UHN Boards of Directors Meeting in Public

Fri 06 February 2026, 12:30 - 15:30

Boardroom, Kettering General Hospital

Agenda

12:30 - 12:30
0 min

1. Welcome, apologies and declarations of interest

Andrew Moore

- 1. UHN Public Boards Agenda 060226.pdf (2 pages)

12:30 - 12:50
20 min

2. Patient/Staff Story - Armed Forces Network

Presentation and Discussion *Suzie O'Neill*

12:50 - 12:50
0 min

3. Minutes of the previous meeting held on 5 December 2025 and Action Log

Decision *Andrew Moore*

- 3.1 051225 Draft Minutes UHN Public Board of Directors meeting.pdf (12 pages)
- 3.2 Board Action Log Updated 051225 Public Boards.pdf (2 pages)

12:50 - 13:00
10 min

4. Chair's report (verbal)

Information *Andrew Moore*

13:00 - 13:05
5 min

5. UHN Chief Executive's Report

Information *Laura Churchward*

- 5. CEO Public Board Report.Jan.2026.V1.pdf (3 pages)

13:05 - 13:45
40 min

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

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

- 6. Integrated Performance Report Cover Sheet Board.pdf (2 pages)
- 6. Dec 2025 Integrated Performance Report Board.pdf (65 pages)
- 6. Group Upward Reporting to UHN 060226 Boards (2).pdf (7 pages)

13:45 - 13:55
10 min

7. National Oversight Framework segmentation (25-26 Q2) (not received)

Rebecca Taylor

13:55 - 14:05
10 min

8. UHN Perinatal Assurance

8.1. Perinatal Scorecard (December 2025)

Assurance *Danni Burnett*

- 8.1 UHN Perinatal Scorecard January 2026 [Dec 2025 Data].pdf (3 pages)
- 8.1 Appendix 1 - UHN Perinatal Scorecard January 2026 [Dec Data] FINAL.pdf (22 pages)

8.2. Maternity Incentive Scheme Annual Submissions (Perinatal Assurance Committee)

Decision *Danni Burnett*

8.2 MIS UHN PAC Chairs Highlight Report [January 2026] final for Boards.pdf (9 pages)

14:05 - 14:20
15 min

9. KGH Maternity Safety Support Programme (MSSP) and CQC Report

Information *Danni Burnett*

BREAK 14:10-14:20

9. KGH MSSP_CQC Update February 2026.pdf (9 pages)

14:20 - 14:30
10 min

10. Emergency Preparedness, Response and Resilience (EPRR) Annual Report

Receive *Sarah Noonan*

10. EPRR Annual Report and CS Report 2025 v1.1.pdf (17 pages)

14:30 - 14:40
10 min

11. Corridor Care

Assurance *Richard Clarkson*

11. Corridor Care paper for board final draft.pdf (8 pages)

14:40 - 14:45
5 min

12. Annual Establishment Reviews: Safe Staffing

Decision *Richard Clarkson*

12. NMAER '25 Cover Sheet - Trust Board.pdf (3 pages)
12. Appx 1 UHN Nursing and Midwifery Annual Board Paper 2025 FINAL JH approved.pdf (19 pages)

14:45 - 14:55
10 min

13. Progress on actions in response to October 2025 Board stories

Assurance *Paula Kirkpatrick*

13. FINAL revised UHN Inclusion Activities April - December 2025 FA-P29Jan2026v2.pdf (8 pages)

14:55 - 15:05
10 min

14. Pay Gap reports

Receive *Paula Kirkpatrick*

14. Board Pay Gap Reports Feb 2026 Final.pdf (6 pages)

15:05 - 15:15
10 min

15. Freedom to Speak Up (FTSU) 2025-26 Quarter 3 report

Assurance *Rebecca Taylor and Luke Sullivan*

15. FTSU Q3 report cover.pdf (2 pages)
15. FTSU 2025-26 Q3 Board report.pdf (11 pages)

15:15 - 15:20
5 min

16. Implementation of NHS England’s 10 Point Plan to Improve Resident Doctors’ Working Lives

Assurance *Hemant Nemade*

16. Boards 10 PP 2026.pdf (5 pages)

15:20 - 15:30
10 min

17. Board Assurance Framework

Assurance *Susan Clennett*

17. UHN BAF Qtr 3 25-26 Board February 2026.pdf (39 pages)

15:30 - 15:30
0 min

18. Use of the NGH Trust Seal

Information *Richard May*

15:30 - 15:30
0 min

19. Questions from the public

18. UHN Cover Sheet NGH Trust Seal 060226.pdf (2 pages)

15:30 - 15:30
0 min

20. 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 Date & Time	Boards of Directors (Part II) Meeting in Public 6 February 2026, 12:30-15:30
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	Presentation – Armed Forced Network	Chief People Officer	12:30	Discussion	Presentation
3	Minutes of the Meeting held on 5 December 2025 and Action Log	Chair	12:50	Decision Receive	Attached Attached
4	Chair's report	Chair	12:50	Information	Verbal
5	UHN Chief Executive's Report	UHN Chief`` Executive	13:00	Information	Attached
Operations					
6	Integrated Performance Report (IPR) and Board Committee Chairs' Reports	UHN Chief Executive, Executive Directors and Committee Chairs	13:05	Assurance	Attached
7	National Oversight Framework segmentation (25-26 Q2)	Director of Continuous Improvement	13:45	Assurance	Not received
8	UHN Perinatal Scorecard (8.1) and Maternity Incentive Scheme Annual Submissions (8.2)	Director of Midwifery	13:55	Assurance (8.1) Decision (8.2)	Attached Attached
9	KGH Maternity Safety Support Programme (MSSP) and CQC Update	Director of Midwifery	14:05	Assurance	Attached

	BREAK		14:10		
10	Emergency Preparedness, Response and Resilience (EPRR) Annual Report	Chief Operating Officer	14:20	Receive	Attached
11	Corridor Care	Group Associate Chief Nurse Urgent and Emergency Care	14:30	Assurance	Attached
12	Nursing and Midwifery Annual Staffing Review	Group Associate Chief Nurse Urgent and Emergency Care	14:40	Decision	Attached
People and Culture					
13	UHN Inclusion Activities April – December 2025	Chief People Officer	14:45	Assurance	Attached
14	Pay Gap Reports 2024-25	Chief People Officer	14:55	Receive and note	Attached
15	Freedom to Speak Up report 2025-26 Quarter three	Director of Continuous Improvement	15:05	Assurance	Attached
16	Implementation of NHS England's 10 Point Plan to Improve Resident Doctors' Working Lives	Medical Director	15:15	Assurance	Attached
Governance					
17	Board Assurance Framework	Deputy Director of Risk and Legal Services	15:20	Assurance	Attached
18	Use of the NGH Trust Seal	Company Secretary	15:30	Information	Attached
19	Questions from the Public	Chair	15:30	Information	-
20	Any Other Business and close	Chair	15:30	Information	-

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) Meeting together in Public
Date & Time	5 December 2025, 12:30-15:00
Location	William Wilson Room, Cripps Postgraduate Centre, Northampton General Hospital

Purpose and Ambition

The Boards are accountable to the public, 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
	Alice Cooper	Non-Executive Director
	Simon Gay	Non-Executive Director
	Polly Grimmett	Director of Strategy
	Julie Hogg	Chief Nurse
	Jill Houghton	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	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		
	Binal Abraham	Matron, Head and Neck Services, Item 2
	Simon Baylis	Lead Governor (KGH)
	Susan Clennett	Deputy Director of Risk and Legal Affairs, Item 13
	Sarika Goel	Guardian of Safe Working (NGH), Item 12
	Kerry Herd	Consultant Oral and Maxillofacial Surgeon, Item 2
	Richard May	Company Secretary
	Mustafa Raza	Guardian of Safe Working (KGH), Item 12
	Kirsty Spazzolino	Deputy Head of Nursing, Item 2

Apology for absence		
	Denise Kirkham	Non-Executive Director

Item	Discussion	Action Owner
1	**Welcome, Apologies and Declarations of Interest** The Chair welcomed colleagues and guests to the meeting, and noted apologies for absence as listed above. There were no declarations of interest relating to specific agenda items.	
2	**Patient Story – Jane's Story** The Boards viewed a video in which Jane described a positive experience of maxillo-facial surgery at NGH to remove a pre-cancerous mole from her face. The Boards welcomed colleagues from the service who described their continuing commitment to excellent patient care through effective multi-disciplinary team working. It was noted that skin cancer was a growing area of clinical activity, and the team had successfully maintained service standards. Head and neck oncology, which included oral cancer, faced a national recruitment challenge for specialist surgeons. In some cases, entire services depended on a single clinician, highlighting the need for robust support and appropriate resources. Nursing teams, clinical nurse specialists, and theatre staff were commended for their efforts in maintaining patient safety and service continuity. Recruitment remained a priority, and creative approaches to attracting candidates were discussed. HR colleagues have been actively engaged, and it was confirmed that four candidates were scheduled for interview for a forthcoming consultant position. The discussion also covered pathway challenges, including interactions with pharmacy and GPs. Referral processes could take several months, and there was a need to identify cases requiring dermatology input earlier. Rising demand in head and neck services required innovative solutions such as AI to manage cases, as diagnostic capacity within acute settings was limited. The Boards heard that cancer-related work usually required consultant care but, for skin conditions, clinical nurse specialists and dentists were often empowered to undertake follow-up care where appropriate. The effectiveness of multi-disciplinary team working was highlighted, with patient feedback describing the team as cohesive and supportive, "like a family." Morale benefits from the small team structure were highlighted, which fostered goodwill and continuous dialogue to identify and resolve issues promptly. This collaborative approach ensured resilience and adaptability in challenging circumstances. The Boards expressed appreciation for the team's dedication and the insights shared. The Chair thanked colleagues for their contributions and commended the service for its commitment to patient care and	

	innovation.	
3	**Minutes of the last meeting held on 7 November 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 November 2025, were approved as a correct record. The Boards noted the action log, actions on which were closed or not yet due.	
4	**Chair's Report** The Chair highlighted the continuing challenge of rising demand against finite capacity within the NHS, which was becoming increasingly evident due to 'flu, urgent and emergency care (UEC) pressures, and wider winter challenges, exacerbated by capacity constraints brought about by industrial action and staff sickness absence. The Boards' role was to ensure visibility, support, and effective communication, while proactively planning to address known circumstances and emerging issues. Strategic issues such as the Medium-Term Financial Plan, future governance arrangements, efficiencies, health and wellbeing, anchor institution responsibilities, and sexual safety were identified as priorities, all of which had direct and positive impacts on patient care. Looking ahead to 2026, the Chair outlined the Group's strategic and far-reaching ambitions to position the organisations to manage known and unknown challenges. It was acknowledged that forthcoming conversations and decisions would be uncomfortable and challenging; they must be based on the long-term interests of patients and colleagues. Boards' members were asked to ensure they sought and received the necessary information to contribute effectively and that their voices were heard. Operational updates were provided on Northampton General Hospital, where recent changes had delivered improvements within UEC pathways, although pressures remained and 'flu admissions were expected to increase. The Chair expressed thanks to operational, medical, and nursing teams for their continued contributions. Boards noted that the local Health and Wellbeing Board formally conveyed appreciation for improvements in the Emergency Department at NGH and the resulting positive patient experiences.	
5.	**UHN Chief Executive's report** The Boards noted the UHN Chief Executive's report and specifically: • The receipt of planning permission for a £15.75m development to transform urgent and emergency care facilities at NGH; • The opening of a Rapid Assessment Unit and Acute Assessment Unit at NGH, contributing to the Trust achieving the best ambulance handover performance in the East Midlands.	

	The Boards commended the contributions of all colleagues to this achievement; • The trusts were planning for the next round of industrial action by resident doctors, which was scheduled to start on 17 December 2025. The Boards joined the UHN CEO in thanking the Medical Director and Chief Operating Officer and their teams for their efforts to maintain safe services during periods of industrial action; • The UHN Excellence Awards ceremony took place on 26 November 2025 and were an opportunity to celebrate remarkable stories from across UHN about colleagues going above and beyond for their patients and teams. The Boards joined the UHN Chief Executive in congratulating the winners, and those shortlisted for awards.	
6.	**Integrated Performance Report (IPR) and Board Committee Summaries** Executive leads drew the following significant items to the Boards' attention from the IPR document set out in the agenda pack: *Safe, Caring and Effective Domains (Chief Nurse and Medical Director)* • Complaints response performance had deteriorated; the corporate nursing consultation had now closed with confidence in finding a way forward to enable sustained performance improvement. • C-Difficile: KGH cases were above threshold; a Quality Improvement Plan for UHN was in place and was monitored internally by the Infection and Prevention Control Assurance Committee, with regional oversight. • Pressure ulcers had increased but from a low baseline, reflecting longer waiting times. • Care hours per patient day was now in the third quartile, showing positive improvement. • Mortality indices remained below or as expected compared to national indicators across both sites. • Incident profiles were stable; themes included diagnostic delays, communication, and recognition of end-of-life pathways. • Winter pressures and overcrowding were noted; surge plans were in place with effective oversight and risk distribution across the local health system. *Responsive Domain (Chief Operating Officer)* • Performance against the Four-hour and 12-hour performance standards within UEC continued to improve; • Ambulance handover performance deteriorated in October but improved significantly in November, especially at NGH following the opening of new assessment and handover pathways (see Chief Executive's report above). Comparator figures to 2024	

	evidenced significant improvement: the NGH average handover reduced from 82 to 28 minutes; KGH from 86 to 32 minutes. • Maximum 60-minute ambulance handover standard was introduced on 1 December 2025; plans were in place to extend hours and reduce target to 45 minutes. • Cancer performance remained challenged (September data), particularly in dermatology; remedial actions were underway with expected improvement in November. • Referral to Treatment (RTT) performance was slightly below plan; November showed improvement due to productivity initiatives. The current activity gap of around 7% was unlikely to be closed during the current financial year but could be reduced through initiatives such as "first-only fortnights," tiered regional support, and shared learning with the University Hospitals of Leicester NHS Trust (UHL). • Both Trusts maintained zero 65-week breaches in October (awaiting treatment); there were two breaches in November, however. • 52-week waits were reducing in line with the annual plan which was projected to meet the target of 1% of all waits by 31 March 2026. • Demand management initiatives were underway, including a digital referral pathway bid with UHL to streamline processes and prevent further RTT deterioration. *Use of Resources Domain (Chief Finance Officer)* • The Year-to-date position at Month 7 (31 October 2025) showed a deficit of £28.6m which was £5.4m worse than plan and largely reflected the increased efficiency requirement in the month. Unfunded inflationary pressures, the continuing need for temporary staffing in hard-to-recruit areas, and UEC demand, were contributing to cash pressures. • There was capital programme slippage of around £5m compared to plan, which was attributable to nationally funded schemes. The position should be corrected by year-end and business as usual capital was ahead of plan. • Discretionary spend controls had extended to additional categories in order to further improve grip and control. • The Financial Recovery Team (FRT) had added significant capacity and governance assurance, supporting 6.5% CIP delivery. Divisions were now switching focus to delivery and planning. • Concerns were raised about the sustainability of improvements post-FRT; there was a particular need to upskill internal teams as the handover date approached. *Well-Led (Chief People Officer)* • Total whole-time equivalent workforce had increased, largely driven by increases in nursing and medical bank in both trusts. • Bank spend remained high (around 10% of total staffing expenditure compared to 6% target) as agency colleagues	

	transferred to the bank; • Agency usage continued to reduce to 1% of total staffing expenditure at KGH and 2.5% at NGH (though this remained above the 2% target); • Vacancy rates were above target but budgeted establishment was reducing as vacancies became recurrent. • Workforce controls tightened; successful recruitment was noted in key areas (e.g., oncology consultants), and changes to medical annual leave arrangements would reduce temporary staffing requirements in Month 12 (March 2026); • Culture metrics: appraisal compliance at KGH showed long-term decline; improvement sustained at NGH but concerns remained for winter period. • Sickness absence rates were increasing with further rises anticipated during the winter period • Flu vaccination uptake was 37% (below national average of 40–45%); winter wellness sessions were planned. Concerns were raised about vaccine hesitancy among staff. • Final Staff survey response rates were KGH 51% and NGH 49%. *Board Committee Summaries:* Committee Chairs drew the following significant items to the Boards' attention: - The **Finance, Investment and Performance** recommended that the respective Boards approve cash drawdown requests for a total of £6.2m (KGH) and £5m (NGH). The respective Boards **ratified and approved** these requests; - The **Quality and Safety Committee** escalated issues to the Boards as detailed in the report. The Chief Digital Information Officer provided assurance that a lead officer had been assigned to progress work to provide an AI tool to address a CT perfusion issue affecting stroke pathways - The **Strategic Development and Transformation Committee** held its first meeting on 1 December 2025 and requested a name change to the Strategy, Development and Transformation Committee. The Boards **approved** this change. The Committee intended to arrange 'in common' meetings with its UHL counterpart to progress clinical and digital strategy objectives, and - The **Audit Committees** expressed significant frustration that salary overpayments continued to occur in large numbers, particularly at NGH and received assurances that UHN and UHL were working together on separate components of a comprehensive automated solution. The Boards noted the IPR.	
7.	**UHN Perinatal Scorecard Highlight Report (October 2025)** The Boards received and welcomed the first consolidated Perinatal Scorecard report for UHN (noting that future iterations would include	

	equality and diversity data) and noted the following headlines: *Incidents and Referrals* - Two maternal safety incident (MSI) referrals reported. - One Patient Safety Incident Investigation (PSII) declared internally. *Clinical Outcomes* - Postpartum haemorrhage rate remained below 4%. - Smoking rates at birth continued to fall; smoking at booking remained unchanged, reinforcing the value of ongoing smoking cessation interventions. - Preterm birth rates exceeded the national 6% target in October, prompting renewed focus on prevention and optimisation initiatives as part of the Saving Babies' Lives Care Bundle. *Training and Workforce* - Training compliance remained strong overall. - The Midwifery vacancy rate was 7.08% across UHN, with higher gaps in maternity support workers and neonatal nurses (18% at KGH, though occupancy levels were lower). *Activity and Pathways* - Induction of labour rates rose to 30.6%, and process improvements reduced average wait times by three hours at KGH. - Friends and Family Test (FFT) performance strong at both sites, though the NGH response rate remained below the 20% threshold. - Maternity Incentive Scheme (MIS) on track, but one domain at risk at KGH relating to obstetric consultant attendance. Boards noted there were continuing cultural risks within KGH as highlighted in recent CQC inspections, but not evidenced as currently impacting outcomes within the dashboard In response to a question, Boards were assured that plans were in place to address training compliance gaps for doctors at KGH. The Boards noted the latest position and indicated assurance in respect of the perinatal performance and safety position, including the ongoing delivery of improvement plans across maternity services.	
8.	**KGH Maternity Safety Support Programme (MSSP) Progress Report (including CQC immediate feedback)** The Boards considered a report setting out progress with the MSSP; the Chief Nurse highlighted the following matters: - 24% of the 91 MSSP actions were complete, representing a 5% increase since the last report;	

	- 38% of the 130 actions arising from the CQC inspection during September were complete; no notification of subsequent enforcement action had been received; - Documentation gaps in the Badgernet system, defining culture metrics and completing consultant job planning were amongst the key areas for focus and improvement; - All midwifery vacancies had been filled, with onboarding by the end of 2025; - 1:1 intrapartum care was maintained, and the consent documentation audit showed 100% compliance for invasive procedures; the audit was subject to triangulation with patient feedback via the Friends and Family Test and complaints; - CQC final reports were awaited. The Boards noted: 1. Progress made in responding to the MSSP Diagnostic Report and towards achieving the MSSP Exit Criteria set out in the report, including the completion of 24% of MSSP actions and alignment with CQC response and actions 2. Current oversight arrangements in place, including weekly Senior Leadership Team meetings, the establishment of new governance and quality improvement structures, and the launch of the Single Perinatal Improvement Plan (PSIP). 3. Continued engagement with staff and service users in co-creating improvement plans, embedding a positive safety culture, and enhancing service-user voice through targeted workstreams and feedback mechanisms.	
9.	**Health and Wellbeing Strategy** The Chief People Officer presented a report recommending approval of a Health and Wellbeing Strategy for UHN, bringing together the work of the occupational health, psychological and trauma support and preventative health services to deliver the following overarching priorities: (1) Integrating Occupational Health and Wellbeing Governance systems and processes (2) Addressing the impact of health conditions and ageing on working life and the impact of work on health management, and (3) Reducing stigma and providing an accessible support system fit for all. The strategy would be delivered through annual action plans, and its effectiveness measured via qualitative and quantitative measures outlined in the report, with oversight being provided by the Cultural Assurance Group, reporting to the People Committee. The Chief People Officer advised that reducing sickness absence due to mental health was a key priority in line with the national focus on this topic, which required managers to be equipped with the right skills and tools to be able to provide the compassionate leadership required; this	

	included a willingness to release colleagues to engage in health and wellbeing activities. The Boards welcomed and **approved** the Health and Wellbeing Five-Year Strategy (2025-2030), committing to actively promote the value of the clinical services within its scope in supporting UHN clinical and operational priorities.	
10.	**Anchor Institution Plan** The Boards of Directors considered a report providing a briefing on the UHN Anchor Institution Programme and Plan, seeking endorsing for proposed next steps and approval for associated governance and reporting arrangements. The discussion noted the context for the programme, its alignment with the NHS 10-Year Plan, and the New Hospitals Programme target operational model. Reference was made to slides 5–6 of the presentation, which set out a framework for addressing local inequalities in partner, aligned to the Group Clinical Strategy. UHN was part of the Anchor network in Northamptonshire alongside local authorities and private sector partners and was leading on the sustainability workstream. The Boards acknowledged the latest position and agreed the approach to developing an internal framework, including a mapping exercise, reporting to the Integrated Leadership Team (ILT), and a gap analysis. Boards emphasised the importance of the programme given UHN's role as a major local employer, supporting wider health and wellbeing. In relation to the sustainability pillar, it was noted that this involved information-sharing and collaboration across seven areas to deliver impact at scale. In response to a query about how patient outcomes could be improved and what role community interest groups might play, the Director of Strategy highlighted that significant activity was already underway within roles and communities, and proposed creating a forum to bring stakeholders together and shape ideas. She also confirmed the need to map the interface with other strategies. Boards stressed the importance of capturing benefits as part of wider work, and suggested that the Strategy, Transformation and Digital Committee provide alignment and offer a route into addressing local inequalities. Following discussion, the recommendations set out in the report were **agreed** and the Boards: (1) Approved the development of the UHN Anchor Institution Programme, including clear governance, reporting lines and delivery plans. (2) Endorsed the nomination of executive leads for each anchor pillar and formation of the community of interest group. (3) Indicated support for a baseline self-assessment using published toolkits and best practice guidelines. (4) Agreed to receive a report in April 2026 including baseline assessment, updates on development of the programme, and	

	initial recommendations for a UHN strategy.	
11.	**Sexual Safety Charter** The Boards considered a report summarising progress on actions to eradicate sexual harassment in the workplace after signing up to the NHS Sexual Safety Charter in November 2024. The report highlighted that staff survey results and other data indicated continued examples of unwanted behaviours, including six formal cases at NGH and one at KGH between 2023-2025 . A review has been undertaken which identified strengths in existing policies and standards, induction processes, and specialised training for certain staff groups, including medical and Estates and Facilities teams. The review also noted the availability of the "Report and Support" tool developed in collaboration with UHL. Areas for improvement included enhanced management of information, provision of specialist training for colleagues, and clearer channels for reporting concerns. It was confirmed that reporting will be via the Cultural Advisory Group to the People Committee. Concerns were raised regarding late shift finishes and associated safety issues in off-site car parks. While these have not been directly linked to harassment concerns, requests had been made for assistance in getting home safely after late-night finishes. It was observed that St Michael's car park in Northampton was poorly utilised for this reason. The Boards noted that Freedom to Speak Up cases at KGH have been raised informally, reinforcing the need for triangulation of data. Boards were advised that the SafeZone app, which provided a means of alerting security or police, was available at UHL and could be explored for UHN. **Action:** Explore the use of the SafeZone app and communicate the Boards' commitment to ongoing safety as part of the Charter. Following discussion, the Boards: (1) Noted, and indicated assurance in respect of, the progress following the implementation of the sexual safety charter outlined in the report; (2) Indicated support for the action plans and assurance pathways specified, and (3) Reiterated a commitment to an organisational culture where sexual misconduct is not tolerated and colleagues are empowered to raise concerns.	**PK**
12.	**Guardians of Safe Working: Consolidated report for May to October 2025** The Boards welcomed Sarika Goel and Mustafa Raza, Guardians of Safe Working for NGH and KGH respectively, to present the consolidated report for May to October 2025, bringing key exceptions	

	for each trust and common themes to the Boards' attention. Boards noted that the UHN position was broadly in line with national trends, with only 1% of issues relating to patient safety and the majority concerning working patterns. The discussion referenced the NHS 10-Point Plan for improving Resident Doctors' working lives, specifically point 7, which sought to make it easier for rota doctors to raise exceptions. Wellbeing issues linked to training were also highlighted. A baseline position had been presented to the Boards, and it was confirmed that the Guardians were part of a working group which would report progress to the People Committee and Boards in January and February 2026, including actions on timely processing of payments, education, clinical supervision, and confidence that issues are addressed within 12 weeks. In response to a question, the Guardians confirmed that rota gaps and staff shortages spanned a broad range of specialities, though exceptions were often more prevalent in urgent and emergency care where surgical assessment units with workforce models were not in place. Boards were advised that fines associated with breaches represented a cost pressure for the organisations. Following discussion, the Boards: (1) Endorsed the embedding of safe working hours governance within directorate and divisional structures, ensuring that local teams are supported to understand and address compliance and wellbeing challenges. (2) Noted the continued implementation of the 10-Point Plan to Improve Resident Doctors' Working Lives, with oversight provided by the Medical Director and the Chief People Officer. (3) Committed to supporting the Guardians of Safe Working, in collaboration with workforce and wellbeing leads, to strengthen assurance processes.	**HN**
13.	**Board Assurance Framework (BAF)** The Boards welcomed the Deputy Director of Risk and Legal Services to present the BAF in its revised format which had been subject to detailed discussion and development work by Committees and lead executives. The Strategy, Development and Transformation Committee had met since the publication of the report and had undertaken a detailed assessment of appetite, likelihood and consequence for each risk within its area of responsibility, identifying transformation as integral to controls and actions for all risks. Audit Committees received the BAF at the 3 December meeting and would be inviting lead executives to provide oversight of key risks on a rolling basis from 2026. Changes agreed by other committees were specified in the report.	

	Boards noted and indicated assurance in respect of the latest position, undertaking to provide robust oversight and challenge to address control gaps and ensure the timely completion of planned actions. Report authors were reminded that all reports should make reference to applicable BAF and corporate risks, with a request that this be extended to the Committee upward report.	**RMay**
14.	**Use of the KGH Trust Seal** The KGH Board of Directors noted the use of the Trust Seal in respect of a Deed of Variation with High Voltage Systems on 28 November 2025, affixed by the Company Secretary and signed by the Director of Strategy and Chief Finance Officer.	
15.	**Audit Committees' Terms of Reference** The respective Boards of Directors **approved** updated Terms of Reference for the Audit Committees as enclosed to the report.	
16.	**Questions from the Public** None	
17.	**Any other business and close** The Company Secretary undertook to circulate the schedule of Board(s) and Committee meetings for 2026.	**RMay**

Action Log

Meeting	Boards of Directors (Part II) Meeting in Public
Date & Time	Updated following 5 December 2025 meeting

Minute Ref.	Action	Owner	Due Date	Progress	Status
Nov 25 6	Monitor against 25-26 forecast in future reports	SS	Mar 26	Discussions remain ongoing with NHS England - Board to be updated a once discussions are concluded	NOT YET DUE
Nov 25 8	Development of dashboard to monitor the patient experience	JH	Apr 26	To follow formal consultation	NOT YET DUE
Nov 25 10	Report to Boards: follow up to October staff stories	PK	Feb 26	Agenda item 13	CLOSE
Nov 25 11	Freedom to Speak: inclusion of benchmarking date on anonymous reporting	BT	Feb 26	Included in report at item 15	CLOSE
Dec 25 11	Explore the use of the SafeZone app	PK	Feb 26	Contact has been made with SafeZone, and an introductory meeting is being arranged. UHL do use this app, so a conversation will also take place with them to explore how they utilise it. UHL use the app alongside the university to support students – UoN are signed up to this app so this will also be a consideration in discussions	CLOSE
Dec 25 12	Resident Doctors' Improvement Plan: report working progress to Boards	HN	Feb 26	Agenda item 16	CLOSE
Dec 25 13	Committee upward reports to identify Board Assurance Framework risks	RMay	Feb 26	Template updated	CLOSE

Dec 25 17	Circulate schedule of Board and Committee meetings for 2026	RMay	Feb 26	Complete	CLOSE

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Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item number	*5*

Title	Chief Executive's report
Presenter	Laura Churchward – UHN CEO
Author(s)	Laura Churchward UHN CEO and UHN Executive Team

This paper is for			
☐ 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 recipients without the in-depth discussion as above	To reassure the recipients that controls and assurances are in place

Link to Group Priorities (select all that apply):		
☒ Transform Patient Care	☒ Strengthen our Culture	☐ Deliver our financial plan

Executive Summary
This report is an update from the UHN CEO, covering key points of note in December 2025 and January 2026.
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 extend my thanks to all colleagues who continue to warmly welcome me and other members of the Executive Team into both clinical and non-clinical services.

In December I was pleased to visit many teams, including Emergency Departments (ED) on both sites, Dryden Ward, and Gynaecology Same Day Emergency Care in NGH. I also attended the KGH Carol Service; thank you to our Spiritual and Pastoral Care Team for organising this event.

Winter Pressures

Our hospitals, and teams across our community, have been incredibly busy over the last few months as winter pressures continue to increase demand for our services.

I would like to thank all of the teams, who are working tirelessly to deliver the best care possible to our patients. As a result of focused work at both KGH and NGH, Northamptonshire now has some of the shortest ambulance waiting times in the Midlands.

Industrial Action

Some of our resident doctors took part in industrial action between 17 and 22 December. Thank you to colleagues who demonstrated the highest standards of care, planning, and organisation to support our patients and colleagues during this period.

Locum's Nest

Locum's Nest, the digital workforce management platform, went live at KGH on 1 December 2025 as the second phase of UHN's groupwide alignment with the University Hospitals of Leicester NHS Trust (UHL), following implementation at NGH in April 2025.

Since launch, over 236,000 hours have been posted at KGH, demonstrating strong early engagement. Current activity is focused on system stabilisation, early adoption, and embedding the platform within core medical workforce processes.

The next phase of the programme will enable medical staff to work seamlessly across sites.

Volunteer Service

The "8 Till Late" initiative, introduced in 2021 to extend volunteer support in ED from 8am–8pm during winter, has continued to grow. Volunteer activity has increased by 514% since 2021, with a further 44% year on year rise in 2025. During November and December 2025, volunteers provided 1,462 hours of support, contributing significantly to patient experience and operational resilience during winter pressures. Thank to to the whole of the Volunteer Team.

Dementia Assessments

KGH's Community Diagnostic Centre in Corby has supported a reduction in waiting times for the Memory Assessment Service, with patients now able to access one-stop appointments. Previously, patients would have to wait for a separate scan appointment after their initial memory assessment. From there they could expect to wait upwards of 16 to 20 weeks for their results.

Launched in July 2025, the new pathway has not only brought testing closer to home for patients in the Corby, Kettering, and East Northamptonshire areas – it has also more than halved the waiting list for those waiting for assessment.

It is due to be expanded to patients in Rushden and Wellingborough shortly, with scope to do the same in West Northamptonshire in the future.

New Surgery for Bowel Disease

A new operation, which creates an internal pouch to partially replace the function of the rectum, was performed for the first time at KGH just before Christmas.

The procedure, called ileoanal pouch formation, marked the launch of a new county pouch service for some complex inflammatory bowel disease patients.

Solar Panels fitted at KGH

We have started work at KGH on a £713,000 project to fit rooftop solar panels to help reduce yearly energy bills by around £150,000.

It is part of a national package of funding to enable the NHS to install solar power and battery storage solutions to help drive down energy bills, offering better value for the taxpayer.

Muslim Midwife of the Year Award

Congratulations to midwife Hauwa Hamza, who won Midwife of the Year at the first ever British Muslim Health Awards 2025.

Hauwa trained and worked at NGH as a midwife and for the last sixteen months has worked in the One Digital and Data team in the role of Digital Clinical Facilitator to help transform and modernise midwifery information systems.

Laura Churchward
UHN Chief Executive Officer

Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	6th February 2026
Agenda item	6

Title	Integrated Performance Report (IPR)
Facilitator	Laura Churchward, UHN Chief Executive
Authors	Julie Hogg, Chief Nursing Officer Hemant Nemade, Medical Director Sarah Noonan, Chief Operating Officer Paula Kirkpatrick, Chief People Officer Sarah Stansfield, Chief Finance Officer Becky Taylor, Director of Continuous Improvement

Link to Group Priorities (select all that apply):		
☒ Transform Patient Care	☒ Strengthen our Culture	☒ Deliver our financial plan

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 Integrated Performance Report (IPR) provides an overview of KGH and NGH's performance.	The IPR is produced monthly and is presented at all public Boards meetings.

Executive Summary

The Integrated Performance Report (IPR) for the February 2026 Boards is enclosed, which reports on December 2025 performance. Executive Leads will draw the Board's attention to significant exceptions within the Caring, Safe, Effective, Responsive, Well-Led and Use of Resources domains.

It has not been possible to provide an update on the metric for 12 hours in the A&E department in October. This data is currently sourced from the National Performance Oversight Dashboard, which has had a data load error and therefore not updated. From February reporting, we will be able to produce this internally.

Enhancements planned for the next month's IPR include:

- Inclusion of additional metrics around distance from capital plans year-to-date and underlying run-rate.
- Update to the ambulance handover metric to be the percentage of ambulance handovers that are within 45 minutes, with a target of 99%

Future planned improvements with target dates:

- Addition of sepsis six bundle compliance metric – Spring 2026
- Addition of 30 day readmission rate metric – Spring 2026

A year on from the refreshed IPR, an annual review of the format will be conducted, with a survey going to all Board(s) members on the format to inform future developments and improvements, for response during February.

An updated on the development of the IPR was shared with Finance, Investment and Performance Committee, which oversees the IPR on behalf of the Boards. The Federated Data Platform (FDP) product will improve the timeliness and process for production of the IPR, build automated data pipelines on top of the new data warehouse (which is in FDP), and support the production of narrative through the use of AI. Testing of the new format and data began during January, with the intention to complete a 'dry run' for the production of the IPR in February, aiming to move to using the FDP production fully in March.

The Boards are asked to take assurance from the IPR on performance, and to engage with the IPR annual survey to support the further development and improvement of the report.

Appendices
Integrated Performance Report, reporting period December 2025 Board Committees summaries from December 2025 and January 2026 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

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NHS
University Hospitals of Northamptonshire
NHS Group

Integrated Performance Report

Kettering General Hospital NHS Foundation Trust
Northampton General Hospital NHS Trust

Reporting December 2025 performance in February Boards

Contents

Introduction

- This month's performance report provides detail of the December 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) February 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 Overall Performance

University Hospitals of Northamptonshire NHS Group

Understanding performance against our key delivery metrics

- Incident reporting remains steady, collaborative working with divisions to ensure timely review. No increase in serious or moderate harms related to resident doctor strikes.
- Patient experience remains high across the Trust, although there has been a decrease in the experience of patients in KGH emergency department and NGH maternity.
- Mortality remains either below or within the expected range. A national data quality issue with SDEC is falsely elevating NGH mortality.
- Continual improvement in ambulance handover times, with a significant improvement since December 2024, when ambulance handover times were 47 (KGH) and 53 (NGH) minutes longer on average.
- Consistent 4 hour performance in KGH, at 79.8% in October. NGH has seen an improvement to 66.5%, which is similar to KGH Type 1 performance of 63.2%, against a backdrop of more ED Type 1 attendances and more non-elective admissions than plan, with admitted patient flow remaining a challenge resulting in use of temporary escalation spaces to manage flow.
- Whilst improvements in skin have improved the NGH Faster Diagnosis Standard, the overall position for FDS remains challenged. NGH has been tiered for cancer based on 62-day performance – despite a small improvement, Gynae, Lung and Lower GI remain challenged.
- 52 weeks remains on track to deliver by the end of the financial year, with some significant mitigating actions taking place in January. Our position is favourable nationally.
- Our overall workforce numbers have increased, driven by medical and nursing bank to manage winter pressures and strikes, and the proportion of workforce that agency continue to reduce; with both Trusts achieving the 2% of pay bill agency target. Bank usage remains high, and there is a gap to the workforce plan for the year.
- The year-to-date I&E position is a £39.1m deficit, £21.2m worse than plan (KGH £8.2m, NGH £12.9m) and largely reflects the increased efficiency requirement in the second half of the year, industrial action and operational pressures. Deficit Support Funding (DSF) for Quarter 4 has been withheld by NHS England.

	Metric	Target	KGH Actual	Variation	Assurance	NGH Actual	Variation	Assurance
Safe	Serious or moderate harms per 1000 bed days	-	0.76			0.84		
Effective caring	Friends and Family Test satisfaction score	90%	94.5%			90.4%		
	SHMI	100	97.40			96.40		
Responsive	Average Ambulance handovers	45	29.84			31.86		
	A&E 4 hour performance	78%	79.77%			66.50%		
	62-day wait for first treatment	70%	70.6%			59.2%		
	52 week waits as a % of the waiting list	1%	1.12%			1.36%		
Well-led	Total WTE (PWR figure)	KGH: 4,903 NGH: 6,199	5,061			6,480		
	Bank Spend as % of Total Pay	6.90%	8.7%			8.8%		
	Agency Spend as % of Total Pay	2%	1.3%			2.3%		
Use of Resources	Surplus / deficit	KGH: -442 NGH: -392	-427			-1,169		
	CIP Delivery	100%	168%			130%		

Our Caring and Effective domain executive summary

Responsible director(s): Julie Hogg, Group Chief Nurse, and Hemant Nemade, Medical Director

	Good news	Areas of concern	Improvement plans in place
Patient experience	Both sites have achieved the composite overall target of 90% for all services – KGH 94.5% & NGH 90.4%. Notable increased patient satisfaction performance seen in the following areas: - KGH Inpatient Wards 96.5%, Outpatients 97.5% and Maternity 100%. Friends and Family Test survey response volumes: -KGH 3,542 -NGH 4,649	• Decrease in NGH Maternity score from 97.2% to 94.0%. KGH ED (84.3% down to 79.1% - below the 80% target). This could be due to the realignment of Middleton Assessment Unit (MAU) moving from the ED section to the Inpatient section in December, thereby influencing the score. • Notification received that NGH FFT provider will cease to supply a system as of Aug 2026. • The corporate nursing restructure will create a more effective and resilient Patient Experience function, supporting meaningful service engagement and driving improvement in patient care.	• Divisional FFT performance packs provided to Div leads who then report performance and mitigating actions to the Patient & Carer Experience & Engagement Committee (PCEEC). • Steps undertaken with UHN Procurement team to go out to tender for a new FFT Survey supplier via the NHS Framework.
Mortality	• UHN Learning from Deaths Group continues to monitor all Mortality metrics for KGH and NGH monthly and report by exception. • KGH's HSMR and SMR metrics remain 'below expected' vs the National average. SHMI remains 'as expected' and below the 100 national average. NGH's HSMR, SMR and SHMI are stable in the 'as expected' range.	• There is a national data quality issue with migration of the SDEC dataset. NGH's reported HSMR and SMR are currently falsely elevated up to 5 points higher than the estimated actual value. We are at risk of "alerting" for HSMR / SMR in the coming months because of this. • At KGH we have a mortality alert for aspiration pneumonia. A deep dive analysis of the data was shared by Telstra Health UK and identified multiple areas where KGH are above the national average. Plans are in development to address.	• All trusts are awaiting further communication from NHS England concerning the SDEC dataset. We have been advised in the interim to continue to review all mortality alerts as normal to provide suitable assurance. • UHN sepsis working group established, as part of the response to mortality alerts at both trusts (KGH 2022-23, NGH 2024-25).

Our Safe domain executive summary

Responsible director(s): Julie Hogg, Group Chief Nurse, and Hemant Nemade, Medical Director

	Good news	Areas of concern	Improvement plans in place
Infection prevention control	• 6 CDI cases across UHN which is a reduction.	• KGH currently sitting over trajectory for C. Diff for the month with 27 cases against a target of 23 (total trajectory at year end is 29) • A risk of line-related infection has been recognised in relation to inconsistent PICC follow-up care, ward support arrangements, and variability in PICC clinical skills training. This risk is formally captured on the IPC risk register and subject to ongoing oversight.	• UHN IPC Quality Improvement Plan continues to be implemented and monitored by IPC Assurance Committee.
Incidents	• Working collaboratively with divisions to ensure moderate and above harms are reviewed in a timely manner. • No increase in or incidences linked directly to resident doctor strike. Incidences will continue to be monitored in relation to this.	• Continued theme of delays in decision making as a contributary factor in incidences. • Monitoring incidences occurring within Temporary Escalation Spaces.	• Task and finish group has been established to increase compliance with Respect and Treatment Escalation Plan policies.
Safe care	• Latest CHPPD remains close to the Trust mean of 9, with no sustained deviation, demonstrating effective deployment of workforce resources during periods of increased demand. • Both sites remain in 3rd quartile nationally	• The vacancy rates for RN's and HCSW's are higher than the regional average	• The annual establishment review will rebase wards and departments with the evidence alongside increased RN: HCSW ratios • Exemplar rostering programme continues roll out • Refreshed recruitment and retention plan

Our Responsive domain executive summary

Responsible director(s): Sarah Noonan, Chief Operating Officer

	Good news	Areas of concern	Improvement plans in place
Urgent and emergency care	• Continual improvement of ambulance handover performance at both sites. • Improved Non-elective length of stay position in December at both sites.	• 4hr Performance from NGH is adverse to plan. • High bed occupancy alongside high numbers of non-criteria to reside.	• 4hr Performance improvement plan. Including preparation for a 78% sprint at NGH. • GIRFT Further Faster improvement plan.
Elective	• 52 weeks remains on track to deliver by the end of the financial year, with some significant mitigating actions taking place in January, particularly in Dermatology, to improve the position further	• We continue to be significantly off plan in RTT and NGH in particular continues to deliver largely flat performance	• ILT have agreed for KGH to take part in the Q4 performance sprint that NHSE have made available – to fund at tariff any additional outpatient firsts over planned activity, this should improve both the 52 week position and RTT
Cancer	• 31 day performance has seen improvement for two month at NGH, with both Trusts very close to the performance standard this month • Skin FDS at NGH improved by 38.7% between October and November, following significant effort and focus from the team.	• NGH has been tiered for 62 day performance, based on the October position. Although we have seen a slight improvement since October, performance remains challenged, particularly in Gynaecology, Lower GI and Lung.	• Days Matter Campaign to drive 62 day performance improvement – agreed actions for Urology, Lower GI, Gynecology and Breast • Enhanced performance meetings to track actions each week and support oversight for tiering • Continued mitigation of risk through IPT between sites

Our Well-Led domain executive summary

Responsible director(s): Paula Kirkpatrick, Chief People Officer

	Good news	Areas of concern	Improvement plans in place
Workforce financial sustainability	• In November UHN sickness saw an overall reduction within registered workforce • Fill rate was 99.43% overall • UHN RN vacancy decreased for the second consecutive month • Agency spend on target KGH 1% of pay bill; NGH 2% of pay bill • Time to hire has reduced at NGH and is now comparable to KGH	• Total WTE increased in M9 with increases in substantive and bank work at KGH and increase in substantive WTE at NGH • Bank use continues to be high at 11.5% of pay bill at KGH and 13.8% at NGH. • Sickness absence increased in M9 due to seasonal trends	• Grip and control measures and oversight of workforce efficiency plans at Workforce Programme Board • Support within safe staffing for effective rostering meetings to improve roster management and effectiveness across UHN • Focused support from HR BPs and health and wellbeing services to teams with high sickness
Culture and safety	• Continued improvement in appraisal completion at NGH • Staff survey results received and action planning has commenced • Bespoke support for improvements in team culture in place in a number of priority areas including maternity at KGH • Support for neuro inclusion launched • Strengthening our inclusive recruitment support	• A high number of Management of Change processes are in progress across UHN leading to uncertainty for some colleagues. • Appraisal continues to be a concern at KGH • Employee relations cases are high, especially at NGH where there are a high number of grievances	• Wrap around organisational development/health and wellbeing/learning and education support for colleagues going through change. • Review of appraisal support and governance, focus on appraisal at Divisional Assurance Meetings • Strategies to support early resolution of issues • Culture improvement plan KGH maternity

Our Use of Resources domain executive summary

Responsible director(s): Sarah Stansfield, Chief Finance Officer

	Good news	Areas of concern	Improvement plans in place
Finance	• Funding was received from NHS England to support the costs of Industrial Action in November and December – this will be accounted for in the January position given the date of notification • KGH and NGH cash drawdown requests were both supported for January	• The year-to-date I&E position is a £39.1m deficit, £21.2m worse than plan (KGH £8.2m, NGH £12.9m) This largely reflects the increased efficiency requirement in the last three months when the net expenditure run rate has remained largely unchanged, along with £1.7m of industrial action costs and other operational pressures. UHN will continue to fall further behind plan in future months if there is no acceleration in efficiency delivery to reduce the run rate. • Deficit Support Funding (DSF) for Quarter 4 has been withheld by NHS England given the Q3 financial performance of both Trusts – this will impact the year end revenue outturn, the Q4 cash position and the 2026/27 financial plan.	• The Financial Recovery team from NHSE continue to work on mitigations for the I&E position with a particular focus on temporary staffing and non-pay for the remainder of the financial year. • Cash flow mitigations are in place and will continue in the short term until cash support for February and March is confirmed.
Productivity and efficiency	• Across UHN, £6.3m of efficiencies have been delivered against a plan of £11.1m, similar in-month efficiency delivery to M8. • YTD delivery now stands at £45.7m against a plan of £52.3m, driven largely by pay underspends. • Development of the CIP plans continues, with 87% of the target in fully developed or plans in progress.	• Of the £74m of schemes with a plan in progress or fully developed, there is risk to delivery within the plans, particularly in the later months of the year where the targets increase and with the impact of winter. • There is risk in the level of development of the remainder of the identified efficiency plan, which represents a risk to delivery through the year. • Refreshed national productivity measures compared to last year show a drop in productivity related to a fall in activity, with both Trusts in lower quartile. • A large driver of our productivity is non-elective length of stay, which will be challenging to realise as financial savings.	• Financial recovery team from NHSE are supporting in de-risking identified plans, mitigating the gap and supporting divisional delivery. • Improved co-ordination of workforce activities with a focus on areas of high temporary spend and consistency of controls. • Cross-cutting radiology and pathology transformation plans, IV to oral switch and 25/26 contract review in progress. • Planning commenced on 26/27 programme. • Corporate teams have plans in progress to deliver 133% of the non-clinical target.

Our Caring domain metrics

Responsible director(s): Julie Hogg, Chief Nursing Officer

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

Caring

Responsible director(s): Julie Hogg, Chief Nursing Officer

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average	Data Quality Indicators
Patient experience											
Friends and Family Test satisfaction score - A&E	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Friends and Family Test satisfaction score - inpatients	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Friends and Family Test satisfaction score - outpatients	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Friends and Family Test satisfaction score - maternity	[illegible]	[illegible]	100%			[illegible]	[illegible]			[illegible]	S T A R
Complaints response performance	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Single sex breaches	0	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R

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Data quality assessment

KGH single sex breaches data only available from November 24.

SPC indicator key

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

Data quality indicator key

S	T	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

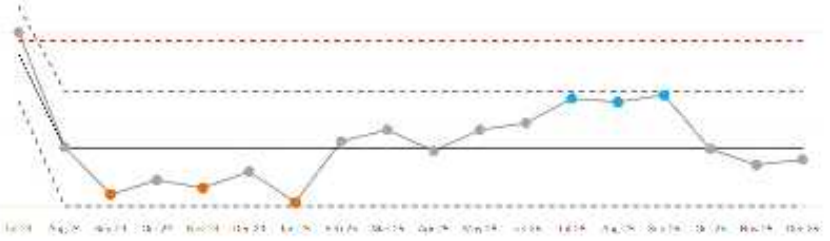
Complaints response performance

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

University Hospitals of Northamptonshire NHS Group

Complaints response performance - Kettering

Complaints response performance - Northampton



Data Quality Indicators

S T A R

Understanding the performance

- 75% for KGH shows an improvement in response rate, slight drop in Family Health due to some delays in sign off.
- 27% for NGH, due to capacity issues in the team.
- 5 cases overdue at KGH, 32 at NGH (older than 60 days).

What are the issues impacting performance?

- Capacity due to sickness and maternity leave affecting ability to perform.
- Logging more cases than closing currently, meaning we have more ongoing active cases.

What SMART actions are being taken to improve?

- Improvement plan in plan, which includes:
  - Focused work on drafting backlog
  - Also focusing on those cases due now to prevent further cases going overdue.
  - Cross site support.

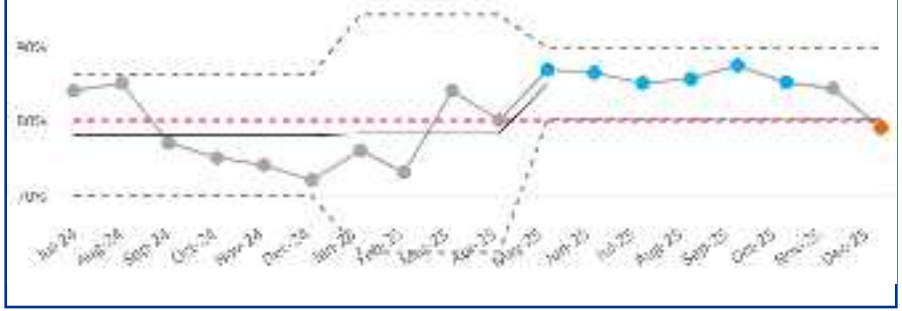
Risks

- Capacity in team (sickness and maternity leave) affecting performance.

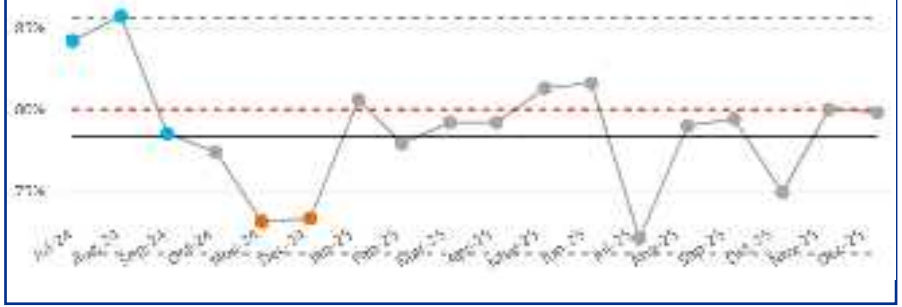
Friends and family test – A&E

The percentage of patients who report their experience as 'Very good' or 'Good' as a proportion of total responses following experiencing care in our A&E departments.

Friends and family test – A&E - Kettering



Friends and family test – A&E - Northampton



Data Quality Indicators

S T A R

Understanding the performance

- KGH saw a decline in patient satisfaction in December down from 84.3% to 79.1.%. This decline could be due to MAU FFT data moving from the ED section to the Inpatient section in December.
- NGH also saw a slight decline from 80.8.% to 79.7%.
- 521 FFT responses received for KGH and 1121 received for NGH.

What are the issues impacting performance?

- Winter pressures and overcrowding impact negatively on patient experience
- The KGH ED heating issues (from November) have now been resolved.

What SMART actions are being taken to improve?

- Deep dive of the results and free text comments to support improvement plans
- The corporate nursing restructure will create a more effective and resilient Patient Experience function, supporting meaningful service engagement and driving improvement in patient care.

Risks

- Winter pressures – increase in flu/RSV.
- Notification received that NGH FFT supplier will cease from Aug 2026.

Our Effective domain metrics

Responsible director(s): Hemant Nemade, Medical Director

	P	?	F	No target
H / L		• SHMI (KGH)		
	• HSMR (KGH) SMR (KGH)			
H / L	• SHMI (NGH) • SMR (NGH)	• HSMR (NGH)		

Effective

Responsible director(s): Hemant Nemade, Medical Director

				Variation	Assurance			Variation	Assurance		Data Quality Indicators
Mortality											
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R

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Data quality assessment

There is an identified national data quality issue with different trusts migrating their SDEC datasets at different times.

SPC indicator key

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

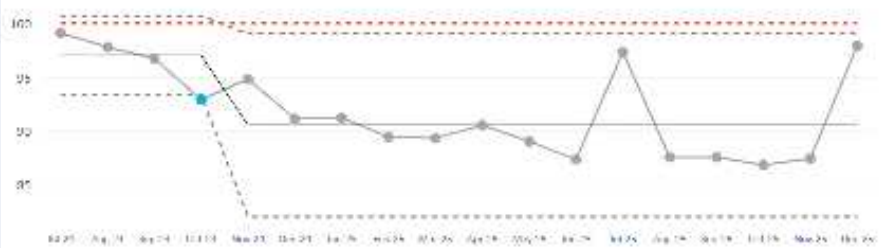
Data quality indicator key

S	T	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

Hospital Standardised Mortality Ratio (HSMR)

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

Understanding the performance

- It is estimated by Telstra Health UK that NGH's actual HSMR is up to 5 base points lower than the reported value.

What are the issues impacting performance?

- There is an identified national data quality issue with different trusts migrating their SDEC datasets at different times. This has significantly impacted NGH, who fully migrated earlier than many other trusts, resulting in a falsely elevated HSMR value.

What SMART actions are being taken to improve?

- We are awaiting further guidance to be issued from NHS England concerning migration of the SDEC dataset.

Risks

- We are at risk of "alerting" for HSMR in the coming months, however it is highly unlikely this will be a true reflection of our actual underlying performance.
- Peer assessment with trusts in a similar position to NGH with their SDEC datasets shows they are also encountering the same challenges.

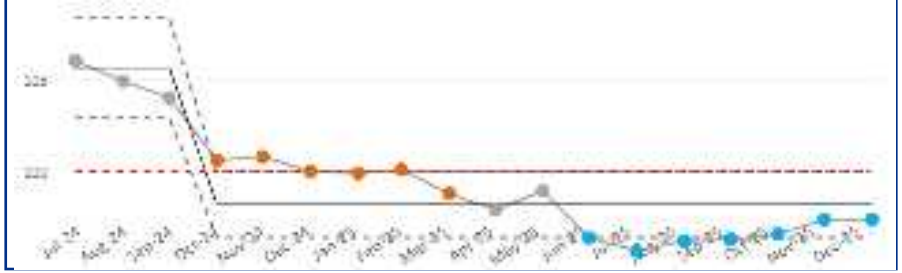
Data Quality Indicators

Summary Hospital-Level Mortality Indicator (SHMI)

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.

University Hospitals of Northamptonshire NHS Group

SHMI - Kettering



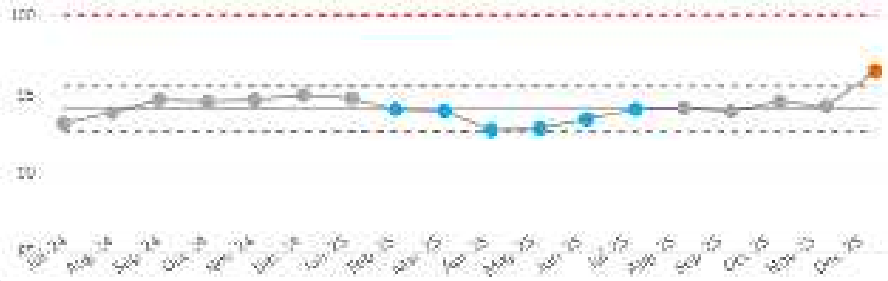
Understanding the performance

- NGHs SHMI continues in the "as expected" range well below the "mean value" of 100.

What are the issues impacting performance?

- There is an identified national data quality issue with different trusts migrating their SDEC datasets at different times. This has significantly impacted NGH, who fully migrated earlier than many other trusts.

SHMI - Northampton



What SMART actions are being taken to improve?

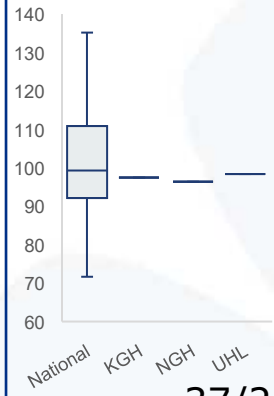
- We are awaiting further guidance to be issued from NHS England concerning migration of the SDEC dataset.

Risks

- Risk of SHMI rising due to the impact of the SDEC dataset migration. At present no significant changes noted.

National comparator

SHMI
(Aug-24 - Jul-25)



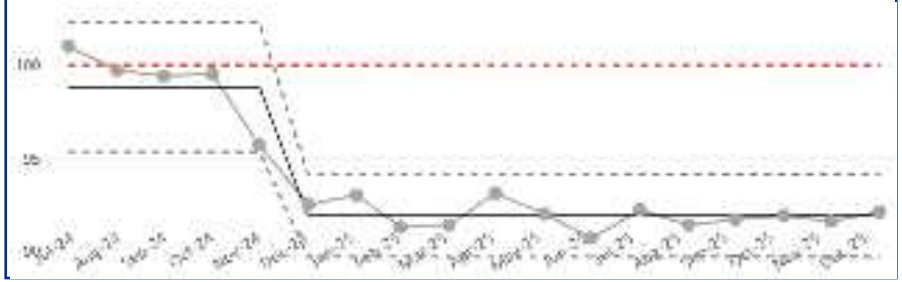
Data Quality Indicators

S T A R

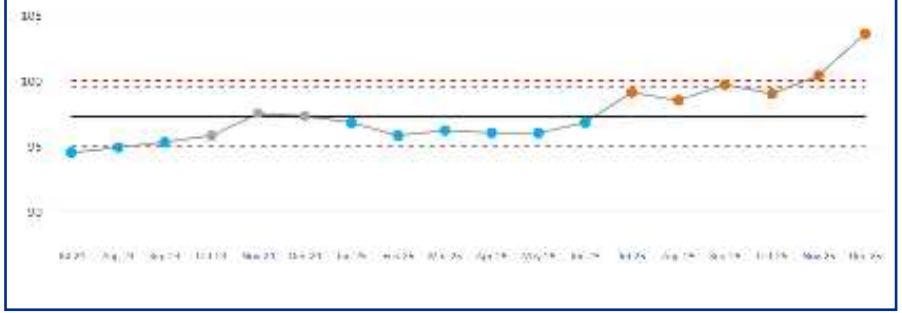
Standardised Mortality Ratio (SMR)

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.

SMR - Kettering



SMR - Northampton



Data Quality Indicators

Understanding the performance

- It is estimated by Telstra Health UK that NGH's actual SMR is up to 5 base points lower than the reported value.

What are the issues impacting performance?

- There is an identified national data quality issue with different trusts migrating their SDEC datasets at different times. This has significantly impacted NGH, who fully migrated earlier than many other trusts, resulting in a falsely elevated SMR value.

What SMART actions are being taken to improve?

- We are awaiting further guidance to be issued from NHS England concerning migration of the SDEC dataset.

Risks

- NGH is at risk of "alerting" for SMR in the coming months, however it is highly unlikely this will be a true reflection of our actual underlying performance.
- Peer assessment with trusts in a similar position to NGH with their SDEC datasets migration shows they are also encountering the same challenges.

Our Safe domain metrics

Responsible director(s): Julie Hogg, Group Chief Nurse, and Hemant Nemade, Medical Director

	P	?	F	No target
H / L		• Never event incidence (NGH)	• Care hours per patient day (NGH)	• Falls per 1,000 bed days (KGH)
	• MRSA (KGH)	• Never event incidence (KGH) • MRSA (NGH) • MSSA • Care hours per patient day (KGH)		• Serious or moderate harms per 1,000 bed days • C. Diff per 100,000 bed days • Pressure ulcers per 1,000 bed days • Falls per 1,000 bed days (NGH)
H / L				

Safe

Responsible director(s): Julie Hogg, Group Chief Nurse, and Hemant Nemade, Medical Director

NHS University Hospitals of Northamptonshire NHS Group

Metric	Target	Latest Data	RHH Actual	Variation	Assurance	RHH Average	NHH Actual	Variation	Assurance	NHH Average	Data Quality Indicators
Incidents											
Serious or irreversible harm per 1000 bed days	-	Dec 25	0.00			0.01	0.00			0.01	S T A R
Never event incidents	0	Jan 26	0			0.06	0			0.03	S T A R
Infection Prevention Control											
Number of MSSA bacteraemia	0	Jan 26	0			0.31	1			0.53	S T A R
C.Diff per 100,000 bed days	-	Dec 25	0.00			17.82	24.74			11.07	S T A R
Number of MRSA Bacteraemia	0	Jan 26	1			0.15	3			1.76	S T A R
Safe care											
Slips, trips and falls	0	Jan 26	0.23			0.30	0.20			0.55	S T A R
Serious or irreversible harm – falls per 1000 bed days	-	Dec 25	0			0.00	0.00			0.10	S T A R
Number of moderate harm pressure ulcers per 1000 bed days		Jan 26	0			0.06	0.00			0.12	S T A R

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

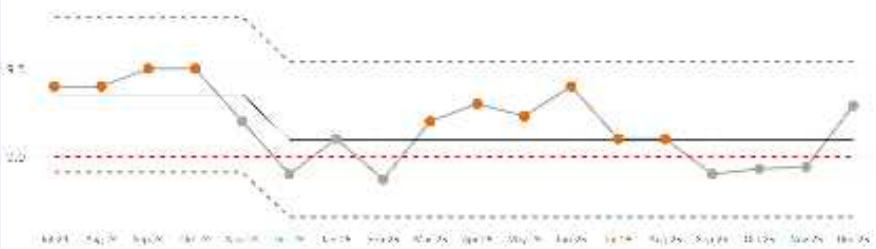
S	T	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

Care hours per patient day

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

University Hospitals of Northamptonshire NHS Group

Care hours per patient day - Kettering



Care hours per patient day - Northampton

Data Quality Indicators

S T A R

Understanding the performance

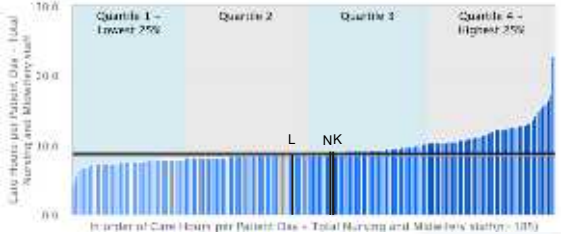
- Latest CHPPD remains close to the mean of 9 following a period of improvement in NGH to achieve the mean.

