

UHN Boards of Directors Meeting in Public

Friday 9 October 2026, 09:30 - 12:30

Boardroom, Northampton General Hospital

Agenda

09:30 - 09:30 0 min	1. Welcome, apologies and declarations of interest <i>Andrew Moore</i>  1. UHN Public Boards Agenda 091026 (3).pdf (2 pages)
09:30 - 10:00 30 min	2. Staff Stories - Leadership Development and Inclusion <i>Presentation and Discussion</i> <i>Paula Kirkpatrick</i>
10:00 - 10:15 15 min	3. Workforce Race (3) and Disability (3.1) Equality Schemes (WRES/WDES) annual submissions <i>Decision</i> <i>Paula Kirkpatrick</i> Assuraance  3. UHN WRES Board Report 2025-26.pdf (4 pages)  3. KGH WRES Report 2026.pdf (20 pages)  3. NGH WRES Report 2026.pdf (20 pages)  3.1 UHN WDES Board Report 2025-26.pdf (4 pages)  3.1 KGH WDES Report 2026.pdf (25 pages)  3.1 NGH WDES Report 2026.pdf (25 pages)
10:15 - 10:15 0 min	4. Minutes of the previous meeting held on 10 September 2026 and Action Log <i>Decision</i> <i>Andrew Moore</i>  4.1 100926 Minutes UHN Public Board of Directors meeting.pdf (17 pages)  4.2 Public action log updated after 100926 meeting.pdf (2 pages)
10:15 - 10:25 10 min	5. Chair's report (verbal) <i>Information</i> <i>Andrew Moore</i>
10:25 - 10:30 5 min	6. UHN Chief Executive's Report (verbal) <i>Information</i> <i>Adam Carson</i>
10:30 - 11:20 50 min	7. Integrated Performance Report (IPR) (not received) and Board Committee Chairs' reports <i>Assurance / Decision</i> <i>Adam Carson / Becky Taylor / Executive Leads / Board Committee Chairs</i> Financial tables and committee reports enclosed.  7. 2026 August IPR Financial tables.pdf (5 pages)

11:20 - 11:30 **Break**
10 min

11:30 - 11:50 **8. Perinatal Report (including KGH Maternity and Neonatal Improvement Support Team update)**
20 min

Assurance *Sarah Jamieson*

Assurance

 8. UHN Perinatal Report Oct 2026 [Aug Data] FINAL.pdf (9 pages)

 8. Appendix 3 - UHN Perinatal Scorecard Sept 2026 [Aug Data] FINAL.pdf (24 pages)

8.1. UHN Maternity Services – Thirlwall Inquiry Update

Assurance *Sarah Jamieson*

 8.1 UHN Maternity Services - Thirlwall Inquiry Oct 2026 FINAL.pdf (6 pages)

11:50 - 12:10 **9. Guardians of Safe Working (GOSW) report for April-August 2026**
20 min

Assurance *Sarika Goel (NGH) / Mustafa Raza (KGH)*

 9. Consolidated Guardian report October 2026.pdf (5 pages)

12:10 - 12:25 **10. Board Capability Self-Assessment (not received)**
15 min

Receive *Rebecca Taylor*

12:25 - 12:30 **11. Report from the Council of Governors**
5 min

Information *Andrew Moore*

 11. Council report to Boards 091026.pdf (3 pages)

12:30 - 12:30 **12. Questions from the public**
0 min

12:30 - 12:30 **13. Any other business and close**
0 min

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

Meeting	Boards of Directors Meeting in Public
Date & Time	9 October 2026, 09:30-12:30
Location	Boardroom, Northampton General Hospital

Purpose and Ambition					
The Boards are accountable to the public and stakeholders; to formulate the Trusts' strategies; ensure accountability; and to shape the culture of the organisations. The Boards delegate authority to Board Committees to discharge their duties effectively and these committees escalate items to the Boards, where Board oversight, decision making and direction is required.					
Item	Description	Lead	Time	Purpose	P/V/Pr
1	Welcome, Apologies and Declarations of Interest	Chair	09:30	-	Verbal
2	Staff Stories – Leadership Development and Inclusion	Chief People Officer	09:30	Presentation	Pr.
3	Workforce Race and Disability Equality Schemes (WRES/WDES) annual submissions	Chief People Officer	10:00	Decision	Attached
4	Minutes of the Meeting held on 10 September 2026 and Action Log	Chair	10:15	Decision Receive	Attached Attached
5	Chair's report	Chair	10:15	Information	Verbal
6	UHN Chief Executive's Report	UHN CEO	10:25	Information	Verbal
Operations					
7	Integrated Performance Report (IPR – not received) and Board Committee Chairs' Reports	CEO, Executive Directors and Committee Chairs	10:30	Assurance	Finance and committee reports enclosed
	BREAK		11:20		
8	Perinatal Report (8) 8.1 UHN Maternity Services – Thirlwall Inquiry Update	Director of Midwifery	11:30	Assurance	Attached Attached

People and Culture					
9	Guardians of Safe Working (GOSW) report for April-August 2026	GOSW	11:50	Assurance	Attached
Governance					
10	Board Capability Self-Assessment	Director of Continuous Improvement	12:10	Information	Not received
11	Report from the Council of Governors	Chair	12:25	Information	Attached
12	Questions from the Public	Chair	12:30	Information	-
13	Any Other Business and close	Chair	12:30	Information	-

Cover Sheet

Meeting	Boards of Directors of the University Hospitals of Northamptonshire NHS Group (Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust) meeting together (public)
Date	9 October 2026
Agenda item	3
Title	UHN Workforce Race Equality Standard (WRES) Annual Report 2025/26
Presenter	Paula Kirkpatrick, Group Chief People Officer
Author	Farhana Ahmedabadi-Patel, Senior Diversity & Inclusion Specialist

This paper is for

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

☐ Transform Patient Care	☒ Strengthen our Culture	☐ Deliver our financial plan
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Reason for consideration / Previous consideration

Reason for Consideration: To present the University Hospitals of Northamptonshire Workforce Race Equality Standard results for 2025/26 and seek approval of the refreshed action plan. The paper provides assurance on progress, identifies areas requiring further improvement and sets out the proposed priorities for 2026/27.	Previous Consideration: The UHN WRES Annual Report 2024/25 was presented to the Board on 3 October 2025. In October 2025, the Board also heard directly from colleagues about their experiences as part of Black History Month. People Committee Engagement Sessions with REACH Network representatives on 30 April 2026
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Executive Summary

This report presents the UHN Workforce Race Equality Standard (WRES) results for 2025/26 and seeks approval of the refreshed action plan. The findings demonstrate continued progress in workforce representation, recruitment and access to development opportunities. Key priorities remain disciplinary disproportionality, experiences of racism, harassment and discrimination, career progression and improving ethnically diverse representation at senior leadership and Board level.

Appendices

- Appendix 1: KGH WRES Report 2025/26
- Appendix 2: NGH WRES Report 2025/26

Risk and assurance

- BAF 18
- UHN Objective - 'Strengthen Our Culture'
- Mandated in the NHS Standard Contract and considered by the CQC under the 'Well-Led' domain

Financial Impact

Racism has adverse financial implications for recruitment, retention costs and everyday operational demands caused due to wellbeing of our colleagues (including long-term sickness). Recommendations in this paper offer sustainable, solutions that improve the experience of our workforce and our patient community, within our existing budgets. Delivery of the refreshed action plan will be managed within existing resources. Failure to address race inequalities may increase costs associated with recruitment, retention, sickness absence and employee relations activity. Any future investment requirements will be considered through the Trust's established approval processes.

Legal implications/regulatory requirements

The Trust is required to comply with the Equality Act 2010, including the Public Sector Equality Duty and the duty to make reasonable adjustments, and to meet the requirements of the NHS Standard Contract. The WRES provides a framework for identifying and addressing inequalities experienced by BME colleagues and supports compliance with the NHS Equality Delivery System and the CQC Well-Led framework.

Equality Impact Assessment

This work focusses on the three general duties of the Equality Act 2010:

1. Enhancing equal opportunities
2. fostering good community relations between groups
3. eliminate discrimination, harassment and victimisation.

With a specific emphasis on the Race as protected characteristics the WRES is an equality analysis. The paper aims to highlight inequalities experienced by our workforce, opportunities to gather soft intelligence and develop actions in response to reduce the disparity. The process established within UHN involves colleagues and stakeholders in the discussion, action planning and assurance.

Paper

Situation

The Workforce Race Equality Standard (WRES) is a nationally mandated NHS framework comprising nine indicators that measure the experiences and outcomes of Black, Asian and Minority Ethnic (BME) colleagues. This report presents the 2025/26 WRES results for University Hospitals of Northamptonshire and seeks approval of the refreshed action plan.

Note on language: The Workforce Race Equality Standard (WRES) and associated NHS England reporting framework continue to use the term Black and Minority Ethnic (BME) when describing the national indicators, benchmarking and reporting requirements. This terminology is therefore used throughout this report where reference is made to WRES measures and national data to maintain consistency with the national reporting framework. UHN recognises that language and terminology continue to evolve and, in line with feedback from the REACH Staff Network, the terms BME and Global Ethnic Majority (GEM) may be used interchangeably within the narrative sections of this report when referring to colleagues from ethnically diverse backgrounds.

Background

The Workforce Race Equality Standard (WRES) was introduced in July 2015 and is a requirement for NHS commissioners and NHS healthcare providers through the NHS Standard Contract. The framework enables organisations to identify inequalities, monitor progress and develop evidence-based actions to improve recruitment, career progression, workforce experience and representation.

UHN has reported annually against the WRES and has used the findings to inform race equality priorities and workforce improvement activity. This has included development of the single UHN REACH Staff Network in January 2025, delivery of the Rethinking Racism programme, reciprocal mentoring, Cultural Ambassadors, colleague engagement activity and strengthened governance arrangements to support race equality across the organisation.

Delivery of the WRES supports the Trust's responsibilities under the Equality Act 2010, including the Public Sector Equality Duty, and contributes to UHN's ambition to create an inclusive culture where all colleagues can thrive.

Assessment

Workforce Representation

The proportion of colleagues from BME backgrounds continues to increase, reaching 42% at KGH and 43% at NGH. Representation is strong across many professional groups, including medical and dental grades, although disparities remain within some senior leadership bands.

Recruitment

Recruitment outcomes demonstrate continued progress. KGH achieved appointment parity with a relative likelihood of 0.98, while NGH reported 0.93, indicating that BME applicants continue to be appointed at least as frequently as white applicants when shortlisted.

Formal Disciplinary Processes

Disciplinary disproportionality remains an area requiring attention. The likelihood of BME colleagues entering the formal disciplinary process increased to 2.20 at KGH and 1.14 at NGH during 2025/26, indicating that BME colleagues remain more likely than white colleagues to enter formal processes.

Access to Training and Development

Access to non-mandatory training and continuing professional development remains broadly equitable across both hospitals, with indicator scores of 0.98 at KGH and NGH.

Harassment, Bullying and Abuse

Experiences of harassment, bullying and abuse remain significant. At KGH, 34% of BME colleagues reported harassment, bullying or abuse from patients, relatives or the public and 24% from colleagues. At NGH, the equivalent figures were 32% and 25% respectively.

Career Progression

Perceptions of equal opportunity for career progression improved slightly, reaching 47% at KGH and 50% at NGH. Despite this progress, around half of ethnically diverse colleagues still do not believe that opportunities for progression are equitable.

Discrimination

Sixteen per cent of BME colleagues at both KGH and NGH reported experiencing discrimination from a manager, team leader or colleague during the previous 12 months. While improvements have been made in recent years, the data continues to demonstrate a disparity in experience.

Leadership and Representation

Board representation remains significantly below workforce representation. BME colleagues comprise over 40% of the workforce at both hospitals but only two of twenty-two Board members identify as BME, resulting in a representation gap of 32% at KGH and 33% at NGH.

Priority Areas for 2026/27

The refreshed action plan focuses on:

1. Inclusive leadership and cultural competence
2. Reducing disciplinary disproportionality
3. Career progression and talent development
4. Tackling racism, harassment and discrimination
5. Strengthening colleague voice and co-production through REACH
6. Increasing accountability for race equality outcomes through governance and leadership oversight

Recommendations

The feedback from the REACH Network has guided the recommendations below.

The Boards are asked to:

1. Note the UHN Workforce Race Equality Standard (WRES) results for 2025/26, including areas of progress and continuing inequalities experienced by ethnically diverse colleagues
2. **Approve** the refreshed UHN WRES Action Plan for 2026/27
3. Recognise its collective and individual responsibility for advancing race equality across UHN and demonstrate personal accountability for creating an inclusive culture and workforce experience consistent with the expectations of the CQC Well-Led framework

KGH Workforce Race Equality Standard (WRES) Report 2025 - 2026



UHN Colleagues & Teams responsible for compiling this report are as follows:

Paula Kirkpatrick, UHN Chief People Officer

Andy Eagle - Weston, UHN Deputy Chief People Officer (Culture & Inclusion)

Brad Scott, Deputy Chief People Officer

Farhana Ahmedabadi-Patel, Head of Organisational Development & Inclusion

Jane Sanjeevi, Senior Diversity & Inclusion Specialist

Alex Ridley, Organisational Culture Lead

Sarah Kinsella, People Partnering Business Partner

Alistair Weston, EDI Engagement Officer (NGH)

Charlotte Cooper, EDI Engagement Officer (KGH)

Sandra Rojo, ESR System Development & Quality Manager

Kevin Gillman, Workforce Information & System Officer

REACH & DAWN Staff Networks

Date this report was presented to the UHN Board of Directors:

October 2026

Date published: October 2026

It is well evidenced through various sources of data and lived experiences, that colleagues from a Black, Asian and Minority Ethnic background have a poorer experience of working within the NHS. At UHN we are committed to improving those lived experiences and focused on creating a culture where:

- **Race and ethnicity are not barriers to progression,**
- **Individuals feel safe in the workplace and**
- **Difference are embraced.**

As a Trust we want to focus on working in partnership with our patients, service users and colleagues, to change our ways of working and interacting with each other. This enables our colleagues to thrive and deliver the best possible services and care to the people of Northampton, Kettering and surrounding areas.

The importance of race equality is embedded into the [NHS People Promise](#) where it states 'We are open and inclusive. We understand, encourage and celebrate diversity, making the NHS a place where we all feel we belong'. The People Promise declares 'a commitment to creating and maintaining a compassionate and inclusive culture where diversity is valued and celebrated as a critical component, and not just a desirable one.' The Trust must also meet its legal obligations under the [Equality Act 2010](#) and [The Human Rights Act 1998](#).

Each year the Trust is required to publish Workforce Race Equality Standard (WRES) data. The WRES provides a framework for NHS organisations to report, demonstrate and monitor progress against nine indicators of workforce equality. The indicators are a combination of workforce data and results from the NHS national staff survey and help to ensure that employees receive fair treatment in the workplace and have equal access to career opportunities. The WRES is included in the NHS Standard Contract and has been a requirement of NHS commissioners and NHS healthcare providers since July 2015.

There are 9 WRES indicators.

4 of the indicators focus on
workforce data from ESR

4 of the indicators are based
on data from the national
NHS Staff Survey questions

1 indicator focuses upon
BME representation on
the Board of Directors



Indicator 1

Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.



Indicator 2

Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts).



Indicator 3

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.



Indicator 4

Relative likelihood of staff accessing non-mandatory training and CPD



Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



Indicator 7

Percentage of staff believing that the trust provides equal opportunities for career progression or promotion



Indicator 8

In the last 12 months have you personally experienced discrimination at work from a Manager/team leader or other colleague



Indicator 9

Percentage difference between the organisations' Board membership and its overall workforce

Workforce indicators for each of the four workforce indicators, compare the data for white and BAME staff -

Indicator 1: the definitions for these categories are based on Electronic Staff Record (ESR) occupation codes except for medical and dental staff, which are based upon grade codes.

Indicator 2: refers to 'Relative likelihood of staff being appointed from shortlisting across all posts', it must be noted that this refers to both external and internal posts through the Trac system linking into ESR.

Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation, this indicator is based on data from a 12month/24 month rolling average of the current year and the previous year

Indicator 4: Relative likelihood of white staff accessing non-mandatory training and CPD compared to BAME staff maybe limited as the data only reflects courses that are managed by ESR. Colleagues attending apprenticeships, learning through regulatory bodies, and additional clinical/professional development sessions may not be captured for this indicator.

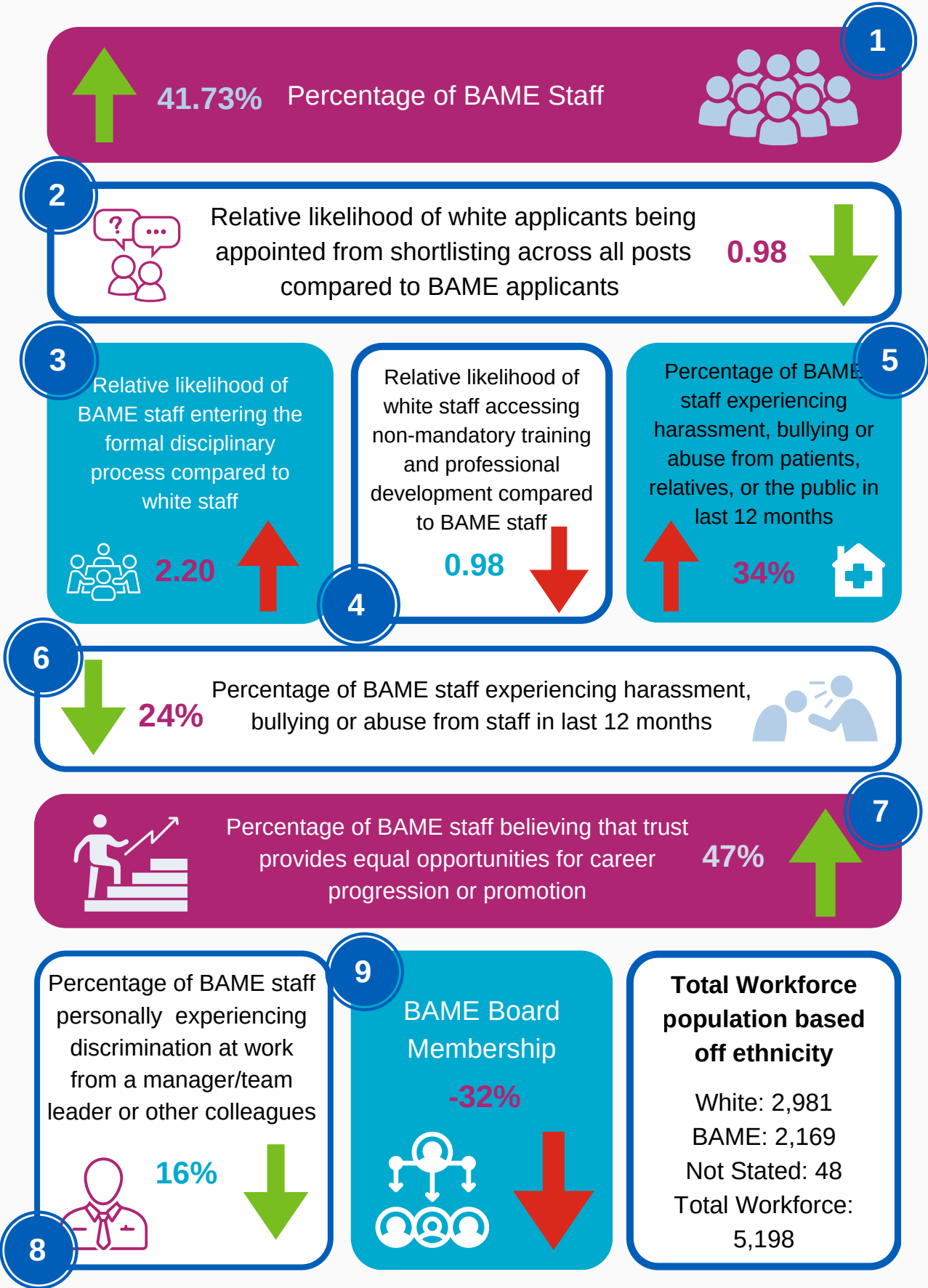
Four of the **WRES indicators (5 to 8)** are drawn from questions in the National NHS staff survey. The reliability of the data drawn from those indicators is dependent upon the overall size of the sample that have responded to the Staff Survey, the response rates to the survey questions, and whether the numbers of BME staff are large enough to not undermine confidence in the data. It should be noted that in the most recent staff survey (2024) only 54% of the total UHN workforce population took part in the survey.

