	512	0	512	667
Estates - CIR - Fire	1,280	1,280	0	1,280	0
MESC - CIR - Aseptics, Pharmacy	126	99	0	99	27
Total National Schemes	**12,109**	**11,403**	**0**	**11,403**	**706**
Charitable Funds	292	292	0	292	(0)
PSDS - Grant Funded	330	330	0	330	0
Gross Capital	**32,562**	**32,087**	**(11)**	**32,076**	**487**
Exclude CFunds and Grant Income	**(622)**	**(622)**	**0**	**(622)**	**0**
Total CRL	**31,940**	**31,464**	**(11)**	**31,453**	**487**

What are the issues impacting the position?

NGH ended the Financial Year with funding of £31,940k and an underspend of £487k. The table above details the schemes, the planned spend and actual spend.

The largest BAU slippages, as forecast were the Vacated Critical Care scheme £606k and the Pharmacy extension scheme £165k. These were mitigated by the Sub Committees and the concept and design costs associated with the potential new £10,800k Urgent Treatment Centre.

In total there was an underspend against the nationally funded schemes of £706k, in main CDC. NGH has received notification from NHSE – Capital and Cash, that the DHSC reserve the right to request repayments for overdrawn PDC and that any PDC spent in future years will need to be recorded as such in future PFRs.

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Interpreting SPC charts and Glossary

Interpreting SPC charts

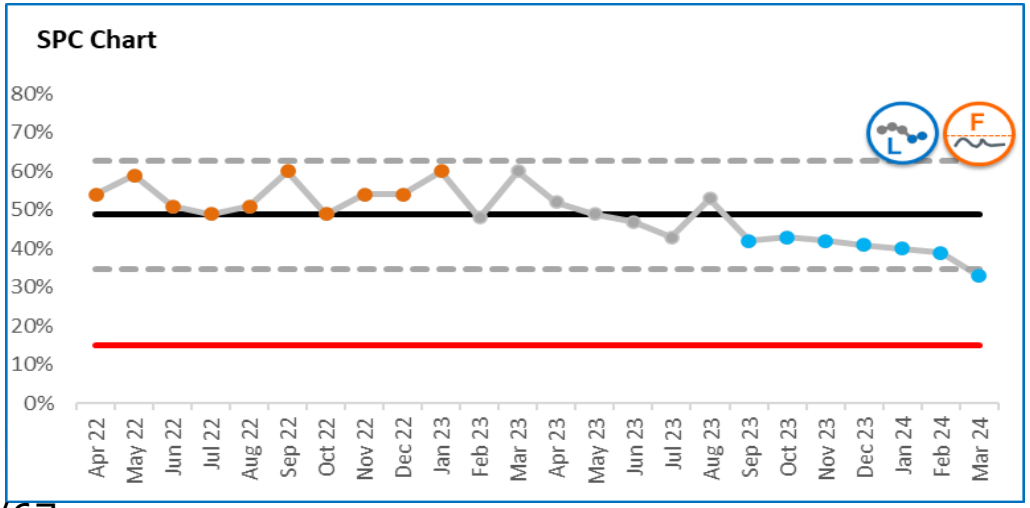
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



UPL

Average

LPL

Target

The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Interpreting summary icons

- These icons provide a summary view of the important messages from SPC charts.

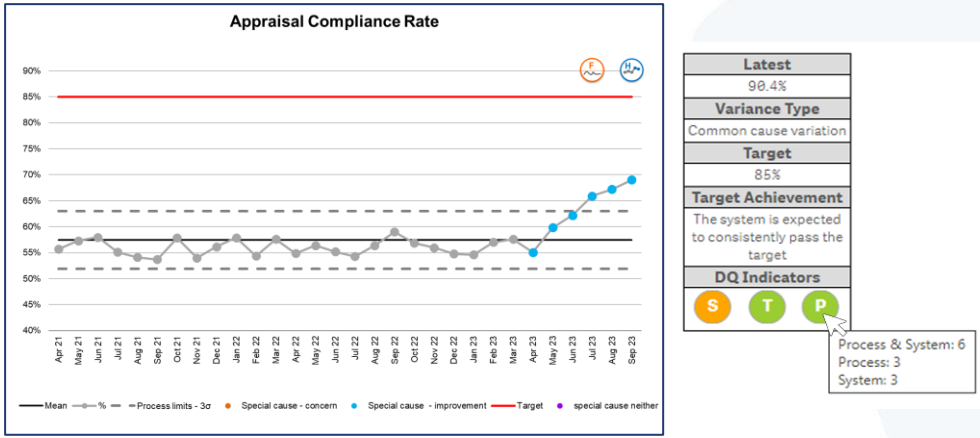
	Variation / performance Icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?

	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Interpreting the data quality indicator

- The indicator provides an effective visual aid to quickly provide analysis of the collection, review and quality of the data associated with the metric. Each metric is rated against the 3 domains in the table below and displayed alongside the SPC chart as in the below example.

Symbol	Domain	Definition
S	Sign off and Review	Has the logic and validity of the data definition been assessed and agreed by people of appropriate and differing expertise? Has this definition been reviewed regularly to capture any changes e.g. new ways of recording, new national guidance?
T	Timely and Complete	Is the required data available and up to date at the point of reporting? Are all the required data values captured and available at the point of reporting?
P	Process and System	Is there a process to assess the validity of reported data using business logic rules? Is data collected in a structured format using an appropriate digital system?



Glossary

Acronym	Name	Description
A&E	Accident and emergency	A consultant-led 24-hour service with full resuscitation facilities in acute hospitals. Also known as an 'emergency department'.
AMS	Anti-microbial stewardship	Antimicrobial stewardship involves a system-wide approach to promote and monitor the responsible use of antibiotics to prevent the development of antimicrobial resistance.
APC	Admitted patient care	A term for any patient who has been admitted to a hospital; whether that be on an emergency or planned basis.
C. Diff	Clostridium Difficile	A bacterium that can cause diarrheal illness which is a common healthcare-associated infection (HAI).
CDC	Community Diagnostic Centre	Facilities that provide a range of diagnostic tests and scans, including X-rays, CT scans, ultrasounds, and blood tests, in a community setting
CEO	Chief Executive Officer	The Chief Executive Officer who leads the organisation.
CIP	Cost improvement programme	A set of initiatives and schemes implemented to improve efficiency and reduce costs while maintaining or enhancing the quality of patient care through making best use of available resources.
CNO	Chief Nursing Officer	The Chief Nursing Officer is the most senior nursing professional in the Trust.
CNS	Clinical nurse specialist	A highly skilled and specialised nurse with in-depth knowledge in a specific area of nursing practice.
COHA	Community Onset Healthcare Associated	Infections occuring in patients in the community who have been recently discharged from hospital in the community.
COO	Chief Operating Officer	The Chief Operating Officer is responsible for overseeing the day-to-day operations of the hospital.
CQC	Care Quality Commission	The independent regulator of health and adult social care in England, whose role is to ensure the quality and safety of care provided by all NHS hospitals, care homes, and other health and social care services.
CTC	Computed Tomography Colonography	CT scan that uses X-rays and advanced computers to create detailed images of the large bowel, helping to diagnose bowel cancer.
CUCC	Corby Urgent Care Centre	Relating to Corby Urgent Care Centre, which provides urgent care services to patients in Corby.
DAM	Divisional / Directorate Accountability Meeting	Divisional or corporate directorate forum where leadership teams from clinical and corporate areas share their progress against their Integrated Business Plans, and are held to account for performance.
DM01	Diagnostic Waiting Times and Activity Report	A monthly data collection on diagnostics waiting times and activity covering 15 key diagnostic tests.
DNA	Did Not Attend	Refers to a missed appointment where a patient doesn't show up for their scheduled healthcare appointment and doesn't notify the clinic or hospital to cancel it
DSE	Dobutamine Stress Echocardiogram	A heart ultrasound test that uses medication to simulate exercise and assess how the heart responds under stress
E. Coli	Escherichia Coli	A bacterium that is commonly found in the intestines of humans and can cause infection.
ED	Emergency Department	A consultant-led 24-hour service with full resuscitation facilities in acute hospitals. Also known as an 'accident and emergency'.
EDD	Expected Date of Discharge	An estimated date for when a patient is expected to be medically ready to be discharged from acute care
EDU	Emergency Decisions Unit	A ward area within a hospital where patients who require further observation, short-term treatment, or discharge preparation are cared for

Acronym	Name	Description
EMAS	East Midlands Ambulance Service	Relating to East Midlands Ambulance Service NHS Trust, which provides ambulance services across the East Midlands, including in Northamptonshire.
ENT	Ear, Nose and Throat	Ear, nose and throat (ENT) services diagnose, evaluate and manage diseases of the head and neck.
ERF	Elective recovery fund	A fund within the NHS budget designed to incentivise hospitals to achieve higher levels of elective activity.
ESR	Electronic Staff Record	A central, integrated HR and payroll system used by many NHS hospitals
FDP	Federated Data Platform	A software platform that securely connects data, breaks down information silos, and provides insights to assist in decision-making, reduce costs, and improve patient outcomes
FDS	Faster Diagnosis Standard	A standard aimed at ensuring patients who are referred for suspected cancer receive a diagnosis (or are told cancer is ruled out) within 28 days of their urgent referral by a GP
FFT	Friends and Family Test	A feedback tool that asks patients to rate their experience of NHS services.
FU	Follow-Up	A scheduled consultation with a healthcare professional after an initial treatment or diagnosis
GIRFT	Getting It Right First Time	A national NHS England programme designed to improve patient care by reducing unnecessary variations in services across the NHS
GNB	Gram Negative Bacteria	Gram negative bacteria are the most common cause of healthcare-related bacterial infections.
HAPU	Hospital Acquired Pressure Ulcer	A pressure ulcer acquired during a patient's stay in hospital.
HCA	Healthcare Assistant	Essential members of the healthcare team, working alongside nurses and other healthcare professionals to provide patient care.
HCAI	Healthcare-associated infection	These are infections that patients acquire while receiving healthcare services in a hospital or other healthcare setting, that they did not have before they entered the setting.
HOHA	Hospital Onset Healthcare Associated	Infections resulting from healthcare provided to a patient in hospital.
HRBP	Human Resources Business Partner	A human resources professional who acts as a key liaison between the HR department and the division they support
HSMR	Hospital Standardised Mortality Ratio	The Hospital Standardised Mortality Ratio (HSMR) shows the overall rate of deaths within the NHS trust each hospital belongs to.
HWB	Health and Wellbeing	Support for the overall well-being of NHS staff, encompassing physical, mental, and emotional aspects
ICB	Integrated Care Board	A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area, in our case Northamptonshire.
ICE	Integrated Clinical Environment	A digital system that allows clinicians to request tests and view pathology and radiology results.
ICS	Integrated Care System	A partnership of health and care organisations within a geographical area, in our case Northamptonshire, which aim to plan and deliver joined up health and care services.
IG	Information Governance	A framework for handling all information, particularly sensitive patient and employee data, in a secure, confidential, and legal manner.
ILT	Integrated Leadership Team	The executive management committee of the hospital, which has delegated decision-making authority from the Board of Directors and manages the running of the hospitals.

Glossary

Acronym	Name	Description
IPC	Infection Prevention Control	Infection prevention control is a set of policies and practices put in place to limit the spread of infection within NHS hospitals.
IPOG	Infection Prevention Oversight Group	A group which oversees infection prevention within the Trust.
IPR	Integrated Performance Report	A report on the performance of the hospitals across the different domains that performance is monitored on, as reported to the Board of Directors.
IPS	Internal Professional Standards	A clear, unambiguous description of the values and behaviours expected in an organisation. These might include specific timeframes for responding to patient needs or protocols for managing certain medical conditions
IPT	Inter-Provider Transfer	The movement of a patient between different healthcare providers, such as a referral from one hospital to another
IS	Independent Sector	Independent Sector providers are organizations that are not NHS trusts or NHS foundation trusts, but which provide healthcare services under contract to the NHS
IT	Information Technology	A broad field encompassing the use of technology, including computers, software, and networks, to manage, store, process, and transmit information. IT is managed by our Digital team in UHN.
IV	Intravenous	The delivery of fluids, medications, and nutrients directly into a patient's bloodstream through a vein
KGH	Kettering General Hospital NHS Foundation Trust	Relating to Kettering General Hospital NHS Foundation Trust
KPI	Key Performance Indicator	Specific, measurable metrics used to assess the effectiveness of NHS programs and services
LATP	Local Anaesthetic Transperineal Biops	A prostate biopsy technique used to diagnose prostate cancer.
LOS	Length of Stay	The duration in days that a patient spends in hospital, from admission to discharge
MDT	Multi-disciplinary team	A group of healthcare professionals with varied expertise come together to review the care plan of one or more patients. The patient may or may not be present.
MH	Mental Health	An individual's emotional, psychological, and social well-being, encompassing how they think, feel, and behave, as well as their ability to cope with life's challenges and form relationships
MIAMI	Minor Injuries and Minor Illness	Services designed to provide a convenient and efficient option for patients needing care for common, less serious conditions
MRI	Magnetic Resonance Imaging	A medical imaging technique that uses strong magnetic fields and radio waves to produce detailed images of the body's internal structures.
MRSA	Methicillin-resistant Staphylococcus aureus	A bacterium that usually lives on the skin, but if it gets inside the body it can cause a serious infection. MRSA is an infection that has become resistant to many of the antibiotics used to treat normal infections.
MSGG	Medicines Safety and Governance Group	A group which oversees the safety and governance of medicines within the Trust.
MSK	Muskuloskeletal	MSK conditions affect the body's movement system, including bones, joints, muscles, and spine. They can range from minor injuries to long-term conditions like arthritis or back pain.
MSSA	Methicillin-resistant Staphylococcus aureus	A bacterium that usually lives on the skin, but if it gets inside the body it can cause a serious infection. MSSA is an infection that can be treated with antibiotics used to treat normal infections.

Acronym	Name	Description
NGH	Northampton General Hospital	Relating to Northampton General Hospital NHS Trust
NHFT	Northamptonshire Healthcare Foundation Trust	Relating to Northamptonshire Healthcare NHS Foundation Trust, which provides community and mental health services in Northamptonshire.
NHSE	NHS England	The organisation that leads the health service in England, and is responsible for overseeing the budget, planning and delivery of healthcare services in England and a regulator of NHS Trusts.
OD	Organisational Development	OD enables people to flourish, thrive and have meaning in their work, ultimately improving the quality and safety of patient care.
OPA	Outpatient appointment	A medical appointment at a hospital or clinic where you are seen for diagnosis, treatment, or procedures, but you don't need to stay overnight
PAG	Patient Access Group	A group which oversees waiting lists and patient access within the Trust.
PALS	Patient Advice and Liaison Service	A service that provides confidential help and advice to patients, their families and carers.
PCEEC	Patient and Carer Experience and Engagement Group	A group which oversees and improves the experience of our patients and carers which reports into our Quality and Safety Committee (QSC).
PED	Paediatric Emergency Department	A consultant-led 24-hour service with full resuscitation facilities in acute hospitals that treats children.
PIFU	Patient-Initiated Follow-Up	A system where patients can arrange their own follow-up appointments with their healthcare team when they feel they need them, rather than being scheduled in advance.
PO	Purchase order	A document that authorizes a specific purchase of goods or services from a supplier
POD	Patient Observation and Decision-making	A facility within a hospital that allows for the temporary, safe, and efficient observation and assessment of ambulance patients when the main Emergency Department is busy.
PSIRF	Patient safety incident response framework	A framework that sets out the NHS's approach to responding to patient safety incidents, focusing on learning and improving safety.
PTL	Patient Tracking List	PTLs are used to monitor and manage referrals, and track patients who need to be treated within a specific timeframe
QI	Quality improvement	A systematic approach to continually improve the quality of healthcare services, focusing on patient safety, effectiveness, efficiency, and overall experience
RCA	Root case analysis	A systematic approach to investigating an incident and identifying the underlying causes.
RPA	Robotic Process Automation	Technology that uses software robots (or "bots") to automate repetitive, rule-based tasks, freeing up human staff to focus on more complex and value-added work
RTT	Referral to Treatment	The process where patients are referred by their GP to a consultant-led service for treatment, and the time it takes for them to receive that treatment
SBAR	Situation, Background, Assessment, Recommendation	A structured communication tool used to facilitate clear and concise information transfer between healthcare professionals. It stands for Situation, Background, Assessment, Recommendation.
SDEC	Same day emergency care	SDEC allows specialists, where appropriate, to assess, diagnose and treat patients on the same day of arrival who would otherwise have been admitted to hospital.

Glossary

Acronym	Name	Description
SHMI	Summary Hospital-Level Mortality Index	The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
SMR	Standardised Mortality Ratio	The Standardised Mortality Ratio (SMR) compares the overall rates of mortality of different groups within a specific condition or population.
SOP	Standard Operating Procedure	A detailed, written document that outlines the steps and procedures for performing a specific task or process consistently
TAT	Turnaround Time	The time between an imaging examination and the time a verified report is made available to the clinician
TCI	To Come In	A patient's scheduled admission date for a planned procedure or treatment
TES	Temporary Escalation Space	A temporary escalation spaces (TES), is a term used to describe a location for providing patient care in spaces not designed for that purpose, like corridors or waiting rooms, when appropriate care environments are unavailable
TOC	Transfer of Care	The process of discharging a patient to another healthcare provider and therefore transferring a patient's care from one healthcare setting to another, ensuring a smooth and coordinated handover of information and responsibility
TOE	Transoesophageal Echocardiogram	A procedure performed in hospitals to visualize the heart and aorta
TTIA	Time to Initial Assessment	The time to an initial assessment by a qualified healthcare professional from arrival in an emergency department.
UEC	Urgent and Emergency Care	Services provided for patients with urgent, non-life-threatening conditions, as well as those requiring immediate emergency treatment for life-threatening illnesses or injuries.
UHL	University Hospitals of Leicester	Relating to University Hospitals of Leicester NHS Trust, which operates as a Group with the University Hospitals of Northamptonshire (UHN), and has shared leadership roles, including the Chair, Group CEO, Chief Nurse and Chief Digital and Information Officer.
UHN	University Hospitals of Northamptonshire NHS Group	Relating to University Hospitals of Northamptonshire NHS Group, a collaboration of Kettering General Hospital NHS Foundation Trust (KGH) and Northampton General Hospital NHS Trust (NGH).
UTC	Urgent Treatment Centre	A centre that provides urgent medical help for conditions that are not life-threatening, but are too urgent to wait for a regular GP appointment
WLI	Waiting List Initiative	An additional session designed to address the backlog of patients waiting for treatment in which staff receive additional payments for the extra hours they work.
WNB	Was Not Brought	Refers to a child who did not attend an appointment, often due to the parents or carers failing to bring them
WTE	Whole Time Equivalent	WTE represents the portion of a full-time workweek that a particular employee contributes. For example, someone working half the standard hours would be 0.5 WTE.
YTD	Year-to-date	A term that refers to the cumulative amount of money or activity that has occurred from the beginning of the current financial year, which starts in April.

BOARD COMMITTEE SUMMARIES

University Hospitals of Northamptonshire Boards of Directors Meeting: 9 May 2025

AGENDA ITEM 5

Operational Performance: 17 April 2025

People: 24 April 2025

Quality and Safety: 25 April 2025

Audit: 28 April 2025

Finance and Investment: 29 April 2025

UHN Operational Performance Committee Upward Report to Board of Directors	Date of reporting group's meeting: 17th April 2025		
Reporting Non-Executive Director: Trevor Shipman (Chair)			
Agenda Item	**Description and summary discussion** **The committee:**	**Decision / Actions and timeframe**	**Assurance level ***
Subgroup upward reports	1. Received upward reports from the Digital Department and UHN Urgent and Emergency Care Steering Group. 2. Noted the revised date for EPR implementation which has been approved by the EPR Programme Board.	-	Reasonable
UHN Emergency Planning Committee Terms of Reference	Approved the terms of reference for the UHN Emergency Planning Committee.	Approved	n/a
Operational performance	Noted that: 1. Weekly Tier 2 meetings with the ICB and NHSE are continuing. 2. KGH Type 1 4-hour performance: improved slightly to 65% (up from 62% in January and February) 3. NGH Type 1 4-hour performance: at 58% (from 59% in Feb and 60% in Jan) 4. A&E 4-hour performance remains a challenge, leading to overcrowding within the department at times and extended 12-hour stays. 5. Stranded and super stranded: The numbers of stranded and super stranded patients reduced at both hospitals. KGH stranded patients reduced to 305, super stranded to 119. NGH stranded patients reduced to 355 and super stranded to 148. 6. UHN's planned care performance remains strong compared to regional peers with the highest referral to treatment (RTT) at 62.1% and faster diagnosis standard (FDS) at 81.6%. 7. Ongoing risk associated with 65-week waits. The committee is cautious about the potential impact of financial plans on future elective care.	-	Reasonable (UEC) Substantial (Planned care)
UHN winter planning update	1. Received a report which provided reflection and assurance on annual winter planning. 2. Supported the proposal for completion of the UHN winter plan by the end of Quarter 1 to ensure improved staff engagement and communication plans are in place to improve staff awareness of plans, and to share how staff and patients will be supported.	On Boards' Agenda	Reasonable
Board Assurance Framework	1. Approved changes in relation to BAF risk UHN04.	On Boards' Agenda	-

People Committee Reports to the Boards of Directors	Date of reporting group's meeting: 24 April 2025 (Strategy workshop)		
Reporting: Denise Kirkham			
Agenda Item	**Description and summary discussion**	**Decision / Actions and timeframe**	**Assurance level ***
-	People Committee in April was one of the two face to face Strategy Meetings per year. There are no assurance items to report to Board. Discussions took place regarding the Board Assurance Framework, Freedom to Speak Up (triangulation with the Staff Survey), and 2025-26 workforce plan.	-:	-

UHN Quality and Safety Committee in Common Upward Report to Board of Directors	Date of reporting group's meeting: 25th April 2025 (1 of 2)		
Reporting Non-Executive Director: Chris Welsh (Convenor)			
Agenda Item	**Description and summary discussion** **The committee:**	**Decision / Actions and timeframe**	**Assurance level ***
Subgroup reports	1. Received upward reports from the Nursing Midwifery & AHP Committee, Health and Safety Committee, Patient & Carer Experience and Engagement Group, Patient Safety Committee and Children and Young People's Board 2. Noted items of limited assurance from these groups and the actions being taken in relation to these.		Reasonable
Patient Story	1. Received a patient story highlighting positive experiences with the maxillofacial service, showcasing seamless care coordination from the community to the acute setting.	-	n/a
Perinatal updates	1. Received an update from the UHN Perinatal Safety Champions meeting, confirming that the identification, investigation and learning from all maternity patient safety incidents are being managed effectively. Additionally maternity services are achieving strong compliance with national maternity safety indicators.	On Boards' agenda – item 7	Reasonable
	2. Confirmed limited assurance regarding the risks arising from the current obstetric scanning service based on initial feedback from an external review completed earlier this month. 3. Confirmed limited assurance concerning the cessation of funding for Maternity Tobacco Dependency Advisor roles, which impacts the provision of smoking cessation services in maternity and may affect compliance with the maternity incentive scheme for year 7. 4. Confirmed limited assurance related to the implementation of Badgernet at both KGH and NGH, due to issues with providing licenses for clinicians to access System C.	Escalate to the Boards.	Limited
Harm Free Care Report	1. Received and noted the harm free care report which provided an overview of hospital acquired harm.	-	Reasonable
Organisational oversight of Temporary Escalation areas (TES)	1. Received assurance that UHN is taking proactive actions to ensure organisational oversight of the quality of care delivered to patients in temporary escalation areas.	-	Reasonable

UHN Quality and Safety Committee in Common Upward Report to Board of Directors	Date of reporting group's meeting: 25th April 2025 (2 of 2)		
Reporting Non-Executive Director: Chris Welsh (Convenor)			
Agenda Item	**Description and summary discussion** **The committee:**	**Decision / Actions and timeframe**	**Assurance level ***
NMAHP Safe Staffing	1. Received a comprehensive overview of safe staffing and associated metrics across UHN.	-	Reasonable
Update on KGH paediatric services	1. Received an update on recent media coverage of KGH paediatric services. 2. Received assurance on the actions being taken to address concerns raised concerning KGH paediatric services. 3. Noted positive feedback received from UHN's publication of an open letter addressed to parents.	-	Reasonable
NGH CQC Urgent and Emergency Care report and action plan	1. Received an update on the immediate action planning and improvements that have been made following high-level feedback from the two-day CQC inspection which took place on 18th February 2025. This had assessed care provided cross urgent and emergency care and medical services including older people's care and formed part of the CQC's national review of pressurised services across England.	On Boards' agenda, item 6	Reasonable
External governance review of patient safety	1. Received the initial findings and recommendations of an external review of UHN's patient safety governance. 2. Noted that an action plan will be developed once the report and its recommendations have been reviewed.	-	Reasonable
Medicines optimisation report	1. Received a report detailing both successes and areas of concern in medicines optimisation and pharmacy services across UHN. 2. Noted the extensive efforts being made in medicines optimisation, which provided the committee with substantial assurance.	-	Substantial
Patient Safety Quarter 4 report	1. Received the quarter 4 patient safety report which provided the committee with assurance that the identification investigation and learning from all patient safety incidents is being effectively managed. 2. Confirmed substantial assurance in relation to this item due to the proactive work being undertaken.	-	Substantial

KGH/NGH Audit Committees (meeting together) Upward Report to Boards of Directors	Date of reporting group's meeting: 28 April 2025 (1 of 2)		
Reporting Chair: Alice Cooper			
Agenda Item	**Description and summary discussion**	**Decision / Actions and timeframe**	**Assurance level ***
Internal Audit Progress Report	Pleasing progress was noted on the reports planned for both Trusts this year, with only a couple now to complete from the 24/25 plan; however, a concern was discussed regarding the interaction between the executive leads and the Internal Audit team due to the significant number of overdue actions outstanding, and also the number that have their due dates revised. It was noted that the Chief Finance Officer has commenced plans to enhance the visibility of, and engagement with Internal Audit findings at Integrated Leadership Team, and it was hoped this situation would improve, but the committee wished to add its weight to the importance of seeing an improvement in this area.	Improved clarity in report actions over responsible Executives as well as managers. Enhancement of the sign-off required to extend action due dates, and the visibility of this.	Limited
Head of Internal Audit Annual Opinion	The committees took substantial assurance from the overall positive conclusions of the Head of Internal Audit regarding the control environment in place at both Trusts.	-	Substantial
Anti-Crime Progress Report	The committees noted concerns about the level of assurance offered by the report on activity at both Trusts due to: The number of actions from the committee from previous meetings remaining outstanding, the lack of a clear timetable for investigating and closing cases, and the lack of benchmarking data to allow the committees to properly assess the Trusts' exposure and the appropriateness of actions.	Closure of agreed actions by next meeting.	(Low) Reasonable
Risk Management Strategy	The committees welcomed the draft strategy and made some suggestions for further enhancement before it is then passed onto the Board for approval and adoption. It was also noted, however, that the way in which the strategy is engaged with and implemented in the wider organisation (i.e. if it really drives the closer integration of risk management into our decision making) would be particularly key.	On Boards' agenda	-

KGH/NGH Audit Committees (meeting together) Upward Report to Boards of Directors	Date of reporting group's meeting: 28 April 2025 (2 of 2)		
Reporting Chair: Alice Cooper			
Agenda Item	**Description and summary discussion**	**Decision / Actions and timeframe**	**Assurance level ***
NHSE Group Governance Review Follow-up	Following a brief update on this, a discussion highlighted the paramount importance of findings from a series of external reports received by the organisations in recent months and years being clearly tracked (or where appropriate – if superseded – evidenced as cleared) in a way that kept executive leads involved in the process, and the Audit Committees and/or Boards able to oversee this effectively and take appropriate assurance.	Clarity on ownership of this to be sought by end May.	-
Draft Annual Accounts Submission Highlights Report	The committees welcomed the confirmation that both Trusts' submissions of draft accounts to NHSE had been made on time on 25th April, following a walk through with two audit committee(s) members the previous day to offer assurance prior to this. The summary of the highlights from those submissions was presented to the committees and the enhanced assurance process around this was welcomed.	-	Substantial
External Audit Contract Award	A proposal for external audit services for the 2025/6 year end onwards was received and considered for value for money and suitability in other respects. A recommendation for the NGH Board and the KGH Governors was agreed.	On agenda	-

UHN Finance and Investment Committee Upward Report to Boards of Directors	Date of reporting group's meeting: 29 April 2025

Reporting Group Chair: Damien Venkatasamy

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
Finance Report Month 12	Following receipt of deficit funding and additional system support funding the forecast submitted at month 11 was a £29.981m residual deficit (£12.947m KGH, £17.035m NGH) The draft accounts confirm that UHN have achieved this forecast position with a final outturn of £29.900m (£12.895m KGH, £17.006m NGH). The annual accounts had been submitted to NHSE and External Audit by the deadline of 25 April. There was likely to be cash flow pressures April-May, and the Committee was informed of the risk related to rejection of cash draw down requests. The Committee expressed concern on the number of non-recurrent items and asked if these could be isolated in future reports, to give a clearer picture of the true run rate.	Future reports to include analysis of underlying run-rate	Reasonable
Workforce Update	Month 12 had seen improvement in the agency position; however, both Trusts were still outliers in the Midlands region. Bank use had also reduced, though was still the worst performer in the Midlands. KGH had seen the total workforce reduced and NGH had seen an increase of 90wte. The Committee discussed workforce controls/initiatives which included no overtime for non-clinical roles, approvals for bank/agency use being escalated to the Chief Nurse, clinical admin review and launch of the MARS scheme. The Committee requested the tracking of substantive/bank/agency delta against plan to be included in future reports.	Tracking of actual workforce data against plan to be included in future reports	Reasonable
Update on Efficiency and Productivity Delivery plan 25-26	Full-year savings 24-25 delivered are £39.6m, which is below plan by £1.8m - less then 50% were recurrent. At 1st April 2025, the total schemes identified for delivery totalled £60.9m, leaving a gap to target of £24.7m. This does include schemes in the pre-pipeline stage (approx £42m). The Committee discussed the risks and that a large proportion sat with one division. The savings plan had been phased over the year with a lower delivery set for months 1-3.	-	Limited
25/26 Deliverables	The Committee approved the 25/26 deliverables for the Finance & Investment Committee.	-	-
NGH Urgent Treatment Centre (UTC)	The outline paper for the NGH UTC was presented to the Committee. UHN has submitted a bid for £10.75m to £15.75m with submission for an early drawdown of up to £1m approved on 16 April 2025. The full funding allocation is dependent on the approval of a Short Form Business Case (SFBC). The Committee was informed of the risks and UHN had taken legal advice from Capsticks in relation to the procurement risk. A further discussion was had on any risks to patient safety whilst the UTC was being built. The NGH Committee agreed with the recommendations with the report including recommending the NGH Board of Directors approve the UTC Short Form Business Case.	On agenda	-

*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	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	9 May 2025
Agenda item	6
Title	NGH CQC Inspection of Urgent and Emergency Care (UEC): Receipt of Section 29a Warning Notice
Presenter	Julie Hogg, Group Chief Nurse
Authors	Jo Smith – Director of Nursing Kate Hepton – Interim Deputy Chief Nurse

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**

Group priority				
✓ Patient	✓ Quality	☐ Systems & Partnerships	☐ Sustainability	☐ People
Excellent patient experience shaped by the patient voice.	**Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation**	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
To inform Boards of receipt of a section 29a warning notice for urgent and emergency care.	Boards of Directors, 4 April 2025

Executive Summary

On 18 February 2025, the Care Quality Commission (CQC) carried out a two-day unannounced inspection at Northampton General Hospital. This was part of a national review focusing on urgent and emergency care (UEC) and medical services, including care for older people, in hospitals experiencing high levels of pressure.

