UHN and UHL Boards of Directors Meeting in Public

Fri 08 May 2026, 10:00 - 13:00

Boardroom, Northampton General Hospital

Agenda

10:00 - 10:05
5 min

1. Formalities: to declare the meeting open, quorate and called in accordance with Standing Orders

Andrew Moore

1.0 Final Boards in common Agenda 8 May 2026.pdf (2 pages)

1.1. Welcome and Apologies for absence

Andrew Moore

1.2. Confirmation of Quoracy

Andrew Moore

To confirm whether the meeting is quorate. The quorum for UHL, KGH and NGH Board meetings is at least one-third of the whole number of Directors are present (i.e., four members) including at least one Executive Director and one Non-Executive Director from each Trust. An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

1.3. Declarations of Interest

Andrew Moore

1.4. Minutes of the previous Meeting held on 9 April 2026

Decision *Andrew Moore*

Paper A

1.4 Paper A - BiC public mins 09.04.26.pdf (13 pages)

1.5. Action Log

Information *Andrew Moore*

Paper B

1.5 Paper B - public BiC actions 09.04.26.pdf (4 pages)

10:05 - 10:30
25 min

2. Patient Story - Lora's Surgical Story

Presentation *Suzie O'Neill*

10:30 - 12:10
100 min

3. Standing Items

3.1. Group Chair's report (verbal)

Information *Andrew Moore*

10:30-10:40

3.2. Group Chief Executive's Report

Information *Richard Mitchell*

10:40-10:50

Paper C

3.2 UHL UHN board report CEO May 2026 final.pdf (3 pages)

3.3. Integrated Performance Reports

Assurance *Richard Mitchell*

10:50-11:30, BREAK 11:30-11:40

Papers D1-D3

3.3 Paper D1 IPR Cover paper for UHN and UHL.pdf (6 pages)
3.3 Paper D2 - UHL Integrated Performance Report and Executive Summary.pdf (56 pages)
3.3 Paper D3 March 2026 Integrated Performance Report Board.pdf (66 pages)

3.4. Board Committee Escalation reports

Assurance and Decision *Committee Chairs*

11:40-12:10

Papers E1-E7

3.4.1. UHL Quality Committee (to follow)

3.4.2. UHL Finance and Investment Committee (to follow)

3.4.3. UHN Finance, Investment and Performance Committee (to follow)

Damien Venkatasamy

3.4.4. UHL Operations and Performance Committee (to follow)

3.4.5. UHL Our Future Hospitals and Transformation Committee

Andy Haynes

3.4.6. UHL Audit Committee (22 and 24 April 2026)

David Moon

Approval items in 'documents' section only for UHN Board Members

3.4 Paper E6 Escalation Report- Extraordinary Audit Committees – 22 April 2026 and 24 April 2026.pdf (4 pages)

3.4.7. UHN Audit Committees (22 April 2026)

Alice Cooper

BREAK 15:10-15:25

3.4 Paper E7 UHN AC report to public Boards 080526.pdf (3 pages)

12:10 - 12:30
20 min

4. High Quality Care for all

4.1. KGH Maternity and Neonatal Intensive Support Team Programme

Assurance *Danni Burnett*

12:10-12:20

Paper F

4.1 KGH Maternity and Neonatal Intensive Support Team Programme.pdf (6 pages)

4.2. UHL PLACE Annual Report

Assurance *Danni Burnett*

12:20-12:30

Paper G

4.2 Paper G - Patient Led Assessment of the Care Environment (PLACE) 2025.pdf (8 pages)

12:30 - 12:45
15 min

5. A Great Place to Work

5.1. UHN Guardians of Safe Working: 2025-26 Consolidated Annual Report

UHN Assurance *Mustafa Raza (KGH) and Sarika Goel (NGH)*

12:30-12:45

5.1 UHN Guardians Annual Report 2526 (1).pdf (5 pages)

12:45 - 13:00
15 min

6. Strategy and Operations

6.1. UHN Community Engagement Strategy 2026-2028

UHN Decision *Suzie O'Neill*

Paper I

6.1 Cover Community Engagement.pdf (1 pages)
6.1 Northampton and Kettering Community Engagement Strategy FOR APPROVAL APRIL 2026.pdf (34 pages)

6.2. UHL Green Plan Delivery (to follow)

UHL Assurance

13:00 - 13:00
0 min

7. Any Other Business

13:00 - 13:00
0 min

8. Questions from the public

13:00 - 13:00
0 min

9. Date and time of next meeting

The next Public Boards meeting will be held on 11 June *2026* in the Clinical Education Centre, Rooms 2-3, Glenfield Hospital, Leicester, starting at 09:30

MEETING IN PUBLIC OF THE BOARDS OF DIRECTORS OF KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST, NORTHAMPTON GENERAL HOSPITAL NHS TRUST AND THE UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MEETING TO BE HELD ON 8 MAY 2026 FROM 10:00-13:00 IN THE BOARDROOM, NORTHAMPTON GENERAL HOSPITAL

AGENDA

Item No:	Item:	Paper ref:	Lead:	Purpose of report:	Timing:
1	**Formalities: to declare the meeting open, quorate and called in accordance with Standing Orders**				
1.1	Welcome and Apologies for absence	Verbal	Andrew Moore, Group Chair	For noting	10:00
1.2	Confirmation of Quoracy To confirm whether the meeting is quorate. The quorum for UHL, KGH and NGH Board meetings is at least one-third of the whole number of Directors are present (i.e., four members) including at least one Executive Director and one Non-Executive Director from each Trust. An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.				
1.3	Declarations of Interest	Verbal	Andrew Moore, Group Chair	For noting	10:00
1.4	Minutes of the Previous Meeting held on 9 April 2026	A	Andrew Moore, Group Chair	For approval	
1.5	Action Log	B	Andrew Moore, Group Chair	For receipt	
2	**Patient Story – Lora's Surgical Story**		UHN Director of Communications and Engagement	For discussion	10:05-10:30
3	**Standing items**				
3.1	Group Chair's report	Verbal	Andrew Moore, Group Chair	For information	10:30-10:40
3.2	Group Chief Executive's report	C	Richard Mitchell, Group CEO	For information	10:40-10:50
3.3	Integrated Performance Reports	D1-D3	Richard Mitchell, Group CEO	For Group assurance (and UHN approval of cash drawdown requests)	10:50-11:30
BREAK 11:30-11:40					
3.4	Board Committee Escalation reports Escalation Reports: 1. UHL Quality Committee* 2. UHL Finance and Investment Committee* 3. UHN Finance, Investment and Performance* 4. UHL Operations and Performance Committee* 5. UHL Our Future Hospitals & Transformation Committee* 6. UHL Audit Committee	E1-E7 *to follow	Board Committee Chairs	For review and assurance, and approval of any recommended items.	11:40-12:10

Item No:	Item:	Paper ref:	Lead:	Purpose of report:	Timing:
	7. UHN Audit Committees				
4	**High Quality Care for All**				
4.1	KGH Maternity and Neonatal Intensive Support Team Programme	F	Danni Burnett, Director of Midwifery	For KGH assurance	12:10-12:20
4.2	UHL Patient-Led Assessment of the Care Environment (PLACE) Annual Report	G	Danni Burnett, Director of Midwifery	For UHL assurance	12:20-12:30
5	**A Great Place to Work**				
5.1	UHN Guardians of Safe Working: 2025-26 Consolidated Annual Report	H	Sarika Goel (NGH) and Mustafa Raza (KGH), Guardians of Safe Working	For UHN Assurance	12:30-12:45
6	**Strategy and Operations**				
6.1	UHN Community Engagement Strategy 2026-28	I	UHN Director of Comms and Engagement	For UHN Decision	12:45-12:50
6.2	Green Plan delivery (to follow)	J	Danni Burnett, Director of Midwifery	UHL assurance	12:50-13:00
7	**Any Other Business**				
8	**Questions from the Press and Public**				
9	**Date and Time of Next Meeting**				
	The next Public Boards meeting will be held on 11 June 2026 in the Clinical Education Centre, Rooms 2-3, Glenfield Hospital, Leicester, starting at 09:30				

BOARDS OF DIRECTORS OF KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST (KGH), NORTHAMPTON GENERAL HOSPITAL NHS TRUST (NGH) (UNIVERSITY HOSPITALS OF NORTHAMPTONSHIRE NHS GROUP - UHN) AND THE UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST (UHL)

MINUTES OF A MEETING OF THE BOARDS IN COMMON HELD ON THURSDAY 9 APRIL 2026 FROM 1.30PM IN SEMINAR ROOMS 2/3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL, LEICESTER

Voting Members present:
Mr A Moore – Group Chair
Mr S Adams – UHL Non-Executive Director and Operations and Performance Committee Non-Executive Director Chair
Mr L Bond – UHL Chief Financial Officer
Professor I Browne OBE – UHL Non-Executive Director and People and Culture Committee Non-Executive Director Chair
Ms L Churchward – UHN Chief Executive
Professor Simon Gay – UHN Non-Executive Director (KGH voting member)
Dr A Haynes MBE – UHL Non-Executive Director & UHL Vice Chair and Quality Committee and Our Future Hospitals & Transformation Committee Non-Executive Director Chair
Ms H Hendley – UHL Chief Operating Officer
Ms J Hogg – Group Chief Nurse
Ms J Houghton – UHL & UHN Non-Executive Director
Mr A Inchley – UHL Non-Executive Director and UHL Finance and Investment Committee Non-Executive Director Chair
Ms D Kirkham – UHN Non-Executive Director and UHL People Committee Non-Executive Director Chair
Ms P Kirkpatrick – UHN Chief People Officer (KGH voting member)
Mr R Mitchell – UHL & UHN Group Chief Executive
Mr D Moon – UHL Non-Executive Director and UHL Audit Committee Non-Executive Director Chair
Dr H Nemade – UHN Medical Director
Ms S Noonan – UHN Chief Operating Officer (KGH voting member)
Professor T Robinson – UHL Non-Executive Director and UHL Charitable Funds Committee Non-Executive Director Chair
Mr T Shipman, UHN Non-Executive Director & Vice Chair and UHN Strategy, Transformation and Digital Committee Non-Executive Director Chair
Ms S Stansfield – UHN Chief Financial Officer
Ms C Stevens – UHN Non-Executive Director
Mr D Venkatasamy – UHN Non-Executive Director and UHN Finance, Investment and Performance Committee Chair (KGH voting member)
Professor C Welsh – UHN Non-Executive Director and UHN Quality and Safety Committee Chair
Dr G Xu – UHL Medical Director

In attendance:
Dr R Abeyratne – UHL Director of Health Equality and Inclusion
Mr S Barton – UHL Deputy Chief Executive
Professor N Brunskill – Group Director of Research and Development (for minute 22/26/2)
Ms D Burnett – Director of Midwifery and Deputy Chief Nurse (UHL) & Interim Director of Midwifery (UHN)
Ms B Cassidy – UHL Director of Corporate and Legal Affairs
Ms E Casteleijn – UHL Director of Communications and Engagement
Ms H Kotecha – Chair, Leicester and Leicestershire Healthwatch
Mr W Monaghan - Group Chief Digital Information Officer
Ms E Moss – Network Director, East Midlands Regional Research Development Network (for minute 22/26/1)
Ms S O'Neill – UHN Director of Communications and Engagement
Mr M Reeves – UHL Corporate and Committee Services Officer
Ms B Taylor – UHN Director of Continuous Improvement
Ms C Teeney – Chief People Officer

		ACTION
13/26	**APOLOGIES AND WELCOME**	

	Apologies for absence were received from Mr S Baylis, Lead Governor (KGH), Ms A Cooper UHN Non-Executive Director, Ms P Grimmett, UHN Director of Strategy and Mr S Harris, UHL Associate Non-Executive Director.	
14/26	**CONFIRMATION OF QUORACY**	
	Resolved – the meeting was confirmed as quorate (i.e. at least one-third of the whole number of Directors were present, including at least one Executive Director and one Non-Executive Director).	
15/26	**DECLARATIONS OF INTERESTS**	
	There were no declarations of interest regarding the business to be transacted at the meeting.	
16/26	**MINUTES**	
	Resolved – that the Minutes of the Boards of Directors of Kettering General Hospital (KGH) and Northampton General Hospital (NGH) meeting held on 6 February 2026 and the University Hospitals of Leicester (UHL) Trust Board meeting held on 12 February 2026 be confirmed as a correct record.	
17/26	**MATTERS ARISING: BOARD ACTION LOG**	
	Paper B provided progress updates for the matters arising from the Boards of Directors of Kettering General Hospital (KGH) and Northampton General Hospital (NGH) meeting held on 6 February 2026 and the University Hospitals of Leicester (UHL) Trust Board meeting held on 12 February 2026 and any outstanding items from previous meetings, the contents of which were received and noted.	
	Resolved – that the matters arising report be received and noted as paper B.	
18/26	**STANDING ITEMS**	
18/26/1	Group Chair's Report	
	The Group Chair noted that had presented his report earlier in the day and asked that details of that report be provided for these minutes: - Colleagues were thanked who had gone to great efforts to ensure that services remained in place and patient impact was minimised during the ongoing Resident Doctors' industrial action. - The first Boards in Common meeting represented a significant step for the populations served by the Trusts within the UHN / UHL Group and all involved were thanked for getting to this point. The meeting would set the foundations for achieving greater benefits, but there were challenges yet to be achieved such as joining up data flows and meeting differing statutory requirements. - There were many reasons for the group collaboration, but key justifications included innovation opportunities, process re-design, procurement, digital innovation and development of new partnerships. - Challenges were noted regarding the tensions between improving quality and meeting financial targets and reducing the collective deficit. - Market disruption innovations in wider business and society were noted such as social media, self-drive vehicles and instant delivery services and this pointed to the need to become confident in thinking in this creative, but disruptive manner.	
18/26/2	Group CEO Update	
	The Group Chief Executive presented paper D, and reported the following: Artemis 2 / Achievements – Reference was made to the current groundbreaking Artemis 2 space mission and how this provided an excellent example of high performing teams and collaboration, through accountability, trust and positivity. During the time of the mission, colleagues at UHL and	

	UHN would have treated 7,000 elective patients, 24,000 emergency and outpatient cases and undertaken 110,000 patient engagements. Treatment at UHL / UHN – colleagues at UHL and UHN were thanked for the treatment they had provided to friends and family of the Group Chief Executive over the Easter period. UHL / UHN Collaboration – the collaboration had commenced in 2023, and this meeting was the first in common meeting and would be followed up shortly by a joint Executive meeting in the following week. The main focus of the collaboration would be about improving safe, effective care for patients and to focus on the 3 group priorities of transforming patient care, strengthening our culture and delivering our financial plan, noting the tensions within those priorities. It was urged that the Boards in Common meeting be open, constructive and effective. The Chair, Leicester and Leicestershire Healthwatch raised queries regarding patient involvement in AI and digital transformation; building trust and confidence in the NHS; and ensuring that residents of Leicester City remained visible within a wider group structure. The Group Chief Digital Information Officer explained that there was a patient group involved in supporting digital development who helped steer procurement and implementation; the Medical Directors and Group Chief Nurse led on processes to ensure clinical safety with regard to the use of AI; and patient feedback was requested where AI was used and no patient had yet declined the use of AI in supporting their treatment. The UHL Director of Health Equality and Inclusion commented on building confidence in the NHS through the effective use of patient data, ensuring equity; active co-production of service development, and work towards the Accessible Information Standard requirements. Further it was noted that the Health Equity Summit would be taking place in the following week. The need to consider voices of those who were not being heard was also noted. The UHL Director of Communications and Engagement referenced the recently approved UHL Communications and Engagement Strategy and the recent proposal to fund in person community engagement activity which would be discussed with the Chair of Healthwatch. The Group Chief Executive noted that Leicester City represented 16% of the population of the wider group area, but agreed it was an important part of the group area population. The benefits of any learning from good practice from other parts of the Group would also impact positively on the people of Leicester City. There were also examples from other groups around the country where the benefits of scale had been utilised whilst retaining a local focus.	**DoC&E (UHL)**
	Resolved – that plans for community engagement in the coming year be discussed with the Chair of Leicester and Leicestershire Healthwatch.	**DoC&E (UHL)**
18/26/3	Integrated Performance Report and Executive Summary (Month 11)	
	The Chief Executive introduced paper E, Integrated Performance Report (IPR), highlighting the monthly basis of the report which provided a high-level assessment of themes – access, quality, safety and money, covering the organisation. The UHL Chief Operating Officer highlighted the following points: - The winter period had been challenging and teams were thanked for their efforts across the period. - There had been improvements in the 4 hour Emergency Department wait time and ambulance handover performance. - Further improvements in cancer performance were planned and this would be managed through the UHL Operations and Performance Committee, but improvements in Radiotherapy performance were highlighted. - Ongoing challenges were noted from ongoing industrial action, implementation and engagement with the Patient Administration System and it was noted that there would be a focus on waiting times going forward. The UHN Chief Operating Officer highlighted the following points: - The operational year ended with positive performance on 4 hour wait times. - The additional sprint funding had delivered clear elective performance improvements. - Significant waiting list reduction had taken place since the Christmas period. - Meeting the 52 week, 1% of the total waiting list was noted as a considerable success.	

- Future focus would be on length of stay, acute assessments, planned care productivity and automated booking.

In discussion, the following points were raised and discussed:

- The UHL report highlighted the lower quartile cancer performance, and the strategy to improve performance was questioned. The previous high-level cancer delivery was noted, but this had deteriorated in recent months, with the increased number of referrals highlighted, despite diagnosis levels remaining constant. There were a number of actions in place at UHL to improve performance and there was confidence that they would improve performance – these would be considered in further detail with Dr A Haynes, UHL Non-Executive Director. Cancer performance would remain a focus at the UHL Operations and Performance Committee going forward. **COO (UHL)**
- Breast cancer performance remained a challenge at UHN and the focus was on planning and working with clinical teams to ensure the right actions were in place. **GpCN DoC&E (UHL & UHN)**
- Recent engagement with the family of 2 cancer patients had indicated the need to improve the cancer pathway and family engagement and this would be taken forward.
- It was acknowledged there would be a downturn in performance following the ending of sprint funding at UHN, but other improvements such as the opening of an Urgent Treatment Centre were felt be delivering improvements.
- The downturn in ambulance wait performance at Northampton General Hospital in February 2026 was noted, but as this was during a difficult winter period with patient flow challenges, improvements were expected in March 2026 performance.

Each of the Executive Director IPR leads were invited to provide an overview of the key aspects of paper E relating to their portfolios as follows:-

(1) Quality – Commenting on UHN, the Group Chief Nurse highlighted increased number of Friends and Family Test responses with deep dives undertaken in response. Mixed sex breaches in wards remained a challenge due to the lack of beds across the organisation and discharge issues. There had been a reduction in harm from falls at Kettering General Hospital with a focus on supporting patients with toileting and this would be monitored at the UHN Quality and Safety Committee.

The UHN Medical Director highlighted the 'above expected' rating for the Hospital Standardised Mortality Ratio (HSMR) at Northampton General Hospital with data issues and depth of coding felt to be key to explaining this. The Summary Hospital-level Mortality Indicator (SHMI) at both KGH and NGH however remained stable.

Commenting on UHL, the Group Chief Nurse highlighted exception reporting regarding gram negative bacteria bloodstream infections noting this was above target, but assurance was provided that there was an action plan in place. Complaint response performance had improved in the month of February 2026. Mixed sex breaches had increased and this was felt to be impacted by the need to meet the 45 minute ambulance handover target.

The UHL Medical Director noted that overcrowding in the Emergency Department over the winter period had been managed well. The HMSR and SHMI were felt to be heading in a positive trajectory. Assurance was provided that care was safe despite the demand challenges and winter pressures.

In discussion the following points were raised and discussed:

- It was suggested that engagement with partners regarding the single sex breaches and patient flow challenges through the Better Care Fund would help to address these pressures in future years.
- Discussions were ongoing with partners on these challenges to arrive at a common understanding of the issues and challenges in order to develop a plan for future winter periods.
- The Neighbourhood Health Programme Board, which covered the UHL / UHN area was also an opportunity to seek agreement on solutions to patient flow challenges.
- It was highlighted that acute beds were the most expensive with community beds providing a more appropriate solution.

	- Assurance was provided that themes arising from complaints were considered in quarterly reports across the group, but it was acknowledged that clearer reporting on actions taken in response to complaints could be reported in more depth. - Examples of positive working across the UHL / UHN group were highlighted such as infection control, implementation of the perinatal framework and Nervecentre system implementation. - The need to ensure progress and cross pollination of ideas across the group was highlighted. It was requested that this be given further consideration and an update provided at the next meeting. **(2) People –** The UHL Chief People Officer noted the following points: - Although the workforce target was approximately 1000 Whole Time Equivalents (WTE) adverse to plan, there were 280 fewer WTE than the start of the financial year. - Agency staffing remained at low levels. - Reducing the use of bank staffing was a key focus going forward – through substantive recruitment and effective rostering. - Sickness absence levels were at 5%, which was above the 3% target – actions to support attendance were in place, particularly around mental health. - There had been a 10% increase in flu vaccine take up over the 2025/26 winter period. Ms J Houghton, UHN / UHL Non-Executive Director commented that there did not appear to be any impact on patient care arising from the reduction in staff numbers. The UHN Chief People Officer noted the following points: - Workforce numbers remained above plan, which was felt to be as a result of a number of factors such as the supernumerary new starters period, increased sickness absence and the sprint activity. - The actions underway to reduce the supernumerary period and awareness of finance when taking staffing decisions and actions to address long term sickness absence. **(3) Finance –** The UHN Chief Financial Officer noted the following points: - UHN was reporting a deficit of £55m at month 11 which was 42m adverse to plan, with removed deficit support funding and under delivery of Cost Improvement Plan (CIP) the main reasons. - The level of deficit exacerbated cash pressures with a request for cash support now having been approved by NHSE. - Both Northampton General Hospital and Kettering General Hospital were on target for the agreed month 12 capital target. The UHL Chief Financial Officer noted the following points: - UHL was reporting a £41m deficit at month 11 which was £38m adverse to plan, again with removed deficit support funding and under delivery of CIP the key factors. - The cash balance was £40m, but £30m of this was support funding. - Patient care income was £8m above plan, which had improved in the second half of the year. - Reliance on bank staff incurred a cost of approximately £6m per month, which would be problematic in the forthcoming financial year where the target was £3.5m. - It was anticipated that the forecast £85m end of year deficit target and capital targets would be met. In discussion, the following points were raised and discussed: - It was queried what actions or plans were in place to ensure that the position at the end of the forthcoming financial year would be different to the current position. In response, the UHL Chief Financial Officer pointed to improvements in financial performance over the current year, but acknowledged that the CIP for 2026/27 would be challenging. Collaboration gains across the group particularly through technology and procurement were anticipated to deliver financial improvements, but it was not clear when these would impact. The UHN Chief Financial Officer noted that it was hoped that corporate service automation would deliver savings towards the end of the year. The 7% UHN CIP target was challenging, but 6.5% had been delivered in the current year. Delivery on bottom-up planning, workforce targets and clinical change could impact the year end position. - The government shift from acute to primary was considered, but this approach was felt to be addressing the growth in acute demand, rather than a retrenchment of acute services.	**GpCEO**

	- The impact of the ongoing industrial action was a factor which could impact the wider financial positions. The Group Chief Executive welcomed the discussion on the IPR noting the contrasting positions between UHN and UHL, but also opportunities for mutual learning and progress made in 2025/26. Challenges were highlighted, as well as consideration of priorities, mutual benefits and any points of tension. It was noted that it was the intention to have a group based IPR in future. The UHN Director of Continuous Improvement confirmed that work was ongoing with national colleagues to develop a single list of group metrics and targets which would take approximately 3 months to complete. The Group Chair supported the development of a single group IPR. The Group Chair highlighted that some of the data contained within the IPR was two months old by the time it was considered at Board meetings and felt that this was not in line with expectations in a modern organisation and asked that consideration be given to providing more up to date data in the IPR.	**DoCI (UHN)** **DoCI (UHN)**
	<u>Resolved</u> – that (A) Dr A Haynes, UHL Non-Executive Director be engaged in discussion regarding actions in place to improve UHL cancer performance; **(B) processes be reviewed and improvements be considered in the group cancer pathway, relating to engagement with families;** **(C) a body of evidence regarding examples of group joint working be developed and consideration be given to how this could be communicated;** **(D) a single group Integrated Performance Report be developed, and** **(E) consideration be given to how best to incorporate more up to date data within the Integrated Performance Report.**	**COO (UHN)** **GpCN DoC&E (UHL & UHN) GpCEO** **<u>DoCI (UHN)</u>** **<u>DoCI (UHN)</u>**
18/26/4	<u>Board Committee Escalation Reports</u>	
	<u>UHL Quality Committee – 26 February 2026 & 26 March 2026</u> Dr A Haynes, UHL Quality Committee Non-Executive Director Chair highlighted the following discussions: - Reductions in harm arising from falls and associated management plans. - The challenge of managing complex complaints noting the level of resource required. - The impact of AI being used in complaints. - Organ donation, transplant rates and actions to increase consent rates, particularly within communities. - The UHL Annual Prevention 2024/25 report appended to the escalation report was commended. - The PSIR Plan 2026/2028, which was appended to the report was recommended for approval. In discussion, particular discussion took place on the issue of the use of AI in complaints; with the following points being raised: - This was also being seen in other sectors including universities and pension schemes and was generating considerable volumes of text making them difficult to deal with. - The Group policy on the use of AI focussed on its use in relation to patient care rather than addressing the use of AI in complaints. - The use of AI was also being seen within Legal Services within UHL and was considered to be a growing challenge. - AI could mean that complaints could become overly complex and there was a need to reach a conclusion as soon as possible. - It was queried whether there was a national NHS approach to the use of AI in complaints or legal contexts. - It was agreed to give further consideration to the impact of AI on the Group in terms of incoming correspondence on complaints and legal issues and whether policy changes were required in response. <u>UHN Quality and Safety Committee – 25 March 2026</u>	**GpCDIO / GpCN / DCLA (UHL)**

Professor C Welsh, UHN Quality and Safety Committee Non-Executive Director Chair highlighted the following discussions:

- There was limited assurance in respect of the UHN Corridor Care and UEC Red Lines oversight report, noting challenges with regard to patient flow, particularly for patients with no right to reside and the need to work System partners was highlighted.
- The GIRFT (Getting it Right First Time) Virtual Ward review for KGH also received limited assurance due to national criteria not being met, but there was assurance the no harms had been identified.
- The long term challenges regarding aseptic service capacity was noted, and received limited assurance and the potential impact on cancer services was noted.
- The upward report from the Children and Young People Board regarding digital access to patient records had received limited assurance due to access to primary care records.
- The CQC Local Assessment Process report on Medical Care received limited assurance due to the Committee seeking further assurance that actions arising from the Section 29a (of the Health and Social Care Act 2008) notice were fully embedded.

In discussion, the following points raised and discussed:

- It was noted that a recent business case had been approved to improve UHL aseptic services which would hopefully assist UHN.
- Work was ongoing to seek the relevant permissions from primary care, being led by the Integrated Care Board to ensure relevant access to children and young people's care records can be achieved.

<u>UHL Finance and Investment Committee 25 February 2026 & 25 March 2026</u>
Mr A Inchley, UHL Finance and Investment Committee Non-Executive Director Chair highlighted discussions regarding the financial outturn position and the focus on the forthcoming financial year. Also noted were discussions regarding Estates and the development of the Computer Aided Facility Management system. The Committee Terms of Reference had been amended and were recommended for approval accordingly.

<u>UHL Operations and Performance Committee – 25 February 2026 & 25 March 2026</u>
Mr S Adams, UHL Operations and Performance Committee Non-Executive Director Chair highlighted the following discussions:

- The deep dive into on the day cancellations at the East Midlands Planned Care Centre (EMPCC), where there was reasonable assurance.
- The impact of the Patient Administration System (PAS) on elective activity was discussed, and the remaining factors to ensure full adoption and system optimisation were noted.
- Construction work had commenced in March 2026 for the new Urgent Treatment Centre based at the Leicester Royal Infirmary.
- There was strong performance across the winter plan in February and March 2026.

In discussion the following points were raised and discussed:

- The importance of training in relation to PAS utilisation was highlighted.
- Colleagues were being supported to engage with PAS, but any continued resistance might require escalation to address.

<u>UHN Finance, Investment and Performance – 24 February and 31 March 2026</u>
Mr D Venkatasamy, UHN Finance, Investment and Performance Non-Executive Director Chair presented the upward report, incorporating the request for retrospective UHN Board approval of Public Dividend Capital (PDC) revenue support for Q1 in 2026/27. The following discussions were highlighted:

- There were 3 areas of limited assurance, Finance, Medium Term Plan and National Oversight Framework (NOF) deterioration.
- The month 11 finance performance was in line with the revised forecast, but was £42m adverse to plan.
- The Medium Term Plan had been submitted as non-compliant and confirmation was awaited regarding acceptance or whether national financial procedures would be implemented.
- The NOF rating for UHN had moved to a rating of 4, limited assurance.

In discussion, the following points were raised and discussed:

- The challenging level of savings required within the Medium-Term Plan was noted, particularly with external pressures arising from industrial action.
- The need for Boards to be able to take robust corrective action where plan targets were not being met in areas such as workforce and CIP delivery was highlighted, with the need for up to date information to inform such action.
- The positive CIP achievement in 2025/26 of £68m was highlighted, half of which was recurring.
- It was the intention to provide greater detail of UHN CIP delivery in 2026/27 in order to provide assurance regarding delivery.

<u>UHL - Our Future Hospitals and Transformation Committee – 25 February 2026 and 25 March 2026</u>
Dr A Haynes, UHL Our Future Hospitals and Transformation Committee Non-Executive Director Chair highlighted the following discussions:

- Improvements to capacity utilisation at Hinckley Community Diagnostic Centre (CDC). The intention was to use CDC capacity to address demand challenges at other UHL sites with greater promotion of the use of the CDC.
- A further CDC was planned for the Leicester General Hospital site.
- The development of data collection to support decision making.

<u>UHN Strategy, Transformation and Digital Committee – 26th March 2026</u>
Mr T Shipman, UHN Strategy, Transformation and Digital Committee Non-Executive Director Chair highlighted the following points:

- All items were noted as being of reasonable or substantial assurance.
- Population health inequalities were considered for the first time and would be discussed further in future.
- There were challenges with trial data migration as part of the implementation of a new Nervecentre Electronic Patient Record (EPR), which may impact the project timeline.

<u>UHL People and Culture Committee – 26 March 2026</u>
Professor I Browne, UHL People and Culture Committee Non-Executive Director Chair highlighted the following discussions:

- The details of follow up actions on the staff survey.
- The Management and Leadership Framework with assurance provided that challenging issues such as bullying were built into management training as well as other issues identified from Freedom to Speak Up processes.
- There had been a significant improvement in flu vaccine take up amongst staff over the winter period and the considerable work to ensure this improvement was acknowledged.

<u>UHL Audit Committee – 16 March 2026</u>
Mr D Moon, UHL Audit Committee Non-Executive Director Chair highlighted the following discussions:

- The level of Declaration of Interest compliance was noted, specifically improvements towards the end of the financial year.
- The updated UHL Managing Conflicts of Interest in the NHS policy was specifically highlighted and UHL Board member colleagues were strongly advised to read the updated policy which was recommended for approval.
- The sealings report was recommend for noting by the UHL Board.
- The 2025/26 Review of Accounting Policies had been approved by the committee and the proposed quinquennial valuation of Trust land and buildings was noted which would likely reduce the asset values across the Trust.
- The Head of Internal Audit Opinion was reported as adequate and effective, but this was felt to be a marginal opinion and the need to continue to implement Internal Audit actions was highlighted.

<u>UHN Audit Committee – 25 February 2026 & 11 March 2026</u>

	Mr T Shipman, UHN Audit Committee Non-Executive Director member highlighted the following discussions: - Limited assurance was noted with regard to the UHN Engagement Strategy, with the view expressed that governors be better utilised as a community voice. - Salary overpayments was noted as limited assurance due to the level of management involvement in recovery of overpayments. - The UHN Estates Strategy remained limited assurance, due to the level of progress on outstanding actions, but it was noted that a new Estates leadership team was in place and there was confidence that the new team would deliver improvements. - There was limited assurance on the financial plan. - Limited assurance was also noted on the Anti-Crime Report, where concerns were expressed about timelines for issue resolution, but it was noted that meetings were taking place with People Services, Finance and Counter Fraud to address these issues.	
	<u>Resolved</u> – that (A) the escalation reports from the UHL Quality Committee held on 26 February 2026 & 26 March 2026, the UHN Quality and Safety Committee held on 25 March 2026, the UHL Finance and Investment Committee held on 25 February 2026 & 25 March 2026, the UHL Operations and Performance Committee held on 25 February 2026 & 25 March 2026, the UHN Finance, Investment and Performance Committee held on 24 February and 31 March 2026; the UHL Our Future Hospitals and Transformation Committee held on 25 February 2026 and 25 March 2026, the UHL People and Culture Committee held on 26 March 2026, the UHL Audit Committee held on16 March 2026, and the UHN Audit Committee held on 25 February 2026 & 11 March 2026, be noted, and any recommendations within be endorsed by the applicable Board, namely; **- The UHL Patient Safety Incident Response Plan (PSIRP) 2026/28;** **- The UHL updated Finance and Investment Committee Terms of Reference;** **- The UHN retrospective approval for PDC Revenue support for Q1 of 2026/27 totalling £8.95m in April, £18.54m in May and £11.68m in June 2026;** **- The UHL updated Managing Conflicts of Interest in the NHS Policy; and** **(B) the impact of AI in terms of growth of complexity in terms of incoming correspondence on complaints and legal issues be considered and determine if policy changes were required in response.**	**Applicable Boards** **GpCDIO / GpCN / DCLA (UHL)**
19/26	**HIGH QUALITY CARE FOR ALL**	
19/26/1	<u>Perinatal Report and Dashboards</u>	
	The Director of Midwifery and Deputy Chief Nurse (UHL) & Interim Director of Midwifery (UHN) presented a consolidated overview of perinatal quality, safety, performance, workforce and experience across UHL, KGH and NGH (UHN) and set out specific recommendations. The following points were highlighted: - The Perinatal Assurance Committees met in March 2026 and received assurance that services were safe, stable and well governed with no systemic risks. - UHL and NGH had met the requirements of the year 7, Maternity Incentive Scheme, with KGH looking to address areas where it did not meet the criteria. - The key metrics regarding 1-1 care and triage had been maintained and there improving responsiveness. - Work was ongoing to explore the causes and mitigate issues with regard to pre-term births through deep dives, considering issues such as maternal complexity, wider determinants of health, diabetes and building community partnerships. - An example of good community engagement within UHL was provided as an example in the report. - Work was ongoing to consider themes regarding infant mortality details of which would be reported to the next Boards in Common meeting. - A Maternity Outcomes Signal System alert had been triggered at UHL, but upon full review it was concluded there was no harm and appropriate learning had been implemented. - Capacity in Fetal Medicine, Sonography and Estates were primary areas of focus across UHN and UHL. - The workforce position continued to strengthen with ongoing recruitment taking place, and the development of good relationships with universities.	

	- The themes of communication, waiting and delays remained consistent themes across complaints. - Managers were undertaking a four day complaints management training scheme. - The Home Birth Service had been paused in KGH, but the offer in NGH was being expanded. - Both UHN and UHL staff were taking part in a perinatal equity programme to address racism and discrimination in maternity. In summary, services were considered to be safe and risks were understood, action plans were actively monitored through the Perinatal Assurance Committees and detailed recommendations were in the report. Any feedback on the consolidated group report was welcomed. In discussion, the following points were raised and discussed: - The consolidated report for the Boards in Common was commended and welcomed. It was requested that key, high level risks be identified clearly in future reports. - The group model was felt to offer opportunities to reduce pressures at busy sites within the group, utilising capacity at less pressured sites. - The variation in booking times between different ethnicities was highlighted, with challenges noted, particularly where women were entering the country when pregnant. Providing signposting to navigate NHS services was felt be a key factor as well as developing trusted relationships, particularly within communities. This would be the subject of a hot topic in the next report. The wider issues regarding late presentation would be raised at the forthcoming UHL Inclusion Summit. - The approach regarding Neonatal pathways in the Group Clinical Strategy was welcomed, noting the challenges of encouraging families to use services other than UHL.	
	<u>Resolved</u> – that (A) UHL and UHN (KGH and NGH) Boards: **(1) support ongoing work to stabilise data quality, improve interoperability and ensure credible, trend data across all three organisations;** **(2) note ongoing recruitment and retention efforts, cross-site leadership alignment, consultant workforce planning, and targeted investment in specialist roles to secure sustainable service delivery;** **(3) note PAC's intention to oversee equity-focused improvement and early-access interventions through the Perinatal Safety Improvement Plan (PSIP);** **(4) support the accelerated delivery of PSIP quality improvement initiatives, strengthening responsiveness and effectiveness across elective pathways and triage;** **(5) note delivery and integration of national programmes to support alignment of the Maternal Care Bundle (MCB), Saving Babies' Lives, Ockenden requirements, and MIS Year 8 within PSIP governance; and** **(B) the UHN Board note the development of a single, strengthened, Northamptonshire Homebirth Service, ensuring reopening criteria, training, competencies and governance are fully met before reinstatement;**	**GpCN** **GpCN** **GpCN** **GpCN** **GpCN** **GpCN**
19/26/2	<u>KGH Maternity and Neonatal Intensive Support Team Programme</u>	
	The Director of Midwifery and Deputy Chief Nurse (UHL) & Interim Director of Midwifery (UHN) presented an update report of the current position regarding the Kettering General Hospital (KGH) Maternity and Neonatal Intensive Support Team. The following points were noted: - The programme was a part of a national programme providing intensive and cultural support in line CQC domains. - Clear and sustained improvements had been put into place with improved oversight based on single regulatory recovery framework. - Assurance was provided that safety remained strong with a focus on consultant attendance. - Support from People Services to for cultural re-sets had been welcomed to improve the working environment. - There had been some slippage on milestones, but no concerns from national advisers had been raised. - The Federated Data Platform had improved metrics and monitoring.	

	- There was regular oversight from the national team, as well as regional and ICB oversight. - A full recovery of the service was expected by the end of the year.	
	Resolved – that the report be received and noted.	
20/26	**RESEARCH AND EDUCATION EXCELLENCE**	
20/26/1	East Midlands Regional Research Development Network report (RRDN)	
	Ms E Moss, Network Director East Midlands RRDN presented a report which provided an update on current RRDN priorities and assurance regarding the latest RRDN financial position and risks and issues, noting the host position of UHL. A key focus for the network at the current time was the Government-set target of setting up research studies in 150 days which was challenging but there had been improved performance in relation to this target. Also highlighted was the level of funding received under the new national model for National Institute for Health and Care Research funding which had increased for Trusts within the network, and the role of the of the Strategic Investment and Wider Care Settings funding to support research outside of hospitals. In discussion, the following points were raised and discussed: - The 150 day set up target was noted and the support being provided to enable projects to meet the target was considered, noting that the despite the challenges, it was a modest target compared to research in other countries. The need for clinical teams and supporting departments to be in alignment with the research teams was highlighted, but also that RRDN could provide advice and guidance regarding funding streams. - In response to a question, regarding what support was needed from the Boards in Common, it was noted that recognition of research being a fundamental part of the delivery of care and supporting awareness raising to ensure that research was a part of ordinary care delivery was key. - It was queried whether a 3-year business plan could be developed in order to provide the Boards in Common with clarity around expectations for research income, particularly the commercial aspect, but it was noted that this would be more appropriate for the Group Research and Innovation function to consider.	
	Resolved – that the report be received and noted.	
20/26/2	Research & Innovation Quarterly Report	
	The Group Director of Research and Development presented an update on Research and Innovation activities across the group and provided assurance of progress. The following points were highlighted: - The Director had been in post as Group Director of Research and Development for 15 months following a considerable period of time as UHL Director of Research and Innovation. - 30,000 people had been recruited into trials across the group in the past year, with significant growth in the UHN area and new studies were commencing on an ongoing basis. - The Government-set target of 150 days to set up research projects had been challenging, and it was noted that within that period, 60 days were taken by the Medicines and Healthcare Regulatory Agency. - Action would be needed to meet the 150-day target, such as undertaking studies which covered the entire group area, and consolidation of departmental permissions for patient involvement, otherwise financial penalties could be imposed. - £6.7m funding had been received from the National Institute for Health and Care Research, the fifth highest amount in the country. - There had been internal discussions amongst Research and Innovation teams to raise awareness of the opportunities to undertake research across the group, noting that this had mostly been received positively, but there was also some loyalty to individual worksites. - The role of the Leicestershire and Northamptonshire Commercial Research Delivery Centre in obtaining funding for research infrastructure. - Development in innovation would be supported by the newly formed Leicestershire and Northamptonshire Academic Health Partners Healthcare Innovation Hub. In discussion, the following points were raised and discussed:	

	- The Director of Research and Development was commended for the growth in research participation over the past financial year. - It was recommended that that a single framework for research across the UHL / UHN group be developed and a proposal would be brought to Boards in Common for consideration. - Noting the potential for 20% funding financial penalties if the 150 day target was not met, it was suggested that different approaches be considered, and possibly the involvement of Quality Improvement Team support. - The report was commended and welcomed, but it was requested that future reports contain further detail regarding the outcomes of trials. - The opportunities of the combined populations of UHN and UHL for recruiting participants into research was highlighted as well as the diverse nature of communities. - It was noted that non-clinical research was undertaken in areas such as resident doctor satisfaction and workforce retention. - It was suggested that research trial participation was limited within the Midlands more generally and access to trials in constituent populations should measured until access improved. - It was confirmed that that research was increasingly moving beyond the acute sector to primary and community care. - The development of the innovation hub was welcomed, and the opportunities arising from the group structure and universities within those areas was highlighted. In summary, the Group Chair noted that the Boards in Common were supportive of the development of research and encouraged the opportunities provided by the group structure. Further, the Boards in Common offered their support in addressing any challenges to progress and delivery of the 150 day target or implementation of the innovation hub.	**MD (UHN & UHL) / DoR&I** **MD (UHN & UHL) / DoR&I** **MD (UHN & UHL) / DoR&I**
	<u>Resolved</u> – that (A) a proposal be presented to the Boards in Common meeting for a single group Research and Innovation framework; **(B) greater detail be included in future reports of trial / research outcomes, and** **(C) trial access across constituent populations across the Group area be measured in order to inform possible approaches for wider inclusion in trials.**	**MD (UHN & UHL) / DoR&I** **MD (UHN & UHL) / DoR&I** **MD (UHN & UHL) / DoR&I**
21/26	**UHL CORPORATE TRUSTEE BUSINESS**	
21/26/1	<u>Charitable Funds Committee escalation report - UHL</u>	
	<u>Resolved</u> - that the escalation report from the UHL Charitable Funds Committee held on 20 February 2026 be noted and any recommendations be endorsed.	
22/26	**ANY OTHER BUSINESS**	
	The Group Chair sought feedback from the meeting about its effectiveness. Mr S Adams, UHL Non-Executive Director felt that the meeting had run smoothly with a group focus perspective and a consideration of strategy. Ms H Kotecha, Chair, Healthwatch, Leicester and Leicestershire queried how papers being considered at the Board could be made more accessible to patients and the public. The Group Chair noted that he had discussed this point with the governors at Kettering General Hospital. The Group Chair encouraged members to pass any further comments they may have to him outside of the meeting.	
23/26	**QUESTIONS FROM THE PRESS AND PUBLIC**	
	There were no questions from the press or public.	
24/26	**DATE AND TIME OF NEXT MEETING**	

	Resolved – that the next Public Boards meeting will be held on Friday 8 May 2026 at Northampton General Hospital at 9.30am.	

The meeting closed at 3.49pm **Matthew Reeves – UHL Committee and Corporate Services Officer**

Cumulative Record of Attendance (2026/27 to date):

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
A Moore (Chair)	1	1	100	D Kirkham	1	1	100
S Adams	1	1	100	P Kirkpatrick	1	1	100
L Bond	1	1	100	R Mitchell	1	1	100
I Browne	1	1	100	D Moon	1	1	100
L Churchward	1	1	100	H Nemade	1	1	100
A Cooper	1	0	0	S Noonan	1	1	100
S Gay	1	1	100	T Robinson	1	1	100
P Grimmett	1	0	0	T Shipman	1	1	100
A Haynes	1	1	100	S Stansfield	1	1	100
H Hendley	1	1	100	C Stevens	1	1	100
J Hogg	1	1	100	D Venkatasamy	1	1	100
J Houghton	1	1	100	C Welsh	1	1	100
A Inchley	1	1	100	G Xu	1	1	100

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Abeyratne	1	1	100	H Kotecha	1	1	100
S Barton	1	1	100	W Monaghan	1	1	100
B Cassidy	1	1	100	S O'Neill	1	1	100
E Casteleijn	1	1	100	B Taylor	1	1	100
S Harris	1	0	0	C Teeney	1	1	100

University Hospitals of Leicester NHS Trust and University Hospitals of Northamptonshire NHS Group

Progress of actions arising from the Boards in Common meeting held on Thursday 9 April 2026 and any outstanding actions from previous UHL and UHN meetings

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
9 April 2026						
1	18/26/2	**Group Chief Executive's Report** To discuss with the Chair of Leicester and Leicestershire Healthwatch, plans for community engagement in the coming year.	**DoC&E (UHL)** **E Casteleijn**	**Immediate**	Verbal update to be provided at the May 2026 Boards in Common meeting.	
2	18/26/3	**UHL & UHN Integrated Performance Reports** To engage with Dr A Haynes, Non-Executive Director about actions in place to improve cancer performance.	**COO (UHL)** **H Hendley**	**Immediate**	Verbal update to be provided at the May 2026 Boards in Common meeting.	
2a	18/26/3	To review and put in place improvements in the cancer pathway, relating to engagement with families.	**GpCN DoC&E (UHL & UHN)** **J Hogg, E Casteleijn, S O'Neill**	**July 2026 QC**	Will be built into the quarterly cancer report for Quality Committees.	**4**
2b	18/26/3	To develop a body of evidence regarding examples of group joint working and consider how this could be communicated.	**GpCEO** **R Mitchell**	**BiC 8.5.26**	Actioned – the Group CEO will provide a verbal update at the BiC meeting on 8 May 2026.	**5**
2c	18/26/3	To develop a single group Integrated Performance Report	**DoCI (UHN)/ COO (UHL)** **B Taylor/ H Hendley**	**BiC 8.10.26**	UHN Director of Continuous Improvement has confirmed that she will be the lead on this action, working appropriately with colleagues across the group.	**4**
2d	18/26/3	To consider how to incorporate more up to date data within the Integrated Performance Report.	**DoCI (UHN)/ COO (UHL)** **B Taylor/ H Hendley**	**BiC 8.10.26**	UHN Director of Continuous Improvement has confirmed that she will be the lead on this action, working appropriately with colleagues across the group.	**4**
3	18/26/4	**UHL Quality Committee Escalation Report** To consider the impact of AI in terms of growth of complexity in complaints and legal issues and determine if policy changes were required in response.	**GpCDIO / GpCN / DCLA (UHL)**	**QC after quarter 2**	Will be incorporated into the quarter 2 patient experience update.	**4**

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
			W Monaghan / J Hogg / B Cassidy			
4	19/26/1	**Group Perinatal Report and Dashboards** To provide greater clarity on key, high level risks in future reports.	**GpCN** **J Hogg**	**June 2026**	To be reflected from June 2026.	**4**
5	20/26/2	**Group Research and Innovation Report** To present a proposal to Boards in Common for a single group Research and Innovation framework.	**MD (UHN & UHL) / DoR&I** **H Nemade / G Xu / N Brunskill**	**BiC 7.8.26**	Verbal update to be provided at the May 2026 Boards in Common meeting.	
5a	20/26/2	To include greater detail in future reports of trial / research outcomes.	**MD (UHN & UHL) / DoR&I** **H Nemade / G Xu / N Brunskill**	**BiC 7.8.26**	Verbal update to be provided at the May 2026 Boards in Common meeting.	
5b	20/26/2	To measure trial access across constituent populations across the Group area in order to inform possible approaches for wider inclusion in trials.	**MD (UHN & UHL) / DoR&I** **H Nemade / G Xu / N Brunskill**	**BiC 7.8.26**	Verbal update to be provided at the May 2026 Boards in Common meeting.	

Progress of outstanding actions arising from University Hospitals of Leicester NHS Trust Board

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

12 February 2026						
6	34/26/1	**Perinatal Quality Surveillance Scorecard / Perinatal Assurance Committee (PAC) Highlight Report** To include feedback from conversations with partners on infant mortality prevention in the next report.	**CN** **J Hogg**	**TB** **April 2026**	To be scheduled accordingly – detail will be incorporated into a spotlight piece within the Perinatal Quality Surveillance Scorecard.	**5**
7	35/26/1	**Freedom to Speak Up** To include details of anonymous complaints in future reports.	**DCLA** **B Cassidy**	**TB** **~~May~~ June 2026**	To be scheduled accordingly.	**4**
11 December 2025						
8	299/25/1	**BAF & Significant Risk Register** To explore ways of demonstrating that mitigating actions are showing a beneficial impact on a risk, such as a progression score.	**DCLA** **B Cassidy**	**TB** **June 2026**	To be scheduled accordingly.	**4**
8 May 2025 ***(approvals recorded in the formal minutes only)***						
9	112/25/1	**Freedom to Speak Up - Q4 and Annual Report** To provide a progress report to the PCC on the recommendations made and provide an update through the escalation report to the Board	**DCLA** **B Cassidy**	**TB** **June 26**	As part of the FTSU annual reporting in May, a review of the recommendations will be presented and will come through the escalation report from the PCC.	**4**

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

Progress of outstanding actions from University Hospitals of Northamptonshire NHS Group Boards in Common

Meeting	UHN Boards of Directors Meeting in Public
Date & Time	Updated following 9 April 2026 meeting

Minute Ref.	Action	Owner	Due Date	Progress	Status
Feb 26 2	Armed Forces Network: (i) review relevant data fields within the NGH electronic patient record in response to issues raised regarding data capture and ensure that data collected was of practical value in informing service provision; this should include the possibility of mandatory identification and recording of armed forces personnel and veterans. (ii) engage with the education teams and local universities to strengthen collaboration and armed forces awareness (iii) Draft statement reaffirming the Boards' commitment to supporting the Armed Forces community, including ensuring equitable treatment in recruitment processes and recognising the implications for reservists and cadets	(i) Will Monaghan / Hemant Nemade (ii) Julie Hogg (iii) Suzie O'Neill	Feb 26	All actions complete	CLOSE

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group – UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together (Public)					
Date of the meeting:	8 May 2026					
Title:	3.2 Chief Executive's report					
Report presented by:	Richard Mitchell – Group CEO					
Report written by:	Richard Mitchell – Group CEO					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	x
Which Group Priorities does this link to	Transform patient care	x	Strengthen our culture	x	Deliver our financial plan	x
Where this report has been discussed previously	The items in the report have been discussed in meetings and committees during April 2026.					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The report covers a wide range of risks in the University Hospitals of Leicester NHS Trust and the University Hospitals of Northamptonshire NHS Group.