Board representation indicator 9: Percentage difference between the organisations' board membership and its overall workforce disaggregated:

- **By voting membership of the board**
- **By executive membership of the board**

Some of the WRES indicators are shown as a score. A score of 1 means there is no difference between ethnic groups. A score below 1 means the outcome is more favourable for ethnically diverse staff, while a score above 1 means the outcome is less favourable and may indicate an area where further improvement is needed. In general, the closer the score is to 1, the more equal the outcome is for all staff.

Workforce Race Equality Standard 2025/26



Yearly Comparison

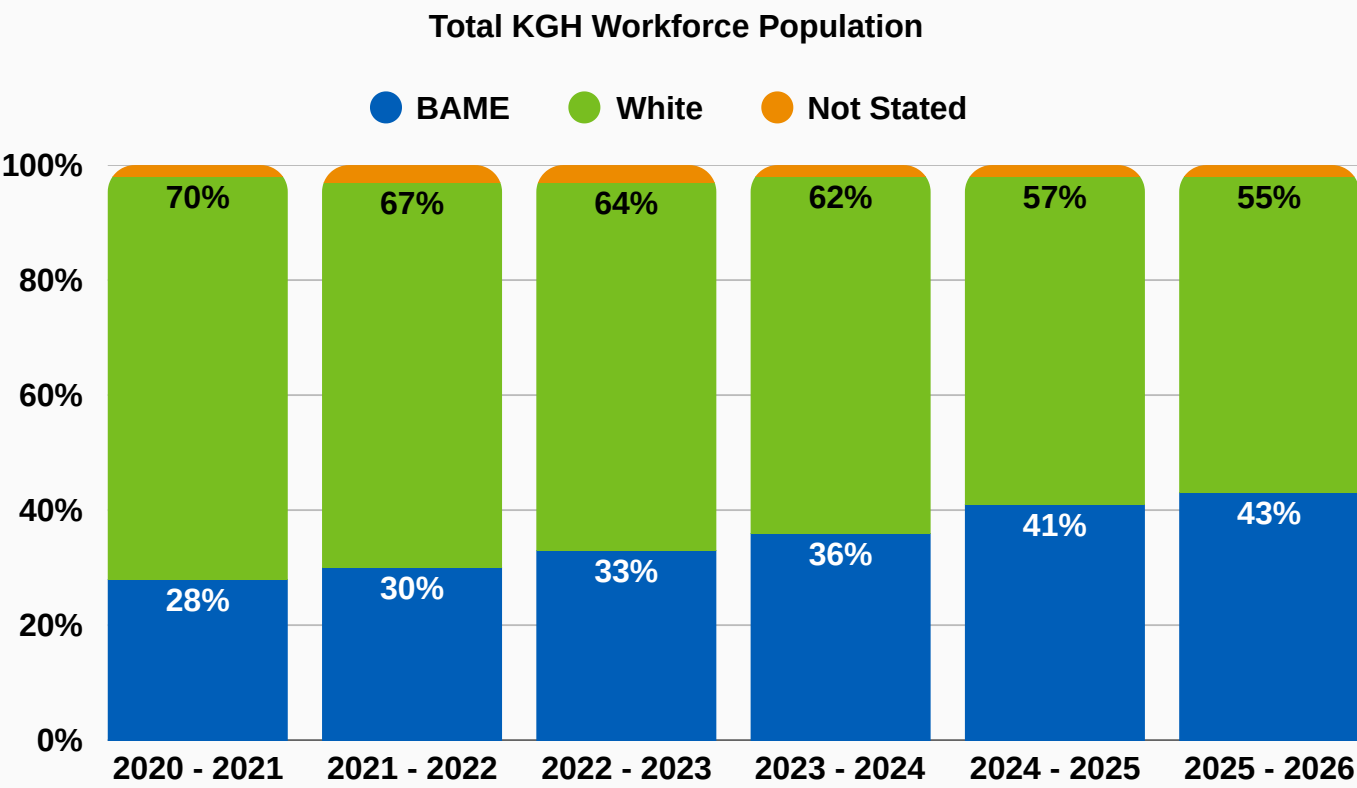


University Hospitals
of Northamptonshire
NHS Group

	WRES Indicator	KGH 2020-2021	KGH 2021-2022	KGH 2022-2023	KGH 2023-2024	KGH 2024 - 2025	KGH 2025 - 2026	Trend	Difference between 24/25 & 25/26
1	Percentage of BAME staff	28%	32%	33%	36%	40%	42%		
2	Likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants	1.48	1.24	3.47	0.92	1.07	0.98		
3	Likelihood of BAME staff entering formal disciplinary process compared to white staff	1.08	0.53	1.19	0.24	0.91	2.20		
4	Likelihood of white staff accessing non-mandatory training and CPD compared to BAME staff	0.79	0.88	0.78	0.99	1.00	0.98		
5	Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	27%	37%	36%	31%	32%	34%		
6	Percentage of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months	31%	36%	34%	31%	27%	24%		
7	Percentage of BAME staff believing that the Trust provides equal opportunities for career progression or promotion	44%	42%	43%	44%	44%	47%		
8	Percentage of BAME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	19%	23%	26%	23%	18%	16%		
9	% Difference between Board membership and overall BAME workforce	-16%	-22%	-28%	-27%	-31%	-32%		

WRES Indicator 1

Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce



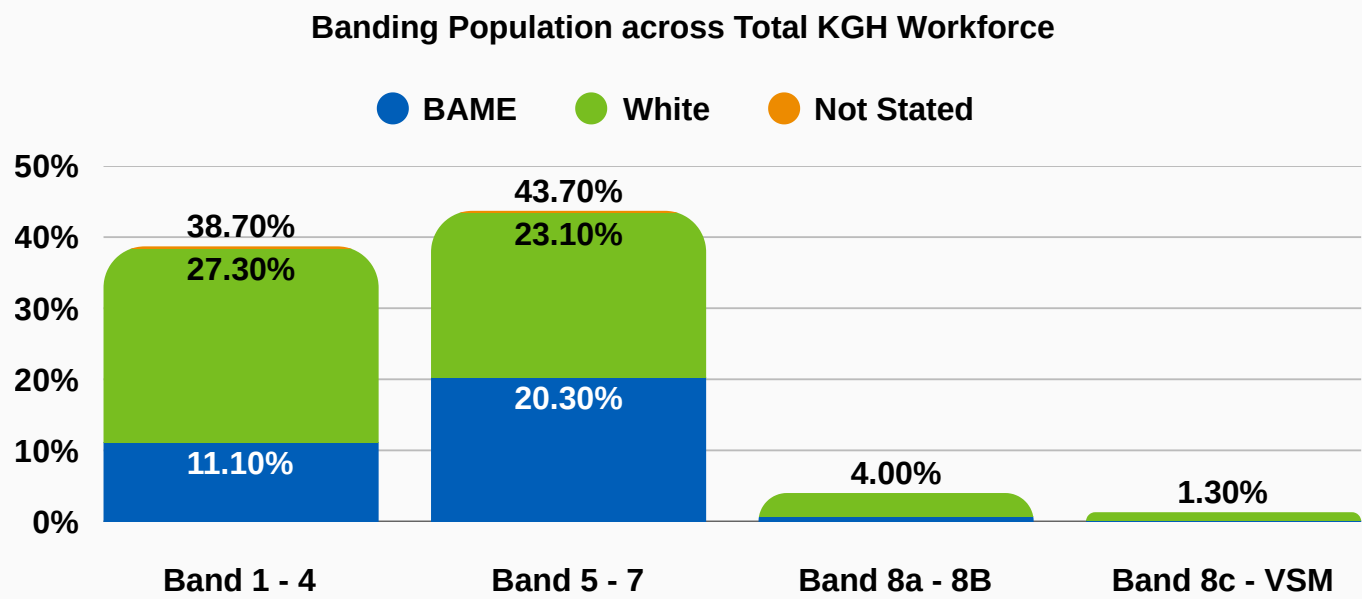
The overall headcount for the Trust is 5,198. This has increased from previous years with the number of staff declaring as BME increasing to 2,196, an additional 119 people.

The Data shows that the percentage of BME staff at the Trust continues to increase, growing by 2% in the last year. The number of colleagues who have not completed their ethnicity reporting on ESR has remained at 2%. There has been an emphasis on the updating of ethnicity information on ESR (Electronic Staff Record).

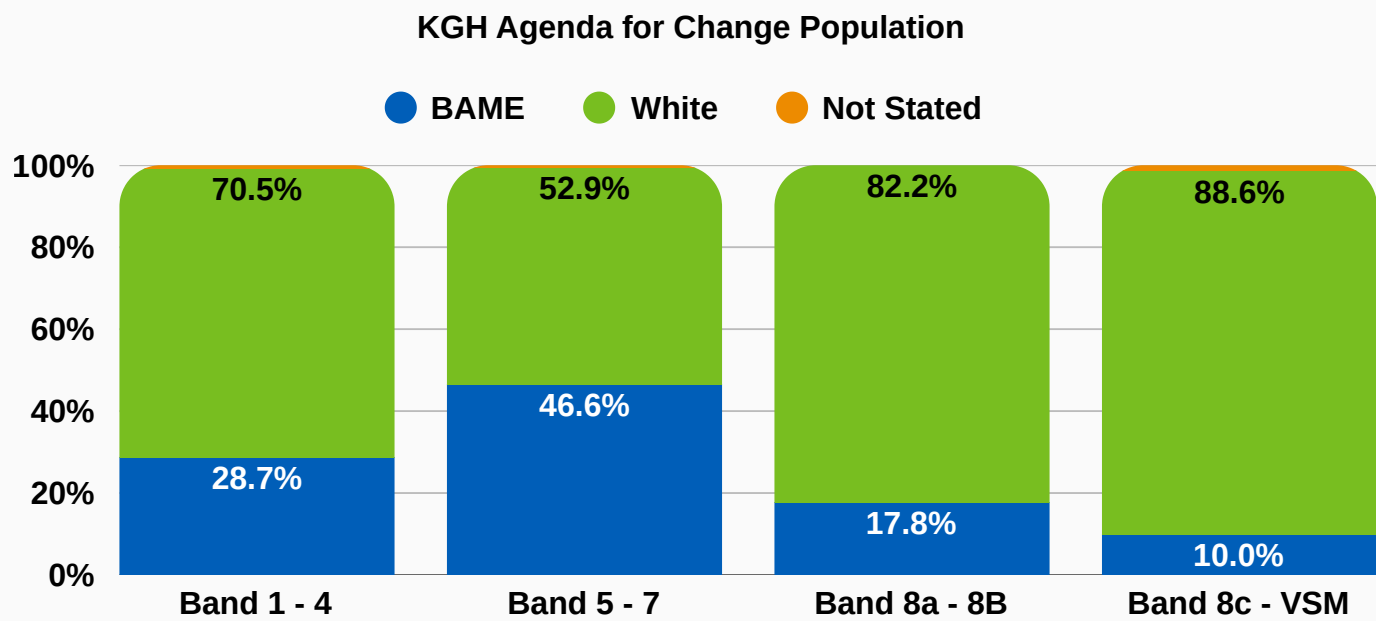
Overall Workforce Headcount at KGH

2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
4,824	4,975	4,901	5,000	5,205	5,198

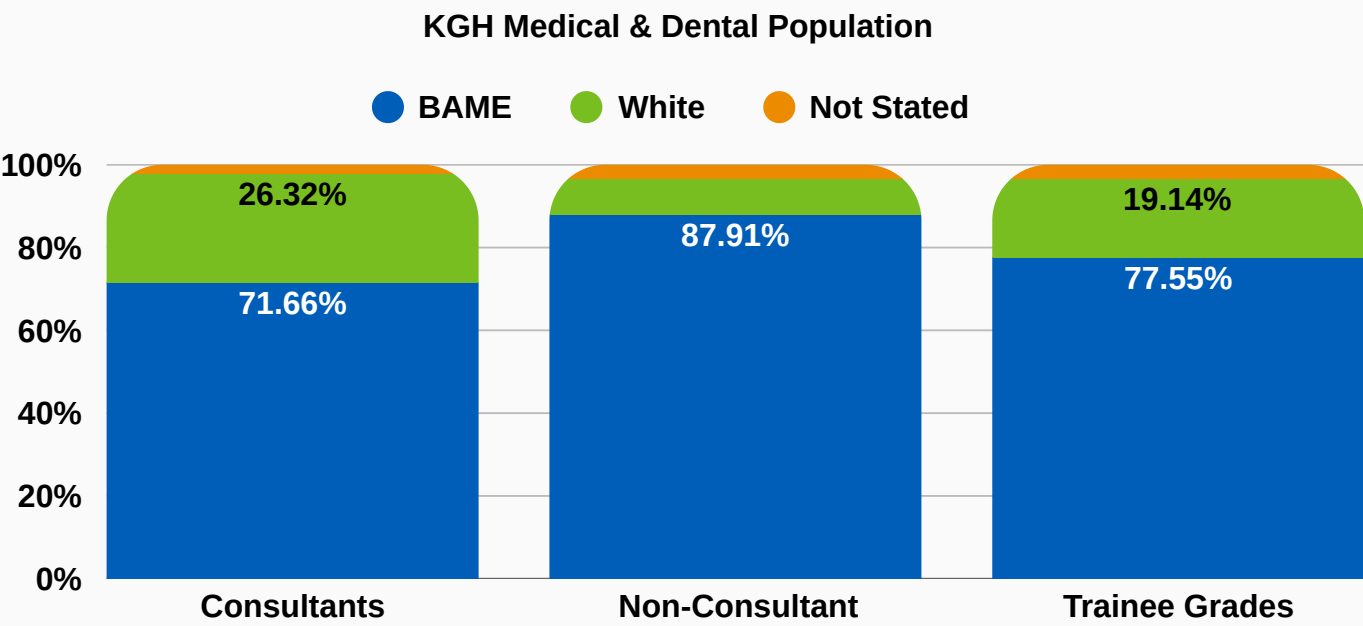
Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce



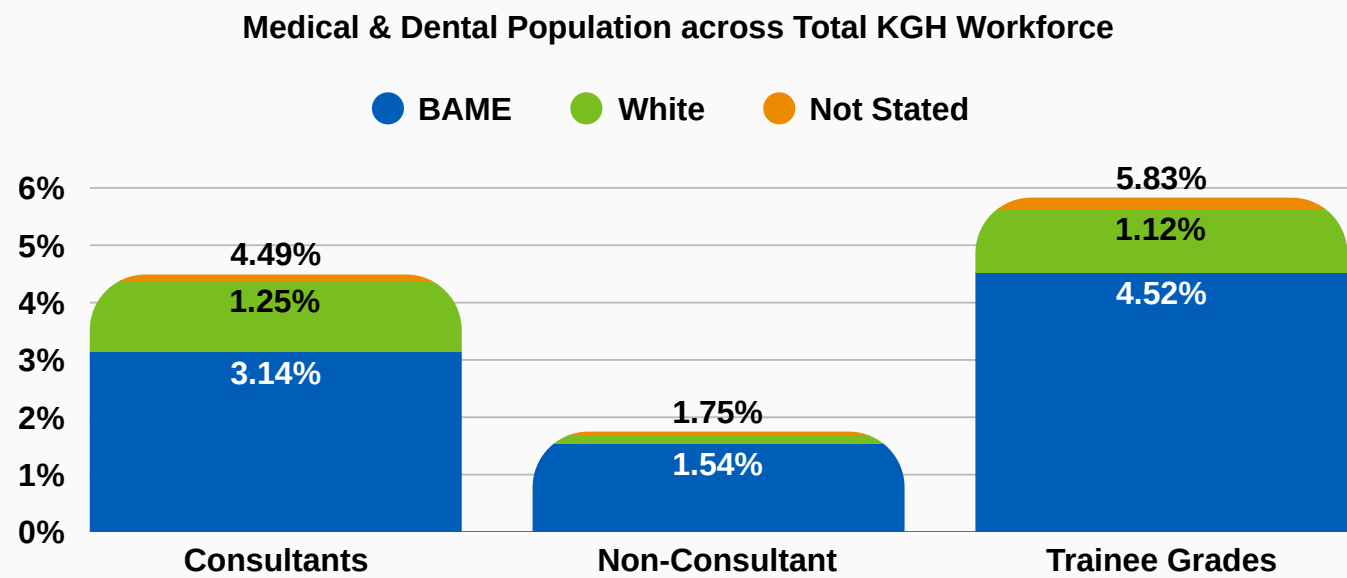
- From bands 1 - 7, our BME representation remains below the national average of BME employed within NHSE, which was 21% in 2025.
- Within Bands 5 - 7, KGH has the most representation at these roles with more BME colleagues working these roles.
- Bands 8A - VSM are below the national average with a representative reflection of our overall workforce.



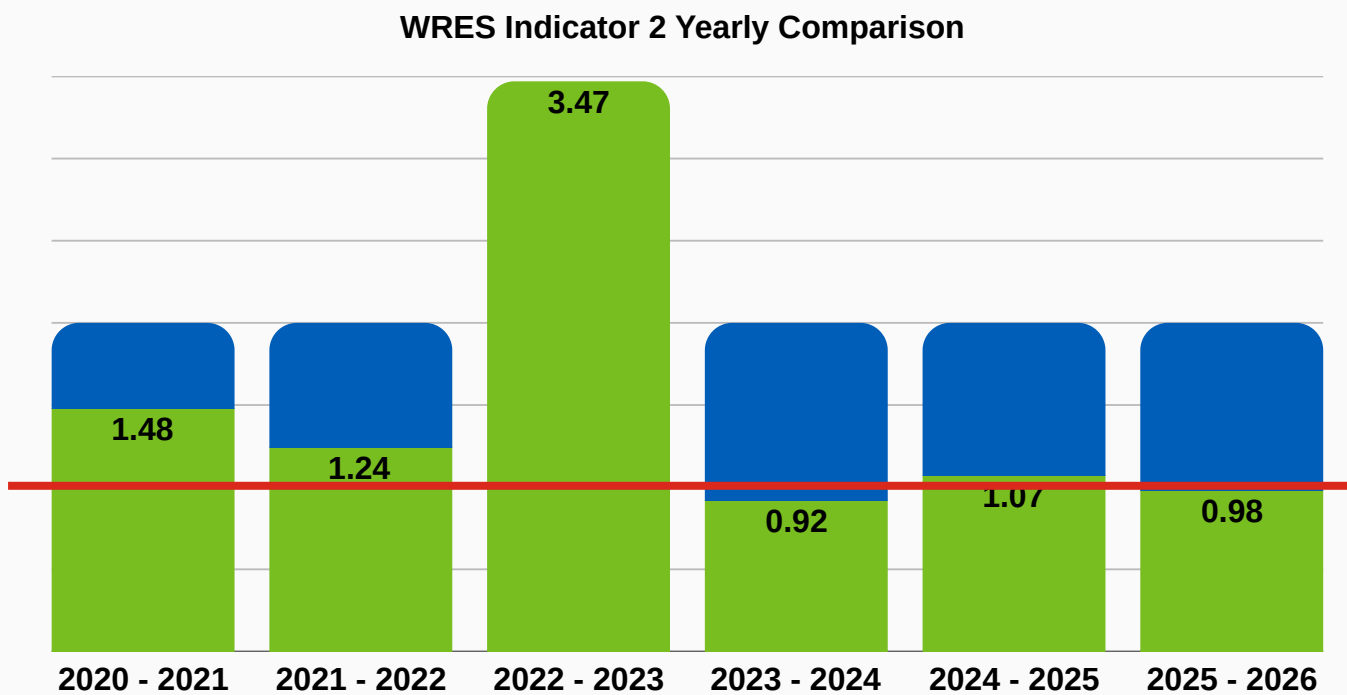
Percentage of staff in Medical and Dental subgroups compared with the percentage of staff in the medical workforce



- Across all Medical & Dental roles, BAME colleagues represent a majority for each role.
- BME colleagues working within Non-Consultant Career Grade roles have the highest representation across KGH with 86% of colleagues being BAME.



Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts)



A relative likelihood below 1 indicates that BAME applicants are less likely to be appointed compared to white applicants.



A relative likelihood of over 1 means that white applicants have a greater likelihood of being appointed from shortlisting than BAME applicants.

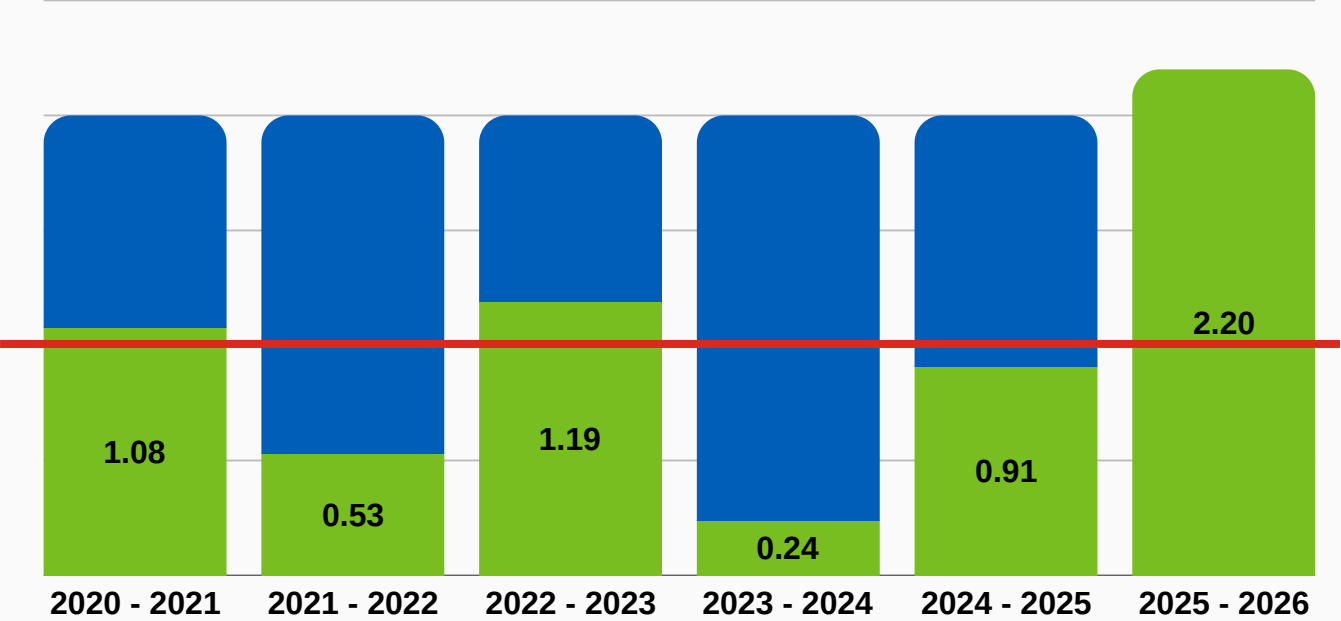
A relative likelihood of 1 means that there is no difference and white applicants are just as likely to be appointed compared to BAME applicants.



2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
1.48	1.24	3.47	0.92	1.07	0.98

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

WRES Indicator 3 Yearly Comparison



A relative likelihood below 1 indicates that White staff are less likely to enter the formal disciplinary process compared to BME staff.



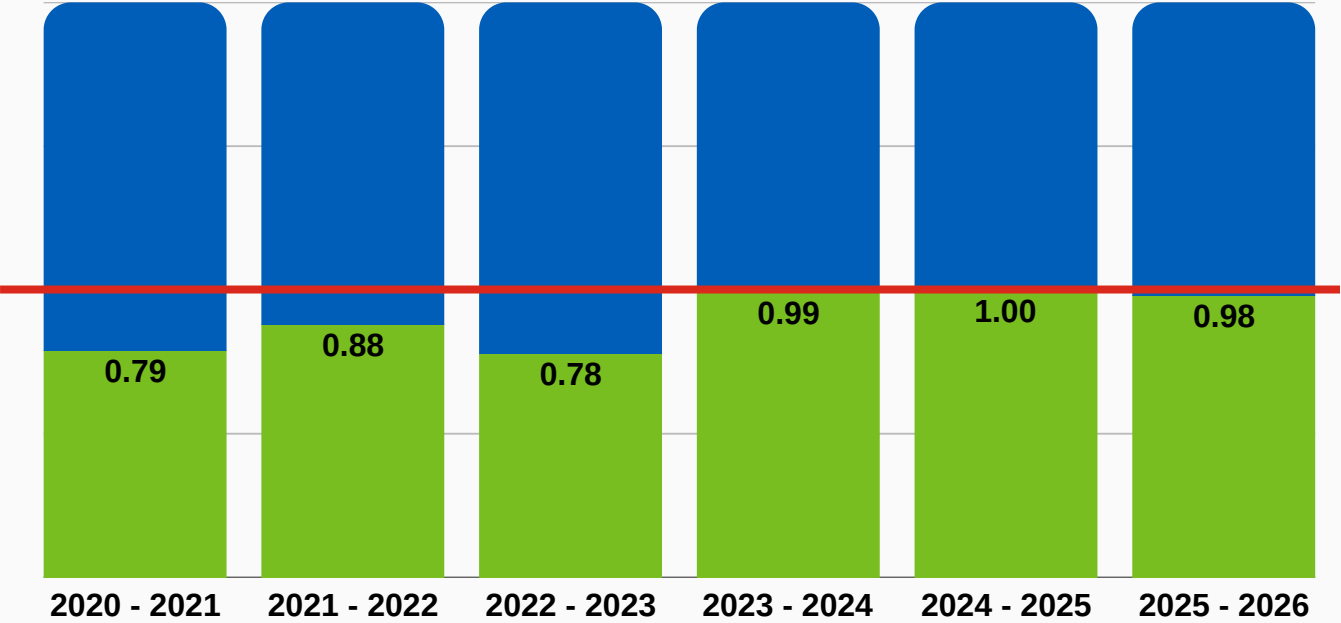
A relative likelihood above 1 means that BME staff are more likely to enter the formal disciplinary process compared to white staff.

A relative likelihood of 1 means that there is no difference and white colleagues are just as likely to enter the formal disciplinary process compared to BAME applicants.

2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
1.08	0.53	1.19	0.24	0.91	2.20

Relative likelihood of staff accessing non-mandatory training and CPD

WRES Indicator 4 Yearly Comparison



A relative likelihood below 1 indicates that white staff are less likely to access non-mandatory training compared to BAME staff



A relative likelihood above 1 means that white staff are more likely to access non-mandatory training compared to BAME staff

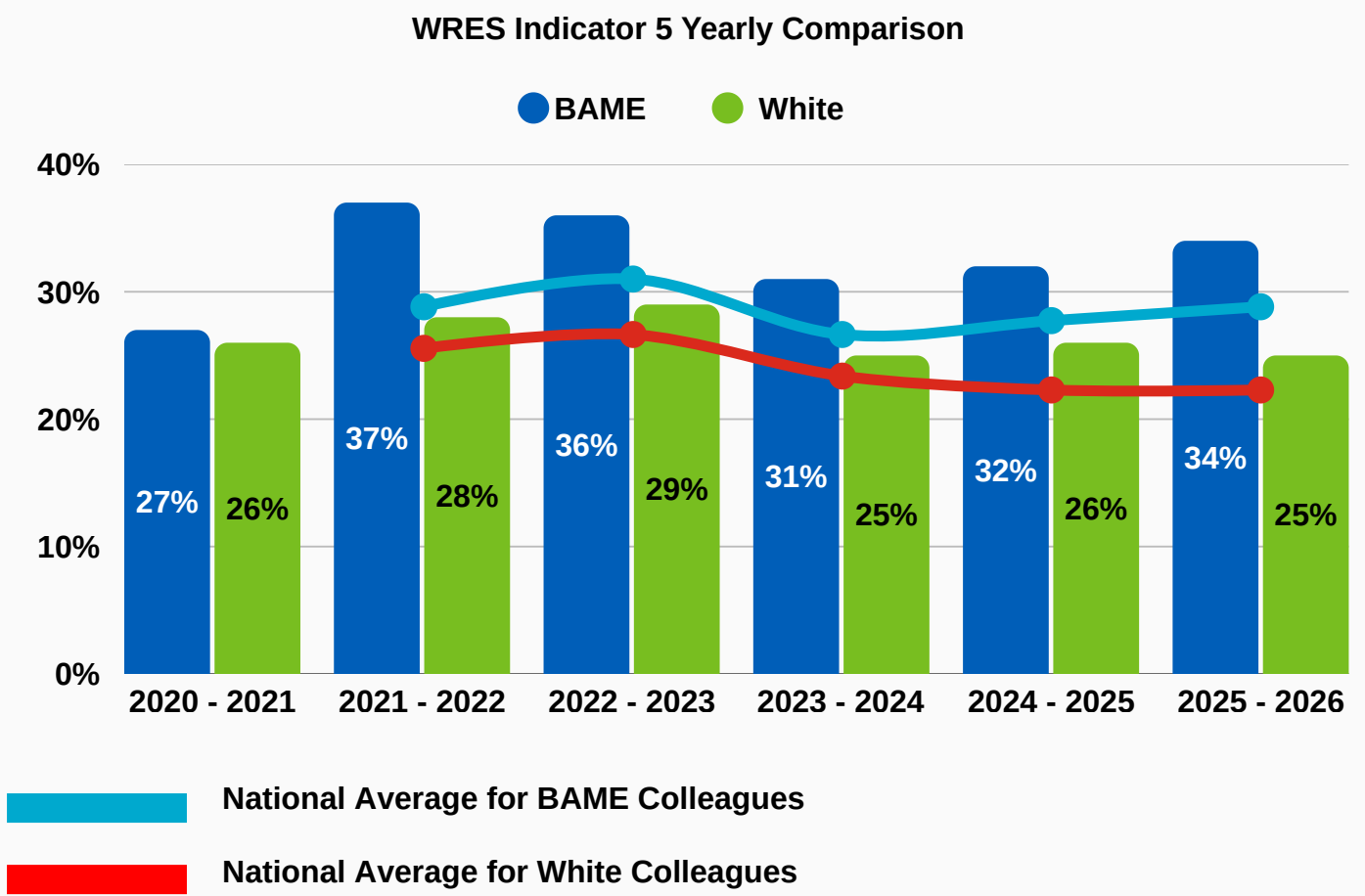
A relative likelihood of 1 means that there is no difference and white colleagues are just as likely to access non-mandatory training as BAME colleagues.



2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
0.79	0.88	0.78	0.99	1	0.98

WRES Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

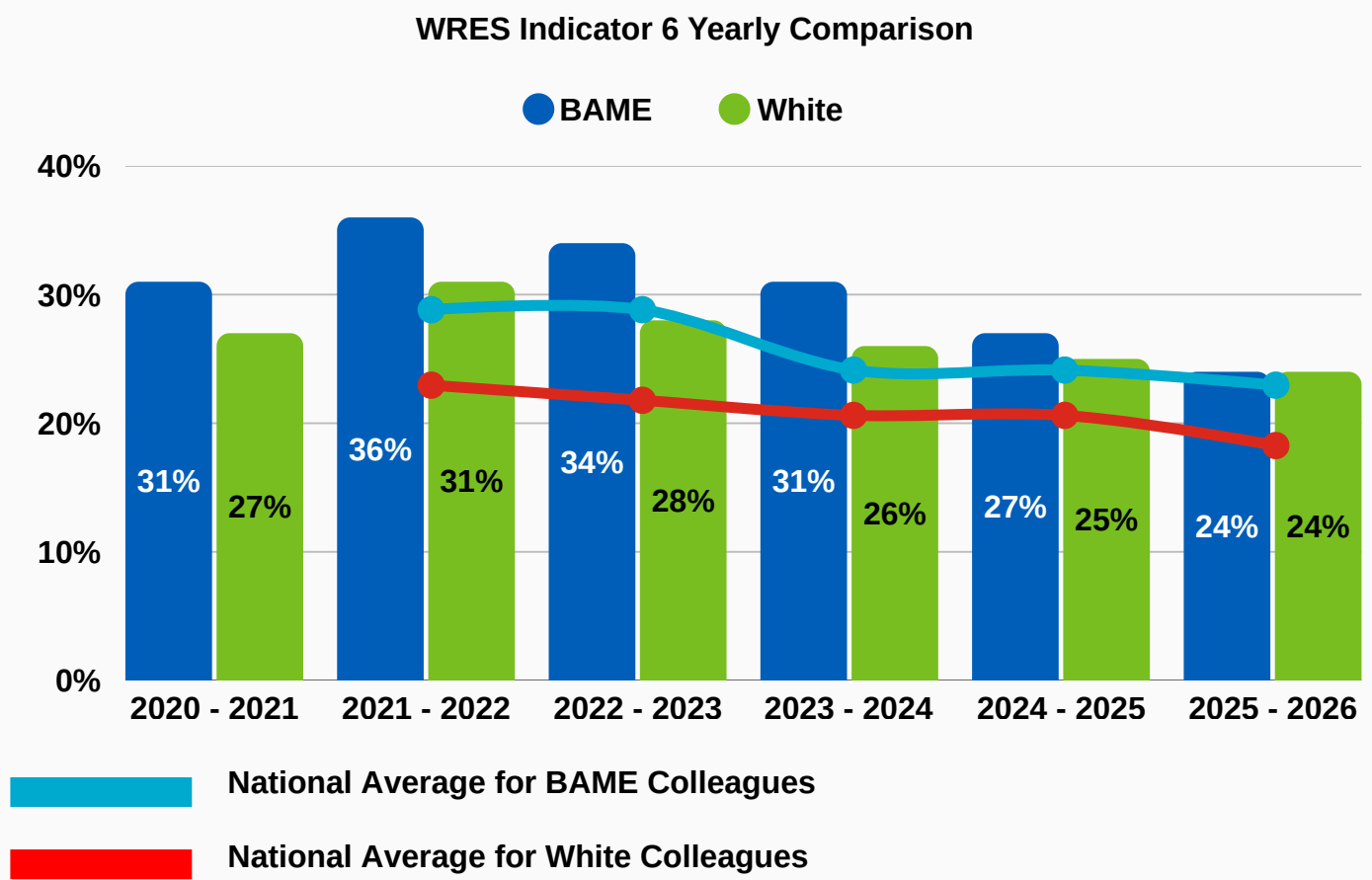


- Over a third of BAME colleagues within KGH have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- There has been an increase of 2% of BAME colleagues experiencing harassment from patients, relatives and the public from 32% to 34% in 2025.

Overall KGH Workforce:	White	BAME
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

WRES Indicator 6

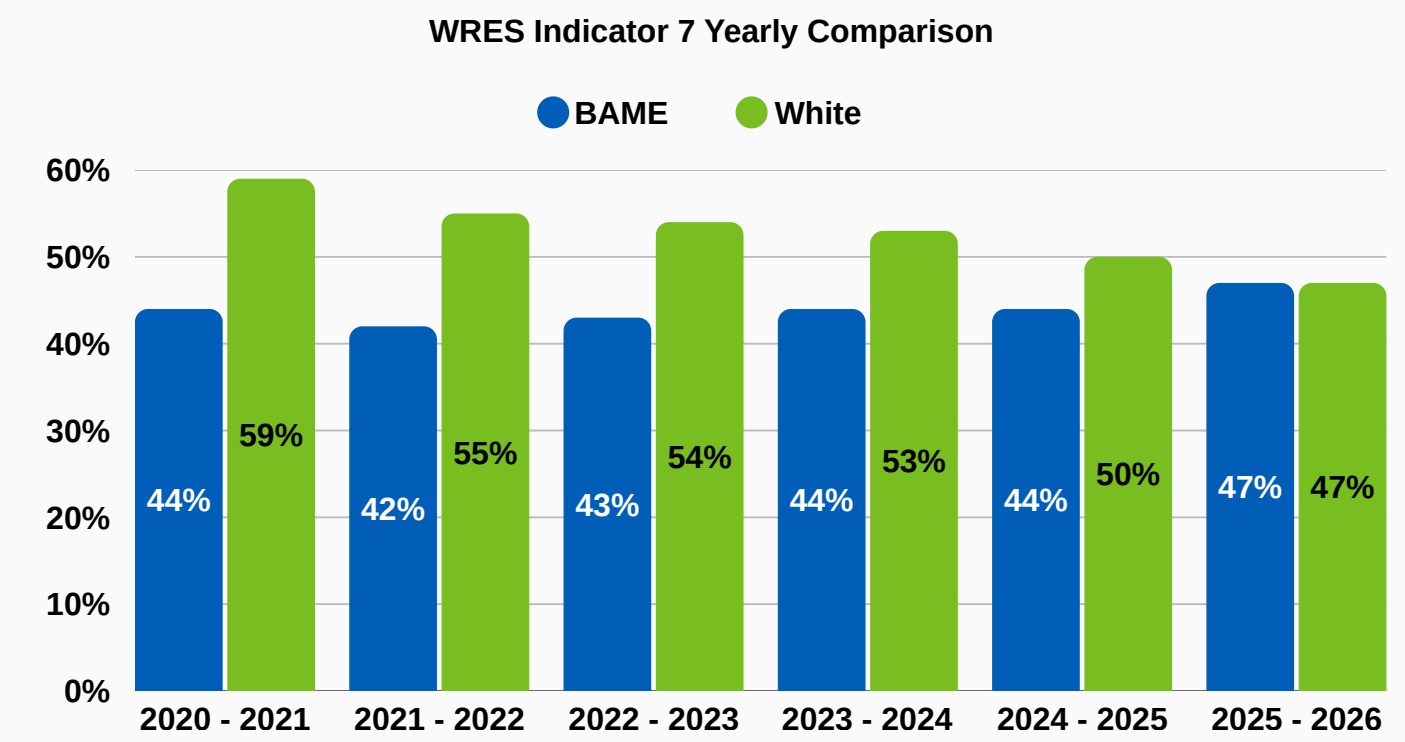
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



- Nearly a quarter of White colleagues within KGH have experienced harassment, bullying or abuse from other members of staff in the last 12 months.
- Nearly a quarter of BAME colleagues within KGH have experienced harassment, bullying or abuse from other colleagues in the last 12 months
- There has been an decrease of 3% of KGH colleagues experiencing harassment from other colleagues from 27% to 24% in 2025.