What SMART actions are being taken to improve?

- Monthly roster metrics shared and reviewed which demonstrate a forward view. This enables a tight alignment against observed activity.
- SPC-based triggers applied to avoid corrective action unless special cause variation emerges.
- Exemplar rostering programme is in progress

National comparator

Sep-25



What are the issues impacting performance?

- NGH sees minor misalignment between planned vs actual hours.
- Short-term operational factors such as maintenance of skill-mix and supervision requirements limit in-month flex.

Risks

- Financial efficiency risk if continued common cause variation is seen as norm.

Our Responsive domain metrics

Responsible director(s): Sarah Noonan, Chief Operating Officer

	P	?	F	No target
H L		• Time to initial assessment (NGH) • Theatre utilisation (KGH)	• Bed utilisation (KGH) • Super-stranded patients (NGH)	
	• Time to initial assessment (KGH)	• A&E 4-hour (KGH) • Average ambulance handovers • Non-elective length of stay • Cancer Faster Diagnostic standard (NGH) • 31-day wait for cancer • 62-day wait for cancer (KGH) • Outpatient appointments per consultant WTE	• A&E 4-hour (NGH) • Bed utilisation (KGH) • Stranded patients • Super-stranded patients (KGH) • Patients with a reason to reside • 52 weeks elective wait (NGH) • Theatre utilisation (NGH) • Average cases per list	• Size of RTT waiting list (KGH)
H L		• Cancer Faster Diagnostic standard (KGH) • 62-day wait for cancer (NGH) • 52 weeks elective wait (KGH)	• RTT performance • 18 weeks until first appointment	• Size of RTT waiting list (NGH)

Responsive – Urgent and Emergency Care

Responsible director(s): Sarah Noonan, Chief Operating Officer

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average	Data Quality Indicators
UEC											
ED 4 hour performance	78%	Dec 25	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Average Ambulance handovers	45	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Time to initial assessment	15	Dec 25	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Bed Utilisation	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Non-elective LOS (Model Hospital (Closed Spells))	5.90	Dec 25	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Stranded patients (7+ day length of stay)	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Super Stranded patients (21+ day length of stay)	[illegible]	Dec 25	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Patients with a reason to reside	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R

Data quality assessment

Ambulance handover currently is only 11 months of data. More historic data was intended to be for May 25 IPR, given the data is now at 12 months and the available data is a longer timeframe, this work will not be completed.

12 hour wait in the department is not calculated internally, this measure is currently from the national performance dashboard and only available for 25/26. An error with the national dashboard means this metric is not available this month. This will be updated in Q4 25/26.

Issues with iBox data provision during Oct 24 and Feb 25 mean the NGH 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 as the denominator currently includes non G&A beds.

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	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

Responsive – Cancer and Elective

Responsible director(s): Sarah Noonan, Chief Operating Officer

NHS University Hospitals of Northamptonshire NHS Group

Metric	Target	Latest data	KQI Refresh	Variation	Assurance	KQI Previous	KQI Refresh	Variation	Assurance	KQI Previous	Data Quality Indicators
Cancer											
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Elective											
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R

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.

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	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

Responsive – Productivity

Responsible director(s): Sarah Noonan, Chief Operating Officer

Metric	Target	Latest Data	BHH Actual	Variation	Assurance	BHH Average	NGH Actual	Variation	Assurance	NGH Average	Data Quality Indicators
Productivity											
Theatre utilisation	85%	Dec 25	84.35%			84.17%	77.74%			76.67%	S T A R
Average length of stay	2.50	Jan 26	2.55			2.54	2.40			2.34	S T A R
Outpatient appointments per consultant FTE	1.15	Dec 25	-			1.39 FTE	-			1.47 FTE	S T A R

Data quality assessment

No data quality issues identified.

SPC indicator key

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

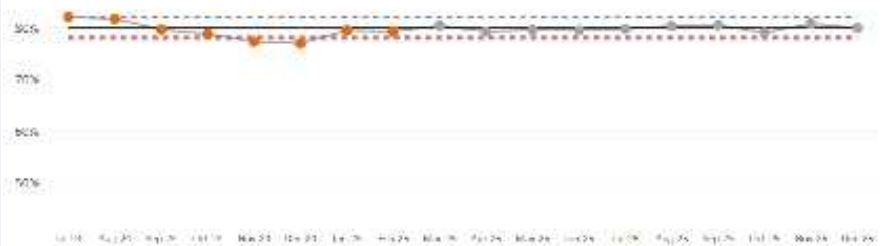
Data quality indicator key

S	T	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

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.

A&E 4 hour performance - Kettering



A&E 4 hour performance - Northampton

Understanding the performance

Overall 4hr performance includes Type 1, Type 2 (NGH) and Type 3 activity for both sites.

KGH performance remains above 78% target.

NGH performance has decreased by 2% from November with additional winter schemes supporting.

What are the issues impacting performance?

- Admitted flow.
- Increase in ED attendances.
- Increase in acuity of patients presenting during winter period.

What SMART actions are being taken to improve?

Develop the Consultant presence at the Front Door to maximise quality, impact, and patient benefit.

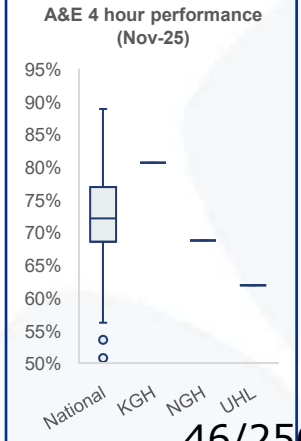
Introduce a lead nurse for discharge and pathways in ED to support 4hr position.

Radiology requesting now a pull from imaging without need for every study to be discussed with radiologist.

Risks

- Overcrowding in dept.
- Poor patient experience.

National comparator



Data Quality Indicators

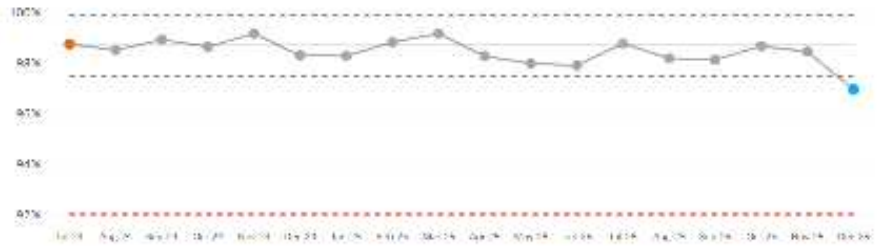
S T A R

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



Bed utilisation - Northampton

Understanding the performance

- High bed occupancy impacts patient flow and admitted pathway delays in the ED.
- Improved bed occupancy in December at both sites.

What are the issues impacting performance?

- Supported discharge pathway delays.
- Stranded and super stranded position.

What SMART actions are being taken to improve?

- Reduction in LoS plans across UHN and system winter support actions to reduce bed occupancy and improve flow.
- Continued use of release 2 respond to support capacity across the organisation.
- 7 day Frailty SDEC and expansion of the AAU model at NGH to reduce LoS for Acute Medicine.

Risks

- Poor patient experience due to ED delays.
- Impact on 12hr performance.
- ED overcrowding.
- Ambulance handover delays.

Data Quality Indicators

S T A R

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

Data Quality Indicators

Understanding the performance

- Improved stranded position at both sites into December.

What are the issues impacting performance?

- Increase in patient acuity during December.
- Number of flu positive patients in inpatient beds during December.

What SMART actions are being taken to improve?

- Boardrounds focus on SHOP model.
- Internal and external escalation delays to discharge.
- Maximise use of discharge lounge.
- Maximise use of SDEC, including Frailty SDEC across 7days at NGH.
- P1 working group focusing on reduced LoS.

Risks

- Delay to discharge impacting admitted flow through the ED.
- All community beds full.

S T A R

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.

University Hospitals of Northamptonshire NHS Group

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

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

Data Quality Indicators

Understanding the performance

- Improved super stranded position into December at both sites.

What are the issues impacting performance?

- P2/3 supported discharge waits across UHN.

What SMART actions are being taken to improve?

Twice weekly escalation group for patients who do not have a supported discharge plan.

Working with partners to reduce P2 delays to discharge – particularly for DTA beds.

Patient flow coordinators to work across all pathways to reduce transfer of care request delays.

Trusted assessor model for NHFT community beds through checklist.

Risks

- Bed occupancy remains high impacting patient flow.
- Ongoing use of corridor care risk across ED and inpatient ward areas.

S T A R

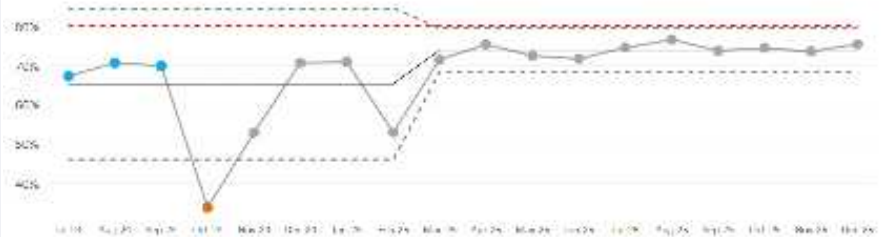
Patients with a reason to reside

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



Understanding the performance

- No significant change in criteria to reside position.
- KGH data is artificially low as the denominator includes non-G&A beds.

What are the issues impacting performance?

- Number of patients waiting supported discharge.
- Housing / waiting for equipment.
- Inpatients awaiting a mental health community bed.

What SMART actions are being taken to improve?

Twice weekly escalation group for supported discharge with system partners.

Trusted assessor started at NGH.

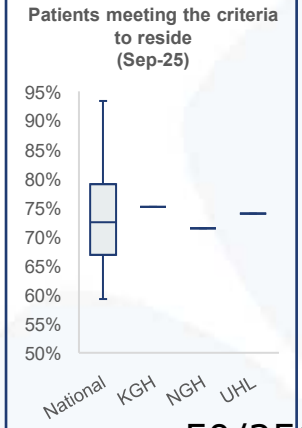
Working with local authorities for housing pathway.

System winter plan.

Risks

- Impact on bed occupancy, use of corridor care and 12hr performance in the ED.

National comparator



Data Quality Indicators

S T A R

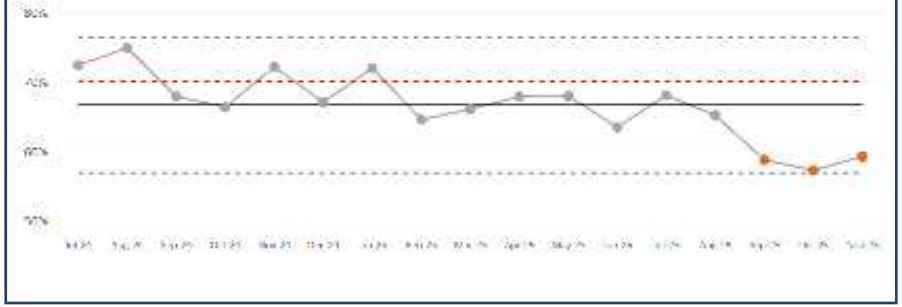
62-day wait to start treatment from referral

The percentage of cancer patients who start treatment within 62 days of an urgent referral.

University Hospitals of Northamptonshire NHS Group

62-day wait for cancer treatment - Kettering

62-day wait for cancer treatment - Northampton



Understanding the performance

- NGH saw a 2% increase in performance achieving 59.2%. Colorectal, Lung, Sarcoma and Upper GI saw a decline from October
- KGH achieved the standard at 70.6% a 7% improvement from the previous month

What are the issues impacting performance?

- Provider initiated delay remains the top breach reason, this means multiple delays rather than one overarching reason.
- Capacity (diagnostic, elective and oncological)
- Patient choice and complex pathways

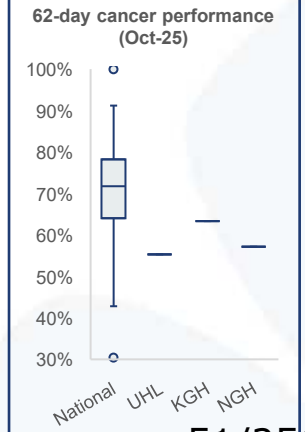
What SMART actions are being taken to improve?

- Work to improve the process to transfer patients who have a decision at KGH to NGH for majors, which is too slow currently
- NHSE funded additionality for Skin and Breast should support improvement
- A focus on MDT streamlining for key tumour sites

Risks

- Capacity constraints
- Delays to the first outpatient appointment in high volume specialties (Skin, Breast)
- Gynaecology MDT deferring patient discussions

National comparator



Data Quality Indicators

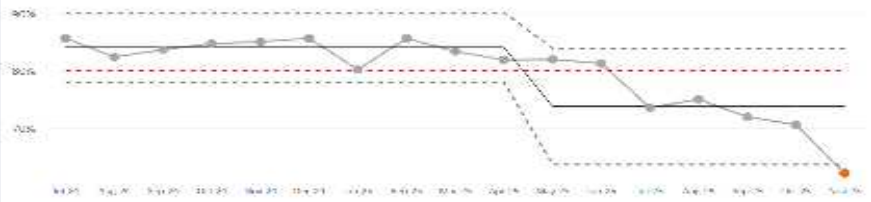
S T A R

Cancer Faster Diagnosis Standard

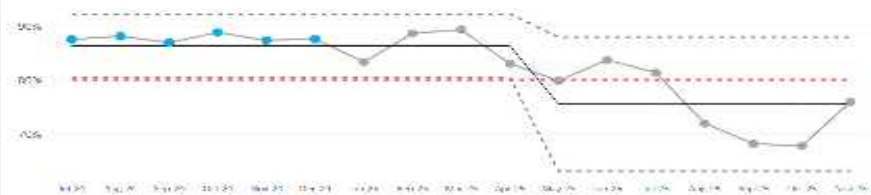
The number of patients who are referred urgently for suspected cancer and receive a diagnosis or have cancer ruled out within 28 days.

University Hospitals of Northamptonshire NHS Group

Cancer Faster Diagnosis Standard - Kettering



Cancer Faster Diagnosis Standard - Northampton



Understanding the performance

- NGH achieved the standard for the first time since July. Challenges remain in gynaecology, haematology, sarcoma, skin and Urology. Skin saw a 38.7% increase this month.
- KGH performance reduction due to a data issue in Breast, where previously the wrong start date had been recorded for pathways. This has now been rectified.

What are the issues impacting performance?

- Waits for first OPA remains challenging in breast and skin, two of the highest volume pathways.
- In both Breast (KGH to NGH) and Skin (NGH to KGH) we have been IPT'ing patients between the two hospitals to mitigate long waits, but this also impacts performance data

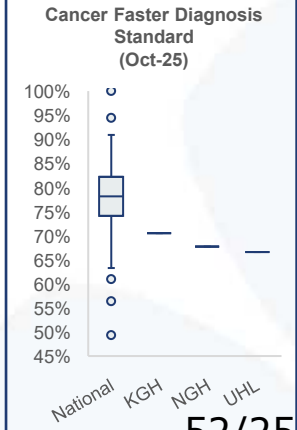
What SMART actions are being taken to improve?

- Weekly meetings with skin to expedite pathways and a number of patients transferred to KGH. Skin 'Super clinics' to commence Jan 26 at KGH.
- Task and finish group to be established to review breast pathway and rollout countywide of mastalgia pathway
- KGH reconfigured Breast one-stop clinics to improve capacity to commence in Feb 26

Risks

- Volume of patients waiting to be seen in Breast and how quickly we con implement additional capacity
- Administrative workload involved in transferring patients to Ozone is a rate limiting factor, this is being supported by funding for Bank via EMCA

National comparator



Data Quality Indicators

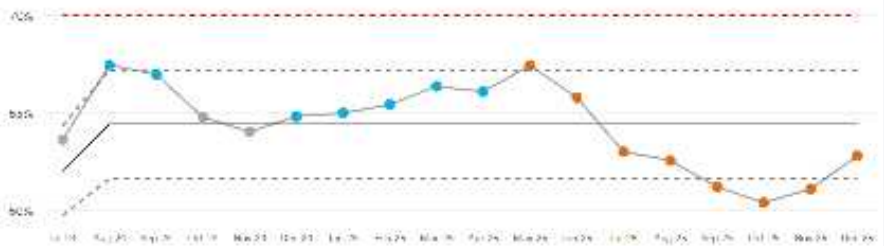
S T A R

Referral to Treatment performance

The percentage of patients who are referred for elective (non-urgent) treatment who receive their first treatment within 18 weeks.

NHS University Hospitals of Northamptonshire NHS Group

RTT performance - Kettering



Understanding the performance

- We have seen particular improvement at KGH since October
- NGH has a flatter position, with a focus on managing the waiting list size overall
- Both Trusts continue to be behind plan and in Tier 2 performance oversight (KGH plan for December was 68%, NGH 67%)

What are the issues impacting performance?

- The reduction in premium activity has impacted RTT performance significantly
- IPTs between the Trusts this year have supported the long waits position but have made RTT performance variable

RTT performance - Northampton

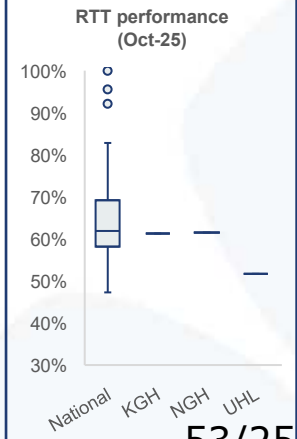
What SMART actions are being taken to improve?

- NHSE have released an Elective Q4 performance sprint, where additional first outpatient activity that supports performance improvement will be paid for by NHSE. KGH is in a good position to maximise activity through the sprint.
- Focused specialty action in Dermatology, Gynaecology and Cardiology.

Risks

- Winter pressures

National comparator



Data Quality Indicators

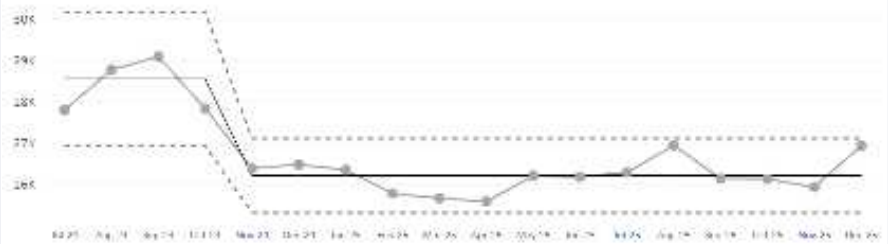
S T A R

Size of RTT waiting list

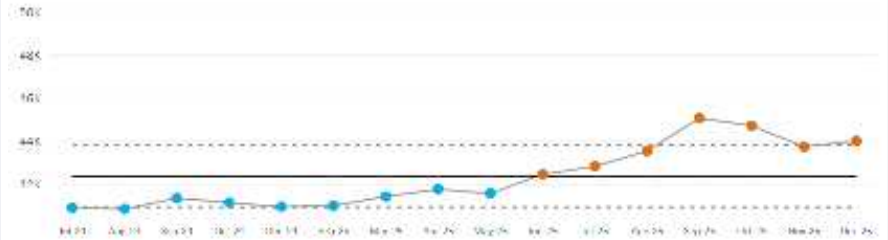
The number of patients waiting for planned, non-urgent care on our waiting list.

University Hospitals of Northamptonshire NHS Group

Size of RTT waiting list - Kettering



Size of RTT waiting list - Northampton



Data Quality Indicators

S T A R

Understanding the performance

- We have seen increases in the size of the waiting list in December, which often happens in December, with the added impact of Industrial Action in both November and December

What are the issues impacting performance?

- Industrial action
- Winter pressures/reduction in activity over Christmas

What SMART actions are being taken to improve?

- Additional focussed validation where patients have had activity on their pathway
- Patient-led validation texts on a rolling cycle

Risks

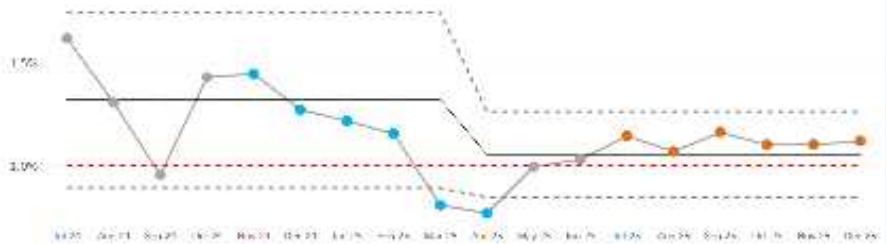
- Level of referral – with significant growth in some specialty areas
- IPTs between organisations to support performance can skew the data on waiting list size
- A growing waiting list size makes delivery of RTT improvement more challenging

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

- Our Monthly validated 52 week actuals were 881 in November, reduced from 949 in October. In December, based on the weekly data, we saw this increase slightly to 898.
- We remain just over 1% of total waiting list size for 52 weeks

What are the issues impacting performance?

- Industrial action
- Winter period – acute pressures and annual leave

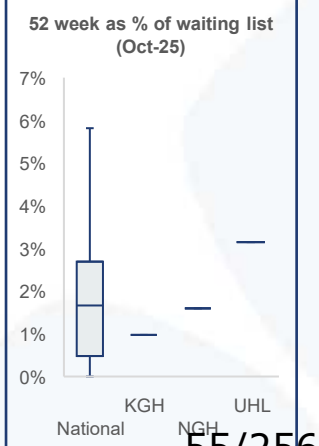
What SMART actions are being taken to improve?

- We have started to outsource long waiting dermatology patients to Ozon, this should start to reduce numbers of long waits in January
- We are working to mitigate the impact of winter on T&O long waiting patients, exploring alternative options for patients and IPTs

Risks

- Winter pressure on T&O

National comparator



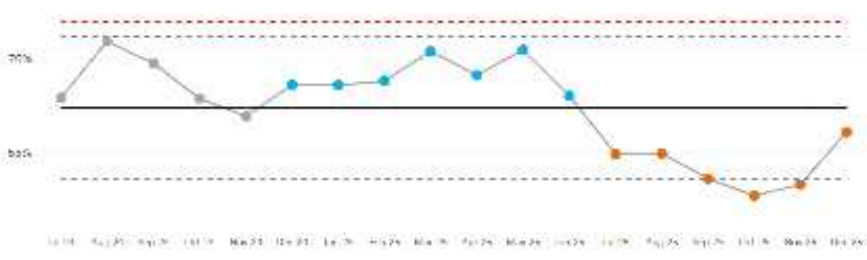
Data Quality Indicators

S T A R

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

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



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

Data Quality Indicators

S T A R

Understanding the performance

- Although we have seen improvement since October at KGH we see continued reduction in performance at NGH.

What are the issues impacting performance?

- Reduction in the delivery of premium activity, particularly at NGH

What SMART actions are being taken to improve?

- Dermatology outsourcing should impact performance
- Q4 performance sprint, and then equalising waits across NGH and KGH should drive improvement in Q4
- Increased validation to ensure appointments are utilised as effectively as possible.

Risks

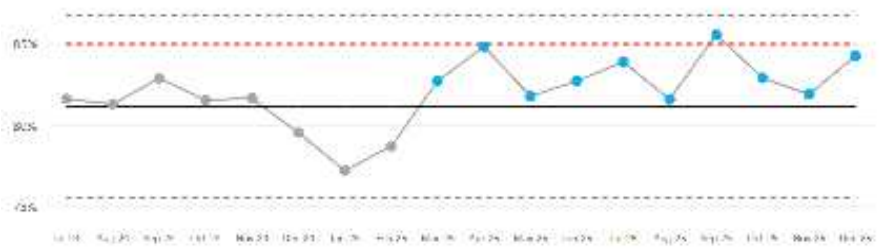
- Reversing the trend at NGH

Theatre utilisation

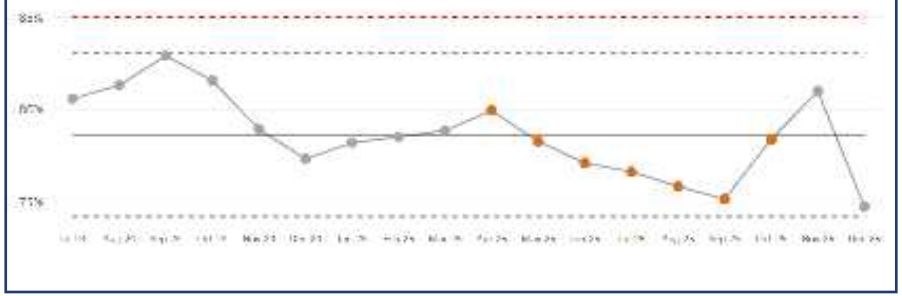
The percentage of the available time in our elective theatre sessions which is spent operating on patients.

NHS University Hospitals of Northamptonshire NHS Group

Theatre utilisation - Kettering



Theatre utilisation - Northampton



Understanding the performance

- KGH very close to the standard this month
- A decline in performance at NGH

What are the issues impacting performance?

- Industrial action, as emergency patients were added to replace some late elective cancellations
- Cancellations in the 3 days prior to TCI - when we have late cancellations, we don't have enough ready and pre-assessed patients to replace the cancelled patients

What SMART actions are being taken to improve?

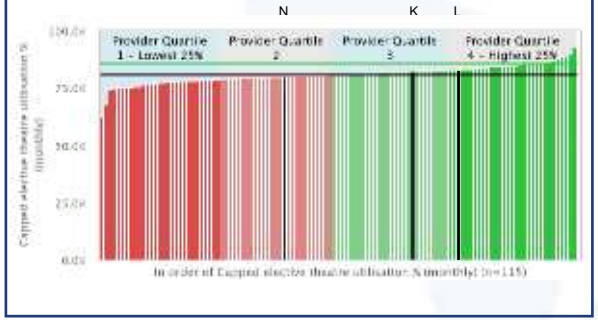
- Increased senior presence at Theatre Scheduling meeting
- Implementation of My Pre Op Plus
- Pre-Assessment deep dive to understand rate limiting steps and reasons for late cancellations
- FDP Inpatient CCS moving to UHN module by end March.

Risks

- Digital implementation timetable

National comparator

Nov-25



Data Quality Indicators

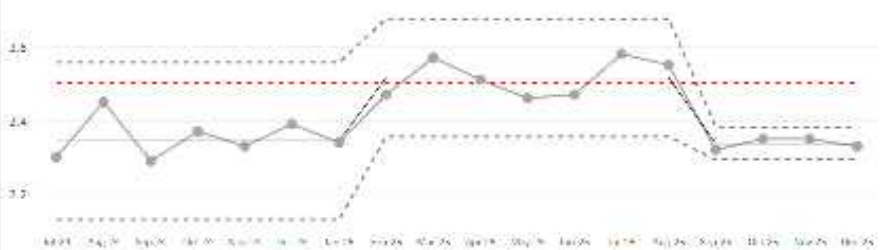
S T A R

Average cases per list

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

NHS University Hospitals of Northamptonshire NHS Group

Average cases per list - Kettering



Average cases per list - Northampton

Data Quality Indicators

Understanding the performance

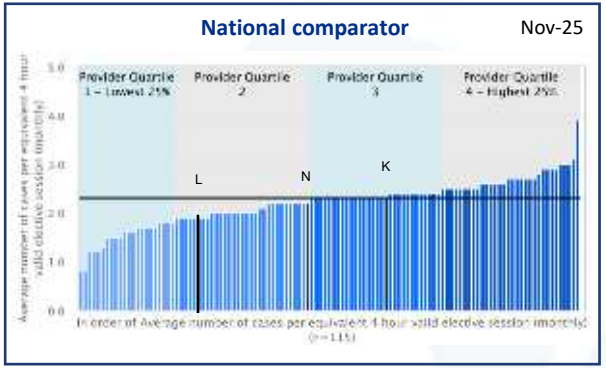
- Very similar performance across the two Trusts now, following improvement at NGH this month. This should put both Trusts in the third quartile for benchmarking

What SMART actions are being taken to improve?

- Review of specialty level GIRFT actions at the Improving Planned Care steering group

National comparator

Nov-25



What are the issues impacting performance?

- Case mix
- Cancellations

Risks

25/26 Activity and Plan

		Kettering General Hospital			Northampton General Hospital			University Hospitals of Northamptonshire Group		
		25/26 M9 Plan	25/26 M9 Actual	% of planned activity	25/26 M9 Plan	25/26 M9 Actual	% of planned activity	25/26 M9 Plan	25/26 M9 Actual	% of planned activity
Outpatients	Total outpatient appointments (incl. non-consultant-led)	36,048	37,658	104%	56,173	46,615	83%	36,048	37,658	104%
	First outpatient appointments (consultant-led)	10,475	9,921	95%	15,231	10,939	72%	10,475	9,921	95%
	Follow up outpatient appointments (consultant-led)	18,958	21,030	111%	30,667	27,314	89%	18,958	21,030	111%
	Outpatient procedures (consultant-led)	6,615	6,707	101%	10,275	8,362	81%	6,615	6,707	101%
Elective	Elective overnight spells	265	281	106%	382	470	123%	265	281	106%
	Day case spells	3,106	3,229	104%	4,343	4,281	99%	3,106	3,229	104%
UEC	Type 1 A&E attendances	10,153	10,731	106%	9,531	12,618	132%	10,153	10,731	106%
	Zero-day non-elective spells	609	1,407	231%	1,022	719	70%	609	1,407	231%
	Overnight non-elective spells	2,056	1,764	86%	2,035	2,562	126%	2,056	1,764	86%

Understanding the position

We continue to be behind plan on outpatient firsts and ahead of plan on outpatient follow up, as we have not met the ambitious shift in activity that we planned for.

What are the issues impacting the position?

- Elective activity levels have been impacted by the reduction in premium activity.

What SMART actions are being taken to improve?

- There is a Q4 first outpatient sprint that KGH is eligible to take part on which should increase activity
- Elective payment is block this year so under performance does not cause financial challenge

Risks

- Underperformance on first activity against plan at NGH excluded them directly taking part in the Q4 sprint

Our Well-Led domain metrics

Responsible director(s): Paula Kirkpatrick, Chief People Officer

	P	?	F	No target
H, L	• Mandatory training (NGH)	• Time to hire (NGH) • Agency spend as a % of total pay (KGH)	• Appraisal (NGH)	
	• Mandatory training (KGH) • Turnover (KGH)	• Sickness absence rate (NGH) • Time to hire (KGH) • Agency spend as a % of total pay (NGH)	• Vacancy rate (KGH) • Total WTE • Bank spend as a % of total pay	• Number of volunteering hours • Employee relations cases (KGH)
H, L	• Turnover (NGH)	• Sickness absence rate (KGH) • Appraisal (KGH)	• Vacancy rate (NGH)	• Employee relations cases (NGH)

Well-Led

Responsible director(s): Paula Kirkpatrick, Chief People Officer

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average	Data Quality Indicators
Culture and safety											
Turnover rate	[illegible]	Dec 25	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Appraisal completion rates	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Mandatory training compliance	[illegible]	Dec 25	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Sickness and absence rate	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Number of [illegible] hours	-	Dec 25	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Vacancy rate	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R

Dedicated to excellence

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	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

Well-Led

Responsible director(s): Paula Kirkpatrick, Chief People Officer

Metric	Target	Latest Data	KGH Actual	KGH Variation	KGH Assurance	KGH Average	NGH Actual	NGH Variation	NGH Assurance	NGH Average	Data Quality Indicators
Workforce financial sustainability											
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]		[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	KGH: 4,903 NGH: 6,199	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R

Dedicated to excellence

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	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

Turnover rate

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

University Hospitals of Northamptonshire NHS Group

Turnover rate - Kettering

Turnover rate - Northampton

Metric	Target	Latest Month	Measure KGH	Measure NGH
Additional clinical services	6.5%	Dec-25	5.96%	4.70%
Allied health professionals	6.5%	Dec-25	8.87%	3.50%
Healthcare scientists	6.5%	Dec-25	3.72%	7.47%
Administrative and clerical	6.5%	Dec-25	8.84%	10.18%
Nursing and midwifery registered	6.5%	Dec-25	4.03%	3.41%
Medical and dental	6.5%	Dec-25	3.82%	5.30%
Additional professional, scientific and technical	6.5%	Dec-25	6.55%	9.06%
Estates and ancillary	6.5%	Dec-25	10.34%	8.62%

Understanding the performance

- Turnover shows stable at KGH and decrease in NGH. Actual turnover rates at NGH 5.9% & KGH 6.2% against a target of 6.5%

What are the issues impacting performance?

- Workflow disruptions may lead to reduced operational efficiency
- Training new hires takes time, resulting in lower short-term productivity
- Loss of experienced staff can create knowledge gaps and negatively affect organisational culture

Risks

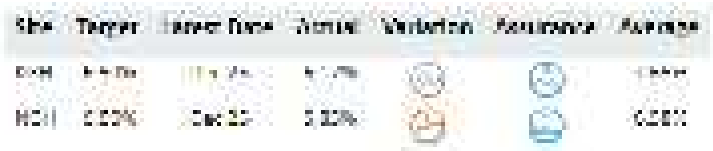
- Erosion of organisational knowledge and expertise
- Decline in overall productivity and operational efficiency
- Potential rise in recruitment and onboarding costs due to increased turnover

What SMART actions are being taken to improve?

- Continue to support priority areas and advance initiatives aligned with organisational development objectives
- Evaluate OD interventions and activities in departments experiencing higher turnover to identify improvement opportunities

Data Quality Indicators

S T A R



Appraisal completion rate

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

University Hospitals of Northamptonshire NHS Group

Appraisal completion rate - Kettering

Appraisal completion rate - Northampton

Metric	Target	Latest Month	Measure KGH	Measure NGH
Additional clinical services	85%	Dec-25	87.15%	85.65%
Allied health professionals	85%	Dec-25	85.93%	83.92%
Healthcare scientists	85%	Dec-25	79.22%	74.81%
Administrative and clerical	85%	Dec-25	78.31%	75.20%
Nursing and midwifery registered	85%	Dec-25	85.59%	86.46%
Medical and dental	85%	Dec-25	69.19%	
Additional professional, scientific and technical	85%	Dec-25	77.36%	83.22%
Estates and ancillary	85%	Dec-25	84.37%	75.24%

Understanding the performance

- Rates of appraisal have maintained at a consistent level although remain under benchmark

What are the issues impacting performance?

- Hospital acuity impacts time for managers to be released form patient care and complete the notification for data accuracy
- Resource to support more personalised reminders outside of automation have not been at capacity but have been recruited to this month.

Risks

- Low appraisal rates can affect staff engagement, development and compliance with regulatory standards, potentially impacting overall care quality and staff morale

What SMART actions are being taken to improve?

S – Target underperforming teams for focused support
M - Track monthly rates and share with divisions
A – Maintain reminder systems and prompts
R – develop an automation option
T- continue to strive for the highest compliance

Data Quality Indicators

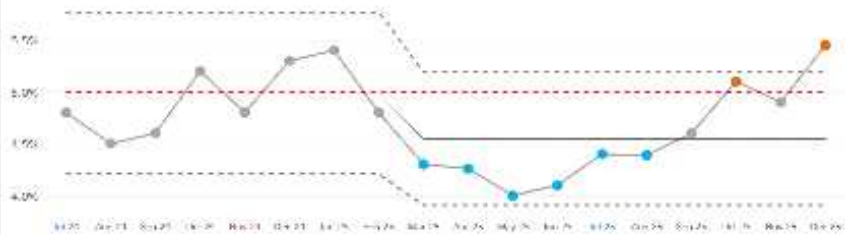
S T A R

Sickness and absence rate

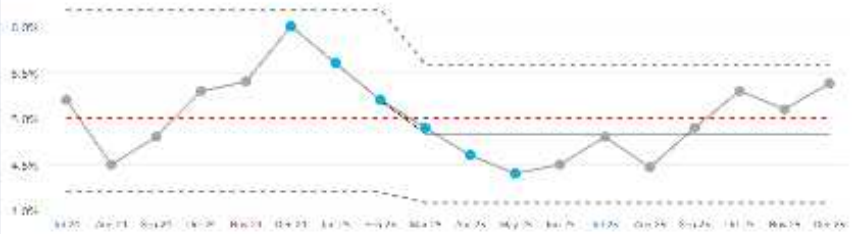
The percentage of total colleague working time lost to sickness or absence.

University Hospitals of Northamptonshire NHS Group

Sickness and absence rate - Kettering



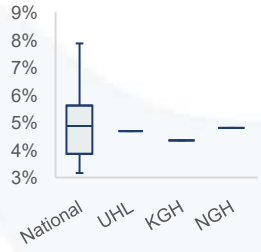
Sickness and absence rate - Northampton



Metric	Measure KGH	Measure NGH
Additional clinical services	7.54%	7.23%
Allied health professionals	4.14%	5.15%
Healthcare scientists	3.32%	2.98%
Administrative and clerical	4.95%	4.64%
Nursing and midwifery registered	5.84%	5.77%
Medical and dental	2.37%	2.34%
Additional professional, scientific and technical	3.84%	8.51%
Estates and ancillary	7.70%	6.66%

National comparator

Sickness absence rate (Jul-25)



Understanding the performance

- Sickness absence is mainly driven by short-term illness, alongside musculoskeletal and stress-related conditions, with variation by staff group. Nursing and midwifery show higher MSK, stress and pregnancy-related absence, while administrative and clerical staff are more affected by stress, anxiety and short-term illness.

What are the issues impacting performance?

- Wider organisational change and ongoing staff consultations, particularly within administrative and nursing staff groups, may be contributing to uncertainty and increased pressure for some teams, alongside seasonal illness and workload demands.

Risks

- Although sickness absence is currently below the Trust target, there remains a risk that seasonal illness or sustained pressure on key staff groups could lead to increased absence and impact service resilience if not closely monitored.

What SMART actions are being taken to improve?

- Ongoing engagement with affected teams is in place during consultation periods, with consultation related referrals prioritised for timely occupational health and wellbeing support. Absence trends continue to be monitored to enable early intervention and support attendance and recovery.

Data Quality Indicators

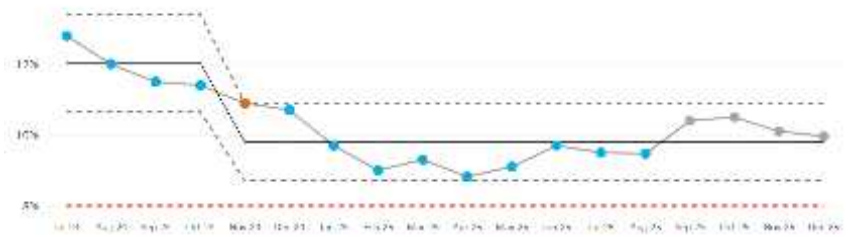
S T A R

Vacancy rate

The percentage of established posts which are currently vacant.

University Hospitals of Northamptonshire NHS Group

Vacancy rate - Kettering



Vacancy rate - Northampton

Metric	Target	Latest Month	Measure KGH	Measure NGH
Additional clinical services	8%	Dec-25	11.52%	8.74%
Allied health professionals	8%	Dec-25	9.06%	6.37%
Healthcare scientists	8%	Dec-25	10.98%	4.62%
Administrative and clerical	8%	Dec-25	14.63%	11.88%
Nursing and midwifery registered	8%	Dec-25	6.57%	9.06%
Medical and dental	8%	Dec-25	4.31%	7.29%
Additional professional, scientific and technical	8%	Dec-25	11.23%	16.03%
Estates and ancillary	8%	Dec-25	17.27%	14.80%

Understanding the performance

- The vacancy rate shows an increase since June 2025 but this is due to pausing recruiting to some vacancies and the average currently sits above 10.0%

What are the issues impacting performance?

- Key challenges include Group enhanced workforce controls

Risks

A reduction of skilled employees can create knowledge gaps, impact productivity and may increase turnover/sickness
Increased use of temporary staffing and enhanced workforce controls creating bottlenecks

What SMART actions are being taken to improve?

Identification of high vacancy areas and hard to recruit to roles to develop resourcing initiatives to support divisional operational delivery and reduction in temporary staffing
Further workforce support sessions taking place with budget holders to identify recruitment opportunities and identify vacancies no longer required and can be removed from establishment

Data Quality Indicators

S T A R

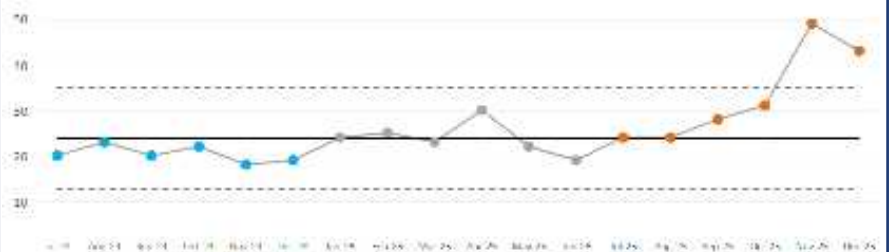
Employee relations cases

The number of formal cases and grievances raised in the organisation.

University Hospitals of Northamptonshire NHS Group

Employee relations cases - Kettering

Employee relations cases - Northampton



Data Quality Indicators

S T A R

Understanding the performance

- There has been a reduction in formal cases at both KGH and NGH.
- Progress with cases is being made and several cases were closed this month.

What are the issues impacting performance?

- Cases remain high, particularly at NGH.
- The majority of formal cases are grievances, which could be linked to the roll out of resolution and civility through awareness of raising concerns.

What SMART actions are being taken to improve?

- Review of cases and themes to be undertaken by end of February 2026 to assist learning and proactive support options
- Review of formality of cases in a just and restorative learning culture.
- Full recruitment to the team is underway to maximise resource available for timely case work.

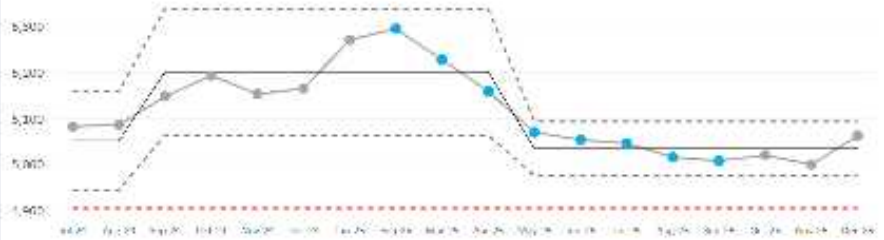
Risks

- The current volume of cases requires significant resource due to the complexity, limiting the capacity for more proactive work.
- Ongoing organisational change activity planned for this quarter is high with several change programmes commencing end of January and early February.

Whole-time equivalent workforce

The number of whole-time equivalent positions the Trust has contracted for.

WTE from the Provider Workforce Return - Kettering



WTE from the Provider Workforce Return - Northampton

Metric	Latest Month	KGH				NGH			
		Dec-24	Nov-25	Dec-25	Dec-25 Plan	Dec-24	Nov-25	Dec-25	Dec-25 Plan
Total WTE	**Dec-25**	**5,227**	**4,998**	**5,055**	**4,963**	**6,721**	**6,497**	**6,480**	**6,345**
Substantive WTE	Dec-25	4,662	4,577	4,587	4,524	5,849	5,783	5,813	5,815
Bank WTE	Dec-25	486	405	451	359	753	653	611	466
Agency WTE	Dec-25	80	16	17	80	118	60	55	65

Understanding the performance

- Total Workforce has reduced by 412.59. since month 1.
- That leaves a remaining reduction target of 368.41 required in the final quarter.
- UHN is +128.61 above plan as at month 9.

What are the issues impacting performance?

- Late-year deterioration is almost entirely attributable to increased Bank utilisation, arising from winter pressures and industrial action.
- Substantive recruitment has increased in each organisation but has not substituted bank
- While agency usage remains below plan across both sites

Risks

- Volume of change
- Temporary staffing dependence
- Leadership & capacity
- Winter

What SMART actions are being taken to improve?

- 6 week forward view meetings established for medical bank.
- Nursing CNST safety actions and training plans are being managed
- Locum Nest system implementation to enhance medical bank booking efficiency
- Divisional VCP strengthened.
- EMAP plan to bring agency rates in line with rate card

Data Quality Indicators

Detailed workforce numbers

NHS University Hospitals of Northamptonshire NHS Group

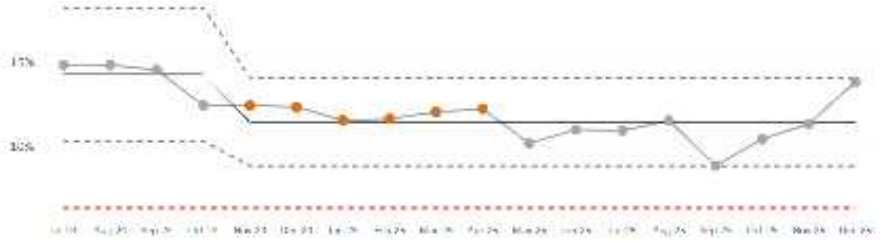
		Kettering General Hospital				Northampton General Hospital				University Hospitals of Northamptonshire Group			
		Dec-24	Nov-25	Dec-25	Change in month	Dec-24	Nov-25	Dec-25	Change in month	Dec-24	Nov-25	Dec-25	Change in month
	Total	**5,227**	**4,998**	**5,055**	**57**	**6,721**	**6,497**	**6,480**	**-17**	**11,948**	**11,495**	**11,535**	**40**
	Substantive	4,662	4,577	4,587	10	5,849	5,783	5,813	30	10,511	10,360	10,400	40
	Bank	486	405	451	46	753	653	611	-42	1,239	1,059	1,062	3
	Agency	80	16	17	1	118	60	55	-5	198	77	73	-4
Substantive	Registered Nursing and Midwifery	1,460	1,508	1,518	10	1,749	1,766	1,766	0	3,209	3,274	3,285	11
	Scientific, Therapeutic and Technical	383	381	382	1	567	577	584	7	950	958	966	8
	Support to Clinical Staff	968	903	903	0	1,279	1,234	1,241	7	2,247	2,137	2,144	7
	Infrastructure support	1,244	1,175	1,173	-2	1,449	1,366	1,374	8	2,693	2,541	2,547	6
	Medical and Dental	601	603	605	2	800	837	844	7	1,401	1,440	1,449	9
Bank	Registered Nursing and Midwifery	172	132	147	15	252	220	200	-20	424	352	347	-5
	Scientific, Therapeutic and Technical	20	19	23	4	16	20	16	-4	36	39	39	0
	Support to Clinical Staff	148	123	133	10	257	203	198	-5	405	327	331	4
	Infrastructure support	74	56	74	18	142	117	105	-12	216	173	179	6
	Medical and Dental	72	75	73	-2	86	93	93	0	158	168	166	-2
Agency	Registered Nursing and Midwifery	45	4	4	0	53	28	25	-3	98	31	29	-2
	Scientific, Therapeutic and Technical	14	3	4	1	27	12	11	-1	41	15	15	0
	Support to Clinical Staff	1	1	1	0	0	1	1	0	1	2	2	0
	Infrastructure support	1	0	0	0	0	0	0	0	1	0	0	0
	Medical and Dental	20	9	8	-1	38	19	19	0	58	28	27	-1

Bank spend as a percentage of total pay

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

Bank spend as a % of total pay - Kettering

Bank spend as a % of total pay - Northampton



Metric	Var	Measure	Var	Measure
		KGH		NGH
Overall		**11.5%**		**13.8%**
Registered nursing, midwifery and health visiting		5.2%		5%
Healthcare scientists and scientific, therapeutic and technical		0.2%		0.6%
Support to clinical		0.8%		0.2%
Medical and dental		4.9%		7.4%
Non-Clinical		0.3%		0.6%

Understanding the performance

- Bank spend is above target in both Trusts
- Bank spend slightly increased from last month at NGH & decreased from last month at KGH

What are the issues impacting performance?

- Reduction in agency use is driving increase in bank
- Increasing demand for UEC services
- Vacancy rates

Risks

- Failure to recruit to vacancies
- Winter demand escalates
- Further strike action

What SMART actions are being taken to improve?

- Recruitment plans behind long term temp workers
- Medical establishment review
- Review of grip and control measures

Data Quality Indicators

Our Use of Resources domain metrics

Responsible director(s): Sarah Stansfield, Chief Finance Officer

	P	?	F	No target
H L				
		• Cash • Surplus/Deficit		
H L		• Acute implied productivity compared to last year • CIP delivery		

Use of Resources

Responsible director(s): Sarah Stansfield, Chief Finance Officer

	Target	Latest Data	ICB Actual	ICB Variation	ICB Assurance	ICB Average	Trust Actual	Trust Variation	Trust Assurance	Trust Average	Data Quality Indicators
Finance:											
[illegible]	KGH: -422 NGH: -392	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
Productivity and efficiency											
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R
[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]			[illegible]	S T A R

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 Feb-25.

SPC indicator key

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

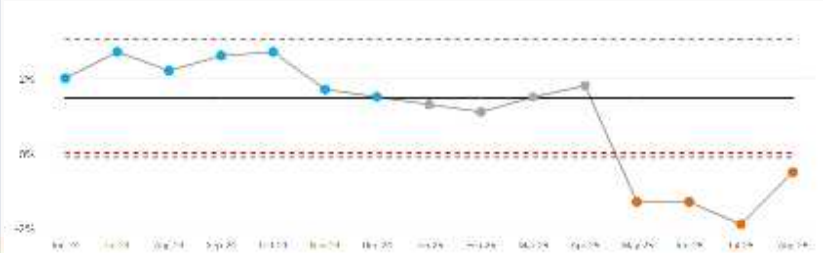
Data quality indicator key

S	T	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

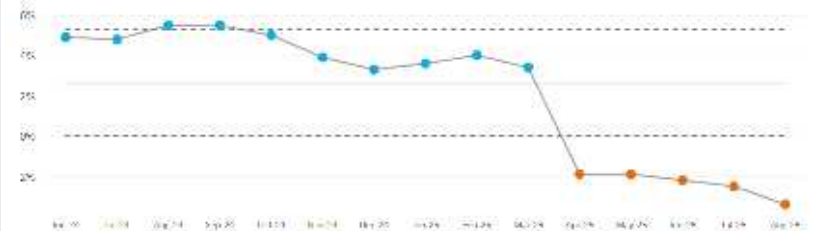
Acute implied productivity compared to last year

Implied productivity of the organisation, using the NHS England data which calculates change in productivity year-to-date since last year as a function of growth in costs compared to growth in activity.

Acute implied productivity - Kettering



Acute implied productivity - Northampton



Understanding the performance

- Compared to last year, both KGH and NGH have seen reduced productivity, whilst productivity increased in August by 1.4% in KGH, it decreased by 0.9% in NGH.

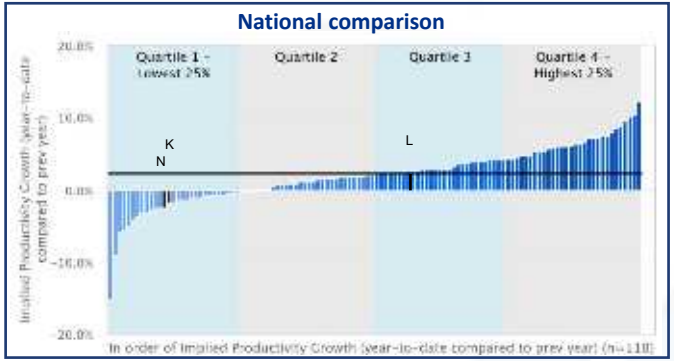
What are the issues impacting performance?

- KGH is seeing a 1.4% reduction in cost compared to last year, whilst NGH is seeing 0% change in cost. KGH is in the best quartile for cost growth, with NGH in a median position.
- Activity in both organisations is down year-on-year, by 3.3% in NGH and 1.9% in KGH, which is the lowest quartile nationally, and driving the position.

What SMART actions are being taken to improve?

- A proxy divisional measure for productivity is being developed to add to Divisional Accountability Meetings
- Productivity packs received from NHSE as part of planning being analysed.
- Focus on productivity within clinical settings, particularly clinic templates and NGH theatres.
- Corporate consolidation and clinical administration being accelerated with the use of AI and automation.

National comparison



Risks

- Cost controls impacting on activity delivery, without requisite productivity improvements to mitigate activity lost from premium capacity.
- Data availability within the Trusts to understand and improve.

Data Quality Indicators

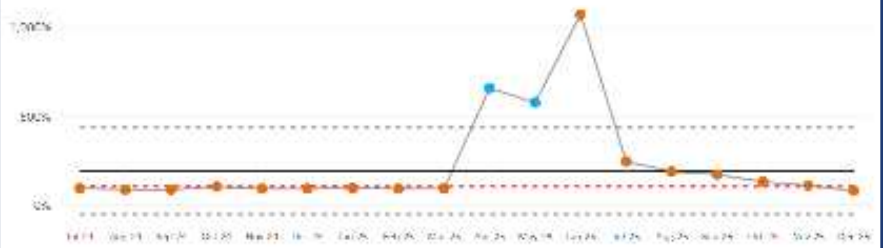
S T A R

Cost improvement plan delivery

NHS University Hospitals of Northamptonshire

The percentage of our planned cost improvement plan that has been delivered in-month.

CIP delivery - Kettering



CIP delivery - Northampton

Understanding the performance

- £45.7m of efficiencies have been delivered across UHN YTD at M8 (£23.4m NGH, £22.2m KGH), against a YTD plan of £52.3m.
- 46% of the M8 delivery is recurrent, which is an increase from 44% last month.

What are the issues impacting performance?

- The efficiency plan was phased to deliver 1.3% of required savings in quarter 1, 21% in Q2, and 38.8% in Q3 and Q4.
- Under-delivery in month 9 is largely driven by material step up in in-month target and ability to identify sufficient savings.

What SMART actions are being taken to improve?

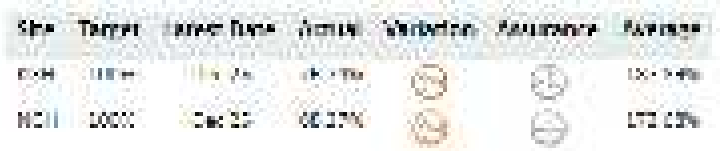
- FIP team driving efficiency gap closure through year-end.
- Divisional and Corporate meetings focused on identifying and delivering savings.
- Workforce sessions underway to make non-recurrent M1–9 pay efficiencies recurrent.
- Mitigation plans in development to close remaining gaps.

Risks

- Rising efficiency targets make savings increasingly hard to deliver.
- Winter pressures may hinder temporary staffing savings planned for H2.
- Efficiency plans face development gaps and delivery risks, even where fully scoped.

Data Quality Indicators

S T A R



% of delivery that is recurrent

Summary Balance Sheet - KGH

TRUST SUMMARY BALANCE SHEET MONTH 9 2025/26	Balance at 31-Mar-25 £000	Current Month Opening Balance £000	Current Month Closing Balance £000	Current Month Movement (in month) £000
NON CURRENT ASSETS				
OPENING NET BOOK VALUE	203,103	203,103	203,103	0
IN YEAR REVALUATIONS	0	0	0	0
IN YEAR MOVEMENTS	0	18,527	22,288	3,761
LESS DEPRECIATION	0	(10,368)	(11,650)	(1,282)
NET BOOK VALUE	**203,103**	**211,262**	**213,741**	**2,479**
NON CURRENT RECEIVABLES	**1,238**	**908**	**885**	**(23)**
CURRENT ASSETS	0			
INVENTORIES	6,795	6,984	7,272	288
TRADE & OTHER RECEIVABLES	12,681	14,438	13,844	(594)
CASH	5,261	6,520	4,881	(1,639)
TOTAL CURRENT ASSETS	**24,737**	**27,942**	**25,997**	**(1,945)**
CURRENT LIABILITIES	0			
TRADE & OTHER PAYABLES	31,224	38,458	40,427	1,969
LEASE PAYABLE under 1 year	1,468	1,464	1,464	0
DHSC LOANS	760	0	0	0
PROVISIONS under 1 year	1,935	901	889	(12)
TOTAL CURRENT LIABILITIES	**35,387**	**40,823**	**42,780**	**1,957**
NET CURRENT ASSETS / (LIABILITIES)	**(10,650)**	**(12,881)**	**(16,783)**	**(3,902)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**193,691**	**199,289**	**197,843**	**(1,446)**
NON CURRENT LIABILITIES	0			
LEASE PAYABLE over 1 year	4,739	6,718	6,426	(292)
LOANS over 1 year	0	0	0	0
PROVISIONS over 1 year	560	550	544	(6)
NON CURRENT LIABILITIES	**5,299**	**7,268**	**6,970**	**(298)**
TOTAL ASSETS EMPLOYED	**188,392**	**192,021**	**190,873**	**(1,148)**
FINANCED BY	0			
PDC CAPITAL	312,800	329,302	331,036	1,734
REVALUATION RESERVE	41,267	41,274	41,274	0
I & E ACCOUNT	(165,675)	(178,555)	(181,437)	(2,882)
FINANCING TOTAL	**188,392**	**192,021**	**190,873**	**(1,148)**

Non-Current Assets

- Capital expenditure in the month was £3,761k,
- Depreciation and in year movements include the impact of right of use assets.

Current Assets

- Cash balance is £4,881k, down £1,639k in-month. Cash remains tight; no Q3 revenue support was requested. Q4 support of £3,500k (January) has been approved, with a further £4,000k (February) and £2,750k (March) submitted to offset the impact of withheld Deficit Support Funding in Q4.
- A £1,413k creditor is held for the surgical robot (payment due January). Trade and other receivables reduced slightly in-month.

Current Liabilities

- Invoices are targeted on 30-day terms and closely monitored, however payment restrictions to suppliers due to working capital controls have negatively impacted BPPC, which remains below target and requires improvement.
- Trade and other payables increased by £1,969k in-month, driven mainly by higher trade creditors (£2,184k), capital creditors (£1,246k) and PDC payable (£506k), partly offset by reductions in deferred income (£1,232k, HEE) and NHS creditors (£1,492k).
- Lease balances are now split between current and non-current liabilities.

Financing

- YTD PDC Revenue Support - £6,638k
- YTD PDC Capital Support - £11,598K, an in-month increase of £1,734k
- YTD I & E Deficit £12,880k, an in-month deficit of £1,803k

Summary Balance Sheet - NGH

TRUST SUMMARY BALANCE SHEET MONTH 9 2025/26				
	Balance at 31-Mar-25	Current Month		
		Opening Balance	Closing Balance	Movement
	£0	£0	£0	£0
NON CURRENT ASSETS				
OPENING NET BOOK VALUE	263,061	263,054	263,054	0
IN YEAR REVALUATIONS	0	0	0	0
IN YEAR MOVEMENTS	0	18,451	21,480	3,029
LESS DEPRECIATION	0	(13,638)	(15,342)	(1,704)
NET BOOK VALUE	263,061	267,867	269,192	1,325
CURRENT ASSETS				
INVENTORIES	9,137	10,127	9,594	(533)
TRADE & OTHER RECEIVABLES	21,814	22,586	20,833	(1,753)
CLINICIAN PENSION TAX FUNDING	628	628	628	0
CASH	2,012	7,121	5,759	(1,362)
TOTAL CURRENT ASSETS	33,591	40,462	36,814	(3,648)
CURRENT LIABILITIES				
TRADE & OTHER PAYABLES	41,335	57,380	54,910	(2,470)
FINANCE LEASE PAYABLE under 1 year	1,336	1,261	1,265	4
SHORT TERM LOANS	163	102	102	0
PROVISIONS under 1 year	3,612	1,383	1,174	(209)
TOTAL CURRENT LIABILITIES	46,446	60,126	57,451	(2,675)
NET CURRENT ASSETS / (LIABILITIES)	(12,855)	(19,664)	(20,637)	(973)
TOTAL ASSETS LESS CURRENT LIABILITIES	250,206	248,203	248,555	352
NON CURRENT LIABILITIES				
FINANCE LEASE PAYABLE over 1 year	14,121	12,211	11,947	(264)
LOANS over 1 year	59	21	18	(3)
PROVISIONS over 1 year	768	768	768	0
NON CURRENT LIABILITIES	14,948	13,000	12,733	(267)
TOTAL ASSETS EMPLOYED	235,258	235,203	235,822	619
FINANCED BY				
PDC CAPITAL	322,343	343,038	347,179	4,141
REVALUATION RESERVE	60,399	60,399	60,399	0
I & E ACCOUNT	(147,489)	(168,234)	(171,756)	(3,522)
FINANCING TOTAL	235,258	235,203	235,822	619

Non-Current Assets

- M9 Capital movements of £3,029k, includes PDC funded UTC works of £972k, Estates CIR works of £782k. BAU spend of £600k. EPR spend totalled £614k.

Current Assets

- Inventories down £533k, driven by Pharmacy (£370k) and Pacing (£164k), following higher pre-Christmas ordering.
- Trade and other receivables down £1,753k, mainly from reduced NHS receivables (£1,337k, incl. EPR funding paid by Northamptonshire ICB) and prepayments (£888k), partially offset by higher income accruals and VAT reclaim.
- Salary overpayments improved: balance down £30k to £369k; YTD £432k vs £560k last year, with occurrences reduced to 156 (241 last year).
- Cash down £1,362k in-month.

Current Liabilities

- Trade and other payables up £2,470k, driven by higher PDC dividend (£596k) and late-received Estates and Digital invoices (£426k). This was partly offset by lower NHS payables, cleared accruals, and a £2,108k reduction in receipts in advance (mainly Education Contract and LVA funding releases).
- Provisions down £209k overall, reflecting reversals of unused HR and redundancy provisions, partly offset by change management provisions in year.