Impact assessment
There are no specific impacts because of this report.

Purpose of the Report

The report is an update for the month of April 2026 on the University Hospitals of Leicester NHS Trust (UHL) and the University of Northamptonshire NHS Group (UHN).

Recommendation

The Boards are asked to receive an update on the items below and to note the report.

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

BOARDS OF DIRECTORS
FRIDAY 8 MAY 2026

GROUP CHIEF EXECUTIVE'S REPORT
PRESENTED BY RICHARD MITCHELL

Use of Artificial Intelligence in Report Preparation
This report includes content and analysis generated with the assistance of artificial intelligence (AI) tools, used to support drafting, summarising, and formatting. All outputs have been reviewed, validated, and finalised by the report author to ensure accuracy, appropriateness, and alignment with our organisational standards and values. The use of AI is intended to enhance productivity and efficiency, not to replace human oversight or judgement.

UHL–UHN Collaboration and Governance
University Hospitals of Leicester (UHL) and University Hospitals of Northamptonshire (UHN) have been collaborating since 2023. The first Boards in Common meeting on 9 April 2026 provided a positive foundation, and we build on that momentum at today's meeting.

The volume of papers (433 pages) at the first meeting reinforced the need to further refine how we strike the right balance between effective Board oversight and detail. This work is underway.

Since April, the UHL and UHN joint executive team has met on four occasions, with continued progress in collaborative working. Strengthened joint leadership and governance arrangements are supporting clearer, more joined-up decision-making, keeping our focus firmly on delivering safe, high-quality, cost effective care for patients.

Together, UHL and UHN have three shared priorities: transforming patient care, strengthening our culture, and delivering our financial plans. I will update Boards on all three. We are making progress and closer working as a Group will enable us to achieve more together than we could alone.

Key events aligned to our priorities

Together we can: Health Equality Summit – 15 April
In partnership with the University of Leicester and with sponsorship from Novartis, more than 250 healthcare professionals, academics and community representatives from Leicester, Leicestershire and Rutland and Northamptonshire came together to agree practical actions to reduce health inequalities. The summit reinforced the importance of partnership working, listening to communities, and delivering targeted, culturally responsive care within existing resources. Evidence-based local initiatives demonstrated improvements in access, experience and outcomes across cancer care, maternity, homelessness and end-of-life care. Powerful personal testimonies highlighted the human impact of inequality and reinforced our responsibility to

reduce unwarranted variation and support compassionate, inclusive care. While the scale of inequalities remains sobering, I was encouraged by the strong collective commitment to practical action. We will be continuing this work over the course of the year and planning for the 2027 summit will get under way soon.

National Administrative Professionals Day – 22 April
To mark this national awareness day, we recognised the contribution of 6,600 administrative colleagues across UHL and UHN, whose work is essential to safe, timely and compassionate care. The date of this year's event coincided with management of change processes at UHL related to the impact of digital and AI-enabled technologies on some administrative roles. We acknowledged the uncertainty this creates for colleagues and restated our commitment to managing change well, consulting with affected colleagues and trade unions and continuing open engagement and dialogue. We will continue to do all we can to support colleagues as we modernise our services and transform patient care.

UHL–UHN Cancer Conference – 24 April
The joint cancer conference brought together more than 50 colleagues to shape the future of cancer care across our counties, where together we serve over 1.8 million people with around 15,000 new cancer diagnoses each year. Discussions focused on oncology capacity, new technologies, MDT working and the importance of tackling inequalities in cancer outcomes. Patient stories reinforced the human impact of this work. The uplifting morning focused on shared purpose: tackling health inequalities and shaping a more joined-up cancer strategy to improve patient experiences and outcomes. Updates will be brought to Boards in due course.

BAPIO Training Academy Conference – 25 April
Hemant Nemade (UHN Medical Director), Julie Hogg (Group Chief Nurse), and I joined many other colleagues at the British Association of Physicians of Indian Origin Training Academy annual conference in Northampton. The theme was advancing healthcare excellence through education and leadership. It was an energising opportunity bringing together educators, clinicians and healthcare leaders focused on how inclusive leadership, mentorship and education can shape the next generation of healthcare leaders. The conference reinforced the value of investing in diverse talent and creating environments where people are supported to lead, innovate and deliver high-quality patient care, very much in line with our shared priorities.

Conclusion
Across these events and ongoing conversations with patients, colleagues and partners, the importance of patient and colleague voice, partnership working and inclusive, compassionate leadership is clear. I am grateful to all who continue to contribute to progress against our shared priorities.

Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group – UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together (Public)
Date of the meeting:	8 May 2026
Title:	3.3 (Paper D1) Integrated Performance Reports
Report presented by:	Richard Mitchell, Group Chief Executive
Report written by:	Julie Hogg, Chief Nursing Officer UHL / UHN Gang Xu, Medical Director UHL Hemant Nemade, Medical Director UHN Helen Hendley, Chief Operating Officer UHL Sarah Noonan, Chief Operating Officer UHN Clare Teeney, Chief People Officer UHL Paula Kirkpatrick, Chief People Officer UHN Lee Bond, Chief Finance Officer UHL Sarah Stansfield, Chief Finance Officer UHN Becky Taylor, Director of Continuous Improvement UHN Sarah Taylor, Deputy COO Emergency Care Kully Kaur, Assistant Director of BI and Information

Action – this paper is for:	Decision/Approval	X (UHN)	Assurance (Group)	X	Update	
Which Group Priorities does this link to	Transform patient care	X	Strengthen our culture	X	Deliver our financial plan	X
Where this report has been discussed previously	Committees of the Boards, April 2026					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The appendices provide key controls and assurances to inform the effective management of strategic risks, set out in the Group Board Assurance Framework.
Impact assessment
No direct impacts arising from this assurance report.

Purpose of the Report: The Integrated Performance Reports (IPR) for UHN and UHL provide an overview of KGH, NGH (both in the UHN report) and UHL's performance.

Recommendations

The Boards are asked to:

1. **Indicate assurance** from the IPR on UHL and UHN performance, and
2. **Note** progress towards the development of a joint IPR for September Boards

The UHN Boards are asked to **approve** the cash draw-down requests for both NGH and KGH for June. KGH at £5.399m and NGH at £3.5m which reflects the lack of deficit support funding (DSF) given the non-compliant financial plan.

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

BOARDS OF DIRECTORS
8 MAY 2026
INTEGRATED PERFORMANCE REPORTS

The Integrated Performance Reports (IPR) for the May 2026 Boards are enclosed, which report on March 2026 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.

A combined summary of key points from both IPRs is included below.

Caring

✓ Good News	⚠ Areas of concern	➜ Improvement Plans
• UHN: FFT satisfaction above 90% target at both Trusts - KGH 93.0%, NGH 90.8%; notable improvements in NGH A&E (78.8%), Eye Casualty (88.4%) and KGH inpatients (94.9%). • UHL: Overall quality position continues to improve; complaints response timeliness improving with clearer executive oversight. • UHN: Improving picture for complaints in NGH, although this still remains low performance overall at 50%.	• UHN: FFT provider for NGH ceasing supply as of August 2026, creating operational risk for patient experience monitoring. • NGH: Maternity FFT score declined to 91.8% (from 97.4%); low satisfaction in triage area linked to waiting time concerns.	• UHN: Procurement underway for new FFT supplier via NHS Framework. • UHN: Maternity triage feedback shared with local manager; civility sessions continued in maternity; focus on improving waiting time experience.

Safe

✓ Good News	⚠ Areas of concern	➜ Improvement Plans
• UHN: Zero MRSA cases in March; KGH has had 0 MRSA cases for over 12 months. • UHN & UHL: No Never Events declared at either KGH, NGH or UHL in March. • UHN: 14% reduction in CDI cases at NGH in 2025/26 versus prior year • UHN: Care Hours Per Patient Day (CHPPD) in KGH showing steady downward trend, demonstrating improved workforce efficiency. • UHL: Hospital-acquired pressure ulcer performance has improved, reflecting sustained prevention focus and improved documentation.	• UHL: C Diff and MRSA rates above target and above national average. • UHN: NGH continues to see higher CHPPD driven by ETOC usage, with actual hours exceeding planned and corridor care adding further staffing demand. • UHN: Antimicrobial prescribing out of guidelines for 50% of C Diff cases; insufficient AMS resource to provide ward-level data to drive improvement.	• UHL: C Diff thematic review completed with MRSA review underway; PSIRF reviews complete for all cases; CMG reduction plans in place. • UHN: AMS resource review planned for Q1-Q2 2026/27; IV to oral switch QI project in place; Task and Finish Group targeting high antimicrobial consumption at KGH. • UHN: 2026 biannual establishment review recommends NGH mirror KGH workforce planning for ETOC; dynamic risk assessment guidance issued.

Effective

✓ Good News	⚠ Areas of concern	➜ Improvement Plans
• UHN & UHL: HSMR remains 'below expected' at KGH and SHMI 'as expected' across all three Trusts, demonstrating strong clinical effectiveness relative to national benchmarks.	• NGH: HSMR and SMR 'above expected' - multifactorial, including SDEC removal, reduced coding of complex patients, and residual April 2025 data error expected to persist until May 2026.	• NGH: Monthly Learning from Deaths Group monitoring; working alongside Dr Foster and Clinical Coding to address accuracy issues; triangulation with SHMI and PSIRF ensures no excess mortality risk.

Responsive

✓ Good News	⚠ Areas of concern	➜ Improvement Plans
• UHN: NGH 4-hour A&E performance improved 6.5% to 75% in March following sprint; KGH sustained above 80%; both Trusts achieved <15-min average time to initial assessment. • UHL: 4-hour performance achieved March trajectory of 66.42%, meeting the >4% sprint improvement target; 12-hour performance at 7.28% against trajectory of 8.80%. • UHL: Ambulance handover significantly improved - average time 24 minutes, a 26-minute improvement year-on-year; zero extended delays (>8 hrs) on ambulances in March	• UHN & UHL: Bed occupancy critically high (NGH >99%, KGH 97%), UHL long-stay patients at 18.3% of G&A occupancy; high non-criteria-to-reside volumes.	• UHL: Weekly escalation meetings with Adult Social Care to address long-stay patients; discharge improvement programme underway; increased use of virtual wards and criteria-led discharge. • UHN: GIRFT Further Faster actions in progress for UEC; frailty front door service planned NGH from May; AAU model at NGH to improve admitted flow; twice-weekly supported discharge escalation group.
• UHN: 52-week waits achieved the <1% target across UHN; significant reduction at KGH through 52-week sprint; cancer metrics improved across all standards in March. • UHN: Breast additionality starting to improve performance; MDT streamlining programme showing positive impact; 31-day cancer performance improving with radiotherapy investment. • UHL: Theatre utilisation at 81.4% overall, rated Green Quartile 3 nationally. • UHL: 31-day cancer position is improving with significant improvements seen following investment into radiotherapy. Drug performance is above the national standard.	• UHL: RTT performance at approximately 58%, with ~115,000 on waiting list; 52-week waits c.2,500 patients (2.17% of list), significantly above the <1% plan; 65-week waits at 49 patients. • UHN & UHL: 62-day cancer performance significantly challenged - UHL 53.0% (target 70%), KGH 62.5%, NGH 58.2% (target 70%); both in Tier 1 for 62-day performance nationally. • UHL: Diagnostic 6-week wait at 12.3% (target 5%) at UHL; endoscopy, sleep, audiology and echocardiography the main	• UHN: Q1 additionality agreed to support RTT and income delivery for 2026/27; specialty-level improvement plans in place; ENT outsourcing being explored; Dermatology working with ICB on primary care pathway. • UHL: Super clinics in orthopaedics and general surgery; additional paediatric and adult maxfac clinics; IS (independent sector) for orthopaedics; focused validation programme ongoing. • UHN: QI approach for 62-day cancer launched for Skin (NGH), Gynaecology (KGH), and Breast MDT streamlining; ENT triage pilot (risk stratification, ICB-approved) planned June 2026. • UHL: Weekly performance meetings from 22 April to drive on-the-day cancellation reduction; EMPCC Super Week planned May; LRI late starts monitoring strengthened;

		Nervecentre/Accurx reminder integration progressing.

Well-Led

✓ Good News	⚠ Areas of concern	➜ Improvement Plans
• UHN: Turnover within target at both Trusts - NGH 5.80%, KGH 6.0% against a 6.50% target; vacancy rates reducing and at target at NGH; volunteer hours stable/increasing. • UHN: Mandatory training compliance above 85% target at both Trusts across most staff groups; Women's History Month and Neurodiversity Celebration Week events held in March. • UHL: Sickness absence reducing - 0.19% reduction in February; unknown absence reasons reduced from 10.06% (M8 2024/25) to 1.97% (M11 2025/26), demonstrating improved HR data quality. • UHL: Staff survey 'We are safe and healthy' People Promise score remains 0.16 above comparators; bank spend at 6.72% below the 8% national KPI cap.	• UHL: Sickness absence at 4.9% (target 3%); highest CMGs E&F 6.28%, W&C 5.58%, ITAPS 4.90%; appraisal compliance at 83.1% (target 95%). • UHN: Employee relations cases remain high at both Trusts despite slight reduction at NGH; significant change programmes and workforce CIP creating additional pressure. • UHL: HCA vacancy rate at 8.4% against 5% target; non-clinical agency use and above-price-cap agency workers (24 staff, mainly medical and specialist AHPs) remain concerns. • UHN: Bank spend above target at both Trusts - KGH 10.2%, NGH 13.2% of total pay; administrative & clerical vacancies high at KGH (14.1%) and NGH (12.65%). • UHL & UHN: Ongoing organisational change creating uncertainty and increased pressure for some staff groups.	• UHL & UHN: UHL working group established to shift from sickness to prevention aligned to NHS 10-Year Plan; Nursing and Midwifery staff group working group reviewing sickness absence. • UHN: Case assessment panel being introduced for ER cases; resource review to support organisational change; prioritised OH referrals for A&C colleagues impacted by change. • UHL: Appraisal automation system implementation planned May 2026 Trust-wide; Managers Self-Serve rollout underway; CMG/Directorate leadership focus on quality appraisal discussions. • UHN: Recruitment plans to back-fill long-term temporary workers; medical establishment review in progress; bank rate grip and control measures being reviewed. • UHL: Band 3 HCA recruitment - 70-80 colleagues appointed following March interviews.

Use of Resources

✓ Good News	⚠ Areas of concern	➜ Improvement Plans
• UHN: Draft annual accounts 2025/26 (subject to audit) confirm achievement of forecast outturn agreed with NHSE at Month 10; capital requirement within identified funding limits. • UHL: Capital expenditure committed £92.7m at Month 12 with only £0.5m underspend against revised CDEL target; cash position £34.7m at year end. • UHN & UHL: Agency spend at 0.58% of paybill, well below the 3.20% NHS KPI; all nursing roles compliant with general nursing agency price cap. Agency spend reduced • UHN: Cashflow risks through Q4 managed successfully following NHSE support.	• UHL: YTD deficit of £46.4m (subject to audit) against a plan of £0m; main drivers are loss of DSF funding £25.9m adverse and non-delivery of CIP £19.4m adverse; excluding DSF equates to deficit of £85.3m. • UHN: Full-year efficiency delivery £68.6m against plan of £85.5m, despite significantly higher delivery than previous years - shortfall driven largely by under-identification of pay efficiencies; underlying deficit results in non-compliant financial plan for 2026/27–2028/29.	• UHL: CIP non-delivery recovery plans in place per CMG; focus on medical workforce vacancies and industrial action cost reduction; pathology, pharmacy and imaging CSI income recovery. • UHN: Detailed scheme planning underway for 2026/27 efficiency programme; cross-cutting transformation programmes in place aligned to key deficit drivers • UHN & UHL: Improved coordination of workforce activities focusing on areas of high temporary spend; medical establishment reviews underway; bank rate reduction programme in UHL • UHL: Capital programme flexibly managed, with £2.1m of bring-forward schemes approved; scheme slippage of £4.1m mitigated without impact on 2026/27 capital plans.

UHL / UHN IPR alignment approach update

As the Boards meet in common across UHL and UHN, an aligned IPR is required to ensure effective Board and committee working. The Group will use the Federated Data Platform (FDP) to support this alignment.

The FDP will be used from May to produce the UHN IPR, in support of the roadmap to a joint IPR. A review of metrics and targets has been completed to identify opportunities to align. A recommendation of metrics and targets from the Executive team will be completed for June Boards.

Once metrics are agreed, development of the shared IPR and production process will then be commenced, with an aim to have a joint IPR for the October Boards.

Boards in Common Paper D2

Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group - UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together					
Date of the meeting:	8 May 2026					
Title:	UHL Integrated Performance Report and Executive Summary					
Report presented by:	Richard Mitchell, Group CEO, Helen Hendley, UHL Chief Operating Officer					
Report written by:	Sarah Taylor, Deputy COO Emergency Care and Kully Kaur, Assistant Director of BI and Information					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Which Group Priorities does this link to	Transform patient care	X	Strengthen our culture	X	Deliver our financial plan	x
Where this report has been discussed previously	Board committees, April 2026					

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

Impact assessment
N/A (assurance report)

Purpose of the Report

This report complements the full Integrated Performance Report (IPR) and the exception reports within that which are triggered automatically when identified thresholds are met. The exception reports contain the full detail of recovery actions and trajectories where applicable.

The executive summary is split into 3 parts

1. Pathways updates for Urgent and Emergency Care, Elective, Cancer, and Maternity
2. Updates on Quality, Finance and Workforce
3. Update on transformation and productivity

Recommendation

The full IPR, encompassing all exception reports will be created for public access. A streamlined version of this repor will be provided to the Board for the purpose of oversight after confirmation from Exec leads.

Any forthcoming changes to the IPR can be integrated using the change control process.

There have been discussions on presenting pathway analysis to Board to highlight the dependencies across metrics to deliver the pathway, this approach will be piloted with the emergency care pathway.

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

BOARD OF DIRECTORS
8 MAY 2026

Main report detail

Key headlines in performance are summarised below:

Summary of UHL Performance: MARCH 2026

Arrow Indication indicates the direction of performance. Colour is a subjective assessment of performance against standards and expectations

Urgent & Emergency Care **Updates on** **Flow in** **Flow through** **Flow out** 	March 2026 saw an increase of 1029 Emergency Department attendances to plan with a year-to-date overperformance of 5319 attendances. Paediatric ED saw a decrease of 559 attendances compared to March 2025 year to date though they are under by 863 thereby overall increase in the adult department. Eye Casualty in March 2026 has seen a year-to-date overperformance of 1278 attendances. 4-hour performance in March achieved the trajectory of 59.62% with a performance of 66.42% (UHL only). This achieved the March sprint of a greater than 4% improvement. LRI monthly ambulance handovers improvement has continued with the implementation of Release to Respond seeing a significant reduction in lost hours pre handover. We had 0 extended delays on ambulances (over 8 hrs) In March 2026, LRI monthly ambulance handovers over 60 minutes decreased to 3.9% (219 out of 5,567 handovers) compared to February 2026 when LRI was 10.0% (503 out of 5,013 handovers). The 12-hour performance (total time in dept) was 7.28% achieving trajectory of 8.80%. Emergency admissions were over plan by 481 admissions, year to date is 4429 admissions over plan. Actions for improvement – Achievements in March • Continuing to embed Release to Respond and 24hr in the Emergency Department SOP – resulting in significant improvement in Ambulance handovers. • Increased the number Same Day Emergency Care services – over performance against trajectory.

	• Implemented direct access pathways for our GP and Ambulance colleagues • Ongoing Implement the Trust's Winter plan including super surge actions • Increase the call volume through clinical bed bureau - achieved. • Ward improvement programme across Specialist medical wards due to completed in February – next steps are to develop a roll out plan and Length of Stay reduction programme. • Discharge improvement programme to improve flow through our hospitals.
Elective Care **Referrals and Outpatient performance** **Elective activity** **Pathway Improvements** 	Performance across Elective Care remains significantly challenged, particularly in relations to waiting list size, RTT (Referral to Treatment) standards and long waits (65 week and 52 week RTT waits). Due to the extension nationally of the March 2026 RTT submission deadline, final submitted figures are not yet available; however, forecasts based on validation of the March month-end snapshot suggest a total waiting list of c. 115,000 and RTT performance of 58%. Data validation activity over the past 28 days has primarily focused on over 18-week pathways and selected cohorts and specialities, helping to build insight that will inform the direction of future training and improvement activity. The current expected March position for 65 week waits is 49 patients. April looks similarly challenged with the impact of Industrial Action and Easter impacting progress. Forecast for the end of April is 50-60 patients waiting 65 weeks or more. Orthopaedics remains the speciality most at risk and alone contributing to 40% of the breached patients. The current expected final March position for 52-week waits is c.2,500 patients (similar to last month) which would represent 2.17% of the total waiting list size (assuming a total waiting list size of c115,000) and is significantly above plan. The plan for 25/26 and 26/27 is to deliver less than 1% of the total waiting list over 52-weeks. Actions being taken to improve performance include: • Super clinics (Orthopaedics and general surgery) • Additional paediatric max fac clinics • Increased insourced adult max fac clinics • Use of Independent Sector (particularly for orthopaedics) • Focused validation.
Cancer **Referrals** **2 week wait** **Faster Diagnosis Standard** **62-day referral to treatment** 	Referrals year to date have seen an increase of 3.9% compared to the previous year. Conversion rates year to date is 5.9% and is in line with the national average. February performance improved markedly compared to January across two of the three standards. February FDS delivered 74.5%, a 6.8% improvement on January. Breast remained the main driver of variance in February due to the ongoing capacity gap, with the emerging risk in ENT beginning to become apparent in the month's results. Both these tumour sites remain a risk for the Trust and are reliant on additional capacity, insourcing and recruitment. Whilst some improvement in

	Breast had been noted in the last few months, it is fragile and significant improvement is not expected until June as vacancies are filled. 31-day performance was the second standard to see an improvement, of 9.1% to 87.2%. This standard has shown steady, sustained improvement since August 2025, supported by the wait times improving in radiotherapy and drug performance becoming more stable. 62-day performance in February saw a slight deterioration of 0.9% to 53.0%. For 62-day performance there are several key challenges across multiple tumour sites. Constraints include increased demand, additional diagnostic tests per patient and decision-making turnaround times (radiology, pathology and MDT sequencing), alongside waits to see an oncologist and surgical theatre capacity. The fragility of staffing levels, most prominent in breast radiology, pathology and ENT has increased the challenge alongside a reduced uptake of waiting list initiatives this year to mitigate these risks. Increased clinical engagement to ensure pathways are streamlined, and a continued drive to reduce backlogs to below 150 patients will be key to improving 62-day performance into 26/27.
Quality 	The overall quality position continues to improve, with strengthened assurance across infection prevention and control (IPC), harm reduction and patient experience. IPC surveillance, governance and ward-level accountability arrangements are well embedded, enabling timely identification of issues and focused improvement action. This has supported a stabilising and improving position, providing increased confidence in IPC oversight. Performance relating to hospital-acquired pressure ulcers (HAPUs) has improved, reflecting sustained focus on prevention, timely risk assessment and improved documentation. Learning from harm reviews is being consistently applied, supporting a reduction in avoidable harm and more reliable care for patients at risk. Patient experience is also improving, with better timeliness in complaints responses and clearer executive oversight of delays. Learning from complaints is increasingly informing quality improvement alongside Duty of Candour and PSIRF processes, strengthening the connection between experience, safety and organisational learning. Continued focus remains in place to sustain progress during ongoing operational pressures.
Finance 	The YTD position for the Trust is a deficit of £46.4m (subject to audit) against a plan of £0m. The main drivers are loss of DSF funding £25.9mA and non delivery of CIP £19.4mA. Excluding DSF, this position equates to a deficit of £85.3m, which is in line with the position notified to NHSE. Emergency/Non Elective inpatient activity continues to over-perform; at M12 the additional activity over the year equated to £28m of income that won't be received due to the block arrangement however the cost of delivery will be in the Trust's non-pay. The Trust committed net capital expenditure of £92.7m to Month 12 resulting in an underspend of £0.5m against its revised CDEL target.

	The cash position at the end of Month 12 was £34.7m, which is a decrease of £5.3m from M11.
Workforce 	The overall Whole Time Equivalent (WTE) workforce in M12 was 18,421 WTE which is 1161 WTEs above plan (a 6.73% variance to plan) largely driven by high bank usage and increase in Agency usage above the planned position. Agency staff usage increased from the previous month's usage by 9 WTEs and was above plan by 9 WTE which equates to a 29.92% variance against plan. This was the first time in year for an above plan position for Agency usage. Spend remained 0.58% which is below the NHS KPI for agency spend of 3.20%. This increase was mostly within CSI (for AHPs Physiotherapy as well as within LRI Ultrasound and Chemistry reporting areas). For MSK, agency use was mostly within Medical staff within the ENT team. ESM also recorded agency use across AHPs, Qualified Nurses and Medical staff with high agency usage within N56 Ward 3 at LGH. Bank staffing has increased compared to previous month by 79 WTE with usage at 1038 WTE which is 798 WTE above plan, equating to 332.52% over the planned position. Bank usage is mostly high in CHUGGS particularly for support to nursing staff with high usage in W64 Ward 21 at LRI and W73 Ward 35 at GGH. ESM also recorded high bank usage mostly for Qualified nursing staff with Preston Lodge recording high usage. RRCV had high bank usage mostly for Qualified Nursing staff especially within cost centre C23 Ward 20, and for Medical staff mostly within C67 Cardiology department. Overall Bank spend is recorded at 6.72% (of the total paybill) which is below the national KPI spend cap of 8%. Contracted Substantive staff was recorded at 17,345 WTE which is 2.08% (354 WTE) above the planned position of 16,991 WTE. This year end position represents a reduction in contracted staff by 278 WTEs compared to M1 (April 2025) position which was 17,623. Workforce turnover has remained at 7.6% in March against the 10% target. All nursing roles now comply with the general nursing agency price cap. A key area is focus is the reduction of bank rates aligned to local benchmarking and consultation with trade unions, bank workers and key stakeholders. From 1 March following consultation, we are paying the rate for the shift, and from 1 April the rates will include WTD (working time directive annual leave), with some exceptions for lower grades to ensure their pay does not reduce below the national minimum wage. Nationally all medical posts are above the agency price cap. NHSE have acknowledged the West Midlands medical agency rate card as an acceptable interim rate cap for Trusts to apply, which UHL has implemented since June 2025 for all new medical agency bookings without exception. There remain long line workers who remain over the price cap, but these are acknowledged to be in specialist fragile services with plans to reach the price cap by April 2026.

	We are over price cap with some AHP specialist roles in Sonography, Radiography and Cardiac Physiotherapists, but across the region we have the lowest rates. For 2026/27, NHSE have kept national agency price caps at the same level as 2025/26. Statutory and Mandatory training remains stable at 94% against the target of 95% Appraisal performance has remained at 83.1% against the 95% target. The focus remains on both improving performance and the quality of appraisals and acknowledge this has been challenging with operational demands over winter. Sickness absence is reported a month in arrears, and we have seen a 0.19% reduction in January. Over the last 12 months, the CMGs with the highest levels of absence are E&F (6.28%), W&C (5.58%) and ITAPS (4.90%). One of the key priorities in the NHS 10-year plan is to shift from sickness to prevention. A UHL working group has been established to take this forward for our workforce, along with plans to achieve the national 4.1% target. Workforce performance is reviewed through CMG Performance Review meetings, CMG Boards, Senior Leadership Teams, and Specialty Reviews. An amber rating remains in place.
Tranformation & Productivity **Key Overview** **e.g Urgent and Emergency Care, Elective, digital, Estates etc**	**Theatres** In March, overall theatre utilisation was 81.4%, representing a slight reduction from February (81.9%), with year-to-date performance at 81.5%. Trust performance continues to be rated Green (Quartile 3) on Model Hospital System. For the week ending 22nd March 2026, utilisation was 83.5%, exceeding both the peer median of 80.7% and the national median of 80.9%. Late starts have increased from 19.0% last month to 23.4%, driven primarily by LRI (38%) and UHLiC (39%). Work is underway to embed consistent 08:20 theatre walk-rounds to enable early identification and escalation of operational issues, alongside strengthened use of the ORMIS free-text field to accurately capture causes of delay and ensure clinically approved Golden Patients Cancellations remained high at 9.7%, predominantly driven by DNAs (61 cases), procedure-complexity-related overruns (56 cases), and lack of adult bed availability (39 cases). Weekly performance meetings will recommence on 22 April to drive specialty-level accountability, address root causes, and deliver a sustained reduction in on-the-day cancellations. BADS performance was reported at 80.5% in December 2026, improving from 77% in August; however, UHL remains in the lowest quartile. Underperformance is largely driven by data quality issues. Management and GIRFT support were requested at the APOM meeting on 16 April to accelerate

	improvement. Internal theatre data shows early improvement, but issues persist with INTMANIG coding, limiting correct management selection at listing. Trust-wide defaulting to day case remains the key improvement opportunity across all procedures with >50% target. EMPCC Super Week is scheduled for w/c 18 May. Planning is underway to increase planned surgery delivery, optimise theatre and workforce utilisation, reduce avoidable cancellations, and improve starts and patient flow. This is a focused improvement week - not business as usual, enabled through clinically approved Golden Patients, use of standby patients, daily huddles, rapid escalation of challenges, and visible senior leadership. **Outpatients** • Patient Initiated Follow-Up (PIFU) performance increased to 5.6% in March from 5.2% in February, bringing the year-to-date average to 5.3%. This remains above the national target of 5% but below the local target of 5.5%. Work is now underway to reset targets in line with national benchmarks and to continue working with clinical teams to identify additional pathways where PIFU can be safely and appropriately implemented. • The DNA rate decreased slightly from 6.1% to 6.0% in March, with a year-to-date position of 6.2%. DNAs remain a key area of focus due to their impact on patient access, clinic efficiency, and waiting times. A range of interventions is underway to improve performance, including strengthening patient communications, enhancing reminder processes, and targeting support for groups facing greater barriers to attendance. Sustained focus and ongoing monitoring will be required to bring DNA rates back within target. • **Appointment Reminders:** A revised Accurx reminder schedule—sending reminders at 14, 7, and 3 or 1 days prior to appointments—is technically ready but currently on hold due to dependencies with the Ambient Scribe rollout. Once resolved, implementation will be prioritised, as the enhanced reminder schedule is expected to support improved attendance and reduce DNAs. Increased character limits will also enable more tailored messaging to patients. • The rollout of Scribe will introduce a live feed from Nervecentre to Accurx, which should further strengthen the flow of communication with patients. **UEC** • 6009 monthly SDEC attendance delivered in March (14% above monthly target) • Surpassed 25/26 target of increasing SDEC activity by 11%. Delivered increase of 19%. (an additional 6263 attendance above target) • 2688 calls received to Clinical Bed Bureau in March which is 17 % above target compared to average calls per month previous year. • Met 25/26 target of increasing the average calls received in CBB per month by increasing calls received by 4.37% • 24hour red line patients at 1% in March, improved from 1.3% in February

	• Average Ambulance Time 24 minutes, a 6-minute improvement from February, and a 26-minute improvement from the same period last year. • GP to Fracture Clinic Pathway Pilot began. • Demand and Capacity piece underway to agree targets for 26/27.

Supporting documentation

The Integrated performance report contains further detail including exception reports of indicators which are not currently achieving targets.

The key changes to the IPR are:

- Removed executive highlight report this will be covered in the front sheet
- Removed highlight reports from metric pages
- Updated metrics to reflect changes requested
- Added in activity position (page 15)
- Highlight reports removed 3 month forecasting
- Highlight reports will only be required for those off track
- Removed explanation of SPC charts at the end

In the IPR there is a combination of national and locally agreed targets. For the locally agreed targets we will document the rationale for future reference.

The following metrics are part of the National KPIs that we do not report in the IPR. We are in the process of seeking clarification from Exec leads regarding where these metrics are reported or if there is a need to incorporate them within the IPR.

No.	NHS Oversight Framework national mandated KPIs
1	Proportion of patients discharged from hospital to their usual place of residence
2	Available virtual ward capacity per 100k head of population
3	National Patient Safety Alerts not completed by deadline
4	Potential under-reporting of patient safety incidents
5	Overall CQC rating
6	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities
7	Proportion of acute or maternity inpatient settings offering smoking cessation services
8	Proportion of patients who have a first consultation in a post-covid service within six weeks of referral
9	Proportion of people over 65 receiving a seasonal flu vaccination
10	Acting to improve safety - safety culture theme in the NHS staff survey
11	CQC well-led rating
12	Aggregate score for NHS staff survey questions that measure perception of leadership culture
13	Staff survey engagement theme score
14	Staff survey bullying and harassment score
15	Proportion of staff in senior leadership roles who are from a) a BME background or b) are women

UHL Oversight Framework Metrics

March 2026

Oversight Framework

Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Clostridium Difficile per 100,000 Bed Days	167 Cases	13.6	19.3	21.3	15.0	?	L		Mar-24	Local	Chief Nurse and Medical Director
Methicillin Resistant Staphylococcus Aureus	0	0	1	1	8	?			Mar-24	Local	Chief Nurse and Medical Director
E-Coli per 100,000 Bed Days		13.6	17.2		16.1				TBC	No Target	Chief Nurse and Medical Director
Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	2.0	2.1	1.3	1.7	?			Jun-21	Local	Chief Nurse and Medical Director
Sickness Absence	3%	5.2%	4.9%		5.0%	F			Mar-25	Local	Chief People Officer
30 Day Readmission Rate		11.2%	10.9%		10.6%		H		TBC	No Target	TBC
Published Summary Hospital-level Mortality Indicator (SHMI)	100				99 (Jul 24 to Jun 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
Emergency Department 4 hour waits UHL *	61%	61.8%	63.0%	66.4%	62.8%	?	H		Mar-23	National	Chief Operating Officer
% of 12 hour waits in the Emergency Department	10.3%	11.5%	9.2%	7.3%	9.2%	?			Mar-23	National	Chief Operating Officer
Referral to Treatment (RTT) 18 wk performance *	62.3%	51.7%	55.7%			F			TBC	Local	Chief Operating Officer
Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes *	0.9%	2.6%	2.1%			F	L		TBC	Local	Chief Operating Officer
6 Week Diagnostic Test Waiting Times *	5%	21.8%	14.3%	12.3%		F	L		Jul-23	National	Chief Operating Officer
28 Day Faster Diagnosis Standard *	80%	67.7%	74.5%		71.3%	?	L		May-24	National	Chief Operating Officer
Cancer 62 Day Combined *	70%	53.9%	53.0%		54.6%	F	L		May-24	Local	Chief Operating Officer
Trust level control level performance	£0m	-£6.7m	-£1.9m	-£5.4m	-£46.4m				Jun-22		Chief Financial Officer
Capital expenditure against plan	£93.2m	£7.8m	£8.3m	£39.6m	£92.7m				Jun-22		Chief Financial Officer

*Please note the indicators marked with * are RAG rated based on monthly plan trajectories (see slide 15 of the Integrated Performance Report for more details).*

Oversight Framework

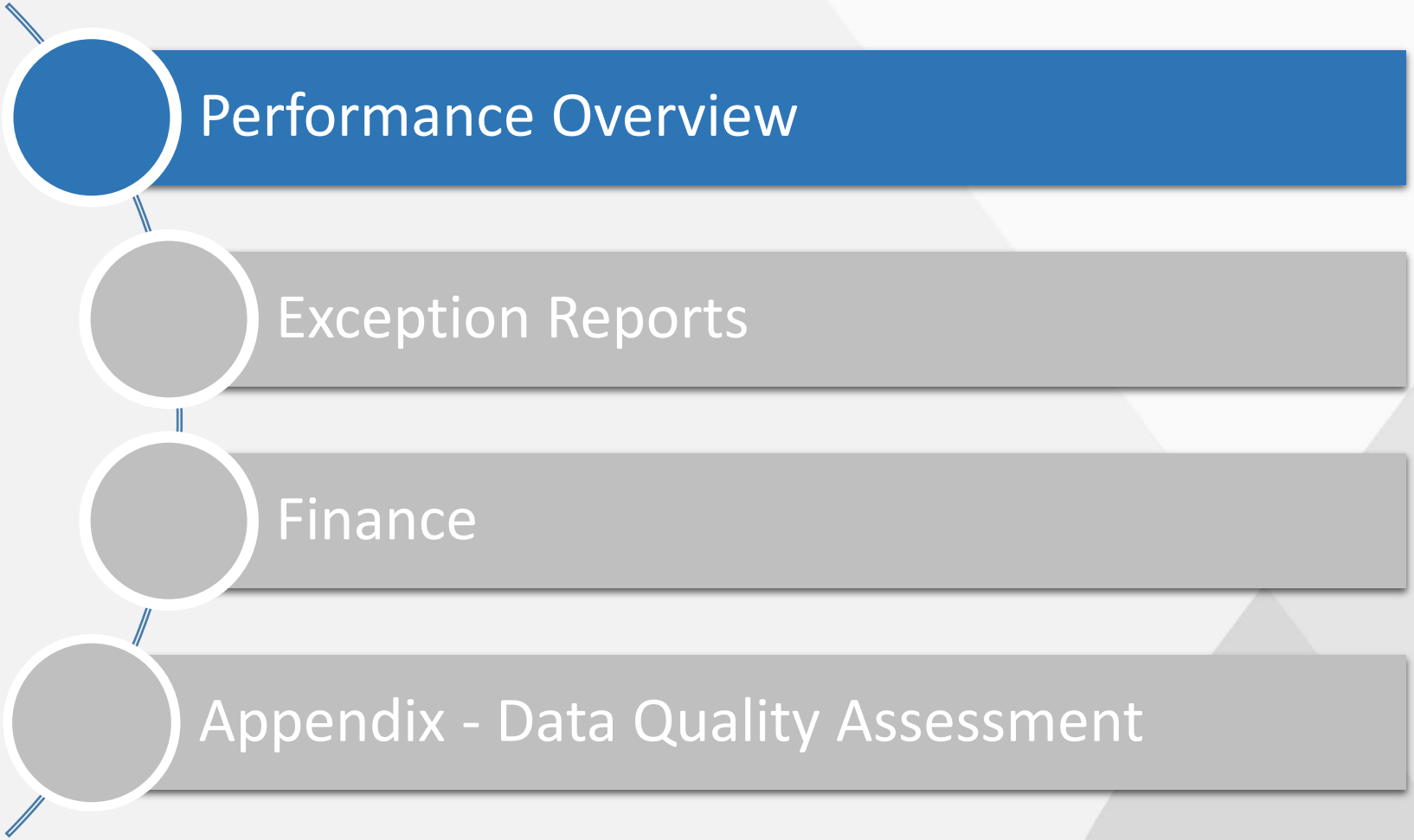
Key Performance Indicator	
CQC inpatient survey satisfaction rate	Data TBC
National maternity survey score	Data TBC
NHS Staff Survey - raising concerns sub-score	Data TBC
NHS staff survey engagement theme score	Data TBC
National Education and Training Survey overall satisfaction score	Data TBC
CQC safe inspection score (if awarded within the preceding 2 years)	Data TBC
Implied productivity level	Data TBC
Under 18s elective waiting list growth	Data TBC

We are currently working with the relevant teams and data owners to source the outstanding metrics.

Integrated Performance Report

March 2026

Contents


Performance Overview
Exception Reports
Finance
Appendix - Data Quality Assessment

Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Safe	Never events	0	0	0	0	4	?			Nov-22	National	Chief Nurse and Medical Director
	Clostridium Difficile per 100,000 Bed Days	167 Cases	13.6	19.3	21.3	15.0	?	L		Mar-24	Local	Chief Nurse and Medical Director
	Methicillin Resistant Staphylococcus Aureus	0	0	1	1	8	?			Mar-24	Local	Chief Nurse and Medical Director
	Methicillin-susceptible Staphylococcus Aureus	40	3	7	1	49	?			Mar-24	Local	Chief Nurse and Medical Director
	All falls reported per 1000 bed days	4.0	3.4	3.7		3.2	P			Aug-22	Local	Chief Nurse and Medical Director
	Rate of Moderate harm and above Falls per 1,000 bed days	0.19	0.07	0.17		0.09	?			Aug-22	Local	Chief Nurse and Medical Director
	Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	2.0	2.1	1.3	1.7	?			Jun-21	Local	Chief Nurse and Medical Director
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	98.0%	97.2%	97.3%	97.3%	P	L		Oct-21	National	Chief Nurse and Medical Director
	Number of Patient Safety Incident Investigations (PSIIs) commissioned		1	1	0	14	Awating more data for assurance and variance			Nov-24	No Target	Chief Nurse and Medical Director
	Number of reported Patient Safety Incidents		2567	2348	2442	29230				Nov-24	No Target	Chief Nurse and Medical Director
	Rate of reported Patient Safety Incidents (per 1000 inpatient, outpatient and ED attendances)		18.3	17.8	16.7	18.4				Nov-24	No Target	Chief Nurse and Medical Director

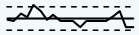
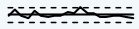
Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Caring	Single Sex Breaches		43	36	15	214				Jul-22	No Target	Chief Nurse and Medical Director
	Inpatient and Day Case Friends & Family Test % Positive	95%	95%	95%	96%	96%				Jul-22	Local	Chief Nurse and Medical Director
	A&E Friends & Family Test % Positive	81%	86%	88%	88%	85%				Jul-22	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 25 Working days	90%	70%	92%		56%				Jul-23	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 60 Working days	90%	100%			79%				Jul-23	Local	Chief Nurse and Medical Director

Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Well Led	Turnover Rate	10%	7.2%	7.6%	7.6%		P	H		Aug-22	Local	Chief People Officer
	Sickness Absence	3%	5.2%	4.9%		5.0%	F			Mar-25	Local	Chief People Officer
	% of Staff with Annual Appraisal	95%	83.6%	83.1%	83.1%		F			Mar-25	Local	Chief People Officer
	Statutory and Mandatory Training	95%	94%	94%	94%		F	H		Dec-22	Local	Chief People Officer
	Adult Nursing Vacancies	7%	4.7%	5.3%	5.0%		?			Dec-23	Local	Chief People Officer
	Paed Nursing Vacancies	10%	3.7%	7.1%	4.3%		?	L		Dec-23	Local	Chief People Officer
	Midwives Vacancies	7%	0.0%	-4.4%	-4.4%		?	L		Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - excluding Maternity	5%	18.3%	9.0%	8.4%		F	L		Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - Maternity	5%	4.1%	9.4%	6.4%		P	H		Dec-23	Local	Chief People Officer
	% Bank spend of Pay Bill	8%	6.6%	6.4%	6.7%		P	H		TBC	National	Chief People Officer
	% Agency spend of Pay Bill	3.2%	0.4%	0.4%	0.6%		P	L		TBC	National	Chief People Officer
	Agency Off Framework activity- No. of shifts	0	0	0	0		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Non Clinical Agency- No. of Staff	0	2	2	2		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Agency Staff above Price cap	0	18	20	24		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Agency shifts above £100/hr but not signed off by Chief Exec	0	0	0	0		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Agency Shifts below £100/hr and is 50% above published price cap But not signed off by Chief Exec	0	0	0	0		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Bank shifts above £100/hr but not signed off by Chief Exec	0	0	0	0		Awating more data for assurance and variance			TBC	National	Chief People Officer

Performance Overview (Effective)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Effective	Published Summary Hospital-level Mortality Indicator (SHMI)	100				99 (Jul 24 to Jun 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	12 months Hospital Standardised Mortality Ratio (HSMR)	100				102 (Sep 24 to Aug 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	Crude Mortality Rate		1.1%	0.8%	0.8%	0.9%				May-21	No Target	Chief Nurse and Medical Director
	DNA Rate - IMD Deciles 1 and 2	5%	9.0%	8.9%	8.8%	8.9%				Feb-24	Local	Director of Health Equality and Inclusion
	DNA Rate - IMD Deciles 3 - 10	5%	5.5%	5.4%	5.3%	5.6%				Feb-24	Local	Director of Health Equality and Inclusion

Performance Overview (Responsive Emergency Care)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits LLR	78%	76.4%	77.0%	79.5%	77.0%	?			Mar-23	National	Chief Operating Officer
	Emergency Department 4 hour waits UHL	61%	61.8%	63.0%	66.4%	62.8%	?	H		Mar-23	National	Chief Operating Officer
	Mean Time to Initial Assessment	15	7.3	6.9	6.2	7.8	P	L		Nov-24	National	Chief Operating Officer
	% 12 hour trolley waits in Emergency Department (DTA)	10.3%	4.5%	3.5%	2.5%	3.2%	P			Mar-23	National	Chief Operating Officer
	% of 12 hour waits in the Emergency Department	10.3%	11.5%	9.2%	7.3%	9.2%	?			Mar-23	National	Chief Operating Officer
	Average Clinical Handover time for ambulance handovers (Minutes)	30	39	30	24	39	?			Data sourced externally	Local	Chief Operating Officer
	Non Elective Average Length of Stay	7.2	7.2	7.7	7.4	7.3	?			Aug-25	Local	Chief Operating Officer
	% of Patients Discharged on Discharge Ready Date	88.3%	88.4%	87.9%	88.6%	88.4%	?			Aug-25	Local	Chief Operating Officer
	Average Delay (Post Discharge Ready Date)	3.8	4.6	4.2	4.6	4.2	?	H		Aug-25	Local	Chief Operating Officer
	Trust Bed Occupancy	92.0%	93.4%	91.5%	88.5%		?			Dec-23	National	Chief Operating Officer
	Long Stay Patients (21+ days) as a % of G&A Bed Occupancy	10%	19.4%	18.9%	18.3%		F	H		Apr-23	Local	Chief Operating Officer

Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 15).

Performance Overview (Responsive Elective Care)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	105,500	105,825	117,449			F	H		Jun-23	Local	Chief Operating Officer
	Referral to Treatment (RTT) 18 wk performance	62.3%	51.7%	55.7%			F			TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	68.1%	60.9%	61.6%			Awating more data for assurance and variance			TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes	0.9%	2.6%	2.1%			F	L		TBC	Local	Chief Operating Officer
	6 Week Diagnostic Test Waiting Times	5%	21.8%	14.3%	12.3%		F	L		Jul-23	National	Chief Operating Officer
	Theatre Utilisation	85.0%	80.0%	81.9%	81.4%	81.5%	F			Dec-23	National	Chief Operating Officer
	Patient Initiated Follow Up	5.5%	5.4%	5.1%	5.6%	5.3%	?	L		Oct-23	Local	Chief Operating Officer
	% Outpatient Did Not Attend rate	4.9%	6.1%	6.0%	6.0%	6.2%	F	L		Apr-23	Local	Chief Operating Officer
	% Outpatient Non Face to Face	25%	27.8%	27.1%	25.4%	27.7%	P	L		Apr-23	National	Chief Operating Officer

Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 15).

Performance Overview (Responsive Cancer)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Cancer)	28 Day Faster Diagnosis Standard	80%	67.7%	74.5%		71.3%	?	L		May-24	National	Chief Operating Officer
	Cancer 31 Day Combined	96%	78.1%	87.2%		77.5%	F			May-24	National	Chief Operating Officer
	62 Day Backlog Combined	152	434	414	271		F			Dec-24	Local	Chief Operating Officer
	Cancer 62 Day Combined	70%	53.9%	53.0%		54.6%	F	L		May-24	Local	Chief Operating Officer

Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 15).

Performance Overview (Finance)

Domain	Key Performance Indicator	Target YTD	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	£0m	-£6.7m	-£1.9m	-£5.4m	-£46.4m				Jun-22	Chief Financial Officer
	Capital expenditure against plan	£93.2m	£7.8m	£8.3m	£39.6m	£92.7m				Jun-22	Chief Financial Officer
	Cost Improvement (Includes Productivity)	£91.9m	£7.2m	£7.4	£9.9m	£72.5m				Dec-23	Chief Financial Officer
	Cashflow	No Target	£5m	£27.8m	-£5.3m	£34.7m				Jun-22	Chief Financial Officer
	Aged Debt	No Target	£13.8m	£14.1m	£15.3m					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (value)	95%	96%	94%	93%					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (volume)	95%	91%	88%	86%					Feb-24	Chief Financial Officer

Performance Overview (Activity)

Domain	Activity Type	Plan 25/26	Plan in Month (M12)	Activity In Month (M12)	Variance In Month (M12)	Plan YTD	Actual YTD	Variance YTD	YTD Variance to 19/20
Activity	New Outpatients (inc. NFTF)	270,077	23,235	24,079	844	270,077	275,328	5,251	9,790
	Follow Up Outpatients (inc. NFTF)	601,725	51,166	42,821	-8,345	601,725	533,605	-68,120	-68,926
	Outpatient Procedures	220,367	18,550	22,652	4,101	220,367	216,524	-3,843	62,909
	Daycase	137,582	11,148	10,459	-689	137,582	117,735	-19,847	11,623
	Inpatient	22,053	1,899	2,348	448	22,053	24,655	2,602	5,191
	Emergency	114,624	10,009	10,488	479	114,624	119,030	4,406	21,160
	Non Elective	22,843	1,938	2,079	141	22,843	24,304	1,461	2,169
	Emergency Department (inc. Eye Casualty)	282,655	24,255	25,388	1,132	282,655	289,092	6,437	35,576
	Diagnostic Imaging (inc. Direct Access)	398,465	33,799	36,748	2,949	398,465	395,288	-3,177	231,638
	Other	11,473,688	942,842	1,046,029	103,187	11,473,688	12,011,484	537,796	3,441,398
	TOTAL	13,544,079	1,118,842	1,223,090	104,248	13,544,079	14,007,046	462,967	3,752,528

**Source Early Cut and Forecasting File*

The DM01 plan for imaging activity for M12 was 646 above plan in month (27,810 vs 28,456) and was 19,711 below plan YTD (333,575 vs 313,864).

