

UHN and UHL Boards of Directors Meeting in Public

Thu 09 April 2026, 13:30 - 16:30

Seminar Rooms 2&3, Clinical Education Centre, Glenfield Hospital, Leicester,

Agenda

13:30 - 13:35
5 min

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

Andrew Moore

 1.0 Final public Boards in common Agenda 9 April 2026.pdf (2 pages)

1.1. 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 Meetings held on 6 February 2026 (UHN) and 12 February 2026 (UHL)

Decision Andrew Moore

Papers A-B

 1.4 Paper A 060225 Draft Minutes UHN Public Board of Directors meeting.pdf (15 pages)

 1.4 Paper B TB public mins 12.02.26.pdf (10 pages)

1.5. Action Logs

Information Andrew Moore

 1.5 Paper C Consolidated Public Boards actions 090426.pdf (3 pages)

13:35 - 15:25
110 min

2. Standing Items

2.1.

Group Chair's report (verbal)

Information

Andrew Moore

2.2.

Group Chief Executive's Report

Information

Richard Mitchell

 2.2 Paper D UHL UHN board report CEO April 2026.pdf (4 pages)

2.3.

Integrated Performance Reports (IPR - UHN 2.3, UHL 2.3.1)

Assurance

Richard Mitchell

13:55-14:40

-  2.3 Paper E Feb 2026 UHN Integrated Performance Report Cover Sheet Board.pdf (3 pages)
-  2.3 Paper E Appendix 1 Feb 2026 UHN Integrated Performance Report Board.pdf (69 pages)
-  2.3 Paper E Appendix 2 UHL UHN IPR alignment approach.pdf (1 pages)
-  2.3 Paper E Appendix 3 Q3 NOF ratings - KGH, NGH & UHL.pdf (2 pages)

2.3.1.

UHL IPR

Assurance

Helen Hendley, UHL Chief Operating Officer

-  2.3.1 Paper E2 Updated - UHL IPR Executive Summary February 2026.pdf (8 pages)
-  2.3.1 Paper E2 UHL Oversight Framework Metrics February 2026.pdf (3 pages)
-  2.3.1 Paper E2 Updated - Integrated Performance Report February 2026.pdf (52 pages)

2.4.

Board Committee Escalation reports

Assurance and Decision

Committee Chairs

14:40-15:10

2.4.1.

UHL Quality Committee – Feb & March (F1-F2)

-  2.4 Paper F1 QC Escalation Report Public February 2026 (1).pdf (1 pages)
-  2.4 Paper F1 QC escal report 26.2.26 (1).pdf (3 pages)
-  2.4 Paper QC Escalation Report Public March 2026.pdf (1 pages)
-  2.4 Paper F2 QC public escalation 26.3.26.pdf (2 pages)

2.4.2.

UHN Quality and Safety Committee (25 March 2026)

-  2.4 F3 UHN Quality and Safety Committee report to Boards 090426.pdf (3 pages)

2.4.3.

UHL Finance and Investment Committee (February and March)

-  2.4 Paper F4 FIC Escalation Report Public February 2026.pdf (1 pages)
-  2.4 Paper F4 FIC public 25.2.26.pdf (1 pages)
-  2.4 Paper F5 FIC public 25.3.26.pdf (2 pages)
-  2.4 Paper F5 FIC Escalation Report Public March 2026.pdf (1 pages)
-  2.4 Paper F5 FIC ToR - to be appended.pdf (4 pages)

2.4.4.

UHL Operations and Performance Committee (26 February, 26 March to follow)

-  2.4 Paper F6 UHL - UHN OPC escal report cover.pdf (2 pages)
-  2.4 Paper F6 OPC public 26.2.26.pdf (3 pages)
-  2.4 Paper F7 UHL OPC Escalation Report - Cover.pdf (1 pages)
-  2.4 Paper F7 UHL OPC public 26.3.26.pdf (3 pages)

2.4.5.

UHN Finance, Investment and Performance Committee (24 February and 31 March 2026)

-  2.4 Paper F8 UHN Finance Investment and Performance Committee report to Boards 090426.pdf (2 pages)
-  2.4 Paper F8 UHN Finance Investment and Performance Committee report to Boards March 2026.pdf (2 pages)

2.4.6.

UHL Our Future Hospitals and Transformation Committee (February and March 2026)

-  2.4 Paper F9 OFHTC Escalation Report - Cover.pdf (1 pages)
-  2.4 Paper F9 OFHTC public escalation 25.2.26.pdf (2 pages)
-  2.4 Paper F10 OFHTC Escalation Report - Cover.pdf (1 pages)
-  2.4 Paper F10 OFHT committee escalation report (Mar).pdf (4 pages)

2.4.7.

UHN Strategy, Digital and Transformation Committee (26 March 2026)

-  2.4 F11 UHN Strategy Transformation and Digital Committee report to Boards 090426.pdf (1 pages)

2.4.8.

UHN People and Culture Committee (March 2026 - to follow)

-  2.4.8 F12 - PCC Escalation report - 26 March 2026.pdf (3 pages)

2.4.9.

UHL Audit Committee (March 2026)

-  2.4 Paper F13 Public UHL Audit Committee escalation report.pdf (5 pages)
-  2.4 F13 UHL TB declarations of interests 2026-27.pdf (3 pages)
-  2.4 Paper F13 - UHL TB Sealings - Quarter 4 2025-26.pdf (2 pages)

2.4.10.

UHN Audit Committees (25 February and 11 March 2026)

BREAK 15:10-15:25

-  2.4 F14 Audit Committees report to Boards 090426.pdf (2 pages)

15:25 - 15:55

30 min

3.

High Quality Care for all

3.1.

Perinatal reports and dashboards

Assurance *Julie Hogg and Danni Burnett*

15:25-15:45

-  3.1 Paper G 2026_04_09 UHL_UHN_Board of Directors_Perinatal Report.pdf (11 pages)
-  3.1 Appendix UHL Perinatal Scorecard_February_2026_Final.pdf (23 pages)
-  3.1 Appendix UHN Perinatal Scorecard_February_2026_Final.pdf (21 pages)

3.2.

KGH Maternity and Neonatal Intensive Support Team Programme

Assurance *Julie Hogg and Danni Burnett*

15:45-15:55

15:55 - 16:25

30 min

4. Research and Education Excellence

4.1.

East Midlands Regional Research Development Network report (RRDN)

UHL Assurance

Gang Xu

15:55-16:10

 4.1 Paper I RRDN Update - cover.pdf (5 pages)

 4.1 Paper I Appendix 1 - EM RRDN - Finance Update Host Governance Group March 26.pdf (2 pages)

 4.1 Paper I Appendix 2 - EM RRDN Risks & Issues Register.pdf (2 pages)

4.2.

Research and Innovation Report

Assurance

Nigel Brunskill

16:10-16:25

 4.2 Cover Paper J R&I UHL UHN board template April 20226.pdf (2 pages)

 4.2 UHN UHL Group R&I Report Apr 2026.pdf (6 pages)

16:25 - 16:30

5 min

5. Corporate Trustee Business (UHL)

5.1.

Charitable Funds Committee Escalation report (UHL)

 5.1 Paper K CFC Public Escalation Report 20.02.26.pdf (4 pages)

**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 9 APRIL 2026 FROM 13:30-16:30 IN SEMINAR ROOMS 2 AND 3,
CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL, LEICESTER**

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	Apologies for absence	Verbal	Andrew Moore, Group Chair	For noting	13:30
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.				13:30
1.3	Declarations of Interest	Verbal	Andrew Moore, Group Chair	For noting	13:30
1.4	Public Boards' Minutes: 6 February 2026 – UHN 12 February 2026 - UHL	A B	Andrew Moore, Group Chair	For approval	
1.5	Action Logs	C	Andrew Moore, Group Chair	For receipt	
2	Standing items				
2.1	Group Chair's report	Verbal	Andrew Moore, Group Chair	For information	13:35
2.2	Group Chief Executive's report	D	Richard Mitchell, Group CEO	For information	13:45
2.3	Integrated Performance Reports	2.3 / E1 (UHN) 2.3.1 / E2 (UHL)	Richard Mitchell, Group CEO	For Group assurance	13:55
2.4	Board Committee Escalation reports Escalation Reports (<i>group together</i>): - UHL Quality Committee – 26 February & 26 March 2026 (F1-F2) - UHN Quality and Safety: 25 March 2026 (F3) - UHL Finance and Investment Committee – 25 February & 25 March 2026 (F4 and F5) - UHL Operations and Performance Committee – 25 February (enclosed) & 25 March 2026 (to follow) (F6-F7) - UHN Finance, Investment and Performance: 24 February and 31 March 2026 (F8)	F1-F14	Board Committee Chairs	For review and assurance, and approval of any recommended items.	14:40

Item No:	Item:	Paper ref:	Lead:	Purpose of report:	Timing:
	6. UHL Our Future Hospitals & Transformation Committee – 25 February & 25 March 2026 (F9-F10) 7. UHN Strategy, Transformation and Digital: 26 March (F11) 8. UHL People and Culture Committee – March 2026 (F12 to follow) 9. UHL Audit Committee – 16 March 2026 (F13) 10. UHN Audit Committees – 25 February and 11 March 2026 (F14)				
	BREAK				15:10
3	High Quality Care for All				
3.1	Perinatal report and dashboards	G	Julie Hogg, Group Chief Nurse	For Group assurance	15:25
3.2	KGH Maternity and Neonatal Intensive Support Team Programme	H	Julie Hogg, Group Chief Nurse	For KGH Assurance	15:45
4	Research and Education Excellence				
4.1	East Midlands Regional Research Development Network report (RRDN)	I	Gang Xu, UHL Medical Director	For UHL assurance	15:55
4.2	Research & Innovation report	J	Gang Xu, UHL Medical Director Hemant Nemade, UHN Medical Director	For Group assurance	16:10
5	Corporate Trustee Business (UHL)				
5.1	Charitable Funds Committee escalation report - UHL	K	Tom Robinson, CFC Chair	For UHL assurance	16:25
6	Any Other Business				
7	Questions from the Press and Public				
8	Date and Time of Next Meeting				
	The next Public Boards meeting will be held on Friday 8 May 2026 at Northampton General Hospital				

Minutes of the Meeting

Meeting	Boards of Directors of the University Hospitals of Northamptonshire NHS Group (UHN) comprising Northampton General Hospital (NGH) and Kettering General Hospital (KGH) Meeting together in Public	
Date & Time	6 February 2026, 12:30-15:15	
Location	Boardroom, Kettering General Hospital	
Purpose and Ambition		
The Boards are accountable to the public, stakeholders and KGH Council of Governors to formulate the UHN Group’s strategy, ensure accountability and shape the culture of the group. The Boards delegate authority to Committees to discharge their duties effectively and these committees escalate items to the Boards where decision making, assurance and direction is required.		
Attendance	Name and Title	
Present		
	Andrew Moore	Trusts’ Chair
	Richard Mitchell	Chief Executive, UHN/UHL
	Laura Churchward	Chief Executive, UHN
	Alice Cooper	Non-Executive Director
	Polly Grimmett	Director of Strategy
	Jill Houghton	Non-Executive Director
	Denise Kirkham	Non-Executive Director
	Paula Kirkpatrick	Chief People Officer
	Will Monaghan	Chief Digital Information Officer
	Hemant Nemade	Medical Director
	Sarah Noonan	Chief Operating Officer
	Suzie O’Neill	Director of Communications and Engagement
	Trevor Shipman	Vice-Chair and Non-Executive Director
	Sarah Stansfield	Chief Finance Officer
	Caroline Stevens	Non-Executive Director
	Becky Taylor	Director of Continuous Improvement
	Damien Venkatasamy	Non-Executive Director
	Chris Welsh	Non-Executive Director
In Attendance		
	Caroline Ashby	Senior Business Manager (Item 2)
	Simon Baylis	Lead Governor (KGH)
	Danni Burnett	Director of Midwifery (Deputy for the Chief Nurse)
	Richard Clarkson	Associate Chief Nurse (Deputy for the Chief Nurse)
	Susan Clennett	Deputy Director of Risk and Legal Affairs (Item 17)
	Richard May	Company Secretary
	Luke Sullivan	Freedom to Speak Up Guardian (Item 15)
	Jason Summerfield	Head of Facilities (Item 2)
Apologies for absence		

	Simon Gay	Non-Executive Director
	Julie Hogg	Chief Nurse

Item	Discussion	Action Owner
1	Welcome, Apologies and Declarations of Interest The Chair welcomed colleagues and guests to the meeting, and noted apologies for absence as listed above. There were no declarations of interest relating to specific agenda items.	
2	Armed Forces Network The Boards welcomed Jason Summerfield, Head of Facilities and an armed forces veteran, to present slides briefly outlining the achievements and status of the network. The presentation showcased the National Armed Forces Healthcare Training and Education Programme, explaining the legal duties of UHN under the Armed Forces Covenant, the demographics and specific healthcare needs of serving personnel (it was estimated that over 25,000 people in Northamptonshire had served in the British Armed Forces), veterans and their families (this aspect was often overlooked), and the importance of recognising and recording Armed Forces status to reduce inequalities and improve personalised care. It outlined the five training modules available to NHS staff, highlighted current gaps and risks within UHN, showcased a patient story to illustrate the impact of effective identification and tailored pathways, and set out actions for Trusts to strengthen training, care pathways, data recording and staff awareness to meet statutory responsibilities and enhance outcomes for the Armed Forces community. Support for staff within Armed Forces communities formed a dedicated workstream within the Network. The Vice-Chair and non-executive lead for the Network emphasised that Armed Forces issues often sat “under the radar” within NHS organisations, despite contractual obligations and the statutory requirement to have due regard to the needs of serving personnel, veterans and their families. He noted that there were alternative clinical pathways, some of which are bespoke for specific conditions, and stressed the importance of ensuring staff were aware of these options. National data collection on Armed Forces indicators was expected to commence next year. The Medical Director and Chief Digital Information Officer agreed to 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. The rationale for, and need for bespoke pathways, should be articulated more clearly to staff, supported by case studies to aid understanding. The Chief People Officer paid tribute to Jason and to Caroline Ashby for their leadership and energy in driving this agenda forward, noting	HN/WM

	the Trust's achievement of Gold Award Employer Accreditation. The next steps for the trusts were to further embed this work across specific service areas and determine priorities for rollout. In response to a query, Boards were advised that, although current links into training schools were limited, this was an important development opportunity, and the Chief Nurse would be requested to engage with the education teams and local universities to strengthen collaboration. The Boards endorsed the work to date and reaffirmed its commitment to support the Armed Forces community, including ensuring equitable treatment in recruitment processes and recognising the implications for reservists and cadets. The Director of Communications and Engagement undertook to a statement to articulate this commitment. The Boards thanked the team for the presentation, noting its value and the insights it provided.	JH SON
3	Minutes of the last meeting held on 5 December 2025 and Action Log The Minutes of the meeting of the Boards of Directors of Kettering General Hospital (KGH) and Northampton General Hospital (NGH) held on 5 December 2025, were approved as a correct record. The midwifery vacancy figure stated for KGH as queried (this was subsequently confirmed to be correct). The Boards noted the action log, actions on which were closed or not yet due.	
4	Chair's Report The Chair reported continuing significant and concerning financial deficits, which would continue into future financial years. The Chair emphasised the need to instil confidence in the organisation's ability to deliver its plans, noting that successful management of the deficit required sustained attention to operational fundamentals, full delivery of the Cost Improvement Programme (CIP), and the development of strategic solutions to address underlying structural issues. These aspects would be essential to achieve progress at greater pace and scale. The Chair reflected on recent learning from other organisations, including a half-day session and visit to University Hospitals Bristol the previous week. Their experience demonstrated how streamlining governance processes had contributed to meaningful progress, and the Chair highlighted the value of learning from such approaches. Effective mechanisms for colleague feedback were identified as critical, providing clear evidence of how staff were feeling and allowing the organisation to design and implement appropriate responses. The Chair also drew attention to a recent case in which patients who had received care from a surgeon at Great Ormond Street Hospital had experienced harm, describing the findings as shocking and a reminder of the importance of strong feedback loops and prompt, decisive action in response to concerns.	

	The Boards were informed that the Government's cancer plan had now been published, including a commitment for all cancer patients to be offered genetic testing to support drug-matching and personalised treatment. The Chair noted that personalised medicine represented a significant opportunity for improved outcomes and highlighted the importance of the Trusts keeping pace with such developments and the wider use of emerging technologies.	
5.	UHN Chief Executive's report The Boards noted the UHN Chief Executive's written report and were advised that, whilst winter pressures on emergency departments remained severe, overall performance was much improved compared to the previous winter on account of the measures put in place to improve flow into and through the departments. The Boards recognized and commended this progress.	
6.	Integrated Performance Report (IPR) and Board Committee Summaries Executive leads drew the following significant items to the Boards' attention from the IPR document set out in the agenda pack: <i>Safe, Caring and Effective Domains (Director of Midwifery and Medical Director)</i> • Friends and Family Test (FFT): Performance was strong overall; however, issues were noted in the KGH Emergency Department (ED) and NGH Maternity, partly attributable to ED data-classification issues and winter overcrowding. • Complaints (NGH): A significant compliance gap remained, with 32 complaints over 60 days. A recovery plan was in place, with teams now working cross-site to strengthen resilience. New processes would ensure that faster responses were not detrimental to their quality. The Patient Experience team restructure and associated recruitment was complete; improvement was anticipated. • Infection Prevention and Control (IPC): The KGH C-Difficile position was being addressed through training and enhanced reporting. Performance and associated risks continued to be monitored by the IPC Committee. • Pressure Ulcers: Rates remained within expected variation; however, risks persisted relating to frailty, acuity and extended lengths of stay. • Moderate and Severe Harms: The position was stable. Boards noted a recent incident where 242 external and 75 internal immunology results had been misdirected; 16 positive results were undergoing risk assessment. No moderate or severe harms had been identified to date; the matter remained under review by the Quality and Safety Committee. • Mortality: All domains showed below expected levels except KGH (as expected). NGH data issues would temporarily raise HSMR (Hospital Standardised Mortality Rate), although the Summary Hospital-level mortality indicator was expected to	

	remain stable. The issue related to changes to reporting requirements which were applied before being paused. <i>Responsive Domain (Chief Operating Officer)</i> <i>Urgent and Emergency Care (UEC)</i> Broadly continued improvement was shown in average ambulance handover times. Average ambulance handovers had reduced by 50-60 mins across November and December compared to 2024. NGH ranked 28th out of 32 Acute sites regionally in June 25, reaching second place in early December; this represented an improvement of 4,400 in lost hours for the local health system in December 2025 compared to 2024. Ambulance conveyances had increased, with NGH variance of 14% and KGH 7% in December compared to the previous year. Four hour wait standard – continued to be met at KGH with a 2% decrease at NGH. This was seasonally expected. ‘Sprint’ initiatives were in development to improve performance before the end of the financial year. Average length of patient stay showed an improved position in December across many metrics, which was expected over the Christmas period. Adult occupancy was 92% at NGH before Christmas, compared to 97% in 2024. <i>Elective Care</i> No waits for treatment above 65 weeks were reported between September and December, with one case anticipated in January. Only four trusts were in this position in the region and only two trusts had one cases, including KGH. The trusts remained on track to deliver 52-week performance standard and the ‘sprint’ initiative’ during quarter four would further support this. Aggregate referral to treatment (RTT) performance remained fairly similar to previous reporting periods. There was increasing collaboration across sites, with 1,433 patients transferring to enable timely treatment. KGH has the sixth best RTT position in the region. The waiting list reduced by 1,600 in January due to outsourcing and validation in Dermatology. NHSE had launched ‘sprint’ initiatives which aimed to increase activity and performance by 31 March 2026. The sprints were focused on first outpatient appointments and fewer patients waiting over 52 weeks for treatment. Plans were in place to engage with these sprints and maximise the opportunities they presented. <i>Cancer treatment</i> Data showed an improved position across the three standards at NGH, notably in Dermatology. The deterioration seen at KGH in performance	

	against the Faster Diagnosis Standard was attributable to a recording change in Breast. Changes to one stop services would take effect in February, following which improved performance was anticipated. Many of the performance challenges during the year were attribute to demand and capacity within Skin and Breast services. For Skin, a number of actions had been taken and were now driving improvement: for example, performance against the faster diagnosis standard improved by 30% between October and November. The actions included: • Staffing restructure of roles, many of which have been appointed to and are beginning to bring additional capacity onboard. • Patient transfers • Additional Waiting List Initiatives • External funding for outsourcing to treat 1,600 patients in quarter four, and to support weekend insourced clinics for over 600 patients. In Breast services, the capacity challenge remained. The KGH One-stop model had been reviewed, as there were a number of on the day cancellations, and would be relaunched 1 February to address this. The Mastalgia pathway had been introduced at KGH, to manage the number of urgent referrals and would be extended to NGH. The national team has provided recovery funding for additional clinics and lists. <i>Use of Resources Domain (Chief Finance Officer)</i> • Month 9 Position (31 December 2025): This showed a £39.1m deficit, which was £21m adverse to plan due to higher efficiency requirements and challenges recruiting to key specialties. £1.7m of industrial action costs would be shown in the Month 10 position. • Deficit Support Funding (DSF): DSF for quarter four (January to March 2026) had been withheld based on Quarter Three performance; this affected the year-end outturn and cash positions and also the 2026-27 plan. Cash flow mitigations were in place and would continue in the short term until cash support for February and March had been confirmed (see also the Finance, Investment and Performance Committee summary, below); • Capital: Underspends remained, largely due to national constraints. Several short-notice requests to utilise capital would be implemented where procurement timescales allowed. <i>Well-Led (Chief People Officer)</i> • Workforce Position: the overall establishment had increased, driven by KGH changes in bank and substantive nursing, medical staffing and Estates & Facilities roles due to winter pressures and Internal Agency cover.	

- **Agency Costs:** Reduced to 2% (NGH) and 1% (KGH) of total compared to 7% and 4% respectively in the previous year.
- **Time to Hire:** NGH performance was now equivalent to KGH and progressing toward the six-week national target.
- **Appraisals:** An improvement plan requested for KGH.
- **Employee Relations:** NGH case numbers remained high (43), reflecting concerns and patterns within specific staff groups. long-term sickness within the HR/OD teams affected capacity to manage cases.
- **Sickness Absence:** At expected winter levels; benchmark performance was reasonable. The East Midlands partnership continued to focus on absence reductions.

Board Committee Summaries:

Committee Chairs raised the following significant items from their reports:

- The respective Boards **approved** the Finance, Investment and Performance Committee's recommendations to retrospectively approve revenue support requests of £5m (KGH £4m NGH £1m) for February, and the further £8.75m request for March (£2.75m JGH £6m NGH);
- The Quality and Safety Committee (QSC) raised concerns regarding complaints performance at NGH and the lack of organisational learning evidence; this echoed themes highlighted in the recent Great Ormond Street case. Boards were assured that the newly appointed Head of Complaints was confident in delivering improvement.
- **Children and Young People (CYP):** QSC highlighted insufficient focus on children's services, referencing previous issues relating to autism and those raised in the committee's report regarding neonatal pharmacy provision, the absence of dedicated asthma nursing specialist posts and the lack of a group policy governing referral thresholds for 16 to 18-year-olds. The Medical Director outlined short-term plans for ward-based pharmacists; sustainable provision across UHN and UHL would be reviewed as part of Group Clinical Strategy (GCS) delivery
- **Asthma Posts:** Boards were advised of ongoing discussions with the NICB regarding specialist-nurse-led pathways. The 16–18 transition remained a national issue. QSC would retain oversight and advise the Boards of any required additional support.
- The Strategy, Transformation and Digital Committee indicated 'Limited' assurance in the position of the Group Clinical Strategy due to public health data issues relating to cancer, key workstreams remaining at formative stages and clarify of the trusts' strategic ambition awaited. The Medical Director reported early-stage work to establish shared data baselines across Northamptonshire and Leicestershire, with the Directors of Public Health to be invited to a future committee.

The Director of Continuous Improvement encouraged colleagues to provide feedback on the IPR after its first full year since relaunch; future

	iterations would be informed by integrated reporting through the Federated Data Platform, and assisted by the automation of manual processes to improve timeliness.	
7.	National Oversight Framework (NOF) segmentations for 2025-26 Quarter Two The Boards received a report on the National Oversight Framework segmentations for Quarter Two 2025/26, published in December 2025. This NOF comprised performance metrics alongside each provider's capability self-assessment, although no written feedback from NHS England had yet been received regarding this element. The Boards noted that both organisations had moved down the rankings, with NGH entering, and KGH remaining in, Segment 4, primarily driven by performance concerns in access to services, finance, and productivity. Areas for improvement were highlighted in the report. Boards were reminded that the Quarter 2 results reflected performance between July and September 2025, which coincided with the launch of the electronic patient record system at NGH; updated trajectories and models for Q3 and Q4 were being prepared. The Boards sought assurance on whether the self-assessment aligned closely with the published segmentation results. The Director of Continuous Improvement confirmed that, given the level of scrutiny across multiple areas, the Trusts had submitted a "partial compliance" position, which was consistent with the outcome of the December segmentation update. The latest position was noted by the Boards.	
8.	Perinatal Scorecard Highlight Report (December 2025 data) The Boards received the Perinatal Scorecard Highlight report and noted the following significant items: • There were no Patient Safety Incident Investigations commissioned in December, with one case referred to the Maternity and Newborn Safety Investigations programme and ten moderate-harm incidents reported and associated review and learning • Clinical quality outcomes remained stable, with expected monthly variation and no sustained adverse trends. Smoking at birth continued to decline, with UHN achieving 4% at delivery, exceeding the national ambition; • Workforce pressures remained a key risk: vacancy rates were 7.1% for midwives and 17.1% for non-registered positions. The position was controlled but fragile and required continued scrutiny and mitigation, noting that a 'pipeline' for filling midwifery vacancies was in place. The Boards joined the Director of Midwifery in congratulating Hauwa Hamza for receiving the award of Muslim Midwife of the Year for 2025. The Boards noted the latest position and indicated assurance regarding	

	ongoing improvement work and awareness of known risks, particularly in relation to workforce sustainability and public health outcomes.	
8.2	Perinatal Assurance Committee (PAC) Highlight report and Maternity Incentive Scheme (Year 7) submission The Boards received the PAC Highlight Report for January 2026, together with the position on the Maternity Incentive Scheme (MIS) Year 7. The Committee reported continued maturation of safety governance across maternity and neonatal services, with overall clinical performance remaining stable and perinatal mortality remaining low. All incidents, including moderate-harm cases, stillbirths and neonatal deaths, continued to undergo structured review with identified learning acted upon. Training compliance remained a significant strength, with both sites consistently achieving over 95% in fetal monitoring, PROMPT and neonatal life-support training. Operational stability also remained strong, with no diversions or suspensions in December and 1:1 care in labour maintained at 100%. The Boards received the MIS submissions: Northampton General Hospital (NGH) provided a high level of assurance, with full evidence for all ten MIS Safety Actions. Workforce stability was improving, supernumerary Labour Ward Coordinator status had been consistently maintained following earlier isolated breaches, and neonatal workforce compliance was fully assured. NGH was therefore in a position to submit an MIS declaration of full compliance for Year 7. At Kettering General Hospital (KGH), improvement work continued following the recent Care Quality Commission (CQC) visit, which highlighted issues in triage, documentation and clinical oversight. These areas formed part of an active Perinatal Safety Improvement Programme (PSIP) supported by strengthened leadership oversight. Recruitment to key neonatal medical roles is underway. KGH was unable to demonstrate compliance with three MIS Safety Actions: • Safety Action 1 due to a late Perinatal Mortality Review Tool (PMRT) case; • Safety Action 4 due to consultant attendance concerns highlighted during CQC inspection, despite meeting the technical audit requirement; and • Safety Action 5, relating to maintaining a supernumerary Labour Ward Coordinator, where recurrent breaches were noted and the action plan was not fully embedded. Although non-recoverable for Year 7, corrective actions were being implemented at pace to ensure resilience for Year 8. PAC emphasised that NGH remained fully compliant, while KGH showed progress but continued to face regulatory, workforce and cultural risks. Boards noted the direct financial implications of non-compliance for KGH in terms of the non-receipt of full incentive payments. The Boards noted the national Manchester homebirth review and the required UHN-wide safety strengthening actions, including a full review of homebirth governance, training, escalation processes and cross-professional emergency planning.	

	The Boards of Directors: 1. Endorsed and authorised the CEO to approve MIS Year 7 declarations (NGH compliant; KGH non-compliant with SA1, SA4 and SA5): a) Noting, in respect of Safety Action 7 – MNVP infrastructure: Engagement activity is ongoing; however, a fully defined, ICB/LMNS-funded and time-bound plan remains required to achieve full MNVP functionality, including formal governance attendance (notably PMRT), by March 2026; and b) Safety Action 4 (KGH) Neonatal Tier 3 Workforce: There are recruitment mitigations and a supporting review in progress to achieve compliance during MIS Year 8. 2. Endorsed the development of a unified UHN Obstetric Workforce Plan, aligned to the RCOG 2025 Workforce Census findings, to ensure sustainable consultant capacity, improved rota resilience, and strengthened job-planning across both NGH and KGH 3. Noted the midwifery establishment reviews and workforce actions, 4. Approved homebirth governance strengthening following national PFD and 5. Undertook to continue oversight of PSIP, MatNeolST (previously known as MSSP), and CQC improvement work.	
9.	KGH Maternity Safety Support Programme (MSSP) and CQC update The Boards received an update on progress within Kettering General Hospital's maternity and neonatal services under the integrated Perinatal Safety Improvement Programme (PSIP), which brought together the Maternity Safety Support Programme (MSSP), CQC requirements and national maternity safety priorities. Since the September–October 2025 CQC inspection, the service has taken prompt action to stabilise operations, strengthen leadership oversight and accelerate improvement, with demonstrable gains in workforce stability, triage timeliness, emergency caesarean responsiveness and mandatory training compliance. Governance had been strengthened through a clear three-lines-of-defence model, enhanced executive oversight and improved alignment between frontline controls, divisional governance and Board assurance. From January 2026, KGH transitioned to NHS England's Maternity and Neonatal Improvement Support Team (MatNeolST), providing intensive external scrutiny and a structured improvement framework. While progress was marked, residual risks remained, including cultural maturity, documentation quality, neonatal Tier 3 workforce compliance and the need to evidence sustained improvement through 'closed-loop' audit. Over 55% of CQC actions were now complete, and further improvements were being embedded across infection prevention, consent, governance and safety processes. Overall, the Boards were	

	assured that KGH had a clear understanding of its regulatory position, strengthened oversight and credible improvement trajectory, with remaining risks actively managed and monitored.	
10.	Emergency Preparedness, Resilience and Response (EPRR) compliance annual report and Core Standards self-assessments The Boards received the EPRR Annual Reports and Core Standards self-assessments for 2025. Both Trusts were assessed as non-compliant against NHS England's EPRR Core Standards, with KGH achieving 27% full compliance, 71% partial compliance and one non-compliant standard, and NGH achieving 31% full compliance, 67% partial compliance and one non-compliant standard. Although overall compliance reduced compared to the prior year, significant work was underway to strengthen governance, cross-site alignment and the Group EPRR function. Plans were in place through the 2025–26 work programme to achieve partial compliance ahead of the next assurance cycle. A January 2026 review indicated improving performance, with 25 standards fully compliant, 25 with high likelihood of full compliance and 12 partially compliant. The report summarised a comprehensive programme of major incident training and exercising, including multi-agency cyber, pandemic, mass-casualty and emergency discharge simulations. Key incidents during the reporting period included the Northamptonshire floods, system outages, multiple critical incident declarations, a burst pipe at KGH, and industrial action. Lessons learned had informed updates to business continuity plans, communications processes, and incident response procedures. The Boards noted the ongoing risks associated with EPRR non-compliance and took assurance from the strengthened Group approach and planned improvements. The Boards received and noted the reports, welcoming evidence of improved engagement in training, including the increasing willingness of managers to release staff. Historically, the trusts responded well to incidents, but were unable to evidence good governance as systems, policies, training and processes were lacking. Boards were assured that there was close alignment between EPRR, business continuity and cyber security teams.	
11.	Corridor Care The Boards received a report setting out the latest position regarding corridor care, which sought to provide assurance on the current position, risks and improvement actions relating to the use of temporary care spaces across KGH and NGH. Corridor care—defined as the placement of patients in non-designated areas—was used only during periods of significant Emergency Department pressure, including overcrowding, ambulance handover delays and prolonged waits following decision to admit. Benchmarking against the Healthcare Safety Investigation Branch (HSIB - January 2026) recommendations showed UHN performed positively overall; however, gaps remained relating to estate constraints, patient flow, workforce availability and inconsistent audit and governance processes. These factors continued to pose risks to patient safety, dignity and experience.	

	A comprehensive improvement plan was in place. Immediate actions included alignment of audits and strengthened site-level review of patients in corridor care. Medium-term actions included development of digital tagging and enhanced incident capture through the risk reporting system. Longer-term measures included estate and pathway developments aimed at reducing reliance on corridor care. All wards and ED areas had been risk-assessed for appropriate capacity, with oversight through daily safety huddles, multi-disciplinary team review and strengthened escalation processes. Boards welcomed the assurances provided but noted the HSIB correspondence did not fully reflect the moral harm experienced by staff. The Associate Chief Nurse reported that corridor care use in EDs had reduced significantly compared with the previous year and now was predominantly used for patients awaiting discharge home, with clear criteria applied. The Medical Director acknowledged the moral injury and outlined the support being communicated to staff, including the use of reflective practice being encouraged. Operational concerns regarding inappropriate patient allocation to corridor care were noted; such concerns fed back to site teams. The Boards noted the gaps and associated risks, took assurance from strengthened controls, and endorsed delivery of the improvement actions and longer-term plans to reduce the need for non-designated care environments.	
12.	Annual Establishment Reviews (Safe Staffing) The Board received the Annual Establishment Reviews for Nursing and Midwifery, confirming that all wards and departments remained safely staffed in line with the Principles of Safe Staffing and with good compliance with Developing Workforce Safeguards. The review identified priorities for 2026, including ensuring adequate registered skill-mix, aligning headroom with UHL, monitoring Enhanced Therapeutic Observation demand, and improving red-flag reporting through the SafeCare system. A cost pressure of £844k was noted, though recommended establishments for 2026 could be met within the current financial envelope. The Boards of Directors: 1. Indicated assurance that the wards and departments were safely staffed utilising the Principles of Safe Staffing (evidence-based tools and data, outcomes and professional judgement); 2. Accepted the recommendations from the UHN Chief Nurse and UHN Medical Director that there is reasonable compliance with the Developing Workforce Safeguards and that staffing is safe, effective and sustainable. Evidence for compliance is provided in the report at appendix 1, and. 3. Indicated support for the proposal for proposed changes to nursing and midwifery establishments, set out in the appendix.	
13.	UHN Inclusion Activities April – December 2025 The Boards received a report summarising inclusion activity across	

	UHN from April to December 2025, aligned to the NHS England Equality, Diversity and Inclusion Improvement Plan, Public Sector Equality Duty requirements and the CQC Well-Led framework. The report had been requested by way of follow up to an engagement session at the October 2025 meeting at which diversity network colleagues shared their experiences of working for UHN; Boards were assured that these individuals had been engaged in the preparation and the report via the networks and also the EDI Steering Group, chaired by the UHN Chief Executive. The report highlighted progress in strengthening organisational culture, advancing equity and embedding inclusive leadership. Staff networks played an increasingly influential role, acting as strategic partners, providing lived-experience insight, and supporting improvements in policy, practice, and colleague experience. Their engagement with the Boards in 2025 has directly informed several organisational actions, including enhanced recruitment support, improved reasonable-adjustment processes, neuro-inclusion initiatives, strengthened pastoral support for internationally educated staff, and leadership development programmes aimed at diversifying senior roles. Inclusion work had been embedded more intentionally across UHN through the <i>We Belong</i> Strategy, Rethinking Racism and Civility programmes, and focused initiatives on sexual safety and neuroinclusion. This was contributing to improved psychological safety, strengthened accountability, and a more consistent colleague experience. The report noted that discrimination continued to negatively affect staff wellbeing, retention and patient care. The Boards noted the progress made, endorsed the multidisciplinary approach to cultural improvement, and reiterated support for transformational leadership behaviours, meaningful appraisal, and visible allyship through engagement with staff networks. The proposal for a Shadow Board was particularly welcomed, which should be open to a range of colleagues with protected equality characteristics.	
14.	Gender pay gap The Boards received the 2024–25 Pay Gap Reports, which provided the legally required annual analyses of gender, ethnicity and disability pay gaps across UHN. The analyses showed a five-year downward trend in the Gender Pay Gap at both Trusts, although a slight deterioration occurred in 2024–25 due to representation changes rather than inequitable pay practices. Women remained concentrated in middle pay bands, while men increased in both upper and lower quartiles, influencing median and mean averages. Ethnicity and disability pay gap data highlighted structural workforce patterns, with lower representation of disabled and some ethnic minority colleagues in higher-band roles; by contrast, other ethnic minority colleagues outperformed white colleagues, which was largely attributable to the proportion of Asian colleagues within the consultant body. The data reinforced themes identified through formal race and	

	workforce equality returns and staff feedback, including disparities in progression, leadership representation and lived experience. The report emphasised that pay gaps reflected broader cultural and systemic factors rather than unequal pay. The Boards received and noted the reports, approving publication on Trust websites by 31 March 2026, and endorsed uploading gender pay gap data to the national benchmarking portal.	
15.	Freedom to Speak Up report: 2025-26 Quarter 3 (October to December) The Boards received the Q3 2025/26 Freedom to Speak Up (FTSU) report, confirming that 64 concerns were raised across UHN, comprising 45 at NGH and 19 at KGH. Anonymous reporting remained significantly higher than the national average (KGH 52.6%, NGH 31.1%), continuing to limit opportunities for feedback and local resolution. Concerns were spread across divisions, with the highest volumes relating to corporate teams, Family Health, and Medicine. Themes included worker safety and wellbeing, behaviours, and issues linked to systems, processes and policies. Estates-related concerns increased, and delays in formal HR processes remained a source of frustration for colleagues. Concerns raised by professional groups were broadly consistent with previous quarters, with nurses and midwives making up 28.1% of cases, in line with national trends. No concerns related to sexual safety, fraud or information governance were recorded this quarter. Patient safety concerns were low in volume, and no cases of actual patient harm were identified. Site-specific themes included maternity triage staffing concerns, environmental issues and workplace conduct (KGH), and communication, sickness-recording queries, estates issues and detriment concerns (NGH). National Guardian Office comparisons showed UHN broadly aligned with national patterns, though with higher proportions of wellbeing and behaviour-related concerns. The People Committee Chair advised that the Committee had received the report at its meeting on 29 January 2026. The Committee noted recurrent issues regarding distrust of the process which had informed a decision to review service provision; the action plan in response to the previous NHS England review had been paused until new arrangements were in place, which was anticipated in April 2026. The Boards joined the People Committee Chair in thanking FTSU Guardians, Jane Sanjeevi and Luke Sullivan, for their contributions to the roles and wishing them well as they moved to new positions within the group following the review. The Boards noted the impacts of major transformation projects on teams and individuals and were assured that all colleagues raising FTSU concerns were reminded of the health and wellbeing support package available. The Boards of Directors noted the report and indicated assurance in	

	respect of the processes in place to support staff to raise concerns.	
16.	Implementation of NHS England's 10-point plan to improve Resident Doctors' working lives The Boards considered a report and indicated assurance regarding actions undertaken by the trusts to implement the recommendations of the review; ongoing oversight of compliance would be provided by the People Committee.	
17.	Board Assurance Framework (BAF) The Boards received the Quarter 3 update of the BAF, confirming that all strategic risks had been reviewed by Executive Directors and relevant Board Committees. Risk scores remained unchanged this quarter, with several areas—patient safety, activity, financial sustainability, workforce and digital transformation—continuing to present significant or extreme risk levels. Committees confirmed that controls, assurances and planned actions were appropriate, and that links between the Corporate Risk Register and BAF risks were being strengthened. Internal audit provided Reasonable Assurance, with all recommendations completed. The Audit Committees had introduced a rolling programme of executive leads to attend meetings to provide additional oversight and assurance on specific risks. Committee chairs commended the new BAF which was being used more proactively as a 'live' document to manage key risks in the context of wider work programmes and the delivery of corporate objectives. The Boards indicated assurance in respect of the latest position.	
18.	Use of the NGH Trust Seal The NGH Board of Directors noted the use of the Trust Seal in respect of: 1. The Design and Build Contract for the Urgent Treatment Centre on 24 December 2025, affixed by the Chief Finance Officer and signed by the Chief Finance Officer and Medical Director, and 2. The Lease of Maggie's Cancer Centre at NN1 5BD on 19 January 2026, affixed by the Company Secretary and signed by the Director of Strategy and Director of Continuous Improvement. .	
19.	Questions from the Public None	
20.	Any other business and close: The Chair informed colleagues of the sad news that Terry Spencer, public KGH Governor for Wellingborough until October 2025, died in December 2025. KGH was represented at Terry's funeral by Lindsay Alvis and Sue Broome. The Boards joined the Chair in extending condolences to Terry's family.	

MINUTES OF A MEETING OF THE TRUST BOARD HELD ON THURSDAY 12 FEBRUARY 2026 FROM 1.30PM IN THE CUMULUS ROOM, LEICESTER DIABETES CENTRE, LEICESTER GENERAL HOSPITAL**Voting Members present:**

Professor T Robinson – Acting Chair for the meeting & Non-Executive Director and Charitable Funds Committee Non-Executive Director Chair
 Mr S Adams – Non-Executive Director and Operations and Performance Committee Non-Executive Director Chair
 Mr L Bond – Chief Financial Officer
 Professor I Browne OBE – Non-Executive Director and People and Culture Committee Non-Executive Director Chair
 Dr A Haynes MBE – Non-Executive Director and Quality Committee and Our Future Hospitals & Transformation Committee Non-Executive Director Chair
 Ms J Hogg – Chief Nurse
 Ms J Houghton – Non-Executive Director
 Mr A Inchley – Non-Executive Director and Finance and Investment Committee Non-Executive Director Chair
 Mr R Mitchell – Chief Executive
 Mr D Moon – Non-Executive Director and Audit Committee Non-Executive Director Chair
 Dr G Xu – Medical Director

In attendance:

Dr R Abeyratne – Director of Health Equality and Inclusion
 Mr S Barton – Deputy Chief Executive
 Ms D Burnett – Director of Midwifery
 Ms B Cassidy – Director of Corporate and Legal Affairs
 Ms E Casteleijn - Director of Communications and Engagement
 Dr S Kaur – Associate Non-Executive Director
 Ms S Kaya – Freedom to Speak Guardian (for minute 34/26/1)
 Ms J McCarthy – Head of Learning and Development (for minute 31/26)
 Mr W Monaghan - Group Chief Digital Information Officer
 Ms R Moss - Freedom to Speak Guardian (for minute 34/26/1)
 Ms H Morzaria – Audit Data Quality Officer (for minute 31/26)
 Mr M Reeves – Corporate and Committee Services Officer
 Dr R Singh – Guardian of Safe Working (for minute 34/26/2)
 Ms S Taylor – Director of Urgent Care (for Chief Operating Officer)
 Ms C Teeney – Chief People Officer

		<u>ACTION</u>
27/26	APOLOGIES AND WELCOME	
	Apologies for absence were received from Mr A Moore, Trust Board Chair, Ms H Hendley, Chief Operating Officer, Mr S Harris, Associate Non-Executive Director.	
28/26	CONFIRMATION OF QUORACY	
	<u>Resolved</u> – 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).	
29/26	DECLARATIONS OF INTERESTS AND UPDATE ANNUAL DECLARATIONS OF INTERESTS	
	The Trust Board received an updated annual declaration of interest, to record the interests declared by Dr G Xu, Medical Director. There were no declarations of interest for the meeting.	
	<u>Resolved</u> – the update to the 2025/26 annual declaration of Trust Board declarations of interests be noted.	
30/26	MINUTES	

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	<u>Resolved</u> – that the Minutes of the public Trust Board meeting held on 11 December 2025 be confirmed as a correct record.	
31/26	MATTERS ARISING: BOARD ACTION LOG	
	Paper B provided progress updates for the matters arising from the 11 December 2025 Trust Board meeting and any outstanding items from previous meetings, the contents of which were received and noted.	
	<u>Resolved</u> – that the matters arising report be received and noted as paper B.	
32/26	STAFF STORY – APPRENTICESHIPS AND SOCIAL MOBILITY	
	The Chief People Officer introduced the staff story which focussed on apprenticeships and was joined by Ms H Morzaria, Audit Data Quality Officer and Mr J McCarthy, Head of Learning and Development. The Head of Learning and Development gave a brief outline of the programmes which UHL supported in order to provide local jobs for local people in its role as a training provider. Ms H Morzaria, Audit Data Quality Officer presented her story to the Trust Board, where following a number of years working in a factory, an opportunity arose to undertake a role in the NHS. Ms Morzaria outlined the various roles she had held within the Trust, including her current role as Audit Data Quality Officer. Ms H Morzaria spoke of her love of her role, how she takes up every possible training and development opportunity and was now undertaking an apprenticeship to become a Team Leader. Ms H Morzaria praised the support she had received in progressing her personal development. In discussion, the Trust Board: - Discussed how the Trust developed talent and built confidence. Ms H Morzaria spoke of the importance of taking opportunities, using available resources and encouraging others to gain skills and knowledge. The Chief People Officer highlighted programmes and placements provided by the Trust, particularly through its work with the King's Trust and working with local colleges and expanding the number of apprenticeships. - Noted the challenges that Ms H Morzaria had overcome to develop herself and the support she had received, but also the opportunities to learn, such as through the UHL Connect intranet site through being self-motivated. - Invited Ms H Morzaria to meet with the Digital and Data Training Team to discuss her experience in promoting digital training opportunities and opportunities to take this further. - Heard about how Ms H Morzaria balanced work, training and outside of work responsibilities, taking advantage of flexible working opportunities, but also starting work early to undertake bite-size training, and supporting others which helped generate positive wellbeing. - Welcomed the positive messages from staff stories and suggested that this could be harnessed as inspiration to staff more generally. - Heard about the recent Ofsted inspection of the apprenticeship programme which was an intense inspection of the accredited programmes which the Trust delivered, where the initial feedback was mainly positive with some further learning to be implemented. The Acting Trust Board Chair thanked Ms H Morzaria for sharing her inspirational story.	GCDIO
	<u>Resolved</u> – that a meeting be arranged with Ms H Morzaria to take forward any learning from a user experience perspective and consider any opportunities, such as digital ambassadorship or training going forward.	GCDIO
33/26	STANDING ITEMS	
33/26/1	<u>Chair's Report</u>	
	This item was deferred.	

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33/26/2	<u>CEO Update</u>	
	The Chief Executive presented paper E, and reported the following: <u>Trust Priorities</u> – the 3 Trust priorities, transform patient care, strengthen our culture and deliver our financial plan were highlighted, but the possible tension between delivering those priorities was acknowledged. <u>University Hospitals of Northamptonshire NHS Group (UHN) Collaboration</u> – the strengthening relationship with UHN was outlined, through examples such as joint Executive and Non-Executive Director appointments and digital technology developments which covered the Group. There were further opportunities to work on shared priorities and taking advantage of the benefits of scale and improvements to patient care. This would be discussed further in a joint Board development session in March 2026. <u>Culture, Leadership and Behaviours</u> – the importance of listening to colleagues was highlighted, particularly when there may be colleagues who, despite being proud of the care they deliver, may feel concerned that patients are waiting longer than would be wanted. It was highlighted that the staff survey results would be published in March 2026 and this was an opportunity for UHL to learn from its staff to become the best possible employer. <u>Financial Plan</u> – there were 47 days left in the current financial year and it was acknowledged that it was challenging to meet the financial plan and these challenges may impact on people who work in the Trust. There needed to be both a focus on the basics of cost control and a focus on bigger strategic changes to meet the challenges of the financial plan. <u>Stabbing incident</u> – the recent sad incident in Leicester, where De Montfort University cyber security student, Khalid Oladipo was stabbed was noted. The UHL staff who supported the victim were thanked for their involvement. <u>Nick Moore</u> – the sad passing of former Medical Director Nick Moore was noted with condolences passed to his family. Dr Moore devised the current Clinical Management Group structure. The Acting Trust Board Chair spoke of setting up a clinic for older patients with breast cancer with Dr Moore and the invaluable help Dr Moore had provided.	
	<u>Resolved</u> – that the report be received and noted.	
33/26/3	<u>Integrated Performance Report and Executive Summary (Month 9)</u>	
	The Chief Executive introduced paper F, Integrated Performance Report (IPR), highlighting the monthly basis of the report which provided a high-level assessment of themes covering the organisation. The Director of Urgent Care provided details of the implementation of the Winter Plan which was felt to be working effectively; noted increased demand in Urgent and Emergency Care (UEC) but performance compared well; and the ongoing challenges and actions in place with regarding waiting lists which remained challenging. The ongoing challenges in cancer performance were also noted with improvements in head and neck, and skin cancer but further work to improve breast cancer was highlighted. Assurance was provided that the current position was not accepted but progress continued to be made. In discussion, the Trust Board: - Considered a recent Health Service Journal article about high demand at Urgent Treatment Centres (UTC) and what this meant in terms of patient behaviour and taking personal responsibility. It was noted that there were many factors which determined UTC attendance such as access to a local service or opening hours, but the importance of education and targeted awareness raising was stressed. Factors regarding prevention such as making better health choices and wider determinants of health were also noted. - Queried the impact of sprint funding on access to elective activity. It was agreed to provide detailed forecast data of the anticipated reduction in waiting lists. - Welcomed improvements and stability in UEC performance.	COO

	Queried the impact of increased use of diagnostics arising from the National Cancer Plan for England. Specific data would be provided outside of the meeting. The challenge of utilising finite diagnostics resource at the optimal time was noted and a growth in diagnostic capacity may present a future revenue implication. Each of the Executive Director IPR leads were invited to provide an overview of the key aspects of paper F relating to their portfolios as follows:- (1) Quality – The Chief Nurse noted that metrics overall were showing improvements as a result of improved Emergency Department performance. Rates of Meticillin-sensitive Staphylococcus aureus (MSSA) had appeared to show an increase but the rate per 1000 bed days showed a stable picture. The Fundamentals of Care programme continued to be rolled out promoting good infection prevention practice. Hospital Acquired Pressure Ulcers (HAPUs) remained at a constant level. Ambulance waiting times had improved. Friends and Family Test responses for the Emergency Department had improved. Complaints performance had improved in December 2025 following a downturn in November 2025. The Medical Director highlighted positive work within UEC to mitigate the impacts of overcrowding during the winter period. The Summary Hospital Level Mortality Indicator (SHMI) remained stable and would be continually monitored. One never event was reported which would be investigated in line with the Patient Safety Incident Response Framework (PSIRF) and no patient harm was reported. A review of all never events would take place at the end of the year. Ms J Houghton, Non-Executive Director noted that fundamental metrics had remained stable over the winter period despite extra attendances, and it was queried how this compared to the previous year. The Chief Nurse commented that the 5% improvement target for metrics deliverables within the Operational Plan had been achieved. There was also stability in the number of HAPUs and deep tissue injuries which compared well to peers. (2) People – The Chief People Officer provided an overview of key metrics in relation to workforce noting that the Trust's whole time equivalent (WTE) figure was just over 18,000, which was adverse to plan, mainly as a result of increased use of bank staff due to winter pressures. Use of agency staff remained low, as did turnover of staff which improved stability of service. The appraisal position was below target, felt to be as a result of demand pressures. Sickness absence was at expected seasonal levels, but there had been good staff vaccination uptake at 45%. (3) Finance – The Chief Financial Officer presented the month 9 financial position, noting ongoing challenges with the deficit position, which was mainly due to the withdrawal of deficit support funding but also undelivered Cost Improvement Programme (CIP) schemes which was forecast to deliver 80% of plan. It was noted that there had been a downturn in elective care income. Capital expenditure was expected to be significant for the remainder of the financial year. An issue was noted regarding the management of creditor payments due to the loss of deficit support funding. Mr D Moon, Non-Executive Director questioned whether the target was still being met for creditor payments. The Chief Financial Officer confirmed that the 90% target was still being met, but performance was expected to diminish. The Acting Trust Board Chair queried whether there were any capital project which would not be going forward. The Chief Financial Officer noted the challenge of a significant number of projects commencing in the final quarter of the financial year and this meant there was an almost daily focus on delivery. In summary, the Chief Executive summarised the discussion in line with the three Trust priorities; transform patient care, strengthen our culture and deliver our financial plan; commenting that progress continued to be made with many quality metrics improving and the winter period had benefited from good planning. It was also felt that there was progress in safety and positive workforce metrics. He acknowledged the pressures faced by staff and noted the importance of learning from the staff survey. The remaining 47 days of the financial year were noted, with some progress in finance highlighted, but there remained work to do, to ensure the Trust was in a good position for the start of the new financial year.	COO

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	Resolved – that (A) data be provided to Mr D Moon, Non-Executive Director regarding the expected elective activity increase as a result of Sprint funding; and (B) details be provided to Dr A Haynes, Non-Executive Director regarding the impact on cancer targets from increased diagnostics arising from the National Cancer Plan for England.	COO COO
33/26/4	Board Committee Escalation Reports	
	<u>Operations and Performance Committee – 18 December 2025 & 29 January 2026</u> Mr S Adams, Operations and Performance Committee Non-Executive Director Chair highlighted discussions at the December 2025 meeting regarding additional winter capacity; the 65 week wait position; the Ophthalmology service and improvements in ambulance handover times. With regard to the January meeting, there were discussions regarding improvements in discharge arrangements; elective activity; electronic prescribing; Patient Administration System (PAS) implementation and noted that moderate assurance was taken in relation to the Committee's 3 Board Assurance Framework (BAF) risks. The Group Chief Digital Information Officer commented in relation to PAS that there was general recognition that the system was working well and there was evidence of hundreds of thousands of patients being successfully booked into care. Professor T Robinson, Acting Trust Board Chair enquired about the Committee's request for a further report on Ophthalmology. Mr S Adams, Operations and Performance Committee Non-Executive Director Chair noted that the Committee had requested more information on the structure of the service. Ms J Houghton, Non-Executive Director, welcomed the deep dive into Ophthalmology and noted there had been a rising number of complaints regarding the service and queried whether there was any evidence of patient harm. The Medical Director was not aware of any instances of patient harm, the Chief Nurse however felt there may have been one example. Dr A Haynes, Non-Executive Director, commented that challenges for Ophthalmology were not unique to Leicester and were not a new issue. The service had retained a backlog since the Covid period, but there had been actions to reduce the backlog and monitoring of any harms or near misses, but despite these actions there remained risk within the service. There were also ongoing demographic challenges from growth in the older population. It was felt that there were opportunities within community services to provide Ophthalmology capacity and checks were being made to ensure that this capacity was being fully utilised. Professor T Robinson, Acting Trust Board Chair highlighted that there had been charitable fund grants awarded to support Ophthalmology investment in community hospitals. The Director of Urgent Care noted that additional Ophthalmology capacity which was put in place during the COVID period had since been decommissioned but discussion was underway with System partners about bringing this service back. In summary, Professor T Robinson, Acting Trust Board Chair noted that the Operations and Performance Committee were undertaking oversight of the Ophthalmology Service configuration and would seek assurance regarding patient harm. <u>Quality Committee – 18 December 2025 & 28 January 2026</u> Dr A Haynes, Quality Committee Non-Executive Director Chair highlighted discussions regarding; the action plan in response to the Fuller report regarding Mortuary systems and processes; the national review of Breast Cancer screening which highlighted good detection rates but some concerns regarding staffing levels; positive news regarding the Waste Management Team winning a team of the year award from NHSE and an award for reducing carbon emissions. The Acting Trust Board Chair put on record the Trust Board's thanks and congratulations to the Waste Management Team. <u>Finance and Investment Committee – 22 December 2025 & 28 January 2026</u> Mr A Inchley, Finance and Investment Committee Non-Executive Director Chair noted points from the meeting including; a change to the Terms of Reference following the ending of Leicester, Leicestershire and Rutland Integrated Care Board (ICB) attendance; the finance position and what this meant for the forthcoming year; and Estates and Facilities priorities in order to reduce the Board Assurance Framework (BAF) score. <u>Our Future Hospitals and Transformation Committee – 17 December 2025 & 28 January 2026</u>	

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	Dr A Haynes, Our Future Hospitals and Transformation Committee Non-Executive Director Chair reported that the following matters were considered; Green Plan investment which meant a reduced risk score which was recommended for Board approval; funding available and opportunities to bid for Community Diagnostic Centres; and Patient Administration System and automation progress. benefits. The Acting Trust Board Chair confirmed that the Board approved the BAF risk 05-Estate-02 (sustainability and delivery of net zero targets) score reduction from 16 to 12. People and Culture Committee – 28 January 2026 Professor I Browne, People and Culture Committee Non-Executive Director Chair noted that any matters for escalation were covered by reports on the agenda.	CN
	Resolved – that (A) the escalation reports from the Operations and Performance Committee on 18 December 2025 & 29 January 2026, the Quality Committee on 18 December 2025 & 28 January 2026, the Finance and Investment Committee on 22 December 2025 & 28 January 2026 the Our Future Hospitals and Transformation Committee on 26 November 2025, the People and Culture Committee on 28 January 2026, be noted, and any recommendations within be endorsed; and (B) the BAF risk 05-Estate-02 (sustainability and delivery of net zero targets) score be reduced from 16 to 12.	CN
34/26	HIGH QUALITY CARE FOR ALL	
34/26/1	<u>Perinatal Quality Surveillance Scorecard – December 2025 / Perinatal Assurance Committee (PAC) Highlight Report</u>	
	The Director of Midwifery presented the Perinatal Quality Surveillance Scorecard and Perinatal Assurance Committee Highlight Reports which provided an update on monitoring and oversight and detailed core safety metrics. A detailed introduction was provided which outlined the increased level of activity in December and the position regarding workforce, but assurance that care remained safe. Further details were provided regarding PAC discussions including; compliance with the Maternity Incentive Scheme; a deep dive into the home birth service with assurance that the service met national expectations; the ongoing embedding of the Badgernet Electronic Patient Record; and efforts to achieve UNICEF baby friendly status which was affected by participation in the National Maternity and Neonatal Investigation. An update was also provided regarding UHL's participation in the National Maternity and Neonatal Investigation which was currently undertaking leadership interviews. Assurance was provided that the PAC provided good oversight of metrics which were safe and improving. The Chief Nurse provided further detail on the processes for evidence gathering for the Maternity Incentive Scheme, for which compliance had been delegated to the PAC who were assured by the evidence they had received. The Trust Board was recommended to approve the progression of the submission and authorise Chief Executive Officer sign off. In discussion the Trust Board: • Welcomed the ongoing improvement of safety standards. • Discussed the possible reasons for the rise in pre-term births, noting that there were likely to be both population factors and the impact of transfers, noting that as UHL was a level 3 centre it meant higher levels of acuity and families seeking higher levels of care. • Agreed to receive feedback from discussions with partners regarding infant mortality. • Considered the reasons for an increase the number of home births which was felt to be mainly due to meaningful discussions with families and focussing on supporting their choices, but ensuring that all options were outlined. The current pause in service from the standalone midwife led birth centre could also be a factor. • Queried any learning from Maternity and Newborn Safety Investigation (MNSI) cases, where it was noted that one case had been accepted for review, but feedback was awaited for any learning, which could take some time. • Noted that the development of the inclusivity dashboard was ongoing, where a prototype had been developed with the aim of providing real-time data, but capacity for development was constrained, although it was hoped to confirm it was operational in April 2026.	CE CN

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	<u>Resolved</u> – that (A) the recommendations in the reports be supported; and	
	(B) the year 7 Maternity Incentive Scheme progression be approved and the Chief Executive Officer be authorised to sign off the submission.	CE
34/26/2	<u>UHL's Deliverables for 2025/26 – Q3 Progress Update</u>	
	The Deputy Chief Executive presented a report summarising the progress to date in delivery of the Trust's 10 key priorities and deliverables for 2025/26. Key areas of progress were noted, such as research excellence in Diabetes and a review of progress over 2 years of deliverables which noted improvements in infection prevention, a stable position in the Stabilised Hospital Mortality Indicator (SHMI), increases in outpatient appointments and a 20% increase in research spend. Cancer performance was noted as an area requiring improvement. Mr A Inchley, Non-Executive Director highlighted the 40% reduction in the use of paper generated at the point of care which was felt to be a considerable achievement. The Chief Executive queried what areas of performance should the Trust be most proud of. The Deputy Chief Executive felt that UEC improvements had been significant particularly in terms of the 4-hour wait target and reduction in ambulance waiting times. He further noted significant improvements in the reduction of hospital acquired infections, as well as progress on finance and use of agency staff. There were examples of achievement related to all 3 main Trust priorities. The Chief Executive thanked the Director of Urgent Care for her role in improving UEC services. The Acting Trust Board Chair welcomed the positive performance regarding research.	
	<u>Resolved</u> – that the report be received and noted.	
35/26	GREAT PLACE TO WORK	
35/26/1	<u>Freedom to Speak Up Q3 report</u>	
	Ms S Kaya, Freedom to Speak Up Guardian presented the Freedom to Speak Up Quarter 3 report. Key points from the report were highlighted regarding upward trend in number of concerns, and those locations, CMGs and job groups within the Trust that were generating the most concerns. Details of activity focus going forward and the deep dive into discrimination were also highlighted. In discussion, the Trust Board: - Noted that there would be a programme of communications regarding action taken in response to discrimination. - Requested that themes for concerns arising during the Winter period be included as part of the review of the Winter programme. - Heard that a deep dive at the People and Culture Committee considered some of the detail behind concerns, and provided a greater understanding and assurance regarding action being taken. - Noted that there would be triangulation from the staff survey results with deep dives into Freedom to Speak Up theme areas. - Noted that the areas of the Trust undergoing change in the forthcoming financial year would be highlighted to the Freedom to Speak Up Guardians in order to focus support. - Heard that there were low levels of concerns raised at the Leicester General Hospital and the Cancer, Haematology, Urology, Gastroenterology and General Surgery (CHUGGS) CMG and these would be focus areas going forward to understand the relative low numbers of concerns. - Requested that details of anonymous complaints be included in future reports. - Noted that there were zero cases of detriment reported, but it was accepted that there may be some cases of detriment across the Trust which were not picked up through Freedom to Speak Up reporting. - Discussed Civility Saves Lives software and resources, but it was noted that the Trust had different resources which it could use for this purpose.	COO / DCLA DCLA

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	Received details of learning from where services had improved as a result of Freedom to Speak Up, and this was now possible through culture based metrics being reported to the People and Culture Committee.	
	<u>Resolved</u> – that (A) themes from Freedom to Speak Up concerns relating to the winter period be incorporated into the winter programme review; and (B) details of anonymous complaints be included in future reports.	COO / DCLA DCLA
35/26/2	<u>Resident Doctors Contract, Guardian of Safe Working</u>	
	Dr R Singh, Guardian of Safe Working (GOSW) presented the report, produced in line with the 2016 Resident Doctors' Contract and meeting the requirement for the Guardian of Safe Working to provide a report on exception reporting to the Trust Board. The Medical Director noted that there was a general increase in the number of exception reports which it was felt indicated that there was a greater awareness of the Guardian of Safe Working service. The reference in the report to a trainee doctor working at a GP practice raising 13 exception reports was highlighted. Dr R Singh, Guardian of Safe Working noted that because the doctor was in training, then the Guardian of Safe Working had a level of accountability (despite the training taking place in a GP surgery), but the level of influence of the Guardian was limited, but could become more involved should the reports be of a serious nature. There were no specific concerns in relation to the exception reports raised in this case. Dr R Singh, Guardian of Safe Working highlighted a number of technical reforms to the exception reporting process which were now being incorporated into the Standard Operating Procedure, along with stakeholder engagement, and the development of guidance and training. There were no specific concerns with this process to highlight.	
	<u>Resolved</u> – that the report be received and noted.	
35/26/3	<u>Equality, Diversity and Inclusion Strategy Progress</u>	
	The Chief People Officer presented an update for assurance on progress against year 1 delivery of the Trust's Equality, Diversity and Inclusion (EDI) Strategy 2025-2030. A detailed introduction outlined the focus of work to date and actions undertaken including; the development of staff networks; increasing the number of ambassador roles; the roll out of active bystander training; progression of the diverse leadership programme, which had received positive feedback and development of the reciprocal mentoring programme which was due to launch in April 2026. Mr S Adams, Non-Executive Director welcomed the progress detailed in the report and questioned how far the strategy had become embedded across the Trust, also whether there were any metrics which were of concern. The Chief People Officer noted that there had been awareness raising through pledges made to sign up to the anti-discrimination statement, and the development of inclusion ambassador roles and promotion of values, but it was noted that staff stories would be included in future awareness raising for greater impact. Data and metrics regarding EDI were considered in detail at the People and Culture Committee with a focus on key EDI metrics such as the gender pay gap.	
	<u>Resolved</u> – that the report be received and noted.	
35/26/4	<u>Nursing and Midwifery Annual Establishment Reviews Board Report 2025</u>	
	The Chief Nurse presented a report for assurance of the six-monthly establishment reviews for UHL which took place for Nursing and Midwifery in September / October 2025. The Chief Nurse described the review process which provided recommendations on the level of safe staffing, and it was noted that changes were recommended in 31 units, particularly in regard to increasing the number of registered staff on duty. Assurance was provided that this was considered safe and	

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	sustainable as the recommendations had been reviewed by the Corporate Nursing Team and Finance staff. This would also support aims to reduce the number of temporary staff and support compliance with national training standards. Mr S Adams, Non-Executive Director sought assurance regarding the scale of the proposed changes. The Chief Nurse felt that big changes were not being recommended, as it was focussed on the skills mix, and did not affect the numbers of staff on a shift. Some challenges were noted due to number of vacancies in certain areas.	
	<u>Resolved</u> – that the changes proposed for the nursing and midwifery establishments be approved (at a reduction in cost of £65,227).	CN
36/26	SUSTAINABLE FINANCES – no items	
37/26	PARTNERSHIPS FOR IMPACT – no items	
38/26	RESEARCH AND EDUCATION EXCELLENCE – no items	
39/26	CORPORATE GOVERNANCE/REGULATORY COMPLIANCE – no items	
40/26	CORPORATE TRUSTEE BUSINESS – no items	
41/26	ANY OTHER BUSINESS	
	The Acting Trust Board Chair, in summary of the meeting, noted that the Board was invited to consider a range of evidence-based papers which considered a range of topics including patient care, culture and finance, and this had been undertaken comprehensively. He thanked Executive and Non-Executive Director colleagues for their participation. The Acting Trust Board Chair reported that this would be the last meeting for Dr S Kaur, Associate Non-Executive Director as she was standing down from the role. Dr S Kaur was thanked for her contributions and engagement on the Trust Board.	
42/26	QUESTIONS FROM THE PRESS AND PUBLIC	
	There were no questions from the press or public.	
43/26	REPORTS AND MINUTES PUBLISHED AND UHL'S EXTERNAL WEBSITE (NOT INCLUDED IN THE BOARD PACKS):	
43/26/1	<u>Resolved</u> – that it be noted that the following Minutes of meetings had been published on UHL's website alongside the Trust Board papers:- • Quality Committee – Minutes of 27 November 2025 & 18 December 2025 • Operations and Performance Committee – Minutes of 27 November 2025 & 18 December 2025 • Finance and Investment Committee – Minutes of 26 November 2025 & 22 December 2025 • Our Future Hospitals and Transformation Committee – 26 November 2025 & 17 December 2025 • People and Culture Committee – 27 November 2025	
44/26	REPORTS DEFERRED TO A FUTURE MEETING	
	None from the workplan.	
45/26	DATE AND TIME OF NEXT MEETING	
	<u>Resolved</u> – that the next Public Trust Board meeting be held in April 2026 – details to be confirmed.	

The meeting closed at 3.49pm

Matthew Reeves – Committee and Corporate Services Officer

Cumulative Record of Attendance (2025/26 to date):

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Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
A Moore	7	6	86	J Hogg	7	6	86
S Adams (from 1.5.25)	6	6	100	J Houghton	7	7	100
L Bond	7	7	100	A Inchley	7	7	100
I Browne	7	5	71	J Melbourne (until 26.10.25)	5	4	80
A Furlong	7	5	71	R Mitchell	7	7	100
A Haynes	7	6	86	D Moon	7	6	86
H Hendley (from 27.10.25)	2	2	100	T Robinson	7	5	71

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Abeyratne	7	6	86	S Kaur	7	5	71
S Barton	7	6	86	H Kotecha	7	4	57
B Cassidy	7	7	100	W Monaghan	7	6	86
E Casteleijn (from 12.9.25)	3	3	100	M Smith (until 11.9.25)	4	4	100
S Harris	7	1	14	C Teeney	7	5	71

Progress of actions arising from the Trust Board meeting held on Thursday 12 February 2026

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
12 February 2026						
1	31/26	Staff Story – Hema’s Story To arrange a meeting with Hema to take forward any learning from a user experience perspective and consider any opportunities, such as digital ambassador or training going forward.	GCDIO W Monaghan	Immediate	Complete.	5
2	32/26/3	Integrated Performance Report To provide data to Mr D Moon, Non-Executive Director regarding the expected elective activity increase as a result of Sprint funding.	COO H Hendley	Immediate	Email to David Moon 12/03/26	5
2a	32/26/3	To provide details to Dr A Haynes, Non-Executive Director regarding the impact on cancer targets from increased diagnostics arising from the National Cancer Plan for England.	COO H Hendley	Immediate	Email to Andy Haynes 25/03/26	5
3	33/26/1	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 May 2026	To be scheduled accordingly – detail will be incorporated into a spotlight piece within the Perinatal Quality Surveillance Scorecard.	4
4	34/26/1	Freedom to Speak Up Q3 Report To incorporate themes from concerns to input into the winter programme review.	COO / DCLA H Hendley / B Cassidy	TBC	The Freedom to Speak Up lead has supplied themes to feed into the winter review session on 25/03/26.	5
4a	34/26/1	To include details of anonymous complaints in future reports.	DCLA B Cassidy	TB May 2026	To be scheduled accordingly.	4
11 December 2025						
5	294/25/3	Integrated Performance Report To consider ways in which productivity metrics within the report can also provide data comparing with peers, and to provide colour coding on the productivity metric data which shows where performance is improving or not.	COO H Hendley	TB April 26	A summary table showing a month-on-month trend for a suite of metrics including average length of stay, bed occupancy and theatre, outpatients and diagnostics against a 25/26 target (where one has been set) and 19/20 baseline was included in the detailed OPC papers for January. The information when fully complete will be included in the detailed IPR report. This is included in the IPR for April Board.	5

UHL and UHN Boards of Directors, 9 April 2026: paper C

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
5b	294/25/3	To feedback to Mr D Moon, Non-Executive Director regarding whether nursing vacancies were now over-establishment.	CPO C Teeney	Immediate	Response sent 31.03.26.	5
6	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
13 November 2025						
7	258/25/3	Integrated Performance Report To provide an update regarding progress towards the development of activity forecasting to identify the points of highest Urgent and Emergency Care demand pressure.	COO H Hendley	TB 12.2.26	This has been discussed at Executive Planning Meeting and action supported to bring together relevant colleagues to take forward explore potential opportunities.	5
8 May 2025 (approvals recorded in the formal minutes only)						
8	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

Meeting		UHN Boards of Directors Meeting in Public			
Date & Time		Updated following 6 February 2026 meeting			
Minute Ref.	Action	Owner	Due Date	Progress	Status
Nov 25 6	Monitor against revised 25-26 forecast in future reports	Sarah Stansfield	Mar 26	Revised forecast reflected in Integrated Performance Report	CLOSE
Nov 25 8	Development of dashboard to monitor the patient experience	Julie Hogg	Apr 26	Dashboard prepared and tested for inclusion in next quarterly report to Quality and Safety Committee	CLOSE
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	(i) Date now being tracked in the Electronic Patient Record Programme: close (ii) Engagement with local universities is underway to explore how Armed Forces health needs and bespoke pathways can be better incorporated into training for trainee nurses and doctors. This will support increased awareness of statutory responsibilities, improve understanding of alternative pathways, and strengthen collaboration with education partners. This collective work ensures we remain aligned with the commitments outlined by the Boards and continue to enhance outcomes for the Armed Forces community Close (iii) Director of Communications and Engagement to update	CLOSE (i)-(ii) OPEN (iii)

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:	9 April 2026					
Title:	2.2 Group Chief Executive's report (Paper D)					
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 March 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 March 2026 on the University Hospitals of Leicester NHS Trust (UHL) and the University of Northamptonshire NHS Group (UHN).

Recommendation

The Boards are asked to note the report.

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

**BOARDS OF DIRECTORS
THURSDAY 9 APRIL 2026**

GROUP CHIEF EXECUTIVE'S REPORT

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.

Review 2025/26

Today is our first board meeting of 2026/27, and it is a good opportunity to briefly review what has been a turbulent but also quietly transformative 12 months. For me, four themes stand out: a gradual return of public confidence, the continuing strain on colleague experience, stronger financial discipline, and the rapid rise of digital and artificial intelligence (AI) transformation.

Public confidence in the health service is beginning to improve for the first time since before the pandemic. The annual [British Social Attitudes poll](#) has tracked attitudes towards the NHS since 1983 and has found that faith in the health service remains low but is slowly recovering, though 'Gen Z' are less happy with the NHS than older people. Overall, 26 per cent of people said they were satisfied with the NHS last year, up from a record low of 21 per cent in 2024. Here at UHL and UHN, we have improved quality, safety and access and early verbal feedback from recent CQC visits is promising.

At the same time, this has been a difficult year for many colleagues across the NHS. The NHS Staff Survey results nationally show engagement and motivation have fallen due to operational pressures, burnout and dissatisfaction with pay. Within the high-level metrics, we know colleagues with protected characteristics, including race and disability, experience higher levels of discrimination, harassment, and reduced opportunities for career progression. The proportion of NHS colleagues who would recommend their organisation as a place to work fell to 56.9% in 2025, down from 59.9% in 2024 and close to its 2022 low. Scores at UHL and UHN deteriorated, and I know this is partly connected to the difficult decisions we have had to take. Some of those decisions have prompted criticism and this is both expected and accepted. We do not always get everything right, and constructive challenge, ideas and solutions help us improve. Over this coming financial year, we also have important choices to make, and we are committed to listening, to improving experience of work and ensuring colleagues with protected characteristics see real change for the better.

Financially, this has been a year of greater grip across the NHS: workforce growth has levelled out and there have been notable reductions in agency use and increases in productivity. Locally, both UHL and UHN are

delivering the financial positions we agreed with NHS England, and at UHL we have reduced the deficit compared to last year. Both UHL and UHN are forecasting a further reduction in deficit next year. Of course, none of this removes the reality of inflation, rising demand and service resilience pressures — all of which mean significant financial challenge, and which contribute to the need for difficult choices. Our focus remains on protecting high-quality care, improving productivity and working closely with partners to reduce duplication and make best use of our collective resources. By planning early and acting decisively, I am confident we will navigate the year ahead.

In a modern NHS, digital technology and AI are essential for enhancing patient outcomes, increasing operational efficiency, and enabling proactive care management. They help improve communication, remote monitoring, and personalised treatments, shifting the focus from reactive to preventative care while boosting efficiency. Key tools with increasing influence over the last year include telehealth, wearable devices, and AI-driven diagnostics. At UHL and UHN we are investing heavily in digital technology and AI and I believe this is the biggest opportunity we have to improve patient care, colleague experience and our finances over the next 10 years. At UHL and UHN, AI will create jobs, change jobs and mean some jobs will no longer be needed. We need to support colleagues as we respond to these changes, and no decisions about roles will be made without engagement and support.

Through all of this, the conversations that stay with me are the simplest ones. When I ask colleagues why they work in the NHS, the answer is almost always the same: *because I want to make a difference*. And UHL and UHN colleagues have done exactly that over the last 12 months.

The year ahead - 2026/27

Since autumn 2023, UHL and UHN have been working more closely together as a Group. Improvements delivered by us working as a Group so far include:

Our Group Clinical Strategy developed with involvement and insight from colleagues, partners, and communities across Leicester, Leicestershire, Rutland, and Northamptonshire, sets out how we will improve care, access, and outcomes for our population over the next decade, including reducing unwarranted variation and making better use of our collective expertise and capacity. Delivering this strategy requires us to work together more consistently across our hospitals and teams.

Our shared **Electronic Patient Record (EPR)** programme. UHL's Patient Administration System (PAS) could not have gone live without UHN colleagues stepping in to support. Equally, tranche one at Northampton General Hospital would not have launched without expertise from UHL. We are now able to share skills and knowledge across organisations in ways that simply were not possible before.

Patient safety – through aligned work on the Patient Safety Improvement Plan, BadgerNet, and maternal medicine.

More consistent care – including a standardised approach reducing enhanced care by 74% at UHN.

Improved flow – with the significant efforts of local clinical and operational teams, supported by a senior UEC nurse working across the group, helping to reduce ambulance handover delays at KGH, NGH, and the LRI.

Digital innovation – including ambient voice technology, still at an early stage but being piloted thoughtfully across sites, spreading both cost and risk.

Better value – including the adoption of UHN’s MRSA decolonisation approach at UHL, delivering £110k in savings.

While there have been benefits, we agree we have not yet made the most of working together. To address this, and in line with many organisations across the NHS, we have decided to share leadership and governance, strengthening our partnership, and enabling improvements that cannot be achieved by any one organisation alone. We are choosing to lead the change rather than react to it.

The UHL and UHN boards have come together and the first joint board ‘in common’ is today. The executive teams in UHL and UHN are coming together as one single team and will meet face to face weekly, with the first meeting on Tuesday 14 April. We will move to shared committees and a single group of Non-Executive Directors. This will make decision-making clearer, simpler and more joined up, helping us focus on what matters most — safe, high-quality care for patients.

For the vast majority of the 30,000 colleagues across our organisations, the changes will not affect their role, their team or reporting line. Most services will continue to be delivered locally, although we will continue to review how services work together where this improves care for patients.

It is also important to be clear this is not a merger or a take-over by one organisation. The legal status of UHL, Kettering General Hospital and Northampton General Hospital, which together make up UHN, is not changing. We believe strengthening shared leadership and governance is the right step now and will deliver greater benefit than a merger, which could be more complex and distracting.

Across the Group we will continue to focus on three shared priorities: transforming patient care, strengthening our culture, and delivering our financial plans responsibly. No single organisation can address these issues or achieve these priorities alone at the pace and scale now required. Working together gives us that. We want patients to receive the same high-quality, safe, and timely care wherever they are treated. Our Group Clinical Strategy sets out how we will improve care, access, and outcomes over the coming years. Shared leadership and governance will help us deliver this.

The year ahead will bring challenges, it always does, but it will also bring opportunities to shape the NHS we want to work in, not just the one we have. I am looking forward to working with colleagues to build on what we have achieved and to keep strengthening the things that matter most.