Overall KGH Workforce:	White	BAME
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

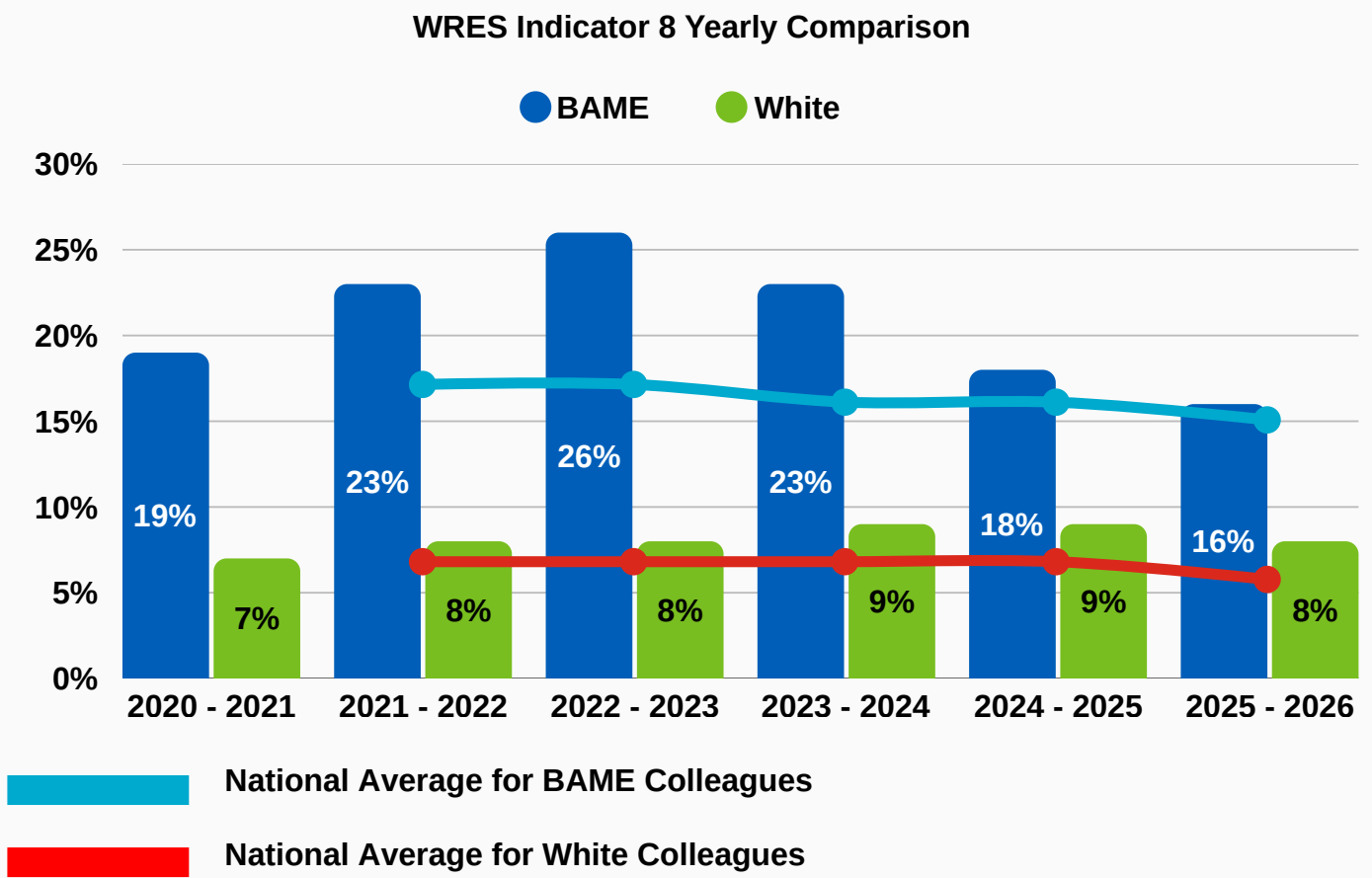


- Less than half of BAME colleagues within KGH believe that the Trust provides equal opportunities for career progression or promotion
- Both BAME & White colleagues are below the national average when believing that the Trust provides equal opportunities for career progression or promotion.
- There has been an increase of 3% of BAME colleagues believing that the Trust provides equal opportunities for career progression or promotions from 44% to 47% in 2025.

Overall KGH Workforce:	White	BAME
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

WRES Indicator 8

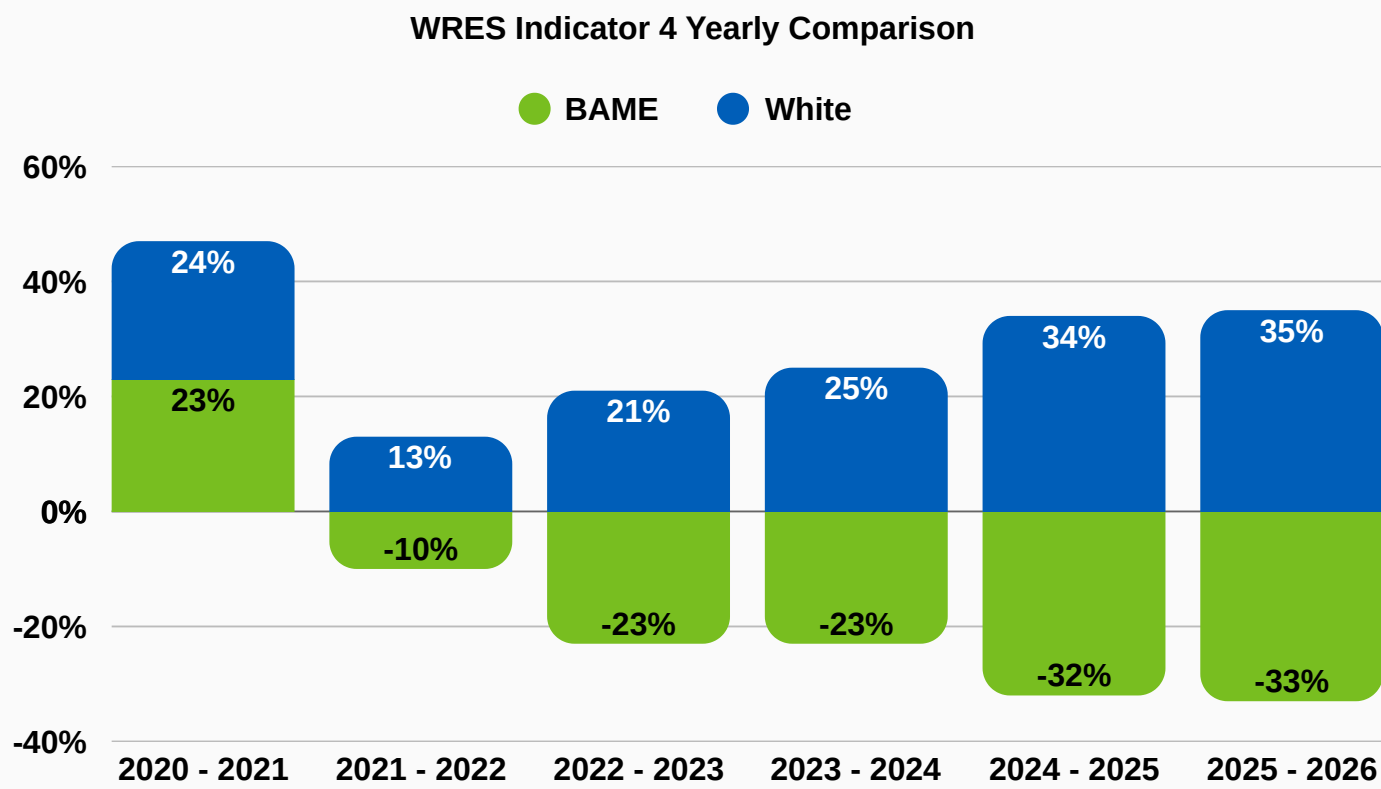
In the last 12 months have you personally experienced discrimination at work from a Manager/team leader or other colleague



- Less than a fifth of BAME colleagues have personally experienced discrimination at work from a manager/team leader or other colleagues in the last 12 months
- Less than 10% of white colleagues have personally experienced discrimination at work from a manager/team leader or other colleague in the last 12 months, higher than the national average.
- There has been an decrease of 2% of BAME colleagues who have personally experienced discrimination at work from a manager/team leader or other colleague from 18% to 16% in 2025.

Overall KGH Workforce:	White	BAME
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

Percentage difference between the organisations' Board membership and its overall workforce



- All board members have voting membership.
- The number of BAME voting board members has decreased by 1%.
- In the last five years there has been a decrease of 23% in terms of BAME representation on the board.
- Out of 22 board members there is only 2 BAME (Exec & Non-Exec) representatives.
- The percentage of BAME members on the board of directors is lower than in the workforce.

Year	Position	White	BAME
2025	Exec	10	1
	Non Exec	8	1

1. Strengthen inclusive leadership and cultural competence by requiring targeted leaders to complete Rethinking Racism and participate in experiential development, including reciprocal mentoring:

- Our aim for 2026/2027 is to see a 80% completion rate for all Bands 8A - VSM of the Rethinking Racism Programme
- Mandating the Rethinking Racism Programme for all Band 7 - VSM roles

2. Reduce disciplinary disproportionality through fair and restorative processes by introducing race-equity oversight, Cultural Ambassador input and early informal resolution:

- We are committed to creating an Inclusive Ambassador Programme where colleagues are trained to support our People Team in formal processes in ensuring equity and belonging are maintained

3. Grow diverse talent and career progression pathways through sponsorship, reciprocal mentoring and targeted development for REACH colleagues, with a focus on senior roles.

4. Strengthen the organisational response to racism, harassment and discrimination by improving reporting, support, learning and leadership accountability for incidents involving colleagues and patients or members of the public.

5. Amplify ethnically diverse colleague voice through co-production by giving REACH colleagues and the network by planning for the future in which our networks are able to develop their members, and develop future network leaders.

6. Increase accountability for race equality outcomes through routine reporting, named leadership ownership and escalation where inequalities do not improve.



Accountability

We take responsibility for our decisions, our actions and our behaviours. We do what we say we will do, when we say we will do it. We acknowledge our mistakes and we learn.



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We value each other, embrace diversity and make sure everyone feels included. We take the time to listen to, appreciate and understand the thoughts, beliefs and feelings of others



Integrity

We are consistently open, honest and trustworthy. We can be relied upon, we stand by our values and we always strive to do the right thing.



Compassion

We care about our patients and each other. We consistently show kindness and empathy and take the time to imagine ourselves in other people's shoes.



Courage

We dare to take on difficult challenges and try out new things. We find the strength to speak up when it matters and we see potential failure as an opportunity to learn and improve.

NGH Workforce Race Equality Standard (WRES) Report 2025 - 2026



UHN Colleagues & Teams responsible for compiling this report are as follows:

Paula Kirkpatrick, UHN Chief People Officer

Andy Eagle - Weston, UHN Deputy Chief People Officer (Culture & Inclusion)

Brad Scott, Deputy Chief People Officer

Farhana Ahmedabadi-Patel, Head of Organisational Development & Inclusion

Jane Sanjeevi, Senior Diversity & Inclusion Specialist

Alex Ridley, Organisational Culture Lead

Sarah Kinsella, People Partnering Business Partner

Alistair Weston, EDI Engagement Officer (NGH)

Charlotte Cooper, EDI Engagement Officer (KGH)

Sandra Rojo, ESR System Development & Quality Manager

Kevin Gillman, Workforce Information & System Officer

REACH & DAWN Staff Networks

Date this report was presented to the UHN Board of Directors:

October 2026

Date published: October 2026

It is well evidenced through various sources of data and lived experiences, that colleagues from a Black, Asian and Minority Ethnic background have a poorer experience of working within the NHS. At UHN we are committed to improving those lived experiences and focused on creating a culture where:

- **Race and ethnicity are not barriers to progression,**
- **Individuals feel safe in the workplace and**
- **Difference are embraced.**

As a Trust we want to focus on working in partnership with our patients, service users and colleagues, to change our ways of working and interacting with each other. This enables our colleagues to thrive and deliver the best possible services and care to the people of Northampton, Kettering and surrounding areas.

The importance of race equality is embedded into the [NHS People Promise](#) where it states 'We are open and inclusive. We understand, encourage and celebrate diversity, making the NHS a place where we all feel we belong'. The People Promise declares 'a commitment to creating and maintaining a compassionate and inclusive culture where diversity is valued and celebrated as a critical component, and not just a desirable one.' The Trust must also meet its legal obligations under the [Equality Act 2010](#) and [The Human Rights Act 1998](#).

Each year the Trust is required to publish Workforce Race Equality Standard (WRES) data. The WRES provides a framework for NHS organisations to report, demonstrate and monitor progress against nine indicators of workforce equality. The indicators are a combination of workforce data and results from the NHS national staff survey and help to ensure that employees receive fair treatment in the workplace and have equal access to career opportunities. The WRES is included in the NHS Standard Contract and has been a requirement of NHS commissioners and NHS healthcare providers since July 2015.

There are 9 WRES indicators.

4 of the indicators focus on
workforce data from ESR

4 of the indicators are based
on data from the national
NHS Staff Survey questions

1 indicator focuses upon
BME representation on
the Board of Directors



Indicator 1

Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce



Indicator 2

Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts)



Indicator 3

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation



Indicator 4

Relative likelihood of staff accessing non-mandatory training and CPD



Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



Indicator 7

Percentage of staff believing that the trust provides equal opportunities for career progression or promotion



Indicator 8

In the last 12 months have you personally experienced discrimination at work from a Manager/team leader or other colleague



Indicator 9

Percentage difference between the organisations' Board membership and its overall workforce

Workforce indicators for each of the four workforce indicators, compare the data for white and BAME staff -

Indicator 1: the definitions for these categories are based on Electronic Staff Record (ESR) occupation codes except for medical and dental staff, which are based upon grade codes.

Indicator 2: refers to 'Relative likelihood of staff being appointed from shortlisting across all posts', it must be noted that this refers to both external and internal posts through the Trac system linking into ESR.

Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation, this indicator is based on data from a 12month/24 month rolling average of the current year and the previous year

Indicator 4: Relative likelihood of white staff accessing non-mandatory training and CPD compared to BAME staff maybe limited as the data only reflects courses that are managed by ESR. Colleagues attending apprenticeships, learning through regulatory bodies, and additional clinical/professional development sessions may not be captured for this indicator.

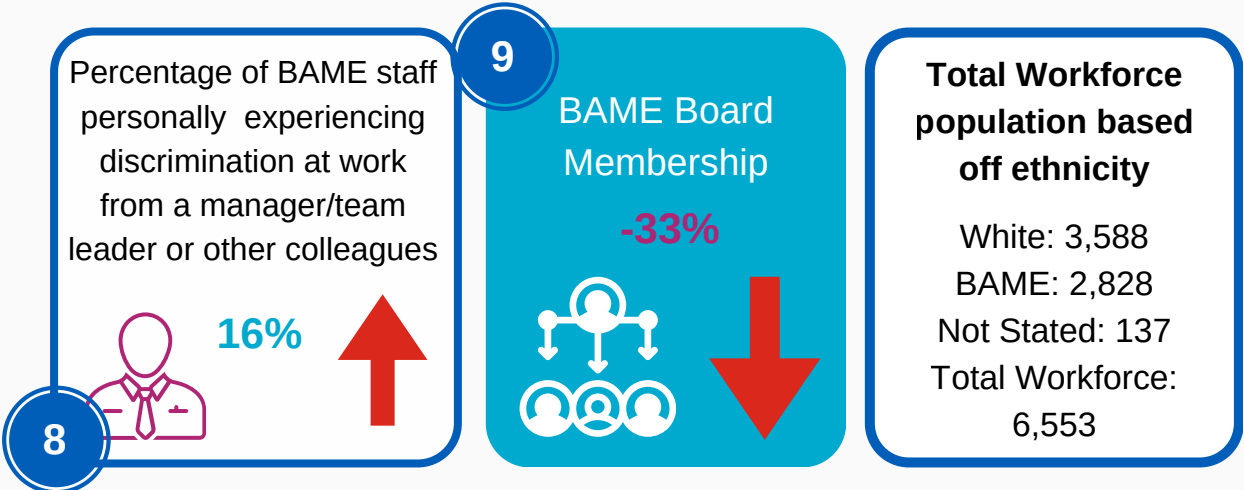
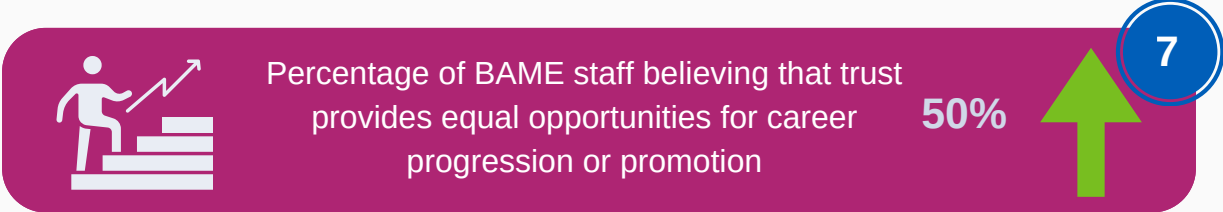
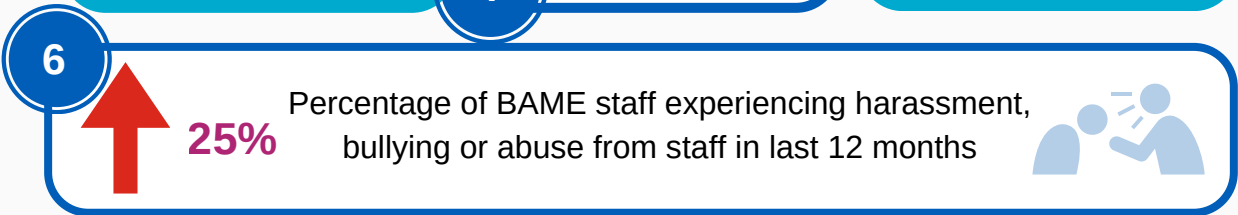
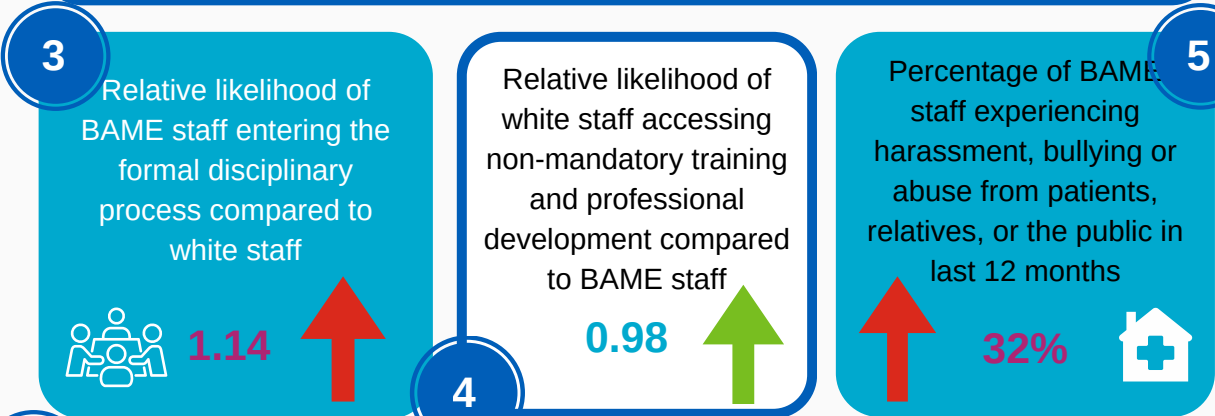
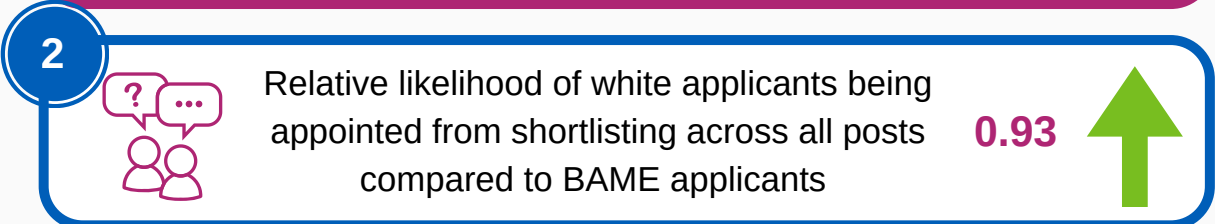
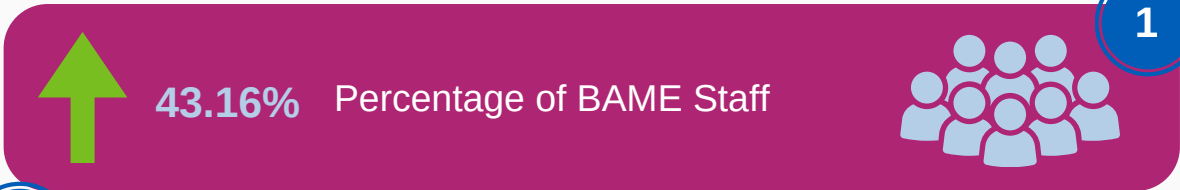
Four of the **WRES indicators (5 to 8)** are drawn from questions in the National NHS staff survey. The reliability of the data drawn from those indicators is dependent upon the overall size of the sample that have responded to the Staff Survey, the response rates to the survey questions, and whether the numbers of BME staff are large enough to not undermine confidence in the data. It should be noted that in the most recent staff survey (2024) only 54% of the total UHN workforce population took part in the survey.