Performance Overview (Productivity Dashboard)

	Productivity Dashboard v4.0 - UHL Trustwide	2025/2026 Actuals												Assurance			
	Metric (Refer to metadata for definitions, derivations, data source and SPC variation/assurance detail)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Variation	Assurance	25/26 Target	19/20 Baseline
£	Finance: CpWAU	4,027	3,945	4,076	3,989	4,010	3,935	4,021	3,923	3,753				3,964			-	4,250
Ops & Clinical Productivity	Ops: Avg LoS for Elective Inpatients (nights)	3.26	3.06	3.05	3.53	3.41	3.05	3.17	3.22	3.36	3.12	3.20	3.22	3.22			-	3.37
	Ops: Avg LoS for emergency admissions	3.74	3.62	3.47	3.41	3.63	3.36	3.51	3.29	3.46	3.46	3.56	3.45	3.50			-	3.85
	Ops: Bed occupancy	86.9%	85.4%	86.5%	89.3%	85.1%	87.4%	92.8%	87.4%	88.9%	93.4%	91.5%	88.4%	88.6%			-	~
	Ops: Do not meet Criteria to Reside (avg pts per day)	469	431	444	436	480	481	476	471	477	511	506	476	471			-	~
Theatres	Theatres: Capped Utilisation	83.3%	83.0%	82.7%	80.9%	80.7%	81.2%	80.7%	81.2%	80.9%	80.2%	82.0%	81.4%	81.5%			85.0%	68.1%
	Theatres: ACPL	1.97	2.00	1.97	1.97	1.99	1.99	1.98	1.92	1.96	1.90	1.96	1.98	1.97			-	2.06
	% Theatre Sessions Utilised																	
	Theatres: OTDC	8.9%	7.9%	8.0%	8.4%	8.2%	8.3%	8.4%	8.5%	8.7%	9.4%	8.9%	9.8%	8.6%			5.0%	8.5%
	Diagnostics (Endoscopy): APPL	8.00	8.10	7.10	7.40	7.50	8.80	8.50	7.80	7.30	7.70	7.90	8.30	7.87			10.50	~
Outpatients	Outpatients: Clinic Utilisation	91.8%	92.2%	92.0%	91.9%	97.0%	96.5%	96.6%	98.5%	96.7%	97.9%	97.7%	98.2%	95.6%			95.0%	90.9%
	Outpatients: DNA Rate	6.3%	6.7%	6.5%	7.0%	6.4%	6.3%	5.9%	6.1%	6.1%	6.1%	6.0%	6.0%	6.3%			5.0%	6.6%
	Outpatients: % PIFU	6.1%	6.2%	5.4%	4.5%	4.9%	4.8%	5.2%	5.5%	5.5%	5.5%	5.1%	5.7%	5.4%			5.5%	~
	Outpatient: % OPA Follow Up without procedure	54.7%	55.3%	56.3%	54.1%	53.2%	52.9%	52.1%	51.2%	51.2%	51.5%	49.9%	49.5%	52.7%			53.4%	~
	A&G: Specialist Advice Utilisation Rate	11.6	13.0	13.6	15.1	13.5	12.7	12.7	11.8	10.6	8.8			12.3			12.6	~
Diagnostics	Diagnostics: MRI Machine Productivity (Adjusted)	76.1%	76.4%	70.4%	70.1%	72.9%	70.4%	71.4%	68.9%	78.5%	72.2%	69.8%	72.7%	72.5%			-	~
	Diagnostics: MRI scans per hour	1.40	1.40	1.30	1.29	1.30	1.30	1.30	1.30	1.30	1.40	1.30	1.30	1.32			1.80	~
	Diagnostics: MRI DNA rate	3.4%	3.8%	3.4%	3.8%	4.1%	4.2%	3.9%	3.7%	4.1%	2.9%	3.4%	3.6%	3.7%			3.0%	~
	Diagnostics (Endoscopy): In session booked utilisation	94.1%	94.3%	89.1%	90.5%	90.4%	92.5%	95.6%	93.4%	86.4%	83.4%	83.3%	90.2%	90.3%			95.0%	~
	Diagnostics (Endoscopy): In session actual utilisation	86.9%	87.7%	81.6%	83.5%	80.3%	85.2%	86.0%	85.3%	79.1%	76.6%	76.3%	82.6%	82.6%			85.0%	~
	Diagnostics: CT Machine Productivity (Adjusted)	79.8%	86.8%	78.4%	77.5%	74.3%	78.2%	82.0%	72.2%	72.0%	79.1%	90.4%	80.8%	79.3%			-	~
	Diagnostics: CT scans per hour	2.19	2.39	2.20	2.13	2.00	2.10	2.30	2.00	2.10	2.30	2.50	2.40	2.22			3.30	~
	Diagnostics: CT DNA rate	3.2%	3.0%	3.5%	3.0%	2.8%	2.7%	2.9%	2.6%	3.2%	1.8%	2.8%	2.9%	2.9%			3.0%	~

Performance Overview (Productivity Dashboard Commentary)

Section	Commentary
Finance	December 25 latest available update. In year CPWAU may be impacted on by move to Nerve Centre PAS and subsequent DQ issues.
Ops & Clinical Productivity	Emergency LoS reduced again in March - year to date lower than 19/20 Baseline. Further plans for continuing improvement in place. Bed occupancy remains high but reducing as Winter pressures decrease. Criteria to Reside also continues to improve in March.
Theatres	See escalation report: Responsive (Elective Care)- Theatre Utilisation for further detail. Theatre utilisation and average case per list remains stable above 80% for capped theatre utilisation. All specialities are being asked to focus on initiatives to reduce on the day cancellation rates across the Trust for the first quarter of the year. This indicator remains high- above the Trust target of 5% and is the single biggest factor in preventing further improvements in overall theatre utilisation.
Outpatients	Outpatient performance remains strong with a significant improvement seen in March for patients added to a PIFU which is positive. More work needs to occur on reducing DNA/DNB rates for clinics, with little progress made across the year, see escalation report: Responsive (Elective Care)-Outpatient DNA rate.
Diagnostics	Endoscopy APPL remains well below target, however shows improvement in March. MRI productivity (adjusted) remains below target in March, with no sustained recovery from the mid year decline. MRI scans per hour remain static and significantly below the expected standard. Endoscopy actual utilisation remains below target but records an improvement in March. Booked utilisation shows improvement as well. CT productivity has deteriorated compared to February and remains below target overall. CT scans per hour remain well below the required level. DNA rates remain low, confirming that capacity and flow, not attendance, are the main constraints.

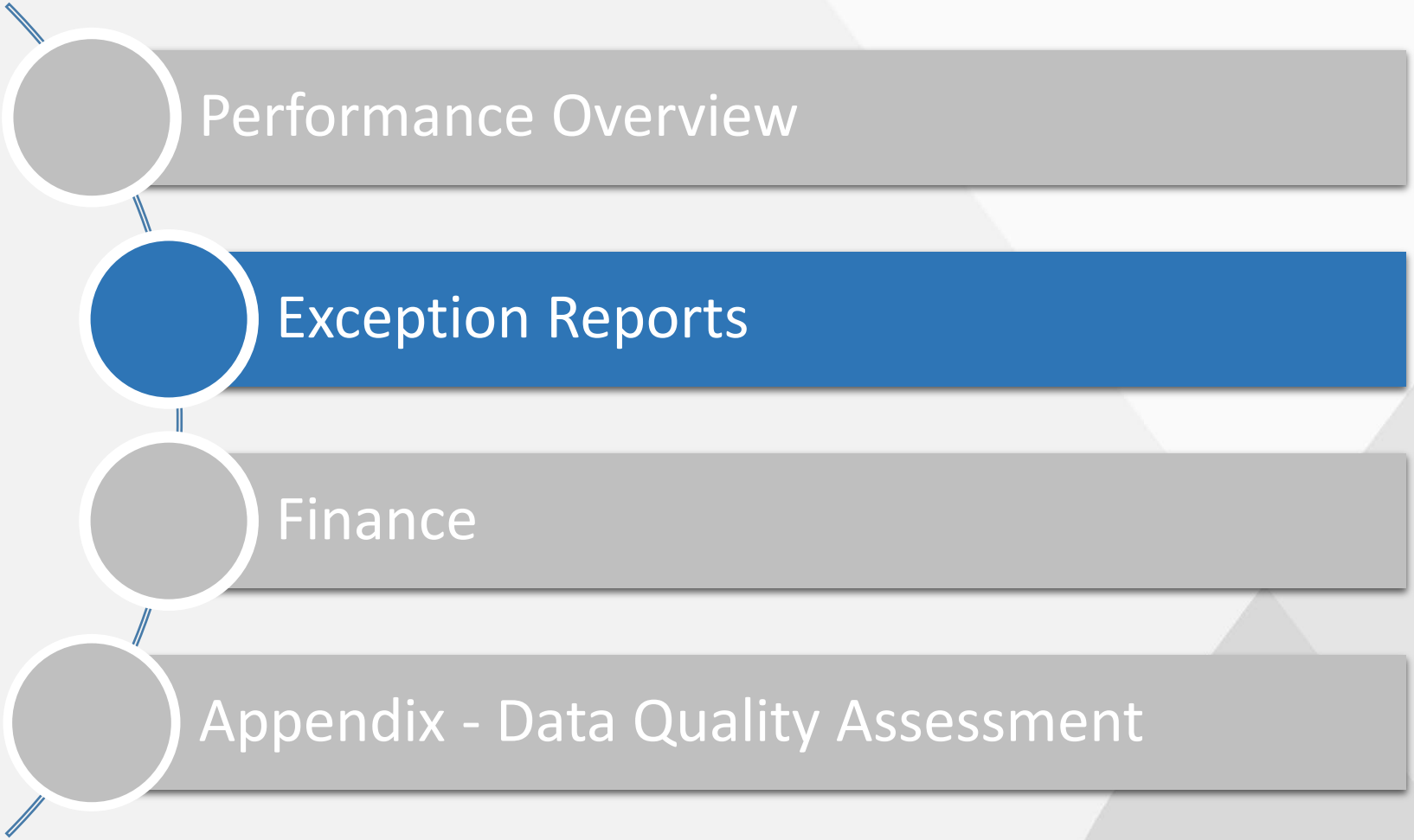
Performance Overview (Workforce Performance Overview)

Activity Type	WTE	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Performance against the workforce plan (Contracted Substantive)	Planned in Month	17,650	17,646	17,653	17,663	17,641	17,528	17,483	17,438	17,393	17,215	17,170
	Actuals in Month	17,623	17,590	17,547	17,486	17,562	17,507	17,487	17,464	17,427	17,389	17,373
	Variance (Actual vs Plan)	-27	-56	-107	-178	-78	-20	5	27	34	174	203
	% Variance (Actual vs Plan)	-0.15%	-0.32%	-0.61%	-1.01%	-0.44%	-0.12%	0.03%	0.15%	0.20%	1.01%	1.19%

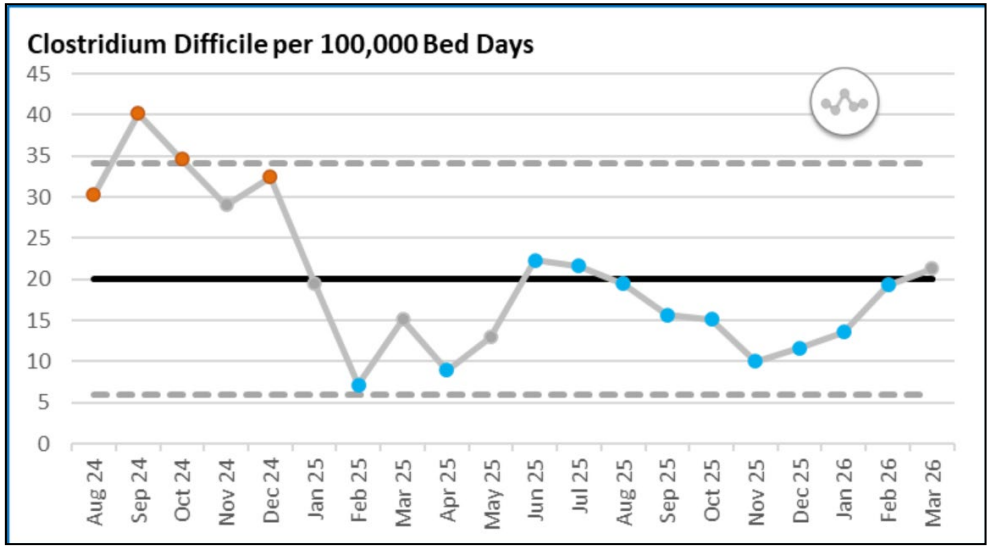
Planned data is from the NHSE submitted 25/26 workforce plan and the actuals are from a combination of the ESR and finance ledger figures.

Performance Overview (Monthly Trajectory Values)

	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Emergency Department 4 hour waits UHL	58.8%	58.9%	57.7%	58.9%	59.7%	59.2%	59.1%	58.3%	58.2%	58.1%	59.4%	59.6%
% 12 hour trolley waits in Emergency Department (DTA)	12.2%	11.6%	11.2%	11.0%	10.9%	10.6%	10.0%	9.5%	9.4%	9.5%	9.4%	8.8%
Average Clinical Handover time for ambulance handovers (Minutes)	41	31	37	35	33	41	41	45	40	49	32	28
Non Elective Average Length of Stay	7.3	7.2	6.8	7.3	7	7.2	7.1	7	7	7.4	7.4	7.4
% of Patients Discharged on Discharge Ready Date	89.5%	89.7%	89.0%	87.8%	87.8%	86.9%	88.4%	87.4%	88.9%	88.1%	87.8%	88.3%
Trust Bed Occupancy	91.0%	89.0%	89.0%	89.0%	88.0%	89.0%	91.0%	92.0%	90.0%	93.0%	93.0%	93.0%
Referral to Treatment Incompletes	108508	108040	112078	110980	109387	107643	106145	106099	106849	106537	106189	105500
Referral to Treatment (RTT) 18 wk performance	56.0%	56.5%	57.6%	57.0%	57.2%	58.1%	59.3%	59.7%	59.4%	60.2%	61.7%	62.3%
Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	59.00%	60.00%	61.50%	61.70%	62.50%	63.40%	64.40%	65.40%	64.90%	65.50%	67.40%	68.10%
Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes	1.8%	1.6%	1.4%	1.3%	1.3%	1.3%	1.2%	1.2%	1.1%	1.1%	1.0%	0.9%
6 Week Diagnostic Test Waiting Times	17.0%	16.0%	14.0%	13.0%	12.0%	11.0%	9.5%	8.0%	8.0%	7.0%	6.0%	5.0%
Patient Initiated Follow Up	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%
28 Day Faster Diagnosis Standard	77.0%	77.0%	78.0%	78.0%	77.0%	77.0%	78.0%	78.0%	77.0%	77.0%	79.0%	80.0%
Cancer 31 Day Combined	74.6%	79.1%	77.6%	78.1%	79.5%	78.5%	83.0%	79.3%	80.9%	88.1%	90.0%	90.0%
Cancer 62 Day Combined	59.1%	60.1%	61.2%	62.1%	63.1%	64.1%	65.1%	66.2%	67.1%	60.0%	69.0%	70.1%


Performance Overview
Exception Reports
Finance
Appendix - Data Quality Assessment

Safe – Clostridium Difficile per 100,000 Bed Days

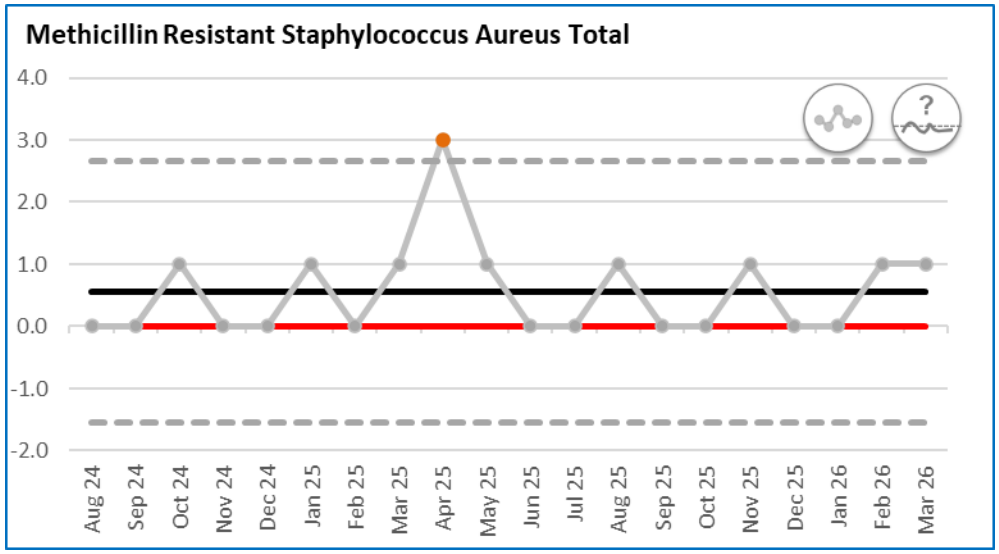


Number of Cases			Number of Cases per 100,000 bed days		
Mar 25	YTD	Target	Mar 25	YTD	Target
18	147	167	21.33	15	

National Position & Overview			
	March 25	Total	
CDIFF NHSE Threshold 25/26	14	167	
* Actual Infections (HOHA) 25/26	11	92	
* Actual Infections (COHA) 25/26	7	55	
* **Actual Infections Total (HOHA & COHA)** 25/26	18	147	
UHL 100,000 Bed Days (HOHA) 25/26	21.33	**15**	*YTD UKHSA Report
National Average	16.88		
National Highest	76.61		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
• No changes to current themes identified in previous month across UHL; Themes include: • Delay in identification of cases ifive tool under utilised • Delay in isolation into a single room on suspicion of infection. • Delay in antimicrobial treatment • Poor compliance with stool chart documentation • Laxatives not reviewed for altered bowel output prior to specimen sample sent.	• A CDI report and reduction plan was submitted to TIPAC Q3 and was discussed at TIPOG on the 5th February. • CMGs are working towards actions identified in the UHL CDI Reduction Plan • These are identified on the Action Trackers for each CMG and monitored via TIPOG • IP PSIRF reviews (Patient Safety Incident Response Framework) are completed for CDI cases, and where required an MDT table top review	• Any immediate actions to be taken will be raised in TIPOG and the wards accordingly and this was further discussed with CMGS at TIPOG 16.04.2026 • CDI thematic review to be submitted for Q4 to TIPAC

Safe – Methicillin Resistant Staphylococcus Aureus

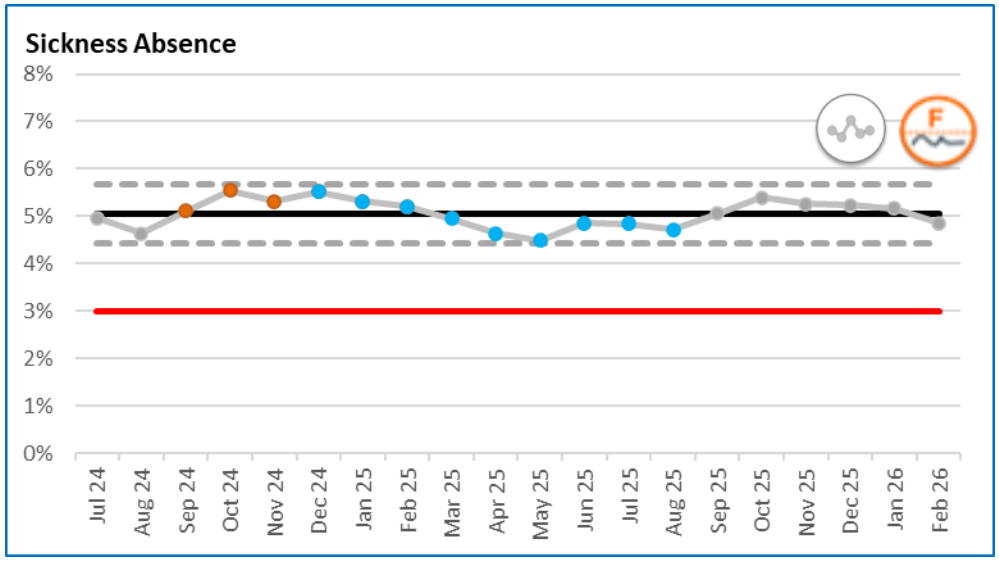


Current Performance		
Mar 25	YTD	Target
1	8	0

National Position & Overview			
	Mar 26	Total	
MSSA NHSE Threshold 25/26	0	0	
* Actual Infections (HOHA) 25/26	1	8	
* Actual Infections (COHA) 25/26	0	0	
*** Actual Infections Total (HOHA & COHA)** 25/26	1	8	
UHL 100,000 Bed Days (HOHA) 25/26	1.94	1.33	*YTD UKHSA Report
National Average	0.67		
National Highest	11.27		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
• Initial review of Trust wide MRSA policy audit and adherence to practice indicated improvement in compliance with the MRSA policy is required. • This was the findings upon review of this case. • Please note this data refers to HOHA cases only, which are in the sphere of UHL review	• Revised IP PSIRF (Patient Safety Incident Response Framework) for HCAI, including MRSA bloodstream infections, has been developed and has been used for this case. • All CMG have completed an MRSA reduction plan and these will be reviewed and managed through TIPOG. Actions will be discussed and the importance of policy compliance reiterated • The first Vascular Access Report from the Transformation Team is now in draft form and is being reviewed.	• MRSA reduction plan was specifically reviewed on the16.04.2026 TIPOG with CMGs • A thematic review of the year 25/26 MRSA incidence will be presented during Q1 to the Quality and Safety Committee

Well Led – Sickness Absence



Current Performance		
Feb 26	YTD	Target
4.9%	5.0%	3%

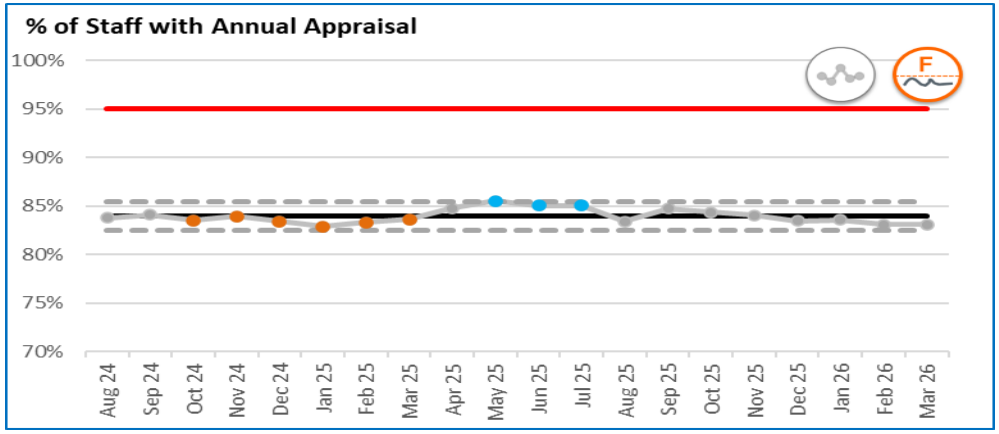
National Position & Overview

Peer data not available.

The February sickness absences rates shows a reduction of 0.19% to the previous month.

Root Cause	Actions	Impact/Timescale
• Clinical CMG's have seen a 021% reduction and Corporate Directorates a 0.10 increase in February December. • Over the last 12 months, the highest levels of absence are in E&F (6.28%), W&C (5.58%) and ITAPS (4.90%). • The areas achieving the 3% target are within the Corporate Directorates • The top 3 reasons for sickness absence are anxiety/stress/depression (23.27%), Other known reasons (15.84%) and cough/cold/flu (10.85%)	• One of the key priorities in the NHS 10-year plan is to shift from sickness to prevention. A UHL working group has been established to take this forward for our workforce, along with plans to achieve the national 4.1% target. • Nursing and Midwifery have also set up a staff group specific working group to review sickness absence / improve attendance. • Improving accurate reporting reasons for sickness absence is essential for CMGs to ensure appropriate local and Trust wide interventions – reducing the 'unknown' absence reasons. • Wellbeing information is shared through corporate and local induction, HWB Ambassadors, monthly restaurant stands and weekly and monthly newsletters • Sickness absence data is reviewed with CMG's through PRM, Board and Specialty Meetings and local 'Making if all happen / Health and Wellbeing' reviews. • CMGs are taking local targeted actions to support the wellbeing of colleagues and management of sickness absence. • For longstanding and complex cases, case conferences with OH occur. • The ER and Health and Wellbeing UHL Connect site covers all aspects of support, training, information, TALK toolkit for wellbeing conversations, template documents etc.	• The NHS Long Term Workforce Plan highlights improved retention of our workforce as one of its key pillars, which includes supporting them to stay well. • Through the 2025 Staff Survey results, we have seen a decline in our score by 0.08 but remain above our comparators by 0.16 in the People Promise Theme "We are safe and healthy". • We have sustained the improvement in recording reasons for sickness absence over the last year where in 24/25 M8 we had 10.06% of absences recorded as 'unknown' reason, and in 25/26 M11we are at 1.97%.

Well Led – % of Staff with Annual Appraisal



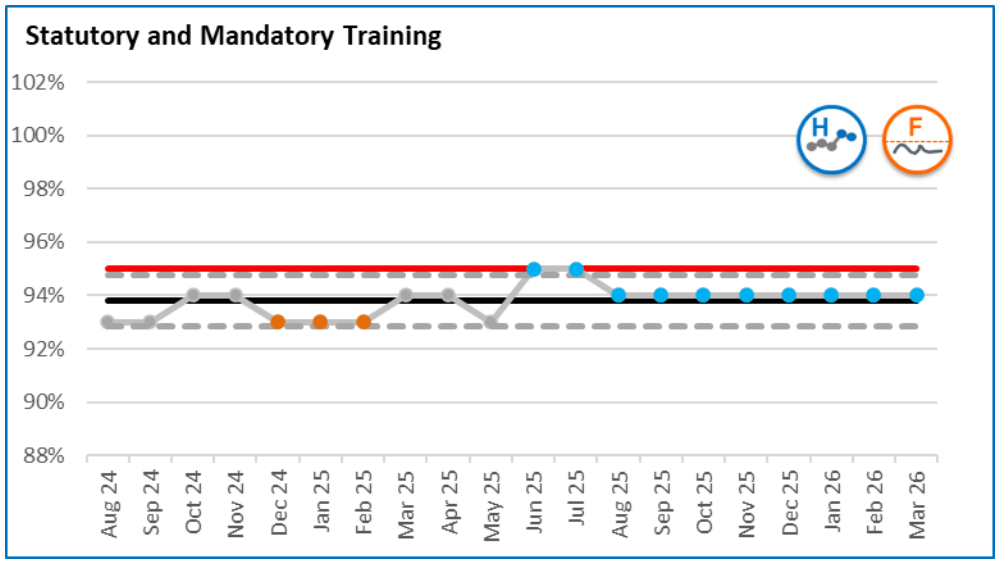
Current Performance		
Mar 26	YTD	Target
83.1%	-	95%

National Position & Overview

Peer data not available.
The March figure shows a static position the previous month. We are still 11.9% away from the Trust target of 95%.

Root Cause	Actions	Impact/Timescale
• A number of colleagues have had appraisals within the last 12 months, outside the reporting/ incremental date and therefore show as non-compliant. • Appraisal reporting/ inputting is still a contributing factor in some areas and continued plans are underway to support capturing this across services. This is regularly highlighted as impacting the data. • In month, the appraisal average for UHL has been static. • The Trust's overall compliance in month has been due to marginal increases in mainly clinical areas and decreases more noticeably in corporate services.	• It is acknowledged in previous exception reports that we would be unlikely to reach full compliance of 95% in the short term. • CMG reports are provided, highlighting performance and areas of focus, to enable targeted support and action in these areas. • The roll out of Managers Self-Serve should see improvements in appraisal performance, particularly through reporting (see 'root cause') • The automation agenda also sees the review of the appraisal system to create administrative efficiencies, improve reporting and to allow a better focus on talent conversations. Implementation is envisaged to be May 2026 Trustwide • Line managers are asked to review appraisal performance and identify any additional targeted support required	• In March 2025 Appraisal performance was at 83.6%, an increase in compliance on the previous month of February 2025, and surpassing this month's compliance. • Appraisals are reviewed through regular line management, service and Board oversight meetings. • CMG/ Directorate leadership are to focus on quality appraisal discussions as essential to the employee experience and achieving our key objectives within areas this year. Engagement work has taken place to review how we carry out appraisals. • The 2025 Staff Survey results show that career progression and talent management will be areas of focus under the Diversity and Equality agenda, all linked to appraisal conversations.

Well Led – Statutory and Mandatory Training



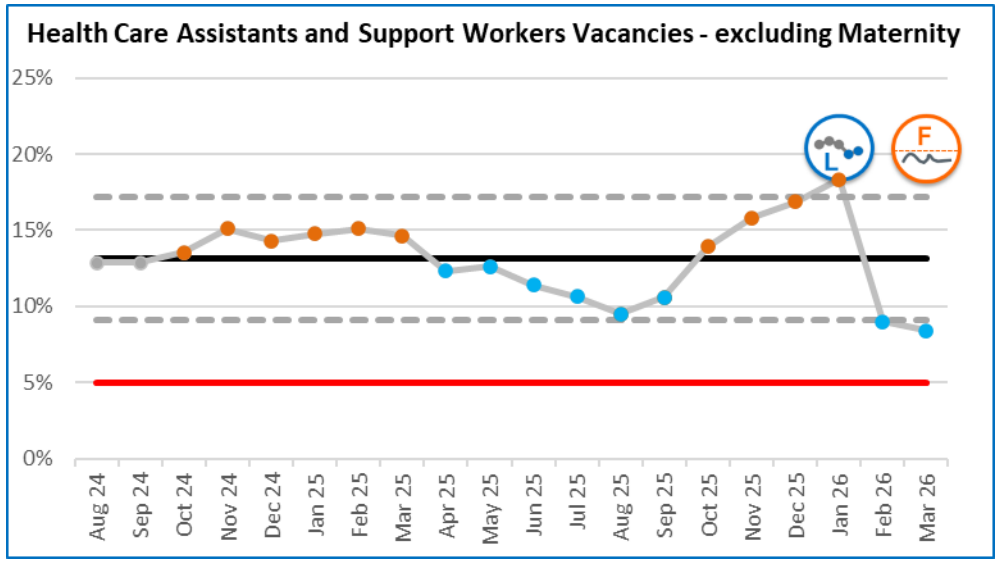
Current Performance		
Mar 26	YTD	Target
94%	-	95%

National Position & Overview

Peer data not available.

Root Cause	Actions	Impact/Timescale
It is recognised that performance for some CMG's, departments or staff groups has been, and is being, affected by: • Operational pressures • Operational demand • Staffing Levels. Although the RAG rating is red, it should be noted that the compliance of 94% is higher than many other NHS organisations nationally and is not an immediate risk, however the target of 95% is desirable. Mandatory training knowledge modules are one of many tools to support patient, visitor and staff safety.	Performance against trajectories is being monitored via Trustwide Performance Reviews. Access to compliance data and emailed reports to 3086 staff. 10,000+ direct reminder emails per month. Some colleagues cannot get online, mandatory training booklets have been updated with SME's for Estates and Facilities Colleagues. The Workforce, Training and Education Steering Group (WTESG) and the Mandatory Learning Oversight Group (MLOG) are looking at Essential Training. NHS England are conducting a review of Mandatory Training topics/frequency; both aims are to ensure a balance between minimising incidents, mitigating risks and releasing staff time into the workforce.	Reviewed through the Making it All Happen reviews chaired by CMG / Directorate leadership teams with support from HR. This is a meeting with each line manager to review sickness, appraisals and S&MT compliance. Drive towards improving the overall percentage of UHL throughout the financial year has been implemented with renewed chasing on non-compliant with organisational support. Review of ESR and HELM data alignment is ongoing as business as usual. Ad hoc Challenges to this data alignment are under consistent scrutiny.

Well Led – HCA and Support Workers Vacancies – excluding Maternity



Current Performance		
Mar 26	YTD	Target
8.4%	-	5%

National Position & Overview

Root Cause	Actions	Impact/Timescale

• Several areas are currently reviewing the proportion of unregistered staff within their workforce and reassessing the optimal skill mix. Consequently, recruitment activity has progressed more slowly while these evaluations are underway but this has had a positive impact on reducing HCA vacancies	• Nursing and Midwifery Annual Establishment Review (NMAER) approved by Trust Board on Thursday 12th February 2026. This will be enacted in M1	Recruitment drive progress:
		• Band 2-3 pathway:
		  • Dec-25 = 12wte (9 within pre-employment checks, 3 applicants with start dates).
		  • Mar-26 = advert closed 04/03/2026; 16 colleagues appointed.
		• Band 3 HCA:
		  • Interviews to taken place on 20/03/2026., with between 70-80 colleagues appointed.

Well Led – Non Clinical Agency- No. of Staff

Current Performance		
Mar 26	YTD	Target
2	39	0

Awaiting more data for SPC chart

National Position & Overview

NHSE Agency Rules stipulate trusts are required to use only substantive or bank workers to fill admin and estates shifts. Trusts should only use agency workers to fill these shifts where they meet exemptions (special projects & exceptional patient safety risks)

Root Cause	Actions	Impact/Timescale
• There are 2 Project officers in capital projects which meet the special projects exemption	The service has been requested to advise on exit plans.	The service has confirmed that these workers are assigned to working on delivery of the capital programme which has been approved by NHSE. A large proportion of the projects are NHSE funded projects, eg Estates Safety and OFH These workers are funded from the capital and not revenue. These roles are supported by the Director of Estates & Facilities . 1 agency worker left on 20th March which leaves 1 remaining agency worker. The service has been advised not to procure any further agency workers.

Well Led – Agency Staff above Price cap

Current Performance		
Mar 26	YTD	Target
24	287	0

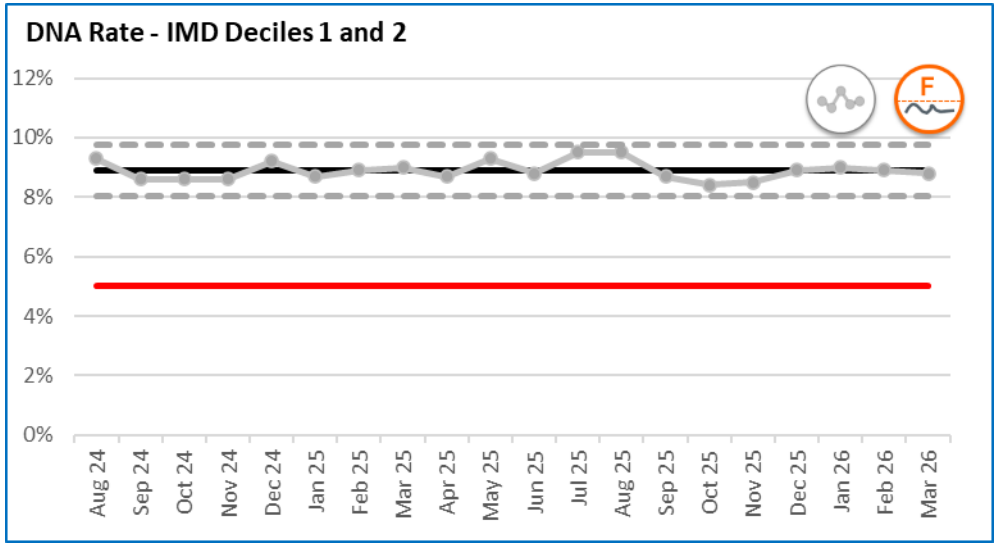
Awaiting more data for SPC chart

National Position & Overview

The price caps set by NHS England apply to the total amount a trust can pay per hour for an agency worker. Trusts should not pay more than the price caps to secure an agency worker, except in exceptional patient safety circumstances

Root Cause	Actions	Impact/Timescale
• Historically, all medical posts are over the agency price caps – this is a national issue • AHP specialist roles such as Sonography, Radiography and Cardiac Physiotherapists are over price cap due to the specialist skill sets and specialist nature of the roles.	Attendance at Regional NHSE steering groups with milestone plans introduced to reach price cap compliance across all staff groups. There has been an increase of 4 additional workers since last month over price cap within the medical staff group due to the service requirements which have received the relevant approval levels. These are in MSS Orthopaedics	Agency price caps have been confirmed to remain the same from April 26 by NHSE. The price cap breaches continue to be reported to NHSE on a monthly basis. Attendance at regional NHSE steering groups continues. Exit plans aligned to recruitment plans are being progressed.

Effective – DNA Rate (IMD Deciles 1-2 & IMD Deciles 3-10)



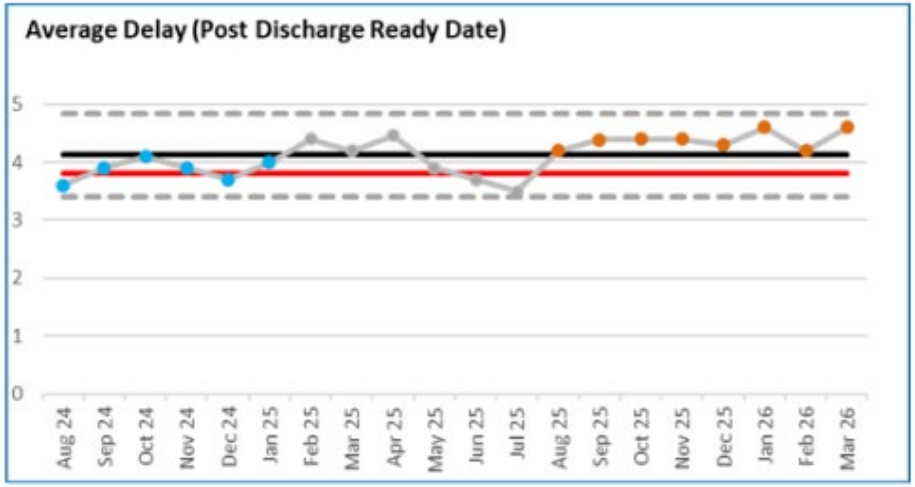
DNA Rate – IMD Deciles 1-2			DNA Rate – IMD Deciles 3-10		
Mar 26	YTD	Target	Mar 26	YTD	Target
8.8%	8.9%	5%	5.3%	5.6%	5%

National Position & Overview

There is no national target for DNA rates, but understanding the role inequity plays in differential rates of non-attendance is vital to UHL's attempts to improve Theatre and Outpatients utilization, whilst enabling high quality care for all. This understanding also plays a broader role in supporting the achievement of targets on productivity and the Trust's aim of embedding health equality & inclusion in all we do.

Root Cause	Actions	Impact/Timescale
• The DNA Florey is no longer being sent to patients, as of Jan 2026, therefore there is no in month root cause data. • However consistent themes that have emerged over the course of the DNA florey have been: 1. Patients or carers tried to contact UHL to cancel but could not get through. 2. Patients had a mobility issue that meant they were unable to access the sites. 3. Patients had a medical or health reason for not attending on the day.	• All IMD1 and IMD2 patients called two weeks prior to their appointment. • Text appointment reminders (all) 7, 5 and 1 day before. • DNA rate data is available for each CMG to identify specific areas of inequality. • Multi-agency MDT established to support the most vulnerable groups eg Inclusion. • DNA rates included in PRM packs, APM discussions and at Outpatient Transformation Board. • Community engagement to explore barriers. • Trialing of AI to support cancellations/re-booking. • Work starting in Community services.	• IMDs 1 & 2 have an average DNA rate of **10%** for Mar 26. Disaggregated by contact these rates are: • **IMD1** • Patients contacted DNA rate 4.96% • Patients not contacted DNA rate 13.27% • **IMD2:** • Patients contacted DNA rate 3.9% • Patients not contacted DNA rate 18.03% • **Inclusion Healthcare:** • DNA rate for those contacted 0% • DNA rate for those not contacted 12.5% • **Paediatric Outpatients** • WNB rate contacted 4.2% • WNB rate not contacted 23.33%

Responsive (Emergency Care) – Average Delay (Post Discharge Ready Date)



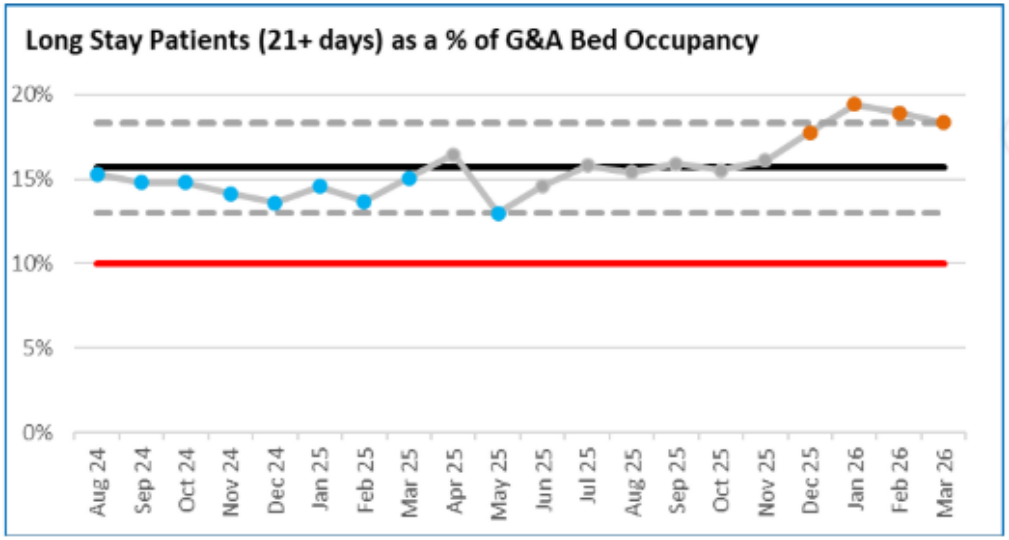
Current Performance		
Mar 26	YTD	Target
4.6	4.2	3.8

National Position & Overview

In January, UHL ranked 33 out of 117 Acute Trusts that submitted acceptable data. The National average was 5.9. 20 out of the 117 Acute Trusts achieved the target. UHL ranked 6 out of the 18 UHL Peer Trusts. The best value within our peer group was 2.1 and the worst value was 9.8.

Root Cause	Actions	Impact/Timescale
Poor outflow from the inpatient wards through • **Process delays** internally relating to ward processes, diagnostics, discharge delays (TTO's etc.) and externally (EMED ambulance, equipment) **286 complex patients stayed an additional night in hospital in March 63 patients more than February (223 February)** • **LLR system discharge hub interface and capacity delays** continue to impact the ability to provide timely P1-3 discharge plans . **99 Patients waiting at the end of March.** • **Deterioration in LOS from MOFD to discharge for P1 (0.46 days from Feb) P3 (2.42 days from Feb).**	•**Continue weekly escalation meetings** with Adult Social Care and CMGs to address long waits, ensuring themes for action are identified and tracked. •**Assess the underlying causes for discharge delays** and highlight recurring themes to inform transformation initiatives. •**Increase early patient referrals** currently at 38% March (39% February) through targeted engagement and process improvements. •**Share learning from LEAF and wider discharge QI projects** to inform approach to practice. •Undertake Pathway 0-3 events during April.	• Aim to reduce number of MOFD (Discharge Ready) patients waiting for discharge in UHL beds. • Reduce time to discharge from MOFD identification • Improving Patient Discharge Project plan in place and reviewed within the discharge improvement meeting with CMG's

Responsive (Emergency Care) – Long Stay Patients as a % of G&A Bed Occupancy



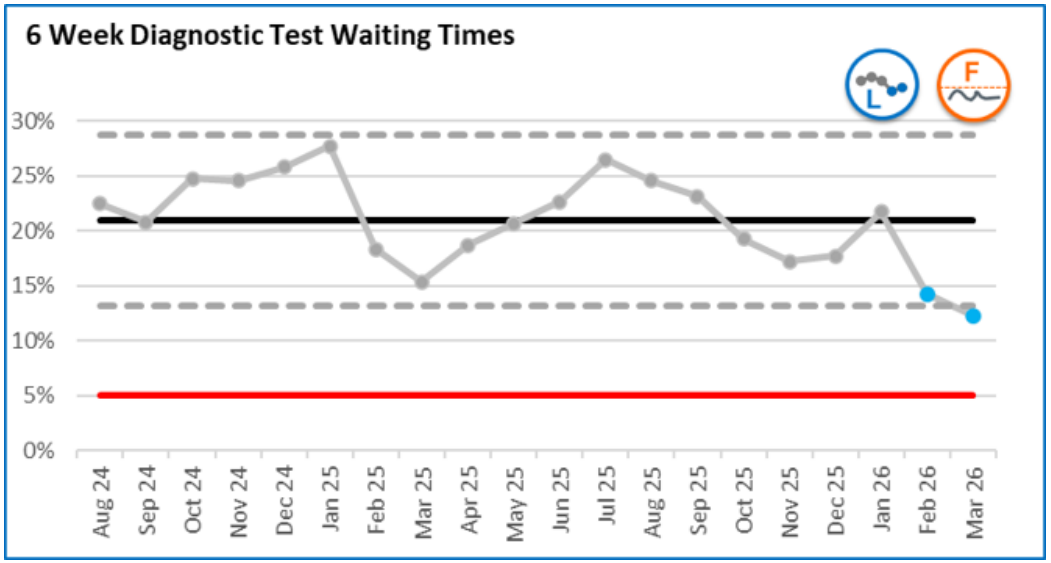
Current Performance		
Mar 26	YTD	Target
18.3%	-	10%

National Position & Overview

- 64 (340) Patients (19%) are receiving appropriate care/ treatment on a neuro rehabilitation or brain injury pathway or on an Intensive Care Unit, Infectious Diseases Unit or in UHL at Preston Lodge (26 patients).
- 75 Patients (22%) are medically optimised complex patients awaiting discharge with no reason to stay in an Acute Trust.
- Approx. 80 (24%) patients data quality issue (not UHL inpatient)

Root Cause	Actions	Impact/Timescale
• **Data quality issues (Approx. 80) continue** to arise following PAS changes. These include the system pulling pre-admission codes, delays in discharge coding, and missing outcomes. • **LLR system discharge hub interface and capacity delays** As of the end of March there were around 75 patients with length of stay over 21 days awaiting a confirmed discharge outcome from LLR.	• A weekly Power BI DQ dashboard highlights patients needing outcomes, with issues monitored through the PAS Data Quality Improvement Plan • Collaborate with Nervecentre to resolve the system fault that is preventing discharge coding from being completed after three months **Throughout April 2026:** **Work with health and social care system partners to:** • Maximise the use of P1/ P2 capacity in LLR. • Discuss >1 week for discharge outcome cases weekly. **Work with CMG's to:** • Promote the early referral of patients to the discharge hub prior to being MOFD. (**38% March** 39% February, 32% January). • Maintain Weekly CMG reviews of > 21 day patients and top 100 day patients • Review impact of Stroke ward PDSA on LoS having an additional 2 therapists.	• Aim to reduce number of MOFD patients waiting for discharge in UHL beds. • Reduce time to discharge from MOFD identification. • Increase use of Virtual wards and criteria led discharge where possible • Staff feel better equipped to manage and coordinate the safe discharge and transfer of Patients

Responsive (Elective Care) – 6 Week Diagnostic Test Waiting Times



Current Performance		
March 26	March Plan	Target
12.3%	5%	5.0%

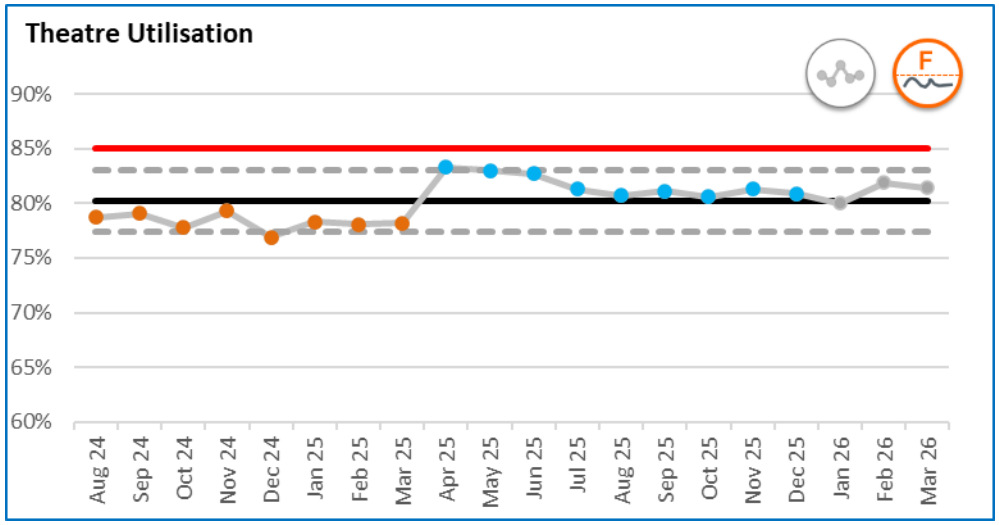
National Position & Overview

Published National data at the end of Feb'26 shows 1.86m patients on the diagnostic waiting list with 20.2% waiting over 6 weeks. For Mar'26, UHL with 23,635 patients would comparatively rank as the 15th highest waiting list. The 6-week trajectory for March was set to deliver 5%, the actual was 12.3%, 7.3% behind plan, driven by Endoscopy, Sleep, Audiology and Echo. There were 2,902 patients waiting >6 weeks, an improvement of 485 patients from Feb '26.