Financing

- PDC Capital - £4,141k for Urgent Treatment Centre works
- I & E Account - £3,522k - In-month deficit

Cash Flow - KGH

MONTHLY CASHFLOW	ANNUAL TOTAL 2025/26 £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	FORECAST DEC £000s	FORECAST JAN £000s	FORECAST FEB £000s	FORECAST MAR £000s
RECEIPTS													
Clinical Income	413,003	33,188	34,338	34,260	38,859	36,276	35,111	38,137	34,873	34,503	34,241	29,138	31,177
Health Education England	13,264	3,109	0	0	2,911	0	0	5,142	0	0	0	2,104	0
VAT	6,844	970	449	988	0	991	402	849	575	619	500	500	500
Other income	12,123	649	1,122	983	1,868	1,905	944	881	570	1,387	614	660	660
PDC - Capital	30,199	0	0	1,200	0	1,200	2,009	688	4,707	1,784	2,900	4,768	10,927
PDC - Revenue	16,888	0	0	0	0	1,100	3,538	0	0	0	3,500	4,000	2,750
Interest Receivable	1,013	132	79	80	20	28	25	28	93	85	83	80	80
TOTAL RECEIPTS	**493,333**	**38,844**	**36,008**	**37,919**	**41,660**	**42,050**	**44,140**	**46,275**	**40,818**	**38,308**	**42,342**	**41,240**	**46,870**
PAYMENTS													
Salaries and wages (incl agency)	314,086	25,380	26,484	25,903	25,581	27,475	27,813	25,865	25,180	25,932	26,583	25,917	25,917
Trade Creditors	129,584	5,911	14,535	9,309	12,007	10,421	9,419	13,910	9,798	10,141	13,161	10,597	10,864
NHS Resolution	14,180	1,418	1,418	1,418	1,418	1,418	1,418	1,418	1,418	1,418	1,418	0	0
Capital Expenditure	32,875	1,752	1,026	1,897	1,413	1,769	1,581	1,239	3,291	2,495	3,809	5,752	6,950
PDC Dividend	5,924	0	0	0	0	0	2,674	0	0	0	0	0	3,250
Repayment of DHSC loan (incl interest)	770	770	0	0	0	0	0	0	0	0	0	0	0
TOTAL PAYMENTS	**497,419**	**35,212**	**43,483**	**38,527**	**41,019**	**41,083**	**42,906**	**42,327**	**38,607**	**39,991**	**44,971**	**42,266**	**46,917**
Actual month balance	-4,086	3,632	7,475	608	491	967	1,234	948	2,121	1,683	2,029	1,046	88
Cash in transit & Cash in hand adjustment	5	0	5	0	1	41	0	746	842	44	37	1	0
Balance brought forward	5,261	5,261	8,893	1,423	815	1,305	2,313	3,547	5,241	6,520	4,881	2,214	1,168
Balance carried forward	**1,180**	**8,893**	**1,423**	**815**	**1,305**	**2,313**	**3,547**	**5,241**	**6,520**	**4,881**	**2,214**	**1,168**	**1,130**

What are the issues impacting the position?

- Closing cash in December was £4,881k, a £1,639k in-month reduction. Cash remains tightly managed, with restricted payments in place and expected to continue for the remainder of the year.
- No revenue support was required in Q3. For Q4, January support of £3,500k is approved, with further support of £4,000k in February and £2,750k in March requested reflecting the NHS England decision to withhold Deficit Support Funding in Q4.
- The cashflow includes profiled capital income (PDC) and expenditure based on the January plan and will be kept under review. March PDC assumes full drawdown of approved capital schemes, although this may reduce if slippage occurs.
- Invoices are targeted on 30-day terms and closely monitored, however payment restrictions to suppliers due to working capital controls have negatively impacted BPPC, which remains below target and requires improvement. A £1,400k payment to NGH for the surgical robot is expected in January, with a further £720k capital settlement forecast in December.
- NHS Resolution payments cease in January, having been paid over 10 months. The Barclays commercial account was closed in November, with balances transferred to the GBS account.

Cash Flow - NGH

MONTHLY CASHFLOW	ANNUAL TOTAL 2025/26 £000	ACTUAL APR £000	MAY £000	JUN £000	JUL £000	AUG £000	SEP £000	OCT £000	NOV £000	DEC £000	FORECAST JAN £000	FEB £000	MAR £000
RECEIPTS													
SLA Block Payments	506,516	42,012	41,272	41,333	45,570	44,555	42,544	43,725	42,787	42,588	42,682	37,432	40,016
Health Education Payments	18,329	4,143	0	0	4,110	0	0	7,216	0	0	0	2,860	0
Other NHS Income	18,713	1,401	2,080	3,846	888	3,270	743	614	389	1,819	2,163	750	750
VAT Claim	10,613	352	2,138	611	916	849	538	(352)	2,075	0	847	1,840	800
PP / Other	8,964	749	498	663	1,045	937	679	720	698	800	725	725	725
PDC - Capital	22,346	0	0	0	0	1,083	3,156	280	1,180	4,141	3,504	2,250	6,752
PDC - Revenue	23,491	0	0	0	0	1,700	13,291	0	0	0	1,500	1,000	6,000
Interest Receivable	1,109	110	102	93	78	82	82	107	113	97	86	80	80
TOTAL RECEIPTS	**610,081**	**48,767**	**46,091**	**46,546**	**52,607**	**52,475**	**61,033**	**52,309**	**47,242**	**49,444**	**51,506**	**46,937**	**55,123**
PAYMENTS													
Salaries and wages	387,925	30,603	31,887	31,901	31,273	33,860	34,572	32,415	32,268	32,372	32,724	32,050	32,000
Trade Creditors	148,412	8,626	14,047	10,639	16,195	12,434	10,291	13,533	9,719	12,128	14,548	12,325	13,927
NHS Creditors	32,149	2,505	2,500	3,500	2,695	2,360	2,637	3,426	3,200	3,734	2,496	1,200	1,895
Capital Expenditure	34,650	3,380	1,542	1,513	1,499	1,234	5,984	3,505	2,922	2,511	2,856	3,900	3,804
PDC Dividend	6,782	0	0	0	0	0	3,206	0	0	0	0	0	3,576
Repayment of PDC Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Salix loan	163	18	0	3	0	61	0	18	0	3	0	61	0
TOTAL PAYMENTS	**610,080**	**45,132**	**49,977**	**47,555**	**51,663**	**49,949**	**56,691**	**52,897**	**48,109**	**50,748**	**52,624**	**49,536**	**55,202**
Actual month balance	1	3,635	(3,886)	(1,009)	944	2,527	4,342	(587)	(867)	(1,303)	(1,117)	(2,599)	(79)
Cash in transit & in hand adjustment	(13)	18	9	8	(1)	(75)	70	16	(35)	(59)	36	0	0
Balance brought forward	2,012	2,012	5,665	1,788	787	1,730	4,181	8,594	8,022	7,121	5,759	4,677	2,079
Balance carried forward	**2,000**	**5,665**	**1,788**	**787**	**1,730**	**4,181**	**8,594**	**8,022**	**7,121**	**5,759**	**4,677**	**2,079**	**2,000**

What are the issues impacting the position?

- Cash & income: Closing cash was £84k below forecast. December income included £102k Winter funding, partly offset by reductions in block and specialist commissioning income. Other NHS income was close to plan, including receipt of £1,264k EPR funding. January is forecast to include £1,143k from the surgical robot transfer from KGH.
- VAT & capital: No VAT income was received in December due to bank holidays; January includes November and December claims, with a further February increase from an NHS Supply Chain correction. Capital PDC drawdown of £4,141k was received for ED modernisation works, with further drawdowns expected monthly in line with spend.
- Deficit support & pay: £1.5m of PDC revenue deficit support has been approved for January, with further support requested for February (£1.0m) and March (£6.0m) reflecting the NHS England decision to withhold Deficit Support Funding in Q4. December pay was £401k above forecast due to consultant backfill during industrial action.
- Creditors & cash controls: Trade creditor payments returned to normal levels, with a focus on clearing NHS creditors ahead of agreement of balances. The invoice register reduced to 671 invoices (£3,557k) over 31 days, mainly trade creditors. Capital creditors were lower than forecast due to invoice timing. Cash mitigations remain in place and under regular review.

Capital - UHN

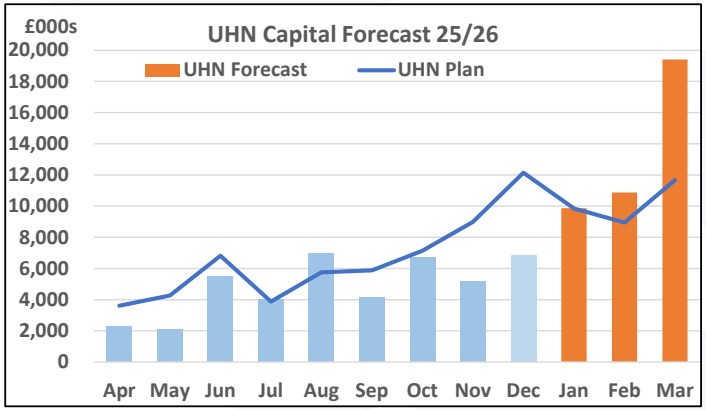
UHN Capital Expenditure	2025/26 Plan			Year to Date		
£000s	Original	Change	Revised	Original Plan	Actual	Variance
BAU - Estates	4,102		4,102	2,110	3,890	1,780
BAU - Medical Equipment	4,000		4,000	2,400	2,314	(86)
BAU - Digital	3,500		3,500	2,100	1,385	(715)
ROU Renewals + Additions	1,094		1,094	0	388	388
Remaining CDC + Slippage	2,556		2,556	2,556	568	(1,988)
Corby CDC ROU Lease	2,500		2,500	2,500	2,500	0
EPR System Implementation	7,600		7,600	5,336	5,082	(254)
Lin Acc Enabling Work + Eqp.	1,380		1,380	1,380	1,178	(202)
Old ITU Refurb to a new Ward	2,600		2,600	2,600	315	(2,285)
UEC Performance Allocation		3,000	3,000			
System Capital	**29,332**	**3,000**	**32,332**	**20,982**	**17,620**	**(3,362)**
Critical Infrastructure Risk Allocation	8,265	2,635	10,900	4,026	2,369	(1,657)
Constitutional Standards UTC	10,750	0	10,750	8,905	6,234	(2,671)
Constitutional Standards Surgical Hub	2,000	(2,000)	0			
Constitutional Standards CDC	0	1,750	1,750		1,750	1,750
CDC Colorectal Pathway		100	100			
Clinical decontamination equipment		19	19			
Rockingham Extension	11,850	(7,093)	4,757	6,400	1,288	(5,012)
Energy Centre	19,990	(3,186)	16,804	14,260	9,284	(4,976)
NHP Wave 2	900	98	998	675	748	73
NHP Enabling MSCP + Data Centre		880	880		215	215
Maternity Building Rebuild	1,039	(774)	265	706	47	(659)
Solar Partnership Scheme	713		713	0	347	347
MESC - Linear Accelerator	2,616		2,616	2,616	2,616	(0)
Digital - EPR	1,180		1,180	0	1,180	1,180
Non BAU Capital Expenditure	**59,303**	**(7,571)**	**51,732**	**37,488**	**26,077**	**(11,411)**
Charitable Funds	**300**	**0**	**300**	**0**	**79**	**79**
Total Capital Expenditure	**88,935**	**(4,571)**	**84,364**	**58,470**	**43,776**	**(14,694)**

What are the issues impacting the position?

Month 9 Capital is £14.694m lower than the original plan to date:
The original UHN plan to spend £88.935m in 25/26, required a £58.470m spend by the end of Month 9. The £43.776m spend is £14.7m lower than planned.

UHN is ahead of plan in Estates BAU expenditure, but lagging in the major schemes of Energy Centre, Rockingham Extension and Urgent Treatment Centre (supported by Constitutional Standards allocation).

Updates to 25/26 Plan:
In the last month UHN has confirmed further Estates Safety work for the NGH site and committed to progressing initial construction works on the Rockingham extension. These are reflected in the Revised plan numbers. There are potentially some additional Digital funding pots, being verified.



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Interpreting SPC charts and Glossary

Interpreting SPC charts

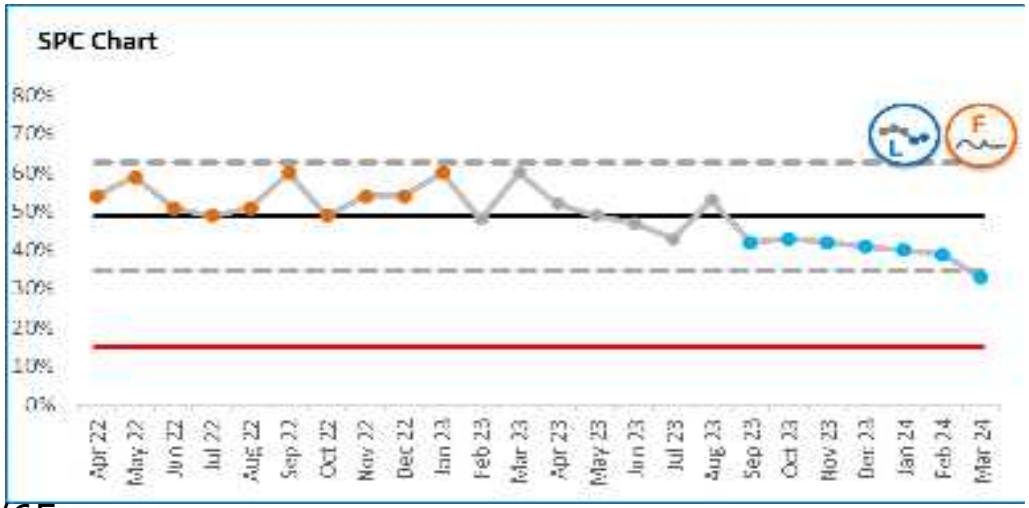
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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.

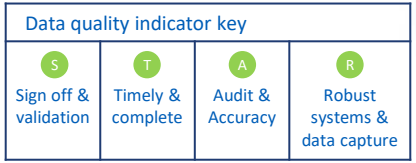
	Variation / performance Icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or 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 Validation	• 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 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?
A	Audit and Accuracy	• Is there a process to audit the validity of reported data using business logic rules? • Are accuracy checks built into the reporting process?
R	Robust systems and Data Capture	• Is data collected in a structured format using an appropriate digital system? • Does the data conform to data dictionary standards where relevant?



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
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. 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. They 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: 6 February 2026

AGENDA ITEM 5

Finance, Investment and Performance: 27 January 2026

Quality and Safety: 28 January 2026

Strategic Transformation and Digital: 29 January 2026

People: 29 January 2026

UHN Finance, Investment and Performance Committee Upward Report to Boards of Directors	Date of reporting group's meeting: 27 January 2026

Reporting Group Chair: Damien Venkatasamy

Agenda Item	Description and summary discussion	BAF Risk	Assurance level *
Finance Report M9	The Committee **supported** the submission of PDC Revenue support request for £5.0m (£4.0m KGH, £1.0m NGH) for February and the further £8.75m request for March (£2.75m KGH, £6.0m NGH) and its escalation to the Boards for retrospective **approval.** It was confirmed that £16.25m of deficit support funding (DSF) for Q4 had been withheld, requiring borrowing with a full-year PDC cost of £465,000, impacting future financial plans.	UHN 16 & 17 Deliver financial plan	Limited
33-Bed Decant and Escalation Ward Refurbishment Business Case	The business case was presented for the FIPC to provide recommendation to NGH Board to approve the preferred option within the case in line with the UHN Standing Financial Instructions and Scheme of Delegation. The ward would provide additional capacity during winter and serve as a decant space for the rest of the year, with a revenue cost of £1.2 million included in next year's plan. The Committee **approved** the business case.	UHN 11,12 & 15 (culture, capacity and demand)	N/a: for NGH Board approval
EPRR Annual Report and EPRR Core Standards Self-Assessment Report 2025	The Committee was presented an update, which detailed progress in compliance with key standards and plans moving forward which included integrating into divisional accountability meetings. The Committee was assured on the progress made. **For Boards' receipt.**	UHN 11 & 12 (culture)	Reasonable

UHN Quality and Safety Committee in Common Upward Report to Board of Directors	Date of reporting group's meeting: 28 January 2026 (1 of 2)

Reporting Non-Executive Director: Chris Welsh (Chair)

Agenda Item	Description and summary discussion **The committee:**	Board Assurance Framework Risk References	Assurance level *
Subgroup reports	1. Received upward reports from the Nursing Midwifery & AHP, Patient and Carer Experience and Engagement, Children and Young People, Health and Safety, Risk Management, Infection Prevention Assurance and Patient Safety sub-groups and confirmed reasonable assurance overall in relation to these, with some items of limited assurance highlighted for escalation below.	-	Reasonable
	2. Items of Limited Assurance: • Noted with concern significant delays with sending follow-up letters within Cardiology; the average time taken had reduced from 70 to 30 days but remained well above the target of seven days. The Committee was assured that the delays did not impact urgent letters and that the trajectory towards performance recovery was being closely tracked. There were also concerns with the length of the ECHO waiting list (up to 52 weeks); the division had been asked to report to the Patient Safety Committee to identify potential risks to patients; • Noted KGH had failed to meet the 2023-24 Standard Contract requirement to reduce total antimicrobial consumption by 10% compared to the 2017 baseline. The Medical Director advised that this issue was being addressed through the roll-out of a new electronic prescribing system, targeted actions to increase awareness of the proper use of antibiotics and thematic reviews to identify and address areas of high usage and address them; • Was advised that the Children and Young People's group indicated Limited assurance regarding neonatal pharmacy provision being non-compliant with national standards at both sites (business case being prepared to provide ward-based pharmacists), the absence of dedicated asthma nursing specialist posts across the group (paediatric asthma consultant clinics were dealing with urgent cases, with funding issues escalated to the Integrated Care Board) and the lack of a group policy governing referral thresholds for 16 to 18-year-olds: whilst a multi-disciplinary team was developing a policy aligned to the referral hospital (UHL Leicester), national practice variations in the treatment of adults and children meant finding consistency was particularly challenging.	UHN11 Positive Safety Culture UHN12 Culture of compassionate, responsive and inclusive care	Limited

UHN Quality and Safety Committee in Common Upward Report to Board of Directors	Date of reporting group's meeting: 28 January 206 (2 of 2)		
Reporting Non-Executive Director: Chris Welsh			
Agenda Item	**Description and summary discussion** **The committee:**	**Board Assurance Framewor Risk References**	**Assurance level ***
Perinatal Assurance Committee	1. Noted that a national review of home births had been commissioned following the issue of a Prevention of Future Deaths Notice following a tragic incident in Manchester **See item 8.2** 2. Noted that NGH planned to indicate full compliance against Maternity Incentive Scheme standards whilst KGH was likely to be non-compliant against three standards; the Perinatal Assurance Committee would be holding a special meeting to confirm the position prior to **submission to Boards for approval at item 8.2.**	UHN11 and UHN12 (as above)	N/a
Urgent and Emergency Care Performance	Welcomed sustained reductions in ambulance handover times despite higher conveyances and attendances; this was acknowledged from an operational performance perspective and as crucial to the wider health of the population.	UHN15 demand on services	Reasonable
Immunology	Received a report advising of significant patient safety concerns arising from a backlog recovery project in immunology result processing, which highlighted instances of misdirected results and delivery gaps due to local health system issues. A full report would be provided to Boards following the completion of harm reviews, which were ongoing. No 'moderate' or 'serious' harms had been identified to date.	UHN11 UHN12 (as above)	Limited
CQC Inspections	Noted the latest position in respect of the completion of key actions following recent CQC Inspections, indicating 'reasonable' assurance regarding progress.	UHN11 UHN12	Reasonable
Improving Together	Received a report setting out progress within the delivery of the Improving Together Strategy, agreed by the Boards in August 2024. The Committee commended significant progress in a number of areas, particularly the development and rollout of an updated quality improvement framework, and the recent successful launch of Rapid Improvement Weeks in adult wards, which would be extended to other areas and had stimulated quick wins and quality improvement projects.	UHN10 continuous improvement plans	Substantial

UHN Strategic Transformation and Digital Committee Upward Report to Board of Directors	Date of reporting group's meeting: 29 January 2026		
Reporting Non-Executive Director: Trevor Shipman (Chair)			
Agenda Item	**Description and summary discussion** **The committee:**	**Board Assurance Framework reference(s)**	**Assurance level ***
Board Assurance Framework	Received the Board Assurance Framework, which had been updated following quarterly reviews with executive leads; there were no changes to risk scores for risks within the Committee's responsibility. The Committee indicated 'reasonable' assurance in respect of the updates and presentation of the document, noting that 4/5 of the Committee's risks remained 'significant' - **For Boards' consideration at item 17**	UHN 14 and 21-24	Reasonable
Digital Report	Noted slippage in the roll-out of the Electronic Patient Record at NGH due to data migration issues, from April to early July 2026. Potential implications for 2025-26 and 2026-27 capital programmes were yet to be fully mitigated, and there was a need to ensure that timeframes for launching future tranches were realistic and deliverable and enabled sufficient time for new ways of working to be embedded within the trusts.	UHN24 Delivery of major digital change	Reasonable
Strategic Estates	(1) Was advised of delays in the issue of planning permission for the KGH car park and Rockingham Wing schemes which gave rise to inflationary risks and potentially impacted Memoranda of Understanding requiring works to commence within the current financial year. (2) Noted provisional capital allocations for 2026-27; there were internal capacity issues affecting the preparation of business cases for major capital schemes, for which prioritisation would be challenging given the schemes' significance to service delivery and transformation. Work was also required to expedite a master plan for the NGH estate, with a report to be submitted to the next meeting. Options were being explored for the relocation of the Sterile Services Department, with no decision at this stage and funding yet to be identified.	UHN14 estate buildings and infrastructure	Reasonable
Group Clinical Strategy (UHN/UHL)	Received progress updates on workstreams making up the strategy; whilst there was good progress in some areas, work remained at a formative stage, with the trusts' strategic ambition required to be agreed and communicated to underpin collaboration and particular challenges accessing public health data to establish baseline, identify local health priorities and measure progress. The Committee undertook to invite the Directors of Public Health to the next meeting to explore how this issue could be progressed together.	UHN20 Collaboration model with UHL	Limited

UHN People Committee Upward Report to Board of Directors	Date of reporting group's meeting: 29 January 2026		
Reporting Non-Executive Director: Denise Kirkham (Chair)			
Agenda Item	**Description and summary discussion** **The committee:**	**Decision / Actions and timeframe**	**Assurance level ***
	TO FOLLOW 29 JANUARY 2026 MEETING		

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

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

Cover Sheet	
Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item	8.1

Title	UHN Perinatal Scorecard Highlight Report (December 2025 Data)
Presenter	Danni Burnett – Interim UHN Director of Midwifery
Authors	Julie Hogg - UHN Chief Nurse Danni Burnett – Interim UHN Director of Midwifery

Link to Group Priorities (select all that apply)		
X Transform Patient Care	**X Strengthen our Culture**	**X Deliver our Financial Plan**
Driving continuous improvement in safety, quality, and equity of perinatal services through robust oversight and evidence-based practice.	*Fostering a culture of transparency, learning, and collaboration across multidisciplinary teams to improve outcomes for women, babies, and families.*	*Ensuring efficient use of resources through data-driven decision-making, reducing avoidable harm, and supporting sustainable service delivery*

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

Reason for Consideration	Previous consideration
To provide assurance to the Boards of Directors on the key clinical quality and performance metrics outlined within the Perinatal Scorecard.	Quality and Safety Committee, 28 January 2026 Perinatal Assurance Committee, 21 January 2026

Executive Summary

Scorecards are produced in alignment with NHS England's Perinatal Quality Surveillance Model, designed to facilitate the flow of safety intelligence from Boards to Frontline and vice versa. These scorecards focus on five key domains and incorporate the minimum dataset outlined in the Maternity Incentive Scheme (MIS):

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

December 2025 marks the third iteration of the University Hospitals Northamptonshire (UHN) Perinatal Scorecard, incorporating data from both NGH and KGH. This continues to be an evolving process, as both organisations have recently implemented BadgerNet maternity electronic patient record (KGH in September, NGH in November), which will enhance data reporting capabilities. Consequently, a small number of elements of the scorecard remain under development.

Summary

UHN continues to demonstrate stable and generally positive delivery of maternity and neonatal services across Kettering General Hospital (KGH) and Northampton General Hospital (NGH). In December 2025, 548 babies were born across UHN. Operational performance improved compared with November, with no service suspensions, diversions or in-utero transfers, and strengthened senior leadership visibility supporting day-to-day resilience.

Quality and Safety: There were no Patient Safety Incident Investigations (PSIIs) commissioned in December, with one case appropriately referred to the Maternity and Newborn Safety Investigation (MNSI) programme and ten moderate-harm incidents reported. All incidents have been reviewed through established governance arrangements, with learning identified and actions tracked. Perinatal mortality remains low, and learning is actively shared across both sites, supported by robust PMRT (Perinatal Mortality Review Tool) processes, cross-site collaboration and external scrutiny, providing assurance of a proactive safety and learning culture.

Clinical Outcomes: Clinical quality indicators remain largely stable with expected month-to-month variation and no sustained adverse trends. Smoking at booking remains above the 6% target, driven predominantly by KGH population demographics; however, smoking at birth continues to decline, with UHN achieving 4% at delivery, exceeding the national ambition. Rates of third- and fourth-degree tears, postpartum haemorrhage ≥1500ml, and preterm birth remain close to target levels, with variation consistent with common-cause fluctuation. Outcome measures remain reassuring, with low rates of low Apgar scores and stillbirth, supported by continued implementation and oversight of Saving Babies' Lives Care Bundle (SBLCB) v3.2.

Training Compliance: Training compliance across UHN remains strong and consistently above 95% for all key domains, including PROMPT (Practical Obstetric Multi-Professional Training), fetal monitoring and neonatal life support, fully meeting CNST Safety Action 8 requirements. Multidisciplinary simulation, Points of Care training and alignment of programmes across both sites continue to embed learning from incidents and governance review, strengthening team preparedness and safety assurance.

Workforce: Workforce pressures persist and remain a key risk. Registered midwifery vacancy rates stand at 7.1% across UHN (KGH 6.4%, NGH 7.6%), with higher non-registered vacancies (17.1%) impacting efficiency. Neonatal nursing vacancies remain highest at KGH (9.6%), while neonatal medical staffing is stable, with planned middle-grade and consultant recruitment supporting future resilience. Workforce risks are actively monitored, with targeted recruitment,

establishment review and workforce modelling underway. Overall, the position is controlled but fragile, requiring continued scrutiny and mitigation.

Operational Pressures: Maternity services predominantly operated at OPEL (escalation levels) 1–2 throughout December, with KGH consistently at OPEL 1. Induction of labour increased to 32.1%, contributing to episodic pressure, particularly at NGH; however, escalation was effectively managed without service disruption. One-to-one care in labour was maintained at 100%, and minimum safe staffing was achieved on 97% of occasions, providing assurance of service continuity and safety.

Experience and Engagement: Patient experience remains consistently positive, with stable complaint volumes and strong Friends and Family Test (FFT) performance. Both sites reported a 12% response rate, with 100% promoters at KGH and 95% at NGH. Feedback continues to highlight compassionate, respectful care and good communication. Targeted improvement actions remain focused on infant feeding support, partner involvement, and clarity of information during labour and postnatal care, supported by initiatives to strengthen staff engagement and leadership visibility.

Maternity Incentive Scheme (MIS): NGH remains on track to meet all ten Safety Actions under MIS Year 7. KGH has not yet met one element of Safety Action 1 (commencement of PMRT reviews within two months at 90%, below the 95% target), and Safety Action 5 remains at risk. This represents a marked improvement from MIS Year 6, where four safety actions were not met at KGH. Final MIS evidence will be assured through the Perinatal Assurance Committee in January 2026, prior to Boards' declaration (agenda item 8.2 refers).

Recommendation
The Boards of Directors are asked to note the perinatal quality surveillance position, recognise the positive performance trajectory and strengthening operational grip, and indicate assurance on the ongoing improvement priorities and known risks, particularly in relation to workforce sustainability and public health outcomes.

Appendices

Appendix 1: UHN Perinatal Quality Assurance Scorecard (January 2026) *Note: Commentary relating to the Maternity Incentive Scheme reflects the position at 31 December 2026. Item 8.2 below sets out the latest position.*

Risk and assurance

UHN11 Positive Safety Culture
UHN12 Culture of compassionate, responsive and inclusive care

Financial Impact

Ensuring efficient use of resources through data-driven decision-making, reducing avoidable harm, and supporting sustainable service delivery. Failure to achieve the NHSR Maternity Incentive Scheme (MIS) incentive could result in financial penalties and reputational risk, while also signalling missed opportunities to improve safety, quality, and learning within maternity services.

Legal implications/regulatory requirements

- Regulatory breaches, including non-compliance with NMC and CQC standards
- Legal risks, such as increased vulnerability to negligence claims and litigation
- Reputational damage, due to poor inspection outcomes and public trust erosion
- Professional accountability issues

Equality Impact Assessment

Assurance through Perinatal Assurance Committee and Family Health Care Group Governance actively considers Equality, Diversity, and Inclusion (EDI) by embedding inclusive practices, monitoring disparities in outcomes, and promoting culturally competent care across maternity services.

NHS
University Hospitals of Northamptonshire

Perinatal Quality Assurance Scorecard

January 2026 (December 25 data)

CONTENTS

SUMMARY December 2025

University Hospitals of Northamptonshire

The month in review

December 2025 performance demonstrates stable and generally positive delivery across UHN, with sustained focus on clinical quality, safety and operational resilience. There were no PSIIs, one MNSI referral and ten moderate-harm incidents, reflecting continued vigilance in incident identification and management. Datix backlog reduction continues at NGH, with KGH progressing an agreed recovery plan to further reduce outstanding cases. Training compliance remains strong, with multidisciplinary PROMPT and simulation programmes supporting safe and effective responses to obstetric and neonatal emergencies. Clinical quality indicators remain largely stable, with expected variation: smoking at booking increased in December, while smoking at birth continues to decline; breastfeeding initiation remains stable; and rates of severe perineal tears, postpartum haemorrhage and preterm birth are close to target levels. Experience remains positive, with December FFT response rates of 12% and promoter scores of 100% at KGH and 95% at NGH, indicating consistently high levels of satisfaction. Staff feedback continues to highlight opportunities to strengthen communication and leadership visibility, with actions underway including initiatives such as "How Was Your Shift" to improve real-time feedback and engagement. Operational performance was stable throughout December, with no service suspensions, diversions or in-utero transfers, and workforce stability continues to improve as recruitment momentum is maintained.

Training and Compliance: Compliance across UHN remains strong and fully meets CNST Safety Action 8 requirements, with multidisciplinary PROMPT and specialist simulation training well embedded across both sites, strengthening teamwork, communication and effective emergency response, and supported by ongoing alignment of programmes and incorporation of local learning to further enhance safety.

Outcomes: Clinical quality trends for December demonstrate generally stable performance across antenatal, intrapartum and outcome indicators for UHN. Smoking at booking increased in month, while smoking at birth continues to decline, and BMI ≥30 at booking remains stable, reflecting consistent population-level patterns. Rates of third- and fourth-degree tears and postpartum haemorrhage ≥1500 ml show expected month-to-month variation but remain close to target levels. Breastfeeding initiation remains strong overall, with occasional variation that is subject to ongoing review. Outcome measures continue to be reassuring, with low proportions of babies with low Apgar scores, stable preterm birth rates and low stillbirth numbers. Across both UHN sites, there are no concerning sustained adverse trends, providing assurance of consistent clinical performance.

Operational Capacity: Remained stable throughout December, with no suspensions of acute maternity services, no diversions, and no in-utero transfers of extremely preterm babies. Both sites predominantly operated at lower OPEL levels, although NGH experienced increased time at OPEL 2, reflecting ongoing operational pressure. Red-flag events were limited and primarily associated with delays in critical activity, including induction of labour and artificial rupture of membranes (ARM). Recent recruitment and new starters have contributed to improved staffing stability. Operational improvement priorities include review of elective caesarean and induction pathways alongside actions to improve flow, supporting more timely care delivery and resilience.

Workforce: Midwifery workforce pressures persist across UHN, with registered midwife vacancy rates between 5.0–7.6% and higher non-registered vacancy rates, most notably at NGH (17%). Neonatal nursing vacancy rates vary by site, with KGH currently reporting the highest level at 9.6%.Medical staffing in neonatal services remains stable, with no vacancies at NGH, although expected month-to-month fluctuations continue. Consultant obstetric workforce planning is underway at both sites to better align establishment with activity and acuity; KGH consultant roles are under active review, while further modelling is required at NGH to ensure future resilience. Leaver rates remain consistent, providing some stability in workforce churn, and maternity support worker (MSW) vacancies are progressing through the appropriate approval pathways. Mitigating actions continue to focus on targeted recruitment, workforce modelling and establishment review to improve sustainability while maintaining safe service delivery.

Clinical Quality and Safety: One case referred to the Maternity and Neonatal Safety Investigation (MNSI) with ten moderate-harm incidents, alongside two stillbirths and one neonatal death; all cases have been appropriately reviewed, with learning identified and actions tracked through local governance arrangements. Perinatal mortality remains low with shared learning across all learning disseminated across both sites, supporting consistent practice improvement and sustained focus on perinatal safety.

Experience: Experience remains positive, with stable complaint volumes and strong Friends and Family Test (FFT) performance. Both sites reported a 12% response rate, with 100% promoter scores at KGH and 95% at NGH, indicating consistently high levels of satisfaction. Feedback continues to highlight supportive staff, respectful care and clear communication as key strengths. Themes for improvement remain consistent and targeted, including feeding support, partner involvement, and clearer information during labour and the postnatal period, with actions underway through local quality improvement and engagement forums. Staff feedback mirrors the importance of effective communication and leadership visibility, with initiatives such as "How Was Your Shift" supporting real-time feedback, learning and responsiveness at ward and departmental level.

December 2026 UHN AT A GLANCE

AVERAGES PER DAY

BOOKINGS	BIRTHS
23	17

BABIES BORN

548

PREV. MONTH 584

BIRTH LOCATION

KGH (Labour Ward)	OOA	HOME
216	5	9
NGH (Labour Ward)	BIRTH CENTRE	HOME
290	17	11

3RD & 4TH DEGREE TEARS

0.75%

▼ Nov 2%

3.88%

BLOOD LOSS >1,500MLS

▲ Nov 2.9%

244 GIRLS / 290 BOYS

4.4%

November 3.6% ▲

FULL TERM BABIES ADMITTED TO NNU

INDUCTION OF LABOUR (IOL)

32.12% November 27.3% ▲

50.78%

CAESAREAN SECTIONS

Nov 51.8% ▼

	November	PREV 12 MTH. AV.
ELECTIVE	169 (30.84%)	127 (19.6%)
EMERGENCY	145 (26.46%)	169 (28.6%)

SETS OF TWINS

11

SETS OF TRIPLETS

0

ASSISTED BIRTHS

41

VENTOUSE	FORCEPS
19	22

PREV. 12 MONTH AV.

VENTOUSE	FORCEPS
24	40

BREASTFEEDING INITIATION

77%

PREV. 12 MONTHS – 79.8%

December 2026 AT GLANCE

AVERAGES PER DAY

BOOKINGS	BIRTHS
KGH 11	KGH 7
NGH 12	NGH 10

BABIES BORN

UHN 548
KGH 230
NGH 318
PREV. MONTH UHN 584

BIRTH LOCATION

	KGH (Labour Ward)	OOA	HOME
	216	5	9
	NGH (Labour Ward)	BIRTH CENTRE	HOME
	290	17	11

3RD & 4TH DEGREE TEARS

KGH 0%
Nov 0.9% ▼
NGH 1.3%
Nov 2.6% ▼

BLOOD LOSS >1,500MLS

KGH 4%
Nov 3.9% ▲
NGH 3.8%
Nov 2.2% ▲

GIRLS

KGH 102
NGH 142

BOYS

KGH 124
NGH 166

FULL TERM BABIES ADMITTED TO NNU

KGH 3.9%
NGH 4.7%

UHN CAESAREAN SECTIONS

50.78%
KGH 56%
NGH 47.0%

			PREV 12 MTH. AV.
ELECTIVE	KGH	59 (25.6%)	55 (22.4%)
	NGH	63 (20.1%)	71 (22.2%)
EMERGENCY	KGH	62 (26.95%)	69 (28%)
	NGH	82 (26.1%)	88 (27.5%)

INDUCTION OF LABOUR (IOL)

KGH 36.3% PREV. 12 MONTHS – 30.4%
NGH 29.1% PREV. 12 MONTHS – 24.0%

SETS OF TWINS

KGH 4
NGH 7

SETS OF TRIPLETS

KGH 0
NGH 0

ASSISTED BIRTHS

KGH 20
NGH 21

VENTOUSE	FORCEPS
KGH 12	KGH 8
NGH 7	NGH 14

PREV. 12 MONTH AV.

VENTOUSE	FORCEPS
KGH 12	KGH 11
NGH 12	NGH 29

BREASTFEEDING INITIATION

KGH 80%
NGH 75%

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

NHS

December 2026 UHN AT A GLANCE

98%

MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

97% Nov

YEAR 7 PROGRESS MATERNITY INCENTIVE SCHEME SAFETY ACTIONS

KGH 9 SAFETY ACTIONS

NGH 10 SAFETY ACTIONS

1

MNSI REPORTABLE CASES & REFERRED

2 Oct

MATERNITY FRIENDS & FAMILY TEST (SATISFACTION %)

98%

VACANCY RATE (October DATA)

MIDWIVES	7.08%
CONSULTANT OBSTETRICIAN	0 WTE
NEONATAL NURSES	9.6%
NEONATOLOGISTS	0 WTE

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)

97%

97.5% Nov

10 MODERATE INCIDENTS

3 – Nov

MINIMUM SAFE STAFFING MET (LABOUR WARD ONLY)

97%

0 PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

0 CORONER'S REGULATION 28

0 Oct

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

100% Nov

December 2026 AT A GLANCE

KGH 99%
NGH 97%
MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

YEAR 6 MATERNITY INCENTIVE SCHEME
10 SAFETY ACTIONS
KGH 6 SAFETY ACTIONS
NGH 9 SAFETY ACTIONS

KGH 1
NGH 0
MNSI REPORTABLE CASES & REFERRED
November

MATERNITY FRIENDS & FAMILY TEST
(SATISFACTION %)
KGH 100%
NGH 96%

VACANCY RATE
(November DATA)

MIDWIVES	KGH 6.4% NGH 7.61 %
CONSULTANT OBSTETRICIAN	KGH 0 % NGH 0 %
NEONATAL NURSES	KGH 9.3 % NGH 4.3 %
NEONATOLOGISTS	KGH 0 WTE NGH 0 WTE

KGH 5
NGH 5
MODERATE INCIDENTS

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)
KGH 99%
NGH 95%

MINIMUM SAFE STAFFING MET (LABOUR WARD ONLY)
KGH 96.8%
NGH 96.7%

KGH 0
NGH 0
PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

KGH 0
NGH 0
CORONER'S REGULATION 28

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

IN FOCUS – UHN Clinical Quality Surveillance

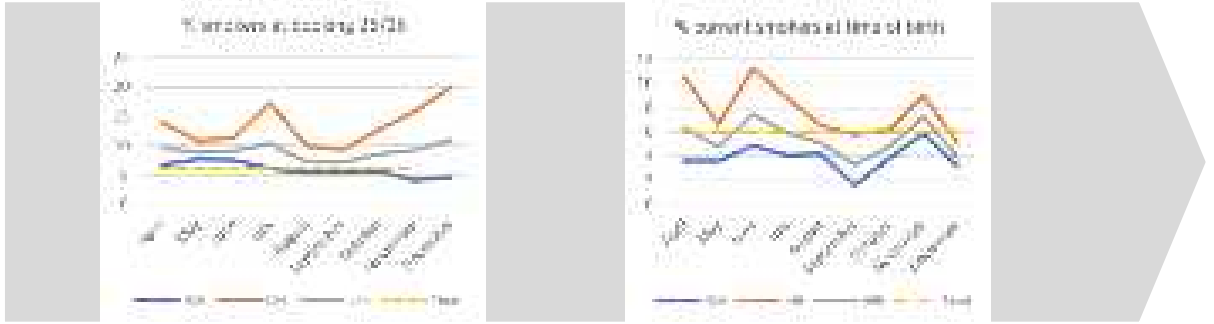
University Hospitals of Northamptonshire

Summary

UHN continues to demonstrate stable and effective delivery across key maternity safety and prevention indicators, with strong early access evidenced by sustained booking by 10 weeks, and a significant reduction in smoking from booking to birth (UHN 11% to 4%, below the national target). Rates of postpartum haemorrhage ≥1500 ml and preterm birth remain low and stable, with observed variation consistent with expected common-cause fluctuation and no sustained adverse trends across NGH or KGH. Immunisation uptake for pertussis, RSV, flu and BCG remains high, supported by service redesign including community clinics at NGH and BCG uptake exceeding 85% within 28 days at KGH, providing confidence that prevention, monitoring and quality improvement arrangements are effective, with no current indicators requiring escalation.

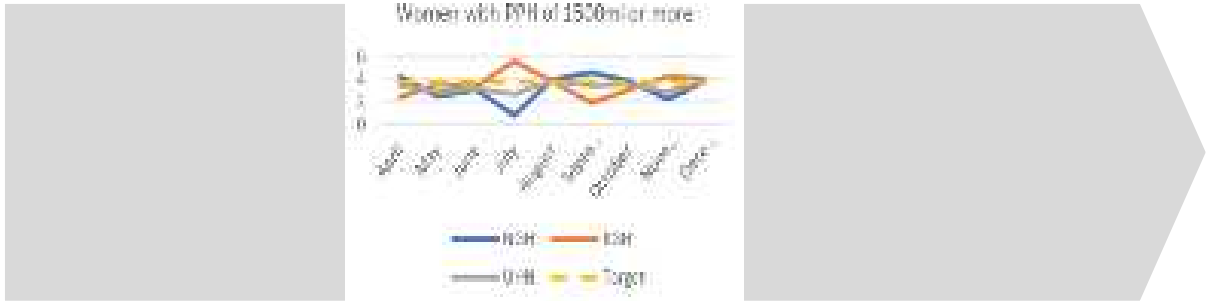
Smoking and Booking and Delivery

Smoking at booking across UHN remains consistently above the 6% national target, driven predominantly by KGH, while NGH continues to perform at or near the target, reflecting differences in local population prevalence. However, comparison between smoking status at booking and at time of birth demonstrates a substantial reduction in December, particularly at KGH. At KGH, smoking prevalence reduced from 19% at booking to 5.2% at delivery, while the UHN rate reduced from 11% at the start of pregnancy to 4% at birth across Northamptonshire, exceeding the national ambition by achieving rates below the 6% target. Higher smoking rates at booking at KGH are reflective of local population patterns, rather than a deterioration in service performance.



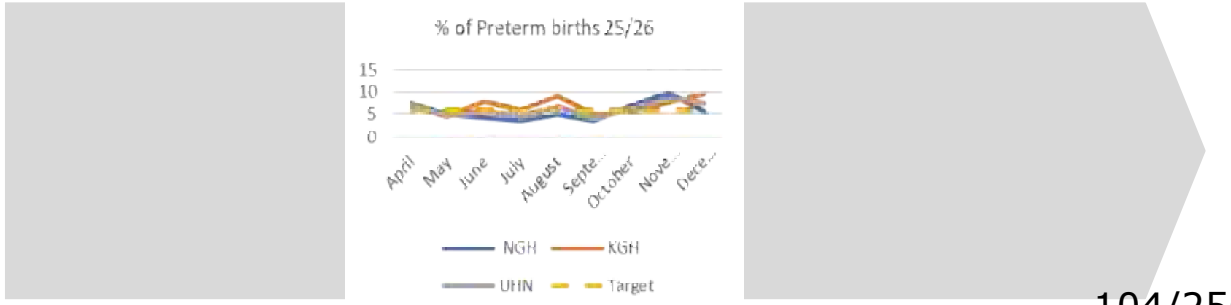
Women with PPH 1500ml or more

From April–December, rates of postpartum haemorrhage ≥1500 ml remain low and stable across NGH and KGH, with observed month-to-month fluctuation representing expected common-cause variation associated with low-frequency events, no evidence of special-cause variation or sustained adverse trends at either site, and quality improvement actions in place to maintain safe outcomes and minimise unwarranted variation.



% Preterm Births

Preterm birth rates remain stable, with observed month-to-month variation consistent with expected fluctuation in small numbers. Performance at both sites remains broadly aligned to the national target, and the combined UHN position demonstrates no sustained increase or concerning trend. Isolated peaks at individual sites do not indicate systemic issues and reflect normal variation rather than adverse change. Assurance is provided through continued implementation of Saving Babies' Lives Care Bundle (SBLCB) v3.2, with established pathways in place to support early identification, prevention and optimal management of threatened preterm birth, including perinatal optimisation where preterm delivery is anticipated. Compliance and impact are monitored through quarterly LMNS-led SBLCB v3.2 reviews, supporting ongoing oversight and sustained improvement.

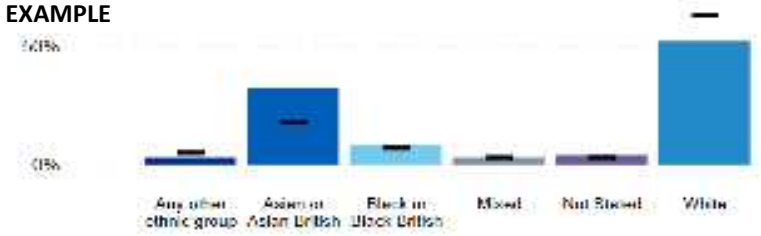


EQUITY AND POPULATION – Under development

University Hospitals of Northamptonshire

Ethnic profile and variations – EXAMPLE Data to be included in future

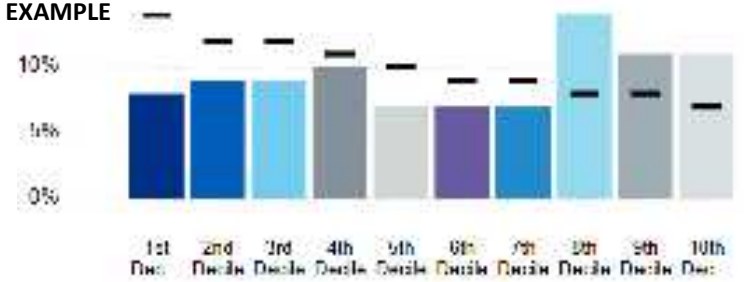
Population profile at booking
EXAMPLE



To include information on proportion of bookings by ethnicity in future scorecard – data source in development

Deprivation – EXAMPLE Data to be included in future

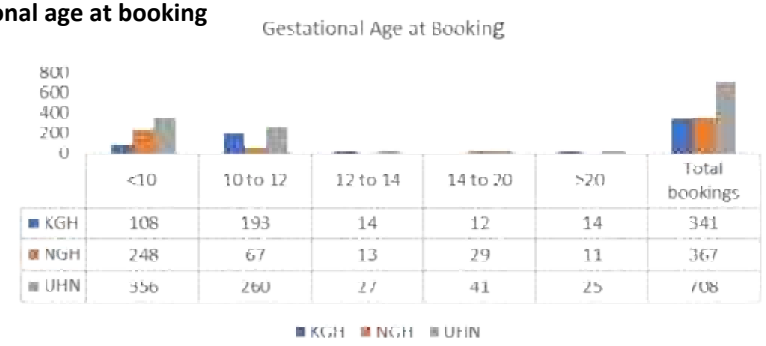
Population profile at booking
EXAMPLE



Overview of where peaks in IMD deciles are and where this relates to ethnic groups and booking gestation information to be included in future scorecard data source in development

Gestational Age at Booking

Gestational age at booking

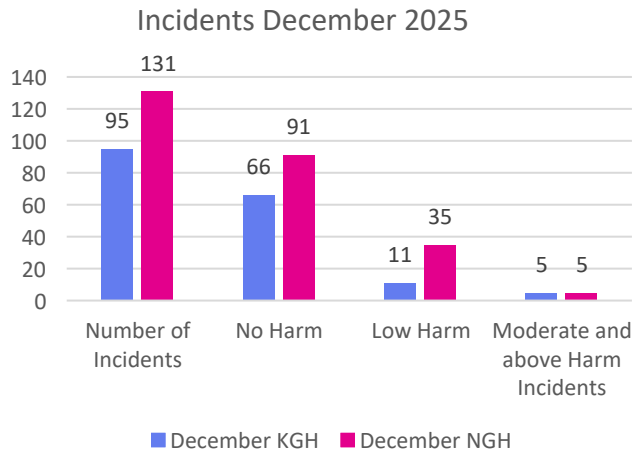


UHN demonstrates strong early access to antenatal care, with 87.0% of women booked by 12 weeks across both sites, supported by excellent early booking at NGH (67.6% <10 weeks) and high overall performance at KGH (88.3% by 12 weeks); later bookings remain low (≥20 weeks: 3.5% UHN), and the marked site variation in <10-week bookings provides a clear opportunity for cross-site learning to further improve timely access to screening and prevention.

CLINICAL QUALITY AND SAFETY

University Hospitals of Northamptonshire

Incidents and Events



MNSI	KGH		NGH	
	Dec	Nov	Dec	Nov
Reportable	1	1	0	0
Referred	1	1	0	0
Total	1	1	0	0

PSII	KGH		NGH	
	Dec	Nov	Dec	Nov
Commissioned	0	1	0	0
Total	0	1	0	0

PMRT	KGH	NGH
Stillbirth	0	2
Neonatal Death	0	1
Total	0	3

What the data is telling us? What do we need to focus on?

In December, UHN reported no Patient Safety Incident Investigations (PSIIs), with one case appropriately referred to the Maternity and Newborn Safety Investigation (MNSI). Ten moderate-harm incidents were reported, alongside two stillbirths and one neonatal death, all of which have been reviewed through established governance processes with learning identified and actions tracked.

Datix timeliness remains a focus area, with KGH implementing an agreed action plan to address 120 overdue incidents, none over 100 days and 26 over 60 days, supported by Perinatal Mortality (PMRT) process improvements to strengthen review timeliness. NGH is updating its risk register to reflect transition to the WEB system, alongside continued actions to reduce overdue Datix and improve assurance.

Learning from patient safety incidents is proactively shared through staff forums, MDT teaching, safety huddles and visual prompts, demonstrating a positive reporting culture and effective multidisciplinary working. PMRT arrangements are well-embedded, with strong cross-site collaboration between NGH and KGH, and UHL contributing as an external reviewer, providing independent scrutiny and strengthening shared system learning.

CQC Maternity Rating

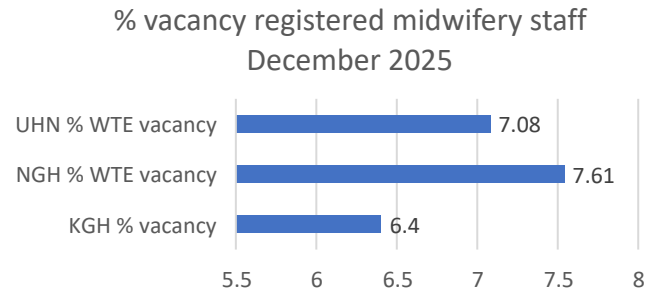
	KGH	NGH
Are services safe?	●	●
Are services effective?	●	●
Are services caring?	●	●
Are services responsive?	●	●
Are services well-led?	●	●
Overall	●	●

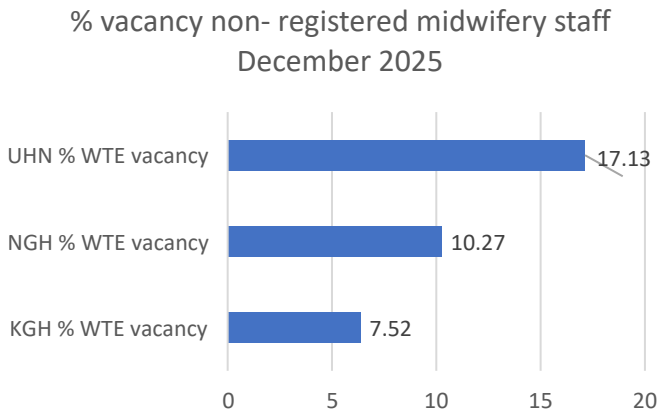
★ Outstanding ● Good
● Requires Improvement ● Inadequate

WORKFORCE – Maternity & Neonates

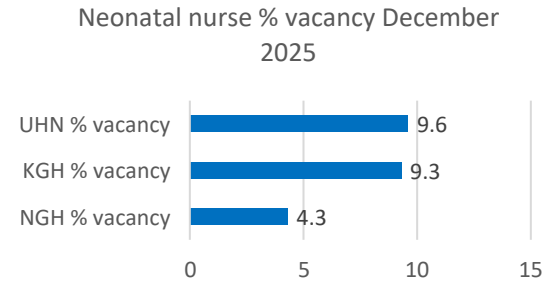
University Hospitals of Northamptonshire

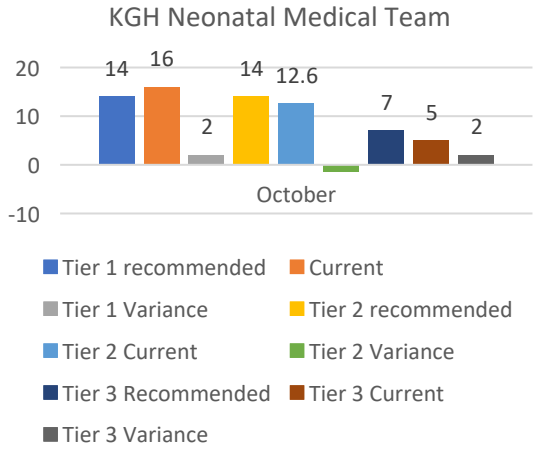
Midwifery vacancy



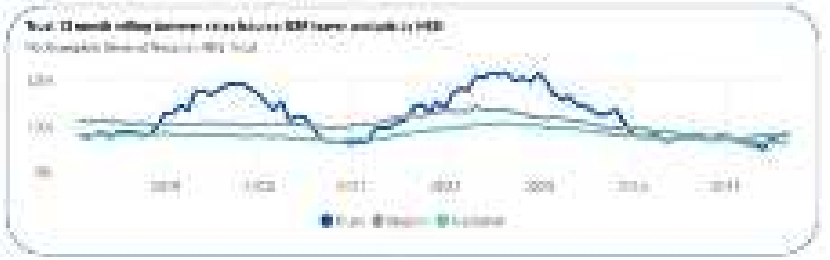


Neonatal vacancy





UHN 12 month rolling leaver rate



Safe Staffing

UHN position to be included in future scorecard

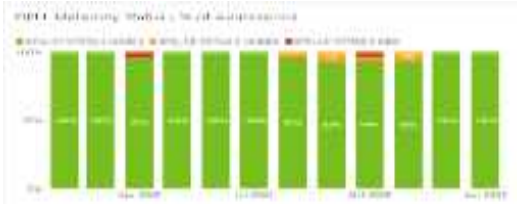
Maternity and Neonatal services continue to operate under sustained workforce pressure; however, risks are known, monitored and actively mitigated. As at December 2025, registered midwifery vacancy rates sit at 7.1% at UHN, comparable with system partners (6.4% KGH; 7.6% NGH), with a higher vacancy evident in non-registered midwifery roles (17.1% UHN) which impacts service efficiency and sustainability. Neonatal nursing vacancy remains a key risk, with rates of 9.6% at UHN and 9.3% at KGH, reflecting limited headroom in a high-acuity service. Medical workforce risks are being addressed through planned, structural interventions rather than reactive mitigation. Obstetric consultant vacancies at both KGH and NGH are under active review with revised job planning, aligned to demand modelling, and strengthened clinical leadership with a new Clinical Director in post from January 2026. In Neonatology, NGH currently has no medical vacancies, with recruitment underway and 10.5 WTE middle-grade starters planned, subject to final financial approval, representing a shift towards a more sustainable staffing model. Despite these pressures, retention provides resilience, with UHN's 12-month rolling leaver rate remaining below both regional and national benchmarks, although recent trends will continue to be closely monitored. Formal safe staffing assurance will be strengthened through future inclusion of UHN in the Safe Staffing scorecard, improving Board-level visibility and triangulation. Overall, the position is assessed as controlled but fragile, with clear mitigation in place and ongoing oversight required to ensure workforce stabilisation is sustained.

OPERATIONAL AND CAPACITY

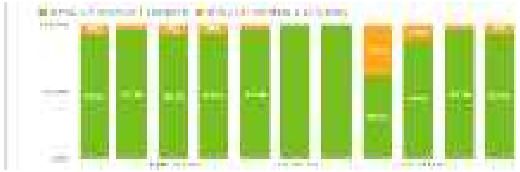
University Hospitals of Northamptonshire

Operational Pressures Escalation Levels

Kettering General Hospital



Northampton General Hospital



Midwifery Red Flag Events

Kettering General Hospital

Northampton General Hospital

What the data is telling us

Services are operating predominantly at OPEL 1–2, with intermittent escalation rather than sustained crisis. KGH shows consistent green performance (OPEL 1), indicating normal operational pressure for the majority of the time. NGH experiences more frequent escalation, with periods at OPEL 3 and occasional OPEL 4, reflecting higher demand and flow pressure, but not continuous red-level operation. Operational pressure is largely episodic and demand-driven, not systemic failure. Red Flag events remain relatively contained in volume and are concentrated around induction of labour (IOL) activity. At NGH, increased IOL demand has resulted in: breaches of recommended wait times, requirement for staff redeployment, occasional cancellation of non-urgent activity. At KGH, Red Flag events are less frequent and occur mainly when delays emerge in the induction or ARM pathways. Core maternity services have remained open. There have been:

- No acute maternity service suspensions or diversions
- No in-utero transfers for extreme preterm birth

This indicates that escalation has been managed effectively within services, without loss of critical service provision.

What we need to focus on

Reducing escalation driven by IOL flow and capacity imbalance: while most time is spent at green or amber levels, transitions to OPEL 3–4 are predictable and linked to IOL pressure, particularly at NGH. Focus is required on:

- Effective IOL prioritization
- Alignment of staffing, space, and flow across the pathway
- Reducing delays between assessment, ARM, and labour progression

Maintaining grip during escalation rather than reacting late. The data shows escalation is recognised, but the aim should be to:

- Reduce the frequency and duration of OPEL 3–4 episodes
- Ensure early mitigation when amber trends appear
- Prevent red escalation becoming normalized

Supporting operational resilience through workforce and QI delivery. Recruitment continues at UHN and improvement programmes are underway; however, delivery must remain focused on:

- Translating staffing into flow improvement
- Embedding learning from Red Flag events
- Maintaining senior oversight during pressure periods

What is going well

Maternity services are operating predominantly within normal pressure (OPEL 1), with escalation processes functioning effectively when demand increases; there have been no acute service suspensions, diversions or in-utero transfers for extreme preterm birth, and targeted quality improvement on the induction of labour pathway and LSCS are underway

TRAINING AND COMPLIANCE

University Hospitals of Northamptonshire

Training compliance

Attendance – All Staff

Kettering General Hospital *Northampton General Hospital*

Module 3: Maternity emergencies and multiprofessional training:

	AUG	SEP	OCT	NOV	DEC
Prompt Midwives	99%	98%	99%	99%	99%
Prompt Doctors Cons	92%	92%	92%	92%	100%
Prompt Doctors Reg	94%	94%	100%	100%	100%
Prompt Anaesc Cons	100%	100%	100%	100%	100%
Prompt Anaes Reg	88%	100%	100%	100%	100%
Prompt MSW	98%	98%	100%	98%	98%

	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Midwives	98%	99%	99%	99%	98%
Consultants	93%	93%	85%	100%	97%
Obstetric Doctors	[illegible]	[illegible]	89%	100%	92%
Anaesthetists	93%	90%	93%	95%	97%
MSW's	98%	99%	99%	100%	95%

Module 6: Neonatal Basic Life Support:

	AUG	SEP	OCT	NOV	DEC
NLS Midwives	99%	98%	99%	99%	99%
NLS MSW	98%	98%	100%	98%	98%

	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Midwives	95%	97%	97%	97%	95%
MSW's	94%	97%	97%	97%	94%

Element 4: Fetal monitoring and surveillance:

	AUG	SEP	OCT	NOV	DEC
CTG Day Midwives	100%	100%	100%	100%	100%
CTG Day Consultants	100%	100%	100%	100%	100%
CTG Day Reg	100%	100%	100%	100%	100%
CTG Competency Midwives	100%	100%	100%	100%	100%
CTg Competency DR	100%	100%	100%	100%	100%

	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Midwives	97%	98%	98%	98%	99%
Consultants	100%	935	92%	100%	100%
Obstetric Doctors	96%	98%	93%	97%	94%

What the data is telling us

Across UHN, training compliance remains strong across all required domains, providing assurance on workforce capability and safety. At NGH, CNST Safety Action 8 compliance has been achieved, with consultant and obstetric doctor attendance consistently above 90% over the final two months of 2025. This improvement reflects a sustained and coordinated effort by the Practice Development team and multidisciplinary clinical teams, resulting in demonstrable and maintained compliance with national training requirements.

What we need to focus on

NGH has successfully rolled out a refreshed programme for PROMPT and Specialties Days, receiving consistently positive feedback and strengthening team-based emergency preparedness. Points of Care (POCs) continue to be implemented in line with local learning from risk, incident review and governance processes, ensuring training content is responsive to identified safety themes. Community-based emergency scenarios are also being delivered, supporting preparedness across the whole pathway. In parallel, training and development is being increasingly aligned across both Trust sites, establishing a consistent, standardised UHN approach and strengthening system-wide assurance.

What is going well

Local learning continues to be systematically embedded into Training Week and POC ensuring education directly reflects themes emerging from risk and governance activity. At NGH, a bespoke training video focusing on communication during forceps delivery and postpartum haemorrhage (PPH) scenarios has been developed and incorporated into training delivery.

SAFETY ACTIONS

University Hospitals of Northamptonshire

Maternity Incentive Scheme

SA	Description	KGH	NGH	Commentary
1	Use of Perinatal Mortality Review Tool	Not Achieved	Complete	KGH have not achieved this standard having achieved 90% of reviews commenced within 2 months (pass mark is 95%). Tracker improved to avoid recurrence. NGH are fully compliant with PMRT reporting.
2	Maternity Services Data Set upload	Complete	Complete	Both Trusts' reporting standards (birth weight and mother's ethnicity) achieved and validated by MSDS.
3	Transitional Care and Avoiding Term Admissions to Neonatal Unit	Complete	Complete	NGH has a BAPM compliant Transitional Care Unit and has demonstrated sound, effective progress with is ATAIN QI plan addrssing causes of hypoglycaemia. KGH's Transitional Care plan (to achieve BAPM compliance) approved by Board and ODN. Progressed QI project to reduce instances of hypothermia as a cause of term admissions to the Neonatal Unit.
4	Obstetric, Anaesthesia and Neonatal workforce standards	Complete	Complete	For both Trusts: locum doctor compliance aconfirmed, anaesthesia24/7 availability confirmed, RCOG consultant attendance audit shows compliance, neonatal workforce plans / compliance status approved by Board and LMNS.
5	Midwifery workforce standards	At Risk	On Track	Joint second six-monthly midwifery workforce paper including action plans for small number of erary status of labour ward co-ordinator to go to PAC at January meeting; this will close action if accepted. KGH SN status action plan yet to be finalised.
6	Saving Babies Lives Care Bundle implementation	Complete	Complete	Both Trusts >90% embedded and compliant with use of NHSE implementation tool, having had at least 3 quarterly review meetings with the LMNS, who have approved progress.
7	Listening to women and families; co-creation with service users	On Track	On Track	Both Trusts have escalated MNVP infrastructure non-compliance. Recovery plan with LMNS in progress. Co-production, CQC survey actions, and service user engagement ongoing. Full governance attendance targeted for 2026; ICB-led plan for achieving this to be submitted to PAC at January 2026 meeting
8	Multi-professional emergencies, fetal monitoring & neonatal resus training	Complete	Complete	KGH have achieved >90% compliance for each training requirement for all respective staff groups as of end of November 2025.
9	Board oversight of maternity and neonatal safety and quality issues	Complete	Complete	Safety Champions fully established and meeting regularly. 'You Said, Together We Did' and Board oversight of complaints, claims, incidents and cultural initiatives is being achieved. Cultural improvement update received by Board.
10	Reporting of incidents and early notification, Duty of Candour	Complete	Complete	Both Trusts fully compliant with MNSI reporting and Duty of Candour protocols for year to date, evidenced by DoC register and Quarterly MNSI reports, as shared with PAC.