Board representation indicator 9: Percentage difference between the organisations' board membership and its overall workforce disaggregated:

- **By voting membership of the board**
- **By executive membership of the board**

Some of the WRES indicators are shown as a score. A score of 1 means there is no difference between ethnic groups. A score below 1 means the outcome is more favourable for ethnically diverse staff, while a score above 1 means the outcome is less favourable and may indicate an area where further improvement is needed. In general, the closer the score is to 1, the more equal the outcome is for all staff.

Workforce Race Equality Standard 2025/26



Yearly Comparison

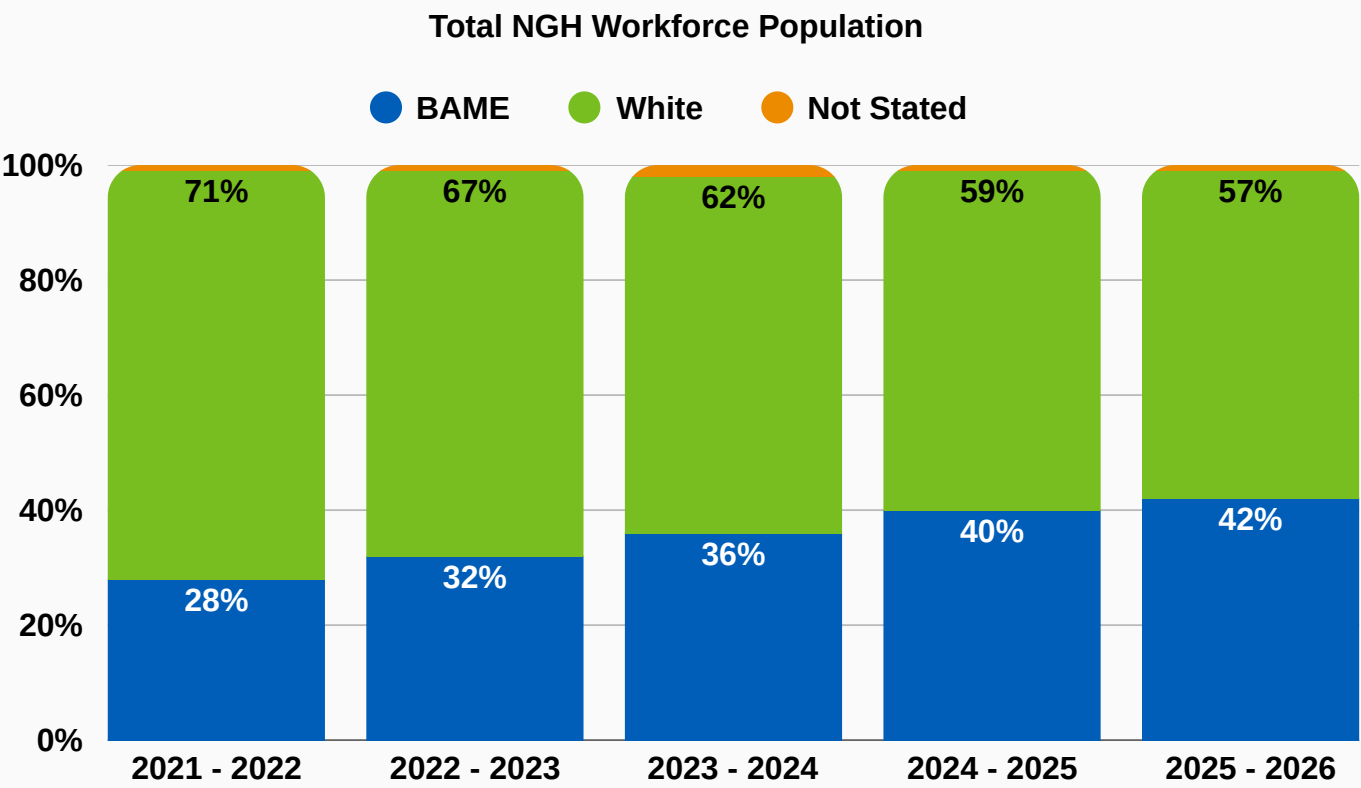


University Hospitals
of Northamptonshire
NHS Group

	WRES Indicator	NGH 2020-2021	NGH 2021-2022	NGH 2022-2023	NGH 2023-2024	NGH 2024 - 2025	NGH 2025 - 2026	Trend	RAG Rating
1	Percentage of BAME staff	28%	30%	33%	36%	41%	43%		
2	Likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants	0.93	0.93	0.90	0.93	0.53	0.93		
3	Likelihood of BAME staff entering formal disciplinary process compared to white staff	1.52	1.00	0.47	0.17	0.12	1.14		
4	Likelihood of white staff accessing non-mandatory training and CPD compared to BAME staff	1.89	0.61	0.97	0.70	0.80	0.98		
5	Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	30%	31%	32%	30%	30%	32%		
6	Percentage of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months	34%	33%	30%	24%	20%	25%		
7	Percentage of BAME staff believing that the Trust provides equal opportunities for career progression or promotion	40%	40%	40%	51%	49%	50%		
8	Percentage of BAME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	22%	25%	19%	14%	14%	16%		
9	% Difference between Board membership and overall BAME workforce	-22%	-10%	-23%	-23%	-32%	-33%		

WRES Indicator 1

Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce



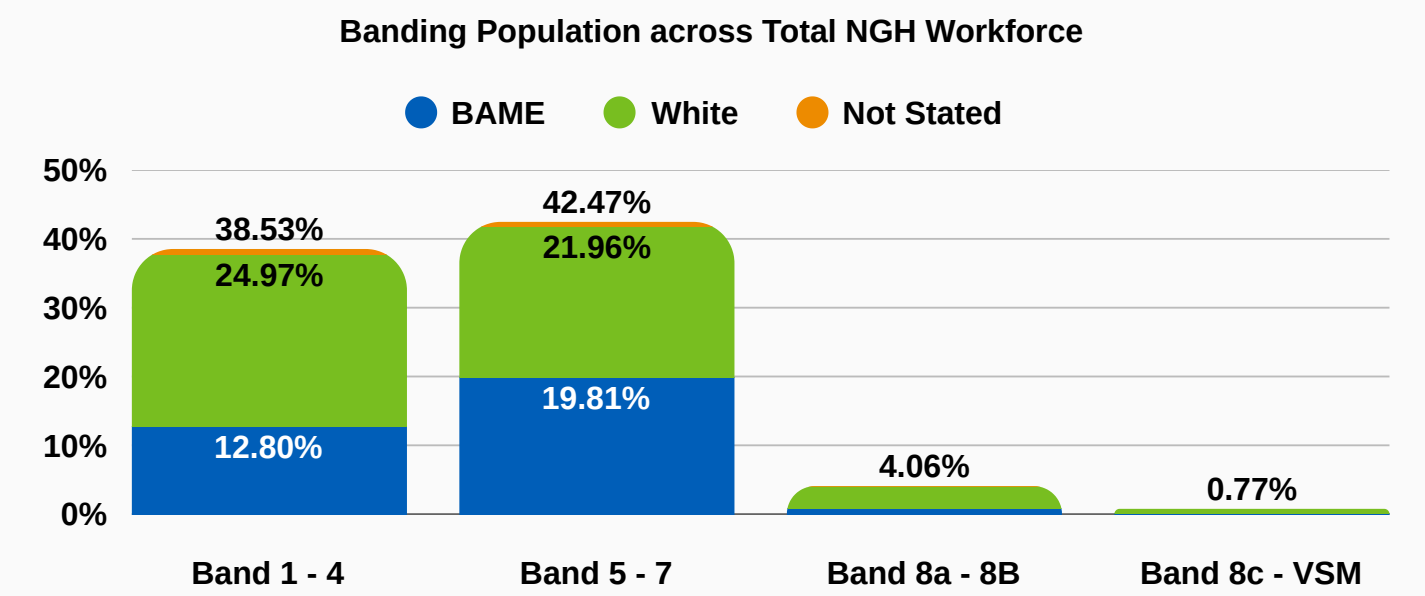
The overall headcount for the Trust is 6,553. This has increased from previous years with the number of colleagues declaring as BAME increasing to 2,828 (43%), an additional 96 colleagues.

The Data shows that the percentage of BAME staff at the Trust continues to increase, growing by 2% in the last year. The number of colleagues who have not completed their ethnicity reporting on ESR still remains at 2%. There has been an emphasis on the updating of ethnicity information on ESR (Electronic Staff Record)

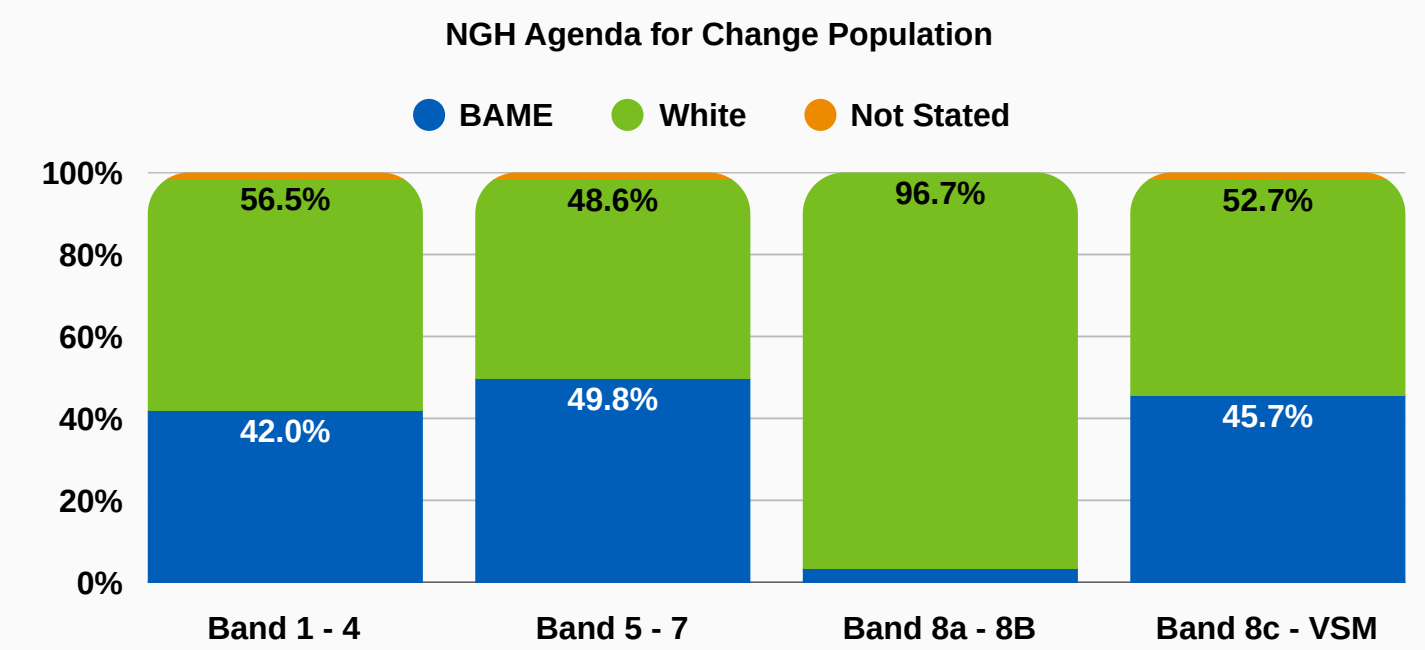
Overall Workforce Headcount at NGH

2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
5,973	5,805	5,913	6,158	6,617	6553

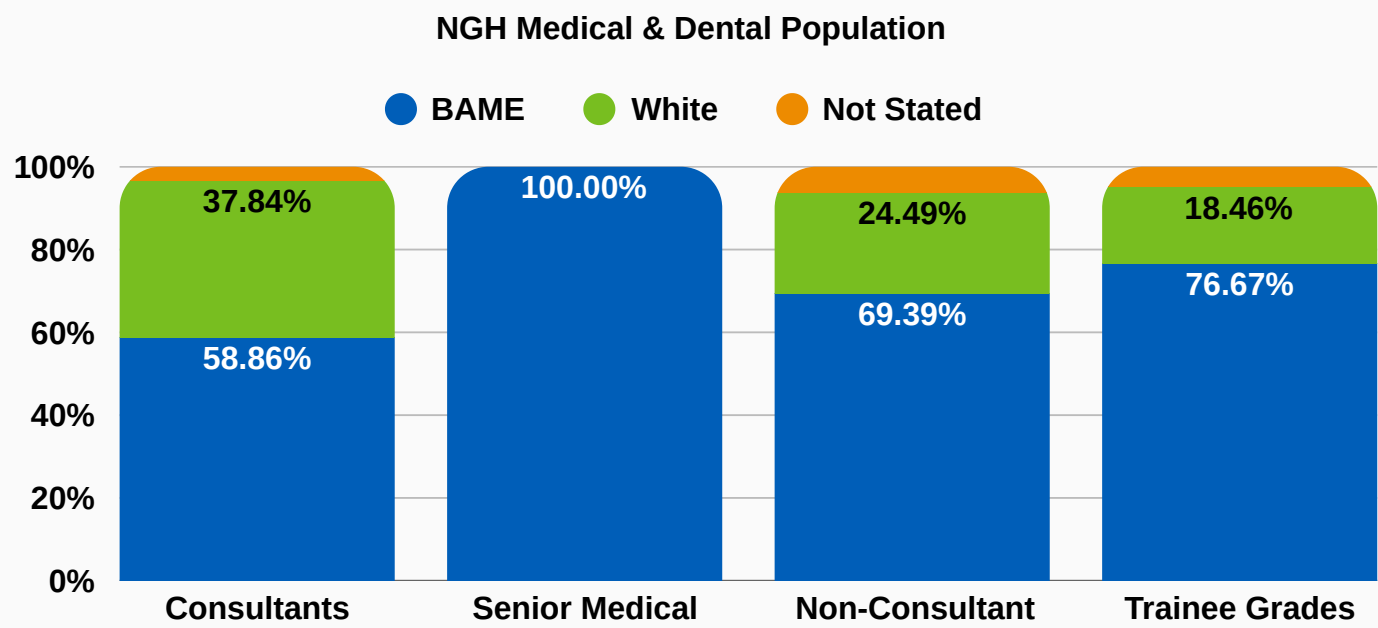
Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce



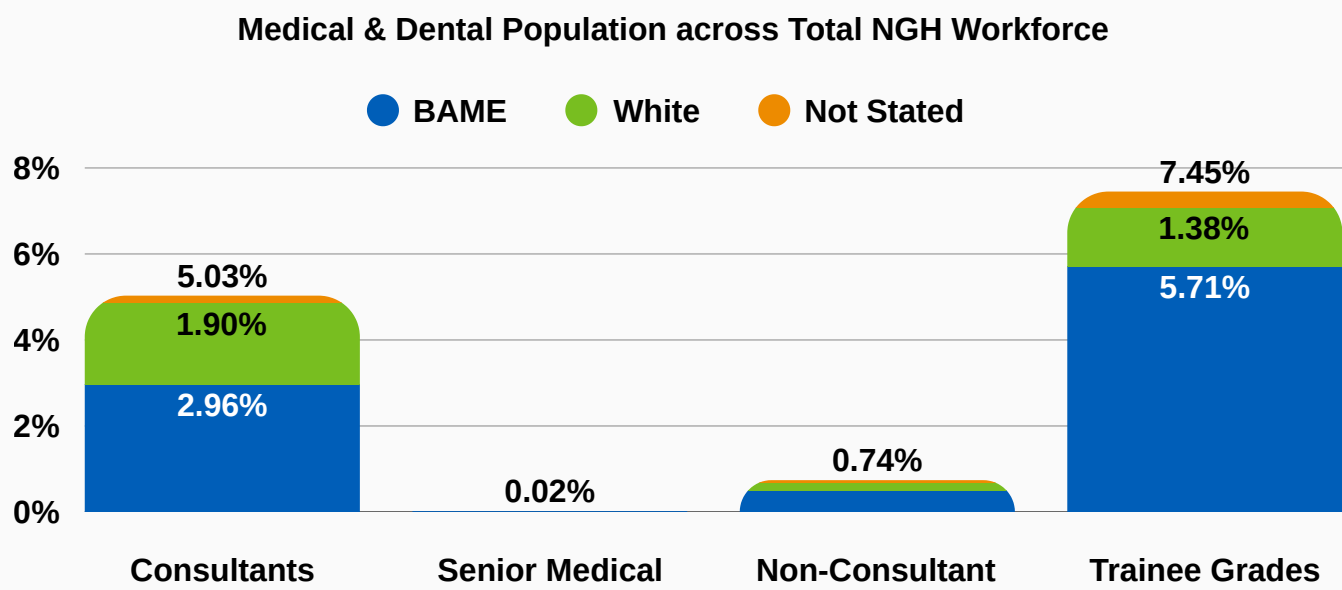
- From bands 1 - 7, our BAME representation remains below the national average of BME employed within NHSE, which was 21% in 2025.
- Within Bands 5 - 7, NGH is nearly split equally with 2.15% being the difference from half of the banding being BAME colleagues.
- Bands 8A - VSM remain below the national average with more white representation within senior level roles.



Percentage of staff in Medical and Dental subgroups compared with the percentage of staff in the medical workforce

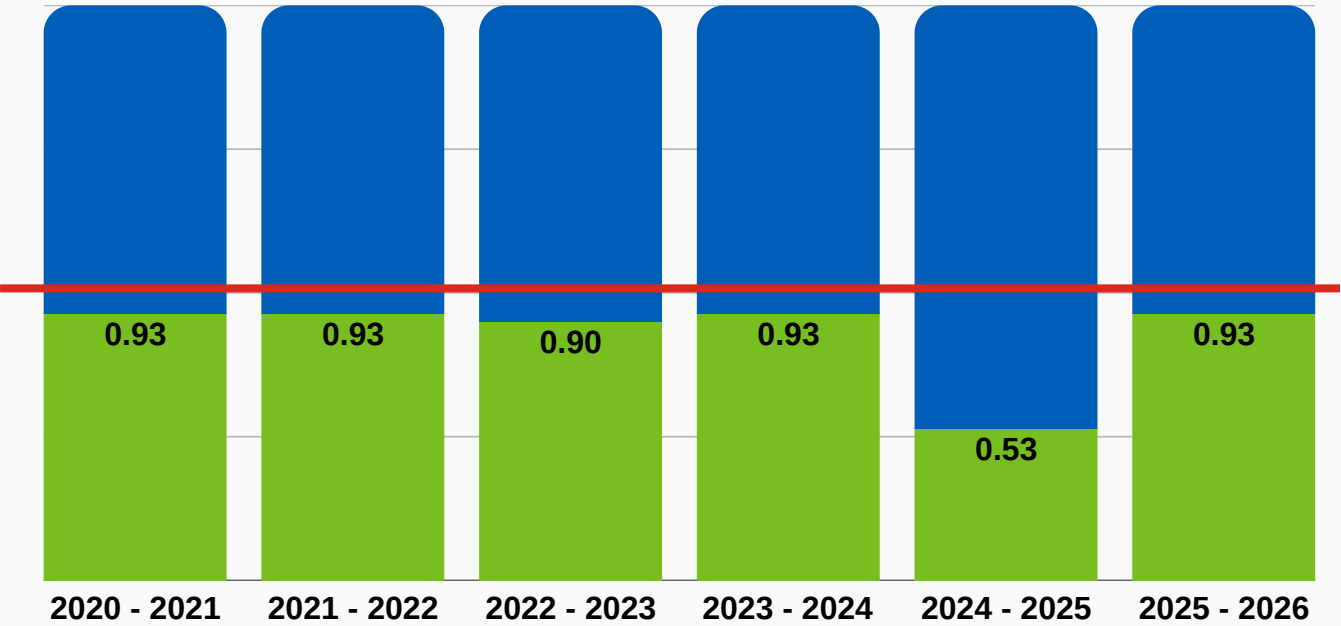


- Across all Medical & Dental roles, BAME colleagues represent a majority for each role.
- BME colleagues working within Trainee Grade roles have the highest representation across NGH with 76.67% of colleagues being BAME
- The Senior Medical Manager role is reserved for the UHN Medical Director



Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts)

WRES Indicator 2 Yearly Comparison



A relative likelihood below 1 indicates that BAME applicants are less likely to be appointed compared to white applicants.