Root Cause	Actions	Impact/Timescale

Diagnostics pressure areas are in the main:
• Endoscopy
• Sleep
• Audiology
• Echocardiography
 	
Root cause
• Clinical & administration workforce gaps
• Reporting and coding errors
• Pressure from emergency, cancer and elective long wait pathways
	• QLIK & PAS WLMDS Data Quality training
	• Improve productivity
	• Increase capacity
	  ◦ New endoscopy unit – opened Nov 25
	  ◦ Hinckley Community Diagnostics Centre – opened June 25
	  ◦ Additional lists (Echo, Audiology)
	• Review demand data with ICB
	• Expand direct access diagnostics
	• 5year MRI/CT D&C plan – complete, £ assessment underway as part of CDC expansion business case.
	• Scope possible CDC expansion opportunities
		• Validation & DQ – ongoing, work in progress with Digital/NC support.
		• Productivity - Improvements seen in CT DNA, MRI productivity and Endoscopy. Sleep paediatric, Cystoscopy and Urodynamics utilisation remain above 90%.
		• Endoscopy – behind plan due to A&C workforce. Weekly escalations in place and additional staff being recruited. Recovery actions to be shared with Committee members this month.
		• Sleep quality improvement project commenced with RTT prioritised, recovery expected later in Q1.
		• Audiology – ERF supporting additional activity, workforce review in progress.
		• CDC & direct access opportunities scoped, await outcome of expansion business case.

Responsive (Elective Care) – Theatre Utilisation



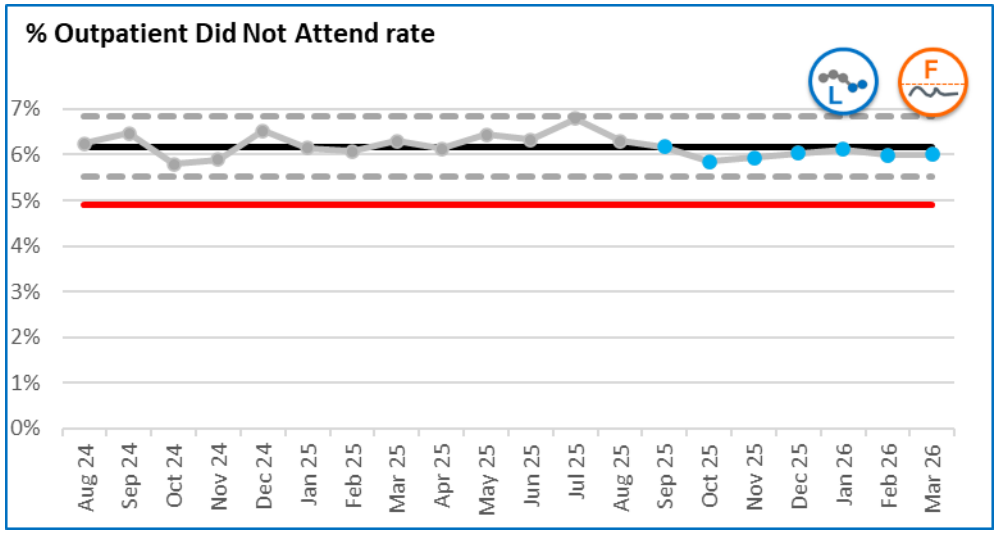
Current Performance		
Mar 26	YTD	Target
81.4%	81.5%	85%

National Position & Overview

In March, overall theatre utilisation was 81.4%, representing a slight reduction from February (81.9%), with year-to-date performance at 81.5%.Trust performance continues to be rated Green (Quartile 3) on Model Hospital System. For the week ending 22nd March 2026, utilisation was 83.5%, exceeding both the peer median of 80.7% and the national median of 80.9%

Root Cause	Actions	Impact/Timescale
• LGH: Utilisation 84.9%, continued improvement. • UHLiC: Utilisation 82.3%, improvement; late starts increased by 9% (from 30% to 39%). Work ongoing to improve scheduling using consultant-level procedural times to reduce underruns (>45 mins) and increase ACPL. • EMPCC: Utilisation 77.2%, static. Only 2 of 8 specialties above 85%. High cancellations at 8.2% (44 patients) occurring across all the pathway. • LRI: Utilisation 75.5%, declining. Emergency and bed pressures drove 62 cancellations (26%). OTDCs (11.7%) and late starts (38.2%) are increasing, with significant specialty variation (83.1%–32.9%). Paediatric services remain among the lowest-performing lists, with paediatric and adult utilisation at 69.9% and 77.5% respectively.	• Weekly performance meetings (from April) to drive a reduction in on-the-day cancellations (OTDC), with clear specialty-level ownership and routine weekly performance tracking. • UHLiC: Implementation of targeted actions to reduce late starts, including mandatory use of the golden patient model across all operating lists. • EMPCC suitability: 50-patient enhanced pre-assessment and anaesthetic review pilot to address suitability-related cancellations (currently delayed). • EMPCC "Super Week" (May): Enhanced patient preparation, embedding best practice and ensuring patients are confirmed fit prior to TCI. • LRI – late starts: Strengthened monitoring and escalation of recurrent delays, alongside process review to improve start-time performance (May – supported by recruitment of a new Service Manager). • LRI: Focused specialty-level performance reviews, prioritising Paediatric services.	• Weekly performance meetings (staring 22nd April): Expected to drive service level actions and drive OTDC supporting utilisation >85% . • UHLiC -To reduce late starts and first-case delays by ensuring a fully prepared and confirmed first patient for each list, allowing theatre set up and prompt start. • EMPCC Suitability Trial (due to start 23rd April – delayed due to POA staffing gaps): Expected to reduce clinical / suitability-related cancellations. • EMPCC Super Week (May): Will test and refine operational processes, identify what works well and inform future best-practice models to improve productivity (planning in progress) • LRI Late Starts: Expected to stabilise and reduce • Paediatric - Expected to reduce specialty-level variation, improve utilisation, and support recovery in overall site (LRI) performance

Responsive (Elective Care) – Outpatient DNA Rate

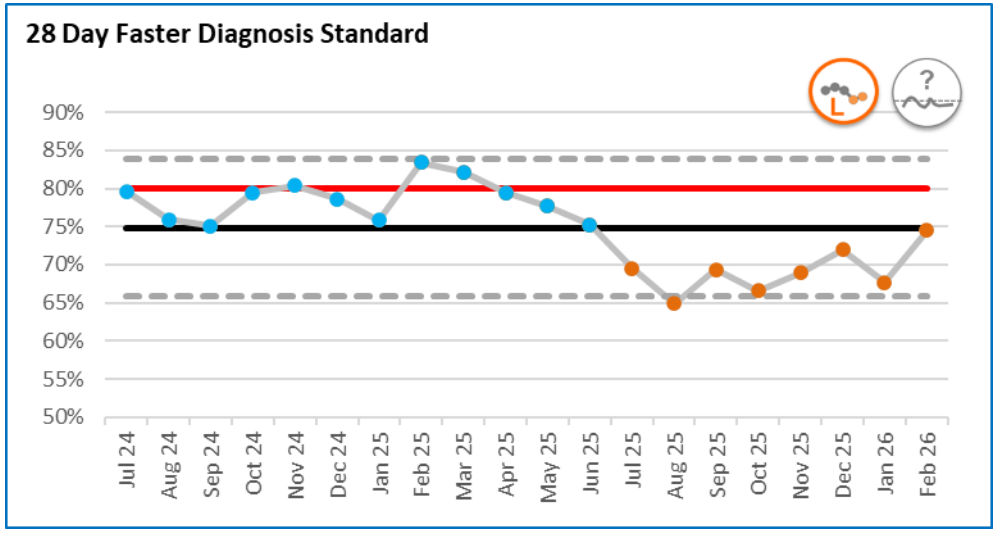


Current Performance		
Mar 26	YTD	Target
6.0%	6.2%	4.9%

National Position & Overview

Root Cause	Actions	Impact/Timescale
1. The launch of Nervecentre PAS has meant continuous issues with the data feed going to Accurx so patients aren't always receiving automated reminders 2. Late cancellations/rebooks often mean patients do not receive their appointment letters on time so unaware of appointment 3. Due to lack of admin staff, patients unable to get through to department to let them know they're unable to attend, or admin are not actioning cancel/rebook requests in Accurx. 4. Services are not always maintaining their appointment reminder house keeping in Accurx 5. For telephone appointments, clinicians not giving the patient enough time to answer or only calling the patient once 6. The NHS App currently allows patients to request to cancel/rebook up to midnight the day before their appointment.	1. Complete Neurons ticket when made aware of any issues with clinic lists in Accurx or feed going from UHL to Accurx. Location issue has been escalated. 2. Remind services of the need to check the patients details are correct and up to date at every contact 3. Services to text patients appointment details if changes are made to appointments 4. Booking Centre are making additional calls to 'Health Inequalities' cohort now including Paediatrics. 5. Accurx automated clinic appointment reminders have gone live in the majority of services including Imaging and Therapies. Clinic lists are also available in Accurx for most services 6. Text fragments has increased to allow services to add bespoke messages to automated appointment reminders 7. Awaiting a decision from IT on whether to increase cancellation window in NHS App as there's a cost	• All actions, plus many others, are happening imminently to help reduce the number of DNAs. • An improvement in the DNA rate should continue over the next 3 months providing the actions are carried out.

Responsive Cancer – Cancer 28 Day Faster Diagnosis Standard



Current Performance			
Feb 26	YTD	Feb Plan	Target
74.5%	71.3%	79.0%	80%

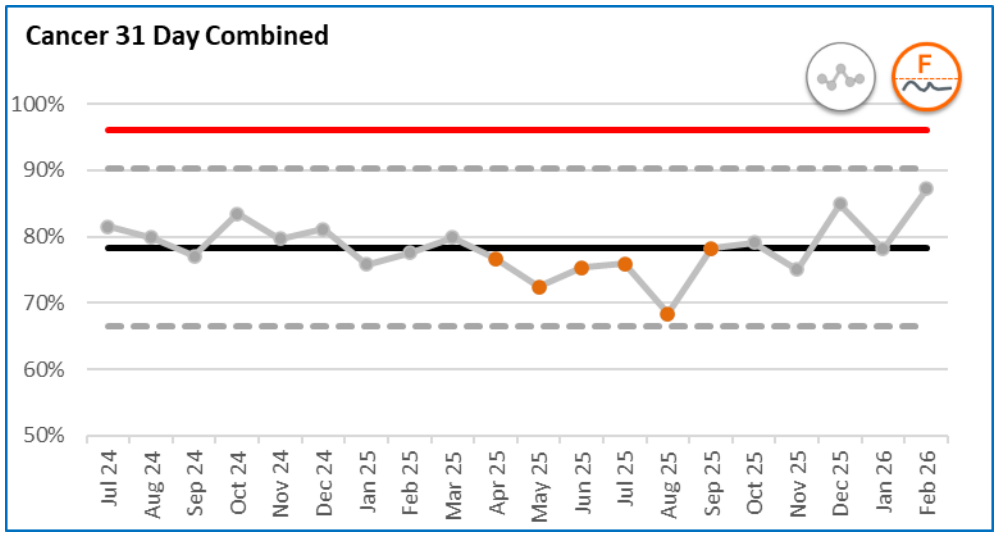
National Position & Overview

In February, UHL ranked 119 out of 141 Acute Trusts. The National average was 80.5%. 110 out of the 141 Acute Trusts achieved the target. UHL ranked 16 out of the 18 UHL Peer Trusts. The best value within our peer group was 86.0%, the worst value was 63.5% and the median value was 82.5%.

UHL's performance deterioration is due to a loss of capacity in Breast and ENT which has been unable to be mitigated.

Root Cause	Actions	Impact/Timescale
The root cause is due to the loss of capacity in Breast since Q2 and ENT Q4. There is a • Demand & Capacity gap for 1st appointments in Breast (50 slots per week) usually covered with WLI/Insourcing. In addition to a decline in uptake of Breast WLI cover. • ENT consultant gap which has been unable to be consistently backfilled This has caused time to first appointment to extend for both tumour sites, resulting in a decline in FDS performance since Jul 25. Without this loss of capacity, performance in February would have been above 80%.	• Breast insourcing and bank/WLI to support 1st appt wait times. • Mutual aid requests – have not been successful • Recruit to ENT consultant gap and backfill with locums. Independent Sector being explored. • Demand review for Breast & ENT pathways • Days Matter Campaign: Breast, LOGI, Gynae, Urology. Improvements noted in Q4. Continue focus on turnaround times across all tumour sites. • Working with clinicians on clarity of correspondence to clearly document if cancer confirmed or excluded at the earliest opportunity	• Breast 1st appt waits improved to 3-4 weeks. Sustainable plan to convert ERF through planning in progress. • ENT 1st Appt waiting times remain 6-7 weeks. Recruitment completed, with a delayed start date, therefore locum adverts continue. • ENT triage pilot to risk stratify and support demand gained approval from ICB leads – planned go live June 26. • Working with ICB leads to encourage increased use of breast pain pathway where more appropriate. • Continued focus on imaging and OPA turnaround times across all tumour sites. • Skin performance remains above 90%

Responsive Cancer – Cancer 31 Day Combined



Current Performance			
Feb 26	YTD	Feb Plan	Target
87.2%	77.5%	90.0%	96%

National Position & Overview

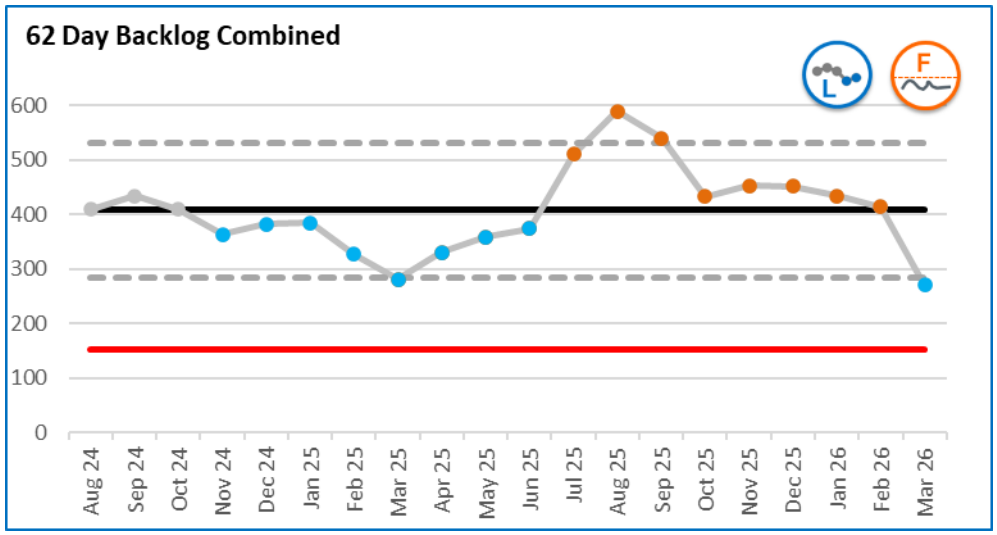
In February, UHL ranked 124 out of 138 Acute Trusts. The National average was 93.0%. 76 out of the 138 Acute Trusts achieved the target. UHL ranked 14 out of the 18 UHL Peer Trusts. The best value within our peer group was 97.0%, the worst value was 76.2% and the median value was 92.6%.

UHL's position is improving with significant improvements seen following investment into radiotherapy. Drug performance is above the national standard.

Root Cause	Actions	Impact/Timescale

Insufficient capacity within surgery and radiotherapy to meet demand.
• Within Radiotherapy this has resulted in a requirement for risk stratification and a waiting list for prostate patients following commencement of hormone therapy
• Within surgery there are
  • Theatre capacity constraints in Urology, Gynaecology and Lung inc. Robotic capacity with rising demand
  • Patient readiness to proceed with surgery impacting ability to date within 31 days
This has resulted in challenges to date patients within 31 days of a decision to treat.
	• Increased emphasis at PTL meetings to bring forward patients within target – weekly
	• Diligence in application of cancer wait time standards (medical and patient fitness or unavailability to proceed with first offer)
	• Offering alternative earlier surgical dates with colleagues where appropriate.
	• Increase theatre capacity
	  • 2nd Robot in Urology & Gynae – in place
	• Review of high risk anaesthetic (HRA) capacity to support surgical pathways – in progress
	• Collaboration with UHN – ongoing
		Radiotherapy
		• Increased capacity 5th linac. Prostate waits continue to improve.
		• Efficiency work programme underway to support & maximise capacity.
		• Paperless planning on all linacs has been achieved with full impact expected by end of Q1.
		Surgery
		• Improvements noted in Feb and Mar/Apr indicative results.
		• 2nd Urology robot supporting a reduction in waiting time. Gynae utilising from April to reduce waits.
		• HRA review to be completed by June.

Responsive Cancer – Cancer 62 Day Backlog



Current Performance		
Mar 26	YTD	Target
271	-	152 (by Mar26)

National Position & Overview

National data is not available. Midland's trend – decreases in backlog seen in all 11/11 systems over 4 week period to 22/03/26, with LLR having largest decrease (-114).

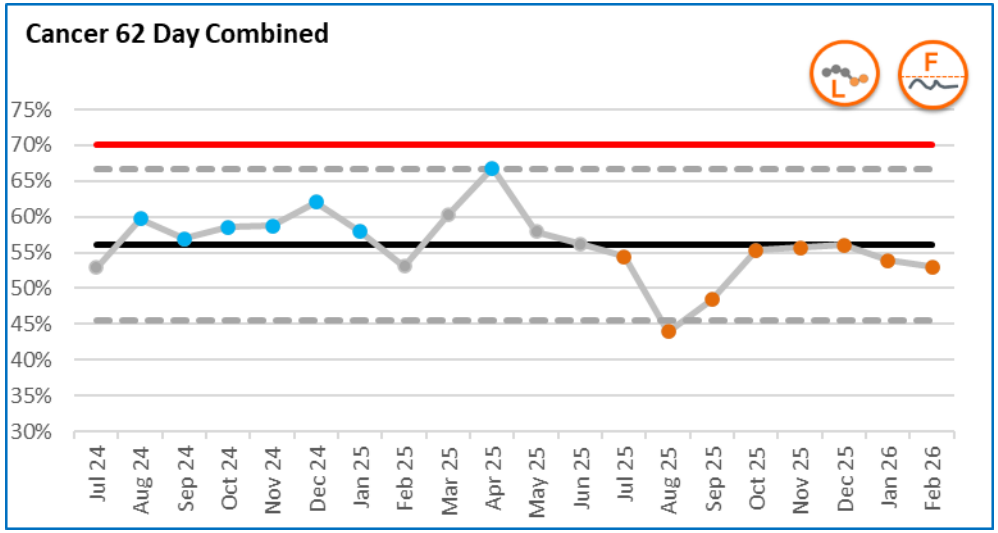
UHL end of March position:

- >62 day 119 behind plan.
- >104 day 67 behind plan.

At the end of March there were less patients over 62 days compared to the start of the year.

Root Cause	Actions	Impact/Timescale
• Breast, Colorectal and Urology drive the largest volume, holding 2/3 of the backlog. • Constraints include capacity, specifically outpatient, diagnostic and workforce. • There has been an increase in diagnostic tests required per patient, patient complexity and choice which have impacted pathway length • There are some bottlenecks in capacity within Oncology OPD capacity, theatre capacity for Urology and plastics capacity for skin, which are causing longer waits for some patients.	• Clinical review & prioritisation of all cancer patients over 42, 62 and 104 days. • Senior Cancer Centre daily backlog review, with additional focus on prioritising backlog patients for TCIs, OPAs and reporting • Focus on reducing delay from results available to action • Increased escalation to clinical leads and senior managers for support • Supporting timely clinical review outside of MDT where appropriate • Oncology improvement project to increase OPD capacity	• Diagnostic imaging project to identify and include cancer patients pre-treatment with the same urgency as pre-diagnosis • Review of test-to-report times for high-volume cancer pathways and identify improvement opportunities. • Urology 2nd robot supporting a reduction in waits – Q4 and Q1 of 26.27. • Oncology opportunities to improve OPD waits outlined, timescales for changes being confirmed. Impact not expected until Q2 26/27. • Plastics are working with UHN to increase LNR capacity.

Responsive Cancer – Cancer 62 Day Combined



Current Performance			
Feb 26	YTD	Feb Plan	Target
53.0%	54.6%	69.0%	70%

National Position & Overview

In February, UHL ranked 140 out of 146 Acute Trusts. The National average was 68.6%. 81 out of the 146 Acute Trusts achieved the target. UHL ranked 16 out of the 18 UHL Peer Trusts. The best value within our peer group was 80.4%, the worst value was 46.7% and the median value was 65.2%.

UHL last achieved the standard in 2014. Average days waits have shown improvements in 2025/26 across most tumour sites however due to remaining backlog this is not reflected in performance.

Root Cause	Actions	Impact/Timescale

• Capacity constraints across various points of the pathways
• There has been an increase in the number of required diagnostic tests per patient, adding >1+ weeks to a pathway
• Oncology time to OPD contribute to longer wait times
• Capacity OPD/Th constraints in some areas (Urology, Breast, H&N, Thoracic & Plastics)
• Performance impacted by clinical prioritisation of patients (i.e. higher clinical priority ahead of longer waits)
	• Clinical prioritisation of patients and emphasis to bring confirmed cancers within target – weekly PTLs
	• Regular audits of pathways - Areas of opportunity identified to
	  • Ensure results are acted on quickly
	  • Increase the use of straight-to-test and parallel investigations (where appropriate) and
	  • Reduce unnecessary repeat MDT discussion.
	• Additional capacity running, including use of insourcing/outsourcing where possible.
	• Strengthened clinical and operational management of pathways
		• Clinical comms emphasising ordering tests in parallel and progressing outside of MDTs discussed in April.
		• Pathology insource/outsourcing of urology & gynaecology supporting TAT – ongoing
		• Breast QI project improvements noted in 2nd test results and action.
		• Gynae improving performance through introduction of 'see&treat' clinics - anticipated uplift to Trust performance ~1.5%.
		• Additional capacity running where possible across services
		Improvements across the year are expected in line with plan

- Performance Overview
- Exception Reports
- Finance
- Appendix - Data Quality Assessment

Executive Summary

- The YTD position for the Trust is a deficit of £46.4m (subject to audit) against a plan of £0m. The main drivers are loss of DSF funding £25.9mA and non delivery of CIP £19.4mA. Excluding DSF, this position equates to a deficit of £85.3m, which is in line with the position notified to NHSE.

- Emergency/Non Elective inpatient activity continues to over-perform; at M12 the additional activity over the year equated to £28m of income that won't be received due to the block arrangement however the cost of delivery will be in the Trust's non-pay.

- The Trust committed net capital expenditure of £92.7m to Month 12 resulting in an underspend of £0.5m against its revised CDEL target.

- The cash position at the end of Month 12 was £34.7m, which is a decrease of £5.3m from M11.

Summary Financial Position – YTD M12

	I&E YTD			
	Plan	Actual	Adjustment for Pension	Variance to Plan
	£'000	£'000		£'000
NHS Patient-Rel Income	1,615,174	1,662,907	(64,957)	(17,224)
Other Operating Income	184,373	181,923		(2,450)
Total Income	**1,799,547**	**1,844,830**	**(64,957)**	**(19,674)**
Pay	(1,110,961)	(1,204,917)	64,957	(28,999)
Non Pay	(595,403)	(609,420)		(14,017)
Total Costs	**(1,706,364)**	**(1,814,337)**	**64,957**	**(43,016)**
EBITDA	**93,182**	**30,493**	**0**	**(62,690)**
Non Operating Costs	(88,646)	(171,239)		(82,592)
Retained Surplus/(Deficit)	**4,536**	**(140,746)**	**0**	**(145,282)**
Donated Assets	(4,536)	(2,666)		1,870
Impairments		97,026		97,026
Control Total Surplus/(Deficit)	**(0)**	**(46,386)**	**0**	**(46,386)**

Comments – YTD Variance to Plan

Total Income: £19.7mA:

- PCI £12F driven by £6.2mF for IA and £2.5m for winter flow and other contract variations
- Other income driven by £2.2mA donated assets, CSI £1.9mA (mainly relating to pathology, pharmacy, imaging), reduced E&F income £1.4mA mainly relating to car parking/catering/CIP non delivery offset by £2mF corporate
- Passthrough **excluded drugs and devices** lower than plan £3.3mA. This includes a reduction of £1.4m relating to hybrid loops.

Pay: £29.0mA:

- Medical and dental £23mA of which £3.4m is due to industrial action (IA) and the balance linked to undelivered CIP and medical gaps in RRCV (£6.7mA), CHUGGS (£3.9mA), ESM (£3.7mA) and W&C (£4.6mA).
- Nursing, midwife and health visitor staffing is driven mainly by vacancies across ITAPS (£2.7mF) offset by undelivered CIP and a provision for band 5 to 6 job role review.
- Other clinical driven by small overspends across multiple CMGs.
- Non-clinical mainly driven by vacancies in E&F £2.4mF, ESM £1.3mF and W&C £1.3mF

Bank (£72.8m) and Agency (£4.3m) spend YTD amounts to £77.1m which is 6.8% of total pay.

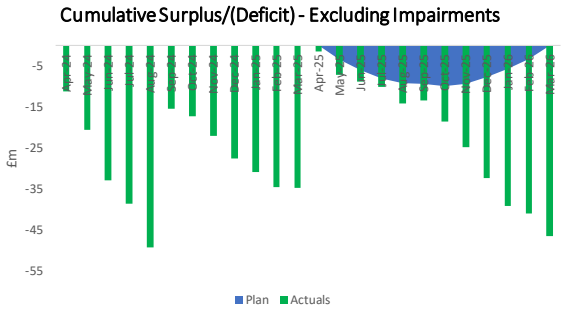
Non-Pay: £14.0mA:

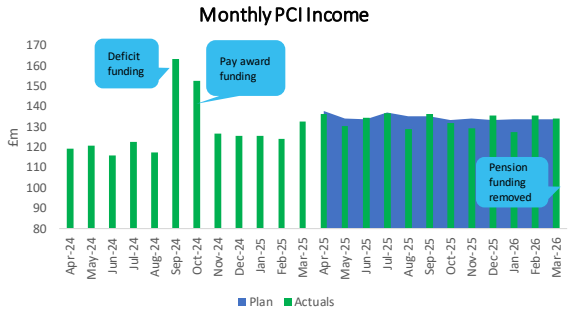
- Clinical Negligence £2.4mF relating to the maternity incentive scheme rebate.
- Clinical supplies £7.2mA driven by increased activity and non-delivery of CIP
- Drugs £5.7mA due to block drugs overspends and non delivered CIP: £1.2mA mainly in CHUGGS Haematology/Oncology, £1.5mA ITAPS in sleep/theatres, £1.3mA RRCV relating to renal and respiratory and £1.4mA W&C.
- Other is driven mainly by CHUGGS reduced Gastroenterology insourcing usage and closure of Vanguard unit (£1.5mF), CSI/CDC unit from lower level of activity (£1.2mF), E&F mainly from the review of prior year food provision and energy credits (£3.1mF).
- Premises & Fixed plant driven in the main by undelivered CIP and addition expenditure in M12 for IT projects (£2.1m) and bed purchases in E&F (£0.7m)

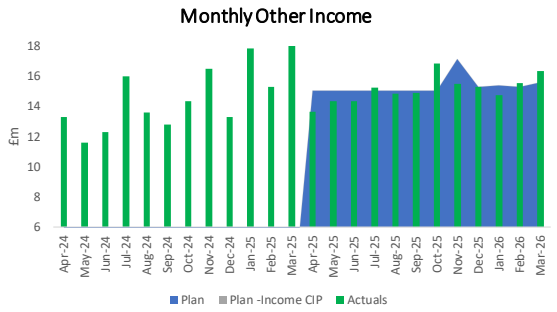
Non Operating Costs: £82.6mA:

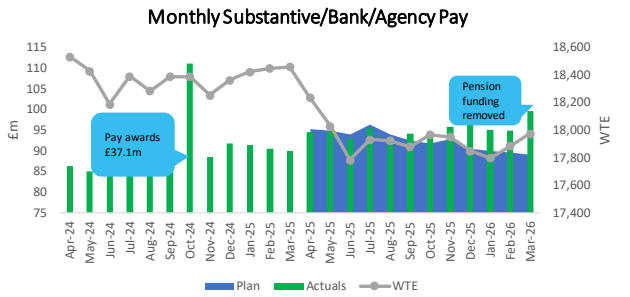
- Modern equivalent asset valuation has generated impairment costs of £97m, reduced depreciation of £5m and reduced PDC of £4m
- Interest payable has reduced due to reassessment of IFRS16 assets

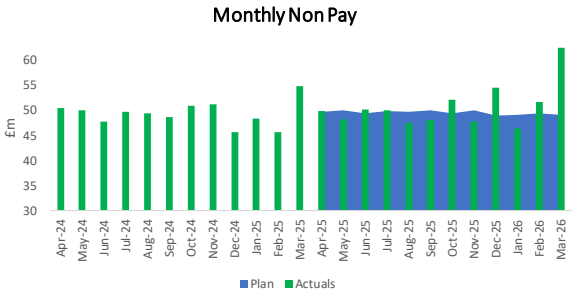
Month 12 I&E Dashboards

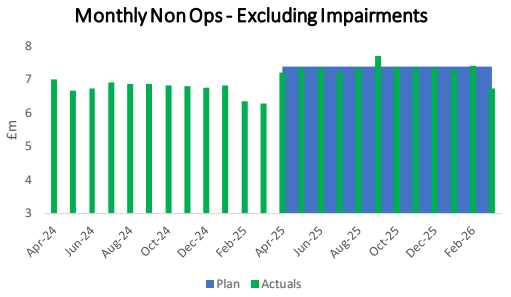




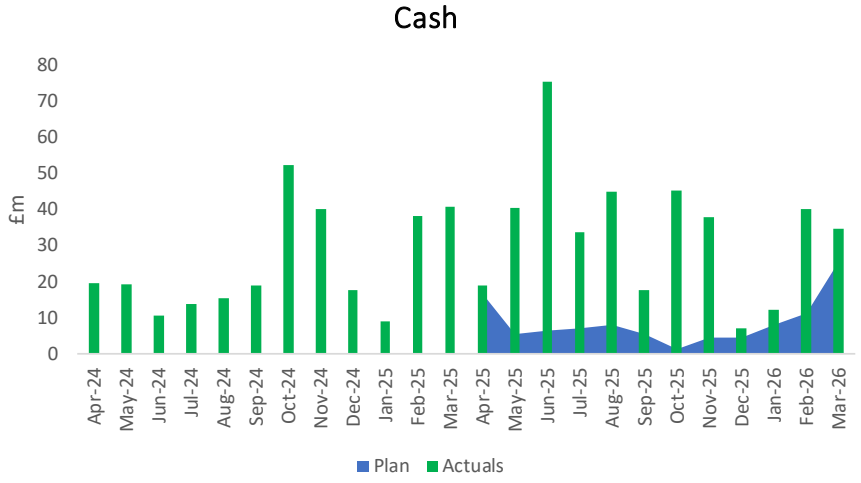


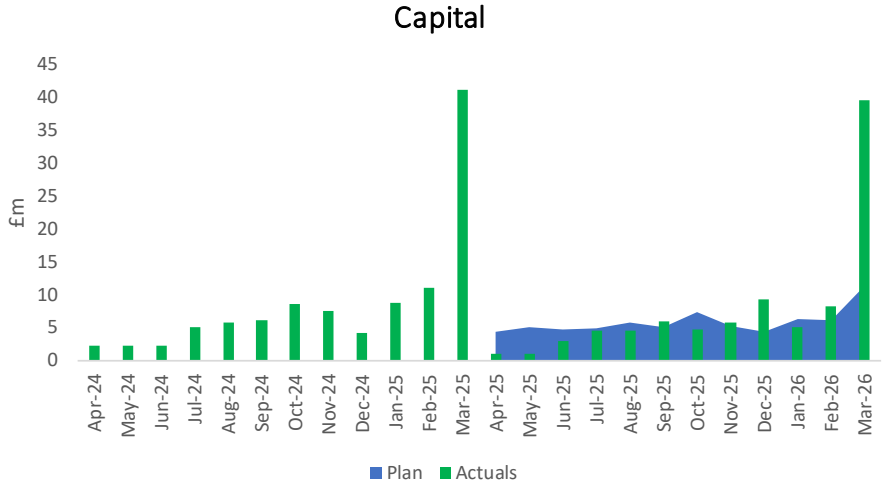


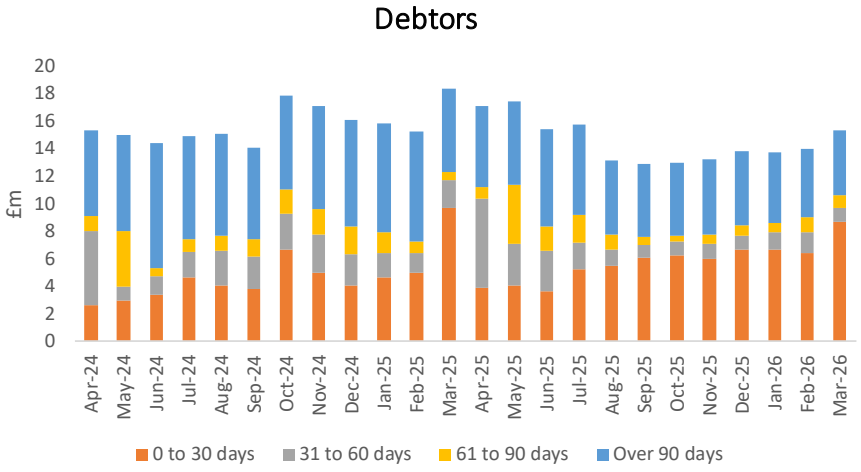


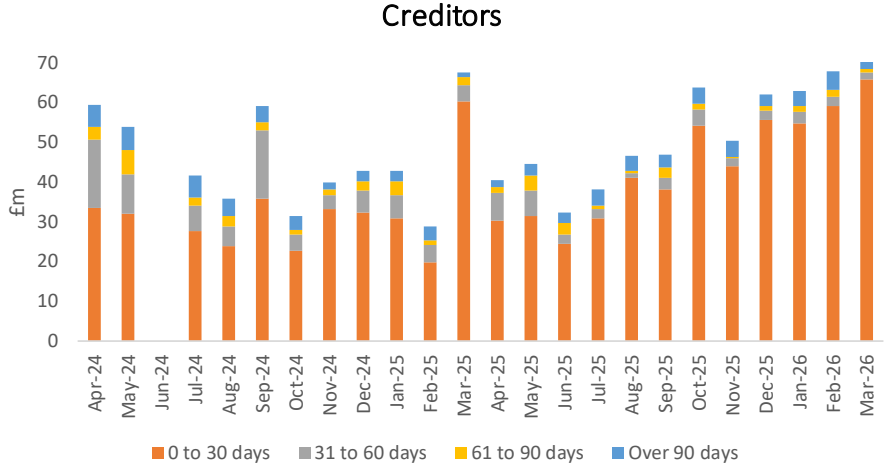


Month 12 Balance Sheet Dashboards









Statement of Financial Position

- **Non-Current Assets -** The value of non-current assets reduced by £106.9m, of which £141.6m relates to the MEA property; offset by the net impact of additions (£40m) and depreciation (£5.3m) in M12.
- **Trade and other receivables –** Trade and other receivables contracted by £14.2m overall, of which accrued income relating to PCI income reduced by £17.7m following its receipt in M12. Prepayments also reduced by £6.4m mainly due to the timing of the CNST premium and other maintenance contracts..
- **Trade and other payables and accruals** – Trade and other payables increased by £22.3m, of which £10.9m relates to registered invoices in month and £9.2m of increased GRNs, largely driven by the acceleration of the capital programme in March.
- **Deferred Income** – Reduced by £17.0m as PCI income was released into the position.
- **Dividend Payable –** Reduced by £9.4m as the second bi-annual installment was paid to DHSC in March.
- **Income and Expenditure Reserve –** The deterioration in the I&E reserve of £101.7m is explained by the I&E impairment relating to the revision to the opening MEA property valuation (£97.0m) and the M12 in month I&E deficit.
- **Public Dividend Capital** - £33.7m increase in PDC due to capital drawn down (£3.7m) and revenue cash support (£30m).
- **Revaluation reserve** – reduced by £49.4m in relation to the impact of the MEA property valuation on asset values.

Statement of Financial Position

£m	31-Mar-25	28-Feb-26	31-Mar-26	In Month Movement	YTD Movement
Non Current Assets					
Intangible assets	31.1	31.3	33.9	2.6	2.9
Property, plant and equipment	776.0	774.9	665.6	(109.3)	(110.4)
Other non-current assets	4.4	4.7	4.6	(0.1)	0.2
Total non-current assets	**811.5**	**810.9**	**704.1**	**(106.9)**	**(107.4)**
Current Assets					
Inventories	28.6	27.6	27.8	0.2	(0.8)
Trade and other receivables	41.2	58.7	44.6	(14.2)	3.4
Cash and cash equivalents	40.7	40.0	34.7	(5.3)	(6.0)
Total Current Assets	**110.4**	**126.3**	**107.0**	**(19.3)**	**(3.4)**
Current Liabilities				0.0	0.0
Trade and other payables	(147.8)	(146.4)	(168.7)	(22.3)	(20.9)
Leases < 1 Year	(9.0)	(7.3)	(12.3)	(5.0)	(3.3)
Accruals	(19.8)	(25.9)	(23.1)	2.8	(3.3)
Deferred income	(4.7)	(21.9)	(4.9)	17.0	(0.3)
Dividend payable	0.0	(9.4)	0.0	9.4	0.0
Provisions < 1 year	(9.3)	(6.6)	(9.1)	(2.5)	0.2
Total Current Liabilities	**(190.6)**	**(217.4)**	**(218.1)**	**(0.7)**	**(27.5)**
Net Current Assets / (Liabilities)	**(80.1)**	**(91.1)**	**(111.1)**	**(20.0)**	**(31.0)**
Leases > 1 Year	(43.3)	(44.7)	(35.8)	8.9	7.4
Provisions for liabilities & charges	(3.6)	(3.6)	(3.0)	0.6	0.6
Total non-current liabilities	**(46.9)**	**(48.3)**	**(38.9)**	**9.5**	**8.0**
Total Assets/(Liabilities)	**684.5**	**671.5**	**554.1**	**(117.4)**	**(130.4)**
Public dividend capital	(924.8)	(950.9)	(984.6)	(33.7)	(59.8)
Revaluation reserve	(223.7)	(223.7)	(174.3)	49.4	49.4
Income and expenditure reserve	464.0	503.1	604.8	101.7	140.7
Total Capital & Reserves	**(684.5)**	**(671.5)**	**(554.1)**	**117.4**	**130.4**

Liquidity and Cash Position – Month 12

• Cash balance at end of March: £34.7m (£33.0m for the Trust). Year End Forecast at M11 was £24.4m.
• In-month reduction of £5.5m.
• The Trust received the £30m PDC revenue cash support in March.
• BPPC impacted in March as YTD performance reduced to 93% by value, 86% by volume, as a result of payment rationing, prior to receipt of the £30m cash support

Receivables & Payables

•Total debt: £15.3m, of which >90 days £4.7m .
- ➢ Overseas visitors >90 days: £1.9m (partially in write-off/collection processes).
- ➢ Salary overpayments >90 days: £0.3m, with recovery actions underway.

• Payables increased by £5.2m to £73.0m (£19m relates to Capital), although >60-day items reduced by £0.7m to £5.5m.

	Month 12						Month 11					
	Total	0 to 30 days	31 to 60 days	61 to 90 days	Over 90 days	Percentage over 90 days	Total	0 to 30 days	31 to 60 days	61 to 90 days	Over 90 days	Percentage over 90 days
	£000	£000	£000	£000	£000	%	£000	£000	£000	£000	£000	%
Non-NHS receivables	**10,947**	6,011	832	521	3,583	33%	**9,704**	4,470	654	478	4,102	42%
NHS receivables	**4,328**	2,666	137	377	1,148	27%	**4,388**	1,951	875	670	892	20%
Total receivables	**15,275**	**8,677**	**969**	**898**	**4,731**	**31%**	**14,092**	**6,421**	**1,529**	**1,148**	**4,993**	**35%**
Non-NHS payables	**64,564**	59,519	1,245	1,255	2,545	4%	**56,376**	50,280	1,903	1,770	2,423	4%
NHS payables	**8,402**	6,217	453	(126)	1,857	22%	**11,378**	8,761	589	(38)	2,066	18%
Total payables	**72,967**	**65,737**	**1,698**	**1,130**	**4,402**	**6%**	**67,754**	**59,041**	**2,492**	**1,732**	**4,488**	**7%**

Capital Programme - 25/26 Position

Summary

• Opening gross capital plan: **£77.1m**

• Net increase of **£20.7m** → revised plan **£97.5m**

• Significant additional allocations mainly received in last quarter.

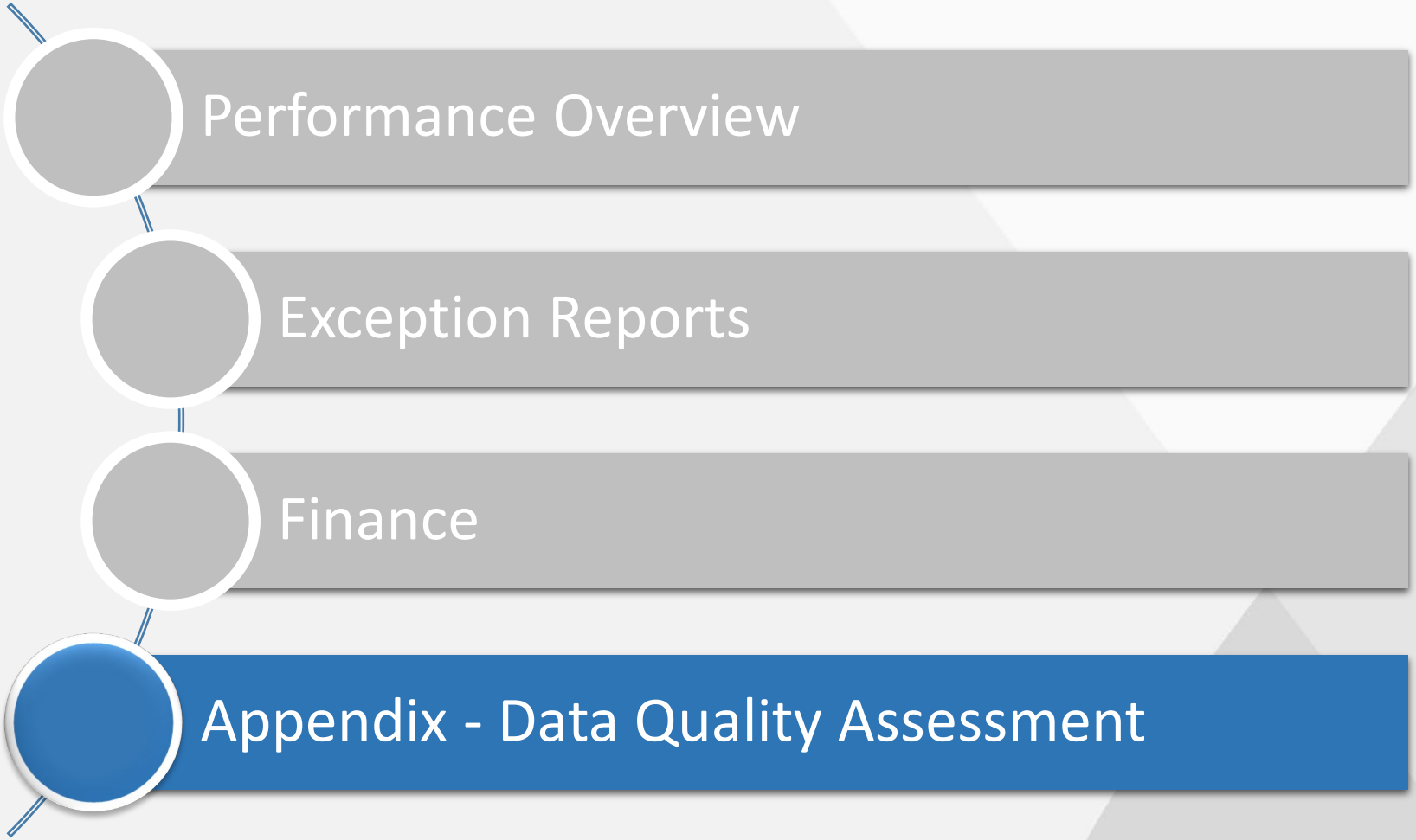
•**£40m** capex committed in m12.

• Underspend of £500k against M11 forecast and revised plan.

• The late notification of allocations presented challenges to commit the funding by 31 March 2026, but was achieved by flexible management of allocations across financial years (bringing forward and deferring), requiring c£2m adjustment to the 26/27 plan. There was a scheme slippage of c£4.1m. The Trust approved funding schemes in 25/26 in mitigation of the £4.1m, including £2.1m of bring forward schemes (for which appropriate reductions have been made to capital plans in 26/27).

•Despite hitting the year end target, there were some compensating under and overspends against the M11 forecast on individual lines, but not sufficiently material to impact on 26/27 capital expenditure plans.

Programme Area	M11 Forecast 25/26	M12 Actuals £000s	(Over) / Under Forecast £'000
IM&T	19,135	19,978	(843)
Estates	26,681	25,490	1,191
MEE	3,150	3,263	(113)
Capex Credits	(2,326)	(1,779)	(547)
IFRS16	6,013	5,860	153
Donated Exp	3,767	4,128	(361)
MES	16,930	16,789	141
NHP	13,333	13,251	82
Operations	10,845	10,449	396
Gross Capex	**97,528**	**97,427**	**100**
Donated Income	(3,767)	(4,128)	361
Disposals	(521)	(560)	39
Net Capex (Against CDEL)	**93,240**	**92,739**	**500**


Performance Overview
Exception Reports
Finance
Appendix - Data Quality Assessment

Data Quality Assessment

The Data Quality Assurance Group (DQAG) panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance that it is of suitably high quality. DQAG provides scrutiny and challenge on the quality of data presented, via the attributes of:

i. Sign off and Validation
ii. Timeliness and Completeness
iii. Audit and Accuracy and
iv. Systems and Data Capture to calculate an assurance rating.

Assurance rating key: Blue = Substantial Assurance, Green = Reasonable Assurance, Amber = Limited Assurance and Red = No Assurance.

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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 March 2026 performance in May 2026 Board

Contents

Introduction

- This month's performance report provides detail of the March 2026 performance for Kettering General Hospital NHS Foundation Trust (KGH) and Northampton General Hospital NHS Trust (NGH) as reported at the University Hospitals of Northamptonshire (UHN) Board meeting.
- In February 2025 an updated format for the Integrated Performance Report (IPR) was agreed to align performance reporting to the CQC domains. The format that follows in this report now includes a single narrative summary slide for each of the CQC domains, forming an executive summary of good news, areas of concern and improvement plans.
- In line with NHS guidance and best practice, we use statistical process control (SPC) charts to help interpret our performance data. Each domain has a slide outlining the key metrics using the SPC chart icons. More detail on metrics which are shown as 'worsening' or 'failing' are included in the report, providing detailed narrative and corrective improvement actions. A guide to interpreting SPC charts is included at the end of the report.
- Information on delivery of activity compared to plan and financial statements are now included in the IPR.
- The IPR format and metrics are used within UHN to with our clinical and corporate divisions, using our Accountability and Continuous Improvement Framework (ACIF) to hold leaders to account for their performance. Each metric in the IPR is weighted and dependent on performance, a score for each CQC domain is given to divisions based on their performance.
- The Accountability and Continuous Improvement Framework will be reported at divisional level a month in arrears in the Board IPR report from the July 2025 Board meeting.

Our Overall Performance

NHS University Hospitals of Northamptonshire NHS Group

Understanding performance against our key delivery metrics

- Incident reporting remains consistent, collaborative working with divisions to ensure timely review. Medication delays / errors, failure to follow policy and delay in treatment/diagnosis remain the top themes.
- Patient experience remains high across the Trust, with increases in NGH emergency departments and KGH inpatients this month.
- SHMI remains within the expected range. A national data quality issue with SDEC is elevating NGH mortality which is being reviewed internally.
- Ambulance handover performance maintained in KGH at over 90%, with improvement in NGH to around 75%.
- 4hr performance at NGH showed significant improvement as part of the sprint, increasing 6.5% to 75%. KGH performance remains consistent. This is against a backdrop of more ED Type 1 attendances and more non-elective admissions than plan, and 12 hours in the department has fallen across UHN.
- There has been an improvement in all cancer metrics in March, although 62-day performance remains challenged, particularly in Gynaecology and Dermatology, where a QI approach is being embedded to support improvement, and Breast, where an MDT streamlining approach is starting to improve delivery.
- A significant improvement in 52 week waits, with UHN achieving overall the 1% target. RTT performance has improved with the sprints.
- Our overall workforce numbers have increased, driven by medical and nursing bank to manage winter pressures and in support of the sprints. We have achieved the national bank and agency targets for the year, although bank usage remains high, and there is a gap to the workforce plan for the year.
- Draft annual accounts for 2025/26 (subject to audit) confirm UHN has delivered the forecast outturn position it agreed with NHSE at month 10. A shortfall in efficiency delivery and loss of Q4 Deficit Support funding in 2025/26 drove the Q4 financial delivery.
- Underlying deficit results in non compliant financial plan for 2026/27 – 2028/29.