Meeting	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	9 th April 2026		
Title	2.3 (Paper E) UHN Integrated Performance Report		
Report presented by:	Richard Mitchell, Group Chief Executive Officer		
Report written by:	Julie Hogg, Chief Nurse, UHN/UHL Hemant Nemade, Medical Director, UHN Sarah Noonan, Chief Operating Officer, UHN Paula Kirkpatrick, Chief People Officer, UHN Sarah Stansfield, Chief Finance Officer, UHN Becky Taylor, Director of Continuous Improvement, UHN		
Which Group Priorities does this link to?			
☒ Transform Patient Care		☒ Strengthen our Culture	☒ Deliver our financial plan
This paper is for			
☐ Approval		☐ Update	☒ Assurance
Where this report has been discussed previously:			
The IPR is produced on a monthly basis and is presented at public Boards on a bi-monthly basis. It was reviewed by the Finance, Investment and Performance Committee at its 31 March 2026 meeting.			
To your knowledge, does the report provide assurance or mitigate any significant risks?			
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.			
Report			
This paper outlines: 1. The UHN Integrated Performance Report 2. Approach to alignment of the UHL / UHN IPRs 3. UHL / UHN Q3 National Oversight Framework (NOF) ratings			
UHN Integrated Performance Report			
The Integrated Performance Report (IPR) for the April 2026 Boards is enclosed, which reports on February 2026 performance. Executive Leads will draw the Boards' attention to significant exceptions within the Caring, Safe, Effective, Responsive, Well-Led and Use of Resources domains.			

Update to the IPR this month:

- Updated the ambulance handover metric to be the percentage of ambulance handovers that are within 45 minutes, with a target of 99%

Future planned metric additions with target dates:

- Addition of sepsis six bundle compliance metric – March 2026

UHL / UHN IPR alignment approach

As the Boards meet in common across UHL and UHN, an aligned IPR is required to ensure effective Board and committee working.

An approach to aligning the IPRs into a joint IPR is outlined, with Board members to be engaged through April and May on the future metrics, design and intended use in the new Committee and Board structure. The joint UHL / UHN IPR will then be developed to the new design, with an aim to have a joint IPR for the September Boards.

UHL / UHN Q3 25/26 NOF ratings

The [National Oversight Framework \(NOF\)](#) describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

The NHS Oversight Framework sets out how NHS trusts and foundation trusts are automatically allocated to a segment (1 to 4) based on performance, with league tables that allow both the public and NHS leaders to compare how NHS Trusts are performing across England. NHSE will use segmentation and an assessment of capability to determine what level of oversight and support providers require.

In Q3 25/26:

Kettering General Hospital NHS Foundation Trust (KGH) has been placed in **Segment 4 of 4**, ranked at **104** out of **134**, with a score of **2.76**.

Northampton General Hospital NHS Trust (NGH) has been placed in **Segment 4 of 4**, ranked at **126** out of **134**, with a score of **3.01**.

University Hospitals of Leicester NHS Trust (UHL) has been placed in **Segment 4 of 4**, ranked at **99** out of **134**, with a score of **2.71**.

Statistical analysis has been conducted on the data in the league tables. A 95% confidence interval means that if the same population was sampled repeatedly, approximately 95% of the intervals would contain the true population parameter. For KGH, our rank could plausibly range from 59 to 130, for NGH from 89 to 133,

and for UHL from 56 to 128, indicating that even modest improvements could lead to visible movement.

The latest 25/26 National Staff Survey results are not included in the Q3 data update and will be incorporated from Q4 25/26. A refreshed set of metrics for the NOF in 26/27 is under development by the national team.

The attached paper outlines the scores by domain and analysis of the drivers of the movement in ratings across the Group.

The Boards are asked to:

1. Take assurance from the IPR on UHN performance
2. Note and provide feedback on the proposed approach to the UHL / UHN IPR alignment
3. Note the Q3 25/26 NOF ratings for KGH / NGH / UHL

Appendices

Appendix 1: UHN Integrated Performance Report, reporting period February 2026

Appendix 2: UHL / UHN Integrated Performance Report alignment approach

Appendix 3: KGH / NGH / UHN Q3 25/26 NOF ratings

Integrated Performance Report

Kettering General Hospital NHS Foundation Trust
Northampton General Hospital NHS Trust

Reporting Feb 2026 performance in Apr 2026

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[Responsive domain](#)

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[Use of Resources domain](#)

[Interpreting SPC charts and glossary](#)

Introduction

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

Our Overall Performance

Understanding performance against our key delivery metrics

- Incident reporting remains consistent, collaborative working with divisions to ensure timely review. Clinical care and treatment, failure to follow policy and delay in treatment/diagnosis remain the top themes.
- Patient experience remains high across the Trust, with increases in NGH maternity, emergency departments and outpatients this month.
- Mortality 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 around 90%, with a dip in NGH over winter pressures to around 70%.
- 4hr performance at NGH remains adverse to plan, however, has improved in February by 1.5%. KGH performance remains consistent. This is against a backdrop of more ED Type 1 attendances and more non-elective admissions than plan, with admitted flow remaining a challenge resulting in use of temporary escalation spaces to manage flow.
- The 62-day performance remains challenged, particularly in Gynaecology, Head and Neck and Breast. Good engagement in recovery plans for 26/27, additional capacity in Breast for March 2026 and discussions are underway regarding a new model for Dermatology.
- A decreasing waiting list size and improving 52 week position in February. ENT makes up the majority of the 52 week waiting patients. Our position is favourable nationally.
- 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.
- The year-to-date I&E position is a £55.0m deficit, £42.2m worse than plan (KGH £17.9m, NGH £24.3m). This largely reflects the efficiency requirement in the last three months. Deficit Support Funding (DSF) for Quarter 4 has been withheld by NHS England. Both Trusts remain on track to deliver the revised year-end forecast position.

	Metric	Target	KGH Actual	Variation	Assurance	NGH Actual	Variation	Assurance
Safe	Serious or moderate harms per 1000 bed days	-	1.88			0.89		
	Friends and Family Test satisfaction score	95%	93.3%			89.9%		
Caring	SHMI	100	97			98.4		
	Ambulance Handover 45 minute Performance %	99%	89.47%			69.89%		
Effective	A&E 4 hour performance	78%	78.91%			68.48%		
	62-day wait for first treatment	70%	54.50%			57.50%		
Responsive	52 week waits as a % of the waiting list	1%	1.02%			1.49%		
	Total WTE (PWR figure)	KGH: 4,903 NGH: 6,199	5,067			6,497		
Well Led	Bank Spend as % of Total Pay	6.30%	9.8%			11.2%		
	Agency Spend as % of Total Pay	2%	1.1%			1.7%		
Use of Resources	Surplus / deficit	KGH: -442 NGH: -392	-4,178			-3,581		
	CIP Delivery	100%	82.3%			78.2%		

Our Caring and Effective domain executive summary

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

Good news

Areas of concern

Improvement plans in place

Patient experience

- KGH saw a slight decline in overall FFT satisfaction scores compared to the overall target of 90% (KGH 93.3% & NGH 89.9%)
- Notable increased patient satisfaction performance seen in the following areas:
 - NGH –Maternity 97.4%, Emergency depts. 79.1% & Outpatients 93.0%
- Friends and Family Test survey response volumes:
 - KGH 4,147
 - NGH 5,766
- UHN Complaints team now operational with complaints processes undergoing digitisation via DatixWeb

- Decrease in NGH Inpatient areas score from 94.8% down to 93.6%. Decrease in KGH Emergency Departments satisfaction down from 84.8% in Jan to 83.0% in Feb (target = 80% still achieved). This may be influenced by winter pressures influencing the score.
- Notification received that NGH FFT provider will cease to supply a system as of Aug 2026.
- Overdue NGH complaints backlog & labour intensive process of transferring paper system to digital platform

- Divisional FFT performance packs provided to Div leads who then report performance and mitigating actions to the Patient & Carer Experience & Engagement Committee (PCEEC).
- Steps underway with UHN Procurement team to go out to tender for a new FFT Survey supplier via the NHS Framework.
- Comprehensive complaints recovery plan in place targeting overdue complaints responses whilst also preventing 60-day breaches where possible

Mortality

- Both Trusts are within 'as expected' banding for SHMI, when compared vs National utilising the NHS England Methodology.

- NGH HSMR and SMR is 'above expected'. Issues are multi-factorial:
- 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.

- All metrics and monitored and discussed monthly at UHN Learning from Deaths Group and Quarterly at Patient Safety Committee.
- SDEC data quality issues are being reviewed by both the Clinical Governance Department and the wider UHN Learning from Deaths Group (discussed monthly).

Our Safe domain executive summary

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

Good news

Areas of concern

Improvement plans in place

Infection prevention control	Reduced number of C.diff cases for third consecutive month	- KGH over C.diff trajectory - Hand sanitiser provider no long in hand hygiene market, plan in place to switch product in April, nil cost pressure	IPC quality Improvement plan in place and monitored via IPAC
Incidents	- Reduction in the number of PSII's commissioned - No Never Events reported	- Themes this month include - Delayed transfers from ED of LOS>12hrs are in relation to mental health bed availability. - Delays in ICU/ HDU stepdown and bed availability. - Medication incidents have increased this month, with the top themes around prescribing and administration issues. - Clinical care and treatment, failure to follow policy and delay in treatment/diagnosis remain the top themes across divisions	Sepsis oversight group continues with a shift to improvement
Safe care	- Both trusts demonstrate stable staffing levels, with no special cause variation identified in Care Hours Per Patient Day (CHPPD). - KGH remains within the target range of 8–9, achieving a CHPPD of 8.93, providing assurance of appropriate staffing deployment.	NGH reports a sustained CHPPD of 9.2, marginally above the target range, reflecting maintained workforce capacity and continued monitoring to ensure staffing levels remain safe, effective and proportionate to patient acuity.	- Roster and reflect meeting remain in place - Temporary staffing reduction plan is ongoing

Our Responsive domain executive summary

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

Good news

Areas of concern

Improvement plans in place

Urgent and emergency care

- Maintaining time to initial assessment <15mins at both sites ensures safety within the ED despite winter pressures demand.
- Ambulance handover performance maintained at KGH.
- Both sites delivering to target for February NEL LoS.

- 4hr performance at NGH remains adverse to plan, however, has improved in February by 1.5%.
- High bed occupancy alongside high numbers of non-criteria to reside patients.

- 4hr improvement plans – including March sprint at both sites.
- GIRFT Further Faster improvement plan.

Elective

- A decreasing waiting list size and improving 52 week position in February
- Lots of focus and activity to support the national sprints, to improve performance for year end

- RTT is still significantly behind plan and we are not yet seeing the impact of the additional sprint activity in the data
- ENT has a deteriorating RTT and long waits position, which will represent the majority of the 52 week waits at year end

- Recovery plan for ENT is in development
- Working with consultant connect on the triage of patients who have not yet been seen, in order to support further reduction in the waiting list size and improvement in RTT

Cancer

- Good Clinical engagement with plans and trajectories for 2026/27
- Improvements in MDT meetings, with no deferrals in Gynaecology since Christmas

- Reduction across all metrics in January, in some areas at a greater level than the normal seasonal impact
- 62 day performance remains challenged, with particular concern in Gynaecology, Head and Neck and Breast

- Additional capacity for KGH Breast in place for March, which should significantly improve FDS performance and also 62 day
- Work on a new model for Dermatology for 2026/27 underway, with discussions with the ICB and primary care

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

- Bank and agency national targets met
- Vacancy rate showing long term sustained improvement
- Volunteers contributed 6,000 hours
- Absence at NGH has reduced (KGH data invalid)

- Increase in WTE at KGH (in part attributed to sprint)
- Time to hire is above target (target has been tightened to reflect national position). Impacted by recruitment controls in place e.g. VCP

- Focus on governance and control in March 2026
- Review of VCP process, proposals for automation under consideration

Culture and safety

- Civility Saves Lives programme launched with Maternity teams at KGH across 3 in person events, received positive feedback during & after the events with an additional 3 planned for March 2026
- Plans for sharing National Staff Survey (NSS) results in place (embargo lifted 12.3.26)
- Armed Forces Network presented to the Board their plans for UHN's Armed Forces Strategy.
- Revalidated our Level 3 Disability Confident Status for 3 years from 2026-2029
- As part of celebrating diversity, UHN held informal discussion panels with staff network members; the Race Equality Week discussion was chaired by CPO & LGBT History Month was chaired by COO & Group Director of Transformation & QI.
- Group CEO & UHN CPO both supported BINA event with International Nursing, Midwifery & AHP colleagues

- Ongoing organisational change and consultation processes creating uncertainty and increased pressure for some staff groups.
- Indicative NSS results show declined results at NGH
- Data from Rethinking Racism Training (commenced June 2024) depicts 5% trustwide uptake and a range of 30-60% of managers between bands 8A - VSM who have attended the training

- Joint working between L&D, OD and OHWB to embed a structured consultation support offer, ensuring staff understand available support and can engage early.
- NSS results will be shared in March alongside the promotion of improvements made last year alongside the Menti tool to capture colleague feedback live at the event.
- To support early action planning ahead of NSS embargo, divisional workshops have been arranged and headline data has been shared to enable early intervention.
- Reform of the IRC programme to allow appointing managers to hold assurance responsibility of the panel.
- Plans to address Supreme Court ruling on staff facilities has been agreed and progress on delivering a fair and inclusive environment for trans and cis women has started
- Delivered 4 thrive sessions aimed at improving respect and inclusion amongst midwives and maternity colleagues since January 2026

Our Use of Resources domain executive summary

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

Good news

Areas of concern

Improvement plans in place

Finance

- Cash draw down requests were supported for February and March.
- Both Trusts remain on track to deliver the revised year-end forecast position.

- The year-to-date I&E position is a £55.0m deficit, £42.2m worse than plan (KGH £17.9m, NGH £24.3m). This largely reflects the efficiency requirement in the last three months when the net expenditure run-rate has remained materially unchanged, along with operational and inflationary cost pressures experienced over the year.
- Deficit Support Funding (DSF) for Quarter 4 has been withheld by NHS England given the Quarter 3 financial performance of both Trusts – this has impacted the Quarter 4 cash position and will also deteriorate the final revenue outturn position.

- The Financial Recovery Team from NHSE continue to work on mitigations for the I&E position with a particular focus on temporary staffing for the remainder of the financial year.
- Cash flow mitigations remain in place and will continue.

Productivity and efficiency

- Across UHN, £7.3m of efficiencies have been delivered against a plan of £11.1m.
- YTD delivery now stands at £59.6m against a plan of £74.4m, driven largely by under identification of pay efficiencies.
- Development of the CIP plans continues to be around 88% of the target in fully developed or plans in progress and is unlikely to change further at M11.
- Efficiency planning for 26/27 is underway.

- Of the £75m of schemes with a plan in progress or fully developed, there is risk to delivery in the last month.
- There is risk in the level of development of the remainder of the identified efficiency plan, which is now unlikely to be mitigated.
- 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 radiology and pathology transformation plans, IV to oral switch and 25/26 contract review in progress.
- 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

				No target
 		• Friends and Family Inpatient (KGH) • Friends and Family Outpatients (KGH)		
		• Friends and Family A&E • Friends and Family Inpatient (NGH) • Friends and Family Outpatients (NGH) • Friends and Family Maternity • Complaint Responses (KGH) • Sex Breaches	• Complaints Responses (NGH)	
 				

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%	Feb 26	83%			84.74%	79.10%			78.40%	S T A R
Friends and Family Test satisfaction score - inpatients	95%	Feb 26	94.60%			94.17%	95.10%			95.11%	S T A R
Friends and Family Test satisfaction score - outpatients	95%	Feb 26	97.60%			96.76%	93%			93.73%	S T A R
Friends and Family Test satisfaction score - maternity	95%	Feb 26	98.60%			96.23%	97.40%			95.75%	S T A R
Complaints response performance	95%	Feb 26	89%			84.27%	50%			33.26%	S T A R
Single sex breaches	0	Feb 26	1			3.75	6			15.44	S T A R



Data quality assessment

KGH single sex breaches data only available from November 24.

SPC indicator key

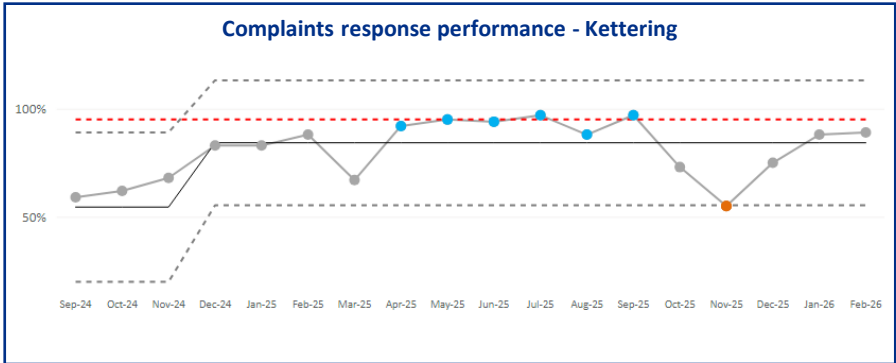
		Worsening		Improving		No change
		Below target		Above target		Inconsistent in whether target achieved

Data quality indicator key

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.

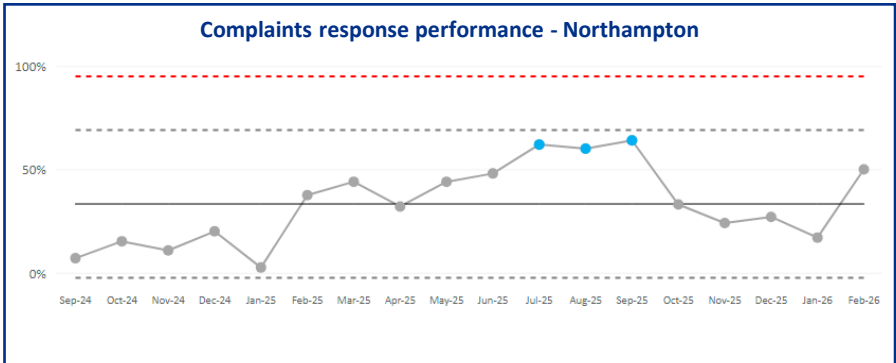


Understanding the performance

- KGH achieved 89% of cases responded to within 60-days. NGH achieved 50% (up from 17% for Jan).
- 62 cases over 60 days old for NGH (down from 70+ for Jan). 5 overdue for KGH with plans for all in place.

What are the issues impacting performance?

- Capacity in team to draft cases, seeking additional resource to fill vacancies on a temporary basis.
- Maternity leave post not covered at present, post is currently being shortlisted and planning to interviews.



What SMART actions are being taken to improve?

- No cases to breach 120-day deadline. 17 due in March- chasers sent to division.
- Migrate NGH paper cases onto Datix Web system so on same system as KGH. Plan to be completed end of March 2026.
- April 2026- introduce overdue meeting (can only be achieved once on electronic Datix web system).
- April 2026- introduce weekly divisional meetings re cases with divisional leads.

Risks

- Currently advertising Maternity leave post, if not filled will impact ability to draft responses and triage new cases. Risk of more cases going above 60 / 120 day deadlines.

Data Quality Indicators		Site	Target	Latest Date	Actual	Variation	Assurance	Average
S	T	KGH	95%	Feb 26	89%			84.27%
A	R	NGH	95%	Feb 26	50%			33.26%

Our Effective domain metrics

Responsible director(s): Hemant Nemade, Medical Director

				No target
 	SHMI (KGH)			
	- HSMR (KGH) - SMR (KGH)			
 	SHMI (NGH)	- HSMR (NGH) - SMR (NGH)		

Effective

Responsible director(s): Hemant Nemade, Medical Director

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average	Data Quality Indicators
Mortality											
SHMI	100	Feb 26	97			98.09	98.40			94.52	S T A R
HSMR	100	Feb 26	88.50			90.84	106.90			101.88	S T A R
SMR	100	Feb 26	92.70			91.98	105.60			98.31	S T A R



Data quality assessment

No data quality issues identified.

SPC indicator key

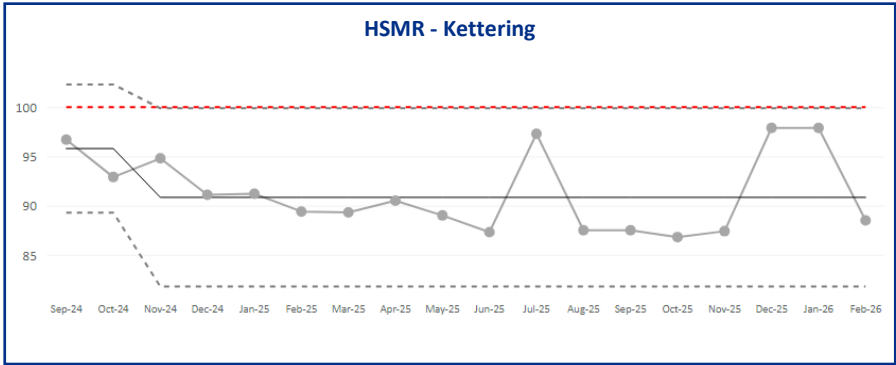
		Worsening			Improving		No change
		Below target			Above target		Inconsistent in whether target achieved

Data quality indicator key

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

Hospital Standardised Mortality Ratio (HSMR)

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

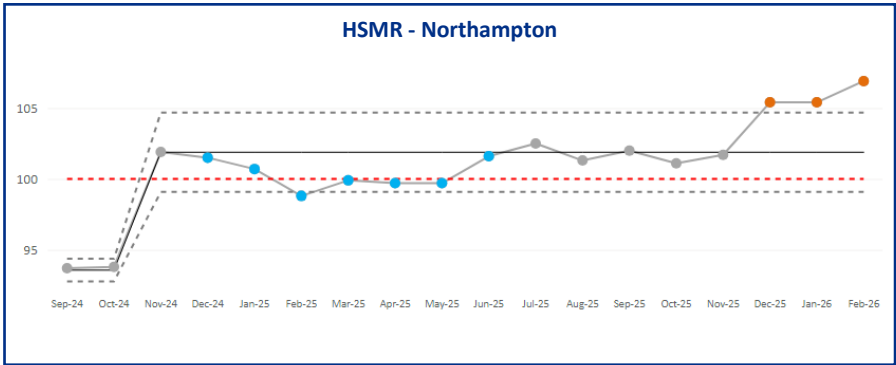


Understanding the performance

- **Kettering General Hospital** – HSMR is currently within ‘below expected’ bandings when compared nationally utilising the Dr Foster methodology.
- **Northampton General Hospital** – HSMR is currently ‘– HSMR is currently within ‘above expected’ bandings when compared nationally utilising the Dr Foster methodology.

What are the issues impacting performance?

- 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?

- All metrics are monitored and discussed monthly at UHN Learning from Deaths Group and Quarterly at Patient Safety Committee.
- ‘Impacting performance’ includes currently areas of focus, both from Clinical Governance and the wider UHN Learning from Deaths Group (discussed monthly).

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.

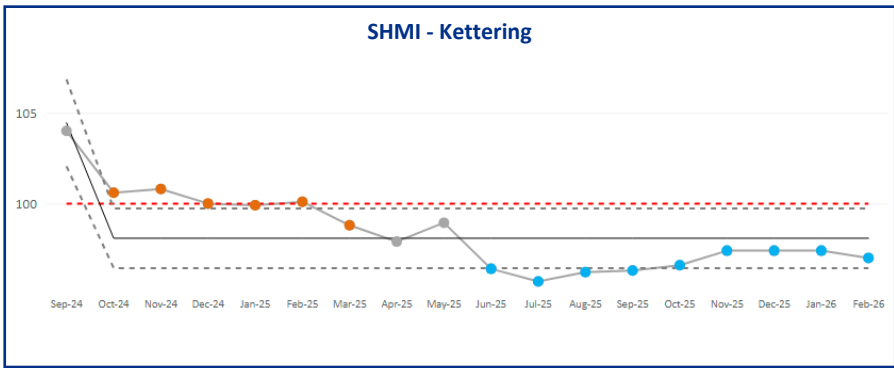
Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	100	Feb 26	88.50			95.80
NGH	100	Feb 26	106.90			93.57

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.

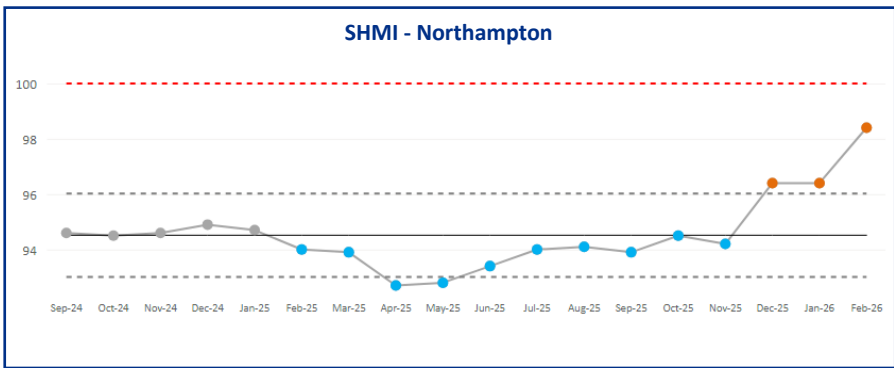


Understanding the performance

- Both Trusts are within 'as expected' banding for SHMI, when compared vs National utilising the NHS England Methodology.

What are the issues impacting performance?

- No issues – both Trusts are within 'as expected' range.

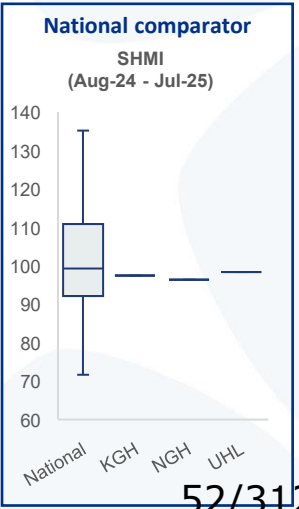


What SMART actions are being taken to improve?

- N/A

Risks

- N/A



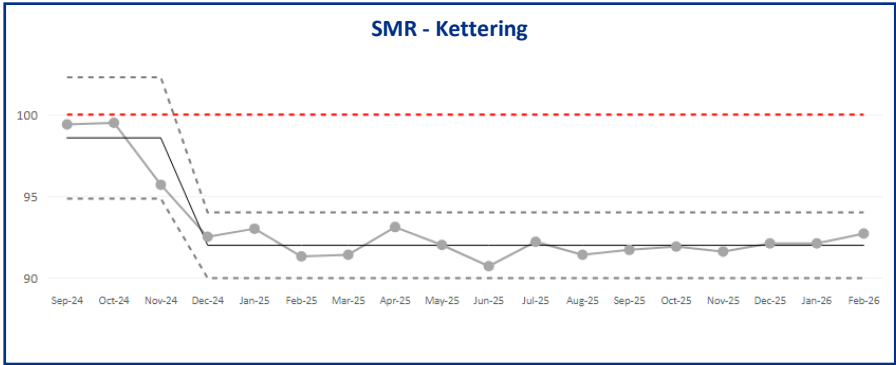
Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	100	Feb 26	97			98.09
NGH	100	Feb 26	98.40			94.52

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.

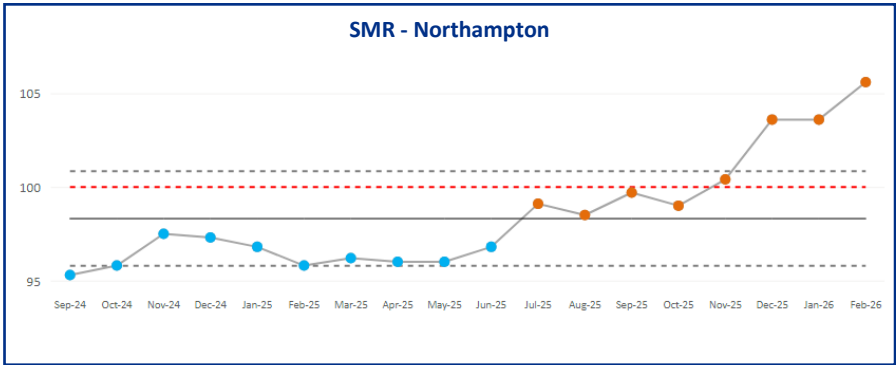


Understanding the performance

- Kettering General Hospital** – HSMR is currently within ‘below expected’ bandings when compared nationally utilising the Dr Foster methodology.
- Northampton General Hospital** – HSMR is currently ‘– HSMR is currently within ‘above expected’ bandings when compared nationally utilising the Dr Foster methodology.

What are the issues impacting performance?

- 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?

- All metrics are monitored and discussed monthly at UHN Learning from Deaths Group and Quarterly at Patient Safety Committee.
- Impacting performances includes currently areas of focus, both from Clinical Governance and the wider UHN Learning from Deaths Group (discussed monthly).

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.

Data Quality Indicators

S

T

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Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	100	Feb 26	92.70			98.58
NGH	100	Feb 26	105.60			98.31

Our Safe domain metrics

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

				No target
 		• Never events (KGH) • MRSA (KGH)	• Never events (NGH) • Care hours (NGH)	
		• MRSA (NGH) • MSSA • Care hours (KGH)		• Serious harms per 1000 bed days • C Diff • Serious harm falls per 1000 days (NGH) • Serious harm pressure ulcers per 1000 days
 				• Serious harm falls per 1000 days (KGH)

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

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average
Incidents										
Serious or moderate harms per 1000 bed days	-	Feb 26	1.88			0.93	0.89			1.10
Never event incidence	0	Feb 26	0			0.53	0			0.17
Infection Prevention Control										
Number of MRSA Bacteraemia	0	Feb 26	0			0.05	0			0.16
C Diff per 100,000 bed days	-	Feb 26	13.96			14.28	21.02			38.38
Number of MSSA Bacterium	0	Feb 26	1			0.84	0			1.63
Safe care										
Care hours per patient day	9	Feb 26	8.93			9.07	9.20			9.48
Serious or moderate harms – falls per 1000 bed days	-	Feb 26	0.28			0.08	0			0.09
Serious or moderate harms – pressure ulcers per 1000 bed days	-	Feb 26	0			0.04	0.26			0.18

Data Quality Indicators

S T A R

S T A R

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S T A R

Data quality assessment

No data quality issues identified.

SPC indicator key

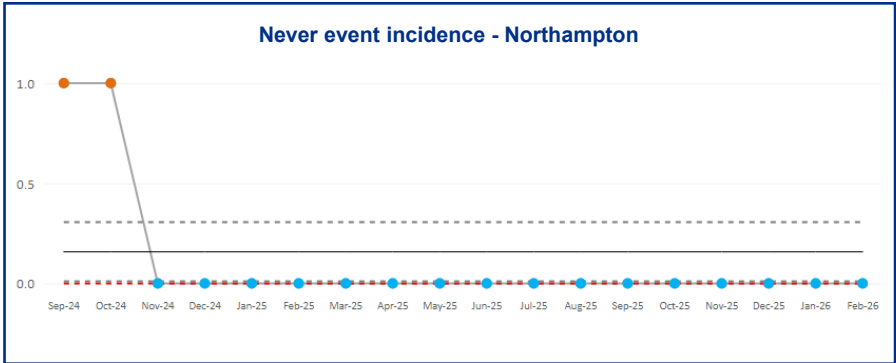
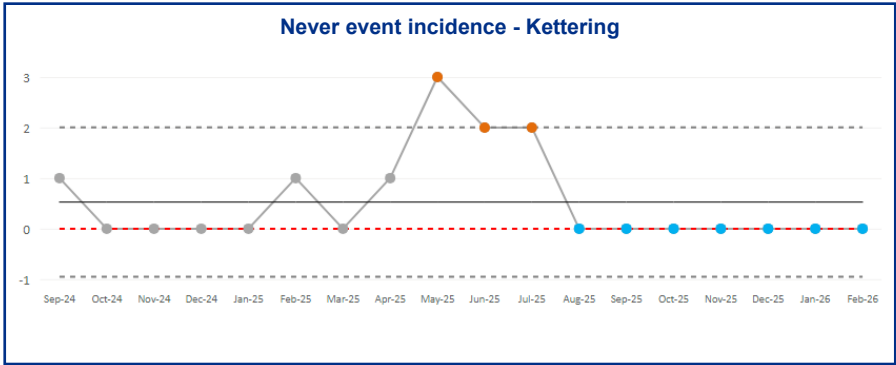
Worsening	Improving	No change
Below target	Above target	Inconsistent in whether target achieved

Data quality indicator key

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

Never event incidence

The number of never events.



Data Quality Indicators		Site	Target	Latest Date	Actual	Variation	Assurance	Average
S T A R		KGH	0	Feb 26	0			0.53
		NGH	0	Feb 26	0			0.16

Understanding the performance

- There have been no NEVER Events declared for this month

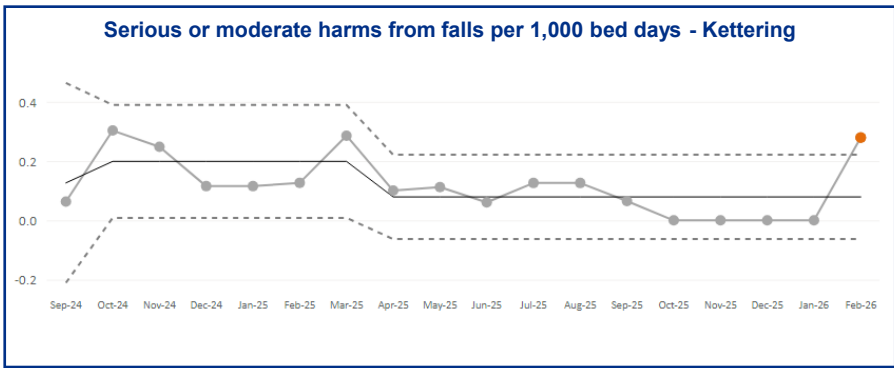
What are the issues impacting performance?

What SMART actions are being taken to improve?

Risks

Serious or moderate harms - falls

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

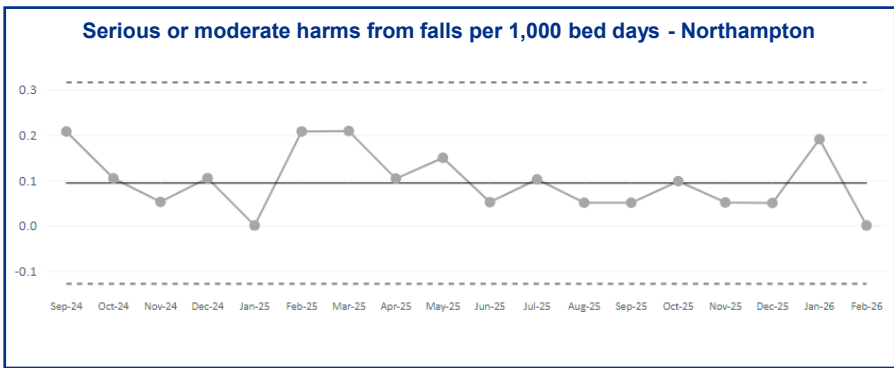


Understanding the performance

- There were 2 moderate harm, 1 severe harm and 1 fatal harm (not as a result of a patient safety incident) inpatient falls at KGH.
- 2 patient sustained hip fractures, 1 patient sustained a fractured pubic rami and 1 patient sustained a fractured wrist.

What are the issues impacting performance?

- Escalation of patient behaviour.
- Following the post falls protocol.



What SMART actions are being taken to improve?

- Local training sessions
- Learning from incidents information shared.
- Collaborative work to align UHN processes.

Risks

- All risks associated with inpatient falls are monitored through the risk register.

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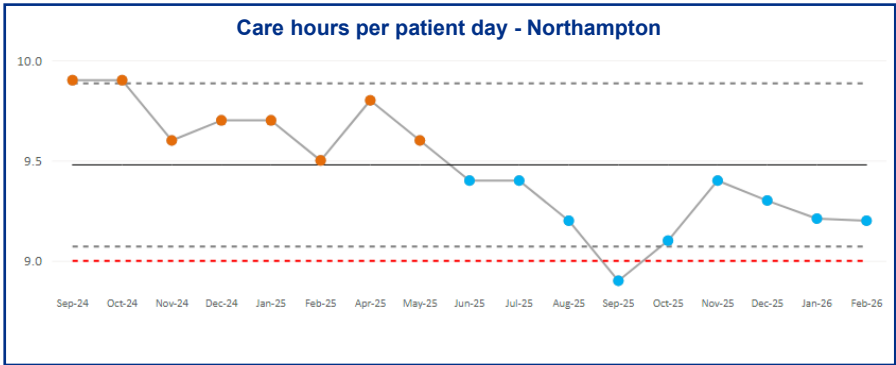
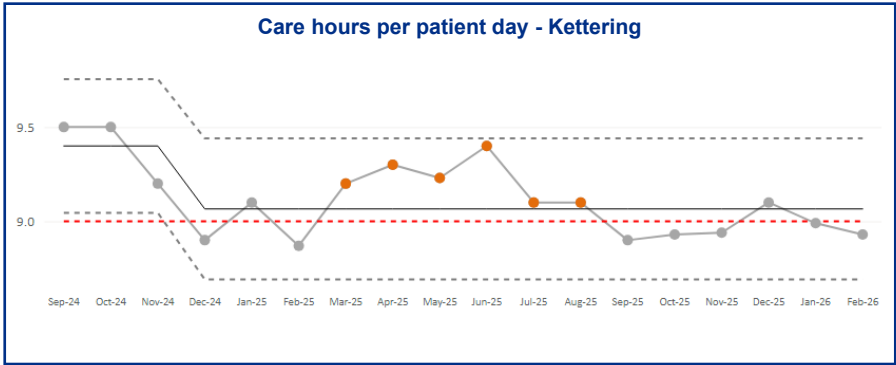
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20/69

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	-	Feb 26	0.28			0.20
NGH	-	Feb 26	0			0.09

Care hours per patient day

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

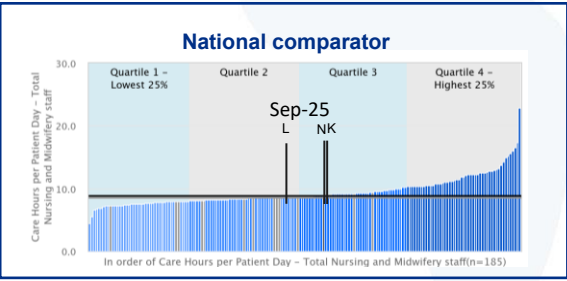


Data Quality Indicators		Site	Target	Latest Date	Actual	Variation	Assurance	Average
		KGH	9	Feb 26	8.93			9.40
		NGH	9	Feb 26	9.20			9.48

- ### Understanding the performance
- Both Kettering and Northampton demonstrate no special cause variation in the number of care hours per patient day (CHPPD).
 - KGH falls within the target range of 8-9 achieving a CHPPD of 8.93. NGH sits just above with a sustained CHPPD of 9.2.
- ### What SMART actions are being taken to improve?
- Temporary staffing usage – grip and control remains in place.
 - ETOC demand to be received as part of Biannual Establishment Review (31 March 2026). This will highlight areas which can support ETOC demand within template.
 - Monitor and support units to align to required staffing template.
 - Breakdown of CHPPD by speciality within safe staffing report to identify areas of focus, where a raised CHPPD may otherwise be masked.

- ### What are the issues impacting performance?
- Staffing exceeding demand template results in an increased CHPPD, in addition small ward phenomena has a negative impact on CHPPD and there are several areas across the group which fall into this remit.

- ### Risks
- Increases risks to patients with higher unregistered workforce ratios providing care
 - Supervisory burden to the ward leader, nurse in charge and registrants
 - Financial risks associated with uncontrolled workforce planning



Our Responsive domain metrics

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

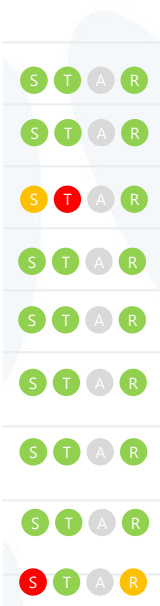
				No target
		Time to assessment (NGH)	Bed utilisation (KGH)	
	- Ambulance Handover (KGH) - Decision to Admit (KGH)	- A&E 4 hour - Ambulance Handover (NGH) - Cancer Faster Diagnosis (NGH) 31 day to first appointment 62 day to first appointment 52 week as % of waiting list (KGH) - Theatre utilisation (KGH) - OP as a % of consultant FTE	- Bed utilisation (NGH) - Stranded patients 7+ days - Stranded patients 21+ days - Reason to reside 52 week as % of waiting list (NGH) - Theatre utilisation (NGH) - Average cases on a list (KGH)	
	- Time to assessment (KGH) - Decision to admit (NGH)	Cancer Faster Diagnosis (KGH)	RTT	Size of RTT

Responsive – Urgent and Emergency Care

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

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average
UEC										
A&E 4 hour performance	78%	Feb 26	78.91%			79.28%	68.48%			65.82%
Time to initial assessment	15	Feb 26	12.26			11.11	11.98			19.11
Ambulance Handover 45 minute Performance %	99%	Feb 26	89.47%			76.06%	69.89%			67.74%
12 hour wait in the department	10%	Feb 26	10.50%			10.97%	12.90%			13.92%
Bed Utilisation	92%	Feb 26	97.22%			98.28%	99.41%			99.24%
Non-elective LOS (Model Hospital Closed Spells)	9.90	Feb 26	9.23			9.81	9.84			10.32
Stranded patients (7+ day length of stay)	42%	Feb 26	53.86%			54.74%	56.72%			57.25%
Super-Stranded patients (21+ day length of stay)	12%	Feb 26	19.04%			19.64%	23.13%			23.31%
Patients with a reason to reside	80%	Feb 26	59.84%			58.90%	68.80%			73.38%

Data Quality Indicators



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

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

A review is ongoing for KGH to ensure all future reported values match the agreed definition as the denominator currently includes non G&A beds.

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

SPC indicator key			
Worsening	Improving	No change	
Below target	Above target	Inconsistent in whether target achieved	

Data quality indicator key			
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

Responsive – Cancer and Elective

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

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average
Cancer										
Cancer Faster Diagnostic Standard	80%	Jan 26	48.90%			69.78%	64.70%			74.29%
31-day wait for first treatment	96%	Jan 26	86.50%			93.43%	89.60%			92.55%
62-day wait for first treatment	70%	Jan 26	54.50%			69.38%	57.50%			65.82%
Elective										
RTT performance	70%	Feb 26	61.80%			64.14%	59.31%			61.96%
Size of RTT waiting list	-	Feb 26	25,274			26121.13	42,959			42432.38
52 week waits as a % of the waiting list	1%	Feb 26	1.02%			1.05%	1.49%			1.73%
Percentage of patients waiting no longer than 18 weeks for a first appointment	72%	Feb 26	66.26%			67.23%	58.81%			64.19%

Data Quality Indicators

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.

S	T	A	R
S	T	A	R
S	T	A	R
S	T	A	R
S	T	A	R
S	T	A	R
S	T	A	R

Data quality assessment

No data quality issues identified.

SPC indicator key		
		Worsening
		Above target
		Inconsistent in whether target achieved

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

Responsive – Productivity

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

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average	Data Quality Indicators
Productivity											
Outpatient appointments per consultant FTE	116	Feb 26	140			139	127			140.95	S T A R
Average cases per list	2.50	Feb 26	2.39			2.35	2.37			2.25	S T A R
Theatre utilisation	85%	Feb 26	82.29%			82.22%	78.95%			78.40%	S T A R

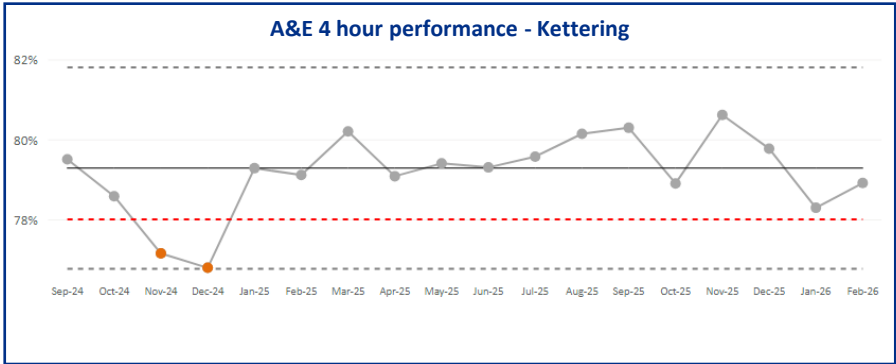
Data quality assessment
None identified

SPC indicator key		
	Worsening	
	Below target	

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

A&E 4-hour performance

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

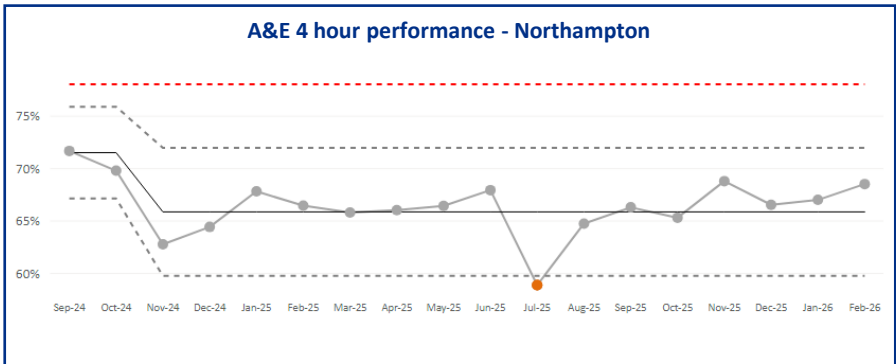


Understanding the performance

- Overall 4hr performance includes Type 1, Type 2 (NGH) and Type 3 (both).
- KGH remains >78% target at 79% in Feb.
- NGH showing a 1.5% improvement in Feb at 68.5% compared to Jan position.

What are the issues impacting performance?

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



What SMART actions are being taken to improve?

4hr sprint for March planned with Consultant at front door (NGH), improved patient pathway from PED to PAU (both sites) and overnight UTC cover(NGH).
Lead nurse in ED for discharge at NGH from March planned.

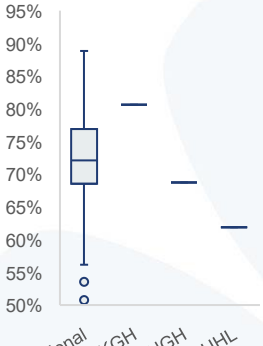
Focus on non-admitted performance.

Risks

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

National comparator

A&E 4 hour performance (Nov-25)



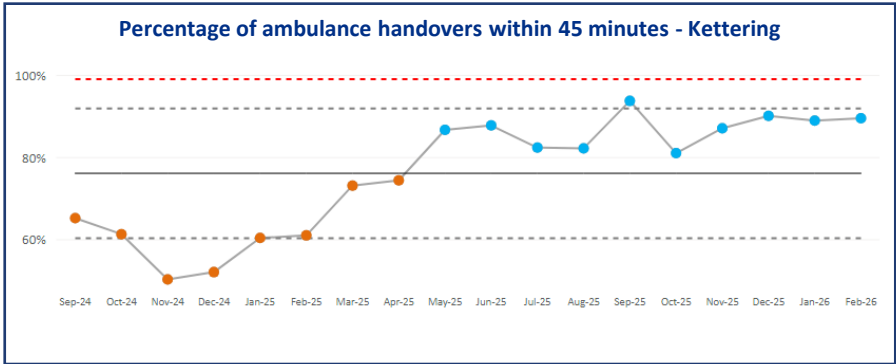
Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	78%	Feb 26	78.91%			79.28%
NGH	78%	Feb 26	68.48%			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.

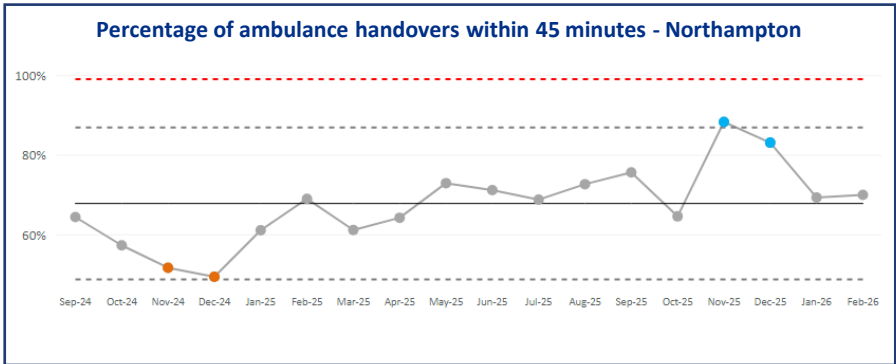


Understanding the performance

- Continued focus on improving ambulance handover times.
- KGH performance has been maintained into Q4 at 90% in <45mins.
- NGH performance has been more challenged into Q4 at 70% in <45mins.

What are the issues impacting performance?

- Admitted patient flow through ED.
- Numbers of patients requiring support discharge waiting.
- Increase in conveyances across Northants, February 5.3% 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.

Use of SIREN for pre arrival information to plan capacity and safe handover.

Maximising use of SDEC.

Release to respond protocol.

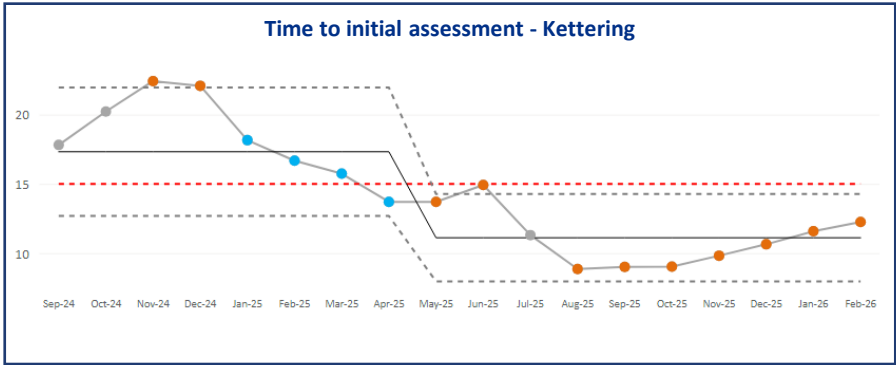
Risks

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

Data Quality Indicators		Site	Target	Latest Date	Actual	Variation	Assurance	Average
		KGH	99%	Feb 26	89.47%			76.06%
		NGH	99%	Feb 26	69.89%			67.74%

Time to initial assessment

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

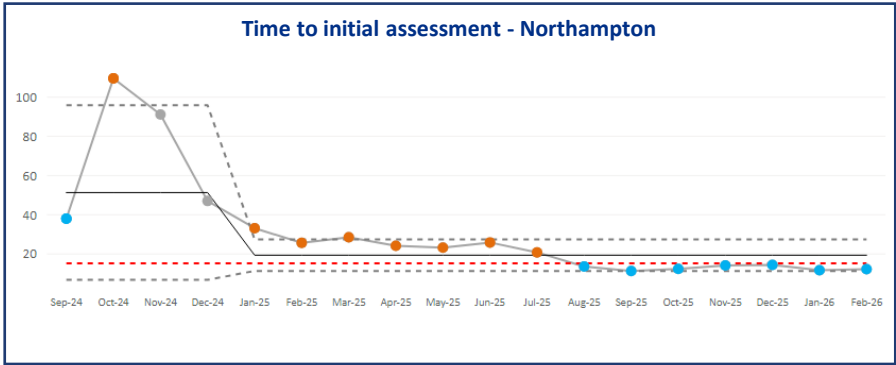


Understanding the performance

- Both departments delivering <15mins average time to initial assessment.
- Slight increase over the last 3 months at KGH. Performance maintained at NGH.

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.

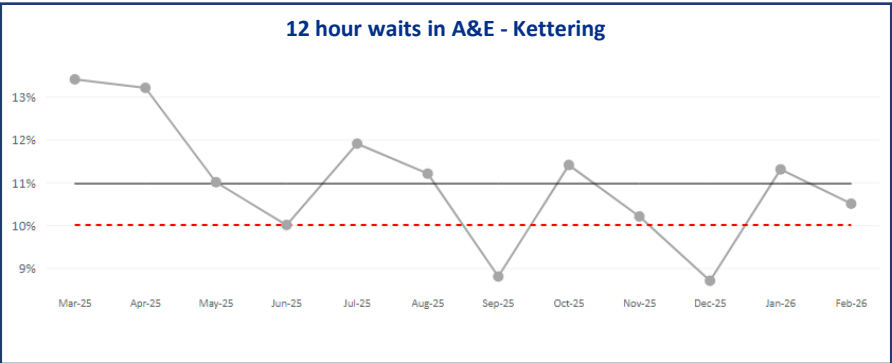
Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	15	Feb 26	12.26			17.32
NGH	15	Feb 26	11.98			51.06

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.

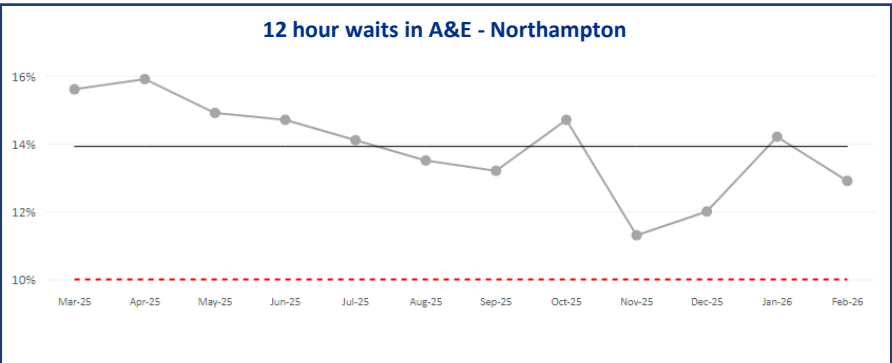


Understanding the performance

- YTD has seen improvement at both sites for 12hr waits in ED.
- KGH 1% decrease in Feb-26.
- NGH 1% decrease in Feb-26.

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.
- Work on Internal Professional Standards to improve admitted patient flow.

Risks

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

Data Quality Indicators

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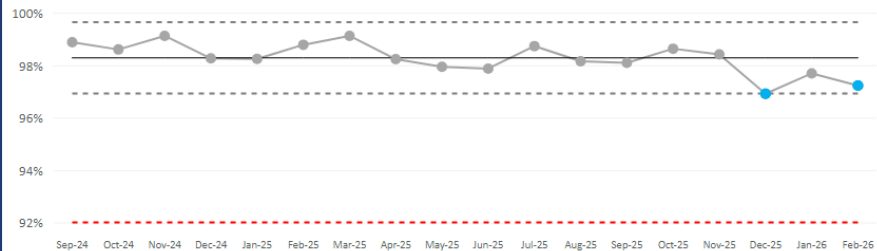
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Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	10%	Feb 26	10.50%			10.97%
NGH	10%	Feb 26	12.90%			13.92%

Bed utilisation

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

Bed utilisation - Kettering



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.

Bed utilisation - Northampton



What SMART actions are being taken to improve?

- Reduction in LoS plans across UHN and system winter support actions to reduce bed occupancy and improve flow.
- Continued use of release 2 respond to support capacity and risk across the organisation.
- Maximise use of SDECs as admission avoidance.

Risks

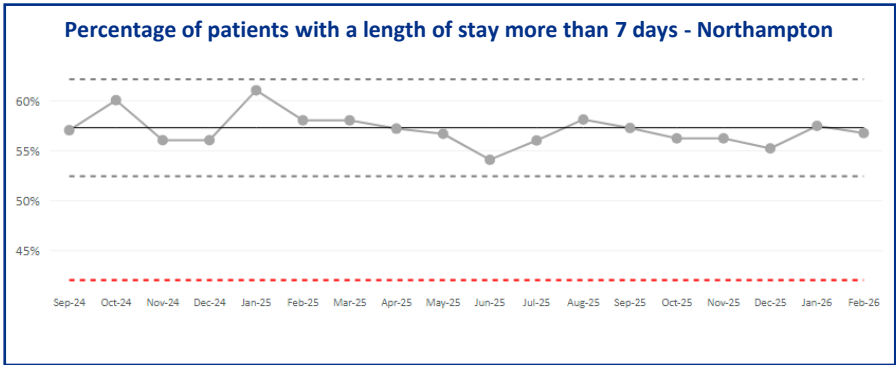
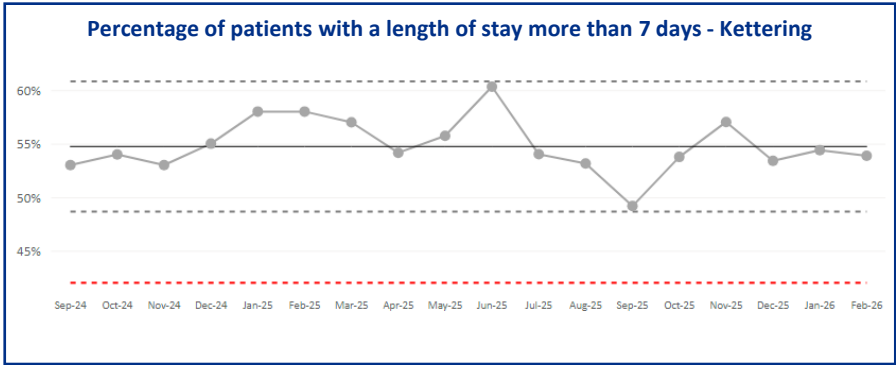
- Poor patient experience due to ED delays.
- Impact on 12hr/24hr performance.
- ED overcrowding.
- Ambulance handover delays.

Data Quality Indicators

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	92%	Feb 26	97.22%			98.28%
NGH	92%	Feb 26	99.41%			99.24%

Patients with length of stay greater than 7 days

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



Data Quality
Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	42%	Feb 26	53.86%			54.74%
NGH	42%	Feb 26	56.72%			57.25%

Understanding the performance

- Slight reduction in stranded position into February compared to January.

What are the issues impacting performance?

- Increase in patient acuity and demand during winter period.

What SMART actions are being taken to improve?

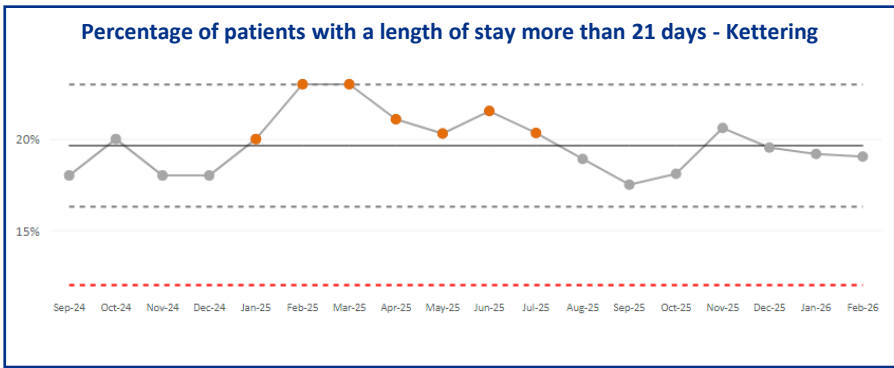
- Boardrounds and focus on SHOP model.
- Internal and external escalation delays to discharge.
- Maximising use of discharge lounge.
- Maximising use of SDEC.
- P1 working group to reduce NEL LOS.

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.

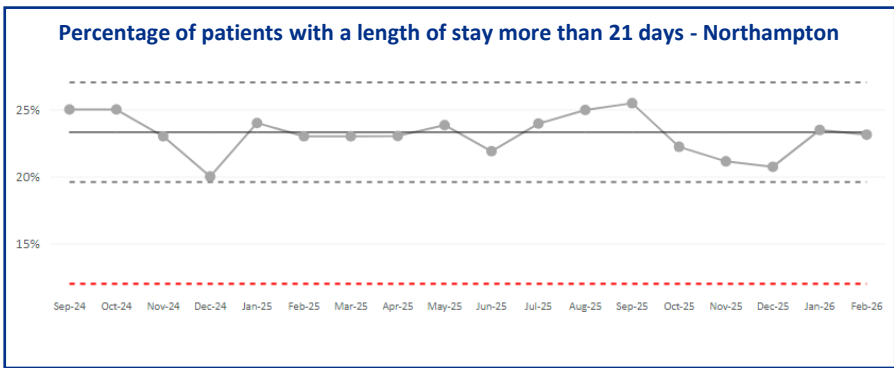


Understanding the performance

- KGH 21 day position is reducing over the last 3 months.
- NGH 21 day position remains high in February at 23% with no change from January.

What are the issues impacting performance?

- P2/3 supported discharge waits across UHN.
- As of week 48 (end of February) 2026 position of 185 patients waiting supported discharge against 75 across UHN.



What SMART actions are being taken to improve?

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

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

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

Risks

Bed occupancy remains high impacting patient flow.

Ongoing use of corridor care risk across ED and inpatient ward areas.

Data Quality Indicators

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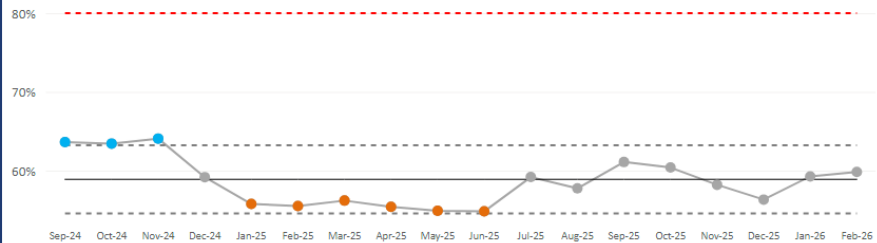
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Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	12%	Feb 26	19.04%			19.64%
NGH	12%	Feb 26	23.13%			23.31%

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.

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.

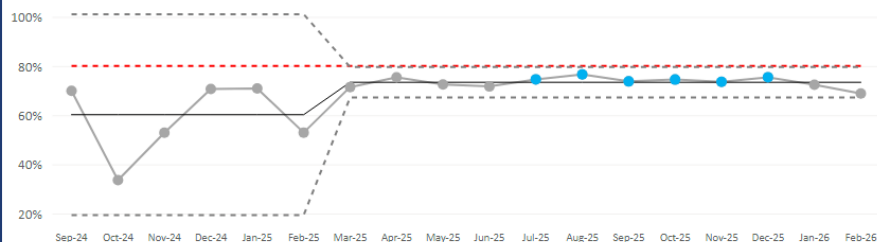
What are the issues impacting performance?

Number of patients waiting supported discharge.

Housing / waiting for equipment.

Inpatients awaiting a mental health community bed.

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.

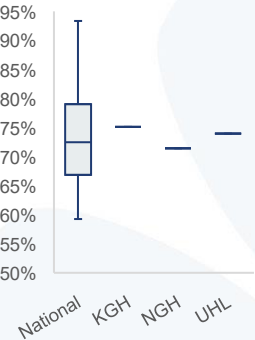
Integrated discharge hub planning.

Risks

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

National comparator

Patients meeting the criteria to reside (Sep-25)

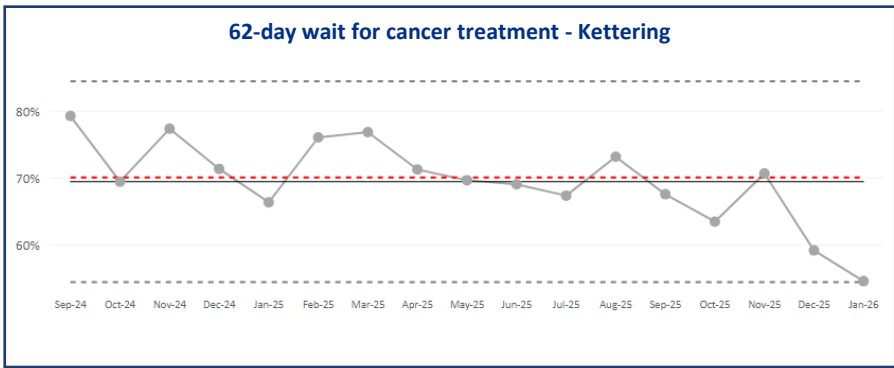


Data Quality Indicators

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	80%	Feb 26	59.84%			58.90%
NGH	80%	Feb 26	68.80%			73.38%

62-day wait to start treatment from referral

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

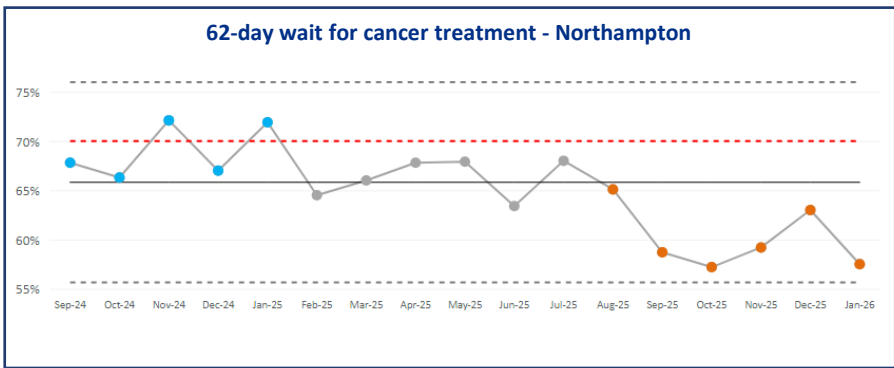


Understanding the performance

- For 62 days, the decline in performance mirrors a similar reduction from December as in the previous year.
- Neither Trust met the standard, recording a further reduction in performance from the previous month

What are the issues impacting performance?

- Breast continues to impact performance, with the main delays being at the start of the pathway.
- Limited robotic capacity has also contributed to pressures within Colorectal and Urology.
- A high number of long waiters were treated, which has helped reduce the backlog but has had an overall impact on performance

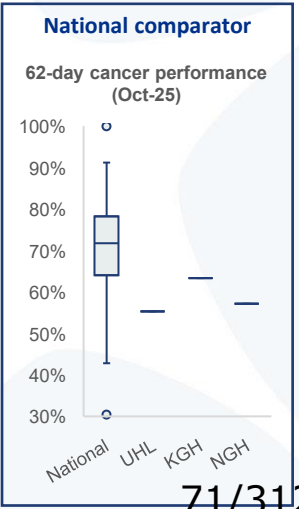


What SMART actions are being taken to improve?

- Trajectories and recovery plans submitted by all specialities
- Meetings with clinical team, GM, Dep COO and Cancer lead taking place to discuss cancer plans
- Weekly PTL and operational meetings continue to take place to provide oversight of performance.

Risks

- Workforce changes in Skin
- Wait times for first OPA and poor performance in diagnosing cancers by day 28, have a consequential impact on the delivery of 62 days



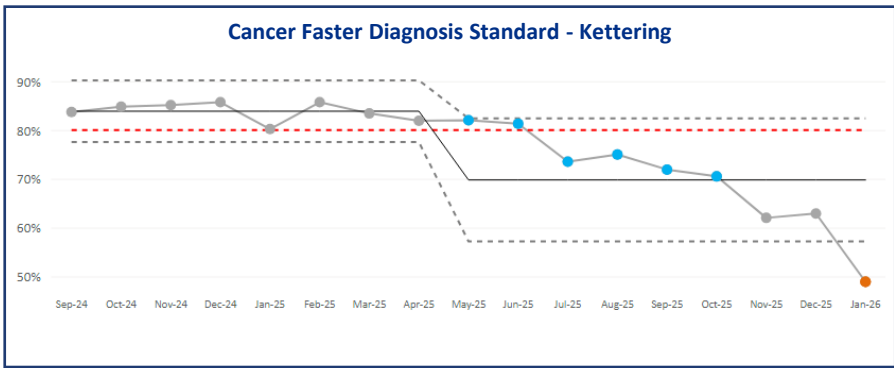
Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	70%	Jan 26	54.50%			69.38%
NGH	70%	Jan 26	57.50%			65.82%

Cancer Faster Diagnosis Standard

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

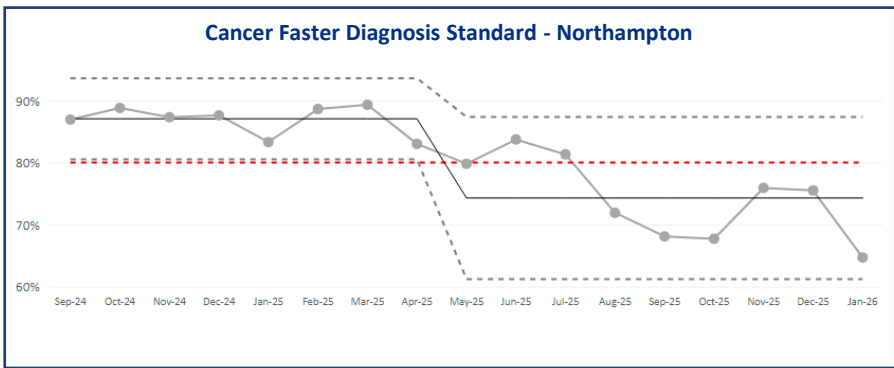


Understanding the performance

- Both Trusts saw a steeper decline in performance than the previous January, likely due to the lack of resilience in pathways currently
- Neither trust met the standard

What are the issues impacting performance?

- Skin and Breast backlogs continued to affect ability to achieve the standard
- Breast booking at day 32 for first OPA and head and neck booking at day 29

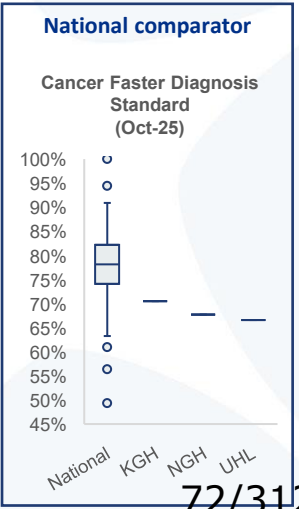


What SMART actions are being taken to improve?

- Super clinics commenced in January to see and treat skin patients
- YMS (insourcing) to commence in Breast in March 2026

Risks

- Recovery of Breast capacity and delivery of sustainable capacity
- Seasonal resilience to changes in referral rates



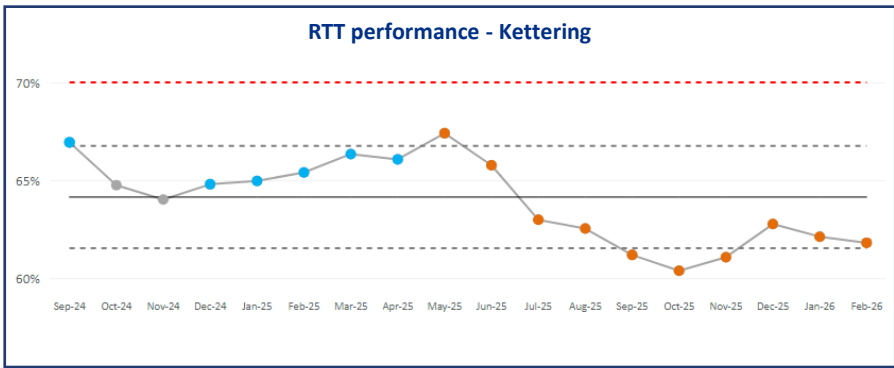
Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	80%	Jan 26	48.90%			83.86%
NGH	80%	Jan 26	64.70%			87.04%

Referral to Treatment performance

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

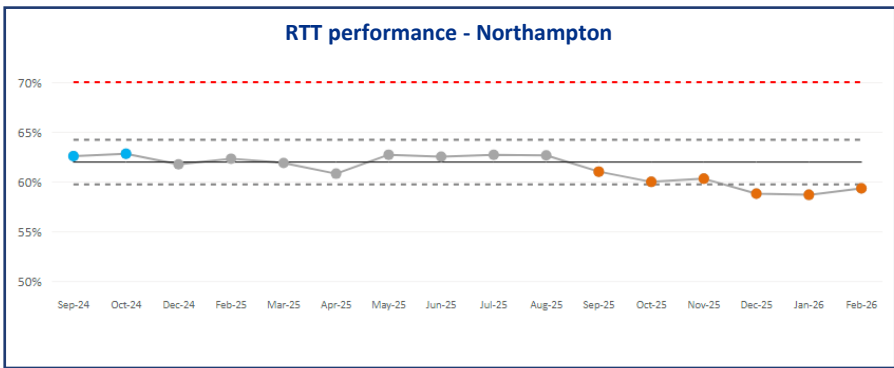


Understanding the performance

- We continue to be behind plan for RTT delivery
- There has been a first only sprint running across February, where we would expect approximately 20% of first appointments to result in a clock stop and improve performance - despite this we saw a decline at KGH
- At a UHN level, performance improved from 59.95% to 60.23% from January to February

What are the issues impacting performance?

- Reduction in activity across the year to support the financial position
- IPTs from NGH to KGH to support the treatment of patients impacts KGH RTT position

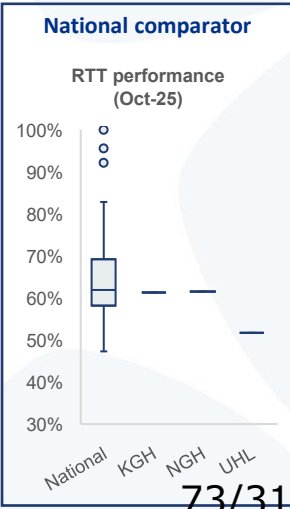


What SMART actions are being taken to improve?

- Use of external Triage companies to support challenged specialties
- Additional outpatient first appointments
- Validation

Risks

- Administrative capacity to book and outcome



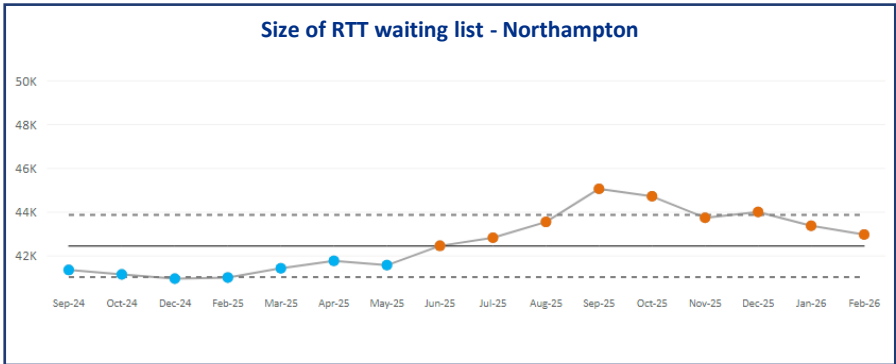
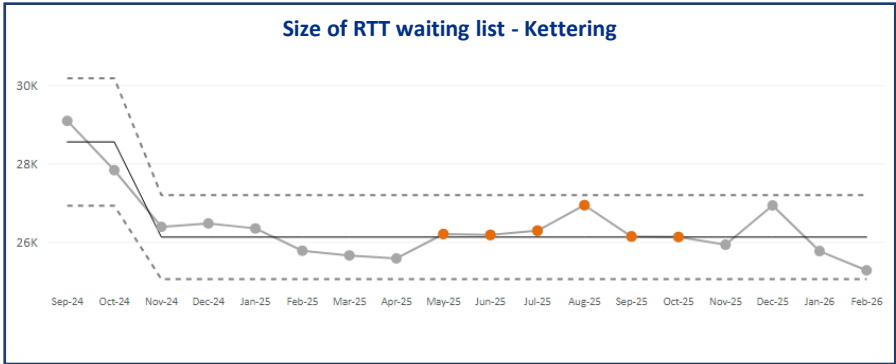
Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	70%	Feb 26	61.80%			64.14%
NGH	70%	Feb 26	59.31%			61.96%

Size of RTT waiting list

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



Data Quality Indicators		Site	Target	Latest Date	Actual	Variation	Assurance	Average
S T A R		KGH	-	Feb 26	25,274			28545.40
		NGH	-	Feb 26	42,959			42432.38

Understanding the performance

- Really positive reduction in the waiting list size since Christmas across both sites

What are the issues impacting performance?

What SMART actions are being taken to improve?

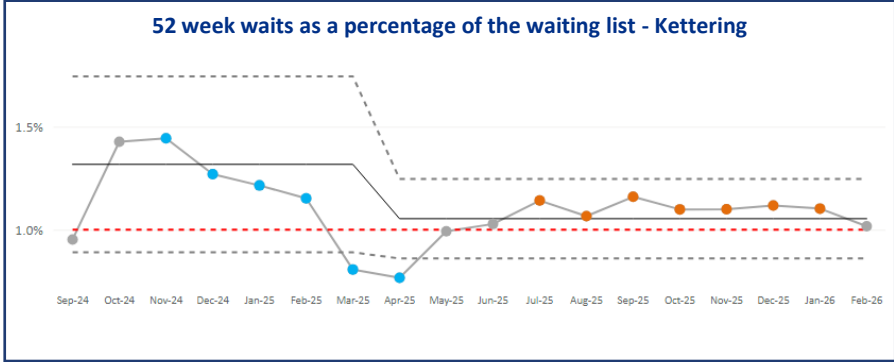
- Focused validation across both sites
- Dermatology outsourcing has helped with reducing the waiting list size and additional triage is taking place in ENT and Gastroenterology

Risks

- We plan to move the ASIs onto the KGH waiting list in April, to support a move to booking only 6 weeks ahead, in preparation for automated booking. This will temporarily increase the size of the waiting list.

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

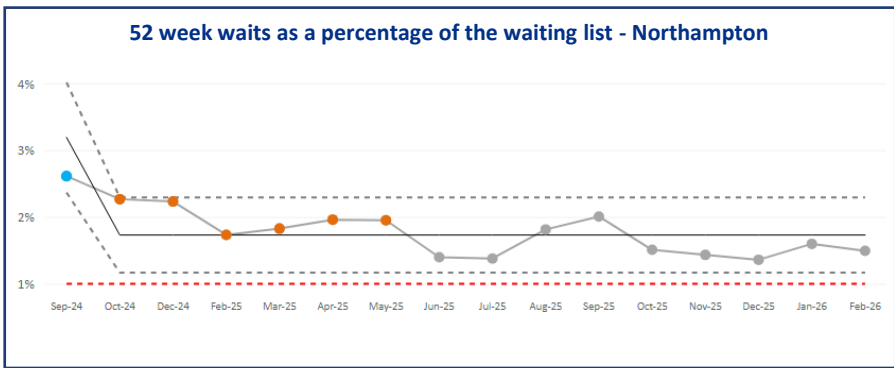


Understanding the performance

- An improvement in the performance in February, following the sprint action being taken across both Trusts
- We expect to deliver the national target of less than 1% of the waiting list waiting 52 weeks or more, the improvement in February is positive given the waiting list size has also reduced

What are the issues impacting performance?

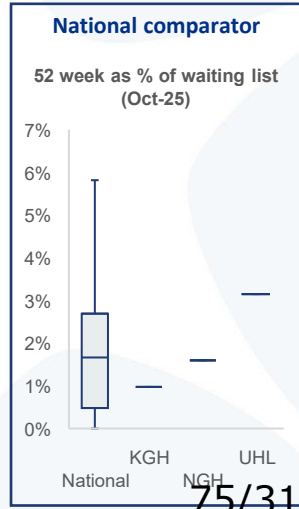
- ENT has a high number of 52 week breaches at NGH which is increasing month on month, we are working with the clinical team on a recovery plan
- Oral Surgery, T&O and Dermatology have the next highest numbers across UHN, although all are below 100



What SMART actions are being taken to improve?