The timing of the inspection coincided with a particularly challenging period for our hospital. During the visit, we were managing high demand in our Emergency Department (ED), delays in patient flow, and the use of Temporary Escalation Spaces to accommodate additional patients. There were also delays in ambulance

handovers, and some patients experienced extended waits in ambulances—issues exacerbated by seasonal pressures and the school half-term.

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 21 March 2025. This notice highlights areas where urgent improvements are required.

We are taking this feedback extremely seriously. Immediate actions have already been put in place, and we are continuing to work closely with partners to address the concerns raised and deliver sustainable improvements for our patients.

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.

Recommendations

The Boards are asked:

1. To receive the report as assurance of immediate action planning and improvements made following feedback from the inspection, and
2. To support the release of the open letter to the public (appendix 1 below)

Appendices

Appendix 1 – Open letter for public & stakeholders

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 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. Following this unannounced inspection a letter of intent of regulation 31 was issued to the Trust and the action plans described in this paper were developed in response to that letter. No formal notice has been issued by the CQC at this time however, we cannot rule out a regulatory notice.

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 18 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.

No formal notices were issued during the visit, but on February 27, 2025, the Trust received a letter indicating the intent to pursue enforcement action under Section 31 of the Health and Social Care Act 2008. In response, the Trust submitted a comprehensive high-level action plan on February 28, 2025.

A section 29a warning notice was received on 21 March 2025.

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 rating for the Trust is Requires Improvement following the 2019 inspection during the focused assessment on falls following a cluster of harmful falls within the organisation.

Assessment

The section 29a warning notice focuses on 3 areas of concern:

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

In response to this and the letter of intent we have made some immediate changes and developed a detailed action plan focused on key points raised within the feedback.

Some immediate actions put in place were:

- Matron for the Day Model: focusing on quality and safety across ED and Medicine.
- Enhanced Audit and Oversight: increased frequency of care process audits in Temporary Escalation Spaces (TES) and embedding established patient areas into routine quality and safety audits.
- Optimised Staffing and Resources: increased Waiting Room 1 staffing, urgent review of pressure-relieving aids, and intentional rounding every two hours in TES for patients exceeding four hours.
- Fit to Sit Model Implementation: developed, implemented, and monitored via matron audits with governance oversight.
- Strengthened Leadership and Decision-Making: senior nurse leadership development, clarification of roles and structured safety huddles with key decision-makers.

- ED Risk Escalation and Governance: regular risk escalation to site meetings, Divisional Triumvirate, and Governance forums, ensuring proactive responses to safety concerns.
- Optimised Patient Flow: allocation of beds based on total time in ED, reduction of COA corridor capacity and release of private rooms for confidential discussions and examinations.
- Identified further escalation beds in alternative clinical areas, to facilitate the closure of the 3 trolley TES in the Resus corridor.

Operational and System-wide Improvements:

- Hospital-wide Flow Improvement: we have set up a group to lead improvements in discharge process across the wider hospital.
- Ambulance POD: immediate suspension, review of escalation capacity and safe reintroduction during peak pressures.
- New UEC Leadership Team: led by the Deputy Medical Director, Director of Operations and Group Associate Chief Nurse.
- System Collaboration: buddying with Sherwood Forest Hospitals to drive improvements, trusted assessor prescribing review and the development of a release-to-respond model to optimise ED flow.
- Weekly Safety Dashboard and Executive Oversight: senior director Executive team daily check-ins, weekly Executive-ED forums, and expanded ED Improvement Group with system and regional support.

Recommendations

The Boards are asked:

1. To receive the report as assurance of immediate action planning and improvements made following feedback from the inspection, and
2. To support the release of the open letter to the public (appendix 1 below)

Please note that the full inspection report will be published within the coming weeks.

Appendix 1 – Open letter for public & stakeholders

We are writing to update you on the recent Care Quality Commission (CQC) inspection at Northampton General Hospital, which took place over two days, beginning on February 18, 2025. This unannounced visit formed part of a national review into urgent and emergency care (UEC) services across England.

The inspection focused on the quality of care in our Urgent and Emergency Care and Medical Services, including care for older people. The visit coincided with a particularly challenging period, marked by increased pressure on the Emergency Department (ED), delays in patient flow, extended stays in ambulances, and the use of Temporary Escalation Spaces (TES) to safely manage demand. These challenges were further impacted by the timing of the inspection during the school half-term break.

Despite these pressures, we were heartened by the CQC’s recognition of our staff's compassion, professionalism, and teamwork, particularly in the Emergency Department. Inspectors noted the strong collaboration across our inpatient services and the unwavering commitment of colleagues delivering care in difficult circumstances.

However, the inspection also raised serious concerns regarding aspects of care within the UEC pathway and patient flow, which we take extremely seriously.

While no formal notice was issued during the inspection, on 21 March 2025, we received a Section 29A Warning Notice, identifying areas where urgent improvements are required.

Actions Taken to Date

We have moved swiftly to address the issues raised and are committed to making sustainable improvements. Key actions already implemented include:

Matron for the Day Model – A daily leadership presence focused on quality and safety across ED and Medicine.

Enhanced Audit and Oversight – More frequent audits of care processes in TES and incorporation into standard quality reviews.

Staffing and Patient Support Enhancements – Additional staff in Waiting Room 1, rapid review of pressure-relieving equipment, and two-hourly intentional rounding in TES for patients waiting over four hours.

Fit to Sit Model – Implemented with ongoing monitoring through Matron audits and governance structures.

Leadership Development – Strengthened senior nurse leadership, clarified roles and responsibilities, and introduced structured safety huddles with clinical decision-makers.

Improved Risk Escalation – Regular updates to site leadership, divisional governance teams, and executive forums to ensure swift, proactive responses.

Patient Flow Optimisation – Smarter bed allocation based on total ED time, reduced corridor use, and improved privacy for patient assessments and discussions.

System-wide and Operational Improvements – New UEC leadership team, revised ambulance POD function, weekly safety dashboards, and closer collaboration across the local health system.

Our Commitment to You

We want to assure our patients, their families, and the wider community that we are fully committed to addressing the concerns raised by the CQC and making the necessary changes to improve safety, dignity, and quality of care.

We are grateful for your ongoing support and understanding as we continue this journey of improvement. We will keep you updated as our action plan progresses, and we remain steadfast in our mission to deliver the highest standards of care to all those who rely on our services.

Hemant Nemade

UHN Medical Director

Julie Hogg

UHN Chief Nurse

Cover Sheet	
Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	9 May 2025
Agenda item	7

Title	UHN Perinatal Scorecards – Highlight Report
Presenters	Julie Hogg - UHN Chief Nurse Ilene Machiva - UHN Director of Midwifery
Author	Ilene Machiva - 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**

Group priority				
X Patient	**X Quality**	☐ Systems & Partnerships	☐ Sustainability	☐ People
Excellent patient experience shaped by the patient voice	**Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation**	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for Consideration	Previous consideration
To brief the Boards of Directors on the key discussions of the Perinatal Quality Surveillance Scorecard shared at the UHN Perinatal Safety Champions Meeting (PSC) on Wednesday 16 April 2025, at which March 2025 data was discussed. 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. Bi-monthly meetings of Board level maternity safety champions and the perinatal safety champions are established and occurring	Quality and Safety Committee (QSC), April 2025

Executive Summary

PURPOSE OF THE REPORT:
The scorecard is produced in line with the Perinatal Quality Surveillance Model designed by NHS England to support sharing safety intelligence Board to Frontline / Frontline to Board.

The scorecard includes 5 areas of focus:

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

The scorecard includes the minimum dataset as described within Maternity Incentive Scheme (MIS), in addition to local insights and operational activity. Neonatal workforce information will be included in future reports.

The Bi-monthly Perinatal Safety Champions Meeting was held on 16 April 2025. The meeting was attended by the Board Safety Champion, the NED safety champion, and the perinatal services safety champions, with clinical leads from wider teams.

SUMMARY:
Perinatal Scorecard is attached as Appendix 1 and 2 (Change in format to align with UHL/UHN approach)
Items for Escalation:

- Risk around provision of scanning pathways at NGH identified in the initial feedback received from the external reviewers, following visit on 07/04/25
- Delays in the implementation of the new (BSOTs) Triage system due to the workforce position
- Cessation of Maternity Tobacco Dependency Advisor roles impacting the provision of stop smoking services in maternity
- Badgernet system implementation. Concerns following System C only providing one hundred read only licences instead of enabling all clinicians to have access.

Moderate and above Incidents
KGH: No Patient Safety Incident Investigations (PSII) declared in March. Two cases referred to Maternity and Newborn Safety Investigations (MNSI). Both going through the MNSI triage process.
There was 1 completed MNSI investigation with no safety recommendations.
NGH: No Patient Safety Incident Investigations (PSII) have been reported in March 2025. Seven moderate incidents reported. Only one confirmed to remain as fatal following MIRF and IRG as a pre-term neonatal death with no care and service delivery issues identified. Six incidents have been reviewed and have been downgraded as there were no care omissions identified.

Governance Compliance
KGH: There were no new or closed claims in March 2025.
NGH: There were no new or closed claims in March 2025. There were four formal complaints made in March 2025.

Service User Feedback
KGH: Recent work with the Motherhood Group has been positively received and several recommendations received for continuous improvement. ‘Listen to me campaign’ launched, with a positive impact for Global Majority women accessing maternity services at KGH.
NGH: In March, 258 responses were received on Friends & Family Test, which is a response rate of 22% The overall satisfaction rate was 96.5%. Common themes continue to be lack of

communication, care and the environment. The Patient Experience midwife continues to work with teams and to provide feedback on feedback received from service users.

Workforce
Both services continue to see a reduction in vacancy rates for midwifery and MSW workforce
KGH: Good progress with reduction in midwifery vacancies with vacancy position of 3.6wte in March. 100% compliance with 1:1 care in labour. No occasions when the labour ward coordinator lost supernumerary status. Business case has been submitted to support Birth Rate Plus recommendation of 9.56 WTE uplift to the establishment. Progress is being made with the recruitment of an obstetric consultant to support roll out of Birmingham triage system (BSOTS). Further medical and midwifery workforce required to support roll out of BSOTS. Awaiting outcome of business case process.
Neonatal KGH: The current Qualified in Specialisms position is above the British Association of Perinatal Medicine (BAPM) standard. The Tier 1 and Tier 2 neonatal medical workforce is fully established with no vacancies. An additional consultant is required to meet BAPM standards.
NGH: Midwifery vacancy is 10.96 whole-time equivalents (WTE) and Maternity Support Worker is 4.65wte. Reduction plans in place regarding Agency and Bank spend. Minimal vacancies within neonates and Bank spend also being looked at 99.6% compliance with 1:1 care in labour. No occasions when the labour ward coordinator lost supernumerary status. Obstetric workforce remains consistent with 1WTE vacancy – Interview for Consultant with special interest in College Tutor role taking place on 14 April 2025.

Red Flags:
KGH: A reduction in red flags was noted in March**.** All the red flags related to delays in the induction of labour pathways
NGH: There were 66 red flags reported in March - high acuity has resulted in 45 occasions where there has been a delay or cancellation of critical activity. Induction of labour quality improvement project in progress, which will support with a reduction of red flags in relation to delays in induction of labour pathways.

Training Compliance
KGH: Obstetric emergency drills in place in clinical areas. Variable compliance with PROMPT (Practical Obstetric Multi-Professional Training) across different professional groups. Actions in progress. However further resource required in the training faculty as currently only 0.8we practise development midwife in post.
NGH: PROMPT overall compliance 96%. Concerns noted around the compliance for Obstetric Doctors for PROMPT and Speciality Day. New born life support compliance has reduced – actions and monitoring in progress

Saving Babies Lives Care Bundle
Good progress with bundle across UHN. KGH compliance is 96% and NGH 93% of the bundle following the latest Local Maternity and Neonatal System (LMNS) quality review. Both services have been set stretch targets for audits due to the good progress made for all elements of the bundle. There is a Risk in to continued compliance due to the lack of funding for the Maternity Tobacco Dependence Advisor role, which is key to the delivery of element one of the bundle.

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. Bi-monthly meetings of Board level maternity safety champions and the perinatal safety champions are established and occurring

Appendices
Appendix 1: UHN Perinatal Surveillance Dashboard (KGH – March 2025 Data) Appendix 2: UHN Perinatal Surveillance Dashboard (NGH – March 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 LMNS and all women accessing care within the LMNS.

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
NGH External scanning review completed on 07/04/25. Immediate action actions to improve safety and quality assurance given. (Report *will be shared at next QSC meeting following discussion at Perinatal Assurance Committee*)**.** Immediate actions required for the following: a. Cease Junior Doctor-led Growth Scanning b. Rapid Quality Assurance of All Current Practitioners c. Develop a Workforce and Assurance Plan d. Retrospective Case Review and Duty of Candour There are wider recommendations relating to the following: e. Digital Infrastructure and Reporting f. Workforce and Training g. Leadership and Governance h. Service Organisation and Co-location i. Protocols, Pathways, and Quality Assurance j. Clinical Practice Improvements k. . Clinic Capacity The report will be shared with an action plan against required actions at following discussion of recommendations with clinical leads and the PAC. Immediate actions already being explored by the Team with the support off the Chief Nurse and Medical Director Scanning External Review for KGH planned for 28 April 2025 **Delays in the implementation of the BSOTs Triage process at KGH due to gaps within the medical workforce provision** Maple ward in use with the designated Triage area now ready for use. Delays due to the medical workforce model required to support pathway. Business case submitted awaiting outcome. Trust signoff to recruit locums to support pathway given. Delays due to the difficulty in recruiting locums with the right level of experience to support with the pathway. **Digital: Risk due to 100 CareFlow maternity read only licences being given to maternity services as part of transition to Badgernet.** 100 people only to be given a licence which presents the following issues: 1. Limited Access to Critical Information	**KGH Maternity Support Programme (MSSP)** (see separate Report at item 7.1) Maternity Improvement Advisor (MIA) bi-monthly report (appendix 3). Site visits, one to one meetings and attendance to some organisational meetings informed the report. Stakeholder event to discuss draft 'Diagnostic report' planned for the **19 May 2025**. Two areas of escalation were identified by the MIAs during reporting period and were clarified and resolved with the support of the Chief Nurse and the Medical Director: • Seconded Midwifery senior leadership roles and specialist midwives' roles. Concerns around the roles that were coming to an end on 31st March 2025 and delays in outcomes of the business case process. This related to the Intrapartum matron role, and the lead Professional Midwifery Advocate (PMA) Role and the communication around next steps for the midwives occupying the roles. The intrapartum matron role is out to advert for a substantive post, and the lead PMA role has been extended for six months. The specialist midwives roles backfilling for the leadership roles have also been extended for six months. • Removal of second Senior House Doctor from April 2025. Short term mitigation agreed signed off by Medical Director to cover with locums while the service goes out to advert for Trust Grade post to support the Team. **Digital** NGH Maternity Nervecentre launch 21 May 2025 UHN Badgernet launch planned for the 7 of July 2025 for KGH and 3 December 2025 for NGH **KGH LNU redesignation** Review meeting planned for 30 April 2025, to assess the readiness of the service to move back to full level two status. Positive feedback has been received from key stakeholders at the bi-weekly oversight meetings.

Patient care delays: Medical staff or midwives, or support staff may not be able to access vital patient data in real-time, leading to delays care, documentation completion etc. This can then lead to inefficient decision making, if the team don't have all the information available. 2. Workflow Bottlenecks People will share logins or will have to wait for someone else to access a patient's record to supply them the information they need. This could slow down the care for a patient 3. Increased Risk of Non-compliance Audit trails compromised: Challenges due to the risk of staff sharing logins to support timely care because of the limited availability of licences The ideal approach will be for all clinical staff to have read only access to support service delivery. Clinical Chief Information Officer (CCIO), currently negotiating with System C to see if the Trust preferred approach will be supported. **Cessation of Maternity Tobacco Dependency Advisor roles impacting the provision of stop smoking services in maternity.** The impact will be: • Failure to meet the requirements of the Saving Babies Care Bundle around some free pregnancy • Failure to achieve MIS year 7 due to non-compliance with safety action 6 which relates to the Saving Babies Lives Care Bundle • The improvement of smoking at time delivery rates (SATOD), will be reduced • Long term impact on population health due to this lost opportunity to support families to stop smoking as part of their pregnancy care **NGH has no Obstetric clinical director, which in turn means no Obstetric Maternity Safety Champion** • Impact on obstetric leadership in the service and the functioning of the Quadrumvirate which is key to the delivery of the perinatal safety improvement plan • Impact on meeting national drivers such as MIS safety action 4, and obstetric leadership roles in line with Ockenden	
Positive assurance to Provide	**Decisions Made**
KGH CQC Actions Update	None

Good progress made against the action plan. Latest Delivery Status as of 10 April 2025: • 7 ‘Must Do actions’ have been completed and finally approved • 1 ‘Should Do’ recommendation has been completed and finally approved • A further three ‘Must Do actions’ have been completed, with evidence awaiting final approval through the CQC MAC process • All the remaining actions are in progress with good progress being made towards completion In summary, 70% of the ‘must do and should do’ actions now have been completed with evidence reviewed. Weekly meetings continue to support traction against remaining actions.	

NHS
University Hospitals of Northamptonshire
NHS Group

KGH Perinatal Quality Assurance Scorecard

April 2025

Dedicated to excellence

March 2025 Dataset

CONTENTS

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.

MARCH 2025 AT A GLANCE

AVERAGES PER DAY

BOOKINGS	BIRTHS
10	8

BABIES BORN

225

PREV. 12 MONTH AV. 250

BIRTH LOCATION

HOME	KGH
5	220

3RD & 4TH DEGREE TEARS

0.4%

February - 0.4% ▼

3.1%

BLOOD LOSS >1,500MLS

February - 2.2% ▲

110 GIRLS / 115 BOYS

PREV. 12 MONTH AVERAGE
390 GIRLS, 421 BOYS

%

February % ▲

FULL TERM BABIES ADMITTED TO NNU

INDUCTION OF LABOUR (IOL)

28.8%

PREV. 12 MONTHS – 30.4%

118 CAESAREAN SECTIONS

	MARCH	PREV 12 MTH. AV.
ELECTIVE	52 (23.1%)	55 (22.1%)
EMERGENCY	66 (29.3%)	69 (27.7%)

SETS OF TWINS

1

SETS OF TRIPLETS

0

ASSISTED BIRTHS

18

VENTOUSE	FORCEPS
8	10

PREV. 12 MONTH AV.

VENTOUSE	FORCEPS
35	61

BREASTFEEDING INITIATION

%

PREV. 12 MONTHS – % ▼

PERINATAL QUALITY SCORECARD SUMMARY

Overview

In March, there were 225 babies born across the service, which was below the monthly average. Activity remained green throughout the month however there continued to be a number of delayed ARMs, however notably reduced in month when compared to previous months. All red flags were relating to induction of labour. There were no escalations to community in March.

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

Staffing gaps were primarily caused by sickness, unexpected absences and challenges around the separation of the ward areas due to ongoing RAAC work.

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

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

Quality & Safety

0 (zero) Patient Safety Incident Investigations (PSII) have been reported. 2 cases were referred to MNSI, I likely to be rejected as MRI normal, 1 awaiting response,.
1 draft report due to be received in April.

Total of 98 incidents reported in March 2025 this is across all maternity areas with 1 severe incident and 1 moderate incident. 1 after action review was also declared in March around medication incident.

There was 1 completed MNSI investigation with no safety recommendations but some safety prompts.

There were 3 perinatal losses reported in March 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 carry out unannounced obstetric emergency simulations to refine maternity teams existing expertise and skill. We remain in a good position for fetal monitoring training with further improvements required to meet MIS standards on MDT training. Actions in place to monitor compliance for Year 7.

Experience

A number of improvements are in progress across maternity following service user feedback. Recent work with the motherhood group has been positively received and several recommendations received for continuous improvement for Global Majority women accessing maternity services at KGH. Following a soft launch of the Listen to Me Campaign we have seen a reduction in the number of women reported they were not listened to and as a result has become positive feedback. An improvement has also been noted on care overnight which has been a complaint theme in previous months. Work still required to improve staff attitude, behaviours and communication with women. Due to the environment challenges at KGH we have been unable to support all women having partners staying overnight but will progress implementation following the move back to Rockingham Wing.

Workforce

Progress is being made with the recruitment of 1 wte obstetric consultant to support roll out of BSOTS. Further recruitment required for BSOTS roll out.. The current QIS position is above BAPM standard . 5 Band 5 Nurses due to commence in April, 1 NA awaiting PIN and 2 more undertaking training. Further recruitment in place to fill remaining vacancy gaps. The Tier 1 and Tier 2 neonatal medical workforce is fully established with no vacancies. An additional consultant is required to meet BAPM standards. A continued reduction in midwifery vacancies can be seen with Midwifery vacancies remaining vacancy rate is around 3 WTE. Business case has been submitted to support BR+ recommendation of 9.56 WTE uplift to the establishment.

WORKFORCE (MATERNITY)

What is the data telling us?

- Our vacancy rate has significantly dropped during the last 12 months however it remains static whilst the additional recruits are reflected in the PWR data.
- To date we have around 3WTE vacancy rate.
- In order to meet the CQC and BR+ recommendations a further uplift of our establishment by 9.56WTE is required

What is going well?

- We have recruited 1WTE obstetrician to support medical staffing within Obs & Gynae
- X6 of our Band 5 midwives completed their preceptorship and have transitioned to Band 6 roles.
- The number of staff requiring supernumerary shifts has reduced and thus supporting the reduction in bank staff
- We have supported on return to practice midwife and proud to announce she received her PIN this week
- X1 leaver in March

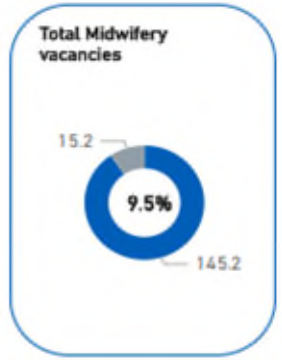
What do we need to focus on?

- Planning for the new Triage service is at point of deployment however we await the decision from the Board as to whether we are granted the 9.56WTE uplift to support the service
- We are working hard to reduce our temporary workforce spend where we can safely support the service.
- Supporting clinical and non-clinical roles that have a positive impact on patient safety within the service
- Recruitment of medical workforce to support roll out of BSOTs

Maternity Workforce Programme - Midwifery workforce

Midwifery headline figures	Establishment	Midwives SIP	Midwife Vacancy FTE	Vacancy rate
Registered Midwives in trust (WTE/KPI tab)	157.8	150.5	7.3	4.6%
Midwives in maternity services (Maternity tab)	160.4	145.2	15.2	9.5%
	BR+ demand	Establishment gap	Vacancy gap	
Midwifery demand (BR+vs.funded establishment)	150.6	9.8	-5.4	

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



AREA	INDICATOR	MEASURE/COMMENT	DATA SOURCE	INDICATOR SOURCE	GREEN	RED	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
																		2025		
WORKFORCE	Weekly hours of consultant cover on labour ward	Hours/week	Intrapartum scorecard	National - Safer Childbirth 2007 Minimum 80 Hours	>80		66	66	66	66	66	66	66	66	66	66	66	66	66	66

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

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?

- **Nursing gaps at Band 7, Band 6 and Band 5.**
- **Medical staffing Non – compliant at Tier 3 (Consultant Level).**

What is going well?

- Currently 83.6% QIS compliant against BAPM 70% recommended standard.
- 5 new Band 5s successfully recruited and starting in April 2025.
- 2 Neonatal Consultants appointed and commencing in April 2025.
- Business case for 7th Neonatal Consultant submitted to be compliant with BAPM standards.

What do we need to focus on?

- **Putting the 0.3WTE Band 7 and Band 6 posts out to advert once the temporary job freeze at the trust has been lifted.**

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 to go out to advert in April 2025.
Band 6	19.78	13.21	6.57	
Band 5	14.63	8.68	5.95	5 x Band 5s starting in April 2025.
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	11.96	

Medical Workforce

Current position:

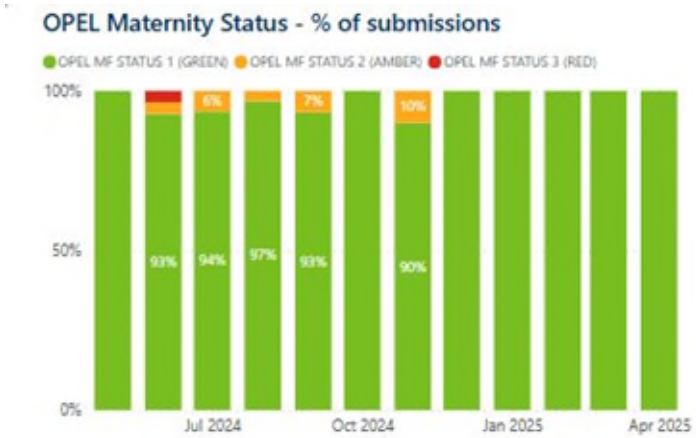
- Tier 1 Compliant – 14WTE. No vacancies.
- Tier 2 Compliant – 14WTE in post. No vacancies.
- Tier 3 Non-compliant – Separated rota from Paediatrics, currently 4WTE Substantive Neonatal Consultants and 1 Locum Consultant.
- Compliant in having Neonatal Consultant designated lead as per BAPM.

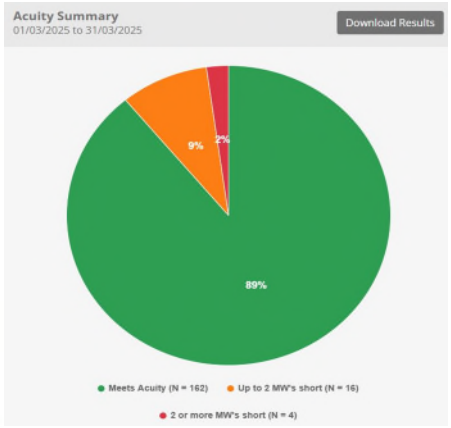
Current Neonatal Consultant Recruitment Plan:

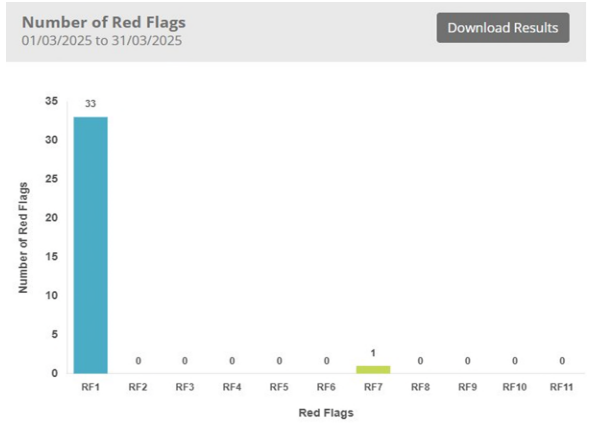
- Post 1 – Substantive Consultant appointed and commencing 7th April 2025.
- Post 2 - Locum Consultant appointed and will start in post on 28th April 2025.
- Business case for 7th Consultant submitted in order to be fully compliant with BAPM recommendations.
- Will continue long line bank staffing to support the rota gaps. We have colleagues who have committed to remain with us for the interim period.

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







Maternity Red Flags – LW

Mar 25 - 34
Feb 25 - 69
Jan 25 - 100

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

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

Supernumerary status of DSC - 24/25	September	October	November	December	January	February	March
No of occasions DSC was NOT supernumerary	5	1	8	3	6	0	0

What is the data telling us?

- Red flags – Delayed or cancelled time critical activity – Delays in ARM and one episode when starting induction of labour (IOL) process was delayed.
- ALL red flags related to IOL

What do we need to focus on?

- Implementation of BSOTs pending – Target May 2025 – will directly impact LW acuity.
- Commence IOL QI project in conjunction with NGH. Working party initial meeting to be scheduled with key stakeholders. To liaise with audit midwife to provide current data for IOL at KGH to aid this project.

What is going well?

- Move back to Rockingham wing – Maple Maternity – 29 bedded AN/PN ward
- No escalation to community in March 25

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)
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										
Q2 2024	JUNE	3	4	4	1	1	1/100%	1/100%	0	2(1CI)	2(2<22/40)	1
	MAY	1										
	APRIL	0										

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

What is the data telling us?

- 1 severe harm incident
- 1 Moderate harm incident
- 1 case of baby born in poor condition transferred out for cooling but sadly died

What is going well?