Summary

Maternity Incentive Scheme for Trusts Year 7

NGH remains on track to meet all ten safety actions under the Maternity Incentive Scheme (MIS) Year 7. KGH has not yet met one element of Safety Action 1, with commencement of reviews within two months currently at 90%, below the 95% target. Final MIS evidence will be assured by the Perinatal Assurance Committee (PAC) at its January 2026 meeting, prior to submission to the Trust Board for formal declaration.

Saving Babies Lives

Element	Interventions Fully Implemented (Self-Assessment)				Interventions Fully Implemented (LMNS Validated)				NHS Resolution MIS	
	KGH		NGH		KGH		NGH		KGH	NGH
Smoking in Pregnancy	Partly	90%	Fully	100%	Partly	90%	Partly	90%	CNST Met	CNST Met
Fetal Growth Restriction	Partly	70%	Fully	100%	Partly	100%	Fully	100%	CNST Met	CNST Met
Reduced Fetal Movements	Not implemented	0%	Fully	100%	Not implemented	00%	Fully	100%	CNST Met	CNST Met
Fetal Monitoring in Labour	Fully	100%	Fully	100%	Fully	100%	Fully	100%	CNST Met	CNST Met
Preterm Birth	Partly	88%	Fully	100%	Partly	88%	Fully	100%	CNST Met	CNST Met
Diabetes	Partly	83%	Fully	100%	Partly	83%	Partly	83%	CNST Met	CNST Met
All Elements	Partly	81%	Fully	100%	Partly	81%	Partly	97%	CNST Met	CNST Met

Summary

UHN has achieved compliance with Safety Action 6 of the Maternity Incentive Scheme (MIS) Year 7. Two ICB quarterly reviews have been completed in 2025/26 for both NGH and KGH. NGH achieved 97% compliance, with ongoing improvement work focused on evidencing diabetes specialist leadership and increasing the proportion of smokers setting a four-week quit date.

KGH compliance reduced in December 2025 (outside the MIS reporting period) due to an overdue guideline impacting elements 2, 3 and 5. The guideline has now been updated and was ratified on 6 January 2026, with an immediate improvement in compliance expected following SBLCB v3.2 implementation.

EXPERIENCE FEEDBACK

University Hospitals of Northamptonshire

Patient Experience

Complaints and Concerns

		Oct-25	Nov-25	Dec-25	YTD	Trend
Maternity	KGH	3	3	0	12	
Neonatal	KGH	0	0	0	0	
Maternity	NGH	10	10	0	28	
Neonatal	NGH	0	0	0	0	

Friends and Family Test (FFT)

Kettering General Hospital

	Target	National	Oct-25	Nov-25	Dec-25	YTD
FFT % Responses	20%	13%	13%	10%	13%	**17%**
FFT % Promoters	96%	93%	99%	95%	100%	**93%**

Northampton General Hospital

	Target	National	Oct-25	Nov-25	Dec-25	YTD
FFT % Responses	25%	13%	25%	19%	12%	**94%**
FFT % Promoters	96%	93%	96%	96%	96%	**96%**

Compliments

- "Was informed about stages and process throughout induction and labour"
- "Given all the information I needed. Theatre team were great.."
- Midwife always explained why she was carrying out certain procedures she answered all my questions
- Staff very helpful and informative all concerns were listened to & didn't feel pushed to do anything

What the data is telling us

CQC Maternity Survey: What we are doing well

1. Midwives providing relevant information antenatally about feeding baby.
2. Midwife or doctor being aware of medical history.
3. Midwife asking about mental health antenatally.
4. Trust in the staff providing antenatal care.
5. Concerns taken seriously during pregnancy.
6. Able to get support or advice about feeding baby during evenings, nights or weekends
7. help and advice from a midwife about feeding baby in the 4 weeks after birth length of time waiting to be seen on triage
8. Being given information about any warning signs to look out for during pregnancy

What we need to focus on

CQC Action planning: a focus on the bottom scores.

1. Partner able to stay as much as possible.
2. Managing pain during labour and birth.
3. Decisions about feeding baby respected.
4. Someone close to you involved as much as you wanted.
5. PN care at home – seen or spoken to a midwife.
6. Being offered a choice about where to have their baby
7. Information from midwife or doctor to help decide where to have their baby.
8. Left alone by midwives or doctors at a time when it worried them

Staff Experience

What are staff telling us?	What actions are we taking?
They would appreciate increased visible leadership presence in operational areas	Increased walk rounds and introduction of 'How Was Your Shift Initiative'
Clinical systems and guidelines across UHN are not aligned	Ongoing programme of cross-site alignment

What we need to focus on

Staff communication and engagement to ensure information on changes and improvement initiatives better communicated.

SPOTLIGHT ON…

University Hospitals of Northamptonshire

What is going on?

KGH are launching Friends and Family Fiend (enthusiast or devotee) 09.01.26 - a staff member in each area will be chose to be the 'fiend' who will lead in collection of feedback from every person, service user or family member, within the service, every Friday. Tea trolley & cakes provided for launch.

ACTING TOGETHER FOR AUTISM
AUTISM CHAMPION NETWORK

NGH & KGH Pt Engagement have joined the Autism Champion Network following feedback from patients with neurodiversity. Plans are in place to complete ‘Sensory audits’ in both trusts, to explore how we can ensure our maternity unit is more sensitive to the needs of all patients, particularly those with autism.

What is going on?

NGH

Congratulations to Hauwa Hamza – Muslim Midwife of the Year 2025! 🏆

We are delighted to share that Hauwa has been recognised at the British Muslim Health Awards. As a Digital Clinical Facilitator at UHN, Hauwa is at the forefront of innovation in midwifery, championing the use of digital solutions such as the Electronic Patient Record to enhance safety and quality of care. Beyond her local impact, she contributes to national networks and supports the delivery of safe maternity care internationally, demonstrating a strong commitment to equity and excellence in healthcare. This award is a testament to Hauwa’s compassion, leadership, and unwavering dedication to improving outcomes for women, babies, and communities.

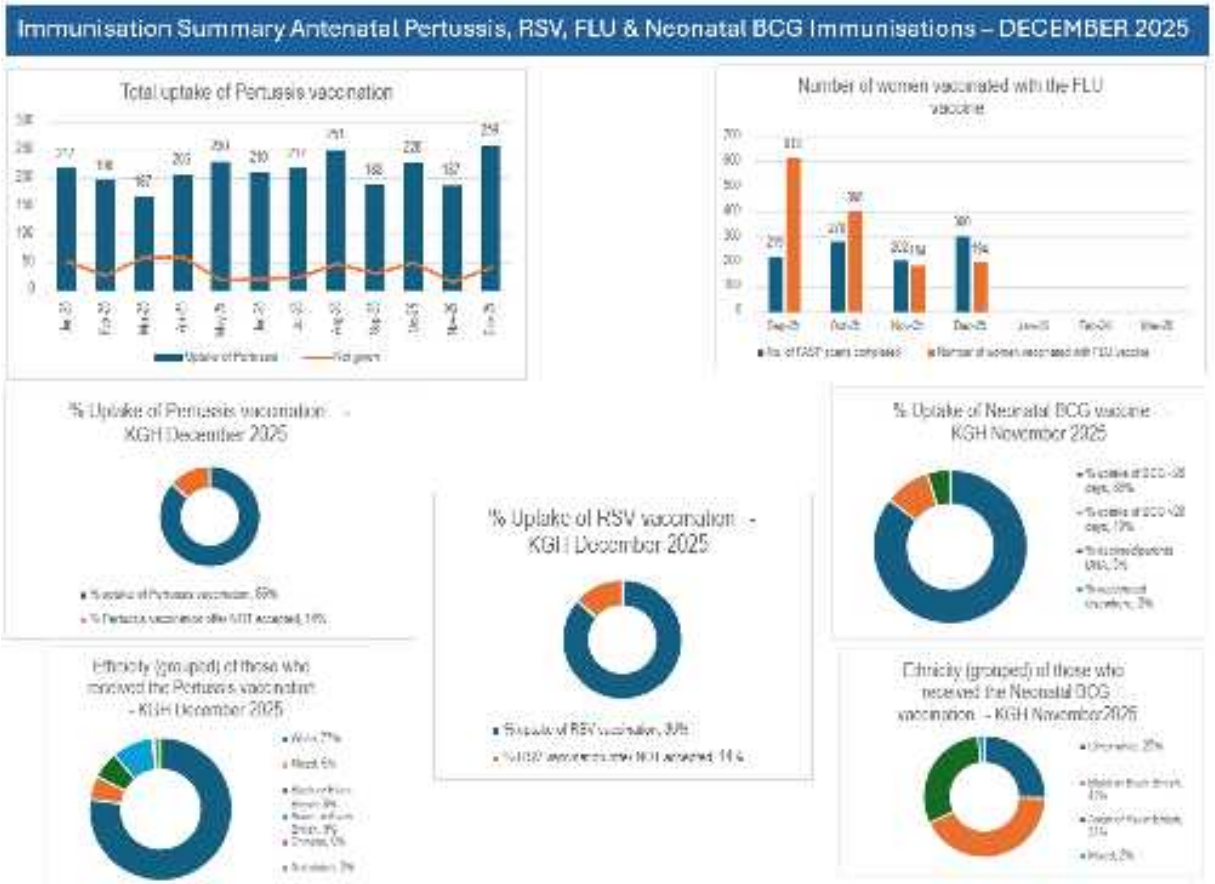
Well done, Hauwa – a truly well-deserved achievement 💙

APPENDICES

IMMUNISATION SUMMARY

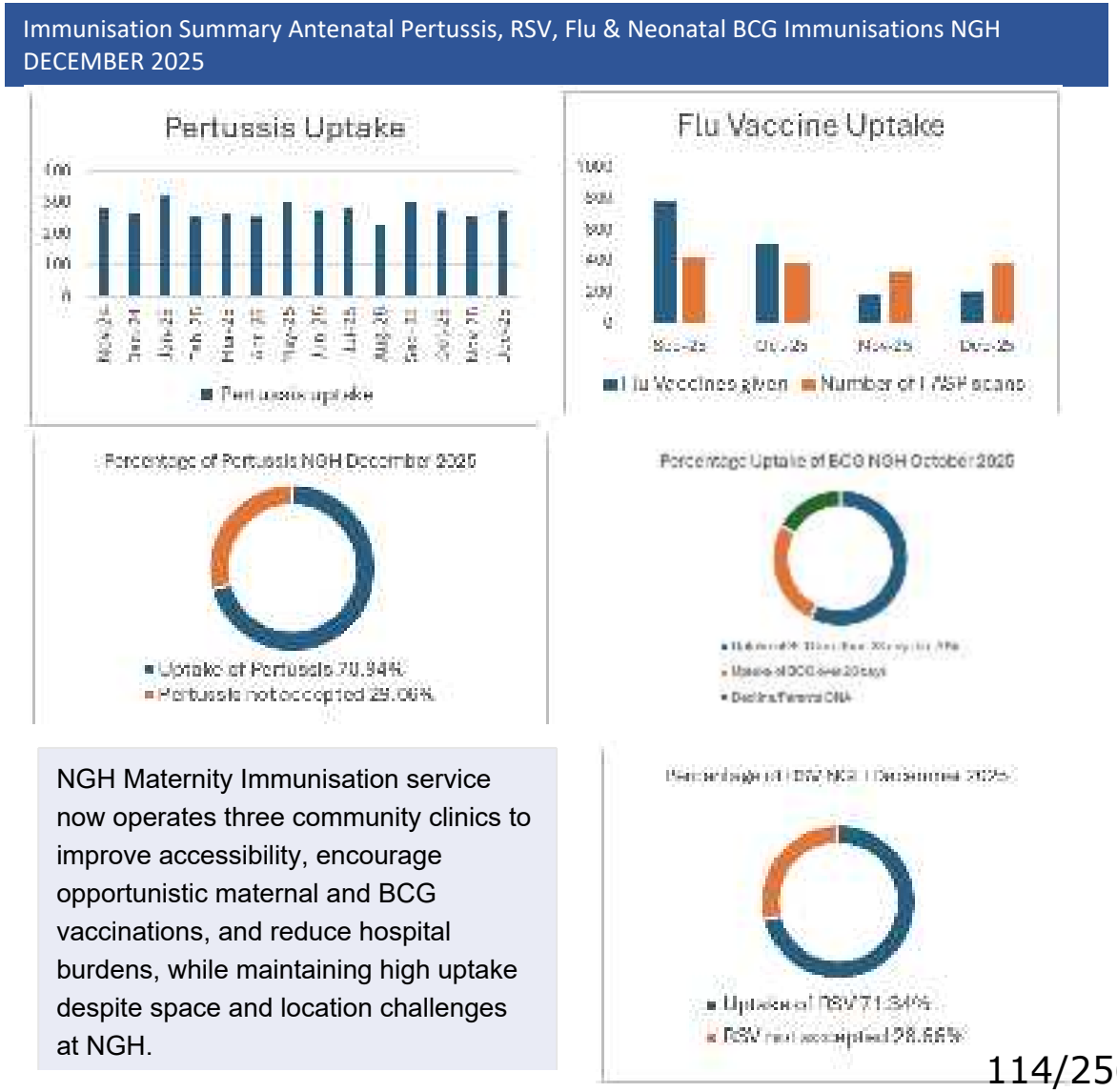
University Hospitals of Northamptonshire

Kettering General Hospital



KGH Immunisation team now fully established, we have seen an increase in the uptake of the BCG this month taking us to 85% <28days. Challenges with space continue to be an issue on site, however we hold satellite clinics in Wellingborough and Corby twice a month

Northampton General Hospital



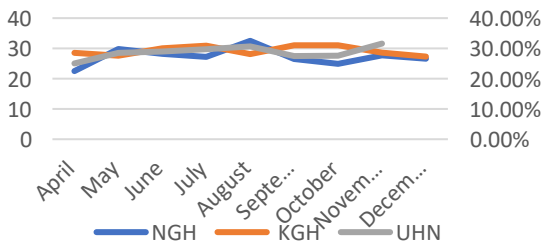
NGH Maternity Immunisation service now operates three community clinics to improve accessibility, encourage opportunistic maternal and BCG vaccinations, and reduce hospital burdens, while maintaining high uptake despite space and location challenges at NGH.

TRENDS: – CLINICAL QUALITY SURVEILLANCE

University Hospitals of Northamptonshire

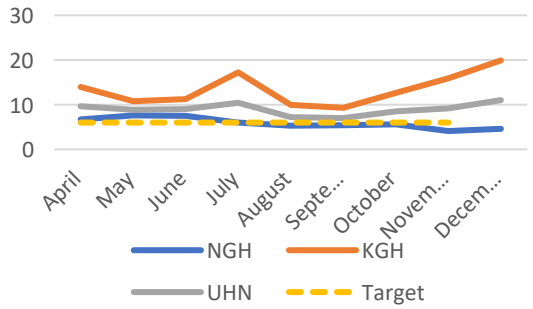
Antenatal

BMI 30 or more at time of booking



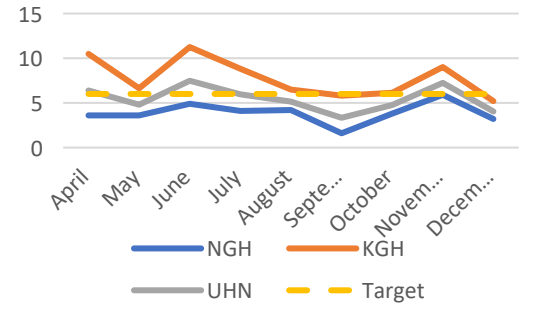
Latest
27.02% a decrease from 31.59%
Variation
N/A
Target achievement
N/A

% smokers at booking 25/26



Latest
11.02% increase from 9.17%
Target
6% SBLCB
Target achievement
Require additional data points to analyse

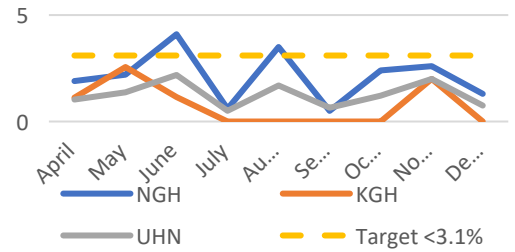
% current smokers at time of birth



Latest
4.04% decrease from 4.76%
Target
6%
Target achievement
Require additional data points to analyse

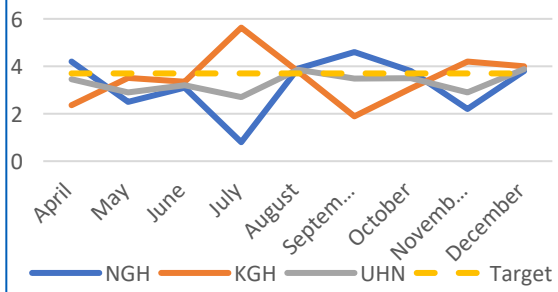
Intrapartum

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



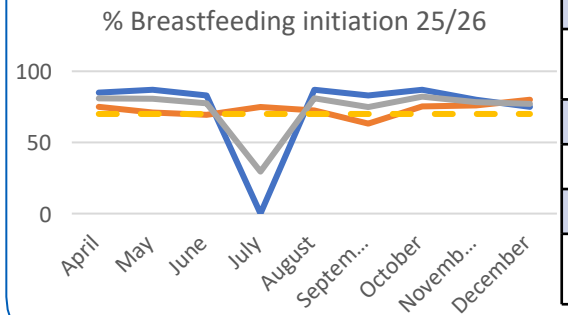
Latest
2% Increase from 1.2%
Target
3.1%
Target achievement
Require additional data points to analyse

Women with PPH of 1500ml or more



Latest
3.88 % increase from 2.9%
Target 3.7%
N/A
Target achievement
N/A

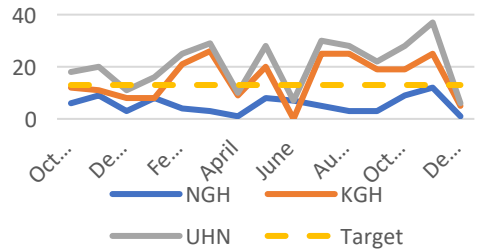
% Breastfeeding initiation 25/26



Latest
77.1% reduction from 78.3%
Target 70%
No NGH data for July
Target achievement
Require additional data points to analyse

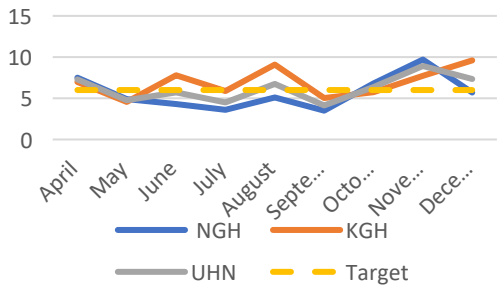
Outcomes

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



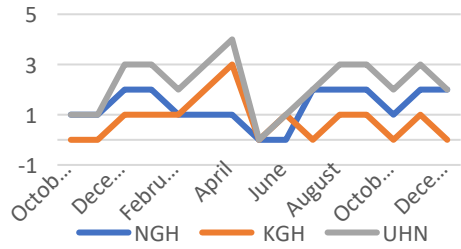
Latest
6
Target 13
N/A
Target achievement
Require additional data points to analyse

% of Preterm births 25/26



Latest
7.34 % of total births
Target
6% SBLCB
Target achievement
Require additional data points to analyse

Stillbirth 25/26



Latest
3.6 per 1000 births – UHN
Target
N/A
Target achievement
N/A

IN FOCUS – Operational KGH

University Hospitals of Northamptonshire

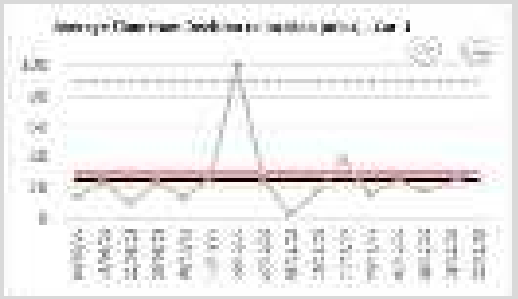
Summary

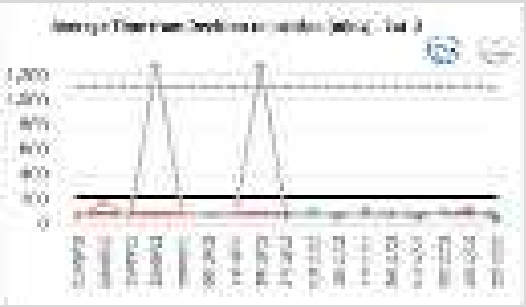
Overall clinical quality and safety performance is broadly stable, with clear evidence of improvement in key intrapartum measures (Category 1 and 2 LSCS decision-to-incision times and BSOTS triage performance), supported by sustained compliance, improving trends, and strong operational grip at KGH. However, outcome and public health indicators (including smoking at booking/birth, breastfeeding initiation, preterm birth, tears and APGAR scores) show expected variation and some deterioration, indicating where further targeted improvement and data maturity are required to strengthen population-level outcomes.

Caesarean Sections

Decision-to-incision performance continues to provide assurance. Category 1 emergency LSCS consistently meets the national standard, with a mean time of 26 minutes (≤30 minutes). Category 2 performance shows clear and sustained improvement, with December 2025 achieving a mean of 77 minutes, close to the 75-minute target, reducing the September–December average from 269 to 224 minutes and demonstrating statistically significant improvement since late October. Case review has identified data quality issues contributing to reported breaches, which are being addressed.

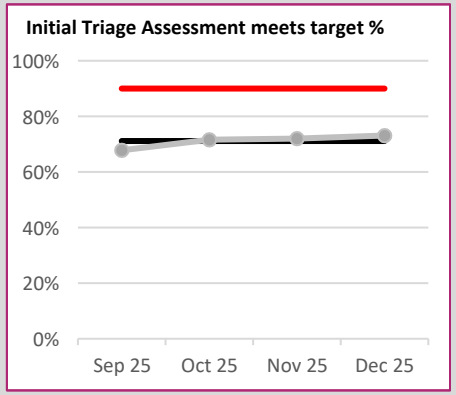
At KGH, robust actions are in place including deep-dive reviews of delays, strengthened theatre prioritisation and escalation, assurance of obstetric and anaesthetic staffing, real-time monitoring via BadgerNet, and implementation of a formal SOP and safety huddle following detailed pathway mapping, providing confidence that improvements will be sustained.

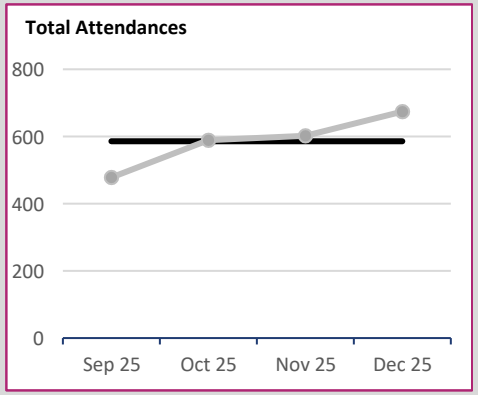




Triage

The BSOTS model for ongoing care in the same clinical area as initial assessment went live on 15 December 2025, with 100% of triage staff trained to BSOTS standard. Early performance demonstrates sustained improvement, including initial assessment within 15 minutes at 73%, ongoing care by a midwife at 69% (up from 55%), and doctor review at 73% (up from 25%). Identified risks relate to digital limitations of the current ward diary, peak-time capacity pressures between 5–9pm, and some process variation in results checking and referral appropriateness; mitigations are in place including transition to the BadgerNet diary, targeted operational actions, and reinforcement of standardised processes. Overall experience remains positive, with strong team engagement and a culture of patient advocacy providing assurance that improvement is being embedded and risks are actively managed.





GLOSSARY OF TERMS

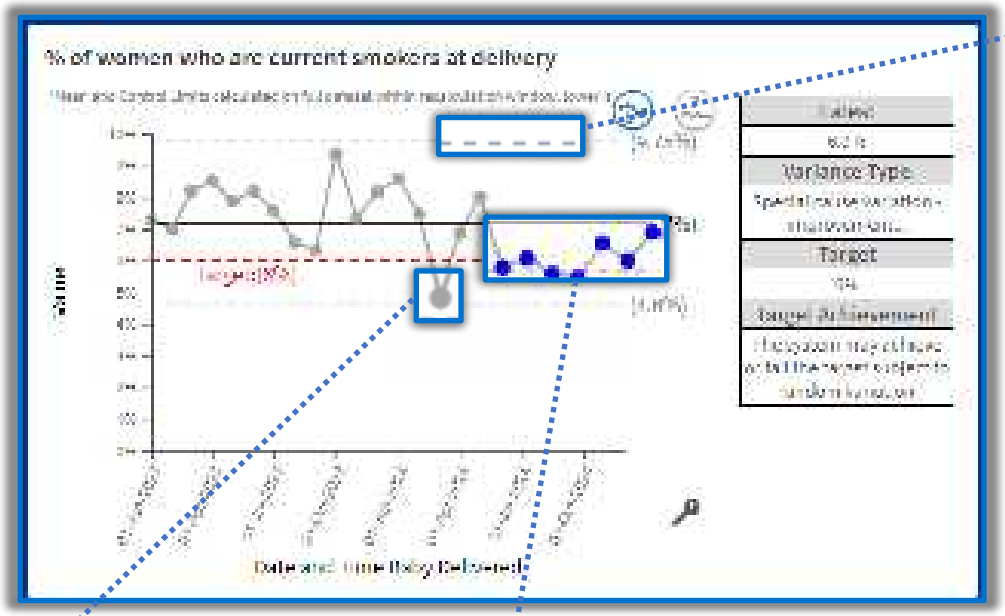
Glossary

Term	Abbreviation
Induction of Labour	IoL
Hypoxic-Ischemic Encephalopathy	HIE
Hospital Readmission	HRA
Postpartum Haemorrhage	PPH
Intensive Care Unit	ICU
Severe Maternal Morbidity	SMM
Kettering General Hospital	KGH
Northampton General Hospital	NGH
Gestational Diabetes Mellitus	GDM
Hyperemesis Gravidarum	HG

INTERPRETING DATA

Throughout this series of slides, we display data that shows you how we are performing in the current month and across time. We primarily do this through single data points on the 'At a Glance' slides and Statistic Process Control (SPC) charts. In this slide, we describe **SPC charts.**

SPC charts are widely used across the NHS to measure changes in data over time.
There is **strong evidence** that these provide a **better basis for decision making** versus isolated data points.



An SPC chart has **three reference lines** that allow you to interpret variation in the data. The **central reference line** shows the average (sometimes the median). The **upper and lower reference lines** show the process limits. These limits are defined by the variability in the data itself. Roughly 99% of the values should fall inside process limits. Sometimes there is also a **target line** – this shows the target that we are aiming to achieve for a given measure.

Common cause variation: a single value that looks abnormally high or low, but remains within process limits, is due to **common cause variation**. This means that it is not statistically significant as an isolated value and can be explained by usual variance in the system.

Special cause variation: this represents a value or trend that is likely to be **statistically significant** and therefore **not due to normal variation**. In our slides, these will be highlighted in **blue**. There are 4 different kinds of special cause variation:

1. **6 or more consecutive points above or below the mean line**
2. **A single data point outside the control limits**
3. **6 or more consecutive points increasing or decreasing**
4. **2 out of 3 consecutive points close to the process limit**

Cover Sheet

Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item	8.2

Title	UHN Perinatal Assurance Committee Highlight Report (January 2026) and Maternity Incentive Scheme Year 7 submission
Presenter	Danni Burnett – UHN Interim Director of Midwifery
Authors	Julie Hogg - UHN Chief Nurse Danni Burnett – UHN Interim Director of Midwifery

Link to Group Priorities		
X Transform Patient Care	**X Strengthen our Culture**	**X Deliver our Financial Plan**
Driving continuous improvement in safety, quality, and equity of perinatal services through robust oversight and evidence-based practice	*Fostering a culture of transparency, learning, and collaboration across multidisciplinary teams to improve outcomes for women, babies, and families*	*Ensuring efficient use of resources through data-driven decision-making, reducing avoidable harm, and supporting sustainable service delivery*

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

Reason for Consideration	Previous consideration
The purpose of this paper is to provide a summary to the Boards on the key discussions at the UHN Perinatal Assurance Committee (PAC) which met on Wednesday 21 January 2026, along with a recommendation to authorise the Group Chief Executive to sign the Maternity Incentive Scheme (MIS) Year 7 for submission	PAC 21 and 29 January 2026 Quality and Safety Committee, 28 January 2026

Executive Summary

The January 2026 Perinatal Assurance Committee reported that maternity and neonatal services across Northamptonshire continue to show growing stability and improved clinical performance. The Committee also highlighted areas at Kettering General Hospital (KGH) where further improvement work is underway, supported by focused executive oversight and ongoing actions to strengthen services.

Across UHN, maternity and neonatal services continue to mature in their safety governance. Clinical outcomes remain generally stable with no sustained adverse trends, perinatal mortality remains low, and all incidents including moderate-harm cases, stillbirths and neonatal deaths are being actively reviewed with identified learning acted upon. Training compliance is a significant strength, with both sites consistently achieving over 95% in fetal monitoring, PROMPT, and neonatal life-support training. Operational resilience also continues to improve; services experienced no diversions or suspensions in December, and 1:1 care in labour was maintained at 100%.

Northampton General Hospital (NGH) is positioned strongly, with full evidence for all ten Maternity Incentive Scheme (MIS) Safety Actions (Year 7). Workforce stability is improving, supernumerary status on the labour ward has been reliably maintained following earlier isolated breaches, and neonatal workforce compliance is assured. NGH is ready for a clean MIS declaration.

KGH continues to work through some well-recognised improvement areas. A recent CQC visit highlighted aspects of care such as triage processes, documentation and clinical oversight where further strengthening is needed, and these areas are now part of an active Perinatal Safety Improvement Programme (PSIP). Recruitment to key roles, including neonatal medical staffing, is underway to bolster resilience and support continued service improvement. KGH's position within MIS reflects that improvement work is ongoing, with demonstrable progress compared to the previous year. The Trust is not yet able to declare compliance against three safety actions:

- Safety Action 1 relates to the late initiation of a single Perinatal Mortality Review Tool (PMRT) review
- Safety Action 4 was achieved in line with the MIS technical guidance; however, in light of CQC inspection feedback and pending report, the Divisional Senior Leadership Team determined that submission of a compliance declaration would not be appropriate at this time. Ongoing, sustainable work is in place to strengthen monitoring, oversight, and assurance of consultant attendance arrangements
- Safety Action 5 concerns the requirement for a robust and sustainable approach to maintaining a supernumerary Labour Ward Coordinator. The evidence submitted confirms that appropriate escalation was undertaken on occasions when supernumerary status could not be maintained. Nevertheless, there is recognition that a fully embedded plan which is clearly articulated and understood by both Labour Ward Coordinators and senior managers is necessary to ensure future compliance.

Equity remains an important theme with PAC receiving insights into the actions in place such as enhanced cultural competence programmes, interpreter access improvements, and daily leadership presence. Actions are underway, but the work is not yet fully embedded.

Despite these pressures, PAC acknowledged meaningful progress: improved triage performance following BSOTS (Birmingham pathway) implementation, strengthened escalation processes, positive pathway redesign work, and a maturing culture programme. Furthermore, the Maternity and Neonatal Voices Partnership (MNVP) continues to engage constructively, although commissioning gaps require an ICB-led solution to ensure compliance with national governance expectations.

Overall, PAC recognised that UHN is progressing well, with NGH providing positive assurance. KGH continues to stabilise, but significant regulatory, workforce and cultural risks persist. The Boards are therefore asked to endorse the CEO to approve MIS declarations full compliance for NGH and transparent non-attainment for KGH.

NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year 7	UHN enters the final stages of MIS Year 7 with a clear organisational split in assurance. NGH provides a strong, stable, and fully compliant position, with all ten Safety Actions evidenced and assured. The site is well-placed for an unqualified declaration and reflects sustained improvement in governance, workforce stability, and safety processes. Conversely, KGH is unable to declare full compliance for MIS Year 7, with three Safety Actions confirmed as non-attained. • Safety Action 1 (PMRT timeliness): One eligible perinatal death review commenced outside the national two-month timeframe (90% vs 95% requirement).

	• Safety Action 4 (consultant attendance in specified acute O&G situations, in line with RCOG guidance): though Trust has complied with the technical guidance (it can evidence 88% compliance via a 100% case notes audit over a consecutive three month period, with any instances of non-attendance checked and actioned), the fact that consultant attendance was flagged as a concern in the CQC visit led the SLT to decide that an attestation of non-compliance would be appropriate. • Safety Action 5 (Labour Ward Coordinator supernumerary status): Recurrent loss of supernumerary status without a demonstrable downward trend and without a sufficiently robust action plan in place during the reporting window. These non-attainments are non-recoverable; however, corrective actions have been implemented at pace, supported by enhanced oversight, strengthened escalation processes, refreshed workforce models, and a developing leadership structure. These provide a more credible pathway towards improved resilience and compliance for MIS Year 8. The declarations for both Trusts will require full transparency of external regulatory context, including the pending CQC reports for both sites as mandated under the MIS scheme rules. PAC indicated assurance on the actions to progress and sustain: • Safety Action 7 – MNVP infrastructure: Engagement activity is ongoing; however, a fully defined, ICB/LMNS-funded and time-bound plan remains required to achieve full MNVP functionality, including formal governance attendance (notably PMRT), by March 2026 • Safety Action 4 (KGH) Neonatal Tier 3 Workforce: There are recruitment mitigations and a supporting review in progress to achieve compliance during MIS Year 8; neonatal nursing workforce is fully BAPM compliant. NGH are fully compliant with BAPM standards for neonatal medical and nursing workforce, Boards are requested to note this in the minutes to the 6-Feb-26 meeting, as this is a MIS requirement. **Next Steps – Declaration and Governance Timeline** • **January 2026:** Final MIS evidence pack issued to PAC (21 January), with draft declarations endorsed for progression to Board. • **February 2026: 6 February – UHN Boards:** Boards to formally authorise the CEO to sign both declarations. • **PQSG / LMNS Board (date TBC, w/c 8 February):** ICB to confirm counter-signature authority. • **17 February–3 March:** National MIS declaration window. • **3 March, 12:00:** Final submission deadline to NHS Resolution.
UHN Q3 Maternity Patient Safety Incident Report	Across Quarter 3, UHN continued to strengthen its maternity and neonatal safety systems, with improved consistency in harm grading, structured case review, and further alignment with PSIRF and PSIP.

(October-December 25)	1. **665 incidents** reported (397 NGH; 289 KGH), reflecting a healthy reporting culture • **Two PSIIs commissioned** • **Three MNSI referrals**. • **Unexpected term neonatal admissions:** 60 babies (3.4%); systematic trend analysis to commence Q4. This period marks a continued improvement in the quality and consistency of governance, supported by enhanced oversight and clearer escalation routes.
UHN Perinatal Safety Improvement Programme (KGH MSSP + CQC Progress)	The single UHN Perinatal Safety Improvement Plan continues to drive a coordinated improvement effort across the system, with clear evidence of traction despite the scale of transformation required. **MSSP:** 91 actions identified; **26% complete**, demonstrating steady progress since autumn. **CQC oversight: 185 action improvement plan – 55% complete**, showing breadth of work underway. Key areas of regulatory concern remain focused on infection prevention and control, leadership behaviours, workforce stability, governance reliability, and pathway consistency. Weekly senior leadership oversight, strengthened governance structures, and a developing cultural reset programme are now in place to sustain momentum and support visible, measurable improvement across all domains.
Manchester Homebirth Review	A national safety review was launched after a coroner investigated the tragic deaths of a mother and her baby during a homebirth in Manchester. The coroner identified several safety gaps through a Prevention of Future Deaths Report in how homebirth services are supported nationally. NHS England has now asked all maternity services to urgently review their homebirth arrangements. The review highlights areas where the NHS must strengthen guidance, training, communication and emergency planning so families can make fully informed choices. UHN remains committed to offering safe, informed and personalised birth choices, including homebirth. The are a clear set of next steps which PAC were sighted to, to strengthen the safety and reliability of its homebirth service. This includes a full Trust-wide safety review covering staffing, senior on-call support, midwifery training requirements, equipment readiness and ambulance transfer arrangements. Risk assessment and care planning will be reinforced so that every woman receives personalised information about her individual risks, with decisions clearly documented throughout pregnancy and labour. Information for families will be refreshed to explain risks, benefits and what happens if a transfer to hospital is needed. Midwifery competency requirements are being reviewed, alongside work with ambulance, obstetric, anaesthetic and neonatal teams to ensure rapid escalation when required. Governance will be strengthened through updated homebirth procedures and regular audits of outcomes and transfers, with findings reported to the Trust Board and NHS England. Finally, the Maternity and Neonatal Voices Partnership will play an active role in shaping information, gathering women's feedback and co-producing future homebirth pathways.

RCOG 2025 Workforce Census	Provides a national snapshot of the obstetrics and gynaecology workforce and highlights the pressures affecting maternity and gynaecology services. The census reinforces existing workforce pressures across UHN's O&G services and provides a clear mandate for strengthened job planning, improved leadership structures, and more sustainable medical staffing models. The emerging UHN action plan will ensure local delivery of the census recommendations and support safer, more resilient maternity and gynaecology services across both Trusts.

PAC were also briefed on:

UHN Perinatal Scorecard (December Data) & Neonatal Exceptions
✓ Stable clinical indicators
✓ Smoking at birth: 4% (better than national target)
✓ FFT Promoters: KGH 100% | NGH 95%
✓ No diversions or suspensions
✓ 1:1 care in labour maintained at 100%
✓ Positive Vaccination uptake
✓ NGH: QIS 62% ↑ and KGH: QIS 74%

Midwifery Bi-Annual Establishment Review
✓ Birthrate Plus compliant across both sites
✓ Midwifery vacancies: KGH 6.4% and NGH 7.6%
✓ Non-registered staff vacancies: 17.1% UHN
✓ Risk: reliance on externally funded specialist midwife posts (end Mar-26)
Key Themes: ↑ Retention, ↑ International midwife pipeline success, with focus required on community caseloads

BadgerNet system Implementation
✓ NGH go live successful
✓ KGH stabilisation work ongoing
✓ Data quality meetings established
✓ Enhanced dataset completeness (feeds Scorecard & MSDS)

Recommendations
The Quality and Safety Committee and Perinatal Assurance Committee, at meeting on 21, 28 and 29 January 2026, received and noted the report, indicated assurance to, and **recommended** that the UHN Boards of Directors:

1. **Endorse and authorise** the CEO to approve MIS Year 7 declarations (NGH compliant; KGH non-compliant with SA1, SA4 and SA5)
    a. **Note and record** Safety Action 7 – MNVP infrastructure: Engagement activity is ongoing; however, a fully defined, ICB/LMNS-funded and time-bound plan remains required to achieve full MNVP functionality, including formal governance attendance (notably PMRT), by March 2026; and
    b. **Note and record** Safety Action 4 (KGH) Neonatal Tier 3 Workforce: There are recruitment mitigations and a supporting review in progress to achieve compliance during MIS Year 8.

2. **Endorse** the development of a unified UHN Obstetric Workforce Plan, aligned to the RCOG 2025 Workforce Census findings, to ensure sustainable consultant capacity, improved rota resilience, and strengthened job-planning across both NGH and KGH
3. **Note** the midwifery establishment reviews and workforce actions.
4. **Approve** homebirth governance strengthening following national PFD.
5. **Continue oversight** of PSIP, MatNeoIST (previously known as MSSP), and CQC improvement work.

Financial Impact

There are direct financial consequences arising from the PAC updates. NGH is expected to recover its full CNST MIS Year 7 incentive, whereas KGH will not receive the full incentive due to non-attainment of Safety Actions 1 and 5, creating a financial pressure unless partially offset through a bid-back linked to its action plan.

Additional cost pressures relate to workforce stabilisation, including the potential need to mainstream several externally funded midwifery roles whose funding ends in March 2026, and ongoing training, audit and improvement activity required to sustain regulatory compliance. This is to be worked through with commissioners. The development and implementation of the unified Obstetric Workforce Plan may generate future financial pressures, including potential business cases for additional consultant capacity, enhanced rota resilience, protected SPA time, and administrative support to reduce non-clinical workload. These requirements may create both recurrent and non-recurrent cost implications necessary to meet national workforce standards and mitigate the risks highlighted in the RCOG Workforce Census.

The homebirth safety review and strengthened governance arrangements may also require non-recurrent investment in training, equipment, and updated pathways. Collectively, these pressures represent both immediate financial impact and future recurrent commitments necessary to mitigate safety, regulatory and workforce risks.

Full business cases will be developed for any changes as a consequence.

Legal implications/regulatory requirements

- The Trust must continue to comply with all CQC regulatory requirements which is requiring timely, evidenced improvement and ongoing engagement with the regulator.
- In addition to meeting statutory obligations for Duty of Candour UHN must fulfil national patient-safety reporting duties, including timely referrals to the Maternity and Newborn Safety Investigations (MNSI) programme and adherence to the Patient Safety Incident Response Framework (PSIRF)
- For NHS Resolution's Maternity Incentive Scheme, the Board must ensure full, accurate declarations including disclosure of relevant external regulatory findings supported by appropriate governance and Board approval.
- Failure to sustain safe staffing, training compliance, escalation processes and adherence to clinical standards may increase legal exposure through claims, inquests or enforcement actions

Equality Impact Assessment

PAC has given due consideration to the potential equality and health-inequality implications. In particular, PAC reflected on the importance of ensuring that improvements to culture across the service, plus strengthening homebirth governance. Actions are being taken to ensure personalised risk assessment, communication, and midwifery competency frameworks support equitable access and safe care for all women and birthing people. No adverse impacts have been identified at this stage, and equality considerations will continue to be embedded and monitored through established perinatal governance and EDI oversight mechanisms as the work progresses.

PERINATAL ASSURANCE COMMITTEE JANUARY 2026 CHAIRS HIGHLIGHT QUADRANT	
Matters of Concern or Key Risks to Escalate	**Major Actions Commissioned / Work Underway**

Regulatory Risk
• **KGH CQC inspection** citing concerns in:
  ○ Triage timeliness and risk-based assessment
  ○ Consultant attendance/decision-making
  ○ Workforce resilience
  ○ Documentation, medicines safety, neonatal equipment checks
  ○ Inconsistent adherence to national guidance (RCOG, NICE, NQB, CNST)
 	
MIS Year 7 Non-compliance (KGH)
• **Safety Action 1 (PMRT timeliness)** – one review 6 days late (90% v 95% threshold).
• **Safety Action 5 (Midwifery workforce)** – *27 supernumerary breaches*, no declining trend, no sufficiently robust Board approved action plan in reporting window.
 	
Workforce Fragility (UHN wide)
• Midwifery vacancy: **7.1%** (KGH 6.4%, NGH 7.6%)
• Significant **non-registered workforce gaps (17.1%)**
• **Neonatal nursing vacancy 9.6%**, especially at KGH
• KGH **Tier 3 neonatal medical workforce non-compliant** with BAPM
 	
Operational / Capacity Risks
• NGH episodic escalation to **OPEL 3–4** driven by induction of labour flow.
• Red flag events mainly linked to delays in IOL or ARM.
 	
Quality & Safety Risks
• Moderate harm incidents continue (10 in Dec; 22 in Q3).
• Ongoing documentation deficits following **BadgerNet** rollout.
	Regulatory / Assurance
	• **185 action improvement programme** at KGH, with weekly oversight.
	• Strengthened audit cycles for triage, consent, medicines safety, equipment, LSCS pathways.
	
	MIS / Safety Improvement
	• NGH & KGH continuing **ATAIN QI projects** (hypoglycaemia/hypothermia).
	• Full implementation of **SBLCB v3.2**, LMNS assured.
	• Biweekly consent audits & refreshed informed choice training.
	• Ongoing PMRT alignment across sites; reciprocal support with UHL.
	
	Workforce & Staffing
	• NGH action plan (completed) to maintain 100% Labour Ward Coordinator supernumerary status.
	• Recruitment streams for midwives & neonatal nurses; international midwife pipeline at NGH (100% retention).
	• Establishment reviews completed using **Birthrate Plus**; recruitment plans aligned.
	
	Equity & Culture
	• Antiracism Strategy, REACH network, equity audits (call bells, meds rounds).
	• Cultural competence training packages; engagement with The Motherhood Group.
	• Daily reassurance rounds; bilingual pain scales; interpreter app rollout.
	• Student safety and learning environment interventions (joint NGH/KGH forum).
	
	Operational Pathway Improvements
	• BSOTS implementation at KGH (100% staff trained).
	• Elective caesarean and IOL pathway reviews underway.

- Equity risks raised and being investigated regarding slower call bell response and less attentive care, with interpreter access variability.

MNVP Infrastructure Risk

- MNVP not fully commissioned/funded to meet governance expectations (attendance at 6 mandated forums).
- ICB level plans in place and approved.

- Digital optimisation: BadgerNet onboarding, data quality meetings, trajectory monitoring.

Positive Assurance to Provide

Quality & Safety

- December 2025: **no PSIIs**, **1 MNSI referral**, moderate harm incidents all reviewed with learning tracked.
- Perinatal mortality remains **low**; good cross site PMRT functioning.
- Clinical outcomes largely stable with no sustained adverse trends.
- **Excellent performance in breastmilk within 48 hours**, best in-region for >18 months
- Strong parental involvement initiatives, with month on month improvement in ward round participation
- Smoking at time of birth continues to decline, demonstrating positive impact of MTDA roles

Operational Performance

- **No service suspensions, diversions or in-utero transfers** in December.
- 1:1 care in labour maintained at **100%** across both sites.

Experience

- FFT promoters: **KGH 100%**, **NGH 95%**.
- Strong feedback on compassionate care, communication, theatre teamwork.

Training

- UHN wide compliance **>95%** in PROMPT, fetal monitoring, NLS;
- Both trusts meeting **MIS Safety Action 8** overall.

Decisions Made

MIS Year 7

- **NGH**: PAC endorses full compliance and progression to Board for CEO declaration.
- **KGH**: PAC records *non-attainment* for **Safety Actions 1 and 5**; CEO declaration to transparently include non-compliance and corrective plans.

Pathways and Governance

- Continued use of BSOTS at KGH and pathway refinement.
- Agreement to track and close CQC actions with PAC oversight.
- Approval to progress final MIS evidence pack and escalate to Trust Board and CEO

MIS Assurance • **NGH fully compliant** with all 10 safety actions. • Strong performance in: MSDS data, transitional care, consultant attendance (94%), neonatal nursing BAPM compliance, board oversight, Duty of Candour. **Workforce Stability** • Improved retention, reduced turnover, filled midwifery pipeline. • Community hubs functioning well, targeted caseload models for safeguarding/complexity.	

Cover Sheet	
Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item	9

Title	KGH Maternity Safety Support Programme (MSSP) and CQC Update
Presenter	Danni Burnett, Interim UHN Director of Midwifery
Author	Danni Burnett, Interim UHN Director of Midwifery

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

Group Priorities		
☒ Transform Patient Care	☐ Strengthen our Culture	☐ Deliver our financial plan

Reason for Consideration	Previous consideration
To brief the Boards of Directors on the progress made with the MSSP (Maternity Safety Support Programme) and immediate CQC feedback following inspection (September / October 2025)	NHS England and Northamptonshire ICB Improvement Oversight & Assurance Group (IOAG) 18 November 2025, 17 December 2025, and 15 January 2026

Executive Summary

Maternity and neonatal services at Kettering General Hospital are operating within a strengthened and increasingly effective governance and oversight framework, following the establishment of a single Perinatal Safety Improvement Programme (PSIP) that integrates MSSP actions, CQC regulatory requirements and national maternity safety priorities.

Since the September–October 2025 CQC inspection the Trust has taken prompt and proportionate action to stabilise services, strengthen leadership oversight, and implement structured improvement at pace. This includes improved workforce stability, consistent delivery of core safety standards, and demonstrable improvements in triage timeliness, emergency caesarean section responsiveness and mandatory training compliance.

Assurance has been materially strengthened through independent external scrutiny. From January 2026, KGH transitioned to NHS England's Maternity and Neonatal Improvement Support Team (MatNeoIST) under an intensive support model. Progress is subject to routine review by NHS England, ICB partners and the Improvement Oversight and Assurance Group (IOAG), providing confidence in the robustness of challenge and assurance.

The service now operates a clear three-lines-of-defence model, with improved alignment between frontline controls, divisional oversight and Board-level assurance.

While progress is evident, the Board retains clear line of sight to residual and systemic risks, particularly in relation to cultural embedding, documentation quality, neonatal Tier 3 workforce compliance and the need to evidence sustainability through closed-loop audit. These risks are actively managed and monitored through defined milestones, bellwether metrics and exception reporting.

Overall, the Board can take assurance that there is a clear understanding of its regulatory position, has effective oversight and controls in place, is responding credibly to external challenge, and has established the conditions necessary for sustained improvement and regulatory recovery.

Recommendations

For the KGH Board to Directors to:

1. Take assurance that effective governance, controls and escalation arrangements are in place to oversee maternity and neonatal safety improvement.
2. Note the transition to NHS England MatNeoIST intensive support, providing enhanced external challenge, executive-level oversight and alignment with national expectations.
3. Acknowledge remaining risks, particularly in relation to cultural maturity, documentation quality and sustainability of improvements, and confirm that these are actively monitored with clear mitigation.
4. Confirm continued Board focus on sustaining improvement, evidencing impact and maintaining pace under ongoing CQC and NHS England scrutiny.

Appendices

Appendix 1: KGH MSSP / CQC Progress Presentation (IOAG 15 January 2026)

Risk and assurance
UHN11 Positive safety culture UHN12 culture of compassionate, response and inclusive care
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 of the safety of maternity services being called into question and the aligned financial and reputational risk
Equality Impact Assessment
This is applicable to all staff within Northamptonshire LMNS and all women accessing care within the LMNS.

Kettering General Hospital (KGH) Maternity Improvement Progress Report: Perinatal Safety Improvement Programme (PSIP), MSSP and CQC

Reporting period: November 2025 – January 2026

EXECUTIVE SUMMARY

Maternity and neonatal services at Kettering General Hospital (KGH) continue to make measurable and sustained progress under the Single Perinatal Safety Improvement Programme (PSIP), which integrates MSSP actions, CQC regulatory requirements and national maternity safety priorities within a single, coherent delivery framework.

Progress during this reporting period demonstrates that the service has moved beyond initial stabilisation and is now delivering structured improvement with increasing assurance. Workforce stability has strengthened, with all midwifery vacancies filled, consultant job planning completed, and improved senior leadership presence. There is evidence of core safety standards being consistently delivered, including 100% 1:1 intrapartum care, sustained training compliance above 95%, and improving performance in maternity triage and emergency caesarean section responsiveness, despite rising activity.

There is also evidence of improving system reliability, supported by the live use of BadgerNet, enhanced governance, and a clearer line of sight from frontline risks to Board oversight. Infection prevention, consent and information governance, and medicines safety have been prioritised following CQC feedback, with over 55% of CQC actions now complete and the response plan embedded within PSIP.

Importantly, the service is now operating within a strengthened assurance environment, with independent scrutiny through NHS England, the ICB Improvement Oversight and Assurance Group (IOAG), and since January 2026 the new Maternity and Neonatal Improvement Support Team (MatNeoIST).

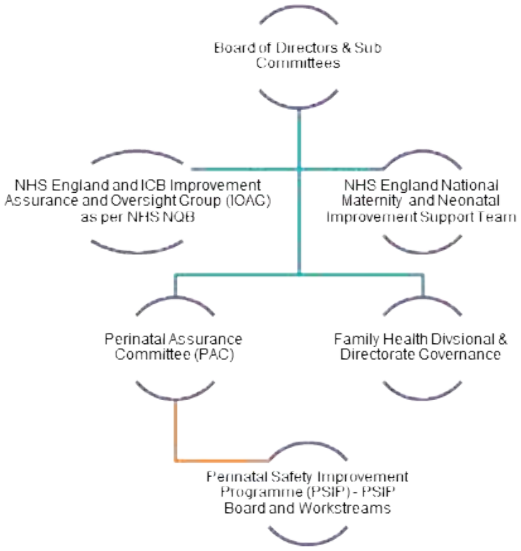
Notwithstanding the progress made, material risks remain, particularly in relation to cultural embedding, documentation quality, neonatal Tier 3 workforce compliance, and the need to fully close audit loops to evidence sustained change. These risks are understood, subject to active mitigation, and are being tracked through defined milestones and evolving bellwether metrics.

Overall, the trajectory is positive. The service has demonstrably strengthened leadership, governance and safety-critical processes, with increasing confidence in direction of travel. The Board is asked to take assurance that improvement is progressing at pace, and remaining risks are clearly identified and actively managed as the service continues towards MatNeoSIT exit readiness within the next 12months.

1. Programme Oversight and Governance

A single PSIP is now operational, providing line of sight from frontline improvement activity through to the Board.

The governance structure shown represents the formal assurance and escalation route; however, it is deliberately underpinned by a broader network of specialist operational forums including Infection Prevention and Control, Digital, Harm-Free Care and Fundamentals of Care groups. These forums provide real-time monitoring, expert scrutiny and early identification of risk, with outputs feeding into Divisional Governance and the Perinatal Safety Improvement Programme.



This layered approach ensures that Board and system-level oversight is informed by triangulated intelligence from frontline, specialty and thematic groups, strengthening assurance without duplicating governance. NB. governance has been strengthened through the introduction of:

- Divisional and Directorate weekly senior leadership oversight meetings
- IAOG scrutiny and exception reporting (monthly)
- CQC exception reporting to Executives (weekly)
- Alignment of MSSP, CQC, and national directives with a longer-term sustainability programme of work (programme impact measures being agreed)
- Executive-led Perinatal Assurance Committee maintains overall oversight of PSIP as per delegated responsibility of the Board of Directors

Transition to the Maternity and Neonatal Improvement Support Team (MatNeoIST)

KGH has formally transitioned from the Maternity Safety Support Programme (MSSP) to the NHS England Maternity and Neonatal Improvement Support Team (MatNeoIST) with effect from 1 January 2026, following agreement with NHS England. This represents a shift to a more intensive, time-limited and executive-led improvement model, designed to strengthen sustained improvement and Board-level accountability.

Under the new arrangements, KGH has been assessed as requiring Intensive MatNeoIST support for a 12-month period. Support will be provided by a dedicated team of midwifery and obstetric Maternity Improvement Advisors (MIAs), with access to specialist national expertise including neonatal improvement, quality improvement, equity and inclusion, workforce and Professional Midwifery Advocacy. The focus is on co-delivery of improvement, not performance management, enabling KGH to lead and embed change sustainably.

New Governance and Oversight Arrangements: A key change within the MatNeoIST model is the introduction of formal monthly executive-level meetings between KGH, NHS England and regional partners. These meetings are a core requirement of the support framework and act as the primary point of assurance, escalation and decision-making for maternity and neonatal improvement. The meetings intend to:

- Maintain direct Board and executive engagement in maternity and neonatal safety
- Provide oversight of progress against the agreed Targeted / Intensive Improvement Plan
- Act as the first formal escalation point should progress stall or risks increase
- Ensure alignment between KGH, regional and national improvement activity

Attendance includes KGH executive leadership, clinical leads, regional maternity and obstetric leadership, service-user representation, and MatNeoIST advisors, reinforcing system-level accountability. In addition, MIAs will attend Board meetings as required during the support period to ensure Board visibility of progress, risks and required actions, and a formal closure meeting will be held at the end of the 12-month period to review outcomes and agree ongoing regional oversight arrangements.

While the monthly executive meetings provide the formal oversight route, assurance is further strengthened through integration with existing governance and specialist forums. Outputs from the MatNeoIST programme and improvement workstreams will continue to flow through Divisional Governance, PAC, and established specialist groups. This ensures that improvement is monitored at operational, divisional and Board level, with triangulation across safety, quality, culture and equity domains.

Progress is tracked against agreed 3-, 6- and 12-month milestones, with defined evidence requirements. Following the conclusion of MatNeoIST support, a co-produced closure report will confirm achievements, outstanding risks and the framework for continued regional enhanced oversight

Evolving bellwether metrics are being developed to support PSIP and demonstrate progress as per MatNeoIST approach. These metrics will complement reporting and will routinely report, with increasing data maturity as part of BadgerNet embedding.

Board assurance: The new and embedding improvement programme, aligned to the new NHS England Maternity and Neonatal Improvement Support Team (MatNeoIST) model, is addressing previous fragmentation; actions are prioritised, tracked and overseen through an integrated governance structure operating within a clear three-lines-of-defence framework.[i].

2. Workforce Stability and Capacity

Midwifery

- All registered midwife vacancies have been recruited, following a Birthrate Plus-aligned uplift.
- 100% compliance with 1:1 care in established labour has been sustained.
- Increase in the Band 7 coordinator template to ensure sufficient capacity for senior leadership and operational oversight, breaches reviewed and mitigated appropriately.
- Completion of a senior Midwifery Leadership management of change across the UHN group to align and strengthen with aim to bring consistent standards of care and sustainable leadership across maternity services, this includes the introduction of new roles (deputy heads of midwifery, antenatal services and complex care matron, and improved clarity of the quality improvement and governance matron roles)

Medical and Neonatal Workforce

- New UHN Clinical Director for Obstetrics commenced January 2026 allowing greater focus and consistency across the group
- Obstetric consultant job plans are 100% completed, a key MSSP milestone. Focus is now on working to further alignment to PSIP and emerging RCOG guidance

- Consultant attendance audits demonstrate >80% compliance, meeting MIS requirements, with further improvement actions underway.
- Neonatal workforce is compliant at BAPM Tiers 1 and 2.
- Tier 3 compliance remains a risk, with mitigations in place including:
    - Appointment of an additional consultant.
    - Review of job plans to create capacity for a 7th neonatal consultant.

Board assurance: Workforce risks have reduced materially, with remaining gaps understood and actively managed. The focus now shifts to implementing and embedding new roles and structures, monitoring skill mix and fill rates, and building resilience as part of ongoing wellbeing and retention plans

3. Clinical Safety, Pathways and Outcomes

Triage and Flow

- BSOTS triage model (ongoing care in the same location as initial assessment) went live in December 2025
- 100% staff trained who work or may be redeployed to triage, with a programme of education to work towards all staff being trained
- Recent sustained improvement demonstrated in December 2025:
    - Initial triage assessment within 15 minutes improved to ~73%.
    - Ongoing midwifery and medical care compliance improved across all urgency categories.
- Performance gains have been achieved despite increasing attendances, demonstrating improved system resilience and more proactive escalation approaches

Emergency Caesarean Section (LSCS)

- Category 1 decision-to-incision times consistently meet the national 30-minute standard (mean ~26 minutes).
- Category 2 performance has improved significantly, with December 2025 averages approaching the 75-minute target, reflecting improved theatre flow and prioritisation.
- Variation is better understood following process mapping, with targeted QI actions underway.

Fetal Monitoring

- Whilst real-time reporting through BadgerNet is being worked through, local audit demonstrates assurance around escalation and key safety steps (≥97–100% compliance in critical areas).
- Ongoing improvement focus on routine hourly CTG review documentation
- No intrapartum stillbirths or HIE cases in 2025 where fetal monitoring was identified as a contributory factor.

Neonatal Outcomes

- ATAIN performance remains better than the national average, indicating effective perinatal optimisation.
- Learning from cooled babies and HIE cases has been commissioned and embedded into PSIP workstreams.

Board assurance: Several of the core safety-critical functions identified through MSSP show sustained improvement, with risks identified early and addressed through targeted QI.

4. Experience, Consent and Equity

Consent practice continues to be an area of focus with repeated audits demonstrating good compliance, December audit demonstrated 100% documentation compliance.

FFT feedback continues to consistently demonstrate positive frontline interactions, with service users describing clear explanations, respect for choice and compassionate staff behaviours. This provides important assurance about day-to-day care quality. The rise in complaints during Q2 2025 predominantly reflected operational pressures rather than staff behaviours, particularly delays in care and communication during periods of increased demand and operational disruption. Since Q3, complaint volumes have declined, coinciding with targeted actions to improve flow, triage performance and communication during waits. This pattern suggests that while interpersonal care was rated positively, system reliability and timeliness were the key drivers of dissatisfaction, and these are now being actively addressed through PSIP and CQC improvement work.

A focused and strengthening equity response is in place and embedded within the Perinatal Safety Improvement Programme, with clear executive oversight and line of sight to delivery. This includes increased leadership visibility through daily walkarounds, regular check-ins and real-time feedback, alongside operational actions to improve responsiveness, such as real-time call-bell audits linked to ethnicity, structured daily reassurance and pain-control rounds, and standardised medicine administration supported by EPMA audits. Interpreter access has been strengthened through use of clinical devices, with further work underway to introduce bilingual pain scales and rapid interpreter escalation. Targeted cultural competence initiatives have been launched, building on learning from the Motherhood Group and the “Listen to Me” campaign, with Trust-wide cultural competence training planned for 2026. A national perinatal equity deep dive, led by Wendy Olayiwola, is scheduled for February 2026 to provide independent scrutiny. The Trust is also actively engaged in the NHS England-sponsored Perinatal Equity and Anti-Discrimination Programme, with progress reported monthly to NHSE, providing assurance that equity concerns are being addressed through measurable actions, robust governance and sustained improvement.

Board assurance: Experience and equity are now explicit improvement priorities, with credible actions and monitoring in place.

5. Culture and Organisational Development

Culture and Organisational Development remain a critical focus of the Perinatal Safety Improvement Programme. The evidence confirms that while foundations are improving, cultural embedding is at an early–to-mid stage and requires sustained leadership attention.

A comprehensive Culture & OD Programme is now in place, aligned to Theme 10 of the Section 29A Response Plan and embedded within PSIP governance. This programme is addressing historic issues of incivility, undermining behaviours, discrimination and psychological safety through a structured, multi-layered approach. Key actions include the reset of values-based behavioural standards, embedding civility and empathy within induction and mandatory training,

appointment of civility champions, introduction of psychologically safe reporting routes, and the roll-out of pulse surveys and real-time feedback mechanisms such as *How Was Your Shift*. Leadership visibility and accountability have strengthened, with consistent senior walkarounds, daily engagement with teams, directorate co-location in clinical areas, and formal monthly senior oversight. Leadership development is being supported through group coaching, reciprocal mentoring, and OD-led interventions, with behavioural expectations increasingly reflected in appraisals, governance forums and incident review processes.