	Metric	Target	KGH Actual	KGH Variation	KGH Assurance	NGH Actual	NGH Variation	NGH Assurance
Safe	Serious or moderate harms per 1000 bed days	-	1.01			1.44		
Caring	Friends and Family Test satisfaction score	95%	93.0%			90.8%		
Effective	SHMI	100	97.60			103.30		
Responsive	Ambulance Handover 45 minute Performance %	99%	92.94%			75.87%		
	A&E 4 hour performance	78%	80.2%			75.0%		
	62-day wait for first treatment	70%	62.5%			58.0%		
	52 week waits as a % of the waiting list	1%	0.40%			1.29%		
Well Led	Total WTE (PWR figure)	KGH: 4,903 NGH: 6,199	5,126			6,574		
	Bank Spend as % of Total Pay	6.30%	10.2%			13.2%		
	Agency Spend as % of Total Pay	2%	1.0%			0.7%		
Use of Resources	Surplus / deficit	KGH: -442 NGH: -392	-4,564			-6,662		
	CIP Delivery	100%	82.0%			78.8%		

Our Caring and Effective domain executive summary

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

University Hospitals of Northamptonshire NHS Group

	Good news	Areas of concern	Improvement plans in place

Patient experience	• NGH saw a slight increase in overall FFT satisfaction scores compared to the overall target of 90%. NGH 90.8% compared with 89.9% the previous month. KGH saw a slight decline of 0.3% in March, but remained above target at 93.0%
	• Notable increased patient satisfaction performance seen in the following areas:
	  • NGH – A&E Department 78.8% compared with 74.4% in Feb. Eye Casualty 88.4% compared with 78.7% in Feb. SDEC 82.3% compared with 81.5% in Feb.
	  • KGH – Inpatients slight increase in March with 94.9% compared with 94.6% in Feb.
	• Friends and Family Test survey response volumes:
	  • KGH 4,957
	  • NGH 6,204
		• Decrease in KGH ED departments score down from 83.0% down to 77.6%. (target = 80% not achieved). This could be due to winter pressures influencing the score.
		• Decrease in NGH Maternity score at 91.8% in March compared with 97.4% in Feb. There was a 0% satisfaction score for the triage area (4 responses). These were all relating to waiting times. Some of the narrative suggested ideas for improvements and this will be passed on to the manger of that area to review.
		• Notification received that NGH FFT provider will cease to supply a system as of Aug 2026.
			• 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	• HSMR remains within 'below expected' for KGH.
	• SMR remains within 'as expected' for KGH.
	• SHMI remains as expected for both NGH and KGH.
	• No new mortality alerts
		• HSMR and SMR are both 'above expected' ranges for NGH.
		• NGH's rise in HSMR and SMR is multifactorial, with the following under review:
		  • SDEC removal has impacted the HSMR by reducing the denominator of total patients included in the calculation.
		  • Reduction in our coding of complex patients with multiple co-morbidities – this will reduce the calculation for "expected deaths".
		  • Residual codes affecting the HSMR in April 25 (likely data error) but will continue to affect HSMR until May 2026.
			• Monitored through monthly UHN Learning from Deaths Group, with upward reporting to Patient Safety Committee. Working alongside Dr Foster representative and Clinical Coding to identify areas of concern amongst data accuracy issues relating to SDEC removal.

Our Safe domain executive summary

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

NHS University Hospitals of Northamptonshire NHS Group

	Good news	Areas of concern	Improvement plans in place
Infection prevention control	• 0 MRSA cases this month • 0 cases of MRSA at KGH for over 12 months • 14% reduction in cases of CDI at NGH for 2025/26 compared to last year, from 94 to 81 cases.	• Antimicrobial prescribing out of guidelines for 50% of CDI cases this month. • Insufficient antimicrobial stewardship (AMS) resource to provide regular ward level AMS data to drive improvement work.	• Review of AMS resource in Q1-2 of 2026/27. • QI project in place IV to Oral switch. • Task and Finish Group planned to target high antimicrobial consumption at KGH site.
Incidents	• No Never events reported	Themes of incidences reported as moderate or above include - Pressure Ulcers - Medication / prescribing incidences - Diagnostic delays - incidences relating to follow up	• All moderate and above harms are reviewed in IRG for validation and commissioning of proportionate response • 2 x PSII commissioned in March
Safe care	• Kettering continues to demonstrate a steady downward trend in CHPPD. • There is no special cause variation across UHN.	• Across UHN, NGH continues to see higher use of ETOC driving actual hours > planned.	• The 2026 biannual establishment review has recommended that NGH mirror KGH workforce planning in relation to ETOC

Our Responsive domain executive summary

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

NHS University Hospitals of Northamptonshire NHS Group

	Good news	Areas of concern	Improvement plans in place
Urgent and emergency care	• NGH showing a significant improvement in March for ED 4hrs delivering 75%, a 6.5% improvement from Feb. • 12hr waits in ED improved across UHN at 9%.	• Stranded and Super stranded NGH position. • High numbers of non-criteria to reside patients. • High bed occupancy across UHN.	• UEC GIRFT Further Faster actions being completed. • A&E 4hr delivery across UHN.
Elective	• 52 week waits have reduced significantly and, across UHN, we have met the target that less than 1% of the waiting list waits longer than 52 weeks • The Sprint activity in February and March supported an increase in RTT and patients waiting less than 18 weeks for their first appointment, although this remained behind plan	• Long waiting patients in ENT is a risk to the overall long waits position. The other speciality with a significant number is Dermatology, but their performance is improving, we need to maintain additionality to support this	• Q1 activity levels will be key to deliver against the 2026/27 target and income. Q1 additionality has been agreed in order to support this • We are exploring a number of mitigations for ENT – increased triage, outsourcing opportunities and additionality • We are working with the ICB on the Dermatology pathway from primary care
Cancer	• We saw an improvement across all the cancer metrics at both sites in February, although 62 day remains very challenged • Breast additionality is starting to improve performance, they have also taken part in an MDT Streamlining programme, which is showing positive impact	• The wait to first appointment for Breast and Skin remains fragile, although showing improvement • 62 days is seeing the downstream impact of poor FDS in earlier months • The cancer waiting list size at both Trusts is higher than previously, causing challenges with tracking and demonstrating growing levels of demand	• We are launching a Quality Improvement approach for Skin at NGH and Gynecology at KGH to focus on pathway savings to support 62 days • EMCA funding is in place for Dermatology pathway changes in primary care in 2026/27

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	• Turnover remains within target • Volunteer hours remain stable at NGH and show long term increase at KGH • Vacancy rates continue to reduce and are at target at NGH	• Sickness absence remains at/marginally above target • Time to hire continues to be above target	• Prioritisation of referrals to OH, targeted support for A&C colleagues impacted by change • TTH process improvements including from approval stage (VCP) through to pre-employments
Culture and safety	• Womens History Month: two Women's History Month Stands (one at NGH and one at KGH) • Neurodiversity Celebration Week (16th - 20th March 2026) • Civility Sessions continued in Maternity • Mandatory training above target	• Ongoing organisational change and consultation processes creating uncertainty and increased pressure for some staff groups. • Appraisal at both Trusts • Employee relations cases remain high in both Trusts, but are reducing at NGH	• NSS results shared in March with a planned improvement week in April to capture colleague feedback for behaviours • Continued support to delivery of thrive and civility sessions aimed at improving respect and inclusion amongst midwives and maternity colleagues since January 2026 • Appraisal – support for underperforming teams, process improvements • ER cases – case assessment panel to be introduced

Our Use of Resources domain executive summary

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

NHS University Hospitals of Northamptonshire NHS Group

	Good news	Areas of concern	Improvement plans in place
Finance	• Draft annual accounts for 2025/26 (subject to audit) confirm UHN has delivered the forecast outturn position it agreed with NHSE at month 10. • Capital requirement not to exceed identified funding limits achieved. • Cashflow risks through Q4 managed successfully following support from NHSE.	• Shortfall in efficiency delivery and loss of Q4 Deficit Support funding in 2025/26 • Underlying deficit results in non compliant financial plan for 2026/27 – 2028/29.	• Delivery partner support, ongoing executive led VCP and other expenditure control processes in place.
Productivity and efficiency	• Across UHN, £9.0m of efficiencies have been delivered against a plan of £11.1m. • Full-year delivery of £68.6m against a plan of £85.5m, driven largely by under identification of pay efficiencies. This total delivery is, however, significantly higher than delivery of CIP in previous years. • Efficiency planning for 26/27 is underway.	• There is risk in the level of development of the remainder of the identified efficiency plan in 26/27. • 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 assuring maintaining delivery through year end and developing plans for 26/27. • Improved co-ordination of workforce activities with a focus on areas of high temporary spend and consistency of controls. • Cross-cutting transformation programmes in place in line with drivers of the deficit, work underway to understand the degree to which this is cashable. • Detailed planning now underway to develop schemes for the 26/27 efficiency programme.

Our Caring domain metrics

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

NHS University Hospitals of Northamptonshire NHS Group

	P	?	F	No target
H / L		• Friends and Family Test satisfaction score - outpatients - KGH		
		• Friends and Family Test satisfaction score - A&E • Friends and Family Test satisfaction score – inpatients • Friends and Family Test satisfaction score – maternity • Complaints response performance - KGH • Single sex breaches	• Complaints response performance - NGH	
H / L				

Caring

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

University Hospitals of Northamptonshire NHS Group

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	80%	Mar 26	77.60%			84.09%	81.80%			78.57%	S T A R
Friends and Family Test satisfaction score - inpatients	95%	Mar 26	94.90%			94.21%	94.40%			95.08%	S T A R
Friends and Family Test satisfaction score - outpatients	95%	Mar 26	96.90%	H		96.77%	92.80%			93.68%	S T A R
Friends and Family Test satisfaction score - maternity	95%	Mar 26	98.50%			96.35%	91.80%			95.56%	S T A R
Complaints response performance	95%	Mar 26	89%			84.56%	50%		F	34.10%	S T A R
Single sex breaches	0	Mar 26	3			3.71	12			15.26	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

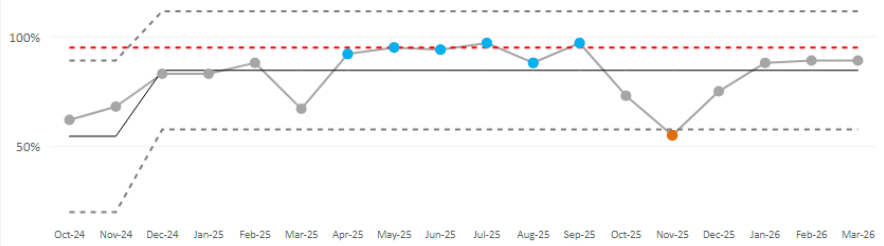
S	T	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

Complaints response performance

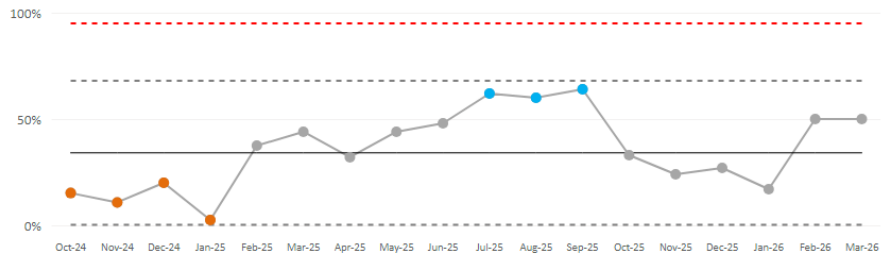
The percentage of complaints responded to within the agreed timescale of 60 days.

University Hospitals of Northamptonshire NHS Group

Complaints response performance - Kettering



Complaints response performance - Northampton



Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	95%	Mar 26	89%			84.56%
NGH	95%	Mar 26	50%			34.10%

Understanding the performance

- Improving picture for NGH with 53% (previous Feb 50% and Jan 17%) for getting cases out on time.
- KGH slightly decreased with 73% out on time (60 day target). No cases older than March 2026.

What are the issues impacting performance?

- Capacity within the team
- Recruitment into vacant mat leave post (interviews scheduled 13/4/26).

What SMART actions are being taken to improve?

- Senior case handler focusing on triage.
- Support in quality checking in place.
- Focus on drafting any cases reaching 120 days.
- Introduced overdue meeting at NGH (where all cases older than 60 days are reviewed).

Risks

- Unexpected leave
- Not recruiting into Mat Leave post

Our Effective domain metrics

Responsible director(s): Hemant Nemade, Medical Director

NHS University Hospitals of Northamptonshire NHS Group

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

Effective

Responsible director(s): Hemant Nemade, Medical Director

NHS University Hospitals of Northamptonshire NHS Group

Metric	Target	Latest Date	KGH Actual	KGH Variation	KGH Assurance	KGH Average	NGH Actual	NGH Variation	NGH Assurance	NGH Average	Data Quality Indicators
Mortality											
SHMI	100	Mar 26	97.57	L	P	98.06	103.32	H	P	94.96	S T A R
HSMR	100	Mar 26	92.20		?	90.92	114.40	H	?	102.62	S T A R
SMR	100	Mar 26	96.50	H	P	92.26	112.20	H	?	99.01	S T A R

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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

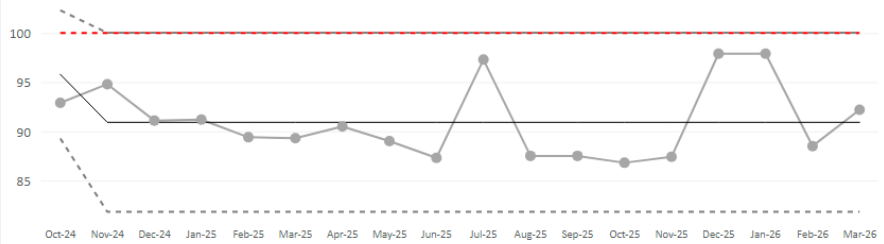
S	T	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

Hospital Standardised Mortality Ratio (HSMR)

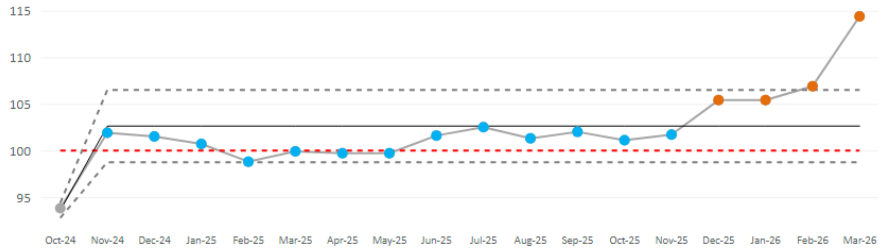
University Hospitals of Northamptonshire NHS Group

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

HSMR - Kettering



HSMR - Northampton



Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	100	Mar 26	92.20			95.80
NGH	100	Mar 26	114.40			93.57

Understanding the performance

- HSMR remains within 'below expected' for KGH.

What SMART actions are being taken to improve?

- Monitored through monthly UHN Learning from Deaths Group, with upward reporting to Patient Safety Committee.
- Working alongside Dr Foster representative and Clinical Coding to identify areas of concern amongst data accuracy issues relating to SDEC removal.

What are the issues impacting performance?

- HSMR is 'above expected' ranges for NGH.
- NGH's rise in HSMR is multifactorial, with the following under review:
- SDEC removal has impacted the HSMR by reducing the denominator of total patients included in the calculation.
- Reduction in our coding of complex patients with multiple co-morbidities – this will reduce the calculation for “expected deaths”.
- Residual codes affecting the HSMR in April 25 (likely data error) but will continue to affect HSMR until May 2026.

Risks

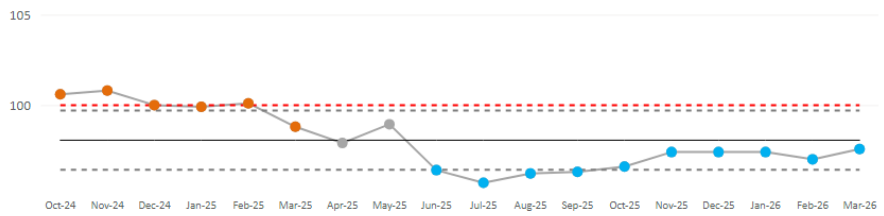
- An increase in HSMR presents a reputational and regulatory risk; however, current analysis indicates that recent HSMR movement is driven primarily by data and methodological factors rather than an increase in observed mortality or evidence of deteriorating care quality. This risk is being actively mitigated through triangulation with SHMI, Learning from Deaths, PSIRF, and coding assurance processes, with no current evidence of excess mortality requiring escalation.

Summary Hospital-Level Mortality Indicator (SHMI)

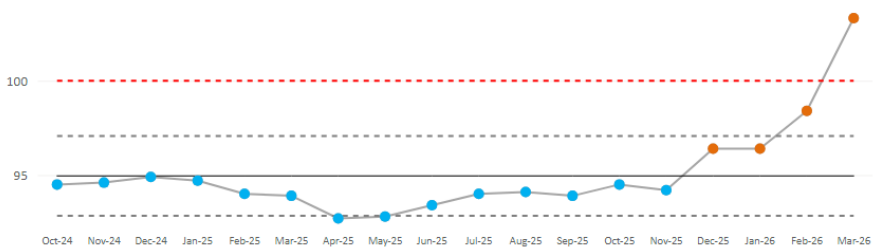
The ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures based on demographics.

University Hospitals of Northamptonshire NHS Group

SHMI - Kettering



SHMI - Northampton



Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	100	Mar 26	97.57			98.06
NGH	100	Mar 26	103.32			94.96

Understanding the performance

- SHMI remains as expected for both NGH and KGH

What are the issues impacting performance?

- NGH's rise is multifactorial, with the following under review:
- - SDEC removal has impacted the HSMR by reducing the denominator of total patients included in the calculation.
- Reduction in our coding of complex patients with multiple co-morbidities – this will reduce the calculation for "expected deaths".
- Residual codes affecting the HSMR in April 25 (likely data error) but will continue to affect HSMR until May 2026.

What SMART actions are being taken to improve?

- Monitored through monthly UHN Learning from Deaths Group, with upward reporting to Patient Safety Committee.
- Working alongside Dr Foster representative and Clinical Coding to identify areas of concern amongst data accuracy issues relating to SDEC removal.

Risks

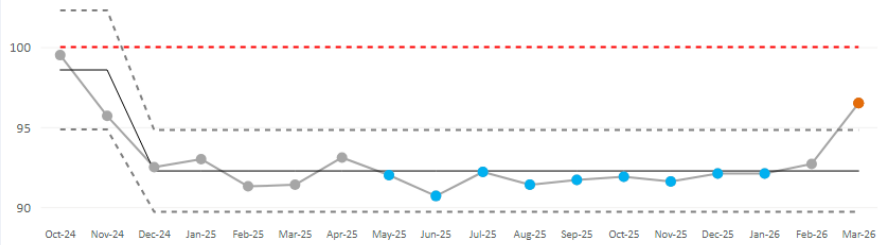
- An increase in SHMI presents a reputational and regulatory risk; however, current analysis indicates that recent SHMI movement is driven primarily by data and methodological factors rather than an increase in observed mortality or evidence of deteriorating care quality. This risk is being actively mitigated through triangulation with SHMI, Learning from Deaths, PSIRF, and coding assurance processes, with no current evidence of excess mortality requiring escalation.

Standardised Mortality Ratio (SMR)

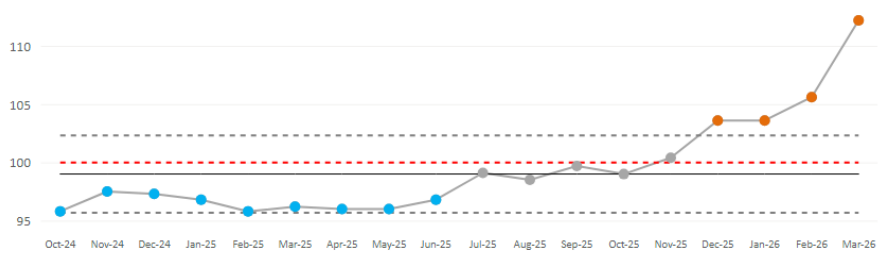
The overall rate of deaths within the population. Rates are given as better, worse, or as expected compared to the national average, which is represented as 100 on the scale.

NHS University Hospitals of Northamptonshire NHS Group

SMR - Kettering



SMR - Northampton



Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	100	Mar 26	96.50			98.58
NGH	100	Mar 26	112.20			99.01

Understanding the performance

- SMR remains within 'as expected' for KGH.

What SMART actions are being taken to improve?

- Monitored through monthly UHN Learning from Deaths Group, with upward reporting to Patient Safety Committee. Working alongside Dr Foster representative and Clinical Coding to identify areas of concern amongst data accuracy issues relating to SDEC removal.

What are the issues impacting performance?

- SMR is 'above expected' ranges for NGH.
- NGH's rise in SMR is multifactorial, with the following under review:
- SDEC removal has impacted the SMR by reducing the denominator of total patients included in the calculation.
- Reduction in our coding of complex patients with multiple co-morbidities – this will reduce the calculation for “expected deaths”.
- Residual codes affecting the SMR in April 25 (likely data error) but will continue to affect SMR until May 2026.

Risks

- An increase in SMR presents a reputational and regulatory risk; however, current analysis indicates that recent SMR movement is driven primarily by data and methodological factors rather than an increase in observed mortality or evidence of deteriorating care quality. This risk is being actively mitigated through triangulation with SHMI, Learning from Deaths, PSIRF, and coding assurance processes, with no current evidence of excess mortality requiring escalation.

Our Safe domain metrics

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

NHS University Hospitals of Northamptonshire NHS Group

	P	?	F	No target
H / L		• Never Event - KGH • MRSA - KGH	• Never Event – NGH • Care hours per patient day - NGH	
		• MRSA – NGH • MSSA • Care hours per patient day - KGH		• Serious or mod harm per 1000 days • Cdif per 100,000 days • Serious or mod falls per 1000 days • Serious or mod pressure ulcers per 1000 days
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 Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average	Data Quality Indicators
Incidents											
Serious or moderate harms per 1000 bed days	-	Mar 26	1.01			0.93	1.44			1.12	S T A R
Never event incidence	0	Mar 26	0			0.50	0			0.15	S T A R
Infection Prevention Control											
Number of MRSA Bacteraemia	0	Mar 26	0			0.05	0			0.15	S T A R
C Diff per 100,000 bed days	-	Mar 26	6.31			13.86	38.28			38.37	S T A R
Number of MSSA Bacterium	0	Mar 26	1			0.80	1			1.65	S T A R
Safe care											
Care hours per patient day	9	Mar 26	8.92			9.06	9.30			9.47	S T A R
Serious or moderate harms – falls per 1000 bed days	-	Mar 26	0.06			0.08	0.05			0.09	S T A R
Serious or moderate harms – pressure ulcers per 1000 bed days	-	Mar 26	0.06			0.04	0.14			0.18	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

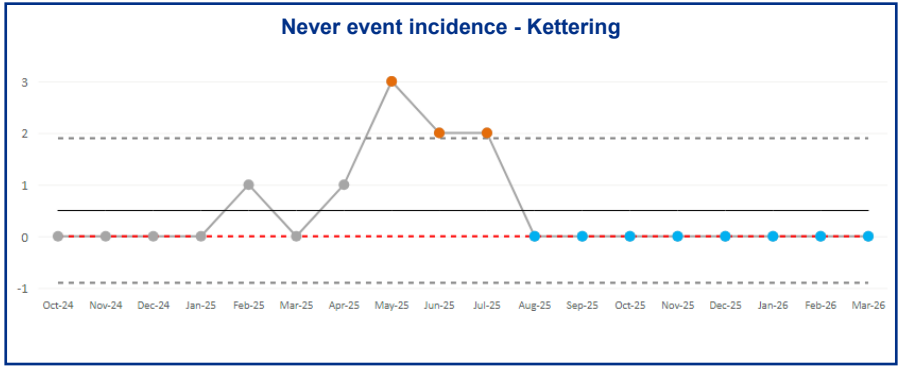
Data quality indicator key

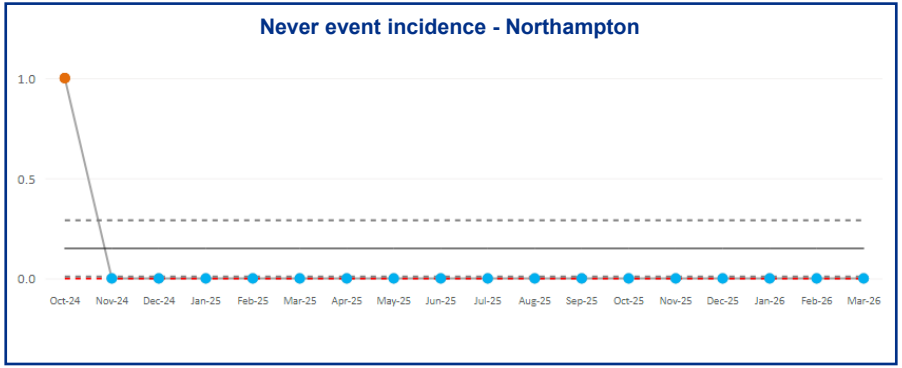
S	T	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

Never event incidence

The number of never events.

University Hospitals of Northamptonshire NHS Group





Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	0	Mar 26	0			0.50
NGH	0	Mar 26	0			0.15

Understanding the performance

- There have been no NEVER Events declared for this month

What are the issues impacting performance?

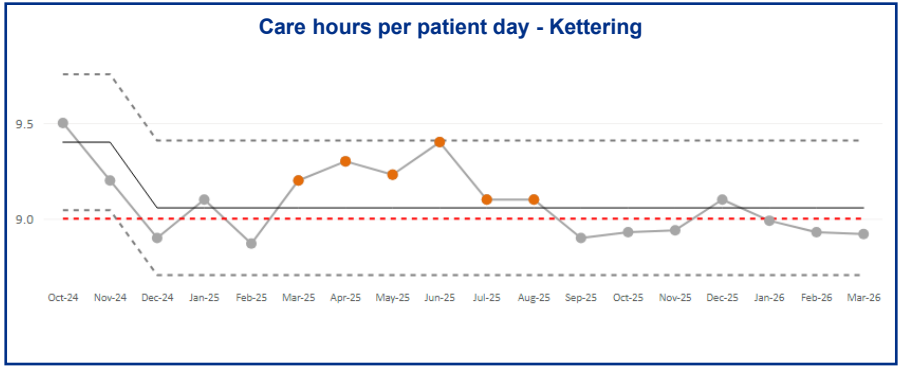
What SMART actions are being taken to improve?

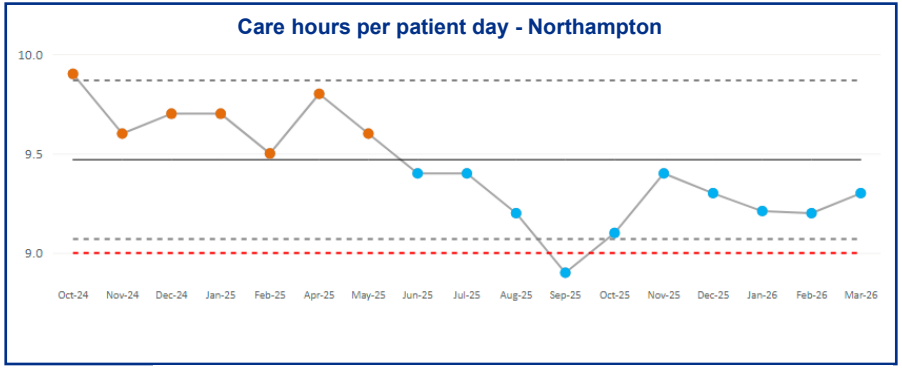
Risks

Care hours per patient day

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

NHS University Hospitals of Northamptonshire NHS Group





Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	9	Mar 26	8.92			9.40
NGH	9	Mar 26	9.30			9.47

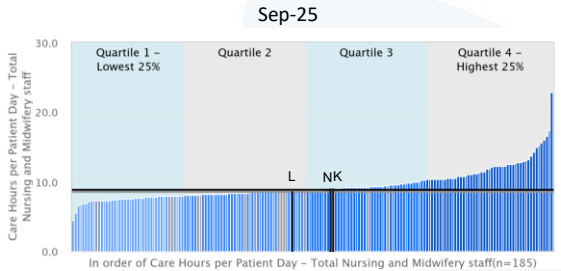
Understanding the performance

- Kettering continues to demonstrate a steady downward trend in CHPPD when compared to NGH who remain within expected ranges of variation. There is no significant cause variation across UHN.

What SMART actions are being taken to improve?

- The 2026 biannual establishment review has recommended that NGH mirror KGH workforce planning in relation to ETOC. Areas that have the ability to absorb the demand within their planned hour template (subject to dynamic risk assessment) are expected to do so.

National comparator



What are the issues impacting performance?

- Across UHN, NGH continues to see higher use of ETOC driving actual hours > planned.
- Corridor care and additional staffing demand for this also influence the performance.
- Small ward phenomena

Risks

- Increase risks to patients with a higher unregistered workforce ratio providing care
- Financial risk associated with uncontrolled workforce planning
- Supervisory burden to the ward leader, nurse in charge and registrants

Our Responsive domain metrics

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

University Hospitals of Northamptonshire NHS Group

	P	?	F	No target
H / L		• Time to initial assessment • Patients with reason to reside NGH • 52 week waits - KGH	• A&E 4 hour performance NGH • 12 hour wait NGH • 52 week wait NGH	
		• 12 hour wait – KGH • Cancer Faster Diagnosis • 31 day wait for treatment • 62 day wait for treatment • Theatre utilisation - KGH • Average cases per list - NGH	• A&E 4 hour performance – KGH • Ambulance hand overs – NGH • Bed utilisation • 7 day stay • 21+ day stay • Patient with reason to reside – KGH • % patients seen within 18 weeks KGH • Theatre utilisation - NGH	• Size of RTT
H / L		• Average cases per list KGH	• Ambulance handovers – KGH • RTT performance • % patients seen within 18 weeks - NGH	

Responsive – Urgent and Emergency Care

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

NHS University Hospitals of Northamptonshire NHS Group

Metric	Target	Latest Date	KGH Actual	KGH Variation	KGH Assurance	KGH Average	NGH Actual	NGH Variation	NGH Assurance	NGH Average	Data Quality Indicators
UEC											
A&E 4 hour performance	78%	Mar 26	80.19%			79.33%	75.01%			66.36%	S T A R
Time to initial assessment	15	Mar 26	12.75			11.26	12.65			18.68	S T A R
Ambulance Handover 45 minute Performance %	99%	Mar 26	92.94%			76.90%	75.87%			68.15%	S T A R
12 hour wait in the department	10%	Mar 26	10.50%			10.93%	12.90%			13.84%	S T A R
Bed Utilisation	92%	Mar 26	97.21%			98.23%	98.99%			99.23%	S T A R
Non-elective LOS (Model Hospital Closed Spells)	9.90	Mar 26	9.26			9.79	10.37			10.32	S T A R
Stranded patients (7+ day length of stay)	42%	Mar 26	50.43%			54.52%	56.44%			57.21%	S T A R
Super-Stranded patients (21+ day length of stay)	12%	Mar 26	18.42%			19.58%	22.58%			23.27%	S T A R
Patients with a reason to reside	80%	Mar 26	60.55%			58.98%	69.26%			73.07%	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. 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 which 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 Sign off & validation	T Timely & complete	A Audit & Accuracy	R 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 Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average	Data Quality Indicators
Cancer											
Cancer Faster Diagnostic Standard	80%	Feb 26	69%			69.70%	73.40%			74.20%	S T A R
31-day wait for first treatment	96%	Feb 26	93.50%			93.44%	93%			92.58%	S T A R
62-day wait for first treatment	70%	Feb 26	62.50%			69.04%	58.20%	L		65.44%	S T A R
Elective											
RTT performance	70%	Mar 26	63.58%	L	F	64.11%	59.93%	L	F	61.87%	S T A R
Size of RTT waiting list	-	Mar 26	25,511			26085.24	41,130			42373.18	S T A R
52 week waits as a % of the waiting list	1%	Mar 26	0.40%	L		1%	1.29%	L	F	1.70%	S T A R
Percentage of patients waiting no longer than 18 weeks for a first appointment	72%	Mar 26	67.98%		F	67.27%	59.31%	L	F	63.96%	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

NHS University Hospitals of Northamptonshire NHS Group

Metric	Target	Latest Date	KGH Actual	KGH Variation	KGH Assurance	KGH Average	NGH Actual	NGH Variation	NGH Assurance	NGH Average	Data Quality Indicators
Productivity											
Theatre utilisation	85%	Mar 26	82.83%			82.25%	80.11%			78.49%	S T A R
Average cases per list	2.50	Mar 26	2.39			2.35	2.32			2.25	S T A R
Outpatient appointments per consultant FTE	116	Mar 26	162			141.09	140			140.90	S T A R

Data quality assessment

Potential discrepancies between Model Hospital definition and our internal theatre utilisation monitoring being reviewed to identify if there is a data quality issue to resolve.

SPC indicator key

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

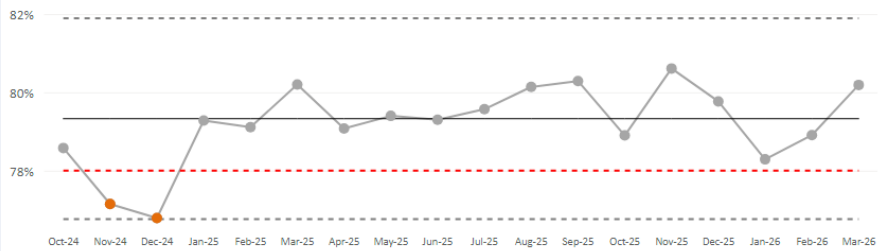
Data quality indicator key

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

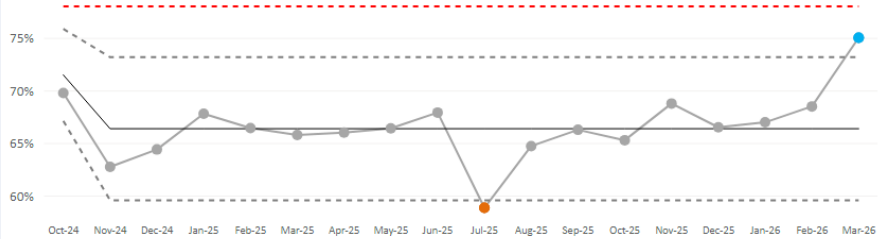
A&E 4-hour performance

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 (both).
- KGH remains >78% target at 80% in Mar an improvement of 1%.
- NGH showing a significant improvement in March delivering 75%, a 6.5% improvement from Feb.

What are the issues impacting performance?

- Admitted flow.
- Increase in ED attendances.

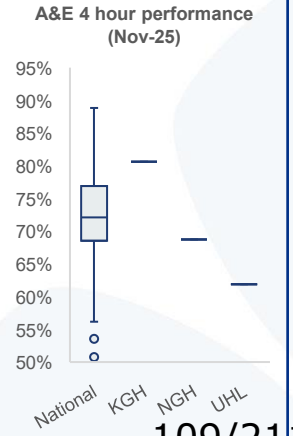
What SMART actions are being taken to improve?

- 4hr sprint for March improved 4hr performance with senior clinical decision maker first point of contact (NGH), improved patient pathway from PED to PAU (both sites) and overnight UTC cover(NGH).
- Improvements embedded and continuing into April

Risks

- Overcrowding risk in the ED.
- Poor patient experience.

National comparator



Data Quality Indicators

S T A R

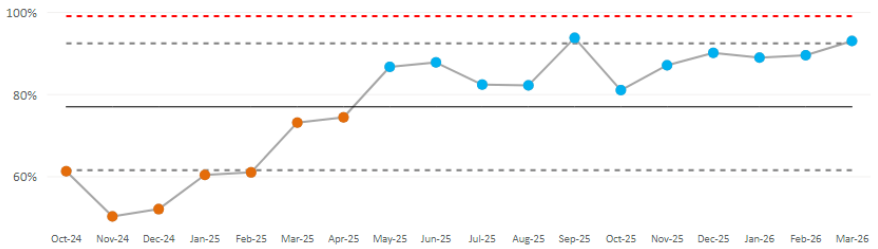
Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	78%	Mar 26	80.19%			79.33%
NGH	78%	Mar 26	75.01%			71.48%

Percentage of ambulance handovers within 45 minutes

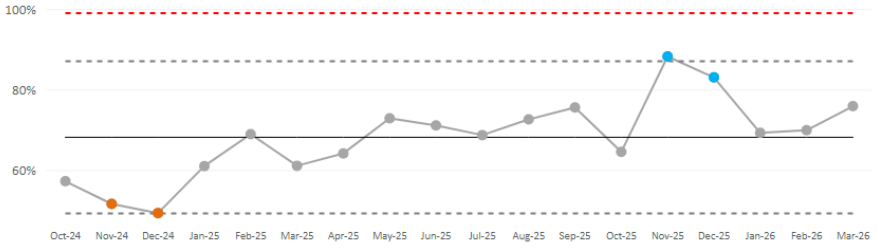
The percentage of ambulance handovers where the time between when an ambulance arrives at our Emergency Department, to when the handover from ambulance staff to our clinicians, is within 45 minutes.

University Hospitals of Northamptonshire NHS Group

Percentage of ambulance handovers within 45 minutes - Kettering



Percentage of ambulance handovers within 45 minutes - Northampton



Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	99%	Mar 26	92.94%			76.90%
NGH	99%	Mar 26	75.87%			68.15%

Understanding the performance

- Continued focus on improving ambulance handover times.
- KGH performance has further improved delivering 93% in March.
- NGH performance has been more challenging into Q4, March showing 76% <45mins

What are the issues impacting performance?

- Admitted patient flow through ED.
- High numbers of non-criteria to reside.
- Increase in conveyances across Northants, March 6.4% variance to plan.

What SMART actions are being taken to improve?

- Ensuring NyeBevan LoS is delivered in line with an AMU / Medical Short Stay ward.
- Boardround improvements.
- Maximising use of SDEC.
- Planned frailty front door service at NGH from May.

Risks

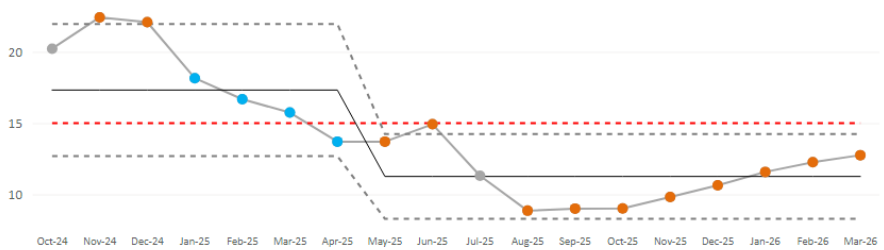
- Ambulance handover delays can contribute to C2 community response delays.
- Poor patient experience.

Time to initial assessment

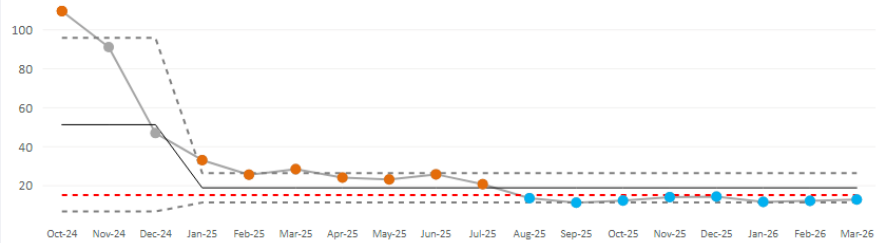
The average time in minutes from the arrival of a patient in our Emergency Department to their initial assessment.

University Hospitals of Northamptonshire NHS Group

Time to initial assessment - Kettering



Time to initial assessment - Northampton



Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	15	Mar 26	12.75			17.32
NGH	15	Mar 26	12.65			51.06

Understanding the performance

- Both departments delivering <15mins average time to initial assessment.

What are the issues impacting performance?

- TTIA can be impacted due to surge in attendances during peak times.

What SMART actions are being taken to improve?

Introduction of the new acuity model at NGH has seen significant improvement in initial assessment times.
Regular safety huddles at both sites with ED NIC/EPIC and clinical site manager.

Risks

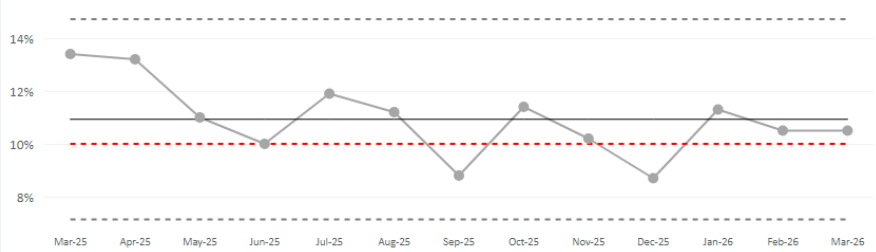
Delays to assessment increases risk within the ED waiting room for undifferentiated patients. Risk mitigation of regular staffing reviews via staffing cell with staff re-deployed from other areas to support safe ED staffing.

12 hour wait in the A&E department

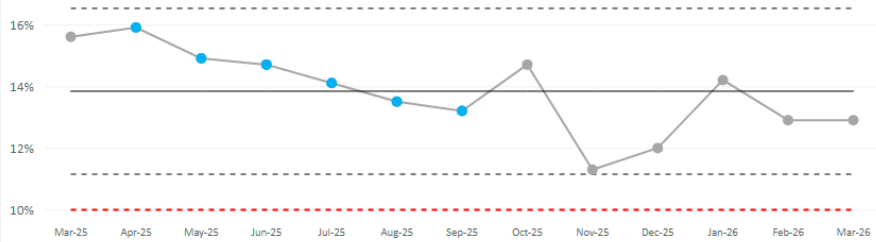
The percentage of patients who have waited more than 12 hours in our Emergency Departments before being admitted or discharged.

University Hospitals of Northamptonshire NHS Group

12 hour waits in A&E - Kettering



12 hour waits in A&E - Northampton



Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	10%	Mar 26	10.50%			10.93%
NGH	10%	Mar 26	12.90%			13.84%

Understanding the performance

- YTD has seen improvement at both sites for 12hr waits in ED.
- KGH at 9% in March improving from Feb of 1.5%.
- NGH has seen a 3.5% improvement in March to 9.4%.

What are the issues impacting performance?

- High numbers of non-criteria to reside will impact on bed occupancy and admitted patient flow.

What SMART actions are being taken to improve?

- GIRFT Further faster actions associated with reduction in LOS.
- AAU Model at NGH to improve admitted flow through ED with plans for frailty assessment area in progress for May.
- Work on Internal Professional Standards to improve admitted patient flow.

Risks

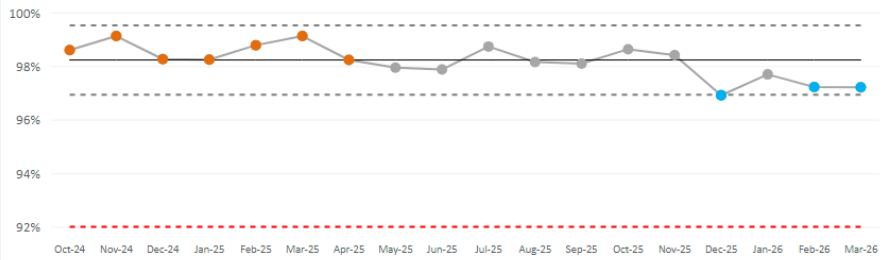
- Impact on bed occupancy, use of corridor care and overcrowding in ED.

Bed utilisation

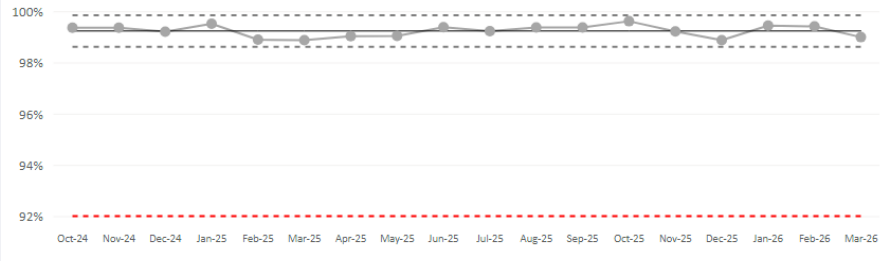
The average percentage of our available general acute beds which are occupied by patients at midnight each day.

University Hospitals of Northamptonshire NHS Group

Bed utilisation - Kettering



Bed utilisation - Northampton



Data Quality Indicators

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	92%	Mar 26	97.21%			98.23%
NGH	92%	Mar 26	98.99%			99.23%

Understanding the performance

- High bed occupancy impacts patient flow and admitted pathway delays in the ED.
- Both sites continue to see high bed occupancy. KGH position has improved into Q4 at 97%. NGH remains challenged at >99%

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 to reduce bed occupancy and improve flow.
- Continued use of release 2 respond to support capacity and risk across the organisation.
- Maximise use of SDECs as admission avoidance.

Risks

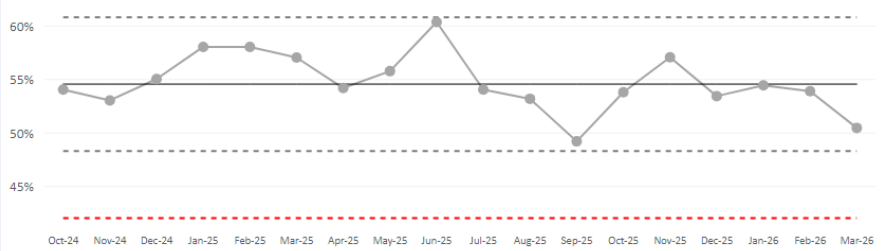
- Poor patient experience due to ED delays.
- Impact on 12hr/24hr performance.
- ED overcrowding.
- Ambulance handover delays.

Patients with length of stay greater than 7 days

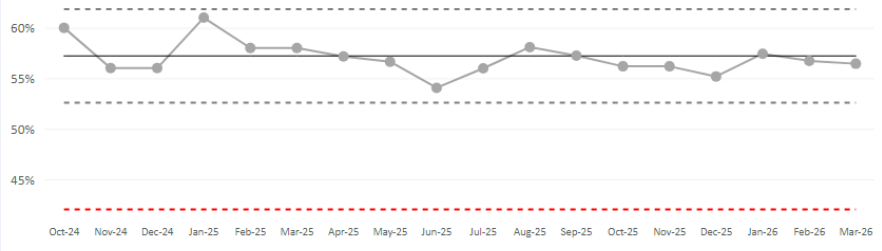
The percentage of general acute hospital beds occupied by patients who have been in hospital for more than 7 days.

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

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	42%	Mar 26	50.43%			54.52%
NGH	42%	Mar 26	56.44%			57.21%

Understanding the performance

- Reduction in stranded position into March for KGH. Similar position at NGH.

What are the issues impacting performance?

- Increase in patient acuity, complexity and demand during winter period.

What SMART actions are being taken to improve?

- Boardrounds and focus on SHOP model.
- Internal and external escalation delays to discharge.
- Maximising use of discharge lounge.
- Maximising use of SDEC.
- P1 working group to reduce NEL LOS.

Risks

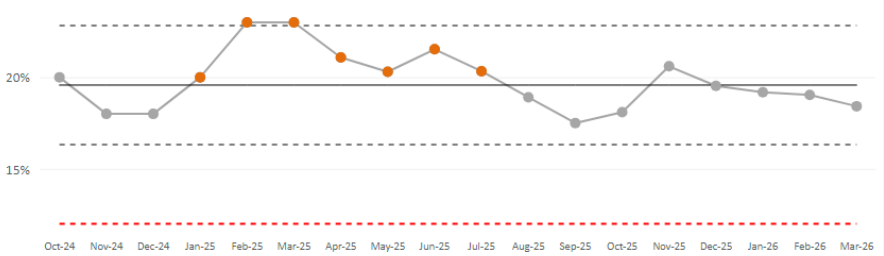
- Delay to discharge impacting admitted flow through ED.
- All community beds are full.

Patients with length of stay greater than 21 days

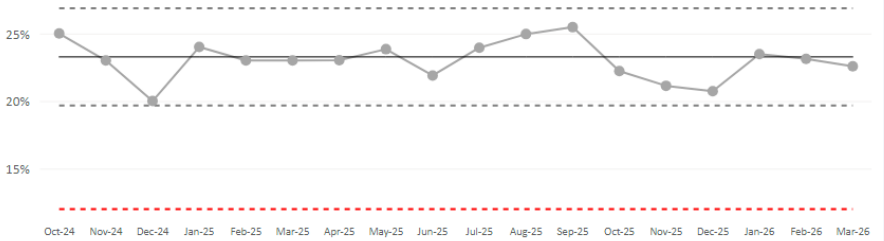
The percentage of general acute hospital beds occupied by patients who have been in hospital for more than 21 days.

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

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	12%	Mar 26	18.42%			19.58%
NGH	12%	Mar 26	22.58%			23.27%

Understanding the performance

- 21 day position at KGH continuing to improve over last 5 months, increase at NGH remaining high at 23%.

What are the issues impacting performance?

- P2/3 supported discharge waits across UHN.
- Complexity of patients.
- Housing delays.

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.