- Prompt escalation of incidents
- After action reviews positively evaluated by staff who attend
- Positive feedback from MNSI around timely escalation of cases

What do we need to focus on?

- Cluster review of cooled babies
- Finalise and share PSII with family
- Timely review and dissemination of safety actions from MNSI case

PSII
PPH in June 2024
MNSI's
Baby transferred for cooling Baby born in poor condition transferred for cooling
AAR's
Baby born in poor condition Pre-term delivery and neonatal transfer out Stillbirth

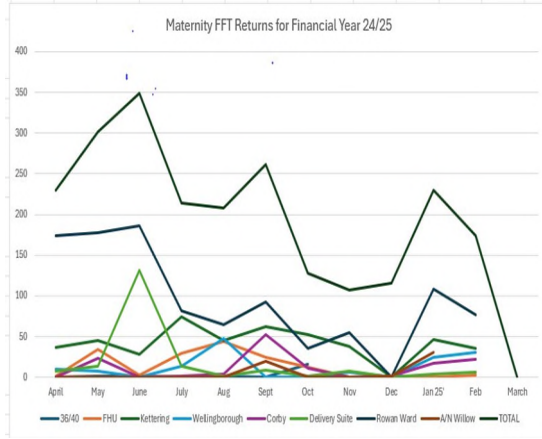
Where do we want to be?

Reduction in number of cooled babies / timely review of incidents at Round Table /

MATERNITY AND NEONATAL EXPERIENCE

Complaints & Concerns	Nov-24	Dec-24	Jan-25	2024/25 YTD
Maternity Complaints	0	0	2	17
Maternity Pals	5	4	3	44

Family & Friends Test (FFT)	UHN Target	National	Nov-24	Dec-24	Jan-25	2024-25 YTD
Maternity Friends & Family % of Responses	**20%**	**13%**	**102**	**116**	**230**	**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

What is the data telling us?

Feedback throughout March includes the following:

- Improve Communication
- Estates Environment
- Partners not being able to stay overnight
- Wait for analgesia
- Staff attitudes and behaviours

What is going well?

Women are reporting an improvement in feeling listened to. Additional feedback includes:

- Care & professionalism
- Food & snack provision
- Considerate at night and questions answered

What do we need to focus on?

- Staff attitude and behavior
- Breast feeding support out of hours and weekends
- Lack of communication
- Length of time taken to administer analgesia on post-natal ward
- Work with patient experience team to get FFT percentages

Breast feeding support team have been very supportive. Midwives in charge have been amazing. Auxiliary staff very helpful with small and big stuff. Thank you Kadi, Sabrina, Yoli, Abbie and Marion.

FFT STM - 2025

I have always felt like my needs are being listened to. I have always felt supported and that it is easy to be open and discuss any concerns.

FFT 2025' Kettering Community Team

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

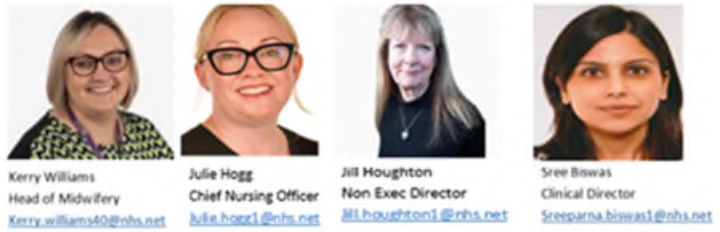
MATERNITY AND NEONATAL FEEDBACK (STAFF)

What is going well?

- Staff remain satisfied with their area of work following the preferences work undertaken in 2023
- HoM continues to have open door policy which is fed back positively by staff
- Continued work within midwifery leadership team and external company to support with Labour Ward coordinator framework and senior leadership development
- Positive feedback from resident Dr & student midwives at KGH
- Continue to have regular staff social events organised by PMA team

What do we need to focus on?

- Continue work with Acorn leadership
- Improve staff survey results for 2025
- Improve communications with the teams to ensure they are fully engaged
- Seek additional support from OD/Occupational health to support with staff welfare



Date of Walkaround : 14th March 2025

SC Name: Jill Houghton

Location: KGH Maternity Rockingham Wing

No. of Staff : Midwives, MSWs, medics

Staff Feedback	Plan
Anxieties around changes within the unit	Inpatient matron held listening event in April to understand staff concerns and support with improvements
Fragile Morale amongst workforce	Scope support from occupational health / OD
Concerns around change in bank process	Multiple listening events held with staff to support use of new Loop system in line with the rest of UHN

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?

April 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%**

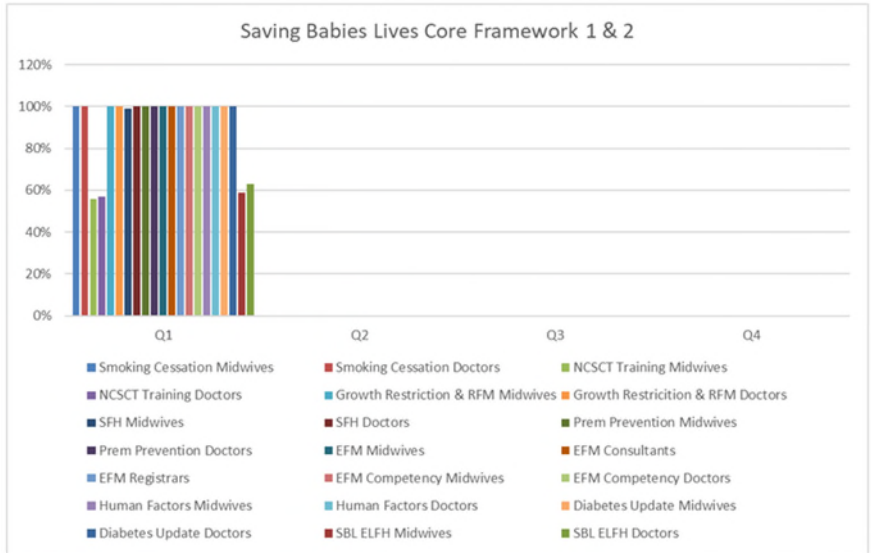
Obs Doctors **97%**

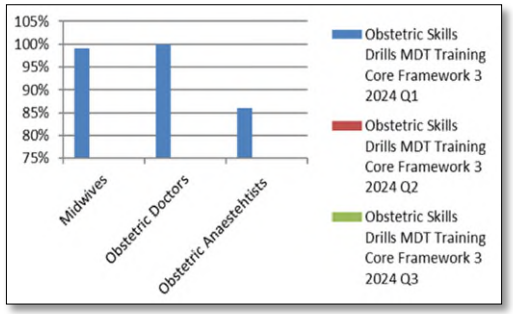
What is going well?

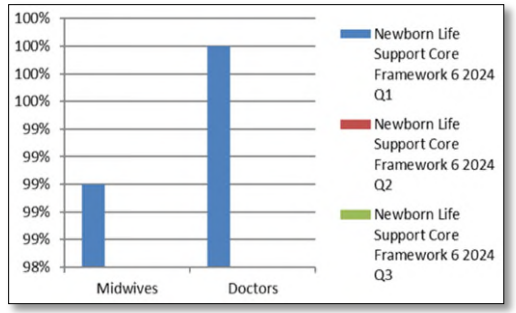
- Protected training continues monthly for staff
- This includes:
- Band 2-4
- Midwives 5-8
- Obstetric Doctors all grades
- Anaesthetists
- Overall training compliance is above the targeted 95% in all areas
- Good engagement with MDT facilitators
- Good engagement from the MNVP in training to get patients 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.

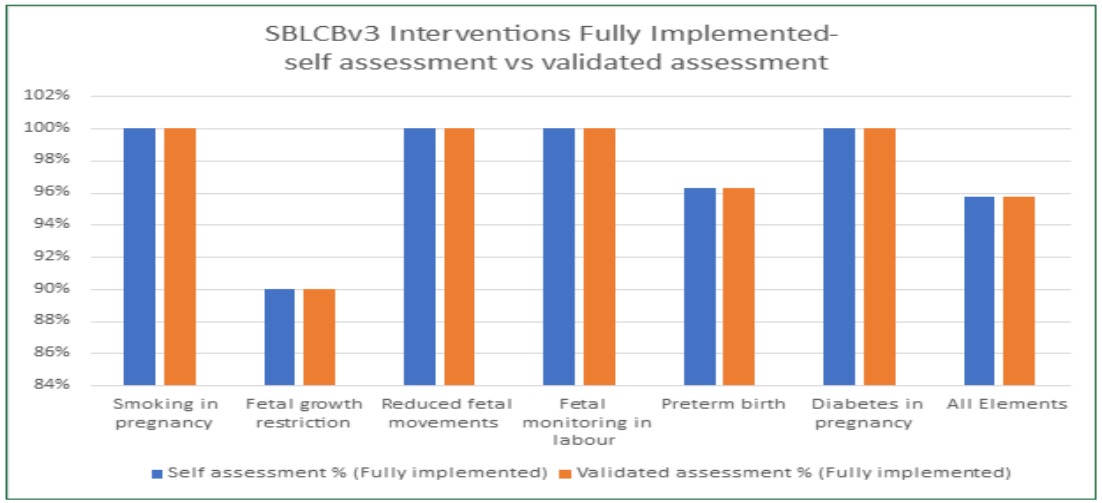
•**Safety Action 8:** Training compliance for obstetric and anaesthetic medical staff did not meet the 90% minimum standard during the reporting period.

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- Fully implemented- Stretch ambition changed for 1.1, 1.3.1.4 and 1.7
Action plan required to achieve 60% of CO verified non-smokers at 4 weeks.
Concern regarding the lack of funding for our MDTA's and the impact this will have on our in-house service. Originally funded for 3 MDTA's this will go down to 1 from April 2025.

Element 2- Partially implemented- previously fully. This is due to a change of audit data required. If data can be reviewed by 10.3.25 may be able to go to fully compliant.
Stretch ambition changed for 2.1, 2.2, 2.4 and 2.10.

Element 3- Fully implemented. Stretch ambition changed on 3.2

Element 4 – Now fully implemented- previously partially. The implementation of Fresh eyes on the hour appears to have sustained the compliance 90% for hourly fresh eyes. Stretch ambition changed on 4.1 and action plan needed to reach 95% on 4.2

Element 5- Remains partially implemented. This is due to being unable to obtain the data of the <34 weeks preterm labour being assessed using the appropriate tools. It is hoped with the introduction of maternity Triage this will be able to be captured. Neonatal team to identify on their Perinatal Exception report those baby's who are extremely premature are seen by Paediatrician prior to delivery if possible.

Element 6- Fully implemented. Stretch ambitions changed 6.2 and 6.4. Discussion regarding the face to face appointment for the diabetics.- currently on risk register.

Q4 data to be reviewed June 2025.

HOT TOPIC –

Successful Re-Launch of Peri-Prem

Facilitated by Vicky Bishop, Kelly Wagstaff Katie Longdon, Gemma Claypole, Sindhu Sajan & Joel Dsouza

Absolutely fantastic! Insightful, knowledgeable and impactful. Loved how interactive it was using different examples. Thank you!!

With additional funding sourced from the LMNS we worked collaboratively with Obstetrics & Neonates to host PeriPrem study days.
These days concentrated on Patients stories and feedback, the introduction of perinatal optimisation, background of PeriPrem, the PeriPrem passport, the patients journey from pregnancy to the postnatal period and how to optimise and give premature babies the best possible start to life

Informative day, really liked the patient story at the beginning found it very thought provoking. Enjoyed scenarios and relating to practice

Excellent session, very informative. Feel more confident

Very informative and enjoyable day, productive to learn alongside midwifery colleagues, taking time to learn from each other and share experiences

It was a really enjoyable and fantastic study day, I have learned so much. It's nice to have time to discuss the situations with colleagues and have real feedback from the ladies thank you

Well done, great day to get together with other colleagues who want to provide the best care for these women, families and babies

Excellent training

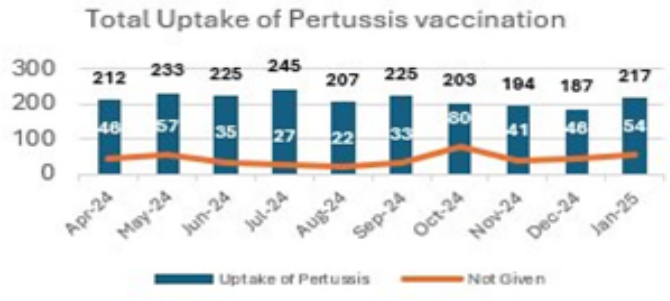
Amazing day, very informative. Thank you.

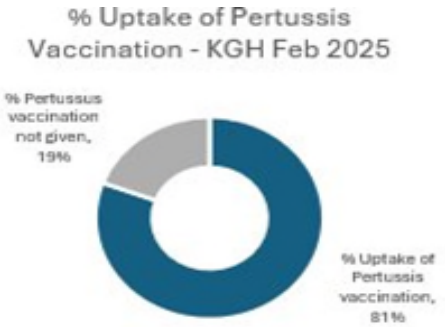
A great day of MDT learning. Enthusiastically presented with group exercises to support learning. The raffle added a competitive element to the day which was fun.

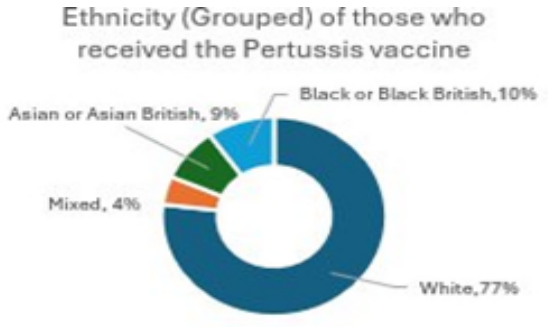
Absolutely amazing helpful beneficial day !! Was great

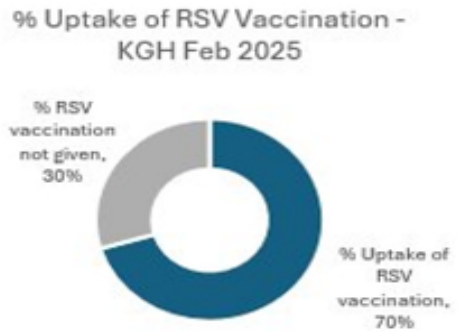
The prem leaflets are a fantastic resourec, xan we update a board in delivery suite so they are visible to staff

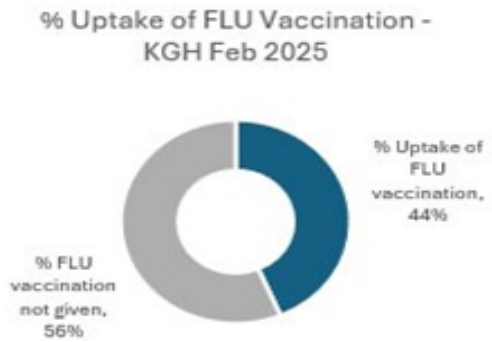
IMMUNISATION SUMMARY: Antenatal Pertussis, RSV, Flu & Neonatal BCG (FEB 25 data)

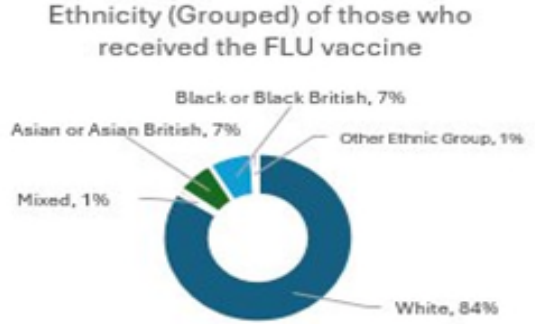




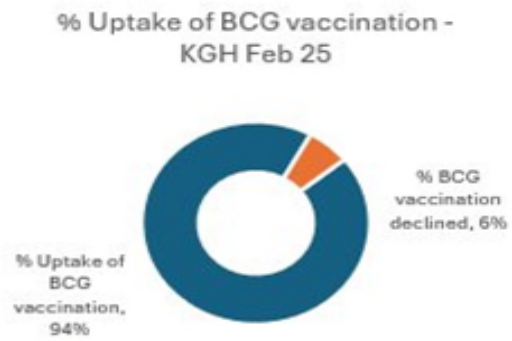


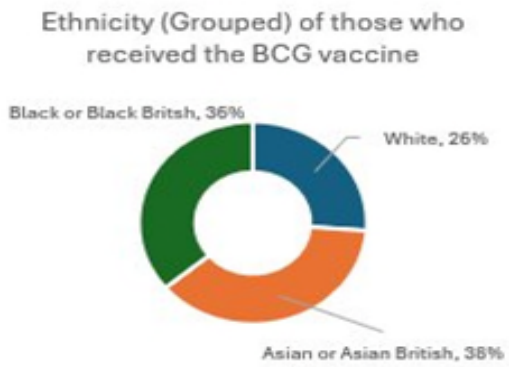






***Proportion of women offered FLU & RSV vaccination who were vaccinated by the Trust's maternity service in the reporting period in comparison to the number of 1st FASP scans carried out**





NHS
University Hospitals of Northamptonshire
NHS Group

NGH Perinatal Quality Assurance Scorecard

April 2025

March 2025 Dataset

Dedicated to excellence

CONTENTS

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.

MARCH 2025 AT A GLANCE

AVERAGES PER DAY

BOOKINGS	BIRTHS
12	11

BABIES BORN

346

PREV. 12 MONTH AV. 316

BIRTH LOCATION

NGH (Labour Ward)

324

BIRTH CENTRE	HOME
3	8

3RD & 4TH DEGREE TEARS

2.9%

February - 4.3% ▲

3.2%

BLOOD LOSS >1,500MLS

February - 2.1% ▼

174 GIRLS / 172 BOYS

PREV. 12 MONTH AVERAGE
146 GIRLS, 170 BOYS

4.3%

FEBRUARY 4.1% ▼

FULL TERM BABIES ADMITTED TO NNU

INDUCTION OF LABOUR (IOL)

25.7%

PREV. 12 MONTHS – 23.6%

168 CAESAREAN SECTIONS

	MARCH	PREV 12 MTH. AV.
ELECTIVE	78 (22.8%)	67 (21.4%)
EMERGENCY	90 (26.3%)	91 (29.0%)

SETS OF TWINS

3

SETS OF TRIPLETS

0

ASSISTED BIRTHS

35

VENTOUSE	FORCEPS
19	21

PREV. 12 MONTH AV.

VENTOUSE	FORCEPS
12	23

BREASTFEEDING INITIATION

83%

PREV. 12 MONTHS – 87.8% ▼

MARCH 2025 AT A GLANCE

96%
MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)
February - 97%

YEAR 6 MATERNITY INCENTIVE SCHEME
9 SAFETY ACTIONS

0
MNSI REPORTABLE CASES & REFERRED
February - 3

96.5%
February 97.2%

MATERNITY FRIENDS & FAMILY TEST (RESPONSE RATE)

VACANCY RATE (Feb Data)

MIDWIVES (January – 7.84%)	6.12%
CONSULTANT OBSTETRICIAN	1.0 WTE
NEONATAL NURSES	1.11%
NEONATOLOGISTS	0 WTE

1 MODERATE INCIDENTS
February - 7

XX.X
February XX.X%

MATERNITY FRIENDS & FAMILY TEST (PROMOTER RATE)

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)
96%
February – 97.5%

0 PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)
February – 1

0 CORONER'S REGULATION 28
February – X

MINIMUM SAFE STAFFING MET (MATERNITY YTD)
XX%
February – xx%

1:1 CARE IN LABOUR **99.6%**
February – 100%

PERINATAL QUALITY SCORECARD SUMMARY

Overview

In March, there were 346 babies born across the service, which was above the monthly average. There were 66 red flags reported in March - high acuity has resulted in 45 occasions where there has been a delay or cancellation of critical activity. Staffing met acuity 87% of the time in March. There was a shortage of up to two midwives for 12% of the time.

Training – escalation in place regarding reduced compliance for Obstetric Doctors on both PROMPT and Speciality Day

Quality & Safety

0 (zero) Patient Safety Incident Investigations (PSII) have been reported. 7 moderate incidents reported but 1 confirmed to remain as fatal following MIRF and IRG. 6 incidents have been reviewed and have been downgraded as there were no care omissions identified.

Training

- PROMPT overall compliance: 96%
- Newborn life support (NBLS/NLS) overall compliance: 90%
- Fetal Monitoring overall compliance: 96%
- Safeguarding Adults Level 3: 85%
- Safeguarding Children's Level 3: 91.5%
- Escalated compliance for Obstetric Doctors for PROMPT and Speciality Day
- NBLS compliance has reduced – actions in place

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 are 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 March we had 258 responses on Friends & Family, which is a response rate of 22% Overall satisfaction rate of 96.5%. Common themes continue to be lack of communication, care and the environment.

Workforce

Month on month reduction in vacancy across Midwives and MSWs, however due to financial controls recruitment pipelines are now under review and a recruitment pause currently in place with Exec sign off for clinical roles in place. Reduction plans in place regarding Agency and Bank spend. Minimal vacancies within neonates and Bank spend also being looked at.

Obstetric workforce remains consistent with 1WTE vacancy – Consultant with special interest in College Tutor role appointed in April 2025. DoM recruitment in progress.

WORKFORCE (MATERNITY)

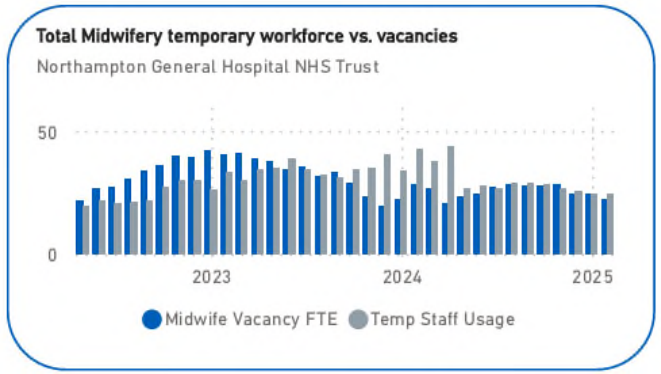
	DEC 2024		JAN 2025		FEB 2025	
	Midwife	**MSW**	**Midwife**	**MSW**	**Midwife**	**MSW**
Funded Establishment*	202.07 WTE		202.07 WTE		202.07 WTE	
Funded Establishment	195.35 WTE	68.74 WTE	195.35 WTE	68.74 WTE	195.35 WTE	68.74 WTE
Vacancy WTE	17.38 WTE	3.84 WTE	15.32 WTE	1.45 WTE	11.95 WTE	3.28 WTE
Vacancy Rate	8.90%	5.59%	7.84%	2.11%	6.12 %	4.84%
LTS WTE	9.27 WTE	2.73 WTE	8.3 WTE	1.9 WTE	3.93 WTE	3.56 WTE
Maternity Leave WTE	10.77 WTE	4.23 WTE	11.8 WTE	3.6 WTE	11.2 WTE	3.6 WTE
Felt Vacancy Rate	**19.16%**	**15.71%**	**18.13%**	**10.11%**	**13.86%**	**15.19%**

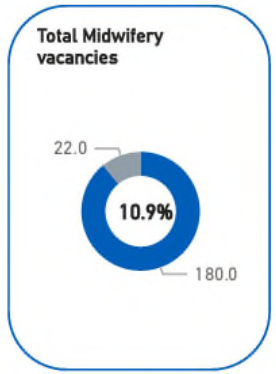
* Number includes 6.72 WTE Registered General Nurses

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	180.0	22.0	10.9%
Midwives in maternity services (Maternity tab)	202.1	180.0	22.0	10.9%
	BR+ demand	Establishment gap	Vacancy gap	
Midwifery demand (BR+vs.funded establishment)	197.4	4.6	-17.4	





What is the data telling us?

- Month on month reduction in vacancy across Midwives and MSWs

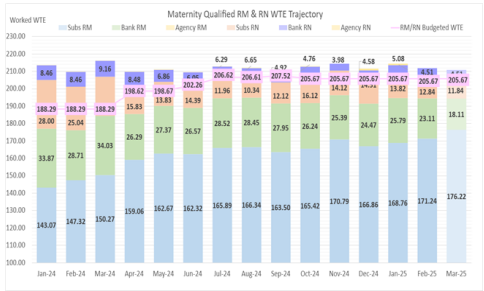
What is going well?

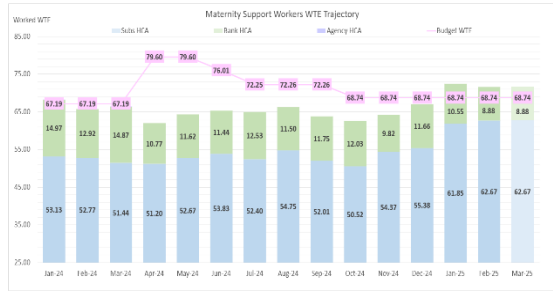
- **OBSTETRIC STAFFING UPDATE:** 10.8 WTE currently in position (10.8 WTE Substantive Consultants + 2.2 WTE Locum Consultant)
- 8.8 WTE Consultant able to undertake full clinical duties
- 1x Vacancy currently with Special Interest in College Tutor role- interview 14.04.25

What do we need to focus on?

- Due to financial constraints recruitment pipelines under review
- Agency and Bank spend – reduction plans in place

Workforce Trajectories





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)

	DEC 2024		JAN 2025		FEB 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	0.22 WTE	0.05 WTE	0.53 WTE	0.05 WTE
Vacancy Rate	0.46%	0.6%	0.46%	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	4.03 WTE	0.00 WTE	3.03 WTE	0.00 WTE
Felt Vacancy Rate	10.67%	0.6 %	10.67%	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 at January 16th 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 rota 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

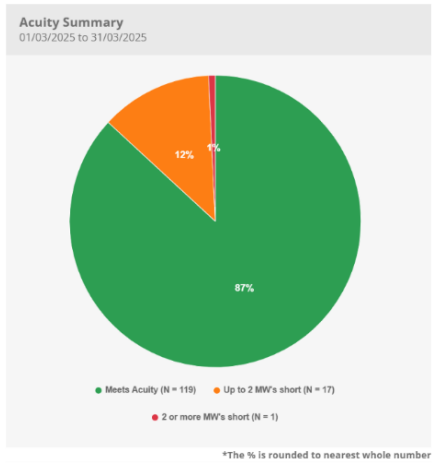
Where do we want to be?

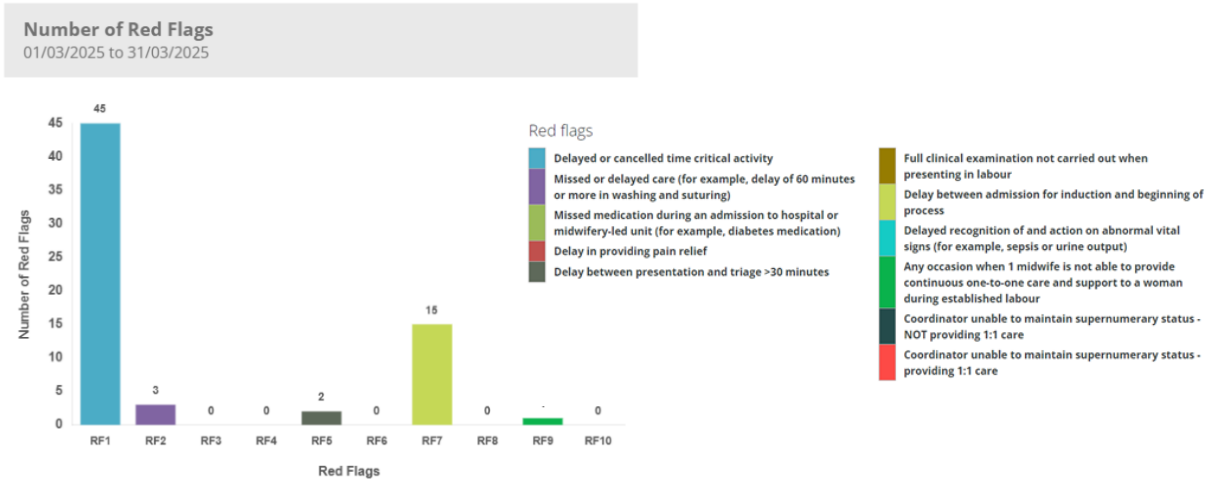
Staffing levels and QIS trained nurse levels for the unit to be compliant with BAPM standards /

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
January 2025 - 64
February 2025– 59
March 2025 – 66





One-to-One Care in Labour	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
% of women receiving 1:1 care in labour	100%	100%	100%	100%	100%	99.6%

Supernumerary Status of LWC	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
No of occasions LWC was NOT Supernumerary	0	2	0	0	0	0

What is the data telling us?

- High acuity has resulted in 45 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 March sits at 73.66%, whilst this reflects a high confidence in the data, the team are working towards a minimum of 85%

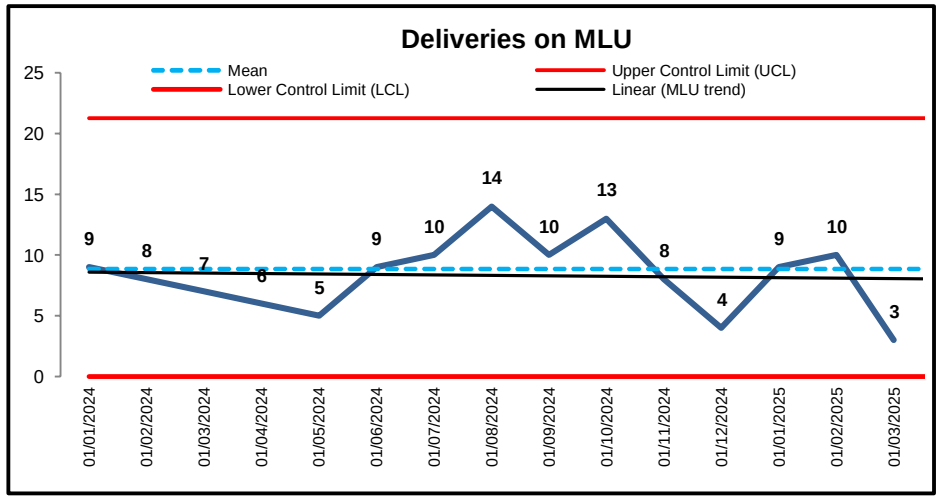
What is going well?