Early indicators show positive movement in staff engagement and willingness to speak up, including increased feedback submission, improved multidisciplinary dialogue, and strengthened use of Freedom to Speak Up pathways. This is being triangulated alongside staff survey data, pulse checks, grievance trends and cultural themes arising from incidents, complaints and FFT.

Importantly, cultural improvement is explicitly linked to safety and equity. Equity-related concerns raised by NHS England Workforce Training and Education (WTE) have been met with rapid leadership action, operational changes, and a scheduled national perinatal equity deep dive, reinforcing the link between culture, inclusion and patient safety.

Board assurance: Overall, there is clear assurance there is an understanding of the scale and nature of the cultural challenge. These are being robustly responded to, and there are plans in place to sustain improvement. The critical next phase is embedding consistency, demonstrating measurable impact, and maintaining momentum as regulatory scrutiny continues.

6. CQC and Section 29A Progress

Of the **CQC action plan**, over **55% of actions are now complete**, with a growing number signed off as assured. This is embedded within the PSIP, and progressing at pace. Key risk areas (IPC, staffing oversight, consent, governance) have demonstrable improvement actions and monitoring.

Board assurance: Regulatory risks are being actively managed with clear delivery milestones and improving assurance.

7. Overall Assessment

PSIP across UHN has enabled KGH to move from **diagnosis and stabilisation** to **demonstrable improvement and assurance**. While challenges remain, particularly in embedding new systems and achieving full neonatal workforce compliance, the service now shows:

- Clear leadership
- Improving performance against safety-critical metrics.
- Strengthened culture and governance.
- A credible trajectory towards MSSP exit readiness.

Board focus should now remain on sustaining improvement, closing residual gaps, and maintaining pace under ongoing regulatory scrutiny.

[i] Structured framework used to clarify roles and responsibilities in risk management and control, ensuring that programmes achieve their objectives without significant failures. It helps prevent gaps in oversight and avoids duplication of effort by separating duties into three distinct, collaborative layers.

Cover sheet

Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item	10

Title	Emergency Preparedness, Resilience and Response (EPRR) compliance annual report and Core Standards self-assessments
Presenter	Sarah Noonan – Chief Operating Officer
Author	Andrea Contini and Andy Howes, EPRR Team

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 Priorities		
☒ Transform Patient Care	☐ Strengthen our Culture	☐ Deliver our financial plan

Reason for consideration	Previous consideration
It is part of the NHS England's Core Standards for EPRR that the Boards of Directors should be fully briefed and aware about the annual Core Standards Self-Assessment position, the work that has been done and plans moving forward.	Finance, Investment and Performance Committee, 27 January 2026 (progress report available in 'documents' section of Board Portal)

Executive Summary

This paper describes the last year of Local Health Resilience Partnership activity and NGH and KGH EPRR Core Standards results.

Both Trusts were deemed non-compliant to the EPRR Core Standards. To achieve overall partial compliance 77% of standards need to be fully compliant, substantial compliance is at 95%, and fully compliant 100%.

There is a total of 62 standards applicable to each Trust, results are as follow:
KGH: 17 were assessed fully compliant (27%), 44 partially compliant (71%) and 1 non-compliant (2%).
NGH: 19 were assessed fully compliant (31%), 42 partially compliant (67%) and 1 non-compliant (2%).
The overall compliance has decreased for both sites, but with robust plans in place to improve this position.

The EPRR function has evolved to a Group working with significantly improved cross-site considerations and more Group approaches to ensuring compliance.

While the results from the core standard review were disappointing but not unexpected, reconfiguration of the EPRR structure and function across UHN was already underway. With the 2025-2026 EPRR workplan there is confidence that UHN will progress its compliance with the core standards to at least partially compliant prior to the 2026 Core Standards Assurance process.

The Boards are requested to **receive and note** the results of this year EPRR Core Standards and the main priorities and objectives for the Team and to indicate assurance regarding the trajectory which, at the time of writing, is on track: in a review at January 2026 (see separate paper) the steps undertaken and planned show 25 standards at Full Compliance, 25 Standards at high likelihood of Full compliance and 12 at Partial Compliance

Risk and assurance

Risks 5665 and 6153: Non-Compliance in NHS England Core Standards for EPRR Assurance process

Patient Experience: Impact on the experiences that patients receive during care and treatment. *Safety/Quality/Statutory*: Impact on the safety of patients, staff or public. Impact on the quality of our services. Impact upon on our statutory obligations, regulatory compliance, assessments and inspections *Business/Reputation*: Impact upon our reputation through adverse publicity Impact upon our business and project objectives. Service and business interruption	There is a risk for both Trusts not to reach compliance under the Civil Contingencies Act 2004, the NHS England EPRR Framework and the annual EPRR Core Standards Self-Assessment. This will lead to a generalised risk of harm to patients, staff and visitors, impact on patients' experience and Trust reputational damage.

Financial Impact

N/A

Legal implications/regulatory requirements

Both Trusts are classed as Category 1 responders under the Civil Contingencies Act 2004 and have six main duties to carry out including risk assessment, planning for emergencies, sharing information with partners agencies and warn and inform the population.

Equality Impact Assessment

Equality impact review available upon request.

EPRR Annual Report for KGH and NGH (UHN)

Contents

1. INTRODUCTION

This paper provides a report on the Trusts' emergency preparedness to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response Framework 2022.

Each Trust has a suite of plans in place to deal with Major Incidents and Business Continuity issues. These conform with the Civil Contingencies Act (2004) and current NHS-wide guidance. All plans have been developed in consultation with internal and external stakeholders to ensure cohesion with other related plans. The plans are ensuring a Group approach is being made with the majority being reviewed to having a Group approach with site specific elements as necessary.

The paper reports on the training and exercising programme, EPRR annual assurance and details the developments of the emergency planning arrangements and plans. The report gives a summary of instances in which each Trust had to respond to extraordinary circumstances.

With the development of a training needs analysis completed by the Group EPRR Manager in September 2025 it is recognised that, although a number of key work streams have been put on hold due to resource challenges, the accessibility and awareness of the Group to EPRR profiles is being revised and sustained. The aim of the EPRR work programme for the next 3 years is to return to a level of activities equivalent to prior to the pandemic in 2020.

Staffing challenges across the EPRR landscape prior to the Group EPRR Manager being in post in July 2025 and the difficulty in recruiting permanent qualified EPRR staff have continued to challenge progress. The team has undergone a refocus of the Emergency Planning Team with clear plans and timelines for a joint Group Working and joint annual work plan. Cross site coverage is key to this accessibility (and ability to provide relevant tactical and strategic advice) with the team ensuring site availability for the majority of the working week.

The WTE for the Emergency Planning Teams is as follow: 1x WTE B8B (started in July 2025), 1x WTE B8A, 0.5x WTE B5, 1x WTE B4.

2. TRAINING AND EXERCISES UNDERTAKEN

A key part of any preparedness arrangements is to ensure that staff are appropriately trained to implement the required response. The UHN EPRR Manager facilitates the delivery of major incident training to staff, in addition to on-call training and specific sessions as required, and this has included:

- KGH and NGH ED staff have continued to deliver quarterly training days which focus on major incidents and CBRN response, including donning the Powered Respiratory Protection suits (PRPS) for clinical staff likely to wear them during HazMat or CBRN incidents.
- EMAS updated train-the-trainer course on HazMat / CBRN and PRPS has been offered again to Urgent Care staff across UHN.
- Loggist training ensures that UHN has sufficiently trained members of staff who can act as loggists during an incident. In addition, sessions have been developed to provide qualified loggists with refresher training in decision logging prior to assisting in the Incident Coordination Centre. The training has now fully restarted. As part of the training, loggists are also encouraged to attend some senior meetings in order to practice the logging of key decisions. During the period of this report the EPRR Team has trained 25 members of staff.
- NHS England Regional Team has, again, offered the Principles of Health Command training for Strategic and Tactical on-call staff. Unfortunately, members of staff are having issues in booking the training due to lack of spaces available. This has unfortunately continued post report dates, but NHS England aware of situation
- Business Continuity training started in February 2025. For the period in consideration, the EPRR Team has trained 18 members of staff. This training has been aligned with the new NHSE BC Framework 2023, and updated templates reflecting these standards are now in active use across UHN. This ensures that all preparedness activities are consistent with current national guidance and best practice.
- Major Incident Medical Management and Support: The Practical Approach at the Hospital (HMIMMS) courses held 3 full onsite courses at KGH to support the Command-and-Control educational requirements of both onsite and on-call commanders. Further 1-day shorter courses were delivered to staff from the Emergency Department across the year.

Several training events postponed last year due to delays in appointing a full-time EPRR Manager are currently being thoroughly reviewed or have already been implemented. For example, EPRR awareness training for all staff is now provided during new starter inductions.

As required by the Core Standards for EPRR, all corporate-level training and exercising is based on the NHS England's Minimal Occupational Standards and referenced to the National Occupational Standards for Civil Contingencies.

The following exercises have taken place over the 12 months period (Sep 2024 - Aug 2025):

- Cyber Security Exercise 24/10/2024, a multi-agency tabletop exercise organised by NHSE and the ICB and based on real cyber security threats.
- Exercise Tangra 08/04/2025 - Pandemic Influenza local ICS response
- Exercise Amnis 09/05/2025 ICB Multi Agency Emergency Discharge Cell (MAED) exercise
- Exercise Toucan 25 12/05/2025 – NHSE unannounced cascade exercise
- Exercise Silver Siren 13/05/2025 – RAF Bi-annual live exercise – UHN and health parallel Mass Casualty Tabletop Exercise
- Exercise Echo One 26/06/2025 - Northants/LLR Pan ICS Cyber Exercise

Staff who have attended exercises have found them to be enjoyable and informative with lots of new and useful information discussed.

3. List of Business Continuity, Critical Incidents and Major Incidents experienced

Incidents reported to the ICB (period 01 September 2024 – 30 August 2025):

Organisation	Incident type (e.g. critical, major, business continuity)	Date(s) of incident (day month year)
Northampton General Hospital NHS Trust	Op Yeovil – Northamptonshire flood	Sunday 22 Sept 2024 to Monday 07 October 2024
Kettering General Hospital NHS Foundation Trust	Op Yeovil – Northamptonshire flood	Sunday 22 Sept 2024 to Monday 07 October 2024
Northampton General Hospital NHS Trust	NGH ED Symphony PAS outage	11/10/2024
Kettering General Hospital NHS Foundation Trust	UHN Critical Incident (Capacity)	19/11/2024
Northampton General Hospital NHS Trust	UHN Critical Incident (Capacity)	19/11/2024
Kettering General Hospital NHS Foundation Trust	UHN Critical Incident (Capacity)	07/01/2025 – 11/01/2025
Northampton General Hospital NHS Trust	UHN Critical Incident (Capacity)	07/01/2025 – 11/01/2025
Kettering General Hospital NHS Foundation Trust	UHN Critical Incident (Capacity)	28/01/2025
Northampton General Hospital NHS Trust	UHN Critical Incident (Capacity)	28/01/2025
Kettering General Hospital NHS Foundation Trust	Burst Pipe in Rockingham Wing	20-21/04/2025
Kettering General Hospital NHS Foundation Trust	Resident Doctors Industrial Action	25-30/07/2025
Northampton General Hospital NHS Trust	Resident Doctors Industrial Action	25-30/07/2025

Weather related alerts received:

Date(s) of incident (day month year)	Type of Alert	
18/11/2024	Amber Cold Weather alert	AMBER alert, in place from Monday 18 November 10am until Saturday 23 November 6pm

02/01/2025	Amber Cold Weather alert	Alert in effect from 12PM on 02/01/2025 until 12PM on 08/01/2025 across the East Midlands. The amber alert has a matrix score of 12.
03/01/2025	Amber Snow and Ice alert	Alert in effect between 18:00 (UTC) on Sat 4 Jan 2025 and 12:00 (UTC) on Sun 5 Jan 2025
06/01/2025	Amber Cold Weather alert	The amber cold health alert is in effect from 12PM on 06/01/2025 until 12PM on 12/01/2025 across the East Midlands. The amber alert has a matrix score of 12.
06/01/2025	Amber Cold Weather alert	cold health alert is in effect from 12PM on 06/01/2025 until 12PM on 12/01/2025 across the East Midlands.
09/01/2025	Amber Cold Weather alert	The amber cold health alert is in effect from 12PM on 09/01/2025 until 9AM on 14/01/2025 across the East Midlands. The amber alert has a matrix score of 13.
19/06/2025	Amber Hot Weather alert	The amber heat health alert is in effect from 12PM on 19/06/2025 until 9AM on 23/06/2025 across the East Midlands. The amber alert has a matrix score of 12.
26/06/2025	Amber Hot Weather alert	The amber heat health alert is in effect from 12PM on 27/06/2025 until 6PM on 01/07/2025 across the East Midlands. The amber alert has a matrix score of 12.
30/06/2025	Amber Hot Weather alert	The amber heat health alert is in effect from 10AM on 30/06/2025 until 9AM on 02/07/2025 across the East Midlands. The amber alert has a matrix score of 12.
11/07/2025	Amber Hot Weather alert	The amber heat health alert is in effect from 12PM on 11/07/2025 until 9AM on 14/07/2025 across the East Midlands. The amber alert has a matrix score of 12.
11/08/2025	Amber Hot Weather alert	The amber heat health alert is in effect from 9AM on 12/08/2025 until 6PM on 13/08/2025 across the East Midlands. The amber alert has a matrix score of 12.

Summary of Weather Alerts (Nov 2024 – Aug 2025)

Cold Weather Alerts (Nov 2024 – Jan 2025)

- **Amber Alerts:**
    - 18 Nov 2024: West Midlands (18–23 Nov), matrix score not stated
    - 02 Jan 2025: East Midlands (2–8 Jan), matrix score 12
    - 06 Jan 2025: East Midlands (6–12 Jan), matrix score 12
    - 09 Jan 2025: East Midlands (9–14 Jan), matrix score 13
- **Amber Snow & Ice:**
    - 03 Jan 2025: East Midlands (4–5 Jan)

Hot Weather Alerts (Jun – Aug 2025)

- **Amber Alerts:**
    - 19 Jun 2025: East Midlands (19–23 Jun), matrix score 12
    - 26 Jun 2025: East Midlands (27 Jun–1 Jul), matrix score 12
    - 30 Jun 2025: East Midlands (30 Jun–2 Jul), matrix score 12
    - 11 Jul 2025: East Midlands (11–14 Jul), matrix score 12
    - 11 Aug 2025: East Midlands (12–13 Aug), matrix score 12

Key Points:

- **Cold weather alerts dominated Nov 2024–Jan 2025**, with multiple amber alerts and matrix scores up to 13.
- **Hot weather alerts were frequent from June to August 2025**, including several amber alerts with matrix scores of 12.

4. Lessons identified and learning undertaken from incidents and exercises

4.1. Op Yeovil –Northamptonshire flood

Op Yeovil –Northamptonshire flood - Sunday 22 Sept 2024 to Monday 07 October 2024 lessons identified

4.1.1. Aspects that went well:

EMAS Silver Cell proactively avoided improper hospital admission of patients on 26/09

4.1.2. Aspects for improvement:

Perceived requirement for increased stakeholder representation. This gave rise to UHN having a reduced potential for situational awareness of the developing incident

4.1.3. Recommendations

Further work to be completed on sharing of key information post Tactical Co-ordination Group calls with dissemination to relevant LRF/LHRP stakeholders

4.2. ED Patient Administration System Outage

4.2.1. Aspects that went well

The emergency department remained functional and had maintained patient and staff safety while pressurised.

Digital downtime contingency boxes were readily available following the appropriate agreed trigger to move to business continuity plans

Corporate memory of colleagues from previous downtimes supported the response well

4.2.2. Aspects for improvement

Reduced operational situational awareness, i.e. tracking times of patient attendances

Internal communications to staff and stakeholders were not consistent in frequency

Parent company for software deemed to not be as responsive as expected

4.2.3. Recommendations

Highlighted area of site not owning their own BCP- for review and support to complete

Table-Top exercise – to have some focus on non-digital functioning

Robust and regular communications both internally and externally, with corporate sign off.

4.3. Broken pipe in Rockingham Wing

4.3.1. What went well?

All relevant key internal and external stakeholders responded well. Agreement on actions was regular and well structured. Fire and Rescue Service and EMAS responded and supported well.

Good local site awareness

Communications across all responders was very good, with the internal teams involved performing local debriefs.

Service users remained safe, and all cared for with minimal disruption.

4.3.2. What didn't go so well?

Security team pressured in response

Communications for getting support could have improved, with clear understanding of escalation and support routes. On-call colleagues at sister site not immediately informed, and not "stood down" at end of incident

Local incident management policies and procedures misleading and require updating

Local BC plans require update to provide realistic options for where patients, staff, and supporting facilities can be relocated to (mitigated by local site awareness at time of incident)

An area in Rockingham was used which was deemed unsafe for use. Comms on handovers, simulating scenarios around BC options.

4.3.3 Lessons identified

Local Security Management Specialists (KHG+NGH) and the UHN EPRR Team working collaboratively to update Lockdown Plans into single UHN Lockdown Plan. Part of this is reviewing staff compliments 24/7/265

Alert Cascade system contract extended for one year and to comprehensively cover all UHN sites and specialties. Stand down messaging review and revamped as part of Alert Cascade service contracting.

Communication to relevant stakeholders including both Site Teams and on weekend plans to pass on messages relating to incidents to ToC and/or SoC both for information and action.

KGH Incident Response Plan (generic response to business continuity, major, and critical incident response) + NGH Major Incident Plan are being amalgamated as part of continued Group working. Stand by, BC, MI, and Critical Incidents declaration and communication detailed.

4.4. Exercise Silver Siren 13/05/2025 – UHN and health sector Mass Casualty Tabletop Exercise

Category	What Went Well	What Went Not So Well	Actions Decided
Team Engagement	Strong multidisciplinary participation Staff willing to learn and collaborate	Some departments felt rushed and underprepared	Include departments earlier in planning Continue tabletop exercises
Communication	Good internal team collaboration	Poor communication from EMAS Delay in major incident declaration Switchboard and staff unclear on processes	Clarify declaration process Improve liaison with EMAS Finalize telephone cascade plans Add risks to corporate risk register
Training & Awareness	ED teams showed strong preparedness	Lack of major incident training for executives General staff unaware of procedures	Mandate training for senior leaders Expand awareness and training trust-wide
Facilities & Logistics	Kettering's portering and facilities teams had strong plans	Difficulty contacting specialist teams Limited access to ICC room	Develop robust systems for specialist team contact

Category	What Went Well	What Went Not So Well	Actions Decided
			Clarify ICC stand-up location
Business Continuity	Recognition of need for continuity planning	Over-reliance on digital systems	Update business continuity plans Ensure paper backups are available
Phone calls		People calling will use a different terminology to contact Tactical / Strategic (Site Manager etc.)	Follow up emails after information passed
Discharge Cell	Very good concept about support and discharges		
Welfare / Wellbeing		Staff not taking breaks or looking after welfare / wellbeing	Remind staff to consider welfare / wellbeing

5. 2025 Organisational assurance summary

NHS England requires providers of NHS funded care to offer assurance surrounding their EPRR readiness through the annual National EPRR Core Standards process.

The annual assurance process for 2024 (August submission) was led by the ICB with assessment by the systems EPRR function. To ensure regional and nationwide

cohesion, transparency and consistency, assessment identical to ICB requirements was completed by NHS England Midlands EPRR Team.

A deep dive was also undertaken in relation to current cyber security arrangements. Specific results from this highlighted the need to broaden and include different cyber security scenarios and enhance planning.

Both Trusts were deemed non-compliant to the EPRR Core Standards. In order to achieve overall partial compliance 77% of standards need to be fully compliant, substantial compliance is at 95%, and fully compliant 100%.

On a total of 62 standards applicable to each Trust, results are as follow:

KGH: 17 were assessed fully compliant (27%), 44 partially compliant (71%) and 1 non-compliant (2%).

NGH: 19 were assessed fully compliant (31%), 42 partially compliant (67%) and 1 non-compliant (2%).

The overall full compliance has decreased, partial compliance has increased,

Details of KGH submission:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	4	2	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	2	9	0
Command and control	2	0	2	0
Training and exercising	4	0	3	1
Response	7	2	5	0
Warning and informing	4	0	4	0
Cooperation	4	4	0	0
Business Continuity	10	2	8	0
Hazmat/CBRN	12	1	11	0
Total	62	17	44	1

Details of NGH submission:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	4	2	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	1	10	0
Command and control	2	0	2	0

Training and exercising	4	0	3	1
Response	7	2	5	0
Warning and informing	4	0	4	0
Cooperation	4	4	0	0
Business Continuity	10	2	8	0
Hazmat/CBRN	12	2	10	0
Total	62	17	44	1

Organisation	2022/2023	2023/2024	2024/2025	Predicted 2025-2026	Predicted 2026-2027
Kettering General Hospital NHS Foundation Trust	Non-Compliant	Non-Compliant	Non-Compliant	Partial compliance as minimum expectation	Substantive/ Full compliance
Northampton General Hospital NHS Trust	Non-Compliant	Non-Compliant	Non-Compliant	Partial compliance as minimum expectation	Substantive/ Full compliance

6. Current Compliance Levels and Future Steps

The table below outlines key compliance indicators, their status, and the planned activities to address any gaps for the period 2025/26. The indicators include group working as it is currently implemented across the two Trusts.

Planned activities to enhance compliance include implementing corrective actions for non-compliance issues, addressing recommendations identified through the confirm and challenge process, and launching a comprehensive training program to ensure 100% completion.

The one non-compliant standard is now fully compliant, with an EPRR session on the “Welcome to the Group” induction days.

Indicator	Current Status	Planned
Strengthen the collaboration between KGH and NGH to align the Emergency Planning Team objectives	Group EPRR Manager and Head of Resilience and Business Continuity working across both sites at least twice a week to enhance visibility	Team accessibility across sites with at least 4 out of 5 working days with EPRR practitioner cover on each site
Shared policies and plans to unify the response, although site individualities are	Significant inroads to overarching Group Plans and Policies.	Incident Response Plan, Mass Casualty, Mass Countermeasure, Incident Command Centre,

recognised and best practices embraced	Incident Response Plan, Pandemic, Adverse Weather, Critical Threat Level Rise	Pandemic, HCID Plans all at last stages of development/ consultation
Management of the UHN Emergency Planning Committee	UHN Emergency Planning Committee ToR reviewed. Bi-monthly full meeting with alternate month smaller policy/plan approval meeting	Further need to gain appropriate representation from key stakeholders from UHN teams
Duty to risk assess	Each risk reviewed bi-monthly at Emergency Planning Committee.	Potential merger onto single risk register with site specific risks as necessary
Exercising	Recognition of increased need for plan validation through exercising, and compliance with regulations	Live exercises planned: NGH for HazMat (March 25) KGH for HCID (May 25) Group Mass Casualty in June 2026 as tabletop
Education	HMIMMS courses currently run at KGH only (registered course centre)	In 2026 3 full HMIMMS courses will run from NGH as well as 3 from KGH to support the training and education of onsite and on-call commanders. Further 1 day courses will run to support NGH ED
Communication	The Group usage of AlertCascade as its means of emergency informing of staff has become challenging	Project being lead by Head of Resilience and Business Continuity to manage system to make fully operational
Business continuity	Business Continuity workshops in place monthly at each site to support the development of operational level business continuity plans	Annual cycle of attendance to BCP workshops to validate each BCP against different exercise scenarios within the workshops
	Electronic equipment checklist put in place to aid ED colleagues in monthly checking. Hazmat training days to	Hazmat training days to include specific exercise scenarios to validate the operational learning and plans.

	include specific exercise scenarios to validate the operational learning and plans	Group Hazmat plan to be developed with input from ED Leads

Cover sheet

Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item	11

Title	Corridor Care
Presenter	Richard Clarkson - Group Associate Chief Nurse (UHN/UHL) - Urgent and Emergency Care
Authors	Robin Binks – Director of Nursing Anna Duke – Head of Nursing

Link to Group Priorities (select all that apply):		
X Transform Patient Care	X Strengthen our Culture	X Deliver our financial plan
Improves safety, dignity and patient experience by reducing corridor care.	Supports safe staffing, staff engagement and standardised practice.	Supports improved flow and reduced inefficiency from delays.

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

Reason for consideration	Previous consideration
To provide Boards with assurance on corridor care controls, gaps and improvement actions across KGH and NGH	Derived from routine UEC performance reporting for Q3 (Oct–Dec 2025).

Executive Summary

This paper seeks to provide assurance to the Boards on the current position, risks, and improvement actions relating to corridor care across University Hospitals of Northamptonshire (KGH and NGH). Corridor care, which is defined as the temporary placement of patients in non-designated spaces, continues to be used during periods of significant Emergency Department (ED) pressure, including overcrowding, ambulance handover delays, and prolonged waits following decision to admit.

Using performance data and quality intelligence from October–December 2025, the paper benchmarks current practice against the Healthcare Safety Investigation Branch (January 2026) recommendations. While UHN compares positively overall, several gaps remain, particularly in estate capacity, patient flow constraints, workforce availability, and inconsistent audit and governance processes. These gaps continue to present risks to patient experience, safety, and dignity.

A comprehensive improvement plan is in place, covering immediate actions such as audit alignment and strengthened oversight, medium-term measures including digital tagging and improved incident capture, and longer-term estate and workforce development to reduce reliance on corridor care.

The Boards are asked to indicate assurance that controls are being strengthened, note the key gaps and associated risks, and endorse the ongoing improvement actions and long-term plans to reduce the need for non-designated care spaces.

Appendices

Appendix 1: NSIB gap analysis

Risk and assurance

Relates to Emergency Department (ED) overcrowding and ambulance handover risks at both sites and associated patient safety/experience impacts. UHN15: If there is insufficient capacity to meet the demand on services patients will wait longer for urgent and emergency care, elective care and cancer care leading to patient harm, compromised clinical outcomes and experience.	Key references: KGH CRR011/KCRR015; KGH ID5033; NGH 5699; NGH 5768; NGH 6159; NGH 5771. Actions strengthen controls via SOP, audits and oversight.

Financial Impact

Work to reduce corridor care may require temporary staffing uplift and investment in pathway/estate solutions; funded status to be confirmed through divisional and corporate processes. Every effort is made to utilise existing staff to care for this group of patients.

Legal implications/regulatory requirements

Corridor care expectations are aligned to national minimum care standards for safe and dignified care; SOP and audit alignment strengthen compliance and assurance.

Equality Impact Assessment
Corridor care can impact vulnerable groups, such as older adults or those with impairments. Mitigations involve identifying appropriate patients, improving observation, and prioritising de-escalation.

Paper

Situation
KGH and NGH are currently encountering substantial operational challenges in their Emergency Departments (ED), which may require the provision of temporary care in areas not designated for patient treatment, such as corridors. This document outlines existing controls, highlights identified gaps, and details ongoing measures to enhance patient safety and governance.
Background
Corridor care refers to the temporary placement of patients in non-designated spaces. Across UHN this has been in place since 2022 and has previously been referred to as rapid flow, boarding, temporary escalation space and release to respond. In accordance with NHSE guidance (December 2025) across UHN we will update our policies to reflect this recommendation and refer to these spaces as corridor care. At UHN, corridor care is utilised during periods of ED congestion, ambulance offload delays, overcrowding, and prolonged waits following decision to admit (DTA). Such pressures are evident across both sites, and it is also experienced by other acute providers.
Assessment

Current Practice Review:

The current practice at UHN has been reviewed against the HSIB (January 2026) standards for patient care in temporary care environments. This assessment draws on a range of operational metrics, including patient attendances, ambulance handover performance, time to initial assessment, and breaches in decision to admit (DTA).

In addition to operational data, the review considers key quality and safety indicators, such as reported incidents, complaints, and patient experience feedback. The assessment also evaluates the existing oversight and governance arrangements and highlights the ongoing and planned work to strengthen and standardise practice across both sites.

Identified Gaps:

The evaluation identifies several established gaps that continue to affect the safe and effective delivery of corridor care. These include estate constraints, linked to the age and configuration of the estate, which limit available capacity; periodic workforce shortages, which reduce the ability to provide consistent staffing cover; and ongoing patient flow challenges, which contribute to the continued reliance on temporary care environments.

Further gaps relate to incomplete audit and assurance processes and variability in governance structures and oversight across sites. Collectively, these issues impact the consistency, reliability, and quality of care provided in corridor areas and highlight the need for strengthened standardisation and oversight.

Benchmarking and Opportunities:

UHN benchmarks favourably against the HSIB (2026) recommendations, as outlined in Appendix 1. Nevertheless, there remains a significant opportunity to strengthen the organisation's oversight and assurance of corridor care environments, ensuring more consistent visibility, governance, and continuous improvement. Enhancing this oversight will support further progress in the safety, reliability, and quality of patient care delivered within these temporary care spaces.

Actions / Improvement Plan

Timeframe	**Action**	**Site(s)**	**Date**
Immediate (0–4 weeks)	Align corridor care audits on AMaT; increase audit compliance so every corridor care patient is audited, including time spent in corridor care.	KGH & NGH	27 February 2026
Immediate (0–4 weeks)	Ensure site meetings include who has been in corridor care the longest and agree a de-escalation plan.	KGH & NGH	27 February 2026
Medium (1–3 months)	Scope digital tagging to identify patients who have received corridor care and prevent repeated corridor care stays.	KGH & NGH	30 April 2026
Medium (1–3 months)	Strengthen incident capture: ensure DATIX captures falls	KGH & NGH	30 April 2026

	and other corridor care-related incidents consistently.		
Long-term (12+ months)	Deliver estate and pathway improvements (including UEC build developments and internal capacity work) to reduce overcrowding and reliance on corridor care.	KGH – planning underway NGH –build commenced	Spring 2027 August 2026

Recommendations

The Boards are asked to:

1. Receive this report and indicate assurance.
2. Note the current gaps in workforce, estate capacity, patient flow, and audit completeness.
3. Support implementation of strengthened audit/oversight via AMaT.
4. Endorse the delivery of the improvement of actions and the longer-term estate and workforce plans to reduce reliance on corridor care.
5. Delegate oversight of corridor care to the Quality and Safety Committee

Gap analysis against HSIB (2026) Recommendation on Corridor Care,

Assurance Domain	What the Board Needs to Know	Assessment	Key Risks Identified	Current Controls / Mitigations	Actions Required	Owner
Policy & Governance	A formal policy exists governing the use of temporary care environments, including risk mitigation strategies	Compliant	Non-adherence to the policy specifically patient placed in locations that have not been approved	Temporary escalation space policy in at UHN which outlines corridor care location with patient exclusion and inclusion criteria	Policy currently under review to reflect NHSE recommendations.	Richard Clarkson & Robin Binks
Patient Safety & Acuity	Patient severity, suitability and clinical risk are explicitly considered before placement	Compliant	Inconsistency in the assessment tool being used.	Assessment tool in place with an inclusion and exclusion criteria. Safety Nurse and streaming models in place; frequent safety huddles. New audit being rolled out from the 2nd 2026 February which will capture all patients in corridor care. Data currently captured on 2 different digital platforms. Daily review of corridor care locations by Ward Leaders and Matrons with prompt escalation of any concerns. DATIX system includes the patient in a corridor care space. As part of the harm review process, areas where the patient was treated are considered.	New audit tool to be rolled out on the 2nd February to support data collection of all patients in corridor care. Ensure the assessment tool is always used. Production of a live dashboard so we have increased visibility of patients in corridor care spaces.	Richard Clarkson & Robin Binks
Exclusion Criteria	Clear criteria define which patients must **not**	Compliant	There is a risk that in extremis some patients who do not meet the	There is a clear exclusion list in the release to respond policy for UHN. This is available to all	Continuous review of incidents	Divisional teams

	be placed in temporary care environments		criteria may have to be moved into corridor care to create capacity in the ED to offload ambulances	divisions, executive colleagues and site teams to ensure we are all making every effort to ensure the safety of our patients.		
MDT Oversight	Multidisciplinary input supports decisions on location and patient placement	Compliant	Sometimes the decisions are made later in the day so there is a risk that not all patients will have oversight of who is being moved into corridor care.	Medical and nursing colleague work collaboratively to identify patients for corridor care places. MDT colleagues have been involved in the development policy. Staffing cells/site meetings and senior decision maker presence support oversight. Medical staff completing board rounds including corridor care patients in the day to review and deescalate as soon as possible. All corridor care locations have been reviewed by the fire officer and Infection prevention control.	Continuous engagement with colleagues to ensure the policy is current. Involve corporate teams in the identification of corridor care spaces	Richard Clarkson & Robin Binks
Staffing Capacity	Staffing ratios are defined and safe for temporary care environments	Compliant	Temporary workforce gap whilst additional colleagues are being identified to deliver corridor care.	Staffing ratios agreed for each area across the organisation. Staffing numbers are reviewed twice daily as part of the staffing cell. If required, colleagues	Monitoring incidents	Governance team

				are redeployed to facilitate corridor care. Escalation to the Director of Nursing if staffing levels are unsafe and corridor care cannot be facilitated. Staff staffing incident formulate part of the safer staffing report that goes to NHAMP committee.		
Workforce Capability	Skill mix, experience and competencies are appropriate to patient need	Green		Registered nursing staff are appropriately allocated via the staffing cell and in the local clinical area to ensure the right staff with the right skills are in place.	On going monitoring	Workforce lead

Cover sheet

Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item	12

Title	Annual Establishment Reviews (Safe Staffing)
Presenter	Richard Clarkson, Group Associate Chief Nurse (UHN/UHL), Urgent and Emergency Care
Authors	Jillian Floody Interim Lead Nurse for Workforce and Jo Dilley, Deputy Director of Nursing, Workforce and Education.

Link to Group Priorities (select all that apply):		
x Transform Patient Care	x Strengthen our Culture	X Deliver our financial plan
By having a evidence based workforce establishment with the right skills, in the right place at the right time. **We will go further in integrating clinical and corporate services across UHN, delivering seamless pathways and improving safety and outcomes for our patients**	**We will foster a learning culture, rolling out our 'Improving Together' continuous improvement methodology and giving teams the tools to improve care, experience, and productivity**	**We will deliver our workforce plan as a key component of financial plan delivery.**

This paper is for			
x 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 October/November 2025 Annual Establishment Reviews provide assurance all wards and departments are safely staffed utilising the Principles of Safe	The paper has been presented and approved at Integrated Leadership Team on 26 January 2026. The results of the 2025 Biannual review were presented to Boards in October 2025.

Staffing (evidence-based tools and data, outcomes and professional judgement). There is evidence of good compliance with the Developing Workforce Safeguards (2018), which state that reviews should be received by Boards.	

Executive Summary

The purpose of the report is to present the results of the annual establishment reviews to the Boards, which commenced for UHN Nursing and Midwifery in August 2025, to receive assurances regarding compliance from the Medical Director and Chief Nurse, and to seek approval of the recommended Nursing & Midwifery establishments.

Summary of key issues

1. 2026 establishment reviews should continue to focus on adequate registered skill mix proportion
2. UHN spring biannual review will continue to monitor and review Enhanced Therapeutic Observations & Care (ETOC) demand & capacity
3. 2026 annual establishment review should consider alignment of headroom % with UHL
4. Further effort is required to ensure 2026-27 financial budgetary alignment with approved Nursing establishments as discrepancies continued throughout the 2025 establishment reviews.
5. Further UHN alignment of establishment review processes will be completed in readiness for the 2026 annual review
6. Further embedding of the red flag process via the SafeCare application is required by the NGH divisional nursing teams. This will be supported by training and education from the NGH Safe Staffing Matron.
7. The October/November 2025 Annual Establishment Review provides assurance all wards and departments are safely staffed utilising the Principles of Safe Staffing (evidence-based tools and data, outcomes and professional judgement). There is evidence of good compliance with the Developing Workforce Safeguards (2018 link).
8. UHN total overall whole-time equivalent variance gives rise to a cost pressure of £844,696 against current Nursing pay budget; however, 2026 recommended establishments should be achieved within the current financial envelope as included within current outturn.

Recommendations

The Boards are requested to:

1. Indicate assurance that the wards and departments are safely staffed utilising the Principles of Safe Staffing (evidence-based tools and data, outcomes and professional judgement);
2. Accept the recommendations from the UHN Chief Nurse and UHN Medical Director that there is reasonable compliance with the Developing Workforce Safeguards and that staffing is safe, effective and sustainable. Evidence for compliance is provided in the report at appendix 1, and.
3. Support the proposal for proposed changes to nursing and midwifery establishments, set out in the appendix.

Appendix
Appendix 1: KGH and NGH annual establishment reviews 2025
Risk and assurance

UHN11 (safety culture), 13 (attract and retain staff) and 19 (workforce controls)	This paper demonstrates recommendations for investment to meet safe staffing requirements as per SNCT recommendations. Failure to meet these recommendations poses risk for patient harm levels, staff retention and correct skill levels within the patient workforce.

Financial Impact
There is a recommended investment of £844,696 across the UHN group. However, 2026 recommended establishments should be achieved within the current financial envelope as included within current outturn. Further work is required to ensure 2026-27 financial budgetary alignment with approved nursing establishments as discrepancies continued throughout the 2025 establishment reviews.
Legal implications/regulatory requirements
Regulatory requirement as specified in ‘reason for consideration’ section above.
Equality Impact Assessment
Neutral: the report provides an analysis of staffing numbers, and does not refer to individual posts or postholders.

UHN Nursing and Midwifery

Evidence-based workforce planning

Annual Establishment Review 2025

Title:	UHN Nursing and Midwifery Annual Establishment Review Board Report 2025
Responsible Director:	Julie Hogg, Chief Nurse
Lead:	Julie Hogg UHN Chief Nurse and Robin Binks UHN Director of Nursing
Author:	Joanne Dilley UHN Deputy Director of Nursing for Workforce & Education, Jillian Floody NGH Interim Lead Nurse for Workforce

Purpose:	As per the National Quality Board (2016) pg. 15 'Expectation 1: Right Staff' and NHS Improvement (2018) pg. 11 'The planning cycle';
Key issues Summary:	• 2026 establishment reviews should continue to focus on adequate registered skill mix proportion • UHN spring biannual review will continue to monitor & review ETOC demand & capacity • 2026 annual establishment review should consider alignment of headroom % with UHL • Further effort is required to ensure 2026-27 financial budgetary alignment with approved Nursing establishments as discrepancies continued throughout the 2025 establishment reviews. • Further UHN alignment of establishment review processes will be completed in readiness for the 2026 annual review • Further embedding of the red flag process via the SafeCare application is required by the NGH divisional nursing teams. This will be supported by training & education from the NGH Safe Staffing Matron.
Recommendations :	• The October/November 2025 Annual Establishment Review provides assurance all wards and departments are safely staffed utilising the Principles of Safe Staffing (evidence-based tools and data, outcomes and professional judgement). Thereis evidence of good compliance with the Developing Workforce Safeguards (2018). • UHN total overall WTE variance 0.77 with cost pressure of £844,696 against current Nursing pay budget. However,*2026 recommended establishments should be achieved within the current financial envelope as included within current outturn.*

1. Introduction

1.1 This briefing provides the Board with an overview of the Annual Establishment Reviews which took place for Nursing & Midwifery in October and November 2025 utilising mean SNCT measured acuity & dependency and recommended staffing levels completed in October/ November 2024, February 2025 and June 2025. Midwifery establishment reviews utilised the nationally recognised & validated tool Birthrate Plus. The following format will be structured as per the 'expectations' set out by the National Quality Board's (2016) 'Safe sustainable and productive staffing' guidance.
In addition, this report includes organisational level of assurance against the NHSI Developing Workforce Safeguards (https://www.england.nhs.uk/wp-content/uploads/2021/04/Developing-workforce-safeguards.pdf 2018) (section 9) .

1.2 The reviews encompassed all inpatient areas, Emergency Department (ED) & Paediatric Emergency Department (PED); and Midwifery (aligned with birth rate plus recommendations). For detailed area by area presentations of the Annual Establishment Reviews, please refer to **Appendix 1**.

2. Background

2.1 **UHN**

Formal annual establishment reviews for both hospitals were conducted in 2024 (Appendix 2) with input from the NHSE Deputy Director & Safer Staffing Faculty CNO (see below for hospital summaries), providing assurance all wards and departments are safely staffed utilising the Principles of Safe Staffing (evidence-based tools and data, outcomes and professional judgement). Both hospital reviews included organisational level of assurance against the NHSI Developing Workforce Safeguards (https://www.england.nhs.uk/wp-content/uploads/2021/04/Developing-workforce-safeguards.pdf 2018).
2025 Spring biannual reviews (Appendix 3) were also conducted in both hospitals providing oversight, monitoring and improvement of safe staffing across the Trust against 2025-26 establishments which were approved and adopted in the 2024 business planning cycle. This enabled operational management adjustments in accordance with NQB (2016) expectations of 'right staff' in the 'right place', at the 'right time' with the 'right skills'. The bullet points below outline the recommendations from the 2024 annual review 7 the 2025 spring biannual reviews.

KGH

- Further effort is required to ensure 2025-26 financial alignment with approved rosters & establishment within the Medicine division. This includes the removal of ETOC & skill mix adjustments within area budgets that are not aligned with the approved staffing plan.
- Further UHN alignment
- Further focus on the timely resolution of red flags via the SafeCare application is required by the divisional nursing teams. This will be supported by training & education from the Safe Staffing Matron.
- The one area requiring a more in-depth review was the joint area of Lamport & Twywell wards; the Medicine division had considered splitting this area into two individual wards for several years and establishment review identified a high harms profile. The review recommended that the split be conducted in accordance with professional judgement by the end of November 2024.
- The recommendation from the Chief Nurse and Medical Director is there is reasonable compliance with the Developing Workforce Safeguards and that staffing is safe, effective and sustainable (NHS Improvement, 2018).

NGH

- There continues to be various actions in ensuring financial planning is aligned across all applications, recruitment and retention, safe staffing metrics, the Safer Nursing Care Tool (SNCT) and workforce transformation.
- The recommendation from the Chief Nurse and Medical Director is there is reasonable compliance with the Developing Workforce Safeguards and that staffing is safe, effective and sustainable (NHS Improvement, 2018).
- Ensuring appropriateness of workforce planning, specifically noting enhanced therapeutic observation care of care (ETOC) and temporary staffing usage
- Further UHN alignment
- Continuing review of Registered % proportion for inpatient areas
- The monitoring of the alignment of financial ledger/ Allocate Optima (previously referred to as HealthRoster)/ ESR (initial meeting setting establishments 08/01/2025).
- Implementation and embedding of Red Flags; which coincides with the UHN Safe Staffing for Nursing and Midwifery Policy and Procedure

3. 2025 UHN Annual Review Recommendations

3.1 **Headroom Alignment**

UHN Alignment of 25% headroom across clinical areas requiring specialist national training requirements in the following areas; NGH ED, NGH Paediatric ED, NGH Paediatric inpatient wards, KGH ICU and UHN neonatal services

Skill-Mix Optimisation

Registered Workforce Optimisation

At KGH, opportunity for Registered optimisation has been identified in line with SNCT recommendations in the following areas: Barnwell B, ICU Renal Service, Skylark and Fotheringhay.

Registered Workforce Enhancement

To further strengthen RN:HCA proportions, enhancement of the registered workforce is recommended in:

- **NGH:** Abington, Brampton, Cedar, Creaton, Holcot, Knightley, Victoria, Rowan, Dryden, Althorp, Spencer
- **KGH:** ED, Paediatric ED, Lamport, Twywell, Ashton, DDU, ICU, LNU, PAU

Unregistered Workforce Realignment

To strengthen RN:HCA skill-mix proportions, realignment of the unregistered workforce is recommended in:

- **NGH:** Abington, Brampton, Cedar, Creaton, Hawthorn, Holcot, Knightley, Victoria, Rowan
- **KGH:** Paediatric ED, Clifford, MAU

The above recommendations are supported by the 3 SNCT data collection periods throughout 2024- 2025 and are aligned to the establishment recommendations with a RN benchmark of 65%.

Future Establishment Review Priorities

- Continue to focus on appropriate registered skill-mix, with an aspirational benchmark of 65% RN proportion.
- The UHN Spring 2026 biannual review will continue to monitor ETOC demand and capacity.
- The 2026 annual establishment review should consider alignment of headroom percentages with UHL.
- Additional work is required to ensure financial alignment for 2026–27, as discrepancies between establishments and budgets remained evident in the 2025 review.
- Further UHN alignment of establishment review processes will be undertaken ahead of the 2026 annual review.
- Continued embedding of the red flag process via the SafeCare application is required within NGH divisional nursing teams. Training and education will be supported by the NGH Safe Staffing Matron.
- Maternity establishment reviews have highlighted the need for further detailed service alignment, particularly within community pathways.

3.2 The recommendation from the Chief Nurse and Medical Director is there is good compliance with the Developing Workforce Safeguards and that staffing is safe, effective and sustainable (NHS Improvement, 2018). Evidence for compliance is provided in section nine of the report, demonstrating the DWS compliance report which was submitted regionally. The Board is asked to receive this report and note the ongoing plans to provide safe staffing levels within nursing, midwifery, and AHP disciplines across the Trust.

4. Expectation 1: Right Staff

4.1 UHN Evidence-based workforce planning

4.1.1 Evidence-based guidance

- UHN adheres to the recommendations set out in the "Safe staffing for nursing in adult inpatient wards in acute hospitals" guideline (National Institute for Health and Care Excellence, 2014); for example, incorporating ward factors (such as ward layout and size) into the Annual Establishment Review.
- UHN acknowledges and incorporates specialty safe staffing recommendations within the Annual Establishment Reviews; for example, compliance with the RCN & RCEM Nursing Workforce Standards for Type 1 Emergency Departments (Nursing-workforce-standards-for-Type-1-EDs-Oct-2020.pdf.

4.1.2 Workforce tool Safer Nursing Care Tool (the Shelford Group, 2023)

- The Nursing workforce tool utilised at UHN, is the Safer Nursing Care Tool (SNCT). In 2024-2025 performance of SNCT was completed utilising the updated 2023 version of the tool . Application included: data collection in October/ November 2024, February 2025 and June 2025 in accordance with the approved UHN SNCT cycle promoting internal validity of the audit results and ensuring capture of seasonal variability. These data sets resulted in calculation of *2025 SNCT establishment recommendations* based on mean acuity & dependency of the 3 data sets. The SNCT results are located within the 2025 establishment review document (**Appendix 1**).
- UHN has valid licences to utilise the following SNCTs: Adult Inpatient Ward, Acute Assessment Unit, Children & Young People and the Emergency Department tools. All inpatient areas within UHN are assigned the appropriately licensed SNCT; for example, Skylark & Disney Ward utilise the Children & Young People SNCT, whilst wards such as Knightley and Lamport use AIPW.
- UHN SNCT acuity and dependency data collection training occurred in accordance with the Safe Staffing Faculty recommendations for assessment to ensure rigour in the audit process and maintain reliability of the results. Further rigour was applied through a weekly senior nursing verification process.
- Stability & consistency of acuity & dependency data was referred to throughout establishment reviews and reduced variation was noted in the application of the levels of care (level 1c & 1d) that were introduced in the 2023 revised tool. Increased audit frequency (3 times per year), training & the verification process increase confidence levels in subsequent recommendations.
- Both hospitals have a budgeted Enhanced Therapeutic Observations & Care (ETOC) team who provide additional expert assistance with those patients meeting the Level 1c & level 1d acuity & dependency definitions. SNCT 2025 WTE averages were provided both including & excluding ETOC to identify areas where substantive ward establishments could reasonably absorb elements of ETOC demand. KGH will continue to implement its previously agreed recommendations (discussed at bi-annual review). At NGH, HCA templates have been adjusted to support a higher registered nurse proportion. As a result, some areas may have reduced capacity to deliver previously agreed ETOC recommendations within their existing establishment. This impact was not explored in detail during the review and will require dynamic risk assessment to ensure safe and appropriate deployment. (Please refer to section 6.3, slide 11).

Birthrate Plus®

- UHN Maternity establishment reviews were conducted utilising the Birthrate Plus® workforce tool
  - The KGH 2024 Birthrate Plus® workforce assessment was received October 2024.The current Midwifery staffing levels align with the recommendation of the report.
  - NGH Birthrate Plus® report was received in October 2023 and is due for review in 2026, safer staffing workforce leads are in discussion to plan this work. The current Midwifery staffing levels align with the recommendation of the report.

University Hospitals of Northamptonshire NHS Group

4. Expectation 1: Right Staff

4.2 Professional judgement

- RN proportion % is included within the Establishment Review document and was referenced throughout UHN Annual Establishment Reviews. The RN % proportion was a particular focus throughout reviews in conjunction with patient & staff outcome data to move towards a minimum 65% RN% as acuity indicates where appropriate. See Chart 1&2 below demonstrating current RN% vs post-review RN%
- The 2025 UHN establishment reviews incorporated the professional judgement framework (Savile et al 2023) advocated by NHSE & RCN Workforce Standards (2025) in both hospitals. Subsequent professional judgement templates were completed & submitted by Divisional Heads of Nursing and discussed at Annual Establishment Reviews; prompting discussions on specialty of service, the environment, staff feedback and the impact of these factors on workforce within the services.

Chart 1: KGH current RN% vs post-review recommended RN%

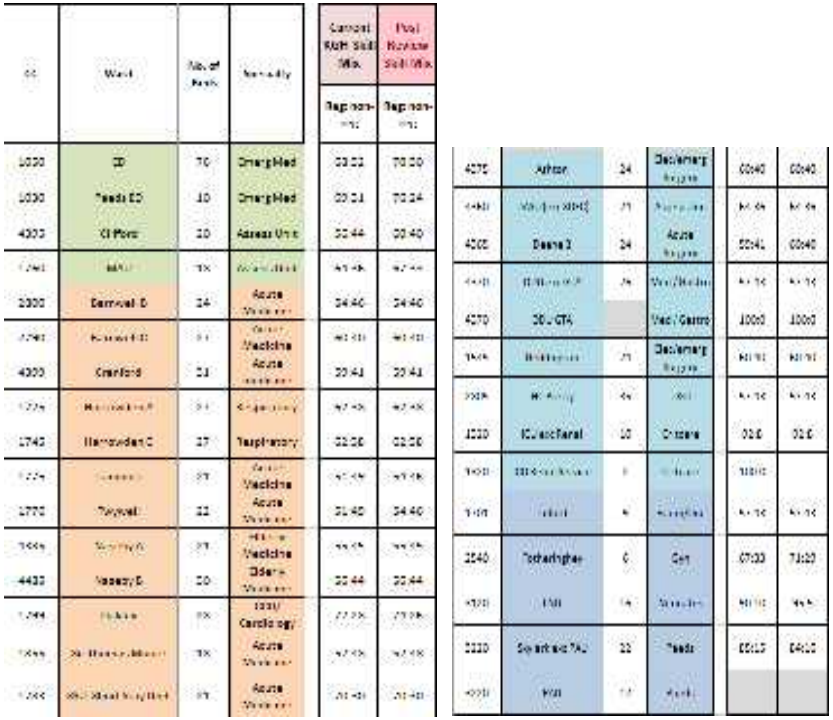


Chart 2: NGH current RN% vs post-review recommended RN%

Cost Centre	Ward	No. of Beds	Division / Speciality	Current NGH Skill Mix Reg: non-reg	Post Review Skill Mix Reg: non-reg
34225	ED		UEC	71:29	69:31
59221	Paeds ED		UEC	80:20	83:17
54225	Esther White	35	UEC AIPW	59:41	59:41
54219	Walter Tull	42	UEC AAU	58:42	58:42
33213	Abington	28	Medicine	48:52	56:44
59255	Allebone	27	Medicine	51:49	51:49
54215	Becket	26	Medicine Respiratory	52:48	52:48
54229	Benham	21	Medicine	69:31	69:31
59252	Brampton	27	Medicine	46:54	54:46
33212	Cedar	30	Medicine	50:50	56:44
54218	Creaton	28	Medicine	53:47	56:44
54217	Dryden	26	Medicine	66:34	65:35
59251	Eleanor	8	Medicine	47:53	56:44
54410	Finedon	18	Medicine	69:31	69:31
54213	Hawthorn	30	Medicine	51:49	56:44
54227	Holcot	7	Medicine	43:57	54:46
54218	Knightley	21	Medicine	44:56	51:49
59219	Victoria	18	Medicine	44:56	54:46
3211	Althorp	18	Surgery	66:34	65:35
22251	Collingtree A	22	Surgery	48:52	48:52
22253	Collingtree B	19	Surgery	55:45	59:41
33311	Compton	18	Surgery	56:44	56:44
39211	Head and Neck	14	Surgery	66:34	65:35
22252	Willow	28	Surgery	64:36	64:36
54216	Rowan	30	Surgery / Gastro	50:50	62:38
28111	ITU	16	Surgery / Critical Care	87:13	87:13
44214	Disney	19	Family Health / Paeds	79:21	70:30
44211	Paddington	28	Family Health / Paeds	81:19	80:20
44213	Gosset	20	Family Health / Neonates	86:14	86:14
	Maternity		Family Health / Obstetrics	76:24	69:31
62211	Talbot Butler	24	CSSCD	60:40	60:40
50219	Spencer	24	CSSCD /Gynae	66:34	68:32

University Hospitals of Northamptonshire NHS Group

4. Expectation 1: Right Staff Cont

4.2.1 Red Flags in nursing

- Red Flags are reported in accordance with the UHN Safe Staffing Policy & Standard Operating Procedure. NGH relaunched the Red Flag system in 2025 and staff training is ongoing. Red Flags were included within the 2025 Annual Establishment Reviews in addition to specified harms metrics for example falls, pressure ulcers & Nursing complaints.
- Maternity services utilise Red Flags via Birthrate Plus®
- Charts 3, 4 & 5 illustrate data relating to red flags raised via the SafeCare application & Datix incident reporting system
    - It is important to note that there is no key performance indicator (KPI) in relation to how many Red Flags are raised; Chart 2 demonstrates improvement required in responding to red flags ie the movement of open to a resolved / reviewed category

Chart 3: Monthly total Red Flags (Nursing, Sep-24 to Sep-25)

Chart 4: Staffing related Datix (Nursing, Sep-24 to Sep-25)

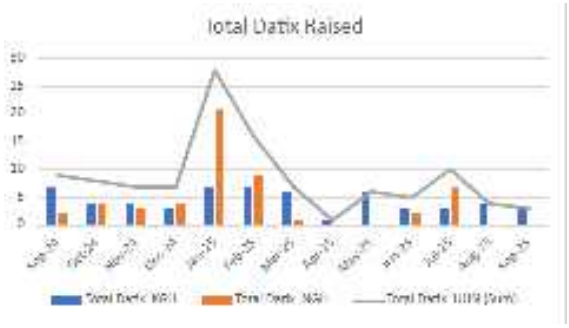
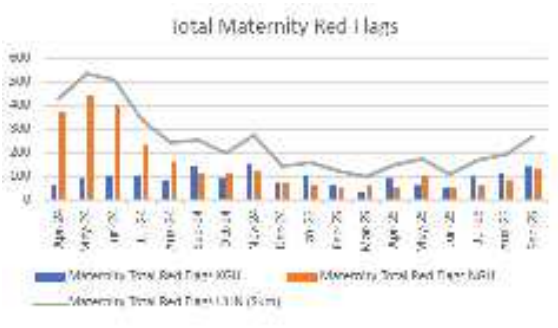


Chart 5: Total maternity Red Flags (Sep-24 to Sep-25)



4. Expectation 1: Right Staff

4.3 Compare staffing with peers

- The monthly UHN Safe Staffing report for Nursing and Midwifery includes comparison nationally and with peers in relation to Care Hours per Patient Day (CHPPD), as demonstrated below. KGH CHPPD indicated by the black bar (chart 10), NGH CHPPD is represented in chart 11. Both hospitals are equivalent to the national median and in the first half of quartile 3 when benchmarked against other national providers. This is an improved position for both hospitals in comparison with 2024 when both hospitals sat within quartile 4 nationally.
- UHN safer staffing metrics demonstrate organisational fill rates >80% in both registered and unregistered staff groups.

Chart 6: Inpatient Overall Fill Rate% Nursing and Midwifery Sep-24 to Sep 25

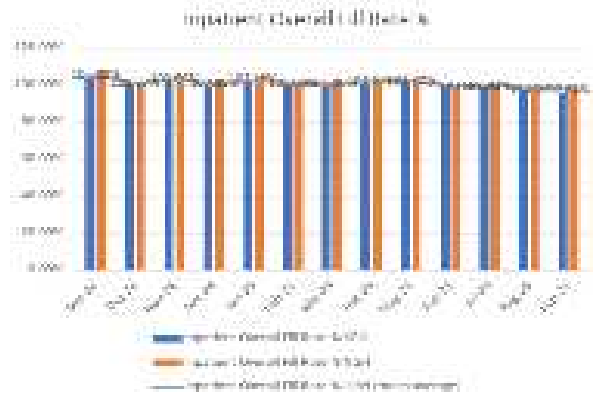


Chart 7: Registered Fill Rate % Sep-24 to Sep-25

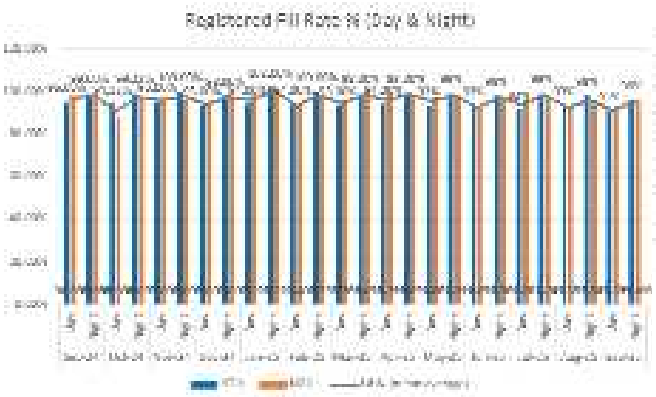


Chart 8: Unregistered Fill Rate % Sep-24 to Sep-25

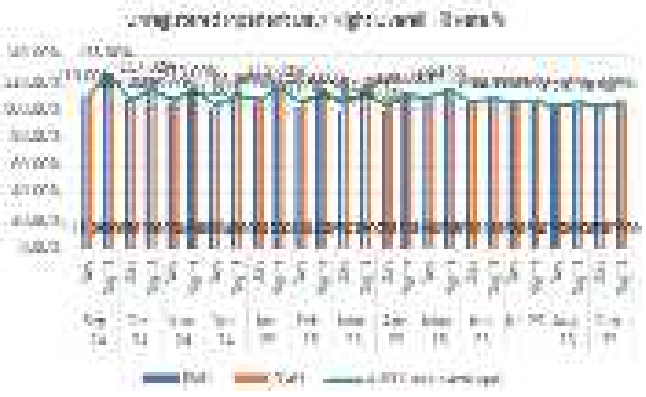
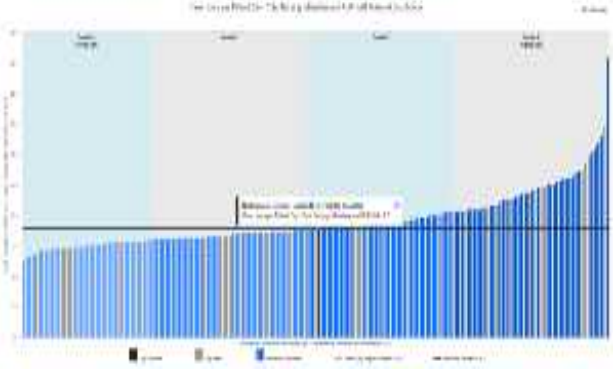


Chart 9: CHPPD Sep-24 to Sep-25

Chart 10: KGH CHPPD via Model Health Application: Aug-25

Chart 11: NGH CHPPD via Model Health Application: July 24



University Hospitals of Northamptonshire NHS Group

5. Expectation 2: Right Skills

5.1 Mandatory training, development and education

- Mandatory training and appraisal rates are reported by HR within the monthly performance dashboard and monitored via monthly divisional Performance Review meetings. This data was incorporated into the 2025 UHN establishment reviews in alignment with UHL practice. KGH also reported staff survey outcomes in relation to learning & development.
- Please also refer to the focus on registered: unregistered ratios in slide 5

5.2 Working as a multi-professional team

- The use of rostering to enable flexibility and productivity within one specialty was noted. This was particularly applicable to Maple and Lilford wards, where staff work flexibly across inpatient, SDEC and day-case areas within the same specialty.
- NGH continues to recognise the value of the Nursing Associate (NA) role, particularly on Rowan ward. The role strengthens RN supply by providing a structured development pathway, supports safe delegation, and contributes to a stable, skilled workforce. The intention is to continue embedding this role within the establishment, with individuals progressing through to RN training as part of the longer-term workforce plan.

5.3 Recruitment and Retention

- Budgeted establishment vs actual establishment and subsequent vacancies were included within the Annual Establishment Reviews.
- A successful recruitment centre in October 25 in relation to the ‘Graduate Guarantee’ positively impacted RN vacancy rates
- The Director of Nursing for Workforce and Education has recently reinforced the requirement for timely advertising of vacancies via TRAC, with posts verified ahead of recruitment centres. A recruitment and verification calendar is being developed for 2026.
- UHN continues to support unregistered international employees to attain UK NMC registration via internal OSCE.
- UHN also supports the Nursing Associate Student programme: further work is required in 2026 to review the Trust appetite for the programme and ensure aligned education & workforce planning. In addition, both hospitals support the Registered Nurse Degree Apprenticeship.
- Whilst UHN unregistered vacancy rates demonstrate a rising trend; the reviews’ focus on registered: unregistered staff ratios will reduce 2026 unregistered establishments and therefore vacancies.

Chart 12: UHN Registered Nursing Vacancy Rate (Oct 24 to Oct 25)

Chart 13: UHN Unregistered Nursing Vacancy Rate (Oct 24 to Oct 25)

University Hospitals of Northamptonshire NHS Group

5. Expectation 2: Right Skills

5.4 **Recruitment and Retention (continued.)**

- Both UHN hospitals hold the NHSE Preceptorship Quality Mark & will be working towards ensuring the same excellent practice for AHP colleagues
- Both hospitals hold the NHSE Pastoral Care award
- UHN is progressing well to meet the nationally required PNA to nurse ratio (1:20). NGH are currently achieving this and are the highest PNA to nurse ratio in the Midlands region and are 4th nationally. KGH currently are working at 1:31 ratio with further training places allocated for January 2026 to support meeting requirement.
- NGH currently have 78 PNAs with KGH having 43, giving a combined total of 121.
- PNA activity including restorative clinical supervision sessions are illustrated in Charts 14 & 15.
- Several reward & recognition programmes are embedded across UHN for Nursing and Midwifery including; Daisy Award, Daisy Leadership Award, Daisy 'in training' award, Rose award and Greatix.
- 25% headroom was included to facilitate specialist national training requirements & ensure UHN alignment in the following areas; NGH ED, NGH Paediatric ED, NGH Paediatric inpatient wards, KGH ICU and UHN neonatal services.