A relative likelihood of over 1 means that white applicants have a greater likelihood of being appointed from shortlisting than BAME applicants

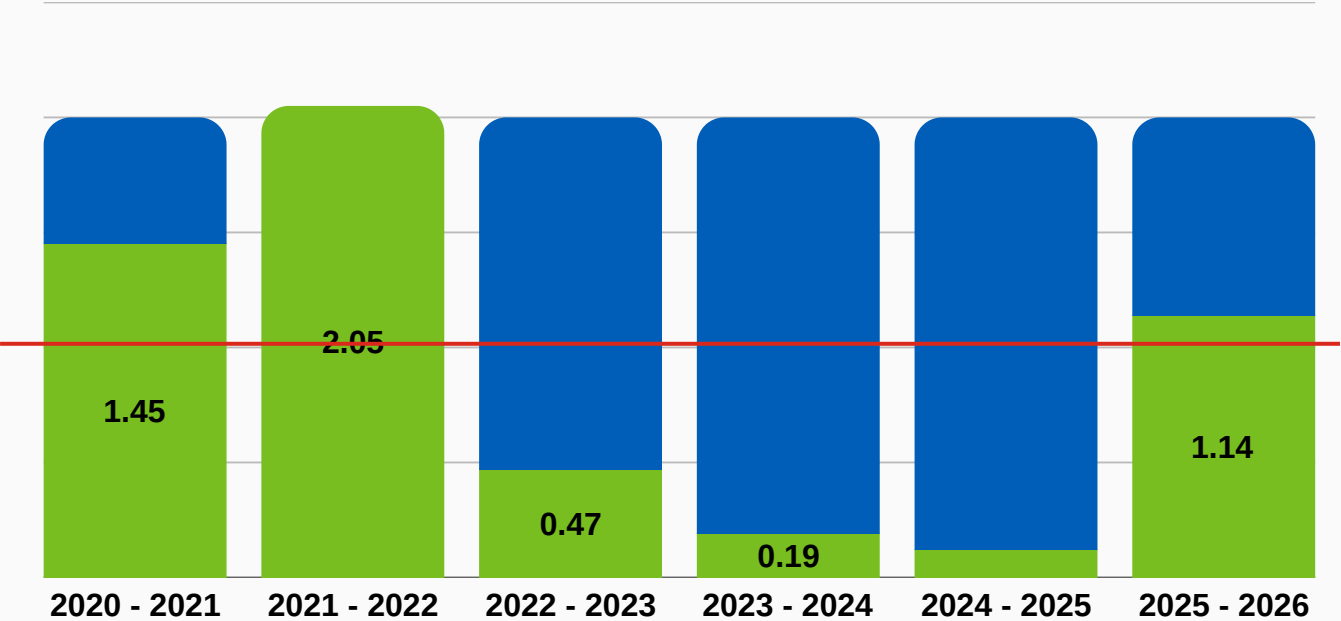
A relative likelihood of 1 means that there is no difference and white applicants are just as likely to be appointed compared to BAME applicants.



2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
0.93	0.93	0.90	0.93	0.53	0.93

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

WRES Indicator 3 Yearly Comparison



A relative likelihood below 1 indicates that White staff are less likely to enter the formal disciplinary process compared to BAME staff

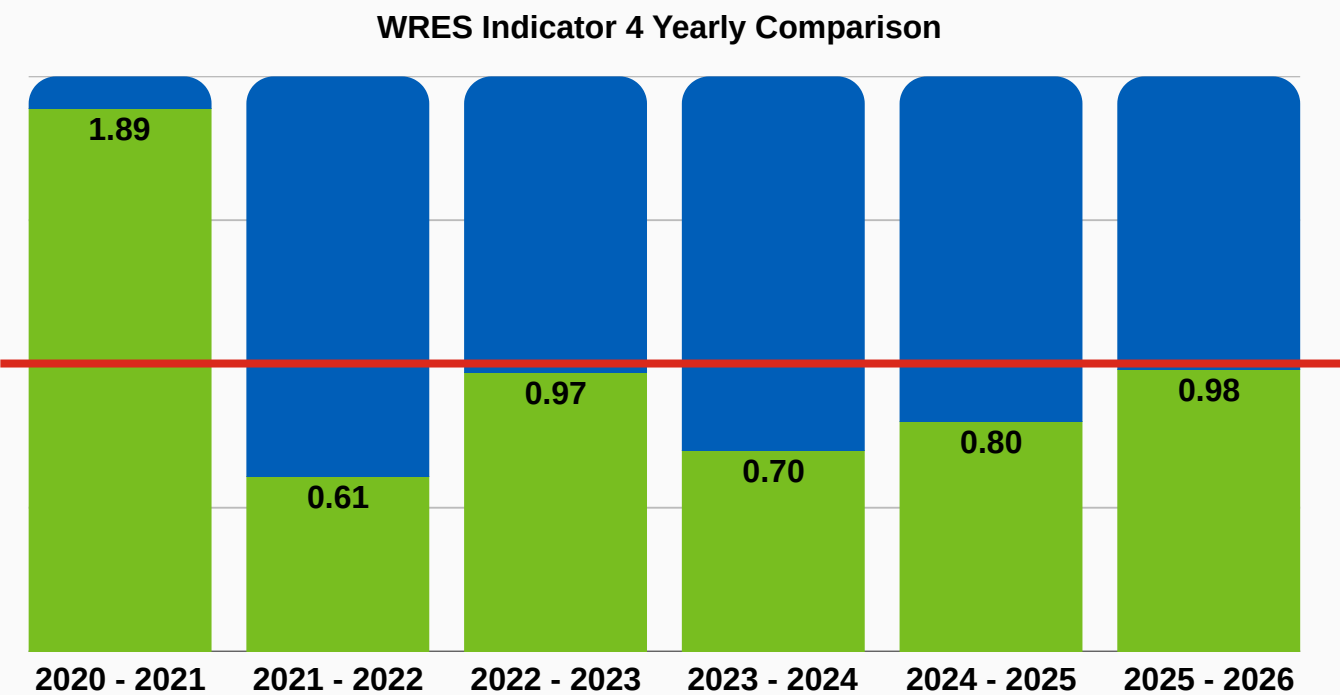


A relative likelihood above 1 means that BAME staff are more likely to enter the formal disciplinary process compared to white staff.

A relative likelihood of 1 means that there is no difference and white colleagues are just as likely to enter the formal disciplinary process compared to BAME applicants.

2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
1.45	2.05	0.47	0.19	0.12	1.14

Relative likelihood of staff accessing non-mandatory training and CPD



A relative likelihood below 1 indicates that white staff are less likely to access non-mandatory training compared to BAME staff



A relative likelihood above 1 means that white staff are more likely to access non-mandatory training compared to BAME staff

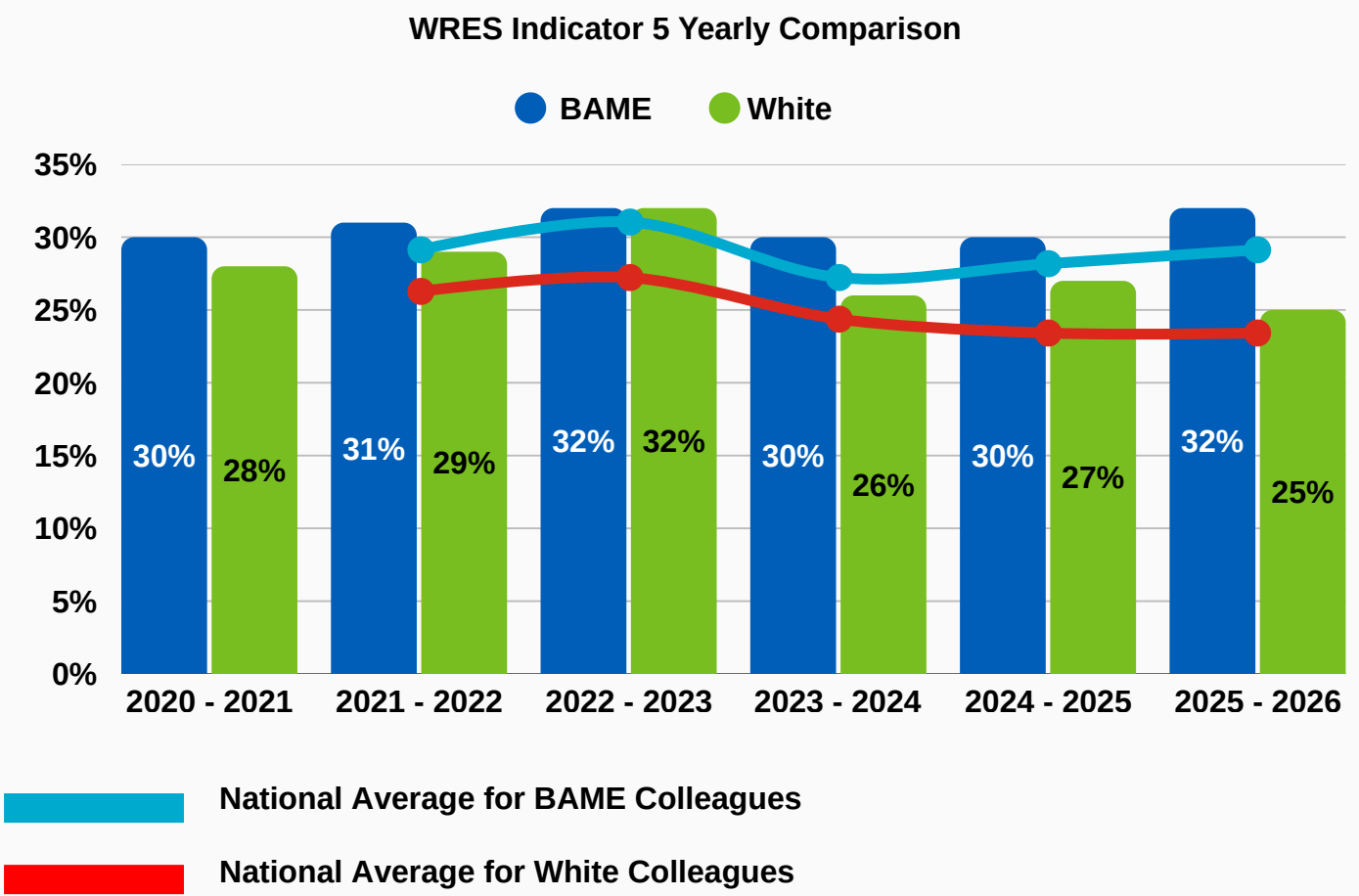
A relative likelihood of 1 means that there is no difference and white colleagues are just as likely to access non-mandatory training as BAME colleagues.



2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
1.89	0.61	0.97	0.70	0.80	0.98

WRES Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

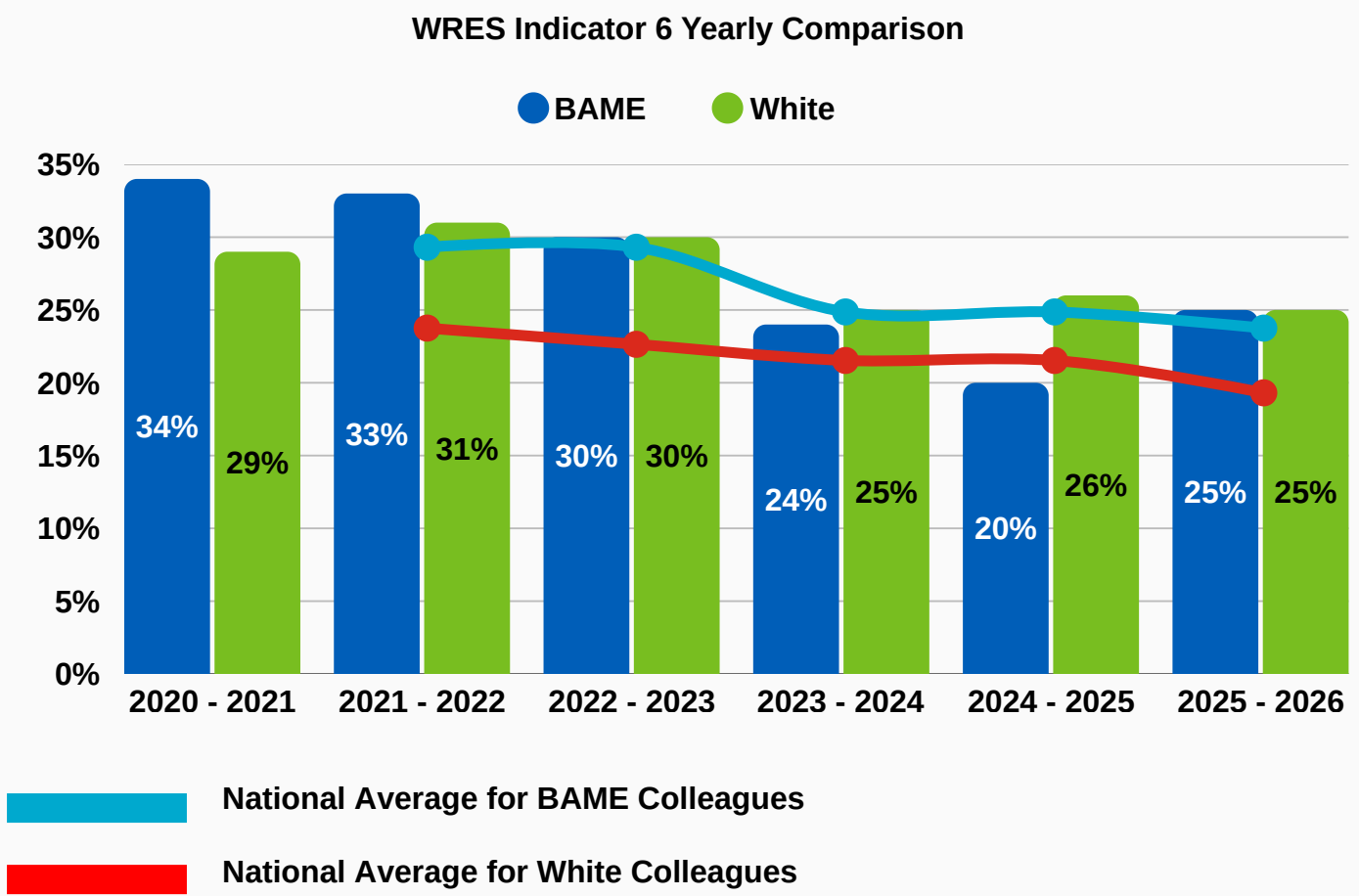


- Over a third of BAME colleagues within NGH have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- There has been an increase of 2% of BAME colleagues experiencing harassment from patients, relatives and the public from 30% to 32% in 2025

Overall NGH Workforce:	White	BAME
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

WRES Indicator 6

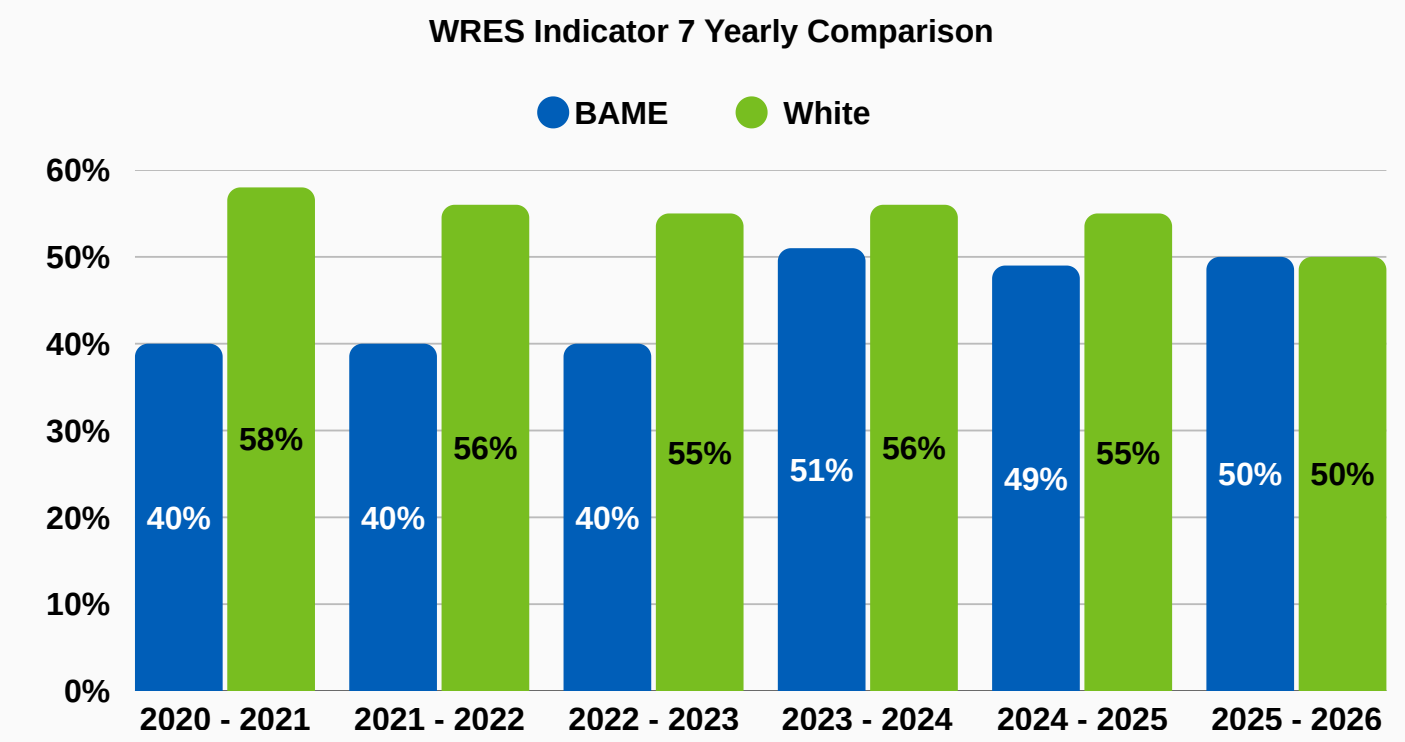
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



- A quarter of White colleagues within NGH have experienced harassment, bullying or abuse from other members of staff in the last 12 months. A decrease of 1% compared to last year’s data
- A quarter of BAME colleagues within UHN have experienced harassment, bullying or abuse from other colleagues in the last 12 months. An increase of 5% compared to last year’s data.