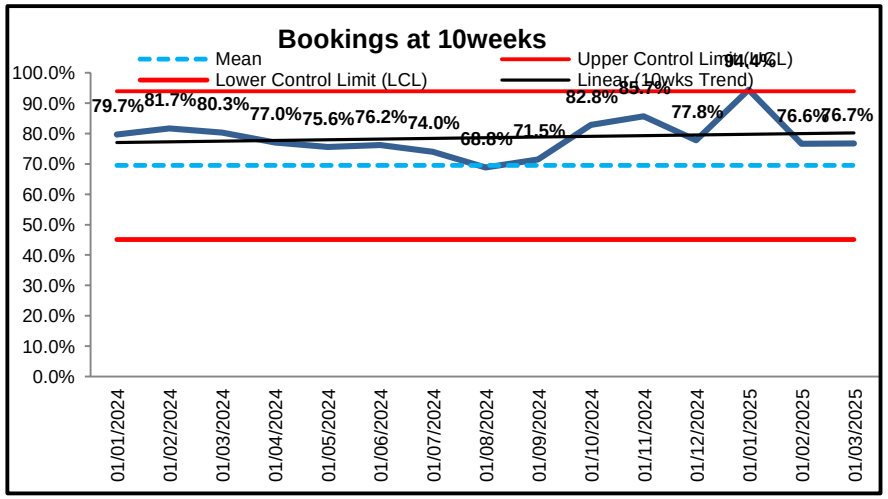
- Labour ward staffing met acuity 87% of the time in March. There was a shortage of up to two midwives for the acuity of women on the labour ward, for 12% of the time.

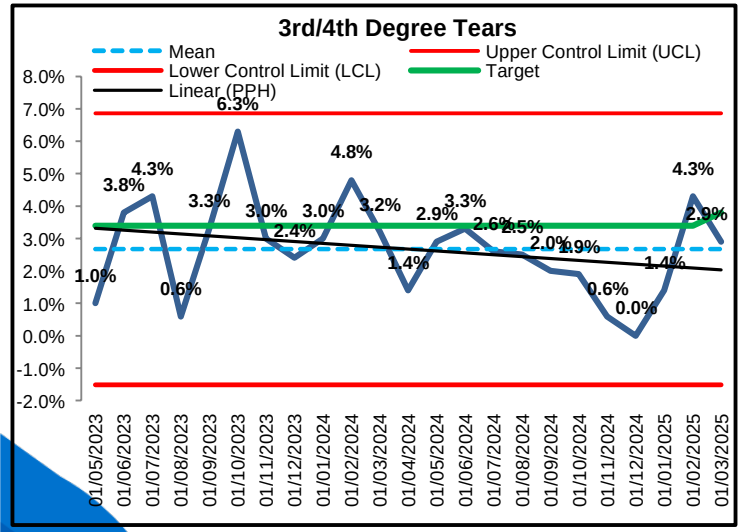
Where do we want to be?

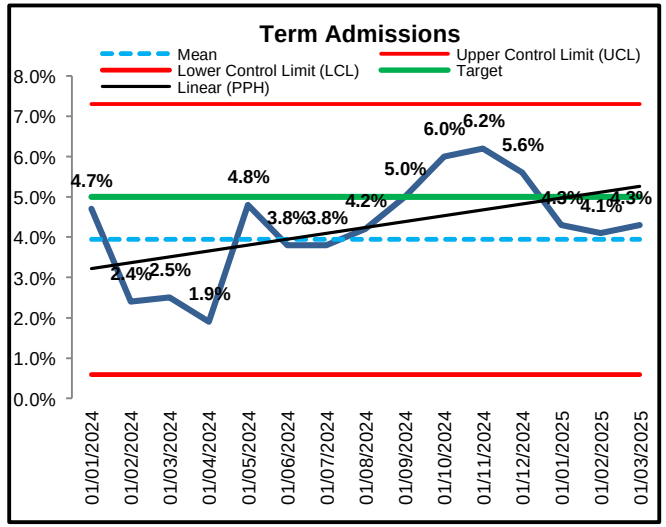
Meet or Exceed 85% BirthRate Plus Compliance / Maintain safe staffing levels / Maintain 1:1 care in labour / Maintain Supernumerary Status of Labour Ward Co-Ordinator / Consistent reporting within the Birthrate plus acuity tool across the service / Reduce reliance on Bank

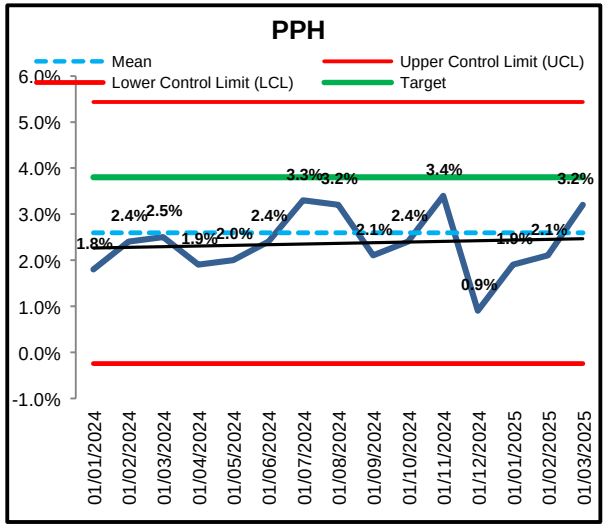
SAFETY: CLINICAL QUALITY SURVEILLANCE METRICS











Summary

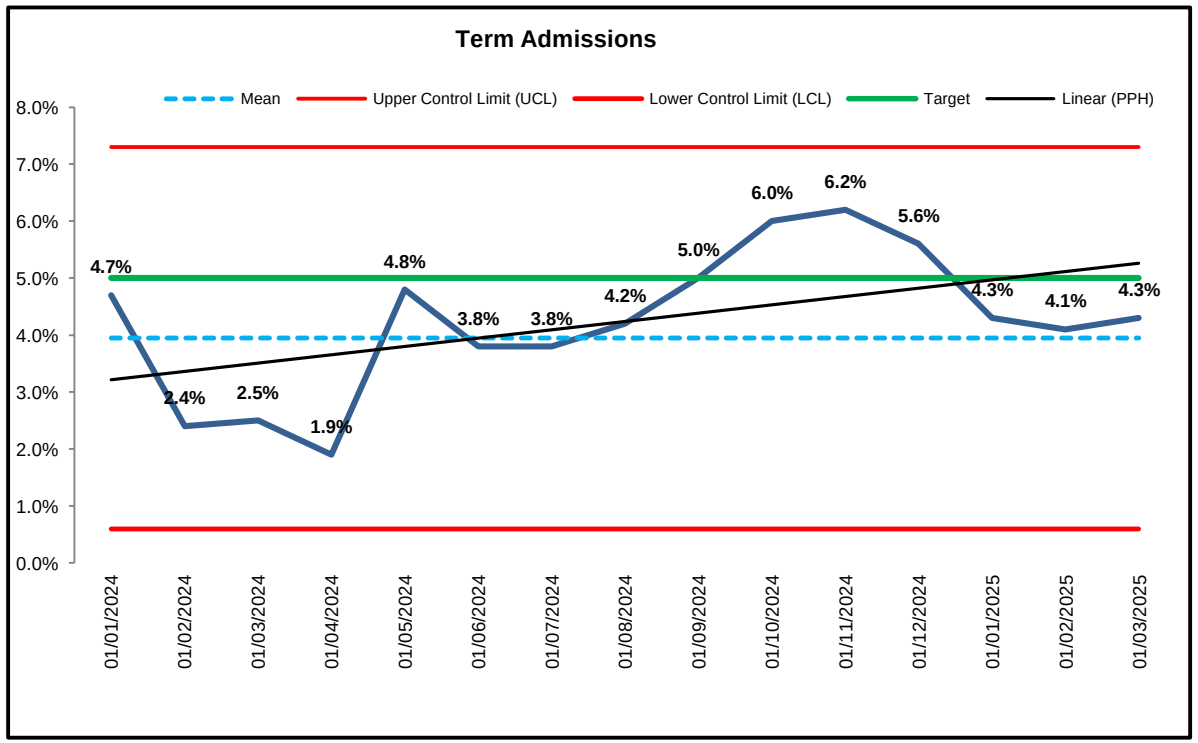
All CQiM Metrics remain within standard cause variation

The percentage of women 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. NGH participating in the Obs UK study on the management of major obstetric hemorrhages

SAFETY: CLINICAL QUALITY SURVEILLANCE METRICS

Area of Focus: ATAIN



What is the data telling us?

The most recent data reflects a 3.4% admission rate into Neonatal Unit and remains within the expected range

The last 3 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

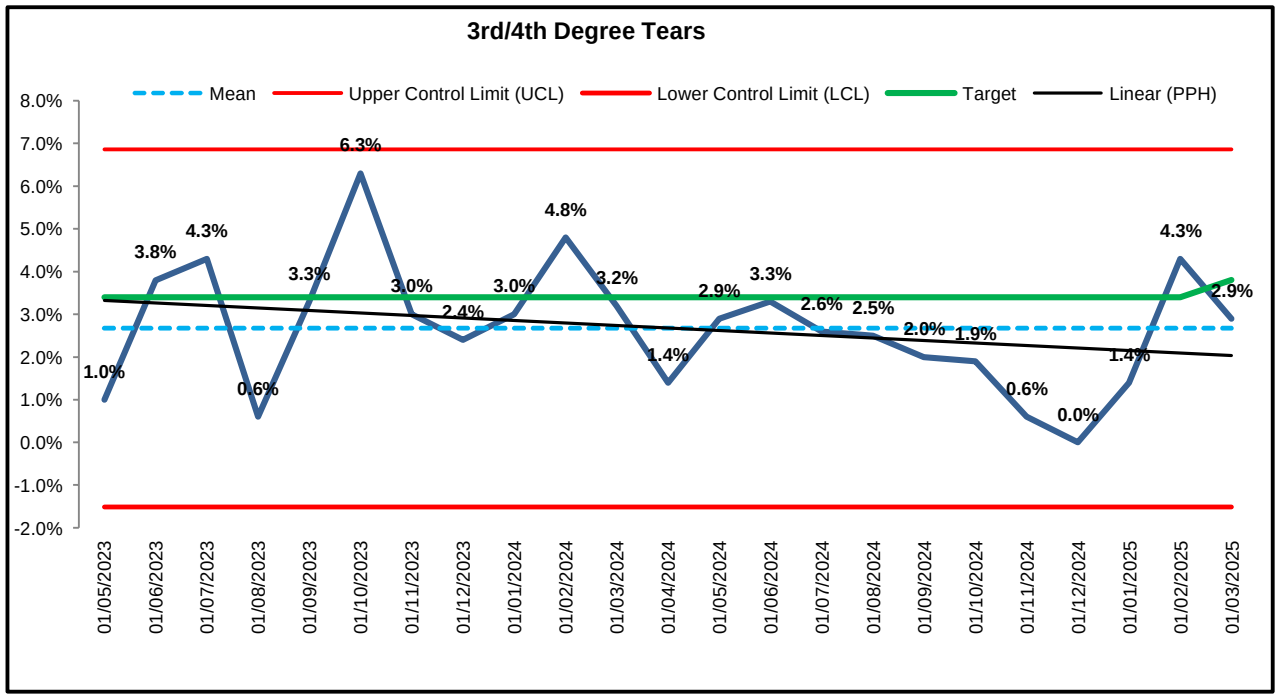
What do we need to focus on?

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 (2.9%) from the previous month (4.3%). 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?

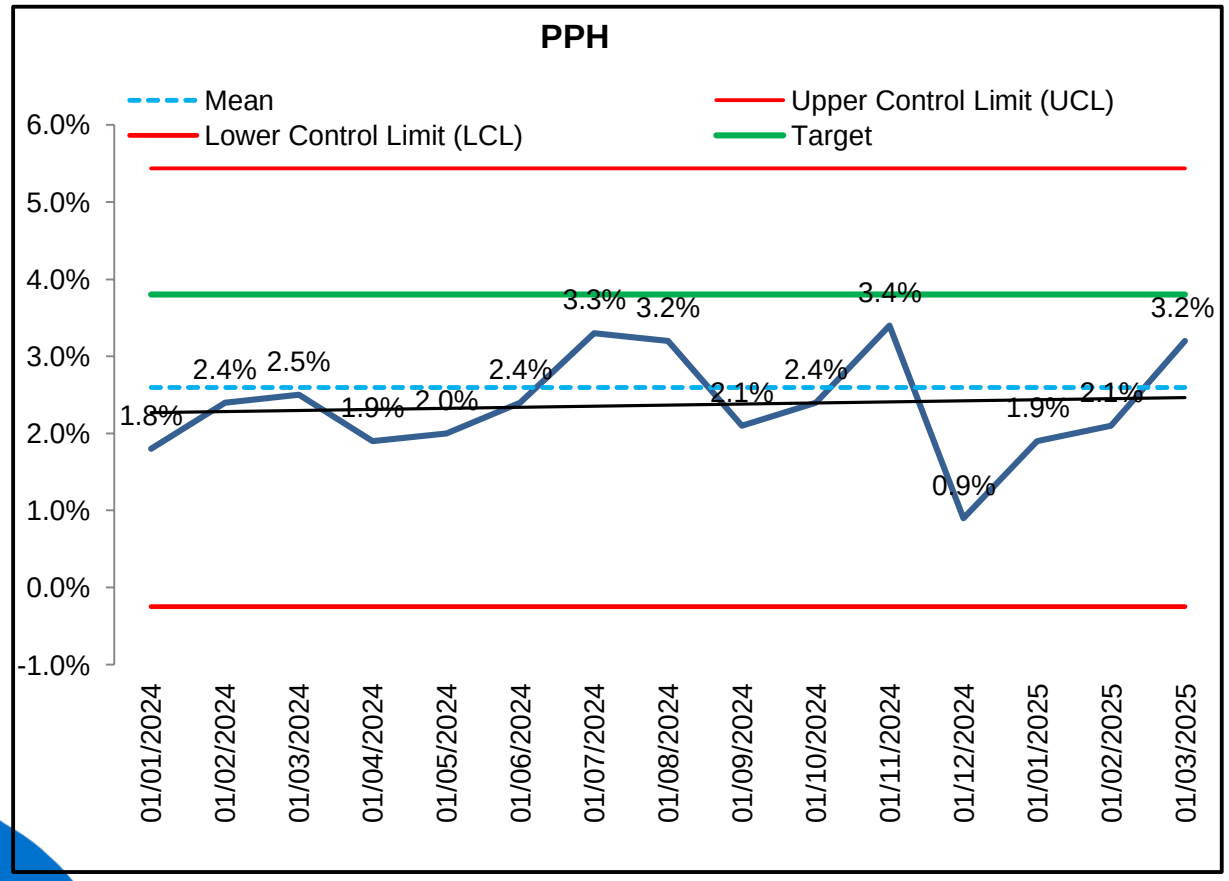
All 3rd/4th Degree tears will continue to be reviewed in MIRF, any learning identified will be actioned accordingly. There were no care omissions in the cases reviewed, however, incidental learning identified is the OASI bundle at delivery is not being followed consistently.

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 (3.2%) shows an increase in comparison to the last 3 months data. This is still below the target and has remained below the target for more than a year.

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.

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)
Q1 2024/25	Apr-24	0	2	2	2	2	100%	1	0	0	0	2
	May-24	4	3	3	3	3	100%	2	1	3	0	0
	Jun-24	5	1	1	1	0	N/A		1	0	0	0
Q2 2024/25	Jul-24	11	4	4	4	4	3	2	0	2	3	0
	Aug-24	9	1	1	1	1	1	3	2	1	0	1
	Sep-24	3	3	3	2	2	100%	2	2	1	1	0
Q3 2024/25	Oct-24	11	2	2	1	1	100%	1	1	1	1	0
	Nov-24	9	2	2	2	1	1	3	0	1	1	0
	Dec-24	10	2	2	2	1	100%	2	2	2	0	0
Q4 2024/25	Jan-25	5	4	4	4	3	3	3	0	2	2	0
	Feb-25	9	2	2	1	1	1	2	0	2	0	0
	Mar-25	9	2	2	2	2	2	2	1	1	0	1

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

PSII UPDATE

Ongoing PSII
4 (MNSI)

Completed PSII
0

AFTER ACTION REVIEW

2

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.
- 7 moderate incidents reported but 1 confirmed to remain as fatal following MIRF and IRG (NND)
- 6 incidents have been reviewed and have been downgraded as there were no care omissions identified
- No themes have been identified through Perinatal Mortality Review Tool
- There was a total of 9 perinatal losses but only 2 cases were reportable to MBRRACE

What is going well?

- There is a positive decrease in term admissions and collaborative work with the Neonatal team continues to show a positive outcome on learning identified through ATAIN meetings and a decrease in Neonatal Hypoglycemia was noted at the latest ATAIN review.
- 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

MATERNITY AND NEONATAL EXPERIENCE

PALS Complaints & Complaints	Jan-25	Feb-25	Mar-25	2024/25 YTD
Maternity	4	5	4	33
Neonatal	0	0	0	0

Family & Friends Test (FFT)	UHN Target	National	Jan-25	Feb-25	Mar-25	2024-25 YTD
Maternity Friends & Family % of Responses	**25%**	**13%**	97.0%	97.2%	96.5%	95.8%

Compliments

"The whole team looking after us have been incredible. At a time when emotions are everywhere, transitioning into motherhood, the team provided guidance and reassurance, calmness and emotional support. They helped my husband and I navigate our new roles with a premature baby. We will be forever grateful for their support during this time, just saying thank you, can never be enough for the positive experience we leave with. They truly are a team of superstars"

"Everyone has gone above and beyond with support, nothing has ever felt too much to ask for really loving, caring staff throughout our whole visit, thank you"

"All staff have been amazing, very compassionate and kind, food was lovely and I've had lots of help, thank you so much"

"Each midwife/support worker/nurse introduced themselves, everyone was so friendly and helpful. They were so busy but they were still visible. Gave lots of info for discharge, everything from pre-op, theatre, post op care was amazing, thanks"

"The entire team from catering, facilities, midwives, doctors and maternity support workers went above and beyond to support us. We are absolutely blown away by the level of care and kindness"

What is the data telling us?

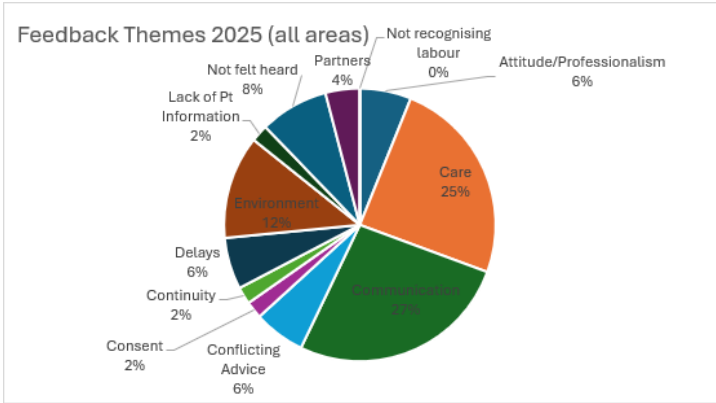
- In March we had 258 responses which is a response rate of 22%
- Overall response rates remained above target at 22%, with an overall satisfaction rate of 96.5%

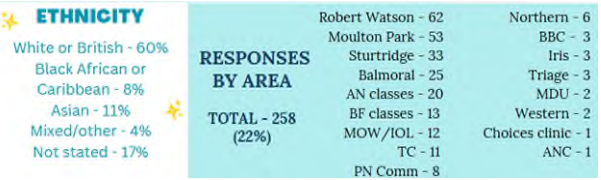
What is going well?

- A great month for 'Birth' with the satisfaction rate being 97.2%!– one of the highest ever scores

What do we need to focus on?

- The poor scores were linked to IOL (x2), post-natal care (x1), unclean environment of RWW
- There were three poor scores which did not provide any narrative





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 Date: MARCH 2025 – Staff Survey Focus Location: NGH	SC Name: Jill Houghton No. of Staff:
Staff Feedback	**Plan**
Bullying, harassment and racial discrimination still featured in the overall survey results - did colleagues think this was still present in our service? Interestingly, some members of staff avoided the question, looked the other way or suddenly had to dash off. Two senior midwives said they were finding it very difficult to navigate conversations with staff in case it was seen as bullying, harassment or racial discrimination. Two recently qualified midwives said they had observed these behaviours but didn't feel able to call it out	Continue Listening Events focussing on Internationally recruited midwives and students Review PMA availability to increase access PMA training in pipeline
The RCOG huddle model was working well - although on Labour Ward the anaesthetists were attending but refusing to participate. More junior staff in anaesthetics were participating	Escalation toolkit (EBC) work continues led by Development Consultant Midwife
Concern about the funding of preceptor posts	Under review with Finance
The team keen to use Foley's catheters on the IOL pathway	Workstream underway led by Development Consultant Midwife and Labour Ward Obstetric Lead
Four gel containers on RW were all empty	Inpatient Matron working with Ward Manager to escalate as required
Staffing issues due to training week	Ongoing review of staffing numbers to ensure consistency across the year

Board Level Maternity & Neonatal Safety Champions

Julie Hogg
UHN Chief Nurse

Jill Houghton
Non-Executive Director

Maternity & Neonatal Safety Champions

Ilene Machiva
Director of Midwifery

Clare Flower
Head of Midwifery

Dr Amrita Datta
Clinical Director

Dr Nick Barnes
Lead Neonatal and Cardiology Consultant

What is going well?

- You Said We Did posters displayed in all areas
- Balmoral Ward Rounds now happening earlier to ensure discharges are done in a timely manner
- Staff on Gosset very happy and again spoke about good MDT work.

What do we need to focus on?

Freedom to Speak up Feedback from Listening Event:

- Reports of Incivility in Midwifery and dismissive of MSW's escalations, minimising their input
- Community Midwives: Clinical documentation and other management duties are done outside of working hours; reports of burnout
- Performance management lack consistency across managers
- Uncertainty around secondments and recruitment
- More leadership visibility and involvement from managers
- Overpayments of staff in midwifery and recouping from bank shifts without prior notice/information
- Triangulation of this feedback, along with Staff Survey Results and NED Walkaround in progress

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:

	Jan 2025	Feb 2025	Mar 2025
Midwives	97%	97%	99%
Consultants	100%	100%	100%
Obstetric Doctors	96%	79%	83%
Anaesthetists	81%	73%	86%
MSW's	95%	100%	99%

Module 6: Neonatal basic life support:

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

Element 4: Fetal monitoring and surveillance:

	Jan 2025	Feb 2025	Mar 2025
Midwives	96%	92%	95%
Consultants	100%	91%	100%
Obstetric Doctors	100%	81%	96%

- Safeguarding Adults Level 3: 85%
- Safeguarding Children's Level 3: 91.5%

What is the data telling us?

- PROMPT overall compliance: 96%
- Newborn life support (NBLS/NLS) overall compliance: 90%
- Fetal Monitoring overall compliance: 96%
- Safeguarding Adults Level 3: 85%
- Safeguarding Children's Level 3: 91.5%

What is going well?

- Anaesthetic Team - this month's figures have increased from 73% to 86% which is a great improvement
- In addition to the Maternity Training Week, additional scenarios (POCS) are being run through the year
- Community Prompts are planned and starting in the Hubs this month.

What do we need to focus on?

- Compliance with Safeguarding Adults Level 3 training
- Escalated compliance for Obstetric Doctors for PROMPT and Speciality Day
- NBLS compliance has dropped – actions in place (Maternity Practice Development Midwife facilitating the NBLS training updates on the core modules day on the Maternity Training Week. Targeted deep dive to ensure those out of date are prioritised to attend NBLS sessions. Further facilitation of NLS days planned across the next 18 months to improve the number of gold standard NLS trained staff)

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

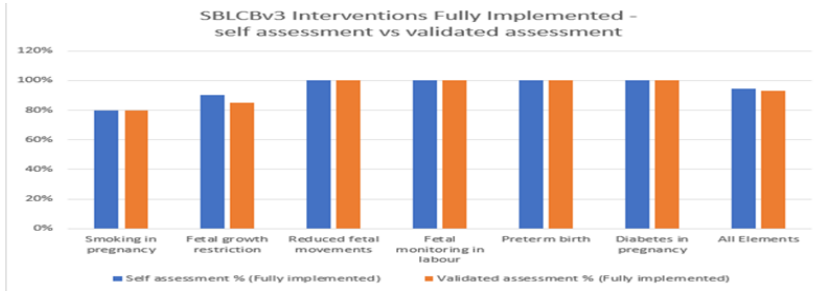
SUMMARY

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

MIS Safety Action – Year 6	MIS Standards	Status
1: Use of Perinatal Mortality Review Tool	6	Awaiting outcome of appeal
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

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

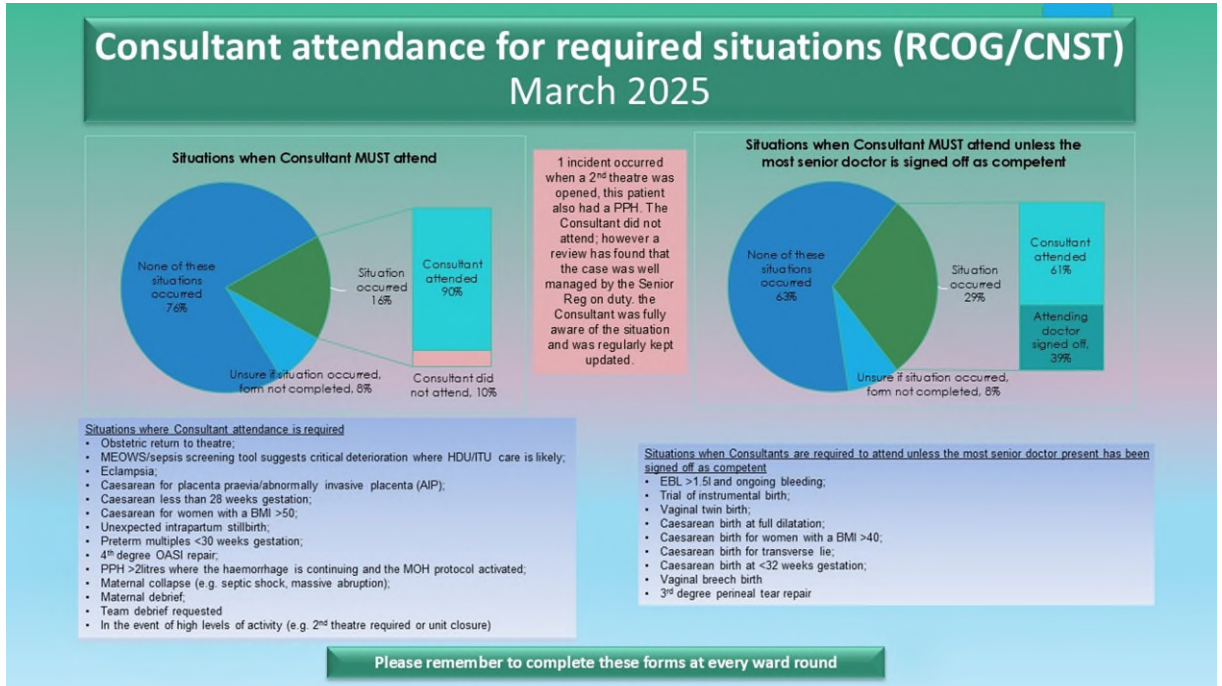
Q3 progress to full implementation following LMNS assurance for March 2025 confirmed at 93%

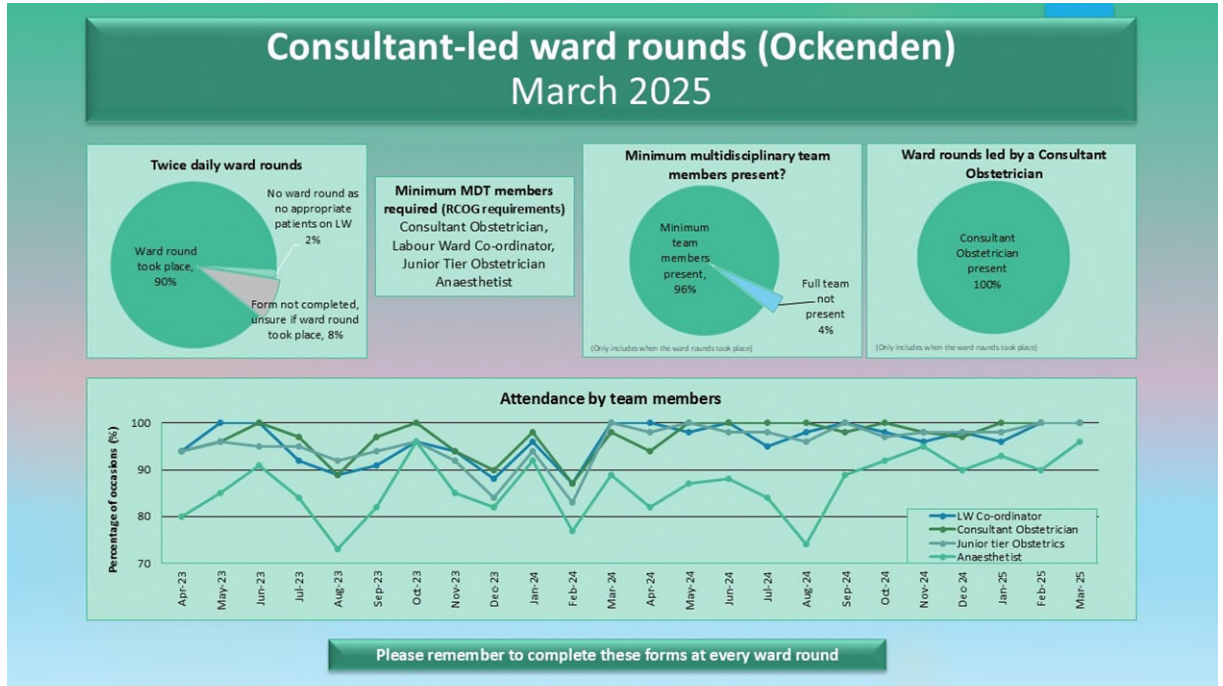
MIS Year 6 – Safety Action 6 SBL fully compliant

MIS year 7 – To be scoped

What do we need to focus on	Actions
RISK/EMERGING ISSUE: Smoking Cessation: Only x1 Maternity Tobacco Dependence Advisor (MTDA) in post Instead of x2 – reduced capacity for follow up at In-house clinic. This in turn is affecting the percentage of smokers that set a quit date and Co verified as none smokers at 4 weeks. Set LMNS Trajectory is 50%, NGH is at 25%	Risk entered onto Risk Register. Awaiting outcome of funding review
Training Compliance/Education: Improvement noticed with January, February and March training figures	From January 2025 all VBA and CO level assessment now done as both face-face and online assessment
Fetal Surveillance/Risk Assessment: GROW 1.5 is no longer used. Since the launch of GROW 2.0 some charts are still being generated on GROW 1.5 which introduces huge clinical risk (23 charts in March)	KGH will remain on paper chart until they move to GROW 2.0, Midwives at KGH should be generating the paper chart and not NGH
Preterm Birth Prevention	To clearly identify women with potential risk of preterm birth- a new PERIPrem logo sticker will now be attached to front page of green note as alert and a new animation video for patient/staff education https://youtu.be/IZaMvyb9wjM Link for NGH Preterm Birth Animation video above

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





What is the data telling us?