Chart 14: KGH PNA Activity Oct 24 – Oct 25

Chart 15: KGH PNA Activity Oct 24 – Oct 25

6. Expectation 3: Right Place and Time

6.1 **Productive working and eliminating waste**

- The UHN Safe Staffing for Nursing and Midwifery Trust Policy (2025) sets out considerations when redeploying staff as well as escalation guidance and scorecards when reviewing staffing.
- The UHN twice daily Staffing Cell monitors actual staffing against planned levels utilising live SafeCare data and local oversight
- The redeployment of staff is captured via Allocate Optima (previously HealthRoster)
- Divisional compassionate & effective rostering meetings monitor and act upon Roster metrics and are overseen by the Heads of Nursing. Terms of Reference have been revised and distributed across UHN for uniformity and consistency in assurances.
- The UHN Safe staffing team circulates weekly Bank & Agency utilisation data (please refer to slide 12)
- A monthly UHN Performance & Productivity meeting considers temporary staffing utilisation at Group, hospital and divisional levels with Heads of Nursing providing feedback with regards to rostering effectiveness.

6.2 **Efficient deployment and flexibility**

- The KGH final establishment review document (Appendix 1) includes detail of post-review agreed shift patterns; the approved review is shared with the HR Rostering team who ensure implementation into the next roster due for release.
- NGH establishment review document (Appendix 1) includes professional judgement which demonstrates the post-review shift patterns. Professional Judgement Templates were then shared with the finance business partners to establish the breakdown of these for budget setting.
- Adhering to the NQB (2016) recommendations; daily, there are operational *check-ins* for Senior Nursing Leaders to review staffing capacity and capability during the Staffing Cell. The Cell offers review of live acuity via the SafeCare application against staff availability with opportunity for internal mitigation for any shortfall.

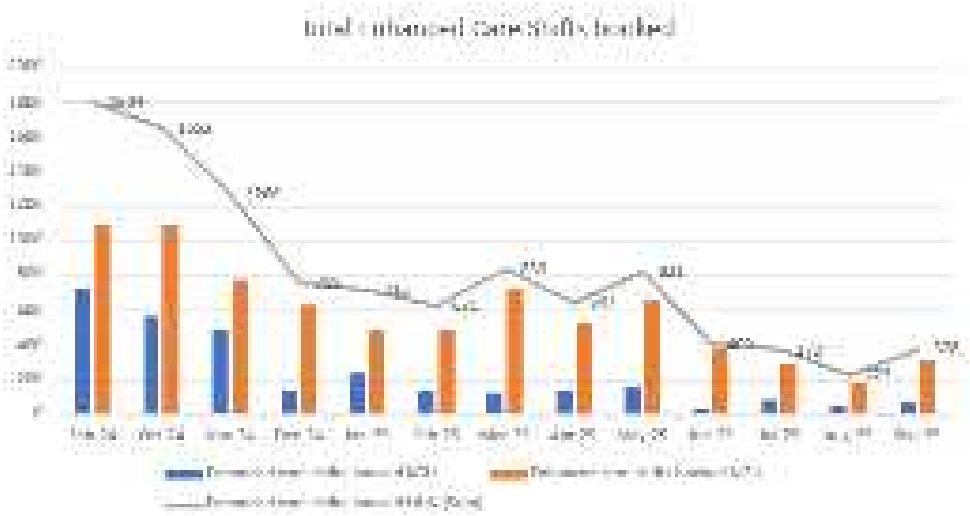
6. Expectation 3: Right Place and Time

6.3 Enhanced Care Team

- The Enhanced Therapeutic Observation and Care (ETOC) service operates across both UHN hospitals, providing enhanced supervision by specially trained staff for patients with complex needs. The team delivers person-centred therapeutic support—including distraction and de-escalation—to reduce the risk of harm to patients and others.
- UHN participated in an NHSE collaborative, concluding in January 2025, aimed at strengthening the appropriate use of the ETOC service. Chart 16 and 17 demonstrate the positive impact on spend and additional shifts booked across the UHN group (outside of the established ETOC service). At KGH the service is led by the Nursing & Quality Transformation Programme Lead, working jointly with the Interim Lead Nurse for Workforce at NGH to ensure enhanced care risk assessments are applied consistently so that patients receive the right support, in the right place, at the right time.
- Since the introduction of SNCT Levels 1c and 1d, both sites have focused on monitoring these patients and applying inclusion and exclusion referral criteria to ensure support is delivered appropriately and in the least restrictive manner.
- As part of the 2025 Bi-Annual Establishment Review, KGH identified wards where planned staffing meets ETOC recommendations and agreed a model to prioritise allocation of additional support to referred patients, where other wards were able to deliver agreed ETOC within their existing template. NGH also operates a model in which some wards have ETOC built into their establishment. Following the Annual Establishment Review, a number of wards adjusted HCA numbers to strengthen RN proportion. Ongoing dynamic risk assessments and referral processes will continue to ensure safe support for patients with enhanced care needs.
- The 2026 Spring Biannual review will introduce an aligned UHN approach to ETOC provision & establishment review.

Chart 16: UHN ETOC Expenditure Run Rate (additional to substantive posts), Sept 24 – Sept 25

Chart 17: UHN ETOC Monthly Shifts Booked (Sept 24 to Sept 25)



6. Expectation 3: Right Place and Time

6.4 Efficient employment and minimising agency

- UHN continues to focus on reducing reliance on agency, and temporary staffing utilisation. Nursing controls include assurance of roster alignment with establishment review, Charts 18 – 20 below depict UHN temporary staffing use from March 2025 when weekly monitoring was introduced.
- This weekly monitoring is shared with the executive team and the Performance & Productivity Committee
- UHN does not utilise agency for unregistered shifts
- UHN has ceased agency use on the base wards since April 2025, with exceptions continuing in ED and Theatres across the group

Chart 18: UHN Weekly Total Bank and Agency Hours 28 Feb 2025 – 04 Dec 2025

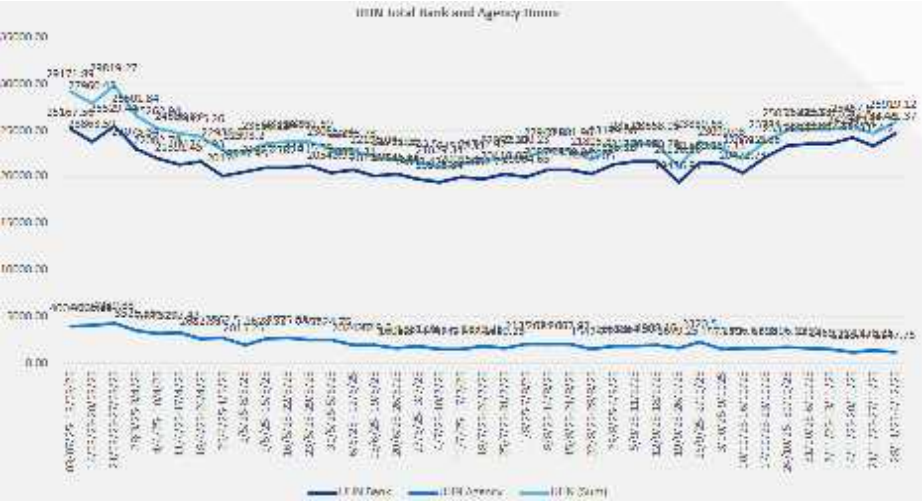


Chart 19: UHN Weekly Agency Usage hours 28 Feb 2025 – 04 Dec 2025

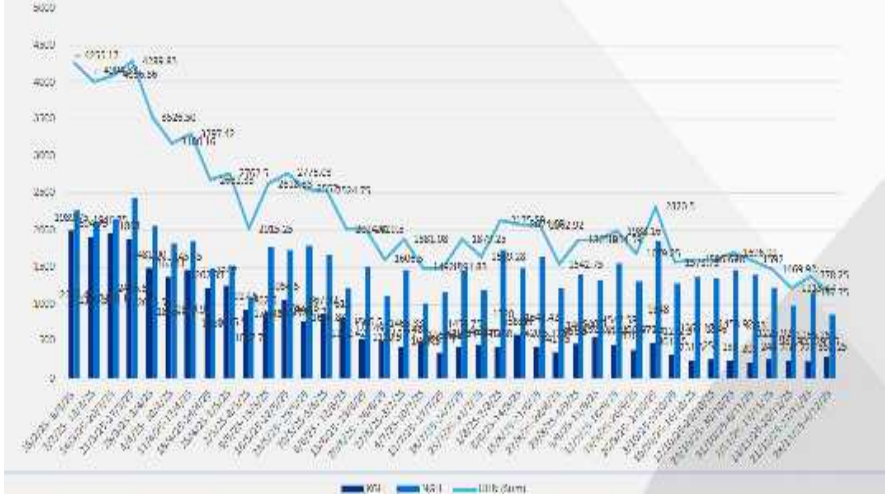
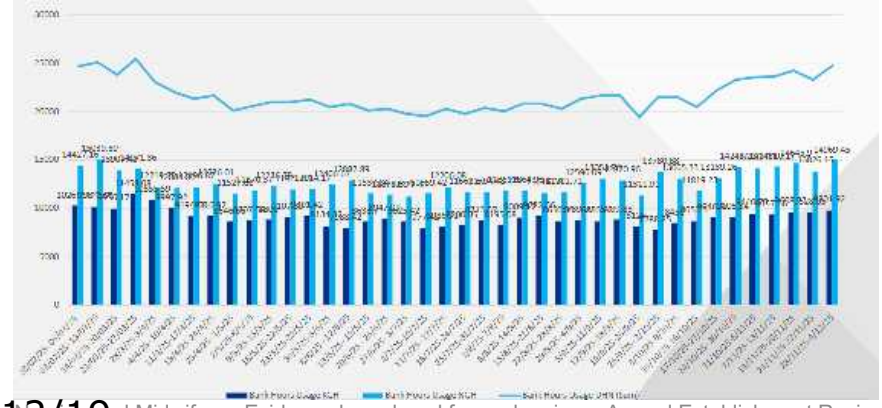


Chart 20: UHN Weekly Bank Usage hours 28 Feb 25 – 04 Dec 25



7. Measure and Improve

7.1 Patient outcomes

- The triangulation of safe staffing metrics and patient harms within establishment review is an essential component in the evaluation of safe staffing. UHN establishment reviews include both quantitative and qualitative harms data: inpatient falls, falls with harm, infection prevention & control incidences, pressure ulcers, Nursing related patient complaints & Nursing red flags.
- KGH Total harms for each area ranged from 1-180 with a mean of 90.
- Each area's harms profile was included within establishment review to support the evaluationof current staffing profile, professional judgement and SNCT recommendations (see Chart 21)

7.2 Assessment and Accreditation Programme

- The UHN Assessment and Accreditation (A&A) programme has been in place for many years. Award status was incorporated into the establishment reviews for the first time this year to enable consideration of the interface with safe staffing.

7.3 Staff Survey results

- KGH incorporated staff survey results in the 2025 Nursing Annual Establishment Review. This will be aligned in the 2026 UHN Annual Review.

Chart 21: KGH Harms Metrics Sept 24- Sept 25

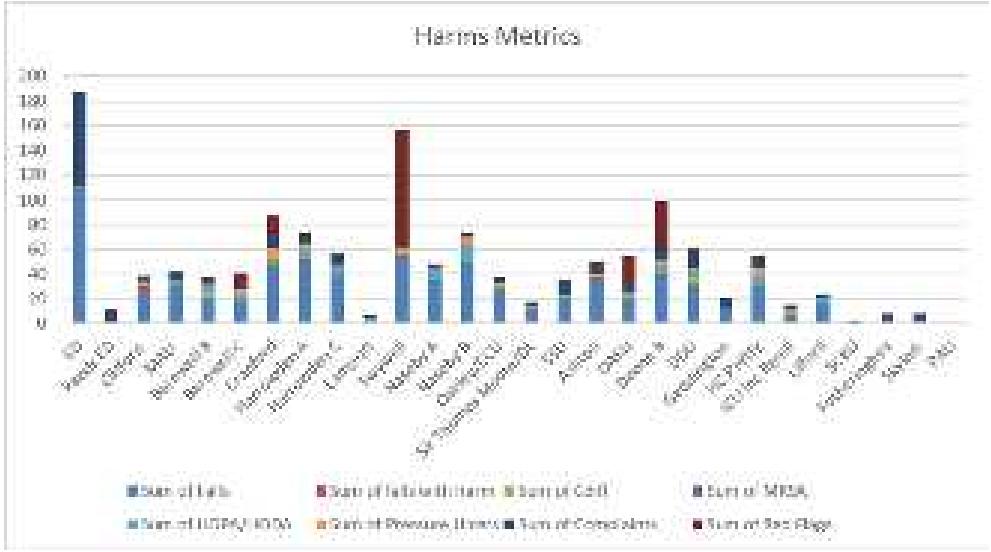
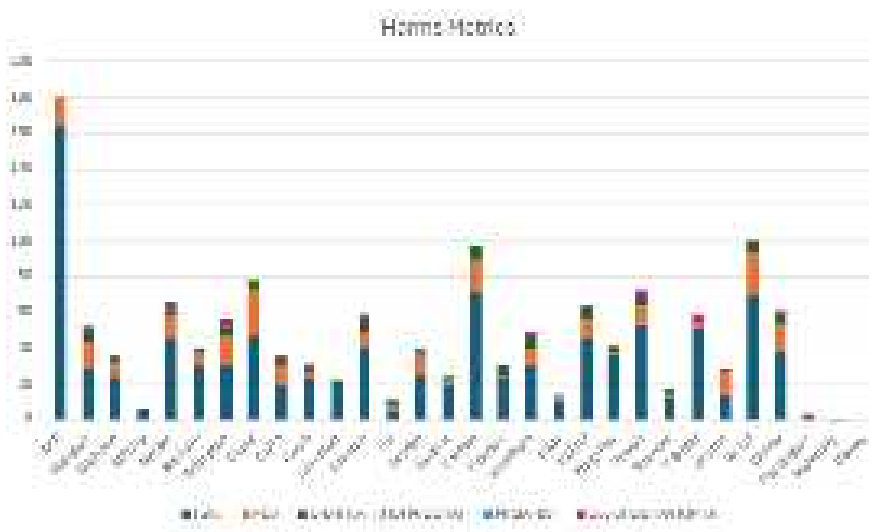


Chart 22: NGH Harms Metrics Jul 24 - Jul 25



8. Establishment / Financial Implications

8.1 The UHN recommended 2026 –27 establishments incorporate the following:

- UHN total overall WTE variance 0.77 with cost pressure of £844,696 against current Nursing pay budget
    - KGH: an overall +4.57 WTE variance with £446,671 pressure against current Nursing budget (*broken down by unit in chart 23)*
    - NGH: an overall -3.80 WTE variance with £398,025 pressure against current Nursing budget, (*broken down by unit in chart 24)*
- The above budgetary implications are funded within current financial outturn

Chart 23: KGH financial breakdown by unit

Unit	Decision WTE			Budgeted Establishment WTE			Proposed Uplift WTE				Proposed Uplift Annual Investment £			
	Reg WTE	Unreg WTE	Total Required WTE	Reg WTE	Unreg WTE	Total Budget WTE	Reg WTE B5 - B7	Reg WTE B4	Unreg WTE	Total WTE	Reg B5 - B7 £	Reg B4 £	Unreg £	Total £
ED	112.00	[illegible]	161.00	[illegible]	49.00	[illegible]	5.60		[illegible]	[illegible]	£284,118.00			£284,118.[illegible]
Paeds ED	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.00		2.00	[illegible]	£77,530.00		£116,790.[illegible]	[illegible]
Clifford	[illegible]	19.12	[illegible]	28.33	21.98	[illegible]	[illegible]		[illegible]	[illegible]			-£113,158.[illegible]	-£113,158.[illegible]
MAU	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]			£113,156.[illegible]	£113,156.[illegible]
Barnwell [illegible]	[illegible]	18.22	[illegible]	21.96	18.33	[illegible]	-0.80		[illegible]	-0.80	[illegible]			[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.06		[illegible]	[illegible]	£77,933.00			[illegible]
[illegible]	[illegible]	18.40	[illegible]	17.40	18.40	[illegible]	1.95		[illegible]	[illegible]	[illegible]			[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		1.76	1.76			£72,071.[illegible]	£72,071.[illegible]
Ashton	24.08	15.71	[illegible]	24.01	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]			[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.07	1.77	1.00	[illegible]	£77,333.00	[illegible]	[illegible]	[illegible]
DCC and [illegible]	[illegible]	19.12	[illegible]	24.14	18.98	[illegible]	2.19	-1.67	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.00	[illegible]	[illegible]	+0.77	[illegible]	[illegible]		[illegible]
ICU	[illegible]	[illegible]	[illegible]	[illegible]	5.47	88.54	[illegible]		[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
[illegible]	[illegible]	0.00	[illegible]	[illegible]	[illegible]	[illegible]	1.06		[illegible]	[illegible]	£77,633.00			[illegible]
[illegible]	45.20	2.80	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	6.00	0.00	6.00	[illegible]	[illegible]	[illegible]	2.17		[illegible]	[illegible]	[illegible]			[illegible]
Total Investment	670.47	263.81	934.28	565.00	[illegible]	833.11	+22.77	-5.30	-12.90	+4.57	+£1,175,946	-£204,033	-£526,212	[illegible]

Chart 24: NGH financial breakdown by unit

Unit	Headroom	Decision WTE			Budgeted Establishment WTE			Proposed Uplift WTE			Proposed Uplift Annual Investment £		
		Reg WTE	Unreg WTE	Total Required WTE	Reg WTE	Unreg WTE	Total Budget WTE	Reg WTE	Unreg WTE	Total WTE	Reg £	Unreg £	Total £
A&E	25%	145.90	64.40	210.30	134.41	62.83	197.24	11.49	1.57	13.06	£917,359	£81,723	£793,391
PED	25%	26.90	5.68	32.58	27.67	6.94	34.61	0.00	0.00	0.00	£0	£0	£0
Abington		27.19	20.96	48.14	24.57	28.19	53.75	2.62	5.23	2.61	£147,813	£205,812	£57,999
Brampton		27.19	23.57	50.76	24.57	28.80	53.37	2.62	5.23	2.61	£147,813	£205,812	£57,999
Cedar		27.19	20.96	48.14	25.79	26.18	51.97	1.40	5.23	3.83	£79,077	£205,812	£126,735
Creaton		26.19	20.96	48.14	24.61	23.56	48.17	0.58	2.61	0.37	£231,731	£102,810	£39,391
Dryden		29.81	15.71	45.52	29.08	11.38	41.02	0.75	0.75	1.53	£12,258	£23,498	£71,741
Hawthorn		27.19	20.96	48.14	27.18	26.19	53.36	0.00	5.23	5.23	£0	£205,812	£205,612
Holcot		27.19	23.57	50.76	24.56	28.80	53.36	2.63	5.23	2.60	£149,177	£205,812	£57,435
Knightley		19.33	18.33	37.66	16.71	23.56	40.27	2.62	5.23	2.61	£147,813	£205,812	£57,999
Victoria		19.33	15.71	35.04	16.71	20.94	37.65	2.62	5.23	2.61	£147,813	£205,812	£57,999
Althorpe		17.93	10.48	28.41	17.93	9.08	27.01	0.00	1.40	1.40	£0	£55,043	£55,043
Rowan		29.61	20.96	50.76	26.32	26.45	53.07	2.09	5.50	2.81	£162,825	£216,227	£53,402
Disney	25%	21.13	9.97	31.10	25.73	6.67	32.40	1.60	3.30	1.70	£90,148	£123,738	£33,591
Paddington	25%	38.57	10.73	48.30	38.58	9.32	47.90	0.00	1.41	1.41	£0	£55,400	£55,400
Cosset	25%	41.2[illegible]	8.[illegible]	48.[illegible]	40.[illegible]	7.[illegible]	48.43	[illegible]	0.34	+0.87	+£[illegible]	+£13,[illegible]	+£43,[illegible]
Total Investment		557.10	310.95	868.05	525.72	348.16	873.88	32.15	35.95	3.80	£1,811,363	£1,413,338	£398,025

8. Establishment / Financial Implications continued

8.1 Maternity establishment reviews have highlighted the need for further detailed service alignment, particularly within community pathways. Realignment of current KGH budgets were recommended with an overall saving of £7,878 identified once this work is completed (please see chart 25). NGH continue to review service optimisation within current establishment constraints.

Chart 25: KGH Maternity financial breakdown by unit

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9. DWS Recommendation Compliance (KGH)

	Developing workforce safeguards recommendations	Current Position	Evidence to Support Current Compliance	Gap analysis outcome (Red = not yet achieved, Amber = partially compliant, in progress, Green = compliant)	State actions required to meet compliance
1	The Trust is formally using National Quality Board 2016 safer staffing guidance: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing.	Expectation 1 Right staff [illegible] Expectation 2 Right skills [illegible] Expectation 3 Right place and time [illegible]	[illegible]	Compliant	Continue with current practices and deliver assurance of meeting the required expectations
2	The Trust apply the principles of safer staffing [illegible]	Expectation 1- Right staff 1.1 Evidence based workforce planning [illegible] 1.2 Professional judgement [illegible]	[illegible]	Compliant	Continue with current practices and deliver assurance of meeting the required expectations
3	Evidence based tools are used where available.	Expectation 1- Right staff 1.1 Evidence based workforce planning [illegible] 1.2 Professional judgement [illegible]	[illegible]	Compliant	[illegible]
4	Trust to confirm that there is no local manipulation of identified nursing resource from approved evidence based	Expectation 1 Right staff. 1.1. Evidence based workforce planning. 1.2 Professional judgement [illegible]	[illegible]	Compliant	Continue with current practices and deliver assurance of meeting the required expectations
5	Monthly actual vs planned staffing levels are available for review	**Expectation 1- Right staff 1.3 Compare staff with peers** **Expectation 3- Right place and time 3.2 Efficient deployment and flexibility** KGH submitts ward level data of planned and actual staffing levels (registered and unregistered) with a breakdown of CHPPD per ward as well as site level. This is reported monthly to NQB (NHSE), as per safe staffing guidance, and published on the public website as per requirement (see attached NStf monthly submission of this data from Jan- Feb 2025> blue tabs below). KGH completes a twice daily staffing cell to review current/ live staffing. This also reflected in the safecare platform which records 3 periods per 24 hours, across all inpatient areas of dependancy and acuity needs, along with staff allocation, inclusive of skills (example of the staffing cell from June > post am and pre pm 19.0.25 is in the zip file). A safe staffing report is submitted monthly to the board providing oversight of monthly staffing status, inclusive of concerns, actions and improvements and triangulated aginast quality dashboard data. UHN staffing, workforce and safecare data for both KGH and NGH is reported monthly through to IPR, formley IGR. (see zip file for UHN safe staffing reports March- May 2025)	UHN Safe staffing report- March- May 2025 within zip file> UHN safe staffing March- April- May 2025 NSft submissions> blue tabs below January to May 2025 Staffing cell example zip file > Post am pre pm 19.05.25	Compliant	Continue with current practices and deliver assurance of meeting the required expectations
6	Director of Nursing & Medical Director must confirm safe staffing review in an annual governance statement to the Public Board	**Expecation 1-Right staff-1.1 Evidence based workforce planning** **Expectation 2-Right skills 2.3 Recruitment and retention** **Expectation 3-Right place and time 3.1 productive working and elimiting waste 3.2 Efficient deployment and flexibility, 3.3 Efficient employment and minimising agency** The staffing establishment annaul reports/ reviews are approved by CNO (see attached establsihment reviews 2024 and 2025). This is highlighted in the Annual quality report (report within zip file and link in evidence for external public accessibility report) and Annual report and accounts (report within zip file and link in evidence for external public accesibility report)	Annual Report, Quality Account and Statement of Accounts | Kettering General Hospital NHS	Compliant	Continue with current practices and deliver assurance of meeting the required expectations
7	A workforce plan must be in place and agreed / signed off annually by CEO & executive leaders and discussed at Public Board meeting	**Expecation 1-Right staff-1.1 Evidence based workforce planning** **Expectation 2-Right skills 2.3 Recruitment and retention** **Expectation 3-Right place and time 3.1 productive working and elimiting waste 3.2 Efficient deployment and flexibility, 3.3 Efficient employment and minimising agency** Workforce plan in zip file 2025 > workforce Op plans 2025-26 excel, with supporting narrative > workforce submission narrative approved by CNO, CEO and executive board 2025	Workforce plan 2025-26 in zip file > Workforce OP plans 2025-26 > Workforce submission narrative	Compliant	Continue with current practices and deliver assurance of meeting the required expectations
8	Nursing and midwifery staffing establishments for all clinical areas must be reviewed twice a year and reported to the Public Board	**Expectation 1-Right staff 1.1 Evidence based workforce planning 1.2 Professional judgment and 1.3 Compare with peers** Staffing establishment reviews are completed biannually with 3 audits carried out over 12 months, which is above the recommended NQB guidenace of biannual reviews. These audits are aligned across UHN and work stimultanously with UHL. This approach allows for inter-reliability across sites to further support objectivity and rigour throughout the audit periods. Establishment reviews provide context on methology, use and application of evidenced based tools and the application professional judgment, and a triangulated approach as required in the NQB guidance. These reviews provide SNCT recommendations, breakdown of ward level staffing and costing, indicating service change/ need since last review (approx 3 months), inclusive of any QIA's needed to reflect changes.(QIA from April 2025 establishment review is within zip file> new template QIA v5PID) Establishment reviews 2024 and 2025 within zip file > KGH biannual establishment review 2025 and 2024 > KGH Nursing safe staff review June 2024 .	KGH establishment review 2024 and 2025 in zip file > KGH Biannual establishment review 2025 > KGH Nursing safe staff review 2024 (excel sheet not establishment review- audit only) > KGH Safe staffing review 2023/24	Compliant	Continue with current practices and deliver assurance of meeting the required expectations

University Hospitals of Northamptonshire NHS Group

9. DWS Recommendation Compliance (KGH, pg2)

9	Agreed local quality dashboards on staffing & skill mix that is cross checked with comparative data each month and reported to the board.	**Expectation 1 Right staff 1.3 Compare with peers** **Expectation 2 Right skills 2.1 mandatory training, development and education** **1.3 Compare staffing with peers:** National and regional benchmarking (use of model health) is carried out monthly and documented in the safe staffing report (see attached reports in zip file > UHN Safe staffing report March- May 2025). Benchmarking across UHN and UHL our peer providers is also completed to access and aid SNCT reviews, deep dives, ward moves, transfers and comparative anaylsis. This comparative data is also obtained and supports the above through NQB monthly submissions NSH/ SCDC reporting for planned and actual staffing. **2.1 Mandatory training, development and education** UHN is supported by weekly Quality reviews from the harm free care team (fortnightly site specific KGH) which provide dashboard data across all quality indicators at ward/ site level, using comparative bench marking, locally, and nationally, and supports and identifies learning/ improvement opportunites via gap analysis. UHN TNA- training needs analysis withi zip file > TNA main and PED 2025 and This is further supported by divisional compassionate rostering reviews, chaired by divisional heads of nursing, addressing rostering performance and KPI's management across divisions at ward level, example of this in zip file > UHN HFC weekly update 9th May > . UHN HFC weekly update 23rd May	UHN Safe staffing report- March- May 2025 within zip file> UHN safe staffing March- April- May 2025 NSH submissions> blue tabs below January to May 2025 Training needs 2025 zip file > TNA main and PED 2025 Weekly harm free care quality review zip file > UHN HFC weekly update 9th May > UHN HFC weekly update 23rd May	Compliant	Performance review meetings with CNO have been set up to further support divisions with aligned dashboard metrics across all rostering KPI's at NGH and KGH. This is starting 30th June 2025
10	Quality Impact Assessment (QIA) review for service changes including skill mix changes, redesign or introduction of new roles	**Expecation 1-Right staff-1.1 Evidence based workforce planning** **Expectation 2-Right skills 2.3 Recruitment and retention** **Expectation 3-Right place and time 3.1 productive working and elimiting waste 3.2 Efficient deplogment and flexibility, 3.3 Efficient emplogment and minimising agency** As part of planned changes to ward estblishments and ward moves as well as the closesure of an offsite bedded facility, Spinneyfields, which was utilisated to support additional capacity over winter 2024. A QIA was submitted whilhc reflects estblaishment needs applicable to these areas. These reviews have been included in the estalishment setting for 2025 and approved by CNO, UHN CNO and board at KGH. QIA is within zip file >new template QIA v5PID	QIA 2025 within zip file > new template QIA v5PID	Compliant	Continue with current practices and deliver assurance of meeting the required expectations
11	Formal risk management and escalation processes in place for all staff groups outlined within a safe staffing policy with appropriate staffing escalation process clearly identified	**Expectation 1 Right staff 1.2 Professional judgment** **Expectation 3 Right place and time 3.1 productive working and eliminating waste 3.2 efficient deplogment and flexibility** KGH reviews staffing across all divisions twice daily. These meetings are documented in staffing cell spread sheet (see example in zip file > Post am pre pm 19.5.25) with live changes being inputted as needed. The supporting SOP- see zip file > UHN safe staffing cell SOP provides guidance on RAG rating and management of workforce escalations through an adapted evidence based workforce scoring system (outlined in SOP), escalation routes to escalations and management and roles and responsabilities of staff in hours and out of hours. There is a daily report send to all Matrons covering staffing, outlining red flags and professional judgements escalated in real time and and upto post 7 days of incident being raised. This is further supported by an annual review of safecare compliance and escalations- red flags and professional judgments across all divisions, see zip file > safecare annual review 2025. All red flag and associated datix data is included in the monthly safe staffing report	Safer staffing policy SSP1 within zip file > Safe Staffing policy final aug 2023 Staffing cell SOP 2025 for UHN within zip file > UHN safe staffing cell standard operating procedure Staffing escalation process and guidance within zip file > safe staffing escalation cards Red flag and safe care review 2024/2025 within zip file > safecare review 2024-2025	Compliant	Continue with current practices and deliver assurance of meeting the required expectations
12	Boards to be made aware of continuing or increasing staffing risks	**Expectation 1 Right staff** **Expectation 3 Right place and time, 3.1 productive working and eliminating waste, 3.2 efficient deplogment and flexibility** Day to day staffing, safety, acuity and dependency needs are reviewed twice daily in a cross site UHN staffing cell, chaired by divisional heads of nursing, who report into capacity/ bed meetings twice daily to ensure board/ executive teams are aware of escalation/ concerns impacting patient care and staffing. Out of hours this is managed through the on call escalation management team and onsite capacity matrons. The trust board receive the monthly staffing reports and biannual establishment reviews for approval and overall oversight	Safer staffing policy SSP1 within zip file > Safe Staffing policy final Aug. 2023 Staffing cell SOP 2025 for UHN within zip file > UHN safe staffing cell standard operating procedure Staffing escalation process and guidance within zip file > safe staffing escalation cards Red flag and safe care review 2024/2025 within zip file > safe care review 2024-2025	Compliant	Continue with current practices and deliver assurance of meeting the required expectations

NHS University Hospitals of Northamptonshire NHS Group

9. DWS Recommendation Compliance (NGH)

	Developing workforce safeguards recommendations	Current Position	Evidence to Support Current Compliance	Gap analysis outcome: Red = not yet achieved Amber = partially compliant, in progress Green = compliant	State actions required to meet compliance
1	The Trust is formally using National Quality Board 2016 safer staffing guidance. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time : Safe sustainable and productive staffing.	Compliant	Establishment reviews a detailed ward profile describing previous six months to a year data sets (incl. acuity and dependency, vacancies, [illegible] training, skill requirements [illegible]) and [illegible]. The Trust Board Paper and the monthly safer staffing paper are all set out as per NQB (2016) expectations. Within the ward profiles, the current required staffing and the desired required staffing through professional judgement is displayed, allowing [illegible] proportionate decision-making within the Annual Establishment Reviews. Any variation which deviates from safer staffing will undergo a Quality Impact Assessment. The UHN safe staffing cell monitors actual staffing numbers and skill mix of clinical staff on shifts against planned numbers and skill mix on a shift-by-shift basis. A clear audit trail is available with mitigation evidenced also.	Green	- Continuation and evolvement of current outputs
2	The Trust apply the principles of safer staffing triangulation	Compliant	The Trust utilises the Professional Judgement Framework (Saville et al., 2020) when reviewing and assessing required staffing. For example, during the Annual Establishment Reviews, [illegible] each ward and reviewing the ward profile, colleagues incorporate professional judgement. This includes the ward layout, the count of side rooms, temporary staffing usage, enhanced patient observations etc. For nursing, the Safer Nursing Care Tool (SNCT) is utilised and triangulated [illegible]. Outcomes are incorporated and themes are assessed to ensure the principles of safe staffing have been applied.	Green	- Continuation and evolvement of current outputs
3	Evidence based tools are used where available.	Compliant	The Trust uses [illegible] of the following: Adult Acute Assessment Units (AAU) SNCT, Adult Inpatient Ward (AIW) SNCT, Children and Young People (CYP) SNCT, Emergency Department (ED) SNCT and Birthrate Plus®. The Nursing and Midwifery Establishment Review Cycle sets out the frequency of data collection, interpretation and incorporation into reviewing the [illegible]	Green	- Continuation and evolvement of current outputs
4	Trust to confirm that there is no local manipulation of identified nursing resource from approved evidence based tools	Compliant	The [illegible] Safer Staffing Team which includes workforce [illegible] are able to demonstrate [illegible] step by step files from data collection, transcription, SNCT calculator to MASTER results, of which each step is stored to evidence rigor. The SNCT training for colleagues stipulates no local manipulation/ adaptation	Green	- Continuation and evolvement of current outputs
5	Monthly actual vs planned staffing levels are available for review	Compliant	The monthly staffing submission of actual vs. planned staffing levels have been delegated to the Interim Assistant Chief Nurse by the Chief Nurse to validate and review. The Interim Assistant Chief Nurse will then summarise the position to the Chief Nurse. Trends are stored separately to the monthly submission to capture progress.	Green	- Continuation and evolvement of current outputs
6	Director of Nursing & Medical Director must confirm safe staffing review in an annual governance statement to the Public Board	Compliant	Evidenced within Annual and Bi-Annual Establishment N&M Review Board papers, included within front summary page.	Green	- Continuation and evolvement of current outputs

University Hospitals of Northamptonshire NHS Group

9. DWS Recommendation Compliance (NGH, pg 2)

7	A workforce plan must be in place and agreed / signed off annually by CEO & executive leaders and discussed at Public Board meeting	Compliant			
8	Nursing and midwifery staffing establishments for all clinical areas must be reviewed twice a year and reported to the Public Board	Compliant			
9	Agreed local quality dashboards on staffing & skill mix that is cross checked with comparative data each month and reported to the board.	Compliant			
10	Quality Impact Assessment (QIA) review for service changes including skill mix changes, redesign or introduction of new roles	Compliant			
11	Formal risk management and escalation processes in place for all staff groups outlined within a safe staffing policy with appropriate staffing escalation process clearly identified	Partially compliant			
12	Boards to be made aware of continuing or increasing staffing risks	Compliant			

Cover sheet

Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item	13

Title	UHN Inclusion Activities April – December 2025
Presenter	Paula Kirkpatrick, Chief People Officer
Authors	Farhana Ahmedabadi-Patel, Head of OD & Inclusion Jane Sanjeevi, Senior Diversity and Inclusion Specialist

Link to Group Priorities:		
☒ Transform Patient Care	☒ Strengthen our Culture	☒ Deliver our financial plan
Strong organisational culture is crucial improving access and experience for our patients through a competent and empowered workforce that is able to meet the diverse needs of our community and deliver safe, effective patient care.	If we fail to put in place sufficient support for colleagues and/or processes that fail to create a safe working environment where people feel valued, included and supported, then this will lead to increased absence, poor engagement, attrition, potential impact on patient care.	Culture & Inclusion are pivotal to attain financial sustainability through workforce efficiency and improved patient care.

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

This report updates the Boards on inclusion activity in 2025 and in particular the response following Board engagement with the DAWN and REACH networks.
 	
DAWN: Disability, Accessibility, Wellbeing and Neuroinclusion
 	
REACH: Race, Ethnicity and Cultural Heritage
	• People Committee:
	  ○ 27 February 2025
	  ○ 31 July 2025
	  ○ 24 October 2025
	• Boards 03 October 2025
	• Integrated Leadership Team 20 October 2025

Executive Summary

This paper provides an update on UHN's alignment with NHSE Equality, Diversity and Inclusion (EDI) Improvement Plan (June 2023), our compliance with the Public Sector Equality Duty (PSED), and the next steps required to deliver the national assurance programme for 'Well Led' CQC standards. It reflects progress made between April and December 2025 in strengthening organisational culture, advancing equity, and embedding inclusive leadership across UHN, with specific actions taken following Board stories as detailed in Appendix 1.

Recommendations

The Boards are asked to:

1. Note the progress made in delivering the EDI agenda and specific actions that followed staff network engagement with the Board.
2. Endorse the proposed collaborative, multidisciplinary approach to sustaining cultural improvement.
3. Reiterate support for transformational leadership behaviours, including:
    a. Coaching and consultative leadership styles
    b. Effective use of statutory and mandatory training
    c. Meaningful appraisal and development conversations
    d. Visible allyship through engagement with staff networks

Appendices

Appendix 1 – Actions taken Staff Network Stories shared at Board Meetings in 2025
Appendix 2 – Celebrating Inclusion at UHN in 2025

Risk and assurance

- BAF UHN18
- Organisational Objective 'Strengthen Our Culture'
- Mandated in the NHS contract and considered by the CQC Well Led
- Oversight of delivery of our Belonging Strategy year 1 actions through reporting to Culture Assurance Group and upwards to People Committee.
- Funding challenges expected in 2026–27 may restrict or end external support.

Financial Impact

Discrimination has adverse effect on the health and wellbeing of our colleagues (including long-term sickness) and financial implications for recruitment, retention costs and everyday operational demands on our organisation. Recommendations in this paper offer sustainable, solutions that improve the experience of our workforce and our patient community, within our existing budgets.

There may be a financial impact if external resource is required in the delivery of any skills-based training as part of this programme. The current implementation plan maximises internal resource as well as existing arrangements through partners such as NHS Elect.

Legal implications/regulatory requirements

In compliance with

- Equality Act 2010 and 2017 Regulations
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Gender Pay Gap (GPG) Report
- Equality Delivery System (EDS)
- NHS 6 High Impact Actions
- Care Quality Commission (CQC) Well Led

- NHS People Plan
- Messenger Review

Equality Impact Assessment
This work focusses on the general duties under the Equality Act 2010, with an aim to highlight inequalities, opportunities to gather soft intelligence and develop actions in response to reduce the disparity. The process established within UHN involves colleagues and stakeholders in the discussion, strategy development and on-going assurance.

Paper

Situation

Inclusion is a strategic priority for UHN, directly linked to all three of our organisational objectives. The annual National Staff Survey (NSS), WRES, WDES, and Pay Gap reports consistently highlight disparities in experience, representation, and outcomes for colleagues from protected groups. These disparities present both a reputational and operational risk, impacting staff morale, retention, and ultimately patient care.

Background

Inclusion is fundamental to creating a culture where every colleague feels safe, respected, and empowered to thrive. Our strategic approach is delivered through the We Belong Strategy, supported by our Rethinking Racism and Civility programmes, alongside focused work on sexual safety and neuro-inclusion, each forming part of a deliberate and intentional set of actions to strengthen our culture at UHN. This integrated approach enhances leadership accountability, improves the consistency of colleague experience, and ensures we reflect the diversity of our communities. In doing so, we fulfil our statutory duties, strengthen engagement and wellbeing, and support the conditions for high-quality patient care and strong organisational performance.

Assessment

Embedding inclusion as the "golden thread" in all that we do

Over the past year, we have initiated a shift in our approach to inclusion at UHN. Although this work is at an early stage, we are moving from a traditional EDI model toward a more intentional, culture-focused approach aligned to our ambition to strengthen our culture. The emerging model will place inclusion at the centre of our leadership expectations and connect it more directly with OD and Health & Wellbeing priorities. This early work is establishing the foundations for inclusion to become a core organisational responsibility that underpins psychological safety, team effectiveness, and colleague and patient experience, rather than operating as a standalone specialist function.

Our staff networks have become central, strategic partners in driving cultural improvement at UHN. Over the past year, they have acted as critical friends, providing lived-experience insight, challenging constructively, and shaping more inclusive practices across the organisation. Their contributions include co-designing policy improvements, co-hosting listening events that surface workforce issues such as racism, disability barriers and menopause experiences, informing leadership development through case studies and behavioural insight, and leading education campaigns during Pride, Black History Month and Disability History Month. They have also advised on patient-facing improvements, such as culturally sensitive care and accessible communication, and supported our Civility and Respect work by sharing real examples that strengthen training and interventions. Through this activity, networks have helped us design more responsive, equitable and culturally sensitive approaches to improving colleague and patient experience.

A transformational alliance between staff networks and their executive sponsors

One of the most transformative developments has been the collaboration between staff networks and the Board, which has reshaped how lived experience informs organisational decisions.

Through innovative storytelling, themed presentations and lived experience insights, networks have brought powerful narratives directly to senior leaders, enabling a deeper

organisational understanding of inclusion challenges and opportunities. This has catalysed visible executive allyship, with Board members championing issues, removing barriers, and supporting programmes that previously struggled to gain traction. This partnership has been both enabling and transformational in embedding inclusion as a priority. The DAWN network (April 2025) and REACH network (October 2025) were the initial staff networks that brought their unique insights to the Board in 2025. Appendix 1 details the progress made, and Appendix 2 showcases a creative and influential culture improvement partnership.

Sharing lived-experience stories with the Board has created emotional connection and urgency, shifting conversations from abstract assurance to the real human impact of our decisions. This has deepened Board insight into the barriers faced by under-represented groups, strengthened leadership accountability, and supported more informed and compassionate decision-making. It has also helped colleagues understand the complex challenges the Board faces, particularly the need to make sustainable choices during difficult economic and budgetary conditions; thus reinforcing transparency and trust. As colleagues see the Board genuinely cares and listens, they feel more confident to speak up, enhancing psychological safety and reinforcing inclusion as a shared organisational responsibility. This reciprocal trust has encouraged networks and teams to share messages more widely across the organisation, ensuring that decisions and cultural expectations are understood and supported throughout UHN.

At UHN, we are committed to advancing a strategic and culturally informed approach in which staff networks and executive partners collaboratively influence inclusive decision-making, foster trust, and integrate inclusion as a collective responsibility throughout the organisation.

Recommendations

The Boards are asked to:

1. Note the progress made in delivering the EDI agenda and specific actions that followed staff network engagement with the Board.

2. Endorse the proposed collaborative, multidisciplinary approach to sustaining cultural improvement.

3. Reiterate support for transformational leadership behaviours, including:

e. Coaching and consultative leadership styles
f. Effective use of statutory and mandatory training
g. Meaningful appraisal and development conversations
h. Visible allyship through engagement with staff networks

Appendix 1 – Actions taken Staff Network Stories shared at Board Meetings in 2025

Staff Network Request	Actions Taken	RAG August 2025	RAG Jan 2026
We need better support for interviews	Defined clear standards for reasonable adjustments during interviews in new UHN Recruitment & Retention Policy		
	Launched Neuro-inclusion Toolkit		
	Introduced centralised process for funded support of reasonable adjustments for neuroinclusion.		
	Drafted Inclusive Recruitment Toolkit, awaiting sign-off		
Alternative methods (other than interview) for additional support	Trust continues to support the various alternate pathways into careers such as Volunteer to Career and work experience. Funding secured for entry level apprenticeships under the Get Britain Working Programme.		
Establish a Shadow Board to reflect diversity of UHN	To determine structure and representation following completion of Reciprocal Mentoring Programme (September 2026) as an Action Learning Opportunity		
Create opportunities for IEHCSWs through apprenticeships	We support HCSW into clinical apprenticeships; however, the national position regarding apprenticeships and visa requirements is specific to individual circumstances.		
Continue providing pastoral care support for IENMs	Pastoral support role has been extended until March 2026 at NGH. A UHN role is included within the new UHN corporate nursing structure.		
Encourage managers to show open and active support when patients are abusive.	Rethinking Racism Education Programme continues to deliver targeted support for managers. To date, 37% of Band 8A–9 managers have attended sessions. Reports on attendance are provided to the Integrated Leadership Team. VARG Meetings are seeking assurance from each Division on allyship and colleague support following patient abuse.		
Create a roadmap and set targets at intervals of 12-18 months, 18-36 months, and 36 months to 5 years	The established leaders programme (Band 8b and above) has been launched, alongside a reciprocal mentoring programme aimed at diversifying leadership pathways up to Board level. This is promoted along with the LEO programme and Developing Diverse Senior Leaders (in partnership		

for Senior BAME Leadership Development	with LLR) programme to increase diversity of clinical leadership		
Recognise religious diversity by decorating main areas for celebrations such as Diwali, Hanukkah, Onam, etc.	Chaplaincy Team has committed to supporting upcoming events. They have planned events for Ramadan, Easter and Passover (February & April 2026)		
	Ramadan & Passover Guidance have been launched to support colleagues and managers		
Address the lack of appreciation and recognition for some staff groups	UHN continues to recognise colleagues through: • Greatix • Daisy and Rose Awards • UHN Annual Awards • SDMC awards New bimonthly awards planned for all colleagues.		
Organise social events for greater connection and reduce social isolation	Launching both We Belong & Health and Wellbeing strategies in November was based on a market place format bringing together a wide range of stakeholders from the community of Northamptonshire to provide colleagues with multiple streams of support and social connections linked to their physical and mental wellbeing		
	An EDI Summit is planned for 21st April 2026		
Addressing workforce health inequities, stigma around mental health & financial difficulties	Supported through Domain 2 - Equality Delivery System (EDS) which is peer evaluated and reported annually		
	Health & Wellbeing Strategy with focus on alignment of our offer, support for psychological wellbeing, improving access to services.		

Appendix 2 – Celebrating Inclusion at UHN in 2025

Gender Equality Network – showcasing their focus on Men's Health at International Men's Day

DAWN Network supporting **Gender Equality Network & Health & Wellbeing Team** at the launch of the Menopause Policy

Clinical 7 Non-Clinical Teams taking part in 'Wear Your Pride' as part of **Pride Month 2025** ensuring patient safety within IPC guidelines

The **Pride Network** attending Northampton Pride to show support for our local community

REACH Network celebrating diverse health & Wellbeing initiatives via a Bollywood fitness session during Black History Month

ISDMC & REACH Network Celebrating Cultural Awareness Day

Armed Forces Network at the Gold Recognition Award Night

Cover sheet

Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item	14

Title	Pay Gap Reports 2024-2025
Presenter	Paula Kirkpatrick, Chief People Officer
Authors	Farhana Ahmedabadi-Patel, Head of OD & Inclusion Jane Sanjeevi, Senior Diversity & Inclusion Specialist

Link to Group Priorities (select all that apply):		
☐ Transform Patient Care	☒ Strengthen our Culture	☐ Deliver our financial plan
This report strengthens our culture through insight into inequities that undermine staff experience and organisational cohesion. It enables targeted, accountable action to reinforce fairness, trust, and an inclusive culture across UHN.		

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

Reason for consideration	Previous consideration
The purpose of the paper is to provide a detailed analysis of the Trusts' pay gaps by protected equality characteristic, ensure compliance with national diversity and inclusion mandates, and outline next steps for addressing any pay disparities.	People Committee, 29 January 2026

Executive Summary

This report provides a comprehensive analysis of the Trusts' pay gaps, fulfilling the legal requirement to publish annual pay gap data. It aligns with NHS England's Equality, Diversity, and Inclusion (EDI) Improvement Plan, which mandates the analysis of pay disparities by gender, race and disability.

Recommendations

The Board of Directors are asked to:

1. Receive and note the Pay Gap reports as evidence of compliance with the Equality Act Regulations 2017 and NHS England EDI Improvement Plan, for onward publication of full reports on the Trusts' websites by 31 March 2026 in compliance with statutory guidance, and
2. That the data will be uploaded to the government Gender Pay Gap website for benchmarking with other organisations and businesses across England.

Appendix

None: the pay gap report is available in the 'documents' section of the Board portal and will be published separately on the Trusts' public websites following approval.

Risk and assurance

The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • Equality Act Regulations 2017 • NHS England EDI Improvement Plan 2023. Risk UHN18 refers: Failure to address poor behaviours in the workplace or to provide key components of a safe workplace culture will lead to a culture in which colleagues feel unsafe and under-valued, unsupported or excluded, resulting in poor staff engagement, retention and morale, elevated sickness absence and will ultimately impact patient care.	The report is part of the Trust's legal requirement to publish gender pay gap data annual and additionally an effort to comply with NHS England's Equality, Diversity, and Inclusion (EDI) Improvement Plan, which mandates the analysis of pay gap data by protected characteristics starting with sex (gender), then race by 2024, and disability by 2025).

Financial Impact

This report fulfils our statutory reporting duties and provides critical insight into structural pay disparities across UHN. While the report itself has no direct financial impact, addressing identified gaps will require strategic workforce investment planning to strengthen equity, retention, and organisational performance.

Legal implications/regulatory requirements

Gender pay gap reporting is a legal requirement for large employers (250+ staff) under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, which mandate annual publication of pay gap data, enforced by the Equality and Human Rights Commission (EHRC) and potentially leading to fines for non-compliance.

NHS EDI Improvement Plan (2023) requires NHS organisations to report pay gaps affecting Ethnic Minority & Disabled colleagues

Equality Impact Assessment

The actions proposed are expected to positively advance equality of opportunity by addressing identified pay disparities, with no adverse impacts on protected groups. The Equality Impact Assessment, supported by the executive summary and full report, confirms measures that shall strengthen fairness and equitable outcomes across UHN.

Paper

Situation

The Equality Act 2017 Regulations require organisations with more than 250 staff to publish their gender pay gap (GPG) and bonus gender pay gap (BGPG) data on the Governments reporting website by 31st March annually. For our reporting purposes, Clinical Excellence Awards (CEA) under Medical & Dental Terms & Conditions are considered as Bonus

The pay gap calculations have been carried out in line with national guidance, available at:

- Closing your gender pay gap - GOV.UK
- NHS England » NHS equality, diversity and inclusion (EDI) improvement plan

Background

The data is a snapshot of the workforce on 31st March from the previous year meaning the data presented in this report is from 31st March 2025. The report in the appendix shows the trends over the past 5 years at UHN.

Additionally data outlined within this report builds a bigger picture of the Trust's performance with pay gaps affecting ethnically diverse and disabled colleagues in line with the requirements of NHS England EDI Improvement Plan in 2023.

Assessment

The 2024–25 Pay Gap report comprising the Gender, Ethnicity and Disability Pay Gap Reports provides an important diagnostic lens into the workforce structures grouping based on gender across the UHN. Collectively, the reports highlight clear areas of progress, but also possible structural challenges that continue to impede equality of opportunity for many of our colleagues. These insights sit alongside and reinforce the national priorities set out in the NHS England EDI Improvement Plan, particularly the requirement for measurable improvements in leadership behaviours, workforce experience and fair outcomes.

Highlights of the Pay Gap Analysis across Kettering General Hospital (KGH) and Northampton General Hospital (NGH) for 2024-2025 are as below:

Gender Pay Gap:

Across the last five years, both hospitals have demonstrated a consistent downward trend in their Gender Pay Gaps, reflecting a maturing approach to inclusion, equitable

recruitment practices, and improved workforce representation. This sustained improvement indicates that our organisational actions particularly around flexible working, inclusive recruitment, and strengthening staff networks have had a positive impact.

In the most recent reporting period, however, both hospitals experienced a slight deterioration in the Gender Pay Gap. This shift is not indicative of widening inequality in pay for equal work; instead, it is directly attributable to changes in the distribution of men and women across pay quartiles depicting a pattern of growth in male representation at both the highest and lowest ends of the pay structure.

Understanding the Impact on the Pay Gap

1. Increase in men in the upper quartile raises the male average (mean) hourly rate.
2. Increase in men in the lowest-paid quartile can depress the male median, creating a widening effect when combined with growth in the upper quartile.
3. Women remain disproportionately clustered in the middle quartiles, continuing a longstanding structural pattern across clinical and administrative roles.

Collectively, these movements create a bimodal representation shift, which affects pay gap calculations despite ongoing progress in gender-inclusive practice.

	KGH	NGH
Median Hourly Pay	Women earn 87p for every £1 earned by men	Women earn 89p for every £1 earned by men
Median Bonus (CEA) Pay	54.6% difference	29% difference

It must be noted that this year's slight worsening of the pay gap is representation driven, not inequity driven. The data indicates:

- Our overall workforce remains predominantly female, particularly in lower and middle pay bands.
- There has been an increase in male recruitment and progression at both ends of the pay spectrum during 2024.
- The observed change reflects structural workforce movement rather than any change in pay policy, pay progression rules, or local practice.
- Long-term improvements remain intact; this year's shift should be interpreted as a transitional fluctuation linked to changing workforce demographics.
- No new CEAs will be issued under the 2024 Consultant pay deal, but existing awards remain until award holders remain in employment.

Ethnicity Pay Gap:

	KGH	NGH
Median Hourly Pay	White colleagues earn 78p for every £1 earned by BME colleagues	White colleagues earn 85p for every £1 earned by BME colleagues
Median Bonus (CEA) Pay	33% difference	59% difference

Ethnicity patterns vary across occupational groups, with differing representation at higher pay bands.

Disability Pay Gap:

Median Hourly Pay

	KGH	NGH
Median Hourly Pay	Disabled colleagues earn 91p for every £1 earned by non-disabled colleagues	Disabled colleagues earn 92p for every £1 earned by non-disabled colleagues
Median Bonus (CEA) Pay	29% difference	50% difference

There is lower representation of disabled colleagues in higher-band roles.

Across the three pay gaps, a consistent narrative emerges: pay gaps are not simply a reflection of isolated pay decisions, but symptomatic of underlying workforce patterns reflective of:

- occupational role segregation
- representation at senior levels
- historic inequities to progression
- differing CEA (bonuses) processes

At UHN, our female workforce are employed predominantly amongst lower and middle bandings within Agenda for Change (AfC), continue to shape gendered income differentials. Similarly, the distribution of ethnic minority and disabled colleagues across roles, departments and pay scales impact both mean and median outcomes, revealing important insights into representation, progression and cultural experience.

From a Gender Pay Gap perspective, the 2025 snapshot shows that women at UHN earn 19.9% less (mean) and 11.4% less (median) than men, with the gap widening slightly from last year. Although bonus gaps have narrowed, a gendered structural pattern remains in both Trusts, noticeable particularly within medical staffing, where seniority and historical CEA bonus pay structures create disproportionality.

In contrast, our first Ethnicity Pay Gap report displays a more complex picture: the mean data indicates that some ethnic minority staff outperform white colleagues, yet median data highlights deeper inequality when the workforce is viewed through granular ethnic categories. Notably, Black colleagues experience the lowest mean hourly rates, while “White Other” groups show the lowest median rates, signalling both workplace clustering and differing access to higher paid positions. Specifically we are seeing progression amongst Asian colleagues (both men and women) across all pay bands and roles but inequities persist amongst colleagues from Black ethnic backgrounds.

The first Disability Pay Gap report establishes a baseline for this protected characteristic; with disabled colleagues comprising around 6% of the workforce, the data confirms meaningful gaps in pay and representation, alongside significantly lower progression into higher band roles.

The findings highlight the need for a coordinated, improvement approach under our We Belong strategy, reviewing pay structures, in the wider cultural context that shape colleague experience. The cross-cutting themes from this year’s pay gap reports are echoed in our National Staff Survey results, WRES and WDES data as inequities persist in areas such as board representation, psychological safety, access to flexible working, disciplinary outcomes and bias in career opportunities.

Between 2022 and 2025, UHN piloted the Levelling Up programme aimed at empowering internationally educated nursing, midwifery and allied health professionals (AfC Bands 5-7) towards career progression. Evaluation of attendance based on ethnicity at this

programme has been reflective of the progress noted in the ethnicity pay gap report in Appendix1, pages 29 & 46 for KGH & NGH respectively.

This detailed view of ethnicity breakdown has provided us with an initial lens to understand barriers and disparity of progression amongst ethnic groups uneven representation amongst colleagues from Black and Other White European colleagues. We need to shift our view from generic to targeted interventions to support colleagues from Black communities to reach their potential and develop a collective support offer.

Our We Belong strategy recommends the following support offer to deliver targeted interventions and need the organisation's collective support to achieve our planned goals to reduce pay disparities including (but not exhaustive):

- career coaching workshops
- role-modelling/mentoring by senior black leaders and managers
- interview preparation workshops
- constructive feedback channels from managers, including interview feedback

Ongoing progress in implementing the actions are reported to the Culture Assurance Group Committee as part of the Trusts' We Belong Action Plan updates. The information will also be shared with the Trusts Staff Side Partnership and staff networks to ensure a collaborative and supported approach.

Recommendations

The Board of Directors are asked to:

1. Receive and note the Pay Gap reports as evidence of compliance with the Equality Act Regulations 2017 and NHS England EDI Improvement Plan, for onward publication of full reports on the Trusts' websites by 31 March 2026 in compliance with statutory guidance, and
2. That the data will be uploaded to the government Gender Pay Gap website for benchmarking with other organisations and businesses across England.

Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item number	15

Title	Freedom To Speak Up (FTSU) Q3 Report
Presenters	Becky Taylor, Director of Continuous Improvement and FTSU Executive Lead Luke Sullivan, FTSU Guardian
Authors	Becky Taylor, Director of Continuous Improvement and FTSU Executive Lead Luke Sullivan, FTSU Guardian

Link to Group Priorities (select all that apply):		
☐ Transform Patient Care	☒ Strengthen our Culture	☐ Deliver our financial plan
Promoting a culture of safety through speaking up		

This paper is for			
☐ 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 recipients without the in-depth discussion as above	To reassure the recipients that controls and assurances are in place

Reason for consideration	Previous consideration
The report provides assurance that processes are in place to support staff to raise concerns which are pertinent to patient and staff safety.	People Committee, 29 January 2026

Executive Summary

The report provides assurance that the **Freedom to Speak Up (FTSU)** service is operating effectively across **University Hospitals of Northamptonshire (UHN)**, encompassing **Northampton General Hospital (NGH)** and **Kettering General Hospital (KGH)**.

During the reporting period, 64 concerns were raised across UHN – 45 at NGH and 19 at KGH, with none being UHN Group specific, with 37.5% raised anonymously, a decrease from the previous quarter. This is lower in both Trusts than in Q2, concerns in KGH

remain comparatively low, in line with the rest of the year. The national proportion of concerns raised as anonymous is 12%, with both Trusts remaining comparatively high.

The Family Health division, with the focus of concerns in NGH being paediatrics and in KGH being Maternity, and the Specialist and Place-Based Medicine (Northampton) division were the divisions with the highest number of concerns.

Concerns categorised as corporate issues are largely centre on estates issues and people matters relating to the approach to consultations and bank processes within nursing.

The majority of concerns raised confidentially or openly were from admin and clerical and nursing staff groups across both hospitals. Limited engagement was noted from Allied Health Professionals, and Estates and Ancillary Staff.

Across UHN, the most frequently reported theme continues to be worker safety / wellbeing, followed by systems policies and processes and behaviours.

There were 2 cases of detriment reported in Q3 in NGH, and a concern raised about the process taken by a manager following a concern being followed up with them in KGH, although this has not been raised as a case of detriment.

Recommendation

The Boards are asked to note and comment on the content of the FTSU Q3 report and indicate assurance in respect of the latest position.

Appendices
FTSU report – 2025-26 Quarter 3
Risk and assurance
UHN18 – An effective FTSU service is a key element in improving the culture for our colleagues. Lack of confidence in FTSU is identified as a gap in control or assurance. This report provides assurance to the Boards on the FTSU service.
Financial Impact
No direct implications relating to this report and recommendations.
Legal implications/regulatory requirements
Freedom to Speak Up Guardians are mandated for NHS organisations and are required to report to the National Guardian's Office quarterly.
Equality Impact Assessment
The report touches on matters of discrimination as raised to the Guardians in the due process of undertaking the role.