- Focused additionality through the 52 week sprint in key specialties
- Additional validation of the long waits cohort

Risks



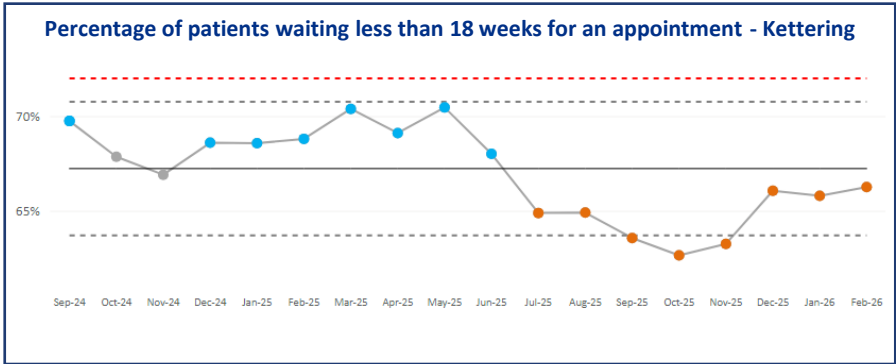
Data Quality Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	1%	Feb 26	1.02%			1.32%
NGH	1%	Feb 26	1.49%			3.19%

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

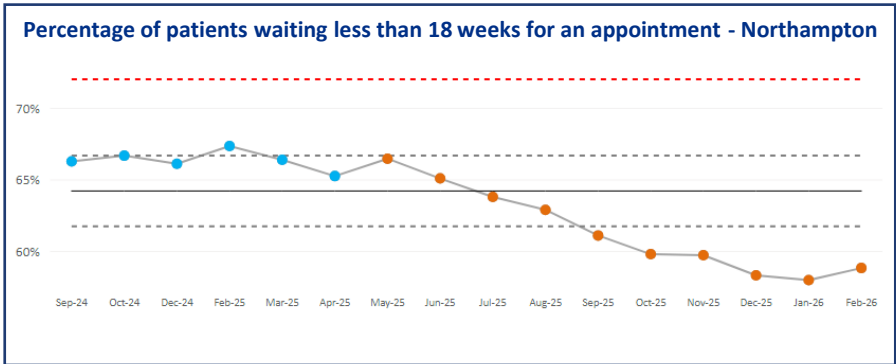


Understanding the performance

- Significant improvement at KGH since Christmas
- NGH has started to alter the deteriorating trend

What are the issues impacting performance?

- Capacity for first appointments
- Balance between urgent and routine referrals, especially in high volume cancer specialties



What SMART actions are being taken to improve?

- Focus on clinic template standardisation and improving the first to follow up ratio
- First only sprint clinics

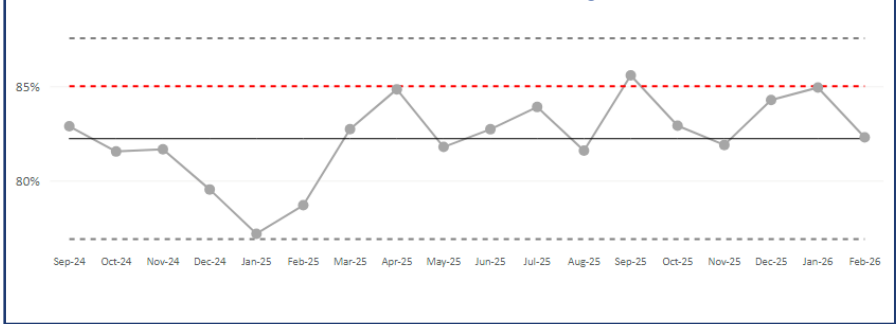
Risks

Data Quality Indicators		Site	Target	Latest Date	Actual	Variation	Assurance	Average
		KGH	72%	Feb 26	66.26%			67.23%
		NGH	72%	Feb 26	58.81%			64.19%

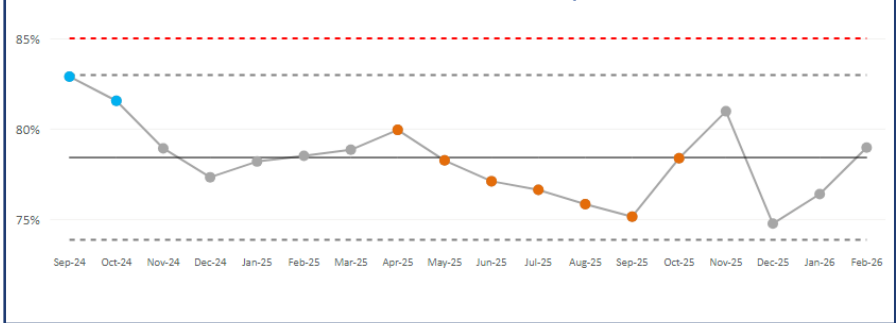
Theatre utilisation

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

Theatre utilisation - Kettering



Theatre utilisation - Northampton



Data Quality
Indicators



Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	85%	Feb 26	82.29%			82.22%
NGH	85%	Feb 26	78.95%			78.40%

Understanding the performance

- An improving picture at NGH, to bring it up to the utilisation delivered at KGH

What are the issues impacting performance?

- NGH not having a centralised booking team and lack of pre-op + digital system means we are seeing a high cancellation rate

What SMART actions are being taken to improve?

- Work is underway to improve the data visibility via FDP
- Lookback data meetings are in place reviewing all OTDC, changes to first patient, Utilisation, late starts and early finishes.

Risks

- High incoming trauma affecting elective sessions

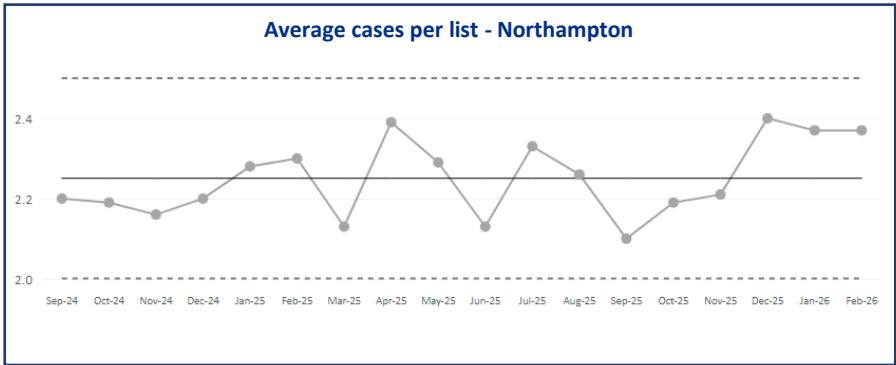
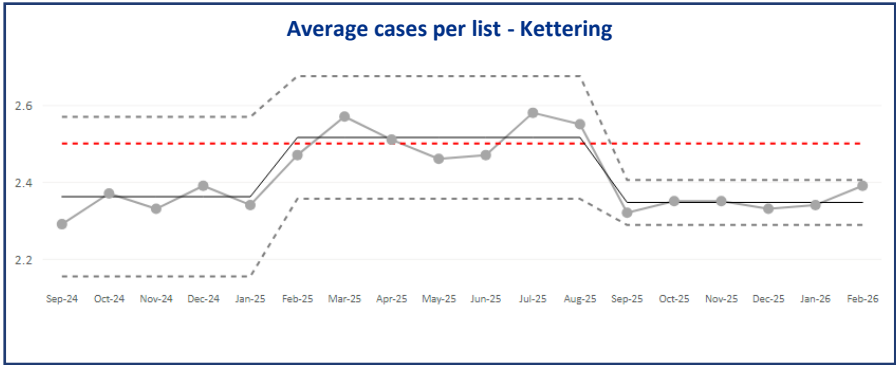
National comparator

Nov-25



Average cases per list

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



Data Quality Indicators		Site	Target	Latest Date	Actual	Variation	Assurance	Average
		KGH	2.50	Feb 26	2.39			2.52
		NGH	2.50	Feb 26	2.37			2.25

Understanding the performance

- Both trusts delivering very similar cases per list in February
- Historical benchmark is good and should be improved with the most recent data

What SMART actions are being taken to improve?

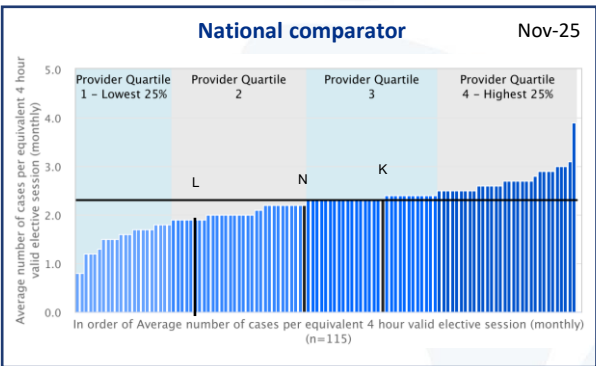
- KGH and NGH case mix is being reviewed during the scheduling process.
- Scheduling at NGH is reviewed by the adjusted and we are working with FDP for improved accuracy

What are the issues impacting performance?

- The move of the surgical robot from NGH to KGH will have impacted on the delivery at each site
- The WL for some specialities is low and therefore we can struggle to completely fill lists based on case mix available.

Risks

- Related the Theatre utilisation – minimising cancellations and late starts



25/26 Activity and 25/26 Plan

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

Kettering General Hospital

Northampton General Hospital

University Hospitals of Northamptonshire Group

Outpatients	Total outpatient appointments (incl. non-consultant-led)	39,840	40,530	102%
	First outpatient appointments (consultant-led)	11,580	11,652	101%
	Follow up outpatient appointments (consultant-led)	20,950	22,136	106%
	Outpatient procedures (consultant-led)	7,310	6,742	92%

53,505	49,363	92%
14,608	11,556	79%
29,058	29,107	100%
9,839	8,700	88%

93,345	89,893	96%
26,188	23,208	89%
50,008	51,243	102%
17,149	15,442	90%

Elective	Elective overnight spells	295	309	105%
	Day case spells	3,485	3,883	111%

362	425	117%
4,133	4,197	102%

657	734	112%
7,618	8,080	106%

UEC	Type 1 A&E attendances	10,022	9,923	99%
	Zero-day non-elective spells	547	1,434	262%
	Overnight non-elective spells	1,855	1,746	94%

10,388	11,183	108%
872	609	70%
1,835	2,343	128%

20,410	21,106	103%
1,419	2,043	144%
3,690	4,089	111%

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

				No target
 		Time to hire (Both)		
	- Turnover - Mandatory training (KGH) - Agency spend as a % of pay	Sickness Absence (KGH)	- Appraisal (NGH) - Vacancy (Both) - Total WTE - Bank spend as a % of pay	Number of volunteering hours
 	Mandatory training (NGH)	- Appraisal (KGH) - Sickness Absence (NGH)		

Well-Led

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

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average
Culture and safety										
Turnover rate	6.50%	Feb 26	6%			6.09%	5.80%			5.79%
Appraisal completion rates	85%	Feb 26	83.10%			84.90%	75.20%			80.42%
Mandatory training compliance	85%	Feb 26	89.20%			89.82%	82.30%			89.08%
Sickness and absence rate	5%	Feb 26	3.80%			4.53%	5.30%			4.92%
Number of volunteering hours	-	Feb 26	3,141			2891.59	3,626			3750.37
Vacancy rate	8%	Feb 26	9.50%			9.78%	9.30%			9.49%
Productivity										
Nursing Roster approved 42 days or over	95%	Feb 26	34.44%			44.13%	35.83%			62.90%

Data Quality Indicators

S	T	A	R
S	T	A	R
S	T	A	R
S	T	A	R
S	T	A	R
S	T	A	R
S	T	A	R



Data quality assessment

No data quality issues identified.

SPC indicator key

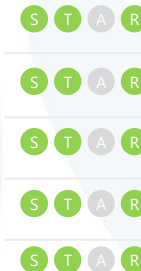
		Worsening			Improving		No change
		Below target			Above target		Inconsistent in whether target achieved

Data quality indicator key

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

Metric	Target	Latest Date	KGH Actual	Variation	Assurance	KGH Average	NGH Actual	Variation	Assurance	NGH Average
Workforce financial sustainability										
Time to hire (days)	65	Feb 26	73.80			68.74	74.80			83.67
Employee relations formal cases	-	Feb 26	25			15.94	37			27.26
Total WTE (PWR figure)	6199	Feb 26	5067.12			5030.61	6496.99			6493.37
Bank Spend as % of Total Pay	6.30%	Feb 26	9.80%			9.85%	11.20%			11.40%
Agency Spend as % of Total Pay	2%	Feb 26	1.10%			1.07%	1.70%			2.41%

Data Quality Indicators



Data quality assessment

No data quality issues identified.

SPC indicator key

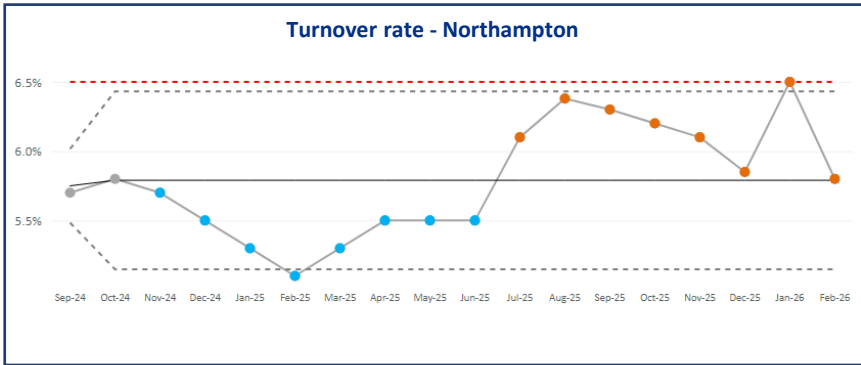
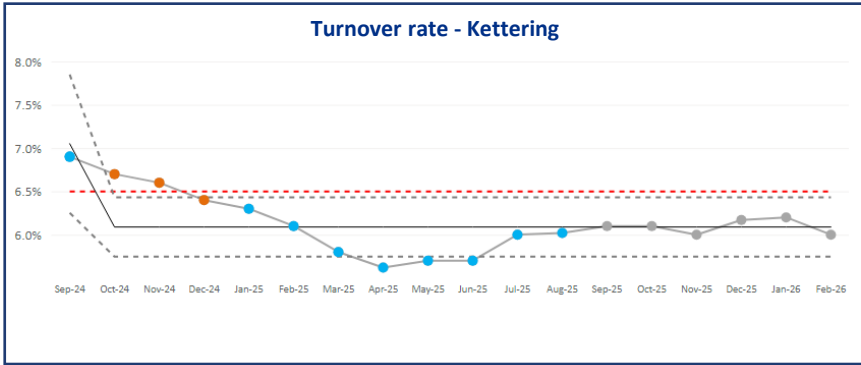
		Worsening			Improving		No change
		Below target			Above target		Inconsistent in whether target achieved

Data quality indicator key

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.



Data Quality Indicators		Site	Target	Latest Date	Actual	Variation	Assurance	Average
		KGH	6.50%	Feb 26	6%			7.05%
		NGH	6.50%	Feb 26	5.80%			5.79%

Metric	Target	Latest Month	Measure	Measure
			KGH	NGH
Additional clinical services	6.5%	Feb-26	5.42%	5.19%
Allied health professionals	6.5%	Feb-26	8.78%	3.62%
Healthcare scientists	6.5%	Feb-26	3.64%	7.42%
Administrative and clerical	6.5%	Feb-26	8.68%	9.72%
Nursing and midwifery registered	6.5%	Feb-26	3.93%	3.39%
Medical and dental	6.5%	Feb-26	3.81%	4.57%
Additional professional, scientific and technical	6.5%	Feb-26	7.48%	9.66%
Estates and ancillary	6.5%	Feb-26	10.31%	8.72%

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%

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 are the issues impacting performance?

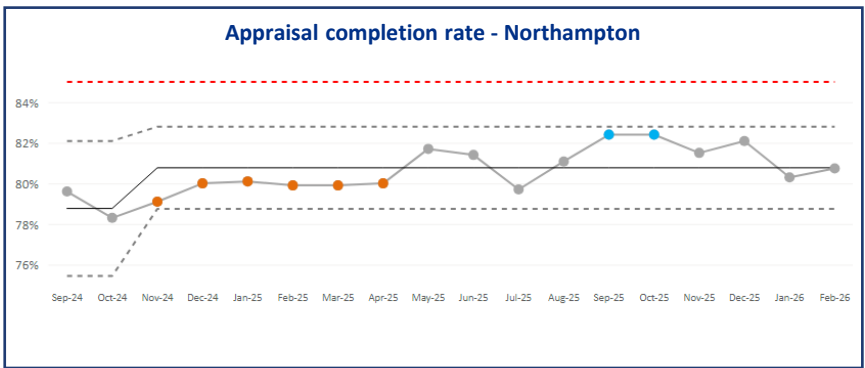
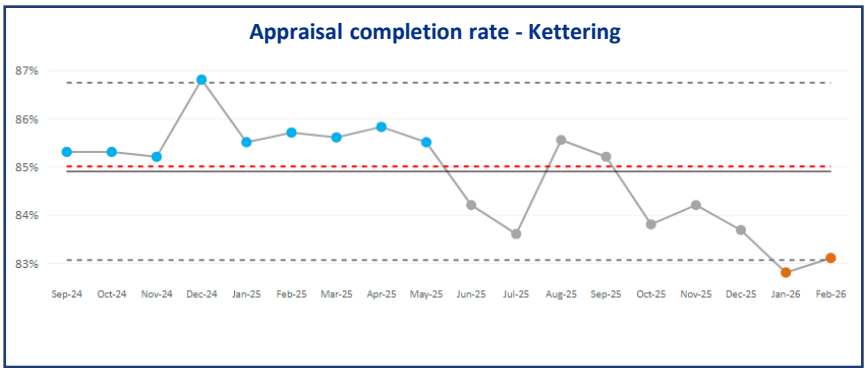
- Workflow disruptions may lead to reduced operational efficiency
- Training new hires takes time, resulting in lower short-term productivity
- Loss of experienced staff can create knowledge gaps and negatively affect organisational culture

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

Appraisal completion rate

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



Metric	Target	Latest Month	Measure	Measure
			KGH	NGH
Additional clinical services	85%	Feb-26	86.47%	86.07%
Allied health professionals	85%	Feb-26	83.87%	84.71%
Healthcare scientists	85%	Feb-26	76.39%	79.14%
Administrative and clerical	85%	Feb-26	80.66%	76.00%
Nursing and midwifery registered	85%	Feb-26	82.69%	83.79%
Medical and dental	85%	Feb-26	83.64%	
Additional professional, scientific and technical	85%	Feb-26	74.15%	79.87%
Estates and ancillary	85%	Feb-26	87.82%	67.35%

Understanding the performance

- Rates of appraisal have marginally improved in this reporting period but remain under benchmark

What are the issues impacting performance?

- In a deep dive analysis, a change of manager and change of role are cited as the main cause of appraisal delay.
- NGH cite that as colleagues they were not aware of appraisal due. It has been identified that the icon has been removed from the ESR colleague home page

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
- Return icon to NGH ESR
- Launch appraisal pack sending to colleagues that are due

Data Quality Indicators

S

T

A

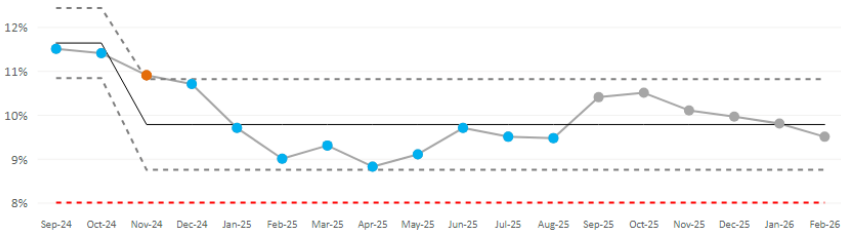
R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	85%	Feb 26	83.10%			84.90%
NGH	85%	Feb 26	80.74%			80.77%

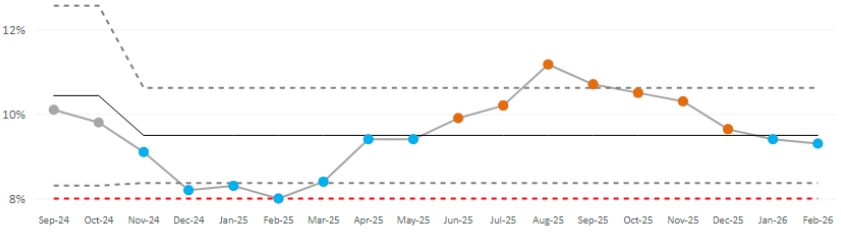
Vacancy rate

The percentage of established posts which are currently vacant.

Vacancy rate - Kettering



Vacancy rate - Northampton



Data Quality
Indicators

S T A R

Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	8%	Feb 26	9.50%			9.78%
NGH	8%	Feb 26	9.30%			9.49%

Metric	Target	Latest Month	Measure	Measure
			KGH	NGH
Additional clinical services	8%	Feb-26	10.90%	9.72%
Allied health professionals	8%	Feb-26	7.45%	7.17%
Healthcare scientists	8%	Feb-26	9.68%	4.67%
Administrative and clerical	8%	Feb-26	14.14%	11.78%
Nursing and midwifery registered	8%	Feb-26	6.21%	7.79%
Medical and dental	8%	Feb-26	3.57%	7.26%
Additional professional, scientific and technical	8%	Feb-26	11.87%	13.86%
Estates and ancillary	8%	Feb-26	17.87%	13.38%

Understanding the performance

- Vacancy is showing long term improvement

Risks

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

What are the issues impacting performance?

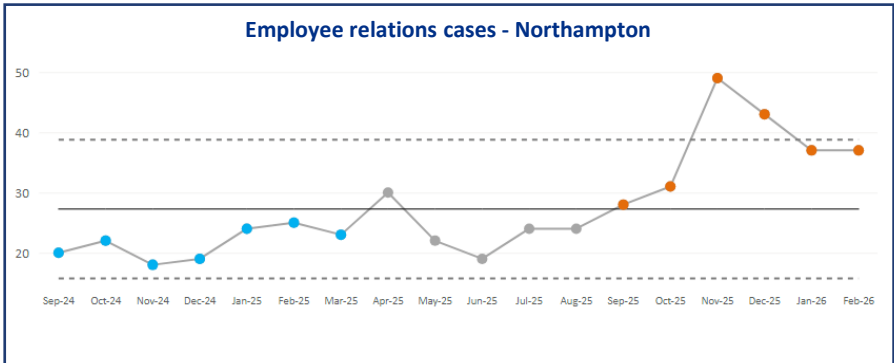
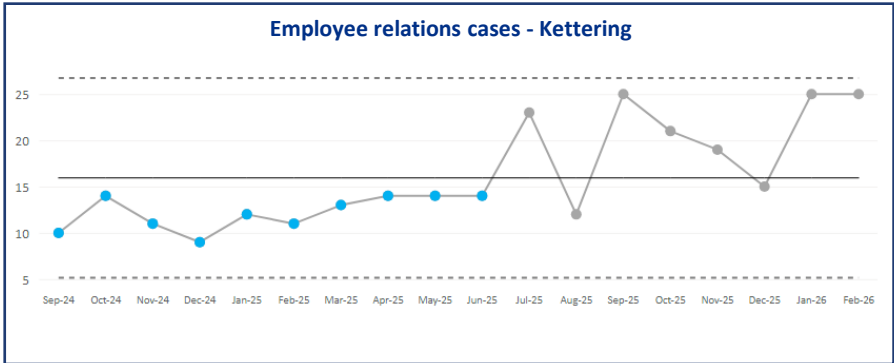
- Key challenges include Group enhanced workforce controls and reduction of workforce

What SMART actions are being taken to improve?

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

Employee relations cases

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



Data Quality Indicators		Site	Target	Latest Date	Actual	Variation	Assurance	Average
S T A R	49/69	KGH	-	Feb 26	25			15.94
		NGH	-	Feb 26	37			27.26

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?

- Absence and vacancy within key roles in the team.
- 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?

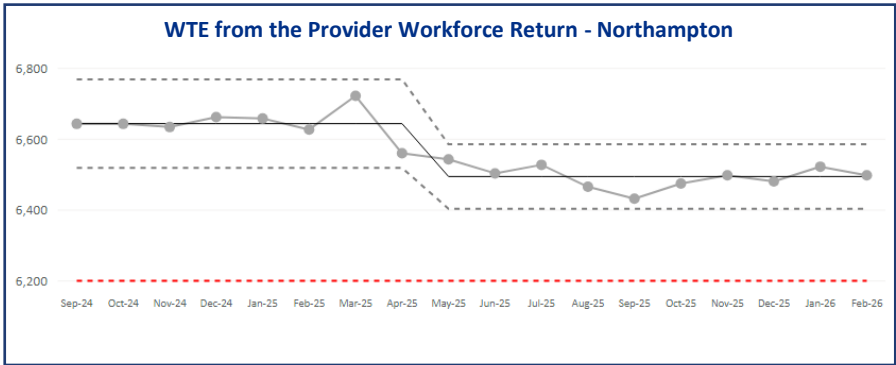
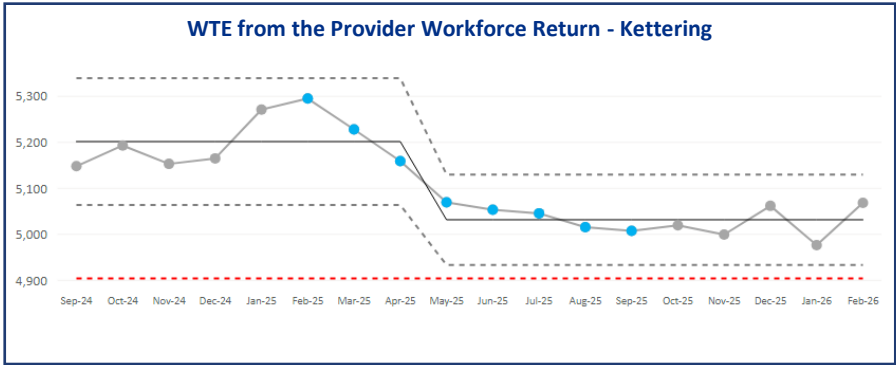
- Case assessment panel to consider actions at fact finding to be implemented in Q1.
- Ongoing review and consistent approach to implementing metrics is underway to focus on timely completion of cases.

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.



Data Quality Indicators	Site	Target	Latest Date	Actual	Variation	Assurance	Average
	KGH	4903	Feb 26	5067.12			5200.50
	NGH	6199	Feb 26	6496.99			6642.63

Metric	Latest Month	Feb-25	Jan-26	Feb-26	Feb-26 Plan	Feb-25	Jan-26	Feb-26	Feb-26 Plan
KGH					NGH				
Total WTE	Feb-26	5,293	4,975	5,056	4,804	6,626	6,521	6,497	6,251
Substantive WTE	Feb-26	4,676	4,582	4,593	4,469	5,868	5,834	5834	5,797
Bank WTE	Feb-26	525	377	446	262	641	632	615	407
Agency WTE	Feb-26	92	17	18	73	117	55	48	47

Understanding the performance

- Substantive, bank and agency increased at KGH in month
- Substantive remained unchanged, whilst bank and agency reduced at NGH

What are the issues impacting performance?

- Vacancy cover
- WLI impact on bank use (sprint KGH)
- Controls and governance

Risks

- ☐ Temporary staffing dependence:
- ☐ Winter/service pressure: .
- ☐ Sickness absence
- ☐ Q4 Sprint

What SMART actions are being taken to improve?

- The FIP team continue to support Divisions with a range of workforce efficiency scheme
- Implementation of the Allocate medical to enhance medical workforce utilisation at KGH
- UHN Collaborative Medical Bank is in the process of being rolled out
- VCP terms of reference have been updated
- Medical workforce meetings to ensure grip and control on medical rostering efficiency, and bank and agency controls.

Detailed workforce numbers

Feb-25	Jan-26	Feb-26	Change in month

Kettering General Hospital

Total	5,293	4,975	5056	81
Substantive	4,676	4,582	4593	11
Bank	525	377	446	69
Agency	92	17	18	1

Feb-25	Jan-26	Feb-26	Change in month

Northampton General Hospital

6,626	6,521	6,497	-24
5,868	5,834	5834	0
641	632	615	-17
117	55	48	-7

Feb-25	Jan-26	Feb-26	Change in month

University Hospitals of Northamptonshire Group

	11,497	11,553	56
	10,416	10,427	11
	1,009	1,061	52
	72	66	-6

Substantive	Registered Nursing and Midwifery	1,463	1,523	1525	2
	Scientific, Therapeutic and Technical	380	382	381	-1
	Support to Clinical Staff	971	903	907	4
	Infrastructure support	1,256	1,170	1175	5
	Medical and Dental	602	598	599	-1

1,751	1,786	1791	5
568	587	588	1
1,291	1,234	1227	-7
1,464	1,379	1383	4
790	845	841	-4

	3,309	3,316	7
	969	969	0
	2,136	2,134	-2
	2,549	2,558	9
	1,444	1,440	-4

Bank	Registered Nursing and Midwifery	194	136	162	26
	Scientific, Therapeutic and Technical	21	21	30	9
	Support to Clinical Staff	168	116	135	19
	Infrastructure support	74	45	70	25
	Medical and Dental	69	57	49	-8

210	217	208	-9
12	20	17	-3
221	200	205	5
132	116	110	-6
66	81	75	-6

	353	370	17
	41	47	6
	316	340	24
	161	180	19
	138	124	-14

Agency	Registered Nursing and Midwifery	58	2	4	2
	Scientific, Therapeutic and Technical	11	5	5	0
	Support to Clinical Staff	0	1	1	0
	Infrastructure support	1	0	0	0
	Medical and Dental	22	8	9	1

52	29	25	-4
20	6	7	1
0	1	0	-1
0	0	0	0
40	19	16	-3

	31	29	-2
	11	12	1
	2	1	-1
	0	0	0
	28	25	-3

Understanding the position

- At M11 substantive 77 WTE above plan (KGH 40 WTE, NGH 77 WTE)
- Bank 297 WTE above plan (200 WTE at NGH). YTD Bank plan 16 WTE below plan.
- Agency 27 WTE below plan (778 WTE below plan YTD at M11).

What are the issues impacting the position?

- NGH continues to deteriorate against plan and is the primary source of the group variance.
- KGH Bank WTE usage increased 70 WTE in M11.
- KGH increases in Nursing and Infrastructure bank drove the variance in M11.

What SMART actions are being taken to improve?

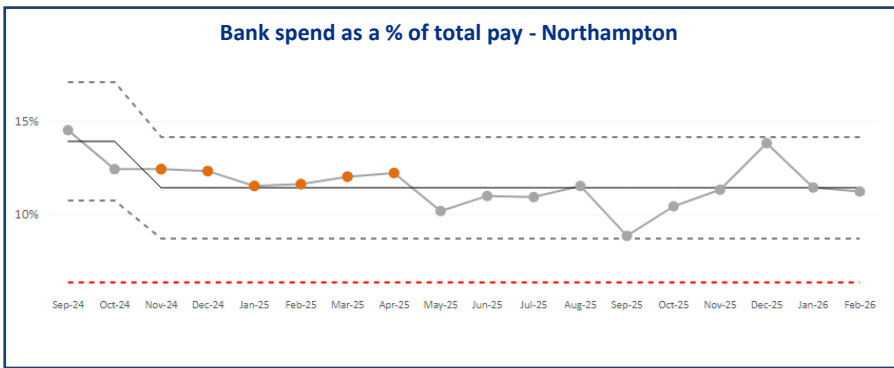
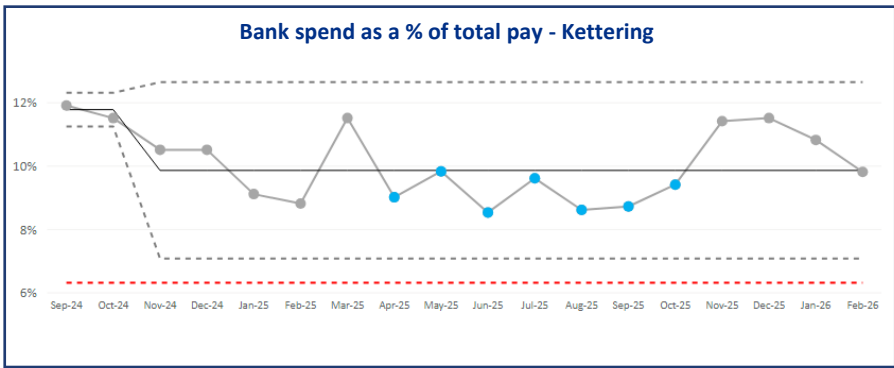
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Risks

- Temporary Staffing dependence
- Winter/Service Pressure
- Sickness Absence
- UHN need to reduce 400 WTE across substantive, bank and agency in M12 to meet 781 WTE target reduction

Bank spend as a percentage of total pay

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



Data Quality Indicators		Site	Target	Latest Date	Actual	Variation	Assurance	Average
S T A R	KGH	6.30%	Feb 26	9.80%	9.80%	9.80%	9.80%	9.85%
	NGH	6.30%	Feb 26	11.20%	11.20%	11.20%	11.20%	13.90%

Metric	Var	Measure	Var	Measure
		KGH		NGH
Overall	9.8%	9.8%	11.2%	11.2%
Registered nursing, midwifery and health visiting	5.0%	5.0%	5.4%	5.4%
Healthcare scientists and scientific, therapeutic and technical	0.2%	0.2%	0.2%	0.2%
Support to clinical	0.9%	0.9%	0.6%	0.6%
Medical and dental	3.4%	3.4%	4.2%	4.2%
Non-Clinical	0.4%	0.4%	0.7%	0.7%

Understanding the performance

- Bank spend is above target in both Trusts
- Bank spend slightly decreased 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

Our Use of Resources domain metrics

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

				No target
 				
		- Cash - Surplus/Deficit		
 		- Acute implied productivity compared to last year - CIP delivery		

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	Feb 26	-4,178			-1163.11	-3,581			-1648.84	S T A R
Cash	6050	Feb 26	7,383			5587	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%	Feb 26	82.30%			214.70%	78.17%			197.24%	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

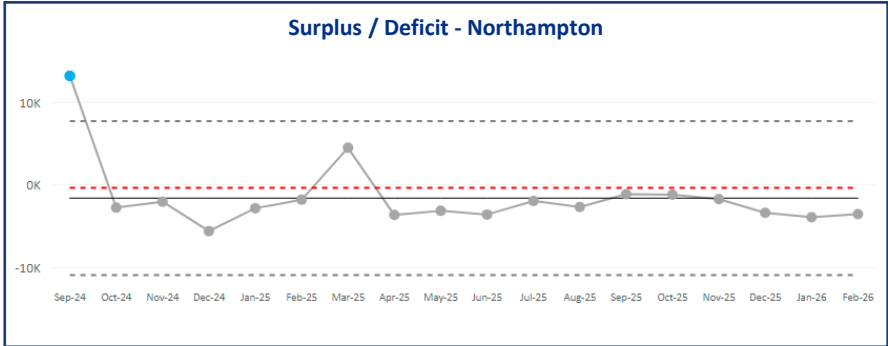
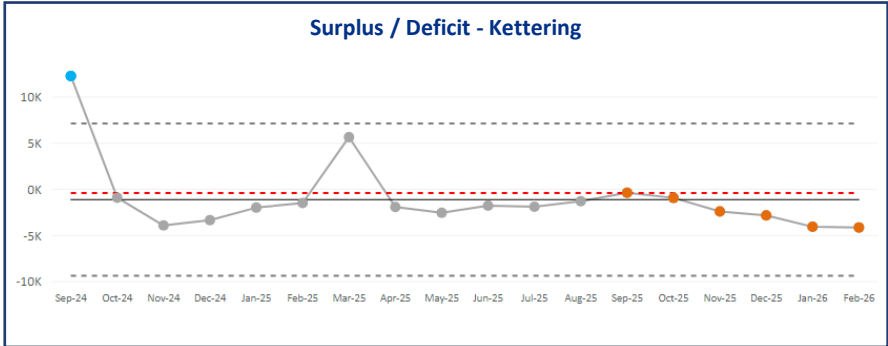
		Worsening			Improving		No change
		Below target			Above target		Inconsistent in whether target achieved

Data quality indicator key

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

Surplus / deficit

Monthly financial position – total income vs total expenditure.



Data Quality
Indicators

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Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	-442	Feb 26	-4,178			-1163.11
NGH	-392	Feb 26	-3,581			-1648.84

Understanding the performance

- The deficit for KGH in January was £4.2m
- The deficit for NGH in January was £3.6m

What are the issues impacting performance?

- The increase in 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 de-risk the outturn position.
- 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

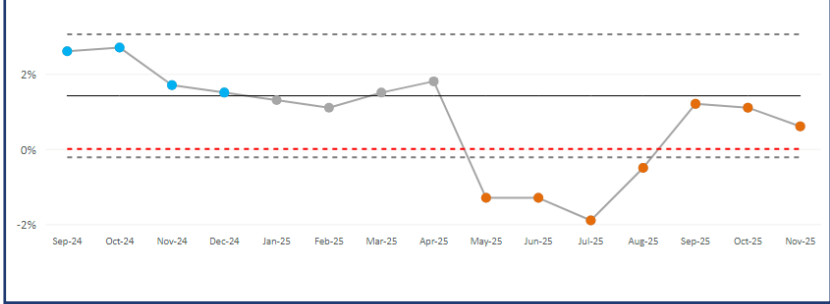
Risks

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

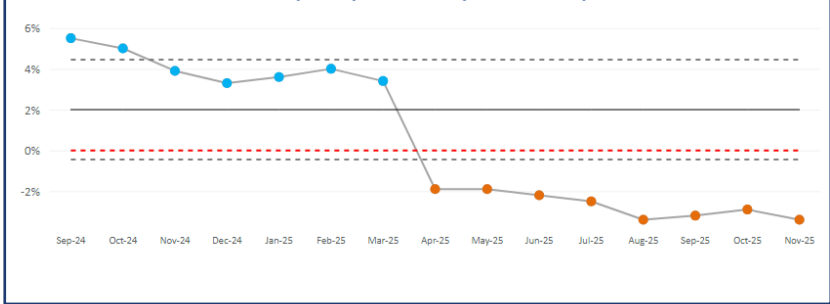
Acute implied productivity compared to last year

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

Acute implied productivity - Kettering



Acute implied productivity - Northampton



Understanding the performance

- Compared to last year, both NGH has seen reduced productivity by 3.4% in November, whilst in KGH an improvement during Q2 in KGH means productivity is better by 0.6%, falling from a peak of 1.2%.

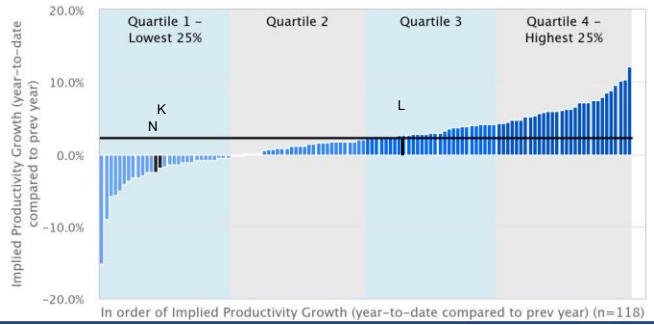
What are the issues impacting performance?

- KGH is seeing a 2.6% reduction in cost compared to last year, whilst NGH is seeing 1.5% reduction in cost. KGH is in the best quartile for cost growth, with NGH in a median position.
- Activity in both organisations is down year-on-year, by 4.8% in NGH and 2.1% in KGH, which is the lowest quartile nationally, and driving the position.

What SMART actions are being taken to improve?

- A proxy divisional productivity measure will be added to Accountability Meetings from April.
- Productivity packs received from NHSE as part of planning have been translated to specialty-level.
- Focus on productivity within clinical settings, particularly clinic templates, length of stay and NGH theatres.
- Corporate consolidation and clinical administration being accelerated with the use of AI and automation.

National comparison



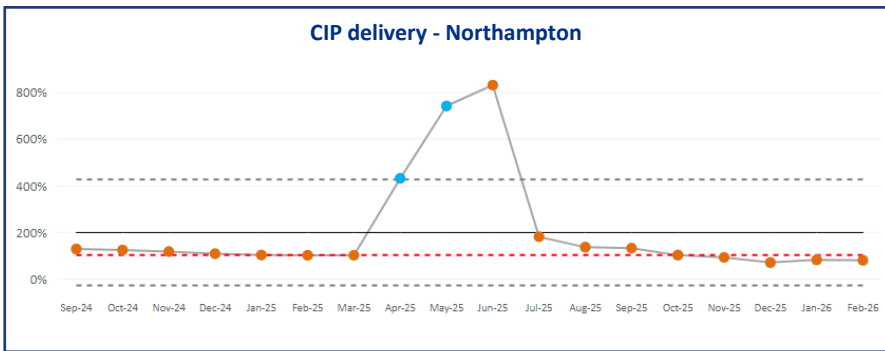
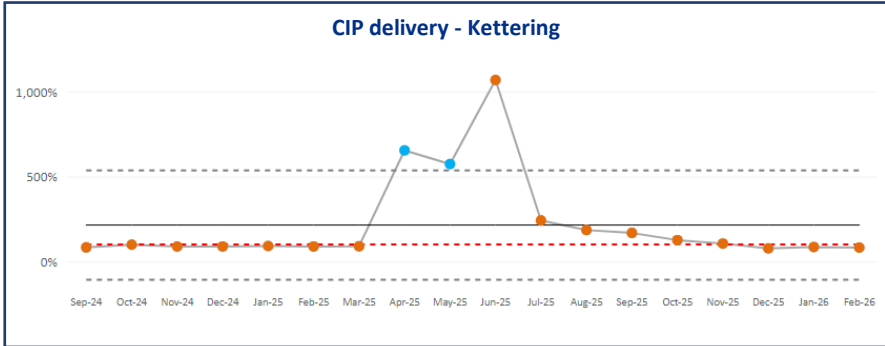
Risks

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

Data Quality Indicators		Site	Target	Latest Date	Actual	Variation	Assurance	Average
		KGH	0%	Nov 25	0.60%			1.41%
		NGH	0%	Nov 25	-3.40%			2%

Cost improvement plan delivery

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



Understanding the performance

- £52.2m of efficiencies have been delivered across UHN YTD at M10 (£27.4m NGH, £24.9m KGH), against a YTD plan of £63.4m.
- 47% of the M10 delivery is recurrent, which is a small increase from 46% last month.

What are the issues impacting performance?

- The efficiency plan was phased to deliver 1.3% of required savings in quarter 1, 21% in Q2, and 38.8% in Q3 and Q4.
- Under-delivery in month 11 is largely driven by material step up in in-month target and ability to identify sufficient savings.

What SMART actions are being taken to improve?

- FIP team 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 next year, work is underway to fully develop the programme.
- Efficiency plans face development gaps and delivery risks, even where fully scoped.

Data Quality Indicators

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Site	Target	Latest Date	Actual	Variation	Assurance	Average
KGH	100%	Feb 26	82.30%			214.70%
NGH	100%	Feb 26	78.17%			197.24%

% of delivery that is recurrent	Site	Target	Latest Date	Actual	Variation	Assurance	Average
	KGH	100%	Feb 26	49%			42.66%
	NGH	100%	Feb 26	51%			33.76%

Summary Balance Sheet - KGH

TRUST SUMMARY BALANCE SHEET						
MONTH 11 2025/26						
	Balance at 31-Mar-25 £000	Opening Balance £000	Closing Balance £000	Movement (in month) £000	Closing Balance £000	Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	203,103	203,103	203,103	0	155,606	(47,497)
IN YEAR REVALUATIONS	0	0	0	0	(385)	(385)
IN YEAR MOVEMENTS	0	26,167	31,781	5,614	19,346	19,346
LESS DEPRECIATION	0	(13,149)	(14,546)	(1,397)	(9,408)	(9,408)
NET BOOK VALUE	203,103	216,121	220,338	4,217	165,159	(37,944)
NON CURRENT RECEIVABLES	1,238	883	883	0	900	(338)
CURRENT ASSETS						
	0					
INVENTORIES	6,795	7,084	7,103	19	5,100	(1,695)
TRADE & OTHER RECEIVABLES	12,681	15,629	13,145	(2,484)	5,000	(7,681)
CASH	5,261	4,577	7,384	2,807	30,217	24,956
TOTAL CURRENT ASSETS	24,737	27,290	27,632	342	40,317	15,580
CURRENT LIABILITIES						
	0					
TRADE & OTHER PAYABLES	31,224	42,105	42,776	671	37,080	5,856
LEASE PAYABLE under 1 year	1,468	1,573	1,573	0	195	(1,273)
DHSC LOANS	760	0	0	0	1,556	796
PROVISIONS under 1 year	1,935	894	921	27	500	(1,435)
TOTAL CURRENT LIABILITIES	35,387	44,572	45,270	698	39,331	3,944
NET CURRENT ASSETS / (LIABILITIES)	(10,650)	(17,282)	(17,638)	(356)	986	11,636
TOTAL ASSETS LESS CURRENT LIABILITIES	193,691	199,722	203,583	3,861	167,045	(26,646)
NON CURRENT LIABILITIES						
	0					
LEASE PAYABLE over 1 year	4,739	5,997	6,029	32	0	(4,739)
LOANS over 1 year	0	0	0	0	3,720	3,720
PROVISIONS over 1 year	560	544	544	0	528	(32)
NON CURRENT LIABILITIES	5,299	6,541	6,573	32	4,248	(1,051)
TOTAL ASSETS EMPLOYED	188,392	193,181	197,010	3,829	162,797	(25,595)
FINANCED BY						
	0					
PDC CAPITAL	312,800	337,442	345,551	8,109	252,344	(60,456)
REVALUATION RESERVE	41,267	41,274	41,274	0	37,486	(3,781)
I & E ACCOUNT	(165,675)	(185,535)	(189,815)	(4,280)	(127,033)	38,642
FINANCING TOTAL	188,392	193,181	197,010	3,829	162,797	(25,595)

Non-Current Assets

- Capital expenditure in the month was £5,614k.
- Depreciation and in year movements include the impact of right of use assets.

Current Assets

- Cash balance increased to £7,384k (+£2,807k), driven by capital receipts.
- £4,000k Q4 support requested in February; no March request due to improved cash position, though cash remains a risk.
- Receivables decreased by £2,484k, mainly from lower prepayments and NHS balances, partly offset by higher non-trade receivables.

Current Liabilities

- Invoices are paid on 30-day terms but are closely monitored to minimise BPPC breaches. Restrictions were put on payments to NHFT, UHL, NHSSC and large Pharma suppliers which has negatively impact BPPC.
- Trade and other payables have increased by £671k in month. This reflects the following key movements: Deferred Income decreased by £2,693k, Trade accruals increased by £1,146k, PDC payable increased by £533k, Other Creditors increased by £445k, Capital Creditors increased by £3,014k

Financing

- YTD PDC Revenue Support - £14,138k, an in-month increase of £4,000k
- YTD PDC Capital Support - £18,613K, an in-month increase of £4,109k
- YTD Income & Expenditure deficit £24,140k, an in-month increase of £4,219k

Summary Balance Sheet - NGH

TRUST SUMMARY BALANCE SHEET MONTH 11 2025/26

	Balance at 31-Mar-25 £0	Opening Balance £0	Closing Balance £0	Movement £0	Closing Balance £0	Movement £0
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	263,061	263,054	263,054	0	263,061	0
IN YEAR REVALUATIONS	0	0	0	0	0	0
IN YEAR MOVEMENTS	0	25,107	28,425	3,318	41,238	41,238
LESS DEPRECIATION	0	(17,049)	(18,751)	(1,702)	(20,473)	(20,473)
NET BOOK VALUE	263,061	271,112	272,728	1,616	283,826	20,765
CURRENT ASSETS						
INVENTORIES	9,137	9,564	9,554	(10)	9,200	63
TRADE & OTHER RECEIVABLES	21,814	19,670	17,175	(2,495)	15,592	(6,222)
CLINICIAN PENSION TAX FUNDING	628	628	628	0	628	0
CASH	2,012	8,488	9,717	1,229	2,873	861
TOTAL CURRENT ASSETS	33,591	38,350	37,074	(1,276)	28,293	(5,298)
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	41,335	57,529	56,570	(959)	54,795	13,460
FINANCE LEASE PAYABLE under 1 year	1,336	1,269	1,272	3	1,335	(1)
SHORT TERM LOANS	163	102	41	(61)	41	(122)
PROVISIONS under 1 year	3,612	1,169	1,169	0	1,490	(2,122)
TOTAL CURRENT LIABILITIES	46,446	60,069	59,052	(1,017)	57,661	11,215
NET CURRENT ASSETS / (LIABILITIES)	(12,855)	(21,719)	(21,978)	(259)	(29,368)	(16,513)
TOTAL ASSETS LESS CURRENT LIABILITIES	250,206	249,393	250,750	1,357	254,458	4,252
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	14,121	11,746	11,753	7	11,699	(2,422)
LOANS over 1 year	59	18	18	0	17	(42)
PROVISIONS over 1 year	768	768	768	0	709	(59)
NON CURRENT LIABILITIES	14,948	12,532	12,539	7	12,425	(2,523)
TOTAL ASSETS EMPLOYED	235,258	236,861	238,211	1,350	242,033	6,775
FINANCED BY						
PDC CAPITAL	322,348	352,183	357,210	5,027	367,796	45,448
REVALUATION RESERVE	60,399	60,399	60,399	0	60,399	0
I & E ACCOUNT	(147,489)	(175,721)	(179,398)	(3,677)	(186,162)	(38,673)
FINANCING TOTAL	235,258	236,861	238,211	1,350	242,033	6,775

Non-Current Assets

- M11 Capital movements of £3,318k, includes PDC funded UTC works of £1,830k and top sliced EPR spend this month totalled £553k.

Current Liabilities

- Overall Payables: Net decrease of £959k.
- Increases: Revenue Trade Payables (£1.5m – pharmacy & NHS Supply Chain timing), PDC Dividend (£926k – ahead of March payment), and Receipts in Advance (£340k).
- Decreases: Fixed Asset Payables (£1.7m – major project payments), Accruals (£1.0m – release incl. Nerve Centre, Ascribe, strike costs), NHS Payables (£632k – lower ICB accrual partly offset), and Tax/Ni (£405k – payroll timing).

Current Assets

- Inventories: Net £10k decrease — reductions in Pacing (£99k) and Pathology (£25k) partly offset by increase in Pharmacy (£114k).
- Receivables: £2.5m decrease driven mainly by prepayments (£1.8m, incl. £1.4m CNST), alongside reductions in NHS receivables, VAT, salary sacrifice, and other balances; partly offset by £129k capital recharge.
- Other movements: Salary overpayments reduced £69k (YTD lower than prior year) and cash increased £1.2m due to lower-than-expected creditor payments.

Financing

- PDC Capital - £5,027k in total, comprised of £2,000k System Capital Support PDC, £1,491k for Urgent Treatment Centre, £536k Critical Infrastructure Works and Revenue Deficit support of £1,000k.
- I & E Account - £3,677k - In-month deficit

Cash Flow - KGH

MONTHLY CASHFLOW	ANNUAL TOTAL 2025/26 £000s	ACTUAL APR £000s	ACTUAL MAY £000s	ACTUAL JUN £000s	ACTUAL JUL £000s	ACTUAL AUG £000s	ACTUAL SEP £000s	ACTUAL OCT £000s	ACTUAL NOV £000s	ACTUAL DEC £000s	ACTUAL JAN £000s	ACTUAL FEB £000s	FORECAST MAR £000s	FORECAST 27/28		
														APR £000s	MAY £000s	JUN £000s
RECEIPTS																
Clinical Income	415,334	33,988	34,338	34,760	36,659	36,776	35,111	36,137	34,873	34,503	35,037	30,492	32,660	32,602	32,602	32,602
Health Education England	13,455	3,106	0	0	2,911	0	0	5,142	0	0	0	2,296	0	3,144	0	0
VAT	6,357	970	449	988	0	991	402	349	575	619	375	345	293	400	400	400
Other income	11,942	649	1,122	883	1,868	1,905	944	881	570	1,367	454	619	680	603	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	13,036	8,179
Interest Receivable	1,017	132	99	89	70	78	75	78	93	85	74	70	74	75	75	75
TOTAL RECEIPTS	492,813	38,844	36,008	37,919	41,509	42,050	44,140	43,275	40,818	38,308	42,347	41,930	45,665	40,773	49,422	45,002
PAYMENTS																
Salaries and wages (incl agency)	318,335	25,360	26,484	25,903	25,581	27,475	27,813	25,865	25,189	25,937	26,542	26,239	29,945	22,996	26,501	26,501
Trade Creditors	127,796	5,911	14,555	9,309	12,607	10,421	9,419	13,810	8,798	10,141	10,717	10,079	12,028	11,079	14,593	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	1,517	1,517	1,517
Capital Expenditure	29,058	1,752	1,026	1,897	1,413	1,769	1,581	1,233	3,291	2,495	3,926	2,810	5,864	4,973	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	495,904	35,212	43,483	38,527	41,019	41,083	42,906	42,327	38,697	39,991	42,603	39,127	50,929	40,565	49,277	45,117
Actual month balance	-3,092	3,632	-7,475	-608	491	967	1,234	948	2,121	-1,683	-256	2,802	-5,264	208	145	-115
Cash in transit & Cash in hand adjustment	5	0	5	0	-1	41	0	746	-842	44	-47	3	-3	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	2,115	2,323	2,468
Balance carried forward	2,174	8,893	1,423	815	1,305	2,313	3,547	5,241	6,520	4,881	4,577	7,383	2,115	2,323	2,468	2,353

What are the issues impacting the position?

- Cash position: £7.4m at February, up £2.8m driven by Capital PDC received in-month.
- Management approach: Cash tightly managed with restricted payments; ongoing monitoring and potential extension of supplier terms (to 45 days if needed).
- Q4 funding & flows: £4.0m support received in Feb; none requested for March due to expected Capital PDC. Cashflow also reflects ICB clawback adjustments (£5.7m Feb, £2.9m Mar).
- Other points: Capital PDC/expenditure profiled but subject to review; NHS Resolution payments ended in Jan; Barclays account closed with balance moved to GBS.

Cash Flow - NGH

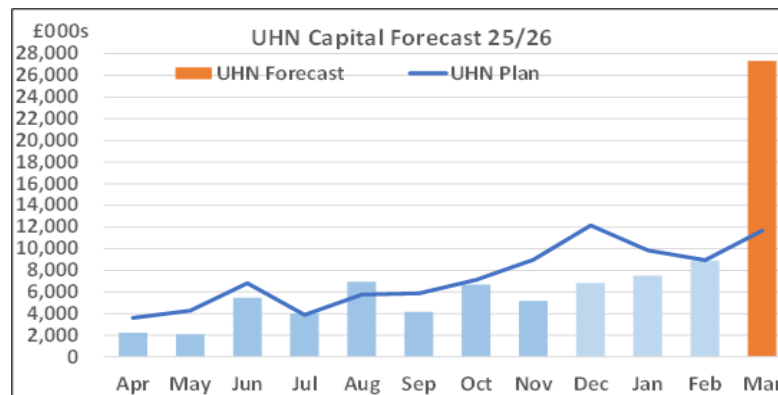
MONTHLY CASHFLOW	ANNUAL TOTAL	ACTUAL												FORECAST	FORECAST 26/27		
	2025/26 £000	APR £000	MAY £000	JUN £000	JUL £000	AUG £000	SEP £000	OCT £000	NOV £000	DEC £000	JAN £000	FEB £000	MAR £000		APR £000s	MAY £000s	JUN £000s
RECEIPTS																	
SLA Block Payments	508,468	42,012	41,272	41,333	45,570	44,555	42,544	43,725	42,787	42,588	42,851	39,204	40,026		40,815	40,815	40,815
Health Education Payments	18,347	4,143	0	0	4,110	0	0	7,216	0	0	0	2,878	0		4,577	0	0
Other NHS Income	18,713	1,401	2,080	3,846	888	3,270	743	614	389	1,819	1,879	684	1,100		850	850	3,025
VAT Claim	8,740	352	2,138	611	916	849	538	(352)	2,075	0	660	636	317		700	600	600
PP / Other	9,603	749	498	663	1,045	937	679	720	698	800	1,100	914	800		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	6,500	4,500
Interest Receivable	1,125	110	102	93	78	82	82	107	113	97	92	75	95		81	81	81
TOTAL RECEIPTS	611,204	48,767	46,091	46,546	52,607	52,475	61,033	52,309	47,242	49,444	51,587	49,419	53,684		52,873	49,696	49,871
PAYMENTS																	
Salaries and wages	389,688	30,603	31,887	31,901	31,273	33,860	34,572	32,415	32,268	32,372	33,039	32,958	32,539		32,860	32,904	32,904
Trade Creditors	146,542	8,626	14,047	10,639	16,195	12,434	10,291	13,533	9,719	12,128	11,281	10,540	17,110		8,938	10,500	11,000
NHS Creditors	30,827	2,505	2,500	3,500	2,695	2,360	2,637	3,426	3,200	3,734	2,063	311	1,895		2,964	3,014	3,014
Capital Expenditure	36,328	3,380	1,542	1,513	1,499	1,234	5,984	3,505	2,922	2,511	2,444	4,378	5,416		8,535	3,631	2,194
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	610,330	45,132	49,977	47,555	51,663	49,949	56,691	52,897	48,109	50,748	48,828	48,247	60,536		53,315	50,049	49,115
Actual month balance	873	3,635	(3,886)	(1,009)	944	2,527	4,342	(587)	(867)	(1,303)	2,759	1,171	(6,852)		(442)	(353)	756
Cash in transit & in hand adjustment	(12)	18	9	8	(1)	(75)	70	16	(35)	(59)	(30)	58	9		0	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		2,873	2,432	2,079
Balance carried forward	2,873	5,665	1,788	787	1,730	4,181	8,594	8,022	7,121	5,759	8,488	9,717	2,873		2,432	2,079	2,835

What are the issues impacting the position?

- Cash position: £9.7m at February, £3.3m above forecast driven by lower creditor payments (£1.8m) and higher NHS/other income (£1.9m), partly offset by higher pay (£0.4m).
- Income & funding: Includes ICB clawback (£5.2m) and industrial action funding (£1.0m), NHSE receipts (£2.9m education, £0.7m cost & volume), VAT reclaim (£0.6m), and £4.0m capital PDC received (with further funding secured/adjusted for March/April).
- Expenditure & creditors: Lower-than-expected payments in-month, with a build-up of invoices (£8.2m awaiting processing); payments expected to increase in March alongside year-end activity.
- Outlook: Capital spend and cash outflows expected to rise significantly in March/April as projects complete and payment runs accelerate.

Capital - UHN

UHN Capital Expenditure	2025/26 Plan			Year to Date			
	£000s	Original	Change	Revised	Original Plan	Actual	Variance
BAU - Estates		4,102		4,102	3,310	5,050	1,740
BAU - Medical Equipment		4,000		4,000	3,400	3,010	(390)
BAU - Digital		3,500		3,500	2,900	2,358	(542)
ROU Renewals + Additions		1,094		1,094	0	647	647
Remaining CDC + Slippage		2,556		2,556	2,556	583	(1,973)
Corby CDC ROU Lease		2,500		2,500	2,500	2,500	0
EPR System Implementation		7,600		7,600	6,464	6,376	(88)
Lin Acc Enabling Work + Eqp.		1,380		1,380	1,380	1,207	(173)
Old ITU Refurb to a new Ward		2,600		2,600	2,600	321	(2,279)
UEC Performance Allocation			3,000	3,000			
System Capital	29,332	3,000	32,332		25,110	22,052	(3,058)
Critical Infrastructure Risk Allocation		8,265	1,195	9,460	6,692	4,306	(2,386)
Constitutional Standards UTC		10,750	0	10,750	9,515	9,692	177
Constitutional Standards Surgical Hub		2,000	(2,000)	0	1,750	0	(1,750)
Constitutional Standards CDC		0	1,750	1,750	0	1,750	1,750
Medical Equipment			1,889	1,889			
Digital Diagnostics			243	243			
Cyber Digital			812	812			
Rockingham Extension		11,850	(8,241)	3,609	10,000	2,656	(7,344)
Energy Centre		19,990	(3,186)	16,804	18,080	13,450	(4,630)
NHP Wave 2		900	98	998	825	949	124
NHP Enabling MSCP + Data Centre			1,083	1,083	0	378	378
Maternity Building Rebuild		1,039	(774)	265	928	63	(865)
Solar Partnership Scheme		713		713	470	737	267
MESC - Linear Accelerator		2,616	2,616	5,232	2,616	2,616	(0)
Digital - EPR		1,180		1,180	1,180	1,180	0
Non BAU Capital Expenditure	59,303	(4,515)	54,788		52,056	37,777	(14,279)
Charitable Funds	300	47	347		100	301	201
Total Capital Expenditure	88,935	(1,468)	87,467		77,266	60,130	(17,136)



What are the issues impacting the position?

Month 11 Capital is £17.136m lower than the original plan to date:

The original UHN plan to spend £88.935m in 25/26, required a £77.266m spend by the end of Month 11. The £60.130m spend is £17.1m lower than planned.

UHN is ahead of plan in Estates BAU expenditure, but lagging in the major schemes of Energy Centre, Rockingham Extension and Estates Critical Infrastructure Risk and Old ITU / 33 Bed ward.

Updates to 25/26 Plan:

In the last month UHN has confirmed additional PDC funding for replacement equipment: x-ray, ultrasounds and linear accelerator, totalling c. £4.5m.

The high amount of end of year capital funding being offered, plus the progression of UHN major schemes, combine to a forecast £27m of capital work in March.

Interpreting SPC charts and Glossary

Interpreting SPC charts

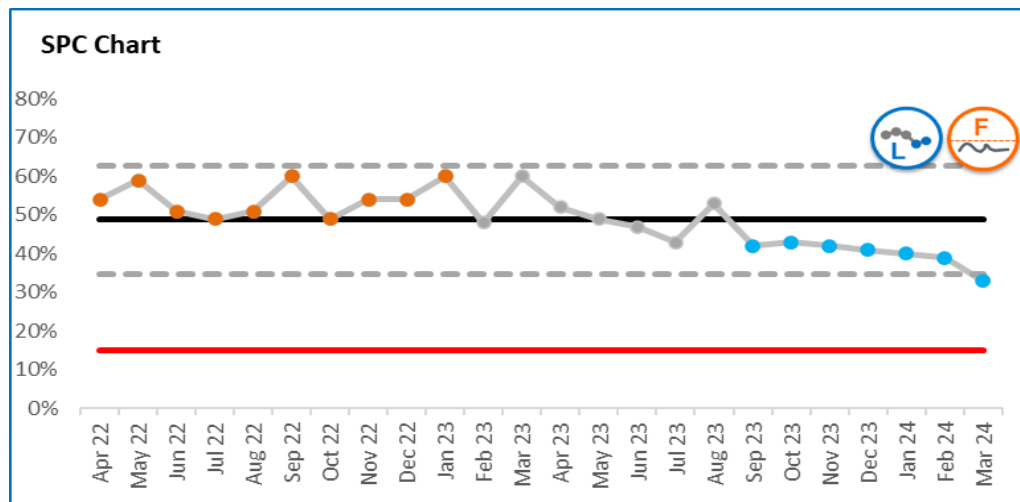
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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



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.

UPL
Average
LPL
Target

Interpreting summary icons

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

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

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

Interpreting the data quality indicator

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

Symbol	Domain	Definition
S	Sign off and Validation	- Has the logic and validity of the data definition been assessed and agreed by people of appropriate and differing expertise? - Has this definition been reviewed regularly to capture any changes e.g. new ways of recording, new national guidance?
T	Timely and Complete	- Is the data available and up to date at the point of reporting? - Are all the required data values captured and available at the point of reporting?
A	Audit and Accuracy	- Is there a process to audit the validity of reported data using business logic rules? - Are accuracy checks built into the reporting process?
R	Robust systems and Data Capture	- Is data collected in a structured format using an appropriate digital system? - Does the data conform to data dictionary standards where relevant?

Data quality indicator key			
			
Sign off & validation	Timely & complete	Audit & Accuracy	Robust systems & data capture

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 occurring 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 hospital.

Glossary

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

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

Glossary

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

UHL / UHN IPR alignment approach

- The Integrated Performance Report is one of the key products that will support effective Board working for the UHL / UHN Boards, and a process of alignment and redesign is required to ensure this is effective. As separate statutory organisations, legally the performance of all three organisations needs to be shared with the public.
- We need to consider as part of the alignment approach how we want to utilise the IPR in the new Board and Committee structures.
- Development will take c. 3 months from agreement of design, with an aim to have a joint IPR for the September Boards.

Metric alignment

- Around 65% of the metrics are common across the two IPRs, with a much smaller proportion of aligned targets. Given the differing operational plans, not all the targets will be the same, but we will review if there are opportunities to align.
- The UHN Continuous Improvement team will work with executive pairs during April to review the existing metrics on the two IPRs, the planning guidance and the metrics for the 26/27 National Oversight Framework (NOF) to propose aligned IPR metrics and targets for approval in May ahead of metric build.

Formatting and structure

- The IPR should support the Boards' understanding of performance, its drivers, successes, areas for concern and plans for improvement.
- The current reports have some similarities in features and some divergence. Both Boards report performance in the CQC domains.
- The new structure will need to work at Group level with an appropriate amount of detail for the joint Boards agenda.
- Board members will be engaged in their views about the structure and features of the IPR in April and May to inform the new proposed joint design.

Production

- As the data platform for the Group, the Federated Data Platform (FDP) will be used to create the Group IPR.
- UHN has been working with the national team to develop an IPR product in line with the national Transparency programme.
- As the business intelligence teams are building the data warehouse into FDP, using FDP as the platform will allow a much greater degree of automation in data production and the use of AI to support insights for Board members.

All three Trusts are in segment 4 for the Q3 25/26 NOF ratings

- All three Trusts are now in Segment 4, with the rank for KGH having slipped by 2, NGH by 7 and UHL by 5. For KGH and UHL, this moves them from Segment 3 in Q2 to segment 4 in Q3.
- The three Trusts have deteriorated by 0.11 (KGH), 0.15 (NGH), and 0.13 (UHL) since Q3 in average score. None of the changes are identified as a statistically significant change in the published statistical analysis.
- Above average performance in Effectiveness and experience and People and workforce has been sustained in NGH, as has Patient Safety and high performing People and Workforce in UHL.

Kettering General Hospital

4 - Low performing
Previous quarter's segment: 3

104 out of 134
Previous quarter's rank: 102 out of 134

2.76
Higher by 0.11 from previous quarter

Access to services	3 - Below average
Finance and productivity	4 - Low performing
Effectiveness and experience	3 - Below average
Patient safety	3 - Below average
People and workforce	3 - Below average

Northampton General Hospital

4 - Low performing
Previous quarter's segment: 4

126 out of 134
Previous quarter's rank: 119 out of 134

3.01
Higher by 0.15 from previous quarter

Access to services	4 - Low performing
Finance and productivity	4 - Low performing
Effectiveness and experience	2 - Above average
Patient safety	3 - Below average
People and workforce	2 - Above average

University Hospitals of Leicester

4 - Low performing
Previous quarter's segment: 3

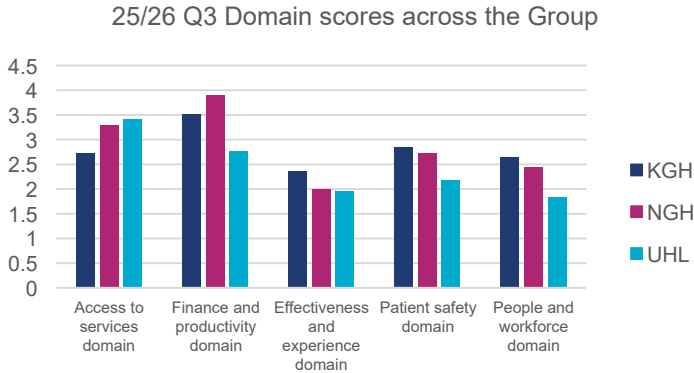
99 out of 134
Previous quarter's rank: 94 out of 134

2.71
Higher by 0.13 from previous quarter

Access to services	4 - Low performing
Finance and productivity	3 - Below average
Effectiveness and experience	2 - Above average
Patient safety	2 - Above average
People and workforce	1 - High performing

In Q3, Effectiveness and Experience is a relative strength across the Group, with challenges in Access and Finance

- Across the group, Access to Services and Finance and Productivity are the most challenged domains, and it is these domains that have driven the deterioration from Q2 to Q3.
- Effectiveness and experience is our best performing domain across the Group, which has remained stable throughout the year.
- Improvements have been since in all three Trusts in the People and Workforce domain, with UHL as high performing.
- The deterioration has been driven predominantly by finance, as well as cancer performance (UHN) and UEC performance (UHL).
- UHN has seen improvements in elective performance, and UHL in sickness and Infection Prevention Control.



Top three drivers of deterioration and improvement across the three Trusts

Kettering General Hospital

Metric	Contribution to change from Q2-Q3
Combined finance	52%
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	42%
Percentage of patients treated for cancer within 62 days of referral	41%
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	-17%
Difference between planned and actual 18 week performance	-19%
Implied productivity level	-25%

Northampton General Hospital

Metric	Contribution to change from Q2-Q3
Combined finance	90%
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	23%
Percentage of patients treated for cancer within 62 days of referral	18%
Percentage of emergency department attendances leaving department in four hours	-9%
Proportion of C. difficile infections	-15%
Percentage of patients waiting over 52 weeks for elective treatment	-15%

University Hospitals of Leicester

Metric	Contribution to change from Q2-Q3
Percentage of emergency department attendances leaving department in four hours	65%
Combined finance	50%
Implied productivity level	20%
Proportion of E. coli bacteraemia	-5%
Sickness absence rate	-11%
Proportion of C. difficile infections	-2%

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:	9 April 2026					
Title:	2.3.1 UHL Integrated Performance Report and Executive Summary (Paper E2)					
Report presented by:	Richard Mitchell, Group Chief Executive 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						

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

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 report 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 9 APRIL 2026

Main report detail

Key headlines in performance are summarised below:

Summary of UHL Performance: FEBRUARY 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 	February 2026 saw an increase of 567 Emergency Department attendances to plan with a year-to-date overperformance of 4497 attendances. Paediatric ED saw an increase of 151 attendances compared to January 2025 year to date though they are under by 1422 thereby overall increase in the adult department. Eye Casualty in February 2026 has seen a year-to-date overperformance of 730 attendances. 4-hour performance in February achieved the trajectory of 59.43% with a performance of 63.07% (UHL only). Focus for March (March Sprint) is to improve performance by 4% on trajectory. 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. In February 2026, LRI monthly ambulance handovers over 60 minutes decreased to 10.0% (503 out of 5,013 handovers) compared to January 2026 when LRI was 16.8% (919 out of 5,488 handovers). The 12-hour performance (total time in dept) was 9.23% achieving trajectory of 9.37%. Emergency admissions were over plan by 306 admissions, year to date is 6041 admissions over plan. Actions for improvement – Achievements in February - 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. - Develop our 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 complete 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 	Elective Care performance remains significantly challenged, especially regarding waiting list volumes, RTT (Referral to Treatment) standards, and patients experiencing long waits (65 and 52 weeks). At the end of February 26, there were 103 patients waiting 65 weeks. The forecast for March is currently 56 patients. MSS specialties represent 73% of potential breaches, with Orthopaedic Surgery alone accounting for 46%. There has been modest progress in reducing the proportion of 52-week waiters, now at 2.1% of the total PTL (Patient Tracking List) size, with expectations to reach 2% by the end of March. This improvement is supported by additional activity from the CMGs elective recovery plan and further efforts funded through accelerator/sprint initiatives. Multiple strategies are being implemented to address prolonged waits and enhance performance against the 18-week standard, including: • Superclinics • Increased use of insourcing • Elective sprint measures expected to deliver a further 750 clock stops by the end of March and a further 300 patients to be sent for treatment in the Independent Sector. • Validation is currently focused on individuals projected to exceed 18 weeks RTT by the end of March, within the next three weeks. February 26 18-week performance was 55.7%, with a total waiting list size of 117,449. This now includes all records awaiting clinical triage and Clinical Genetics (different PAS). We expect overall RTT performance to improve to 57% by the end of March.
Cancer Referrals 2 week wait Faster Diagnosis Standard 62-day referral to treatment 	Referrals year to date have seen an increase of 3.8% compared to the previous year. Conversion rates year to date is 6.2% and is in line with the national average. As anticipated, January performance deteriorated from December, partly due to volume of patient choice to delay treatments until after Christmas. January FDS delivered 67.7% a 4.3% deterioration on December. Breast remains the main driver of variance due to the ongoing capacity gap, with other tumour sites on or ahead of plan. This remains a risk for the Trust and is reliant on additional capacity and insourcing. Whilst some improvement in Breast has been noted in the last two months, significant improvement is not expected until June as vacancies are filled. For 62-day performance there are several key challenges across multiple tumour sites. Constraints include increased demand, additional diagnostic tests 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. 62-day performance in January saw a deterioration of 2.1% to 53.9%. 31-day performance met the same challenges mentioned above but improvements anticipated later in Q4 with wait times improving in radiotherapy and drug performance stable. Recovery actions with support from EMCA/NHSE continue, increasing capacity wherever possible. Focus continues to reduce overall pathways using evidence from audits with emphasis that each day matters. Overall average waits have reduced compared to the previous year, however this has not yet driven corresponding rise in performance due to the volume of patients still waiting beyond 62 days. To reduce variability and sustain improvements into 26/27, increased diagnostic capacity and MDT sequencing will be key.
Quality 	Quality exceptions highlight gram-negative bloodstream infections and hospital-acquired pressure ulcers remaining above target. Clear mitigation and governance arrangements are in place, including executive-led oversight, weekly pressure-harm review and targeted training programmes, with early indications of improved grip and consistency in practice. Complaints response times have improved in-month, supported by a CHUGGS process trial and strengthened monitoring, although year-to-date performance remains below target and continues to be impacted by service pressures, requiring sustained management focus.
Finance 	The YTD position for the Trust is a deficit of £41m which is £37.7m adverse to plan. The main drivers are loss of DSF funding £21.6mA, non delivery of CIP £16.2mA and pay pressures circa of £3mA. In month the Trust received an additional allocation of £2.5m for winter flow. Emergency/Non Elective inpatient activity continues to over-perform; at M11, the Trust has delivered 4.2% more activity which equates to £26m 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 forecast for the year remains at - £85m deficit excluding deficit support funding The Trust committed net capital expenditure of £53.1m to Month 11 resulting in an underspend of £6.2m against CDEL target of £59.5m. The cash position at the end of Month 11 was £40m, which is an increase of £27.8m from M10.
Workforce 	The overall Whole Time Equivalent (WTE) workforce in M11 was 18,360 which is 774 WTE above plan (a 4.40% variance) continuing a trend of being above plan since M7 driven mostly by continued high bank staff usage and substantive staff increase above the planned position. Agency staff usage reduced from previous month's usage by 3 WTEs and remains favourably below plan by 2.44% and spend is 0.44% which is below the NHS KPI for agency spend of 3.20%. Bank staffing has increased compared to previous month with usage at 571 WTE above plan, equating to 147.24% over the planned position. Bank usage is mostly high in ESM, particularly for N41 Emergency Nursing, Y06 Preston Lodge, and N82 Ward 19 LGH (Qualified Nurses & Unqualified Nursing Support staff), as well as in E&F for Cleaning, Catering, Portering and Security staffing.

Usage is also high within W&C for Nurse Qualified & Nurse Unqualified staff (notably within the Delivery Suite at LRI). Bank spend is recorded at 6.41% (of the total paybill) which is below the national KPI spend cap of 8%.

Contracted Substantive staff was recorded at 17,373 WTE which is 1.19% (203 WTE) above the plan. The projected year end position for Contracted substantive staff (March'26 outturn) is 17,350 WTE which will be 359 WTEs above the planned position of 16,991 representing a 2.11% variance to plan.

Workforce turnover has increased in February 7.2% to 7.6% and remains within the 10% target.

Registered Nursing and Midwifery vacancies are reducing with the appointment of newly qualified staff. Through recent HCSW appointments, vacancies have reduced to 3.3 against the 5% target.

On 12 February 2026, the Trust Board approved the annual nursing and midwifery establishment review, which will see a reduction in HCSW posts by 72.57 WTE and increase in registered posts by 50.84 WTE.

All nursing roles now comply with the general nursing agency price cap. A key area of 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.

Statutory and Mandatory training remains stable at 94% against the target of 95%

Appraisal performance has seen a 0.5% decrease to 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 0.07% reduction in January. Over the last 12 months, the CMG's with the highest levels of absence are E&F (6.08%), W&C (5.72%) and ITAPS (5.15%). A key area of focus over winter has been the flu vaccination programme to

	protect our patients, colleagues and families. Absences related to cough / cold / flu have reduced by 4.34% from December levels. 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.
Transformation & Productivity Key Overview e.g Urgent and Emergency Care, Elective, digital, Estates etc	Theatres • In February, overall theatre utilisation was 81.9%, with the year-to-date average stable at 81.5%. Trust performance remains rated Green (Quartile 4) nationally and regionally. For the week ending 22 February 2026, utilisation reached 84.8%, outperforming both the peer median (79.1%) and national average (80%). • Late starts have improved from 30.6% to 19.0% (Feb 2025–Feb 2026). Further improvement is expected as the Trust embeds consistent 08:20 theatre walk-rounds to enable early identification and escalation of operational issues, alongside reinforced use of the ORMIS free-text field to capture accurate causes for delay. • Cancellations remained static at 8.9% in February, primarily driven by DNAs (51 cases), patients' self-declaring unfit (49 cases), and procedural-complexity-related overruns (49 cases). Weekly performance meetings will resume in April to strengthen specialty-level ownership and reduce on-the-day cancellations. • Model Hospital reports BADS performance of 75.4% for November 2026. By comparison, UHL internal theatre-based data shows January day-case performance of 76%. The variance is linked to ongoing data-quality issues, particularly incorrect INTMANIG (intended management) coding, which prevents some specialties from selecting the correct management at listing. A Neurons request has been raised to address this. Before system go-live, performance was 84% and improving, indicating that current reductions are largely data-quality-related rather than operational. <u>Outpatients</u> • Patient Initiated Follow-Up (PIFU): Patient Initiated Follow Up (PIFU) performance decreased in February to 5.2%, bringing the year to date average to 5.3%. This remains above the national target of 5% but is below the local target of 5.5%. Work is now underway to re set targets against 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 from 6.3% to 6.1% in February, with a year to date position of 6.2%, DNAs continue to be 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 patient groups experiencing 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 before appointments is technically ready but on hold due to dependencies with the Ambient Scribe rollout. Once resolved, implementation will be prioritised, as the enhanced reminders are expected to help reduce DNAs and improve attendance. The increased fragment limits will also allow more tailored messaging to patients. UEC • 5718 monthly SDEC attendance delivered in February (18% above monthly target) Meeting trajectory target to hit yearly target of 11% increase. • 2521 calls received to Clinical Bed Bureau (CBB) which is 14 % above target compared to average calls per month previous year. • Ambulance handover times decreased from 39 minutes in January to 30 in February. A 51% improvement from February 2025. • .GIRFT 24H red line performance improved by 0.6% previous month. Sitting at 1.4% of patients breaching. • GP to Fracture Clinic Pathway Trial agreed to prevent patient waiting i ED – to begin March

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

February 2026

Oversight Framework

Key Performance Indicator	Target	Dec-25	Jan-26	Feb-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Clostridium Difficile per 100,000 Bed Days	167 Cases	11.6	13.6	19.3	14.4				Mar-24	Local	Chief Nurse and Medical Director
Methicillin Resistant Staphylococcus Aureus	0	0	0	1	7				Mar-24	Local	Chief Nurse and Medical Director
E-Coli per 100,000 Bed Days		9.7	13.6		15.1				TBC	No Target	Chief Nurse and Medical Director
Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	1.8	2.0	2.1	1.8				Jun-21	Local	Chief Nurse and Medical Director
Sickness Absence	3%	5.2%	5.2%		5.0%				Mar-25	Local	Chief People Officer
30 Day Readmission Rate		10.8%	11.2%		10.6%				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%	65.7%	61.8%	63.0%	62.5%				Mar-23	National	Chief Operating Officer
% of 12 hour waits in the Emergency Department	10.3%	7.0%	11.6%	9.2%	9.4%				Mar-23	National	Chief Operating Officer
Referral to Treatment (RTT) 18 wk performance *	62.3%	52.0%	51.7%	55.7%					TBC	Local	Chief Operating Officer
Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes *	0.9%	2.6%	2.6%	2.1%					TBC	Local	Chief Operating Officer
6 Week Diagnostic Test Waiting Times *	5%	17.7%	21.8%	14.3%					Jul-23	National	Chief Operating Officer
28 Day Faster Diagnosis Standard *	80%	72.0%	67.7%		71.0%				May-24	National	Chief Operating Officer
Cancer 62 Day Combined *	70%	56.0%	53.9%		54.8%				May-24	Local	Chief Operating Officer
Trust level control level performance	-£3.3m	-£7.5m	-£6.7m	-£1.9m	-£41m				Jun-22		Chief Financial Officer
Capital expenditure against plan	£59.5m	£7.3m	£7.8m	£8.3m	£53.1m				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.