- 57/62 form were completed = 92%)
- 1 ward round was documented as not taking place during March, this was due to there not being any appropriate patients on Labour Ward

What do we need to focus on?

- One incident occurred when a second theatre was opened, this patient also had a PPH. The Consultant did not attend, however a review has found that the case was well managed by the Reg on duty and the Consultant was fully aware of the situation and was regularly kept updated

HOT TOPIC – INFANT FEEDING

Celebrating Maternity Excellence

INFANT FEEDING TEAM

March 2025

NHS University Hospitals of Northamptonshire NHS Group

Theme of the month

Daily infant feeding assessments/talks

Feeding assessments and discussions, regardless of the feeding method should take place on a daily bases for every baby. IFT has created aid memoire laminates and placed across maternity wards to support these discussions. Some of the emerging themes following audit results and reports from mothers :

- Discussion on bonding and developing loving relationship especially with bottle feeding mothers
- Having meaningful discussions to enable and support informed choices
- Teaching bottle feeding mothers on paced responsive bottle feeding
- Enabling mother to effectively and safely feed her baby after being discharged home.

Without complete feeding assessment we are at the greater chance to miss fixable problem that could potentially lead to weight loss and readmission..

Thank you everyone for your support! It is much appreciated

Breastfeeding initiation rate 83%

21 baby was referred to tongue tie clinic

33 breast pumps were loaned.

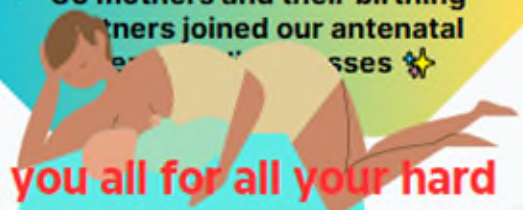
128 mothers and babies had 1-2-1 support from IFT across postnatal wards, PAU, paediatric ward and Gosset

176 community calls and follow ups !

12 families seen in one to one Thursday clinic

Face to face training:

- **26 Midwives and MSW**
- **79 x staff support across maternity wards**
- **Emergency department training 18 nurses and HCA's**
- **86 mothers and their birthing [illegible]ners joined our antenatal [illegible]sses**



Thank you all for all your hard work in supporting breastfeeding journeys especially those challenging ones

1

Cover Sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	9 May 2025
Agenda item	7.1

Title	KGH Maternity Support Programme (MSSP) Update
Presenters	Julie Hogg - UHN Chief Nurse Ilene Machiva - UHN Director of Midwifery
Author	Ilene Machiva - UHN Director of Midwifery

This paper is for			
☐ Approval	**X Discussion**	**X 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

Group priority				
X Patient	**X Quality**	☐ Systems & Partnerships	☐ Sustainability	☐ People
Excellent patient experience shaped by the patient voice	**Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation**	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for Consideration	Previous consideration
To brief the Boards of Directors on the progress made with the MSSP (Maternity Safety Support Programme) and the Maternity Improvement Advisors (MIA) feedback to the service. The UHN Board of Directors are asked to receive and note the report.	UHN Perinatal Safety Champions Meeting Quality and Safety Committee

Executive Summary
Summary of recent activity and feedback Site visits, one to one meetings and attendance to some organisational meetings have taken place, with a stakeholder event to discuss draft 'Diagnostic report' planned for 19 May 2025. Two areas of escalation were identified by the MIAs during reporting period and were clarified and resolved with the support of the Chief Nurse and the Medical Director: 1. Seconded Midwifery senior leadership roles and specialist midwives' roles. Concerns around the roles that were coming to an end on 31st March 2025 and delays in outcomes of the business case process. This related to the Intrapartum matron role, and the lead Professional Midwifery Advocate Role and the communication around next steps for the midwives occupying the roles. The intrapartum matron role is out to advert for a substantive post, and the lead PMA role has been extended for six months. The specialist midwives' roles backfilling for the leadership roles have also been extended for six months 2. Removal of second Senior House Doctor from April 2025. Short term mitigation has been agreed by the Medical Director to provide Locum cover while the service recruits to a Trust Grade post to support the Team.
Appendices
None
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 LMNS and all women accessing care within the LMNS.

Cover sheet	
Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	9 May 2025
Agenda item	8
Title	UHN Freedom to Speak Up (FTSU) 2024-25 Quarter Four (January to March 2025)
Presenters	Jane Sanjeevi, Freedom to Speak up Guardian, NGH Susan Clennett, Deputy Director of Integrated Governance/Acting Freedom to Speak Up Guardian, KGH
Authors	Jane Sanjeevi and Luke Sullivan, Freedom to Speak up Guardians, NGH Susan Clennett, Deputy Director of Risk and Legal Serviecs/Acting Freedom to Speak Up Guardian, KGH

This paper is for			
Approval	X 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

Group priority				
X Patient	X Quality	Systems & Partnerships	Sustainability	X People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
To discuss themes and required actions to further improve the Board's involvement in FTSU to continuously develop a positive culture across UHN. To be assured on the work of the FTSU Guardians to support staff to speak up and organisational improvements.	The report was considered by the People committee in April 2025

Executive Summary

UHN Highlights from Q4

- 24/25 Q4 update is included along with graphs displaying an annual overview, in advance of a more detailed annual breakdown report for 24/25.
- UHN Policy and Strategy drafts are complete and going through peer and stakeholder consultation.
- Guardians have observed a higher level of distress in staff approaching them with concerns through Q4 at both trusts.
- 242 concerns have been raised in total across 24/25 with 135 concerns heard at NGH and 107 concerns heard at KGH.
- For Q4, 44 were heard at NGH and 22 at KGH. Some concerns from NGH are taken from discussions/engagement sessions with staff and the feedback used for

concerns data. Divisions are presented separately for this quarter and will be joined up going into Q1 of 25/26.

- Nursing staff account for the largest group of staff speaking up across UHN and this is true of both sites. Anonymous concerns are the second highest.
- Inappropriate behaviours and attitudes remain the most consistent theme in Q4 for UHN, with more communication concerns heard at KGH and more worker safety/wellbeing heard at NGH.
- An account of FTSU learning and feedback is included within the report

Included within the paper are some short commentaries on questions 25e and 25f from the staff survey 2024 and some triangulation insights are to follow.

Recommendation

The Boards are requested to receive and discuss the report and to indicate assurance on the work of the FTSU Guardians to support staff to speak up and organisational improvements.

Appendices
FTSU report
Risk and assurance
As detailed in Staff Survey responses, staff report a lack of confidence that speaking up will result in improvements/changes. More work is required to promote the benefits of speaking up and sharing learning. Work is underway to design UHN policy and strategy to outline our approach to speaking up.
Financial Impact
None
Legal implications/regulatory requirements
There is a legal requirement under the Health and Social Care Act to appoint a Freedom to Speak Up Guardian. A safe speaking up culture is part of CQC Well Led.
Equality Impact Assessment
Promoting a positive FTSU culture will give rise to positive impacts for colleagues and patients with all protected equality characteristics.

University Hospitals of Northamptonshire

Freedom to Speak Up Report: Q4 2024/2025

Including NGO Comparisons, Annual Graphs & Staff Survey

Authors:

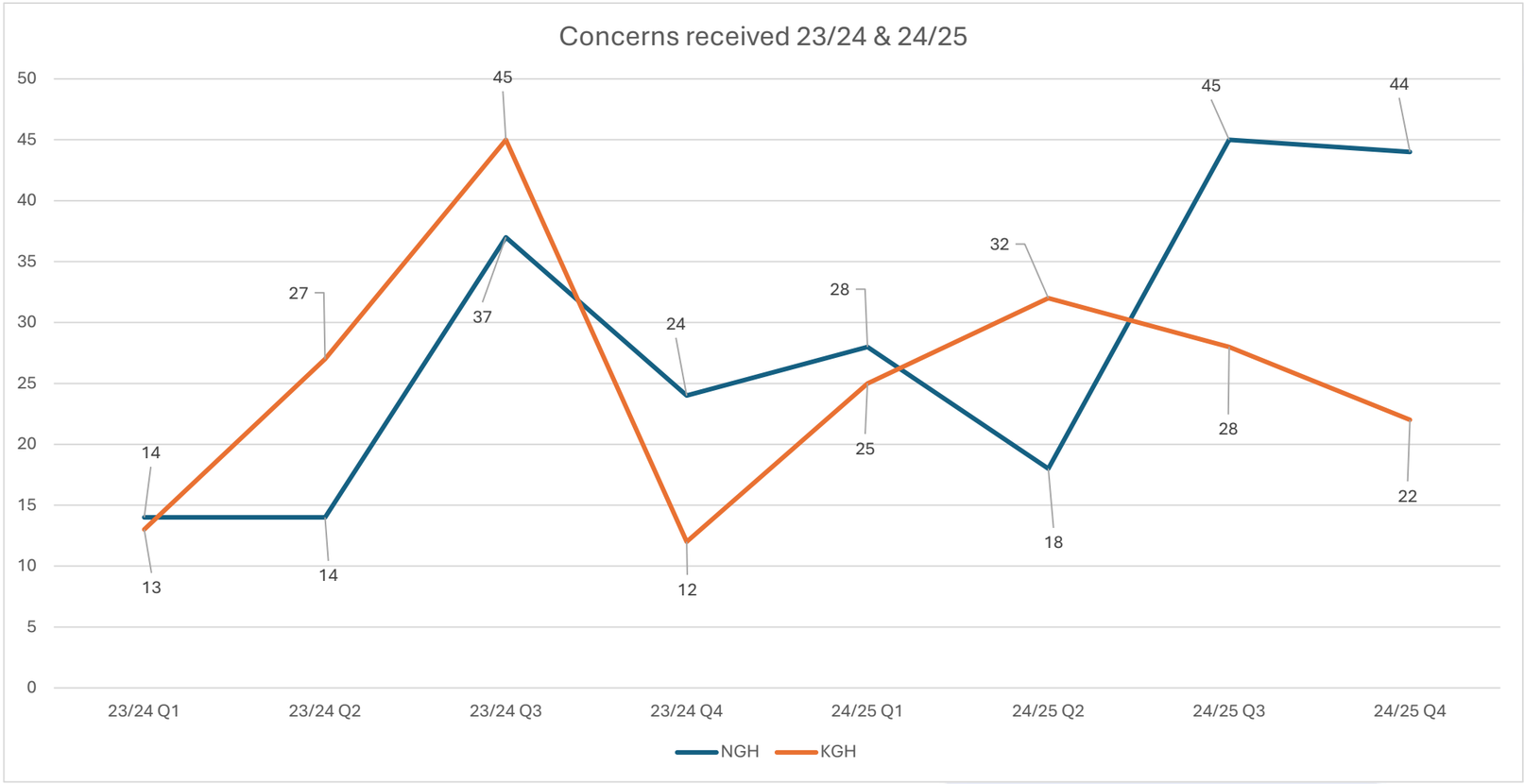
Susan Clennett – Acting FTSU Guardian, KGH

Jane Sanjeevi - FTSU Guardian, NGH

Luke Sullivan - FTSU Guardian, NGH

Contents

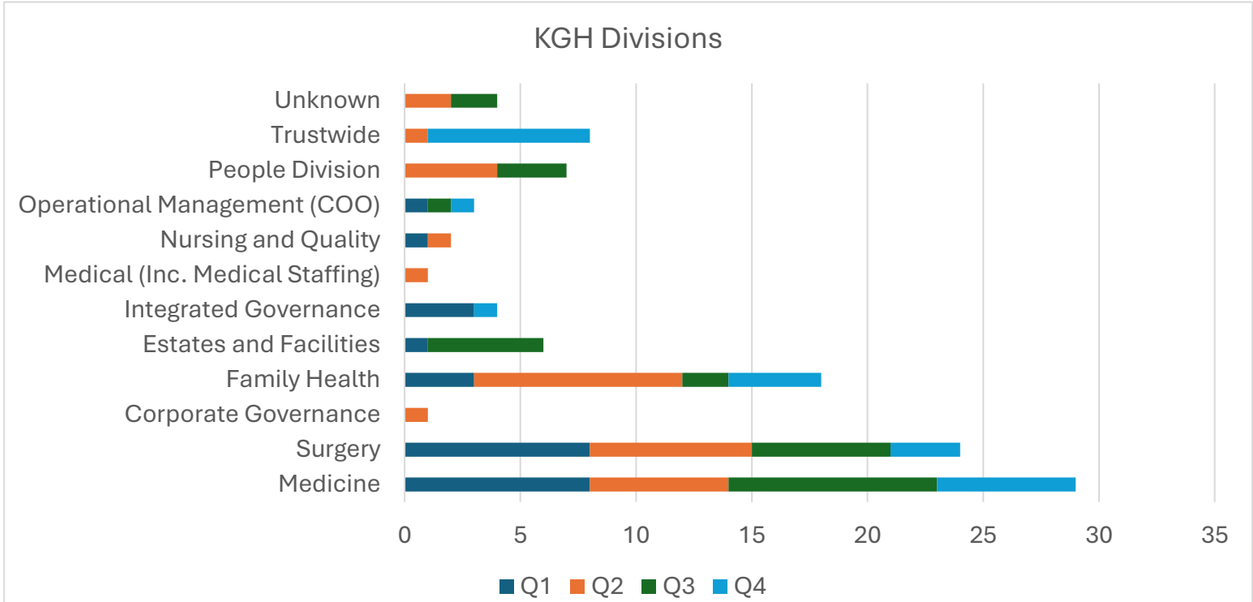
Freedom to Speak Up Overview

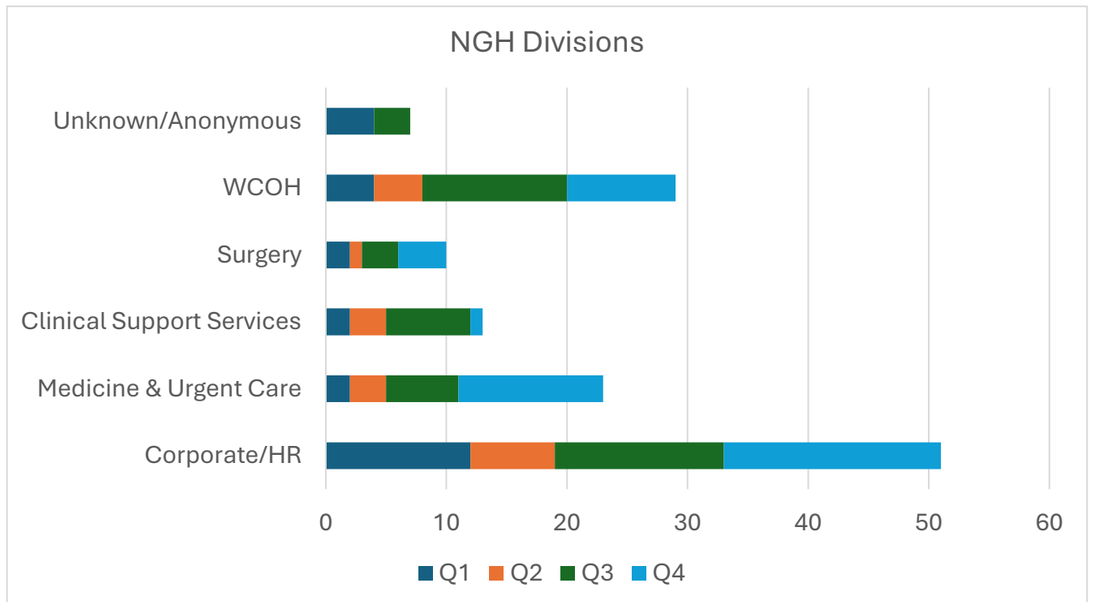


- There were a total of **242** concerns heard across UHN for 24/25; with **135** Concerns heard at NGH and **107** at KGH.
- Concerns reported at KGH have remained consistent across 24/25 as compared to the previous year. Concerns at NGH doubled from 24/25 Q2 into Q3 and have remained at this level into Q4.
- A rise in concerns seen during Q3/Q4 concerns at NGH can in part be attributed to an increase in anonymous reporting as there has been more awareness through the year of the anonymous form.
- Sharp increase in Q3 23/24 at KGH attributed to a group or nursing from one ward speaking up.

Concerns by Division Q4

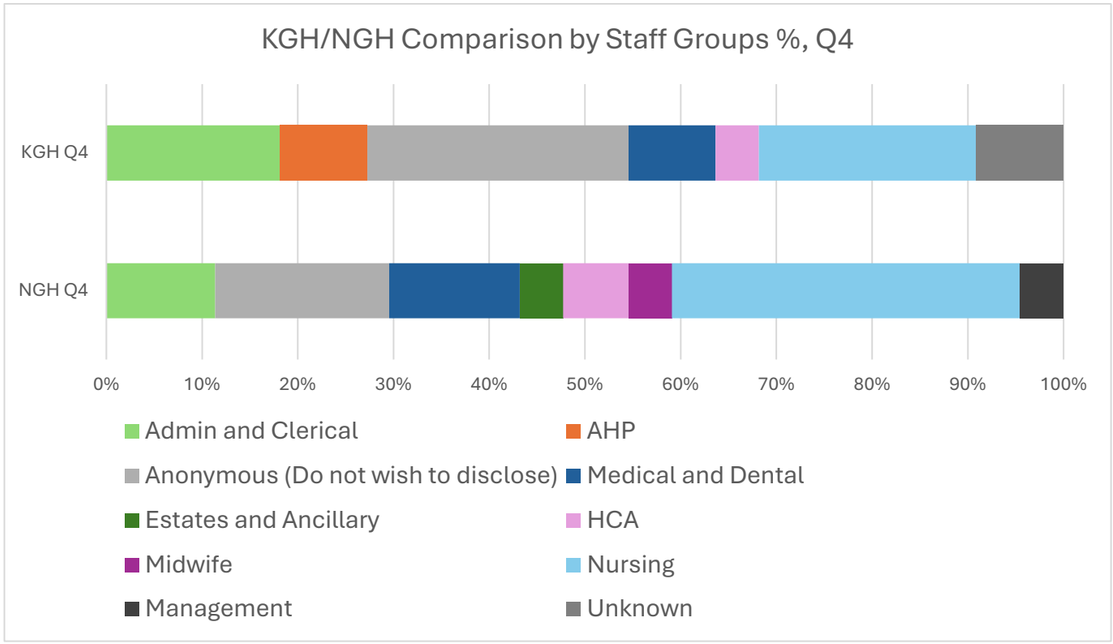
- Concerns reported by division will be aligned across UHN for 25/26 with a look back exercise to ensure 24/25 data is comparable. Concerns by division refers to which division the concern was raised about, rather than the division it came from (not always necessarily the same).
- Medicine and Surgery consistently highly represented in concerns raised across all three quarters in KGH.
- Increase in concerns relating to family health reported in Q2 as compared to Q1/Q3, reporting has otherwise remained consistent but lower than surgery and medicine.

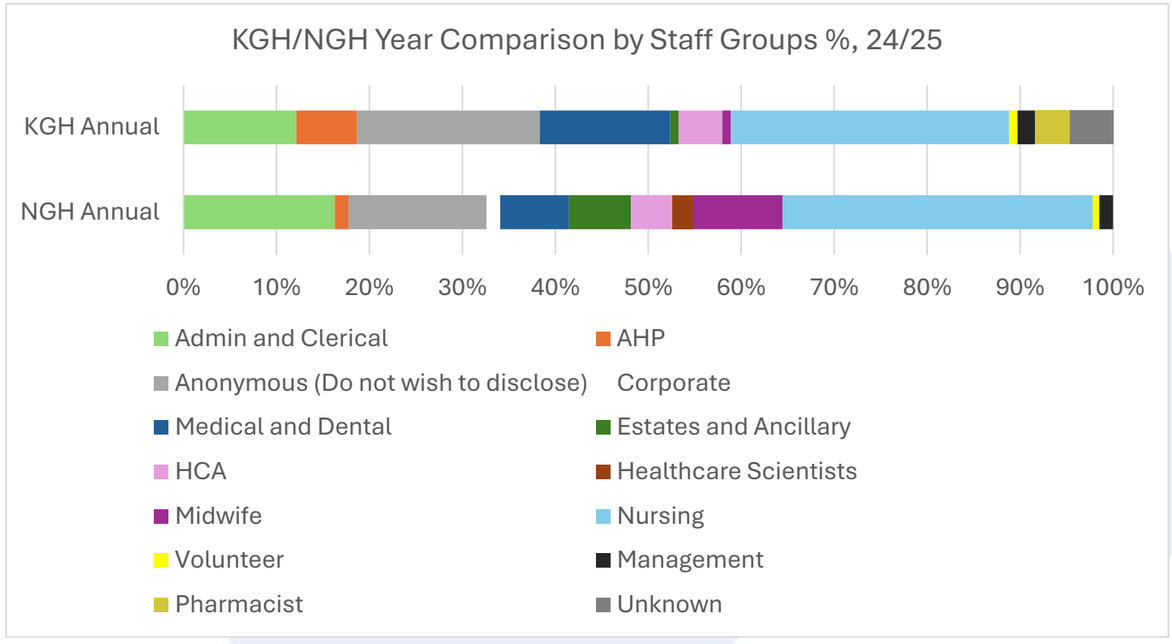




- Majority of concerns across NGH continue to be heard around corporate and HR issues.
- Increase in concerns heard from clinical divisions into Q4, with medicine and urgent care seeing 12 of the 44 concerns. Part of this is attributed to increased engagement with Victoria Ward through PNA sessions.
- Concerns heard around collaboration across UHN are reported under corporate and have all been anonymous across Q4.

Concerns by Professional Group Q4

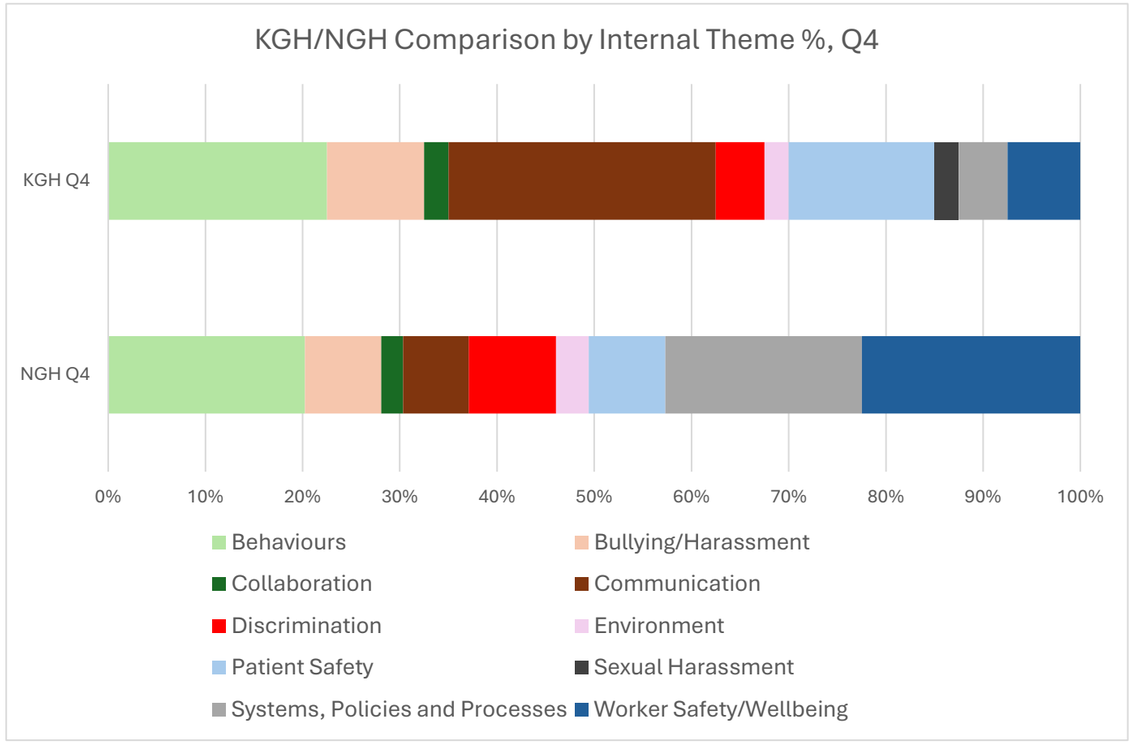


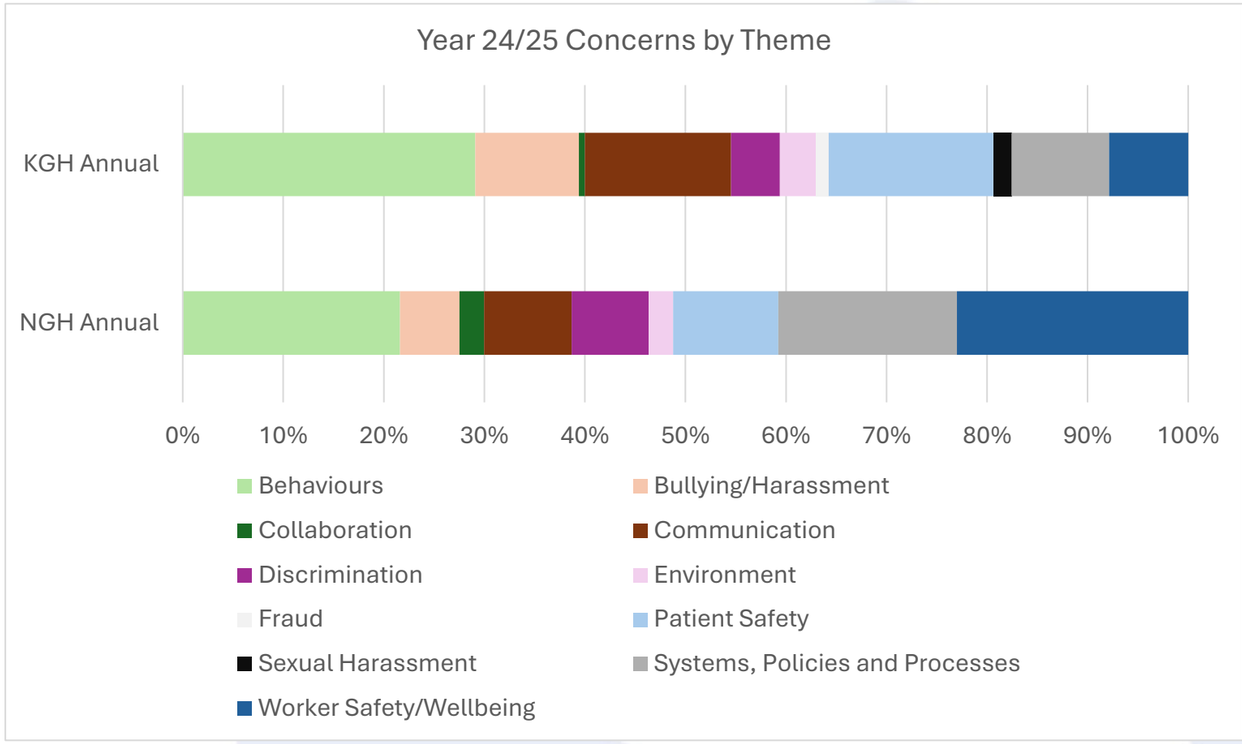


- Into Q4, nursing remains as the largest staff group raising concerns across UHN at 31.8% (36.4% at NGH and 22.7% at KGH). Nursing concerns are trending higher than national average at NGH (national is 28.3% combined for nurses/midwives).
- Anonymous and unknown concerns follow closely, accounting for 24.2% across UHN in quarter 3 (36.4% for KGH, 18.1% for NGH), higher than the NGO national average of 9.5% for 23/24.
- In contrast with previous quarters of 24/25, concerns raised by doctors (medical and dental) were raised at a higher rate in NGH than KGH for Q4. Most of these related to consultant behaviour.
- Staffing groups including pharmacists and healthcare scientists are not represented in Q4 and have raised minimal concerns across UHN for 24/25. Similarly, estates across both hospital sites have raised few concerns across the year with only 2 at NGH in Q4. Few senior leaders or staff in corporate positions have spoken up across 24/25.

Concerns by Category Q4

Internal themes represented by rate of occurrence in total concerns, per quarter





Q4 Concerns by Category Overview

- Concerns are shown as a % rate of occurrence of total concerns at either site.
- Worker Safety and Wellbeing concerns continue to be reported at a higher rate of total concerns as compared to KGH. Majority of these relate to psychological wellbeing.
- Whilst more cases of patient safety have been reported at NGH (7) than KGH (6) these still make up a much smaller % of total concerns raised.
- Inappropriate behaviours and attitudes concerns are heard at a similar rate across both sites.
- Cases with an element of discrimination have remained consistent after increasing into Q3 with 8 heard at NGH and 2 at KGH.
- Concerns around communication are heard at a higher rate in KGH whereas systems, policies and processes occurs at a higher rate for NGH.