Risks

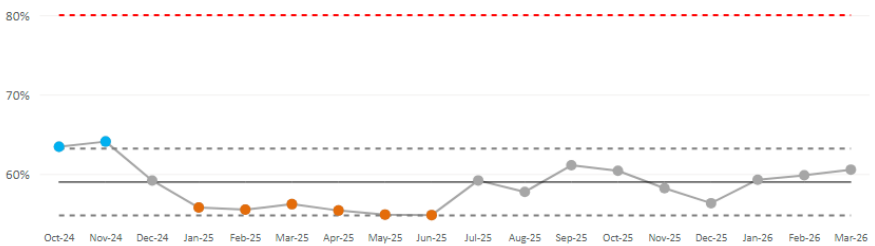
- Bed occupancy remains high impacting patient flow.
- Ongoing use of corridor care risk across ED and inpatient ward areas.

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.

NHS University Hospitals of Northamptonshire NHS Group

Patients with a reason to reside - Kettering



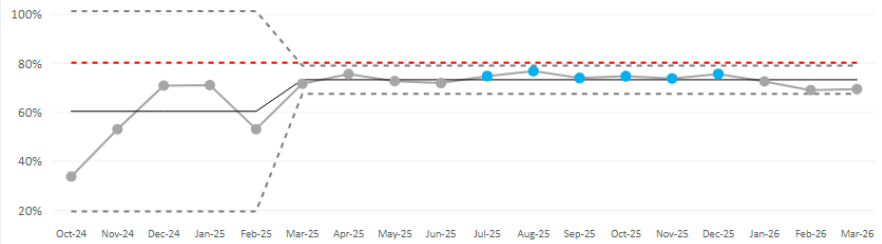
Understanding the performance

- 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 / house clean / equipment.

Patients with a reason to reside - Northampton



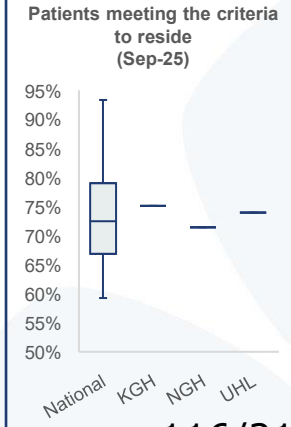
What SMART actions are being taken to improve?

- Twice weekly escalation group for supported discharge with system partners.
- Trusted assessor started at NGH.
- Working with local authorities for housing pathway.
- Integrated discharge hub planning.

Risks

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

National comparator



Data Quality Indicators

S T A R

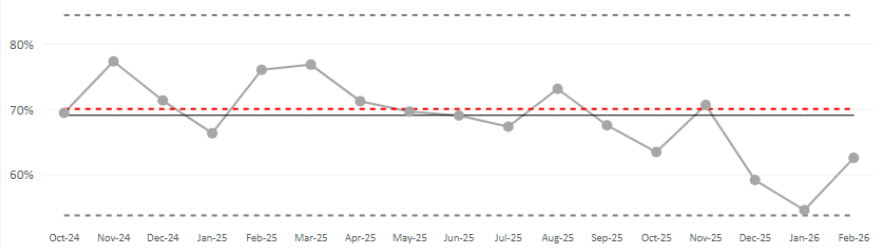
Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	80%	Mar 26	60.55%			58.98%
NGH	80%	Mar 26	69.26%			73.07%

62-day wait to start treatment from referral

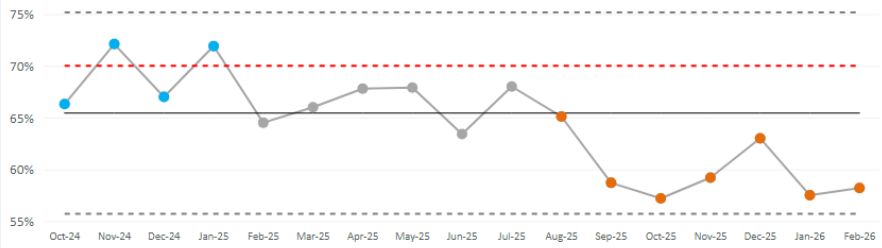
The percentage of cancer patients who start treatment within 62 days of an urgent referral.

University Hospitals of Northamptonshire NHS Group

62-day wait for cancer treatment - Kettering



62-day wait for cancer treatment - Northampton



Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	70%	Feb 26	62.50%			69.04%
NGH	70%	Feb 26	58.20%			65.44%

Understanding the performance

- Neither Trust met the standard.
- KGH improved by 8%from January, when we typically see patient deferral of treatment due to Christmas, achieving 62.5%.
- NGH delivered 58.2%, marginal improvement of 0.7% compared to January.
- We are in Tier 1 for 62 day performance

What are the issues impacting performance?

- KGH performance was driven by the impact of Breast capacity challenges. Patient choice and fitness, histology reporting and complex pathways have also contributed.
- Despite treating 16.5% less patients at NGH in February, performance remained static. Skin saw a further decline in performance, due to waits for first OPA and capacity in maxfax and plastics

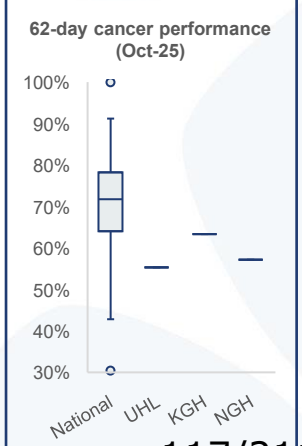
What SMART actions are being taken to improve?

- Weekly reports supplied to all tumour site teams showing patients who have breached or at risk to enable restorative action, capacity reliant.
- Existing robust governance in place by Cancer Services Team with full oversight of PTL
- Working to introduce a QI approach for 62 days in two tumour sites

Risks

- Further downstream capacity constraints in Skin and Breast
- Workforce challenges within Skin

National comparator

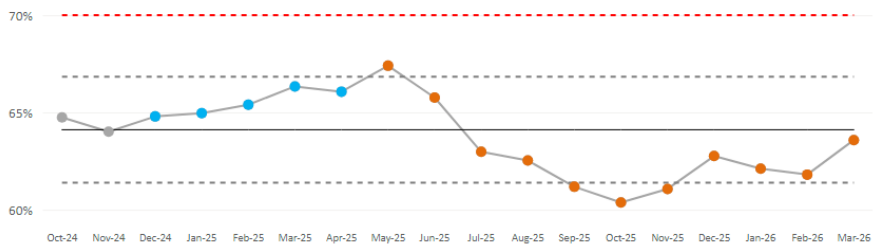


Referral to Treatment performance

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



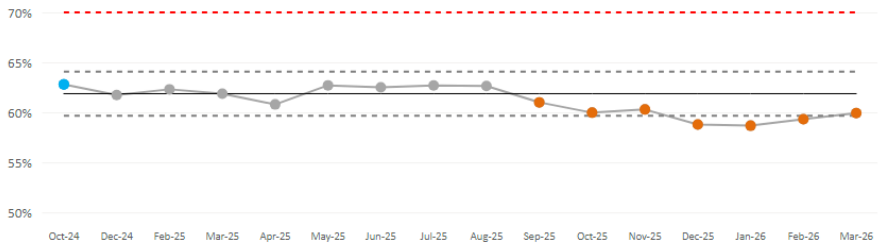
Understanding the performance

- We saw an improvement in performance across both sites in March, which was supported by the Sprints
- Further validation is taking place for the Monthly RTT position (which is published nationally), we expect this to show a year end position of 61% for NGH and 64.5% for KGH.

What are the issues impacting performance?

- The sprint has supported the improvement in performance in March, with funding for additional activity in February and March
- Overall across the year, gap to plan has been driven by the removal of premium activity

RTT performance - Northampton



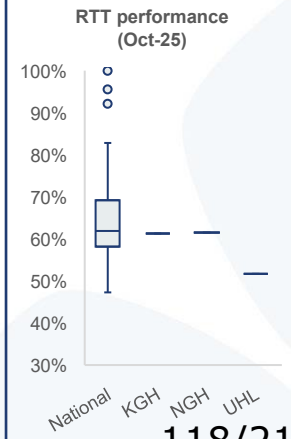
What SMART actions are being taken to improve?

- Specialty level plans for performance improvement, driven by productivity and additionality have been drawn up and Q1 actions have been agreed

Risks

- Level of demand increase

National comparator



Data Quality Indicators

S T A R

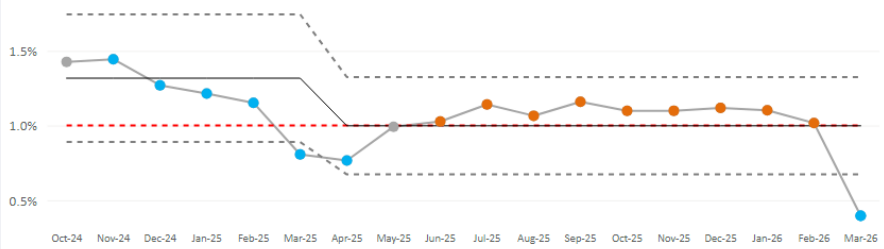
Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	70%	Mar 26	63.58%			64.11%
NGH	70%	Mar 26	59.93%			61.87%

52 week waits as a percentage of the waiting list

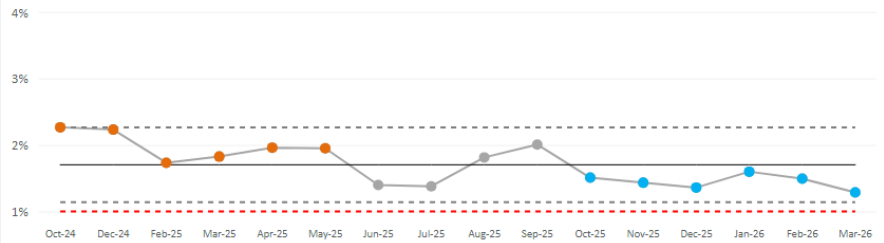
The percentage of patients who have been waiting on our planned care waiting list for 52 weeks or more

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

- Across UHN we met the target of less than 1% of the waiting list waiting more than 52 weeks
- There was a significant reduction in March at KGH due to the 52 week sprint
- The majority of the 52 week waits in NGH are in ENT

What are the issues impacting performance?

- Capacity in the ENT service

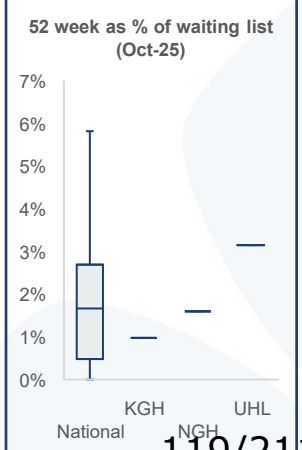
What SMART actions are being taken to improve?

- Exploring outsourcing for ENT, although there is a limited Independent Sector market for ENT services
- 52 week trajectories agreed at a specialty level and monitored through patient access

Risks

- Ozone support for Dermatology has come to an end, having made a significant reduction in the 52 week waits, plans are being progressed with the ICB but timescales need to be confirmed

National comparator



Data Quality Indicators

S T A R

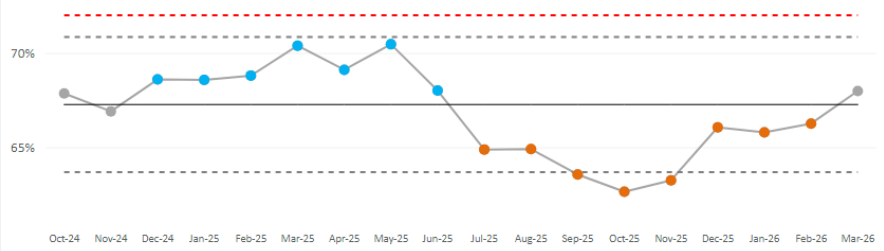
Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	1%	Mar 26	0.40%			1.32%
NGH	1%	Mar 26	1.29%			1.70%

Wait for first appointment less than 18 weeks

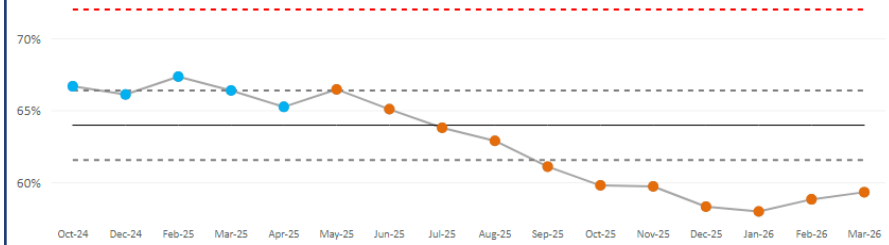
The percentage of patients who have their first appointment within 18 weeks of referral of all the planned care referrals we receive

University Hospitals of Northamptonshire NHS Group

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



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



Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	72%	Mar 26	67.98%			67.27%
NGH	72%	Mar 26	59.31%			63.96%

Understanding the performance

- There has been an improvement in this metric in February and march, driven by the additional first appointments delivered through the sprints

What are the issues impacting performance?

- The sprint has supported the improvement in performance in March, with funding for additional activity in February and March
- Overall across the year, gap to plan has been driven by the removal of premium activity

What SMART actions are being taken to improve?

- Specialty level plans for performance improvement, driven by productivity and additionality have been drawn up and Q1 actions have been agreed

Risks

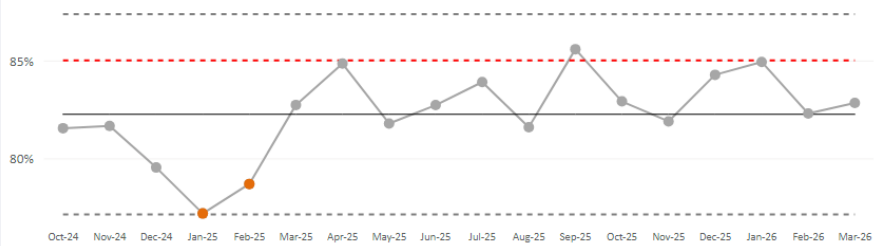
- Split of activity between first and follow up activity
- Clinical buy-in to a reduction in follow ups

Theatre utilisation

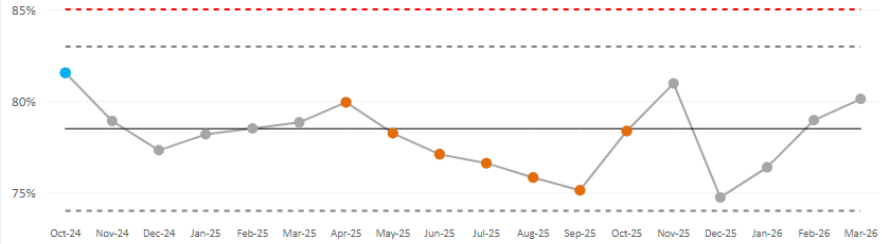
The percentage of the available time in our elective theatre sessions which is spent operating on patients.

University Hospitals of Northamptonshire NHS Group

Theatre utilisation - Kettering



Theatre utilisation - Northampton



Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	85%	Mar 26	82.83%			82.25%
NGH	85%	Mar 26	80.11%			78.49%

Understanding the performance

- Both Trusts have seen an improvement in Theatre utilisation in month, but there remains a gap to the GIRFT standard of 85%

What are the issues impacting performance?

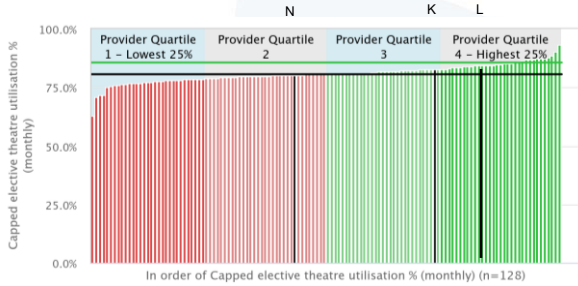
- Cancellations rates
- Workforce challenges

What SMART actions are being taken to improve?

- Lookback data meetings are in place reviewing all OTDC, changes to first patient, Utilisation, late starts and early finishes.
- Combining our 2 separate data platforms into 1 system to allow users to access the two sites individually.

National comparator

Feb-26



Risks

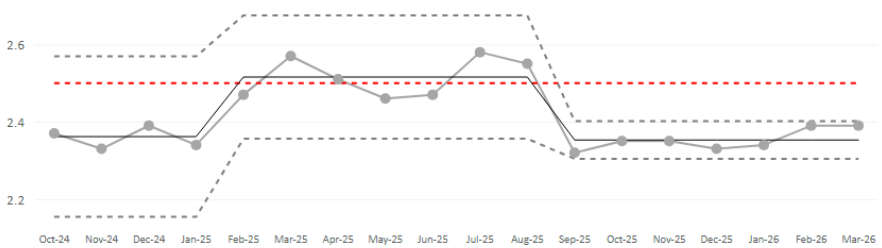
- Pre op limitations at NGH
- Before the day cancellations at NGH are high.
- KGH High incoming trauma affecting elective sessions.

Average cases per list

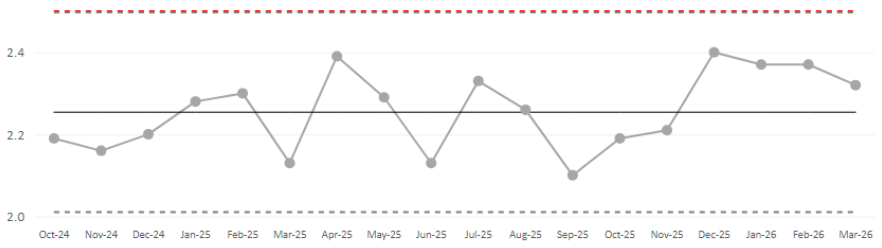
The average number of cases per operating theatre list, normalised to a 4-hour operating list.

University Hospitals of Northamptonshire NHS Group

Average cases per list - Kettering



Average cases per list - Northampton



Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	2.50	Mar 26	2.39			2.52
NGH	2.50	Mar 26	2.32			2.25

Understanding the performance

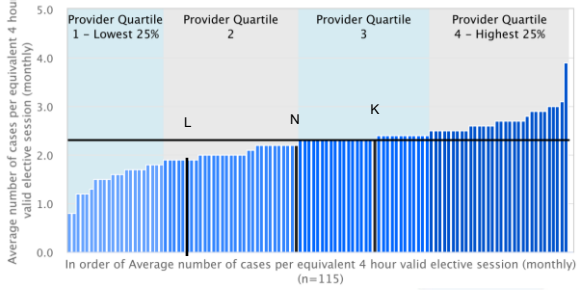
- Across the year KGH has met the target average case per list, with a small gap for NGH
- Performance is impacted by Theatre Utilisation

What SMART actions are being taken to improve?

- KGH and NGH case mix is being reviewed during the scheduling process.
- Scheduling at NGH is reviewed by the adjusted and we are working with FDP for improved accuracy

National comparator

Nov-25



What are the issues impacting performance?

- Cancellations rates
- Workforce challenges

Risks

- The waiting list for some specialities is low at KGH and therefore we can struggle to completely fill lists based on case mix available.
- KGH Robot has impacted on build up of non robotic cases and we are seeing more demand for backfill to support the management of this.

24/25 and 25/26 Activity and 25/26 Plan

NHS University Hospitals of Northamptonshire NHS Group

		Kettering General Hospital			Northampton General Hospital			University Hospitals of Northamptonshire Group		
		25/26 M8 Plan	25/26 M8 Actual	% of planned activity	25/26 M8 Plan	25/26 M8 Actual	% of planned activity	25/26 M8 Plan	25/26 M8 Actual	% of planned activity
Outpatients	Total outpatient appointments (incl. non-consultant-led)	37,941	39,502	104%	59,023	48,896	83%	96,964	88,398	91%
	First outpatient appointments (consultant-led)	11,025	11,437	104%	16,042	12,178	76%	27,067	23,615	87%
	Follow up outpatient appointments (consultant-led)	19,956	21,398	107%	32,134	27,797	87%	52,090	49,195	94%
	Outpatient procedures (consultant-led)	6,960	6,667	96%	10,847	8,921	82%	17,807	15,588	88%
Elective	Elective overnight spells	281	332	118%	399	467	117%	680	799	118%
	Day case spells	3,268	3,695	113%	4,550	4,249	93%	7,818	7,944	102%
UEC	Type 1 A&E attendances	10,886	10,776	99%	10,241	9,006	88%	21,127	19,782	94%
	Zero-day non-elective spells	562	1,267	225%	1011	763	75%	1,573	2,030	129%
	Overnight non-elective spells	2,056	1,800	88%	2,035	2,414	119%	4,091	4,214	103%

Understanding the position	What are the issues impacting the position?	What SMART actions are being taken to improve?	Risks

Our Well-Led domain metrics

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

	P	?	F	No target
H / L			• Vacancy rate - NGH	• Number of volunteering hours - KGH
	• Turnover rate – KGh • Mandatory training - NGH	• Sickness and absence rate • Time to Hire	• Appraisal completion rates - NGH • Vacancy rate - KGH	• Number of volunteer hours - NGH
H / L	• Turnover rate – NGH • Mandatory training - KGH	• Appraisal rate - KGH	• Employee formal cases	

Well-Led

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

NHS University Hospitals of Northamptonshire NHS Group

Metric	Target	Latest Date	KGH Actual	KGH Variation	KGH Assurance	KGH Average	NGH Actual	NGH Variation	NGH Assurance	NGH Average	Data Quality Indicators
Culture and safety											
Turnover rate	6.50%	Mar 26	6%		P	6.08%	5.80%	H	P	5.79%	S T A R
Appraisal completion rates	85%	Mar 26	84.30%	L	?	84.87%	80.20%		F	80.74%	S T A R
Mandatory training compliance	85%	Mar 26	89.50%		P	89.79%	89.40%		P	89.44%	S T A R
Sickness and absence rate	5%	Mar 26	5.20%		?	4.58%	4.90%		?	4.92%	S T A R
Number of volunteering hours	-	Mar 26	3,425			2921.22	3,810			3753.35	S T A R
Vacancy rate	8%	Mar 26	9.10%	L	F	9.74%	9.40%		F	9.49%	S T A R

Dedicated to excellence

Data quality assessment

No data quality issues identified.

SPC indicator key

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

Data quality indicator key

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

Well-Led

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

NHS University Hospitals of Northamptonshire NHS Group

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average	Data Quality Indicators
Workforce financial sustainability											
Time to hire (days)	65	Mar 26	83.30			69.47	76.40			83.31	S T A R
Employee relations formal cases	-	Mar 26	30			16.68	31			27.45	S T A R
Total WTE (PWR figure)	KGH: 4,903 NGH: 6,199	Mar 26	5125.67			5039.25	6574.08			6500.71	S T A R
Bank Spend as % of Total Pay	6.30%	Mar 26	10.20%			9.87%	13.20%			11.51%	S T A R
Agency Spend as % of Total Pay	2%	Mar 26	1%			1.07%	0.70%			2.24%	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

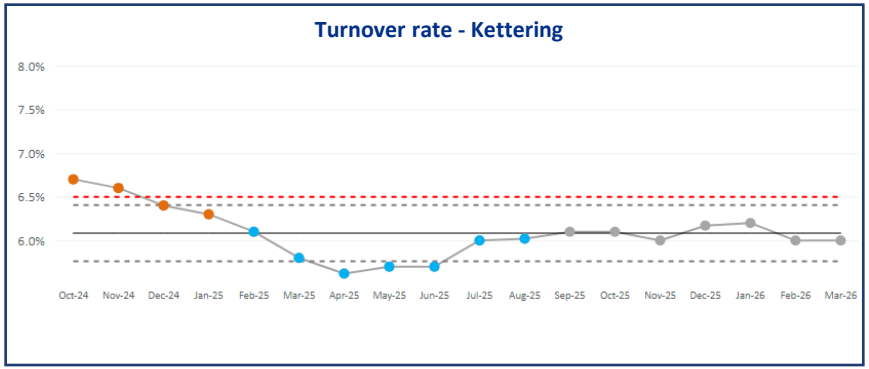
Data quality indicator key

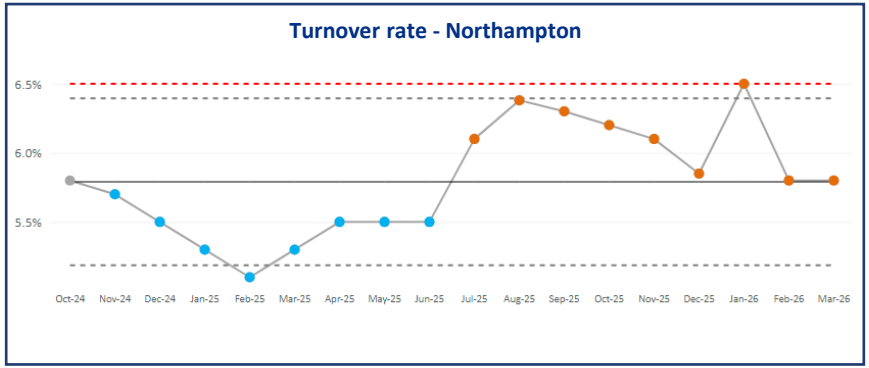
S	T	A	R
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

Turnover rate

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

University Hospitals of Northamptonshire NHS Group





Metric	Target	Latest Month	Measure KGH	Measure NGH
Additional clinical services	6.5%	Mar-26	5.25%	5.10%
Allied health professionals	6.5%	Mar-26	9.86%	4.09%
Healthcare scientists	6.5%	Mar-26	3.59%	7.36%
Administrative and clerical	6.5%	Mar-26	8.64%	9.80%
Nursing and midwifery registered	6.5%	Mar-26	3.86%	3.30%
Medical and dental	6.5%	Mar-26	3.95%	4.40%
Additional professional, scientific and technical	6.5%	Mar-26	8.31%	8.21%
Estates and ancillary	6.5%	Mar-26	9.28%	8.70%

Understanding the performance

- Turnover has decreased at KGH and reduced at NGH. Actual turnover rates at NGH 5.80% & KGH 6% against a target of 6.50%

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

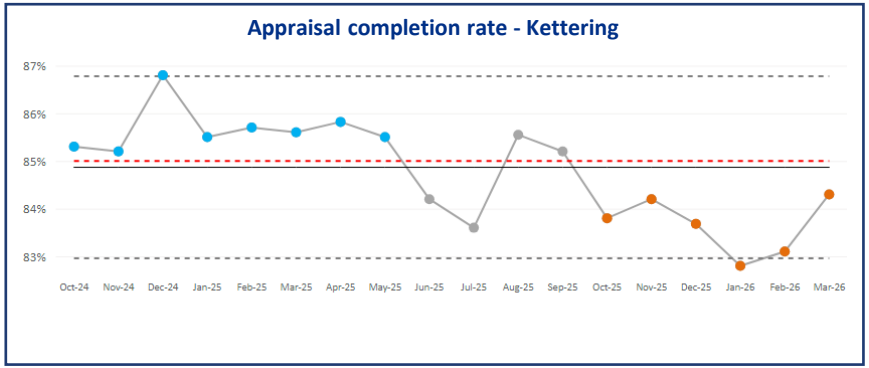
S T A R

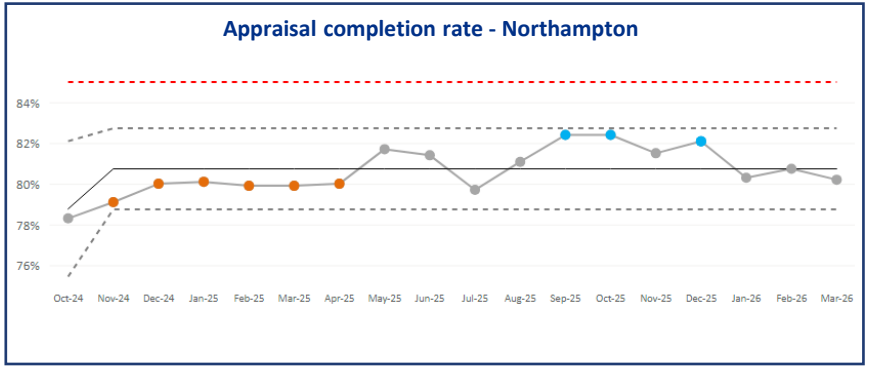
Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	6.50%	Mar 26	6%			6.08%
NGH	6.50%	Mar 26	5.80%			5.79%

Appraisal completion rate

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

University Hospitals of Northamptonshire NHS Group





Metric	Target	Latest Month	Measure KGH	Measure NGH
Additional clinical services	85%	Mar-26	88.41%	85.15%
Allied health professionals	85%	Mar-26	83.98%	85.31%
Healthcare scientists	85%	Mar-26	81.94%	80.14%
Administrative and clerical	85%	Mar-26	79.49%	76.47%
Nursing and midwifery registered	85%	Mar-26	85.89%	81.74%
Medical and dental	85%	Mar-26	86.49%	
Additional professional, scientific and technical	85%	Mar-26	79.08%	82.47%
Estates and ancillary	85%	Mar-26	84.15%	68.68%

Understanding the performance

- Rates of appraisal have improved at KGH and maintained at NGH in this reporting period but both remain under benchmark

What are the issues impacting performance?

- The current period is influenced by operational pressures
- Change of manager and movement in role impacts appraisal timing, often right for colleague but not for compliance reporting

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?

SMART– Target underperforming teams for focused support both via divisional challenge, local manager and colleague notifications

- Accept colleague notification of completion
- Appraisal pack released to colleagues that are out of date / due in the coming 3 months.
- Review with UHL for a more unified approach

Data Quality Indicators

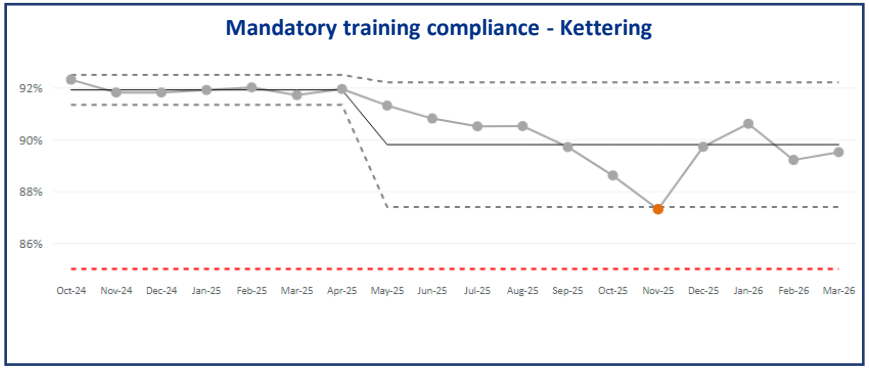
S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	85%	Mar 26	84.30%			84.87%
NGH	85%	Mar 26	80.20%			80.74%

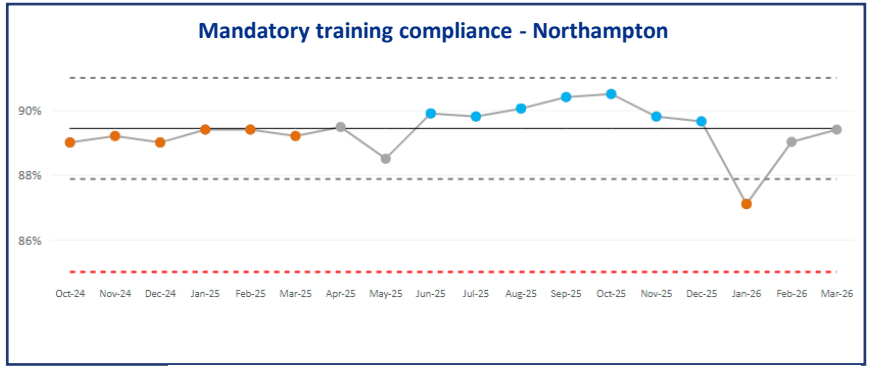
Mandatory training compliance

The percentage of colleagues who are up-to-date with their required mandatory training.

University Hospitals of Northamptonshire NHS Group



Metric	Target	Latest Month	Measure KGH	Measure NGH
Additional clinical services	85%	Mar-26	89.17%	93.82%
Allied health professionals	85%	Mar-26	88.29%	92.64%
Healthcare scientists	85%	Mar-26	91.84%	89.49%
Administrative and clerical	85%	Mar-26	90.72%	88.21%
Nursing and midwifery registered	85%	Mar-26	90.73%	93.44%
Medical and dental	85%	Mar-26	82.37%	76.27%
Additional professional, scientific and technical	85%	Mar-26	91.45%	88.10%
Estates and ancillary	85%	Mar-26	93.09%	86.37%



Understanding the performance

- Compliance remains challenging but have maintained at similar levels this period.

What are the issues impacting performance?

- Ongoing challenges cited as organisational pressures impacting on time for staff to complete.

Risks

- Statutory and mandatory training is critical to managing clinical and operational risk, ensuring compliance with regulatory standards and maintaining staff and patient safety

What SMART actions are being taken to improve?

- The new mandatory training guide has been shared across UHN
- Focus on key competencies and staff groups with the lowest compliance
- Included within the divisional data interrogation.

Data Quality Indicators

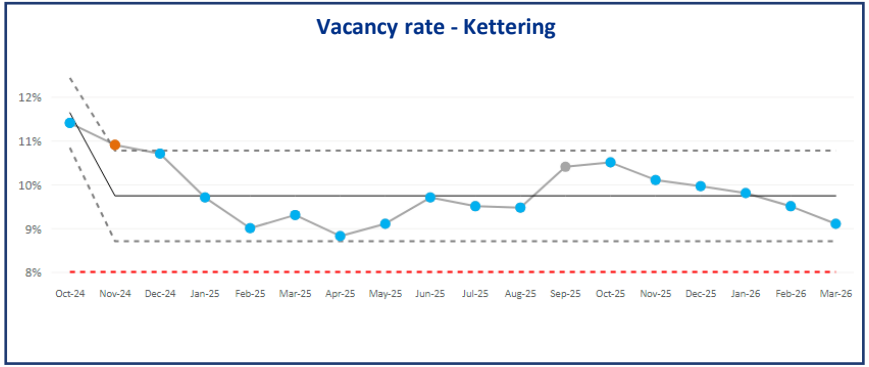
S T A R

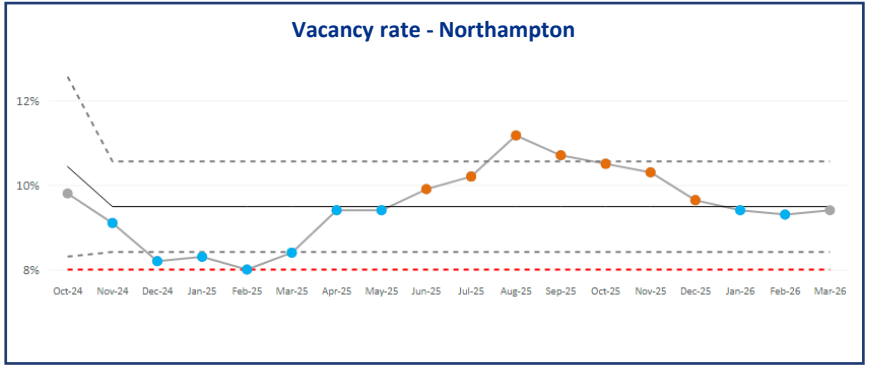
Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	85%	Mar 26	89.50%			91.90%
NGH	85%	Mar 26	89.40%			89.44%

Vacancy rate

The percentage of established posts which are currently vacant.

University Hospitals of Northamptonshire NHS Group





Metric	Target	Latest Month	Measure	Measure
			KGH	NGH
Additional clinical services	8%	Mar-26	9.46%	9.33%
Allied health professionals	8%	Mar-26	8.81%	5.66%
Healthcare scientists	8%	Mar-26	8.37%	4.04%
Administrative and clerical	8%	Mar-26	14.10%	12.65%
Nursing and midwifery registered	8%	Mar-26	6.26%	7.60%
Medical and dental	8%	Mar-26	3.14%	7.53%
Additional professional, scientific and technical	8%	Mar-26	11.75%	14.64%
Estates and ancillary	8%	Mar-26	16.52%	14.27%

Understanding the performance

What are the issues impacting performance?

Risks

What SMART actions are being taken to improve?

Data Quality Indicators

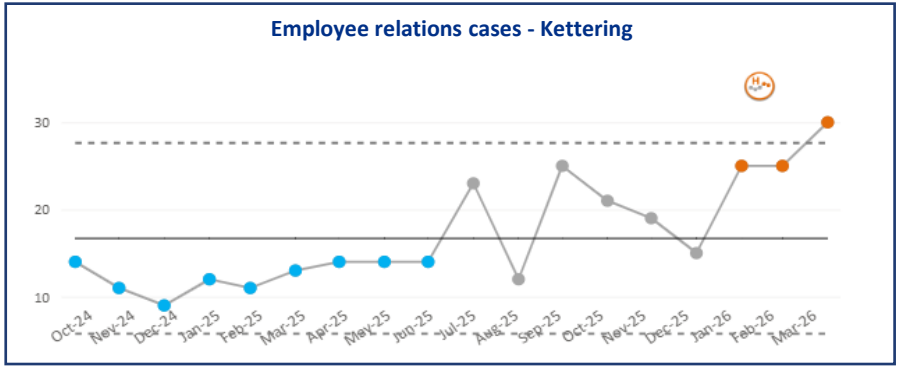
S T A R

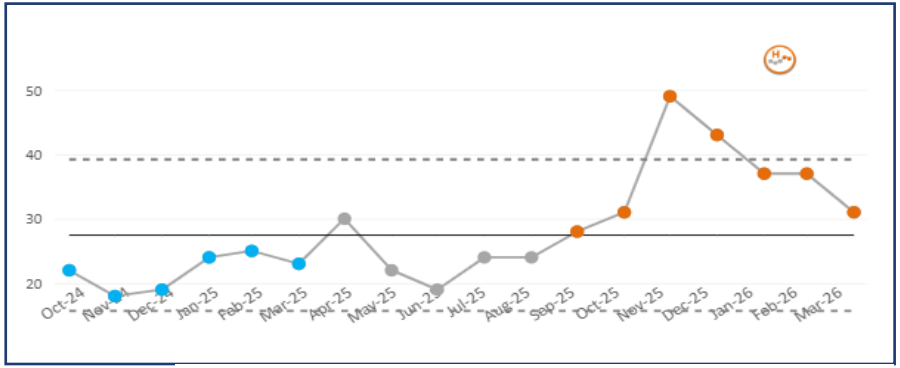
Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	8%	Mar 26	9.10%			9.74%
NGH	8%	Mar 26	9.40%			9.49%

Employee relations cases

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

NHS
University Hospitals of Northamptonshire
NHS Group





Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	-	Mar 26	30			16.68
NGH	-	Mar 26	31			27.45

Understanding the performance

- Employee relations formal cases have seen a further slight increase in February.
- The case volume remains high with significant new cases each month.

What are the issues impacting performance?

- Significant change programmes and focus on workforce CIP requires time and resource from the same team delivering employee relations case support.

What SMART actions are being taken to improve?

- Case assessment panel to consider actions at fact finding to be implemented in Q1.
- Resource review to support organisational change.

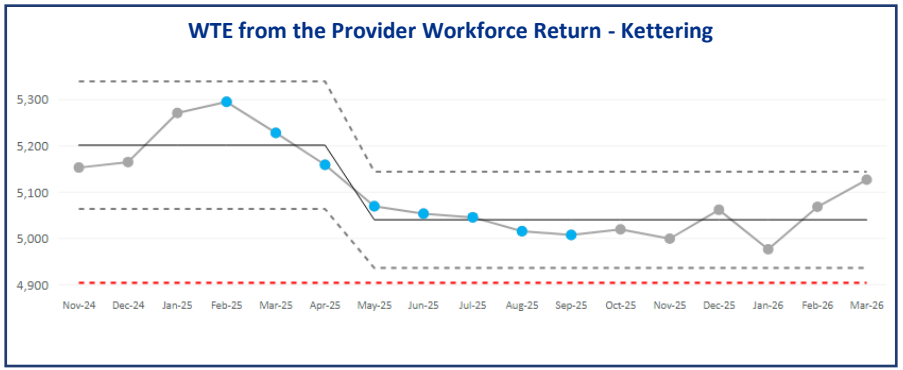
Risks

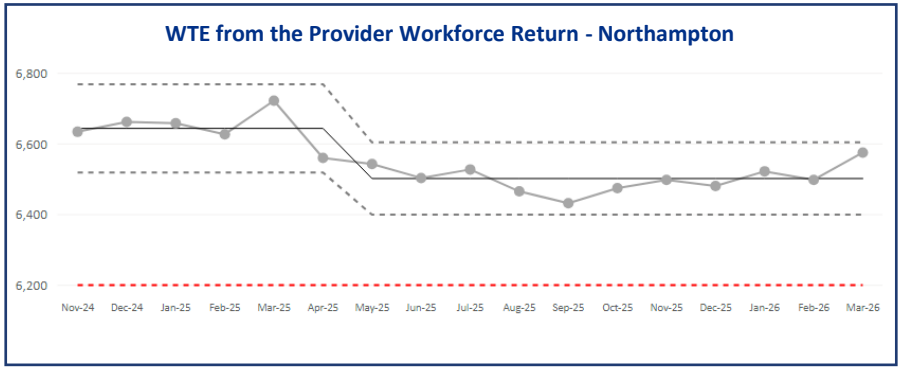
- Sustained levels of high formal employee relations cases remains a pressure for the people team and for investigating officers to identify time to support processes.

Whole-time equivalent workforce

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

University Hospitals of Northamptonshire NHS Group





Metric	Latest Month	KGH				NGH			
		Mar-25	Feb-26	Mar-26	Mar-26 Plan	Mar-25	Feb-26	Mar-26	Mar-26 Plan
Total WTE	**Mar-26**	**5,228**	**5,056**	**5,125**	**4,726**	**6,807**	**6,497**	**6.574**	**6,199**
Substantive WTE	Mar-26	4,662	4,593	4,599	4,443	5,928	5834	5,832	5,784
Bank WTE	Mar-26	486	446	512	213	761	615	694	377
Agency WTE	Mar-26	80	18	15	71	118	48	48	38

Understanding the performance

What are the issues impacting performance?

Risks

What SMART actions are being taken to improve?

Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	4903	Mar 26	5125.67			5200.50
NGH	6199	Mar 26	6574.08			6642.63

Detailed workforce numbers

		Kettering General Hospital				Northampton General Hospital				University Hospitals of Northamptonshire Group			
		Mar-25	Feb-26	Mar-26	Change in month	Mar-25	Feb-26	Mar-26	Change in month	Mar-25	Feb-26	Mar-26	Change in month
	Total	**5,330**	**5,056**	**5,126**	**70**	**6,808**	**6,497**	**6,574**	**77**	**12,138**	**11,553**	**11,700**	**147**
	Substantive	4,752	4,593	4,599	6	5,928	5,834	5,832	-2	10,680	10,427	10,431	4
	Bank	497	446	512	66	761	615	694	79	1,258	1,061	1,206	145
	Agency	81	18	15	-3	118	48	48	0	199	66	63	-3
Substantive	Registered Nursing and Midwifery	1,551	1,525	1,528	3	1,828	1,791	1,795	4	3,379	3,316	3,323	7
	Scientific, Therapeutic and Technical	383	381	379	-2	567	588	589	1	950	969	969	0
	Support to Clinical Staff	968	907	921	14	1,279	1,227	1,234	7	2,247	2,134	2,156	22
	Infrastructure support	1,244	1,175	1,181	6	1,449	1,383	1,363	-20	2,693	2,558	2,544	-14
	Medical and Dental	601	599	584	-15	800	841	848	7	1,401	1,440	1,431	-9
Bank	Registered Nursing and Midwifery	183	162	196	34	260	208	230	22	443	370	427	57
	Scientific, Therapeutic and Technical	20	30	33	3	16	17	24	7	36	47	57	10
	Support to Clinical Staff	148	135	154	19	257	205	230	25	405	340	384	44
	Infrastructure support	74	70	79	9	142	110	126	16	216	180	205	25
	Medical and Dental	72	49	49	0	86	75	83	8	158	124	133	9
Agency	Registered Nursing and Midwifery	46	4	5	1	53	25	27	2	99	29	32	3
	Scientific, Therapeutic and Technical	14	5	3	-2	27	7	4	-3	41	12	7	-5
	Support to Clinical Staff	1	1	1	0	0	0	0	0	1	1	1	0
	Infrastructure support	1	0	0	0	0	0	0	0	1	0	0	0
	Medical and Dental	20	9	6	-3	38	16	17	1	58	25	23	-2

Understanding the position

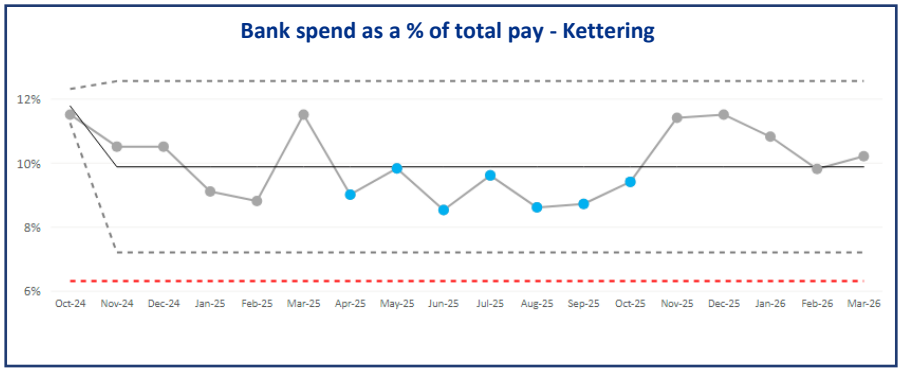
What are the issues impacting the position?

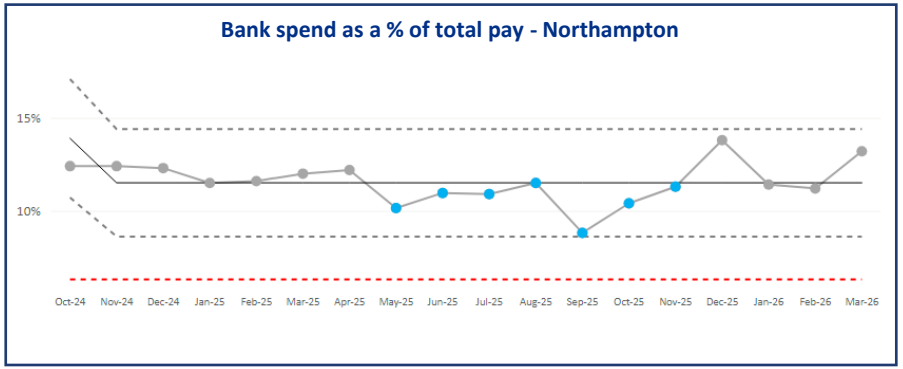
What SMART actions are being taken to improve?

Risks

Bank spend as a percentage of total pay

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





Metric	Var	Measure	Var	Measure
		KGH		NGH
Overall		**10.2%**		**13.2%**
Registered nursing, midwifery and health visiting		3.8%		5.6%
Healthcare scientists and scientific, therapeutic and technical		0.2%		0.3%
Support to clinical		0.8%		0.7%
Medical and dental		4.9%		5.9%
Non-Clinical		0.6%		0.8%

Understanding the performance

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

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	6.30%	Mar 26	10.20%			9.87%
NGH	6.30%	Mar 26	13.20%			13.90%

Our Use of Resources domain metrics

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

University Hospitals of Northamptonshire NHS Group

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

Use of Resources

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

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average	Data Quality Indicators
Finance											
Surplus / deficit	KGH: -422 NGH: -392	Mar 26	-4,564			-1333.15	-6,662			-1899.50	S T A R
Cash	6050	Mar 26	2,631			5439.20	9,717			5943.53	S T A R
Productivity and efficiency											
Acute Implied Productivity compared to last year	2%	Nov 25	0.60%			1.41%	-3.40%			2%	S T A R
CIP Delivery	100%	Mar 26	82.04%			208.06%	78.75%			191.32%	S T A R

Data quality assessment

Acute implied productivity is produced by the national team and taken from Model Hospital, which is several months out of date.

SPC indicator key

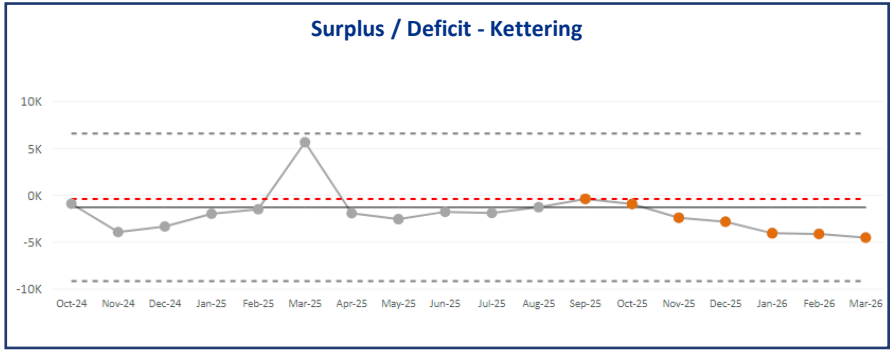
Worsening	Improving	No change
Below target	Above target	Inconsistent in whether target achieved

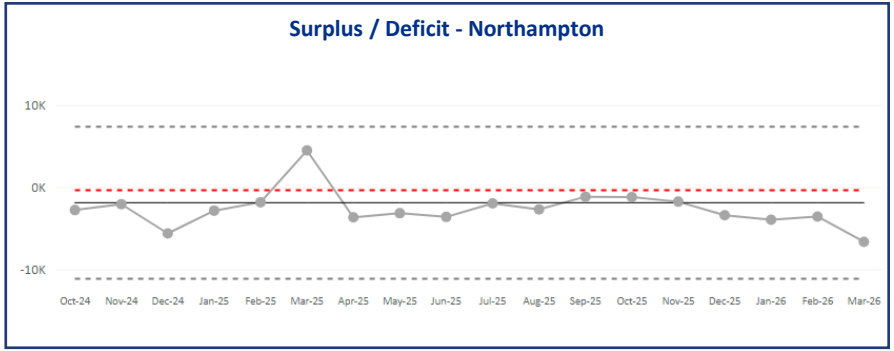
Data quality indicator key

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

Surplus / deficit

Monthly financial position – total income vs total expenditure.





Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	-442	Mar 26	-4,564			-1333.15
NGH	-392	Mar 26	-6,662			-1899.50

Understanding the performance

- The deficit for KGH in March was £4.6m
- The deficit for NGH in January was £6.7m
- For the full year, draft accounts for 2025/26 (subject to audit) confirm achievement of the forecast outturn position agreed with NHSE in month 10.

What are the issues impacting performance?

- Under delivery of CIP phased into the plan from M7 onwards is now the main driver of the over-spends in both pay and non-pay.
- Cost pressures include temporary staffing costs in hard to recruit areas, the prolonged failure of the NGH combined heat and power plant and operational pressures across both Trusts.

What SMART actions are being taken to improve?

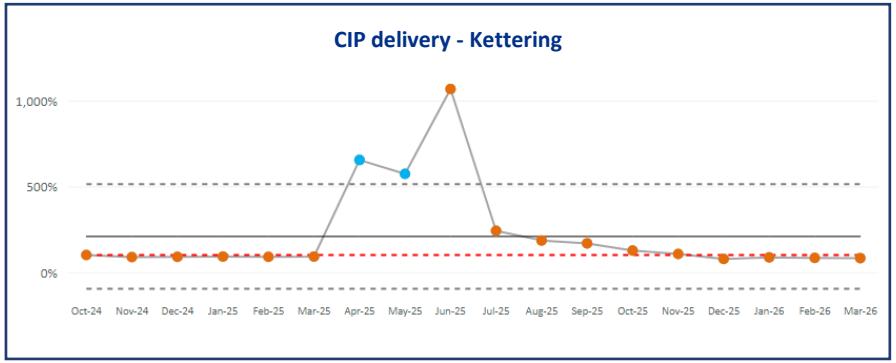
- The Financial Recovery Team are supporting the assurance of efficiency delivery and the identification of further schemes to support 2026/27 delivery.
- Grip and control measures are being extended to widen the scope of discretionary spend control whilst maintaining vacancy control panel and other Executive led control processes

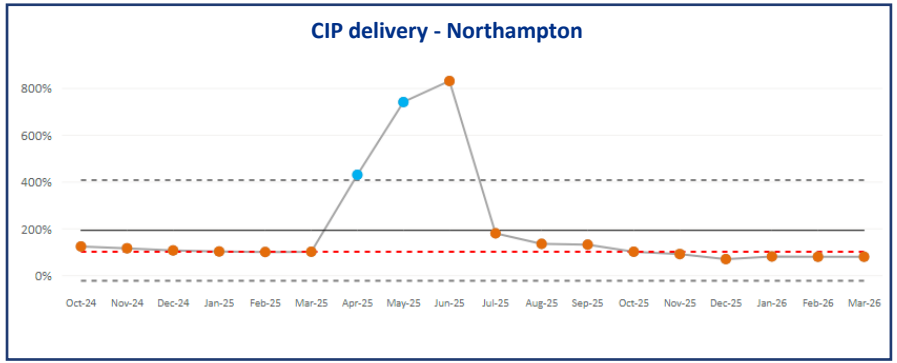
Risks

- There are insufficient mitigations identified to deliver the remaining financial gap and to offset other operational pressures in 2025/26.

Cost improvement plan delivery

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





Understanding the performance

- £68.6m of efficiencies have been delivered across UHN for the year (£32.2m NGH, £36.5m KGH), against a full year plan of £85.5m.
- A number of the 2025/26 schemes will have a beneficial full year effect into 2026/27.

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 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 assuring delivery of identified value through year-end, unlikely to substantially change the efficiency run-rate for M12.
- Divisional and Corporate meetings focused on identifying savings plans for 26/27 and de-risking plans.
- As part of budget planning, working to ensure as many savings are taken recurrently as possible.

Risks

- Rising efficiency targets make savings increasingly hard to deliver.
- The full scope of the efficiency programme has not been identified yet for 2026/27, work is underway to fully develop the programme.
- Efficiency plans face development gaps and delivery risks, even where fully scoped.

Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	100%	Mar 26	82.04%			208.06%
NGH	100%	Mar 26	78.75%			191.32%

% of delivery that is recurrent

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	100%	Mar 26	48%			42.93%
NGH	100%	Mar 26	51%			34.62%

Summary Balance Sheet - KGH

University Hospitals of Northamptonshire NHS Group

TRUST SUMMARY BALANCE SHEET MONTH 12 2025/26	Balance at 31-Mar-25 £000	Current Month Opening Balance £000	Current Month Closing Balance £000	Current Month Movement (in month) £000	Forecast end of year Closing Balance £000	Forecast end of year Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	203,103	203,103	203,103	0	203,103	0
IN YEAR REVALUATIONS	0	0	620	620		0
IN YEAR MOVEMENTS	0	26,167	39,755	13,588	39,755	39,755
LESS DEPRECIATION	0	(13,149)	(13,229)	(80)	(13,229)	(13,229)
NET BOOK VALUE	203,103	216,121	230,249	14,128	230,249	27,146
NON CURRENT RECEIVABLES	1,238	883	1,186	303	1,186	(52)
CURRENT ASSETS	0					
INVENTORIES	6,795	7,084	7,211	127	7,211	416
TRADE & OTHER RECEIVABLES	12,681	15,629	12,324	(3,305)	12,324	(357)
CASH	5,261	4,577	3,126	(1,451)	3,126	(2,135)
TOTAL CURRENT ASSETS	24,737	27,290	22,661	(4,629)	22,661	(2,076)
CURRENT LIABILITIES	0					
TRADE & OTHER PAYABLES	31,224	42,105	41,204	(901)	41,204	9,980
LEASE PAYABLE under 1 year	1,468	1,573	1,349	(224)	1,349	(119)
DHSC LOANS	760	0	0	0	0	(760)
PROVISIONS under 1 year	1,935	894	1,296	402	1,296	(639)
TOTAL CURRENT LIABILITIES	35,387	44,572	43,849	(723)	43,849	8,462
NET CURRENT ASSETS / (LIABILITIES)	(10,650)	(17,282)	(21,188)	(3,906)	(21,188)	(10,538)
TOTAL ASSETS LESS CURRENT LIABILITIES	193,691	199,722	210,247	10,525	210,247	16,556
NON CURRENT LIABILITIES	0					
LEASE PAYABLE over 1 year	4,739	5,997	6,271	274	6,271	1,532
LOANS over 1 year	0	0	0	0	0	0
PROVISIONS over 1 year	560	544	532	(12)	532	(28)
NON CURRENT LIABILITIES	5,299	6,541	6,803	262	6,803	1,504
TOTAL ASSETS EMPLOYED	188,392	193,181	203,444	10,263	203,444	15,052
FINANCED BY	0					
PDC CAPITAL	312,800	337,442	357,509	20,067	357,509	44,709
REVALUATION RESERVE	41,267	41,274	40,636	(638)	40,636	(631)
I & E ACCOUNT	(165,675)	(185,535)	(194,701)	(9,166)	(194,701)	(29,026)
FINANCING TOTAL	188,392	193,181	203,444	10,263	203,444	15,052

Non-Current Assets

- Capital expenditure in the month was £13,614k, including £1,730k Energy Centre, £1,249k site wide power supply architecture and £1,043k Rockingham extension expenditure.
- Depreciation and in year movements include the impact of right of use assets.

Current Assets

- Cash – £3,126k balance, down £1,451k in-month.
- Cash Management – No revenue cash support required due to high capital PDC receipts; some spend remains in creditors for payment in Q1 2026/27.
- Trade & Other Receivables – £3,305k decrease, driven by lower prepayments and receivables, and higher credit loss allowance; includes additional ICB pay award funding.

Current Liabilities

- BPPC – 30-day terms in place; performance impacted by payment restrictions to NHFT, UHL, NHSSC and large Pharma suppliers.
- Trade & Other Payables – £901k decrease. Driven by lower deferred income (£2,693k, incl. HEE training), partly offset by increases in accruals (£1,146k), other creditors (£445k) and capital creditors (£3,014k).

Financing

- YTD PDC Revenue Support - £14,138k, no change from February.
- YTD PDC Capital Support - £30,571K, an in-month increase of £11,958k
- YTD Income & Expenditure deficit £29,026k, an in-month increase of £4,886k

Summary Balance Sheet - NGH

University Hospitals of Northamptonshire NHS Group

TRUST SUMMARY BALANCE SHEET MONTH 12 2025/26	Balance at 31-Mar-25 £0	Current Month Opening Balance £0	Current Month Closing Balance £0	Current Month Movement £0	Forecast end of year Closing Balance £0	Forecast end of year Movement £0
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	263,061	263,054	263,054	0	263,054	(7)
IN YEAR REVALUATIONS	0	0	3,909	3,909	3,909	3,909
IN YEAR MOVEMENTS	0	28,425	41,784	13,359	41,784	41,784
LESS DEPRECIATION	0	(18,751)	(20,415)	(1,664)	(20,415)	(20,415)
NET BOOK VALUE	263,061	272,728	288,332	15,604	288,332	25,271
CURRENT ASSETS						
INVENTORIES	9,137	9,554	9,142	(412)	9,142	5
TRADE & OTHER RECEIVABLES	21,814	17,175	16,243	(932)	16,243	(5,571)
CLINICIAN PENSION TAX FUNDING	628	628	587	(41)	587	(41)
CASH	2,012	9,717	2,631	(7,086)	2,631	619
TOTAL CURRENT ASSETS	33,591	37,074	28,603	(8,471)	28,603	(4,988)
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	41,335	56,570	53,977	(2,593)	53,977	12,642
FINANCE LEASE PAYABLE under 1 year	1,336	1,272	1,276	4	1,276	(60)
SHORT TERM LOANS	163	41	41	0	41	(122)
PROVISIONS under 1 year	3,612	1,169	2,467	1,298	2,467	(1,145)
TOTAL CURRENT LIABILITIES	46,446	59,052	57,761	(1,291)	57,761	11,315
NET CURRENT ASSETS / (LIABILITIES)	(12,855)	(21,978)	(29,158)	(7,180)	(29,158)	(16,303)
TOTAL ASSETS LESS CURRENT LIABILITIES	250,206	250,750	259,174	8,424	259,174	8,968
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	14,121	11,753	11,668	(85)	11,668	(2,453)
LOANS over 1 year	59	18	18	0	18	(41)
PROVISIONS over 1 year	768	768	720	(48)	720	(48)
NON CURRENT LIABILITIES	14,948	12,539	12,406	(133)	12,406	(2,542)
TOTAL ASSETS EMPLOYED	235,258	238,211	246,768	8,557	246,768	11,510
FINANCED BY						
PDC CAPITAL	322,348	357,210	368,556	11,346	368,556	46,208
REVALUATION RESERVE	60,399	60,399	63,989	3,590	63,989	3,590
I & E ACCOUNT	(147,489)	(179,398)	(185,777)	(6,379)	(185,777)	(38,288)
FINANCING TOTAL	235,258	238,211	246,768	8,557	246,768	11,510

Non-Current Assets

- M12 Capital movements of £13,359k, includes PDC funded schemes - 2nd Linear Accelerator £2,587k, UTC works £2,4385k, Critical Infrastructure estate works £1,610k, Cancer diagnostic £737k, Cyber security spend £353k. Further spend on EPR £1,838k, BAU Med. Equipment £1,283k, BAU Estates works £1,561k

Current Assets

- Inventories – £412k movement from stock take; decreases in Pacing/Theatres offset by increases in Pharmacy/Pathology and £196k across other areas.
- Trade & Other Receivables – £932k increase, driven by VAT, NHS receivables, PDC dividend and impairment provision, partly offset by lower prepayments, non-NHS receivables, sales ledger and salary overpayments.
- Salary Overpayments – £34k increase; balance £401k. YTD £670k (lower than LY) with fewer cases.
- Cash – £7,086k decrease in line with forecast, mainly due to PDC dividend and high creditor payments

Current Liabilities

- Trade & Other Payables – £2,831k increase. Driven by fixed asset payables (£6,762k) and rises in trade payables, payroll-related liabilities, and accruals (annual leave/Week 52), partly offset by PDC dividend payment (£3,310k) and reductions in NHS payables, accruals, and receipts in advance.
- Provisions – £1,298k increase, mainly medical pay arrears (£1,167k), with smaller redundancy and legal costs; partly offset by utilisation and reversals

Financing

- PDC Capital – £11,346k total: £8,846k capital (incl. Linear Accelerator, UTC, Boiler Works, CIR, EMCA, Cyber) and £2,500k revenue deficit support.
- Revaluation Reserve – £3,590k from site-wide valuation.
- I&E Account – £6,453k in-month deficit; retained earnings include £73k historic equipment adjustment.

Cash Flow - KGH

NHS University Hospitals of Northamptonshire NHS Group

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	ACTUAL DEC £000s	ACTUAL JAN £000s	ACTUAL FEB £000s	ACTUAL MAR £000s	FORECAST 27/28 APR £000s	FORECAST 27/28 MAY £000s	FORECAST 27/28 JUN £000s
RECEIPTS																
Clinical Income	416,384	33,988	34,338	34,760	36,659	36,776	35,111	36,137	34,873	34,503	35,037	30,492	33,710	35,103	34,586	34,294
Health Education England	13,455	3,106	0	0	2,911	0	0	5,142	0	0	0	2,296	0	3,512	0	0
VAT	6,357	970	449	988	0	991	402	349	575	619	375	345	293	500	400	400
Other income	12,407	649	1,122	883	1,868	1,905	944	881	570	1,367	454	619	1,146	850	1,103	953
PDC - Capital	30,571	0	0	1,200	0	1,200	2,069	688	4,707	1,734	2,906	4,109	11,958	0	2,206	2,793
PDC - Revenue	14,138	0	0	0	0	1,100	5,538	0	0	0	3,500	4,000	0	3,949	11,236	6,979
Interest Receivable	1,020	132	99	89	70	78	75	78	93	85	74	70	77	89	84	79
TOTAL RECEIPTS	**494,332**	**38,844**	**36,008**	**37,919**	**41,509**	**42,050**	**44,140**	**43,275**	**40,818**	**38,308**	**42,347**	**41,930**	**47,183**	**44,003**	**49,615**	**45,498**
PAYMENTS																
Salaries and wages (incl agency)	314,645	25,360	26,484	25,903	25,581	27,475	27,813	25,865	25,189	25,937	26,542	26,239	26,256	27,072	26,921	26,921
Trade Creditors	131,080	5,911	14,555	9,309	12,607	10,421	9,419	13,810	8,798	10,141	10,717	10,079	15,312	6,702	14,093	10,846
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	1,534	1,534	1,534
Capital Expenditure	29,985	1,752	1,026	1,897	1,413	1,769	1,581	1,233	3,291	2,495	3,926	2,810	6,791	9,399	6,666	6,253
PDC Dividend	5,765	0	0	0	0	0	2,674	0	0	0	0	0	3,091	0	0	0
Repayment of DHSC loan (incl interest)	770	770	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL PAYMENTS	**496,425**	**35,212**	**43,483**	**38,527**	**41,019**	**41,083**	**42,906**	**42,327**	**38,697**	**39,991**	**42,603**	**39,127**	**51,450**	**44,707**	**49,214**	**45,554**
Actual month balance	-2,094	3,632	-7,475	-608	491	967	1,234	948	2,121	-1,683	-256	2,802	-4,266	-704	401	-55
Cash in transit & Cash in hand adjustment	5	0	5	0	-1	41	0	746	-842	44	-47	3	10	0	0	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	4,577	7,383	3,126	2,422	2,823
Balance carried forward	**3,172**	**8,893**	**1,423**	**815**	**1,305**	**2,313**	**3,547**	**5,241**	**6,520**	**4,881**	**4,577**	**7,383**	**3,126**	**2,422**	**2,823**	**2,768**

What are the issues impacting the position?

- Closing cash balance in March was £3,126k an decrease of £4,257k. This is mainly due to the increased Capital spend in month and payment of other Trade creditors.
- The Trust monitored its cash position throughout the year. The position in March was managed to ensure a low year end balance
- For Q4, support in February was been received (£4,000k). No support in March was requested due to high levels of Capital PDC in March.
- The cashflow reflects the ICB clawback of deficit funding, with adjustments in February (£5,667k) and March (£2,883k)
- This cashflow includes Capital Income (PDC) and Expenditure profiled in month. The profile was based on the March plan but will be reviewed throughout the year.
- The Trust continues to use 30 days payment terms for most suppliers. If required, the Trust will move NHSSC and large Pharma companies to 45 days to manage the cash position.
- The Trust will monitor cash and adjust weekly payment runs accordingly.
- The NHS resolution payments stopped in January as these are paid over 10 months.
- The commercial bank account with Barclays was closed in November, with the balance transferred to the GBS account.

Cash Flow - NGH

NHS University Hospitals of Northamptonshire NHS Group

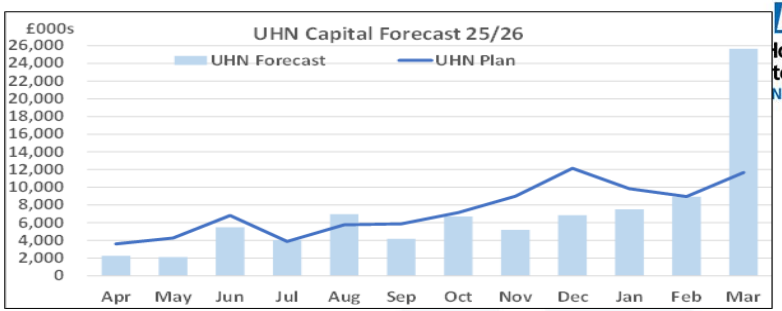
	ANNUAL TOTAL	ACTUAL												FORECAST 26/27		
MONTHLY CASHFLOW	2025/26	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000s	£000s	£000s
RECEIPTS																
SLA Block Payments	508,420	42,012	41,272	41,333	45,570	44,555	42,544	43,725	42,787	42,588	42,851	39,204	39,979	42,770	41,871	41,371
Health Education Payments	18,347	4,143	0	0	4,110	0	0	7,216	0	0	0	2,878	0	4,744	0	0
Other NHS Income	19,241	1,401	2,080	3,846	888	3,270	743	614	389	1,819	1,879	684	1,628	850	850	3,025
VAT Claim	8,423	352	2,138	611	916	849	538	(352)	2,075	0	660	636	0	1,533	500	600
PP / Other	9,516	749	498	663	1,045	937	679	720	698	800	1,100	914	713	850	850	850
PDC - Capital	26,217	0	0	0	0	1,083	3,156	280	1,180	4,141	3,504	4,027	8,846	0	0	0
PDC - Revenue	19,991	0	0	0	0	1,700	13,291	0	0	0	1,500	1,000	2,500	5,000	5,500	3,500
Interest Receivable	1,125	110	102	93	78	82	82	107	113	97	92	75	95	94	81	81
TOTAL RECEIPTS	**611,280**	**48,767**	**46,091**	**46,546**	**52,607**	**52,475**	**61,033**	**52,309**	**47,242**	**49,444**	**51,587**	**49,419**	**53,760**	**55,840**	**49,652**	**49,427**
PAYMENTS																
Salaries and wages	389,731	30,603	31,887	31,901	31,273	33,860	34,572	32,415	32,268	32,372	33,039	32,958	32,582	33,628	33,415	33,108
Trade Creditors	146,204	8,626	14,047	10,639	16,195	12,434	10,291	13,533	9,719	12,128	11,281	10,540	16,771	10,866	10,000	9,698
NHS Creditors	30,756	2,505	2,500	3,500	2,695	2,360	2,637	3,426	3,200	3,734	2,063	311	1,824	4,295	2,531	2,531
Capital Expenditure	37,034	3,380	1,542	1,513	1,499	1,234	5,984	3,505	2,922	2,511	2,444	4,378	6,122	6,677	4,814	3,157
PDC Dividend	6,782	0	0	0	0	0	3,206	0	0	0	0	0	3,576	0	0	0
Repayment of PDC Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Salix loan	163	18	0	3	0	61	0	18	0	3	0	61	0	18	0	3
TOTAL PAYMENTS	**610,670**	**45,132**	**49,977**	**47,555**	**51,663**	**49,949**	**56,691**	**52,897**	**48,109**	**50,748**	**48,828**	**48,247**	**60,875**	**55,484**	**50,760**	**48,497**
Actual month balance	611	3,635	(3,886)	(1,009)	944	2,527	4,342	(587)	(867)	(1,303)	2,759	1,171	(7,115)	356	(1,107)	930
Cash in transit & in hand adjustment	8	18	9	8	(1)	(75)	70	16	(35)	(59)	(30)	58	29	(20)	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	8,488	9,717	2,631	2,967	1,859
Balance carried forward	**2,631**	**5,665**	**1,788**	**787**	**1,730**	**4,181**	**8,594**	**8,022**	**7,121**	**5,759**	**8,488**	**9,717**	**2,631**	**2,967**	**1,859**	**2,790**

What are the issues impacting the position?

- Closing cash at year end was £2,631k, below the £2,873k target due to a delayed VAT refund (received 1 April, with Feb and Mar claims now reflected in April).
- ICB contract income included a £2,583k deficit support clawback and £721k depreciation adjustment. Other NHS income was £528k above forecast due to high-value March invoices settled in-month, while other income was slightly below forecast.
- PDC funding included £8,846k capital (Linear Accelerator, UTC, Boiler Works, CIR, EMCA) and £2,500k revenue support for March, with further applications submitted for April (£5,000k) and May (£5,500k).
- Trade creditor payments were £339k below forecast, with improved invoice clearance (90-day+ invoices reduced). Most NHS payments were to UHL, supporting cash management.
- Capital spend increased in March and is expected to remain high in April due to project completions and equipment deliveries. The PDC dividend was based on the Month 9 full-year estimate.

Capital - UHN

UHN Capital Expenditure	2025/26 Plan			2025/26		
£000s	Original	Change	Revised	Revised Plan	Actual	Variance
BAU - Estates	4,102	1,833	5,935	5,935	7,716	1,781
BAU - Medical Equipment	4,000	100	4,100	4,100	4,801	701
BAU - Digital	3,500		3,500	3,500	3,838	338
ROU Renewals + Additions	1,094		1,094	1,094	1,339	245
Remaining CDC + Slippage	2,556		2,556	2,556	932	(1,624)
Corby CDC ROU Lease	2,500		2,500	2,500	2,500	0
EPR System Implementation	7,600		7,600	7,600	8,214	614
Lin Acc Enabling Work + Eqp.	1,380		1,380	1,380	1,209	(171)
Old ITU Refurb to a new Ward	2,600	(1,833)	767	767	447	(320)
Critical Infrastructure Risk Allocation		1,585	1,585	1,585	1,602	17
UEC Performance Allocation		3,000	3,000	3,000	1,400	(1,600)
Disposals			0	0	(145)	(145)
BAU Capital net of Disposals	**29,332**	**4,685**	**34,017**	**34,017**	**33,853**	**(164)**
Critical Infrastructure Risk Allocation	8,265	(390)	7,875	7,875	6,948	(927)
Constitutional Standards UTC	10,750	0	10,750	10,750	10,750	(0)
Constitutional Standards Surgical Hub	2,000	(2,000)	0	0	0	0
Constitutional Standards CDC	0	1,750	1,750	1,750	1,750	(0)
Medical Equipment		1,889	1,889	1,889	1,712	(177)
Digital Diagnostics		243	243	243	189	(54)
Cyber Digital		812	812	812	782	(30)
Rockingham Extension	11,850	(8,241)	3,609	3,609	3,590	(19)
Energy Centre	19,990	(3,186)	16,804	16,804	16,804	(0)
NHP Wave 2	900	98	998	998	998	0
NHP Enabling MSCP + Data Centre		1,083	1,083	1,083	880	(203)
Maternity Building Rebuild	1,039	(774)	265	265	98	(167)
Solar Partnership Scheme	713		713	713	713	(0)
MESC - Linear Accelerator	2,616	2,616	5,232	5,232	5,203	(29)
Digital - EPR	1,180		1,180	1,180	1,180	0
Non BAU Capital Expenditure	**59,303**	**(6,100)**	**53,203**	**53,203**	**51,596**	**(1,607)**
Charitable Funds	**300**	**(18)**	**282**	**282**	**282**	**0**
Total Capital Expenditure	**88,935**	**(1,433)**	**87,502**	**87,502**	**85,732**	**(1,770)**



Year to Date Capital Spend	KGH	NGH	UHN
Capital Allocation	14,934	19,209	34,143
PDC Funded	29,202	21,869	51,071
Total CDEL	**44,136**	**41,314**	**85,450**
Grants Donations	47	235	282
Total Capital Expenditure	**44,183**	**41,549**	**85,732**

What are the issues impacting the position?

25-26 Capital spend finished £1.770m lower than the revised capital plan:
The original UHN plan to spend £88.935m was updated via MOU changes and new funding opportunities. The net changes being a £1.433m reduction on the original plan.

BAU Capital spend £164k lower than allocation:
The total spend on internally funded schemes closed 0.5% under the allocation, enabled by a significant March Energy Centre valuation which pushed this expenditure £0.8m above the £16.8m agreed funding in 25-26.

Non BAU Capital £1.6m under plan:
These PDC funded schemes were updated in year for known and agreed forecast changes. The remaining underspends accumulated from time slippage in Estates CIR schemes, Maternity rebuild and some genuine underspends when equipment and digital items ultimately sourced.

Dedicated to excellence

NHS
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Interpreting SPC charts and Glossary

Interpreting SPC charts

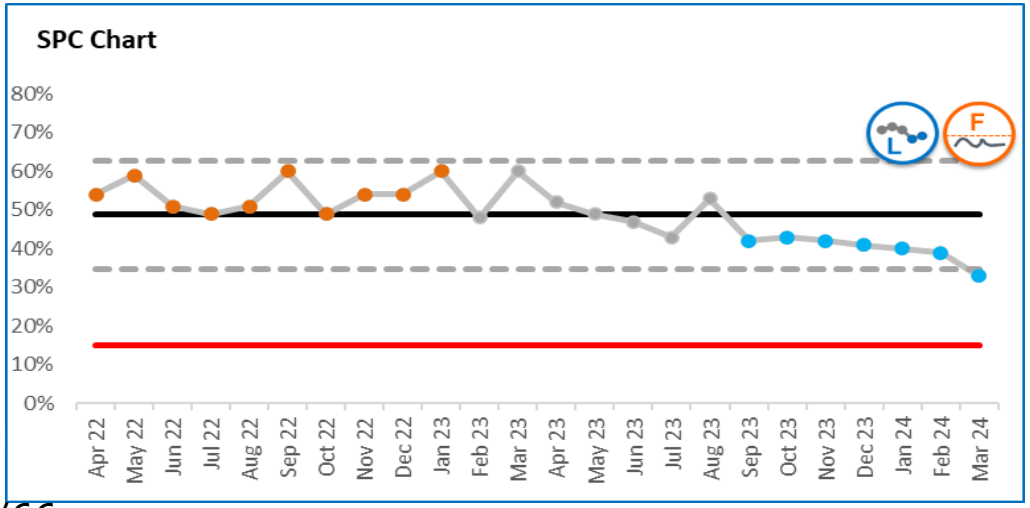
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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.

NHS University Hospitals of Northamptonshire NHS Group

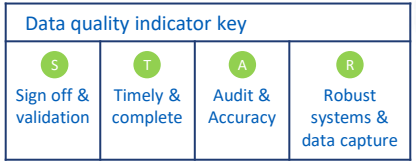
	Variation / performance Icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or 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

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

Glossary

Acronym	Name	Description
IPC	Infection Prevention Control	Infection prevention control is a set of policies and practices put in place to limit the spread of infection within NHS hospitals.
IPOG	Infection Prevention Oversight Group	A group which oversees infection prevention within the Trust.
IPR	Integrated Performance Report	A report on the performance of the hospitals across the different domains that performance is monitored on, as reported to the Board of Directors.
IPS	Internal Professional Standards	A clear, unambiguous description of the values and behaviours expected in an organisation. These might include specific timeframes for responding to patient needs or protocols for managing certain medical conditions
IPT	Inter-Provider Transfer	The movement of a patient between different healthcare providers, such as a referral from one hospital to another
IS	Independent Sector	Independent Sector providers are organizations that are not NHS trusts or NHS foundation trusts, but which provide healthcare services under contract to the NHS
IT	Information Technology	A broad field encompassing the use of technology, including computers, software, and networks. 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.
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.

Boards in Common Paper E6

Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group - UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together					
Date of the meeting:	8 May 2026					
Title:	**Escalation Report: Extraordinary Audit Committees – 22 April 2026 & 24 April 2026**					
Report presented by:	David Moon, Audit Committee, Non-Executive Director, Chair					
Report written by:	Matthew Reeves, Corporate and Committee Services Officer					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Which Group Priorities does this link to	Transform patient care		Strengthen our culture		Deliver our financial plan	x
Where this report has been discussed previously						

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

Impact assessment
N/A

Purpose of the Report

To provide assurance to the Trust Board on the work of the Audit Committee and escalate any issues as required.

Recommendation

To receive the escalation report, and to note recommendations for the Trust Board to approve items 2.1 - 2.2, which are appended to this escalation report.

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

BOARD OF DIRECTORS
8 MAY 2026

1. Summary

1.1 The Audit Committee met on 22 and 24 April 2026. The meetings were quorate and considered the following reports.

2. Recommended Items – Meeting on 22 April 2026

2.1 Procurement Proposed Changes to Trust Standing Orders, Standing Financial Instructions and Scheme of Delegation

The Committee considered a report which proposed a number of legal, technical and administrative changes to the Trust Standing Orders, Standing Financial Instructions and Scheme of Delegation and ensuring that the Procurement Act 2023 was fully reflected. Specific changes to waiver justifications, waiver approval levels and personnel were highlighted. The Committee supported the changes.

It was noted that work was ongoing to review the SOs, SFIs and SoD in light of the UHL / UHN Group collaboration, and further work to ensure that relevant reference to modern slavery had been addressed.

The Procurement Proposed Changes to Trust Standing Orders, Standing Financial Instructions and Scheme of Delegation is recommended for UHL Trust Board approval. The associated report is appended to this escalation report.

2.2 Audit Committee Terms of Reference – Review

An updated Audit Committee Terms of Reference was presented for approval with only one minor terminology amendment noted. A further amendment to references of 'public sector internal audit standards' with 'global internal audit standards' was also requested.

The amended Audit Committee Terms of Reference are recommended for UHL Trust Board approval. The amended Terms of Reference are appended to this escalation report.

3. Discussion Items – Meeting on 22 April 2026

3.1 2025/26 Annual Report and Annual Governance Statement

The Committee noted the considerable work which had been undertaken to prepare a well-developed Annual Report and Annual Governance Statement in time for the committee, and commended those involved in its preparation.

It was agreed to provide further clarity in the report to explain the differing terminology of Head of Internal Audit opinion for the two most recent years due to the change of service provider.

The report would also be amended to make further reference to UHL / UHN Group collaboration, noting planning and direction of travel during 2025/26.

The Committee supported the submission of the draft 2025/26 Annual Report and Annual Governance Statement to External Audit colleagues by 27 April 2026.

The discussion regarding the 2025/26 Annual Report and Annual Governance Statement is highlighted for the Boards in Common meeting's awareness.

3.2 **Declarations of Interest – Update**

It was noted that the end of year compliance rate of 97% had been achieved, up from 84% at the last meeting. It was recommended that for individuals who did not make the relevant declarations, the matter be discussed in their annual appraisal.

The discussion regarding the suggestion that non-declarations be raised in annual appraisals is highlighted for the Boards in Common meeting's awareness

3.3 **Internal Audit Strategy 2025/26 – 2029/30 including the Internal Audit Plan for 2026/27**

It was noted that there had been considerable engagement and discussion in order to develop the Internal Audit Plan for 2026/27 and the proposed plan was considered to be a broad reflection of the Trust's activities and addressed areas of known challenge.

3 areas which weren't included in the plan, were highlighted: the development of UHL / UHN governance; digital Business Continuity Planning and EPR benefits tracking and realisation.

Assurance was provided that the actions arising from the previous Accounts Payable audit review would be actively followed up in the current year and it was proposed that a further Accounts Payable review be included in the 2027/28 Internal Audit Plan.

The 2026/27 Internal Audit plan was approved.

The approval of the 2026/27 Internal Audit plan is highlighted for the Boards in Common meeting's awareness.

3.4 **Internal Audit – actions from historic 360 Assurance reports**

The Committee received an update on progress of closing any historic 360 Assurance audit actions. It was noted that only 9 actions remained open. The Chief Financial Officer provided assurance that the 6 outstanding actions regarding finance would be closed by the next Audit Committee.

The progress in closing 360 Assurance audit actions is highlighted for the Boards in Common meeting's awareness.

4. Discussion Item – Meeting on 24 April 2026

4.1 2025/26 Draft Annual Accounts Submission

The Committee considered the draft 2025/26 Annual Accounts Submission. It was noted that the end of year position was in line with NHSE agreement, with a deficit of £85m minus any deficit support funding.

It was confirmed that the accounts had been prepared on the basis of the 2025/26 Modern Equivalent Asset revaluation which had a material impact on the final deficit position.

The deficit position between 2024/25 to 2025/26, had improved by £15m.

Noting the challenge to deliver the Cost Improvement Plan, and by extension the deficit target in 2026/27, it was stated that it was the intention for this to be robustly monitored in detail at the Finance and Investment Committee going forward.

Further clarity was requested regarding consultancy expenditure in 2025/26 in the final accounts.

The Committee approved the 2025/26 draft accounts for submission to NHSE and External Audit. The Deputy Director of Finance and his team were commended on the preparation of the accounts to this point.

KGH/NGH Audit Committees (meeting together) Upward Report to Boards of Directors	Date of reporting group's meeting: 22nd April 2026 (1 of 2)		
Reporting Chair: Alice Cooper			
Agenda Item	**Description and summary discussion**	**Relevant BAF risk**	**Assurance level ***
Board Assurance Framework – Deep Dives with Executives	**UHN 10 – Transformation/Continuous Improvement -** The committees welcomed the updates by the Director of Continuous Improvement, and welcomed the large amount of work ongoing in this area. It was also noted that the success of managing this risk rested in a number of other areas of responsibility, and success in this area required the UHN Executive to work effectively together on supporting these challenges.	UHN10	Reasonable
Audit Committee Assurance over actions from external reports	The UHN CEO updated the committees that the piece of work to offer the assurance as to the progress of the actions of recent governance related reports, and the proposed process for monitoring and assurance going forward was underway, and would be presented at the next meeting in June 2026.	-	No assurance taken at this point.
Financial Governance Report	The committees welcomed the continued enhancements to the analysis and narrative in this report, and also the positive improvements it showed in tender waivers and maverick transactions, supporting the narrative of a greater degree of order, consideration and control over financial and contracting decisions with both organisations, and across directorates, which is to be commended. The committees also noted the inevitable pressure over compliance with the Better Payment Practice Code caused by the cash flow pressures the trust was managing, but was assured that the process was being managed as fairly as possible, and with a mind to the need to maintain continuity of essential supplies. The Committees were disappointed to see the slight deterioration seen in the Salary Overpayments position in the report, and to hear that the automations expected had not yet been implemented due to problems identified during testing. The committees requested an update from the People Team at the next meeting in June 2026 regarding the implementation, and the impact being seen on error levels.	UHN17 Delivery of financial plans	Reasonable
Draft Annual Accounts and Credit Loss Allowance	The Committees received the draft accounts (financial submission only) prior to the submission to NHS England, and also approved the revised policy with respect to the approach for provisioning for Road Traffic Accident Recovered income. **Board(s) Members to be reminded of their responsibilities to declare all gifts and hospitality in time for the annual reporting.**	UHN17 delivery of financial plans	N/A

KGH/NGH Audit Committees (meeting together) Upward Report to Boards of Directors	Date of reporting group's meeting: 22nd April 2026 (2 of 2)		
Reporting Chair: Alice Cooper			
Agenda Item	**Description and summary discussion**	**BAF risk references**	**Assurance level ***
Internal Audit: **Update on Outstanding/Overdue Audit Actions**	At the previous meeting the committees had requested updates and attendance from the Executives responsible for the areas where the most significantly overdue actions remained: These included reports regarding: Engagement Strategy, Salary Overpayments and Estates Strategy. During the meeting the Director of Communications shared a draft of the new Engagement Strategy to satisfy the committee of the completion of the overdue actions in that report. In the update it was, however, clear that actions from the other two reports, plus a number of other significant actions were now beyond, at, or fast approaching their due dates, with no update having been given to the IA team. The committees stressed the need for these actions to receive greater management focus, which the CFO and CEO agreed to take up at the Exec Meeting for action.	-	Limited
Progress Report	The committees received the progress report, including discussion of the findings of the recent Technology Audit. This report plus the need to revisit the effectiveness of the communication on both sides over audit findings lead to the limited assurance rating at this point.	UHN21 Cyber Security	Limited
Annual Opinion	The committees received the Annual Opinion of Reasonable Assurance.	-	Reasonable
Plan for 2026/27	The committees noted the draft plan, requesting that it receive further Exec scrutiny prior to formal approval: To circulate outside meeting and formally ratify in June meeting	-	Not yet approved
Anti-Crime: **Progress Report**	The committees discussed again how the Trusts might expedite the number of ongoing HR related anti-crime investigations, which appeared to last for longer than would be desirable. A request was made that a member of the relevant HR leadership be invited to a future meeting to discuss how improvements might be enabled in this area. A meeting would be convened between NEDs and anti-crime team to progress.	-	Limited
Plan for 2026/27	The plan was not presented to the committee as planned. Plan to be discussed with Exec lead and submitted to June 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

Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group – UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together (Public)					
Date of the meeting:	8 May 2026					
Title:	4.1 KGH Maternity and Neonatal Intensive Support Team (MatNeoIST) Programme					
Report presented by:	Julie Hogg, Chief Nurse Danni Burnett, Director of Midwifery					
Report written by:	Danni Burnett, Director of Midwifery					
Action – this paper is for:	Decision/Approval		KGH Assurance	X	Update	
Which Group Priorities does this link to	Transform patient care	X	Strengthen our culture	X	Deliver our financial plan	X
Where this report has been discussed previously	NHS England and LNR ICB facilitated Improvement Oversight & Assurance Group (IOAG): most recent meeting 22 April 2026					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
UHN11 Transforming Patient Care (positive safety culture) UHN12 Culture of compassionate responsive and inclusive care

Impact assessment
Financial: The maternity safety improvement programme supports efficient use of resources through strengthened governance, data-driven decision-making and reduced avoidable harm. Improved safety, workforce stability and control reduce the risk of costly adverse events, litigation, premium staffing and regulatory intervention, supporting sustainable service delivery. Overall, continued improvement represents good value for money and contributes positively to the Trust's financial sustainability. *Legal and regulatory* The maternity safety improvement programme supports efficient use of resources through strengthened governance, data-driven decision-making and reduced avoidable harm. Improved safety, workforce stability and control reduce the risk of costly adverse events, litigation, premium staffing and regulatory intervention, supporting sustainable service delivery. Overall, continued improvement represents good value for money and contributes positively to the Trust's financial sustainability. *Equalities* Assurance through the Perinatal Assurance Committee (PAC) actively embeds Equality, Diversity and Inclusion by promoting inclusive practice, monitoring disparities in outcomes and supporting culturally competent maternity care across services.

Kettering General Hospital (KGH) Maternity Improvement Progress Report: Perinatal Safety Improvement Programme (PSIP) and NHS England MatNeoIST
March 2026 – April 2026

EXECUTIVE SUMMARY

Maternity services at KGH continue to demonstrate clear, observable and sustained improvement, with increasing evidence that services are now operating within control across safety, governance, workforce and culture. Immediate patient-safety risks identified have been mitigated, core controls are embedded, and the service is now functioning within a more mature, transparent and reliable improvement architecture, supported by strengthened oversight at divisional, corporate and system level.

The implementation of the Perinatal Safety Improvement Programme (PSIP), underpinned by a high-quality, bi-weekly SitRep and Bellwether metrics, has created a single, coherent regulatory recovery framework. This aligns PSIP, CQC actions, MatNeoIST milestones and wider national requirements (including PSIRF, Ockenden and MIS), significantly improving Board visibility, grip and pace. Risks are now identified earlier, escalated appropriately and actively managed through a clear ward-to-board governance line of sight.

All PSIP workstreams are now embedding. There is strong evidence of improved clinical governance, stabilising workforce resilience and early but sustained cultural recovery. While the overall trajectory is positive, continued focus remains required on front-door triage responsiveness, specialist workforce capacity, estates and documentation reliability, and data quality, to ensure improvements are demonstrably sustained and to support regulatory exit.

KEY IMPROVEMENTS DEMONSTRATED THIS REPORTING PERIOD

Clinical safety and reliability

- Consultant attendance: 88–89% overall compliance, with 98% compliance where consultant or suitably competent senior presence is required.
- BSOTS triage:
  - 73–77% of women assessed within 15 minutes (initial assessment)
  - 80–85% compliance at 1 hour (Yellow/Orange)
  - 90–95% compliance sustained at 4 hours (Green)
- Neonatal resuscitaire safety checks: 92–98% both AM/PM, within control limits.
- Theatre medicines safety: 100% compliance, with timely rectification of any isolated gaps.

Service-user experience

- Consent and communication: 100% compliance in March/January audits.
- FFT feedback consistently references improved information-giving, involvement in decision-making and respect for autonomy.

- No evidence of inequity in consent processes; interpreter provision timely and appropriate. However further work required to explore differential care across demographics

Workforce stability

- All funded midwifery vacancies filled.
- Mandatory training sustained at 92–96%.
- Enhanced senior medical presence and strengthening consultant job planning.
- Shift fill consistently 90–100%, with breaches contained within control limits.

Culture and leadership

- Improved leadership visibility and multidisciplinary engagement.
- Increased Freedom to Speak Up activity with high resolution rates.
- Strong uptake of civility and respect interventions and OD-led coaching.
- Early evidence of improving psychological safety and reduced formal employee-relations activity.

Board Assurance: The cumulative evidence demonstrates increasing maturity and reliability, with maternity services progressing toward sustained regulatory recovery and MatNeoIST exit, subject to continued embedding and assurance over time.

1. **Perinatal Safety Improvement Programme (PSIP) Oversight and Governance**

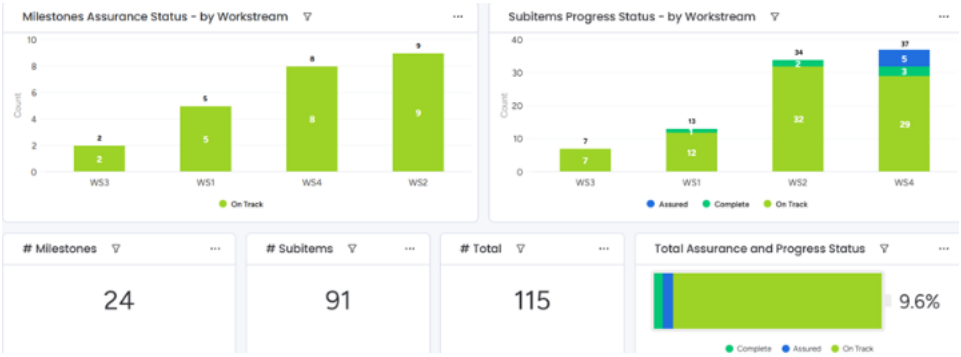
A single, integrated PSIP governance model remains fully operational, maintaining a clear ward-to-board line of sight supported by cross-site specialist forums. Routine executive, divisional and IOAG oversight continues through exception-based reporting, with PSIP, CQC and MatNeoIST actions fully aligned under the Executive-led Perinatal Assurance Committee (PAC). This three-lines-of-defence approach has reduced duplication and strengthened the quality and timeliness of assurance.

Monthly NHS England executive assurance meetings provide external oversight, with outputs embedded into PAC and divisional governance, ensuring aligned and non-fragmented delivery. **Appendix A** indicates that progress is being made across the agreed improvement actions, with clear priorities identified following recent site visits and implementation plans in place. Some short-term milestones have required agreed extensions due to workforce capacity, leadership and perinatal governance complexity, all of which are escalated and being addressed with executive oversight.

2. **MatNeoIST Progress**

The MatNeoIST programme continues to demonstrate forward momentum despite the scale and concurrency of change. Delivery has advanced overall (+7% month-on-month), with seven milestones achieved this period and the majority of remaining milestones either on track or

progressing within tolerance. As discussed at the executive assurance meeting a small number of milestones are in transition.



Progress is increasingly output-focused rather than process-driven, with tangible movement across priority areas including elective LSCS pathways, induction of labour, diabetes care, equity oversight and bereavement support. Governance grip and executive ownership have strengthened further, supporting improved pace across multiple workstreams. Where milestones have moved closer to tolerance, this reflects the breadth and interconnectedness of delivery, rather than loss of engagement, and recovery against revised monthly trajectories is already evident.

The programme remains clinically led and actively managed, with continued support from regional and national partners, including MIAs, adding value to both the quality and sustainability of delivery.

Board Assurance: Overall, assurance continues to improve as interim arrangements are converted into embedded practice and evidence maturity increases.

3. **Culture & Organisational Development (OD)**

A substantive culture reset is underway as part of PSIP, addressing historic concerns relating to behaviours, psychological safety and supervision.

Key indicators following the range of interventions demonstrate:

- Improved escalation behaviours
- Strengthened psychological safety
- Increased recognition and positive feedback
- Reduced reliance on formal employee-relations processes

Residual risks remain around sickness absence, screening/immunisation and fetal medicine capacity, requiring continued wellbeing focus and specialist workforce investment.

Board Assurance: Cultural trajectory is positive and improving, though sustained leadership visibility and targeted support remain essential for full embedding.

4. **Bellwether Metrics & Monitoring for Impact**

The developing Bellwether framework is now providing meaningful, triangulated assurance on whether improvement activity is translating into safer and more reliable care. Trend data is available for the majority of measures, with increasing stability across core safety, governance, workforce and cultural domains. Remaining gaps relate to a small number of pathway-specific measures (notably diabetes and MNVP activity) that are still maturing through active QI delivery rather than representing control failures.

The latest Bellwether intelligence demonstrates that maternity services remain stable and improving overall, with no evidence of emerging or unmanaged risk. Clinical safety indicators are holding within control limits, governance arrangements are operating effectively with closed-loop assurance, and cultural indicators continue to show positive movement. Importantly, these trends have been maintained during periods of sustained operational pressure, indicating increasing system resilience rather than reliance on short-term mitigation.

Variation that remains visible within the dashboard is controlled and explainable, most often relating to documentation timing or data capture as digital systems embed, rather than gaps in clinical practice or escalation. This is supported by exception-based deep dives (for example in triage, fetal monitoring and consent), which consistently demonstrate functioning safety behaviours, appropriate escalation and learning.

Board Assurance: The Bellwether metrics now provide credible, routine assurance that improvements are embedding and being sustained. While data quality and pathway-level maturity remain active areas of focus, the overall position reflects a service operating within control, with high confidence in direction of travel and no indicators of systemic deterioration.

5. **Overall Board Assurance Summary**

KGH maternity services are demonstrating measurable, sustained and credible improvement across all core domains. While further embedding is required in targeted areas, the current trajectory supported by strengthened governance, PSIP discipline and MatNeoIST alignment, provides the Board with a high degree of confidence that services are moving toward regulatory recovery, sustained assurance and the delivery of safe, high-quality maternity care.

6. **Recommendation**

The KGH Board is asked to **note and indicate assurance regarding** the positive trajectory, endorse continued focus on sustainability, and support targeted actions to secure long-term assurance and safe, high-quality maternity services.

Appendix A – MatNeoIST Monthly Report

Maternity and Neonatal Improvement Support Team

Monthly Update Report

Trust name:	Kettering General Hospital (University Hospitals of Northamptonshire Trust)	**Report date:**	March 2026 update (reported in April Exec Meeting)	
MIA(s):	Sarah Latham, Emily Brace – Midwifery MIAs Sabeena Panicker, Sonji Clarke – Obstetric MIAs Elizabeth Pilling, Elizabeth Langham – Neonatal MIAs	**Level of support:**	Intensive	
Site visits in past month:	10th, 13th, 17th, 18th, 24th, 25th – March 2026	**Support start date:**	January 2026	**Support end date:** January 2027

Achievements and progress of milestones

- Progress continues in relation to the milestones
- Neonatal improvement advisors came on site visit on 18th March – potential areas of focus for neonatal milestones to include workforce, perinatal governance and Transitional Care
- Community review completed by MIA awaiting final comments from community matron
- Actions ongoing regarding plan to reinstate Homebirth Service, comprehensive implementation plan in place. EQIA completed by Trust and shared with Regional Chief Midwife
- Plan to implement cross site 7 day a week Bereavement Service cover by end of April
- PSIP board established and due to commence in April
- EDI deep dive – focus groups now completed, report expected by end of May. MIA has requested Wendy Olayiwola to share initial feedback and any immediate recommendations with DoM, CN and CD ahead of the full report

Escalations

Minor slippage in relation to some of the 3 month milestones escalated to Exec as follows.
Governance and Board Effectiveness – UHN perinatal governance deep dive scheduled to take place in April and May – 2 month extension requested and agreed
Obs Leadership and Capacity – job planning ongoing, scoping of workforce capacity – 2 month extension requested and agreed
Service User Voice – MNVP collaborative assessment benchmarking now taking place in April – 1 month extension requested and agreed
Workforce Planning – work ongoing by DoM and senior midwifery leadership team in relation specialist Mw review and maternity support worker competency framework. Cross site escalation framework being devised – request for 2 month extension requested and agreed

Escalation for Exec oversight in relation to operational/obstetric input and support for clinical pathways – see action log

Boards in Common Paper G

Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group - UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together					
Date of the meeting:	8 May 2026					
Title:	Patient Led Assessment of the Care Environment (PLACE) 2025					
Report presented by:	Julie Hogg, Chief Nurse, Ben Widdowson, Director of Estates, Facilities and Sustainability					
Report written by:	Sue McLeod, Head of Patient Experience; Preena Jethwa, Performance Manager, Estates and Facilities; Lee Clarke, Soft FM Transformation Manager; Kerry Morgan, Head of Nursing, Estates and Facilities					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Which Group Priorities does this link to	Transform patient care	x	Strengthen our culture		Deliver our financial plan	
Where this report has been discussed previously	N/A					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Providing assurance on actions already taken, and those planned, following the annual externally led assessment of University Hospitals of Leicester NHS Trust (UHL) against the requirements of the PLACE audit tool.