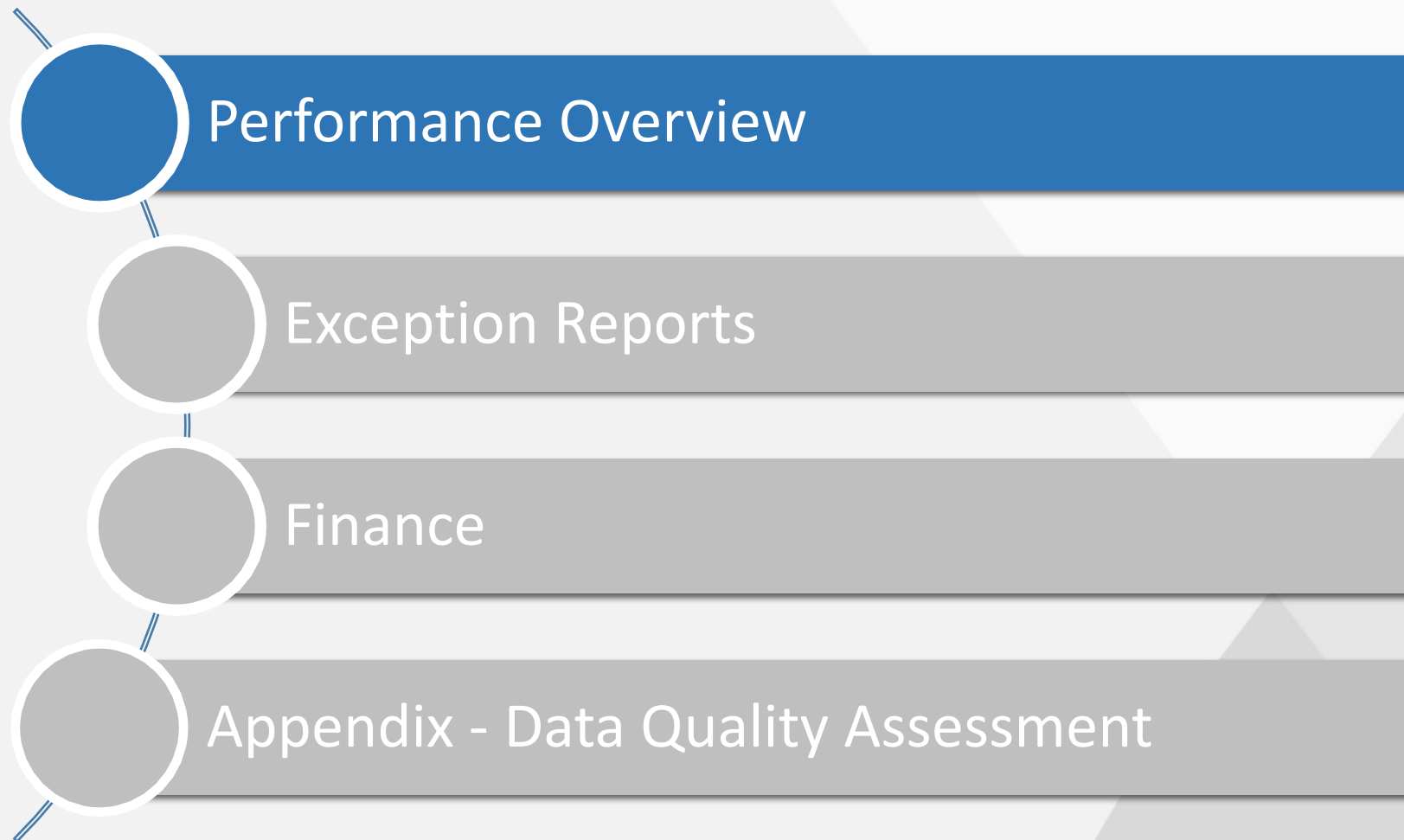
Integrated Performance Report

February 2026

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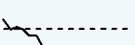
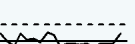


Performance Overview (Safe)

Safe

Domain	Key Performance Indicator	Target	Dec-25	Jan-26	Feb-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Safe	Never events	0	1	0	0	4				Nov-22	National	Chief Nurse and Medical Director
	Clostridium Difficile per 100,000 Bed Days	167 Cases	11.6	13.6	19.3	14.4				Mar-24	Local	Chief Nurse and Medical Director
	Methicillin Resistant Staphylococcus Aureus	0	0	0	1	7				Mar-24	Local	Chief Nurse and Medical Director
	Methicillin-susceptible Staphylococcus Aureus	40	7	3	7	48				Mar-24	Local	Chief Nurse and Medical Director
	All falls reported per 1000 bed days	4.0	3.7	3.4		3.1				Aug-22	Local	Chief Nurse and Medical Director
	Rate of Moderate harm and above Falls per 1,000 bed days	0.19	0.05	0.07		0.09				Aug-22	Local	Chief Nurse and Medical Director
	Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	1.8	2.0	2.1	1.8				Jun-21	Local	Chief Nurse and Medical Director
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	98.3%	98.0%		98.0%				Oct-21	National	Chief Nurse and Medical Director
	Number of Patient Safety Incident Investigations (PSIIs) commissioned		2	1	0	14	Awaiting more data for assurance and variance			Nov-24	No Target	Chief Nurse and Medical Director
	Number of reported Patient Safety Incidents		2484	2567	2348	26788				Nov-24	No Target	Chief Nurse and Medical Director
	Rate of reported Patient Safety Incidents (per 1000 inpatient, outpatient and ED attendances)		18.7	18.3	17.8	18.5				Nov-24	No Target	Chief Nurse and Medical Director

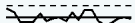
Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Dec-25	Jan-26	Feb-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Caring	Single Sex Breaches		4	43	36	199				Jul-22	No Target	Chief Nurse and Medical Director
	Inpatient and Day Case Friends & Family Test % Positive	95%	96%	95%	95%	96%				Jul-22	Local	Chief Nurse and Medical Director
	A&E Friends & Family Test % Positive	81%	87%	86%	88%	84%				Jul-22	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 25 Working days	90%	55%	82%		55%				Jul-23	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 60 Working days	90%	95%			78%				Jul-23	Local	Chief Nurse and Medical Director

Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Dec-25	Jan-26	Feb-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Well Led	Turnover Rate	10%	7.6%	7.2%	7.6%					Aug-22	Local	Chief People Officer
	Sickness Absence	3%	5.2%	5.2%		5.0%				Mar-25	Local	Chief People Officer
	% of Staff with Annual Appraisal	95%	83.5%	83.6%	83.1%					Mar-25	Local	Chief People Officer
	Statutory and Mandatory Training	95%	94%	94%	94%					Dec-22	Local	Chief People Officer
	Adult Nursing Vacancies	7%	4.5%	4.7%	5.3%					Dec-23	Local	Chief People Officer
	Paed Nursing Vacancies	10%	5.8%	3.7%	7.1%					Dec-23	Local	Chief People Officer
	Midwives Vacancies	7%	3.5%	0.0%	-4.4%					Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - excluding Maternity	5%	16.9%	18.3%	9.0%					Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - Maternity	5%	5.1%	4.1%	9.4%					Dec-23	Local	Chief People Officer
	% Bank spend of Pay Bill	8%	6.7%	6.6%	6.4%					TBC	National	Chief People Officer
	% Agency spend of Pay Bill	3.2%	0.4%	0.4%	0.4%					TBC	National	Chief People Officer
	Agency Off Framework activity- No. of shifts	0	0	0	0		Awaiting more data for assurance and variance			May-25	National	Chief People Officer
	Non Clinical Agency- No. of Staff	0	3	2	2		Awaiting more data for assurance and variance			May-25	National	Chief People Officer
	Agency Staff above Price cap	0	26	18	20		Awaiting 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		Awaiting 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		Awaiting 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		Awaiting more data for assurance and variance			TBC	National	Chief People Officer

Performance Overview (Effective)

Domain	Key Performance Indicator	Target	Dec-25	Jan-26	Feb-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		1.0%	1.1%	0.8%	0.9%				May-21	No Target	Chief Nurse and Medical Director
	DNA Rate - IMD Deciles 1 and 2	5%	8.9%	9.0%	8.9%	8.9%				Feb-24	Local	Director of Health Equality and Inclusion
	DNA Rate - IMD Deciles 3 - 10	5%	5.5%	5.5%	5.4%	5.6%				Feb-24	Local	Director of Health Equality and Inclusion

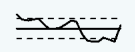
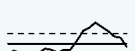
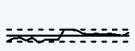
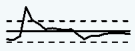
Performance Overview (Responsive Emergency Care)

Responsive (Emergency Care)

Domain	Key Performance Indicator	Target	Dec-25	Jan-26	Feb-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits LLR	78%	78.9%	76.4%	77.0%	76.7%				Mar-23	National	Chief Operating Officer
	Emergency Department 4 hour waits UHL	61%	65.7%	61.8%	63.0%	62.5%				Mar-23	National	Chief Operating Officer
	Mean Time to Initial Assessment	15	6.5	7.3	6.9	8.4				Nov-24	National	Chief Operating Officer
	% 12 hour trolley waits in Emergency Department (DTA)	10.3%	2.4%	4.5%	3.5%	3.3%				Mar-23	National	Chief Operating Officer
	% of 12 hour waits in the Emergency Department	10.3%	7.0%	11.6%	9.2%	9.4%				Mar-23	National	Chief Operating Officer
	Average Clinical Handover time for ambulance handovers (Minutes)	30	27	39	30	41				Data sourced externally	Local	Chief Operating Officer
	Non Elective Average Length of Stay	7.2	7.0	7.2	7.7	7.3				Aug-25	Local	Chief Operating Officer
	% of Patients Discharged on Discharge Ready Date	88.3%	88.9%	88.4%	87.9%	88.4%				Aug-25	Local	Chief Operating Officer
	Average Delay (Post Discharge Ready Date)	3.8	4.3	4.6	4.2	4.2				Aug-25	Local	Chief Operating Officer
	Trust Bed Occupancy	92.0%	89.8%	93.4%	91.5%					Dec-23	National	Chief Operating Officer
	Long Stay Patients (21+ days) as a % of G&A Bed Occupancy	10%	18.1%	19.8%	19.6%					Apr-23	Local	Chief Operating Officer

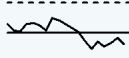
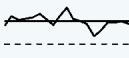
Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 15).

Performance Overview (Responsive Elective Care)

Domain	Key Performance Indicator	Target	Dec-25	Jan-26	Feb-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	105,500	107,775	105,825	117,449					Jun-23	Local	Chief Operating Officer
	Referral to Treatment (RTT) 18 wk performance	62.3%	52.0%	51.7%	55.7%					TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	68.1%	60.4%	60.9%	61.6%		Awaiting 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%	2.6%	2.1%					TBC	Local	Chief Operating Officer
	6 Week Diagnostic Test Waiting Times	5%	17.7%	21.8%	14.3%					Jul-23	National	Chief Operating Officer
	Theatre Utilisation	85.0%	80.9%	80.0%	81.9%	81.5%				Dec-23	National	Chief Operating Officer
	Patient Initiated Follow Up	5.5%	5.4%	5.5%	5.2%	5.3%				Oct-23	Local	Chief Operating Officer
	% Outpatient Did Not Attend rate	4.9%	6.0%	6.1%	6.1%	6.2%				Apr-23	Local	Chief Operating Officer
	% Outpatient Non Face to Face	25%	27.9%	27.7%	26.2%	27.7%				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	Dec-25	Jan-26	Feb-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Cancer)	28 Day Faster Diagnosis Standard	80%	72.0%	67.7%		71.0%				May-24	National	Chief Operating Officer
	Cancer 31 Day Combined	96%	84.9%	78.1%		76.5%				May-24	National	Chief Operating Officer
	62 Day Backlog Combined	152	452	434	414					Dec-24	Local	Chief Operating Officer
	Cancer 62 Day Combined	70%	56.0%	53.9%		54.8%				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	Dec-25	Jan-26	Feb-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	-£3.3m	-£7.5m	-£6.7m	-£1.9m	-£41m				Jun-22	Chief Financial Officer
	Capital expenditure against plan	£59.5m	£7.3m	£7.8m	£8.3m	£53.1m				Jun-22	Chief Financial Officer
	Cost Improvement (Includes Productivity)	£78.8m	£4.4m	£7.2m	£7.4	£62.6m				Dec-23	Chief Financial Officer
	Cashflow	No Target	-£30.5m	£5m	£27.8m	£40m				Jun-22	Chief Financial Officer
	Aged Debt	No Target	£13.8m	£13.8m	£14.1m					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (value)	95%	98%	96%	94%					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (volume)	95%	95%	91%	88%					Feb-24	Chief Financial Officer

Performance Overview (Activity)

Domain	Activity Type	Plan 25/26	Plan in Month (M11)	Activity In Month (M11)	Variance In Month (M11)	Plan YTD	Actual YTD	Variance YTD	YTD Variance to 19/20
Activity	New Outpatients (inc. NFTF)	270,077	21,310	25,557	4,247	246,842	251,250	4,408	3,864
	Follow Up Outpatients (inc. NFTF)	601,725	47,759	46,235	-1,524	550,559	490,785	-59,774	-64,213
	Outpatient Procedures	220,367	17,326	19,649	2,323	201,817	193,872	-7,945	50,166
	Daycase	137,582	10,701	9,706	-995	126,434	107,276	-19,158	7,852
	Inpatient	22,053	1,713	2,118	405	20,153	22,307	2,154	4,202
	Emergency	114,624	9,486	9,791	305	104,615	108,542	3,927	17,893
	Non Elective	22,843	1,751	2,705	954	20,905	22,225	1,320	1,915
	Emergency Department (inc. Eye Casualty)	282,655	22,065	22,922	858	258,400	263,704	5,304	26,238
	Diagnostic Imaging (inc. Direct Access)	398,465	32,836	32,283	-553	364,667	358,540	-6,126	206,760
	Other	11,473,688	938,520	964,914	26,394	10,530,846	10,965,455	434,609	2,930,393
	TOTAL	13,544,079	1,103,466	1,135,881	32,415	12,425,237	12,783,956	358,719	3,185,070

*Source Early Cut and Forecasting File

The DM01 plan for imaging activity for M10 was 639 below plan in month (27,810 vs 27,171) and was 17,783 below plan YTD (277,955 vs 260,172).

Performance Overview (Productivity Dashboard)

Productivity Dashboard v4.0 - UHL Trustwide		2025/ 2026 Actuals													Assurance				Comments/ Narrative
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	To provide high level commentary on issues driving performance improvement, deterioration or against in month or YTD targets.
Ops & Clinical Productivity	Finance: CpWAU	4,027	3,945	4,076	3,989	4,010	3,935	4,021	3,923	3,753				3,964			-	4,250	Dec 25 latest available.
	Ops: Avg LoS for Elective Inpatients (nights)	3.26	3.06	3.11	3.50	3.31	2.98	3.08	3.12	3.25	3.02	3.24		3.18			-	3.37	Emergency LoS has reduced compared to last year 3.74 representing an overall improvement. A trust wide LoS improvement plan is in development in discussion with the CMG's.
	Ops: Avg LoS for emergency admissions	3.74	3.62	3.47	3.41	3.64	3.38	3.53	3.31	3.48	3.48	3.57		3.51			-	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%		88.6%			-	~	
	Ops: Do not meet Criteria to Reside (avg pts per day)	469	431	444	436	480	481	476	471	477	511	506		471			-	~	
Theatres	Theatres: Capped Utilisation	83.5%	83.4%	83.3%	81.0%	81.5%	81.3%	80.8%	81.3%	80.9%	80.0%	81.9%		81.7%			85.0%	68.1%	Capped theatre utilisation remains below the 85% target however has shown improvement from the previous month with a marginal improvement in ACPL. On the day cancellations (OTDC) remain elevated, although better than the previous two months. Reducing OTDC needs to continue to be a key focus. Assessment: Theatre performance in February is constrained and fragile, with cancellations and bed pressures continuing to limit utilisation and throughput.
	Theatres: ACPL	2.01	2.04	2.00	2.02	2.01	2.00	2.00	1.92	1.94	1.89	1.96		1.98			-	2.06	
	% Theatre Sessions Utilised																		
	Theatres: OTDC	9.1%	7.9%	7.8%	7.9%	8.1%	8.3%	8.2%	8.5%	9.0%	9.6%	8.3%		8.4%			5.0%	8.5%	Endoscopy APPL remains well below target, with no significant improvement evident in February.
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		7.83			10.50	~		
Outpatients	Outpatients: Clinic Utilisation	89.9%	90.3%	89.6%	88.4%	93.0%	93.1%	93.1%	94.5%	92.9%	94.2%	94.2%		92.1%			95.0%	90.9%	Clinic utilisation remains strong in February, exceeding 94% and continuing upward trajectory. DNA rates remain broadly stable, above target but not worsening. PIFU performance remains around target, sustaining improvements achieved earlier in the year. Follow ups without procedure remain lower than early year levels, supporting outpatient transformation objectives.
	Outpatients: DNA Rate	5.6%	5.9%	5.8%	6.3%	5.8%	5.7%	5.4%	6.0%	6.1%	6.3%	6.1%		5.9%			5.0%	6.6%	
	Outpatients: % PIFU	6.1%	6.2%	5.4%	4.5%	4.9%	4.9%	5.2%	5.5%	5.5%	5.6%	5.3%		5.4%			5.5%	~	Assessment: Outpatients continue to be the strongest area of performance, with sustained high utilisation and improved pathway efficiency.
	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%		52.9%			53.4%	~	
	A&G: Specialist Advice Utilisation Rate																	~	
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%		72.5%			-	~	MRI productivity (adjusted) remains below target in February, 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 despite high booked utilisation, indicating lost capacity on the day. CT productivity shows some improvement compared with earlier months but 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. Assessment: Diagnostics continue to represent a key limiting factor, with productivity below target and no clear step change evident in February.
	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	1.40		1.34			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%		3.7%			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%		90.3%			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%			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%		79.2%			-	~	
	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		2.20			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%			3.0%	~	
															All SPC charts and variation/assurance icons use data from April 2023 (where available) to latest reported month. No recalculations are currently applied to any metrics.				

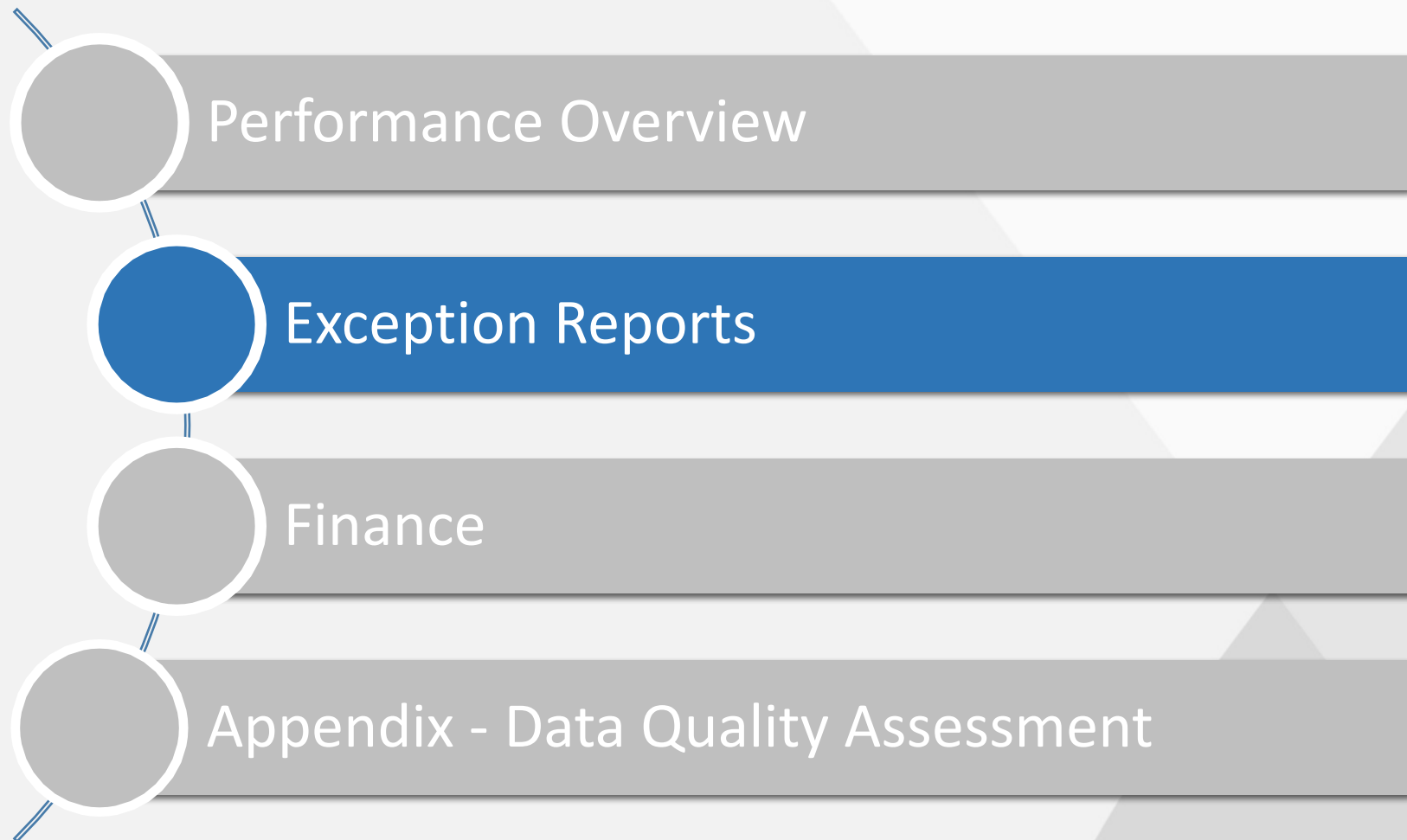
Performance Overview (Workforce Performance Overview)

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.

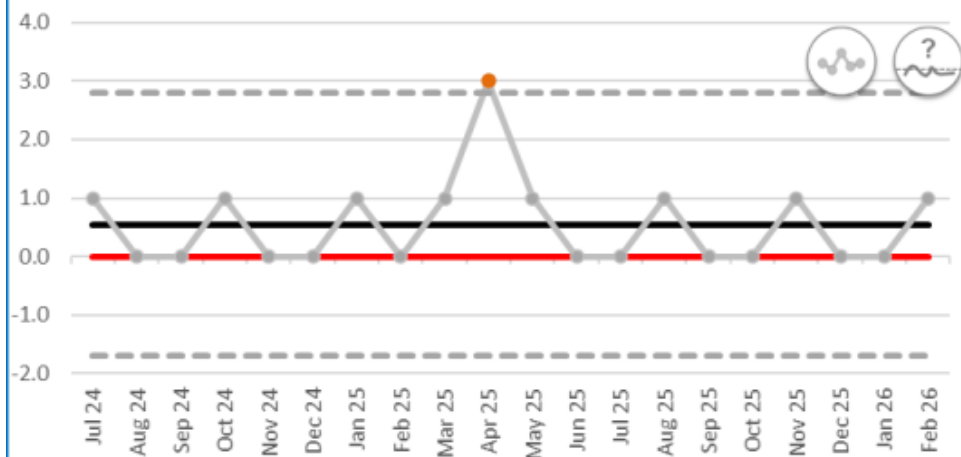
Performance Overview (Monthly Trajectory Values)

	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%



Safe – Methicillin Resistant Staphylococcus Aureus

Methicillin Resistant Staphylococcus Aureus Total



Current Performance

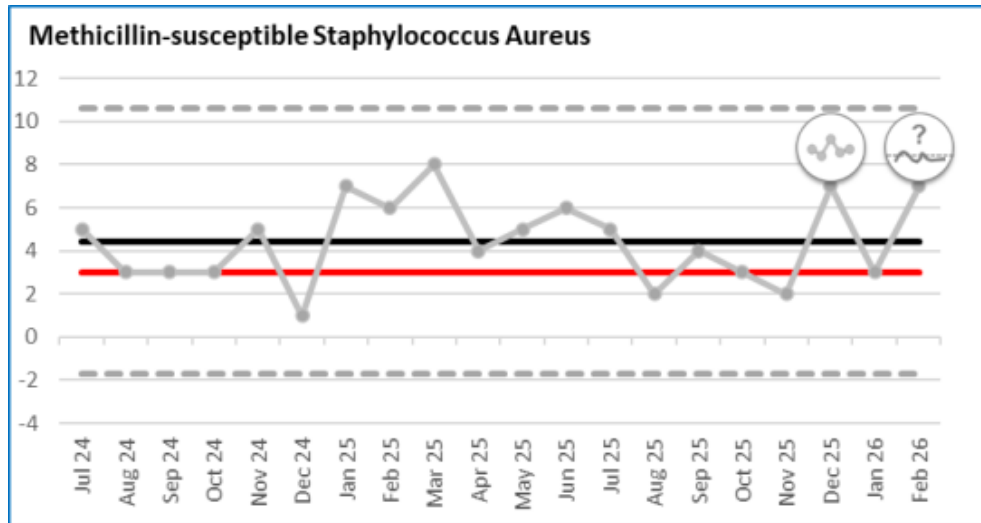
Feb 25	YTD	Target
1	7	0

National Position & Overview

	Feb 26	Total	
MSSA NHSE Threshold 25/26	0	0	
* Actual Infections (HOHA) 25/26	1	7	
* Actual Infections (COHA) 25/26	0	0	
* Actual Infections Total (HOHA & COHA) 25/26	1	7	
UHL 100,000 Bed Days (HOHA) 25/26	2.15	1.28	*YTD UKHSA Report
National Average	1.19		
National Highest	13.45		
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.	MRSA reduction plan will be monitored through TIPOG during Q4

Safe – Methicillin-susceptible Staphylococcus Aureus

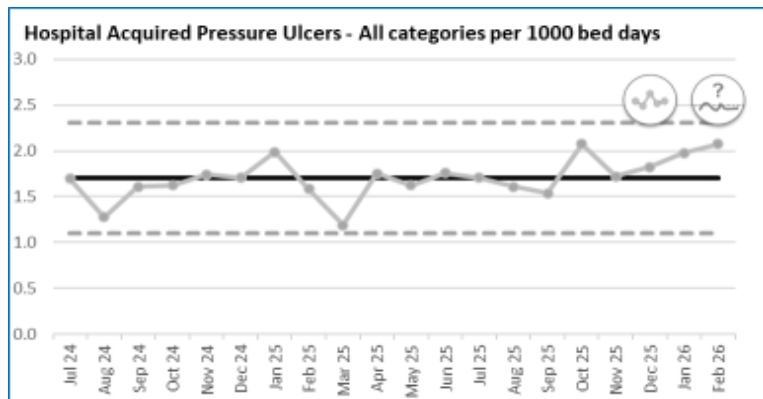


Current Performance		
Feb 26	YTD	Target
7	48	40

National Position & Overview			
	Feb 26	Total	
MSSA NHSE Threshold 25/26	4	40	
* Actual Infections (HOHA) 25/26	4	24	
* Actual Infections (COHA) 25/26	3	14	
* Actual Infections Total (HOHA & COHA) 25/26	7	38	
UHL 100,000 Bed Days (HOHA) 25/26	8.59	5.59	*YTD UKHSA Report
National Average	10.66		
National Highest	78.33		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
- No new emerging themes locally or Nationally. - UHL themes include: Issues with compliance of the PVAD and CVC management	- HCAI is scheduled as a routine agenda item at TIPOG - Monitoring of actions required following the PVAD/CVC audits will continue to be monitored through TIPOG - ANTT programme continues across UHL	A full review of the MRSA policy and current UHL practise is underway and is being monitored through TIPOG

Safe - Hospital Acquired Pressure Ulcers - All categories per 1000 bed days



Current Performance

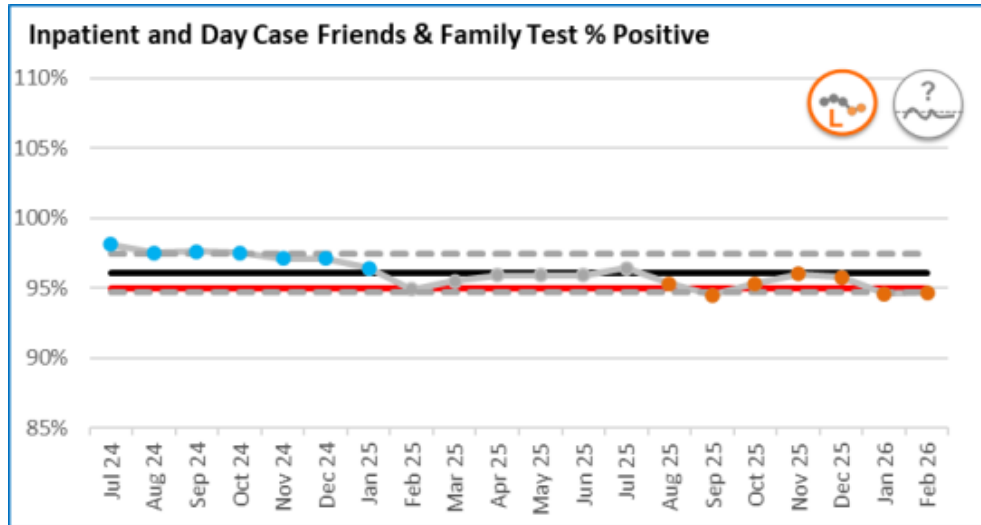
Feb 26	YTD	Target
2.1	1.8	1.7

National Position & Overview

Currently there remains no national bench marking or reporting to provide comparative data, however the UHL position in February 2026 reflects 120 HAPUs in total numbers and 2.07 per 1000OBD. This includes x2 Category 4 and x2 Category 3 HAPUs. This is an increase per 1000 OBD >2 which was last observed in October 2025.

Root Cause	Actions	Impact/Timescale
- Continued Increase in acuity and winter seasonal variability throughout the month of February 2026. - Acuity and compromised Skin Integrity on admission noted across the CMG Clinical Teams - Variability in staff adhering to Tissue Viability Care Plans. - Variability in staff knowledge in Categorisation and onward referral to the Tissue Viability Team. - Appropriate and prompt surface escalation.	- Ongoing monitoring of HAPUs during weekly HAPU Validation Meeting, chaired by the Deputy Chief/ Assistant Chief Nurse and Tissue Viability Lead. With triangulation with LEAF Harms Data across Adult In patient areas. - Weekly Complex Case review meetings continue with Pioneer. - Bi-monthly categorisation training from Pioneer, TV team to begin delivery of additional in-house education programme throughout 2026/2027 - alongside Purpose T education package from April onwards. - Deep Dive into Data Analysis of HAPUs by OBD per CMG to identify specifics - Purpose T Model completed within Nervecentre, awaiting confirmation of roll out date 29th April. - Ongoing support from the Fundamentals of care programme, roll modelling best practice. - Non compliance with Care plans now being reported on Datix, to identify areas requiring improvement.	- An additional 13 DTI's over the course of the month were successfully resolved, reflecting proactive intervention and effective management strategies. Ongoing monitoring. - Ongoing weekly complex case reviews with shared learning for UHL and UHN - New training to commence in April - CMG and ward based analysis available each month for clinical areas. - Change to reduced timeframe for skin assessment already implemented. Roll out of PurposeT from April 29th. - Fundamentals of care continues to be rolled out across all CMG areas. - Harm Free Care Matron and TV Teams providing QA walk rounds to provide additional support and bedside teaching.

Caring — Published Inpatients and Daycase Friends and Family Test - % positive

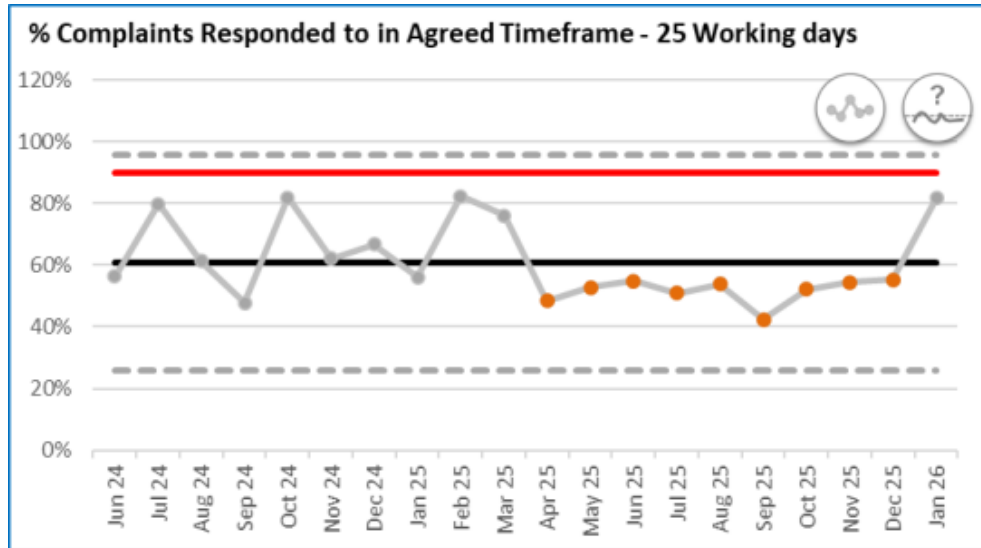


Current Performance		
Feb 26	YTD	Target
94.7%	95.5%	95%

National Position & Overview
National Inpatient % positive result in January 2026 (most recent available) was 94.4%. Trust Peer Group result for January 2026 was 94.9%.

Root Cause	Actions	Impact/Timescale
The reduction in the overall FFT positive score reflects a shift from paper to electronic collection. In November 2025, 60% of feedback was paper-based with a 96% positive score; by February 2026 this fell to 40%, following printing restrictions. Paper feedback remains higher (97%) than electronic (93%), so further decline is expected as electronic responses increase. Ongoing bed pressures may also have contributed to lower satisfaction.	CHUGGS: New Endoscopy unit opened; booking and staffing models optimised to reduce cancellations; joint working with Children's services to improve paediatric experience. CSI: Scanner relocation completed in response to patient feedback. EM: Appointment system introduced in SDEC wards; renewed focus on care fundamentals. MSS: Ward-round pilot underway to improve patient information and experience. RRCV: Bathrooms and showers refurbished; care-fundamentals improvement programme rolling out across wards. SM: Targeted ward-based projects, including LEAF pain-relief focus and dementia screening tool training.	Results will be reviewed again in March to assess trend sustainability. CMGs continue to monitor and report patient experience actions via PIPEEAC.

Caring – % Complaints Responded to in Agreed Timeframes



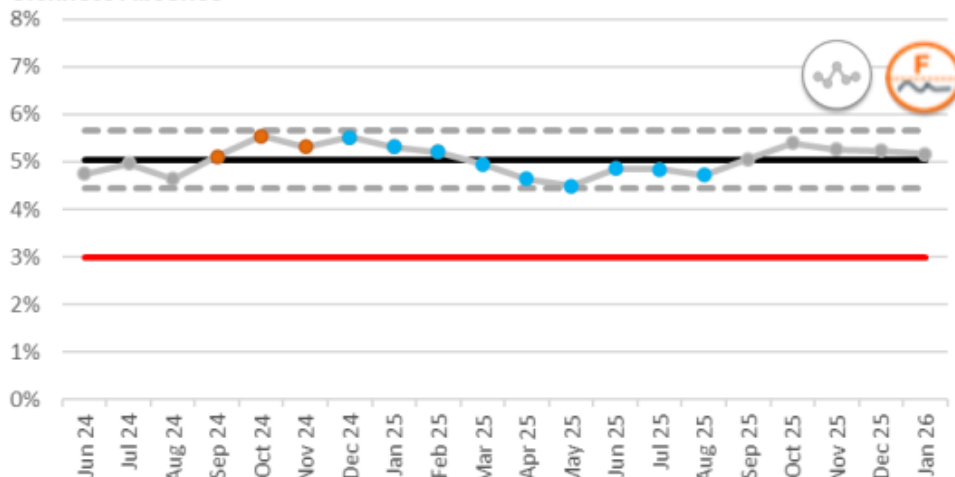
25 Working Days			60 Working Days		
Jan 26	YTD	Target	Dec 25	YTD	Target
81.7%	54.7%	90%	95.5%	78.0%	90%

National Position & Overview

Root Cause	Actions	Impact/Timescale
- Significant improvement in % of complaints responded to within 25 working days (below 60% -> 82%) 96% complaints responded to in 60 working days in December 2025 - Complaint meetings are being organised in a more timely fashion	- Continuation in monitoring of complaint response times and positive actions to support the services - Current 3 month trial with CHUGGS whereby complaints are not triaged in first instance by the Complaint managers. The complaints are sent to the appropriate staff to respond to and the senior signatory decides on the themes. The CMG can alter the response timeframes if felt to be required - If this trial, is successful, there are plans to eventually roll out to the remaining CMG's	Continued improvement of % complaint response times

Well Led – Sickness Absence

Sickness Absence



Current Performance

Jan 26	YTD	Target
5.2%	5.0%	3%

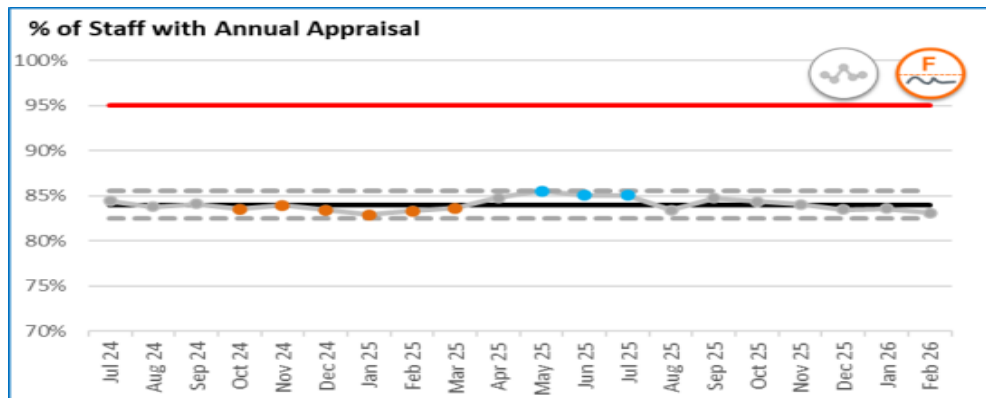
National Position & Overview

Peer data not available.

The December sickness absence rates shows a reduction of 0.07% to the previous month.

Root Cause	Actions	Impact/Timescale
- Clinical CMG's have seen a 0.08% reduction and Corporate Directorates a reduction of 0.01% in December. - Over the last 12 months, the highest levels of absence are in E&F (6.08%), W&C (5.72%) and ITAPS (5.15%). - The areas achieving the 3% target are within the Corporate Directorates - The top 3 reasons for sickness absence are anxiety/stress/depression (23.04%), Other known reasons (16.27%) and cough/cold/flu (10.81%)	- 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 it 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 flu vaccination programme continues until the end of March, and we will see a 10% increase in uptake from the previous year. - 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 M10 we are at 1.89%. - Absences due to cough / cold / flu have reduced by 4.34% between December and January.

Well Led – % of Staff with Annual Appraisal



Current Performance

Feb 26	YTD	Target
83.1%	-	95%

National Position & Overview

Peer data not available.

The February figure shows a 0.5 decrease following a slight increase in the previous month. We are now 11.9% away from the Trust target of 95%.

Root Cause

- 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 seen a 0.5 increase.
- The Trust's overall compliance in month has been due to marginal increases and decreases in clinical areas with more noticeable differences in corporate services.

Actions

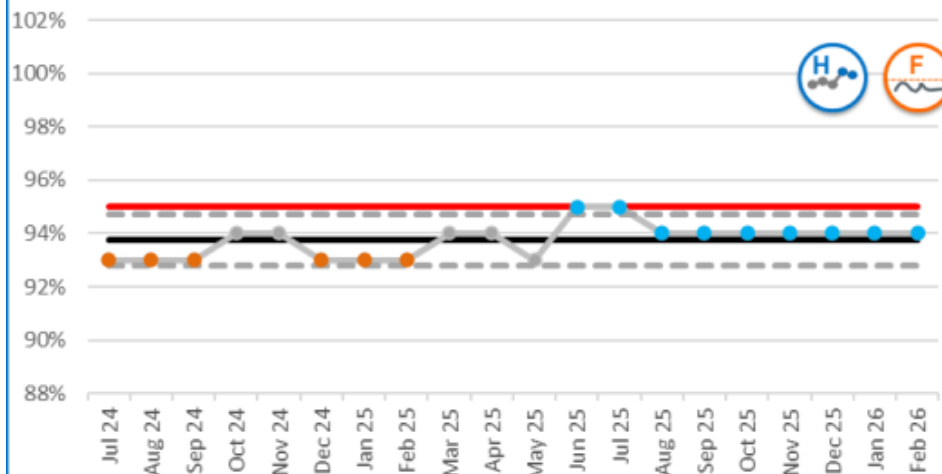
- It is acknowledged in previous exception reports that we would be unlikely to reach full compliance of 95% in the short term.
- CMG reports are provided, highlighting performance and areas of focus, to enable targeted support and action in these areas.
- The roll out of Managers Self-Serve should see 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 at CMG level are asked to review appraisal performance and identify any additional targeted support required

Impact/Timescale

- In February 2025 Appraisal performance was at 83.3%, an increase in compliance on the previous month of January 2025, a decreased position compared to the February 2025 figure.
- 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

Statutory and Mandatory Training



Current Performance

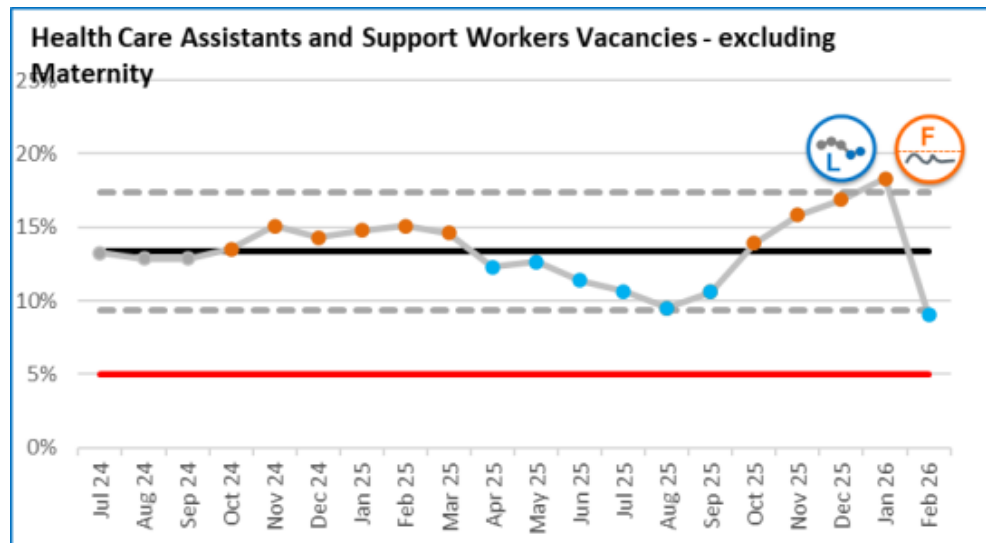
Feb 26	YTD	Target
94%	-	95%

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		
Feb 26	YTD	Target
9.0%	-	5%

National Position & Overview

Recent changes to Skilled Worker visa rules, specifically the removal of eligibility for Healthcare Support Worker roles unless they meet the £25,000 salary threshold, may be limiting the pool of candidates and reducing overall applicant supply.

Root Cause	Actions	Impact/Timescale
- Some internal recruitment delays particularly in relation to applicants requiring sponsorship. - 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.	- A review and revision of internal processes is being undertaken in partnership with Peoples Services to mitigate the recruitment challenges associated with sponsorship this has been completed mid-February 2026. - Nursing and Midwifery Annual Establishment Review (NMAER) approved by Trust Board on Thursday 12th February 2026. This will see a deduction of HCA posts by 72.57wte (increase of registered posts by 50.84wte).	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; for 20 wte – shortlisting 102 applicants currently. - Band 3 HCA: - Nov-25 = 16 wte commenced in post (8 wte currently within pre-employment checks; 26 withdrew due to visa requirements) - Feb-26= advert closed at 300 applicants, 208 shortlisted and 144 scheduled for interviews to take place on 20/03/2026.

Well Led – Non Clinical Agency- No. of Staff

Awaiting more data for SPC chart

Current Performance		
Feb 26	YTD	Target
2	37	0

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 . The continued use and reasons for these workers have been submitted to NHSE

Well Led – Agency Staff above Price cap

Awaiting more data for SPC chart

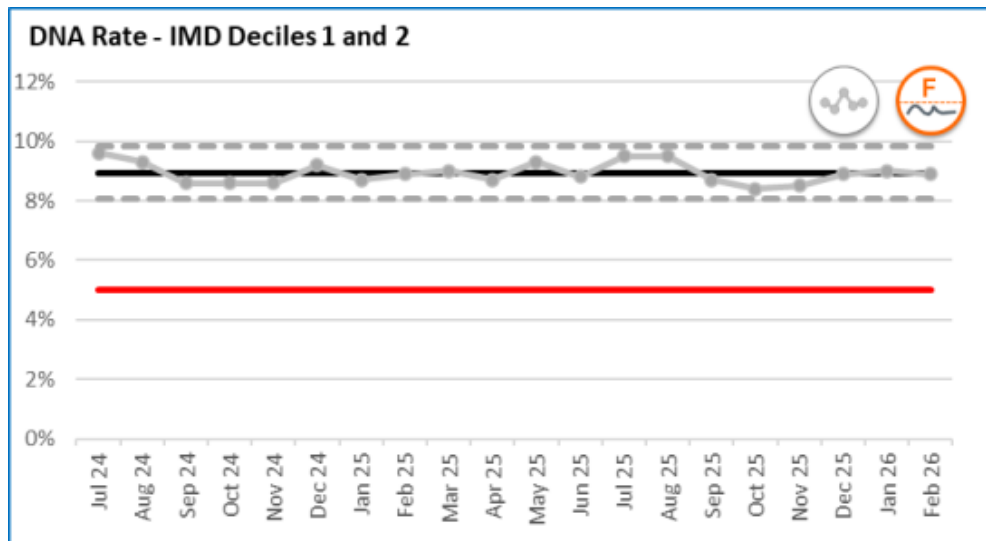
Current Performance		
Feb 26	YTD	Target
20	263	0

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 2 additional workers since last month over price cap within the medical and AHP/ST&T staff group due to the service requirements which have received the relevant approval levels.	NHSE have acknowledged the West Midlands medical agency rate card as an acceptable interim rate cap for Trusts to apply and UHL have implemented this since June 25. There remains some long line workers who remain over the price cap but these are acknowledged to be in specialist fragile services. A milestone plan has been submitted to reach price cap by April 26 We are over price cap only in specialist roles in Sonography, Radiography and Cardiorespiratory for AHP/ST&T. Attendance at regional group by Chief AHP. Milestone plan in place, however across the region we have the lowest rates

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



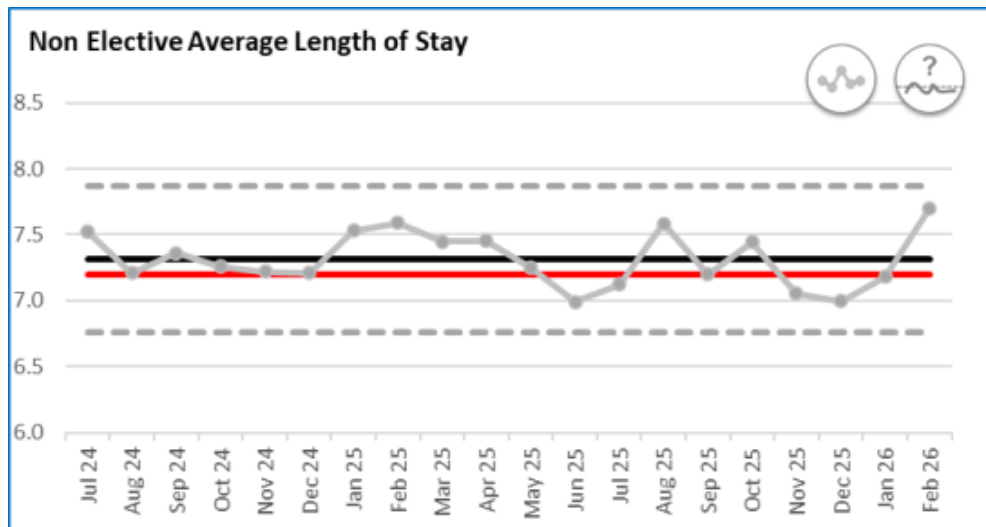
DNA Rate – IMD Deciles 1-2			DNA Rate – IMD Deciles 3-10		
Feb 26	YTD	Target	Feb 26	YTD	Target
8.9%	8.9%	5%	5.4%	5.6%	5%

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 9.89% for Feb 26. Disaggregated by contact these rates are: IMD1 - Patients contacted DNA rate 5.23% - Patients not contacted DNA rate 15.74% IMD2: - Patients contacted DNA rate 4.49% - Patients not contacted DNA rate 14.10% Inclusion Healthcare: - DNA rate for those contacted 21.43% - DNA rate for those not contacted 61.54% Paediatric Outpatients - WNB rate contacted 5.13% - WNB rate not contacted 14.29%

Responsive (Emergency Care) – Non Elective Average Length of Stay

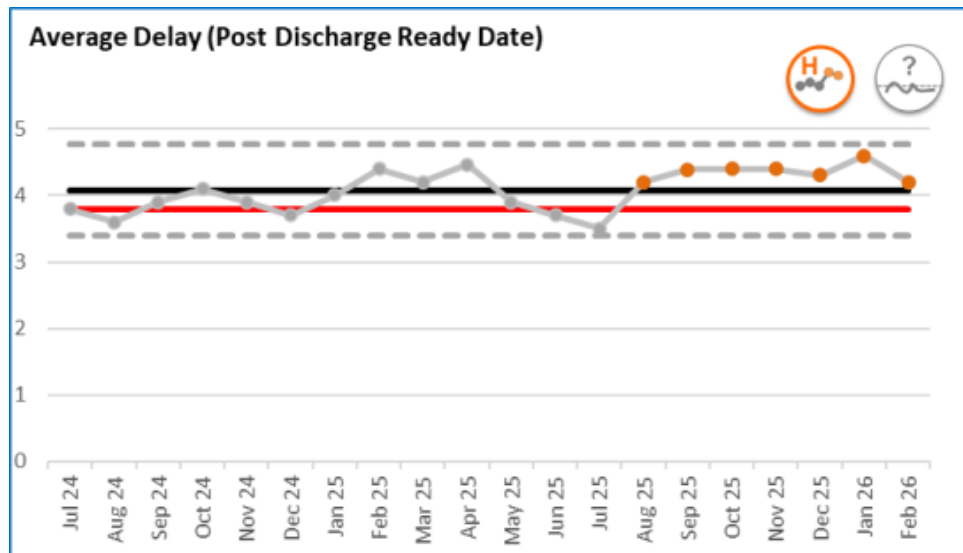


Current Performance			
Feb 26	YTD	Feb Plan	Target
7.7	7.3	7.4	7.2

National Position & Overview

Root Cause	Actions	Impact/Timescale
- Process delays internally relating to ward processes, diagnostics, discharge delays (TTO's etc) - Process delays externally to provide timely plans for discharge	SDEC plans to avoid admission Frailty working group –implement action plan Diagnostic access for SDEC / Emergency Floor Ward improvement programme with ESM	- From April – project plan available – target of 11% increase set for 25/26 0 monthly trajectory is being achieved - Ongoing - April 2026 - Diagnostic phase commenced in August – due to be completed in February 2026. Impact and roll out plan in development – April 2026

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



Current Performance

Feb 26	YTD	Target
4.2	4.2	3.8

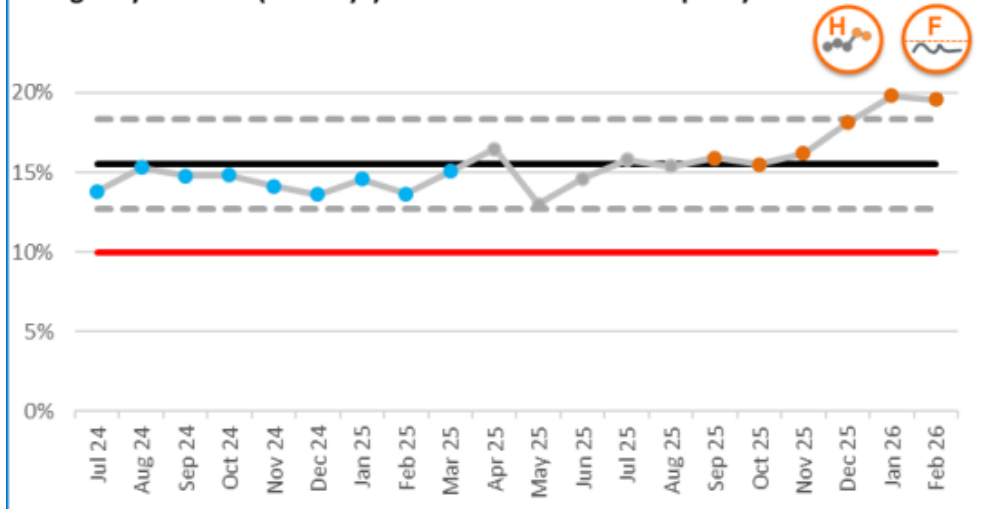
National Position & Overview

In December, UHL ranked 35 out of 127 Acute Trusts that submitted acceptable data. The National average was 6.0. 28 out of the 127 Acute Trusts achieved the target. UHL ranked 5 out of the 18 UHL Peer Trusts. The best value within our peer group was 2.2 and the worst value was 8.9

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) 223 complex patients stayed an additional night in hospital in February (249 January) • LLR system discharge hub interface and capacity delays continue to impact the ability to provide timely P1-3 discharge plans . 115 Patients waiting at the end of February. • Deterioration in LOS from MOFD to discharge for P3. A 4.67 day deterioration from August 22 to Feb 26 and a 1.63 day deterioration from Jan 26	• 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 39% February (32% January) through targeted engagement and process improvements. • Embed the process to enable early referrals at Preston Lodge during February • Share learning from LEAF and wider discharge QI projects to inform approach to practice.	• 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

Long Stay Patients (21+ days) as a % of G&A Bed Occupancy



Current Performance

Feb 26	YTD	Target
19.6%	-	10%

National Position & Overview

- 75 (328) Patients (23%) 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 (28 patients).
- 82 Patients (25%) are medically optimised complex patients awaiting discharge with no reason to stay in an Acute Trust.
- Approx. 70 (21%) patients data quality issue (not UHL inpatient)

Root Cause

- **Data quality issues (Approx. 70) continue** to arise following PAS changes. These include the system pulling pre-admission codes, delays in discharge coding, and missing outcomes. There are currently 34,042 outstanding outcomes from June 2025 to January 2026. The target is to reduce this to a one-month backlog by 31 March 2026.
- **LLR system discharge hub interface and capacity delays** As of the end of October there were around 82 patients with length of stay over 21 days awaiting a confirmed discharge outcome from LLR.

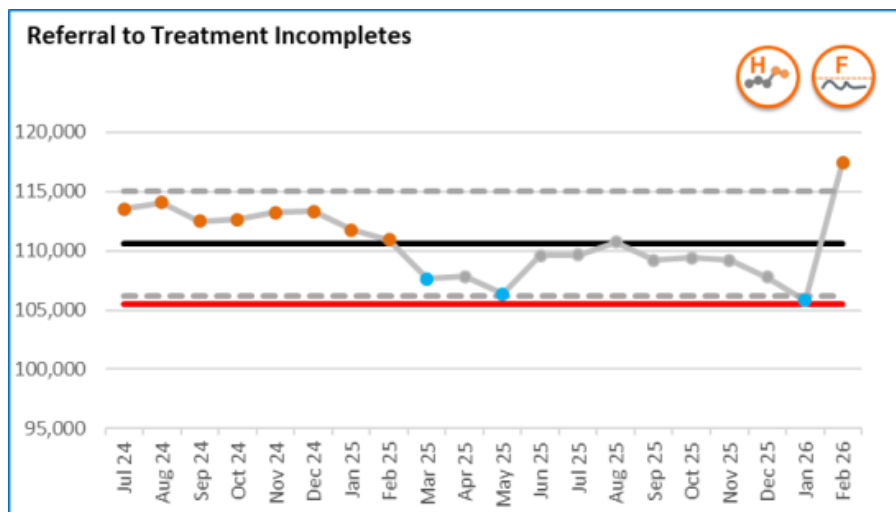
Actions

- 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 March 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.
 - Review P2 referrals as a multiagency team to understand case mix.
- Work with CMG's to:**
- Promote the early referral of patients to the discharge hub prior to being MOFD. (39% February, 32% January).
 - Embed process to deliver early referral at Preston Lodge.
 - Maintain Weekly CMG reviews of > 21 day patients and top 100 day patients

Impact/Timescale

- 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) – RTT Incompletes

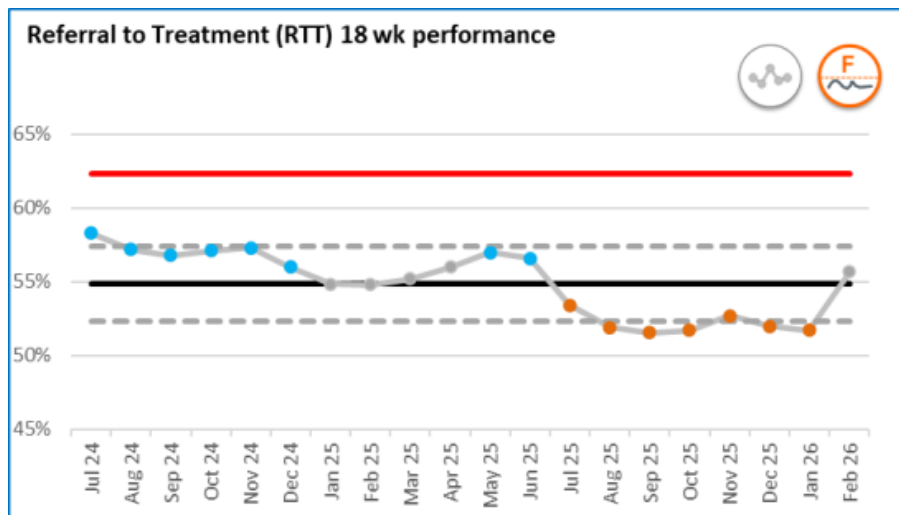


Current Performance		
Feb 26	Feb Plan	Target
117,449	106,189	105,500

National Position & Overview
At the end of January, UHL ranked 14 out of 17 trusts in its peer group with a total waiting list size of 105809 patients. The best value within our peer group was 65375, the worst value was 174556 and the median value was 84471. (Source: NHSE published monthly report). The national benchmarking position will deteriorate from February due to the sharp increase in waiting list size driven by the inclusion of clinical e-triage within the total waiting list.

Root Cause	Actions	Impact/Timescale
- Continued growth in demand against a significant number of specialities - Industrial action- loss of activity - Continued workforce challenges within ITAPS reducing theatre capacity - Estate: lack of theatre capacity and outpatient capacity to increase sessions and also age of estate leading to problems with losing capacity for maintenance work - Emergency pressures resulting in elective cancellations. - PAS productivity – the PAS roll out has had a bigger impact on productivity than expected and has led to decreased activity in some areas. This was also impacted by the 2-week delay to PAS go live. - Workforce controls impacting on ability to maintain baseline and undertake additional activity through WLIs. The total waiting list now includes all patients waiting clinical e-triage (previously excluded). This is the cause of the significant upward spike seen in the latest month. There are currently between 11 and 12,000 pathways awaiting triage now on the PTL. Approximately 10% of all patients waiting e-triage of referrals will be rejected back to referrer and previously would never have been recorded as part of the TWL.	- Theatre productivity and outpatient transformation workstreams to improve productivity and increase capacity. - Improvement plan to reduce total WL with 4 workstreams: Validation, Appointment Outcomes, Triage and Increased activity - Planned additional data quality validation each month to support overall reduction of WL – as per funded National Validation ‘Sprint’ exercise 25/26. - Focused actions with the CMGs regarding meeting activity plans in the EMPCC, CDC and Endoscopy unit. - Continued learning and fix finding in new PAS - Onboarding of external validation company- Sourcegroup to increase validation capacity - Specialities asked to provide recovery plans to reduce numbers of patients awaiting clinical triage. Figures are now being regularly reported to Senior Clinical Cabinet	- Increased ACPL on theatre lists- improving activity through existing resource- ongoing. - Outpatient clinic template standardisation- to increase the number of new and follow-up appointments within clinic templates- ongoing. - Q3 validation sprint generated £140k income. To date Q4 has generated a lower ~£60k. External validation support sourced and funded from income. External validators have delivered 30,160 validations between December and February. Current pathway closure rate of all those validated is an average 20%. - Additional regional funds to support key actions to deliver: - Zero 65+ as soon as possible 52+ back to <1% of TWL March 26 - FDS back to plan December 25 31 day to plan by March 26 62 day to plan by March 26

Responsive (Elective Care) – RTT 18 Week Performance



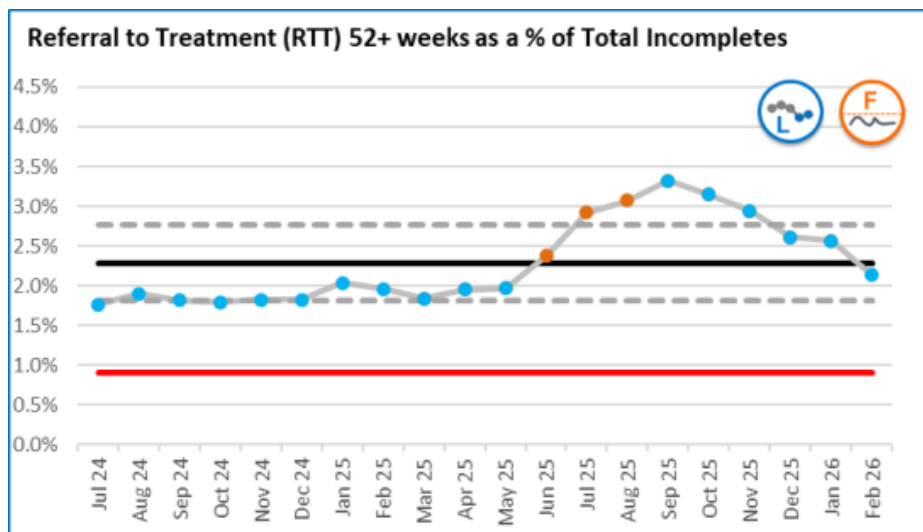
18 Week Performance			First Attendance - 18 Week Performance		
Feb 26	Feb Plan	Target	Feb 26	Feb Plan	Target
55.7%	61.7%	62.3%	61.6%	67.4%	68.1%

National Position & Overview

At the end of January, UHL ranked 16 out of 17 trusts in its peer group with RTT 18 Week Performance at 51.7%. The best value within our peer group was 71.0%, the worst value was 51.3% and the median value was 58.5%. (Source: NHSE published monthly report)

Root Cause	Actions	Impact/Timescale
- Continued growth in demand against a significant number of specialities - Emergency pressures resulting in elective cancellations, with specialities at the LRI site particularly challenged. - PAS productivity – the PAS roll out has had a bigger impact on productivity than expected and has led to decreased activity in some areas. This was also impacted by the 2-week delay to PAS go live. - Industrial Action- has led to reduced activity throughout the year. - Workforce controls impacting on ability to maintain baseline and undertake additional activity through WLIs - The inclusion of pathways awaiting triage from February has caused the spike in total waiting list numbers and associated improved performance (from 51.7 to 54.7%)	- Planned additional data quality validation each month to support overall reduction of WL – as per funded National Validation 'Sprint' exercise 25/26. - Demand and Capacity modelling to support future planning. - Assessment of demand for elective treatment by specialty to understand where maximum impact for UHL can be delivered to support 18wk standard improvements. - Theatre productivity and outpatient transformation workstreams to improve productivity and increase capacity. - Plan developed with CMGs to undertake additional work funded by the region to support RTT and Cancer performance improvement (25/26 Q4 Sprints). - Fortnightly escalation meetings chaired by Director for Planned Care with specialties that have potential to go further against the 18w target and will positively contribute to overall Trust total (high volume). - Focus on validation by internal and agency team is on those pathways who will be over 18 weeks by the end of March.	- Targeted validation in the sprint periods and month end processes to maximise removals of the longest waiters and those waiting over 18 weeks. - Increased ACPL on theatre lists- improving activity through existing resource- ongoing. - Outpatient clinic standardisation plans agreed at TLT in July are required as a prerequisite to implementing ambient AI scribe technologies. This will support an increase in outpatient clinic appointments and in turn improved 18ww performance. - Additional regional funds to support key actions to deliver: - Zero 65+ as soon as possible 52+ back to <1% of TWL March 26 - Improvements to 18 wk performance - FDS back to plan December 25 31 day to plan by March 26 62 day to plan by March 26

Responsive (Elective Care) – RTT 52+ weeks as a % Of Total Incompletes



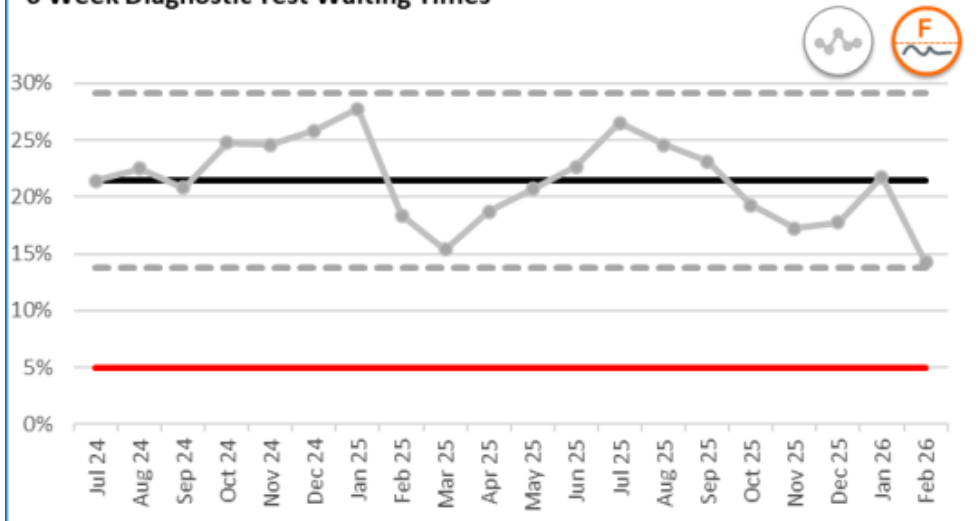
Current Performance		
Feb 26	Feb Plan	Target
2.1%	1.0%	0.9%

National Position & Overview
At the end of January UHL ranked 12 out of the 17 Trusts in it's peer group with 2.6% of patients on the waiting list waiting over 52+ weeks. The best value within our peer group was 0.5%, the worst value was 3.9% and the median value was 2.1%. (Source: NHSE published monthly report)

Root Cause	Actions	Impact/Timescale
- Challenged Cancer position and urgent priority patients requiring treatment - Workforce challenges in anaesthetics leading to cancellations of theatre lists - Emergency pressures resulting in elective cancellations, with specialities at the LRI site particularly challenged. - Increased volumes of patients on waiting list (increased demand) and reduction of additional activity funded previously through ERF. - Nervencentre implementation: Reduction in activity due to PAS rollout. Activity and administrative actions including validation not yet up to pre-roll out levels across the Trust. - High levels of administrative vacancies and reduction of bank due to workforce controls has led to a reduction in staff able to book clinics, reducing productivity and activity levels. 52 ww as % of the total PTL has improved this month in part due to the addition of the triage pathways onto the PTL – which increases the TWL but none are long waiters.	- Super-clinics to increase capacity to see new outpatients. - Continued roll-out and focus on PIFU and DNA processes to increase capacity for new patients - Focus on productivity to increase capacity and reduce waits. - Weekly escalation meetings chaired by COO/ Director for Planned Care with CMGs with the bulk of long waiters (65ww) - Increased use of mutual aid and independent sector support, particularly within Orthopedics 52ww and 65ww forecasting models for specialities with large volumes of long waiters - Plan developed with CMGs to undertake additional work funded by the region to support RTT and Cancer performance improvement (Q4 Sprints).	- Actions agreed with CMG leads weekly in challenge and support meetings. - Additional regional funds to support key actions to deliver: - Zero 65+ as soon as possible 52+ back to <1% of TWL March 26 - FDS back to plan December 25 31 day to plan by March 26 62 day to plan by March 26 - Zero 65+ week waiters not achieved. 28th February final position was 103. Escalation meetings continue with CMGs. Current forecast for end March is 56, with a small number also forecast for April for complex/challenged specialties with patients booked TCIs into May. National and regional colleagues supporting mutual aid and IS requests in areas with the biggest risk (MSS specialities accounting for 75% of the breach risks with Orthopaedics alone accounting for 50% of this). - The number of 52 week waiters at month end continues to reduce each month.

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

6 Week Diagnostic Test Waiting Times



Current Performance

Feb 26	Feb Plan	Target
14.3%	6%	5.0%

National Position & Overview

Published National data at the end of Jan '26 shows 1.81m patients on the diagnostic waiting list with 24.7% waiting over 6 weeks. For Feb'26, UHL with 23,746 patients would comparatively rank as the 15th highest waiting list. The 6-week trajectory for February was set to deliver 6%, the actual was 14.3%, 8.1% behind plan, driven by NOUS, Dexa, CT and Endoscopy. There were 3,387 patients waiting >6 weeks, an improvement of 1,621 patients from January '26.

Root Cause

Diagnostics pressure areas are in the main:

- NOUS
- Endoscopy
- CT
- DEXA

Root cause

- Clinical workforce gaps
- Admin recruitment
- Reporting and coding errors
- Overall NOUS growth
- Pressure from emergency, cancer and elective long wait pathways

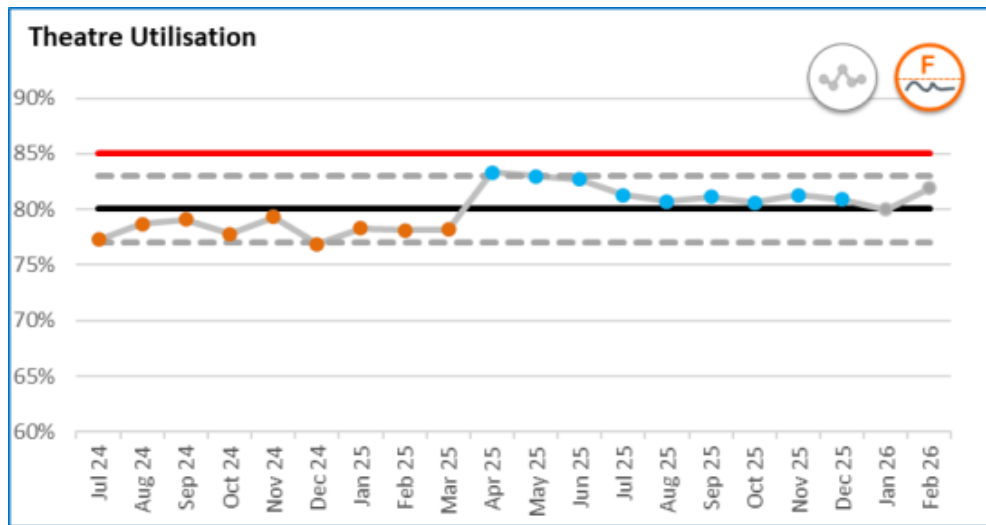
Actions

- QLIK & PAS WLMDs and DQ training
- Improve productivity
- Increase capacity
 - New endoscopy unit – opened Nov 25
 - Hinckley Community Diagnostics Centre – opened June 25
 - NOUS and Audiology – ERF to return to plan – Q4
 - DEXA 2nd scanner – March 26
- Review demand data with ICB for further opportunities
- Expand direct access diagnostics 25/26
- 5year MRI/CT D&C plan – complete, £ assessment underway as part of CDC expansion business case.
- Scope possible CDC expansion opportunities

Impact/Timescale

- Validation & DQ – ongoing, DQ challenges are being worked through, biggest impact in Endo.
- Productivity metrics – in February CT DNA rate remains on target, and CT productivity improved. MRI DNA and productivity show a small deterioration. Endoscopy booking and in-session utilisation static. Sleep paediatric, Cystoscopy and Urodynamics utilisation remain above 90%.
- MRI recovery on track vans x2 on site supporting recovery – Q4
- CT – rebalance staff between MRI and CT to support recovery by Q4
- NOUS recovery on track – Q4
- DEXA – 2nd machine and van March - Q4
- Endoscopy recovery – unlikely to return to plan end of Q4, due to A&C – weekly escalations in place and additional staff being recruited.

Responsive (Elective Care) – Theatre Utilisation



Current Performance

Feb 26	YTD	Target
81.9%	81.5%	85%

National Position & Overview

In February, overall utilisation was 81.9%, with the year-to-date average remaining stable at 81.5%. Trust performance continues to be rated Green (Quartile 4). For the week ending 22/02/2026, utilisation reached 84.8%, exceeding both the peer median of 79.1% and the national average of 80.0%.

Root Cause

- LGH (84.4% utilisation): Performance improving, but on-the-day cancellations remain the main constraint to further utilisation gains.
- LRI (76.6% utilisation): Emergency and bed pressures caused 63 cancellations (29%), with General Surgery particularly affected when emergency operating hours exceeded 24 hours. Paediatric and adult utilisation remain low (74.6%, 77.4%).
- EMPCC (77.2% utilisation): High OTDC (8.6%), rising late starts in some specialties (e.g., consenting on the day), and persistent non-clinical cancellations despite consistently booking >100%.
- UHLiC (79.5% utilisation): Large variation in list performance (>85% to 41%) driven by limited standby capacity and under-booking following short-notice cancellations. Work ongoing to improve scheduling using consultant-level procedural times.

Actions

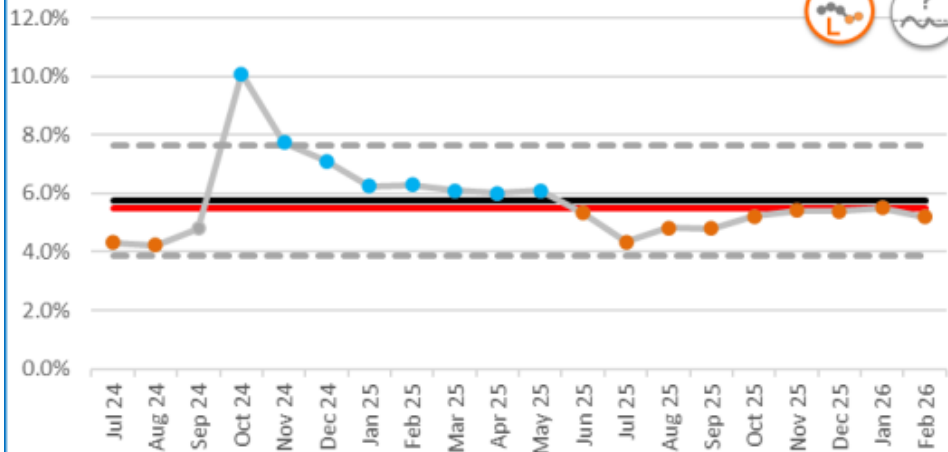
- Weekly performance meetings (from April) to drive reduction in OTDC, with clear specialty-level ownership and weekly tracking.
- LGH: Targeted deep-dive into Orthopaedics and Pain Management (49.6% of site OTDC) to identify drivers and implement corrective actions (pre-op).
- EMPCC: Fortnightly CMG-supported meetings to strengthen oversight and action delivery.
- EMPCC Suitability: 50-patient enhanced pre-assessment and anaesthetic review trial (March) to address suitability-related cancellations.
- Late Starts: Continued strengthened monitoring, escalation of recurring delays, and process review to improve performance.
- Gynaecology & Ophthalmology: Shift consenting to clinic-based consenting to reduce late starts and out-of-session cancellations.
- EMPCC Super Week (May): Enhanced patient preparation and proactive contact to test processes, identify best practice, and highlight areas that do not work

Impact/Timescale

- Weekly performance meetings (April onwards): Expected to drive OTDC to <5%, supporting utilisation >85% and improving reliability of elective activity.
- Late Starts: Reduced from 30.6% to 19.0% (Feb 2025–Feb 2026); further measurable improvement anticipated over the next 2–3 months as actions embed.
- EMPCC Suitability Trial (March): Expected to reduce suitability-related cancellations, improve day-of certainty, and enable some inpatient activity to shift to (ease Inpatient demands at the LRI).
- Clinic-based Consenting: Anticipated to reduce late starts and out-of-session cancellations, improving theatre efficiency.
- EMPCC Super Week (May): Will test and refine operational processes, identify what works and what does not, and inform future best-practice models to improve productivity

Responsive (Elective Care) – PIFU

Patient Initiated Follow Up



Current Performance

Feb 26	YTD	Target
5.2%	5.3%	5.5%

National Position & Overview

National Expectation: NHS England has set a target for 5% of outpatient activity to result in a PIFU outcome.