National Guardians Office Data Annual Comparison with UHN

Highlights from NGO report 2023/2024 on national data compared to UHN 2024/2025

One in every three cases raised (32.3%) involved an **element of worker safety or wellbeing.**

KGH: 12.1% ↓ **NGH: 48.9%** ↑

Two in every five cases (38.5%) involved an element of **innapropriate behaviours and attitudes**.

KGH: 44.9% ↑ **NGH: 46.7%** ↑

19.8% of cases reported included an **element of bullying or harassment.**

KGH: 15.9% ↓ **NGH: 12.6%** ↓

18.7% of cases raised included an element of **patient safety/quality**

KGH: 25.2% ↑ **NGH: 22.2%** ↑

Detriment for speaking up was indicated in 4% of cases

KGH: 0% ↓ **NGH: 3%** ↓

2024/2025	KGH Q1	NGH Q1	KGH Q2	NGH Q2	KGH Q3	NGH Q3	KGH Q4	NGH Q4
Behaviours	13	12	17	10	9	22	9	19
Bullying/Harassment	1	2	9	1	3	7	4	7
Patient Safety	7	7	4	4	10	12	16	17
Worker Safety	1	11	3	11	6	24	3	20
Detriment	0	1	0	1	0	1	0	1

Q4 Themes and Trends

- Generally into Q4, staff at both sites have noticeably more distressed when raising concerns to their guardians, and citing greater impacts on their wellbeing.
- There have been increasing queries around how UHN and UHL work together with staff reporting that they are unclear on the relationship between the organisations at present.
- Incivility within the workplace, including behaviours, attitudes and bullying have remained a consistent theme across 24/25 and into Q4. Concerns around managers continue to include elements of micromanaging and workers report they do not feel their managers are equipped to handle behaviours and conflicts within the workplace.
- Concerns around parking availability and processes continue to be raised. With the implementation of paid parking staff have raised concerns around the impact of this on them across the financial year.

KGH Specific Themes and Concerns

- Staff continue to increasingly speak up about unacceptable behaviours and communication linked to senior managers/leaders in the organisation.
- A number of concerns linked to one ward have been received in relation to the ward manager allowing and participating in speaking in a language other than English in clinical areas.
- A number of concerns from individuals around communication and leadership within two separate specialties have been received. The responsible operational directors are engaging with staff and investigating.
- Anonymous concerns continue to be received and where staff ask that their name be kept confidential, all advise it is because they fear detriment as a result of speaking up.
- Sexual safety concerns (2) were received during the quarter, one in relation to an alleged sexual assault and one in relation to behaviours. Each allegation was managed in line with Trust HR policy.

NGH Specific Themes and Concerns

- Prolonged time for grievances being resolved with a historic case from 22/23 being reopened in Q4.
- Staff are reporting difficulties getting bank shifts in areas where they have worked for a number of years, stating that they don't feel valued.
- There has been an observed increase in the number of global majority staff raising concerns indicating a growing confidence - however staff are still reluctant to share equality monitoring data making this difficult to quantify.
- Increase in concerns from nursing across Q4, which can partly be attributed to increased engagement at PNA sessions and the nursing and midwifery listening event held in March.
- Reports of a culture of incivility within midwifery, where staff are rude to each other in their interactions; MSW have also stated they feel their role is considered insignificant by doctors.

A number of concerns have been raised by junior doctors in Q4, including:

- Staff shortages in some areas posing a threat to patient safety (Hawthorn, Creaton, Rowan) – including lack of coverage at times from registrars.
- Doctors advised to not put in exception reports for unplanned overtime by educational supervisors
- Changes in night shifts meaning there is too much workload on surgical FY1s having to cover medical patients on assigned wards and a disparity between medical/surgical FY1 induction quality
- Three junior doctors have raised independent concerns about separate consultants behaviour, with two constituting bullying and harassment.

Learning actions from Speaking Up

NGH Q4

- Concerns continue to be heard around staff use of other languages in handovers, excluding some staff. Managers have been advised of the languages toolkit and have fed back to staff the expectations of them.
- Concerns raised around bias in recruitment for senior roles with processes not being followed for IRC appointment; individuals have met with EDI to feedback their experiences.
- A thematic review of nursing concerns has been submitted to the chief nurse and director of midwifery, with continued engagement from them to address arising concerns.
- New national uniform changes meant band 6 and 5 staff could not be differentiated. This was escalated with work already ongoing to address, and the uniforms have been duly reviewed and changes brought forward in policy.
- Concerns of attitudes of nursing managers have been escalated and addressed by senior nursing engaging with individuals concerns and offering mediation and reflective conversations.
- Guardians are currently reviewing how they will feed back actions on anonymous concerns, with a plan to include a section on a quarterly FTSU newsletter available to all staff.
- A number of staff across Q4 have been encouraged to raise their concerns directly with their line managers and have done so successfully, reporting productive conversations and actions taken as a result.

Learning actions from Speaking Up

KGH Q4

- Various supervision and coaching provided to address concerns around behaviours and/or communication standards;
- Increase in number of junior medical staff in ED together with an additional clerking SHO for the department;
- Mediation facilitated to improve working relationships/understanding;
- Banding review support achieved with recognition of increased responsibilities within a role;
- Staff reminded not to request visitors to momentarily observe a ward area;
- Improved standards linked to the appraisal process in relation to a manager's development;
- Improved accessibility of a matron for staff when they wish to escalate concerns;
- Consultant staff in a specialty reminded of the importance of utilising Datix to report incidents;
- Toolkit utilised on the use of other languages other than English in the workplace.

Freedom to Speak Up – Q4 Feedback

KEY: **KGH**
NGH

‘I felt that my concerns were valid and that they were taken seriously’

‘I had invaluable support from FTSU and felt supported and listened to when I raised my concern about the way I felt I had been treated, and I was supported in resolving the concern. I am very grateful for the kindness and support I received’

‘I am grateful you were able to escalate my concern and keep my name out of it’

‘Thank you for your time and listening to my concerns – I appreciate your time and support so far with this.’

‘I was able to express my thoughts for better improvement of managing the department. Through FTSU, the management listens to any perspective’

‘Thank you for seeing me again at short notice, and for being compassionate’

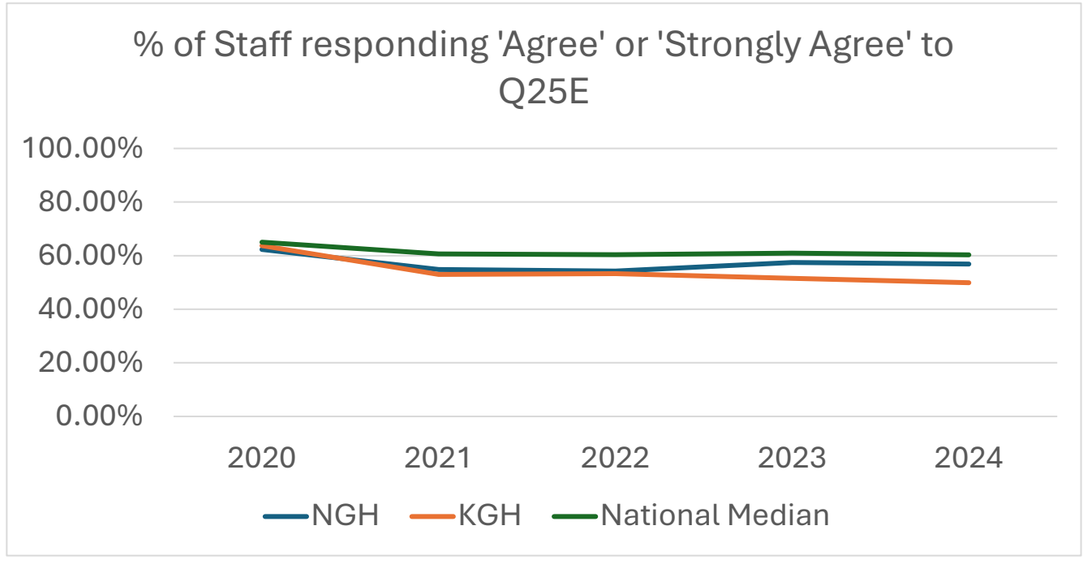
‘This was my first time speaking up and I needed some time to think before escalating, thank you for taking the time to wait for me to be comfortable’

‘I am very grateful for your kindness and support in resolving this’

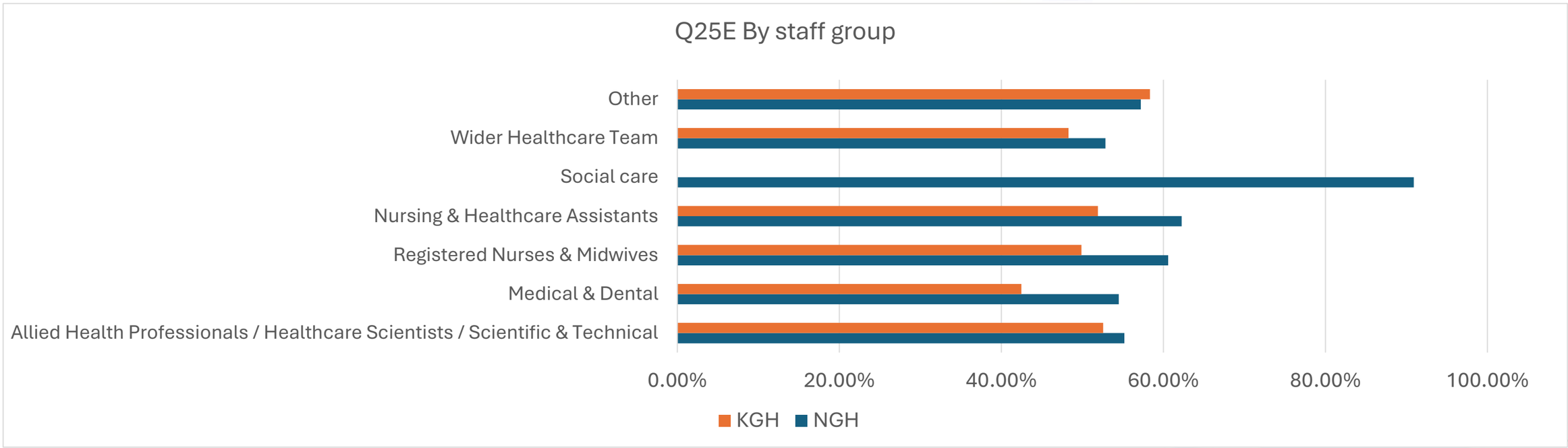
2024 Staff Survey; Questions 25e and 25f Highlights

Following is an overview of highlights and key takeaways from the 2024 staff survey results for questions 25E and 25F:

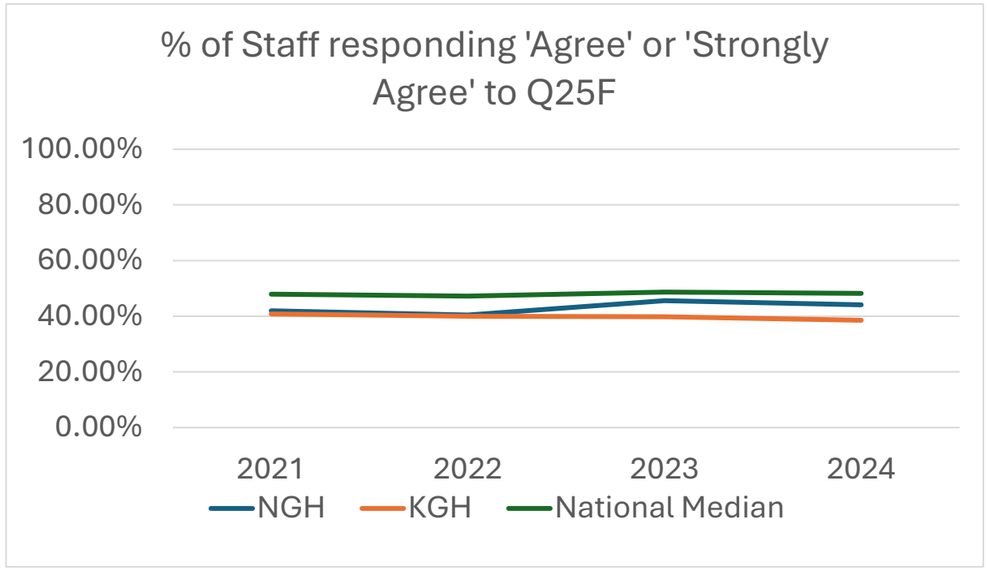
25E- I feel safe to speak up about anything that concerns me in this organisation



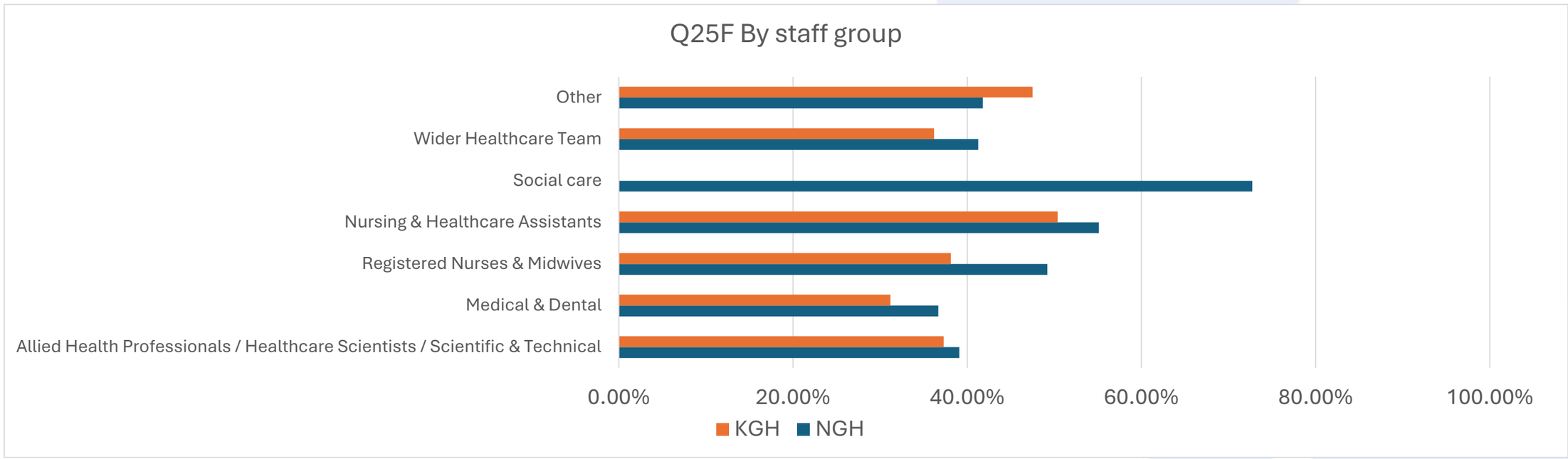
Q25e	% Agree/Strongly Agree
NGH	56.85%
KGH	49.89%
National Median	60.29%



25F- If I spoke up about something that concerned me I am confident my organisation would address my concern.



Q2f	% Agree/Strongly Agree
NGH	44.06%
KGH	38.55%
National Median	48.23%



Overview

NGH and KGH both sit beneath the national average medium for both questions 25e and 25f, with Northampton scoring higher for both questions across the 4-5 year span. Staff feeling safe to speak up has declined at both trusts with a small decline for confidence that their concerns will be addressed.

- **Age:** Responses to the questions based on age groups are inconsistent across UHN. NGH Trends towards feeling less safe (25E) and confident in concerns being addressed (25F) the older the age bracket staff fall into, whereas for KGH it starts at its lowest at 16-20, raises to a peak at 31-40 and then declines again.
- **Ethnicity:** Across UHN, White English/Welsh/Scottish score lower on both questions than staff from all other ethnic groups combined. The difference is less pronounced at KGH. However, individual ethnic groups across UHN report varying levels of feeling safe/confident, with mixed/multiple ethnic backgrounds trending amongst the lowest across both sites.
- **International status:** International staff score higher on both questions at NGH than non-international staff, with the reverse being true at KGH.
- **Religion:** Differences for both questions across religions at NGH see larger differences than KGH, though Hindu staff score higher than other religions for UHN. For both sites, staff citing no religion or any other religion score lowest.
- **Gender:** Across UHN male staff score higher than female staff in safety/confidence with the difference being more pronounced at NGH. There is not enough/no data on non-binary staff and those preferring to self describe. For those staff who's gender is not the same as the one assigned at birth, there is only data for NGH and this indicates those staff feel less safe to speak up (but have a similar level of confidence in action being taken).
- **Sexual Orientation:** At both hospitals, staff identifying as gay, lesbian, bisexual or other score higher on 25e, though there is little difference for 25f. Bisexual staff at KGH feel the least confident that their concerns will be addressed.
- **Long Term Conditions:** Staff stating they have a long term condition or disability score lower on both questions than otherwise across both hospitals with similar differences seen.
- **Carers:** Staff at both trusts report feeling less safe and confident in actions being taken if they report as being carers for individuals with LTC.

Cover sheet				
Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)			
Date	9 May 2025			
Agenda item	10			
Title	UHN Risk Management Strategy			
Presenter	Richard Apps, Director of Corporate and Legal Affairs			
Author	Susan Clennett, Deputy Director of Risk and Legal Services			
This paper is for				
X 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	
Group priority				
X Patient	X Quality	X Systems & Partnerships	X Sustainability	X People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference
Reason for consideration		**Previous consideration**		
The UHN Risk Management Strategy has been reviewed to reflect the UHN's Group approach to risk management, ensuring that risk management systems and reporting are aligned. Objectives have also been reviewed.		Organisational consultation is detailed within the Strategy. Audit Committees endorsed the Strategy on 28th April 2025.		

Executive Summary

The UHN Risk Management Strategy is updated to:

- Reflect UHN priorities;
- Set clear objectives for the development of risk management systems across UHN including achievement of a single digital risk management tool, aligned to the new UHN structures;
- Align UHN risk registers at an operational and corporate risk register level and enable further development of the UHN BAF, building on triangulation with external stakeholders strategic risks and external reports;
- Further develop ownership of strategic risks associated with the BAF;
- Leverage quality improvement programmes as part of the reduction/control element of management of risks.

The Boards are requested to **approve** the attached UHN Risk Management Strategy.

Appendices

Draft UHN Risk Management Strategy for approval

Risk and assurance

The draft UHN Risk Management Strategy provides the framework for Risk Management across the Group, including the systematic identification and management of all risks (ward to Board), together with reporting and monitoring of effectiveness.

Financial Impact
No direct implications
Legal implications/regulatory requirements
Well led compliance requires effective risk management systems to be in place.
Equality Impact Assessment
Neutral

Document Reference Number UHN-ST-RM03

Title:	UHN Risk Management Strategy
Executive Summary:	This strategy sets out the Group's risk management framework and the arrangements for the identification, evaluation, ownership, management and reporting of risks and the key responsibilities for individuals, directorates, divisions and committees for the 2025/26 fiscal year. It describes the Group's appetite for risk for a range of circumstances and objectives. The form and functions of the Board Assurance Framework (BAF), which is informed by strategic risks and the risk register structure for operational risks, are also set out. This strategy is written in the context of good governance, business planning, performance management and assurance.
Supersedes:	UHN-ST-RM03
Description of Amendment(s):	Changes to objectives Amendments to training
This policy will impact on: As part of its development, this policy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation or religious belief. No detriment was identified.	
Financial Implications:	

Policy Area:	Governance	Approval Date:	9th May 2025
Version Number:	2	Review Date:	1st January 2026
Issued By:	Deputy Director of Risk and Legal Affairs	Expiry Date:	30th June 2026
Author:	Deputy Director of Risk and Legal Affairs	Impact Assessment Date:	19 November 2024

APPROVAL RECORD

	Committees / Groups	Date
Consultation:	UHN Risk Management Committee UHN Operations Oversight Group UHN Risk Management Committee Audit Committee Board of Directors	19 November 2024 2 December 2024 15 January 2025 31 March 2025 and 28 April 2025 *Scheduled for 9th May 2025*
Approved by Director:	UHN Director of Corporate and Legal Affairs	

Ratified by:	UHN Procedural Document Ratification Group	
Received for Information:	Pending	

Contents

1. INTRODUCTION

Risk is an inherent part of the delivery of healthcare. This risk management strategy outlines the approach to risk management throughout the University Hospitals of Northamptonshire Group (referred to as UHN and/or the Group).

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them.

This strategy identifies the accountability arrangements, the resources available, and provides guidance on what may be regarded as acceptable risk within the organisation.

Successful risk management involves:

- Identifying and assessing risks;
- Taking action to anticipate or manage risks;
- Monitoring risks and reviewing progress in order to establish whether further action is necessary or not;
- Ensuring effective contingency plans are in place.

2. AIM

The aim of this strategy is to set out UHN's vision for managing risk. Through the management of risk, UHN seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities. The strategy seeks to ensure that:

- The Group's risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, systems and income are protected.
- The implementation and ongoing management of a comprehensive, integrated UHN system-wide approach to the management of risk is based upon the support and leadership of the Board.

3. OBJECTIVES

This Strategy is based on achieving the ten objectives below:

1. Establishment of an effective UHN Risk Management Committee;
2. Progressing a single digital solution for risk management (including risk registers) and developing our training (via a training needs analysis) and support;
3. Enhance risk management integration across UHN, supporting the new divisional structures and migrating from NGH and KGH Corporate Risk Registers (CRR) to a unified UHN CRR;
4. Alignment of risk register processes and reporting formats across all services and departments;

5. Establish effective risk management reporting within divisional governance meetings evidencing ward, departmental and horizon scanning risks inform divisional risk registers;
6. Ensure alignment of UHN BAF risks with those risks contained within risk registers owned by the Integrated Care Board/System Partners;
7. Ensure that the Risk Management Team within UHN are equipped to enable delivery of training, design of systems and support to staff across the entire Group;
8. Leveraging our Quality Improvement (QI) capabilities to improve our control environment and deploy best practice in assurance (measurement for improvement) alongside ensuring consistency in our approach to action planning;
9. Embed triangulation of internal and external audits, including CQC and other external regulatory or advisory reports with the BAF and CRR;
10. Ensure an annual deep-dive of the BAF risks and active monitoring of risk appetite by the Audit Committee with assurance reporting to the Board.

The above objectives will be delivered through a programme of improvement, with an implementation plan reported to the Risk Management Committee on a quarterly basis.

4. SCOPE

This strategy applies to all UHN staff, contractors and other third parties, including honorary contract holders, working in all areas.

Risk management is the responsibility of all staff at all levels. Senior staff at all levels are expected to make risk management a fundamental part of their approach to all aspects of governance.

UHN will provide ongoing risk management training to ensure adequate awareness and skills for staff at all levels to manage risk effectively. UHN values an open culture that requires all staff, contractors and third parties working to operate within the systems and structures outlined in this strategy.

This Strategy sets out the requirements for the management of risks at all levels of the organisation from ward/departmental, directorate, divisional, corporate and the Board Assurance Framework (strategic risks).

5. RISK APPETITE AND TOLERANCE OF RISK

The risk appetite of UHN can be described as the decision on the appropriate exposure to risk it will accept in order to deliver its objectives over a given time frame. UHN has considered the various dimensions to acceptance of risk covering:

- The nature of the risks to be assumed;
- The amount of risk to be taken on;
- The acceptable balance of risk versus reward

On an annual basis, or more frequently if determined by the Board in exceptional circumstances, UHN will publish its risk appetite statement covering the overarching areas linked to its strategic objectives which in summary are:

Assessment	Description of potential effect
Zero Risk Appetite	The Trusts Boards aspire to avoid risks under any circumstances that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance with no or negligible potential risk to staff / patients.
Low Risk Appetite	The Trusts Boards aspire to avoid (except in very exceptional circumstances) risks that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk to staff / patients.
Moderate Risk Appetite	The Trusts Boards are willing to accept risks in certain circumstances that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk to staff / patients.
High Risk Appetite	The Trusts Board are willing to accept risks that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk to staff / patients.
Very High Risk Appetite	The Trusts Boards accept risks that are likely to result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential serious risk of injury to staff / patients.

UHN will continue to adopt the approach of giving each Board level committee the opportunity to reflect on the risk appetite aligned to Group Priorities. Mapping to the Group Priorities and risk Domains:

Domains	UHN Priorities	Risk Appetite	
Q - Impact on the quality of our services. Includes complaints and audits	**Transforming patient care**	Low Risk Appetite	The UHN Board aspires to avoid (except in very exceptional circumstances) risks that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
Safety/Quality/Statutory *S*- Impact on the safety of patients, staff or public. *Q* - Impact on the quality of our services. Includes complaints and audits *St*- Impact upon on our statutory obligations, regulatory compliance, assessments and inspections	**Transforming patient care**	Low Risk Appetite	The UHN Board aspires to avoid (except in very exceptional circumstances) risks that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
Business/Reputation *B*- Impact upon our reputation through adverse publicity *R* - Impact upon our business and project objectives. Service and business interruption	**Transforming patient care**	High Risk Appetite	The UHN Board **is willing to accept risks that may result** in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory
Finance *F*- Impact upon our finances *E* - Impact upon our environment, including condition of estates, chemical spills, our carbon footprint	**Delivering our financial plan**	Moderate Risk Appetite	The UHN Board is **willing to accept some risks in certain circumstances that may** result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
Workforce *W* - Impact upon our human resources (not safety), organisational development, staffing levels and competence and training	**Strengthening our culture**	Moderate Risk Appetite	The UHN Board is **willing to accept some risks in certain circumstances that may** result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.

Risks throughout UHN will be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

6. ROLES AND RESPONSIBILITIES FOR RISK MANAGEMENT

All staff are responsible for risk management and for the delivery of high quality, safe care, ensuring their own actions contribute to the well-being of patients, staff, visitors and UHN. The Board is responsible for ensuring risk management is embedded and effective across the Group, supported by a nominated Executive Director lead.

All staff must:

- Contribute to the statutory requirement on the identification, management, reporting and assessment of risks, taking positive action to manage risks appropriately;
- Be aware of and comply with this Risk Management Strategy and associated procedural documentation.

7. RISK IDENTIFICATION

Risks are identified in many ways; we identify risk proactively by assessing corporate objectives, work related activities, analysing adverse event trends and outcomes, and anticipating external possibilities or scenarios that may require mitigation by services and the Board. The following list are examples but not an exhaustive list:

- Delivery of day to day work related tasks or activities;
- The review of strategic or operational objectives;
- Quality improvement and project/programme risks;
- From an incident, incident themes or the outcome of investigations;
- Patient feedback/experiences/litigation;
- Internal and external assessments, inspections, audit reports and associated horizon scanning;
- National requirements and guidance and the Group's ability on compliance;
- External stakeholder risks and requirements impacting on the Group's services;
- Management of and allocation of available resources;

Risk quantification (scoring) is calculated using a risk scoring matrix, known as a 5x5 matrix. This is detailed at Appendix 1 and must be used throughout the Group.

8. RISK ASSESSMENT

Risk assessment involves the analysis of individual risks, including any plausible risk aggregation (the combined effect of different risks) where relevant. The assessment evaluates the consequence and likelihood of each risk and determines the priority based on the overall level of risk exposure.

9. QUALITY IMPROVEMENTS, PROJECT AND PROGRAMME RISKS

Project and programme opportunities and threats are generally identified:

- During project or programme start up
- By other projects or programmes with dependencies or interdependencies with the project or programme
- By operational areas affected by the project or programme.

Although a project or programme should adhere to this Risk Management Strategy, additional guidelines should be followed that:

- Identify current risks to be addressed by way of the programme of work/project;

- Be cross referenced within risk assessments and risk registers by way of detailing the programme of work/project as either a control or planned action, with regular updates to the risk assessment/register;
- Identify the individual programme/project owners within the programme;
- Identify additional benefits of adopting risk management in the project/programme;
- Identify the nature and acceptable level of risk within the programme and associated Projects (linked to the Group's strategic objectives);
- Clarify rules of escalation of risks from projects to the programme and delegation from programme to projects. Or, for a project with no overarching programme, the escalation link from the project risks to the divisional or corporate level;

10. RISK MANAGEMENT GOVERNANCE FRAMEWORK

UHN's governance structure identifies the relevant Committees and their relationship to the Board in providing assurance of the robustness of risk processes and to support the Board in achievement of objectives. Specific responsibilities in relation to this Strategy are monitored by the following UHN Committees as delegated by the Board:

- Audit Committee (AC)
- People Committee (PC)
- Quality and Safety Committee (QSC)
- Finance and Investments Committee (FIC)
- Operational Performance Committee (OPC)

Operational meetings:

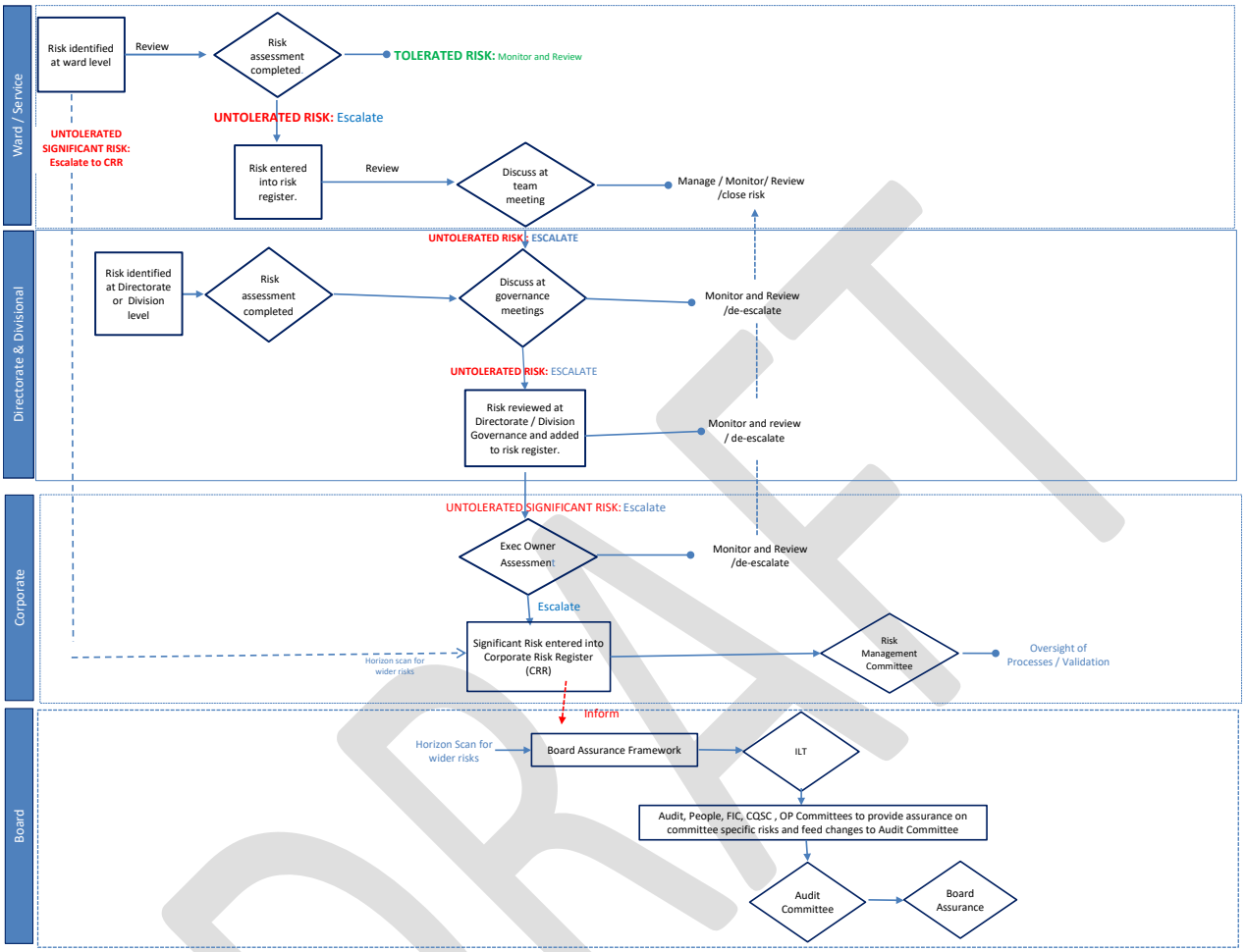
- Each division and corporate area will have a forum where risk assessments and registers are considered;
- Risks will be identified and managed where appropriate at operational levels (wards, departments etc) with upward assurance reporting into the divisional and corporate forums; with escalations into divisional risk registers where risks cannot be tolerated;
- Present risk registers as determined by a work programme via the Risk Management Committee in order to provide assurance of effective risk management processes.