Overall NGH Workforce:	White	BAME
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

Percentage of staff believing that the trust provides equal opportunities for career progression or promotion



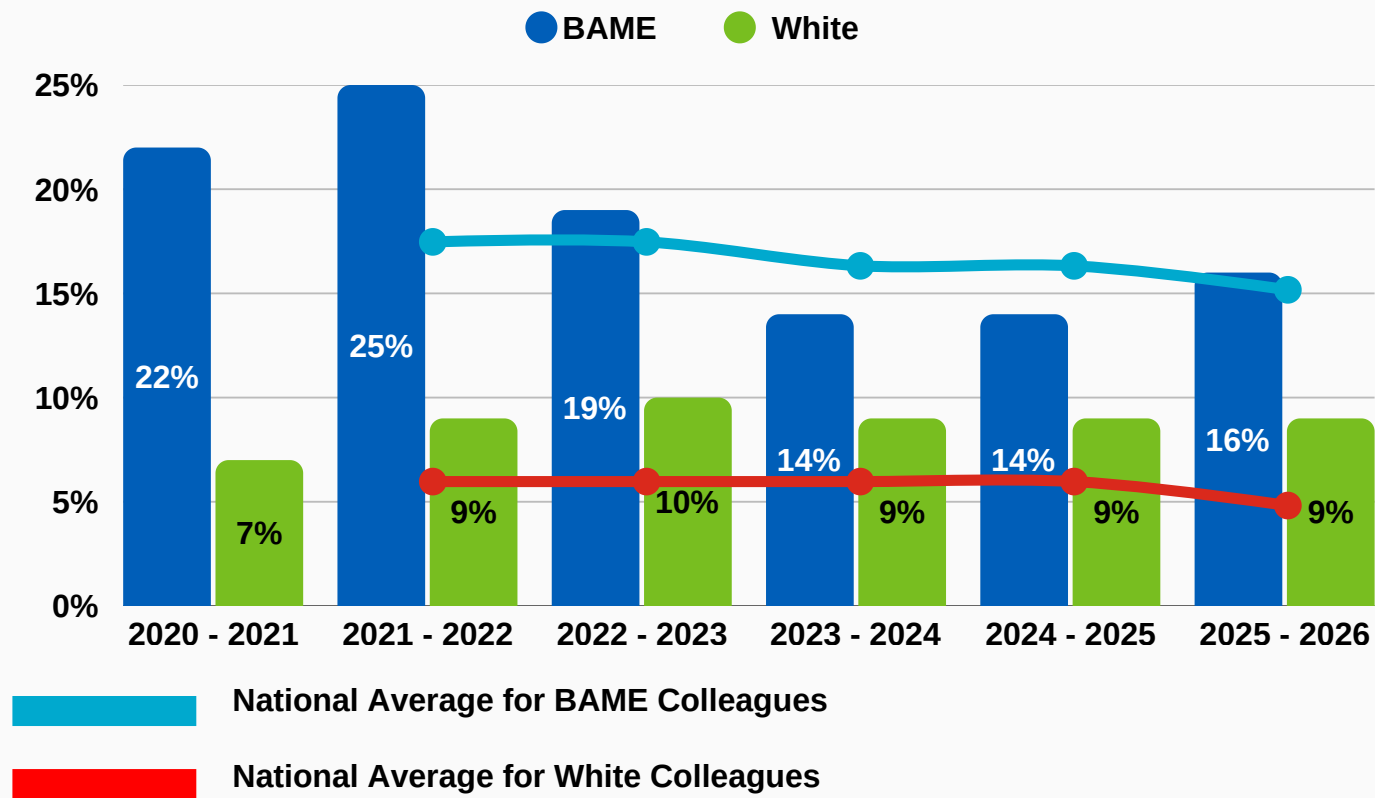
- Half of BME colleagues within NGH believe that the Trust provides equal opportunities for career progression or promotion
- Both BAME & White colleagues are below the national average when believing that the Trust provides equal opportunities for career progression or promotion.
- There has been an improvement of of 1% of BAME colleagues believing that the Trust provides equal opportunities for career progression or promotions from 49% to 50% in 2025

Overall NGH Workforce:	White	BAME
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

WRES Indicator 8

In the last 12 months have you personally experienced discrimination at work from a Manager/team leader or other colleague

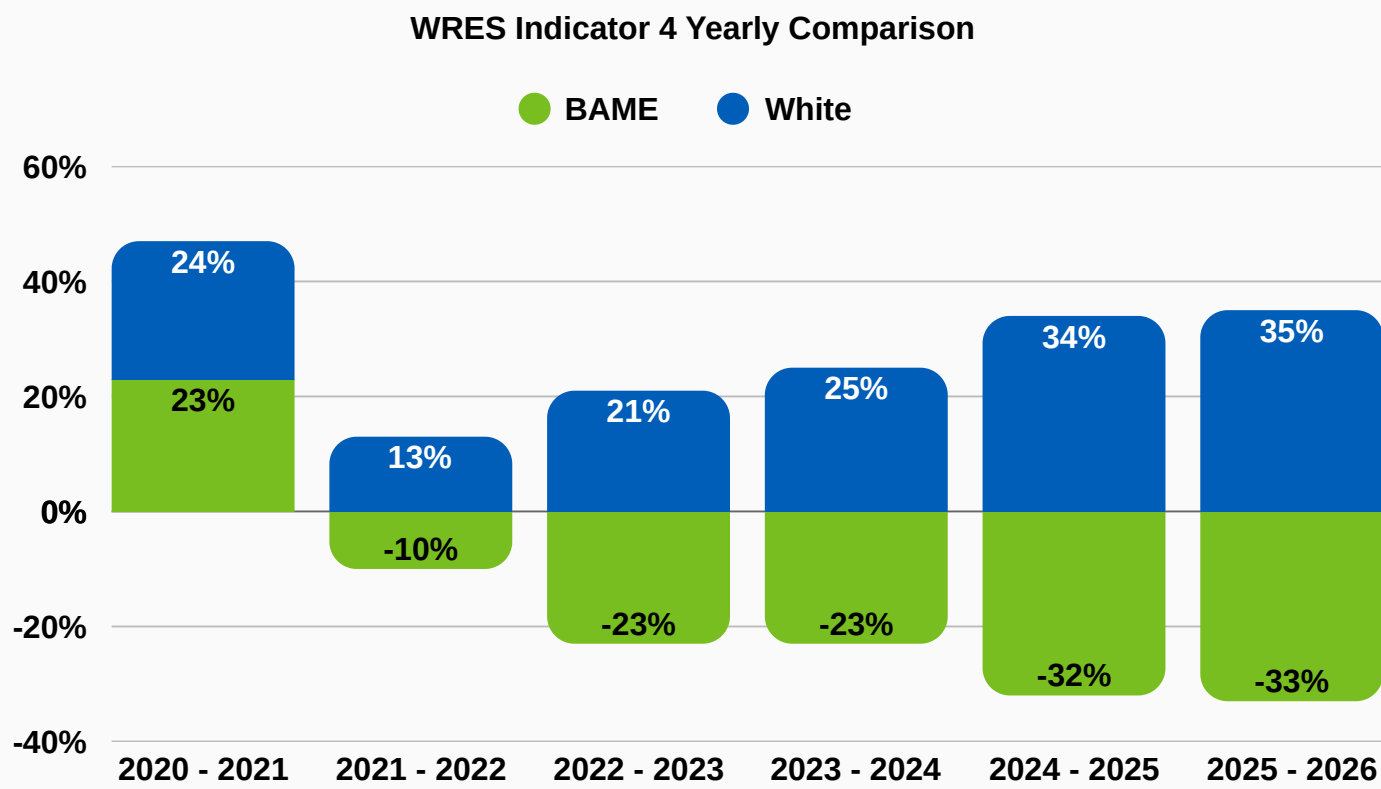
WRES Indicator 8 Yearly Comparison



- Less than a fifth of BAME colleagues have personally experienced discrimination at work from a manager/team leader or other colleagues in the last 12 months
- Nearly 10% of white colleagues have personally experienced discrimination at work from a manager/team leader or other colleague in the last 12 months, higher than the national average.
- There has been an increase of 2% of BAME colleagues who have personally experienced discrimination at work from a manager/team leader or other colleague from 14% to 16% in 2025

Overall NGH Workforce:	White	BAME
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

Percentage difference between the organisations' Board membership and its overall workforce



- All board members have voting membership.
- The number of BAME voting board members has decreased by 1%.
- In the last five years there has been a decrease of 23% in terms of BME representation on the board.
- Out of 22 board members there is only 2 BME (Exec & Non-Exec) representatives.
- The percentage of BAME members on the board of directors is lower than in the workforce.

Year	Position	White	BAME
2025	Exec	10	1
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- Our aim for 2026/2027 is to see a 80% completion rate for all Bands 8A - VSM of the Rethinking Racism Programme
- Mandating the Rethinking Racism Programme for all Band 7 - VSM roles

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- We are committed to creating an Inclusive Ambassador Programme where colleagues are trained to support our People Team in formal processes in ensuring equity and belonging are maintained

3. Grow diverse talent and career progression pathways through sponsorship, reciprocal mentoring and targeted development for REACH colleagues, with a focus on senior roles.

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5. Amplify ethnically diverse colleague voice through co-production by giving REACH colleagues and the network by planning for the future in which our networks are able to develop their members, and develop future network leaders.

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Cover Sheet

Meeting	Boards of Directors of the University Hospitals of Northamptonshire NHS Group (Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust) meeting together (public)
Date	09 October 2026
Agenda item	3.1
Title	UHN Workforce Disability Equality Standard (WDES) Annual Report 2025/26
Presenter	Paula Kirkpatrick, Group Chief People Officer
Author	Farhana Ahmedabadi-Patel, Senior Diversity & Inclusion Specialist

This paper is for

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

Link to Group Priorities:

Transform Patient Care	☒ Strengthen our Culture	Deliver our financial plan
------------------------	--	----------------------------

Reason for consideration / Previous consideration

Reason for Consideration:	Previous Consideration:
To present the University Hospitals of Northamptonshire Workforce Disability Equality Standard results for 2025/26 and seek approval of the refreshed action plan. The paper provides assurance on progress, identifies areas requiring further improvement and sets out the proposed priorities for 2026/27.	The UHN WDES Annual Report 2024/25 was presented to the Boards on 3 October 2025. In April 2025, the Boards also heard directly from colleagues about their experiences of neurodiversity as part of Autism Awareness Week.

Executive Summary

This report presents the UHN Workforce Disability Equality Standard (WDES) insights for 2025/26 and seeks approval of the refreshed action plan. The findings show progress in disability declaration, reasonable adjustments and aspects of workforce experience. Key priorities remain recruitment equity, career progression, engagement and representation of disabled colleagues at senior levels.

The Boards are asked to:

1. Note the UHN WDES results for 2025/26, including areas of progress and continuing inequalities experienced by disabled colleagues
2. Approve the refreshed UHN WDES Action Plan for 2026/27
3. Recognise its collective and individual responsibility for advancing disability equality across UHN and demonstrate personal accountability for creating an inclusive culture and workforce experience consistent with the expectations of the CQC Well-Led framework

Appendices

- Appendix 1: KGH WDES Report 2025/26
- Appendix 2: NGH WDES Report 2025/26

Risk and assurance

- BAF 18
- UHN Objective – 'Strengthen Our Culture'

- Mandated in the NHS Standard Contract and considered by the CQC under the 'Well-Led' domain

Financial Impact

Delivery of the refreshed action plan will be managed within existing resources. Failure to address disability inequalities may increase costs associated with recruitment, retention, sickness absence and employee relations activity. Any future investment requirements will be considered through the Trust's established approval processes.

Legal implications/regulatory requirements

The Trusts are required to comply with the Equality Act 2010, including the Public Sector Equality Duty and the duty to make reasonable adjustments, and to meet the requirements of the NHS Standard Contract. The WDES provides a framework for identifying and addressing inequalities experienced by disabled colleagues and supports compliance with the NHS Equality Delivery System and the CQC Well-Led framework.

Equality Impact Assessment

This work focuses on the general duties under the Equality Act 2010, with specific emphasis on the protected characteristic of disability. The paper aims to highlight inequalities experienced by disabled colleagues, gather soft intelligence, and develop actions to reduce disparity. The process established within UHN involves colleagues and stakeholders, including the DAWN Network, in discussion, action planning and assurance.

Paper	
Situation	
The Workforce Disability Equality Standard (WDES) is a nationally mandated NHS framework comprising ten indicators that measure the experiences and outcomes of disabled colleagues and colleagues with long-term health conditions. This report presents the 2025/26 WDES results for University Hospitals of Northamptonshire and seeks approval of the refreshed action plan.	
Background	
The WDES was introduced in 2019 and is a requirement for NHS commissioners and NHS healthcare providers through the NHS Standard Contract. The framework enables organisations to identify inequalities, monitor progress and develop evidence-based actions to improve recruitment, retention, career progression and workforce experience. UHN has reported against the WDES annually since its introduction and has used the findings to inform its disability equality priorities. During this period, the Trust has strengthened governance arrangements, developed the Disability, Accessibility, Wellbeing and Neuroinclusion (DAWN) Network, introduced Health Passports and Disability Leave, and published a Neuroinclusion Toolkit and Reasonable Adjustments Standard Operating Procedure. The 2025/26 report provides an opportunity to assess the impact of these interventions and identify priorities for future improvement. Delivery of the WDES supports the Trust's responsibilities under the Equality Act 2010, including the Public Sector Equality Duty, and contributes to UHN's wider ambition to be an inclusive employer where all colleagues can thrive.	
Assessment	
Workforce Representation	
Disability declaration increased from 6% to 7% at KGH and remained at 6% at NGH, with both organisations reporting above the most recently published national average. Representation remains lower within senior bands and some medical and dental groups, where under-declaration continues to limit understanding of workforce diversity.	
Recruitment	
Recruitment outcomes vary significantly between the two hospitals. KGH achieved appointment parity between disabled and non-disabled applicants, while NGH's Indicator 2 score increased from 1.25 to 2.22, indicating that non-disabled applicants were more than twice as likely to be appointed from shortlisting as disabled applicants. This represents the most significant area of concern within the 2025/26 results.	
Harassment, Bullying and Abuse	
Reported experiences of harassment, bullying and abuse reduced or remained stable across most measures at both hospitals. However, reporting rates remain low, with only half of disabled colleagues at KGH and 55% at NGH stating that incidents were reported, indicating further work is required to build confidence in reporting mechanisms.	
Career Progression and Workforce Experience	
Less than half of disabled colleagues believe the Trust provides equal opportunities for career progression, with performance remaining static at KGH and declining at NGH. Satisfaction that the organisation values their contribution also reduced at both hospitals, suggesting that disabled colleagues continue to experience barriers to inclusion and development.	
Reasonable Adjustments	
Access to reasonable adjustments improved from 70% to 78% at KGH and from 76% to 77% at NGH. This reflects continued investment in Health Passports, Disability Leave, the Neuroinclusion Toolkit and the Reasonable Adjustments Standard Operating Procedure, although consistency of application remains a priority.	
Staff Engagement	
Disabled staff engagement scores reduced slightly at both hospitals and remain below national averages. Alongside declining perceptions of organisational value, this indicates a continuing need to strengthen inclusion, belonging and the overall employee experience for disabled colleagues.	

Leadership and Representation

The gap between workforce and Board representation narrowed during 2025/26; however, disabled colleagues remain under-represented at Board level relative to the wider workforce. Strengthening visibility, representation and leadership accountability will remain a key priority within the refreshed action plan.

Priority Areas for 2026/27

The refreshed action plan focuses on six areas:

1. recruitment equity
2. disability declaration
3. reasonable adjustments
4. reducing harassment and bullying
5. career progression and engagement
6. strengthening leadership accountability through development of a Board Charter

Recommendations

The feedback from the DAWN Network has guided the recommendations below.

The Boards are asked to:

1. Note the UHN WDES results for 2025/26, including areas of progress and continuing inequalities experienced by disabled colleagues
2. Approve the refreshed UHN WDES Action Plan for 2026/27
3. Recognise its collective and individual responsibility for advancing disability equality across UHN and demonstrate personal accountability for creating an inclusive culture and workforce experience consistent with the expectations of the CQC Well-Led framework

KGH Workforce Disability Equality Standard (WDES) Report 2025 - 2026



UHN Colleagues & Teams responsible for compiling this report are as follows:

Paula Kirkpatrick, UHN Chief People Officer

Andy Eagle - Weston, UHN Deputy Chief People Officer (Culture & Inclusion)

Brad Scott, Deputy Chief People Officer

Farhana Ahmedabadi-Patel, Head of Organisational Development & Inclusion

Jane Sanjeevi, Senior Diversity & Inclusion Specialist

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It is well evidenced through various sources of data and lived experiences, that colleagues with disabilities or long - term health condition have a poorer experience of working within the NHS. At UHN we are committed to improving those lived experiences and focused on creating a culture where:

- **Working with a disability is not a barrier to progression,**
- **Individuals feel safe in the workplace and**
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As a Trust we want to focus on working in partnership with our patients, service users and colleagues, to change our ways of working and interacting with each other. This enables our colleagues to thrive and deliver the best possible services and care to the people of Northampton, Kettering and surrounding areas.

The importance of disability equality is embedded into the [NHS People Promise](#) where it states 'We are open and inclusive. We understand, encourage and celebrate diversity, making the NHS a place where we all feel we belong'. The People Promise declares 'a commitment to creating and maintaining a compassionate and inclusive culture where diversity is valued and celebrated as a critical component, and not just a desirable one.' The Trust must also meet its legal obligations under the [Equality Act 2010](#) and [The Human Rights Act 1998](#).

Each year the Trust is required to publish Workforce Disability Equality Standard (WDES) data. The WDES provides a framework for NHS organisations to report, demonstrate and monitor progress against ten indicators of workforce equality. The indicators are a combination of workforce data and results from the NHS national staff survey and help to ensure that colleagues with disabilities receive fair treatment in the workplace and have equal access to career opportunities. The WDES is included in the NHS Standard Contract and has been a requirement of NHS commissioners and NHS healthcare providers since April 2017.



Indicator 1

Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.



Indicator 2

Relative likelihood of non-disabled staff compared to staff with disabilities being appointed from shortlisting across all posts.



Indicator 3

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Indicator 4

Percentage of staff with disabilities compared to non-disabled staff experiencing harassment, bullying or abuse from:

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Indicator 5

Percentage of staff with disabilities compared to non-disabled staff believing that the Organisation provides equal opportunities for career progression or promotion.



Indicator 6

Percentage of staff with disabilities compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



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Percentage of staff with disabilities compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.



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Percentage of staff with disabilities saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.



Indicator 9

NHS Staff Survey and the engagement of staff with disabilities

- The staff engagement score for staff with disabilities, compared to nondisabled staff.
- Have you taken action to facilitate the voices of staff with disabilities in your organisation to be heard (Yes or No)?