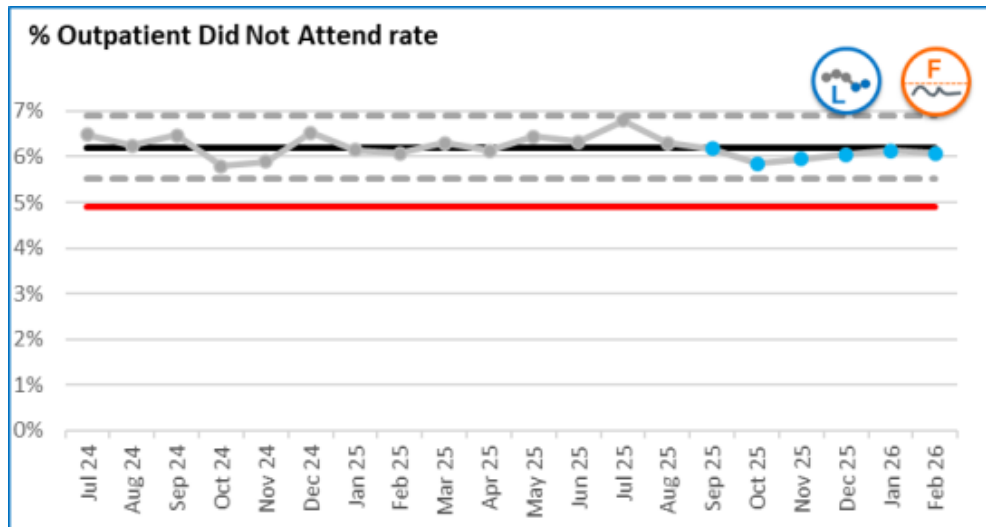
UHL Ambition: UHL has committed to a more ambitious target of 5.5% as part of its operational plan.

Performance (January 2026): UHL achieved a ranking of 22 out of 143 NHS Trusts for the proportion of outpatient appointments resulting in a PIFU outcome. This ranking reflects the percentage of episodes transitioned to a PIFU pathway following patient attendance.

Data Source: Provider E-ROC

Root Cause	Actions	Impact/Timescale
Contributing Factors - Variable clinical engagement across specialties, limiting consistent adoption. - Difficulty in consistently identifying appropriate patient cohorts for PIFU. - Fragmented or inconsistent communication between teams. - Additional administrative burden caused by documentation requirements. - Recent PAS deployment has led to inconsistencies in how PIFU pathways are recorded in certain scenarios.	Performance & Targets: Specialty-level targets are in place, with stretch ambitions for high performers. Areas below trajectory receive targeted support through focused performance discussions. Targets to be revised for 26/27 Specialty Focus: Specialties to provide PIFU progress updates at the Outpatient Board- Monitoring & Benchmarking: Weekly reporting and national benchmarking (Further Faster, GIRFT) are used to, identify variation, and share best practice. Expansion & Efficiency: Further opportunities to expand PIFU—through helplines and post-discharge pathways—are being identified.	Governance Oversight: PIFU performance is overseen through established governance structures, including the Outpatient Transformation Board, specialty-level meetings, and access performance meetings. These forums provide systematic visibility of issues and enable timely, responsive planning. Performance & Targets: Targets for 2026/27 are being reset in line with national benchmarking and planning targets. Any proposed deviation from the benchmark position for individual specialties will require formal approval from the Director of Planned Care and the Deputy Medical Director for Planned Care.

Responsive (Elective Care) – Outpatient DNA Rate



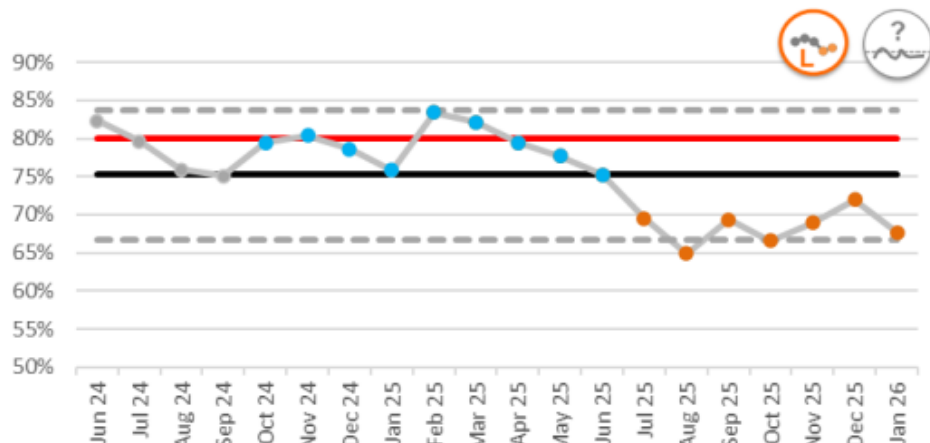
Current Performance		
Feb 26	YTD	Target
6.1%	6.2%	4.9%

National Position & Overview

Root Cause	Actions	Impact/Timescale
- The launch of Nervecentre PAS has meant continuous issues with the data feed going to Accurx so patients aren't always receiving automated reminders - Late cancellations/rebooks often mean patients do not receive their appointment letters on time so unaware of appointment - 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. - Services are not always maintaining their appointment reminder house keeping in Accurx - For telephone appointments, clinicians not giving the patient enough time to answer or only calling the patient once - The NHS App currently allows patients to request to cancel/rebook upto midnight the day before their appointment.	- 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. - Remind services of the need to check the patients details are correct and up to date at every contact - Services to text patients appointment details if changes are made to appointments - Booking Centre are making additional calls to 'Health Inequalities' cohort now including Paediatrics. - 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 - Text fragments has increased to allow services to add bespoke messages to automated appointment reminders - Request approval from NHSE to increase cancellation window	- 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

28 Day Faster Diagnosis Standard



Current Performance

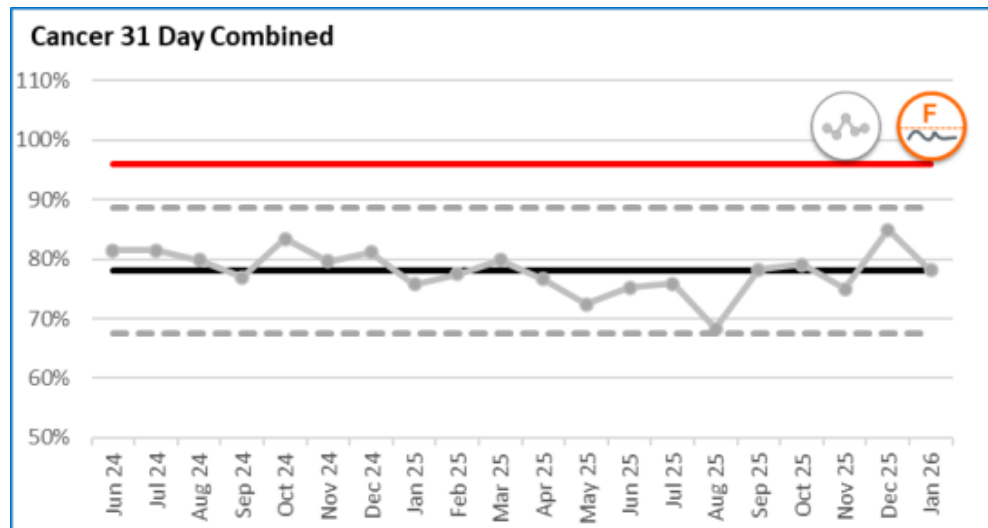
Jan 26	YTD	Jan Plan	Target
67.7%	71.0%	77.0%	80%

National Position & Overview

In January, UHL ranked 109 out of 138 Acute Trusts. The National average was 72.8%. 54 out of the 138 Acute Trusts achieved the target. UHL ranked 13 out of the 18 UHL Peer Trusts. The best value within our peer group was 80.8%, the worst value was 52.9% and the median value was 73.1%.

Root Cause	Actions	Impact/Timescale
The root cause is due to the loss of capacity in Breast since Q2. - D&C gap for 1st appointments in Breast (50 slots per week) usually covered with WLI/Insourcing - Decline in uptake of WLIs This has caused time to first appointment to extend resulting in a decline in FDS performance for the eighth month since Sep 23. Without this loss of Breast capacity performance would have been above 80%. Emerging risk within H&N following inability to backfill vacancies likely to impact through to Mar 26	- Breast insourcing and bank/WLI to support 1st appt wait times. - ENT recruitment & locums requested. Mutual aid use of IS being explored. Triage results to advise on appropriate pathway changes to manage demand. - Days Matter Campaign – Breast, LOGI, Gynae, Urology. Improvements noted in Q4. - Continued focus on pathway audits, time to first appointment and turnaround times (TAT) to support FDS performance in all other tumour sites.	- Improving Breast 1st appt waits down to 3-4 weeks. Sustainable plan to convert ERF through planning for 26.27 in progress. - ENT 1st Appt waiting times 6-7 weeks due to vacancies. Locum in place. Mutual aid has not been possible. Use of IS being explored with support from EMCA and review of demand management in progress with ICB clinical leads. - LOGI PTL changes and working to improve time to booking OPA/tests – late Q4 - Skin performance above 90% and Skin AI offered within 5 days. - Urology TAT for template Bx showing initial improvement from Jan.

Responsive Cancer – Cancer 31 Day Combined

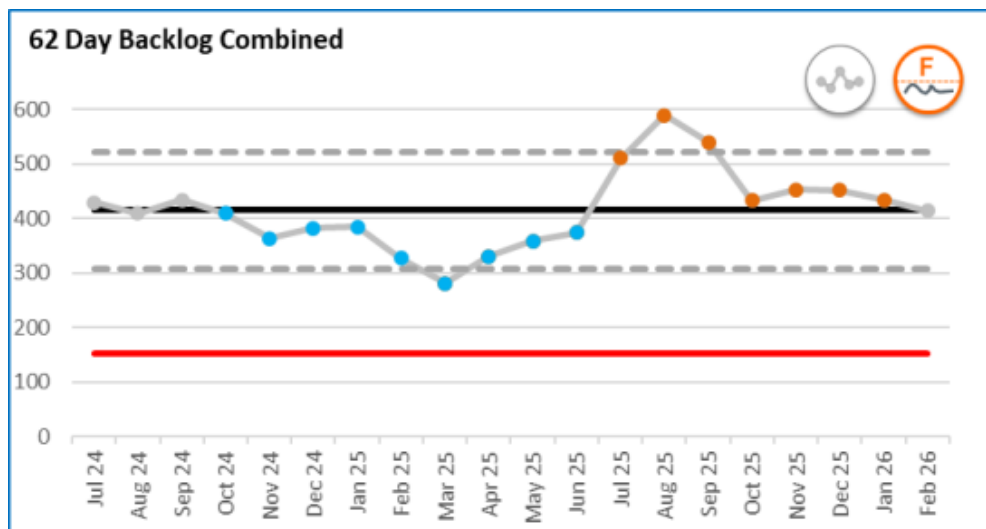


Current Performance			
Jan 26	YTD	Jan Plan	Target
78.1%	76.5%	88.1%	70%

National Position & Overview
In January, UHL ranked 138 out of 146 Acute Trusts. The National average was 68.4%. 76 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 80.3%, the worst value was 47.8% and the median value was 64.4%.

Root Cause	Actions	Impact/Timescale
- Insufficient capacity within surgery, chemotherapy and radiotherapy to meet current demand - Radiotherapy demand exceeded capacity – affecting prostate and breast category 2 patients - Theatre capacity constraints inc. Robotic capacity with rising demand (Urology, Gynaecology, Lung). - Patient readiness to proceed with surgery impacting ability to date within 31 days 31 Day anti-cancer drug regimes capacity is constrained within pharmacy	- Increased emphasis at PTL meetings to bring forward patients within target – weekly - Radiotherapy 5th linac in place with waits improving - Ensuring unused robotic time is released to other CMGs – ongoing 2nd Robot in Urology & Gynae now in use for 3-6 months - Review of HRA capacity - Oncology SACT efficiency review - Pharmacy workforce review to support increased SACT capacity - Collaboration with UHN – ongoing	Radiotherapy 5th linac – Breast waits back to 0, Prostate waits improving – Q4. Efficiency work programme underway to support & maximise capacity. Surgery - Surgical dating –improvements noted in Feb/Mar indicative results, focus to remain. 2nd Urology robot supporting a reduction in waiting time. Oncology - First digital form is now embedded within SACT with a review of time being saved.

Responsive Cancer – Cancer 62 Day Backlog

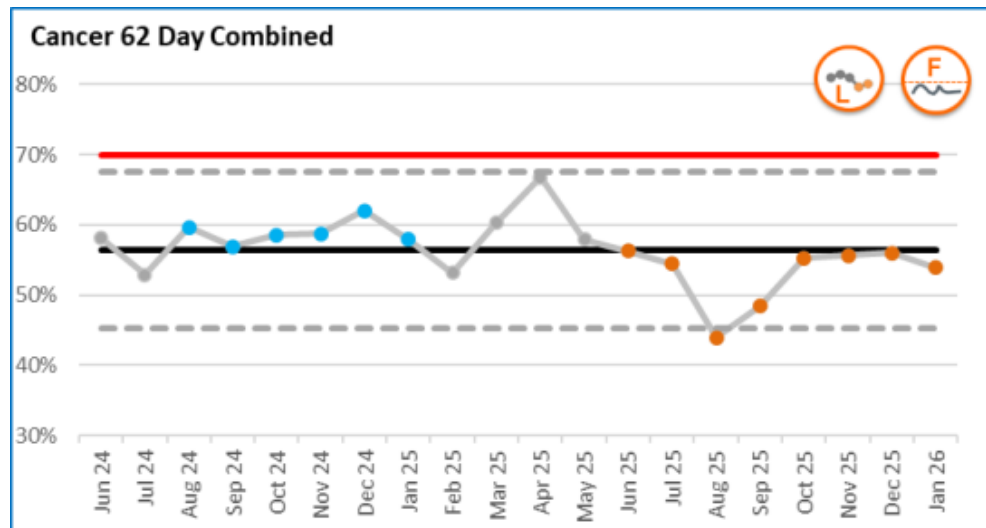


Current Performance		
Feb 26	YTD	Target
414	-	152 (by Mar26)

National Position & Overview
National data is not available. Midlands trend – decreases in backlog seen in all 11/11 systems over 4 week period to 08/03/26, with LLR having largest decrease. UHL end of February position: > 62 day 218 behind plan. > 104 day 113 behind plan.

Root Cause	Actions	Impact/Timescale
- Breast, Colorectal, Skin and Urology drive the largest volume, holding 3/4 of the backlog, constraints include capacity, specifically outpatient, diagnostic and workforce. - There has been an increase in diagnostic tests required, patient complexity and choice impacting pathway length - Oncology OPD capacity, alongside theatre capacity for Urology and plastics capacity within skin have led to a longer waits for some patients.	- Clinical prioritisation of all cancer patients and clinical review of cancer patients treated over 104 days. - Increased escalation to clinical leads and senior managers to further support - Rapid clinical review of all pts over day 42 6 week intense daily backlog review with additional focus on prioritising 104+ day waiters for reporting - Digital solutions to support pathway progression approved by Digital Demand Panel - EMCA/NHSE cancer recovery funds supporting additional capacity - Oncology review of OPD capacity	- Breast improvement QI project with focus on 2nd test TAT together with trial for listing onto earlier MDT - commenced Jan 26 with improvements noted. - Average TAT of pathways note improvements in 2025 compared to previous years. Backlog focus expected to support PTL volume – Q4. - Utilisation of cancer recovery funds (Tier 1 EMCA & NHSE Cancer Recovery Funds) for additional activity – ongoing. - Urology 2nd robot supporting a reduction in waits – Q4 and Q1 of 26/27 - Oncology opportunities to improve OPD waits outlined. Impact not expected until Q2 26/27.

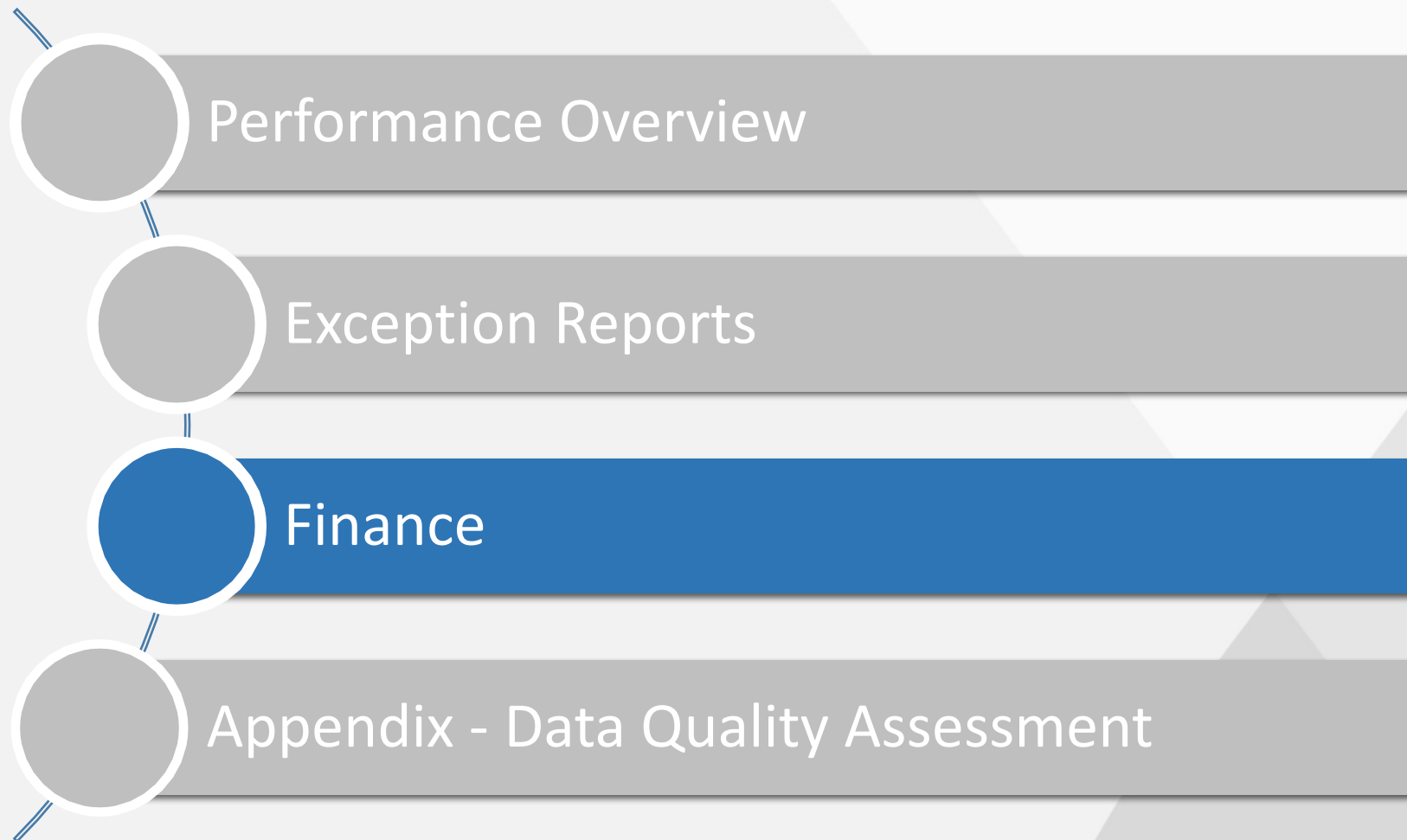
Responsive Cancer – Cancer 62 Day Combined



Current Performance			
Jan 26	YTD	Jan Plan	Target
53.9%	54.8%	69.0%	70%

National Position & Overview
In January, UHL ranked 138 out of 146 Acute Trusts. The National average was 68.4%. 76 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 80.3%, the worst value was 47.8% and the median value was 64.4%.

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 - Ongoing risks for H&N and Breast due to workforce challenges affecting time to first appointment - Performance impacted by clinical prioritisation of patients	- Clinical prioritisation of patients and increased emphasis at PTL meetings to bring confirmed cancers within target – weekly - Increased comms to reduce sequential diagnostic ordering and agree next steps ahead of MDTs - Additional capacity required – Urology, Breast, H&N, Thoracic and Plastics. - EMCA & NHSE additional funding supporting increased activity - LOGI Clinical PTL and pre-MDT processes underway – impact Q4. 2nd Urology robot will support overall waiting times – impact Q4 - Oncology OPD opportunity review	- Commenced trial for Breast pathology & listing onto earlier MDT with improvements already visible - Gynae increased major operating capacity and ‘See & Treat’ clinics commenced end of Feb – anticipated uplift to Trust performance ~1.5%. - Pathology insource/outourcing of urology & gynaecology supporting improved TAT – ongoing - Oncology OPD changes to scheduling– impact not expected until Q2 26/27 - Clinical comms emphasising ordering tests in parallel and progressing outside of MDTs – Feb 26



Executive Summary

- The YTD position for the Trust is a deficit of £41m which is £37.7m adverse to plan. The main drivers are loss of DSF funding £21.6mA, non delivery of CIP £16.2mA and pay pressures circa of £3mA. In month the Trust received an additional allocation of £2.5m for winter flow.
- Emergency/Non Elective inpatient activity continues to over-perform; at M11, the Trust has delivered 4.2% more activity which equates to £26m 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 forecast for the year remains at -£85m deficit excluding deficit support funding
- The Trust committed net capital expenditure of £53.1m to Month 11 resulting in an underspend of £6.2m against CDEL target of £59.5m.
- The cash position at the end of Month 11 was £40m, which is an increase of £27.8m from M10.

Summary Financial Position – YTD M11

	I&E YTD		
	Plan	Actual	Variance to Plan
	£'000	£'000	£'000
NHS Patient-Rel Income	1,481,335	1,463,698	(17,637)
Other Operating Income	168,752	165,420	(3,332)
Total Income	1,650,087	1,629,118	(20,969)
Pay	(1,021,804)	(1,040,325)	(18,522)
Non Pay	(546,192)	(546,948)	(756)
Total Costs	(1,567,995)	(1,587,273)	(19,278)
EBITDA	82,092	41,845	(40,247)
Non Operating Costs	(81,259)	(80,942)	317
Retained Surplus/(Deficit)	833	(39,096)	(39,930)
Donated Assets	(4,158)	(1,912)	2,246
Control Total Surplus/(Deficit)	(3,325)	(41,008)	(37,684)

Comments – YTD Variance to Plan

Total Income: £20.9mA (£0.6mF plus £21.6mA deficit support):

- PCI £8F driven by £2.8mF 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 £4.1mA. This includes a reduction of £1.3m relating to hybrid loops.

Pay: £18.5mA:

- Medical and dental £20.1mA of which £3.4m is due to industrial action (IA) and the balance linked to undelivered CIP and medical gaps in RRCV (£5.9mA), CHUGGS (£3.5mA), ESM (£3.2mA) and W&C (£4.1mA).
- Nursing, midwife and health visitor staffing is driven mainly by vacancies across ITAPS (£2.7mF) offset by undelivered CIP.
- Other clinical driven by vacancy control across most CMGs.
- Non-clinical mainly driven by vacancies in E&F £2.4mF, ESM £1.4mF and W&C £1.2mF

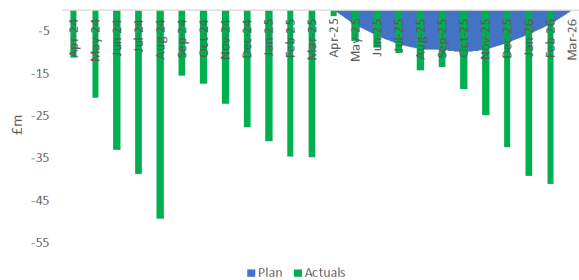
Bank (£66m) and Agency (£3.7m) spend YTD amounts to £69.8m which is 6.7% of total pay.

Non-Pay: £1.2mA:

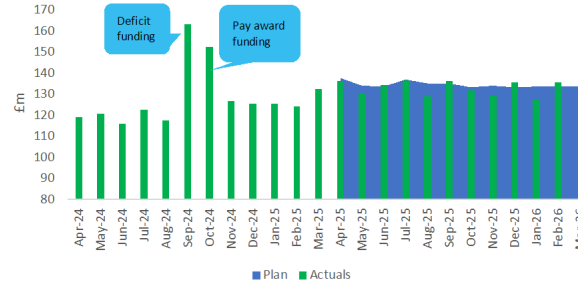
- Clinical Negligence £2.2mF relating to the maternity incentive scheme rebate.
- Clinical supplies £3.1mA driven by increased activity
- Drugs £5.6mA due to block drugs overspends and non delivered CIP: £1.5mA mainly in CHUGGS Haematology/Oncology, £1.3mA ITAPS in sleep/theatres, £1.3mA RRCV relating to renal and respiratory and £1.4mA W&C.
- Other is driven mainly by CHUGGS reduced Gastroenterology insourcing usage and closure of Vanguard unit (£1.6mF), CSI/CDC unit from lower level of activity (£1.5mF), E&F mainly from the review of prior year food provision and energy credits (£3.3mF).
- Premises & Fixed plant driven in the main by undelivered CIP

Month 11 I&E Dashboards

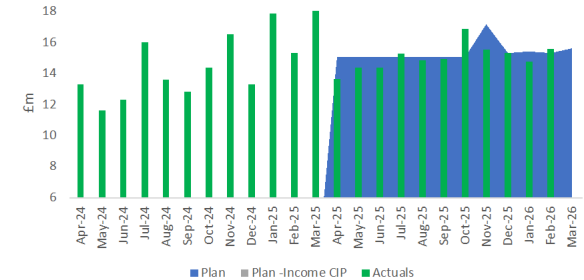
Cumulative Surplus/(Deficit) - Excluding Impairments



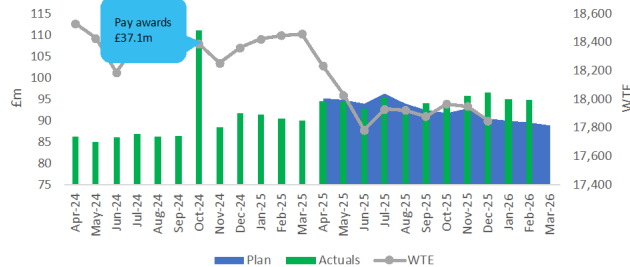
Monthly PCI Income



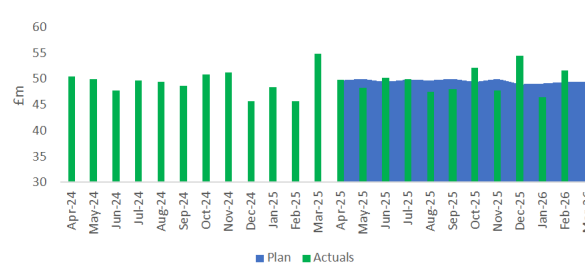
Monthly Other Income



Monthly Substantive/Bank/Agency Pay



Monthly Non Pay

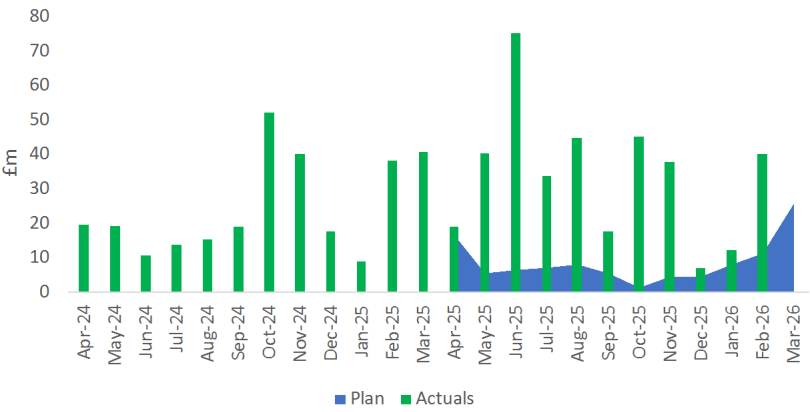


Monthly Non Ops - Excluding Impairments

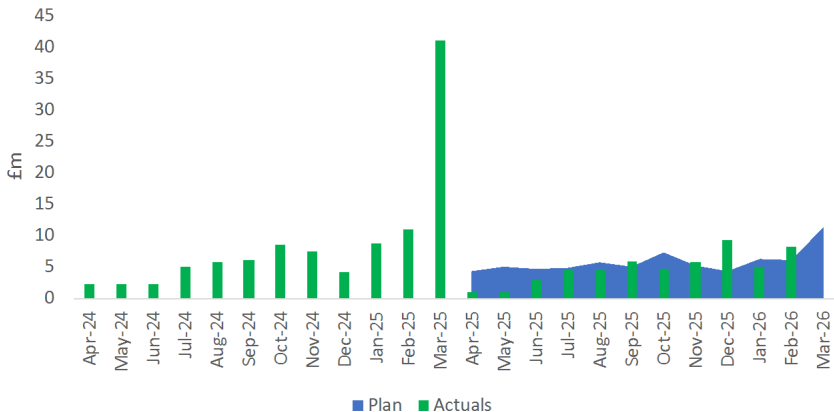


Month 11 Balance Sheet Dashboards

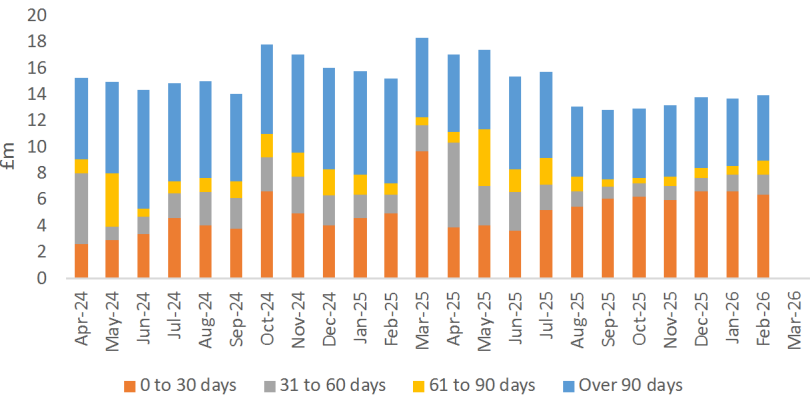
Cash



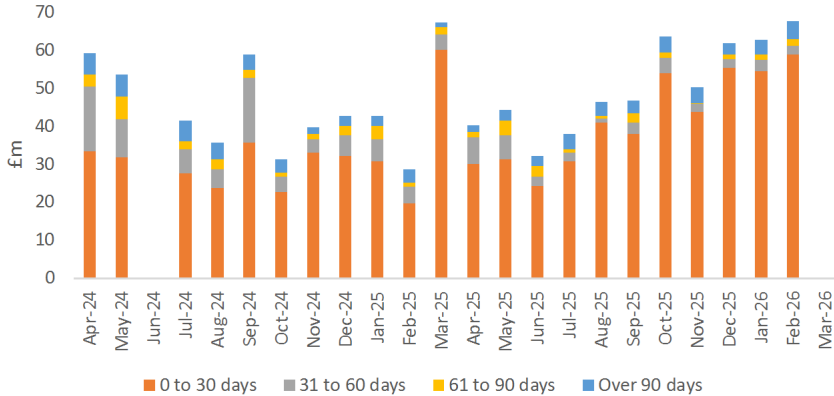
Capital



Debtors



Creditors



Statement of Financial Position

- **Non-Current Assets** - Non-current assets increased by £2m as acceleration of capex of £7.2m was offset by depreciation of £5.2m.
- **Trade and other receivables** – Trade and other receivables reduced by £8.7m, the majority of which related to the timing of CNST prepayments (£6.0m) (paid 10 instalments).
- **Trade and other payables and accruals** – Trade and other payables reduced by £4.4m. This was offset by an increase in accruals of £3.2m, largely within CSI for Roche (£1m), Ergea (£1.9m) and Optimed contracts (£0.5m).
- **Deferred Income** – Reduced by £1.3m which related to the release of PCI income into the position; offset by an increase in HEE income.
- **Dividend Payable** – Increased by £1.9m due M11 forecast PDC dividend liability.
- **Income and Expenditure Reserve** – The deterioration in the I&E reserve of £3.0m is consistent with the in year reported income and expenditure position.
- **Public Dividend Capital** - £20.2m of PDC funded capital schemes drawn down.

£m	31-Mar-25	31-Jan-26	28-Feb-26	In Month Movement	YTD Movement
Non Current Assets					
Intangible assets	31.1	31.0	31.3	0.4	0.3
Property, plant and equipment	776.0	773.2	774.9	1.7	(1.1)
Other non-current assets	4.4	4.7	4.7	(0.0)	0.3
Total non-current assets	811.5	808.9	810.9	2.0	(0.6)
Current Assets					
Inventories	28.6	28.7	27.6	(1.0)	(1.0)
Trade and other receivables	41.2	67.4	58.7	(8.7)	17.5
Cash and cash equivalents	40.7	12.2	40.0	27.8	(0.7)
Total Current Assets	110.4	108.2	126.3	18.1	15.9
Current Liabilities					
Trade and other payables	(147.8)	(150.8)	(146.4)	4.4	1.4
Leases < 1 Year	(9.0)	(7.5)	(7.3)	0.3	1.7
Accruals	(19.8)	(22.7)	(25.9)	(3.2)	(6.0)
Deferred income	(4.7)	(23.3)	(21.9)	1.3	(17.3)
Dividend payable	0.0	(7.5)	(9.4)	(1.9)	(9.4)
Provisions < 1 year	(9.3)	(6.6)	(6.6)	(0.0)	2.7
Total Current Liabilities	(190.6)	(218.3)	(217.4)	0.9	(26.9)
Net Current Assets / (Liabilities)	(80.1)	(110.1)	(91.1)	19.0	(11.0)
Leases > 1 Year	(43.3)	(40.9)	(44.7)	(3.8)	(1.4)
Provisions for liabilities & charges	(3.6)	(3.6)	(3.6)	0.0	0.0
Total non-current liabilities	(46.9)	(44.5)	(48.3)	(3.8)	(1.4)
Total Assets/(Liabilities)	684.5	654.3	671.5	17.2	(13.0)
Public dividend capital	(924.8)	(930.7)	(950.9)	(20.2)	(26.1)
Revaluation reserve	(223.7)	(223.7)	(223.7)	0.0	0.0
Income and expenditure reserve	464.0	500.1	503.1	3.0	39.1
Total Capital & Reserves	(684.5)	(654.3)	(671.5)	(17.2)	13.0

Statement of Financial Position

Liquidity and Cash Position – Month 11

- Cash balance at end of February: £40m (£37.0m for the Trust).
- This represented an in-month increase of £28.0m.
- Trust continues to ration payments to maintain minimum daily cash levels, pending receipt of PDC revenue cash support (£30m).
- BPPC impacted in February as YTD performance reduced to 94% by value, 88% by volume, as a result of payment rationing.
- £30m will allow outstanding supplier payments to be cleared in March

Receivables & Payables

- Total debt: £14.8m, of which >90 days £4.9m .
 - Overseas visitors >90 days: £2.2m (partially in write-off/collection processes).
 - Salary overpayments >90 days: £0.4m, with recovery actions underway.
- Payables remained largely unchanged £67.8m, although >60-day items increased by £0.9m to £6.2m.

	Month 11						Month 10					
	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	9,704	4,470	654	478	4,102	42%	9,395	4,117	559	568	4,150	44%
NHS receivables	4,388	1,951	875	670	892	20%	4,369	2,625	649	180	914	21%
Total receivables	14,092	6,421	1,529	1,148	4,993	35%	13,763	6,742	1,208	749	5,064	37%
Non-NHS payables	56,376	50,280	1,903	1,770	2,423	4%	53,870	48,162	2,567	566	2,576	5%
NHS payables	11,378	8,761	589	(38)	2,066	18%	8,923	6,631	123	1,106	1,064	12%
Total payables	67,754	59,041	2,492	1,732	4,488	7%	62,793	54,793	2,690	1,671	3,640	6%

University Hospitals Leicester

February 2026

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.
- Late national notifications have created risk to **committing funds before 31 March 2026**
- Weekly monitoring in place; all PDC funds drawn down.

Key Capital Risks

- **Delivery risk** of up to £4.1m slippage of which £2.1m needs re-providing in 26/27 and is now included in the 26/27 plan.

- Additional recurrent revenue consequences of c£3m (depreciation/PDC dividend/maintenance) not fully funded, associated with additional allocations.

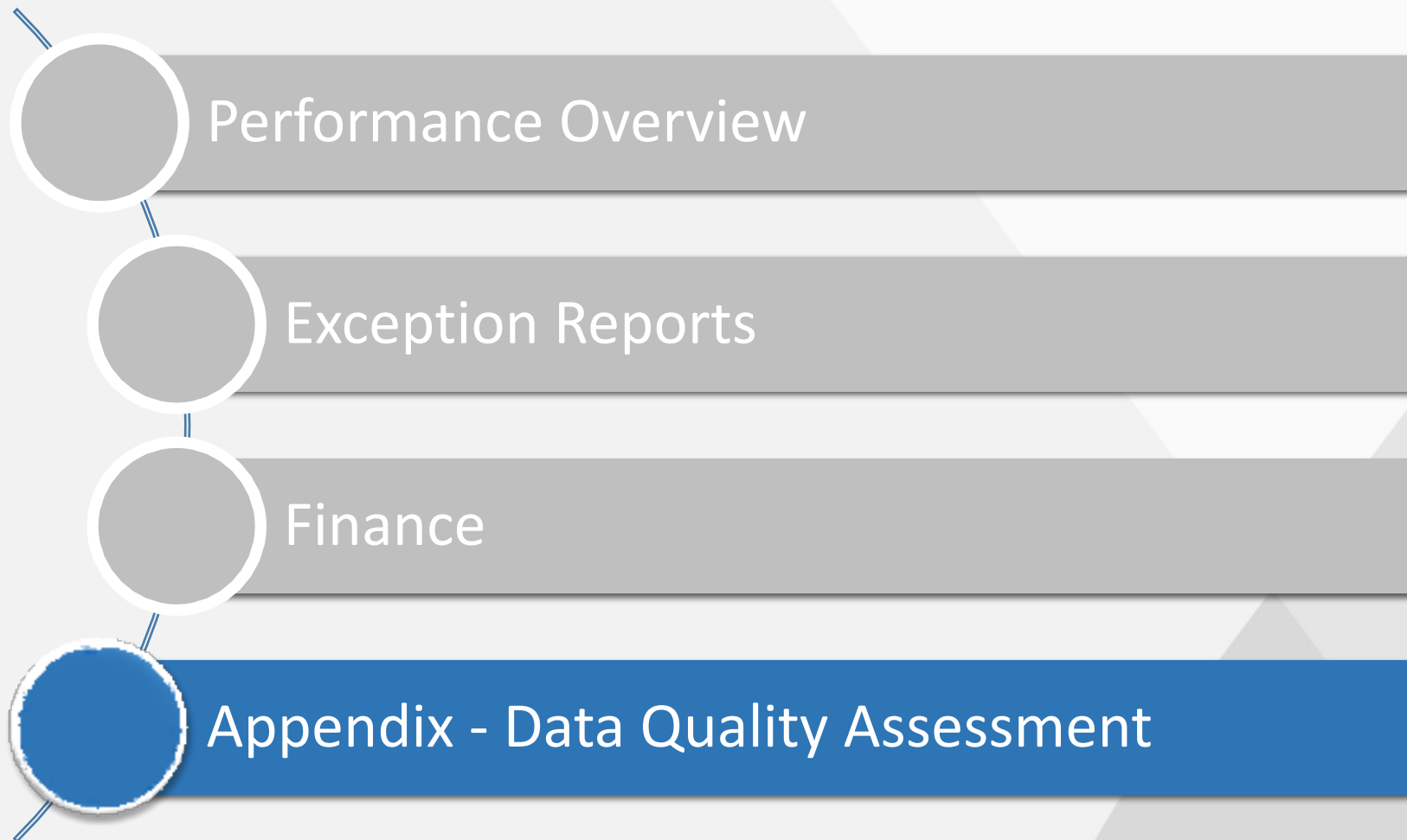
- Any slippage or overspend will push pressure into 26/27

Area	Capital Spend	Bring Forward		New spend				Total (£000s)
		£000s	Replacement (£000s)	New (£000s)	Invest to Save (£000s)	Revenue to Capital (£000s)		
OFH	UTC contractor spend acceleration	1,290	26					1,316
Digital	Rubrik	532						532
Digital	End User Devices		200					200
MES	Ergea contract	300						300
Beds	Additional beds						500	500
Cardiology	Additional Echo Machine				119			119
Medical Equipment	LCMS Mass Spec		350					350
Medical Equipment	QTOFT		288					288
Surgical instruments	Surgical instruments to mitigate cancellation of operations		375					375
Medical Equipment	Replacement BabyPOD for Childrens Transport service (COMET)		9					9
Environment and Facilities	POTENTIAL - estates survey for CYP Asthma pathway		2					2
Medical Equipment	Pathology Faxitron			130				130
Total		2,122	1,250	130	119	500		4,121

Area	Revised Plan £'000	YTD Plan £'000	M11 Actuals YTD £'000	Variance to M10 YTD Plan £'000	M11 Movement £'000	Forecast 25/26 £'000	Forecast Variance 25/26 £'000	Plan Movement
System Funded								
IM&T - Infrastructure & Obsolescence	5,500	5,444	4,445	(999)	320	5,739	239	0
Medical Equipment	3,150	2,888	1,651	(1,237)	383	3,150	0	0
Estates Backlog Maintenance	4,615	2,380	4,324	1,944	528	4,615	0	2,000
MES Equipment	10,760	4,033	7,853	3,820	5,123	10,760	0	5,800
MES Enabling	6,150	5,464	4,673	(791)	(1,498)	6,150	0	0
Demand & Capacity	0	1,435	0	(1,435)	0	0	0	0
CHP	1,361	0	169	(1,192)	59	1,361	0	1,361
Contingency inc.	658	312	(0)	(312)	288	521	(136)	(1,454)
TGH Compliance	760	480	(0)	(480)	0	760	0	300
Mortuary	1,773	0	1,456	1,456	60	1,773	0	1,773
LGH Endoscopy	4,244	4,165	4,013	(152)	19	4,174	(70)	0
EPR	6,650	5,257	6,658	2,411	1,056	7,611	961	1,100
EPR additional funding	1,600	0	1,600	1,600	0	1,600	0	1,600
Aseptic Lab	983	0	50	50	(9)	68	(915)	0
Leicester Diabetes Centre	1,537	1,537	1,018	(519)	(104)	1,550	13	0
Preston Lodge (UEC)	3,605	3,000	3,034	34	(0)	3,600	(5)	605
UTC	500	0	0	0	0	500	0	500
Maternity Theatre Refurbishment		0	0	0	0	800	800	0
Capex Credits	(1,920)	0	(1,779)	(1,779)	378	(2,276)	(356)	(1,920)
NHP	0	0	0	0	0	0	0	0
Corporate Accommodation Scheme	3,500	0	0	0	0	3,500	0	3,500
Primary Clary Dyskinesia Diagnostic Centre - Microscopes	56	0	56	56	26	30	(26)	56
QCT Machines	150	0	0	0	0	165	15	150
Procurement of hospital clinical decontamination equipment	20	0	0	0	0	20	0	20
Revenue to Capital transfer	1,500	0	0	0	0	1,500	0	1,500
ESF: Patient and Staff Safety, working environment/Safety & Compliance	288	0	0	0	0	288	0	288
GH Robot Business Case development								0
25/26 Slippage: Additional Echo Machine								0
25/26 Slippage: LCMS Mass Spec								0
25/26 Slippage: Additional beds								0
Leases: IFRS 16 (including re-measurement)	7,168	6,568	791	(5,777)	(860)	7,168	0	0
Total System Funded Schemes	64,626	42,943	42,000	(1923)	5,798	65,147	521	17,178
PDC Funded Schemes								
Medical Equipment UEC Capacity (Elective)	255	500	321	(179)	(0)	255	0	(495)
UEC Schemes: Diagnostics	7,263	6,460	6,004	(456)	1,122	7,263	0	50
Estates Safety (CIR)	2,000	5,640	529	(5,111)	31	2,000	0	(8,200)
NHP	1,073	1,413	1,123	(290)	171	1,073	0	(424)
NHP LRI Enabling Works	2,949		713	713	278	2,949	0	2,949
Medical Equipment UEC Capacity (Elective)	2,296	2,503	2,296	(207)	(100)	2,296	0	(1,400)
Histopathology Modernisation with Automation	435	0	0	0	0	435	0	435
NHS chargepoint accelerator scheme	424	0	0	0	0	424	0	424
Solar: Preston Lodge	288	0	0	0	0	288	0	288
Community Diagnostics Centres Pathway	415	0	0	0	0	415	0	415
Genom: Testing	1,192	0	17	17	0	1,192	0	1,192
Deva	194	0	152	152	0	194	0	194
Estates Safety (CIR)	230	0	0	0	0	230	0	230
Decarbonisation Funding	575	0	0	0	0	575	0	575
NHP Incoming Power for LRI & GH	762	0	453	453	0	762	0	762
RCS Design Fees	804	0	0	0	0	804	0	804
The Diagnostics Digital Capability	313	0	0	0	0	313	0	313
Cardiac Equipment	350	0	0	0	0	350	0	350
COC Business Case Development	1,000	0	0	0	0	1,000	0	1,000
Maternity Equipment	763	0	0	0	0	763	0	763
Diagnostics - Digital Capability Programme	550	0	0	0	0	550	0	550
Diagnostics - Digital Capability Programme	550	0	0	0	0	550	0	550
CYBER - Cyber Improvement Programme	100	0	0	0	0	100	0	100
Shared LIMS	1,500	0	0	0	0	1,500	0	1,500
Clinical Decontamination Unit	20	0	11	11	11	20	0	100
THL Endoscopy	700	0	0	0	0	700	0	700
LGH - Robot	2,000	0	0	0	0	2,000	0	2,000
25/26 Slippage: Replacement QTOFT								0
25/26 Slippage: Replacement Surgical Instruments								0
25/26 Slippage: Replacement BabyPOD for Childrens Transport service (COMET)								0
25/26 Slippage: estates survey for CYP Asthma pathway								0
25/26 Slippage: Pathology Faxitron								0
25/26 Slippage: CTO replacement x 4								0
Total PDC Funded Schemes	28,614	16,515	15,618	(4,999)	1,492	28,614	0	5,178
Charitable Schemes								
Leicester Diabetes Centre (D3)	3,761	3,761	3,221	(540)		3,221	(540)	0
NHP Aseptic	1,835	0	0	(1,835)	0	0	0	(1,200)
Hope Charity	300	0	0	0	0	0	0	(300)
UHL Charity		0	0	0	0	0	0	(500)
Total Charity Funded Schemes	4,561	6,056	3,853	(2,203)	86	3,767	(794)	(17,708)
Total Capital Programme	97,891	65,515	57,491	(8,024)	7,328	97,528	(273)	20,657
Donated Income Grant rec'd	(4,561)	(8,056)	(3,853)	(2,203)	(80)	(3,167)	734	1,700
Less: Book value of asset disposals							(173)	0
Less: Book value of IFRS 16 disposals			(345)	(345)	0	(345)	(345)	0
Net CDEL	93,240	59,459	53,417	(6,342)	7,268	93,240	(9)	22,357

University Hospitals Leicester

February 2026



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.

Paper F1

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:	9 April 2026
Title:	2.4 Escalation Report from the Quality Committee (FIC): 26 February 2026
Report presented by:	Andy Haynes, MBE, QC Non-Executive Director Chair
Report written by:	Andy Haynes, MBE, QC Non-Executive Director Chair

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Not applicable					
To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which						
BAF Risk 01 Quality 02- Harm Free Care						
BAF 01 Quality 03 Patient and Carer Experience						
Impact assessment						
N/A						

Purpose of the Report

To provide assurance to the Trust Board on the work of the Trust's Quality Committee (QC).

Summary

Quality Committee met on 26 February 2026 and was quorate. The attached escalation report identifies any issues which the Committee either needs to recommend, or wishes to highlight, to the Trust Board, and sets out the QC's level of assurance.

This escalation report follows the new quadrant template, focusing on assurance levels and aiming to provide an 'at a glance' report from the Board Committees. The template covers: **key escalations; actions to take outside the Committee; positive assurances, and decisions taken.**

The escalation report also sets out any items recommended for Trust Board approval, and any items referred to other Committees.

The report is not intended to be a narrative account of all issues discussed at the meeting.

Key escalations to notify the Board	Actions to take outside of the committee
BAF 01 Quality 02- Harm Free Care Gap relating to fundamental care compliance not consistent National Falls Audit Update 2025 There were 61 falls with moderate or greater harm and 47 eligible for reporting (over 65yrs). On the national multi risk factor assessment tool we are above the 2024 national average on 4/10 areas. We are significantly below the national average on 5 areas (completing an assessment, delirium screening, vision assessment, removing patients safely from the floor and medical assessment within 30' of fall). An action plan is in place and will be reported through monthly Falls Safety Team meetings to NMAHP and up to QC. Overall, our rate of falls with harm remains below the national average. However, we recognise that there is more to do to strengthen how we identify risk, minimise harm, and respond effectively to falls resulting in moderate or greater harm. Our focus is on ensuring consistent application of preventative measures, timely response, and learning where incidents do occur. (Moderate Assurance) BAF 01 Quality 03 Patient and Carer Experience Gap identified with variability in response rate and experience across groups. The Trust is seeing an increase in complex complaints where responses from family are using AI to respond to UHL communications. A deep dive has recommended that the collaborative working between patient experience and safety needs strengthening with a focus on clarity for the patient/family, a compassionate approach and a clear audit trail of engagement. This will be reported through Patient Experience updates to QC and cases will be reviewed by the independent panel. QC suggested that the deep dive showed cases where there were no safety concerns and	None

those where there were hence a different approach may be required for these 2 groups. (Moderate Assurance) Organ Donation Biannual Report UHL is a level 1 service reporting 12 or more donations a year. These may be after brainstem (BS) and cardiac death (CD). At M9 we have recorded 5 donations hence off track for the year. For BS donations there was 100% referral and Senior Nurse review with a 50% consent rate. For CD, 88% referral, 71% Senior Nurse review and 50% consent. These compare to 66 and 56% consent rates nationally. There was a recognition that communication with community groups needed to be strengthened. The Associate Director of Health Inequalities offered support and access to Comms. There was a suggestion that Charitable Funds could be approached for funds to assist. (Moderate Assurance)	
Positive Assurance taken	Decisions taken
BAF Risk 01 Quality 02 Harm Free Care Q3 Learning From Deaths Report Published SHMI for Oct 24 to Sep 25 is 108, a significant increase from the previous rolling 12 months result of 97. Crude mortality and HSMR remain stable. Investigation has shown that the data submission contained a high number of cases with an invalid primary diagnosis which led to UHL having 300 more deaths than expected. The data has been corrected and the SHMI will return to below 100 when the analysis is repeated. A review of data quality controls has taken place. The number of neonatal deaths in 2025 has returned to pre pandemic levels for the first time. Between April and September there were 2 cases where care may have impacted on outcomes and actions are in progress. Between July and September there were 9	2026 QC Work Plan approved

neonatal deaths; 3 were transferred for care to UHL and 7 had congenital anomalies. (Strong Assurance) Reports received and reviewed: Monthly Quality and Safety Q3 Patient Experience Q3 Quality Strategy Q3 Perinatal Safety Perinatal Assurance Cttee Highlight Report Q3 TIPAC (Strong Assurance)	
Items recommended for Board approval:	
None	
Items referred to other committees:	
None	

SIGNIFICANT ASSURANCE	Clear understanding of the issues with a robust, deliverable plan which will achieve the required outcomes. Only insignificant residual risk. There may be external evidence to corroborate this view
MODERATE ASSURANCE	Good understanding of the issues, a clear plan with timescales that are credible and deliverable but some action still required. The residual risk is more than insignificant
LIMITED ASSURANCE	Recognised material weaknesses which may be incomplete understanding of the issues or an action plan which is not comprehensive, credible or deliverable. A significant amount of residual risk remains
NO ASSURANCE	A fundamental failure to understand the issues. An action plan is inadequate with fundamental gaps, weaknesses or breakdown in compliance. A significant of residual risk remains and immediate action is required

Paper F2

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:	9 April 2026
Title:	2.4 Escalation Report from the Quality Committee (QC): 26 March 2026
Report presented by:	Andy Haynes, MBE, QC Non-Executive Director Chair
Report written by:	Andy Haynes, MBE, QC Non-Executive Director Chair

Action – this paper is for:	Decision/Approval	X	Assurance	x	Update	
Where this report has been discussed previously	Not applicable					
To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which						
BAF Risk 01 Quality 05 – Tackling Health Inequalities						
Impact assessment						
N/A						

Purpose of the Report

To provide assurance to the Trust Board on the work of the Trust's Quality Committee (QC).

Summary

Quality Committee met on 26 March 2026 and was quorate. The attached escalation report identifies any issues which the Committee either needs to recommend, or wishes to highlight, to the Trust Board, and sets out the QC's level of assurance.

This escalation report follows the new quadrant template, focusing on assurance levels and aiming to provide an 'at a glance' report from the Board Committees. The template covers: **key escalations; actions to take outside the Committee; positive assurances**, and **decisions taken**.

The Committee recommends UHL approval of the Patient Safety Incident Response Plan (PSIRP) 2026/28 which is appended (UHN documents section only of Board portal).

The escalation report also sets out any items referred to other Committees.

The report is not intended to be a narrative account of all issues discussed at the meeting.

Key escalations to notify the Board	Actions to take outside of the committee
BAF Risk 01 Quality 05 – Tackling Health Inequalities Gap identified in visibility of equity insights UHL Annual Prevention Report 2024/5 This report will be launched at the third UHL Health Equality Summit in April. It relates the background, position and progress on Smoking Cessation, Alcohol Abuse, Obesity, TB, Blood Borne Viruses and Workforce Wellbeing. Progress has been made but more remains to be done. The report recommends that we use our digital infrastructure to offer pathways to those that need them most, enhance communication across OP services and to primary care whilst continuing to evaluate impact to maximise funding opportunities. QC fully supports and recommends this report. Recent national guidance covers all of these areas and cardiovascular disease (CVD); QC asked how CVD prevention fits into our local strategy and this will come in a future report. The Committee's discussion on this report is highlighted to the Board for information and the report attached for the Board's awareness. (Strong Assurance)	
Positive Assurance taken	Decisions taken
Reports reviewed: Monthly AQIP Quality and Safety Q3 Patient Safety Q3 Safeguarding (Strong Assurance)	PSIRP Plan 2026/8 approved
Items recommended for Board approval:	
Patient Safety Incident Response Plan (PSIRP) 2026/28 (appended to this report for approval)	
Items referred to other committees:	

None	
SIGNIFICANT ASSURANCE	Clear understanding of the issues with a robust, deliverable plan which will achieve the required outcomes. Only insignificant residual risk. There may be external evidence to corroborate this view
MODERATE ASSURANCE	Good understanding of the issues, a clear plan with timescales that are credible and deliverable but some action still required. The residual risk is more than insignificant
LIMITED ASSURANCE	Recognised material weaknesses which may be incomplete understanding of the issues or an action plan which is not comprehensive, credible or deliverable. A significant amount of residual risk remains
NO ASSURANCE	A fundamental failure to understand the issues. An action plan is inadequate with fundamental gaps, weaknesses or breakdown in compliance. A significant of residual risk remains and immediate action is required

UHN Quality and Safety Committee Upward Report to Board of Directors

Date of reporting group's meeting: 25th March 2026
(1 of 3)

Reporting Non-Executive Director: Chris Welsh (Chair)

Agenda Item	Description and summary discussion	BAF links	Assurance level *
	The committee:		
UHN Corridor Care and UEC (Urgent and Emergency Care) Red Lines oversight	- Notes that UHN continues to experience significant operational pressure across the UEC pathway. High Emergency Department (ED) attendances, low conversion to admission rates and a high number of patients who no longer meet the criteria to reside are creating sustained congestion at both the front and back door. As a result, both sites remain reliant on corridor care to maintain flow and safety. - Notes the forthcoming NHS England requirement to eliminate corridor care and the introduction of public reporting from May. - Recognises the ongoing mitigation work to strengthen patient flow, improve board round effectiveness and enhance oversight of corridor care. However, it emphasises that achieving UEC red lines and reducing corridor care to national standards will require system level action, particularly to support safe and timely discharge. - Confirms limited assurance based on continued system wide pressures affecting both the front and back door, and the ongoing use on corridor care.	UHN15 demand on services	Limited
GIRFT (Getting it Right First Time) Virtual Ward review	- Received assurance that the Getting it Right First Time (GIRFT) reviews of UHN's virtual wards and the KGH HomeLink service identified safe practice with no evidence of patient harm. - Noted areas that do not fully align with national virtual ward criteria. Assurance was provided that operational teams and system partners are already addressing these gaps through ongoing pathway review and ICB led workshops. A further update will be provided once improvement actions and commissioning alignment are complete. - Confirms limited assurance on this item given the further work that is required to achieve full compliance.	UHN11 Positive safety culture	Limited

UHN Quality and Safety Committee Upward Report to Board of Directors

Date of reporting group's meeting: 25th March 2026
(2 of 3)

Reporting Non-Executive Director: Chris Welsh (Chair)

Agenda Item	Description and summary discussion	BAF refs.	Assurance level *
Medicines Optimisation and Antimicrobial stewardship	The committee: 1. Noted the continued high fragility of aseptic services across both sites due to ageing estate, capacity constraints and specialist workforce shortages. 2. Noted NGH continues to perform well on antibiotic usage. KGH's usage is increasing due to ED demand pressures, digital limitations and inconsistent clinical engagement. 3. Noted that the plans for nationally funded regional aseptic production hubs are years away. Urgent oncology pathways (e.g acute leukaemia) still require local aseptic capability. Work with UHL continues to explore medium to long term solutions. 4. Notes that despite mitigations, underlying risks require long term estates and workforce solutions, hence limited assurance for the medium/long term and reasonable assurance in the short term with patient needs being met.	UHN11 Positive safety culture	Reasonable – short term
			Limited – medium/long term
Subgroup upward reports: Children and Young People's Board	1. Agreed to escalate to the Board of Directors, concerns from the Children and Young People's Board regarding limited digital visibility of primary care records in urgent and emergency care settings. Current licence restrictions prevent access to System One, and the Shared Care Record does not yet provide sufficient clinical information to support decision-making. This issue has contributed to clinical risk in recent cases and requires system-level action and investment. 2. Recommends that the Board considers this as a priority area for system-wide resolution.	UHN24 digital transformation	Limited

UHN Quality and Safety Committee Upward Report to Board of Directors

Date of reporting group's meeting: 25th March 2026
(3 of 3)

Reporting Non-Executive Director: Chris Welsh (Chair)

Agenda Item	Description and summary discussion	BAF refs.	Assurance level *
	The committee:		
Perinatal reports	1. Noted full NGH compliance with Maternity Incentive Scheme safety actions and non-compliance with two actions at KGH. 2. Noted positive feedback from the CQC's follow up inspection of NGH maternity services with staff praised for being friendly, dedicated and providing person-centred care. The committee commended relevant teams for their work on this. 3. Noted progress on key actions has been slow following a foetal medicine and scanning pathway review which took place last year, with business cases still under development and unresolved financial implications. Acceleration actions are in progress. 4. Noted the temporary pause to the KGH home birth service for three months while required improvements are undertaken.	UHN11 Positive safety culture UHN12 inclusive care	Reasonable
UHN Mortality Quarter 3 report	1. Noted mortality metrics at both sites remain broadly stable with no new mortality alerts and positive structured judgement review outcomes. All deaths continue to undergo Medical Examiner (ME) review and a joint ME lead is in place. 2. Noted ongoing work to strengthen earlier recognition of end-of-life needs and the impact of wider system pressures on palliative care pathways. While some areas of improvement remain, the committee was assured that risks are understood and appropriate quality improvement actions are underway.	UHN11 Positive safety culture UHN12 inclusive care	Reasonable
CQC Local Assessment Process report on Medical Care	1. Received positive assurance following the CQC's local assessment of medical care. 2. Noted all requirements of the NGH Section 29A notice have been fully met. 3. Noted positive feedback received from the CQC which had observed compassionate, person-centred care, strong MDT working, effective risk oversight and good leadership.	UHN11 Positive safety culture UHN12 inclusive care	Limited

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:	9 April 2026
Title:	2.4 Escalation Report from the Finance and Investment Committee (FIC): 25 February 2026 (Paper F4)
Report presented by:	Andrew Inchley, FIC Non-Executive Director Chair
Report written by:	Andrew Inchley, FIC Non-Executive Director Chair

Action – this paper is for:	Decision/Approval	X	UHL Assurance	x	Update	
Where this report has been discussed previously	Not applicable					
To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which						
BAF Risk (03) Finance Short and Long Term						
Impact assessment						
N/A						

Purpose of the Report

To provide assurance to the UHL Board on the work of the Trust's Finance and Investment Committee (FIC).

Summary

Finance and Investment Committee met on 25 February 2026 and was quorate. The attached escalation report identifies any issues which the Committee either needs to recommend, or wishes to highlight, to the Trust Board, and sets out the FIC's level of assurance.

This escalation report follows the new quadrant template, focusing on assurance levels and aiming to provide an 'at a glance' report from the Board Committees. The template covers: **key escalations; actions to take outside the Committee; positive assurances, and decisions taken.**

The escalation report also sets out any items recommended for Trust Board approval, and any items referred to other Committees.

The report is not intended to be a narrative account of all issues discussed at the meeting.

Key escalations to notify the Board	Actions to take outside of the committee
None to report	None to report
Positive Assurance taken	Decisions taken
BAF Risk (03 Finance – short term & long term) - M10 finances – (i) remain aligned with projected year end close outlook, (ii) expect to achieve planned capital spend for the year, (iii) continue to monitor and manage projected cash requirements – moderate assurance - RDO report – continue to monitor planned 2025/26 activities, but focus shifting to planning for 2026/27, including detailed activities required to support CIP target – moderate assurance.	None to report
Items recommended for Board approval:	
None	
Items referred to other committees:	
None	

SIGNIFICANT ASSURANCE	Clear understanding of the issues with a robust, deliverable plan which will achieve the required outcomes. Only insignificant residual risk. There may be external evidence to corroborate this view
MODERATE ASSURANCE	Good understanding of the issues, a clear plan with timescales that are credible and deliverable but some action still required. The residual risk is more than insignificant
LIMITED ASSURANCE	Recognised material weaknesses which may be incomplete understanding of the issues or an action plan which is not comprehensive, credible or deliverable. A significant amount of residual risk remains
NO ASSURANCE	A fundamental failure to understand the issues. An action plan is inadequate with fundamental gaps, weaknesses or breakdown in compliance. A significant of residual risk remains and immediate action is required

Key escalations to notify the Board	Actions to take outside of the committee
None to report	None to report
Positive Assurance taken	Decisions taken
BAF Risk (03 Finance – short term & long term) - BAF risk for short term financials will reset to 2026/27 financial year from April FIC, score likely to remain high given level of CIP in plan. - M11 finances – (i) remain aligned with projected year end close outlook, (ii) expect to achieve planned capital spend for the year, (iii) continue to monitor and manage projected cash requirements – moderate assurance - RDO report – continue to monitor planned 2025/26 activities, but focus very much on planning for 2026/27, including detailed activities required to support CIP target – moderate assurance. - Investment dashboard – reviewed proposed enhancements to business case monitoring / tracking processes, to be piloted from April – moderate assurance BAF Risk (05 Estate 01) - Estates & facilities quarterly report – detailed CAFM review remains on track for June 2026, will result in updates to action plan and priority investments required to reduce BAF risk score – moderate assurance on process, noting the need for investment to reduce substantive risk.	None to report
Items recommended for Board approval:	
FIC Terms of Reference – updated to add Commercial Director to committee members, with quarterly report on commercial matters. Appended to this escalation report for approval.	
Items referred to other committees:	
None to report	

SIGNIFICANT ASSURANCE	Clear understanding of the issues with a robust, deliverable plan which will achieve the required outcomes. Only insignificant residual risk. There may be external evidence to corroborate this view
MODERATE ASSURANCE	Good understanding of the issues, a clear plan with timescales that are credible and deliverable but some action still required. The residual risk is more than insignificant
LIMITED ASSURANCE	Recognised material weaknesses which may be incomplete understanding of the issues or an action plan which is not comprehensive, credible or deliverable. A significant amount of residual risk remains
NO ASSURANCE	A fundamental failure to understand the issues. An action plan is inadequate with fundamental gaps, weaknesses or breakdown in compliance. A significant of residual risk remains and immediate action is required

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:	9 April 2026
Title:	2.4 (Paper F5) Escalation Report from the Finance and Investment Committee (FIC): 25 March 2026
Report presented by:	Andrew Inchley, FIC Non-Executive Director Chair
Report written by:	Andrew Inchley, FIC Non-Executive Director Chair

Action – this paper is for:	Decision/Approval	X	Assurance	x	Update	
Where this report has been discussed previously	Not applicable					
To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which						
BAF Risk (03) Finance Short and Long Term BAF Risk (05 Estate 01)						
Impact assessment						
N/A						

Purpose of the Report

To provide assurance to the UHL Board on the work of the Trust's Finance and Investment Committee (FIC).

Summary

Finance and Investment Committee met on 25 March 2026 and was quorate. The attached escalation report identifies any issues which the Committee either needs to recommend, or wishes to highlight, to the Trust Board, and sets out the FIC's level of assurance.

This escalation report follows the new quadrant template, focusing on assurance levels and aiming to provide an 'at a glance' report from the Board Committees. The template covers: **key escalations; actions to take outside the Committee; positive assurances, and decisions taken.**

The Committee recommends approval of revised terms of reference which are appended.

The escalation report also sets out any items recommended for Trust Board approval, and any items referred to other Committees.

The report is not intended to be a narrative account of all issues discussed at the meeting.

Finance and Investment Committee

Terms of Reference

1. Constitution

The University Hospitals of Leicester NHS Trust hereby resolves to establish a Committee of the Trust Board (hereafter referred to as “the Board”) to be known as the Finance and Investment Committee (hereafter referred to as “the Committee”).

The Committee shall have terms of reference conferring delegated authority from the Board and will be subject to conditions such as reporting its activities of the Board, as the Board shall decide and act in accordance with any legislation, regulation or direction issued by regulators or statutory bodies.

Aligned with the scheme of delegation, the Finance and Investment committee have delegated authority to approve revenue and capital expenditure between £2,000,000 and £4,999,999.

2. Purpose

The purpose of the Committee is to seek and receive assurance on the stewardship of the Trust’s finances and investments; including planning, financial performance, capital expenditure, and the delivery of the financial plan and annual capital programme. The Committee is also responsible for holding to account the delivery of the Estates and Facilities Strategy.

3. Membership

The Committee shall comprise:

Core Members

- 3 x Non-Executive Directors (not including the Trust Chair) one of whom will chair the Committee
- Chief Financial Officer
- Group Chief Digital Information Officer
- Director of Estates and Facilities
- Deputy Chief Executive
- Chief Operating Officer
- Medical Director
- Chief People Officer

Additional Attendance

- Colleagues will be asked to attend to present and discuss relevant topics as is appropriate

A standing invitation to attend the Committee will be extended to the following:

- Chief Executive
- Trust Chair
- Other Non-Executive Directors
- Representatives of Internal and External Audit
- Director of Corporate and Legal Affairs
- Deputy Director of Finance (Financial Services)
- Deputy Director of Finance (Financial Management)
- Deputy Director of Finance (Strategic Finance and Planning)
- Head of Procurement
- Head of Risk and Assurance
- Commercial Director

The secretary and administrative support to the Committee shall be provided through the Corporate and Committee Services Team.

A deputy shall be nominated to attend a meeting of the Committee when the absence of one of the members (detailed above) would prevent an item of business being addressed. The deputy attending shall count towards meeting quorum, but not to the attendance record of the Committee member him / herself.

All members shall attend a minimum of 75% of meetings of the Committee on a rolling 12 month basis.

4. Quorum

Quorum shall be 4 members to include 2 Non-Executive Directors (one of which will chair if the chair is unable to attend), and 2 Executive Directors of whom 1 must be the Chief Financial Officer or their representative.

5. Meetings

The Committee shall meet monthly. Additional ad hoc meetings may be convened as and when required.

The chair of the committee shall consider items for approval and discussion to be taken within the open and closed sessions of the committee. The closed session is for core members of the committees and additional attendance will be by invitation of the chair only.

6. Duties

Financial planning and performance

- 6.1 The Committee will review and monitor the following, receiving assurance on the progress against each plan and where it is off plan understand the controls and mitigations in place to manage any risk:
 - 6.1.1 Trust's annual financial plan
 - 6.1.2 Trust's medium term financial plan and underlying financial position
 - 6.1.3 The Capital annual and longer term plan
 - 6.1.4 Cost Improvement Programme
 - 6.1.5 Performance against the KPIs of the Trust's subsidiary
- 6.2 Receive and scrutinise the Trust financial forecasting
- 6.3 The Committee will review and support all business cases valued over £2m, ensuring the outcomes and benefits are clearly defined, before recommending any case over £5m to the Trust Board for approval
- 6.4 Receive updates on ICS wide finances, risks and opportunities
- 6.5 Receive a quarterly update on shared workforce and finance reporting – the same report will also be submitted to the People and Culture Committee to enhance visibility and enable an appropriate deep dive by both groups
- 6.6 Receive reports providing oversight on overall operational annual planning
- 6.7 Receive quarterly reports on commercial matters

Financial Recovery and Improvement

- 6.8 Receive updates on the progress to delivering financial sustainability
- 6.9 The Committee will receive assurance there are improvements to continue to strengthen the culture within financial services across the organisation via 6-monthly reporting against agreed KPIs

Contracting and Procurement

- 6.10 Receive monthly updates and assurance report from the Procurement Contracts Committee, including recommended contracts awards requiring Trust Board sign off

IT Contract Performance

- 6.11 The Committee will monitor the performance of the IM&T managed business partner Contract (oversight of strategic IM&T issues being through the Our Future Hospitals and Transformation Committee).

Estates and Facilities

- 6.12 The Committee will monitor progress against the delivery of the Trust's Estates and Facilities strategy.

Core responsibilities and sub group reporting

- 6.13 To review and support the Trust's core strategies associated within the Committee's remit
- 6.14 To monitor, review and assess the level of assurance received on the finance risks and infrastructure related risks, controls and governance processes identified in the Board Assurance Framework delegated to the committee by the Board, providing reports to the Board of Directors and/or Audit Committee when requested

- 6.15 To review the reporting subcommittee structure to ensure both efficiency and effectiveness of reporting, including any addition of new sub groups or working groups as required
- 6.16 To escalate issues of concern requiring Board attention
- 6.17 To develop and maintain an annual work programme to reflect and enable assurance in relation to the above duties
- 6.18 Annually review the Committee terms of reference to ensure they remain fit for purpose and align with annual work programme
- 6.19 The Committee will produce an annual report incorporating its effectiveness to adhere to the duties placed upon it

7 Reporting and Governance Procedures

The Committee shall produce minutes of its meetings which will be formally ratified at the following meeting. A written summary of each meeting shall be submitted to the next scheduled meeting of the Board. The summary will focus on items of escalations, items which have been approved and specific items connected to strategic risks (including risks on the Board Assurance Framework) and strategic direction. The Chair of the Committee will present this report.

An annual report will be produced setting out the Committee's compliance with its terms of reference, performance of its duties and strategic priorities for the next 12 months. This will be informed by an annual self-assessment conducted by the Committee, ensuring its work and responsibilities are reflective of the changing environment within which the committee functions. The Board will receive and approve the annual report.

8 Review

The Committee will continually review the effectiveness, and where appropriate, revise the Committee membership and terms of reference at least annually. Ratification will be by the Board.

9 Ratification:

Most recently updated and reviewed by: Finance and Investment Committee

Date: 22 December 2025

Ratified by: Trust Board

Date: February 2026

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:	9 April 2026					
Title:	2.4 Escalation Report from the UHL Operations and Performance Committee (OPC): 26 February 2026 (Paper F6)					
Report presented by:	Scott Adams, OPC Non-Executive Director Chair					
Report written by:	Scott Adams, OPC Non-Executive Director Chair					
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	x
Where this report has been discussed previously	Not applicable					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
UHL BAF risk 2 (Activity 01, 02, 03)

Impact assessment
N/A

Purpose of the Report

To provide assurance on the work of the UHL Operations and Performance Committee (OPC).

Recommendation

The OPC met on 26 February 2026 and was quorate. The attached escalation report identifies any issues which the Committee either needs to recommend, or wishes to highlight, to the Board, and sets out the OPC's level of assurance.

There are no items requiring formal recommendation from the February 2026 UHL OPC meeting.

This escalation report follows the new quadrant template, focusing on assurance levels and aiming to provide an 'at a glance' report from the Board Committees. The template covers: **key escalations; actions to take outside the Committee; positive assurances**, and **decisions taken**.

The escalation report also sets out any items recommended for approval, and any items referred to other Committees.

The report is not intended to be a narrative account of all issues discussed at the meeting.

Key escalations to notify the Board	Actions to take outside of the committee
No significant items to escalate although see commentary below related to on the day, (OTD), cancellations at EMPCC.	None
Positive Assurance taken	Decisions taken
BAF Risk 02 Activity -01 UEC overcrowding and Patient flow Pressure on improvement to key metrics still being experienced. • Strong winter performance over reporting multiple reporting period, with the challenge now shifting to sustaining the performance level alongside de-escalation activity. • CQC inspection took place during February for UEC services with initial informal feedback constructive. March committee will consider the output of the formal report. • Committee received early visibility of reporting and tracking format against MTP commitments for 26/27 and beyond and provided feedback. • Discussions with the system to reintroduce a LUECS were noted and the committee requested a further update in March. • OPC discussed hospital discharges, average lengths of stay, performance for the Paediatrics ED four hour wait standard • Initial view of Criteria Led Discharge materials contained within committee materials with positive discussion as a result. BAF Risk 02 Activity -02 Elective Care backlog and timeliness Total waiting list remains above plan and trajectory. • Zero 78week waits position continues, 65 ww position remains constant at 90 across Dec25 to Feb 26 • OPC noted the performance for diagnostic services. The total waiting list has reduced by 1,200 approximately patients. Whilst performance for the 13 weeks wait standard has improved it is still behind plan.	

• The report outlined the actions being taken with respect to equity of access to diagnostic services and the GIRFT recommendations. • Further discussion on PAS report expected in March Committee to ensure that PAS interface to database is also covered. • Committee again received early visibility of reporting and tracking format against MTP commitments for 26/27 and beyond and provided feedback. The committee received a deep dive on the reasoning behind the level of on the day, (OTD), cancellations at the EMPCC facility, with detailed action plans explored over the three primary causation areas of clinical cancellations, non-clinical cancellations and patient related. The committee were assured by the report and will continue to monitor the effectiveness of the action plans. BAF Risk 02 Activity -03 Timely and effective cancer care Continued improvement in faster diagnostic standard metrics although still off all national FDS standards, with the overall fragility of the service still a concern. • Notable improvement in 31day standard. December 84.9%, January 78%. Improved position does not sustain through to 62 day performance so further focus required in this area for the committee. • Radiotherapy waits continue to reduce, with Breast backlogs cleared at the end of September 2025 and prostate recovery on track to return to plan in Quarter 4. The challenge to further improve 31 Day waits for 2026/27 will focus on surgery. • 10 of 12 Tumour sites showed improvement ongoing from December, with LOGI and H&N remaining as concerns. • OPC noted that the Trust will be submitting a non-compliant plan for 2026/27 for both 62 and 31-day wait standards.	

Committee were informed that we had experienced no cancellations due to national bone cement issue. No changes to any BAF ratings based upon materials received.	
Items recommended for Board approval:	
None	
Items referred to other committees:	
None	

SIGNIFICANT ASSURANCE	Clear understanding of the issues with a robust, deliverable plan which will achieve the required outcomes. Only insignificant residual risk. There may be external evidence to corroborate this view
MODERATE ASSURANCE	Good understanding of the issues, a clear plan with timescales that are credible and deliverable but some action still required. The residual risk is more than insignificant
LIMITED ASSURANCE	Recognised material weaknesses which may be incomplete understanding of the issues or an action plan which is not comprehensive, credible or deliverable. A significant amount of residual risk remains
NO ASSURANCE	A fundamental failure to understand the issues. An action plan is inadequate with fundamental gaps, weaknesses or breakdown in compliance. A significant of residual risk remains and immediate action is required

UHL/UHN Boards in Common Paper F7

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:	9 April 2026					
Title:	Escalation Report from the Operations and Performance Committee: 26 March 2026					
Report presented by:	Scott Adams, OPC Non-Executive Director Chair					
Report written by:	Scott Adams, OPC Non-Executive Director Chair					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	X
Which Group Priorities does this link to	Transform patient care		Strengthen our culture		Deliver our financial plan	
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

BAF Risk 02 – Activity

Impact assessment

Purpose of the Report

To provide assurance to the Board of Directors on the work of the UHL's Operations and Performance Committee (OPC).

Summary

The Operations and Performance Committee met on 26 March 2026 and was quorate. The attached escalation report identifies issues which the Committee wishes to highlight, to the Trust Board, and sets out OPC's level of assurance.

There are no items requiring formal recommendation to the Trust Board from the March 2026 meeting.

This escalation report follows the new quadrant template, focusing on assurance levels and aiming to provide an 'at a glance' report from the Board Committees. The template covers: **key escalations; actions to take outside the Committee; positive assurances, and decisions taken.**

The report is not intended to be a narrative account of all issues discussed at the meeting.