University Hospitals of Northamptonshire

Freedom to Speak Up Report: Q3 2025/2026

Authors:

Jane Sanjeevi - FTSU Guardian, UHN

Luke Sullivan - FTSU Guardian, UHN

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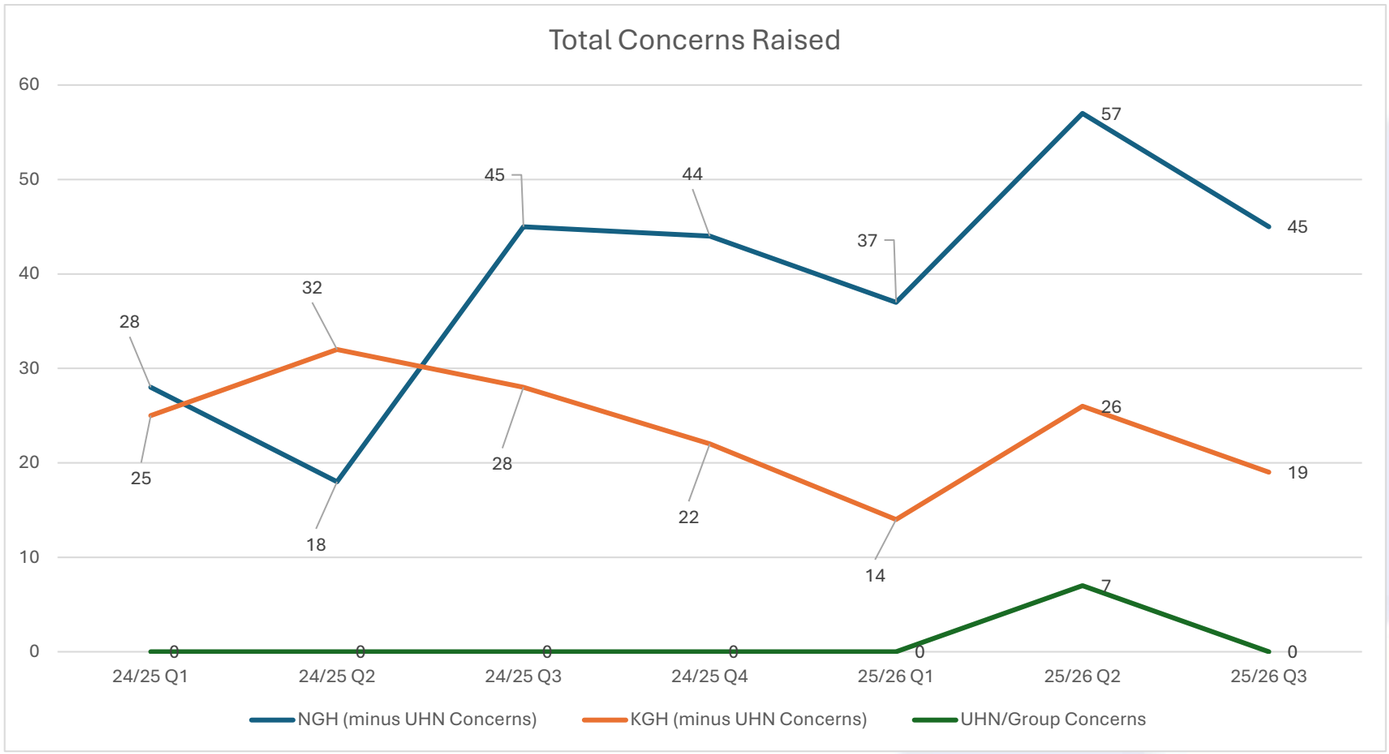
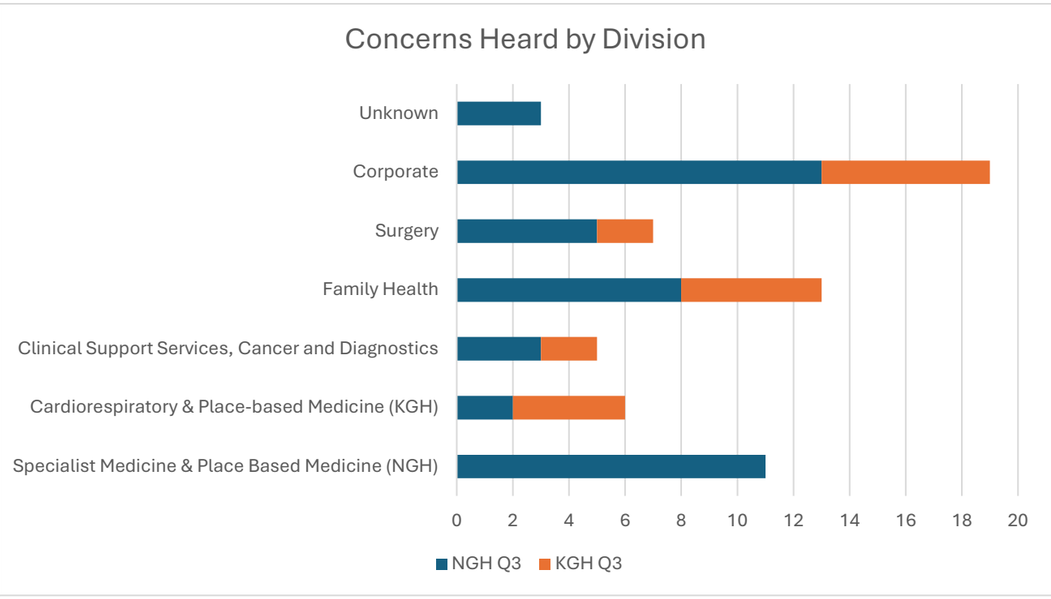
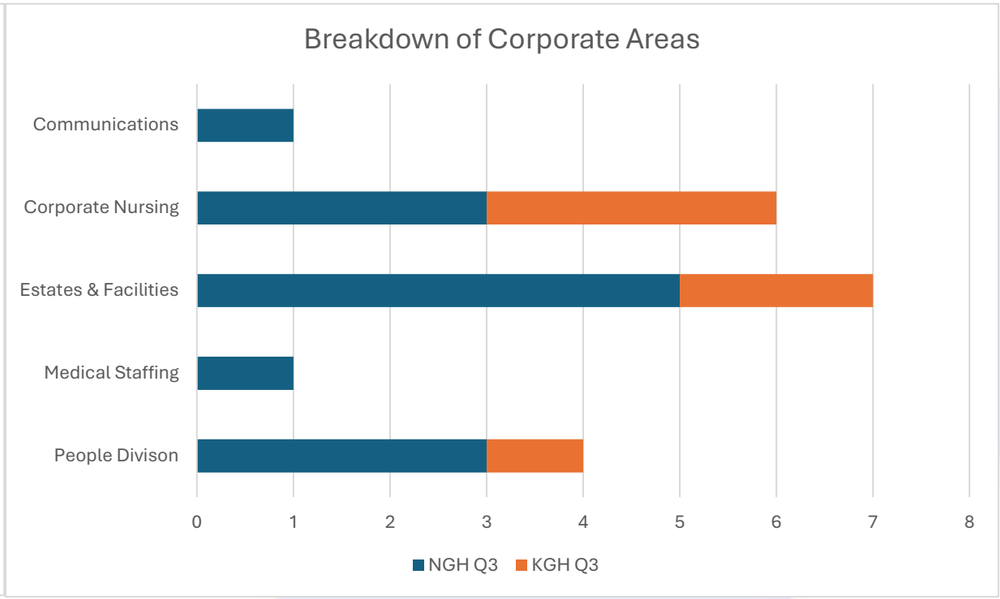
Freedom to Speak Up Overview



- Total of 64 concerns raised at UHN for quarter 2 of 2025/2026. 45 of these were raised at NGH and 19 at KGH. There were no Concerns were raised about UHN as a group.
- Of these 64 concerns, 39 **(37.5%)** were anonymously reported – 14 (31.1%) at NGH, 10 (52.6%) at KGH.
- Anonymous concerns at NGH come primarily via the Microsoft Form and pertain to nursing/ward concerns. Anonymous concerns at KGH are predominantly reported via the KGH Datix web form.
- The number of concerns heard at NGH remains consistent with a increase noted in quarter 2. Concerns heard at Kettering remain comparatively low though consistent with the past year.
- Concerns were heard consistently across Quarter 3 (October, November, December). Concerns have all been heard from separate individuals rather than multiple individuals bringing the same concern.

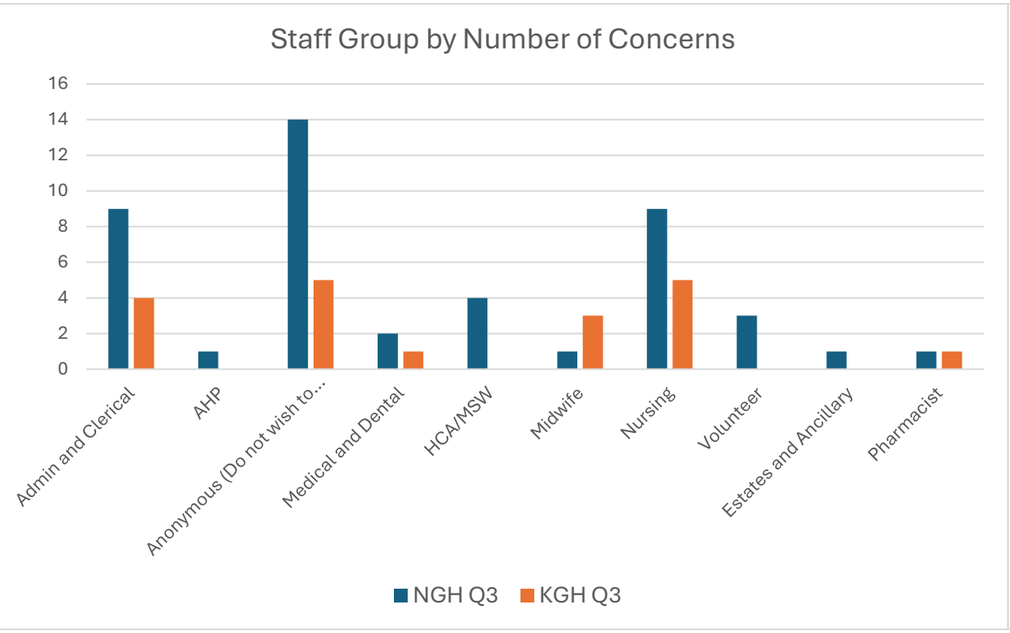
Concerns by Division Q3

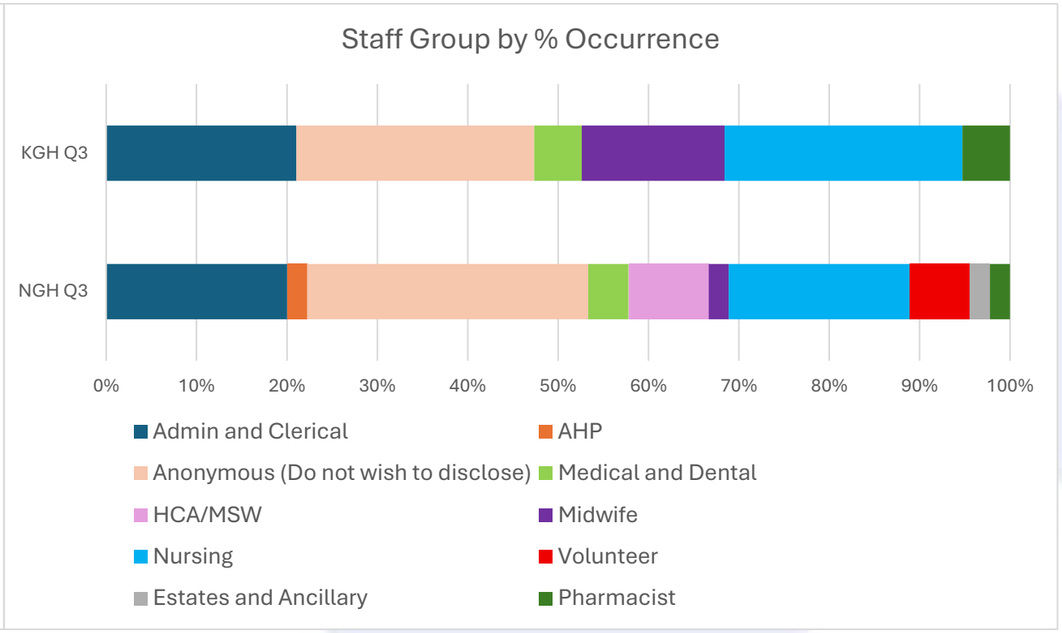




- Second to Corporate and Trustwide concerns, Family Health continue to make up the largest combined concerns for UHN and for KGH. At NGH, more concerns are reported in the Medicine division as compared to others.
- Family Health concerns at NGH have related primarily to paediatrics whereas at KGH they have been about maternity/neonatal care.
- A largest proportion of concerns were brought about corporate areas/teams (19 across UHN) in keeping with previous quarters; 7 related to environmental/estate issues and were referred to appropriate leads within estates to handle; 6 related to corporate and Trustwide nursing issues including anonymous concerns asking for a compassionate approach to consultations and concerns about the bank process in nursing.
- Concerns continue to be raised about the length of time grievances and formal processes take to resolve.
- The communications concern related to an issue in weekly comms that the individual has taken up openly with the Group CEO.
- Estates concerns have seen an increase from previous quarters and all relate to issues that could be reported via the estates helpdesk. There may be scope for renewed communications on how staff can report estates issues.
- Medical staffing concerns at NGH have related to financial queries and has been taken up openly with the CEO.

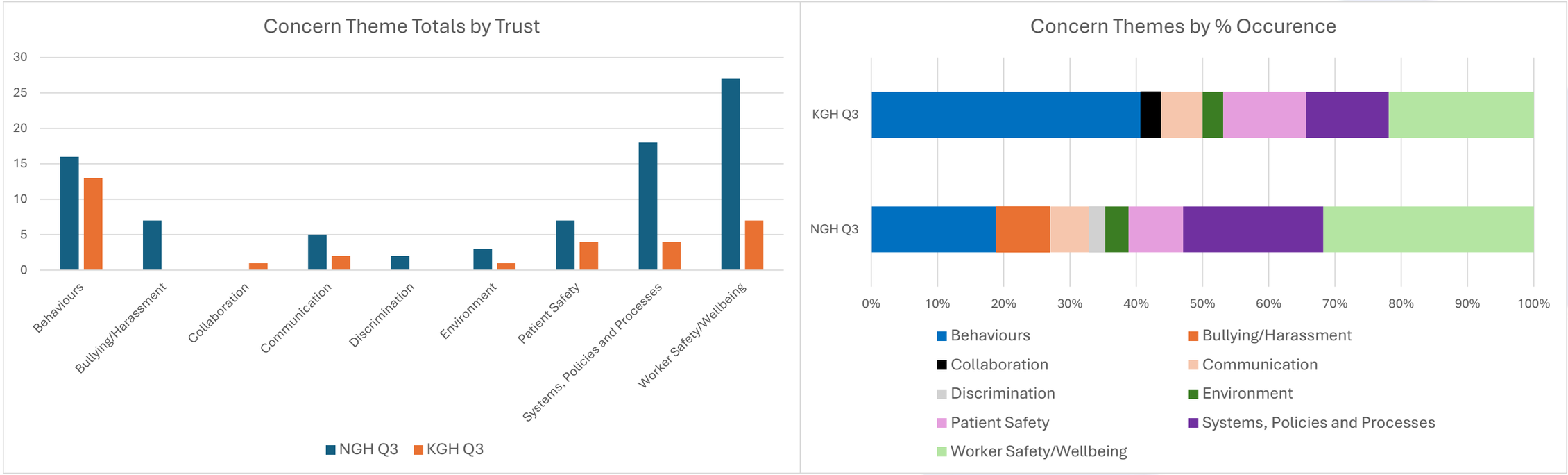
Concerns by Professional Group Q3



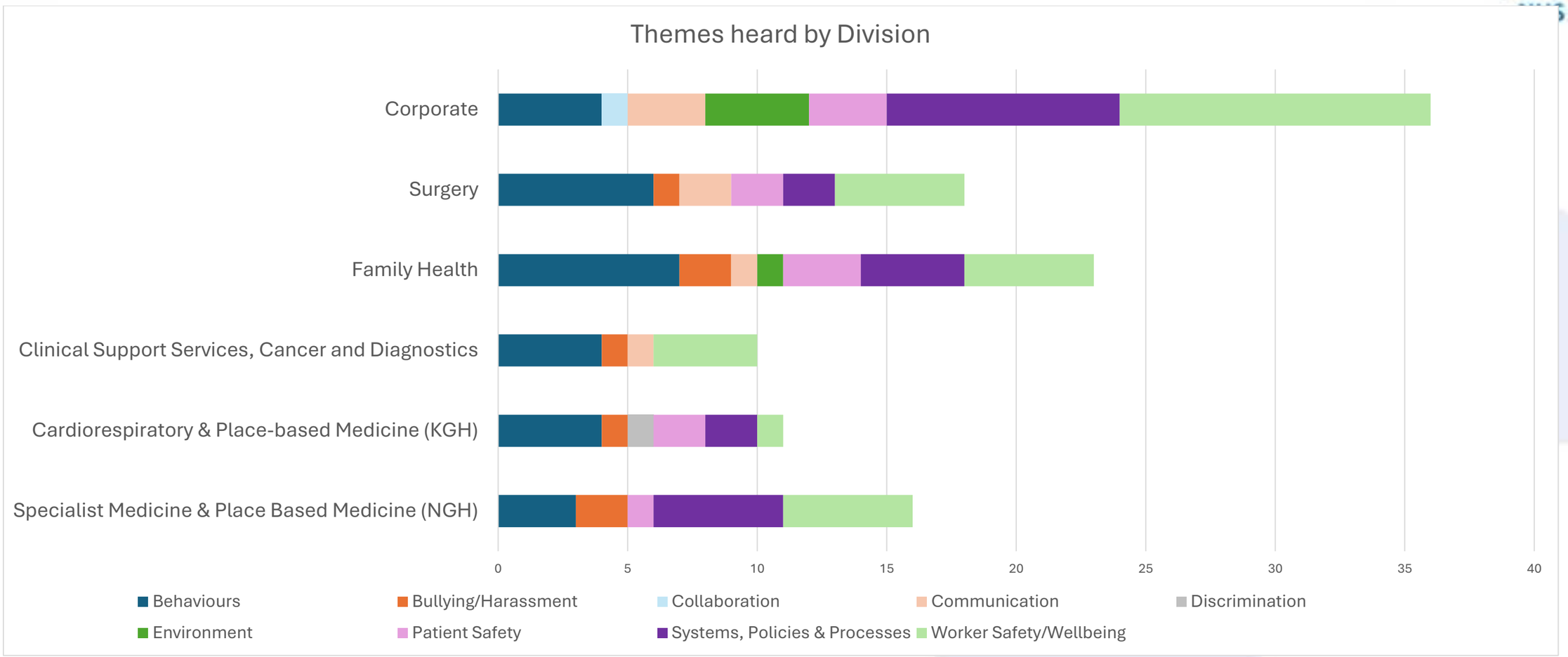


- 37.5% of concerns were raised anonymously, a small reduction from 43.3% in Q2. This continues to present a challenge in identifying which staff groups are speaking up and feeding back to colleagues who raise concern. The national average for 2024/25 was at 11.6%. Whilst some trusts do not have anonymous routes, this cannot account for the significantly higher rate.
- For 2024/2025 nationally, 28.3% of concerns were raised by Nurses and Midwives with UHN a similar rate at 28.1%. For UHN this is mostly made up by nurses (21.9%) with midwives only accounting for 6.3%.
- A larger proportion of midwives speak up at KGH across the past 3 quarters compared to NGH in the Family Health Division. More concerns are raised by Nurses in this Division (primarily around paediatrics) in NGH.
- The proportion of admin/clerical staff to concerns raised remains consistent across NGH and KGH.
- Continued engagement is required with pharmacists, AHPs, students and Medical/Dental colleagues (including any staff on rotation/FTC/any other short term work arrangements).
- Whilst the numbers continue to differ slightly between KGH/NGH, the proportion of staff groups speaking up continues to remain consistent across the group.

Concerns by UHN Theme Q3



- Concerns heard nationally for 2024/2025 have increased for worker safety/wellbeing and behaviours, but are still heard across UHN at slightly higher rates. These two themes have previously been heard at a similar rate but for Quarter 3, more frequently at NGH.
- For quarter 3 there were no concerns relating to information governance, fraud, or sexual safety. Concerns heard by colleagues experiencing bullying and harassment sit lower for both trusts and are comparatively lower than national figures.
- Systems Processes and Policies was a key theme for NGH earlier this year and for Quarter 3 is prominent for both trusts. Process concerns have related to bank shifts, formal processes and recruitment processes.
- Inappropriate Behaviours/Attitudes has been a prominent theme in KGH compared to previous quarters. Whilst higher at NGH in numbers as a proportion of total concerns raised, behaviours was lower than usual.
- Of patient safety concerns raised, there were no instances of actual patient harm reported or discovered from investigation into patient safety concerns for quarter 3.



- Concerns relating to behaviours are heard consistently across each division in Q3.
- Patient safety concerns were raised in small numbers but consistently across each division, with the exception of CSS/CD where concerns were raised primarily about staff wellbeing and behaviours.
- With the aforementioned exceptions themes across divisions remained consistent.
- For corporate concerns there was a larger proportion of worker safety/wellbeing concerns, which correlates to concerns raised in this quarter about the length of formal processes and concerns about the impact of consultations on staff wellbeing.
- One concern themed as discrimination related to where a colleague felt that differing treatment of them could be explained by their ethnicity.
- One concern was raised relating to collaboration across the trusts, and referred to their poor experience of moving from one organisation to another including delays in payment.

Q3 Themes and Trends (UHN – Cross Site Issues)

Recruitment Processes: Separate concerns have been raised across both trusts about recruitment processes for both medical and nursing roles. These have been raised via the MD/Chief Nurse and in one instance the individual has come forward openly with their concerns. All have been investigated with no indication of inappropriate processes taking place at this time.

Behaviours/Attitudes: Individuals continue to come forward with concerns about specific colleague's behaviours. Where appropriate and consented this is escalated to the appropriate manager for review and in cases where the individual is happy to pursue are signposted to the resolution policy.

Historic Behaviours: Separate concerns were raised for three separate teams across UHN, relating to historic behaviours of individuals and the impact this has on the individual speaking up. In one case this has been escalated to the service manager, another the individual has left and raised their concern openly with the divisional director, and the other is seeking a resolution via the resolution/grievance policy.

KGH Specific Themes and Concerns

Pharmacy/New Starters: Anonymous individual felt as a new member of the trust they were unable to contribute to meetings and their views were not welcomed. Escalated to Chief Pharmacist for sharing.

FTSU and Mediation: Concern raised about the process followed by a manager once the concern was followed. Individual felt that other colleagues were unnecessarily linked in to conversations and that the process was a blame focus rather than remedial.

BSOTS Triage Concerns: Issues flagged with the BSOTS triage in maternity; staff feel there are not enough doctors to run it fully, and unnecessary admissions due to the fact the grading system does not allow for clinical decisions and judgement. This has reportedly led to delays in managing the delivery suite. Escalated to Head of Midwifery for oversight.

Blood taking in Maternity: Concern that anaesthetists when assisting with blood taking have requested midwives record their names inappropriately on bloods. Escalated via lead anaesthetist who has communicated expectations, reported improvement from individual speaking up.

Environmental/Estates Concerns: A number of environmental concerns were raised and escalated for appropriate action by estates, including a lack of heating on specific days and ongoing concerns about rats on the premises.

NGH Specific Themes and Concerns

Sickness Recording: Individual raised concerns about a colleague's sickness patterns and their suspicions this has not been recorded appropriately. Raised with the relevant manager who has confirmed proper process has been followed as part of a colleague's return to work.

Communication from Senior Managers: One individual brought ongoing concerns about poor communication from senior managers and a lack of response to emails. They have been signposted and opted to raise their concern openly with the CEO going forward.

Prolonged Patient Stay: A colleague brought a patient safety concern that a patient has been in care for a prolonged period of time and does not feel their bed space is appropriate. Escalated with the matron who has confirmed this is a complex case discussed regularly at MDT and with communication to NOK, and current arrangements are most appropriate for current circumstances.

Accidents at Work: A colleague reported an accident at work, upon returning from leave they felt little action had been taken. They have been appropriately signposted to and raised this openly with H&S for learning going forward to ensure this does not happen for other colleagues.

Work Conduct: Concerns raised about separate individual's conduct across NGH including coming to work late, leaving early, not completing jobs and failing to document work. These instances have been escalated with relevant heads of service for oversight.

Length of Processes: Colleagues continue to report formal processes taking a long time to complete. One individual has closed their grievance after no resolution for 2 years; whilst they feel their situation has improved they do not feel this is as a result of any action taken.

Environmental/Estates Concerns: Some estates issues have been raised via FTSU and raised with Head of Estates. Colleagues have been signposted to estates helpdesk where appropriate. A process is also under development to improve communications and reporting between volunteers and estates. Throughout Q2/3 a number of concerns were raised about cigarette smoking and waste outside of ED which has seen more waste bins and receptacles put in place to help remedy.

Detriment: 2 cases of detriment were reported for NGH. One anonymous report themed as detriment about an unknown area included reports that when raising concerns locally, managers 'tell them off' in front of colleagues and discourage it. In the other case, an individual had raised concerns confidentially via senior leadership but felt once some fact finding took place that their identity became apparent and that they have experienced different treatment at work as a result.

National Guardians Office Data Annual Comparison with UHN

Highlights from NGO report 2024/2025 on national data compared to UHN Q3 2025-2026

One in every three cases raised (38.9%) involved an **element of worker safety or wellbeing.**

KGH: 40.9% ↑ **NGH: 53.4%** ↑

Two in every five cases (39.7%) involved an element of **innapropriate behaviours and attitudes**.

KGH: 54.5% ↑ **NGH: 40.4%** ↑

18.4% of cases reported included an **element of bullying or harassment.**

KGH: 10.6% ↓ **NGH: 8.2%** ↓

17.8% of cases raised included an element of **patient safety/quality**

KGH: 19.7% ↑ **NGH: 20.5%** ↑

Detriment for speaking up was indicated in 2.9% of cases

KGH: 0% ↓ **NGH: 1.4%** ↓

Note: Following advice from the National Guardian's Office, those concerns raised and reported internally as UHN/Group-specific must be reported for both NGH and KGH in our national submissions.

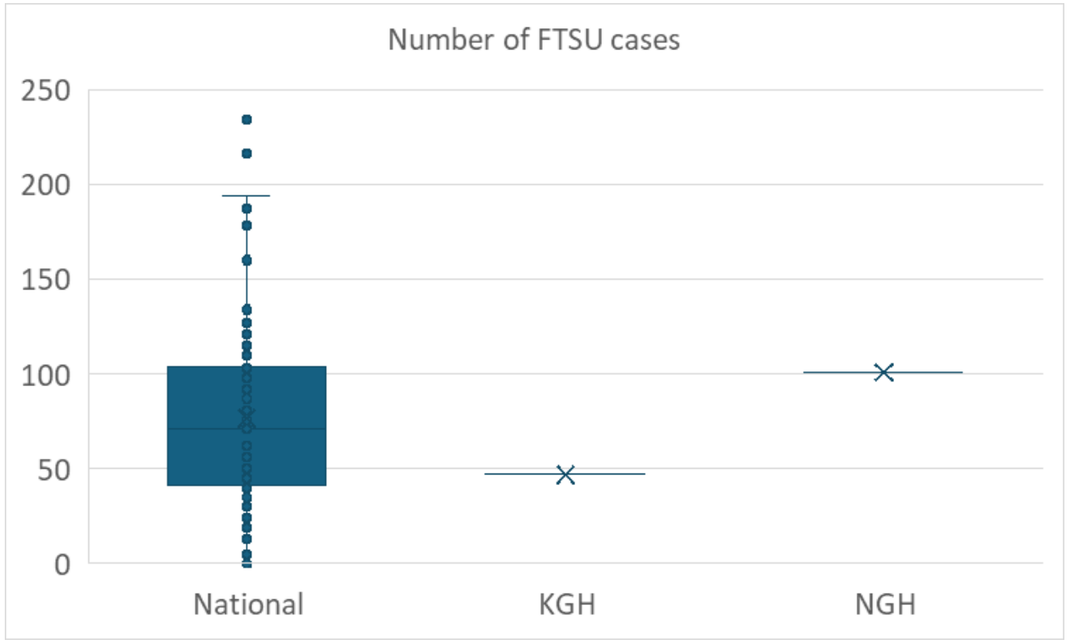
There were no group specific concerns submitted for Quarter 3.

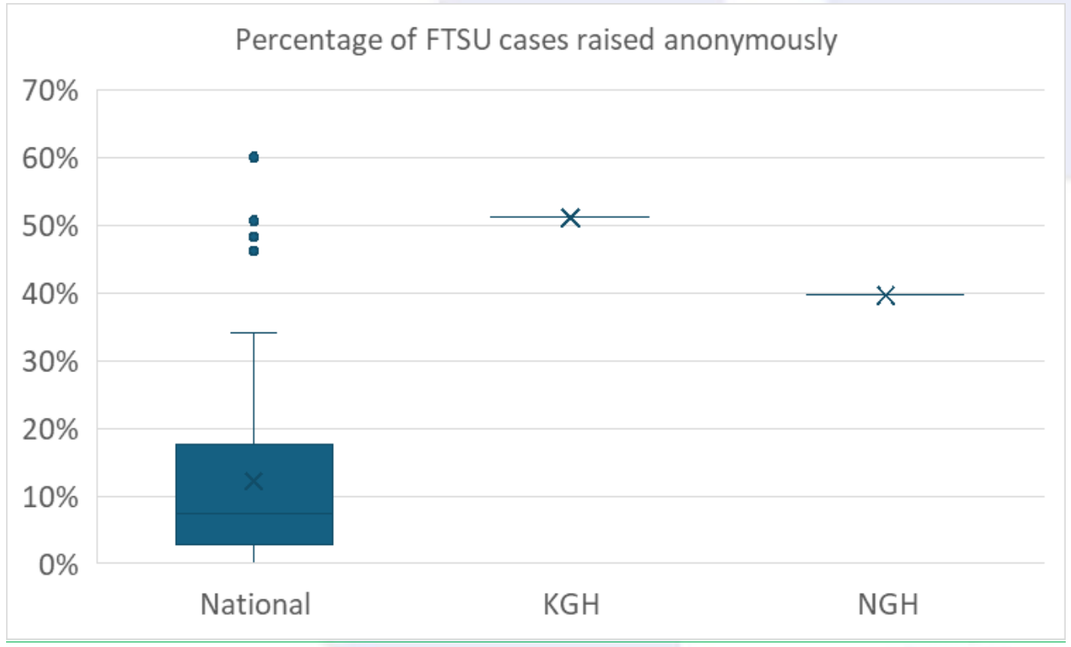
2025/2026	KGH Q3	NGH Q3
Inappropriate Behaviours and Attitudes	13	16
Bullying or Harassment	0	7
Patient Safety/Quality	4	7
Worker Safety or Wellbeing	7	27
Detriment	0	2

Comparing the concerns raised and propostion raised anonymously – Q1 & Q2 data

KGH is in the lower quartile for concerns raised, whilst NGH is in the upper quartile.

Both Trusts are outliers for the proportion of concerns raised anonymously, significantly above the average national rate of 12% at 51% (KGH) and 40% (NGH). Based on discussions in the Guardian networks, we are making it easier to report anonymously than most Trusts, but this does not fully explain the high proportion of anonymous responses.





Report – Boards of Directors

Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item	16

Title	Implementation of NHS England's 10 Point Plan to Improve Resident Doctors' Working Lives
Presenter	Hemant Nemade, Medical Director
Author	John Evans, Deputy Medical Director

Link to Group Priorities (select all that apply):		
☐ Transform Patient Care	X Strengthen our Culture	☐Deliver our financial plan
Engaged colleagues deliver excellent patient care.	*Engaged colleagues deliver excellent patient care*	*Engaged colleagues will support the delivery of our financial plan*

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

Reason for consideration	Previous consideration
NHS England issued a 10 Point Plan for improving the working lives of resident doctors (2025). This paper is to assure the boards that all necessary actions have been undertaken.	Boards of Directors, October 2025 People Committee, January 2026

Executive Summary

A steering group was established to respond to the national request for action and met every two weeks to ensure progress. The initial survey was completed in September with a follow up survey at the start of December. Much of the initial work had been done in a previous work programme entitled “Enhancing Doctors’ Experience” and this enabled us to provide a very positive response in September. During the steering group meetings, it became clear that there was still work to be done and the follow up survey suggested a step backwards. Now that the ‘unknowns’ have been established, all necessary initial work has been completed.

Appendices

None

Risk and assurance

A new Board Assurance Framework entry has been mandated by NHSE to track delivery, with oversight through the People Committee and escalation to the Boards as required.

Financial Impact

Quote for work to improve access to lockers for all resident doctors approved at £9,249.60 + VAT. Audits and reporting will require resource from People Services and Medical Education. Improved retention and reduced payroll errors are expected to generate longer-term savings.

Exception reporting reforms may increase requests for payment from LEDs for working extended hours. Exception reporting fines will be redistributed internally and so should have no net effect.

Legal implications/regulatory requirements

The 10 Point Plan is a national mandate from NHS England. Compliance will be considered part of organisational assurance.

Equality Impact Assessment

Several elements of the plan directly address inequality, including tackling payroll errors, and ensuring fairness in training and rota processes. Implementing the plan will therefore have a positive impact on equality of opportunity and workforce inclusion.

Paper

Situation

The NHS England 10 Point Plan is designed to improve the day-to-day experience of resident doctors. It builds directly on the *Improving the Working Lives of Doctors* letter issued in 2024, which led UHN to establish the Enhancing Doctors' Experience (EDE) Group.

The EDE Group brought together multiple workstreams, but in practice much of the work progressed within existing teams, and the group did not operate as an enduring forum. The 10 Point Plan introduces mandatory requirements and clearer accountability, meaning UHN must now ensure that progress is consistently captured, monitored, and reported at Board level.

Delivery requires a coordinated organisational response across both NGH and KGH. Integrated Leadership Team (ILT) has endorsed this direction and recommended the establishment of a group to oversee implementation and progress. The group will operate initially in line with the national timeline and is expected to continue thereafter, providing a mechanism for sustained oversight, assurance and alignment across both sites.

Background

The Enhancing Doctors' Experience (EDE) Programme provided a platform for improvement across payroll, rota management, wellbeing, engagement, IMG support, and facilities, with several workstreams already aligned to NHS England's high-impact actions. This programme gave us a strong platform for improvement, with several workstreams already aligned to NHS England's earlier high-impact actions.

The publication of the 10 Point Plan in 2025 changed the landscape by making a number of requirements mandatory and by introducing additional expectations. These include:

- Appointing a Board-level lead and peer representative for resident doctors.
- Auditing and reporting payroll errors specifically linked to rotational changeovers.
- Ensuring study leave expenses are reimbursed within 4–6 weeks.
- Implementing the new national framework for exception reporting once published.
- Preparing for the introduction of a Lead Employer model.

Assessment

1. **Workplace wellbeing:** Audit of access to rest areas/hot food etc has been completed by the Chief Registrar and Estates team. Deficiencies in locker provision are being addressed by remedial work with budget approved.

2. **Work schedules and rotas:** UHN is broadly compliant with the 8-week/6-week notice standard, though this is occasionally affected by late deanery information or departmental submissions. Incidences of late notice are being monitored by People Services, and performance will be submitted to the People Committee.

3. **Annual leave equity:** Good annual leave practice is covered in Resident Doctor Inductions. Leave policy includes references to Resident Doctors, and Residents are able to carry over leave between rotational placements at NGH or KGH if necessary (although not to a different Trust).

4. **Board-level accountability:** Hemant Nemade (Medical Director) and Bashar Adeen (Chief Registrar) have been identified as Board Lead and peer representative respectively. The Chief Registrar role now needs to be formally recognised in governance documents and Board reporting cycles.

5. **Payroll errors:** Mechanism to monitor payroll errors is now in place with monthly reporting now submitted to NHSE. This will be reported to the Board via the People Committee.

6. **Training portability:** UHN is compliant, with CSTF alignment and portability arrangements in place following the national StatMand programme.

7. **Exception reporting:** A Task & Finish Group has been established locally, led by the new Guardians of Safe Working in order to implement the Exception Reporting Reforms. Mechanisms for levying and distributing fines have been put in place. LEDs are already able to submit Exception Reports at KGH and will be able to do so at NGH prior to the deadline of February 4th 2026.

8. **Expenses:** Successful implementation of processes to approve expense reimbursement as soon as the course is paid for (rather than awaiting evidence of attendance) has now been achieved at both NGH and KGH.

9. **Rotation impact:** This is being led nationally, but UHN should begin to consider local risks and implications.

10. **Lead Employer model:** This is being led nationally, but UHN should begin to consider local risks and implications.

Recommendations

The Boards of Directors are asked to:

1. Note, and indicate assurance in respect of, the work that has been done so far in response to the 10-point plan, and
2. Endorse ongoing monitoring of compliance via the People Committee.

Meeting	Boards of Directors of KGH and NGH Meeting together in public as the University Hospitals of Northamptonshire NHS Group
Date	6 February 2026
Agenda item number	17
Title	Quarter 3 25/26 Board Assurance Framework (BAF) Report
Presenter	Susan Clennett, UHN Deputy Director of Risk and Legal Services
Author	Susan Clennett, UHN Deputy Director of Risk and Legal Services

Group Priorities		
☒ Transform Patient Care	☒ Strengthen our Culture	☒ Deliver our financial plan
Identification of strategic risks and management of those risks.		

This paper is for			
☐ 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 recipients without the in-depth discussion as above	To reassure the recipients that controls and assurances are in place

Reason for consideration	Previous consideration
To receive and be assured: 1. That the identification and management of strategic risks within the BAF is robust. 2. That Executive Directors and Committees of the UHN Boards of Directors ensure that strategic risks are dynamically managed and integral to delivery of UHN's objectives.	Qtr 2 25/26 BAF on 5th December 2025. Committees of the Boards, January 2026

Executive Summary

The quarter 3 25/26 updated BAF has been reviewed in January 2026 by those executive directors responsible for strategic risks, as indicated in the attached report.

Additionally during January 2026, all committees of the UHN Boards of Directors have received and discussed the updated strategic risks. Committees' consideration of the BAF has also included:

- Agreement that the current assessed level of risk scoring is appropriate (there has been no change in risk scoring during quarter 3);
- Ensuring that report cover sheets detail associated strategic risks and that risk descriptions in each are clear;
- Provision on agendas to allow for both consideration of the BAF and reassessment of meeting content that may inform future updates;
- A view that the revised format of the BAF is now a more interactive document, assisting the various committees' understanding of risks, controls, assurances and planned actions.

The December 2025 Boards requested assurance that each BAF risk is informed by risks within the Corporate Risk Register (CRR).

An initial review of the 52 risks within the CRR evidenced that there are significant operational risks (scoring 15 and above) informing all strategic risks within the BAF. This work is ongoing in terms of validating links with the BAF and where those operational risks may inform multiple BAF risks. For example, BAF risks on collaborative working across UHN, infrastructure, activity and culture are linked to similar BAF risks but also inform

other risks such as patient safety and experience. CRR links with the BAF are shown on the “Summary of BAF Risks” section of the attached report.

The 2025 internal audit of the BAF reported Reasonable Assurance with recommendations all now completed:

- Controls and assurances clarified on a number of risks and committee responsibility for assurance on this confirmed;
- All planned actions have due dates
- Confirmation that all strategic risks are allocated to a responsible committee.

As part of the process of gaining further assurance over the BAF, and therefore the management of the strategic risks of UHN, the Audit Committees are requesting Executive Directors to attend on a rotational basis and provide assurances.

Following consideration of the risks, any updates agreed at this committee will be actioned, in order to evidence a culture of dynamic risk management and to inform onward reporting of the BAF to the Boards.

Appendices
BAF Report Appendix 1: UHN Risk Appetite for 2025/26
Risk and assurance
The Risk Management systems and processes up to and including the BAF support a well-led organisation and evidence ownership and continual assessment of and assurance on the management of risks. Risks are assessed quarterly (or more frequently as required) and quarterly assurance updates are provided against each BAF risk. Reports into the UHN Boards Committees now include reference to relevant BAF risks.
Financial Impact
None
Legal implications/regulatory requirements
Supports CQC Well-led requirements
Equality Impact Assessment
Neutral

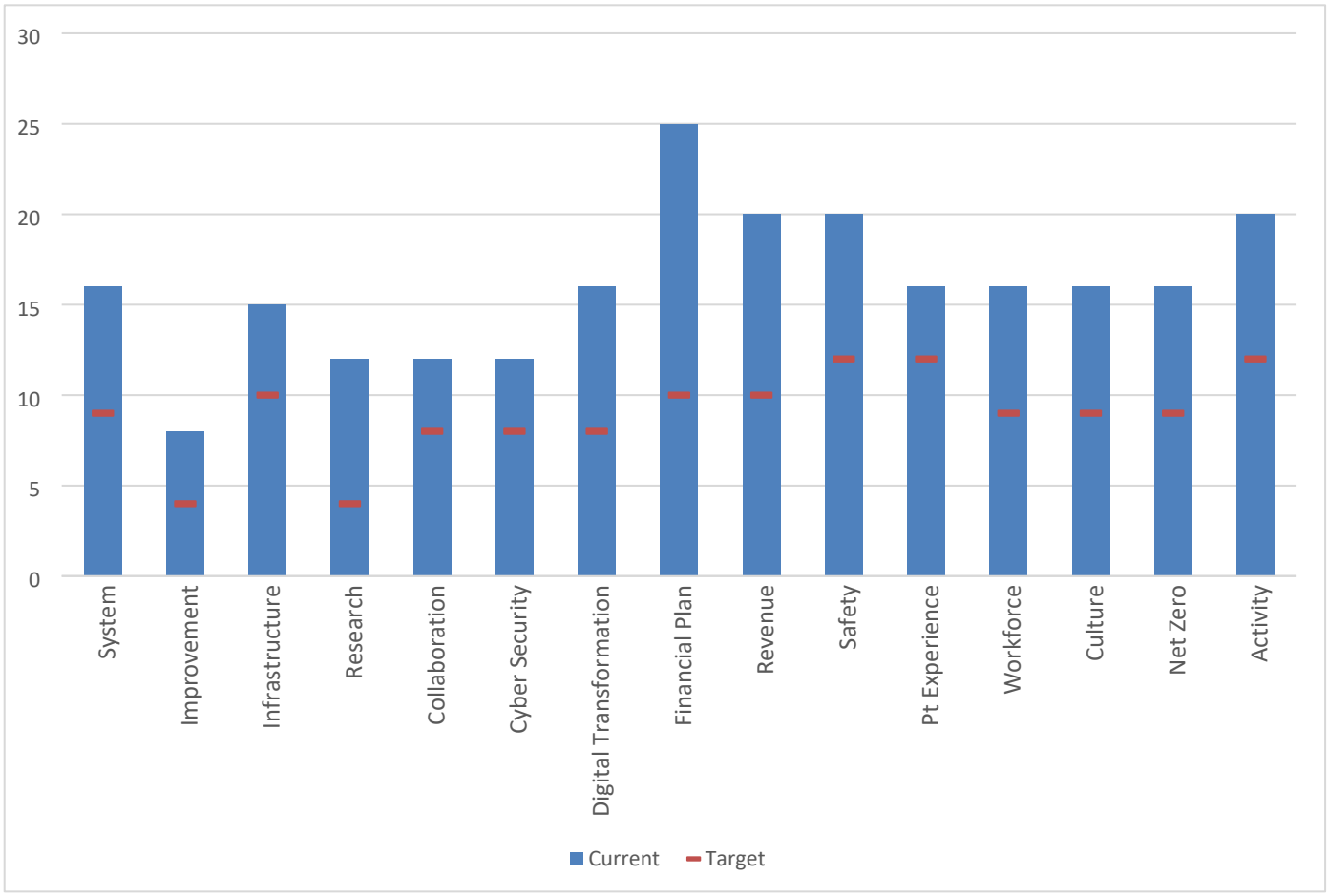
Summary of BAF Risks

Risk ID	Linked Corporate Risks Validation Pending	Strategic Priority / Deliverable	Risk Description	Lead and Committee	Current Score	Current Tolerance	Domain Risk Appetite
UHN10	KCRR4604 KCRR5001	**Transform Patient Care** Learning Culture/Continuous Improvement	If UHN does not progress with continuous improvement plans, we will not have the capability and capacity to deliver the level of patient care that we wish to achieve, resulting in impact on the quality of care, efficiencies and staff morale impacted by potential restrictions on working in an autonomous organisation, supporting individuals to thrive.	Director of Continuous Improvement Quality and Safety	**8** **C4xL2**	**4** **C2xL2**	Quality / Patient Exp **Open**
UHN11	KCRR5140 KCRR4388 KCRR4748 (Noting most corporate risks may impact patient safety)	**Transform Patient Care** Improved clinical outcomes, experience and effectiveness	If we do not have a positive safety culture consistently embedded across our services there is a risk that we will fail to continuously learn and improve and that: Healthcare acquired infections and harm do not reduce as planned; families and carers will not be fully engaged in service development; care for all patients and especially those with mental health needs, learning disabilities, autism, dementia, or at end of life will remain inconsistent; patients from underserved groups continue to experience poorer access, communication, and outcomes	Chief Nurse / Medical Director Quality and Safety	**20** **C4xL5**	**12** **C3xL4**	Patient Safety **Minimal**
UHN12	Linked to corporate risks as in UHN11 and noting most corporate risks may impact patient experiences	**Transform Patient Care** Patient voice strengthened and improved patient and carer exp.	If we do not consistently embed a culture of compassionate, responsive, and inclusive care across all services, there is a risk that we will fail to deliver a positive and equitable patient experience. This may result in: Patients and families feeling disengaged or unheard, leading to reduced trust and satisfaction; Continued variability in the quality of fundamental care, especially for patients with complex needs or communication barriers; Poor compliance with accessible information standards, limiting patients' ability to understand and participate in their care; Delays or inconsistencies in responding to complaints and feedback, missing opportunities for service improvement; Patients from underserved groups continuing to experience inequitable access, communication, and outcomes; Reduced ability to meet national and regulatory expectations for patient involvement and experience	Chief Nurse / Medical Director Quality and Safety	**16** **C4xL4**	**12** **C3xL4**	Quality / Patient Exp. **Open**
UHN13	NCRR5607 NCRR5659 NCRR5488	**Transform Patient Care / Strengthen Culture** 10% Increase Research Activities/Trials	If UHN is unable to attract and retain high calibre staff then this may result in UHN being unable to deliver on our research and Development ambitions, resulting in UHN being unable to increase our research and clinical trial activities by 10% and where support to take an innovative role in healthcare research will not achieve the best possible outcomes for our patients.	Medical Director Quality and Safety	**12** **C4xL3**	**4** **C4xL1**	Innovation **Open**
UHN14	KCRR2096, 2199, 2527, 3206, 3574, 3833, 4391, 3999, 3575, 4764, 5305 NCRR 5500, 5499	**Strengthen Culture / Transform Patient Care / Finance** Deliver our quality priorities	If estate buildings and infrastructure continue to deteriorate and/or fail, then delivery of services may be impacted resulting in delayed or sub-optimal patient care, safety of all persons and an inability to deliver key UHN strategies.	Director of Strategy Strategic, Transformation and Digital	**15** **C5xL3**	**10** **C5xL2**	Infrastructure **Minimal**

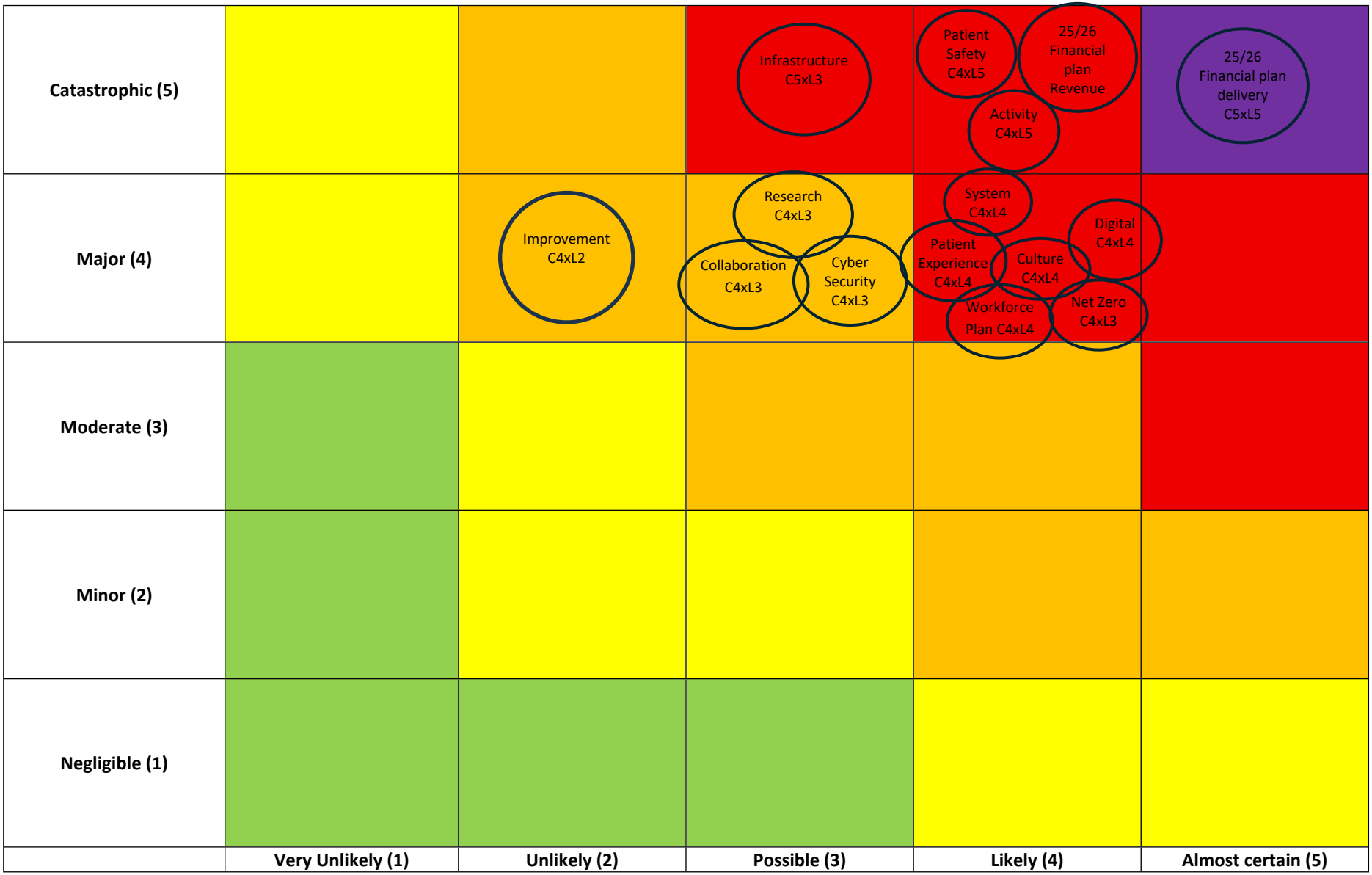
UHN15	KCRR5033, NCRR5699, 5705	**Transform Patient Care** Deliver national access targets	If there is insufficient capacity to meet the demand on services patients will wait longer for urgent and emergency care, elective care and cancer care leading to patient harm, compromised clinical outcomes and experience.	Chief Operating Officer Finance, Investment and Performance	**20** **C4xL5**	**12** **C4xL3**	Activity **Open**
UHN16	NCRR5544	**Deliver Financial Plan** Development of a medium term robust financial plan	The risk of impacts on patients and services of increased regulatory intervention (NHSE) and medium-term financial penalties (revenue and capital) arising from failure to deliver improvement in the underlying revenue position and delivery of a break-even financial position over the medium term	Chief Finance Officer Finance, Investment and Performance	**20** **C5xL4**	**10** **C5xL2**	Finance **Minimal**
UHN17	KCRR4181, NCRR5542	**Deliver Financial Plan** Delivery of 25/26 financial/workforce plan	The risk of impacts on patients and services because of increased regulatory intervention (NHSE) and loss of deficit support funding resulting from non-delivery of the 2025/26 financial plan.	Chief Finance Officer Finance, Investment and Performance	**25** **C5xL5**	**10** **C5xL2**	Finance **Minimal**
UHN18	NCRR5607, 5608,	**Strengthen Culture** Take action on 2024 staff survey / deliver people plan actions for 2025	Failure to address poor behaviours in the workplace or to provide key components of a safe workplace culture will lead to a culture in which colleagues feel unsafe and under-valued, unsupported or excluded, resulting in poor staff engagement, retention and morale, elevated sickness absence and will ultimately impact patient care.	Chief People Officer People Committee	**16** **C4xL4**	**9** **C3xL3**	Culture **Minimal**
UHN19	KCRR2556, NCRR5488, 5606, 5659	**Deliver Financial Plan** Workforce plan as component of financial plan delivery	A robust resourcing and workforce controls strategy in support of our workforce plan is required to ensure the provision of safe patient care whilst managing workforce numbers and costs. Failure to deliver the workforce plan will lead to inefficient use of resources (skill gaps in areas covered by bank or agency or over-establishment use driving inefficiency) creating financial pressures and constraints and having a negative impact on the quality of patient care.	Chief People Officer People Committee	**16** **C4xL4**	**9** **C3xL3**	Workforce **Open**
UHN20	KCRR3659, 3754, 5135, 2517, 4830, NCRR5651, 5707, 5762,	**Transform Patient Care** Go further in integrating clinical and corporate services across UHN, delivering seamless pathways and improving safety and outcomes for our patients.	If there are delays in the delivery of the collaborative working model with UHL this will impact on improving productivity and creating joint plans which will impact on the trust being able to deliver seamless pathways and improve patient safety and outcomes for our patients.	Medical Director Quality and Safety	**12** **C4xL3**	**8** **C4xL2**	Patient Safety **Minimal**
UHN21	KCRR1582, 3558, NCRR5652,	**Transform Patient Care** Cyber security	Failure to maintain robust cyber security and information systems infrastructure may result in service disruption, data breaches, or compromise of patient safety and organisational operations. This includes risks from cyber-attacks, network	Group Chief Digital	**12** **C4xL3**	**8** **C4xL2**	Information **Minimal**

	5655, 5654, 5704		instability, inadequate data protection measures, and failure to meet national security standards and impact on patients.	Information Officer Strategic, Transformation and Digital			
UHN22	5615	**Deliver Financial Plan** Deliver our quality priorities	If we do not eliminate our greenhouse gas emissions, limit our impact on the environment and take action to achieve our net zero targets then we will fail to be compliant with UK legislation, NHS targets, and our own publicly declared ambitions leading to potential patient harm to patients and staff through pollution and service outages, an increase in waste, inefficiency and spend and potential regulatory action from failing to meet Trust, NHS and legislative targets.	Director of Strategy Strategic, Transformation and Digital	**16** **C4xL4**	**9** **C3xL3**	Net Zero **Open**
UHN23	KCRR1972	**Transform Patient Care** Accelerate work to integrate patient care, removing barriers between secondary, community and primary care services	If integrated working with wider partners in our county or region is not sufficiently mature, our ability to deliver key elements of the NHSE 10 yr plan, realise our Anchor Institution ambitions or address demand from population health longer term, becomes compromised, impacting on high quality patient care and experience.	Director of Strategy Strategic, Transformation and Digital	**16** **C4xL4**	**9** **C3xL3**	Pt Experience/ Quality **Open**
UHN24	NCRR5658, 5653, 5657, KCRR5045, 2135	**Transform Patient Care** Deliver major digital change	Failure to deliver the Group's digital transformation agenda may result in continued operational inefficiencies, inability to standardise care delivery across sites, and failure to realise productivity benefits. This specifically includes risks to EPR implementation, automation programmes, and the broader digital strategy delivery impacting our ability to transform services and achieve digital maturity.	Group Chief Digital Information Officer Strategic, Transformation and Digital	16 C4xL4	8 C4xL2	Information **Minimal**

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


Overview of current risk v target risk
30
25
20
15
10
5
0
System
Improvement
Infrastructure
Research
Collaboration
Cyber Security
Digital Transformation
Financial Plan
Revenue
Safety
Pt Experience
Workforce
Culture
Net Zero
Activity
Current
Target

Board Assurance Framework Heatmap



BAF DETAIL

Risk ID:	UHN10
Strategic Priority:	Transform Patient Care
Risk Description:	If UHN does not progress with continuous improvement plans, we will not have the capability and capacity to deliver the level of patient care that we wish to achieve, resulting in impact on the quality of care, efficiencies and staff morale impacted by potential restrictions on working in an autonomous organisation which supports individuals to thrive
Key Deliverable:	Foster a learning culture, rolling out our "Improving Together" continuous improvement methodology
Executive Lead:	Becky Taylor, Director of Continuous Improvement
Assurance Committee:	Quality and Safety Committee

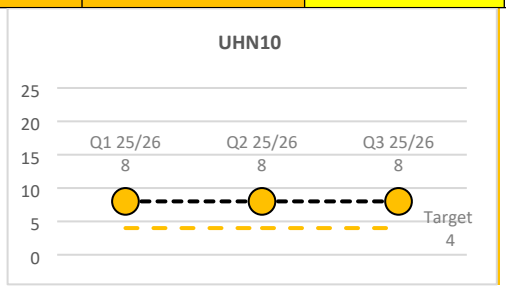
Key Controls	Key Assurance
Improving together five year strategy	Monthly assurance reporting via Improving Together Steering Group
Annual workplan aligned to strategy	Corporate accountability metrics/reporting - commencing
Metrics for delivery	Self assessment (NHSE Impact Framework)
Annual schedule of quarterly events (building staff morale)	
QI Training Programmes	
Corporate Accountability Meetings	

Gaps in control or assurance

Schedule of annual self assessments (NHSE Impact Framework) – agreed delay due to organisational restructure, now planned for Q1 26/27
Embedding the corporate accountability metrics/reporting

Risk Scores

	Qtr2 25/26	Qtr3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	4	4	2	Innovation Open
Likelihood	2	2	2	
Risk Scores	**8**	**8**	**4**	



Planned Actions (by due date)

Metrics agreed for corporate accountability with corporate execs – due Jan 2026
QI development within the N-LEAF ward accreditation framework – to be launched Feb 26
Improvement week for NGH and KGH wards – Dec 25 & Jan 26, respectively
Second annual QI awards to be held – Apr 26
QI training to be embedded in Emerging and Established Leadership Programmes and training capacity to be doubled – Apr 26

Q3 25/26 executive commentary

Key successes in Q3 25/26 of the Improving Together strategy:

- Increase in the number of QI projects from 80 to 140 from December 2024 to December 2025
- First UHN Rapid 'Improving Together' Week held to support improved working on the wards in Northampton
- Secured funding for, and collaborative design of QI and metric approach with the corporate nursing team to support the new ward accreditation framework, to be built on the Federated Data Platform

Key challenges and risks in Q2 25/26:

- Capacity for clinical and operational colleagues to engage in continuous improvement
- Communications capacity to be able to support organisation-wide communications around improvement
- Availability of data and metrics to support data driven improvement

Risk ID:	UHN11
Strategic Priority:	Transform patient care
Risk Description:	If we do not have a positive safety culture consistently embedded across our services there is a risk that we will fail to continuously learn and improve and that: - Healthcare acquired infections and harm do not reduce as planned - Families and carers will not be fully engaged in service development - Care for all patients especially those with mental health needs, learning disabilities, autism, dementia, or at end of life will remain inconsistent - patients from underserved groups continue to experience poorer access, communication, and outcomes
Key Deliverable:	Improved clinical outcomes, patient experience and clinical effectiveness
Executive Lead:	Chief Nurse & Medical Director
Assurance Committee:	Quality Committee

Key Controls	Key Assurance
Implementation of the patient safety incident response framework	Quality and Safety Committee oversight Regular updates on incident trends, divisional risks, and improvement actions are reviewed, with triangulation of claims, inquests, and audit data.
Clinical policies and guidelines	Policies and guidelines are in date and compliance with monitoring reporting through PSC Compliance with Statutory and mandatory training programme
Clinical audit and improvement programme	Regular audits and thematic reviews (e.g., VTE, sepsis, antimicrobial stewardship) drive targeted improvements and accountability across divisions. Nursing metrics and medicines management reports to NMAHP committee
NLEAF assessment and accreditation programme	Ward to board oversight of key metrics and accreditation ratings
Freedom to speak up strategy	Quarterly thematic updates on freedom to speak up service including fear of detriment monitoring
Targeted improvement plans for key domains of the quality strategy	Quarterly update on implementation of the quality strategy
Duty of Candour and Family Engagement	Thematic reviews of concerns, complaints, national surveys and the friends and family test Compliance with duty of candour
Subject matter experts and specialist teams employed across the organisation	Annual reports from relevant teams such as Infection prevention, safeguarding, patient safety and patient experience
CQC improvement programmes	Organisational and service level CQC ratings /external validation Peer review outcomes Quality assurance visit outcomes Compliance with Maternity Incentive Scheme

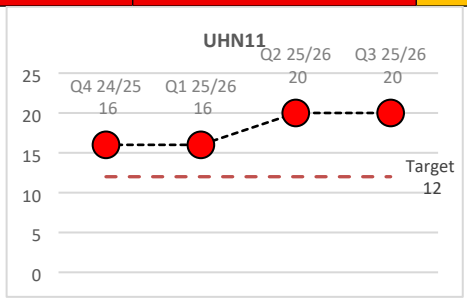
Gaps in control or assurance

- Concerns about effective learning from incidents and adoption of PSIRF across the group
- Compliance with sepsis six care bundle across both sites and mortality alert for NGH
- Neither maternity service has full compliance with the Maternity Incentive Scheme
- Regulatory breaches identified by the CQC across UEC and medicine (NGH) and maternity (KGH) resulting in enforcement notice
- We did not meet all nationally set trajectories for healthcare acquired infection in 2024/25
- Increasing ambulance handover delays; Crowding within the ED and normalisation of boarding; Delayed supported discharges; Delays to planned care. NGH in tier 1 for the provision of UEC
- Kettering General Hospital remains on the maternity safety support programme due to safety and cultural concerns
- Concern about teamworking and uncivil behaviours impacting on the safety culture
- CYP urgent and emergency care remain under regional oversight due to safety concerns
- The financial position at UHN is significantly challenged - leading to a £80million CIP programme with proposed headcount reductions. Pressure to deliver savings rapidly could result in rushed implementation of CIPs without robust clinical engagement or risk mitigation, heightening risk of harm
- Deterioration in Staff Wellbeing and Psychological Safety: Ongoing uncertainty about job security and workload increases may lead to presenteeism, rising sickness, and reluctance to speak up - masking early signs of harm or dysfunction.
- ICS Financial Pressures Impacting Shared Services: Financial recovery plans across the ICS could reduce support services (e.g. community capacity, mental health input, diagnostics), intensifying acute pressures at UHN

- The estate is aged and doesn't meet modern standards for healthcare including ventilation, water and lifts
- Fundamental care compliance not consistently embedded
- Timely response to complaints and engagement with patients, families and carers and variability in engagement and accessibility
- Compliance with accessible information standards
- Implementation of the risk management policy across the group
- Medicine safety management and optimisation compliance is not consistently embedded
- Increasing concern from the regional team about our organisation
- Deterioration in culture metrics following staff survey

Risk Scores

	Qtr 2 25/26	Qtr 3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	4	4	3	Patient Safety Minimal
Likelihood	5	5	4	
Risk Scores	**20**	**20**	**12**	



Proposed Actions (by due date)

1. Roll out of PSIRF with internal audit assessment planned for end of year 2 – April 2026
2. Sepsis working party in place chaired by Deputy Medical director – April 2026
3. Perinatal safety programme in development to support delivery of MSSP exit criteria and CQC enforcement actions – April 2027
4. CQC rapid improvement programme in place for UEC and medicine – Rapid programme now complete. Sustainability in progress
5. Infection prevention and control work plan in place – April 2026
6. UEC improvement programme in place to improve flow in, through and out of the organisation April 2026
7. Robust QIA process in place to ensure safe delivery of CIP Programme. Clinical representation in place on all groups – Ongoing
8. Launch of civility saves lives programme – Initiated
9. Development of the NLEAF assessment and accreditation programme with fundamentals of care – April 2026
10. Corporate nursing restructure to support consistent delivery of care across UHN – February 2026
11. Accessible information standards working group developing a road map to compliance – March 2026
12. Review of the corporate risk registers across UHN – Initiated
13. Medicine management improvement programme – March 2026
14. Strengthening of freedom to speak up guardian services –Plan approved by ILT, implementation in progress.
15. Implementation of the recommendations from the "what good looks like" review for quality governance – April 2026

Q3 25/26 executive commentary

We continue to face significant challenges across safety, access, workforce, and financial domains, which are collectively impacting our ability to deliver consistently high-quality care. These pressures are heightened by sustained operational and internal system strain, inconsistent adoption of core care processes, and ongoing issues with data reliability, all of which limit our ability to drive improvement at pace and with confidence.