Impact assessment
PLACE assessments were introduced to provide valuable feedback to healthcare providers and to identify opportunities to improve the patient environment. They are undertaken annually and informed by patient-led assessment. Involving patients and the public in the process ensures that the evaluation reflects the perspectives and experiences of our patients, their carers and parents. Assessment teams must comprise equal representation of patient assessors and Trust multidisciplinary team (MDT) staff. To maintain independence, Trusts cannot plan assessment routes or influence which areas assessors visit. This ensures organisations cannot pre-plan the process or 'mark their own homework'. PLACE assessments are undertaken in Quarter 3 (Q3), with results published in Quarter 4 (Q4). A senior MDT remains in place to oversee delivery of the improvement actions required for UHL and to ensure changes are implemented and sustained.

1. Purpose of the Report

To provide assurance to the Boards in Common on the outcomes of the Patient Led Assessment of the Care Environment (PLACE) 2025, summarise key themes and risks identified across University Hospitals of Leicester NHS Trust (UHL), and outline the priority improvement actions planned for 2026.

1.1 Recommendation

To note the PLACE feedback for 2025 and our plans for improvement going forward.

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

BOARD OF DIRECTORS
8 MAY 2026

2. Background and Context

PLACE assessments are undertaken annually and are externally led, with equal representation from patient assessors and Trust colleagues. The process provides independent feedback on the patient environment and experience and evaluates performance across the following domains:

- Cleanliness
- Food (organisation and ward level)
- Privacy, Dignity and Wellbeing
- Condition, Appearance and Maintenance
- Dementia-friendly environment
- Disability access

The 2025 assessments were completed in Quarter 3, with results benchmarked against organisational and national averages and published in Quarter 4.

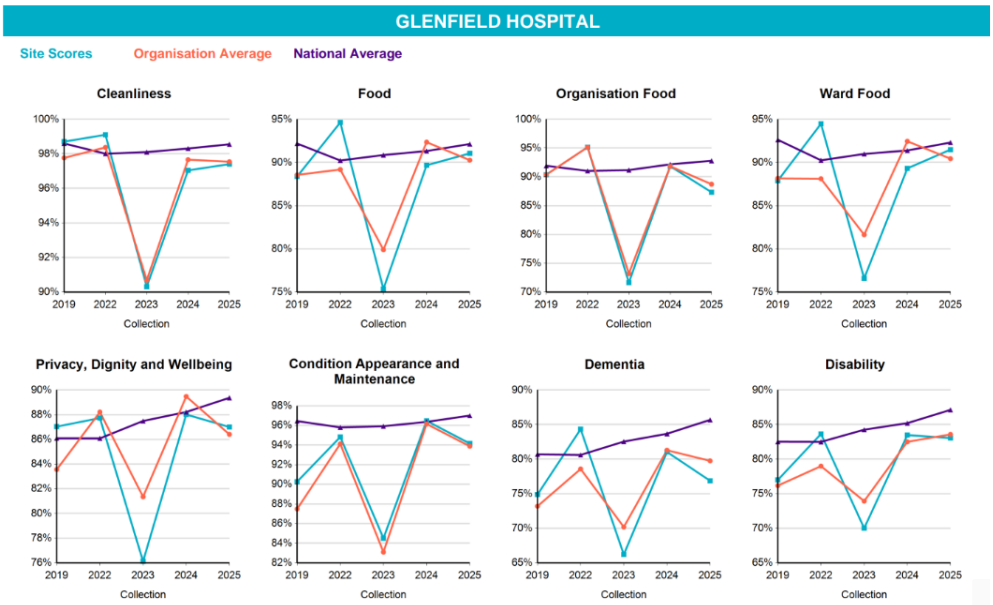
3. Summary

- **Sustained improvement:** has been demonstrated across all three hospital sites compared with earlier PLACE collections.
- **Cleanliness** and **Condition, Appearance and Maintenance:** remain areas of strength, with scores close to or exceeding national averages
- **Food and Nutrition:** performance is stable overall, supported by positive patient feedback on choice and dietary accommodation, although ward-level variability remains.
- **Privacy, Dignity and Wellbeing** continue to show gradual improvement, with some residual inconsistency at ward level.
- **Dementia and Disability:** domains remain the lowest scoring themes across all sites, reflecting known estate and environmental limitations.

The PLACE 2025 results demonstrate consolidation of improvements achieved in recent years, while clearly identifying system-wide risks requiring continued focus and investment.

4. Performance by Site

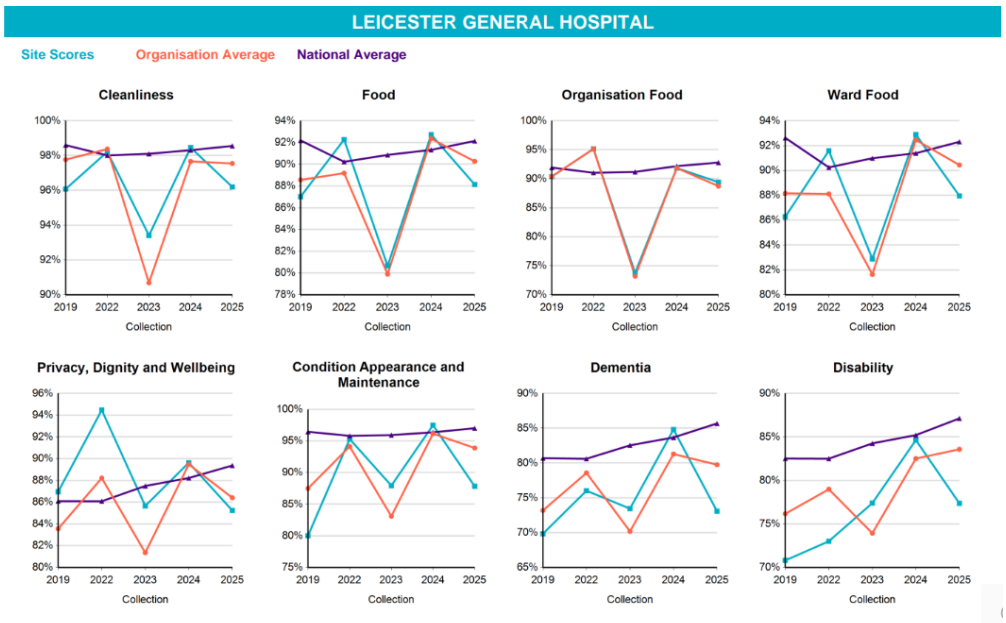
4.1 Glenfield Hospital (GH)



Overall summary:

- High and stable scores in cleanliness and condition.
- Continued improvement in ward food and organisational food scores.
- Dementia and disability domains show modest improvement but remain below organisational ambition.
- Positive assessor feedback regarding staff engagement and discharge processes.

4.2 Leicester General Hospital (LGH)



Overall summary:

- Sustained improvement in cleanliness and condition, appearance and maintenance.
- Recovery in food scores following previous variability.
- Incremental improvement in privacy and dignity, with isolated issues relating to unattended patient information noted.
- Significant dementia-friendly environment and disability access constraints- linked to the age and layout of the estate.

4.3 Leicester Royal Infirmary (LRI)

Overall summary:

- Strong performance in cleanliness and food domains.
- Continued upward trend in overall site scores.
- Wayfinding and signage identified as a recurring concern for patients and visitors.
- Variable ward-level performance in privacy, dignity and dementia-supportive design.

5. Key Themes Identified

5.1 Ward Areas and Staff

Strengths:

- Consistent praise for professionalism, compassion and engagement of nursing, medical and support staff.
- Ward environments generally described as clean and well maintained.
- Positive collaboration with patient assessors during inspections.

Areas for Improvement:

- Variable staff awareness of PLACE purpose and expectations.
- Isolated incidents of patient information being left unattended.
- Limited availability and consistency of ward-based social and day spaces.

5.2 Buildings and Environment

Strengths:

- Improved internal and external presentation across all sites.
- Positive perception of Estates responsiveness to reported issues.
- Reduced inappropriate use of corridor spaces to support patient flow and safety.

Areas for Improvement:

- Wayfinding and signage, particularly at LRI.
- Suitability and availability of communal seating.
- Ongoing backlog maintenance pressures in older estate.

5.3 Food and Nutrition

Strengths:

- Good patient feedback on menu choice and accommodation of cultural and dietary needs.
- Positive commentary on food quality, portion size and variety overall.
- Evidence of good ward-level practice in meal support in selected clinical areas.

Areas for Improvement:

- Inconsistency in food quality and temperature at ward level.
- Occasional delays in meal service linked to staffing pressures.
- Presentation issues with specific dishes.

6. Risks and Gaps

The PLACE 2025 assessment highlights the following ongoing risks:

- Partial non-compliance with the revised National Cleaning Standards (2025), formally recorded on the Trust Risk Register.
- Dementia-friendly environment deficits, corroborated by other external assessment tools, requiring estate-level solutions
- Limited availability of ward-based social and day rooms, particularly within older people's and emergency care pathways.
- Financial constraints impacting the pace and scope of estate-related improvements.

7. Planned Actions and Next Steps (2026)

1. PLACE Lite Programme - commenced in the Children's Hospital in April 2026. Nutrition and Hydration Strategy - A new Trust-wide Nutrition and Hydration Strategy covering patients, colleagues, and visitors is in development. Once ratified, it will ensure full compliance with the NHSE 2022 National Standards for Healthcare Food and Drink.

   Action owner: Sue Burton: Deputy Chief Nurse: For completion: September 2026

2. Food Safety Committee - A dedicated Food Safety Committee will be established and report to the Health and Safety Committee, with a focus on:
   - Prioritising ward-based staff food safety training
   - Ensuring compliance with Food Safety Regulations
   - Providing assurance to the Local Authority Environmental Health Officer

   Action owner: Kerry morgan: Head of Nursing : Estates and facilities: September 2026

3. Meal Pathway Mapping - End-to-end process mapping is underway to ensure meals are ordered, delivered, and served in line with patient needs—focusing on quality, timeliness, and choice. This includes improved access to drinks (e.g. squash, milky drinks) and snacks.

   Action owner: Sue McLeod Head of patient experience: QI colleagues: December 2026

4. Work is ongoing to ensure preparation of patient prior to mealtimes as observations have shown this is not the case, e.g. washing of hands, sitting out for meals and toileting

   Action owner: Sue McLeod Head of Patient Experience / Head's of Nursing: Ongoing

5. #saferUHL Campaign - The #saferUHL infection prevention campaign will reinforce clear expectations and consistent monitoring of infection prevention practices in clinical areas.

Action Owner : Liz Collins: In progress

6. Wayfinding Improvements - A Trust-wide review of wayfinding is in progress, aligned to available financial resources, with the aim of improving patient and visitor navigation across the organisation.

   Action owner: Ben Widdowson: Director of Estates and Facilities: December 2026

Gaps / Risks within the Plan

We are working towards full compliance with the 2025 National Cleaning Standards, supported by a formal risk assessment and oversight through the Trust Risk Register, ensuring clear executive visibility and assurance. Soft Services are actively transforming service delivery to ensure it is fit for purpose, sustainable and responsive to the needs of patients, staff and the wider UHL organisation. This includes the implementation of a robust and transparent reporting framework, aligned explicitly to the National Cleaning Standards, to support consistent monitoring, escalation and improvement.

A review of catering services has been commissioned to assess how national standards can be adopted effectively, with a clear focus on safety, quality and value for money. This work will be undertaken through a collaborative approach with key clinical and operational stakeholders, ensuring menus are compliant with British Dietetic Association standards, enhance the nutritional quality of the patient experience, and remain financially viable and sustainable.

The dementia component of the audit identified significant and well-evidenced deficits, corroborated by the King's Fund Dementia Audit using the EHE Environmental Assessment Tool. In response, a focused and prioritised action plan will be developed for 2026/27. This will take account of financial constraints while identifying opportunities to deliver meaningful and proportionate improvement.

As part of this approach, the Dementia and Delirium Strategy Group proposes the development of Wards 29 and 30 at LRI as an older people's ward that meets the requirements of the King's Fund Dementia Audit, including the provision of an appropriate wandering pathway. This recognises that some inequity will remain in the short term but provides a clear, staged and deliverable improvement trajectory.

Within older people's wards, day rooms intended for meaningful activity have been recommissioned for their original purpose. A further review is planned to assess the feasibility of reinstating additional spaces that were repurposed during COVID-19 back to their original function, including day rooms within Specialist Medicine and Emergency Department portfolios. This programme of work is expected to contribute to improved PLACE scores in 2026/27, alongside wider benefits to patient experience and dignity.

Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group – UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together (Public)					
Date of the meeting:	8 May 2026					
Title:	5.1 (Paper H) Guardians of Safe Working: Consolidated annual report for 2025-26					
Report presented by:	Sarika Goel (NGH) and Mustafa Raza (KGH), Guardians of Safe Working					
Report written by:	Sarika Goel (NGH) and Mustafa Raza (KGH), Guardians of Safe Working					
Action – this paper is for:	Decision/Approval		UHN Assurance	X	Update	
Which Group Priorities does this link to	Transform patient care	X	Strengthen our culture	X	Deliver our financial plan	
Where this report has been discussed previously	N/a					

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

As set out in the executive summary below. Board Assurance Framework Risk UHN18 refers: 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 sickness absence, poor staff engagement, poor retention, a negative impact on morale and potential impact on patient care.

Impact assessment

Financial:

Fines are imposed on a department when specific safe working rules are breached. The triggers for fines include:

- Exceeding the 48-hour weekly average limit
- Working more than 72 hours in any consecutive 7-day period
- Reducing the minimum 11-hour rest period to 8 hours or less
- Missing 25% of scheduled breaks within 4 weeks

Cost centres have been created to facilitate fine payment.

Legal: No contract breaches identified during the reporting period.

Equalities: No equality concerns raised during the reporting period.

Purpose of the Report

This is the first annual consolidated Guardians of Safe Working report. It seeks to provide assurance to Boards that resident doctors are safely rostered, and working hours comply with the 2016 Terms and Conditions of Service (TCS), with exception reporting monitored and well-being initiatives in place.

Recommendation

The Boards are requested to receive the report and to indicate assurance in respect of the trusts' ongoing commitment to safe working hours, proactive exception reporting, and staff well-being.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST AND UNIVERSITY HOSPITALS OF NORTHAMPTONSHIRE GROUP
BOARDS OF DIRECTORS: 8 MAY 2026

1. Background

The Guardians of Safe Working are responsible for monitoring resident doctors' working hours and ensuring they do not exceed safe limits. Exception reports are submitted when doctors work beyond rostered hours, miss breaks, or experience unsafe workloads. Analysis of these reports, alongside work schedule reviews and rota monitoring, informs actions to protect doctors and patients and ensures adherence to contractual and legal requirements.

2. Overview

Across Kettering General Hospital (KGH) and Northampton General Hospital (NGH), there is sustained progress in strengthening safe working hours governance, improving responsiveness to exception reporting, and enhancing support for Resident Doctors. Operational pressures remain significant—particularly in General Medicine and rota-dependent specialties—but both sites demonstrate proactive oversight, timely escalation, and alignment with the national 10-Point Plan to Improve Resident Doctors' Working Lives.

3. Key Activity and Trends 2025-2026

KGH

1. Recruitment of **two FY2 doctors** has reduced late finishes and improved rota resilience mainly in General surgery department.
2. Urology rota concerns regarding **Specialist Registrars' overnight rest** addressed through rota redesign and increased FY2 support.
3. **75 exception reports** submitted; **four ISC reports**, none meeting ISC criteria after review. All exception reports were related to working hours. Since August, there has been a notable reduction in the overall number of exception reports, largely due to proactive engagement with medical staffing teams, trainee and non-trainee doctors, and supervisors. By addressing key areas of concern, we have ensured rota compliance and strengthened support for doctors
4. improvements made to handover processes, ward support, and communication following escalations.

NGH

1. **671 exception reports** submitted; volume doubled over the year. This is largely attributable to rota gaps and additional hours worked by doctors. Numbers have increased since we provided access to Locally Employed Doctors.
2. **February 2026 peak (127 reports)** following extension of exception reporting to Locally Employed Doctors.
3. **FY1/FY2 doctors submitted 78%** of all reports.
4. **General Medicine** accounted for **54%** of all reports and **56%** of ISC-flagged reports.
5. **652.7 additional hours** claimed (≈16.3 working weeks).
6. **62%** resolved by payment; **24 Guardian's fines** issued.

4. ***February 2026 Exception Reporting Reforms***

1. Educational and Clinical Supervisors removed from the process.
2. Medical Staffing actions all reports under 2 hours.
3. GOSW investigates and actions all reports over 2 hours.
4. Confidentiality fines introduced for breaches.
5. Doctors can now choose payment or TOIL for additional hours.
6. Trusts must provide system access within 10 days (reducing to 7 days in August) or face a fine.
7. Reporting access extended to Locally Employed Doctors, contributing to increased transparency and reporting volume.

5. ***Common Themes***

1. Excessive working hours, late finishes, and missed rest breaks.
2. Persistent rota gaps, particularly in General Medicine, Oncology, and Haematology.
3. Inconsistent senior support on ortho-geriatric and postnatal wards, which has been addressed.
4. Teaching overruns and missed educational opportunities.
5. Barriers to exception reporting improving post reform.
6. Fatigue, burnout, and reduced morale linked to workload intensity.

6. ***Key Risks***

1. **Workforce fatigue and burnout** affecting wellbeing and retention.
2. **Patient safety risks** due to staffing gaps and delayed senior review.
3. **Rota non-compliance**, including rest requirements, leading to fines and reputational impact.
4. **Training quality concerns**, including missed SDT and reduced supervision.
5. **Financial pressures** from increased exception reporting, fines, and locum use.

7. ***Assurance Measures***

1. Strengthened Guardian visibility across clinical areas and at induction.
2. Proactive monitoring and timely resolution of exception reports.
3. Rota adjustments and improved handover processes.
4. Updated Safe Working Hours Policy reflecting TCS changes pending ratification.
5. Dedicated cost centre for Guardian's fines to ensure transparent use.
6. Collaboration with HR, divisional leads, and Medical Education to address recurring issues.
7. Planned wellbeing sessions and continued promotion of exception reporting as a safety and improvement tool.

8. **Summary**

Both KGH and NGH have demonstrated ongoing commitment to safe working hours, proactive exception reporting, and staff well-being. While systemic pressures and operational challenges persist, robust assurance processes and collaborative problem-solving are in place. Continued focus on rota management, senior support, and staff engagement — aligned with the national 10-Point Plan— is recommended to sustain compliance and promote a positive working environment for resident doctors

9. **Recommendation:** The Boards are requested to receive the report and to indicate assurance in respect of the trusts' ongoing commitment to safe working hours, proactive exception reporting, and staff well-being.

Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group – UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together (Public)					
Date of the meeting:	8 May 2026					
Title:	6.1 UHN Community Engagement Strategy 2026-2028					
Report presented by:	Suzie O'Neill, Director of Communications and Engagement					
Report written by:	Bobbie Kelly, Head of Communications and Engagement - External					
Action – this paper is for:	UHN Decision/Approval	X	Assurance		Update	
Which Group Priorities does this link to	Transform patient care	X	Strengthen our culture	X	Deliver our financial plan	
Where this report has been discussed previously	UHN Audit Committees and Integrated Leadership Team					
To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which						
The report provides assurance and mitigates several key risks, including inconsistent engagement practice across UHN, failure to meet statutory patient and public involvement duties, reputational risk from communities feeling unheard or excluded, and missed opportunities to address health inequalities. Assurance will be provided through a clear strategy and supporting Standard Operating Procedures (SOP) that set consistent controls and processes, with oversight via established committees. Regular reporting and evaluation will monitor delivery and risk, implementation will be tracked, and strengthened feedback mechanisms (including "You Said, We Did") will support continuous learning and improvement.						
Impact assessment						
Positive impact on patient and public experience, engagement consistency and compliance with statutory involvement duties. Supports reduction of health inequalities and mitigates reputational risk. No significant financial or workforce impact; activity to be delivered within existing resources.						

Purpose of the Report

This paper seeks Boards' approval of the UHN Community Engagement Strategy 2026–2028. The strategy sets out a consistent, evidence-based approach to building meaningful two-way engagement with local communities, with a particular focus on those experiencing health inequalities or barriers to access. Informed by local insight, national guidance and feedback from colleagues, Governors and partners. The strategy will be accompanied by supporting SOPs providing clear and proportionate processes for planning, delivering and evaluating engagement activity. The strategy also introduces the Community Connectors model, enabling trusted community voices to support ongoing engagement, including a proposed future role for KGH Governors following the anticipated changes to Foundation Trust governance from April 2027; engagement with Governors is ongoing.

Recommendation

The Boards are asked to **approve** the UHN Community Engagement Strategy 2026–2028, and to **note** the proposed approach to implementation and monitoring.

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Community engagement strategy 2026-2028

Our strategic approach for working together with people and communities

Dedicated to excellence

A message to our local communities

At University Hospitals of Northamptonshire, our patients, families and local communities are at the heart of everything we do. This strategy is our commitment to listening more closely, involving you earlier, and making sure your experiences lead to real improvements in care. Our goal is to build genuine two-way conversations with people and our communities.

Whether you've shared your story, taken part in a survey, attended a community event or simply told us what matters to you, your voice is helping to shape our services. Thank you for helping us make healthcare across Northamptonshire better, fairer and more responsive for everyone.

How this strategy will benefit you

- You will be able to share your views earlier, before decisions are made.
- We will keep you updated and show how your feedback has influenced change.
- Services will be designed **with** you, not just **for** you.
- Engagement opportunities will be more accessible, with online, in-person, evening and community-based options – meaning more opportunities to get involved at a time and place that suits you
- Communities who are seldom heard will receive more focused outreach and involvement.
- Your experiences will directly help shape improvements in care, access and communication.

Introduction – why this strategy matters

This Community Engagement Strategy sets out how we will build stronger, more meaningful relationships with the people and communities we serve. It brings together a shared approach to involving patients, carers, families and partners in shaping services across the University Hospitals of Northamptonshire Group. Many of our colleagues also live locally and use our services, and their lived experience is a vital part of our understanding of what our communities need.

We know that engagement hasn't always felt consistent across our hospitals. At times it has developed in pockets or in response to immediate pressures. This Strategy moves us towards a more coordinated and joined-up way of working, ensuring that feedback from local people becomes a routine, valued and influential part of how services are designed, delivered and improved.

Most importantly, this Strategy responds directly to what our communities have told us: they want to be involved earlier, communicated with more clearly, and shown how their feedback leads to real change. This document is our commitment to doing better. It provides the foundations, tools and direction to make meaningful engagement part of everyday practice, and a core element of how we improve care.

The Strategy aligns closely with our Dedicated to Excellence framework, our Group Strategic Direction and our Group Clinical Strategy, which together set out our ambition to deliver high-quality, equitable care and work more cohesively as a Group. It also reflects our role within Integrated Care Northamptonshire (ICN), recognising that by working together across the whole health and care system, we can tackle inequalities and shape services alongside the people who use them.

Who our communities are

- **Population** Over 750,000 people across Northamptonshire, including Northampton, Corby, Kettering, and Wellingborough. People live in a mixture of towns, new neighbourhoods, and rural villages.

- **Diversity** Our communities include growing Asian, Black, Mixed, and Eastern European populations (notably Polish and Romanian families), as well as established British communities.

- **Deprivation and inequalities** More than 105,000 residents live in areas among the most deprived in England. These communities face higher risks of poor health, reduced life expectancy, and barriers to accessing care.

- **Disabilities and long-term conditions** Many people live with physical, sensory, learning, or mental health disabilities. Barriers include inaccessible information, digital literacy, and environments not adapted for sensory needs.

- **Age profile** The population is ageing, with significant growth in residents aged 65+ (Kettering has the oldest profile). Our services must also meet the needs of younger families and children.

- **Access barriers** Language, culture, digital exclusion, transport, and mistrust of public institutions can all limit engagement and access to care—especially for minority ethnic groups, disabled people, carers, and those in rural areas.

- **Seldom-heard groups** Includes people experiencing homelessness, LGBTQ+ communities, refugees, and unpaid carers.

- **Our commitment** We use local data (JSNA, ONS, Core20PLUS5) and work with trusted partners to identify and prioritise communities experiencing poorer health outcomes, ensuring our engagement is inclusive, accessible, and evidence-based.

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Backgound and context

The foundations which support the development of this strategy

Dedicated to excellence

Why change is needed – what people have told us

University Hospitals of Northamptonshire NHS Group

Through a series of in-depth 1:1 interviews and engagement activities across the Group, we have heard a wide range of views from staff, partners and community representatives. The insights that emerged from these conversations centred around several recurring themes, which are summarised on this page. More detailed insights are in the Appendix.

1. We lack clear direction and consistency

Engagement varies widely across our hospitals, with activities happening in isolation rather than through shared standards or long-term plans.

2. Insights are not joined-up or easy to use

Valuable feedback exists across PALS, patient stories, surveys and listening events, but it is not held centrally. This makes it harder to spot trends, share learning or use insight effectively to inform decisions across the Group.

3. Feedback is often driven by complaints not wider engagement

Complaints remain the main route for raising issues, reinforcing a reactive culture and limiting opportunities for broader, proactive involvement.

4. Engagement is sometimes limited by resources and skills

Capacity, planning time and confidence varies across UHN, leading to engagement that can feel reactive rather than proactive.

5. Good practice exists, but it isn't always shared

Strong examples of engagement are localised, meaning learning and best practice isn't routinely shared across UHN.

6. Some communities feel unheard or underrepresented

People told us engagement does not always reach minority groups or communities affected by inequalities, and partners with trusted links are not always used effectively.

7. Engagement doesn't always lead to visible change

Feedback doesn't consistently translate into actions, and without clear "you said, we did" feedback, communities may feel their contributions are not valued.

8. Collaboration with external partners could be stronger

There are opportunities to work more closely with voluntary groups and specialist organisations, but capacity, unclear processes and competing priorities often get in the way.

9. A more coordinated, long-term and co-designed approach is needed

People want engagement to be part of everyday practice and not a 'tick-box' exercise. They emphasised the need for genuine co-design with communities, ensuring insights directly shape decisions, address long-standing issues and inform future service planning.

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Engagement positively impacts our work – Stacey's experience

Across UHN, meaningful engagement with patients, carers and communities is already driving real improvements in care, access and experience. These examples show what is possible when we listen with purpose, work alongside people with lived experience, and use insight to shape decisions. They also highlight the power of sustained relationships - with patient groups, families, voluntary organisations and community partners - in helping us understand what matters and make changes that benefit the people we serve.

The following case studies illustrate how engagement has informed service improvement, strengthened inclusion and supported better outcomes across our Group.

Deaf service user advocacy

Need / issue: Deaf patients highlighted significant barriers to communication across their care journey, affecting understanding, confidence and experience.

Who we involved: A deaf service user , Stacey, shared her lived experience through a video story, alongside service leads and Patient Experience colleagues.

What we did: The video account was reviewed with relevant teams and used to inform improvement planning, focusing on communication support and accessible information.

What changed (impact): A business case was developed to expand our interpreter provision from one interpreter to five, improving access and ensuring deaf and hard-of-hearing patients can communicate effectively during their care.

Learning / next steps: Lived-experience testimony is a powerful driver for change. We will continue to use patient stories to identify barriers, strengthen accessibility and inform improvements.

Pictured left: Service user Stacey

Engagement positively impacts our work – Kirstie's experience

University Hospitals of Northamptonshire NHS Group

Autism awareness and engagement

Need / issue: Autistic people and their families told us they face challenges when accessing hospital services, including sensory environments, communication difficulties and uncertainty about what to expect. Staff also wanted more confidence in supporting autistic patients.

Who we involved: Autistic people, parents and carers, local autism organisations, and colleagues from Kettering General Hospital's Patient Experience and Engagement teams.

What we did: We held dedicated autism awareness engagement events to hear directly from autistic people and their families about their experiences. These sessions created a safe space for honest discussion about what helps, what doesn't, and what changes would improve care. One of the participants was Kirstie, who had a positive experience when admitted to KGH's Intensive Care Unit.

What changed (impact): Staff gained a clearer understanding of autistic patients' needs, particularly around communication and sensory sensitivities. The insights collected are now informing service improvements and shaping future staff training and awareness work.

Learning / next steps: Sustained engagement rather than one-off sessions is key to building trust with autistic people and improving their experience of care. We plan to build on this work through ongoing involvement and co-design.

Kirstie: "When I came into KGH, [it was] amazing because for the first time someone had read my communication passport - they seemed to know everything about me and that wasn't because somebody had told them.

"When I woke up, I was in intensive care and I didn't know anything or what was going on. And somehow they'd already put my ear defenders on me as they had read that I didn't like loud noises."

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Pictured left: Kirstie

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Our approach and priorities

Setting a clear, consistent approach across the group and establishing our priorities

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Our vision

"We work in partnership with people and communities in Northamptonshire, especially those affected by inequalities, on issues that are important to them.

As a Group we deliver services that have been designed with and influenced by local people to better serve the people who use them. We want everyone to know how their contribution has made a difference."

Our aim

"Our aim is to consistently embed and deliver good, effective and coordinated community engagement in the way we work across UHN."

Our community engagement strategy themes

University Hospitals of Northamptonshire NHS Group

These four themes guide how we will work with people and communities across 2026–2028.

1. Embedding a consistent approach to co-production

We will work with colleagues, patients, carers, governors and communities from the start of projects, ensuring involvement is clear, proportionate and built into everyday practice.

2. Ensuring diversity and inclusion is at the core of our approach

We will actively involve underserved and marginalised groups, remove barriers to participation, and make engagement accessible through trusted relationships and inclusive methods.

3. Making best use of insight to improve health and wellbeing

We will bring together patient experience intelligence (Friends and Family Tests, compliments, complaints, PALS, surveys, patient stories) with community insight to inform decisions and shape service change.

4. Evaluating what we do, sharing learning and celebrating success

We will measure impact, share “you said, we did” outcomes, build learning into future work and celebrate good practice so that improvement is visible and continuous.

These themes underpin all of our priority programmes and ensure that engagement is consistent, insight-driven and focused on improving patient experience and reducing inequalities. These themes are explored in more detail on the following pages.

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Engagement strategy theme 1 -
Embedding a consistent approach to co-production

Definition
We will involve people and communities at the earliest possible opportunity, so their insights and lived experience shape how services are designed and improved.

Key commitments
- We will build co-production into all major programmes and service changes.
- We will use one clear, coordinated approach across UHN.
- We will ensure staff have the guidance, training and tools they need to involve people confidently and consistently.
- We will ensure community insight is considered in decision-making and governance.

What this means for people
People will have real opportunities to shape decisions before they are made, feel listened to throughout the process, and see how their voices directly influence the healthcare services they rely on.

University Hospitals of Northamptonshire NHS Group

Engagement strategy theme 2 –
Ensuring Diversity and Inclusion is at the core of our approach

Definition

We will ensure our engagement reflects the diversity of Northamptonshire by actively involving people from all of our communities.

Key commitments

- We will reach out to underrepresented, marginalised and underserved communities.
- We will make engagement accessible by offering hybrid, in-person and online sessions at times that work for people, and by providing information in formats such as BSL and easy-read. This will reduce digital and practical barriers and help more people take part.
- We will work with our trusted community and voluntary sector partners to build stronger relationships.
- We will build a diverse and representative Community Connector network.

What this means for people

People from all backgrounds will have fair, respectful and meaningful opportunities to take part in shaping healthcare services, especially those who may not have felt included before.

Engagement strategy theme 3 – Making best use of insight to improve health and wellbeing

Definition

We will bring together views and feedback from people across our hospitals, our partners and communities, so decisions are informed by real experiences and needs.

Key commitments

- We will bring insight from PALS, compliments, complaints, FFT, patient stories and surveys into a single, shared picture of what people are telling us.
- We will make insight easy for staff to access, interpret and act upon.
- We will use this insight to identify inequalities, highlight issues early and focus improvements where they matter most.
- We will share feedback openly across teams and communities to support learning and transparency.

What this means for people

People will see that feedback they share can lead to tangible improvements and change, with services becoming more responsive, more consistent and more aligned with community needs.

Engagement strategy theme 4 –
Evaluating what we do and sharing learnings and success

Definition
We will measure the impact of our engagement, learn from what works, and celebrate the positive difference people make.

Key commitments
- We will set clear aims and measures for all engagement activity.
- We will provide timely and meaningful “you said, we did” updates.
- We will capture and share learning so our engagement continually improves.
- We will recognise and celebrate colleagues, partners and community members who contribute to meaningful involvement.

What this means for people
People will know that their time and contributions matter, will see how their involvement has shaped change, and will feel confident that the organisation listens and responds.

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Objectives

What we will deliver for our communities.

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Our objectives – What we will put in place (Inputs)

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To deliver our aims we will…

Inputs

- Develop a tiered, proportionate community engagement approach across the Group by April 2026, supported by a clear operating procedure that sets expectations for using feedback, co-design and reaching underserved communities.
- Establish a robust governance structure by April 2026 to ensure:
  - Community and patient experience feedback informs decisions at the right levels
  - Consistent and effective engagement practice is embedded across all programmes
  - The Executive Team, Board, Governors and other people of influence have clearer sight of engagement activity.
- Establish (or refresh) group-wide policies and procedures to ensure a consistent approach.
- Identify a Senior Responsible Officer to oversee effective planning, delivery and use of all community engagement activity across the Group.
- Refresh the Patient Engagement Pool and Members groups, and promote how people can get involved to increase numbers and diversity.
- Establish a UHN Community Connector Network made up of Governors, Patient Experience Group members, volunteers, VCSE partners, faith groups and community stakeholders, and provide a simple, shared process for gathering community feedback, sharing themes, and helping us maintain a real-time understanding of patient and public sentiment.

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Our objectives – What we will deliver (outputs)

University Hospitals of Northamptonshire NHS Group

Outputs

- Publish twice-yearly Community Engagement Delivery Plans with clear priorities and named owners. Plans to be monitored through the UHN engagement group with progress and key issues reported to the People Committee for assurance.
- Produce ‘You said, we did’ updates within 8 weeks of major engagement activity.
- Continue to provide a quarterly Patient Experience Repot (PEX) to the Quality and Safety committee, bringing together themes and trends from FFT, PALS,, Complaints, Compliments and patient stories, with actions tracked through existing governance routes.
- Publish an annual Community Engagement Impact Report showing how people’s feedback has shaped decisions and improved care.
- Implement a standard evaluation framework for all engagement activity, supported by simple SOPs so teams can apply it consistently.
- Embed Patient Engagement Pool members, Community Connectors and community partners early in all priority programmes.
- Deliver a rolling “Talks” programme, offering accessible virtual sessions led by UHN experts or trusted guest speakers/partners.

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Our objectives – What we will achieve (outcomes)

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Outcomes

- Clear evidence that community feedback shapes decisions at project and strategic levels.
- Improved patient experience, with measurable changes linked directly to what people tell us.
- Greater reach into underserved communities, helping reduce health inequalities.
- Increased trust and confidence, with communities feeling heard, valued and acted upon.
- Stronger governance, transparency and accountability in how we involve and listen to people.

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Community Connectors

We already have a strong network of Governors, Patient Engagement Pool members, volunteers, VCSE partners, and faith and community representatives who help UHN understand what life is really like for people across Northamptonshire.

We will bring this network together as Community Connectors - people who are already part of local conversations and trusted within their communities. The Community Connectors help us hear what people are saying in their own words: their experiences, their worries and their everyday realities. These conversations matter, as they help us to build trust, uncover things people won't put in an online form or survey, help prevent problems early, make people feel valued, and show us what really matters.

What Community Connectors do:

- Amplify community feedback, gather what people are saying about care, access, communication and barriers.
- Act as trusted bridges to share community perspectives with UHN, and take updates back into their networks.
- Support outreach by attending local events, listening sessions, forums and cultural or faith-based groups.
- Spot inequalities early, highlighting emerging issues affecting seldom-heard or marginalised communities.
- Feed insight into programmes and share feedback to inform service design, improvement and decision-making.

How it works:

- Connectors gather community feedback using a simple insight form.
- Insight is combined with PALS, FFT, complaints and patient stories to build a real-time picture.
- The Engagement Team provides support, including briefings, training, a named contact and quarterly updates.
- Themes are reported regularly to Trust Boards, Governors, Patient Experience groups, programme leads and service teams to shape decisions.

Outcome:

- A richer, real-time understanding of community mood and needs, helping improve trust, inclusion, patient experience and decision-making across UHN.

Our priorities and where we will focus engagement

University Hospitals of Northamptonshire NHS Group

Our Group ambitions

- Excellent patient experience shaped by the patient voice
- An inclusive place to work where people are empowered to make a difference
- Outstanding quality healthcare underpinned by continuous, patient-centered improvement and innovation
- Seamless, timely pathways for all people's health needs, working with our partners
- A resilient and innovative University Hospital Group, embracing every opportunity to improve care.

Where we will focus engagement

We will prioritise programmes involving:

- Major pathway or service change
- Group Clinical Strategy delivery
- Estates and digital transformation
- Programmes targeting inequalities or access barriers

Our expectations for these programmes

- Use existing insight to inform planning
- Involve Community Connectors, governors, patient representatives and community partners early
- Consider potential impact on health inequalities as part of decision-making
- Embed co-design and accessible engagement methods throughout
- Show clearly community insight has shaped decisions and outcomes

All engagement activities will follow clear rules: use existing insight, involve connectors early, consider health inequalities, and show how feedback shapes outcomes. This ensures that the programmes with the greatest impact on local people are shaped by those who use and rely on our services.

Important note: Engagement activities support early understanding and help shape proposals, but they do not replace any formal statutory consultation where this is required (please see next page for further details).

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When formal consultation is required

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When planning changes to services, we follow NHS England guidance to help us understand when formal consultation is needed. A service change means any change to how, where or when services are provided, or how patients access our care.

The guidance explains that:

- NHS commissioners and providers have a responsibility to involve people and work with local authorities when planning and delivering service changes.
- The guidance does not set a fixed definition of a “substantial” service change. We work with the relevant local authority to agree whether formal consultation is required and keep them involved throughout the change process.
- Changes to how or where healthcare services are provided – including service closures or a change of location – are normally considered substantial and require formal consultation.
- Effective service change involves early and ongoing conversations with patients, the public, staff, clinicians, neighbouring NHS organisations and local authorities.

All service change is considered against the Government’s four tests:

- Strong public and patient engagement
- Consistency with patient choice
- A clear clinical evidence base
- Support from clinical commissioners

Where formal consultation is required, the Trust will run a clear, structured and time-limited process to explain proposed changes, listen to the views of patients, colleagues and stakeholders, and use this feedback to help inform final decisions.

Reference: NHS England – Planning, assuring and delivering service change for patients.

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Evaluation

Measuring the impact and outcomes of our community engagement

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Evaluating our community engagement

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We currently evaluate our community engagement using a range of insight and reporting processes which together give us a consistent picture of patient experience, issues and actions across UHN.

We will strengthen this further so evaluation is clearer, more inclusive and more transparent.

How we evaluate now

- Our Friends and Family Test results, Divisional Packs and the Quarterly Patient Services Report help us monitor trends and track improvement.
- These reports provide assurance to the Patient & Carer Experience and Engagement Committee (PCEEC), the Nursing, Midwifery and Allied Health Professionals Committee (NMAHP), and the Clinical Quality and Safety Committee in Common (CQSCiC), highlighting where further engagement or action is needed.
- Insight from PALS, complaints, surveys and patient stories already informs our quality, safety and experience discussions.

How we will strengthen our evaluation

University Hospitals of Northamptonshire NHS Group

1. Clear objectives, metrics and plans

- We will set clear SMART objectives and success criteria for engagement activities.
- We will agree KPIs to measure outcomes such as participation, inclusivity, experience and demonstrable change.
- We will track delivery against our objectives.

2. Collecting feedback that matters

- We will gather structured feedback through post-engagement surveys and interviews.
- We will build ongoing feedback loops through the Patient Engagement Pool, community partners and Community Connectors.

3. Bringing insight together

- We will improve how insight is combined to provide a single, coherent picture of what people are saying.
- We will increase visibility of what has changed as a result of engagement.
- We will check regularly how inclusive our engagement is and who we are not reaching.

How we will strengthen our evaluation

University Hospitals of Northamptonshire NHS Group

4. Analysing data for impact

- We will review demographic participation data to understand representation.
- We will link engagement insight to changes in experience, safety and access.
- We will identify themes that indicate early risks, gaps or inequalities.

5. Benchmarking and continuous learning

- We will benchmark our activity, inputs and outcomes annually to identify strengths and gaps.
- We will use lessons learned to refine our processes, strengthen engagement design and improve digital reach.

What this means for people

- People will see clearer evidence of how their involvement influences decisions, and they'll know their feedback leads to transparent learning, improvement and accountability.

How we will measure our impact

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Reach and inclusion

We will assess whether engagement is reaching the people who most need to be heard.

Community reach in areas of highest deprivation (measured as % of total participants) and proportion joining via non-digital routes.

Year-on-year increase in participation from underserved groups.

Proportion of identified access barriers addressed through specific actions.

Influence on decisions and pathways

We will measure how insight shapes design and decision-making.

Proportion of care pathway projects with early community involvement.

Number of programme decisions supported by "you said, we did" evidence.

Reduction in redesign/rework caused by late engagement.

Quality and consistency of engagement

We will monitor whether engagement is well-planned and aligned to our UHN approach.

Completion rate of priority engagement plans.

Proportion of engagement activities aligned with the UHN SOP.

Number of expert-led talks delivered per year, with schedule and attendance tracked.

Partnerships and system impact

We will measure how we work with partners to improve equity and outcomes.

Number of initiatives delivered with VCSE and community partners.

Reduction in key access disparities informed by data (e.g. wait times, uptake).

How you can get involved

You can get involved by:

- Joining our Patient Engagement Pool or Volunteer team
- Becoming a Community Connector
- Taking part in surveys and listening sessions
- Following us on social media
- Attending our expert talks and events
- Sharing your experiences with our teams and partners.

Please contact our communications team to register your interest (new contact details and web page to follow).

Contact:

- **Northampton** – Email: ngh-tr.communications@nhs.net or telephone: 01604 545372
- **Kettering** – Email: kgh-tr.Comms@nhs.net or telephone: 01536 491770.

Please note, the team are available Monday to Friday during office hours.

Appendix

Our place in the wider healthcare system

The NHS has a clear expectation that people and communities should play a central role in shaping the services they use. This Strategy reflects that responsibility and aligns with the national and local frameworks that guide how we work.

National duties and expectations

The Health and Care Act 2022 introduced a duty on all NHS organisations to consider the impact of decisions on:

- the health and wellbeing of local people
- the quality of services
- the sustainable use of NHS resources

It also emphasises collaboration over organisational boundaries, ensuring decisions are made with a wider population in mind rather than in isolation.

In addition, NHS England's Working in Partnership with People and Communities guidance sets out 10 principles for high-quality involvement. These principles, including listening well, working inclusively, building trust, and showing how feedback makes a difference, underpin the approach in this Strategy.

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Our role within Integrated Care Northamptonshire (ICN)

University Hospitals of Northamptonshire NHS Group

Working together for better health and care across the county

Integrated Care Northamptonshire (ICN) brings together NHS organisations, local authorities and voluntary organisations, local Healthwatch, community, faith and social enterprise partners to improve health and wellbeing across the county. These relationships have supported the development and delivery of services and care pathways for many years and are central to how we work as a system.

A shared approach to community engagement

ICN has co-produced a county-wide Community Engagement Framework with partners and community representatives. The framework sets a shared vision, common ambitions and priority actions so engagement is consistent, coordinated and inclusive.

We were pleased to have contributed to the development of the framework. Our Strategy builds on that shared work and translates it into a clear, consistent approach for UHN, with practical actions tailored to our hospitals and the communities we serve.

How UHN will put this into practice

- **Align our approach:** We will align our engagement practice with the ICN framework so it is consistent and inclusive across our hospitals
- **Share and use insight**: We will share feedback and contribute our learning to build a shared picture of community needs
- **Plan together**: We will coordinate activity with system partners to reduce duplication and reach communities who are less often heard
- **Embed co-production:** We will make involvement and co-design part of everyday practice across services at UHN.

Why this matters for our communities

Working together with ICN will ensure that people across Northamptonshire have more joined-up, accessible and meaningful opportunities to share their experiences, influence decisions and help shape local health and care, wherever they live and whichever organisation is supporting them.

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A SWOT analysis of our current community engagement approach

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Strengths	Weaknesses
Effective use of patient stories and experiences are driving some improvements	A lack of a unified, overarching engagement strategy and clear objectives for community engagement
Initiatives like the Patient Engagement Pool are supporting broader engagement activities across services and enable a more diverse range of views	Leadership and governance structures for community engagement are unclear, leading to decisions not necessarily being informed by the full range of insights and inconsistent approaches in decision-making
There is a resource in the data and insights collected by PALS in both Trusts that could be harnessed more strategically to drive Group-wide improvements	The lack of clarity on approach and governance structures for engagement also leads to inconsistencies in providing 'you said, we did' feedback. This demotivates people from participating in future engagement activity as they don't feel heard
There are examples of successful partnerships with external stakeholders, such as Northamptonshire Carers, charity groups and GPs, which could be harnessed to address and/or support broader community engagement needs	Engagement is often seen in the context of complaints and responded to defensively rather than used as an opportunity for making improvements
Engagement tools like the Friends and Family Tests (FFT) are well-received and provide data and insights to guide actions and decision-making	Lack of adoption of the ICN community engagement framework and resources limits engagement efforts, and insights from across the system aren't being effectively utilised
Opportunities	**Threats**
A central record of Group engagement activity and insights, with clear accountability for its upkeep and deployment in decision-making, would help to ensure learning is held centrally and used effectively (while also contributing to and utilising the ICN insights library)	Resource constraints, including staff capacity and skills, and funding for engagement activity. Resource is needed to plan, prepare and deliver activity but also to follow through afterwards to make sure outputs are considered wisely in the shaping of decisions and outcomes, and 'you said, we did' feedback is shared with participants
Expand outreach to underrepresented communities (for example, Black, Asian, and minority ethnic groups) to foster co-design of services with the community for inclusive solutions to service challenges	Rising costs of living and persistent deprivation in certain areas may worsen health outcomes and complicate efforts to engage affected communities
Projects such as Well Northants involve communities in decision-making, fostering trust and engagement and present an opportunity – collaboration with voluntary, private, and local government sectors could expand resources, create innovative solutions for addressing inequalities, and help to co-ordinate activity with VCSEs so individual organisations and community groups are not overwhelmed with requests	Mistrust in public institutions, particularly among marginalised communities, can create barriers to effective engagement. In addition, this mistrust may mean that these communities, may not currently feel included or represented in engagement efforts, which can lead to a reluctance to seek medical advice and treatment
There is opportunity to create more engaging resources and develop more creative ideas to enhance community engagement efforts	Rural and underserved areas face difficulties in accessing healthcare services, limiting the reach of engagement efforts

UHN gap analysis against the 10 Principles for Working with People and Communities

University Hospitals of Northamptonshire NHS Group

NHS England principle	Current UHN position	Gap / compliance issue	Workstream
1. Listen to and understand people and communities	Strong Friends and Family Test (FFT) data, patient stories, PALS/complaints handled well, some thematic listening reported	Feedback not consolidated, no single system for sentiment tracking, engagement not routine across all divisions and hospitals	Insight and reporting
2. Start engagement early	Some early involvement but varies by programme and service – not standardised. Regular local engagement at KGH from estates team	Engagement often begins after service design starts, rather than being co-produced	Co-production
3. Work with communities, using their strengths	Chaplaincy, voluntary sector links, Governor outreach	Community Connector Network not in place, under represented communities not consistently reached	Inclusive engagement
4. Understand different needs and tailor approaches	Accessibility support often present (good digitally), interpreters used where possible, examples of autism-sensitive work	Accessible information standard compliance inconsistent, materials not always accessible	Inclusive engagement
5. Work in partnership across systems	Engagement connected to ICN	ICN insight library not routinely used, inconsistent cross-system collaboration, silo working	Insight and reporting
6. Share information transparently	FFT, divisional packs and quarterly reports shared internally, external sharing via media and website of some stories	'You Said We Did' not routinely shared in a timely manner	Evaluation and feedback
7. Work with people and communities to set priorities	Some priorities shaped by insight – ie accessibility, autism, deaf services	Community-led priority setting – what do the community need?	Co-production
8. Provide feedback to people on how involvement made a difference	Happens sometimes but not consistent	No system to track feedback loops or You Said We Did feedback	Evaluation and feedback
9. Evaluate involvement	Quarterly Patient Services report includes some evaluation – collaborative report includes PALS, bereavement and complaints	No standard evaluation framework	Evaluation and feedback
10. Build involvement into organisational culture	Good intent and local champions, pockets of great activity	Not yet embedded via SOPS, governance or training	Co-production

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Ends

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