Key escalations to notify the Board	Actions to take outside of the committee
The committee received the joint Digital and Operations report on the impact of the new PAS system on Elective Services	Follow up to PAS report to be received in May.
Positive Assurance taken	Decisions taken
BAF Risk 02 Activity -01 UEC overcrowding and Patient flow Pressure on improvement to key metrics still being experienced. • Strong winter performance has sustained through March. • Committee received confirmation that construction has commenced on the UTC facility. • CQC inspection took place during February for UEC services with initial informal feedback constructive. It had been anticipated that formal feedback would be available for March OPC but this has yet to be received. • Update on the roll out of training support Criteria Led Discharge and further visibility of CLD reporting contained within OPC materials BAF Risk 02 Activity -02 Elective Care backlog and timeliness Total waiting list remains above plan and trajectory. • Zero 78 week waits position continues • Significant progress on Q4 Sprint activity with over 3000 patients seen in the quarter, this has driven the 65 ww position to an anticipated end of March position of 56 • Extensive discussion related to PAS reporting, with confirmation given from the Ops teams that they agree that the correct criteria are being focussed on for resolution, alongside recognition from Ops colleagues of their role in assuring the success of the PAS implementation BAF Risk 02 Activity -03 Timely and effective cancer care Performance has deteriorated across all three cancer standards since January 2026, which was anticipated following the Christmas period, as some patients had chosen to delay investigations or treatment. Performance for February 2026 was expected to show	None expected

improvement for the Faster Diagnosis Standard (FDS) and the 31-day standard, although performance against the 62-day standard remained significantly challenged. • Pockets of improvement identifiable across several of the tumour sites, however overall, the performance remains adrift from expected national reporting standards with Breast remaining a concerning area. • Committee considered the current performance versus the BAF risk expectation and agreed that it still aligned with the BAF however concern remains over the vulnerability of the cancer plans and their impact on the required trajectory going into 26/27 The committee recognised that this was the last OPC attended by Serbjit Kaur, Associate Non-Executive Director, and as such the committee thanks Serbjit for contribution to the committee over the last year. No changes to any BAF ratings based upon materials received.	
Items recommended for Board approval:	
None	
Items referred to other committees:	
None	

SIGNIFICANT ASSURANCE	Clear understanding of the issues with a robust, deliverable plan which will achieve the required outcomes. Only insignificant residual risk. There may be external evidence to corroborate this view
MODERATE ASSURANCE	Good understanding of the issues, a clear plan with timescales that are credible and deliverable but some action still required. The residual risk is more than insignificant
LIMITED ASSURANCE	Recognised material weaknesses which may be incomplete understanding of the issues or an action plan which is not comprehensive, credible or deliverable. A significant amount of residual risk remains

NO ASSURANCE	A fundamental failure to understand the issues. An action plan is inadequate with fundamental gaps, weaknesses or breakdown in compliance. A significant of residual risk remains and immediate action is required

Finance, Investment & Performance Committee Upward Report to Boards of Directors		Date(s) of reporting group’s meeting(: 24 February 2026	
Reporting Group Chair: Damien Venkatasamy Executive Directors: Sarah Stansfield & Sarah Noonan			
Agenda Item	Description and summary discussion	BAF references	Assurance level *
Month 10 financial report	Received – see Month 11 report for more recent commentary	--	-
Medium Term Planning	Latest position noted – plan since approved under delegated powers	-	-
Operational performance	Discussed – see Integrated Performance Report for latest figures (28 February 2026 position)	-	-

Finance, Investment & Performance Committee Upward Report to Boards of Directors		Date(s) of reporting group's meeting(: 31 March 2026	
Reporting Group Chair: Damien Venkatasamy Executive Directors: Sarah Stansfield & Sarah Noonan			
Agenda Item	Description and summary discussion	BAF references	Assurance level *
Month 11 Finance Report	There was a year-to-date deficit of £55.03 million, a variance of £42 million to plan, which took into account lost Deficit Support Funding. The organisation was on track to deliver the forecasted outturn position. Cash at the end of February was £17.1m, which was slightly better than plan. The Committee SUPPORTED the requests for PDC Revenue support for Q1 of 2026/27 totalling £8.95m in April, £18.54m in May and £11.68m in June and escalated to the Boards for retrospective approval. For Boards' approval	UHN 16 & 17 Deliver financial plan	To be advised
Medium Term Plan	The medium-term plan was resubmitted in mid-March, with changes limited to performance assumptions in Years 2 and 3, while the financial position remained unchanged. The Committee noted that the Trusts were entering national financial escalation and that this would be taken to the Boards for discussion, including consideration of the draft year-end position in a private session.	UHN 16 & 17	To be advised
IPR and NOF	There had been a deterioration in National Oversight Framework ratings, and KGH had moved from a rating of 3 to 4. The drivers of deterioration for UHN were financial performance and cancer treatment.	UHN 16 and 17 UHN 15 Demand and Capacity	To be advised

Finance, Investment & Performance Committee Upward Report to Trust Board		Date(s) of reporting group’s meeting(s): 31 March 2026	
Reporting Group Chair: Damien Venkatasamy Executive Director: Sarah Stansfield & Sarah Noonan			
Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
Month 11 Finance Report	There was a year-to-date deficit of £55.03 million, a variance of £42 million to plan, which included lost DSF. The organisation was on track to deliver the forecasted outturn position. Cash at the end of February was £17.1m, which was slightly better than plan. The Committee SUPPORTED the requests for PDC Revenue support for Q1 of 2026/27 totalling £8.95m in April, £18.54m in May and £11.68m in June and escalated to the Board for retrospective approval. Limited Assurance considering the £42m variance to plan.	None	Limited
Medium Term Plan	The medium-term plan was resubmitted in mid-March, with changes limited to performance assumptions in Years 2 and 3, while the financial position remained unchanged. The Committee noted that the Trust was entering national financial escalation and that this would be taken to the Board for discussion, including consideration of the draft year-end position in a private session. Limited assurance due to be being placed in national financial escalation and limited progress against the underlying deficit in FY26/27.	None	Limited
IPR and NOF Deterioration	There had been a deterioration in NOF ratings, and KGH had moved from a rating of 3 to 4. The drivers of deterioration for UHN were financial performance and cancer. Limited assurance due to deterioration in NOF rating.	None	Limited

*The Committee will indicate the level of assurance it is able to provide to the Boards of Directors using the definitions below. **Committee Chairs will be asked to determine the level of assurance the committee is able to provide following the conclusion of discussion of each item.**

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

Paper F9

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:	9 April 2026					
Title:	2.4 Escalation Report from the Our Future Hospitals and Transformation Committee: 25 February 2026					
Report presented by:	Andy Haynes, MBE, OFHTC Non-Executive Director Chair					
Report written by:	Andy Haynes, MBE, OFHTC Non-Executive Director Chair					
Action – this paper is for:	Decision/Approval		UHL Assurance	X	Update	X
Which Group Priorities does this link to	Transform patient care		Strengthen our culture		Deliver our financial plan	
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
BAF Risk 05 OFH-03 NHP

Impact assessment
-

Purpose of the Report

To provide assurance to the Board of Directors on the work of the UHL's Our Future Hospitals and Transformation Committee (OFHTC)

Summary

Our Future Hospitals and Transformation Committee met on 25 February 2026 and was quorate. The attached escalation report identifies issues which the Committee wishes to highlight, to the UHL Board, and sets out OFHTC's level of assurance.

There are no items requiring formal recommendation to the Trust Board from the February 2026 meeting.

This escalation report follows the new quadrant template, focusing on assurance levels and aiming to provide an 'at a glance' report from the Board Committees. The template covers: **key escalations; actions to take outside the Committee; positive assurances**, and **decisions taken**.

The report is not intended to be a narrative account of all issues discussed at the meeting.

Key escalations to notify to the Board	Actions to take outside of the committee
None	None
Positive Assurance taken	Decisions taken
BAF Risk 05 OFH-03 NHP Live projects: Olivers, Rogers and Jarvis: on site Mar 26 Baldwin Lodge: on site Mar 26 Substation 6a: on site Mar 26 Liquid Nitrogen: on site April 26 Windsor Extension: on site June 26 Staff Relocation to County Hall: expected Aug 26 Hearing and Balance: completion Dec 26 LGH CDC Scoping Core: to consolidate existing services to one site Opportunity: POCT/Imaging to support access, Gynae and MSK one stop pathways to reduce referrals and support faster diagnosis (Moderate Assurance) Hinckley CDC Update M9 delivering 67% of Plan activity with a FoT of 69% Delivering 99% of planned Endoscopy activity Largely due to a shortfall in US and plain XR Positive staff and patient feedback Staffing shortages being managed, restricting activity at GH to divert to Hinckley where appropriate, walk in Chest x-ray service and pre fracture clinic x-ray service opening Achieved PaperLite operation CYP Asthma pathway increasing support which should reduce ED attends. Direct access endoscopy for GPs will reduce 2ww referral by diverting low risk patients, transnasal endoscopy (TNE) to support this and use of Endosponge. Direct access	None

Gynae pathways are reducing 2ww referrals and time to diagnosis by delivering correct imaging prior to assessment.	
(Moderate Assurance)	
Items recommended for Board approval:	
None	
Items referred to other committees:	
None	

SIGNIFICANT ASSURANCE	Clear understanding of the issues with a robust, deliverable plan which will achieve the required outcomes. Only insignificant residual risk. There may be external evidence to corroborate this view
MODERATE ASSURANCE	Good understanding of the issues, a clear plan with timescales that are credible and deliverable but some action still required. The residual risk is more than insignificant
LIMITED ASSURANCE	Recognised material weaknesses which may be incomplete understanding of the issues or an action plan which is not comprehensive, credible or deliverable. A significant amount of residual risk remains
NO ASSURANCE	A fundamental failure to understand the issues. An action plan is inadequate with fundamental gaps, weaknesses or breakdown in compliance. A significant of residual risk remains and immediate action is required

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:	9 April 2026					
Title:	2.4 Escalation Report from the Our Future Hospitals and Transformation Committee: 25 March 2026 (Paper F10)					
Report presented by:	Andy Haynes, MBE, OFHTC Non-Executive Director Chair					
Report written by:	Andy Haynes, MBE, OFHTC Non-Executive Director Chair					
Action – this paper is for:	Decision/Approval		UHL Assurance	X	Update	x
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						

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
BAF Risk 04 Digital-04 02 Digital Solutions Adoption and Usability BAF Risk 04 OFH-03 Digital Innovation, Data and Technology Use
Impact assessment
-

Purpose of the Report

To provide assurance to the UHL Board of Directors on the work of the UHL's Our Future Hospitals and Transformation Committee (OFHTC)

Summary

Our Future Hospitals and Transformation Committee met on 25 March 2026 and was quorate. The attached escalation report identifies issues which the Committee wishes to highlight, to the Trust Board, and sets out OFHTC's level of assurance.

There are no items requiring formal recommendation to the Trust Board from the March 2026 meeting.

This escalation report follows the new quadrant template, focusing on assurance levels and aiming to provide an 'at a glance' report from the Board Committees. The template covers: **key escalations; actions to take outside the Committee; positive assurances**, and **decisions taken**.

The report is not intended to be a narrative account of all issues discussed at the meeting.

Key escalations to notify to the Board	Actions to take outside of the committee
BAF Risk 04 OFH-02 Digital Solutions Adoptability and Use Impact OF PAS Implementation on Planned Care Performance Three areas identified: improving Data Quality, Training and NC/UHL data warehouse interface improvement. All three are under review, with clear actions in place that are also reporting to OPC. (Moderate Assurance) BAF Risk 04 OFH-02 Digital Solutions Adoptability and Use Digital Roadmap Delivery Update Ambient Voice Technology Programme in place with roll out planned for April 26. Patient Electronic Record: the planned pilot of endoscopy has been shelved due to national requirements to interface with NHS App. Planned read only access pilot for May 26 Future report to clarify deployment/optimising/embedded for schemes to link to full benefit realisation and highlight what has not been delivered and why UHL has improved its Digital Maturity index for 2025 (2.5 v 1.9 in 2024). This is excellent improvement and puts UHL in a similar position to other local Trusts. We are ranked 64th out of 134 acutes compared to 120th last year (Moderate Assurance) BAF Risk 04 OFH-03 Digital Innovation, Data and Technology Use	

Gap identified around fragmented data Six key elements to the plan: Bring Data Together Making Data Insights and Analysis Available Using Analytics to Transform Care Building Capability Harnessing Strategic Partnerships Assured and Trusted Data The plan was approved and agreed to have a sound structure. Key areas of collecting the right data, assured at source into a warehouse format with tools to provide self service access were strong. There was a recognition that our analytical capability and capacity is currently focussed on the FDP. Recognition that capacity building requires clarity around models (hub and spoke with CMGs v central team with strong prioritisation), the analysts required and how we make UHL an attractive offer. Future update when an implementation programme is agreed. (Moderate Assurance)	
Positive Assurance taken	Decisions taken
BAF Risk 04 Digital-04 02 Digital Solutions Adoption and Usability Gaps in aligning UHL UHN and the reliance on hybrid paper/digital platforms and use of multiple systems Electronic Prescribing System Pilot in Ophthalmology progressing towards national accreditation for EPS in OP for NerveCentre. Likely accreditation Sep 26. Plan to roll out to replace FP10 paper prescribing and solve virtual/telephone clinic prescribing. (Moderate Assurance)	BAF Risk 04 OFH-03 Digital Innovation, Data and Technology Use Data Strategy approved

Endoscopy Lessons Learned • Key staff groups not identified in business case • Need for better engagement with key staff earlier in process • More robust design brief required • Equipment coordinator role valuable • Recruitment not always aligned to supply risks • Need an internal rather than external project manager To be incorporated into a full Post Implementation report which will include staff/patient/organisational impact. Suggested that a standard “things to consider” template may benefit future developments and avoid some of these issues (Moderate Assurance)	
Items recommended for Board approval:	
None	
Items referred to other committees:	
Review of procurement routes for building schemes and value for money in the use of external services for building schemes to come to FIC and OFHTC but main discussion at FIC.	

SIGNIFICANT ASSURANCE	Clear understanding of the issues with a robust, deliverable plan which will achieve the required outcomes. Only insignificant residual risk. There may be external evidence to corroborate this view
MODERATE ASSURANCE	Good understanding of the issues, a clear plan with timescales that are credible and deliverable but some action still required. The residual risk is more than insignificant
LIMITED ASSURANCE	Recognised material weaknesses which may be incomplete understanding of the issues or an action plan

	which is not comprehensive, credible or deliverable. A significant amount of residual risk remains
NO ASSURANCE	A fundamental failure to understand the issues. An action plan is inadequate with fundamental gaps, weaknesses or breakdown in compliance. A significant of residual risk remains and immediate action is required

UHN Strategy, Transformation and Digital Committee Upward Report to Boards of Directors		Date of reporting group’s meeting: 26 th March 2026	
Reporting Non-Executive Director: Trevor Shipman (Chair)			
Agenda Item	Description and summary discussion	BAF refs.	Assurance level * a n
Digital	The committee: 1. Received an update on the Digital programme, noting substantial progress in the digital portfolio. 2. Highlighted risk to the EPR go-live associated with data migration.	UHN24	Substantial
Strategic Estates	1. Received an update on strategic estates, noting urgent actions required for Warren Hill House, ,multi-storey car park redesign challenges, Rockingham Wing funding and emerging risks to construction costs and supply chains linked to global instability. 2. Noted national support to progress major capital schemes.	UHN14	Reasonable
Strategic Transformation	Received an update on the transformation programmes for the coming year noting clear priorities across planned care, urgent and emergency care, administration redesign and specialty transformation.	UHN10	n/a
UHN-UHL Clinical Strategy	1. Received an update on the UHL-UHN Clinical Strategy and notes strong early progress across key workstreams. 2. Recognises that benefits are yet to be realised and several long-term enablers and system dependencies remain in development. 3. Confirms reasonable assurance on the Clinical Strategy given the scale and long-term view of this project.	UHN20	Reasonable
Digital Roadmap Delivery update	1. Received an update on the Digital Roadmap delivery, noting improvements in digital maturity across UHN and programme delivery. 2. Confirms substantial assurance in the short term and reasonable assurance in the long term.	UHN24	Substantial – short term
			Reasonable – long term
Population health inequalities	Received an update on UHN’s Health Inequalities and Anchor Institution Programme, noting strong early progress and the need to strengthen capacity, data quality and system wide engagement.	UHN23	Reasonable
One Digital Strategy 2025-2028	Approved the One-Digital Strategy 2025-2028	Approved	n/a

UHL/UHN Boards in Common Paper F12

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:	9 th April 2026					
Title:	Escalation Report from the People and Culture Committee (PCC): 26th March 2026					
Report presented by:	Professor Ivan Browne, OBE – PCC Non-Executive Director (Chair)					
Report written by:	Ninakshi Patel – 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	x	Deliver our financial plan	
Where this report has been discussed previously	None.					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Yes. BAF risks within the remit of PCC: Risk 10: Failure to recruit retain and transform the workforce.

Impact assessment
N/A

1. Purpose of the Report

To provide assurance to the Trust Board on the work of the Trust's People and Culture Committee (PCC) and escalate any issues as required.

2. Recommendations

To note the report and approve any recommended items contained therein.

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

BOARD OF DIRECTORS 9 APRIL 2026

3. Summary

The following items from the PCC meeting of 26th March 2026 are summarised below.

3.1 Recommended Items- none

3.2 Discussed Items

3.2.1 **Consideration of the BAF Risks in the remit of the People and Culture Committee: BAF Risk 10**

The Committee received the latest iteration of the BAF relevant to its remit.

The PCC Non-Executive Director Chair was assured on the contents of the report.

3.2.2 **Chief People Officer Update**

The Chief People Officer presented an overview of the national, regional and local People priorities and work in progress. Comprehensive updates and supporting detail were set out in the full report. As part of the Chief People Officer update, the Committee noted that the Trust's Gender Pay Gap report had been submitted in line with statutory requirements.

The PCC Non-Executive Director Chair was assured on the contents of the report.

3.2.3 **National Staff Survey**

Ms Z Marsh, Deputy Chief People Officer provided an update on the delivery plan for communications and staff engagement around the results from the 2025 NHS Staff Survey (NSS). The PCC Non-Executive Director Chair was assured on the report presented.

3.2.4 **NHS Management and Leadership Framework (MALD)**

Ms T Francis, Head of Organisational Development, Culture & Talent presented the report and provided assurance through a high-level overview on what the NHS Management and Leadership Framework is, the key national timelines for implementation and the actions already taken by the Trust to prepare for and embed the framework. The PCC Non-Executive Director Chair was assured on the report presented.

3.2.5 Annual Plan and Workforce Change Programmes

The committee noted the report, and a further update scheduled to be presented at the next meeting.

3.2.6 Health and Wellbeing Update – Colleague Flu Vaccination

Ms L Kasatkin, Head of Health and Wellbeing provided an update and highlighted to the committee the overall improvements in colleague vaccinations rates and the program of work that had commenced to plan for 2026/27 colleague vaccination program.

4. Items for Noting

- None

5. Date of Next Meeting – Thursday 30th May 2026

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:	9 April 2026 (Item 2.4 paper F13)					
Title:	Escalation Report: Audit Committee 16 March 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:	UHL Approval	x	Assurance		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	Not applicable					

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

Impact assessment
Not applicable

Purpose of the Report

To provide assurance to the Boards in Common on the work of the UHL Audit Committee and escalate any issues as required.

Recommendation

To receive the escalation report, and to note recommendations for the UHL Trust Board to approve items 4.1 - 4.2, which are appended to this escalation report.

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

BOARD OF DIRECTORS 9 APRIL 2026

1. Summary

- 1.1 The Audit Committee met on 16 March 2026. The meeting was quorate and considered the following reports.

2. Recommended Items

2.1 **Declarations of Interest 2025/26 (decision-making staff)**

The Committee noted the current compliance rate of 88% for those decision making staff required to make a declaration of interest. Assurance was provided that those who had not made the relevant declaration would be actively followed up.

The Committee requested that the Disclosure UK website be reviewed for UHL declarations to ensure alignment with the Trust's declarations system.

The Committee also requested that a comparison be undertaken between declarations in the current year and in the previous year and take appropriate action regarding any individuals who had not made the relevant declaration in either year.

The updated Conflicts of Interest Policy was received and supported. Retention of the £25 hospitality declaration level was specifically supported.

The discussion regarding Declarations of Interest is highlighted for the Boards in Common's awareness. The Conflicts of Interest Policy is recommended for Boards in Common approval. The Declarations of Interest 2025/26 and the Conflicts of Interest Policy is appended to this escalation report.

2.2 **Sealings Report**

The Committee received details of those Deeds that the Trust has entered into for Quarter 4, 2025/26.

The Sealings Report is highlighted for Boards in Common's awareness. The Sealings Report is appended to this escalation report.

3. Discussion Items

3.1 **Risk Committee Escalation Reports**

Escalation reports from the Risk Committees held on 2 December 2025, 6 January 2026 and 3 February 2026, were received and noted.

3.2 **Email and Internet Usage Policy**

The Email and Internet Usage Policy was received and supported.

3.3 **Audit and Quality Improvement Programme (AQIP) Update**

The Committee received assurance that there was good grip on process and outcomes related to the Audit and Quality Improvement Programme (AQIP).

The level of value for money achieved by the resource engaged in audits was considered. It was acknowledged that many audits were mandatory and they were a part of a doctor's role. Assurance was provided that there was now a focus on audits which addressed Trust priorities. It was requested that future reports to the Committee provide assurance regarding the value provided by audits.

Also considered was the monitoring through governance of audit outcomes and gaps in the audit programme.

3.4 **Discretionary Procurement Actions**

The Committee considered an update on the number of procurement waivers that had been approved for the period November 2025 to February 2026 and the reasons for the waiver. The report also responded to previous Audit Committee actions to review the reasons for a waiver, with new reasons being recommended and a tighter approval process recommended and an analysis of capital waivers was provided.

The proposed new waiver reasons were supported by the Committee and action would be taken to ensure Trust documentation (ie Standing Financial Instructions) were updated to reflect the changes.

Following discussion, it was agreed to ensure that non-compliant spend would be reported in future to the Trust Leadership Team, Finance and Investment Committee and oversight by the Audit Committee.

The changes to waiver reasons, tightening of approval process and subsequent change to Trust policy / documentation is highlighted to the Boards in Common for information.

3.5 **2025/26 Annual Governance Statement (and Annual Report) – format and timeline**

The Committee received an update on progress toward producing the 2025/26 UHL Annual Governance Statement (AGS) and Annual Report in line with national annual accounts submission timescales. Assurance was provided that work was progressing well in order to meet External Audit submission timelines.

3.6 **2025/26 Review of Accounting Policies**

The Committee received details of the Trust's accounting policies and principles that would be adopted in preparing the 2025/26 Accounts. There had been no significant changes to national guidance in accounting standards.

Details of the land and property valuation approach including the quinquennial valuation of Trust land and buildings was discussed. The need for this to be taken into account in terms of audit timelines and completion was highlighted. The proposed audit timelines were detailed in the report.

The policies presented in the report were approved for adoption in the Trust's 2025/26 Accounts.

3.7 **Internal Audit Draft Annual Report and Head of Internal Audit Opinion 2025/26**

The draft Internal Audit annual report and Head of Internal Audit Opinion was presented to the committee which identified progress made in relation to completion of work from the Trust's 2025/26 Internal Audit Plan.

3 completed audit reports were also included with the paper, and findings were outlined for the meeting. The reports are listed below with level of assurance:

Accounts payable – partial assurance.

Cost Improvement Programme (CIP) – minimal assurance.

Board Assurance Framework – substantial assurance.

The minimal assurance level regarding the Cost Improvement Programme was highlighted, but it was noted that the Finance and Investment Committee was monitoring progress of the actions arising. The Chief Financial Officer acknowledged the details in the report, but noted a key factor from the review was the content of the CIP rather than grip of the CIP progress.

The Head of Internal Audit Opinion was discussed, noting that the Trust was rated as having an adequate and effective framework for risk management, governance and internal control. The Audit Committee chair welcomed the positive outcome but anticipated that the positive score was marginal and urged that the Trust continue to actively respond to Internal Audit recommendations.

The levels of assurance received regarding Internal Audit reports listed above is highlighted to the Boards in Common for information.

3.8 Internal Audit – actions from RSM and 360 Assurance reports, and Financial Improvement Plan action progress

The Committee received an update on progress on outstanding actions from Internal Audit reports. Assurance was provided that action leads were being actively engaged to ensure completion of outstanding actions. Two health and safety action implementation dates were extended following Committee approval. An update on outstanding actions would be presented to the April 2026 Audit Committee to maintain momentum on action completion.

An update was provided regarding the 2026/27 Internal Audit plan which remained oversubscribed and was therefore subject to further discussion. The plan would be presented to the April 2026 Audit Committee.

The proposed action to address outstanding Internal Audit actions and the position regarding the 2026/27 Internal Audit plan is highlighted to the Boards in Common for information.

3.9 Draft Counter Fraud 2026/27 Work Plan

The Committee considered the draft Counter Fraud 2026/27 work plan which was approved.

The Committee supported the involvement of Counter Fraud in the forthcoming Internal Audit review regarding overseas visitors.

3.10 Audit plan and strategy for the year ending 31 March 2026

The External Audit plan and strategy for 2025/26 audit was received and supported.

4. Items for Noting

The Minutes of Board Committees were noted.

UHL NHS Trust Board declarations of interest – 2026/27

NAME	POSITION	INTEREST(S) DECLARED
Andrew Moore	Group Chair, UHL-UHN (formerly UHL and KGH Non-Executive Director)	- Chair, University Hospitals of Northamptonshire (UHN) NHS Group - Member of the UHL Corporate Trustee Board
Ruw Abeyratne	Director of Health Equality and Inclusion	- Shareholder in Larks Ameus Ltd - Paid speaker at events on topics relating to coaching and wellbeing. Value less than £500 per annum - Board Committee member, Trent College and The Elms
Scott Adams	Non-Executive Director	- Line manager of Head of Charity for Portsmouth Hospital Trust and Isle of Wight Hospital Trust charities, although no activity role in the running of either charity - Member of the UHL Corporate Trustee Board
Simon Barton	Deputy Chief Executive	no declarations to be made
Lee Bond	Chief Financial Officer	- Trustee of the Healthcare Financial Management Association (HFMA) (registered charity) - Member of the UHL Corporate Trustee Board
Professor Ivan Browne	Non-Executive Director	- Outside employment with De Montfort University - Trustee of Leicester African Caribbean Centre - Spouse works as a GP at the Victoria Park Medical Centre, Leicester - Member of the UHL Corporate Trustee Board
Becky Cassidy	Director of Corporate and Legal Affairs	Company Secretary for Trust Group Holdings Ltd
Emma Casteleijn	Director of Communication and Engagement	Confirmed no declarations to be made
Steve Harris	Associate Non-Executive Director	- Director of Trust Group Holdings (TGH) - Director of Selco Builders Warehouse Ltd (from 18 August 2025)
Dr Andrew Haynes	Non-Executive Director	- Registered as an expert (Principal Clinical Adviser) with Academic Health Solutions - Member of the UHL Corporate Trustee Board
Helen Hendley	Chief Operating Officer	Member of the UHL Corporate Trustee Board
Julie Hogg	Chief Nurse	- Chief Nurse representative, CNO England safe staffing faculty, NHSE/I - Shelford Group Safe Staffing Faculty Planning Group - Non Shelford CN representative - Associate, Birmingham City University - Family members employed by KPMG & Deloitte

Unclassified

UHL NHS Trust Board declarations of interest – 2026/27

NAME	POSITION	INTEREST(S) DECLARED
		• Chair, National Quality Board Safe Staffing Midwifery Review Group, NHSE • Chief Nurse, University Hospitals of Northamptonshire (UHN) NHS Group • Honorary Professor (unpaid), University of Leicester • Member of the UHL Corporate Trustee Board
Jill Houghton	Non-Executive Director	• Non-Executive Director of University Hospitals of Northamptonshire NHS Group • University Hospitals of Northamptonshire Nominated Trustee of Northamptonshire Charities • School Governor at Robert Smyth Academy, Market Harborough • Member of the UHL Corporate Trustee Board
Andrew Inchley	Non-Executive Director	• Director – Accenture Retirement Savings Plan Trustees Limited • Director – Accenture Pension Trustees Limited • Member of the UHL Corporate Trustee Board
Richard Mitchell	Chief Executive	• Member NHS IMPACT: National Improvement Board • Member NHS Providers Board • Chair, East Midlands Acute Providers Network • Deputy Chair, National Cancer Leadership Forum Steering Group • Chair, East Midlands Pathology Network • Chair, East Midlands Cancer Alliance • External consultancy work not exceeding £500-£1000 per year • Member of the UHL Corporate Trustee Board • CEO of University Hospitals of Northamptonshire (UHN) Group
Will Monaghan	Group Chief Digital Information Officer	• Lecturer with Imperial College London on the NHS Digital Academy and course content advisor • Director of Monaghan Insight Ltd (private limited company providing occasional consulting and advisory services on healthcare technology and digital transformation). Spouse is co-director • Member (CDIO and Acute Hospitals Rep) Department of Health and Social Care — AI in Health and Care Advisory Group. • Chief Digital Information Officer, University Hospitals of Northamptonshire (UHN) Group
David Moon	Non-Executive Director	• Non-Executive Director, Black Country Healthcare NHS Foundation Trust (<i>until 31 July 2025</i>) • Trustee (Treasurer), Shipston Home Nursing • Consultant (part-time) for SWFT Clinical Services Ltd (wholly owned subsidiary of South Warwickshire University NHS Foundation Trust)

Unclassified

UHL NHS Trust Board declarations of interest – 2026/27

NAME	POSITION	INTEREST(S) DECLARED
		- Family member has a training contract with PwC - Member of the UHL Corporate Trustee Board
Professor Thompson Robinson	Non-Executive Director	- Outside employment with University of Leicester (Pro Vice-Chancellor and Head of the College of Life Sciences, Dean of Medicine) - Member of the UHL Corporate Trustee Board (and Chair of the UHL Charitable Funds Committee)
Clare Teeney	Chief People Officer	no declarations to be made
Gang Xu	Medical Director	Member of the UHL Corporate Trustee Board

Paper K

Meeting title:	Audit Committee					
Date of the meeting:	16 March 2026					
Title:	SEALING REPORT					
Report presented by:	Becky Cassidy, Director of Corporate and Legal Affairs					
Report written by:	Steve Murray, Assistant Director of Corporate and Legal Affairs					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	x
Where this report has been discussed previously	None Required					

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

That Standing Order 12 has been complied with.

Impact assessment

- Patients – No direct impact
- Workforce – No direct impact
- Equality, Diversity & Inclusion – No impact
- Services – No direct impact
- Finance – No direct impact
- Reputation/legal – Legal requirements have been complied with.

Acronyms used:

None Used

Purpose of the Report

To enable the Audit Committee to be sighted to those Deeds that the Trust has entered into during the period covered by this report.

Recommendation

Note this report and receive an update next quarter.

Summary

1. The Trust's Standing Orders (Standing Order 12) set out the approved arrangements for custody of the Trust's seal and the sealing of documents.
2. This report lists the details of the Trust sealings for the 2025-26 financial year to date (by quarter).

Main report detail

List of Trust Sealings for Quarter 4, 2025/26

Date of Sealing	Nature of Document	Date of Authority and Minute Reference	Sealed by	Remarks
23.12.2025	Deed relating to Leicester Diabetes Centre	TB14/11/2024 366/24/22	Vice Chairman/Assistant Director of Corporate and Legal Affairs	Original handed to Adrian Middleton of Estates and Facilities on 14.01.26
14.01.26	Deed relating to Lease between (1) UHL and (2) University of Leicester relocating to part of the Diabetes Centre at LGH.	TB-14/11/2024 366/24/22	Chairman/Assistant Director of Corporate and Legal Affairs	Original handed to Adrian Middleton of Estates and Facilities on 14.01.26

Supporting documentation

None

KGH/NGH Audit Committees (meeting together) Upward Report to Boards of Directors		Date of reporting group’s meetings: 25 th February and 11 th March 2026 (1 of 2)	
Reporting Chair: Alice Cooper			
Agenda Item	Description and summary discussion	BAF risks	Assurance level *
Outstanding / Overdue Internal Audit Actions	The committees had requested updates and representation at the committee from the Executives responsible for the areas where the most significantly overdue actions remained:		
	Engagement Strategy (Communications) – The committees received an update on the proposed revisions to the original actions to increase usability of the strategy once complete. The committees were disappointed that the strategy was still not at a more advanced stage, and felt the governors could be more involved in the process set out, but welcomed the update.	UHN12 Patient voice	Limited
	Salary Overpayments (People) – The committees received an update on the progress of the actions proposed (including the automations for part of the process – implementation of which is imminent) to address these control gaps. The improvements due were welcomed, but the committees stressed the need to train users in the new automations, and explain the importance of the procedures, and also asked to continue to monitor losses after these are implemented to assess the impact of these and other measures.	UHN19 workforce controls	Limited
	Estates Strategy (Estates) – the committees received an update and agreed that the actions were welcome and appropriate. There was also greater confidence in their progress going forward with new leadership in the teams concerned.	UHN14 Estates buildings and infrastructure	Limited
Board Assurance Framework – Deep Dives with Executives	UHN 16 & 17 (Finance) - The committees welcomed the openness of the CFO in discussing the challenges of managing both the in-year financial performance, but also critically the medium-term plan, and the controls in place. It was also noted that the latter risk may more properly be described in broader strategic terms, as finance is more an output of this medium term plan, rather than determining it in isolation. This lack of ability to fully control all variables (and bring the risks within appetite) for both risks lead to the Limited Assurance rating, but the work ongoing was welcomed.	UHN 16-18	Limited
	UHN 18 & 19 (People) – The committees welcomed the summary note received for the meeting, and the open discussion of the risks around workforce and culture. Whilst both remain outside appetite at present, the committees were reasonably assured that the actions currently ongoing would have a significant impact on the risks in the long term.		Reasonable
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.	UHN16 financial plan	High Reasonable to Low Substantial
	The committees 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.		

12227/31

KGH/NGH Audit Committees (meeting together) Upward Report to Boards of Directors		Date of reporting group's meetings: 25 th February and 11 th March 2026 (2 of 2)	
Reporting Chair: Alice Cooper			
Agenda Item	Description and summary discussion	BAF risks	Assurance level *
Internal Audit Progress Report	The committees noted the slight concern at the length of time being taken to finalise reports, given the importance of issuing reports and taking action, rather than allowing findings to become less relevant over time.	-	Reasonable
Anti-crime report	The committees noted the continued themes being seen in terms of an increase in fraud attempts across the service nationally (and in the broader economy). They discussed how the Trusts might expedite the number of ongoing HR related anti-crime investigations, which appeared to last for longer than would be desirable.	-	Limited
External Audit Plan	The Committee received the update from Grant Thornton, and welcomed the positive position in terms of the interim work having been completed so far.	UHN16	Reasonable
Going Concern Assessment and decision on Key Accounting Policies	The committee welcomed the detailed paper setting out the organisations' key accounting policies and judgements, and their assessment of the Trusts' ability to continue as going concerns. These were discussed, understood, and approved by the committee.	UHN16	N/a

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:	9 April 2026					
Title:	3.1 (Paper G) Perinatal Report and Dashboards					
Report presented by:	Julie Hogg, Group Chief Nurse (UHL & UHN) & Deputy Chief Executive (UHL) Danni Burnett, Director of Midwifery and Deputy Chief Nurse (UHL) & Interim Director of Midwifery (UHN)					
Report written by:	Danni Burnett, Director of Midwifery and Deputy Chief Nurse (UHL) & Interim Director of Midwifery (UHN) Karradene Aird, Interim Head of Midwifery (UHL) Angela Boyce, Head of Perinatal Governance & Quality Improvement (UHN)					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	X
Where this report has been discussed previously	UHL Womens & Children’s CMG and UHN Family Health Divisional Governance / UHL Perinatal Assurance Committee (PAC) / UHN PAC (March 2026)					
To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which						
Current UHL Clinical Management Group (CMG) and UHN Family Health Care Group risks indicate challenges around workforce and culture, please read this report alongside corporate risks to consider any additional actions and mitigations.						
Impact Assessment						
Finance: UHL is on track and expected to recover its full NHS Resolution’s Maternity Incentive Scheme (MIS) for Year 7. UHN is on track and expected to recover its full NHS Resolution’s Maternity Incentive Scheme (MIS) for Year 7 for NGH however not KGH.						
Legal/regulatory: The Trusts must continue to comply with all CQC regulatory requirements which is requiring timely, evidenced improvement and ongoing engagement with the regulator. In addition to meeting statutory obligations for Duty of Candour UHL and UHN must fulfil national patient-safety reporting duties, including timely referrals to the Maternity and Newborn Safety Investigations (MNSI) programme and adherence to the Patient Safety Incident Response Framework (PSIRF). For NHS Resolution’s Maternity Incentive Scheme, the Boards must ensure full, accurate declarations including disclosure of relevant external regulatory findings supported by appropriate governance and Boards’ approval. Failure to sustain safe staffing, training compliance, escalation processes and adherence to clinical standards may increase legal exposure through claims, inquests or enforcement actions						
Equality: UHN and UHL PAC has given due consideration to the potential equality and health-inequality implications. In particular, PAC reflected on the importance of ensuring sustained improvements to culture and inclusivity across the service. Actions are being taken to ensure personalised risk assessment, communication, and midwifery competency frameworks support equitable access and safe care for all women and birthing people. No adverse impacts have been identified at this stage, and equality considerations will continue to be embedded and monitored through established perinatal governance and EDI oversight mechanisms as the work progresses.						

Appendices

Perinatal dashboards for UHL (G2) and UHN (G3)

Executive Summary

The Perinatal Report provides a consolidated overview of perinatal quality, safety, performance, workforce and experience across UHL, KGH and NGH (UHN). The overall system position remains stable and improving, with strong assurance against core maternity and neonatal standards, no service diversions, and a maturing safety and reporting culture. UHL continues to show sustained improvement in key outcomes and avoidable term admissions, while KGH and NGH maintain expected performance with targeted oversight in areas such as neonatal mortality variation (KGH) and operational flow (NGH).

Workforce resilience is strengthening across all sites—UHL now has 0% midwifery vacancy, NGH has a significant pipeline of new starters, and KGH staffing trajectories are improving. Safety-culture indicators show clear positive movement, particularly through increased safety-champion activity across UHN.

Operational performance is robust, with stable escalation status across all Trusts. Experience remains positive, with consistently high FFT satisfaction and strengthened community engagement, especially at UHL. Quality outcomes, while generally stable, continue to show variation in preterm birth, early booking, smoking in pregnancy and IOL timeliness; these are being addressed through targeted PSIP actions and strengthened governance.

Recommendation

The Boards are asked to note and indicate assurance in respect of the consolidated position, acknowledge key risks, and support continued oversight of data quality, workforce sustainability and cultural improvement.

Specifically:

1. UHL and UHN Boards to **support** ongoing work to stabilise data quality, improve interoperability and ensure credible, trend data across all three organisations.
2. UHL and UHN Boards to **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. UHL and UHN Boards to **note** PAC's intention to oversee equity-focused improvement and early-access interventions through PSIP
4. UHN Board to **note** the development of a single, strengthened, Northamptonshire Homebirth Service, ensuring reopening criteria, training, competencies and governance are fully met before reinstatement.
5. UHL and UHN Boards to **support** the accelerated delivery of PSIP quality improvement initiatives, strengthening responsiveness and effectiveness across elective pathways and triage
6. UHL and UHN Boards to **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

UHL & UHN PERINATAL REPORT (MARCH 2026)

The purpose of this paper is to provide the Boards with a consolidated, system-wide overview of perinatal quality, safety, performance, workforce and experience across University Hospitals of Leicester (UHL) and University Hospitals of Northamptonshire (KGH and NGH). It brings together intelligence from the latest PAC Chair's Highlight Reports, Perinatal Scorecards and key assurance papers to give the Board clear line-of-sight on current performance, areas of improvement, outstanding risks, and the maturity of the Perinatal Safety Improvement Programme (PSIP) across the system.

1. PERINATAL SERVICES SUMMARY

Across perinatal services, the overall safety picture remains stable and improving, with strong assurance in core maternity and neonatal standards, robust reporting cultures and maturing digital infrastructure. Despite continued pressures in workforce and estates, all three organisations have maintained resilient operational performance, with no service suspensions, diversions or unsafe escalation outcomes. Our PSIP is increasingly acting as the unifying framework for consistent improvement in variation, workforce sustainability, data maturity and equity.

Across UHN and UHL, clinical outcomes remain within expected variation. UHL continues to demonstrate progressive improvement in perinatal safety indicators, including reductions in Obstetric Anal Sphincter Injury (OASI)ⁱ, postpartum haemorrhage and avoidable term admissions (ATAIN).

Across all organisations, no new systemic safety risks have been identified through MOSS (Maternity Outcomes Signal System), Perinatal Mortality Review Tool (PMRT) or Patient Safety Investigation (PSII) processes, although KGH continues to require targeted oversight for neonatal mortality trends and fetal surveillance, and UHL is undertaking more detailed analysis of emerging preterm-birth variation.

2. PERINATAL SURVEILLANCE & ASSURANCE HIGHLIGHTS

PAC members received several papers as part of ensuring robust perinatal surveillance, highlighting areas of progress and risks to delivery of the key national and regional drivers for change and improvement:

a) Workforce & Culture

Workforce pressures remain a defining challenge, but overall indicators are improving. UHL is currently the strongest-performing site with 0% midwifery vacancies and improving neonatal staffing. KGH and NGH both report robust recruitment pipelines, including >12 whole-time equivalent (WTE) midwives commencing at NGH by September, and improved midwifery and

neonatal staffing trajectories at KGH. Medical workforce resilience continues to require focus, with NGH reliant on a locum obstetrician until June and UHL holding several consultant vacancies.

Culture is strengthening across UHN: safety-champion reporting has grown from 18 actions (2024) to 63 (2025), with most actions closed—demonstrating enhanced psychological safety, earlier escalation and maturing learning behaviours.

b) Performance

No sites reported whole service diversion or critical incidents linked to capacity over the most recent reporting period.

- UHL saw improved OPEL (operational performance escalation) stability through February with low numbers of red-flag events and sustained timely MAU triage performance.
- NGH maintained OPEL 1 throughout February with no escalations, though variation persists in Induction of Labour (IOL) flow and triage timeliness.
- KGH performed more consistently than NGH in time-critical obstetric metrics, although the temporary homebirth pause has added operational and governance demands.

Screening and immunisation programmes remained stable across the system, with persistent variation in RSV (Respiratory Syncytial Virus), pertussis and equity-related access. BadgerNet Electronic Patient Record (EPR) rollout has improved tracking and reporting, although sites remain at different stages of digital maturity.

c) Experience & Engagement

Experience remains consistently positive across UHN, particularly regarding staff compassion and intrapartum care. NHS Friends and Family Test ([FFT](#)) satisfaction remains high (97–100%), though response rates are more variable due to demographic factors and EPR transition.

Patient experience data demonstrated a mixed picture at UHL. Maternity complaints reduced to their lowest level since August 2025, with no complaints received in neonatal services. Positive feedback continues to be received for the Single Point of Contact model, community midwifery and intrapartum care. Targeted improvement work within the Maternity Assessment Unit (MAU) and postnatal services is ongoing. A notable system strength is UHL's community engagement, delivering almost 20 events against a target of five, significantly improving equity of access and population reach.

Communication, waiting times and the postnatal environment remain the principal themes, with targeted PSIP actions underway across UHN and UHL.

d) Quality & Outcomes

Across UHL, KGH and NGH, there is evidence of stable and improving perinatal outcomes however variation persists. It is well-recognised and supported by targeted improvement programmes within the Perinatal Safety Improvement Programme (PSIP) with oversight by PAC:

Perineal Trauma / Intrapartum Injury	Instrumental birth, shoulder dystocia, and intrapartum complication rates remain within expected limits across UHL and UHN. UHL continues to show sustained reductions in perineal trauma , supported by strengthened PPHS pathways, warm compress guidance, and full compliance with OASI referral processes. UHN performance remains within expected variation ; fluctuations are linked to small numbers.
Postpartum Haemorrhage (PPH)	UHL continues to improve , and UHN remains stable across both sites.
Preterm Birth	UHL remains an area of special cause variation ; a deep dive is planned for May 2026. Early evidence suggests links to clinical complexity rather than pathway failures. UHN shows expected month to month variation; KGH shows greater fluctuation due to low numbers. System improving risk identification via enhanced surveillance and the “ <i>Period Late, Tell Us by 8</i> ” campaign.
Access: Early Booking (<10 weeks)	73% of UHL women book early, though Black African/Black Caribbean women are 1.6 times more likely to book late . NGH performs strongly ; KGH shows variation linked to deprivation. New equalities dashboards (local + national) are driving targeted outreach and PSIP actions.
Smoking in Pregnancy	UHL performs better than the 6% target . NGH meets target. KGH remains variable and a priority for joint work with public health partners.
Avoidable Term Admissions (ATAIN)	UHL remains within national standards (5.8% for 2024/25), with a 44% reduction in hypoglycaemia admissions . Thermal regulation is the next improvement focus. UHN remains within expected limits with no outlier concerns.
Neonatal Mortality	UHL unvalidated data reports the lowest levels in a decade (2025) . NGH stable. KGH and UHL remain under enhanced

	monitoring with system level work on wider determinants. An LLR Infant Mortality System Meeting has occurred during this reporting period - well attended, bringing together all key stakeholders from UHL, CDOP, Public Health, Primary Care and MBRRACE. CDOP and Public Health delivered excellent presentations outlining Leicester's infant mortality position, followed by open and constructive discussion. A series of workshops generated collective ideas for reducing infant mortality. Public Health are now collating the outputs and establishing a stakeholder group to take forward the agreed actions.
Incident Reporting & Learning	Reporting remains high across all three sites, reflecting strong safety culture and early escalation. No new MOSS alerts at UHN; one Level1 alert at UHL with no avoidable harm. PSII, MNSI, and PMRT processes remain within required timescales, with UHN strengthening cross site governance.

Please refer to [Appendix 1 for a site-specific summary](#), and [Appendix 2, 3, 4, and 5](#) for the relevant [Perinatal Scorecards](#) and [PAC Chair Highlight Reports](#).

3. ADDITIONAL PERINATAL HIGHLIGHTS

PAC received progress reports on the implementation of the actions in relation to the Perinatal Safety Improvement Programme (PSIP) and wider perinatal assurance:

KGH MatNeoIST Improvement Programme: The PSIP programme has established a coherent regulatory-recovery framework that is delivering clearer oversight, faster escalation and stronger Board assurance as the vehicle for improvement as part of KGH and the MatNeoIST programme. Improvements through the milestone monitoring have been consistently high for consultant labour-ward presence, BSOTS (Birmingham triage system) performance, neonatal equipment and theatre-medicines safety, alongside early positive cultural gains in psychological safety, leadership visibility, civility and speaking-up, with remaining work on estates, documentation, specialist workforce and pathway embedding still required but overall demonstrating increasing maturity, reliability and clear progress toward regulatory recovery and eventual MatNeoIST exit.

UHL Complaints: The maternity complaints deep-dive showed that a temporary rise in complaints was linked to operational pressure rather than declining quality, with timely reporting improving, themes remaining consistent (communication, compassion and delays), no evidence of inequity or

unsafe care, and clear actions already in place to strengthen responsiveness and patient experience.

Director of Midwifery Highlight Report: outlines significant national, regional and local developments shaping maternity and neonatal services, including preparations for the CQC Maternity Survey, early findings from the interim Amos report, and implementation planning for the new Maternal Care Bundle, alongside important population insights from the National Perinatal Health Inequalities Dashboard which will inform targeted improvements; the report highlights ongoing escalation of the Perinatal Pelvic Health Service, progress with reconciling workforce data following regional scrutiny, and an update on the NHS England Perinatal Heatmap. PAC were briefed on the implementation of the new cross-site Midwifery Management of Change to strengthen leadership and governance at UHN plus the emerging strategic planning through the UHN/UHL Group Clinical Strategy.

4. PERIANTAL SURVEILLANCE & ASSURANCE FOR ESCALATION

PAC was assured that each service continues to operate safely and effectively, with strong assurance in core maternity and neonatal standards. The predominant challenges relate to variation, data maturity, workforce sustainability, and equity, all of which are being managed through strengthened governance, PSIP oversight, and targeted local actions.

- Variation in perinatal outcomes and operational metrics, particularly triage and Induction of Labour (IOL) timeliness
- Data maturity challenges associated with BadgerNet rollout across UHL and UHN.
- Homebirth governance at KGH with the recent pause to due inability to safety staff. UHL and NGH model are assured but national guidance updates pending.
- Fetal medicine / Sonography / Diabetes capacity constraints across all sites, requiring estate and digital investment (CRIS® replacement, BadgerNet imaging integration). Work being prioritised as part of the Group Clinical Strategy.
- Equity in access with late bookings and socioeconomic and ethnicity-linked variation remain visible across UHL and UHN.

The Boards are invited to note this consolidated narrative and endorse the ongoing UHL & UHN focus on harmonising pathways, strengthening digital maturity, and addressing operational variation across the three organisations.

5. RECOMMENDATIONS

7. UHL and UHN Boards to **support** ongoing work to stabilise data quality, improve interoperability and ensure credible, trend data across all three organisations.

8. UHL and UHN Boards to **note** ongoing recruitment and retention efforts, cross-site leadership alignment, consultant workforce planning, and targeted investment in specialist roles to secure sustainable service delivery.
9. UHL and UHN Boards to **note** PAC's intention to oversee equity-focused improvement and early-access interventions through PSIP
10. UHN Board to **note** the development of a single, strengthened, Northamptonshire Homebirth Service, ensuring reopening criteria, training, competencies and governance are fully met before reinstatement.
11. UHL and UHN Boards to **support** the accelerated delivery of PSIP quality improvement initiatives, strengthening responsiveness and effectiveness across elective pathways and triage
12. UHL and UHN Boards to **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

APPENDIX ONE – Perinatal Report (Site Specific Summary)

University Hospitals Leicester (UHL)	• UHL continues to demonstrate a strengthening safety trajectory, with Q3 data confirming reductions in OASI, PPH, and term neonatal admissions, and 100% Duty of Candour compliance. • The first MOSS Level 1 alert was fully reviewed with no avoidable harm, no service quality concerns identified. February scorecard data showed stability, with Apgar<7 and preterm birth requiring ongoing analysis but no emerging systemic risk. Sepsis management remains highly reliable (98% antibiotics within 1 hour) and assessment of unwell postnatal women continues to meet national standards. • Midwifery vacancies have reduced to zero, with improved sickness absence and progress in neonatal-nursing recruitment. Consultant obstetric recruitment is underway with additional pipeline activity in junior medical workforce expansion. Cultural and engagement indicators are improving. • Operational pressures earlier in the period did not translate into adverse outcomes. February saw improved escalations, sustained MAU timeliness, and stable IOL and caesarean section metrics. No service suspensions or significant risks were identified. • Complaints have stabilised at low levels, with positive intrapartum and community feedback. Themes remain centred on communication and waiting times. Community engagement reached record levels, demonstrating improved reach across diverse groups. • UHL's asylum-seeking women's project achieved 80% antenatal and 60% postnatal continuity, recognised as a top three national Core20PLUS5 programme. • UHL continues to embed immunisation prompts through digital platforms and multi-agency partnership working: RSV uptake remains a concern, with early implementation challenges linked to administrative gaps and booking processes. Uptake is improving following recruitment of administrative support and expansion of community follow-up. Pertussis vaccination shows steady performance with common-cause variation around a stable mean and no significant deterioration. Flu vaccination continues to follow expected seasonal patterns, with robust forward planning for 2026–27 vaccine ordering. BCG uptake remains below target, though collaborative work across NHSE, LPT and CHIS is underway to improve coverage and reconcile movers in/out of area. • UHL maintains full MIS Year 7 compliance, strong Perinatal Safety Improvement Programme (PSIP) progress, positive Ockenden trajectories, and maturing digital safety systems. • Risks relate to fetal medicine estates, data quality, and MAU capacity, all actively managed through governance channels.

Kettering General Hospital (KGH)	• KGH continues to provide safe, stable maternity and neonatal services, though areas requiring targeted oversight persist, particularly neonatal mortality trends and fetal surveillance quality. An external thematic review of cooled babies described generally strong escalation and CTG practices, though targeted actions are underway to strengthen variation across all cases. • Ongoing PSII cases are progressing appropriately, with no MOSS and 1 SPENⁱⁱ signals reported (Q3). • National Neonatal Audit Programme (NNAP) 2024 results were strong, with excellent performance in magnesium sulphate use, deferred cord clamping, admission temperature, and parental consultation • Workforce stability continues to improve, supported by cultural-development programmes and strengthened senior leadership. Midwifery vacancies remain but are reducing, and neonatal staffing is progressing well. Consultant workforce planning is underway to ensure sustainable leadership. • KGH performs consistently across time-critical categories such as Category 1/2 caesarean and IOL flow. • The homebirth service was paused as a precaution following national PFD learning, with a robust recovery plan and strengthened governance in place. • FFT promoter rates remain high (approaching 100%). Experience insight themes include communication, discharge delays and clarity of plans of care. Improvement projects are underway to address these concerns. • KGH's immunisation activity in February shows steady performance across pertussis, RSV, flu and neonatal BCG programmes, with clear documentation of accepted/declined vaccinations. The site continues to deliver its antenatal immunisation activity consistently, with no safety concerns raised. • While seven MIS Safety Actions were achieved, three (1, 4, 5) did not fully meet the required evidence standard, impacting CNST incentive recovery. Action plans are in place and monitored through PSIP and PAC.
Northampton General Hospital (NGH)	• NGH continues to demonstrate strong clinical outcomes with exceptional NNAP performance, particularly with zero bloodstream infections, high-quality stabilisation at birth, and strong parental-consultation standards. • Workforce pressures increased due to repurposing of Band 3 roles, but significant recruitment is in progress (over 12 WTE scheduled to join between March and September). Obstetric and anaesthetic staffing remain areas for ongoing focus, with reliance on locum cover until summer 2026. • NGH maintained OPEL 1 throughout February but displays the greatest operational variation across the system, particularly in triage performance, IOL median waits and Category 1–2 response times. BadgerNet rollout is contributing to some data instability. Targeted recovery work is active and supported by regional PSIP alignment.

	• NGH exceeded FFT response targets (26%) with sustained high satisfaction (97–100%). Communication and discharge delays remain consistent themes. New discharge-education videos are now deployed Trust-wide. • NGH’s antenatal immunisation uptake is the strongest across the system, supported by three community clinics that have improved accessibility and reduced pressure on hospital settings: Pertussis 62.3%, RSV 89.7%. Strong alignment with flu vaccination pathways, with detailed month-by-month tracking. NGH’s community-based model is reportedly improving BCG uptake and overcoming estate constraints affecting hospital delivery. • NGH fully met all MIS Year 7 requirements. CQC must/should actions are largely complete, though medicines management and ward-security actions remain open and are progressing to plan.

ⁱ An [OASI](#) is an obstetric anal sphincter injury that can occur during vaginal birth, also referred to as severe perineal tearing or third- and fourth-degree

ⁱⁱ (SPEN) [Submit a Perinatal Event Notification](#) is a one-stop service designed for reporting specific perinatal safety events to NHS Resolution

Perinatal Quality Assurance Scorecard

February 2026

Data presented in this scorecard is sourced from Badgernet following the Trust's transition to a new Electronic Patient Record system. Data quality assurance and validation are ongoing as part of this transition. The figures shown represent the best available data at the time of reporting and may be subject to minor revision as validation continues.

01	Summary	07	Workforce Overview
02	At a Glance 1	08	Operational and Capacity
03	At a Glance 2	09	Training and Compliance
04	Clinical Quality Surveillance	10	Safety Actions
05	Equity and Population	11	Experience Feedback
06	Clinical Quality and Safety	12	Spotlight On...



Activity reduced in February 2025, with fewer OPEL escalations and low numbers of midwifery red flags, and MAU triage consistently met BSOTS standards. Maternity complaints fell to their lowest level since August 2025, although communication continues to be a recurring theme, and FFT response and promoter rates remained below national averages despite positive feedback for SPOC, community midwifery and intrapartum care. Key improvement areas include MAU waiting times and postnatal experience. No new PSIs were commissioned, one case was escalated to MNSI and one final report was received with a single recommendation; two moderate-harm incidents occurred and learning has been triangulated through the perinatal improvement programme. Clinical indicators were largely stable, with favourable smoking and stillbirth rates but increased Apgar <7 and preterm birth rates. Workforce measures improved, including reduced sickness, ongoing recruitment across all staff groups, and progress with neonatal and obstetric consultant appointments, and MIS Safety Action 8 compliance remained strong as preparations continue for the 2026/27 education programme.

Clinical Quality and Safety

No new Patient Safety Incident Investigations (PSIs) were commissioned in February. One case was referred to the Maternity and Neonatal Safety Investigation (MNSI) programme and accepted for national investigation, and one final MNSI report was received with a single safety recommendation and no safety prompts. Two moderate-harm incidents were reported across maternity and neonatal services. Learning continues to be reviewed and triangulated through the Perinatal Safety Improvement Programme to inform ongoing safety improvement.

Outcomes

Clinical quality indicators across antenatal, intrapartum and neonatal care remained broadly stable during February, with the majority of measures demonstrating common cause variation. Smoking at both booking and delivery continued to perform favourably against target. Intrapartum outcomes, including third- and fourth-degree tears, postpartum haemorrhage $\geq 1500\text{ml}$ and breastfeeding at discharge, remained stable, providing assurance of consistent performance. An increase was observed in Apgar scores <7 at 5 minutes and in preterm births, with preterm birth continuing to demonstrate special cause variation, largely associated with clinical complexity and iatrogenic factors. Stillbirth rates remained low and stable, with no emerging upward trend.

Workforce

Active recruitment continues across Midwifery and Neonatal Nursing to address outstanding vacancies. Sickness absence improved in month across nursing and midwifery. Midwifery vacancies remain low and neonatal nursing vacancies have begun to reduce with a further pipeline of 6 wte nurses recruited. Turnover rates remain low compared to the Trust and national average. Recruitment to neonatal consultant posts is now complete with all posts now filled and one consultant obstetrician has been recruited following interview. Further recruitment is pending to continue to strengthen medical workforce resilience. Increased establishment for junior medical workforce has now been agreed and recruitment is underway to fill these posts.

Training and Compliance

Compliance across all three MIS Safety Action 8 targeted training areas remained stable during February, with performance sustained above the internal benchmark of 80%. This reflects consistent delivery of core safety and quality training. Priorities remain strengthening training coordination and governance alignment, while the Maternity and Neonatal Education teams continue development of the 2026/27 Education Programme, due to launch in April 2026.

Operational and Capacity

Activity reduced during February, with a corresponding improvement in OPEL Level 2 and 3 escalations. A small number of OPEL Level 4 episodes were recorded, with no associated safety incidents. Induction of labour and caesarean section rates remained stable. Red Flags reduced and remained low for the month (n=5). Performance within Maternity Assessment Unit remained timely, with an average triage time of 10 minutes; 79% of women were triaged within 15 minutes and 95% within 30 minutes, consistent with BSOTS national recommendations.

Experience

Maternity complaints reduced this month and lowest since August 2025 (n=9), with no complaints received in Neonatal Services. No clear themes this month however communication remains a concern. FFT response and promoter rates below national average however accurate monthly totals impacted by Badgernet launch and addition of 3 new surveys. Positive feedback noted for Single Point of Contact, community midwifery and intrapartum care with focus needed on wait times in Maternity Assessment Unit and postnatal ward environment. Successful Meet the Experts event held this month at LGH with >100 attendees. Free parking (up to 7 days) now offered to support bereaved families.

FEBRUARY 2026 AT A GLANCE



AVERAGES PER DAY

BOOKINGS **32**

BIRTHS **27**

BABIES BORN



757

PREV. 12 MONTH AV. 800

BIRTH LOCATION



LRI

451

LGH

288

ST MARY'S

0

HOME

18

3RD & 4TH DEGREE TEARS



1.9%

Jan 2.5% ▼



3.1%

BLOOD LOSS >1,500MLS

Jan 2.9% ▲

367 GIRLS



384 BOYS



PREV. 12 MONTH AVERAGE 383 GIRLS, 413 BOYS



5.3%

Jan 5.7% ▼

FULL TERM BABIES ADMITTED TO NNU

INDUCTION OF LABOUR (IOL)

29.3%

PREV. 12 MONTHS – 30.8%



344

CAESAREAN SECTIONS

	JAN	PREV 12 MTH. AV.
ELECTIVE	123 (16.4%)	143 (18.0%)
EMERGENCY	221 (29.5%)	221 (27.8%)

SETS OF TWINS



15

SETS OF TRIPLETS



0

ASSISTED BIRTHS

82

VENTOUSE **26**

PREV. 12 MONTH AV. 31

FORCEPS **56**

PREV. 12 MONTH AV. 61





BREASTFEEDING INITIATION

74.5%

PREV. 12 MONTHS – 67.3% ▲

FEBRUARY 2025 AT A GLANCE

93%

MDT CLINICAL
SIMULATION
TRAINING
COMPLIANCE (YTD)
Exc Med. Staff starting >1st Jul 25



January- 92% ▲

100%

YEAR 7
MATERNITY INCENTIVE
SCHEME
10 SAFETY ACTIONS

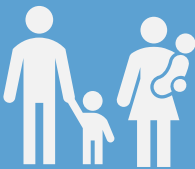


1

MNSI
REPORTABLE
CASES &
REFERRED

January - 1

11.5%



January
16.9% ▼

MATERNITY FRIENDS &
FAMILY TEST (RESPONSE
RATE)

VACANCY RATE

MIDWIVES
January –void

1.0%

CONSULTANT OBSTETRICIAN

5_{WTE}

NEONATAL NURSES

8.0%

NEONATOLOGISTS

8.1%

89%



January
84.4% ▲

MATERNITY
FRIENDS &
FAMILY TEST
(PROMOTER
RATE)

NEWBORN LIFE
SUPPORT TRAINING
COMPLIANCE (YTD)

89%



January– 89% ◀▶

2

MODERATE
INCIDENTS

January - 3



0

PATIENT SAFETY
INCIDENT
INVESTIGATIONS
(PSII)

January - 0 ◀▶

0

CORONER'S
REGULATION 28

January - 0 ◀▶

MINIMUM SAFE STAFFING
MET (MATERNITY YTD)

Data not available



September– 93.9%



1:1 CARE IN
LABOUR

100%

January- 100% ◀▶

Summary

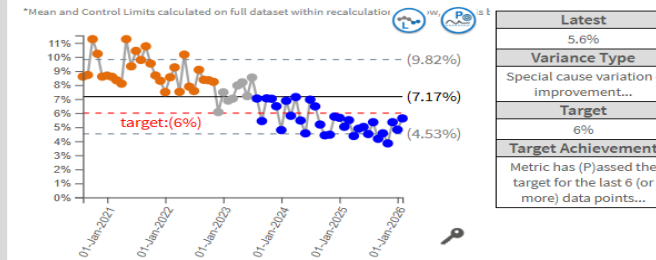
CQIMs continue to demonstrate common cause variation (see slide 16). A reduction has been observed in both postpartum haemorrhage and third- and fourth-degree tears. There has been a slight increase in stillbirths and preterm births during this period, with the former remaining within common cause variation. Smoking prevalence at both booking and delivery remains consistently low. Encouragingly, breastfeeding initiation continues to show a positive upward trend. In addition, the proportion of women with a BMI >35 at booking has decreased.

Smokers at Booking & Delivery

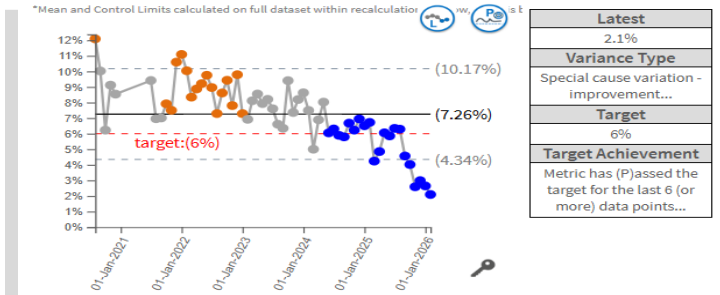
Smoking indicators continue to demonstrate sustained improvement. Smoking at booking remains consistently below the 6% target, with the latest data confirming the target has been maintained for a prolonged period. Smoking at delivery has also reduced further, showing special cause improvement and indicating a genuine shift in performance rather than random variation.

Focus now moves to maintaining these gains by supporting women to remain smoke-free throughout pregnancy and strengthening follow-up through smoking cessation services to reduce relapse prior to delivery.

Smoking at time of booking
LMNS: 6% (Ref 1.3a SVBL)



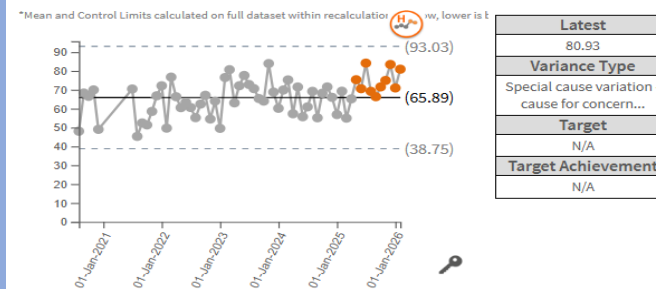
% of women who are current smokers at delivery



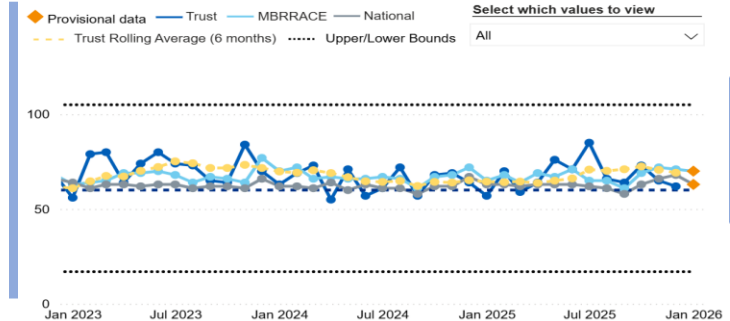
Preterm Births

Preterm births increased slightly to 80.93 per 1,000 births, remaining above the process mean with ongoing special cause variation. Cases continue to be largely iatrogenic and associated with complex maternal conditions. This work is being actively triangulated with the neonatal mortality system review, recognising the inter-relationship between preterm birth and neonatal outcomes, to strengthen system-wide learning and assurance. Improvements in timely treatment have been maintained, alongside a continued focus on prevention through education, early assessment and prioritisation within the Preterm Prevention Clinic.

Preterm Births
Rate per 1000 births



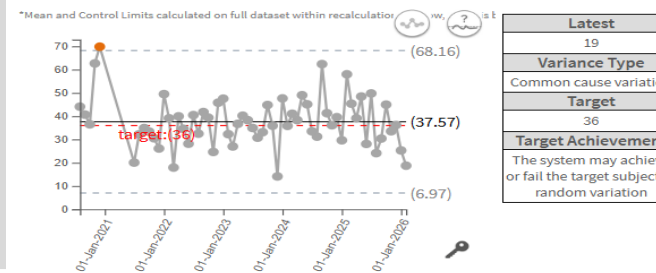
Babies who were born preterm values comparison over time for University Hospitals of Leicester NHS Trust (Rate per 1,000)



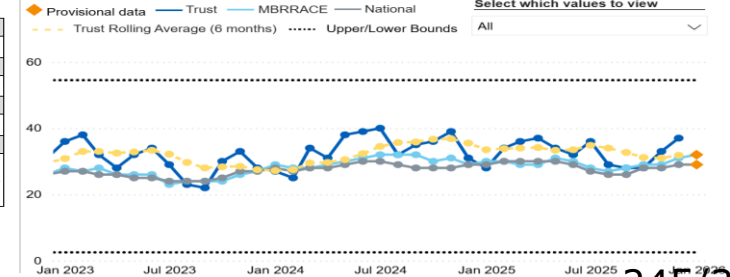
3rd and 4th degree tears

The 3rd and 4th degree tear rate has reduced significantly and remains below the target, with variation consistent with common cause performance. Preventative work continues, including the introduction of warm compress equipment in line with evidence-based practice. The Perinatal Pelvic Health Service (PPHS) continues patient education through the Leicester Maternity Matters podcast and maintains a 100% referral rate for OASI via EPR failsafe processes. Women experiencing OASI are contacted by physiotherapy within 5 days, and the new community-based midwifery/physiotherapy clinic is now supporting follow-up care.

Women who had a 3rd & 4th degree tear
Rate per 1000 births

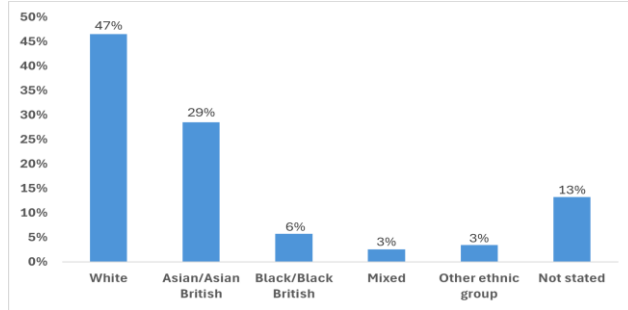


Women who had a 3rd or 4th degree tear at delivery values comparison over time for University Hospitals of Leicester NHS Trust (Rate per 1,000)

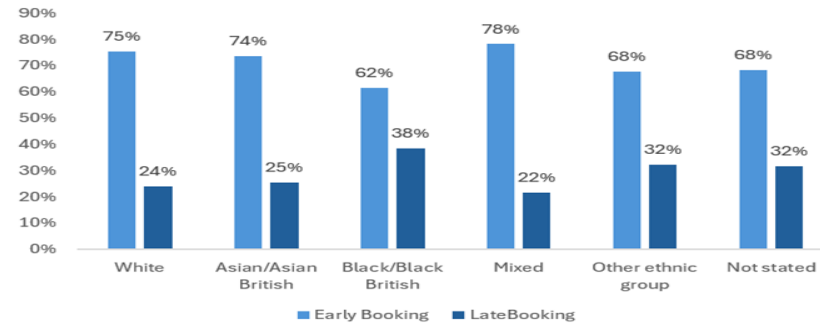


Ethnic profile and variations

Population profile at booking



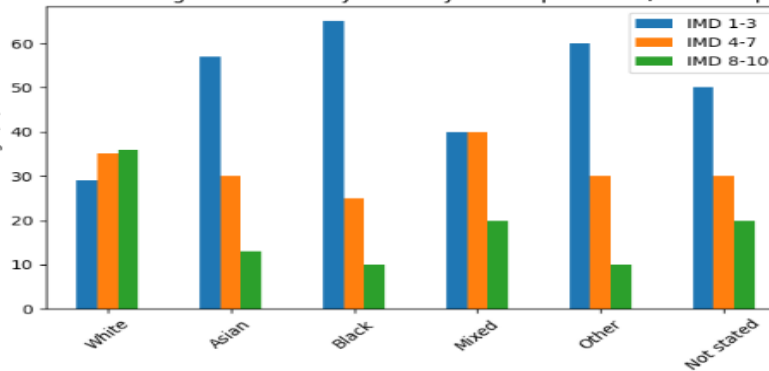
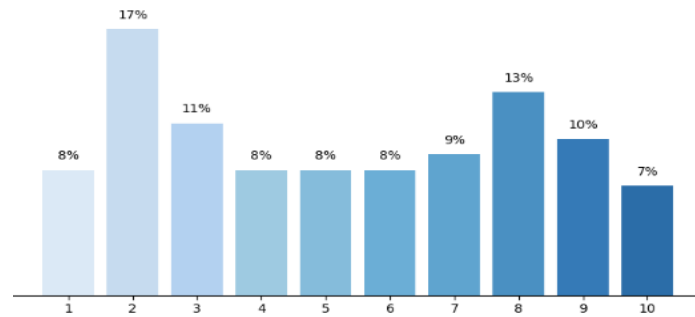
Variation in booking times



Commentary

During the reporting period, 73% of women booked by 10 weeks, with 27% booking at 11 weeks or later. While overall early access remains strong, persistent variation is evident when analysed by ethnicity. Black African/Black Caribbean women represent 6% of total bookings but have the highest proportion of late bookings (38%), meaning they are approximately 1.6 times more likely to book late than White women (38% vs 24%). In contrast, late booking rates among White (24%) and Asian/Asian British women (25%) are closer to, or below, the overall position. Mixed ethnicity women continue to demonstrate the most favourable booking profile, with the highest early booking rate (78%) and the lowest proportion of late bookings (22%). These patterns reinforce the importance of targeted, culturally responsive approaches to improve timely access for groups experiencing disproportionate delay.

Deprivation

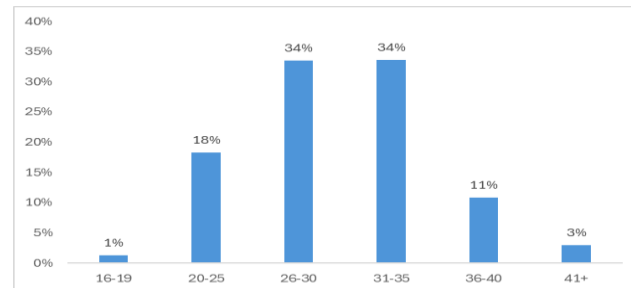


Commentary (Late bookings by deprivation)

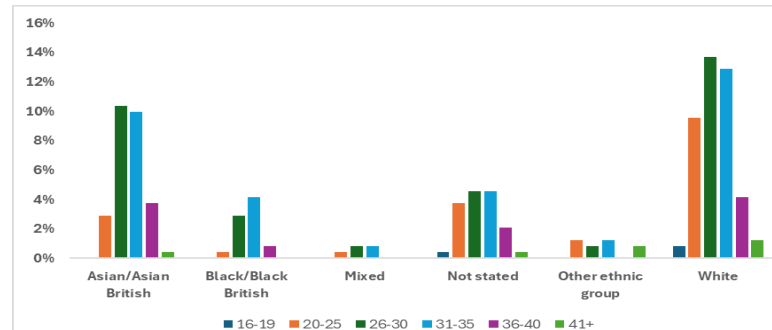
The observed deprivation gradient in late booking, particularly for Black/Black British women living in IMD deciles 1–3, is significant because early access to antenatal care is a key protective factor for identifying and managing clinical and social risk. This insight aligns with other areas of focus, including the ongoing special cause variation seen in preterm birth rates and the system review of neonatal mortality, reinforcing the importance of addressing upstream access and equity as part of a whole-pathway approach to safety and outcomes. It also mirrors themes emerging from patient experience and community engagement work, where barriers to access and navigation are more pronounced for women living in deprivation. In response, current workstreams focused on health equity, early engagement and community partnership are being prioritised towards the most affected populations and geographies, with continued monitoring through the PQRM.

Age of parent

Population profile at booking



Variation in booking times



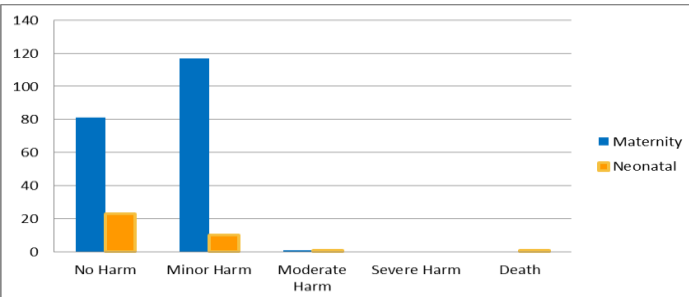
Commentary (Late bookings by age of parent)

Late booking is concentrated within the 26–30 and 31–35 age groups, accounting for around two-thirds of all late bookings and reflecting the underlying maternity population. This indicates that delayed access is not driven by younger age or teenage pregnancy, but by wider system and access barriers affecting women of typical childbearing age. As such, improvement activity is focused on reducing structural and navigation barriers to early booking, rather than age-specific interventions, and aligns with wider equity and early-access workstreams.

CLINICAL QUALITY AND SAFETY

Incidents and Events

Incidents



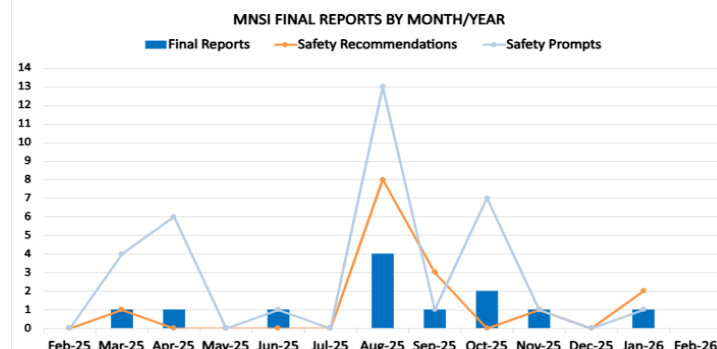
MNSI cases

	Current month	Prior month
Referred	1	1
Accepted	1	1

PSII cases

	Current month	Prior month
Commissioned	0	0

MNSI Referrals



What the data is telling us

- **0 Patient Safety Incident Investigations (PSII)** commissioned
- **1 Case referred** to Maternity and Newborn Safety Investigation (MNSI): Case accepted for external review
- **2 Moderate Incidents** reported: 1 within Maternity Services: Unexpected admission to the Neonatal unit, case referred to Maternity and Newborn Safety Investigation (MNSI) following therapeutic cooling. 1 within Neonatal Services: Complication of treatment following the insertion of an umbilical vein catheter
- **4 Stillbirths recorded** during February (25+4-30+3 week's gestation)
- **3 Early Neonatal Deaths** (33+3-36+1 week's gestation)
- **Themes:** Consanguinity

What we need to focus on

Clinical Safety and Risk Management

Strengthening the accuracy of cardiotocograph (CTG) interpretation to support the early identification of fetal compromise, ensuring prompt obstetric assessment and timely intervention, alongside effective neonatal resuscitation and escalation at birth

Practice and Technical Skills

Strengthening procedural safety by ensuring competent insertion technique with consistent monitoring in place to identify and manage complications promptly

Perinatal Mortality

Perinatal Mortality Learning highlights the need for strengthened system support for very early preterm birth, including improved coordination between clinical care and social support to reduce postnatal risk and promote safe practices such as safe sleeping.