Risk Management Mechanisms

The Board Assurance Framework (BAF) sets out the strategic objectives (priorities), identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation.

The Corporate Risk Register is an operational risk register used as a tool for operational managing risks that are assessed at an extreme level and for monitoring actions and plans against them. Corporate risks can individually be informed by a number of collective operational risks across UHN and where those risks are extreme or of a sufficiently high level to collectively indicate an extreme risk.

Divisional Risk Registers are risk registers held by each Division or Corporate team that is informed by departmental, ward and directorate risk registers (known as local risk registers). Divisional risk registers are also informed by risks identified separately as impacting on the Division/Corporate Team's ability to deliver its objectives.



11. TRAINING

Training required to fulfil this framework will be provided in accordance with a UHN training needs analysis and in line with UHN's Statutory and Mandatory Training Policy.

The Board will receive refresher training on an annual basis aligned to Board development sessions linked to risk management and review of UHN's risk management appetite against its strategic objectives.

12. MONITORING EFFECTIVENESS

- The relevant Board Committees will undertake a review of strategic risks owned by each committee (described as 'deep dives') in order to provide assurance to the Board of the effectiveness of identification and description of risks, controls and assurances, together

with planned actions to reduce levels of risk. The deep dive will also include consideration of levels of identified risk and risk appetite in line with the Board's agreed risk appetite;

- The Audit Committee will by rotation 'call-in' Committee Chairs and Lead Executives to seek assurance on the effective oversight of strategic risk at Board Committees, which will include a focus on risk appetite;
- Divisional and Directorate risk registers will be subject to a "deep dive" presentation on a rotational basis to the Risk Management Committee;
- Upward assurance reporting on effective governance of risk management systems from the Risk Management Committee into the UHN Audit Committee and Quality and Safety Committee;
- Quarterly reporting into the Risk Management Committee against progress with this strategy's objectives;
- Internal audit of risk management systems and processes in line with the agreed audit cycle;
- The Audit Committee will undertake regular reviews of the effectiveness of the risk management strategy and process against its objectives and any audit recommendations and will draw upon the internal audit function for independent assurance on the effectiveness of the risk management strategy and Risk Management Committee.

13. EQUALITY IMPACT ASSESSMENT

As part of its development; this strategy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible, remove any disproportionate impact on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

Appendix 1 Risk Management Scoring Matrix (5x5 Matrix)

Consequence Score/Domain		Likelihood Score/Domain				
		1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost certain
5	Catastrophic	5	10	15	20	25
4	Major	4	8	12	16	20
3	Moderate	3	6	9	12	15
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5

For grading risks, the scores obtained from the risk matrix are assigned grades as follows

1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-20	Significant risk
25	Extreme risk

Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	9 May 2025
Agenda item	11

Title	Board Assurance Framework (BAF)
Presenter	Richard Apps, Director of Corporate and Legal Affairs
Author	Debbie Spowart, Head of Risk

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

Group priority				
☑Patient	☑Quality	☑Systems & Partnerships	☑Sustainability	☑People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
To provide assurance of relationship between the Group Board Assurance Framework (BAF) and the Corporate significant risks at both Kettering General and Northampton General Hospitals.	Previously considered by Board Committees during April 2025.

Report

This report provides oversight of the Group Board Assurance Framework at 17th April 2025 and the relationship between the strategic risks on the Group BAF and the significant risks contained on the Corporate Risk Registers at both Kettering General (KGH) and Northampton General Hospitals (NGH) that potentially impact on the BAF's strategic risks.

Risk Management is both a statutory requirement and an indispensable element of good management and is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the Trusts abilities to discharge its functions as a partner in the local health and social care community, as a provider of health services to the public and an employer of significant numbers of staff.

To ensure best practice in good governance, and to reach an outstanding rating under the CQC well-led domain, the Trust must demonstrate delivery of best practice and performance in risk management.

Each assigned BAF monitoring committee received the Group BAF in April 2025 alongside the associated significant corporate risks from each hospital.

Following Executive reviews, the following changes were made:

UHN01	L1: additional current controls and gaps in assurances added and updated. L2,3 4: tension to due dates L7: further planned actions removed as no longer viable
UHN02	No changes noted in Q4
UHN03	L1,L2, L4: Updates to gaps in controls, gaps in assurance and further planned actions
UHN04	Risk title updated. L1: current controls updated L2: Gaps in controls added / updated L2: Further planned actions achieved
UHN05	No update received for Q4
UHN06	No changes noted in Q4
UHN07	Control gaps removed as further planned actions achieved Residual risk score increased
UHN08	Three further planned actions achieved on L2 and L3

Appendix A details the group BAF and Appendix B details the alignment of significant corporate risks at both KGH and NGH at 17 April 2025.

In line with good governance, deep dives of each BAF risk are scheduled with the relevant committees throughout 2025.

Appendices

Appendix A – UHN Group BAF at 17/04/2025

Appendix B – Alignment of significant corporate risks at both KGH and NGH at 18/11/2024

Risk and assurance

As set out in the report.

Financial Impact

Financial risks are detailed within the BAF

Legal implications/regulatory requirements

Duty to identify and manage risks / CQC Well-Led

Equality Impact Assessment

Neutral

Group Board Assurance Framework
17th April 2025

University Hospitals of Northamptonshire NHS Group

Ref	Group Priority	Scrutinising Committee	Risk Title	Initial Risk Level (July 2022)	Current Risk Level (April 2025)	Movement (from Initial)	Residual Risk Level	Risk Appetite	Date Last Reviewed	Summary Updates
UHN01	People	People Committee	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.	**16**	**16**	→	**12**	**Moderate**	March 2025	L1: additional current controls and gaps in assurances added and updated. L2,3 4: tension to due dates L7: further planned actions removed as no longer viable,
UHN02	Quality	Clinical Quality and Safety Committee	Failure to deliver the UHN Clinical Strategy and clinical collaboration may result in some areas of clinical and financial unsustainability	**12**	**16**	↑	**8**	**Low**	November 2024	No update received for Q4
UHN03	Patient	Clinical Quality and Safety Committee	Deterioration in patient outcomes and experience as a result unwarranted variation in the provision of patient care	**12**	**16**	↑	**8**	**Low**	March 2025	L1,2 4: Updates to gaps in controls, gaps in assurance and further planned actions.
UHN04	Systems and Partnership	Operational Performance Committee	Failure of some or parts of the integrated care system (ICS) and wider partners to deliver transformed care will result in an impact on the level and quality (safe, effective, experience) services provided across the group	**16**	**16**	→	**12**	**High**	March 2025	Risk title updated. L1: current controls updated L2: Gaps in controls added / updated L2: Further planned actions achieved.
UHN05	Sustainability	Finance and Investments Committee	Risk of failing estate buildings and infrastructure due to age and suitability and, failure to deliver Group strategic estates plans, may prevent delivery of key Group strategies, e.g. Clinical Strategy	**12**	**12**	→	**6**	**High**	November 2024	No update received for Q4
UHN06	Quality	Clinical Quality and Safety Committee	Failure to deliver the long-term Group Academic Strategy may result in University Hospitals Northamptonshire's (UHN) ability to attract high calibre staff and research and education ambitions. Recognition of impact on financial income to the Group	**12**	**12**	→	**4**	**Low**	November 2024	No update received for Q4
UHN07	Quality	Clinical Quality and Safety Committee	Failure to deliver the Group Digital Strategy may result in our staff and patients not having the tools or information they need to deliver, and receive safe, high quality patient care.	**16**	**16**	↑	**16**	**High**	March 2025	Scrutinising committee updated. All further planned actions achieved to address existing control and assurance gaps
UHN08	Sustainability	Finance and Investments Committee	Failure to deliver a Group Medium Term Financial Plan results in an inability to deliver Trust, Group and system objectives.	**16**	**20**	↑	**12**	**High**	March 2025	L2 , L3: Further planned actions achieved

Principal Risk No:	UHN01	Risk Title:	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.
		Materialising in [any/several] of the following circumstances:	The Group People Committee will determine circumstances in which it considers the risk to have materialised, having regard to key qualitative and quantitative evidence including: (1) Sustained declines in Staff and People Pulse Survey key indicators in respect of response rates, discrimination, engagement and advocacy (2) Key metrics relating to sickness absence, turnover, vacancies and statutory and mandatory training/appraisal completions in special cause variation for at least three consecutive reporting periods (3)Key metrics relating to safe staffing in special cause variation for at least three consecutive periods (4)Customer experience performance/concerns referred from quality committees (5) Cumulative qualitative and anecdotal evidence identified in the course of business-as-usual activities e.g. Non-Executive site visits/presentations to Committee/regular communication mechanisms. (6)Corporate Risks (below) materialise.

Date Risk Opened:	April 2021	Date last reviewed	March 2025	Risk Classification:	Operational / Infrastructure	Risk Owner:	Group Chief People Officer	Scrutinising Committee:	People Committee

Corporate Risk Register Links:			
NGH CRR:	NCRR004 - Detrimental staff wellbeing and mental health including self-harm and suicide (Current risk score 20) NCRR005 - HCSW Retention (Current risk score 16) NCRR006 - Staff Morale (Current risk score 16)	KGH CRR:	KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 16)

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
16 (Extreme)		16 (Extreme)		12 (High)		Moderate
Consequence	Likelihood	Consequence	Likelihood	Consequence	Likelihood	Group Priority
4	4	4	4	4	3	People

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	Culture, Leadership & Inclusion programme.	National Staff Survey staff engagement and morale scores reviewed by People Committee (Internal) Anti- racism plan (Internal) UHN Anti-racism statement (Internal) Board Development session delivered compassionate inclusive leadership with commitment to individual EDI objectives (internal) Numbers completing leadership training & impact assessment reported to People Committee (Internal) National Staff Survey staff engagement and morale scores reported to People Committee (Internal) Appraisal completion rates reported to People Committee (Internal) Freedom to Speak Up staff survey scores (internal) Leadership programmes for all professional groups (internal) Flexible working and sexual safety programmes (internal)	.	Improvement plans based on staff survey results not in place Rethinking Racism education programme not fully embedded across the organisation EDI Strategy not in date Recognition that there is further work to develop new leadership skills as a result of restructure	Staff experience and improvement plans to be implemented Delivery of Rethinking Racism programme and associated toolkits to be embedded across UHN Revise new EDI strategy Develop management skills excellence programme to support capacity and capability	Culture Lead Inclusion Lead Head of OD and inclusion Head of People Development	31.03.2026 31.03.2026 31.06.2025 31.12.2025

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
2	Attraction and Resourcing Strategy, including international recruitment and Agency Transformation Programme	KPIs to identify whether risk is being realised: Vacancy rates, Turnover rates, Time to Hire, Agency Spend reported to People Committee (Internal) UHN induction programme Aligned bank rates and enhanced/escalated rates (internal) Temporary staffing hub governance processes at NGH (internal) DBS recheck process commenced in NGH (internal) Agency spend (WTE, % pay bill above cap and off framework) reported to Finance Committee and People Committee (Internal) and ICB Financial Recovery Board (external) National Staff Survey morale score reported to People Committee (Internal) Audit of recruitment processes reported to Audit Committee according to schedule (Internal)	Challenges recruiting shortage groups Time to Hire - process improvements required supported by automation People Digital including ESR functionality constraints and different use on both sites Aligned approach to DBS recheck funding Stabilisation of current substantive workforce Challenge in ability to attract and retain and engage Jnr/middle grade doctors		Targeted improvement programme to address high agency/bank use, growing worked WTE People Digital and ESR strategy to develop plan for increasing and aligning functionality and self service Complete DBS harmonisation by introducing Trust pays across UHN Workforce plan to stabilise current substantive workforce to reduce agency and bank reliance Develop and implement improving working lives for Jnr Doctors national programme	Head of People Planning/Process Head of People Planning/Process Head of People Planning/Process Deputy Chief People Officer (Workforce) Head of People Planning/Process	31.03.2026 31.03.2026 31.05.2025 31.03.2026 31.03.2026
3	Retention Strategy, including Health and Wellbeing and Recognition	Vacancy & Turnover rates, Absence rates reported to People Committee (Internal) Exit interview analysis reported to People Committee (Internal) National Staff Survey engagement and morale scores reported to People Committee (Internal) Greater consistency in approach to restorative justice across UHN evidenced in similar case load in both Trusts(internal) Opened Our Space at NGH & Basement Brasserie facility at KGH (internal) Just Culture approach embedded throughout policy harmonisation (Internal)	Restructure, alignment and funding of the UHN staff support offers . No group Recognition Strategy, recognised from poor staff survey results HCA career pathway	.	Development of Health and Wellbeing Strategy Delivery of UHN stay conversation tool kit Development of UHN Recognition strategy Review HCA pathway to provide clear developmental opportunities and improve retention	Head of HWB Head of Planning and Process Director of Comms and Engagement Director of People with DoN	30.06.2025 31.03.2025 30.06.2025 01.04.2025
4	Learning and Development Strategy	Statutory and mandatory training completion rates (MAST) and Appraisal completion rates reported to People Committee (Internal) Training audit (internal)	Approval process designed but not embedded Potential to not meet the target for national changes		Embed approved new appraisal process and supporting training package National induction alignment National mandatory training alignment	Head of People Development	31.08.2025 30.06.2025 31.07.2025

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
5	Clinical Strategy including detailed speciality strategies and workforce plans	Oversight of strategy documents to Group Transformation Committee (Internal) Workplan of prioritised alignment of policies (internal)	Prioritised timebound plan to deliver clinical collaboration (including enabling functions) 14 policies remaining to complete over remainder of year. Challenge for capacity with staff side to review and meaningfully consult	Development of People structure to support integrated clinical divisions to be finalised when agreed clinical model developed	Development of updated clinical strategy and associated supporting service strategies Deliver People team structure Completion of workplan of prioritised aligned UHN policies	Board Chief People Officer Head of People Partnering	31.03.2025 30.10.2025 30.09.2025
6	Safe Staffing Strategy	Safe staff metrics including Roster publication performance reported to People Committee (Internal) Compassionate rostering programme (KGH) (Internal) Self-rostering pilot (NGH) (Internal) Agile working Audit (NGH) (Internal) UHN Agile working policy ratified (internal)		No Nursing and midwifery and AHP workforce plan	Nursing and midwifery and AHP workforce plan to be developed	CNO	31.12.2025
7	Volunteering strategy	Number of volunteer hours/month reported to People Committee (Internal) Volunteer to career programme launched January 2024 (Internal) Improved diversity profile of volunteers reported to People Committee (internal)	Additional transport options needed for KGH to support patients/carers with mobility needs to move within the building No funding for schools' outreach work		Additional promotion required for current services provided	Head of Volunteer Services	31.03.2025 30.06.2025

Principal Risk No:	**UHN02**	**Risk Title:**	Failure to deliver the UHN Clinical Strategy and clinical collaboration may result in some areas of clinical and financial unsustainability						
		Materialising in any/several of the following circumstances:	Fragmented and inefficient service delivery Service cessation or interruption of service provision for fragile services Sub-optimal outcomes and patient experience Negatively impacting staff retention, recruitment and morale						
Date Risk Opened:	April 2021	**Date last reviewed**	November 2024	**Risk Classification:**	Quality, Operational, Infrastructure, Financial	**Risk Owner:**	Medical Director	**Scrutinising Committee:**	Clinical Quality and Safety Committee

Corporate Risk Register Links:			
NGH CRR:	NCRR007 - Failure to Meet National Cancer Waiting Times Standards (Current risk score 16) NCRR023 - Loss of PIFU data leading to loss of patient care and unquantifiable harm (Current risk score 16) NCRR028 - Equipment failure: Whole Blood Oximeter SpO2: AVOXimeter (Current risk score 15) NCRR029 - IVUS Intravascular Ultrasound. Not supported from March 2025. Essential Cath Lab Equipment. (Current risk score 16)	**KGH CRR:**	KCRR065 – Safe delivery of T&O Spinal Surgery (Current Risk score 15)

Initial Risk Score		**Current Risk Score**		**Residual Risk Score**		**Risk Appetite**
12 (High)		20 (Extreme)		8 (High)		Low
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	3	4	5	4	2	Quality

	Current Controls	**Plan Delivery Assurance/ Group IGRs (Internal / External)**	**Control Gaps**	**Assurance Gaps**	**Further planned actions to mitigate gaps**	**Action Owner**	**Due date**
1	The Clinical Strategy oversight through UHN ILT and the Clinical Quality and Safety Committee (Axis 1) and the UHN / UHL partnership board (Axis 2)	UHN Board governance updates (Quality, Finance, Transformation) (Internal) ILT updates and assurance (Internal) External reviews (Neonatal) (External) Agreement of 11 workstreams at partnership board April 2024 (Internal)	Resource constraints – clinical and project resource (Industrial action, Financial deficit. Ability to influence systemwide patient pathway changes		Review of enabling clinical capacity to affect change. Progress pathway reviews across system UEC and across Axis 2 (UHN/UHL)	Medical Director, Chief Operating Officer Medical Director, Chief Operating Officer	31.12.2024 31.12.2024
2	Detailed plan for subsequent phase of work that will focus on the integration of specific services – Review of Target Operating Models	Schedule of service strategy developments (Group) (Internal) Oversight monitoring through Asana Project Software (Group) (Internal) Standing clinical collaboration updates to Clinical Quality Safety and Performance Committees (Group) (Internal)	Resource Gaps Resource constraints – clinical and project resource		Progress the review of all services against Target Operating Model Review of enabling clinical capacity to affect change	Chief Operating Officer, Medical Director	Commence 30.09.2024

Principal Risk No:	**UHN03**	**Risk Title:**	Deterioration in patient outcomes and experience as a result unwarranted variation in the provision of patient care						
		Materialising in any/several of the following circumstances:	Increase in mortality and morbidity Hospital associated harm Adverse impact on patient, family and carer experience						
Date Risk Opened:	April 2021	**Date last reviewed**	March 2025	**Risk Classification:**	Quality, Operational, Infrastructure, Financial	**Risk Owner:**	Chief Nurse	**Scrutinising Committee:**	Clinical Quality and Safety Committee

Corporate Risk Register Links:			
NGH CRR:	NCRR003 - Risk that patients in NGH will suffer harm from falling (Current risk score 15) NCRR017 - There is a risk of an adverse event as a result of incorrect CTG interpretation (current risk score 15) NCRR021 - Not Sharing the Newborn NHS Number at Birth with Social Care	**KGH CRR:**	KCRR063 - A lack of formal outpatient parenteral antimicrobial therapy (OPAT) service is restricting our ability to provide high-quality care for people with complex infections in their usual residence KCRR068 - Improvements are required and assurances needed to ensure Children & Neonatal Services are safe. KCRR075 -National shortage of O Negative Blood KCRR080 - If the department is unable to take handover from EMAS within the required standard of 45 minutes, there is the risk that patients will be cared for on the back of an ambulance for an extended time KCRR081 - Demand for Homecare service exceeds to staffing levels to deliver a high quality service

Initial Risk Score		**Current Risk Score**		**Residual Risk Score**		**Risk Appetite**
12 (High)		16 (Significant)		8 (High)		Low
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	3	4	3	Patient

	Current Controls	**Plan Delivery Assurance/ Group IGRs (Internal / External)**	**Control Gaps**	**Assurance Gaps**	**Further planned actions to mitigate gaps**	**Action Owner**	**Due date**
1	Quality - standardisation	Policies and Guidelines and monitoring of compliance (Internal) Internal audit programme (external) Ward based Assessment & Accreditation (Internal) Self-assessments e.g., national IP BAF (Internal) CQC inspections January 2024 - Maternity Safe rating improved to RI and UEC Well Led improved to good. Both section 29a's lifted (External) Peer reviews and quality assurance visits accreditation programmes in specific services. e.g. CNST, JAG, HTA, HSIB, PLACE (External) Health inequalities report (Internal Assurance) Safeguarding report (Internal) Internal audit review of Safeguarding governance - limited assurance (2023/24) (External) Infection Prevention Control report and BAF (Internal) Internal audit review of IPC BAF - significant assurance 2023/24 (External) Quality and Safety Performance dashboard (Internal) Emergency Preparedness, Resilience and Response (EPRR) annual report (Internal) Internal audit review of CMG risk management and clinical governance - significant assurance (2023/24 and 2024/25) (External) UEC demand and capacity plan (Internal) Check my kit roll out alongside MEG (Internal) HAPU's below national benchmark for 3 months (internal)	Demand outstrips capacity across the UEC pathway; crowding and ambulance handover delays G&A bed deficit is necessitating consistent use of rapid flow and boarding. Coronial concerns – 2 x Neglect riders issued and 2 x PFD's Section 29a issued to NGH UEC pathway Ward to board oversight of outcomes and care process compliance is immature	Audit of care processes demonstrates poor compliance with some processes. Aligned quality and safety dashboard CQC have rated Emergency department as inadequate for safe at KGH Maternity services at KGH are on the MSSP National and regional concern. BSOTS is yet to be implemented. Healthcare associated infections are above nationally set trajectories. Increased incidence of unstageable and category 3 pressure ulcers. Falls per 1000 bed days at Spinneyfields is significantly above the national average.	Development of Winter plan 25/26 Development of UHN ward / department assessment & accreditation programme QSC oversight of the following improvement programmes via relevant exec led committee: - Perinatal safety (UHN) - Paediatric safety (KGH) - UEC (UHN) - Harm free care Oversight of care in TES Development of a Quality and Safety dashboard for QSC. Programme of safety reviews to identify unknown risks	Chief Operating Officer Chief Nurse / Medical Director	30.06.2025 31.03.2026 Ongoing Ongoing 30.04.2025 30.04.2025

Current Controls		Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
2	Quality - Learning & QI	Patient safety incident response plan (internal) Complaints and concerns (internal) Colleague engagement and feedback (internal) CQSCiC oversight of Q&S across the organisation (internal) Participation in national audits (external)	Readiness to implement new national standards PSIRF Concerns about responsiveness and quality of complaints Lack of patient and carer involvement in Shared Decision Making Proactive response to patient experience	Internal audit of PSIRP implementation demonstrated limited assurance at KGH (external) Evidence from paediatric service that learning has not been embedded and sustained	Total quality management review planned – externally led Development of UHN ward / department assessment & accreditation programme with QI embedded	Chief Nurse / Medical Director	31.03.2026
3	Quality – training	Statutory and mandatory training programme reported to PCC (Internal) Statutory and mandatory training performance below the expected compliance rate is driven through PRMs (Internal)	The is variation in training between sites for areas such as restrictive practices resulting in variation in outcomes	Some courses are below the expected compliance rate of 90% .	Oversight of compliance with PCC Review of statutory and mandatory programme to ensure this is reflective of best practice	Chief Nurse / Medical Director / Chief People Officer	Ongoing
4	Quality – workforce and culture	Clinical establishments set using evidenced based tool, national guidance and professional judgement (Internal) Oversight of staff survey outcomes and pulse survey (External) Freedom to speak up concerns (internal) Reasonable compliance with National Workforce Safeguards including bi-annual staffing report to Board (Internal)	Workforce plan Agency and temporary staffing use is above plan Concerns about culture in a number of services including paediatrics at KGH, cardiology across UHN, ITU at KGH, ophthalmology at NGH	Vacancy rate in midwifery, children's and healthcare support worker (HCSW) exceed national average (Internal) UHN financial deficit is unsustainable - impact on headcount and unfunded vacancy on clinical establishment (external)	Recruitment, retention & pastoral care plan to be monitored via NMAHP committee. Organisational Cultural change work Clinical workforce CIP programme	Chief Nurse / Medical Director / Chief People Officer	01.04.2026

Principal Risk No:	**UHN04**	**Risk Title:**	Failure of some or parts of the integrated care system (ICS) and wider partners to deliver transformed care will result in an impact on the level and quality (safe, effective, experience) services provided across the group						
		Materialising in any/several of the following circumstances:	Risk to delivering locally for our patients the core aims of Integrated Care Systems to; 1. Improve outcomes in population health and healthcare. 2. Tackle inequalities in outcomes, experience and access.3. Enhance productivity and value for money 4. Help the NHS support broader social and economic development.						
Date Risk Opened:	April 2021	**Date last reviewed**	March 2025	**Risk Classification:**	Quality, Financial	**Risk Owner:**	Director of Strategy Chief Operating Officer	**Scrutinising Committee:**	Operational Performance Committee

Corporate Risk Register Links:			
NGH CRR:	NCRR018 - Risk of reduced patient safety when demand exceeds capacity (Current risk score 20) NCRR032 - GPs will no longer provide prescriptions for conditions identified through tests not directly undertaken by the woman's surgery. (Current risk score 16)	**KGH CRR:**	KCRR011 - Continued extreme pressure on capacity and reported incidents of low nursing levels and delayed discharges creates the risk of creates the risk of poor quality of care and patient safety, combined with staff well-being. (current risks core 20)

Initial Risk Score		**Current Risk Score**		**Residual Risk Score**		**Risk Appetite**
16 (Extreme)		16 (Extreme)		12 (High)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	4	4	3	Systems and Partnership

	Current Controls	**Plan Delivery Assurance/ Group IGRs (Internal / External)**	**Control Gaps**	**Assurance Gaps**	**Further planned actions to mitigate gaps**	**Action Owner**	**Due date**
1	The effective working across the ICS and the wider partners including the Northamptonshire Integrated Care Board and the Northamptonshire Integrated Care Partnership	UHN Chair and GCEO representation at the Integrated Care Partnership and the Integrated Care Board (internal/ external) Integrated Care Partnership 10-year Strategy and Outcomes Framework (external) Alignment of the Health and Wellbeing Boards (North and West) strategies and ICB 5-year plan to the ICP 10-year strategy (external) ICB Strategy and planning group established to deliver the 5 year forward plan as per national guidance (internal / external) UHN non executive attendance on ICB committees (EXTERNAL) Governance mapping complete and shared with ILT (internal) UHL / UHN Partnership committee (internal / external) East Midland Acute Providers Network (internal / external)	Alignment of ICB plan with the Integrated Care Partnership strategy, Health and Wellbeing Boards strategies, operational planning requirements and UHN Group strategies and planning	Re-confirm level of focus on system resilience and working as a system to ensure delivery of collaborative working to deliver the strategies and supporting operational plans. Lack of assurance on delivery of system delivery plans	Further strengthening of the System Urgent and Emergency and discharge planning to Be Plans developed- delivery to be led at Place for North and West Mapping of all partnership strategies and plans into a clear framework and resetting of governance workstreams	DTQI DoS	30.09.2025 31.03.2025
2	Implementation of the ICS operating model to deliver good quality care, financial balance and improved outcomes. UHN leadership system, workstreams to develop Collaboratives, Place, Clinical Model, and enablers e.g., Digital, People, Estates, Finance with supporting delivery plans	Collaborative Boards developing prioritised delivery plans ((Internal / External); • MHLDA • Elective Care • CYP Establishment of Place Delivery Boards, Local Area Partnerships to deliver improved outcomes in population health and healthcare (Internal / External) Population Health Board (Internal / External) System Clinical Leads Board (Internal / External) System Quality Board (Internal / External) System Boards for enablers(Internal / External); • Estates • People • Digital Urgent and Emergency Care system Board and Planning (Internal / External)	Connection of decision making across the ICB to include Place and Collaboratives Lack of shared understanding of drivers of UEC pressures and delivery of the strategy to address the pressures UHN Place based approach and strategies	Limited assurance on delivery of effective and transparent place and neighbourhood working Consistent and contemporaneous board understanding of ICS operating model	Prioritisation of delivery and Out of Hospital, discharge, UEC strategy and Plans (to replace iCAN) priorities across the collaboratives and Place ICB / NEDs meeting to focus on operating model Monthly brief of ICS activity	DTQI DoS	31.03.2025 Commence 01/04/25