Concerns remain about the effective embedding of learning from incidents and the full adoption of the Patient Safety Incident Response Framework (PSIRF) across the group. While training and support are underway, uptake remains inconsistent, undermining the development of a mature safety culture and reducing our ability to use harm reviews to drive meaningful and sustained learning.

Clinical compliance remains variable in key risk areas. Delivery of the Sepsis Six care bundle is inconsistent, although recent weeks show early signs of improvement. This underscores the need for strengthened clinical oversight, reliable data capture, and targeted improvement interventions. In maternity services, neither site has achieved full compliance with the Maternity Incentive Scheme (MIS), and Kettering General Hospital continues on the Maternity Safety Support Programme due to ongoing concerns

around safety, culture, and leadership behaviours. These issues sit alongside regulatory breaches identified by the CQC across urgent and emergency care (UEC), medicine, and maternity services (KGH), reinforcing the scale and persistence of the challenge.

We did not meet all nationally set trajectories for healthcare-acquired infections (HCAIs) in 2024/25 despite focused effort; however, early evidence from the current improvement plan is encouraging and suggests emerging progress.

Operational pressure remains significant. Ambulance handover delays are increasing, and crowding within the emergency department has become normalised, with corridor care now routine. Delayed supported discharges and extended waits for planned care continue to constrain patient flow and adversely affect experience. The winter plan for 2025/26 has had wide engagement and aims to deliver a much smaller bed deficit than last year, but the system remains fragile.

Fundamental care compliance is not consistently embedded, and there remains variability in the timeliness and quality of complaint responses and engagement with patients, families, and carers. Compliance with accessible information standards also remains inconsistent. Implementation of the risk management policy is progressing but not yet fully embedded across services. Medicines safety improvement work is underway, though further assurance is required regarding optimisation and safe practice.

Despite these significant and wide-ranging risks, core quality outcomes remain strong when viewed through the Integrated Performance Report (IPR). However, the breadth and depth of challenges require sustained executive focus, strengthened clinical leadership, reliable data, and robust mitigation planning to ensure the delivery of safe, effective, and equitable care across the group.

Risk ID:	UHN12
Strategic Priority:	Transform patient care
Risk Description:	If we do not consistently embed a culture of compassionate, responsive, and inclusive care across all services, there is a risk that we will fail to deliver a positive and equitable patient experience. This may result in: - Patients and families feeling disengaged or unheard, leading to reduced trust and satisfaction - Continued variability in the quality of fundamental care, especially for patients with complex needs or communication barriers - Poor compliance with accessible information standards, limiting patients' ability to understand and participate in their care - Delays or inconsistencies in responding to complaints and feedback, missing opportunities for service improvement - Patients from underserved groups continuing to experience inequitable access, communication, and outcomes - Reduced ability to meet national and regulatory expectations for patient involvement and experience
Key Deliverable:	Patient voice is strengthened and improved patient and carer experience
Executive Lead:	Chief Nurse & Medical Director
Assurance Committee:	Quality and Safety Committee

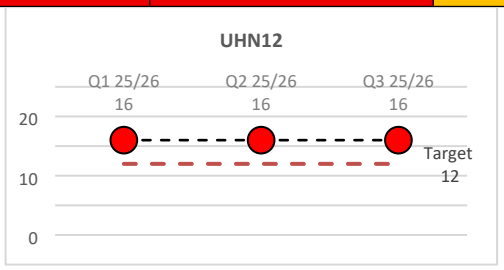
Key Controls	Key Assurance
Patient experience strategy	Quality and Safety Committee oversight Regular reporting on patient experience metrics, complaints, and engagement activities, with triangulation against safety and workforce data.
Accessible information standards compliance	Policies, training and technology in place to ensure patients receive information in formats that meet their communication needs, including easy-read, large print, and translation services.
Fundamental Care Audits supporting NLEAF assessment and accreditation programme	Routine audits of nutrition, hydration, hygiene, and dignity standards to ensure consistent delivery of fundamental care across all wards and departments. Ward to board oversight of key metrics and accreditation ratings
Complaint and feedback handling	Quality and Safety Committee oversight Regular reporting on patient experience metrics, complaints, and engagement activities, with triangulation against safety and workforce data.
Freedom to speak up strategy	Quarterly thematic updates on freedom to speak up service including fear of detriment monitoring
Family and carer engagement	Patient stories, co-design workshops, and involvement in service reviews to ensure families and carers are active partners in care improvement.
Equity and inclusion framework	Targeted actions to reduce disparities in access and outcomes for patients from underserved communities, supported by data monitoring and staff training. Mandatory training on communication, equality, and person-centred care embedded into induction and ongoing development programmes.
Patient experience surveys	Monthly reporting of patient experience indicators, including FFT scores, complaint response times, and accessibility compliance. Benchmarking of national surveys with appropriate action plans
CQC Improvement Programmes	Organisational and service level CQC ratings/validation Peer review outcomes Quality assurance visit outcomes

Gaps in control or assurance

- Concerns about effective learning from complaints and patient experience surveys
- Regulatory breaches identified by the CQC across UEC and medicine (NGH) and maternity (KGH) in relation to the safe and caring domains.
- Increasing ambulance handover delays; Crowding within the ED and normalisation of boarding; Delayed supported discharges; Delays to planned care. NGH in tier 1 for the provision of UEC
- Kettering General Hospital remains on the maternity safety support programme due to safety and cultural concerns
- CYP urgent and emergency care remain under regional oversight due to safety concerns
- The financial position at UHN is significantly challenged - leading to a £80million CIP programme with proposed headcount reductions. Pressure to deliver savings rapidly could result in rushed implementation of CIPs without robust clinical engagement or risk mitigation, heightening risk of harm
- Deterioration in Staff Wellbeing and Psychological Safety: Ongoing uncertainty about job security and workload increases may lead to presenteeism, rising sickness, and reluctance to speak up - masking early signs of harm or dysfunction.
- Fundamental care compliance not consistently embedded
- Timely response to complaints and engagement with patients, families and carers and variability in engagement and accessibility
- Compliance with accessible information standards
- Implementation of the risk management policy across the group

Risk Scores

	Qtr 2 25/26	Qtr 3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	4	4	3	Quality/Patient Experience Open
Likelihood	4	4	4	
Risk Scores	**16**	**16**	**12**	



Proposed Actions (by due date)

- Perinatal safety programme in development to support delivery of MSSP exit criteria and expected enforcement notice from the CQC– April 2027
- CQC rapid improvement programme in place for UEC and medicine – Complete and sustainability programme in progress.
- UEC improvement programme in place to improve flow in, through and out of the organisation - April 2026
- Robust QIA process in place to ensure safe delivery of CIP Programme. Clinical representation in place on all groups – Ongoing
- Launch of civility saves lives programme and ongoing roll out – April 2026
- Development of the NLEAF assessment and accreditation programme with fundamentals of care – April 2026
- Corporate nursing restructure to support consistent delivery of care across UHN – February 2026
- Accessible information standards working group developing a road map to compliance – March 2026
- Review of the corporate risk registers across UHN – Initiated
- Development of targeted actions to reduce disparities – Delayed April 2026
- Development of a patient experience strategy – Delayed April 2026
- Strengthened freedom to speak up programme – ILT have agreed the new model. Implementation by April 2026
- Refresh of consent training for KGH maternity colleagues following CQC – Ongoing

Q3 25/26 executive commentary

The Trust continues to face significant and multifaceted challenges that impact the delivery of a consistently positive patient experience. While there is evidence of improvement in some areas, the overall picture remains one of variation and vulnerability.

Internal audit findings provide reasonable assurance that complaints are being managed in line with policy, with improvements in timeliness and responsiveness noted in several divisions. However, concerns persist regarding the depth and consistency of learning derived from complaints and patient experience feedback.

Performance in the Friends and Family Test (FFT) and national patient surveys remains variable across divisions and care settings. While some specialties report high satisfaction scores, others—particularly urgent and emergency care—show fluctuating trends. These pressures are being intensified by significant winter pressures across the organisation, including ambulance handover

delays, ED crowding, normalisation of corridor care, and increased clinical acuity, all of which directly affect patient experience and dignity. NGH remains in Tier 1 for urgent care provision, and regulatory breaches identified by the CQC relating to privacy and dignity further underscore the need for urgent cultural, behavioural, and environmental improvements.

Kettering General Hospital continues to receive support through the Maternity Safety Support Programme, with recent reviews highlighting cultural concerns and inconsistent care delivery. Similarly, Children and Young People's (CYP) urgent care services remain under regional oversight following a coroner's verdict and a comprehensive cultural review that identified systemic issues in leadership, psychological safety, and team collaboration.

Despite these substantial pressures, there are positive developments. The Trust has now completed the corporate nursing consultation, which will establish a single, unified Patient Experience Team across UHN. This new structure is designed to strengthen governance, enhance consistency, and drive improvement more effectively across complaints, PALS, bereavement, patient information standards, and wider experience functions. This consolidated approach is well-placed to support divisions during periods of heightened winter pressure, ensuring that learning, improvement, and responsiveness remain visible and coordinated.

While pockets of good practice and innovation continue to emerge, sustained leadership focus, investment, and cultural alignment are required to embed these improvements and ensure that patient experience is not compromised by ongoing operational, seasonal, workforce, and financial pressures.

Risk ID:	UHN13
Strategic Priority:	Strengthen our Culture/Transform Patient Care
Risk Description:	If UHN is unable to attract and retain high calibre staff then this may result in UHN being unable to deliver on our research and Development ambitions, resulting in UHN being unable to increase our research and clinical trial activities by 10% and where support to take an innovative role in healthcare research will not achieve the best possible outcomes for our patients.
Key Deliverable:	Increase our research and trial activities by 10%
Executive Lead:	Medical Director
Assurance Committee:	Quality & Safety Committee

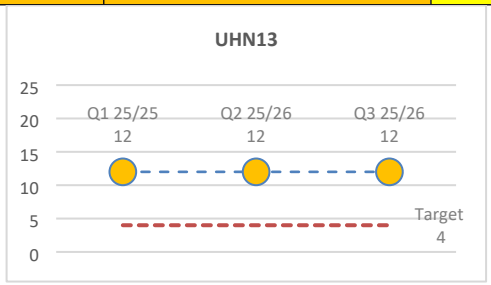
Key Controls	**Key Assurance**
Agreed UHN UHL workstream on growing and developing	Academic research strategy oversight through UHN ILT
Research and trials portfolio.	Oversight through Quality and safety committee and UHN/UHL partnership board
Agreement of 11 workstreams	

Gaps in control or assurance

Academic strategy has expired and requires review
Financial deficits
Impact of industrial actions

Risk Scores

	Qtr 2 25/26	**Qtr 3 25/26**	**Target Score**	**Risk Domain and Risk Appetite**
Consequence	4	4	4	Innovation Open
Likelihood	3	3	1	
Risk Scores	**12**	**12**	**4**	



Proposed Actions (by due date)

Progress standardisation of academic and research governance, operational structures, recruitment key joint posts and expansion of opportunities for cross organisational trials – Planned completion Q4 25/26
Review of enabling clinical capacity to affect change. Planned completion Q2 26/27

Q3 25/26 executive commentary

- Joint Research strategy in progress .
- Director of research and innovation has been appointed to and in post.
- Director of research appointed at UHL working with UHN director to progress the Joint research strategy.
- Job plans are being aligned to allow protected time to be allocated to research activity.

Risk ID:	UHN14
Strategic Priority:	Improving Culture, Transforming Patient Care and Deliver our Financial Plan
Risk Description:	If estate buildings and infrastructure continue to deteriorate and/or fail, then delivery of services may be impacted resulting in delayed or sub-optimal patient care, safety of all persons and an inability to deliver key UHN strategies.
Key Deliverable:	Deliver our quality priorities (Safe and efficient physical infrastructure within which our staff can effectively treat patients).
Executive Lead:	Director of Strategy
Assurance Committee:	Strategic, Transformation and Digital Committee

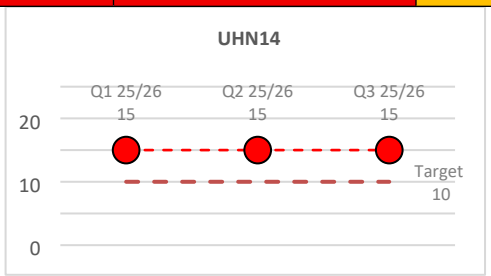
Key Controls	Key Assurance
Kettering Hospital have a full Development Control Plan for the site and Northampton Hospital has a site masterplan. A Local Development Order has been signed with Kettering Planning Authority to cover all developments	Kettering are part of the New Hospital Programme which will replace 70% of the Trust estate and 100% of the estate over 25 years old that is used for patients or staff.
NGH energy systems and aged steam infrastructure, Approval of KGH Energy Centre plans Both these schemes reduce the hospitals reliance on fossil fuels.	KGH continues to engage with national and regional NHP meetings to regularly confirm its place and priority on the NHP programme.
Rockingham Wing at KGH have had funding to failsafe prop all RAAC concrete panels and have plans approved to build a decant extension.	Funding received for failsafe propping SFBC submitted and approved in for the decant extension subject to Target Cost confirmation. Funding received for Option Appraisal for RAAC removal.
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 Health and Safety Committee Technical meetings in place to review progress against audit plans (internal)
Business continuity plans and infrastructure resilience/backup systems are in place	Estates infrastructure is regularly tested (internal) Risk rated capital backlog plans in place (internal)
UHN estates backlog capital programme in place with applications for national funds to address critical safety issues made annually.	UHN capital committee (internal) oversees progress with agreed capital schemes.
Group Clinical Strategy approved which forms the basis of understanding what a UHN estates strategy needs to look like	

Gaps in control or assurance

- NGH need to develop a full Development Control Plan to include how a sequence of developments over a time period will address the highest priority areas for our clinical services.

Risk Scores

	Qtr 2 25/26	Qtr 3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	5	5	5	Infrastructure Minimal
Likelihood	3	3	2	
Risk Scores	**15**	**15**	**10**	



Planned Actions (by due date)
Funding secured relating to RAAC at KGH for the extension, and support given for an OBC for its entire removal. NGH are almost complete in replacing their energy systems and aged steam infrastructure, KGH have had their Energy Centre plans approved and have begun to replace their energy infrastructure. Due to complete September 2027.
Q3 25/26 executive commentary
Full Risk register overhaul at KGH and NGH complete, so a full and thorough understanding of the risk on both sites as relates to our estate is now known and documented. NGH UTC scheme has national approval and planning permission, which release the pressure in the current ED and start to allow for refurbishment in 2026. KGH energy centre has completed one of its high risk phases of undertaking the works under the railway bridge. NHSE national and regional meeting regarding the KGH site masterplan in order to further their support for continued work on Rockingham Wing, of which we are entering RIBA 4. Critical Infrastructure works and all BAU capital estates schemes are on track for delivery. NGH energy centre de-steamed and now providing site with low temperature hot water (LTHW). 2no boilers being installed Q4 25/26 through NHSE CRIS funding. Capex £1.9m. replacing 52-year-old boilers and offering £20k p.a. efficiency savings. NGH Area K & Billing house awarded NHS CRIS funding for new thermal generation plant. Capex £700k. Delivery Q4 25/26 NGH Energy centre awarded NHS CRIS funding for CHP waste LTHW heat plate exchanger. Capex £860k Delivery Q4 25/26- Q1 26/27. This scheme will offer efficiency savings circa £7-900k p.a. Trust AE appointed in Q3 25/26 for KGH & NGH. Common AE for both sites to allow UHN joint appointment and better aligned Estates strategies based on common engineering methodologies. Q4 25/26 will deliver action plans for Estates disciplines to enable gap analysis of service function/compliance.

Risk ID:	UHN15
Strategic Priority:	Transform Patient Care
Risk Description:	**If there is insufficient capacity to meet the demand on services patients will wait longer for urgent and emergency care, elective care and cancer care leading to patient harm, compromised clinical outcomes and experience.**
Key Deliverable:	Aim to deliver national access targets in planned care and transform pathways with system partners to safely reduce the number of people accessing UEC in our hospitals
Executive Lead:	Chief Operating Officer (COO)
Assurance Committee:	Finance, Investment & Performance Committee

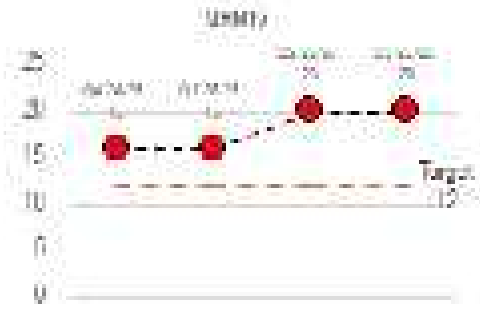
Key Controls	Key Assurance
Clinical prioritisation of patients and increased focus on specialties with high volumes of 52-week waiters and where forecast to be high waiting list growth.	➢ Weekly tracking of clearance of long waiting patients in relation to national standards ➢ Monthly monitoring of performance against waiting time standards and other access metrics ➢ Clinical harm and root cause analysis reviews for patients who have waited too long on cancer or RTT patients ➢ External review of management of waiting lists conducted by the Elective Intensive Support Team; good assurance relating to longer waiting patients. ➢ Harm reporting through patient safety committee
Clinical prioritisation of cancer patients, regular pathway tracking of cancer patients and dissemination of reports	
Demand and capacity modelling to generate forecasts in performance and waiting list size to agree nature and level of intervention needed.	
Continued delivery and increase of virtual and face to face appointments, patient-initiated follow-ups and advice and guidance to release capacity and help reduce waiting times.	
Delivering the GIRFT recommendations including adoption of standardised clinical templates.	
Continued focus on theatre utilisation and cases per list to maximise use of available capacity.	
All patients who are not treated with their clinically timed pathway have a thematic review of their pathway and long waiters have a harm review through MDT	
Delivering the GIRFT recommendations including the implementation of the clinical operational standards.	➢ Daily, weekly, monthly tracking of ambulance handover and time in department metrics ➢ Clinical harms and root cause analysis reviews for patients who have waiting too long on an ambulance or in the department ➢ Adherence to the UHN red lines
Continued improvement in length of stay across non-elective inpatient wards.	
Rapid Assessment Unit - new ambulance handover unit at NGH.	
Continued work to maximise admission avoidance opportunities such as SDEC	
Embedding the adherence to Internal Professional Standards	
Establishment of UHN red lines and maintain a zero tolerance to these	
Proactively engage in System transformation work to make improvements to patient pathways and demand management	

Gaps in control or assurance

Elective block contract means that we where we have a demand and capacity mismatch we currently to not have the income to mitigate the gap.
Financial challenge means that we cannot use premium capacity to mitigate the gap.
No opportunity to expand G&A bed capacity in support of UEC pathway.
No additional capacity available across DTA pathways resulting in delays to discharge.
Increase seen in emergency department attendances including conveyances against plan.
A significant number of initiatives in support of winter are for Partners to enact.

Risk Scores

	Qtr2 25/26	Qtr 3 25/26	Target Score	Risk Domain and
Consequence	4	4	4	Activity Open
Likelihood	5	5	3	
Risk Scores	**20**	**20**	**12**	



Proposed Actions (by due date)

- WLI policy in place for WLIs if there is a risk to cancer or long waits performance. This will be reviewed for the next financial year. NHSE have made some funding available in Q4 for additional outpatient first appointments which may provide an opportunity for additionality. – decision required from ILT on 19 January
- Weekly cancer performance meetings to be established from w/c 12 January 2026 to increase the level of assurance around cancer delivery.
- UEC Steering Group and place based UEC Board relaunched from January 2026 following Q4 Winter Task and Finish Group

Q3 25/26 executive commentary

- Strengthened data oversight in Divisional Accountability meetings for the key performance metrics, this is now in place
- Cancer performance is challenged currently, with significantly higher waiting lists and reduced performance. Recovery plans are in place for key tumour sites (Skin, Breast, Head and Neck) and we are engaging in MDT streamlining programmes.
- We delivered zero 65 week waits in November and December, but the forward position looks challenged due to mutual aid required for Spinal patients and cancellations due to winter pressures
- Planned care performance remains challenged and we continue to be significantly behind plan for RTT performance at both Trusts. KGH has seen an improvement in performance across November/December and we will look to maintain this in Q4.
- NGH ED attendances are adverse to plan by 6% YTD, KGH ED are adverse to plan YTD by 1%, mainly driven by a 4% increase during December.
- Ambulance handovers have continued to improve during the year with max of <45mins delivered in December 83% NGH and average handover time of 32mins, and 90% KGH with average handover time of 30mins. In comparison to Dec-24 average handover times at NGH 89mins and KGH 83mins.
- NGH 4hr performance remains adverse to plan at 66% in December against plan of 76%. KGH 4hr performance delivery in December 80% against plan of 78%.
- Bed occupancy remains high. Adult G&A bed occupancy by Christmas at 92% NGH (5% lower than last winter), and 85% KGH (10% lower than last winter). Delivery of supported discharges remain adverse to plan impacting admitted flow from ED.

Risk ID:	UHN16
Strategic Priority:	Deliver our Financial Plan
Risk Description:	The risk of impacts on patients and services of increased regulatory intervention (NHSE) and medium-term financial penalties (revenue and capital) arising from failure to deliver improvement in the underlying revenue position and delivery of a break-even financial position over the medium term
Key Deliverable:	Under strategic priority to deliver financial plan - Development of a medium term robust financial plan (MTFP) with a focus on recurrent improvement
Executive Lead:	Chief Finance Officer
Assurance Committee:	Finance, Investment and Performance Committee

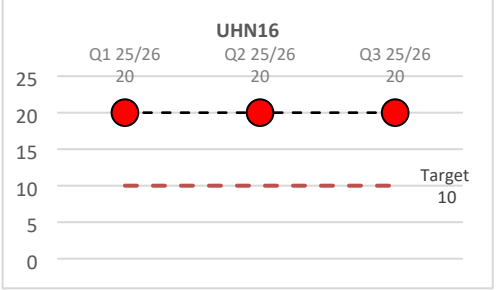
Key Controls	Key Assurance
Business Planning framework to support budget setting, investment decisions and understanding of cost pressures over time	• NHS England revised planning guidance and timetable – NHSE will review and sign off plans in line with their national timetable
Assumptions on inflation and efficiency requirements to inform the MTFP time horizon	
Weekly Financial Recovery Group (chaired by the CFO) with all clinical and corporate divisions in attendance	
NHS England Financial Improvement (FIP) Team deployed across UHN to support development of plans for future years	• Weekly assurance meeting with NHS England and CFO to monitor and manage the FIP team
Business Partnering resource in place to support Directorates with financial management.	
External reporting to NHSE and Northamptonshire Integrated Care Board / System	• Annual External Audit Value for Money report

Gaps in control or assurance

- A detailed 5-year plan which triangulates finance, activity and workforce based on the current underlying financial position
- Pipeline efficiency plans for future years
- Capacity of Divisional Teams to focus on the recovery agenda when faced with competing priorities
- Finance and Procurement teams currently have capacity gaps within the function due to sickness and recruitment / retention

Risk Scores

	Qtr 2 25/26	Qtr 3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	5	5	5	Finance Minimal
Likelihood	4	4	2	
Risk Scores	**20**	**20**	**10**	



Action updates (by due date)
1. Full assessment of underlying financial position in line with a set of assumptions agreed by System CFOs – Underlying assumptions have been shared, System CFOs to agree during Q4 2025/26 2. Development of a 3-year planning model which triangulates finance, activity and workforce – Q4 2025/26 3. Engagement with the national NHSE workstreams on medium term planning - ongoing 4. Development of pipeline reporting for 2026/27 efficiency programme – Q3 2025/26 The pipeline is developing but not yet at target, action to continue across Q4 2025/26
Q3 25/26 executive commentary
NHS England wrote to Chief Executives and Chairs on 13th August 2025 to outline a new approach to medium term planning. This letter outlined the need for all organisations to prepare robust five-year plans. Plans will need to address the delivery of core quality and performance standards including financial sustainability alongside the actions to drive the reforms set out in the 10 Year Health Plan that will support this. Phase one ran until the end of September and has defined multi – year priorities. The current 3 year planning exercise is due for submission on the 12th February. The position that NHS England have requested for UHN is challenging and will require a savings target well in excess of that within the published guidance in order to deliver.

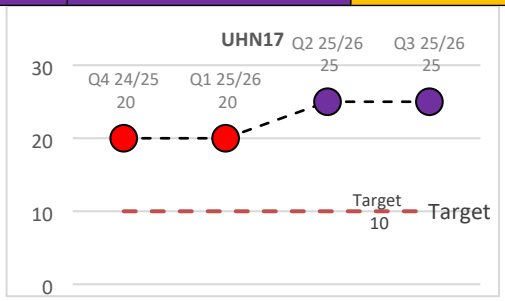
Risk ID:	UHN17
Strategic Priority:	Deliver our Financial Plan
Risk Description:	The risk of impacts on patients and services because of increased regulatory intervention (NHSE) and loss of deficit support funding resulting from non-delivery of the 2025/26 financial plan.
Key Deliverable:	Strategic Priority: Deliver our Financial Plan - Delivery of our 25/26 financial plan and our workforce plan as a key component of financial plan delivery
Executive Lead:	Chief Finance Officer
Assurance Committee:	Finance, Investment and Performance Committee

Key Controls	Key Assurance
Monthly finance report to ILT, Finance, Investment and Performance Committee and as part of the IPR, to Board	• 2025/26 Financial Plan approved by UHN Board • Submission of financial plan to ICB and NHSE • Annual External Audit of Accounts and Value for Money report.
Monthly efficiency reporting to ILT, Finance, Investment and Performance Committee and as part of the IPR, to Board	• Monitoring delivery of efficiency plans by Finance Team
Weekly Financial Recovery Group (chaired by the CFO) with all clinical and corporate divisions in attendance	• Weekly tracking of the gap in efficiency programme
NHS England Financial Improvement (FIP) Team deployed across UHN to de-risk the in-year CIP programme	• Weekly assurance meeting with NHS England and CFO to monitor and manage the FIP team
SFIs, SO's and Scheme of Delegation, supported by detailed budgets	• Audit Committee reporting and review of all exceptions (waivers, mavericks etc.)
Revised Budget Holder Training implemented across UHN	• Use of the Budget Holder Power BI dashboard
Business Partnering resource in place to support Directorates with financial management.	
Monthly Divisional Accountability Meetings	• Reported regularly to Integrated Leadership Team
Programme of internal audit review of financial management arrangements	• Head of Internal Audit Opinion
External reporting to NHSE and Northamptonshire Integrated Care Board / System	• Annual External Audit of Accounts and Value for Money report

Gaps in control or assurance

- Efficiency programme not fully identified for the 2025/26 financial year
- Triangulation of finance budgets with workforce establishment and activity
- Budget signatures have not been gained for all cost centres
- Budget setting processes remain inconsistent across KGH and NGH teams
- Capacity of Divisional Teams to focus on the recovery agenda when faced with competing priorities
- Finance and Procurement teams currently have capacity gaps within the function due to sickness and recruitment / retention

Risk Scores				
	Qtr2 25/26	Qtr 3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	5	5	5	Finance Minimal
Likelihood	5	5	2	
Risk Scores	25	25	10	



Action updates (by due date)

1. Ensure capacity issues addressed as part of team structure review – Key Senior Team positions are now filled and broader team restructuring is likely to take place across Q4 and Q1 of next financial year.
2. Use of the One NHS Finance development tools to support professional development and talent management across finance – Ongoing
3. Ensure best practice and consistency is adopted across both teams and all budgets are issued and signed for the 26/27 year – Q4 2025/26
4. 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 – ongoing
5. Ongoing engagement with and use of the FIP team to bridge the gaps in the efficiency programme – Q2-Q4 2025/26

Q3 25/26 executive commentary

The financial position of UHN at Month 9 reports a deficit of £39.1m (£15.6m KGH, £23.5m NGH) which was an adverse position against plan of £21.2m (£8.2m KGH, £12.9m NGH) at this point in the year. This has increased from a break-even position against plan at Month 6 of the financial year. Deficit funding for Q4 as been confirmed as withheld and this will have significant impact on both cash positions. Efficiency delivery to Month 9 was £45.7m across UHN which was £6.6 adverse to the planned position. The impact of the under-delivery of the efficiency programme, combined with a number of operational pressures and other costs mean that the forecast outturn now assumes that the financial plan will be missed for 2025/26. We are liaising with NHS England to execute the appropriate governance in this respect.

Risk ID:	UHN18
Strategic	Strengthen our culture
Risk Description:	Failure to address poor behaviours in the workplace or to provide key components of a safe workplace culture will lead to a culture in which colleagues feel unsafe and under-valued, unsupported or excluded, resulting in poor staff engagement, retention and morale, elevated sickness absence and will ultimately impact patient care.
Key Deliverable:	Take action on 2025 staff survey feedback and deliver our People Plan prioritised actions for 2026 which includes action to tackle bullying, discrimination and harassment.
Executive Lead:	Chief People Officer
Assurance Committee:	People Committee

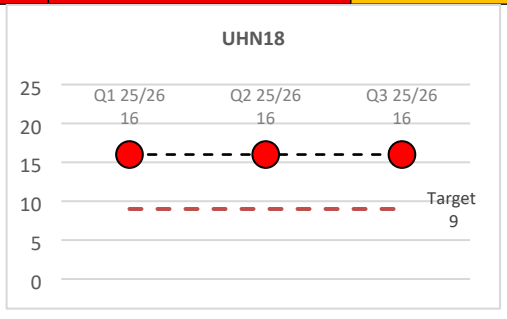
Key Controls	Key Assurance
UHN induction programme (UHN Welcome day)	Numbers attending, qualitative feedback
Learning and development programmes for all professional groups incl. mandatory training and leadership development	Mandatory training rates, NETS survey, course uptake rates, qualitative feedback
UHN values-based appraisal	Appraisal completion rates, qualitative feedback
Belonging strategy and associated plans	WRES and WDES and gender/race pay gap
Health and wellbeing strategy	Absence rates (IPR)
People Promise culture programme including Civility, Flex @ UHN and sexual safety	Turnover rates (IPR), Report and Support concerns raised
Safe staffing processes, use of acuity tools, and prioritised workforce deployment. QIA process	Safe staffing report to Board
Exit interview and local intelligence	Exit interview analysis
Freedom to speak up service	FTSU quarterly and annual reports to People Committee
Violence and aggression reduction group	Reports of violence and aggression to colleagues
Staff engagement and Reward and Recognition strategies	Staff engagement score reported to People Committee. Culture Assurance Group oversight to People Committee
Resident Doctor Ten-Point Plan actions	Ten-point plan assurance report to People Committee.

Gaps in control or assurance

Staff engagement score in both Trusts reduced in 2024.
Although some improvement has been seen in equality data, levels of discrimination remain too high.
Exit interview completion rates are low and the data is not used to inform improvements.
Appraisal rates below target in some areas, particularly in NGH
Freedom to Speak up service requires strengthening with < 50% of colleagues with confidence in FTSU

Risk Scores

	Qtr 2 25/26	Qtr 3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	4	4	3	Culture minimal
Likelihood	4	4	3	
Risk Scores	16	16	9	



Planned Actions (by due date)
• **We Belong:** Enhance NSS aligned reporting with divisional insights by 31 March 2026. We Belong delivery plan monitored at Culture Assurance Group. • **Staff survey response/Culture Improvement Plan**: Launch refreshed, data-driven plan to create a safe, respectful, and inclusive workplace in line with staff survey action planning by 31 March 2026. • **Leadership Development**: Develop Leadership Strategy by 31 March 2026. Leading the Way programme continues. • **Health & Wellbeing**: Continue phased implementation of HWB Strategy with focus on integrated wellbeing calendar and development of automation; monitor engagement and impact. Specific focus on developing menopause support and healthy eating on straightened finances by 31 March 2026. • **Appraisal** – focus on aligned reporting, automation, training and embedding within wider leadership development strategy by 30 September 2026. • **Speaking up** – review provision and implement improvement strategy by 1 April 2026. • **Metrics**- development of the Culture Dashboard to Bellwether metrics 6 Feb 26
Qtr 3 25/26 Executive Commentary

• **Civility Launch**: Civility at UHN programme introduced at September Leadership Forum with Chris Turner.
• **We Belong & Health & Wellbeing Strategies**: Both strategies finalised and launched as scheduled in Q3
• **Maternity Support**: Targeted interventions supporting maternity teams at both NGH & KGH. This includes leadership development, 'Stay & Thrive' retention programme away days and cultural support.
• **Sexual Safety Audit**: Completed against national framework to strengthen safeguarding and reporting.
• **Reasonable Adjustments**: SOP co-designed with DAWN network ahead of launch in December 2025.
• **Neuro-inclusion toolkit:** launched in December 2025, during Disability History Month.
• **NSS Engagement**: Above average participation achieved; initial data collated for analysis.
• **Management of Change (MoC) Support**: Support to teams undergoing MoC programmes and service redesign.
• **Cultural Assurance Group (CAG)**:
  ○ Fully embedded as an assurance forum, meeting monthly with the aim to Strengthen Our Culture
  ○ Culture Dashboard: created as a key metric set for assurance, aligned to People Plan, H&WB, 6HIAs and Inclusion reporting.
• **HWB Automation:** Automation Anywhere project initiated to streamline wellbeing processes.

Risk ID:	UHN19
Strategic Priority:	Deliver the workforce plan in support of our financial plan
Risk Description:	A robust resourcing and workforce controls strategy in support of our workforce plan is required to ensure the provision of safe patient care whilst managing workforce numbers and costs. Failure to deliver the workforce plan will lead to inefficient use of resources (skill gaps in areas covered by bank or agency or over-establishment use driving inefficiency) creating financial pressures and constraints and having a negative impact on the quality of patient care.
Key Deliverable:	We will deliver our workforce plan as a key component of financial plan delivery Deliver our workforce plan as a key component of financial plan delivery
Executive Lead:	Chief People Officer
Assurance Committee:	People Committee

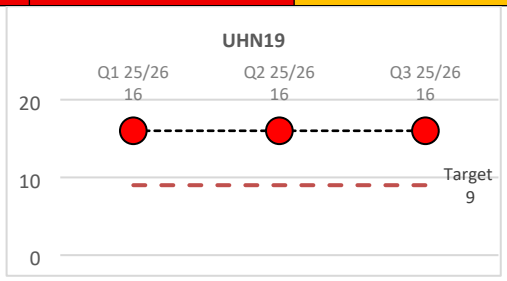
Key Controls	Key Assurance
Attraction strategy with targeted campaigns	Vacancy rates, bank and agency use reported/monitored to Finance and Investment and People Committee
Organisational change support to deliver integration and organisational redesign	Vacancy and turnover rates reported to People Committee
Programmes of work to improve retention	Turnover rates, vacancy rates reported to People Comm
Apprenticeships for new starters and as development pathways	Apprentice numbers, levy use
Robust suite of workforce controls including temp staffing, additional hours and recruitment	Vacancy rate, bank and agency WTE/spend and overtime spend – reported as above
SNCT and establishment/roster reconciliation supported by daily staffing huddles to mitigate gaps	Safer Staffing report to Board
Regular monitoring of safe staffing including fill rates with oversight at monthly NMWAHP Board	Minutes of NMWAHP Performance and Productivity Board
Nursing workforce plan	Vacancy rates, NQN, TNA, NA, return to practice and other routes to entry reported to People Committee

Gaps in control or assurance

There is a significant gap in our workforce plan to deliver the required reduction in WTE in 2025/26
Workforce analytics and forecasting tools need strengthening to inform decision-making
Workforce planning is a “once a year” process (IBP) which misses the opportunity to create multi-year workforce plans
Transformation plans are required to deliver the magnitude of improvement required

Risk Scores

	Qtr 2 25/26	Qtr 3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	4	4	3	Workforce Open
Likelihood	4	4	3	
Risk Scores	**16**	**16**	**9**	



Planned Actions (by due date)
• Continue to follow and refine, measure and report recruitment and temporary staffing controls. On-going • Continue to enhance Locum Nest Implementation at KGH by Q4 25/26 • Initiate collaborative Medical Bank with UHL by Q4 25/26 • Enhance Divisional VCP data for consideration at Group VCP by Q4 25/26 • Complete annual business planning and develop protocol for ongoing workforce plan development overseen by Workforce Programme Board by end Q2 26/27
Qtr. 3 25/26 executive commentary
• Development of full workforce metrics data pack and instigation of Workforce Programme Board reporting to Finance Recovery Group to provide data to support evidence based decisions and formal governance and oversight • Focus on strengthening and reinforcing workforce controls, ensuring we manage turnover by controlling the numbers of new starters (prioritisation to those that replace bank/agency). • Launched Locum Nest at KGH. Refinements to the system are ongoing to optimise approval controls. • Commenced centralisation of annual leave within rostering team to strengthen control and availability at NGH. • Amended the NGH consultant annual leave year to start date to maximise consultant availability and reduce bank and agency usage. KGH to follow. • Notable change in the labour market with success in recruiting to specialities that have previously proved challenging e.g. Oncology • Significant change programme in both corporate teams and divisional teams delivering both integration and CIP benefit. Additional resource approved to support People Services facilitation of change processes.

Risk ID:	UHN20
Strategic Priority:	Transform patient care
Risk Description:	If there are delays in the delivery of the collaborative working model with UHL this will impact on improving productivity and creating joint plans which will impact on the trust being able to deliver seamless pathways and improve patient safety and outcomes for our patients.
Key Deliverable:	1. Go further in integrating clinical and corporate services across UHN, delivering seamless pathways and improving safety and outcomes for our patients. 2. Further develop our collaborative model with UHL, improving productivity and creating joint plans for clinical and corporate services where appropriate. 3. Accelerate work to integrate patient care, removing barriers between secondary, community and primary care services
Executive Lead:	Medical Director, Hemant Nemade
Assurance Committee:	Quality and Safety Committee

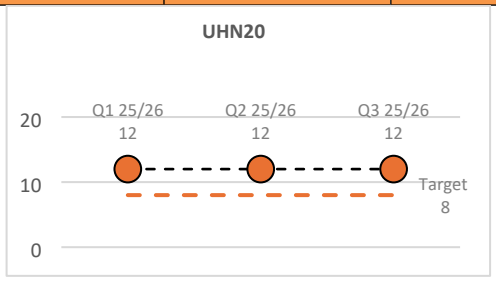
Key Controls	Key Assurance
Clinical strategy group initiated across UHN / UHL	UHN Board
Oversight through UHN Integrated Leadership Team (ILT)	ILT updates
Clinical strategy via UHN/ UHL Partnership board	
Phased work that focuses on integration of specific services.	External

Gaps in control or assurance

Resource constraints – clinical and project resource (Industrial action, financial deficit.
Ability to influence systemwide patient pathway changes

Risk Scores

	Qtr 2 25/26	Qtr 3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	4	4	4	Patient Safety Minimal
Likelihood	3	3	2	
Risk Scores	**12**	**12**	**8**	



Planned Actions (by due date)

Establish clinical senate – due date Q3 – complete
Involve wider leadership teams and conduct leadership events and communications to improve understanding of the strategy and their role within this. Due date – Q4 Complete

Q3 25/26 executive commentary
UHN Clinical senate has been established in October 2025 Project leads have been identified across all 6 domains The group is reviewing whether there are any opportunities for other services to contribute and improve the sustainability of the 6 domain services UHL/UHN Group Clinical Strategy governance established with an Executive steering group and six workstreams with involvement from UHN clinicians: - Safe and Sustainable Services focus on plastics, oncology, nuclear medicine, spinal. Groups are established and action plans agreed. Plastics designing joint governance and clinical leadership, while plastics and spinal are both considering joint appointments in February, Nuclear Medicine considering single team options in January, with proposed operating model by April. - Frailty. Established a working group across UHL and UHN with agreed action plan. Next steps are to make a stock take of current best practice across Northants and Leicester and use population health data to identify intervention across Leicester and Northants that could support people most at risk of acute admission. - Community/neighbourhood care group established, and plan developed with next steps to use population health data to map the priority high demand areas and engage the relevant clinicians and public health. a workshop will be held in January - Maternity CYP has established a working group and supporting plan. Next steps are to establish a review framework and patient engagement framework and areas for initial focus e.g. neonatal - Strengthen cancer services, group has been established and plan agreed. Sharing Somerset to track patients across Northants and Leicester e.g. when patients require tertiary care. Oncologists have met across Leicester and Northants to agree process to make their service sustainable. Next steps include identifying variance in pathways and agree how to adopt best practice, gather performance data to identify variance in performance, waiting times, patient satisfaction, survival rates, finance etc. This will be presented to all tumour site leads at a conference in April - Improving access. Group meeting and plan agreed. Next steps are to share best practice on waiting well by February and identify specialties for development of shared waiting lists

Risk ID:	UHN21
Strategic Priority:	Transform Patient Care
Risk Description:	Failure to maintain robust cyber security and information systems infrastructure may result in service disruption, data breaches, or compromise of patient safety and organisational operations. This includes risks from cyber-attacks, network instability, inadequate data protection measures, and failure to meet national security standards and impact on patients.
Key Deliverable:	Achieve and maintain robust cyber security posture and reliable information infrastructure across UHL and UHN.
Executive Lead:	Group Chief Digital Information Officer
Assurance Committee:	Operational Performance Committee (to transfer to new committee)

Key Controls	Key Assurance
DSPT compliance frameworks in place	DSPT annual submission and compliance (External)
Cyber security assessment and penetration testing programme	Cyber security assessments and penetration testing reports
Network infrastructure monitoring and incident response protocols	Network uptime and performance metrics (Internal)
Information Governance framework and policies	Information governance incident reporting (Internal)
Monthly infrastructure performance reporting to Digital Hospitals Board (Internal)	Internal audit reviews of information security controls (Internal)
Data Protection Impact Assessments (DPIAs) for new systems	
24/7 Security Operations Centre monitoring	
Business continuity and disaster recovery plans	

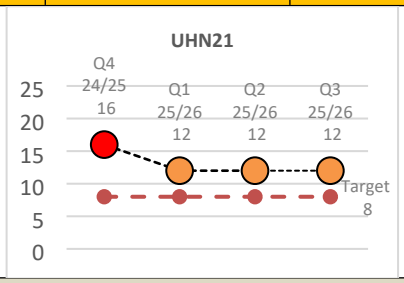
Gaps in control or assurance

Gaps in Controls or assurance:

1) Cyber security maturity assessment indicates areas requiring strengthening (as presented to private board)
2) Legacy infrastructure impacting resilience
3) Incomplete data quality dashboard for clinical safety oversight
4) Resource constraints in security team affecting proactive threat monitoring
5) Some legacy systems not meeting current security standards

Risk Scores

	Q2 25/25	Qtr 3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	4	4	4	Information Minimal
Likelihood	3	3	2	
Risk Scores	**12**	**12**	**8**	



Planned Actions (by due date)

- Ensure patching and updates are delivered within 6 weeks of release (unless technical reason to deprecate). Majority of systems to Version -1 by March 2026 SRO Will Monaghan
- Complete cyber security improvement programme to meet NHS Cyber Security Framework standards by June 2026. SRO Will Monaghan
- Implement enhanced Security Information and Event Management (SIEM) solution by June 2026. SRO Will Monaghan
- Establish 24/7 cyber security operations capability by April 2026. SRO Will Monaghan

Q3 25/26 executive commentary
Executive update (Q3 25/26) — UHN Assurance position. DSPT remains on track. CAF-aligned audit actions from earlier in the year continued at pace across NGH and KGH, with evidence collation and owner tracking tightened during the quarter to support the year-end assurance narrative. Incident learning embedded. No UHN patient-impacting cyber incidents in Q3. Actions from the July policy-library incident review have been translated into updated notification and escalation steps and are being built into UHN playbooks and briefings. **Threat monitoring & patching:** Multiple national HSAs were triaged within target windows and remediated or risk-accepted as appropriate: – Citrix NetScaler (CC-4695) remains closed across KGH and NGH. – Cisco switching alert (CC-4702) reviewed; no material UHN exposure identified. – ED 25-03 (Cisco) assessed as supplier-side risk; ongoing vendor assurance maintained. We also reinforced social-engineering controls in light of December's uptick in impersonation attacks (verification before payment/bank-detail changes). **External partnerships and dependencies:** NetApp architecture/strategy conversations continued, with follow-ups scheduled to unblock dependencies and keep the security-tooling roadmap aligned to plan. Governance: BAF entries prepared for Q3 submission with a clearer separation between the cyber risk and the information-systems quality/standards risk. Mapping of digital and data risks to the appropriate governance forums progressed. Regionally, we picked up ICS cyber actions (e.g., Bitsight Cloud Sync review; Resilience Direct registration) to strengthen collective resilience. **Focus for Q4:** • Close out remaining TIAA/DSPT actions and complete evidence packs ahead of year-end. • Decide on Bitsight Cloud Sync following the Q3 review; implement or document the rationale for non-adoption. • Integrate NHSE/NCSC incident 'grab-bag' materials into UHN BC/EPRR plans and test via a tabletop exercise. • Maintain rapid HSA triage (including Cisco watch items) and keep NHSE portal updates within SLA. • Land the NetApp architecture decision and any linked security-tooling steps (backup immutability, monitoring integrations, access hardening). • Continue anti-impersonation measures with finance and procurement: reinforce call-back verification and track exceptions. • Finalise updated cyber playbooks (notification/escalation) and baseline response metrics (e.g., mean-time-to-notify, patching lead times) for ongoing reporting.

Risk ID:	UHN22
Strategic Priority:	Deliver our Financial Plan
Risk Description:	If we do not eliminate our greenhouse gas emissions, limit our impact on the environment and take action to achieve our net zero targets then we will fail to be compliant with UK legislation, NHS targets, and our own publicly declared ambitions leading to potential patient harm to patients and staff through pollution and service outages, an increase in waste, inefficiency and spend and potential regulatory action from failing to meet Trust, NHS and legislative targets.
Key Deliverable:	Deliver our quality priorities (Reduction in wasted resources and carbon emissions)
Executive Lead:	Director of Strategy
Assurance Committee:	Strategic Transformation and Digital Committee

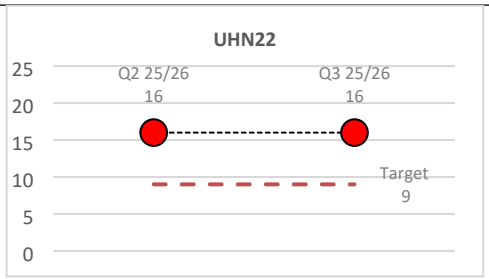
Key Controls	Key Assurance
Carbon footprint reported annually through Annual Report and ERIC data	NGH – third party verification of data through Investors in the Environment
Board approved sustainability plans; submitted to Greener NHS	NGH – monitored via SD Committee
Carbon management plans commissioned from external consultant for NGH and KGH	
Task force for climate related financial disclosure in annual report	
Energy scheme at NGH	Carbon emissions monitored through Carbon Energy Fund – relates to items under the two energy schemes only
New Energy Centre at KGH planned for commissioning in 2027	
Programme of environmental projects	NGH - Monitored through the SD Committee, Sustainable Surgery and Greener Nursing and AHP group.
Renewable energy projects	NGH – metering and annual reporting (iiE and UHN Board), also monitored through the CEF contract

Gaps in control or assurance

- There is no data for the carbon footprint plus available other than the 2019/20 data supplied by Greener NHS which is believed to be incorrect. Updated data not expected until at least the end of the financial year. PO raised for NGH for baseline data to be calculated in April 2024, but unable to obtain appropriate reports from Finance Department. No baseline data is available for KGH.
- There has been no sustainability resource utilised at KGH and there are gaps in the data for the carbon footprint information for travel, f-gas, and inhalers.
- KGH carbon management plans revolved around the New Hospital Programme; if this is not forthcoming then targets are likely to be missed as much of the reduction projected relates to demolition and replacement of buildings.
- UHN still uses gas boilers for heating and hot water. Carbon emission reductions are at risk from the additional installation of further fossil fuel boilers using the Critical Infrastructure funding, albeit, these will be more efficient and therefore reduce carbon emissions. The nature of the two estates means that there is limited room for onsite renewable production and will be reliant on further grid decarbonisation. In the case of NGH, most buildings are poorly insulated; to remedy this will cost several million pounds. Funding constraints make this difficult to remedy.
- Changes to carbon emissions from business mileage have not been tackled,
- The majority of work to reach net zero will require changes in the way that care is delivered. This requires more education and engagement – currently there is no mandated sustainability training and it has not been included in any QI training, although initial engagement with the new lead has occurred. Limited resource within the Sustainability team reduces the direct influence.
- There is some difficulty finding a champion for the removal of Nitrous Oxide in theatres in Kettering, but initial contact has been made within Pharmacy- this is also the subject of discussion with Greener NHS

Risk Scores

	Qtr 2 25/26	Qtr 3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	4	4	3	Net Zero Open
Likelihood	4	4	3	
Risk Scores	**16**	**16**	**9**	



Proposed Actions (by due date)

1. Create streamlined reporting system for UHN and determine reporting and governance frameworks (Dec 2025)
2. Create and install UHN metering strategy (2027)
3. Feasibility study for UHN relating to renewables and battery storage with Greater South East Energy Hub (appointed by DESNZ to review public sector requirements for renewables) (2026)
4. Update Carbon Management plans for UHN to include proposed infrastructure changes (2026)
5. Remove KGH nitrous oxide manifolds (2025)
6. Remove UHN maternity manifolds and move to bottled nitrous (2026)
7. Include Sustainability impact assessment in all business plans and capital plans (2026)
8. Get accurate baseline of scope 3 emissions and set reduction targets for different procurement categories (2026)
9. Make reuse first choice for all procurements (2030)
10. Review business mileage and fleet and create a plan to reduce all transport related emissions (2027)
11. Increase staff training and introduce requirement for sustainability into all senior management objectives and recruitments (2027)
12. Reduce carbon emissions from medicines through reduction of wastage and use of lower carbon alternatives e.g. DPIs to MDIs, IV to oral switches (2030)
13. Remove fossil fuel boilers from the UHN estate (2038)
14. Establish joint sustainability committee and write longer term Sustainability Strategy for UHN linking with Estates and Clinical Strategies (2028)

Q3 25/26 executive commentary

Some good progress has been made in Q3:

- UHN leading on the sustainability stream for the Northamptonshire Anchor Institution network, and hosted an initial meeting with relevant stakeholders in September.
- The Green Team competition has been launched and an additional team accommodated from KGH – projects from ITU (NGH), Anaesthetics (NGH), Radiology (KGH), ENT (KGH), Urology/Procurement (UHN), Continence Care (NGH), IPC (NGH).
- Critical Infrastructure funding for newer gas boilers at NGH is being used this financial year which will reduce carbon emissions.

There remain some challenges:

- No further progress has been made yet in removing nitrous oxide from KGH which had a 2025 date in our Green Plan.
- Delays to the E&F seniors restructure and leadership bandwidth has slowed expected progress on new UHN governance overseeing delivery of the Green plan.
- There remains no overall costed or funded plan for reducing NGH reliance on fossil fuels. KGH Energy Centre will address this issue on that site, and progress on this build remains on track.

Plans for Q4:

- Begin new governance model and complete E&F seniors restructure to release more capacity into this agenda.

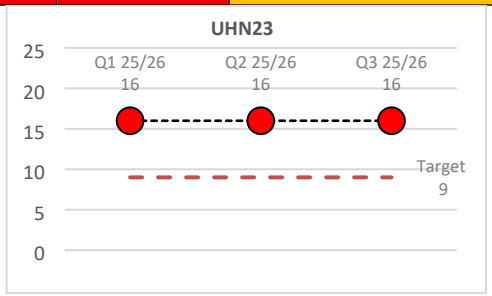
Risk ID:	UHN23
Strategic Priority:	Transform patient care
Risk Description:	If integrated working with wider partners in our county or region is not sufficiently mature, our ability to deliver key elements of the NHSE 10 yr plan, realise our Anchor Institution ambitions or address demand from population health longer term, becomes compromised, impacting on high quality patient care and experience.
Key Deliverable:	Accelerate work to integrate patient care, removing barriers between secondary, community and primary care services
Executive Lead:	Director of Strategy
Assurance Committee:	Finance Committee (moving to new Transformation/Future Hospital Committee)

Key Controls	**Key Assurance**
Effective working across the ICS and the wider partners including the Northamptonshire Integrated Care Board and the Northamptonshire Integrated Care Partnership	➢ New Board committee to have dedicated time to track progress and assess risks against delivery. ➢ ICS governance architecture tracks progress of the outcomes of integrated working. ➢ Establishment of Place Delivery Boards, Local Area Partnerships to deliver improved outcomes in population health and healthcare (Internal / External) ➢ Population Health Board in place that produces single sets of integrated data and information on health inequalities. ➢ Delivering the GIRFT recommended pathways are end to end and include system partners. ➢ Primary care to attend UHN Clinical Senate.
Implementation of the ICS operating model to deliver good quality care, financial balance and improved outcomes.	
UHN leaders (Executives, non-executives and senior divisional clinical leaders) as members throughout the ICS governance system to ensure strong development and delivery against plans.	
Proactively engage in System transformation work to make improvements to patient pathways and demand management	
UHN Anchor Institution Strategy to clearly set out our ambitions and actions to deliver them, including to address health inequalities.	

Gaps in control or assurance

Limited assurance on delivery of effective and transparent place and neighbourhood working – still in development.
Unknown impact of Cluster arrangements and reduced headcount across the system to work on these programmes
Consistent and contemporaneous board understanding of ICS operating model at UHN
Robust SMART delivery plan in agreement with all partners

	Qtr2 25/26	Qtr 3 25/26	Target Score	Risk Domain /Risk Appetite
Likelihood	4	4	3	**Pt Exp/Quality Open**
Consequence	4	4	3	
	16	**16**	**9**	



Actions (by due date)

Drive the establishment of the Northants system architecture for Neighbourhoods end Q1 26/27.
Ensure UHN Senior team have a consistent understanding of roles and responsibilities to drive delivery of actions end Q1 26/27.
Agree UHN priorities for tackling health inequalities April 26.
Hold first UHN Board committee with dedicated discussion time on this topic - complete

Qtr 3 25/26 executive commentary
Anchor Institution and Health Inequalities approach approved at ILT and Board and a working group of willing participants are driving this work forward. First Social Value meeting held across the system with TOR approved. UHN to be a regular member of the group. System Neighbourhood development session held which was widely attended by all system partners, and debated priority themes for our neighbourhoods and how these can be supported by system partners. Draft Neighbourhood strategy has been written and is with stakeholders for comment. This sets out a much clearer framework for what we want to achieve in this space and will assist UHN in considering its approach in how we can ensure benefits to demand and patient outcomes are maximised. 26/27 planning round has capital funding set aside for out of hospital UEC schemes to assist in demand mitigations. Local Authority are keen to work with UHN and UHL on population health mapping and linking work in the JSNA to those of the acute's.

Risk ID:	UHN024
Strategic Priority:	Transform Patient Care
Risk Description:	Failure to deliver the Group's digital transformation agenda may result in continued operational inefficiencies, inability to standardise care delivery across sites, and failure to realise productivity benefits. This specifically includes risks to EPR implementation, automation programmes, and the broader digital strategy delivery impacting our ability to transform services and achieve digital maturity.
Key Deliverable:	Implementation of One Digital Strategy - unified digital transformation across UHL and UHN including EPR, automation, and system rationalisation
Executive Lead:	Will Monaghan, CDIO
Assurance Committee:	Strategic Transformation and Digital Committee

Key Controls	Key Assurance
One Digital Strategy approved by Board	Monthly Digital Hospitals Board oversight reports (Internal)
Dedicated EPR programme teams with defined budgets and milestones (Internal)	Digital Maturity Assessment annual review (External)
Programme Management Office providing oversight and benefits tracking (Internal)	NHSE EPR Gateway reviews (External)
Clinical and Operational Design Authority (CODA)	Programme delivery dashboards and KPI monitoring (Internal)
Technical Design Authority (TDA) established	Benefits realisation reports - Wave 1 automation delivered £480K Q1
Digital transformation governance structure including programme boards	ICS Digital Board alignment and reporting (External)
Regular reporting to ILT and Board committees	
Benefits realisation tracking for automation programmes (Internal)	

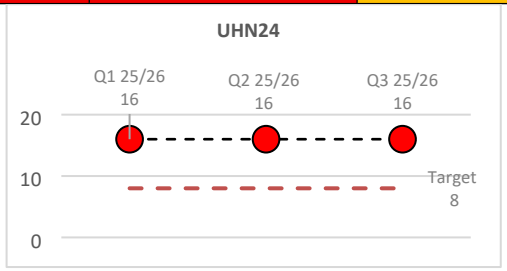
Gaps in control or assurance

Gaps in Controls or assurance:

1) UHN/UHL governance process not fully embedded - collaborative working arrangements still maturing
2) Digital Maturity Index - both organisations in bottom 20% nationally (23/24 assessment)
3) System fragmentation - ambition to reduce number of systems by 50% by April 2027
4) EPR not implemented at KGH - business case in development for post-merger alignment
5) Resource constraints in digital teams affecting delivery capacity
6) Clinical and operational pressures impacting staff availability for digital transformation
7) Dependency on capital funding reliability for future phases
8) Cultural change management programme needs strengthening

Risk Scores

	Qtr 2 25/26	Qtr 3 25/26	Target Score	Risk Domain and Risk Appetite
Consequence	4	4	4	Information Minimal
Likelihood	4	4	2	
Risk Scores	**16**	**16**	**8**	



Action updates (by due date)

1) Implement NGH EPR Tranche 2 (PAS, Outpatients, Care Plans, Investigations) by April 2026. SRO Andy Carruthers
2) Implement NGH EPR Tranche 3 (Theatres, Critical Care, Patient Centre app) by July 2026. SRO Andy Carruthers
3) Complete KGH EPR strategy and alignment plan for UHN by March 2026. SRO Andy Carruthers
4) Deliver Wave 2 automation benefits across UHL/UHN by March 2026. SRO Will Monaghan
5) Achieve 25% reduction in number of systems by April 2026 (50% by April 2027). SRO Will Monaghan
6) Establish AI Academy and governance framework by October 2025. SRO Will Monaghan
7) Complete unified data platform implementation (FDP) by March 2026. SRO Will Monaghan
8) Secure capital forecast for future EPR and automation phases by March 2026. SRO Will Monaghan

Qtr 3 25/26 executive commentary
Executive update (Q3 25/26): EPR delivery — governance and stability. The programme board met through quarter 3 and looked at replanning PAS implementation on the back of lessons learnt from UHL and from Tranche-1. RCAs were received and used to inform resilience actions going into Tranche-2 planning. Cross-system interoperability (NCR). The ICB escalated delays to the Nervecentre single sign-on to Northamptonshire Care Record and flagged MFA introduction for web users in September; actions were placed on the Group to re-engage and resolve This has made good progress with improved access for data to the care record. KGH maternity digitisation. KGH went live successfully with BadgerNet. Badgernet continues to bed in with teams and risks in maternity are reducing directly linked to the successful implementation. Ambient AI / AVT procurement. The ITT pack was prepared and issued with IG schedules reviewed; procurement artefacts were shared with partner trusts for market engagement, and additional ICB assurance requirements for AI scribes were noted. Automation (Wave 2) Group contract was signed mid-August; UHN contributions covered via a UHL↔UHN MOU process. UHN focus is on occupational health work. Data platform (FDP) — scope and governance. The joint UHL/UHN proposal to migrate data warehousing into FDP (with HDS) was tabled in late July; the HDS DPA annex and DPIA drafting progressed during Q2. Delivery remains on track Focus for Q4: lock Tranche-2 EPR dependencies (interfaces/SSO), keep AVT procurement to plan through evaluation and assurance, drive Wave-2 automation recoveries, and progress FDP migration.

Appendix 1

UHN Risk Appetite 25/26

Risk Appetite Levels	
1	None
2	Minimal
3	Open
4	Seek/ Significant

The Board recognises that UHN's long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners, including our staff, wherever possible.

The risk appetite statement has individual statements across 11 key risk areas (domains). The statements and the supporting definitions seek to establish our capacity for taking and absorbing risk and will act as guiding principles for the management of risk across UHN.

Our image of risk appetite set against domains denotes the level of risk appetite within the maximum range.

In assessing risks, there will be recognition of levels of tolerance that may sit outside of the overarching risk appetite.

Strategic Domains: Risk Appetite 25/26

1. **Patient Safety: Minimal**
Although the preference is for risk avoidance for safety, decisions may be taken that might have the possibility of improved patient outcomes where appropriate controls are in place.

2. **Patient Quality/Experience: Open**
Any risks to patient experience that might be required to achieve quality improvements or where there are longer-term gains. Some individual patient care and treatment experiences that may achieve improved clinical outcomes or innovation in emerging fields.

3. **Finance: Minimal**
Any risk that UHN may be required to take to mitigate risk to patient safety or quality of care, with value for money still being the main concern. Price may not always be the overriding factor if appropriate controls are in place.

4. **Reputation: Open**
Any risk that may result in improvements in the design or delivery of healthcare services through collaboration or innovation.

5. **Net Zero: Open**
Any risks that may result in increasing overall achievement of the net zero targets through collaboration or innovation but that result in short-term delays.

6. **Information: Minimal**
Any risk that may impact the availability of systems that support critical business functions and for threats to its assets arising from external malicious attacks.

7. **Activity: Open**
Due to operational pressures, it may be necessary to take a more open approach to risks except where there are implications for a safe delivery of care.

8. **Infrastructure: Minimal**
Limited action may be taken which may impact on operational service delivery only where it is essential to deliver safe and effective patient care and outcomes. Decision making authority held by senior management.

9. **Workforce: Open**
Appetite to take workforce management decisions which may have short term implications for our workforce for potential longer term gains.

10. **Culture: Minimal**
Prepared to take limited risk with regards to culture as long as this could yield opportunities elsewhere within the UHN for longer team cultural and leadership development.

11. **Innovation: Open**
Any risk that may result in improvements in the design or delivery of services through innovation, creativity, external income or clinical research. We will pursue innovation where there is the potential for significant longer-term rewards and improvement on quality and safety outcomes.

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	6 February 2026
Agenda item	18
Title	Use of the NGH Trust Seal
Presenter	Richard May, Company Secretary
Author	Richard May, Company Secretary

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

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

Executive Summary

The **NGH** Board of Directors is requested to note the use of the Trust Seal in respect of:

(1) The Design and Build Contract for the Urgent Treatment Centre on 24 December 2025, affixed by the Chief Finance Officer and signed by the Chief Finance Officer and Medical Director
(2) Lease of Maggie's Cancer Centre at NN1 5BD on 19 January 2026, affixed by the Company Secretary and signed by the Director of Strategy and Director of Continuous Improvement.

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