What is going well

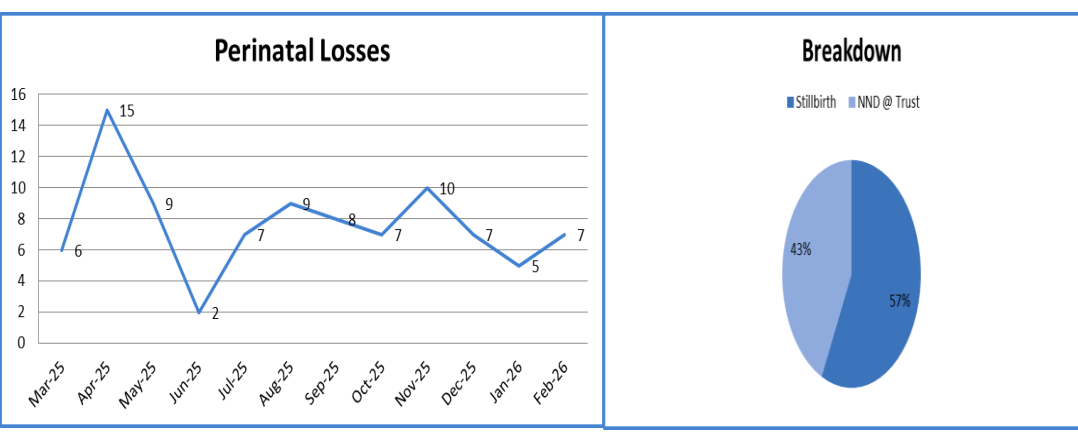
Perineal Trauma

3rd and 4th degree perineal trauma rates have significantly reduced and continue to remain consistently below the agreed target indicating sustained improvement rather than random fluctuation. On-going preventative initiatives are supporting progress in-line with evidence based National Guidance

Postpartum Haemorrhage

The rate of women experiencing postpartum haemorrhage (PPH) of 1500 ml or more has remained stable over the reporting period, This stability provides assurance that current processes for identifying, managing, and escalating PPH remain effective. On-going monitoring continues to be essential

Perinatal Mortality

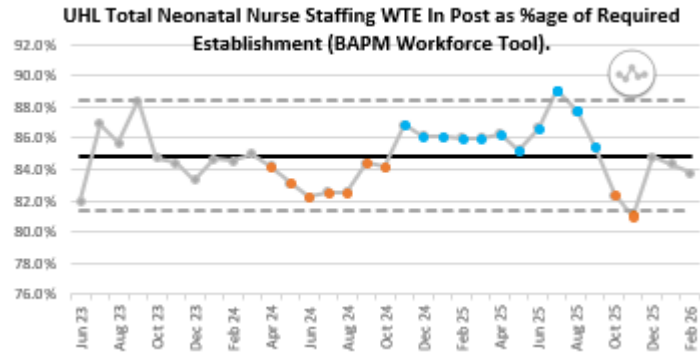


CQC Maternity Rating

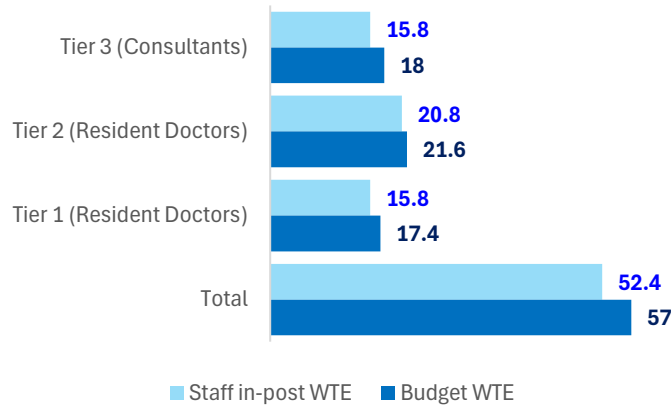
	LRI	LGH	StM
Are services safe?	●	●	●
Are services effective?	●	●	●
Are services caring?	●	●	●
Are services responsive?	●	●	●
Are services well-led	●	●	●
Overall	●	●	●

★ Outstanding ● Good
● Requires Improvement ● Inadequate

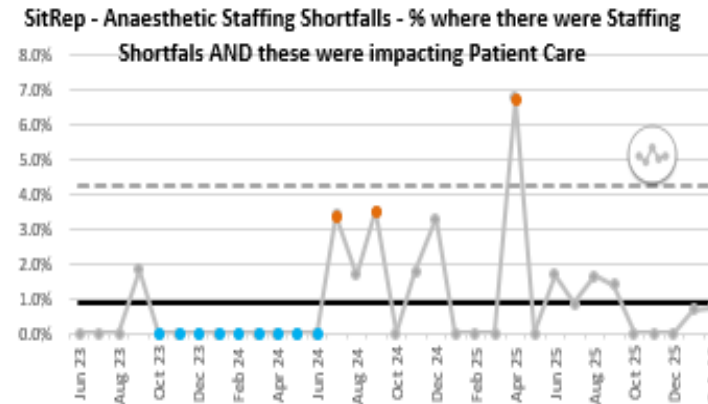
Workforce



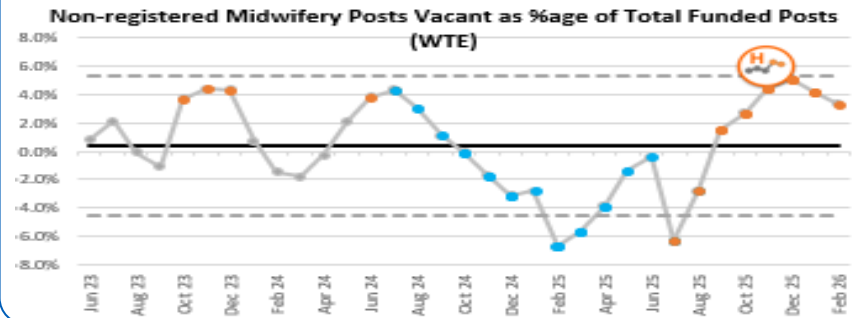
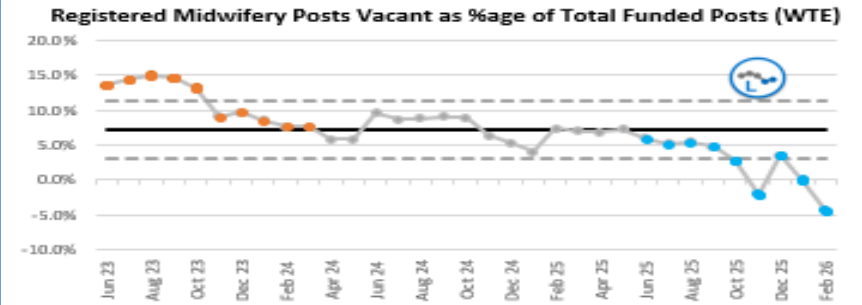
Neonatal Medical Workforce - Dec 2024



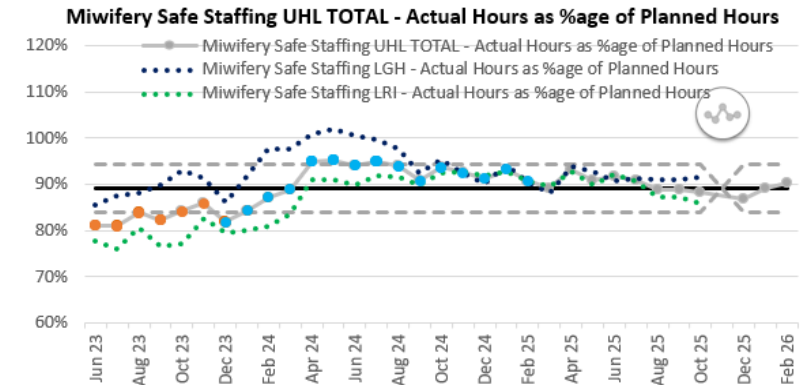
Shortfalls



Vacancies



Safe Staffing

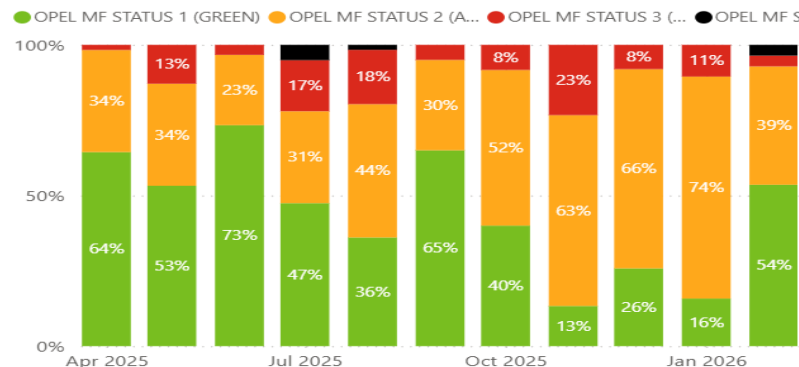


OPERATIONAL AND CAPACITY

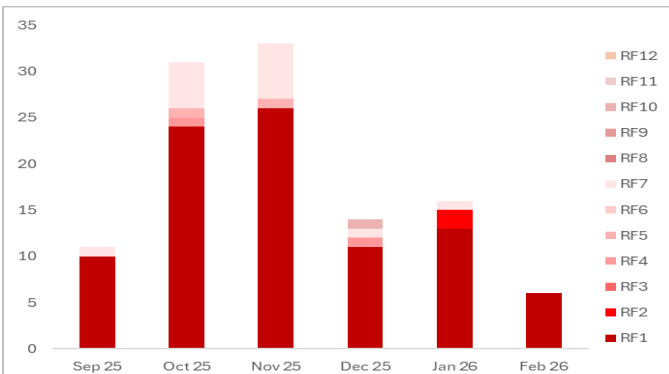
Key Information

Operational Pressures Escalation Levels

OPEL Maternity Status - % of submissions



Midwifery Red Flag Events



What the data is telling us

- Activity levels reduced during February with the OPEL Level 2 and 3 escalations improving in line with this. There was a small amount of level 4 OPEL acuity, but no safety incidents related to these episodes.
- Induction of labour and Caesarean section rates remained stable.
- Red Flags were significantly reduced in month stable in month (5) with no reported incidents where the coordinator did not maintain supernumerary status or inability to provide one to one care in labour.
- Average triage times were 10 mins, with 79% of patients triaged within 15 minutes of arrival and 95% within 30 mins indicating prompt assessment of patients in line with BSOTS national recommendations.
- The average time for women to wait for an ARM from decision to perform was 23 hours.

Efficiency and Timeliness

Average time from attendance to triage

10 mins

% Seen within 30 Mins

95%

Avg. time from ARM decision to perform

23 hours

Seen within 15 Mins

79%

Average volume of calls to triage (antenatal)

4,777

Average call response time for triage

2 Mins 2secs

Average talk time for triage

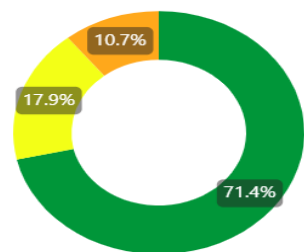
3 Mins 26secs

Categorised on admission (triage within target)

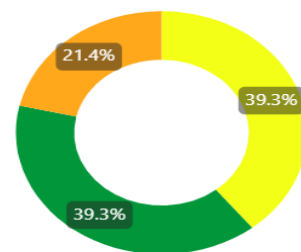
1710
(94%)

Bed Capacity

Delivery suite



Maternity ward



- Yes - beds available and no impact on admission or transfers
- Yes - reduced bed capacity but no impact on inpatient flow
- Yes - limited beds available impacting on inpatient flow
- No - no beds available and no planned discharges

What we need to focus on

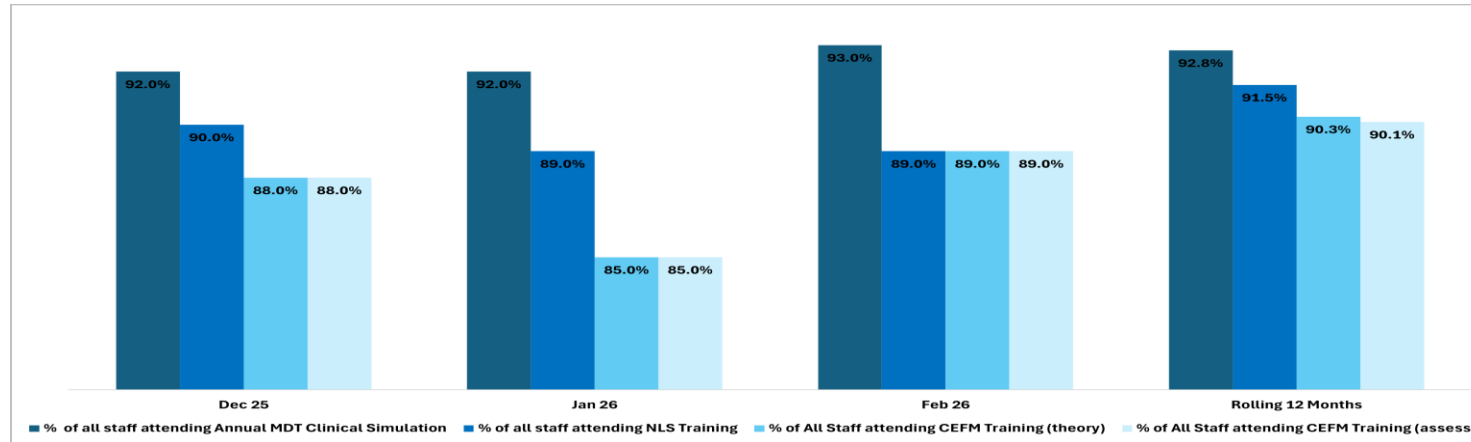
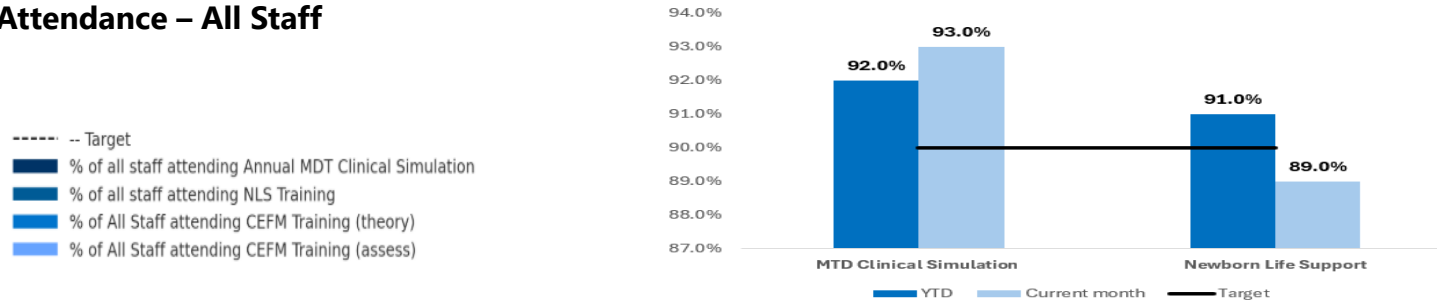
- Review impact of LGH Maternity Day Assessment Unit (MDAU) and optimisation of capacity to support Maternity Assessment Unit
- Bed capacity and demand modelling
- Review of elective pathway and demand
- Transition into the Single Point of Contact from Telephone Triage
- Progress consultant recruitment and succession planning.
- Strengthen sickness management through proactive monitoring, early intervention, and targeted support to reduce avoidable absence.
- Reducing time from decision to perform ARM.

What is going well

- Enhanced triage performance, reflecting more efficient patient assessment and flow
- Supporting the long-term sustainability of specialist services through ongoing succession planning, and workforce development
- Sustained trajectory to increase the Qualified in Speciality (QIS) neonatal nursing workforce
- Positive recruitment and reduced vacancies of Midwives and Neonatal Nurses
- Oversight of red flags and Matron validation of Birthrate plus acuity scoring

Training compliance

Attendance – All Staff



Key Performance Indicator	Target	Dec-25	Jan-25	Feb-26	Rolling 12 months
% of all staff attending Annual MDT Clinical Simulation	90%	92.0%	92.0%	93.0%	92.8%
% of all staff attending NLS Training	90%	90.0%	89.0%	89.0%	91.5%
% of all staff attending CEFM Training (theory)	90%	88.0%	85.0%	89.0%	90.3%
% of all staff attending CEFM Training (assess)	90%	88.0%	85.0%	89.0%	90.1%

What the data is telling us

- In February as predicted we have seen no further decline in compliance across our three MIS Safety Action 8 areas of targeted training. With compliance in all areas remaining above our internal benchmark of 80%
- In March we predict there may be a slight fall in compliance, as we draw to close our 25/26 Training Calendar at the end of the month. Thus, within March the number of study days that link to the compliance reduces.

What we need to focus on

- Moving into Q4, the Maternity Education Team will continue to prioritise actions aligned with safety, compliance, and quality improvement. Our Key initiatives focusing on sustaining high standards in maternity care through improved staff training coordination, enhanced clinical governance collaboration, and proactive efforts to reduce avoidable harm.
- The Maternity and Neonatal Education teams will move into the next stages of Education Programme Development for the 26/27 training year, due to start in April 2026.
- 1.0 WTE Education and Practice Development Midwife remains vacant with a in internal Job advert going live in February.
- Continued partnership work with PSIP team around postpartum haemorrhage management.

What is going well

- MIS Year 7 SA8 achieved
- Consistency in training compliance across all areas, with close oversight and early preventative action taken and communicated where required.
- 26/27 Training Needs Analysis launched for line managers and due for submission 1st April 2026.
- Joint Neonatal and Maternity Insitu Skill Drill Completed

SAFETY ACTIONS



Maternity Improvement Scheme

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

Summary

Year 7 of the scheme

All requirements of the Year 7 Maternity Incentive Scheme (MIS), have been completed and the Trust has achieved all 10 Safety Actions and the associated 95 individual standards, in accordance with the MIS Guidance issued by NHS Resolution.

Confirmation from NHS Resolution of safe receipt of Declaration form received.

Year 8 of the scheme launch date 2 April 2026

Year 8 of the Maternity Incentive Scheme (MIS) will introduce major changes to make the programme clearer, more outcome-focused, and better aligned with national learning on maternity safety. It will replace detailed requirements with six core safety actions, highlighting 'what good looks like', allowing NHS Trusts greater local flexibility, while requiring Boards to demonstrate strong governance, safety assurance, service-user involvement, and clear evidence of improvement.

Full publication and confirmation of changes due for release 31st March 2026

Saving Babies Lives

Element	Interventions Fully Implemented (Self-Assessment) Q2		Interventions Fully Implemented (LMNS Validated) Q2		NHS Resolution MIS
Smoking in Pregnancy	Fully	100%	Partly	100%	CNST Met
Fetal Growth Restriction	Partly	95%	Partly	95%	CNST Met
Reduced Foetal Movements	Fully	100%	Fully	100%	CNST Met
Fetal Monitoring in Labour	Fully	100%	Fully	100%	CNST Met
Preterm Birth	Fully	100%	Partly	96%	CNST Met
Diabetes	Fully	100%	Fully	100%	CNST Met
All Elements	Partly	99%	Partly	97%	CNST Met

Summary

Submission 8 (Q2 25/26) 97% implemented

Element 2 95% implemented. Lab now confirmed ability for on-site testing and plan for PIGF roll out by March 2026 and Consultant Lead in place.

Element 5 96% implemented. Action plan update- Badger Net now live. New App built by Neonatal Data Analyst and MDT plan in place for accurate data submissions and tracking via App.

Submission 9 (Q3 25/26) Retrospective review due April 2026

EXPERIENCE FEEDBACK

Patient Experience

Complaints and Concerns	Dec-25	Jan-26	Feb-26	25 / 26 YTD
Maternity	10	13	9	111
Neonatal	2	0	0	7

Friends and Family Test (FFT)	Target	National	Dec-25	Jan-26	Feb-26	25 / 26 YTD
Maternity FFT % Responses	25%	13%	11.9%	16.9%	11.5%	13%
Maternity FFT % of Promoters	96%	93%	92.3%	88.4%	89%	92.7%

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

Birth Reflections	Dec-25	Jan-26	Feb-26	25 / 26 YTD
Number of appointments	19	31	31	81
% attended within 12 months of birth	68.4%	77.4%	80.6%	76.5%

Compliments

"Every staff member was so kind and compassionate and there was always somebody available to help"

Ward 30 LGH

"The triage was smooth and the doctor was attentive"

Maternity Assessment Unit LRI

What the data is telling us (Complaints)

- 2 complaints this month relate to care received in 2021 and 2022
- No complaints received related to recent care in MAU. Complaints relate to varying wards/departments
- No clear complaint themes this month however 3 complaints relate to staff attitude/communication (2 x support staff, 1 x medical staff) - similar noted from Birth Reflections Service
- FFT concerns remain about cleanliness of postnatal wards (score = 87%) and communication regarding wait time on MAU (score = 54%)
- Single Point of Contact data available this month; 30 completed surveys with 29 rating either 'good' or 'very good' experience
- Lowest response rates in community midwifery
- No poor promotor rates for community midwifery and labour and birth
- Areas for improvement include; induction of labour delays, temperature of rooms and waits for doctors on MAU
- Birth reflections themes include: patient involvement in plans of care/communication, staff attitude, consent (assisted birth and vaginal examinations) and delays in care

What are we working on?

- Implementation of Self-Administration of Medications
- Change to obstetric cover on Maternity Assessment Unit out of hours (weekend)
- Re-launch of QR codes in MAU at triage to inform women of triage system
- Mandatory consent training for all staff from April 2026 with a focus on vaginal examinations and assisted births

What we need to focus on

- Using text messaging to send full FFT surveys at 3 stages of maternity journey to increase response rates
- Link with Avoiding Term Admissions to Neonatal Unit group to introduce room thermometers to monitor temperatures on postnatal wards
- Progress Fundamentals of Care review across postnatal wards



Following the success of its inaugural launch, the maternity 'Meet the Expert' community event returned for a second time, with engagement continuing to grow and nearly 150 women and families in attendance. Held in the antenatal clinic at Leicester General Hospital, the event provided an accessible and welcoming space for families to connect directly with maternity and partner services, helping them better understand the care available throughout pregnancy and supporting informed choice, early engagement and continuity.

A wide range of services were represented—including Smoking Cessation, Public Health, Pelvic Health, Birth Reflections, Birth Centres, the Home Birth Team, Fetal Monitoring, the MNVP, Janam app, Infant Feeding and Immunisations

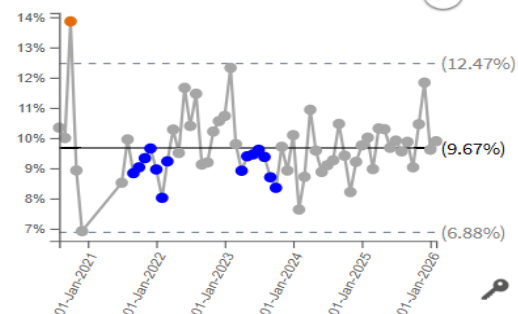
This provided families the opportunity to speak with professionals from across the pathway in one place. Crucially, the event supports wider system aims by addressing known barriers to access, navigation and engagement, particularly for women who may face disadvantage or delayed entry into care.

APPENDICES

Antenatal

BMI at Booking >35

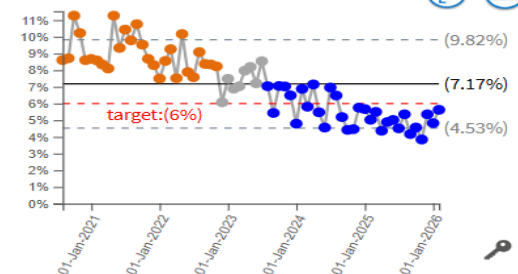
*Mean and Control Limits calculated on full dataset within recalculation



Smoking at time of booking

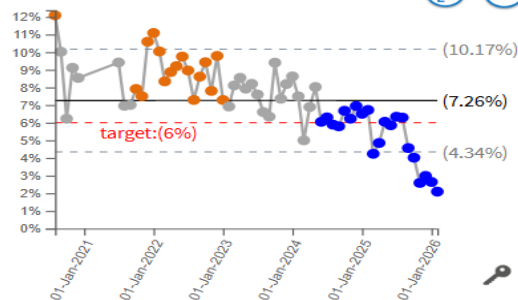
LMNS: 6% (Ref 1.3a SVBL)

*Mean and Control Limits calculated on full dataset within recalculation



% of women who are current smokers at delivery

*Mean and Control Limits calculated on full dataset within recalculation

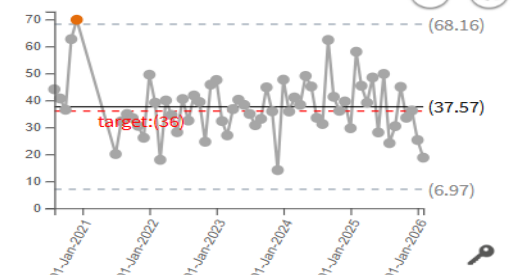


Intrapartum

Women who had a 3rd & 4th degree tear

Rate per 1000 births

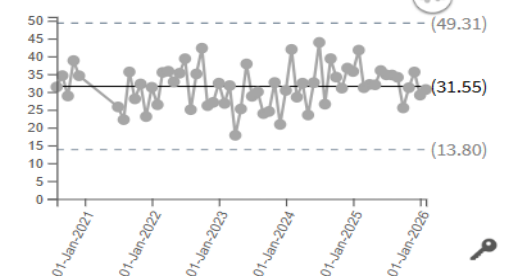
*Mean and Control Limits calculated on full dataset within recalculation



Women with PPH of 1500ml or more

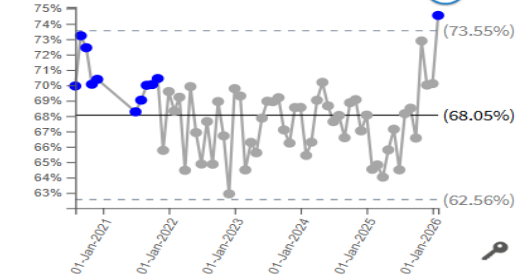
Rate per 1000 births

*Mean and Control Limits calculated on full dataset within recalculation



BREASTFEEDING

*Mean and Control Limits calculated on full dataset within recalculation

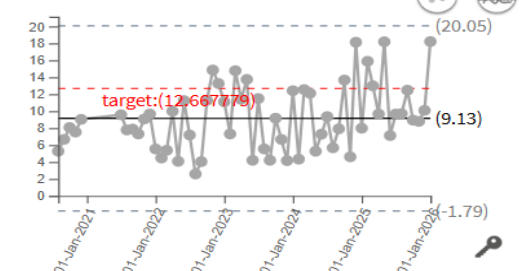


Outcomes

Babies with Apgar @5mins less than 7

Rate per 1000 births

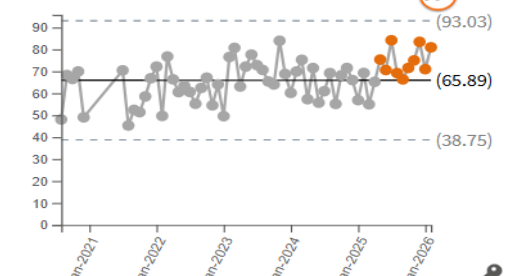
*Mean and Control Limits calculated on full dataset within recalculation



Preterm Births

Rate per 1000 births

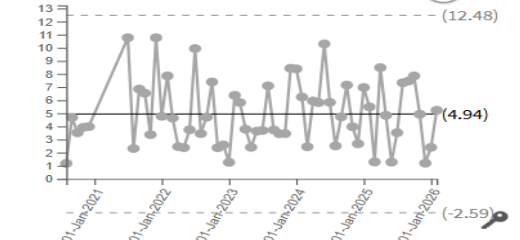
*Mean and Control Limits calculated on full dataset within recalculation



Stillbirths

Rate per 1000 births

*Mean and Control Limits calculated on full dataset within recalculation



THE HEADLINES – Key Delivery Insights

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

Total Births
(in month)

757

12 mth avg.= 800

Preterm Births
(in month)

82

Prev. month = 71

Stillbirths (in month)

4

Prev. month = 2

Born Before Arrival (in month)

6

Prev. month = 4

Homebirth (in month)

18

Prev. month = 18

Sickness Rates

UHL Women's Services- Dec 2025

Data is reported with a standard two-month reporting lag

5.88%

Monthly Sickness Absence

6.14%

Year-to-Date (Cumulative)

Safe Staffing (UHL Total)

Monthly actual staff hours as a percentage of planned staff hours

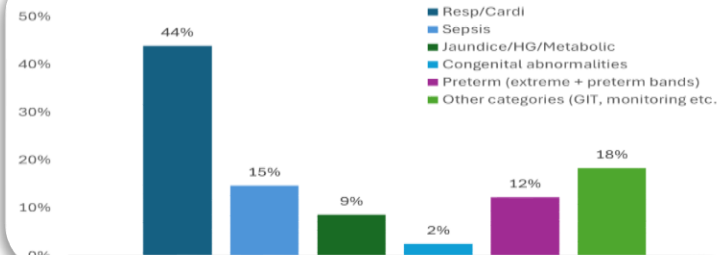
90.2%

Prev. month.= 89.2%

Feb '26	WTE	%
Actual Vacancy	5	1.2%
Felt Vacancy	43.61	11.6%

Outcomes

Neonatal Outcomes



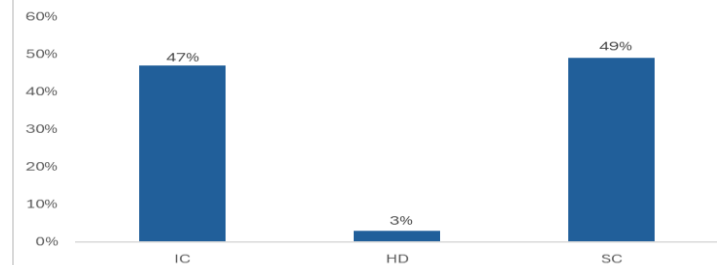
Skin to Skin < 1hr (full-term w/o complication)

57%

Prev. month = 59.6%

National Avg = 74.2%

Babies in NNU



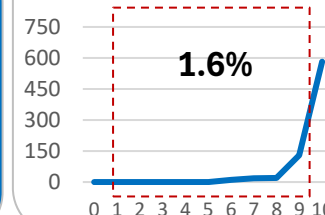
NNU ATAIN Rate (full-term babies)

5.3%

0.4% from prev. month

National Avg = 6%

Apgar < 7 at 5 mins



Maternal Wellbeing

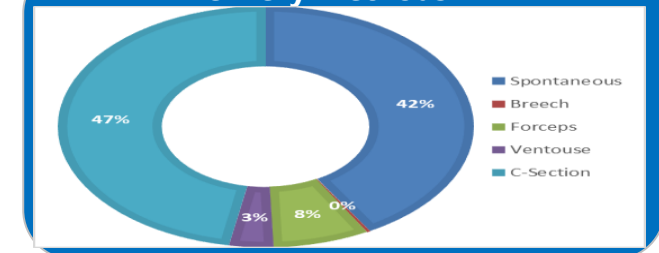
Vaginal Birth Rate in month (natural / total)

53.6%

Prev. month = 51.5%

National Avg = 42%

Delivery Methods



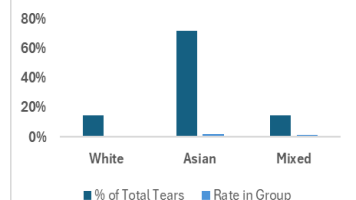
One-One Care in Labour

100%

10 % from prev. month

National Avg = 51%

Tears 3rd / 4th degree



Blood Loss > 1.5ltr

	% of Tot. PPH	% Rate in Group
White	48.0%	3.5%
Asian	36.0%	3.7%
Black	8.0%	3.9%
Mixed	8.0%	2.9%
Other	0	0

Total Bookings

907

Last month = 1,078

Triage Attend.

1,927

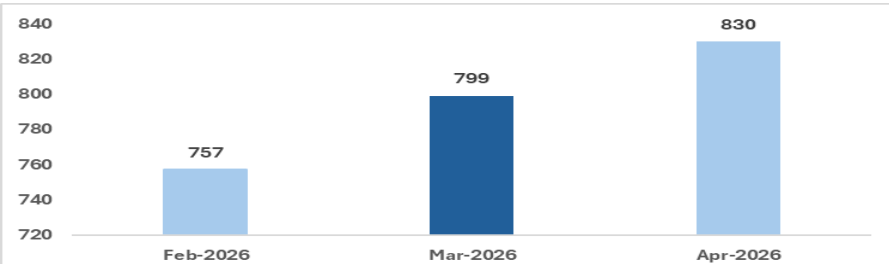
Last month = 2,164

Triaged within 15 minutes

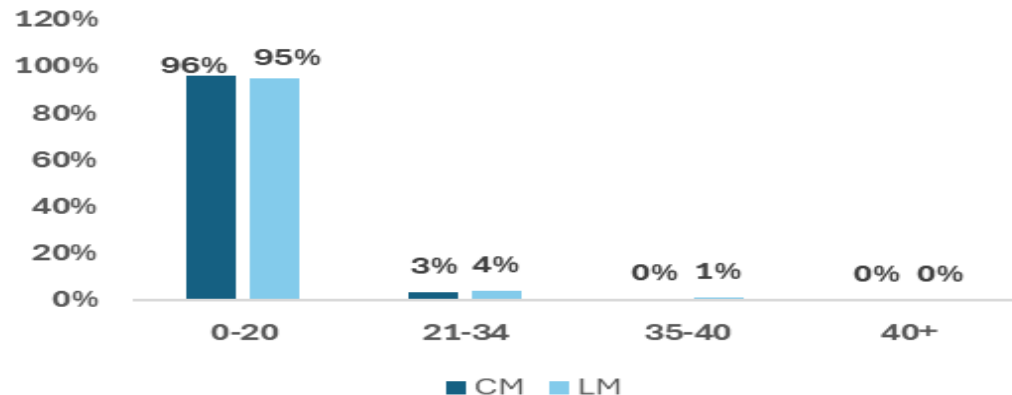
79.0%

Last month = 70.2%

Expected Deliveries (by gestational age)



Comparison of Bookings by Gestational Age (Current Month vs Last Month)



Antenatal Wellbeing

Missed apps. In community (#all missed appointments)

837

Last month = 911

Screening Uptake (tests declined / tests offered)

97.9%

National Avg ~ 97.5%

Risk identified at booking

Risk	% of bookings
Smoking	5.6%
BMI>35	11.6%
Alcohol/Drugs	3.1%
Mental Health	25.5%

Postpartum Support

Maternal Readmissions

(count of readmissions in month)

204

Last month = 216

Breastfeeding Data

Journey	UHL Feb	UHL Prev.Month
Initiation Rate	74.5%	70.1%
Breastfeeding only @ 10 days	34.8%	22.5%
Breastfeeding only @ transfer to Health Visit.	39.6%	39.5%

NEONATAL OUTCOMES

Total Babies in Month

135

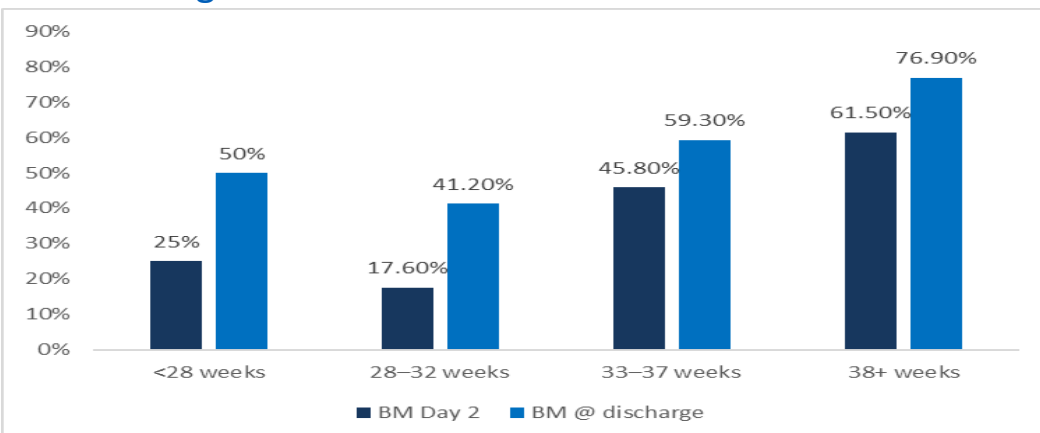
Total Admissions in Month

145

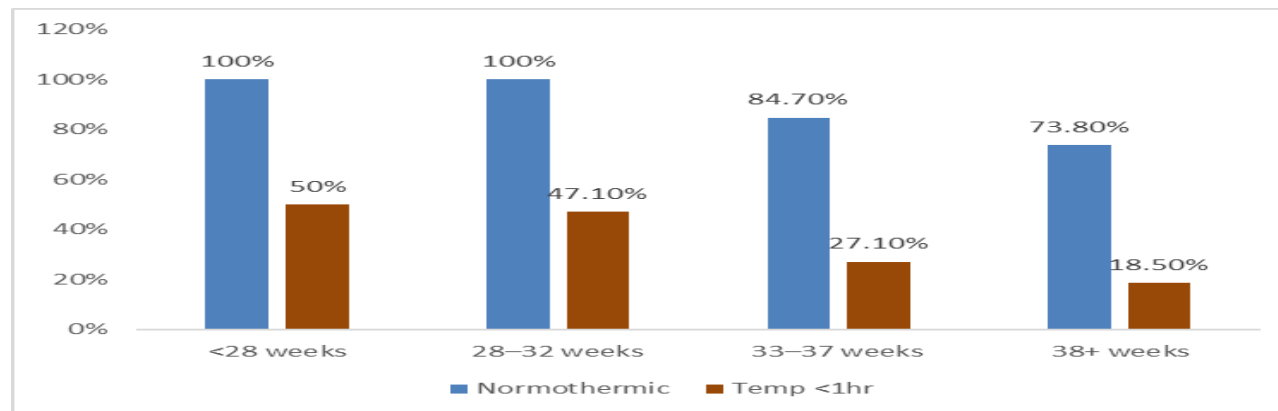
Summary

Neonatal outcomes demonstrate low mortality and morbidity with expected variation by gestation. Feeding outcomes improve consistently to discharge, while thermal care remains high across all groups, particularly in preterm infants.

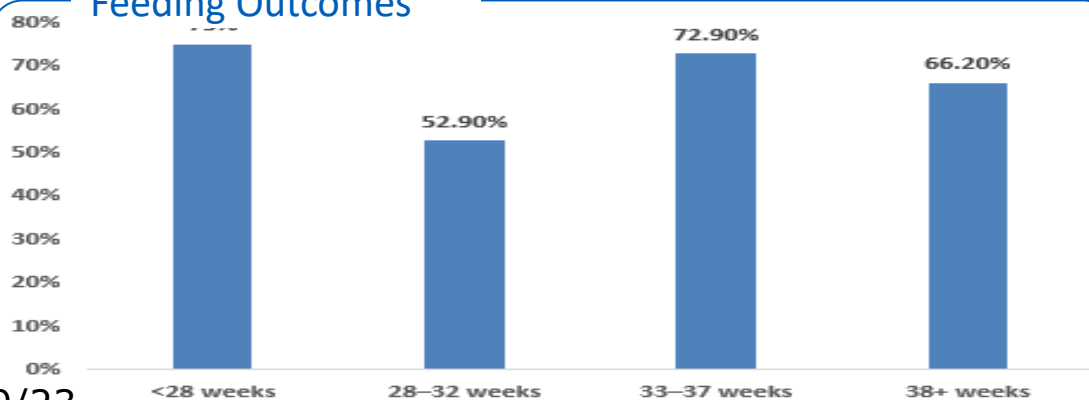
Feeding Outcomes



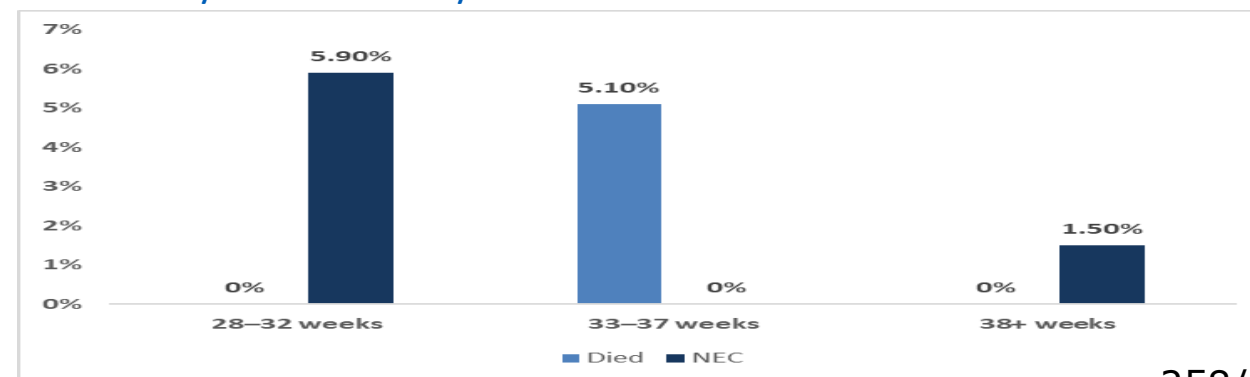
Thermal Care



Feeding Outcomes



Mortality and Morbidity

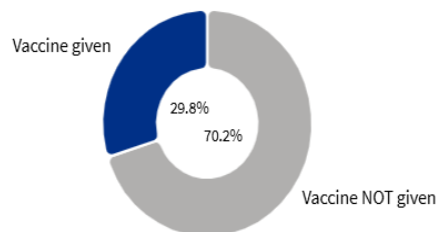


IMMUNISATION SUMMARY

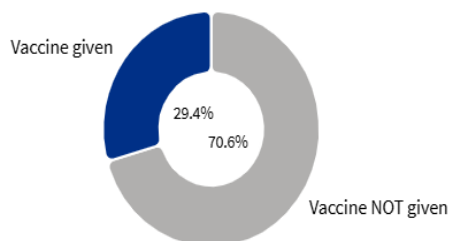
RSV Uptake

RSV uptake remains a concern across UHL Maternity. Although a booking service launched in February, early challenges and an administrative vacancy have limited its success. Recruitment is now complete, and we expect improvements in booking, as well as follow-up for DNAs and declines in the community. Staff and public education continues, with VIP Nurses attending April's parent education sessions to further promote uptake. NHSE have reduced the touch points with UHL following the action plan as they are assured with current actions.

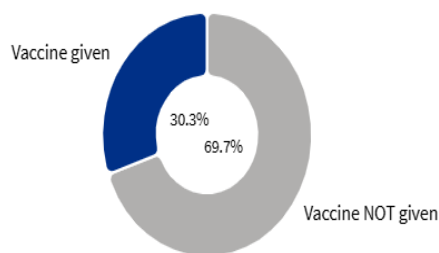
Uptake of RSV Vaccination - UHL Total
Given/Not given



Uptake of RSV Vaccination - LRI
Given/Not given



Uptake of RSV Vaccination - LGH
Given/Not given

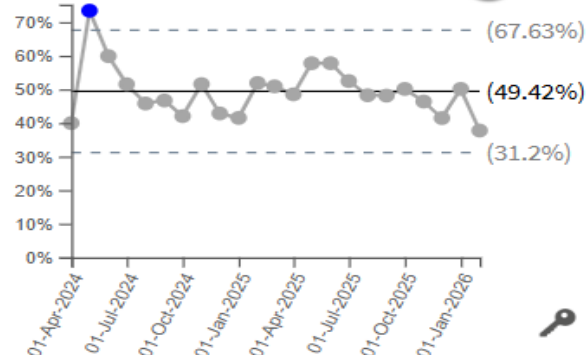


Pertussis Uptake

Uptake of pertussis vaccination for UHL demonstrates common cause variation, with performance fluctuating around a stable mean. No special cause signals are observed within the reporting period, indicating a consistent underlying process. The latest data point remains within expected control limits. Continued monitoring of vaccination is recommended

% Uptake of Pertussis Vaccination for UHL TOTAL

*Mean and Control Limits calculated on full dataset within reporting window

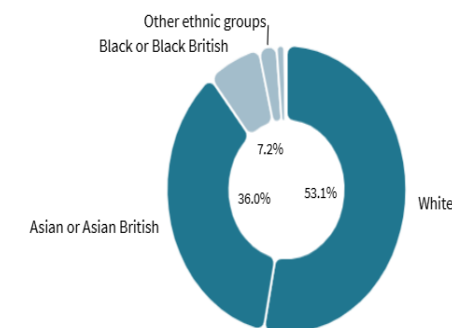


Latest
37.7%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Insights

BCG vaccine uptake remains below target, with the current pattern reflecting common cause variation. Work is also underway to support the movers in and out of UHL in collaboration with NHSE, LPT and CHIS

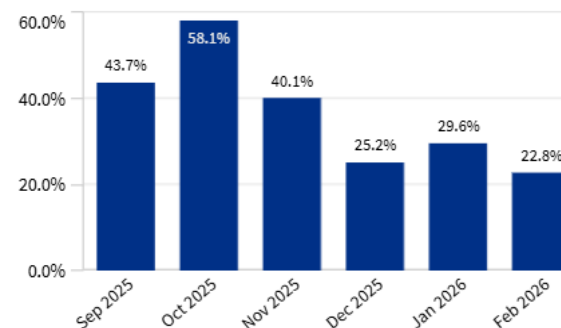
Ethnic Group of those who received the Pertussis Vaccine (UHL)
Reporting Period: Feb-2026 to Feb-2026



Flu Vaccination

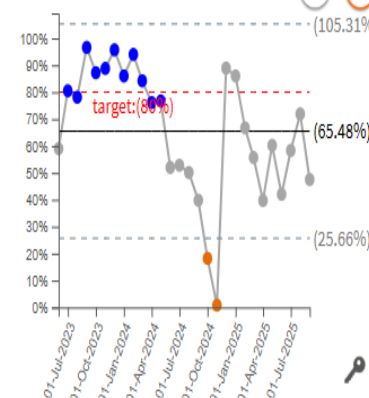
The pattern remains consistent with a seasonal vaccination programme, where demand is typically highest at the start of the winter campaign. Uptake will continue to be monitored across the remainder of the season, with ongoing emphasis on opportunistic vaccination. Plan are already underway for 2026-27 flu season i.e. ordering of vaccinations and PGD's.

% Uptake of FLU Immunization



Of those eligible (number 1b) the percentage of BCG vaccinations given ≤ 28 days
(with appropriate SCID screening outcome) KPI=80% (i.e. coverage)

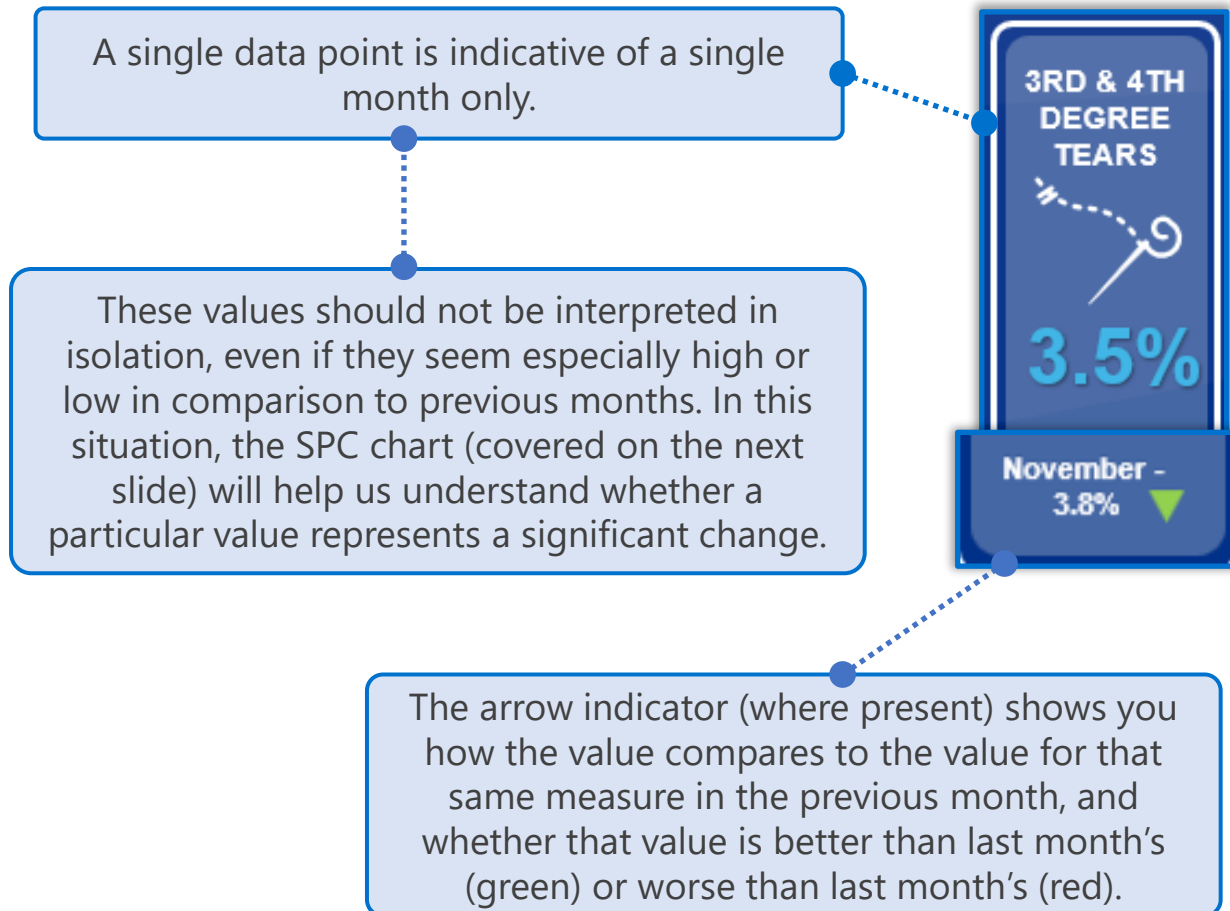
*Mean and Control Limits calculated on full dataset within reporting window



Latest
47.5%
Variance Type
Common cause variation
Target
80%
Target Achievement
Metric has (F)ailed the target for the last 6 (or more) data points...

INTERPRETING DATA

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



Sometimes a measure will appear both as a single data point and an SPC chart within these slides. You may notice that the numbers do not align for the same month for that same measure. Good spot! This is because we may calculate a measure differently, depending on what we are trying to measure.

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

SPC charts
these will be calculated in line with standard national calculations so that we can compare ourselves meaningfully to other Trusts. These calculations may exclude certain categories of people.

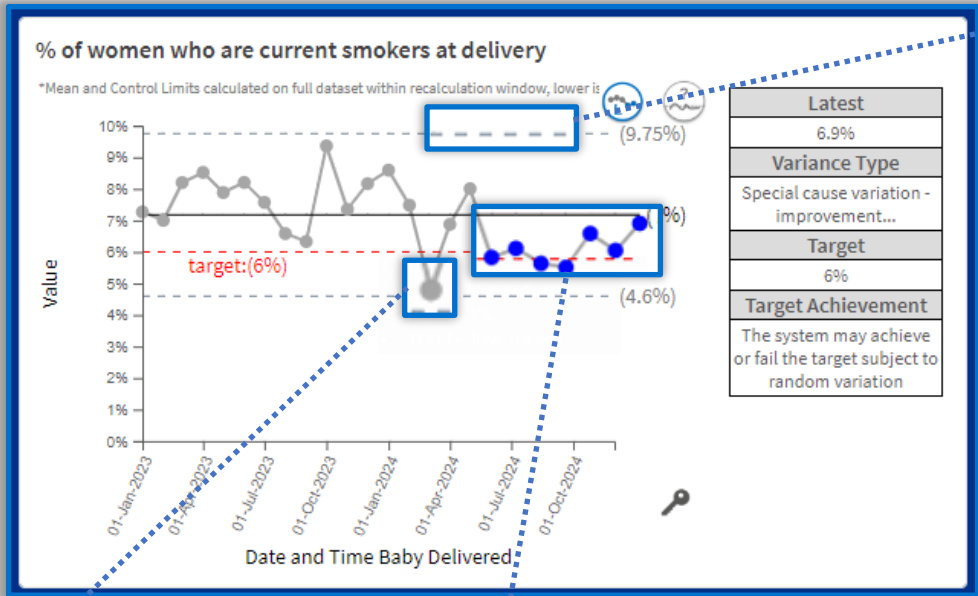
INTERPRETING DATA

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

SPC charts are widely used across the NHS to measure changes in data over time.

There is **strong evidence** that these provide a **better basis for decision making** versus isolated data points.

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



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

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

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



Glossary

Term	Abbreviation
Induction of Labour	IoL
Hypoxic-Ischemic Encephalopathy	HIE
Hospital Readmission	HRA
Postpartum Haemorrhage	PPH
Intensive Care Unit	ICU
Severe Maternal Morbidity	SMM
Leicester General Hospital	LGH
Leicester Royal Infirmary	LRI
Gestational Diabetes Mellitus	GDM
Hyperemesis Gravidarum	HG

Perinatal Quality Assurance Scorecard

March 2026 (February 2026 data)

03	Summary	
04	At a Glance 1 UHN	
05	At a Glance 1 KGH & NGH	
06	At a Glance 2 UHN	
07	At a Glance 2 KGH & NGH	
08	Clinical Quality and Surveillance	
09	Clinical Quality and Safety	

10	Workforce – Perinatal	
11	Operational and Capacity	
12	Training and Compliance	
13	Safety Actions	
14	Experience and Feedback	
15	Spotlight on...	
16	Appendices	



The month in review

UHN maternity services remained safe and stable throughout February, with clinical quality indicators, outcomes and operational performance all within expected ranges and no significant safety concerns identified. Workforce and operational pressures persist however strong recruitment pipelines, sustained training compliance and improved governance alignment continue to strengthen service resilience. Patient experience is positive overall, though response rates and communication-related feedback highlight areas for continued focus, while targeted improvement work across smoking, preterm birth, triage, IOL flow and CNST/MIS requirements is progressing well through the Perinatal Single Improvement Programme (PSIP). Vaccination uptake remains steady across both sites, with NGH showing strong RSV and pertussis acceptance supported by expanded community clinics, and KGH maintaining consistent antenatal immunisation activity, ensuring continued protection for mothers and newborns.

Training compliance:

Training across NGH and KGH remains consistently strong, with the majority of modules achieving near-complete (approaching 100%) attendance. PROMPT and CTG training are firmly embedded in practice, providing robust assurance of safe, coordinated multidisciplinary care. Neonatal life support compliance continues to be high, reflecting sustained focus on critical clinical skills. Variability in anaesthetic attendance at NGH persists due to rota and release-time constraints, and targeted work is ongoing to address this. Overall, the evidence demonstrates strong engagement with safety-critical training and provides solid assurance against CNST requirements and national standards.

Clinical Quality and Safety

Clinical quality indicators across UHN remain stable, supported by active and reliable incident reporting. No Maternity Outcomes Signal System (MOSS) MNSI alerts were identified during the reporting period, and PMRT reviews continue to be completed within expected national timeframes. Perinatal mortality demonstrates normal month-to-month variation with no concerning trends emerging. Ongoing work to align governance processes across NGH and KGH is strengthening consistency, standardising reporting, and improving data quality. The introduction of Perinatal Quality and Safety Matrons is already enhancing clinical oversight, promoting cross-site learning, and providing increased assurance around safety and continuous improvement.

Patient experience

across UHN remains positive, with strong engagement in the Friends & Family Test. Complaints remain low, and initiatives such as Family & Friends Friday are improving visibility and feedback, while language, communication and discharge information continue to be key themes highlighted by service users. Staff feedback also emphasises the need for clearer communication and updates on improvement work, and ongoing actions are focused on strengthening consistency, cultural awareness and real-time responsiveness across both sites.

Outcomes:

Clinical outcomes in February were stable across maternity services. Most measures remained close to expected levels. Smoking rates and high BMI at booking continue to vary and will be monitored. Key indicators during labour, such as perineal trauma, major blood loss and breastfeeding, stay within expected ranges, despite normal month-to-month changes. Outcomes like APGAR scores, preterm birth and stillbirth also show typical variation with no signs of deterioration. Regular monthly monitoring ensures any concerns are identified early and acted on.

Operational & Capacity:

Operational performance across UHN remained stable throughout February. NGH maintained OPEL 1 with no escalation, and KGH experienced no significant increases in pressure, demonstrating effective capacity management across both sites. Red-flag events were recorded at each site primarily linked to delays and activity pressures. Homebirth services at KGH were temporarily paused due to staffing pressures, and one in-utero transfer for an extreme preterm case took place; however, there were no suspensions of acute maternity services at either site. Continued focus on maintaining safe staffing, strengthening escalation processes and improving Birthrate Plus compliance remains essential to ensuring resilient, evidence-based workforce planning.

Workforce:

Workforce pressures remain across UHN, with vacancies increasing at NGH following the repurposing of Band 3 funding, though recruitment progress and pipeline for midwifery and neonatal roles remains strong. KGH continues to manage a smaller midwifery vacancy gap with a confirmed recruitment pipeline, while medical workforce gaps persist and are being addressed through locum recruitment and plans to convert posts to substantive roles. Consultant job planning and a demand-and-capacity review are underway to ensure sustainable consultant presence, safe staffing and alignment of service needs across both sites.

February 2026 UHN AT A GLANCE

AVERAGES PER DAY

BOOKINGS 12

BIRTHS 18

BABIES BORN

519

PREV. MONTH
Jan - 598

BIRTH LOCATION

KGH (Labour Ward)	OOA	HOME
193	15	6
NGH (Labour Ward)	BIRTH CENTRE	HOME
227	17	8

3RD & 4TH DEGREE TEARS

2.37%

Jan 1.6%

BLOOD LOSS >1,500MLS

4.76%

Jan 3.88%

251 GIRLS

264 BOYS

4.45%

January 3.7%

FULL TERM BABIES ADMITTED TO NNU

INDUCTION OF LABOUR (IOL)

26.6%

Jan 30.65%

51.35%

CAESAREAN SECTIONS

Jan 41.03%

	AUGUST	PREV 12 MTH. AV.
ELECTIVE	118 (24.5%)	59 (22.7%)
EMERGENCY	136 (24.5%)	81 (29.36%)

SETS OF TWINS 15

SETS OF TRIPLETS 0

ASSISTED BIRTHS

9.1%

VENTOUSE 2.34%

FORCEPS 4.81%

BREASTFEEDING INITIATION

79%

PREV. 12 MONTHS – 79.4%

February 2026 AT GLANCE



AVERAGES PER DAY

BOOKINGS

KGH 10
NGH 12

BIRTHS

KGH 8
NGH 10

BABIES BORN



UHN 519

KGH 214
NGH 305

PREV. MONTH UHN
598



KGH 3.7%
NGH 5.2%

FULL TERM BABIES ADMITTED TO NNU



BIRTH LOCATION

KGH
(Labour Ward)

OOA

HOME

193

15

6

NGH
(Labour Ward)

BIRTH
CENTRE

HOME

227

17

8

3RD & 4TH DEGREE TEARS

KGH

0.9%

Jan
0.4%

NGH

3.4%

Jan
2.5%

BLOOD LOSS >1,500MLS

KGH

5.7%

Jan
4%

NGH

4.1%

Jan
2.3%

GIRLS

KGH 93
NGH 158



BOYS

KGH 119
NGH 145



SETS OF TWINS



KGH 6
NGH 9

SETS OF TRIPLETS



KGH 0
NGH 0

INDUCTION OF LABOUR (IOL)

KGH 37% PREV. 12 MONTHS – 30.4%

NGH 26.7% PREV. 12 MONTHS – 24.0%



UHN CAESAREAN SECTIONS

51.35%

KGH 54.7%

NGH 49.0%

ELECTIVE

KGH

51

(24.5%)

PREV 12 MTH. AV.

55

(23.47%)

NGH

67

(22.6%)

64

(22.2%)

EMERGENCY

KGH

58

(27.9%)

78

(29.6%)

NGH

78

(26.3%)

84

(29.2%)

ASSISTED BIRTHS

KGH 18

NGH 29

VENTOUSE

KGH 12

NGH 10

PREV. 12 MONTH AV.

VENTOUSE

KGH 8

NGH 4

FORCEPS

KGH 6

NGH 19

FORCEPS

KGH 14

NGH 24



BREASTFEEDING INITIATION

KGH 74.9%

NGH 77%



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

Month 2026 UHN AT A GLANCE

98%

MDT CLINICAL
SIMULATION
TRAINING
COMPLIANCE (YTD)



98% Jan

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



1

MNSI
REPORTABLE
CASES &
REFERRED

2 Jan

MATERNITY FRIENDS &
FAMILY TEST
(SATISFACTION %)

95.5%



VACANCY RATE
(February DATA)

MIDWIVES

8.4%

CONSULTANT
OBSTETRICIAN

0 WTE

NEONATAL NURSES

7.3%

NEONATOLOGISTS

0 WTE

NEWBORN LIFE
SUPPORT TRAINING
COMPLIANCE (YTD)

97%



97% Jan

5

MODERATE
INCIDENTS

13 Jan



0

PATIENT SAFETY
INCIDENT
INVESTIGATIONS
(PSII)

0 Jan



0

CORONER'S
REGULATION 28

0 Jan

MINIMUM SAFE STAFFING
MET (LABOUR WARD ONLY)

82.5%

88.4% Jan



1:1 CARE IN
LABOUR

100% Jan

100%



Month 2026 AT A GLANCE

KGH 99%
NGH 97%

MDT CLINICAL
SIMULATION
TRAINING
COMPLIANCE (YTD)



YEAR 6
MATERNITY INCENTIVE
SCHEME

9 SAFETY ACTIONS

KGH 6 SAFETY ACTIONS

NGH 9 SAFETY ACTIONS



KGH 1

NGH 0

MNSI
REPORTABLE
CASES &
REFERRED

November

MATERNITY FRIENDS &
FAMILY TEST
(SATISFACTION %)

KGH 95%
NGH 96%



VACANCY RATE

MIDWIVES	KGH 7.95%	NGH 8.68 %
CONSULTANT OBSTETRICIAN	KGH 0 %	NGH 0 %
NEONATAL NURSES	KGH 9.3%	NGH 5.61 %
NEONATOLOGISTS	KGH 0 WTE	NGH 0 WTE

NEWBORN LIFE
SUPPORT TRAINING
COMPLIANCE (YTD)

KGH 99%

NGH 96%



KGH 2

NGH 3

MODERATE
INCIDENTS



KGH 0
NGH 0

PATIENT SAFETY
INCIDENT
INVESTIGATIONS
(PSII)

KGH 0
NGH 0

CORONER'S
REGULATION 28

MINIMUM SAFE STAFFING
MET (LABOUR WARD ONLY)

KGH 79%
NGH 86%



1:1 CARE IN
LABOUR

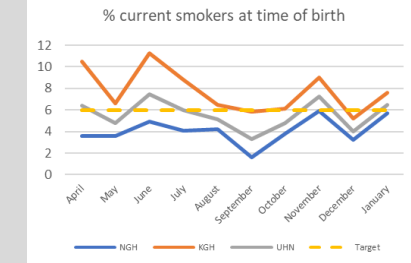
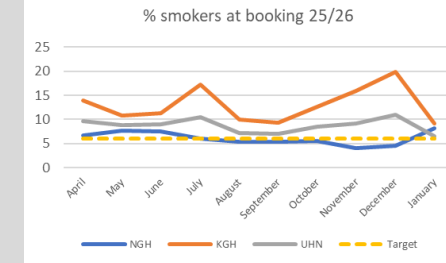
KGH 100 %
NGH 100 %

Summary

Overall clinical quality across UHN remains stable, with most antenatal, intrapartum and outcome measures showing expected month-to-month variation and no sustained deterioration. NGH generally performs close to target across indicators, while KGH contributes more variation, particularly in smoking rates, APGAR scores and preterm birth, although patterns largely reflect small numbers and high-impact single cases. Intrapartum measures such as PPH, perineal trauma and breastfeeding initiation stay within normal ranges, and outcomes including stillbirth and preterm birth remain broadly aligned with national expectations. Rising BMI at booking and persistent smoking variation indicate areas requiring continued focus, alongside strengthening intrapartum surveillance, early-pregnancy risk assessment and cross-site standardisation. Ongoing monitoring through the Perinatal Single Improvement Programme will ensure emerging trends are identified early and addressed consistently across both sites.

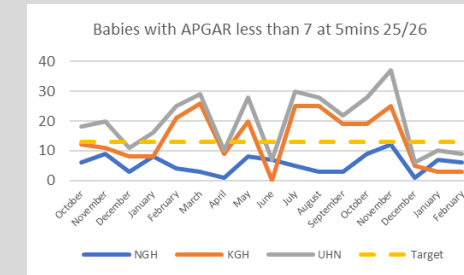
Smoking in Pregnancy

NGH continues to perform close to the smoking-reduction target, with consistently low rates at both booking and birth. KGH's rates remain significantly higher throughout the year, with several peak months that drive the overall UHN figures above target; as a result, UHN's combined trajectory closely mirrors KGH's trend. Improvement actions include strengthening pre-conception cessation work with public health partners, reviewing cross-site interventions to identify effective and transferable practice, implementing standardised UHN-wide monitoring and shared learning, and working with the MNVP to enhance communication campaigns and promote available support.



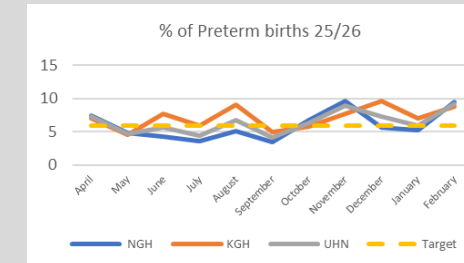
APGARs less 7 @ 5mins

NGH remains relatively stable and consistently below the target threshold, with only minor month-to-month variation. In contrast, KGH demonstrates greater fluctuation with several clear peaks, particularly in March, May and October, suggesting performance is influenced by small numbers and single high-impact cases, as well as periods of increased acuity or variation in intrapartum and immediate newborn care. To address this, key improvement actions include strengthening intrapartum surveillance and escalation pathways, enhancing consistency in fetal monitoring skills, expanding simulation-based newborn resuscitation training, and improving cross-site learning with standardised data definitions and recording. Progress will be monitored through the PSIP to ensure variation is reduced and practice becomes more consistent across both hospitals.

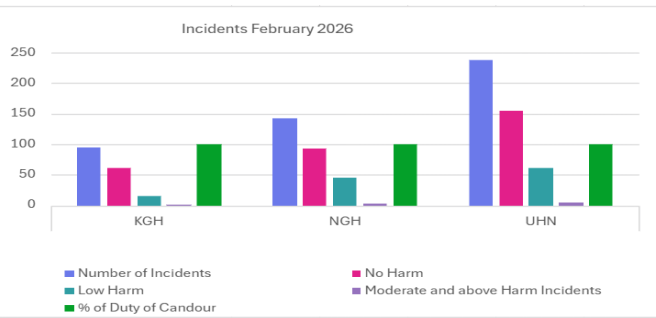


% of Preterm Births

Rates across UHN fluctuate around the national 6% target, with most months sitting close to or slightly above the threshold. NGH remains relatively stable with modest variation, while KGH shows slightly greater fluctuation with intermittent peaks. The combined UHN rate reflects this pattern and remains within a moderate range, showing normal statistical variation rather than a sustained upward trend. However, repeated months above target highlight opportunities to strengthen prevention and early risk identification. UHN is enhancing early-pregnancy risk assessment and launching a system-wide "Period Late, Tell Us By 8" campaign to support earlier booking, enabling timely identification of women at higher risk of preterm birth and ensuring consistent access to preterm birth prevention and optimisation – Deep Dive to be presented at the next PAC meeting

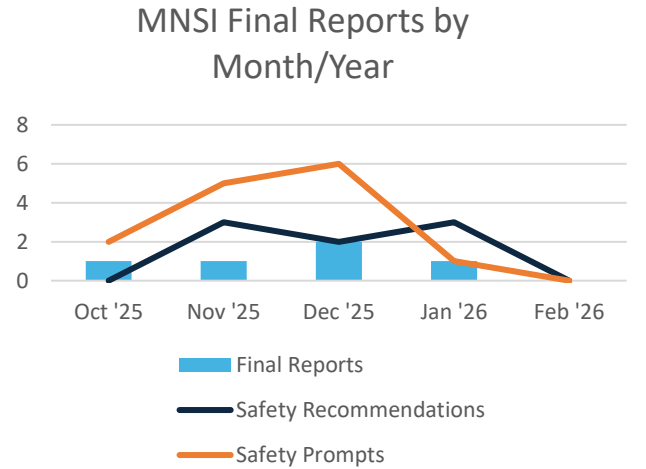


Incidents and Events



MNSI Cases	Current Month	Prior Month
Referred	1	1
Accepted	1	0

PSII Cases	Current Month	Prior Month
Commissioned	0	0



What the data is telling us

- 0 Patient Safety Incident Investigations (PSII) commissioned
- 1 Case referred to maternity and Newborn Safety Investigation (MNSI): Cases accepted
- 238 Datix's reported. Themes related to medication incidents and staffing due to transitional care. 5 Moderate Incidents with no immediate cause for concern.
- 2 Early Neonatal Deaths (21-36 week's gestation) and 2 Stillbirth Births. Spontaneous pre-viable labour and care provided outside of the UK identified as a themes.

What we need to focus on

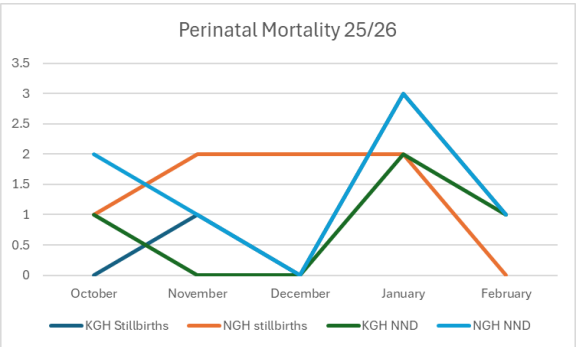
Postpartum Hemorrhage: NGH are undertaking a deep dive into PPH as numbers have increased, this is currently attributed to more accurate measuring and reporting however further analysis required

Clinical Quality and Safety: Ongoing work to strength governance alignment across NGH and KGH to ensure standardised reporting and improve data quality. Workshops beginning in April 2026

What is going well

Perinatal Safety Improvement Programme (PSIP) continues to progress at pace. The workstreams, Listening to and working with women and families, Growing, retaining and supporting our workforce, Developing and sustaining a culture of safety, learning and support and standards and structures that underpin safer, more equitable & personalised care are becoming well embedded. With good representation across the MDT and sites.

Perinatal Mortality



	MOSS Signal	SPEN referral
KGH	0	1
NGH	0	0

PMRT reviews include external panel member - no outstanding cases, all reviewed within correct time frames. SPEN Referral is in relation a Q3 MNSI case (baby transferred for cooling)

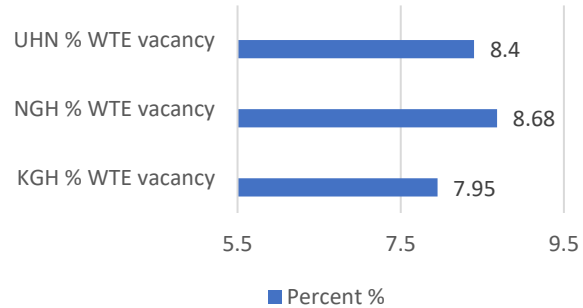
CQC Maternity Rating

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

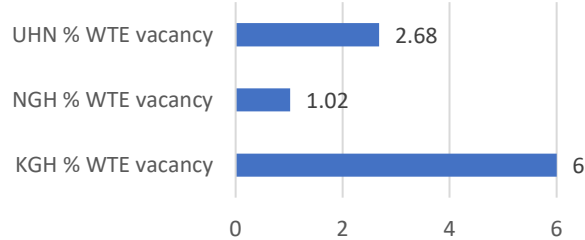
★ Outstanding ● Good ● Requires Improvement ● Inadequate

Midwifery vacancy

% vacancy registered midwifery staff
February 2026

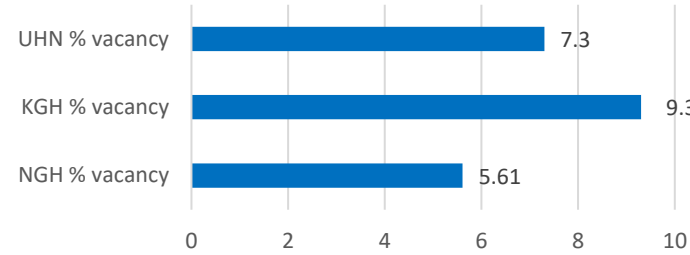


% vacancy non registered midwifery staff
February 2026

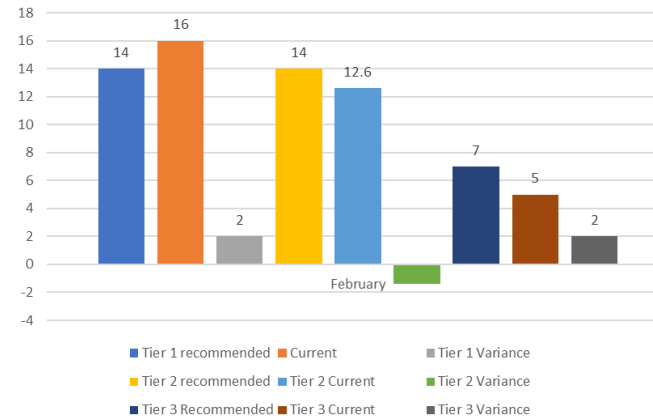


Neonatal vacancy

Neonatal nurse % vacancy Month Year



KGH Neonatal medical team



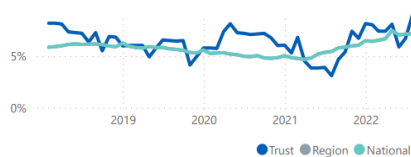
At NGH, vacancies have risen this month following the repurposing of Band 3 funding, although recruitment remains strong with 3.70 WTE midwives due to start in March and a further 8.81 WTE joining between April and September 2026. At KGH, the vacancy position stands at 7.95 WTE, supported by a healthy recruitment pipeline with appointed candidates and confirmed start dates. Neonatal nurse staffing continues to reduce across both sites month-on-month, but sustained recruitment activity is in place to address this.

Within the medical workforce, NGH currently relies on one agency locum obstetrician until June 2026. Recruitment is underway for two NHS locum posts on 12-month fixed-term contracts, with the agency locum being retained to maintain safe service cover until new staff are established in post. A business case will be developed to convert these roles into substantive positions, supporting long-term stability and reducing reliance on agency provision.

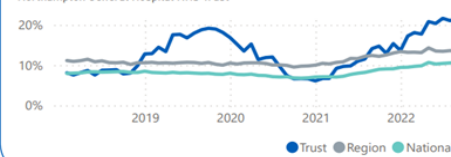
At KGH, obstetric consultant job planning continues with a focus on aligning clinical activity, supervision requirements and service needs. A comprehensive demand-and-capacity review is now required to identify current and emerging pressures and support the development of a sustainable consultant service model. This work will help ensure appropriate consultant presence, safe staffing levels and the resilience needed to meet current and future activity demands.

UHN 12 month rolling leaver rate

Trust 12 month rolling leaver rates (source: ESR leaver analysis by HEE)
Kettering General Hospital NHS Foundation Trust



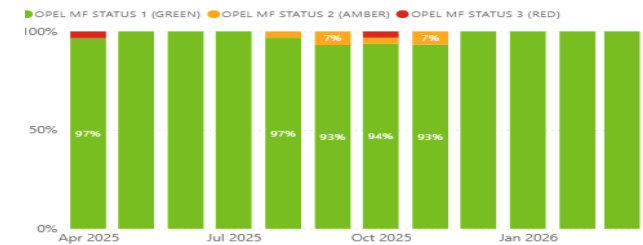
Trust 12 month rolling turnover rates (source: ESR leaver analysis by HEE)
Northampton General Hospital NHS Trust



Key Information

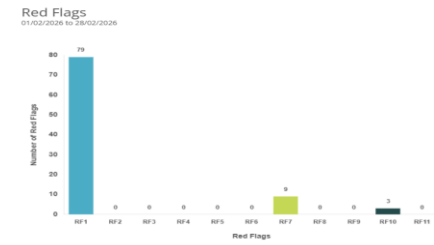
Operational Pressures Escalation Levels

Kettering General Hospital



Midwifery Red Flag Events

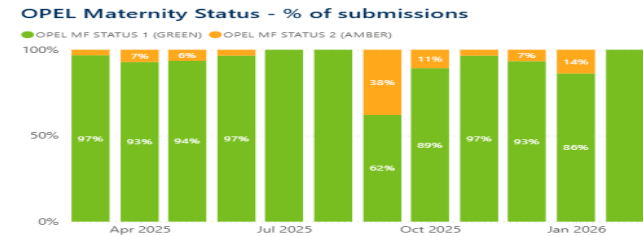
Kettering General Hospital



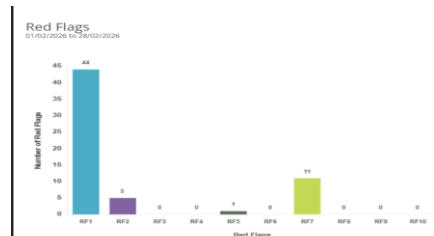
What the data is telling us

UHN maintained stable OPEL levels throughout February, with NGH remaining at OPEL 1 and KGH showing no significant escalation. Red flag events were recorded at both sites, mostly linked to delayed or cancelled critical activity, but without triggering service disruption. KGH homebirth services were pause on 24 February in response to a review of the service following the national PFD. An In-utero preterm transfer was undertaken supporting birth in the right place for gestation reflecting safe planning and good MDT working across the system.

Northampton General Hospital



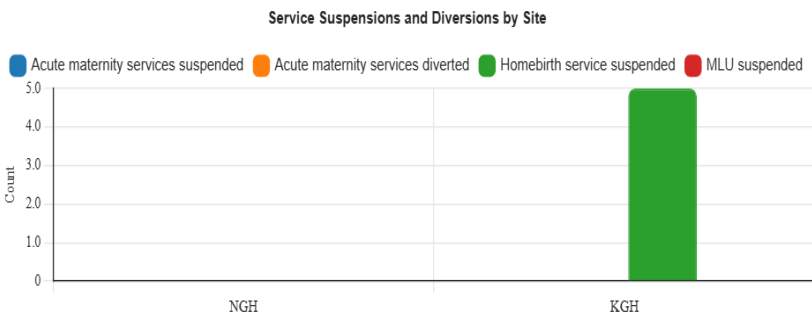
Northampton General Hospital



What we need to focus on

Continue recruitment and close monitoring of maternity capacity to maintain safe staffing, manage demand surges and reduce red flags. Maintain early escalation through established pathways. At NGH, improve Birthrate Plus compliance to strengthen evidence-based workforce planning. The plan to restore Homebirth service at KGH involves immediate safety actions, strong governance, clear communication, workforce training, guideline review, and ongoing assurance to provide safe, sustainable, and personalised homebirth care for women across UHN.

Performance Levels



In-Utero Transfers – extreme preterm births (Northamptonshire)

KGH 1
NGH 0

What is going well

Operational performance across UHN remains strong, with no acute maternity service suspensions, diversions or unit closures reported at either NGH or KGH. Both sites maintained stable OPEL escalation levels throughout February, demonstrating effective capacity management despite activity pressures. Midwifery red flag events were monitored closely, with delays or cancellations managed safely and no associated service disruptions. In-utero transfers for extreme preterm births were recorded as zero across both hospitals, indicating stable clinical pathways and safe local management. Overall, maternity services continued to deliver consistent, resilient care with uninterrupted service availability. Individualised support for booked homebirths at KGH

Training compliance

Attendance – All Staff

Kettering General Hospital

Northampton General Hospital

Module 3: Maternity emergencies and multiprofessional training:

	Dec-25	JAN	FEB
Prompt Midwives	99%	99%	99%
Prompt Doctors Cons	100%	100%	100%
Prompt Doctors Reg	100%	100%	100%
Prompt Anaesc Cons	100%	100%	100%
Prompt Anaes Reg	100%	100%	100%
Prompt MSW	98%	100%	100%

PROMPT	December	January	February
All Staff	98%	97%	97%
Anaesthetists	97%	89%	83%
Obstetric Consultants	92%	100%	100%
Obstetric Doctors	97%	87%	95%
Midwives	98%	100%	99%
Maternity Support Workers	99%	97%	99%

Module 6: Neonatal Basic Life Support:

	Dec-25	JAN	FEB
NLS Midwives	99%	99%	99%
NLS MSW	98%	100%	100%

NBLS/NLS	December	January	February
Midwives	97%	97%	96%
Maternity Support Workers	97%	97%	94%

Element 4: Fetal monitoring and surveillance:

	Dec-25	JAN	FEB
CTG Day Midwives	100%	99%	100%
CTG Day Consultants	100%	100%	100%
CTG Day Reg	100%	100%	100%

What the data is telling us

Training compliance remains consistently strong across both NGH and KGH, with the majority of modules achieving 95–100% attendance. NGH continues to perform above the 90% threshold and remains close to the 95% stretch target, providing strong assurance against CNST requirements. PROMPT attendance is high across all clinical groups—including obstetric, anaesthetic, midwifery and maternity support staff—demonstrating robust engagement with safety-critical training. While anaesthetic attendance shows a recent dip due to rota and release-time constraints, targeted coordination is already underway to ensure protected time for staff. Overall, the data provides clear evidence of sustained commitment to mandatory training and ongoing investment in safe, high-quality clinical practice.