Principal Risk No:	**UHN05**	**Risk Title:**		Risk of failing estate buildings and infrastructure due to age and suitability and, failure to deliver Group strategic estates plans, may prevent delivery of key Group strategies, eg Clinical Strategy.					
		Materialising in any/several of the following circumstances:		May result in care delivery from poor clinical environments, cost inefficiencies, health and safety incidents, accidents and statutory non-compliance attributable to some degree to substandard existing estate, and lost opportunities for integrated care delivery at place, resulting in serious safety incidents causing injury or death, fines, prosecution and associated reputational damage.					
Date Risk Opened:	April 2021	**Date last Reviewed**	November 2024	**Risk Classification:**	Quality, Finance Infrastructure	**Risk Owner:**	Director of Strategy Director of Operational Estates	**Scrutinising Committee:**	Finance and Investments Committee
Corporate Risk Register Links:									
NGH CRR:	NCRR011 - Risk of exposure to asbestos fibre from lack of management to exposure (Current risk score 15) NCRR012 - Risk of asbestos related diseases from exposure to asbestos fibre (Current risk score 20) NCRR013 - Risk of failure to meet national standards of cleaning (Current risk score 16)			**KGH CRR:**	KCRR015 - No sustainable capacity for urgent care (Current risk score 20) KCRR026 - Risk of loss of power or reduced power to site if the main high voltage incoming switchgear fails (Current risk score 15) KCRR030 - Loss of heating and hot water failures and interruptions to some or all areas of the trust due to age of boiler system (Current risk score 16) KCRR059 - Risk to patient safety and quality of care due to the current layout of LNU as there is a lack of visibility of all babies and the lack of continuous supervision of these babies (Current risk score 16) KCRR036 - Recognition that due to the age of the Trusts estate not all wards or services have suitable environments to be able to provide a high-quality service from. (Current risk score 16) KCRR045 - A significant increase in headcount coupled with reduced useable office accommodation puts at risk operational and clinical efficacy and compliance with workplace occupational health and safety regulations (Current risk score 16) KCRR055 - Recognition that areas of Trust could fall into darkness due to aged lighting that is no longer available (Current risk score 15) KCRR070 - Impact on delivery of services during inspection of RAAC found to be present in Rockingham Wing (Current risk score 15)				

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
12 (High)		12 (High)		6 (Moderate)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
3	4	3	4	3	2	Sustainability

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	Completed and approved Group Clinical Strategy will define the clinical requirements of both sites for the future.	Clinical service strategy focus and implementation plan (internal) Target Operating Models complete for 30+ clinical services (internal) D&C complete for inpatients and diagnostics (internal)		UHN UHL Clinical Strategy Capacity Long Term plan	Development of UHN UHL Clinical Strategy Development of Capacity Long Term Plan	Director of Strategy	31.03.2025
2	Kettering Hospital now have a full Development Control Plan for the whole site, forming part of the HIP2 and other programmes. Northampton Hospital have a site masterplan. OBC has been submitted NGH Masterplan funding	Kettering HIP2 SOC has been submitted and a Local Development Order has been signed with Kettering Planning Authority (Internal / External) Board oversight of KGH outline business case (internal) Development Control Plan (NGH)		No single Board committee that oversees all estate and strategic estate development.	Developmental Control Plan (NGH)	Director of Strategy	31.03.2025

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
3	These foundations will come together to start to form the Group Strategic Estates Plan.			The Group requires a joint Strategic Estates Plan that supports delivery of the Group Clinical Strategy	Group Strategic Estates Plan to be commissioned following completion of the Group Clinical Strategy.	Director of Strategy	31.12.2024
4	A System Estates Board is in place across the ICS with all Health and Care partners.			The System Estates Strategy is not strategic and needs further development System wide view of all provider / partner strategic estate need / plans	Outcome of Draft Northamptonshire Infrastructure Strategy that has been completed and submitted Strategy to be refreshed on completion of Estates planning demand and capacity modelling – ICB Director of Strategy and Planning. Undertake an annual review of the strategy in line with our 5 Year plan – ICB, Director of Strategy and Planning System Infrastructure strategy to be completed by ADEPT	ICB Director of Strategy and Planning UHN DoE&F	31.12.2024 01.04.2025 01.08.2025 31.03.2025
5	All key estates infrastructure elements have independent AE (authorising engineers) appointed, annual audits and action plans in place; technical and trust meetings in place.	Monthly estates assurance report for each hospital is presented at the Finance CiC (internal) Technical meetings in place to review progress against audit plans (internal)					
6	Business continuity plans and infrastructure resilience/back up systems are in place	Estates infrastructure is regularly tested (internal) Risk rated capital backlog plans in place (internal) Estates strategies for each site (internal)	Infrastructure is aging and estates capital plans are insufficient to replace all equipment	assurance for Estates infrastructure BCP to be included in estates assurance reporting, with input from EPRR leads	Annual review of Business Continuity Plans	EPRR Leads	31.03.2025
7	Estates backlog capital programme	Trust capital committees (internal) KGH 6 Facet Survey (internal)		NGH 6 Facet survey due for renewal 24/25	Tender for completion of a full site 6 facet survey for NGH	DofE NGH	01.01.2025

Principal Risk No:	**UHN06**	**Risk Title:**	Failure to deliver the long-term Group Academic Strategy may result in inability to attract high calibre staff and deliver on our research and education ambitions.						
		Materialising in any/several of the following circumstances:	Sustainability of 5-year project Impact on financial income to the Group Impact on patient outcomes and experience Lack of progress with our academic partnerships and collaborations with local universities, with potential to impact on University status						
Date Risk Opened:	April 2021	**Date last Reviewed**	November 2024	**Risk Classification:**	Quality, Finance	**Risk Owner:**	Medical Director Director of Strategy	**Scrutinising Committee:**	Clinical Quality and Safety Committee

Corporate Risk Register Links:

NGH CRR:		**KGH CRR**	KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 20)

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
12 (High)		12 (High)		4 (Moderate)		Low
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	3	4	3	4	1	Quality

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1.	Academic and Research Strategy oversight through UHN ILT and the Clinical Quality and Safety Committee (Axis 1) and the UHN / UHL partnership board (Axis 2)	UHN Board governance updates (Quality, Finance, Transformation) (Internal) ILT updates and assurance (Internal) External reviews (Neonatal) (External) Agreement of 11 workstreams at partnership board April 2024 (internal) Appointment of UHN UHL Director of Research (internal) Agreed UHN UHL workstream on growing and developing together our research and trials portfolio (internal)	Resource constraints – clinical and project resource (Industrial action, Financial deficit Ability to influence systemwide recruitment of patients into research.		Review of enabling clinical capacity to affect change. Recruitment of UHNUHL Director of Medical Education Progress standardisation of academic and research governance, operational structures, recruitment key joint posts and expansion of opportunities for cross organisational trials	Medical Director Medical Director Chief Nursing Officer	31.12.2024 31.12.2024 31.12.2024

Principal Risk No:	**UHN07**	**Risk Title:**	Failure to deliver the Group Digital Strategy may result in our staff and patients not having the tools or information they need to deliver, and receive safe, high quality patient care.						
		Materialising in any/several of the following circumstances:	- Patients are not in control of, or kept well informed of, their care so we fall behind standards and expectations of patients - Clinicians do not have the access to full, accurate and timely patient information when they need it, leading to a negative impact on patient care decisions - and therefore outcomes - Staff (clinical and non clinical) do not have the tools, (or the tools are not based on a secure and reliable supporting digital infrastructure), to perform their roles effectively, resulting in poor productivity, poorer outcomes for patients, and a block on their ability to collaborate easily and well, within UHN and also more widely. - Managers and clinicians do not have relevant, accurate, consistent and reliable data readily available in a useful form, to make timely informed decisions, leading to greater operational challenges for UHN, and poorer patient outcomes as result.						
Date Risk Opened:	April 2021 Revised April 2023	**Date last Reviewed**	March 2025	**Risk Classification:**	Quality, infrastructure, finance	**Risk Owner:**	Group Chief Digital Information Officer	**Scrutinising Committee:**	Clinical Quality and Safety Committee
Corporate Risk Register Links:									
NGH 93 - Clin Apps - No Electronic Prescribing and Medicine Administration System (EPMA) (Current risk score 16) NGH 114 - TECH - threat to our IT systems and / or infrastructure from a cyber or malware attack resulting in a loss of service or data (Current risk score 15)				**KGH CRR:**	KCRR038 - Loss of the current Intranet service and experience a loss of data contained therein. (Current risk score 16) KCRR009 - Threat to IT systems from Cyber security and malware attacks (Current risk score 16)				

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
16 Signifiiant)		16 (Significant)		16 (Significant)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	4	4	**2**	Sustainability

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	Digital Transformation governance structure to monitor and support project delivery against plan	Digital Transformation governance structure including programme boards (EPR; digital transformation, infrastructure boards; health intelligence transformation; robotic process automation and communication and engagement group) with accompanying reports (internal) UHN Digital Forward View summarising plan and priorities for the year ahead – agreed by ILT (internal) Regular updates to ILT on digital delivery and any UHN decisions needed (e.g. on re-prioritisation of the plan as needs arise) (internal) UHN attendance at ICS digital and data board to help tie UHN and ICS ambitions together and also secure support from wider ICS colleagues where required (Internal) TIAA audit (reasonable assurance report)(Internal) ICS Digital Director involvement and ICS involvement with digital strategy (external) Digital Delivery Group set up as sub-committee of Quality Committee – upward reports sent for assurance (internal) Robotic Process Automation feeds into Digital Delivery Group (internal) UHN Digital attendance at wider governance forums for updates/ sharing of information – e.g. Divisional meetings (internal) ICS Digital Strategy oversight group linked to all CIOs from Northamptonshire (upward group from ICS digital and data board) (internal/ external) Digital collaboration with Uhl (external)					

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
2	Operational governance structure (meetings/committees) to review and oversee the performance of the 'business as usual' parts of the Digital Division's work (e.g. financial control & risk management, and performance of ICT areas such as security, systems performance, upgrades, hardware management, etc))	Digital Operational Meeting oversees with reports feeding in from Data Security and Protection Group, risk, finance as well as oversight of operational KPIs and incident management. Digital Operational Meeting feeds into sub-committee structure through Digital Delivery Group (internal) Regular meetings and joined up strategic discussions with UHL/ICB CISO (External/ Internal) Visibility of ICS wide CISO over plans (internal) ICB/UHN/UHL CISO scheduled meetings. (internal / external) Digital and Finance UHN / UHL overview of position and funding Opportunities (Internal / External) Weekly DSLT meetings (Internal) Joined up function with UHN and UHL (Internal) Governance structure agreed at Senior Exec and DSLT level (internal)					
3	Prioritisation governance process (including representatives from a diverse range of staff) to oversee digital transformation prioritisation.	Regular updates to ILT on digital delivery and any UHN decisions needed regarding re-prioritisation of the plan as needs arise) (internal) Operation of key forums from Digital which feed into prioritisation process including the Clinical Design Authority (main forum for clinical and operational input into digital transformation agenda) and Technical Design Authority (main forum for checking ideas are technically feasible for consideration) authority groups. (internal / External) Digital Clinical and Operational Design Authority (CODA) with strong clinical leadership (internal)					
4	Structured communication and engagement activities with clinical and operational leadership on the digital agenda including:	UHN Digital Communications and Engagement Group with communication and engagement plan (internal) UHN Digital Champion network (internal) UHN Digital academy to oversee digital training and support and digital competency Internal) Digital UHN branding (internal) UHN Digital Communications and Engagement Group feeds into sub-committee structure through Digital Delivery Group (Internal) Regular attendance at patient engagement forums (internal and ICS) (Internal/ External)					
5	Plan to have the resource (digital, clinical and operational) required to ensure capability and capacity required to deliver	Restructure of digital teams into UHN team for greater flexibility and wider skill set to draw upon (internal) Reporting through digital programme groups on resource requirements/ engagement (internal)					

Current Controls		Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
6	Supplier management process to manage relationships with key digital suppliers and key contracts, to ensure confidence in their ability to deliver and manage any risks.	Contractual meetings between Digital SLT and account managers of suppliers (internal) Reporting through digital programme groups on supplier delivery (internal) Regular Exec meetings with KGH EPR supplier (internal) East Midlands Acute Partners group set up to jointly manage/ mitigate NGH EPR supplier risk– regular attendance by UHN CDIO (External / Internal) EPR governance across UHN reviewed and reinvigorated with steering groups chaired by Medical Director and CDIO (Internal) Attendance at East Midlands Acute Partners EPR group (External) UHL engagement to review supplier commonality and collaborate on engagements (internal)					
7	Strategy/ approach to seek out nationally funded programmes of work (e.g. EPR) to ensure necessary funding to deliver as much of our strategic ambitions as possible, as soon as possible	CDIO / ICB Digital Director/ NHFT CDIO collaboration – regular meetings to determine national funding options (External) CDIO interaction with National CDIO forums and NHS England (External)					

Principal Risk No:	**UHN08**	**Risk Title:**	Failure to deliver improvement in underlying revenue finances and develop a path out of financial deficit to breakeven over the medium term:						
		Materialising in any/several of the following circumstances:	The Finance and Investment Committee will advise the Trust Boards on financial performance: - Financial run rate deteriorating - Efficiency delivery not meeting targets - Cost assumptions including inflation materialising at high levels than planned - Industrial actions creating unplanned and unfunded costs - Medium term financial plan development is not underpinned by clinical and operational strategy. - Capacity, consistency and accountability leads to different approaches in each Trust						
Date Risk Opened:	April 2021	**Date last reviewed**	March 2025	**Risk Classification:**	Financial Operational	**Risk Owner:**	Chief Finance Officer	**Scrutinising Committee:**	Finance & Investment Committee

Corporate Risk Register Links:			
NGH CRR:	NCRR025 - Failure in having financial control measures to deliver the 24-25 Financial Plan and return to medium term financial balance (Current risk score 20) NCRR026 - The Trust may not have sufficient capital for Capital requirements or may not be able to maximise its capital spend (Current risk score 15)	**KGH CRR:**	KCRR056 - Failure in having financial control measures to deliver the 22-23 Financial Plan and return to medium term financial balance (Current risk score 20)

Initial Risk Score		**Current Risk Score**		**Residual Risk Score**		**Risk Appetite**
16 (Extreme)		20 (Extreme)		12 (High)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	5	3	2	Sustainability

	Current Controls	**Plan Delivery Assurance/ Group IGRs (Internal / External)**	**Control Gaps**	**Assurance Gaps**	**Further planned actions to mitigate gaps**	**Action Owner**	**Due date**
1	Budgets	Documented, understood and signed off budgets by budget managers (internal) Alignment of bottom up evidenced based budgets with top down high level budget (internal) Agreed risk and contingency approach aligned to Board risk appetite (internal)	Budget setting and management processes are not fully aligned across both Trusts Capacity gaps within the function due to sickness and recruitment / retention Triangulation of finance budgets with workforce and activity		Ensure capacity issues addressed as part of team structure review Ensure best practice and consistency is adopted across both teams and all budgets are issued and signed for the 25/26 year	Chief Finance Officer & Senior Finance Team	31.03.2025
2	Affordability / Accountability	Equal focus is given to funding (affordability) of investments as determining the costs (Internal) Defined goals and priorities to support budget setting (internal) Stakeholder involvement in the budget process sharing analysis, risks, and working to understand choices (internal/ External) Financial performance has significant focus and increased profile across UHN (internal) Benefits and Affordability Business cases (internal)	Culture of investigating funding options and focus on affordability		Ensure all financial controls are operating efficiently and effectively.	Chief Finance Officer	31.03.2025
3	Reporting / Risk Appetite / Planning / Performance Management	Risk appetite / risk and contingency planning (internal) Financial planning for effective public financial management along with budget preparation, performance management and stakeholder reporting (internal) Power BI budget manager reporting (internal) Refreshed Performance assurance process (internal). Methodology and governance in place to support effective use of staffing, reduce variation and deployment. (internal)	Static reporting and access to financial information is lacking.		Further Progression of KPI dashboards – including conduct a full review of KPI's across the organisation, including all contractual and local indicators along with a review of all performance reports across each tier, ensuring appropriate levels of analysis is available to strengthen challenge and decision making.	Chief Finance Officer	31.03.2025

4	Culture / Choices / Control	Scenario planning and advanced forecasting provided by Finance's partnership role (internal) Streamlined intergroup transactions and recharges (internal)	Single set of Standing Financial Instructions across UHN (currently in draft and awaiting approval) Capacity in Financial Management teams with a high level of turnover High number of procurement waivers and non-compliance Senior Finance team structure does not promote accountability and ownership across UHN		Exploit the technology, including through automation to eliminate manual tasks within finance Budget management training and support effectiveness to be reviewed Financial Services restructure timeline to be finalised Framework for tough choices to be developed Support identification of organisational choices Reduce use of exceptions in relation to procurement, locally described as maverick and waivers, only use direct awards where appropriate and drive value through documented outcome-based specifications. Corporate teams within finance directorate to consider optimised arrangements across UHL /UHN Develop senior finance team capacity and support professional development including One NHS Finance resources	CFO	31.01.2025

Corporate Risks Aligned to BAF risks @ 17th April 2025

BAF Link	Risk ID (BAF/CRR)
UHN001 (Group People Plan)	KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 16)
	NGH46 - Detrimental staff wellbeing and mental health including self-harm and suicide (Current risk score 20) NGH47 - HCSW Retention (Current risk score 16) NGH49 - Staff Morale (Current risk score 16)
UNH002 (Clinical Strategy)	KCRR065 – Safe delivery of T&O Spinal Surgery (Current Risk score 15)
	NGH88 - Failure to Meet National Cancer Waiting Times Standards (Current risk score 16) NGH885 - Loss of PIFU data leading to loss of patient care and unquantifiable harm (Current risk score 16) NGH 965 - Equipment failure: Whole Blood Oximeter SpO2: AVOXimeter (Current risk score 15) NGH976 - IVUS Intravascular Ultrasound. Not supported from March 2025. Essential Cath Lab Equipment. (Current risk score 16)
UHN003 (Group Nursing, Midwifery and Allied health Professionals strategy)	
	NGH42 - Risk that patients in NGH will suffer harm from falling (Current risk score 15) NGH307 - There is a risk of an adverse event as a result of incorrect CTG interpretation (current risk score 15) NGH752 - Not Sharing the Newborn NHS Number at Birth with Social Care
UHN004 (Integrated Care Board)	KCRR011 - Continued extreme pressure on capacity and reported incidents of low nursing levels and delayed discharges creates the risk of creates the risk of poor quality of care and patient safety, combined with staff well-being. (current risks core 20)
	NGH424 - Risk of reduced patient safety when demand exceeds capacity (Current risk score 20) NGH890 - GPs will no longer provide prescriptions for conditions identified through tests not directly undertaken by the woman's surgery. (Current risk score 16)
UHN005 (Group Strategic Estates Programme)	KCRR015 - No sustainable capacity for urgent care (Current risk score 20) KCRR036 - Recognition that due to the age of the Trusts estate not all wards or services have suitable environments to be able to provide a high-quality service from. (Current risk score 16) KCRR059 - Risk to patient safety and quality of care due to the current layout of LNU as there is a lack of visibility of all babies and the lack of continuous supervision of these babies (Current risk score 16) KCRR030 - Loss of heating and hot water failures and interruptions to some or all areas of the trust due to age of boiler system (Current risk score 16) KCRR055 - Recognition that areas of Trust could fall into darkness due to aged lighting that is no longer available (Current risk score 15) KCRR026 - Risk of loss of power or reduced power to site if the main high voltage incoming switchgear fails (Current risk score 15) KCRR070 - Impact on delivery of services during inspection of RAAC found to be present in Rockingham Wing (Current risk score 15) KCRR077 – Significant leaks in roof over Skylark ward resulting in loss of beds (Current risk score 15) KCRR045 - A significant increase in headcount coupled with reduced useable office accommodation puts at risk operational and clinical efficacy and compliance with workplace occupational health and safety regulations (Current risk score 16)
	NGH258 - Risk of incorrect disposal of clinical waste at source (Current risk score 15) NGH259 - Risk of exposure to asbestos fibre from lack of management to exposure (Current risk score 15) NGH 262 - Risk of asbestos related diseases from exposure to asbestos fibre (Current risk score 20) NGH 265 - Heating and hot water infrastructure (Current risk score 16) NGH 270 - Risk of failure to meet national standards of cleaning (Current risk score 16) NGH 301 – Risk of failure of gas interlock system (Current risk score 15)
UHN006 (Group Academic Strategy)	KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 20)
UHN007 (Digital Strategy)	KCRR038 - Loss of the current Intranet service and experience a loss of data contained therein. (Current risk score 16) KCRR009 - Threat to IT systems from Cyber security and malware attacks (Current risk score 16) KCRR079 – Adult Endocrinology do not have the right software for national data submissions (Current Risk Score 15) KCRR074 - Maternity services at risk of failing to meet the national requirements on recording of maternity care (Current Risk Score 15) KCRR072 – Destruction of Medical records (Current risk score 15)
	NGH 93 - Clin Apps - No Electronic Prescribing and Medicine Administration System (EPMA) (Current risk score 16) NGH 114 - TECH - threat to our IT systems and / or infrastructure from a cyber or malware attack resulting in a loss of service or data (Current risk score 20) NGH 904 - Failure to Implement NGH EPR due to resourcing (Current risk score 16) NGH 887 - Systems purchased with no Digital or Data Security and Protection checks (Current Score 16) NGH 940 - Current Oracle DWH stops working (Current Score 15)
UHN008 (Group Medium Term Financial Plan)	KCRR056 - Failure in having financial control measures to deliver the 23-24 Financial Plan and return to medium term financial balance (Current risk score 20)
	NGH 905 - Failure in having financial control measures to deliver the 24-25 Financial Plan and return to medium term financial balance (Current risk score 20) NGH 906 - The Trust may not have sufficient capital for Capital requirements or may not be able to maximise its capital spend (2024/25) (Current risk score 15)

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	9 May 2025
Agenda item	12
Title	Integrated Leadership Team (ILT) Terms of Reference
Presenter	Richard Apps, Director of Corporate and Legal Affairs
Author	Richard May, Company Secretary

This paper is for			
X Decision	☐Discussion	☐Note	☐Assurance
To formally receive and discuss a report and make a decision/decisions based on the option/options recommended	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
Changes to ILT's Term of Reference are required to be approved by the Boards of Directors.	ILT, 7 April 2025

Executive Summary

ILT has reviewed its Terms of Reference to reflect the new divisional leadership structure which was implemented on 1 April 2025. The proposed changes are marked in red text in the appendix and are intended to:

- Clarify membership and chairing arrangements (note that the UHN/UHL Chief Executive is no longer a member of ILT) and quorum (paragraphs 2.1 and 4), and
- Add finance and divisional accountability reports to the list of standing items (section 7).

The Boards of Directors are requested to **approve** the revised ILT Terms of Reference set out in the Appendix, noting that further review will be required following the conclusion of the ongoing review of group corporate governance.

Appendices

Draft revised ILT Terms of Reference

Risk and assurance

No direct implications for the Board Assurance Framework

Financial Impact

None

Legal implications/regulatory requirements

As 'reason for consideration' above.

Equality Impact Assessment

Neutral

Integrated Leadership Team Terms of Reference

Approved by the UHN Boards on 4 October 2024

Version control table

Version	Date	Summary of changes
V1.0	December 2023	Drafted by Teneo
V1.1	March 2024	Presented to ILT for approval
V1.2	August 2024	Cross-reference ILT duties when constituted as the Patient Safety Committee. Minor typographical amendments
V1.3	April 2024	Reviewed post Divisional Consultation

1.Purpose

1.1. The purpose of the Integrated Leadership Team (ILT) is to act as the executive-level decision making group of UHN, with delegated authority to undertake a leadership role on behalf of the Chief Executive to drive and support collaboration and ensure the delivery of the UHN strategic objectives.

1.2. The ILT will be accountable to the UHN Boards of Directors.

2. Membership

Membership

2.1 ILT comprises the following postholders:

- UHN Chief Executive (Chair, to nominate a Deputy in their absence)
- UHN Executive Directors
- UHN Divisional Clinical Directors

2.2 If a member is unable to attend a meeting of the ILT, they will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered to represent their topic effectively.

2.2.1 The Deputy should be notified to the Chair in advance of the relevant meeting

2.2.2 The Deputy is eligible vote and should count in the quorum

2.3 At the discretion of the chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

2.3.1 Senior managers where items are discussed relating to their portfolio

2.3.2 Representatives of Trust organisations, who are not part of the core membership

2.3.3 Members of the Trust core teams and external advisers.

3. Secretary

3.1 The Director of Corporate and Legal Affairs will make arrangements to ensure effective administration support is provided to the meeting, including agenda and workplan setting, timely papers distribution, minute taking and recording and tracking of meeting actions. In addition, they will ensure adequate training and support, and effective systems for the distribution of papers are available to the team administrator.

4. Meetings and Quorum

4.1 The quorum for meetings is at least three Executive Directors (excluding the ILT Chair or Vice Chair) and three Clinical Directors. The Chief Financial Officer (or nominated deputy) must be in attendance for all items seeking financial investment.

4.1 No more than two deputies shall count towards the quorum. A duly convened meeting of the Integrated Leadership Team at which a quorum is present shall be competent to exercise all or its authorities, powers, and discretionary duties.

Frequency of meetings

5.1 The ILT will meet weekly (including by telephone or video conferencing), or as determined by the Chair. Any member of the Group can ask the Chair to call a meeting to be convened in person, by videoconference, or by telephone, or for a matter to be considered in correspondence.

5.2 Once per month the ILT will be constituted as the Patient Safety Committee (under separate Terms of Reference). The Patient Safety Committee will report to the Clinical Quality and Safety Committee of the Boards of Directors.

5.3 Members are expected to attend a minimum of 75% of meetings on an annual basis. Attendance will be monitored as part of the appraisal process.

Notice of meetings

5.4 Unless otherwise determined by the Chair, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers shall be circulated to each member of the ILT and any other person required to attend, no later than two clear working days before the date of the meeting (i.e. excluding the day of dispatch and the day of the meeting).

6. Declarations of Interest

6.1 All members must declare any actual or potential conflicts of interest relevant to the work of the meeting, which shall be recorded in the Minutes accordingly.

6.2 Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict of interest.

7. Duties and responsibilities

7.1 Ensure timely clinical and strategic decision making in line with the Schemes of Delegation (SoD) and Standing Financial Instructions (SFIs). (Note: Decisions relating to the collaboration between UHN and UHL should be referred to the Partnership Board.)

7.2 Oversee major work and UHN-wide risks set out in the Board Assurance Framework

7.3 Oversee the delivery of UHN's objectives and annual plans

7.4 Development, oversight and delivery of UHN's Strategy, Priorities and transformation initiatives, ensuring that a joined-up approach is taken across UHN

7.5 Develop, provide oversight to ensure delivery of the Trusts' annual integrated business plans, covering quality, finance, people and performance

7.6 Ensure a UHN-wide approach is taken to performance review and strategy development

7.7 Be responsible for the achievement of strategic objectives, compliance with statutory duties, performance standards and quality care

7.8 Promote and embed UHN's values and reinforce an open and inclusive culture

7.9 Support individual Executive Directors to deliver their delegated responsibilities by providing a forum for exchange of information, mutual support, and resolution of issues and achievement of agreement.

7.10 Identify issues for escalation to the appropriate Board committee as appropriate

7.11 Scrutinise any issues recommended for escalation to the Board and Committees, to ensure quality and accuracy

7.12 Identify opportunities for strategic alignment with external partners

7.13 Determine, or make recommendations, in respect of business cases, proposals and decisions, in line with approved limits set out within the Standing Financial Instructions and Schemes of Delegation and Reservation

7.14 Receive any escalations from the UHN Policy Ratification Group, regarding any documents which have a significant implication for UHN and are delayed in review

7.15 Provide a forum for exchanging information and providing mutual support between the trusts, identifying and disseminating good practice and/ or discussing and agreeing corrective actions where performance needs to improve, across UHN

7.16 Provide a mechanism for effective two-way communication and engagement between the Boards, ILT, and divisions.

Standing agenda items

The agenda and work plan will be structured around the themes of performance, finance, workforce and quality, Once per month the ILT will be constituted as the Patient Safety Committee (under separate Terms of Reference). The Patient Safety

Committee will report to the Quality and Safety Committee of the Boards of Directors.

- Feedback from the Board, Committees and Partnership Board
- Significant exceptions from trust operational teams and key messages for dissemination
- Finance Reports
- Divisional Accountability framework updates
- Group BAF, including escalation of distributed risk
- Items to escalate to the Board, Committees and Partnership Board
- Reports from sub-groups (where established)
- Policy approvals

8. Reporting responsibilities

The ILT is accountable to the UHN Boards through the Chief Executive, and it will formally escalate issues and decisions as required (as set out in its terms of reference), at the request of the UHN Board, or at the discretion of the Integrated Leadership Team Chair.

The ILT will make whatever recommendations to the UHN Board and Committees it deems appropriate in any area within its remit

The ILT will receive escalations / exceptions from its sub-groups.

9. Other matters

9.1 Amendments to these Terms of Reference must be approved by a resolution of each of the Boards of Directors. (KGH, NGH)

The ILT will:

9.2 Have access to sufficient resources to carry out its duties, including access to the Corporate Governance Team Governance team for assistance as required;

9.3 Consider any other matters where requested to do so by the UHN Boards;

9.4 Review its Terms of Reference to ensure that it is operating effectively at three monthly intervals for the first 12 months from the approval of these Terms of Reference, and thereafter annually. These reviews will be formally reported as part of the Chief Executive's appraisal.

10. Authority

The ILT is authorised to:

10.1 Seek any information it requires, or request attendance at a meeting, from any employee of KGH or NGH, in order to perform its duties;

10.2 To appoint groups with such membership and terms of reference as the Integrated Leadership Team may determine and delegate any of its responsibilities to such groups.

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	9 May 2025
Agenda item	13

Title	Use of the NGH Trust Seal
Presenter	Richard Apps, Director of Corporate Affairs
Author	Richard May, Group 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 **NGH** Board of Directors is requested to note 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.

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