What we need to focus on

Anaesthetic training compliance at NGH continues to require focused attention, with recent rota pressures and limited release time contributing to reduced attendance. Ensuring protected time for anaesthetic staff remains a priority to restore compliance levels. Preparation for the next PROMPT cycle is underway, including updating training content and ensuring reliable attendance across all staff groups. Maintaining high compliance across all modules remains essential, with early variation—particularly in multidisciplinary sessions—being monitored closely. Improved coordination between training teams and service leads will help prevent missed sessions and secure consistent access to safety-critical learning across both sites.

What is going well

Training compliance across both NGH and KGH remains strong, with the majority of modules achieving 95–100% attendance. PROMPT training is well-embedded, with consistently high participation from midwives, obstetricians, anaesthetists and maternity support staff. Fetal monitoring (CTG) training shows 100% compliance across all staff groups. At NGH, local learning continues to be systematically embedded through Training Week and ongoing simulation programmes. Multidisciplinary engagement is strong, and recent clinical skills updates have supported safe practice. New starters and rotation planning are progressing well, helping maintain continuity of learning and strengthening overall training culture.

Maternity Improvement Scheme

MIS Safety Action – Year 7	MIS Standards	KGH Status	NGH Status
1. Use of Perinatal Mortality Review Tool	6	Not Attained	Complete
2. Submitting data to the Maternity Services Data Set	2	Complete	Complete
3. Transitional Care and Avoiding Term Admissions to Neonatal Unit	4	Complete	Complete
4. Clinical workforce planning	10	Not Attained	Complete
5. Midwifery workforce planning	6	Not Attained	Complete
6. Saving Babies Lives Care Bundle	6	On Track	Complete
7. Listening to women, parents, and families	5	On Track	Complete
8. Multidisciplinary training	3	On Track	Complete
9. Ward to Board assurance	9	On Track	Complete
10. MNSI and Early Notification Scheme Reporting	9	On Track	Complete

Summary

[Maternity Incentive Scheme for Trusts Year 7](#) UHN has submitted CNST declaration forms for both Trusts. NGH fully achieved all ten Safety Actions, providing strong assurance of compliance. At KGH, Safety Actions 1, 4 and 5 were not fully met for MIS Year 7, as the evidence submitted did not yet demonstrate consistent embedding of required standards. Specifically, one PMRT review closure fell slightly outside the expected timeframe, the frequency of labour ward coordinator supernumerary breaches—though low—did not sufficiently evidence robust mitigations, and the consultant attendance audit, while compliant, lacked a replicable and assured methodology. Targeted improvement work is already underway to strengthen governance, workforce planning and evidence-gathering processes, providing confidence that the outstanding requirements are being actively addressed and will be fully met in the next submission cycle.

Saving Babies Lives

Element	Interventions Fully Implemented (Self-Assessment)				Interventions Fully Implemented (LMNS Validated)				NHS Resolution MIS	
	KGH		NGH		KGH		NGH		KGH	NGH
Smoking in Pregnancy	Partly	90%	Fully	100%	Partly	90%	Partly	90%	CNST Met	CNST Met
Fetal Growth Restriction	Fully	100%	Fully	100%	Fully	100%	Fully	100%	CNST Met	CNST Met
Reduced Fetal Movements	Partly	50%	Fully	100%	Partly	50%	Fully	100%	CNST Met	CNST Met
Fetal Monitoring in Labour	Fully	100%	Fully	100%	Fully	100%	Fully	100%	CNST Met	CNST Met
Preterm Birth	Partly	96%	Fully	100%	Partly	96%	Fully	100%	CNST Met	CNST Met
Diabetes	Partly	83%	Fully	100%	Fully	83%	Partly	83%	CNST Met	CNST Met
All Elements	Partly	94%	Fully	100%	Partly	94%	Partly	97%	CNST Met	CNST Met

Summary

UHN has achieved full compliance with Safety Action 6 of the Maternity Incentive Scheme (MIS) Year 7, with both NGH and KGH completing two ICB-led quarterly reviews in 2025/26. NGH was assured at 97%, with ongoing improvement work focused on evidencing diabetes specialist leadership and increasing the proportion of smokers achieving a four-week quit date. At KGH, improvement initiatives include the introduction of a preterm birth signs-and-symptoms leaflet to support optimisation pathways; however, challenges with meeting scan referral times have affected full compliance. A UHN-wide quality-improvement programme focused on scanning has now been incorporated into PSIP to address this, strengthen referral processes, and ensure consistent delivery across both sites.

EXPERIENCE FEEDBACK

Patient Experience

Complaints and Concerns

		Dec 25	Jan 26	Feb 26	YTD	Trend
Maternity	KGH	3	3	1	13	→
Neonatal	KGH					
Maternity	NGH	10	10	0	28	→
Neonatal	NGH	0	0	0	0	→

Friends and Family Test (FFT)

Kettering General Hospital

	Target	National	Dec-26	Jan-26	Feb-26	YTD
FFT % Responses	20%	13%	13%	10%	12%	17%
FFT % Promoters	96%	93%	99%	95%	98%	99%

Northampton General Hospital

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



I had an amazing (very quick) birth on the labour ward in the birthing pool MW and St were both great with making me feel comfortable and respecting my wishes in my birth plan. They also gave me the confidence to listen to my own body and trusted when I was ready to push which felt really empowering and I'm really grateful for. I felt reassured throughout labour and after and the care I received from them both from start to finish was excellent. the student will be a fab midwife once you qualify and your words of encouragement throughout really got me through - thank you so much!!



The Doctor was very communitive, polite , and made sure we understand what was going on and what was going to happen next. 2. All staff welcoming + friendly- lovely attentive. Great facilities +comfortable appreciate being able to have politeness around. What could have be done better; Clear communication on delivery would waiting times/ plan of action for long wait times when busy.

What the data is telling us

- KGH has launched the 'Friends & Family Friday' initiative to increase routine feedback collection, aiming to capture views from every service user each Friday. Continued support from ward managers is essential to maintain momentum.
- Current Friends & Family Test (FFT) promoter scores stand at 98% for KGH and 97% for NGH.
- Complaints increased at both sites in February, with KGH reporting two cases and NGH three cases. Overall FFT response rates at KGH remain low at 12% (141).
- In February, NGH exceeded the 20% response-rate target, achieving 26% (272 responses). The 'Birth' area achieved 100% satisfaction for the second time, contributing to an overall satisfaction rate of 97.4%.
- At NGH, communication and use of language remain the most common themes highlighted by service users. Lower satisfaction persists within triage and postnatal wards, where targeted improvement work continues.

What we need to focus on

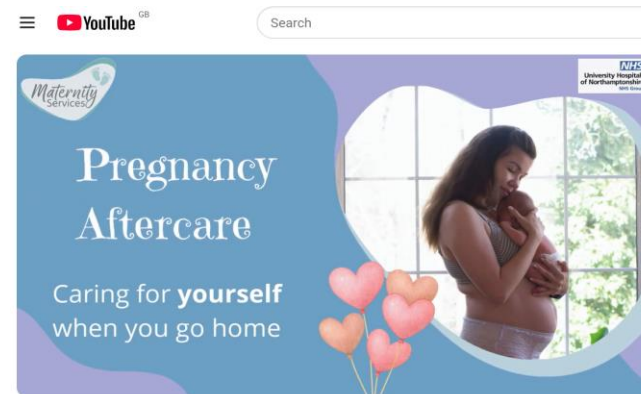
- Delays in discharge continues to be an area of dissatisfaction on the PN wards at NGH & KGH – discharge animations have now been approved via governance and are available for sharing which will hopefully speed up 'discharge talks' and support patients at home.
- The 'Motherhood group' has been contacted to explore staff training around black maternal health and cultures, with a focus around stigma, cultural differences, language and listening.
- Feedback rates continue to be a focus with regular sharing on social media. Work is being done with the digital team to add the FFT links to BadgerNet so that link can be sent directly to patients via badger notes. New links have been added to the NGH website to ensure the links are more accessible.

What is going on?

Two new patient-facing discharge animation videos are now available across both trusts, designed to support families in understanding key postnatal information before leaving the ward and again at home. Separate videos have been developed for maternal postnatal care and newborn care, created by the Patient Engagement Midwife in response to feedback highlighting delays in discharge and the need for clearer, more consistent information. These resources aim to ease pressure on ward teams by supporting the 'discharge talk' and ensuring patients receive accessible, standardised guidance. The videos can be accessed via the links below

[Mother Discharge Video Subs](#)

[Baby Discharge Video](#)



Pregnancy aftercare: Going home after giving birth

What is going on?

With the introduction of revised portfolio's for the UHN Senior Midwifery Team there are now Perinatal Quality Improvement Matrons working cross-site to provide dedicated leadership and collaboration on both ongoing and emerging QI programmes. Current QI priorities include:

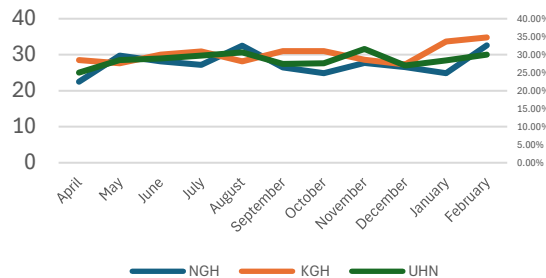
- **Induction of Labour (IOL) Pathway** – supported by the NHSE Regional Perinatal Team, with task-and-finish groups in place to progress pathway redesign, strengthen consistency and address operational inefficiencies
- **Elective LSCS Pathway** – KGH has begun implementing a BadgerNet-based booking system, with actions from recent process-mapping now being taken forward. Longer-term plans include aligning the elective caesarean process across UHN and reviewing workforce models for the elective section team and enhanced recovery pathways
- **Medicines Management** – the next QI project to launch, with cross-site process mapping planned to identify variation, highlight system challenges and establish priority areas for improvement

Collectively, these programmes provide a structured and coordinated approach to perinatal improvement, ensuring both sites move toward more aligned, reliable and efficient pathways.

APPENDICES

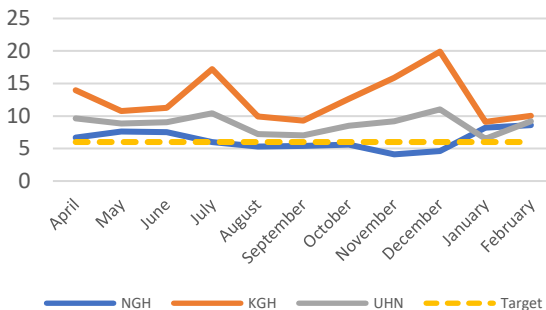
Antenatal

% BMI 30 or more at time of booking



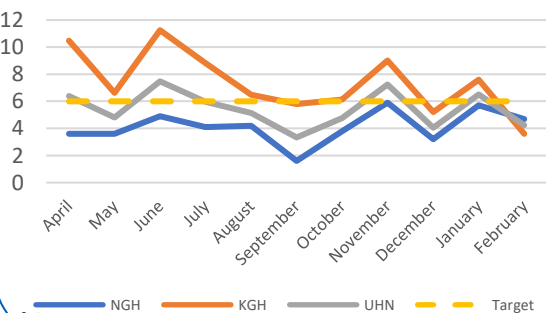
Latest	
30.05% increase from	28%
Variation	
No NGH data so UHN value artificially lower	
Target achievement	
N/A	

% smokers at booking 25/26



Latest	
9.214 % increase from	8.6%
Target	
6% SBLCB	
Target achievement	
Require additional data points to analyse	

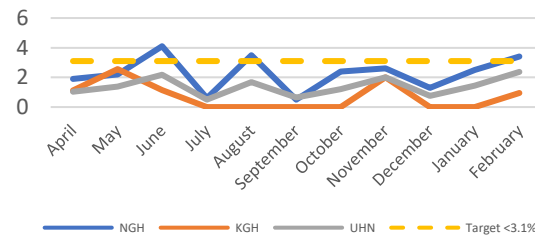
% current smokers at time of birth



Latest	
4.24% decrease from	6.5%
Target	
6%	
Target achievement	
Require additional data points to analyse	

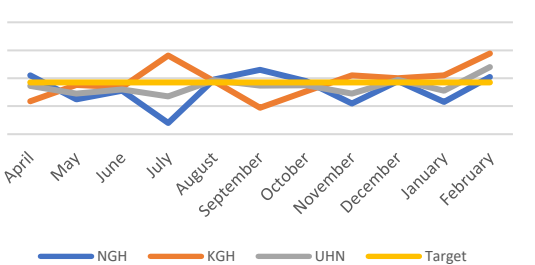
Intrapartum

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



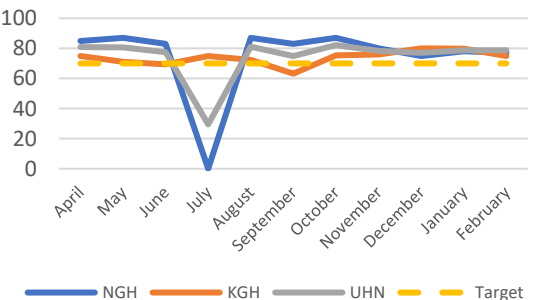
Latest	
2.37% Increase from	1.45%
Target	
3.1%	
Target achievement	
Require additional data points to analyse	

% Women with PPH of 1500ml or more



Latest	
4.8% increase from	3.1%
Target	
3.7%	
Target achievement	
N/A	

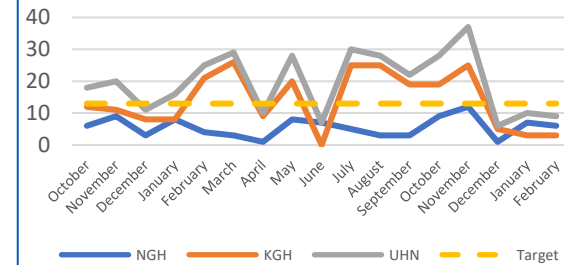
% Breastfeeding initiation 25/26



Latest	
76.12% reduction from	78.76%
Target	
70%	
Target achievement	
No NGH data for July	
Target achievement	
Require additional data points to analyse	

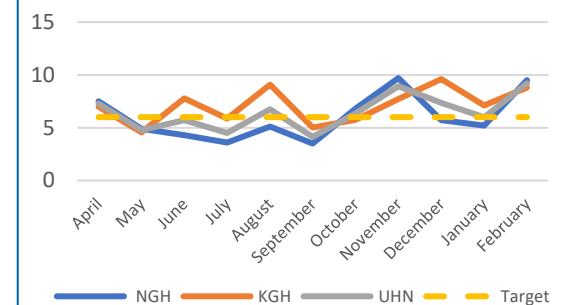
Outcomes

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



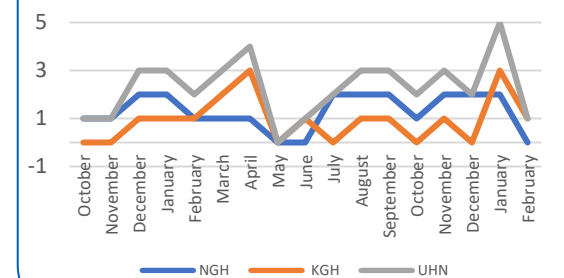
Latest	
9 decrease from 10 .	17/1000 births higher than target
Target	
13/1000 births	
Target achievement	
N/A	
Target achievement	
Require additional data points to analyse	

% of Preterm births 25/26



Latest	
8.92% of total births	
Target	
6% SBLCB	
Target achievement	
Require additional data points to analyse	

Stillbirth 25/26

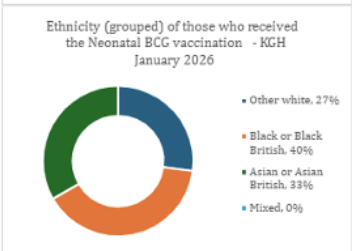
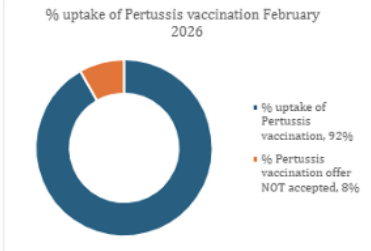
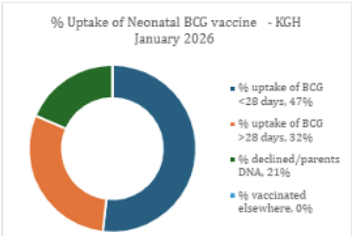
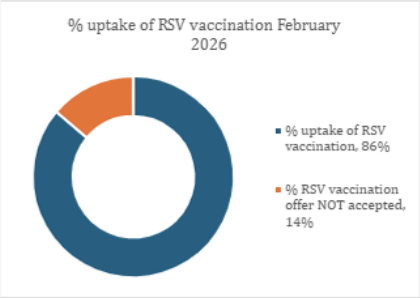
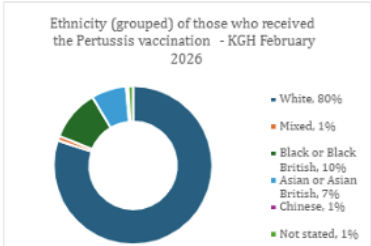
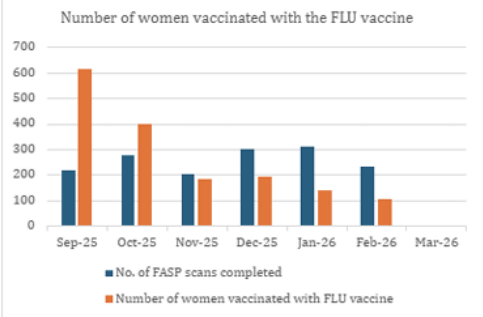
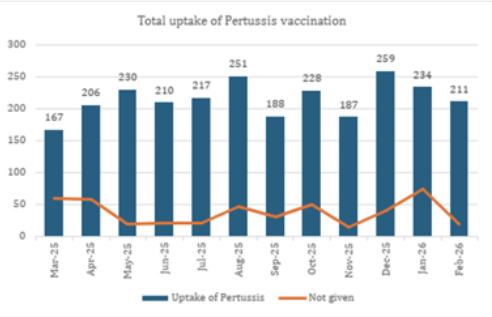


Latest	
1.93 per 1000 births –	UHN reduction from 5.36
Target	
N/A	
Target achievement	
N/A	

IMMUNISATION SUMMARY

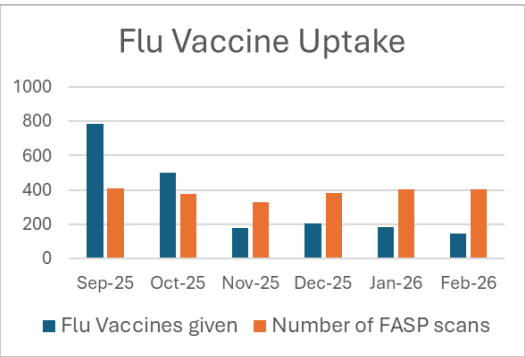
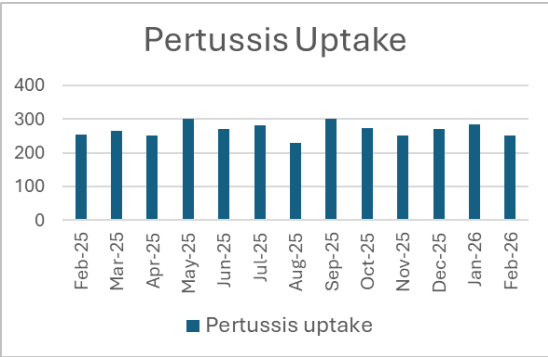
Kettering General Hospital

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

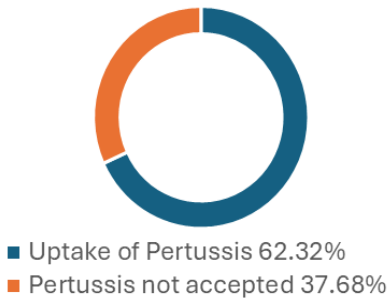


Northampton General Hospital

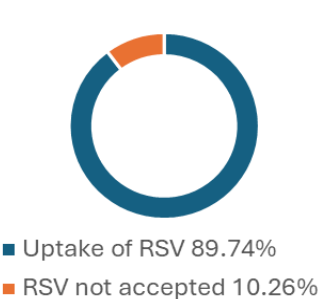
Immunisation Summary NGH February 2026



Percentage of Pertussis NGH February 2026



Percentage of RSV NGH December 2025

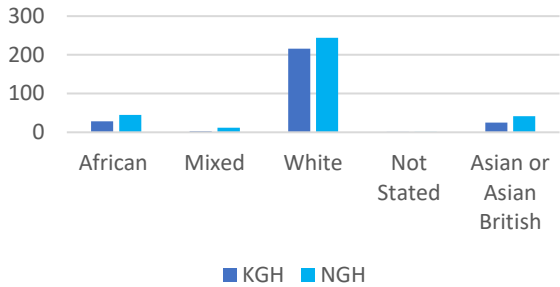


KGH reports steady antenatal immunisation activity, with February data showing uptake across pertussis, RSV, flu and neonatal BCG programmes, alongside visual breakdowns of accepted and declined vaccinations. NGH shows detailed February 2026 uptake trends for pertussis and flu, with pertussis acceptance at 62.32% and RSV acceptance at 89.74%. Flu vaccine volumes are tracked monthly against FASP scan numbers. NGH highlights improved accessibility through three community clinics, supporting higher maternal and BCG vaccination rates while reducing hospital burden and mitigating space and location challenges

EQUITY AND POPULATION

Ethnic profile and variations

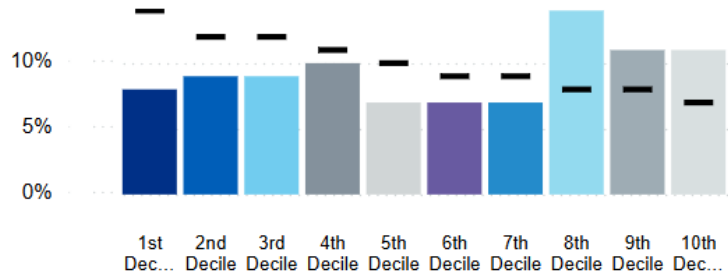
Population profile at booking



Across both sites, the vast majority of births occur within the White ethnic group, with NGH recording slightly higher numbers than KGH. Small numbers of births are recorded among African and Asian or Asian British families at both sites, with NGH again reporting marginally higher activity. Very low numbers appear in the Mixed category, and a small proportion of records are classified as Not Stated. The distribution reflects the population profile of the local maternity service, and the pattern is broadly similar across both hospitals, with no major disparities between sites except for overall activity volume.

Deprivation

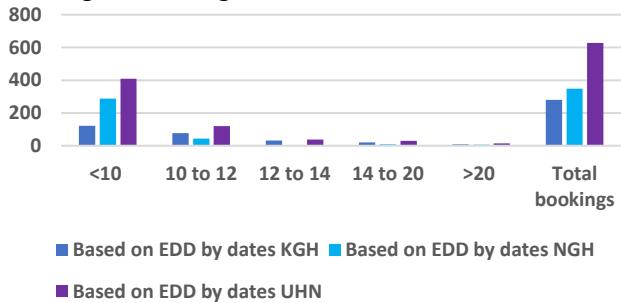
Population profile at birth



The chart shows the distribution of births across deprivation deciles, from the most deprived (1st decile) to the least deprived (10th decile). Births are spread across all deciles, but the pattern indicates no strong clustering at either extreme. The mid-range deciles (3rd–5th) show moderate representation, while the 8th decile displays a noticeable peak, suggesting a higher proportion of births from less deprived areas. The 1st and 2nd deciles also show steady contributions, indicating a continued presence of families from more deprived communities. Overall, the data suggests a mixed population with slightly higher birth activity in the less deprived deciles.

Gestational Age

Gestational age at booking



The chart shows the distribution of gestational age at booking across KGH, NGH and the combined UHN totals. Most women book before 10 weeks, with NGH showing the highest proportion of early bookings, followed by the combined UHN total. A smaller number of women book between 10–12 weeks and very few book after 12 weeks, with numbers declining further in the 14–20 week and >20-week categories. Total booking numbers are higher at NGH, reflected in the slightly larger bars across most gestational age groups. Overall, the data indicates that the majority of women access maternity care early in pregnancy, with relatively few late bookers across both sites. To further support early access to perinatal services across UHN a new campaign has been launched – ‘Period Late Tell Us By 8’

Glossary

In February, there were 716 babies born across the service, which was below the monthly average and notably lower than January, partly due to the shorter month. Irrespective of the decrease in number of babies born, activity remained high noted in our amber and red OPEL status, along with higher acuity levels and a corresponding rise in reportable red flags. Tactical meetings ensured decisions were made to maintain 1:1 care during labour and ensure safe staffing levels. Staff were redeployed, and services were diverted as necessary with no impact or negative harm. Staffing gaps were primarily caused by high levels of sickness and unexpected absences. Induction of Labour (IOL) activity remained high, but there was a positive improvement in the time taken from decision-making to performing artificial rupture of membranes compared to previous month. Our latest position on the regional heatmap has improved significantly, now sitting at 34.3, down from 53.3. As a result of improvements within the service, ICB/Regional oversight has been stepped down, with ongoing monitoring through routine perinatal quality surveillance.

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

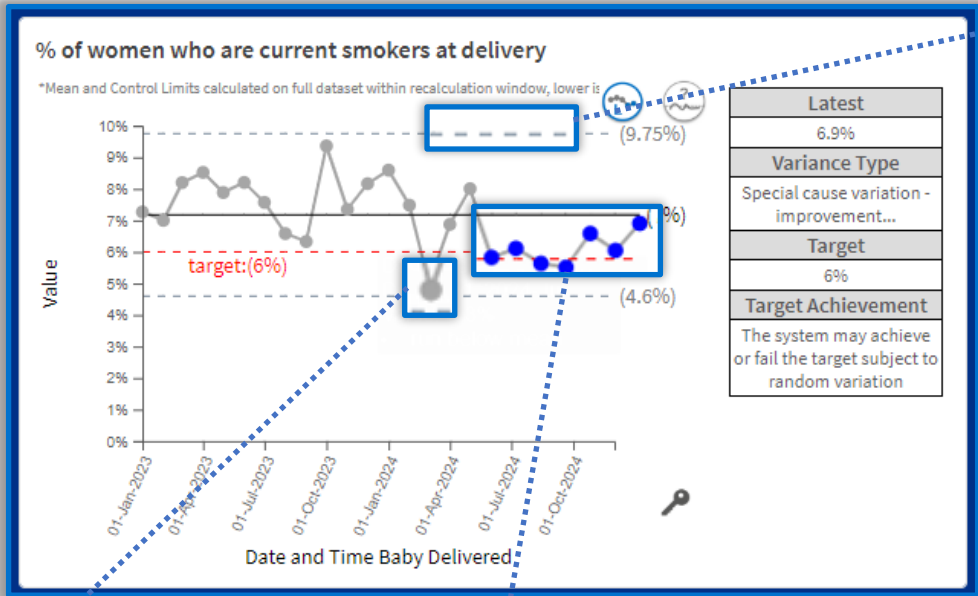
INTERPRETING DATA

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

SPC charts are widely used across the NHS to measure changes in data over time.

There is **strong evidence** that these provide a **better basis for decision making** versus isolated data points.

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



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

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

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

Meeting	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	9 April 2026		
Title	KGH Maternity and Neonatal Intensive Support Team (MatNeolST) Programme (Item 3.2 Paper H)		
Presenters	Julie Hogg, Chief Nurse Danni Burnett, UHN Interim Director of Midwifery		
Author	Danni Burnett, UHN Interim Director of Midwifery		
Action: this paper is for			
☐ Decision (indicate, UHL, UHL, KGH or NGH as required)		☒ Assurance (KGH)	☐ Update
Which Group Priorities does this link to?			
☒ Transform Patient Care		☒ Strengthen our Culture	☐ Deliver our financial plan
Where has this report has been discussed previously?			
NHS England and Northamptonshire ICB Improvement Oversight & Assurance Group (IOAG) 18 November 2025, 17 December 2025, and 15 January 2026, 5 March 2026			
Does the report provide assurance or mitigate any significant risks? If yes, please detail which			
UHN11 Improved clinical outcomes, experience and effectiveness UHL BAF risk reference			
Appendix			
Appendix 1: MatNeolST Monthly Report (February 2026) (enclosed below)			
Impact assessment			
Financial: Potential for increased/changes to workforce and equipment. Failure to achieve our CNST incentive reduction (>£200k). Possible support available through NHS England funding vis LMS work streams. Legal: Risk of the safety of maternity services being called into question and the aligned financial and reputational risk Equality: This is applicable to all staff within Northamptonshire LMNS and all women accessing care within the LMNS.			

Executive Summary

Maternity services at KGH continue to demonstrate clear, observable and sustained improvement, with positive movement across safety, governance, workforce and cultural indicators. The service is now operating within a far more mature, reliable and transparent improvement architecture, with strengthened oversight from divisional, corporate and system-level partners.

The implementation of the Perinatal Safety Improvement Programme (PSIP) alongside a high-quality bi-weekly SitRep has created a single, coherent regulatory recovery framework, aligning PSIP, CQC actions, and MatNeolST milestones and improving Board visibility, grip and pace. These mechanisms ensure that risks are proactively identified, mitigated and escalated through a strengthened governance line of sight.

All PSIP workstreams are embedding. There is clear evidence of improved clinical governance, strengthened workforce resilience and early cultural recovery. Continued focus on estates, documentation, policy governance and specialist workforce capacity will be critical to securing sustained improvement and delivering regulatory exit.

Recommendations

For the **KGH** Board of Directors to:

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

Kettering General Hospital (KGH) Maternity Improvement Progress Report: Perinatal Safety Improvement Programme (PSIP) and NHS England MatNeolST

Reporting period: February 2026 – March 2026

EXECUTIVE SUMMARY

Maternity services at KGH continue to demonstrate clear, observable and sustained improvement, with positive movement across safety, governance, workforce and cultural indicators. The service is now operating within a far more mature, reliable and transparent improvement architecture, with strengthened oversight from divisional, corporate and system-level partners.

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All PSIP workstreams are embedding. There is clear evidence of improved clinical governance, strengthened workforce resilience and early cultural recovery. Continued focus on estates, documentation, policy governance and specialist workforce capacity will be critical to securing sustained improvement and delivering regulatory exit.

Key Improvements (demonstrated this reporting period):

- Clinical safety indicators:
 - Consultant attendance: 88%
 - BSOTS triage: 73% seen within 15 minutes; 80–95% compliance across 1-hour/4-hour markers
 - Neonatal resuscitaire checks: 92–98%
 - Theatre medicines safety: 100% compliance
- Service-user experience improving: 100% compliance with consent/communication standards (January audit) and FFT comments referencing improved information-giving and autonomy.
- Workforce stability: All midwifery vacancies filled; mandatory training sustained at 92–96%; strengthened senior medical presence.
- Culture indicators improving: Increased *speaking up* engagement, leadership visibility, civility training uptake, and psychological-safety feedback.

The overall trajectory indicates increasing maturity and reliability, with clear evidence that KGH is progressing towards sustained regulatory recovery and MatNeolST exit.

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

A single, integrated PSIP governance structure is now fully operational, ensuring direct line of sight from frontline improvement activity through to the Board. This is supported by a network of cross-site specialist forums (i.e. IPC, Digital, Harm-Free Care, Fundamentals of Care) which provide real-time intelligence, expert validation and early risk detection.

Key enhancements to governance include:

- Weekly divisional/directorate senior leadership oversight
- Monthly IAOG scrutiny and exception reporting
- Weekly CQC exception reporting to Executives
- Full alignment of PSIP, CQC, national policy and strategic sustainability planning
- An Executive-led Perinatal Assurance Committee (PAC) as the formal Board-delegated oversight body

This layered approach provides the Board with triangulated assurance, reduces duplication, and ensures risk is actively managed using a three-lines-of-defence model.

KGH formally transitioned from MSSP to Intensive MatNeoIST Support on 1 January 2026. This introduces:

- A 12-month period of intensive, executive-led support
- Dedicated midwifery and obstetric Maternity Improvement Advisors (MIAs)
- Access to national expertise (neonatal, QI, equity, workforce, PMA)
- A focus on co-delivery rather than performance management

Monthly NHS England executive meetings now form the primary assurance mechanism for the improvement programme, with attendance from KGH executives, clinical leadership, Maternity Voice partnerships and regional teams. The monthly MatNeoIST report is shared in Appendix 1. MIAs also attend Trust Board as required, ensuring direct Board visibility of progress, risks and required actions.

Outputs from these meetings are integrated into PAC, Divisional Governance and specialist forums—providing aligned, multi-layered oversight and preventing fragmentation historically seen in maternity improvement programmes.

Evolving MatNeoIST bellwether metrics will further enhance oversight as data maturity improves through BadgerNet implementation.

Board assurance: Governance is now functioning cohesively, with risks actively managed, actions tracked, and assurance strengthened through integrated reporting and executive leadership visibility.

2. MatNeoIST Progress

The MatNeoIST programme continues to progress, with strong clinical engagement and clear ownership across all workstreams. Several deadline extensions are now required, and the newly created PSIP Board (reporting directly into PAC) will be asked to approve (week beginning 30 March 2026). The primary issue has been capacity, rather than a lack of progress or commitment. Over recent months, a significant proportion of clinical leadership time has necessarily been directed toward delivering the CQC response plan, resulting in slower-than-planned mobilisation of certain MatNeoIST strands.

Despite these operational pressures, several key components of the programme are now underway or already embedded, including:

- The Induction of Labour (IOL) Quality Improvement Group,
- Strengthened Diabetes improvement work, supported regionally,

- Consultant job planning to strengthen medical workforce resilience,
- Pathway mapping for Elective Lower Segment Caesarean Section (ELCS), and
- Continued progress in implementing BSOTS (Birmingham Symptom-Specific Obstetric Triage System).

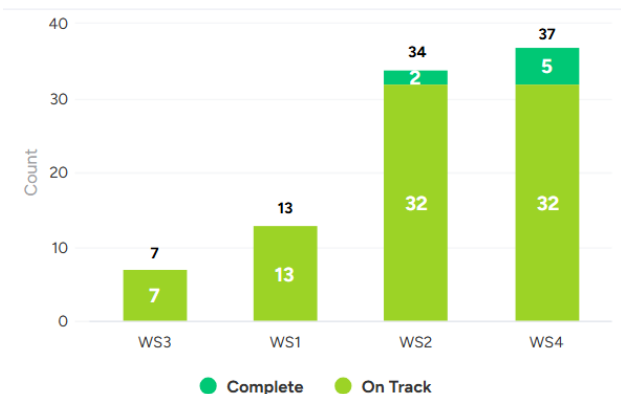
Revised Milestones and Workstream Extensions

The following areas in which timeline extensions are proposed:

- Workstream 1: MNVP workplan and collaborative assessment
- Workstream 2: Community review, obstetric leadership/capacity, workforce strategy development, OPEL/escalation framework, and the EDI deep dive
- Workstream 3: Governance and board effectiveness, and further embedding of PSIRF
- Workstream 4: IOL and ELCS pathway milestones

Workstream 4 additionally proposes the establishment of a dedicated ELCS Task & Finish Group, mirroring the existing structures for IOL, Diabetes, and the Triage group, to accelerate progress and ensure clinical ownership of pathway redesign.

With the new extensions all actions (115 actions) will be on track for delivery:



Overall Programme Position

All MatNeolST milestones remain aligned to the updated timelines, which have now been formally approved and supersede previous MSSP expectations. These milestones span 3-, 6- and 12-month horizons, giving the programme a clear recovery trajectory and enabling strengthened national oversight.

Although operational stretch is recognised due to the number of concurrent improvement programmes, it is important to note that:

- Milestones are fully mapped into governance routes
- Clinically led, multidisciplinary teams hold delivery ownership
- Delivery pace, engagement, and intent remain high

Next Phase of Delivery

The forthcoming phase of MatNeolST implementation will provide tangible evidence of:

- increasing cultural maturity,
- greater workforce resilience,
- strengthened and embedded clinical governance, and
- demonstrable improvements across priority pathways, including elective LSCS, community provision, equity, maternity IQI, and strategic workforce planning.

The programme remains on a positive trajectory, and the requested extensions reflect a pragmatic and transparent approach to ensuring high-quality, sustainable delivery.

3. Culture & Organisational Development (Culture & OD)

As part of PSIP a significant culture reset is underway, addressing known issues including inconsistent behaviours, strained psychological safety, and variable supervisory structures.

Progress includes:

- High leadership visibility
- Civility and Respect interventions
- OD-led coaching
- “How Was Your Shift” real-time feedback
- Strong FTSU engagement and early resolution trends
- Mandatory training at 92–96%

Early indicators show:

- Improved escalation behaviours
- Strengthened psychological safety
- Increased recognition awards
- Less formal employee-relations activity

However, risk hotspots remain in sickness, screening/immunisation, and fetal medicine capacity. Sustained investment in wellbeing, supervision and retention will be essential.

Board assurance: Culture trajectory is positive, but full embedding will require continued leadership visibility, behavioural consistency and targeted support for specialist teams.

4. Bellwether Metrics & Monitoring for Impact

A developing 59-metric Bellwether dashboard provides triangulated insight across governance, pathways, workforce, fetal monitoring, triage, elective/emergency pathways, culture, and service-user voice. Approximately two-thirds of metrics now have trend data, with remaining gaps linked to diabetes pathways, MNVP workplan, and developing QI projects.

The latest clinical, governance, workforce and cultural performance metrics provide a high level of assurance that maternity services continue to progress towards sustained safety and regulatory compliance. Evidence presented through routine audit, triangulated intelligence, and PSIP-aligned oversight demonstrates that core safety processes are increasingly reliable and embedded across the service.

Clinical safety indicators remain strong. Consultant labour-ward presence is consistently achieved at 88–89%, and significant improvement has been sustained in BSOTS triage performance, with Yellow/Orange (1-hour) compliance increasing from 45–50% to 80–85% and Green (4-hour) performance maintained at 90–95%. Neonatal resuscitaire checks remain within control limits (AM 92%, PM 98%), and theatre medicines-safety audits continue to demonstrate 100% compliance, with any isolated lapses promptly rectified. These metrics indicate a stable and well-governed clinical environment with effective risk controls in place.

Governance arrangements provide further assurance. Approximately 90% of actions arising from the 2024 CQC inspection have been completed, supported by strengthened closed-loop assurance mechanisms, comprehensive audit logging, independent oversight via PSIP, and routine triangulation of incidents, complaints and performance data. This reflects a maturing governance system with clear line-of-sight from frontline practice to executive and Board-level oversight.

Cultural indicators show early but sustained positive movement. The latest pulse survey reports strong awareness of safety processes, improving leadership visibility and escalation behaviours, and rising Freedom to Speak Up activity with high closure rates. Formal employee-relations activity remains low, indicating issues are increasingly resolved proactively and informally. These trends demonstrate progressive strengthening of psychological safety and team communication, though continued attention is required to ensure consistency across all clinical areas.

Workforce and training data further reinforce service stability. Mandatory training is progressing towards the ≥90% target, Enhanced Maternal Care competencies embedding, and midwifery shift-fill remains consistently between 90–100%. Supernumerary labour-ward coordinator breaches remain within control limits and are effectively mitigated. Midwife-to-birth ratios continue to align with Birthrate Plus® benchmarks, and recruitment actions are underway to deliver a fully dedicated 24/7 registrar presence for triage and FHU.

Pathway and documentation improvements, most notably full adoption of BSOTS, high antenatal escalation documentation (100%), strong risk-assessment and CTG accuracy, and stable induction-of-labour intervals. This provides further assurance that safety-critical processes are reliable and consistently applied. All key clinical policies are in-date or formally extended, and a new Duty of Candour policy has been approved.

Board Assurance: Key metrics demonstrate that maternity services are operating within a strengthened safety, culture and governance framework. While further work remains to fully embed improvements and address residual variation, the evidence provides the Board with a high degree of confidence in the direction of travel, the reliability of current safety processes, and the organisation's continued commitment to delivering safe, high-quality care and meeting regulatory expectations.

5. Overall Board Assurance Summary

KGH is demonstrating measurable and sustained improvement across all core domains. While further embedding is required the current trajectory, supported by strengthened governance and MatNeoIST alignment, provides the Board with a high degree of confidence that KGH is progressing towards regulatory recovery and sustainable, high-quality maternity care.

Appendix 1 – MatNeoIST Monthly Report

Maternity and Neonatal Improvement Support Team

Monthly Update Report

Trust name:	Kettering General Hospital (University Hospitals of Northamptonshire Trust)	Report date:	Feb 2026	
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:	2 nd , 3 rd , 4 th , 16 th , 17 th , 23 rd , 24 th - Feb	Support start date:	January 2026	Support end date: January 2027

Achievements and progress of milestones

- Milestones – positive progress in relation to all milestones. Some minor slippage in relation to IOL, ELCS, governance benchmarking, revised timeframes in place with the view to be on track by end of Q1.
- EDI deep dive undertaken, lead by Wendy Olayiwola, National Maternity Lead for Equity NHSE, final group sessions to take place in mid March.
- Trust focused work in relation to culture ongoing – staff wide training in relation to civility with use of innovative 'lived experience' staff videos
- Triage / BSOTS has made excellent progress and is exceeding 3 month milestone (inclusive of governance arrangements)
- Homebirth service review for KGH and NGH undertaken by MIAs
- Neonatal NIAs in place and will be on site in March
- Community review complete (report in development)

Escalations

- Trust review of Homebirth Service, inclusive of benchmarking and Quality Impact Assessment – decision to temporarily pause the Homebirth service for 3 months at KGH. Briefing paper, comms and comprehensive action plan to restore service
- Strengthening legal teams interface relating to birth outside of guidance pathway
- Emerging Obs consultant gap due to upcoming mat leave – out to recruit locum cover, potential challenge in relation to covering leadership roles for Triage, People and Culture.

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:	9 April 2026					
Title:	4.1 East Midlands RRDN Quarterly Board Report (Paper H)					
Report presented by:	Gang Xu, Interim Medical Director and Elizabeth Moss, Network Director, East Midlands RRDN					
Report written by:	Elizabeth Moss, Network Director, East Midlands RRDN and Carl Sheppard, Corporate Services Manager, East Midlands RRDN					
Action – this paper is for:	Decision/Approval		Assurance (UHL)	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	East Midlands Regional Research Development Network (RRDN) Host Governance Group on 25 March 2026.					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The purpose of the report is to provide assurance against the RRDN Host Contract. The report does not relate to any significant risks.

Impact assessment
N/A

Purpose of the Report

The purpose of this report is to provide an update on current RRDN priorities and assurance regarding the latest RRDN financial position and risks & issues.

University Hospitals of Leicester (UHL) NHS Trust is the Host Organisation for the National Institute for Health and Care Research (NIHR) East Midlands Regional Research Delivery Network (RRDN). UHL is contracted by the Department of Health and Social Care (DHSC) to take overall responsibility for the monitoring of governance and performance of the Network.

Recommendation

We would welcome the Boards' input to review the report and provide any comments or feedback and seek the **UHL Board's** assurance regarding the RRDN host contract.

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

BOARDS OF DIRECTORS

9 April 2026

Summary

This report provides an update on recent progress and current priorities for the RRDN. This includes work to support the government's 150 day target for research study set-up, information regarding 2026/27 RDN funding and a change to the RRDN Host Organisation Nominated Executive Director. For assurance purposes, the report also includes information pertaining to the RRDN 2025/26 financial position and an update on key risks. Appended to this report is our latest Finance update report and current risks & issues register.

Main report detail

1. RRDN progress and priorities

i) 150 days set-up metric

A key priority for the RDN continues to be supporting the government's metric to reduce clinical trial set up time to 150 days by March 2026 for all NIHR RDN research studies. Recently this has involved working with NHS Trusts to provide timely, accurate data supported by regular communication and guidance. NHS Trust dashboards for study set-up have been developed by the RDN to help organisations view and monitor performance, improve data quality and identify challenges. Furthermore, the Network has provided additional in-year funding of £220,000 to support projects across five NHS Trusts aimed at improving performance. Early feedback demonstrates that this has started to free up capacity of staff, enable the review of critical processes around feasibility and allow enhanced coordination of set-up activities.

The initial 60 days of the 150 day metric captures the time taken for the Medicines and Healthcare products Regulatory Agency (MHRA) and Research Ethics Committee (REC) to deliver a combined review decision. National reporting shows that this part of the metric is performing well.

The Network is focussed on supporting the following 90 days, which comprises the time from regulatory approval or site selection to first site ready to start at a Trust (60 days) and the time from site ready to start to first participant recruited (30 days).

Current data for all RDN portfolio studies shows all regions are falling significantly short of the expectation to meet this target. However, out of the 12 Regional Research Delivery Network regions, East Midlands is one of the better performing regions in relation to meeting the 90 day target 50% of the time as of 17th March 2026 (up from 43% of the time as of 12th January 2026). We are keen to collect case studies in relation to progress and impact in order to share good practice where things are going well, as we know there is work going on across the region to try to improve this metric and set studies up promptly.

Formal measuring of this metric by DHSC comprises a sub-set of commercial contract studies, with publication due by the start of next financial year (April 2026). When the Prime Minister announced

this initiative, in March 2025, between 30-35% of studies were meeting the 150 days metric; currently performance of this sub-set of studies is around 70-75%, progressing well towards year end. There is likely to be an ongoing expectation that all studies achieve this on an ongoing basis in future years.

ii) **RDN Funding for 2026/27**

As detailed in our previous report, a new national funding model for the NIHR Research Delivery Network (RDN) is being introduced from April 2026. Under the new model, each NHS Trust will receive a nationally derived annual funding allocation. This funding is provided to support the delivery of NIHR RDN portfolio research. Final allocations were confirmed to NHS Trusts on 27th February 2026.

This investment across NHS Trusts is to support all elements of research delivery, focussing on staff costs for the delivery of NIHR RDN portfolio studies and can include investment in clinical supporting services. To further support some of this investment, the East Midlands RRDN will also be in receipt of Clinical Supporting Services funding to invest across the region. This dedicated funding is to build capacity within clinical services supporting research to better enable study delivery, and where possible with a particular focus on the 150 days study set-up metric. This is intended primarily to fund staff related costs, with a focus on Pharmacy, Imaging and Laboratories, although not exclusively. Across the East Midlands, £392,902 is available to support this activity for 2026/27, guidance has been circulated, requests submitted and allocations agreed for delivery organisations. This dedicated funding stream is positive, however, it is recognised that greater investment in clinical supporting service is needed in the longer term.

In addition, two trusts in the East Midlands will continue to receive Pharmacy Capacity funding for the third year (2024/25 to 2026/27), which has been allocated by DHSC. The purpose of this funding is to address immediate staffing needs within NHS Trust pharmacy departments and therefore support pharmacy services for commercial and non-commercial clinical trials.

As part of the RRDN funding allocation, there are also opportunities to support growth across the region in the form of Strategic Investment and Wider Care Settings funding. Applications for these funding calls closed on 13th January 2026 and the following table sets out the number of applications received and total value of funding that was confirmed on 27th February.

Type of funding	Number of applications received	Number of applications funded	Total value of funding applications received	Funding available	Funding allocated
Strategic Investment	83	36	£7,795M	£1.281M 3% of this will be set aside to fund national strategic projects	£1.183M regional £14,252 national
Wider Care Settings	241	233	£3,795M	£2.187M	£2.301M

To note that funding can be moved across Strategic Investment and Wider Care Settings. As in previous years the total commitment is intentionally higher than the allocation due to allocations being maximum amounts and that not all awarded funding will be fully utilised. This does not pose a risk to the trust.

iii) **East Midlands RRDN Host Organisation Nominated Executive Director**

Following the retirement of Andrew Furlong in February 2026, Gang Xu, Interim Medical Director, took on the role of the Host Organisation Nominated Executive Director for the RRDN. We would like to extend our huge thanks to Andrew for the excellent leadership and support he has provided to the RDN and the previous Clinical Research Network over the last 10 years. Andrew's support and direction has been invaluable in helping to raise the profile of the Network at UHL, its role as a regional support mechanism for all organisations and providing helpful insights as to NHS business which have allowed the leadership team to manage risks and issues effectively. We wish Andrew every success for the future.

We are also looking forward to working with Gang Xu to further the business of the Network.

2. Financial Position

Our latest Host finance report is attached at Appendix 1. This report provides an update on our latest financial position for 2025/26, with a balanced year end position currently forecast, in line with DHSC requirements.

3. Risks & Issues

Risks and issues are formally reviewed through the RRDN Host Governance Group chaired by Gang Xu. A risks & issues register is maintained with risks/issues discussed and mitigating actions agreed; this is shared periodically with the NIHR RDN Coordinating Centre (RDN CC).

Risks and issues are recorded on the RRDN register (Appendix 2) as follows:

- **Risk: R09** - There is a requirement to grow the Agile Research Delivery Team (ARDT) in line with a nationally defined structure and set funding allocation. This will involve recruiting c.20 vacant posts across the team by the end of 2026/27. The team is currently under capacity, which could result in an inability to deliver this service effectively across the region and meet Host contractual requirements until the full team is established. Notably, this could impact our ability to support commercial & urgent public health studies along with expanding research into wider care settings and other key government priorities. To mitigate this risk, the ARDT is working across regional clusters, building agility & flexibility across the team. Currently the probability is scored as possible and the impact is scored as moderate giving a medium risk rating overall.
- **Risk: R10** - Host HR processes could result in delays appointing to vacant RRDN posts, specifically for the Agile Research Delivery Team (see risk R09 above). This could reduce the ability of the RDN to support all organisations across the region and increase pressure on existing staff, leading to further reduced capacity due to burn out. This concern has been escalated to the RRDN Host Executive Lead and Chief Executive and agreement has been provided by Host HR Leadership regarding the need for swift HR processes. We are continuing to work with HR links and Recruitment Services to expedite pending vacancies through the exception process and will monitor this process closely, as the process in place does still include some delays. One further issue we have recently encountered, which is again creating delay, is a lack of clarity with respect

to visa status for applicants, although we are receiving HR support from the Host in this regard. Currently the probability is scored as possible and the impact is scored as moderate giving a medium risk rating overall.

- **Risk: R12 (NEW)**- There is only one Band 8a post in the nationally consistent structure for the Agile Research Delivery Team (ARDT) which could impact on our ability to deliver this service effectively. This area of work is significant in the East Midlands, we strongly feel additional capacity is needed in the region. This is largely out of our control as the RRDN organisational structure is set nationally, however, we have highlighted this concern to the RDN Co-ordinating Centre and are keen to propose some options to alleviate this. The current postholder will be leaving at the end of April 2026, however, we have successfully recruited and will be offering the role as a job share between two individuals. Each will work 0.6 WTE (Whole Time Equivalent) which reflects a slight increase in overall capacity compared to the previous postholder. The probability is scored as possible and the impact is scored as moderate giving a medium risk rating overall.
- **Issue: I05 (CLOSED)** - The new national RDN funding model has resulted in some increases and critically some reduction in 2026/27 funding allocations for some regional NHS Trusts. This could lead to a reduced capacity to deliver research and contribute to national research initiatives. We have worked closely with organisations to support planning and management of their budgets, and this will be an ongoing conversation in the context of managing the overall RRDN budget in the next financial year. Therefore, this is no longer a concern and has been closed on the register.

If you have any questions about this report or require any further information, please contact:

- Elizabeth Moss, Network Director, elizabeth.moss@nihr.ac.uk or
- Carl Sheppard, Corporate Services Manager, carl.sheppard@nihr.ac.uk

Supporting documentation

- Appendix 1 - Finance update report
- Appendix 2 - Risks & issues register

PAPER E: RRDN EM Finance Update – 25/26 Forecast Outturn**REPORT TO: UHL Host Governance Group****DATE: 25th March 2026****FROM: Parita Yadav, RRDN Finance Business Partner, Mahendra Wadhwana, Head of Finance****Purpose**

This report provides an update on the 25/26 in year position and an explanation of any significant variances to the annual plan with relevant information in relation to the financial management of RRDN. It reflects the expenditure against allocation.

1. Allocation

The below table notes the RRDN Funding Allocation at M11. The Funding Allocation has increased from the month 09 position to include Pharmacy Pump Prime, NCVR and Primary Care Research Champions Scheme.

Funding Stream	ACTUAL TO DATE (YTD) to FEBRUARY 2026 £'000s	FUNDING ALLOCATION £,000s	FORECAST OUTTURN AT FEBRUARY 2026 £'000s	VARIANCE Under/(Overspend) £,000s	Comments
Fixed RRDN Team	2,552	2,831	2,826	5	Forecast broadly in line with budget. Variances due to vacancies across Management Team, post "Management of Change". £168k forecasted underspend against allocation moved to Fixed Prospective Allocations at M06, in line with virement limits.
Total Agile costs	1,759	1,915	1,901	14	RRDN's have been instructed by DHSC to rebalance any underspends in this category to cover exceptional payments for all RRDN's. £374K moved to Fixed Prospective Allocations at M08. At M09, EM RRDN is forecasting a £70k underspend against allocation, which will be adjusted to match actual expenditure.
RRDN staff SUB TOTAL	4,311	4,746	4,727	19	
Host Services	310	494	494	0	Overall costs are being finalised. Costs relating to Paget House are awaiting finalisation, so are estimated.
LPMS	188	188	188	0	Fixed cost matched to allocation, as detailed in LPMS contract.
Host Services Costs SUB TOTAL	498	682	682	0	
Fixed Prospective Allocations	19,377	21,399	21,306	93	Any forecasted underspend will be used to support Delivery Organisations. Plans currently being reviewed/finalised.
Clinical Support Services	366	393	406	-13	EM RRDN may only spend within original allocation. Quarterly reporting will transfer any balancing figure to Fixed Prospective Allocations.
Pharmacy Capacity Funding	253	276	276	0	DHSC pass-through funding. Reported from an impact perspective.
Pharmacy Pump Prime	207	207	207	0	
NCVR	7	14	14	0	
PC Research Champion Scheme	28	28	28	0	
Support for delivery to NHS sites	0	0	89	-89	Estimate at M11 of amount required to support research delivery at NHS sites.
Research Delivery Support to Sites SUB TOTAL	20,238	22,316	22,326	-10	
Strategic Development	824	1,101	1,110	-9	Current estimate of overall strategic commitment across 3 areas of strategic development.
Other SUB TOTAL	1	1,101	1,110	-9	
Total	25,047	28,845	28,845	0	

2. YTD Position

The table above notes the YTD expenditure to M11 of £25m which is broadly in line with the forecast.

Forecast Outturn Position

The table above summarises the forecast outturn position as at Month 11 (*February 2026*). The summary provides a breakdown of the expenditure plans against the funding allocation categories. These align with reporting requirements to the NIHR Co-ordinating Centre. At the end of month 11, EM RRDN is forecasting a balanced position.

*Note: RRDN has some restrictions on the ability to move between funding categories.

The RRDN has previously moved funds from Fixed RRDN Team to Fixed Prospective Allocations. This has enabled the budget that was previously ringfenced for the RRDN Management Team to be allocated instead to partner organisations for research delivery.

3. Recommendations

The Host Governance Group is asked to note the forecast outturn position.

Host organisation: University Hospitals of Leicester NHS Trust

PRE-RESPONSE (INHERENT)										POST-RESPONSE (RESIDUAL)							
Risk ID	Primary category	Date raised	Risk owner	Risk Description (event)	Risk Cause and Effect	Probability	Impact	Value (PxI)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (PxI)	Risk status (open or closed date)	Trend (since last reviewed)
R09	Services	09.10.25	Operations Director	There is a requirement to grow the Agile Research Delivery Team (ARDT) in line with a nationally defined structure and set funding allocation. The team is currently under capacity, which could result in an inability to deliver this service effectively and meet Host contractual requirements.	Cause: East Midlands RRDN is required to implement the new nationally defined ARDT structure in compliance with a set funding allocation. This will involve recruiting c.20 vacant posts across the team by the end of 2026/27. Effect: Period of reduced capacity could impact on our ability to fully deliver the ARDT service, particularly with respect to supporting commercial & urgent public health studies and expanding research into wider care settings (strategic priorities). This could potentially have an impact on the new national 150 day metric to set up trials any any other government priorities. Additionally, there is a minor risk that the ARDT funding allocation is not fully utilised, although this is somewhat mitigated.	4	3	12	Ongoing	Develop a recruitment strategy to ensure the vacancies are shared across the regional wider health and care workforce, linking with recruitment teams where appropriate.	HRD (SWCS)	4	3	3	9	Open	Static
										Manage recruitment in 3 phases, according to the needs of the service, to ensure the recruitment, onboarding and induction processes can be managed effectively	HRD (SWCS)	4					
										Ensure the ARDT capacity we have is deployed in line with national priorities, some placements may be reduced/curtailed to achieve this	HRD (SWCS)	1					
										ADRT is working across regional clusters, building agility & flexibility across the team	HRD (SWCS)	4					
R10	Services	30.10.25	Operations Director	Host HR processes could result in delays appointing to vacant RRDN posts specifically for ARDT (see risk R09 above)	Cause: Host recruitment control processes have been tightened (e.g. reduced frequency to monthly for Vacancy Control panels) due to financial & workforce requirements across the NHS. This coupled with a lack of clarity in relation to visa status for these roles is adding notable delays. Effect: Delays in appointing to RRDN vacancies (notably c. 20 posts for ARDT) could reduce the ability of the RDN to support all organisations across the region and increase pressure on existing staff, leading to again further reduced capacity due to burn out. Potential non-compliance with Host Contract.	4	3	12	Ongoing	Work with HR links and Recruitment Services to expedite pending vacancies through the exception process	HRD (SWCS)	4	3	3	9	Open	Static
										Developed RRDN specific Case of Need form in line with HR recommendations for exemption of RDN posts, requirement to update this to aid swift approval	CSM	5					
										Monitor this process closely	HRD (SWCS)	4					
										Seek urgent clarity and support from HR in relation to visa status	HRD (SWCS)	5					
										Flagged visa issue nationally to the ARDT Workforce Delivery Group who will undertake scoping work	HRD (SWCS)	5					
R12	Services	09.01.26	Operations Director	There is only one Band 8a post in the Agile Research Delivery Team (ARDT) which could impact on the ability to deliver this service effectively	Cause: Only one Band 8a post in ARDT in the nationally set RRDN Organogram. For the size of the team, current and future (expected) volume of work and growth, this is not sustainable and more capacity needed. In addition, the current postholder will be leaving at the end of April 2026 which amplifies the risk. Effect: This could impact on the ability to deliver this service effectively especial wrt delivering strategic priorities. This could also increase the pressure on the Head of Research Delivery & Support for Wider Care Settings and other team members.	4	3	12	Ongoing	Highlight risk nationally via RDN Operational Status Report	OD	4	3	3	9	Open	Reduced
										Approach NIHR RDN Coordinating Centre to consider both temporary and longer term capacity support	ND	5					
										Reappointed to post as a job share (2 individuals working 0.6 WTE)	HRD (SWCS)	5					

SCORING:

PROBABILITY	IMPACT				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Highly Likely (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Highly Unlikely (1)	1	2	3	4	5

1-5 GREEN = LOW*
6-11 YELLOW = MEDIUM
12-19 AMBER = HIGH
20-25 RED = EXTREME

*Only risks with an Inherent Risk of 6 or above are recorded on this Risk Register
* Risks with a scoring of 12 and above should be monitored and escalated

Action RAG Status Key:

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

East Midlands RRDN - Issues Register

Date last updated: 25.03.2026

Issue ID	Issue Type	Date Raised	Owner	Description	Severity	Priority	Actions	Action Owners	Action status	Issue status
I05	Financial	03.11.25	Network Director	The new national RDN funding model has resulted in some increases and critically some reduction in 2026/27 funding allocations for some regional NHS Trusts. This could lead to a reduced capacity to deliver research and contribute to national research initiatives	Moderate	Medium	Work closely with NHS Trusts via their Senior Team Links (STLs) to manage budgets and prioritise investment of RDN funding	STLs	4	Closed 19.3.26
							Deliver drop-in sessions for discussion and feedback	OD	4	
							Promote other funding opportunities such as strategic funding and wider care funding (where applicable)	OD	4	
							Identify any areas where ARDT could potentially provide support	STLs	1	
							Share further detail on the funding model, to support organisations to maximise future income via improved performance	STLs/OD	4	

Key

Severity	Priority
Minor	Low
Moderate	Medium
Major	High
Catastrophic	Critical

Action RAG Status Key:

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

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:	9 th April 2026					
Title:	4.2 (Paper J) Group Research and Innovation Report					
Report presented by:	Prof Nigel Brunskill, Director of Research and Development					
Report written by:	Prof Nigel Brunskill, Director of Research and Development					
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	
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

UHN13: If UHN is unable to attract and retain high calibre staff then this may result in UHN being unable to deliver on our research and Development ambitions, resulting in UHN being unable to increase our research and clinical trial activities by 10% and where support to take an innovative role in healthcare research will not achieve the best possible outcomes for our patients.

UHL Risk 4560 – There is a risk that UHL may fail to achieve the national 150 day clinical trial set up target due to bottlenecks and duplication in set up processes across specialties and support departments leading to loss of income, delays in study initiation and missed national performance metrics.

Impact assessment

Finance and Funding: Section (3) of the report.

Purpose of the Report

To update the Board on R&I activities across the Group and provide assurance of progress.

Recommendation

The Board should note the report and be assured of its contents.

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

GROUP RESEARCH AND INNOVATION REPORT
APRIL 2026

1.0 INTRODUCTION

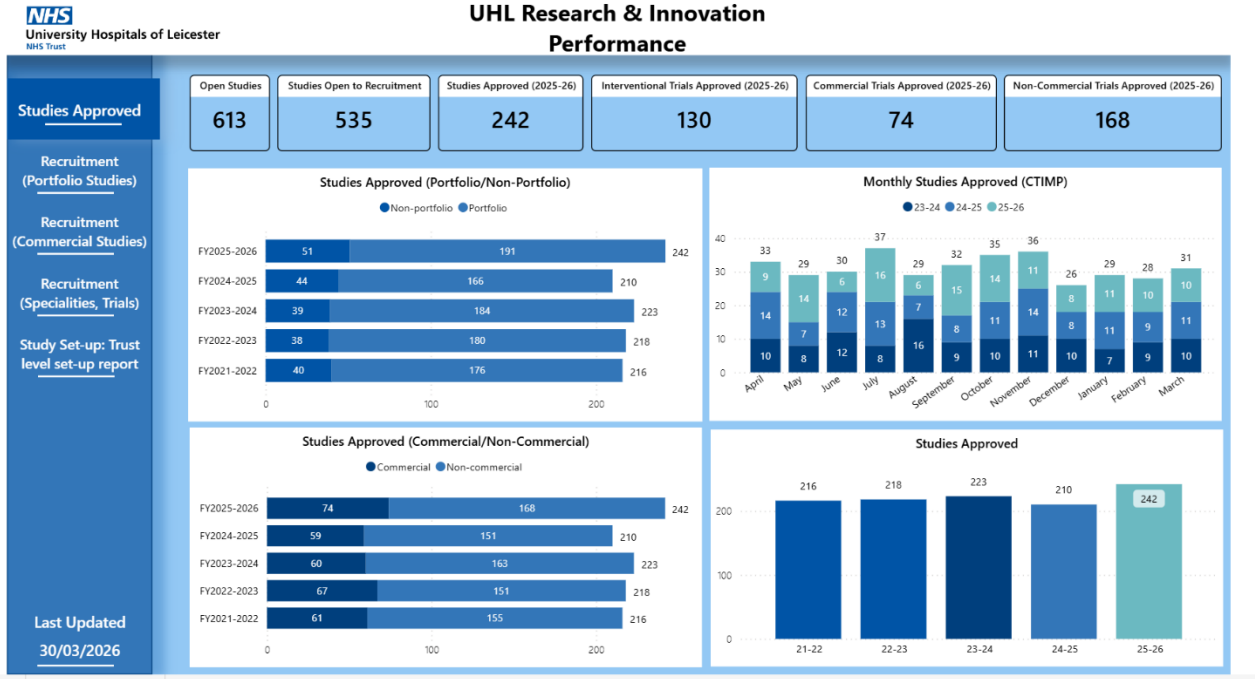
Research and Innovation teams at UHN and UHL work closely together and for 15 months there has been a Group Director of Research and Innovation. This arrangement has brought closer working and more collaborations and increased funding. A Director of R&I has been appointed at UHN supported by a deputy. Being separate legal entities means that performance, delivery and financial metrics for UHL, KGH and NGH are collected and handled separately. However, decisions about collaborative strategy, funding bids and research applications are reached after Group discussion.

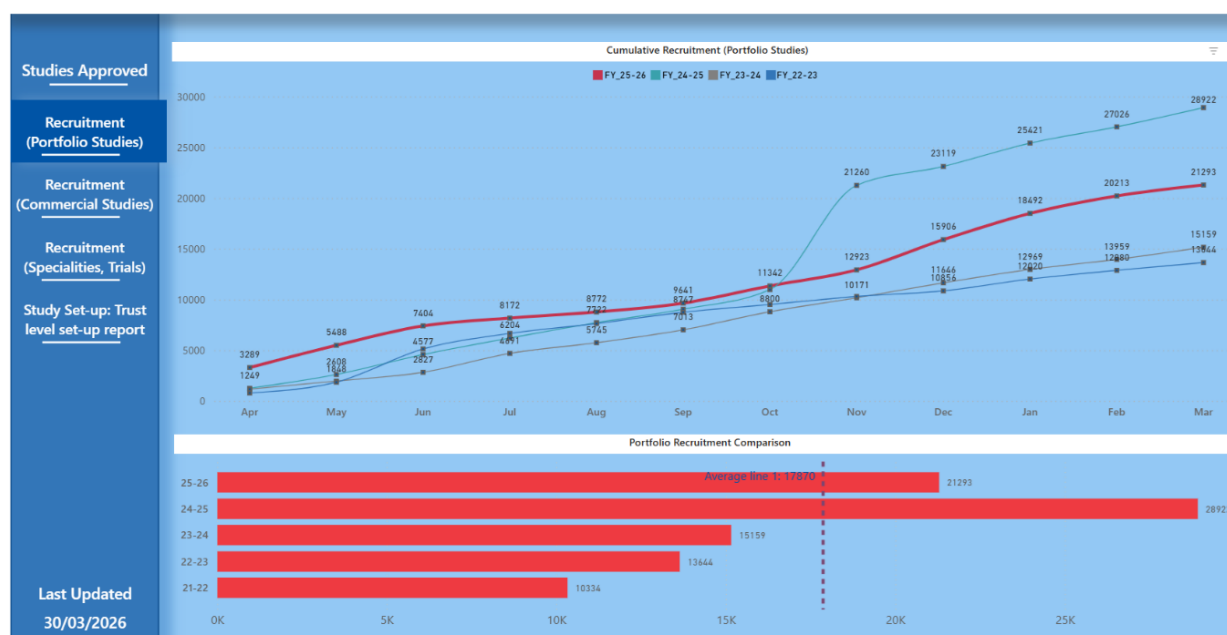
2.0 RESEARCH PERFORMANCE

Recruitment into NIHR portfolio studies and opening studies are key performance metrics that remain healthy across the Group.
For 2025/26 so far **34,000 participants** have been recruited into clinical studies across the Group.

2.1 UHL Performance

The tables and Figures below depict UHL study performance data for 2025/26 and comparative data for the four preceding years. This shows a generally sustained increased in recruitment activity over the years.





2.2 UHN Performance

Northampton General Hospital:

Portfolio Recruitment in 2025/26 – 4,761

Current Number of Studies

100 studies open and in follow-up (59 open to recruitment/41 in follow-up)

14 studies in set-up

Kettering General Hospital

Portfolio Recruitment in 2025/26 – 7,946

Current Number of Studies

~120 studies open and in follow-up (61 open to recruitment)

Overall UHN recruitment is healthy and growing.

2.3 THE 150 DAY TARGET

Over the last few years UK commercial clinical trial activity has decreased. Industry funders find NHS research to be expensive and processes complex and slow. The UK has therefore become less competitive compared to the US, Asian and other European countries.

The 150-day target is a UK government initiative aimed at reducing the setup time for commercial clinical trials to under 150 days by March 2026 to boost life sciences investment. The timeline includes a 60-day target for regulatory/ethics approvals, 60 days to open for recruitment, and 30 days to recruit the first participant.

For NHS Trusts the challenge is to set up studies within 60 days of site selection and to recruit the first patient within the next 30 days. The government target is that 90% of trials should reach this target.

These targets will be very closely monitored with associated KPIs that impact on future funding.

Currently performance for commercial studies in Trusts in England is:

% studies set up within 90 days 54%

% studies first patient visit in 30 days 49%

The research governance teams at UHL and UHN are evaluating simultaneous set up of studies and radical changes to other internal set up processes in the organisations to meet these targets.

3.0 RESEARCH FINANCE AND FUNDING

3.1 NIHR Research Delivery Network Funding Model Allocations

This is the key annual funding stream that supports Trusts’ research infrastructure. RDN annual funding allocations are nationally calculated and based on:

- 50% based on previous years funding for stability
- 30% based on volume of non-commercial NIHR portfolio trial activity comprising complexity and number of open and recruiting studies
- 20% of the NIHR RDN funding model allocation is based on achievements against a suite of key performance indicators aligned with national priorities

For 2026/27 the Group funding allocations are indicated below.

Northampton General Hospital NHS Trust	£ 824,049
University Hospitals of Leicester NHS Trust	£ 5,122,068
Kettering General Hospital NHS Foundation Trust	£ 815,234

For the Group, this increased total allocation of £6,761,351 for 2026/27is the 5th highest in England.

3.2 Other Successful UHN Funding Bids

Circa £500k extra funding has come into UHN for 2026 following competitive bidding.

Northamptonshire Diabetes and Obesity Research (NDOR) Centre

- An award of £315,000 has been received after competitive application by Dr Dimitris Papamargaritis from the UHN Hospitals Charity to establish a centre for Diabetes and Obesity research at KGH.

RDN Strategic Funding

- NGH has received £98,000 strategic funding to support a commercial research delivery team based at NGH.
- Dr Papamargaritis has received £55,000 for a Grade 7 Research Co-ordinator.

4.0 RESEARCH REFLECTIONS AT UHN AND UHL

In mid-2025, the Research Reflections programme offered all research staff at UHL and UHN the opportunity to share ideas, comments and suggestions around what

works well in their Departments, what might be improved, and what their visions of shared working across sites might incorporate.

At both NGH and KGH, two in-person workshops were provided. Each workshop ran for approximately three hours, and staff were encouraged to 'drop-in' and 'drop-out' as their commitments permitted. At UHL, three workshops were hosted, with one taking place at each hospital site.

The workshops consisted of a small number of collaborative and communicative activities and required no prior preparation from staff members. The central premise of these workshops was to offer teams the opportunity to respond to four key questions:

- What works well within your Department?
- What could be improved within your Department?
- What are your hopes for shared approaches to working across UHL and UHN in the future?
- What are your concerns around shared approaches to working across UHL and UHN in the future?

4.1 UHN Findings

Key Positives:

- i. The relationships between colleagues within teams are an important positive factor for staff at UHN.
- ii. Staff at UHN particularly find that their engagement with patients offers them fulfilment and satisfaction within the workplace.
- iii. Staff value the opportunities for continual professional growth and learning that working within R&I at UHN provides.

Key Areas of Improvement:

- i. Staff feel concerned about the culture within R&I at UHN, especially in relation to fairness, parity and shared drive to improve across the board.
- ii. The workload across R&I at UHN is a key concern for staff.
- iii. UHN staff feel that there is lack of clear and transparent communication, particularly in relation to consistent leadership.

Shared Working Hopes:

- i. Staff at UHN report that the opportunity for shared best practice and collaboration across sites would be valuable.
- ii. Staff at UHN feel that there is potential for improving patient access to treatments and trials through shared working.

Shared Working Concerns:

- i. A key concern shared by staff at UHN relates to workplace autonomy, with worries around how shared working might impact the locality of the services provided.
- ii. Staff at UHN feel that the logistics of shared approaches to working might be an issue, particularly in relation to job security, as well as potential requests to work across all sites.

4.2 UHL Findings

Key Positives:

- i. Staff at UHL enjoy working collaboratively, and value both their professional and social relationships with their colleagues and wider teams.
- ii. Staff at UHL report feeling trusted and challenged in their positions, with a particular emphasis on an appreciation for the new and novel in their day-to-day roles.
- iii. Staff value the long-term role they often play in the health journeys of patients and their relatives.

Key Areas of Improvement:

- i. Staff feel concerned about systems at UHL, particularly in relation to requiring more efficient and helpful IT processes.
- ii. A lack of space and equipment is a key concern for staff at UHL.
- iii. UHL staff report feeling that approaches across R&I can be disjointed, with a need for better communication and a more streamlined way of managing tasks across teams.

Shared Working Hopes:

- i. Staff at UHL feel that shared approaches to working might help to improve recruitment to studies, with a wider range of participants able to get involved.
- ii. Staff at UHL feel that shared approaches to working might result in more efficient services, with a central space for accessing information.

Shared Working Concerns:

- i. A key concern shared by staff at UHL relates to shared approaches to working resulting in issues with funding and potential job losses.
- ii. Staff at UHL feel that shared approaches to working could result in delays to projects, due to the nature of working across such large and disparate sites.

5.0 RESEARCH INFRASTRUCTURE DEVELOPMENTS

5.1 NIHR Leicestershire and Northamptonshire Commercial Research Delivery Centre (CRDC)

Hosted by UHL the CRDC was launched in 2025 and has UHN as a formal partner. This has resulted in new funding into UHN to fund research administration at KGH and consultant PA time at NGH to support CRDC liaison lead. It has been instrumental in the award of extra RDN funding to support a research nurse team at NGH (see above). UHN will link with a Northants primary care research network to develop new trial delivery models.

5.2 NIHR Leicester Clinical Research Facility

Hosted by UHL, the CRF also has UHN as a formal partner. Funding for 2PAs of consultant time has been provided to support early phase cancer research at NGH.

5.3 NIHR Applied Research Centre East Midlands

After an award of £9M the NIHR ARC East Midlands began a new, five-year funding tenure on 1st April 2026 (<https://arc-em.nihr.ac.uk/news/new-funding-underway-arc-east-midlands>), enabling it to expand its work and deliver lasting benefits across the region focusing on the following themes:

- Multiple Long-Term Conditions
- Building Resilience in Later Life
- Ethnicity and Health Inequalities
- Data4Health
- Translation and Implementation Research

6.0 NEW SUPPORT FOR INNOVATION

Support for innovation in the NHS has been patchy and unstructured. To combat this problem Leicestershire and Northamptonshire Academic Health Partners has established a Healthcare Innovation Hub.

(<https://www.uhleicester.nhs.uk/research/health-innovation-hub/about-us/>) to bring the joint expertise of the partners, including Health Innovation East Midlands, to provide a single point of entry that will support colleagues to develop innovative ideas from concept to wider adoption, tech transfer and commercialisation, and to attract wider investment for innovation across Leicestershire and Northamptonshire. Both UHL and UHN are members of LNAHP and will thus participate in the hub.

7.0 CONSULTANT PAs FOR RESEARCH AT UHL

In Dec 2025 after an open competition and an independent panel assessment of applications, the UHL R&I Department agreed to fund 13.25 PAs for consultants to support job planned time for research activity. For two years in the first instance dependent on a review after 12 months, 20 consultants received PA support.

8.0 RESEARCH NEWS

NIHR20 Research Delivery Leaders Prizes

Three colleagues (the maximum possible) from UHL were supported to apply for these awards.

Channel 4 News features Leicester BRC cardiovascular research

Last weekend, Channel 4 News broadcast an item on the vital research being carried out into Spontaneous Coronary Artery Dissection (SCAD) in Leicester.

The COLOPREVENT Study led from KGH has received an extra £500k funding to support ongoing trial activities.

New Honorary Consultant in Respiratory Medicine at KGH. Employed by University of Leicester, Dr Tom Ward was awarded a prestigious NIHR Fellowship and has chosen KGH as his clinical base.

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:	9 April 2026					
Title:	Escalation Report from the Charitable Funds Committee (CFC): 20 February 2026 (item 5.1 Paper K)					
Report presented by:	Prof Tom Robinson, Non-Executive Director Chair					
Report written by:	Gill Belton, Corporate and Committee Services Officer					
Action – this paper is for:	Decision/Approval		UHL Assurance	x	Update	
Which Group Priorities does this link to	Transform patient care	x	Strengthen our culture		Deliver our financial plan	x
Where this report has been discussed previously	Not applicable.					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The report provides assurance re: the appropriate spend and governance of charitable funds, and re: progress on fundraising activities.

Impact assessment
Not applicable.

Purpose of the Report

To provide assurance to the Trust Board as Corporate Trustee on the work of the UHL Charitable Funds Committee, and escalate any issues as required.

Recommendation

To receive the escalation report.

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

BOARD OF DIRECTORS 9 APRIL 2026

1. Recommended Items

There were no recommended items from the Charitable Funds Committee meeting held on 20 February 2026.

2. Discussion Items

2.1 Finance and Governance Report

The Committee received a report, the contents of which were received and noted, which documented the financial position of Leicester Hospitals Charity as at 31 January 2026 including the position of the general purposes fund, compared to the previously agreed plan for the 2025/26 financial year.

Particular discussion took place regarding: (1) the areas in which the Charity was under-performing and the fact that these related to areas in which there had been staff vacancies (2) the timeline for fully implementing the new financial model, with significant progress expected over the new few weeks as the finance team returned to full staff capacity (3) the development of a shared language between fundraising and finance (i.e in respect of terms such as 'restricted', 'designated', 'undesignated' etc.) which would ensure clarity on the definition and application of funds and compliance with the Trust's Reserve Policy. The CFC NED Chair recommended having a 'service level agreement' style document for the Charity's overheads so there was clarity around this; the Director of Corporate and Legal Affairs confirmed that she and the Acting Head of Charity were working on such a document and would submit this to CFC in due course.

2.2 UK Charity Governance Code 2025 – Overview and Implications for Leicester Hospitals Charity

The CFC received a report documenting: (a) an overview of the UK Charity Governance Code 2025 (b) a summary of key changes from the previous version (c) an assessment of relevance for Leicester Hospitals Charity and (d) proposed proportionate next steps.

The Charitable Funds Committee: (1) noted the publication of the UK Charity Governance Code 2025 (2) agreed that Leicester Hospitals Charity would undertake a proportionate self-assessment against the eight governance principles during FY 2026/27 (3) supported the inclusion of a refreshed Governance Code statement within the Charity's Annual Report and (4) noted that trustee induction and governance documentation would be reviewed and updated accordingly.

3. Meeting Dates 2026

A series of potential meeting dates for the CFC meetings in 2026 were detailed for members' agreement. Members agreed to meet before Trust Board meetings wherever possible.

Subsequently, the dates for meetings of the Charitable Funds Committee in 2026 were confirmed as follows:

- Friday 10 April 2026
- Friday 12 June 2026
- Friday 7 August 2026
- Friday 9 October 2026
- Friday 4 December 2026
- Friday 5 February 2027