Indicator 10

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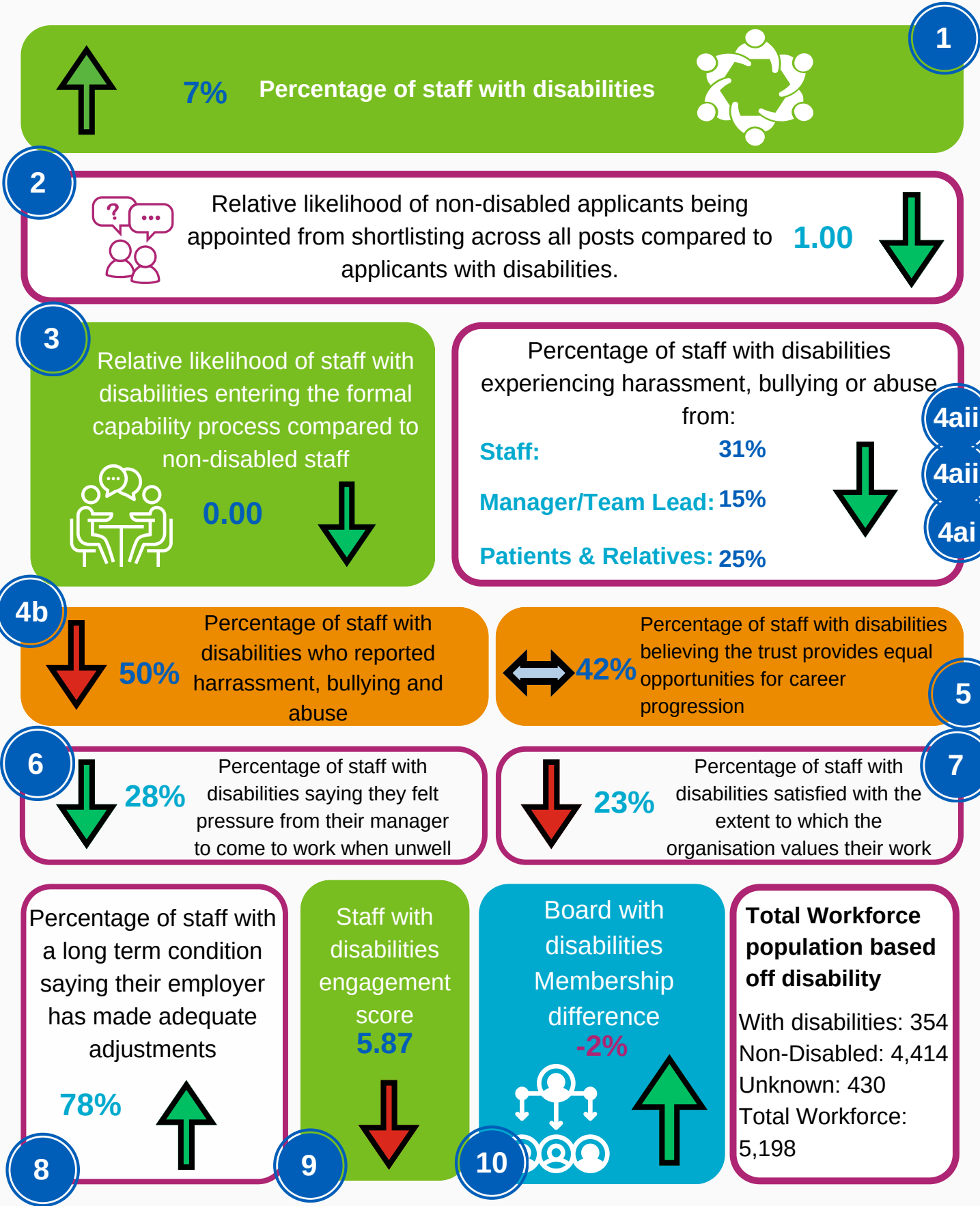
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Some of the WDES indicators are shown as a score. A score of 1 means there is no difference between staff with disabilities and non-disabled staff groups. A score below 1 means the outcome is more favourable for staff with disabilities, while a score above 1 means the outcome is less favourable and may indicate an area where further improvement is needed. In general, the closer the score is to 1, the more equal the outcome is for all staff.

Workforce Disability Equality Standard 2025/26



Yearly Comparison



University Hospitals
of Northamptonshire
NHS Group

	WDES Indicator	KGH 2020-2021	KGH 2021-2022	KGH 2022-2023	KGH 2023-2024	KGH 2024 - 2025	KGH 2025 - 2026	Trend	RAG Rating
1	Percentage of staff with disabilities	3%	3%	4%	5%	6%	7%		Green
2	Likelihood of Non-Disabled applicants being appointed from shortlisting across all posts compared to applicants with disabilities	1.31	1.29	0.66	0.86	1.03	1.00		Green
3	Likelihood of staff with disabilities entering formal capability process compared to Non-Disabled staff	1.69	0.00	0.00	4.19	4.56	0.00		Green
4ai	Percentage of staff with disabilities experiencing harassment, bullying or abuse from Patients/Service users, their relatives or other members of the public in last 12 months	30%	37%	36%	32%	34%	31%		Orange
4aii	Percentage of staff with disabilities experiencing harassment, bullying or abuse from managers in last 12 months	20%	27%	19%	19%	19%	15%		Orange
4aiii	Percentage of staff with disabilities experiencing harassment, bullying or abuse from other colleagues in last 12 months	31%	34%	27%	31%	30%	25%		Orange
4b	Percentage of staff with disabilities saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	47%	49%	49%	46%	52%	50%		Red

Yearly Comparison

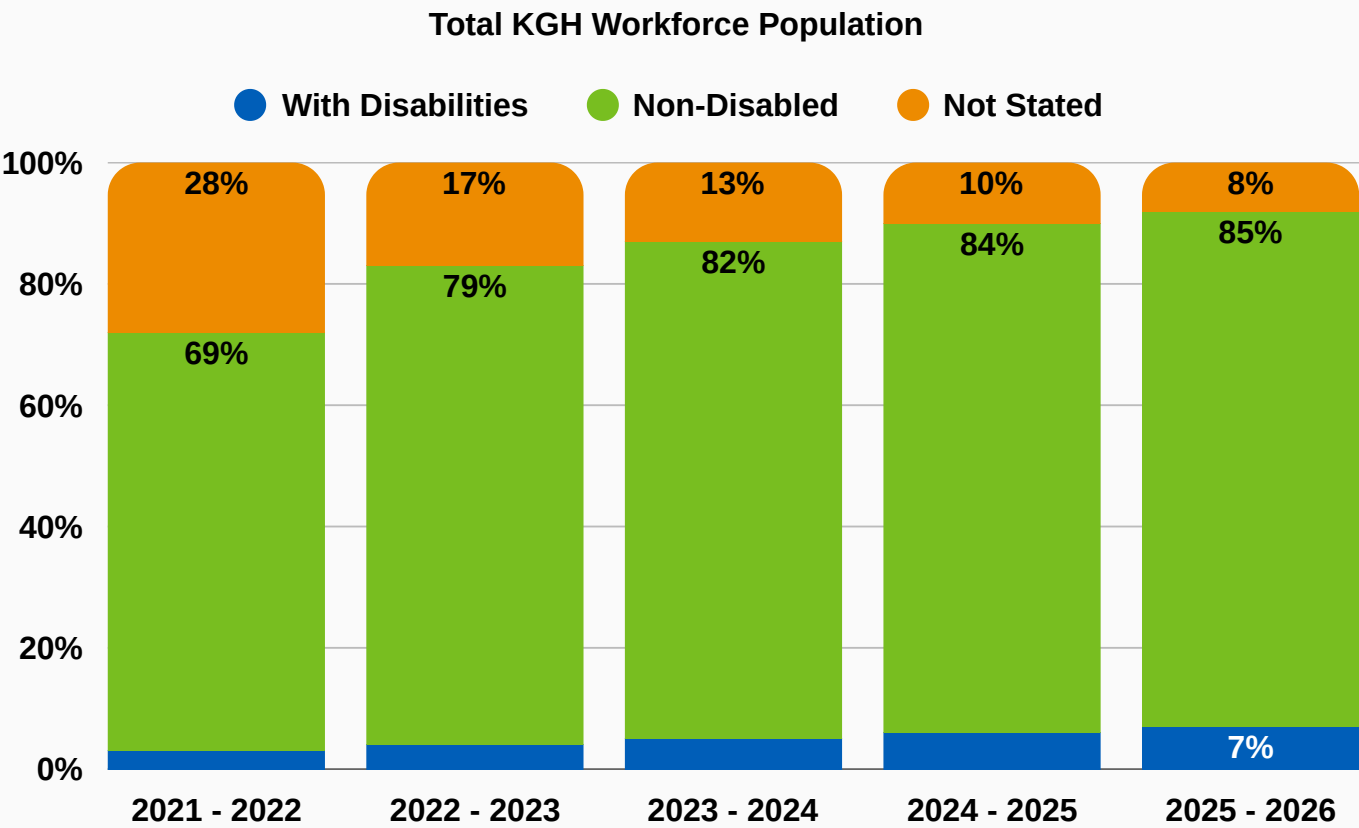


University Hospitals
of Northamptonshire
NHS Group

	WDES Indicator	KGH 2020-2021	KGH 2021-2022	KGH 2022-2023	KGH 2023-2024	KGH 2024 - 2025	KGH 2025 - 2026	Trend	Difference between 24/25 & 25/26
5	Percentage of staff with disabilities believing that trust provides equal opportunities for career progression or promotion.	52%	52%	50%	44%	42%	42%		
6	Percentage of staff with disabilities saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	36%	37%	37%	33%	36%	28%		
7	Percentage of staff with disabilities satisfied with the extent to which their organisation values their work.	36%	29%	29%	27%	25%	23%		
8	Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry on working.	72%	67%	74%	71%	70%	78%		
9	Staff engagement score for staff with disabilities.	6.59	6.15	6.12	5.94	5.94	5.87		
10	Percentage difference between the organisation's Board membership and its organisation's overall workforce (with disabilities)	-3%	-3%	-4%	0%	-6%	-2%		

WDES Indicator 1

Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce



The overall headcount for the Trust is 5,198. This has decreased from previous years with the number of staff declaring a disability increasing to 354 (7%).

The Data shows that the percentage of colleagues with disabilities at the Trust continues to increase, growing by 1% in the last year. The number of colleagues who have not completed their disability reporting on ESR has decreased by 2%. There has been an emphasis on the updating of disability information on ESR (Electronic Staff Record)

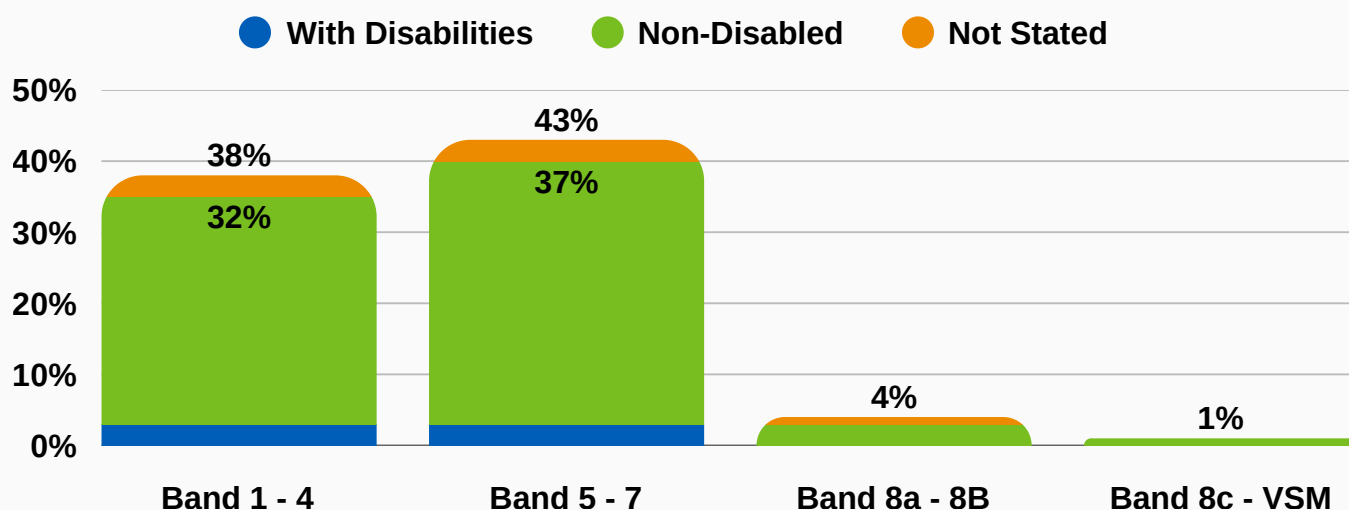
Overall Workforce Headcount at KGH

2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
4,824	4,975	4,901	5,000	5,205	5,198

WDES Indicator 1

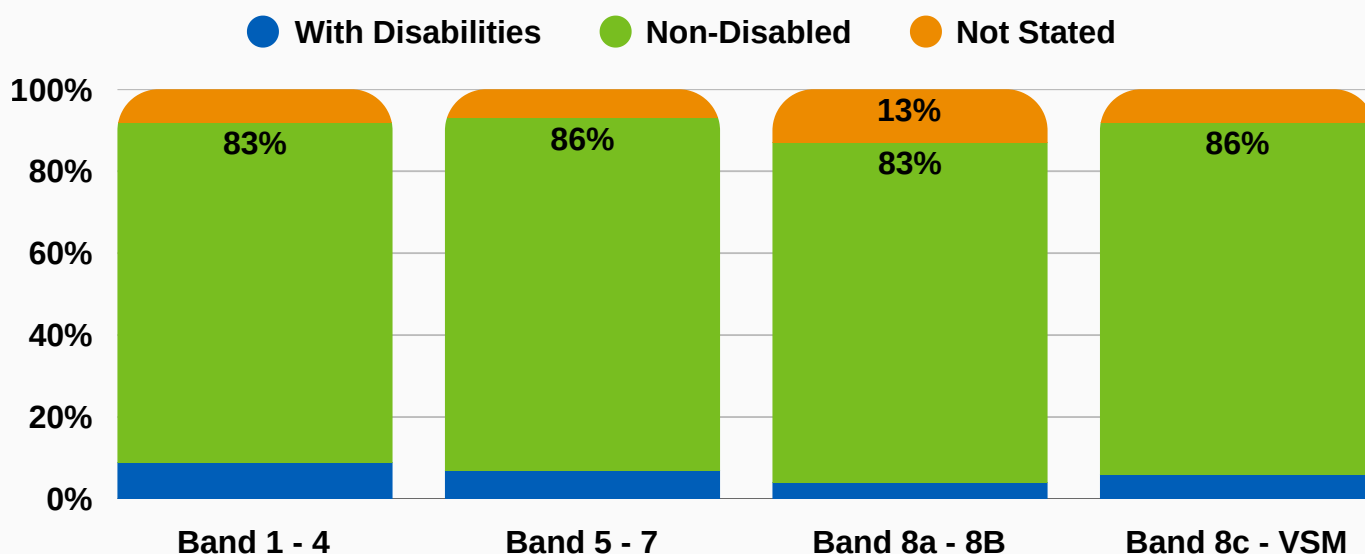
Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

Banding Population across Total KGH Workforce

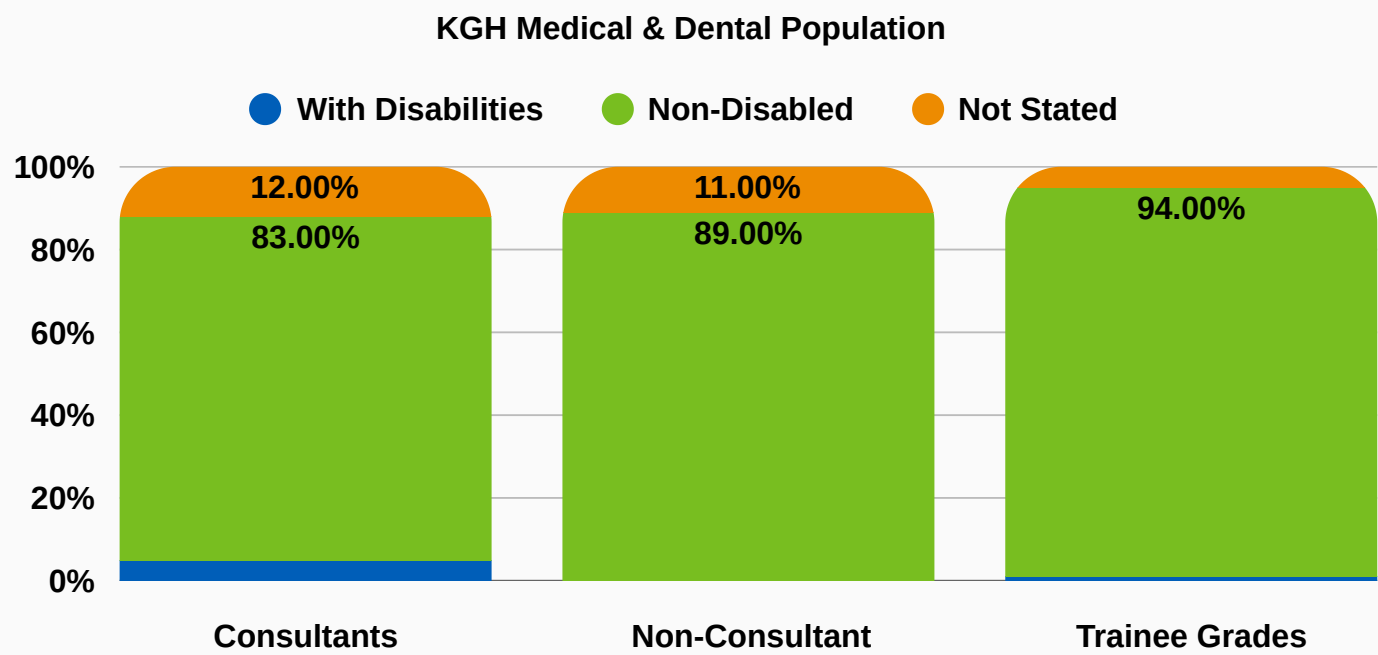


- Across most bands KGH disability representation remains above the national average of disabled colleagues within NHSE, which was 5.7% in 2024.
- Within Bands 8a - VSM, KGH is sees a lower representation figure for colleagues with disabilities employed showing less than 1%.
- Bands 1 - 7 show the highest representation of colleagues with disabilities at KGH, at 3%, compared to the whole organisation.

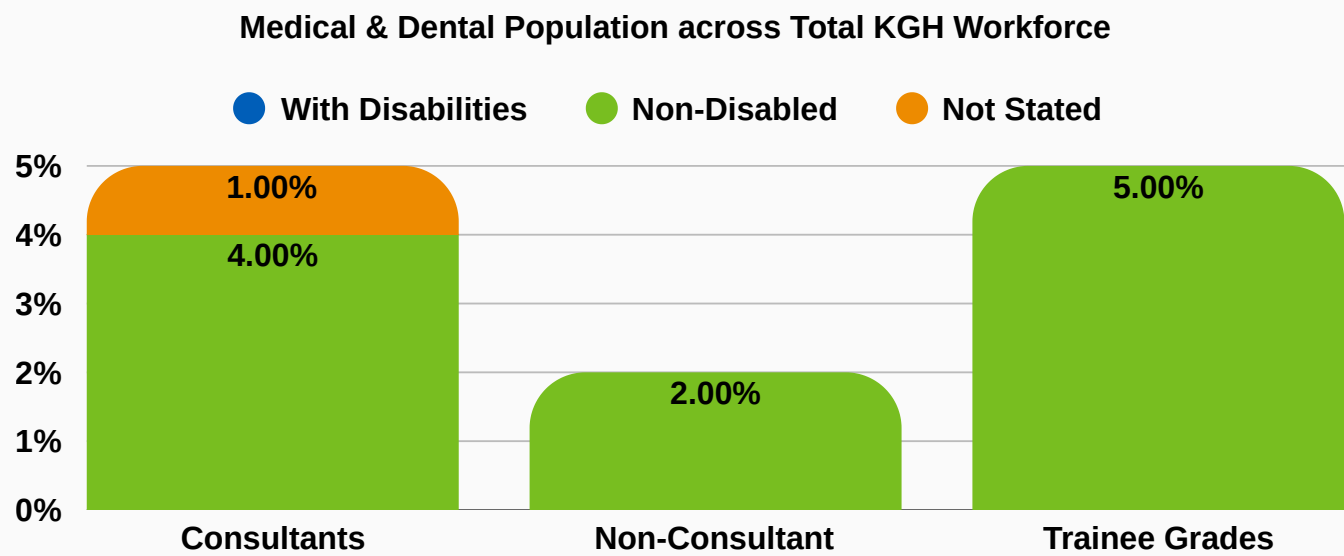
KGH Agenda for Change Population



Percentage of staff in Medical and Dental subgroups compared with the percentage of staff in the medical workforce

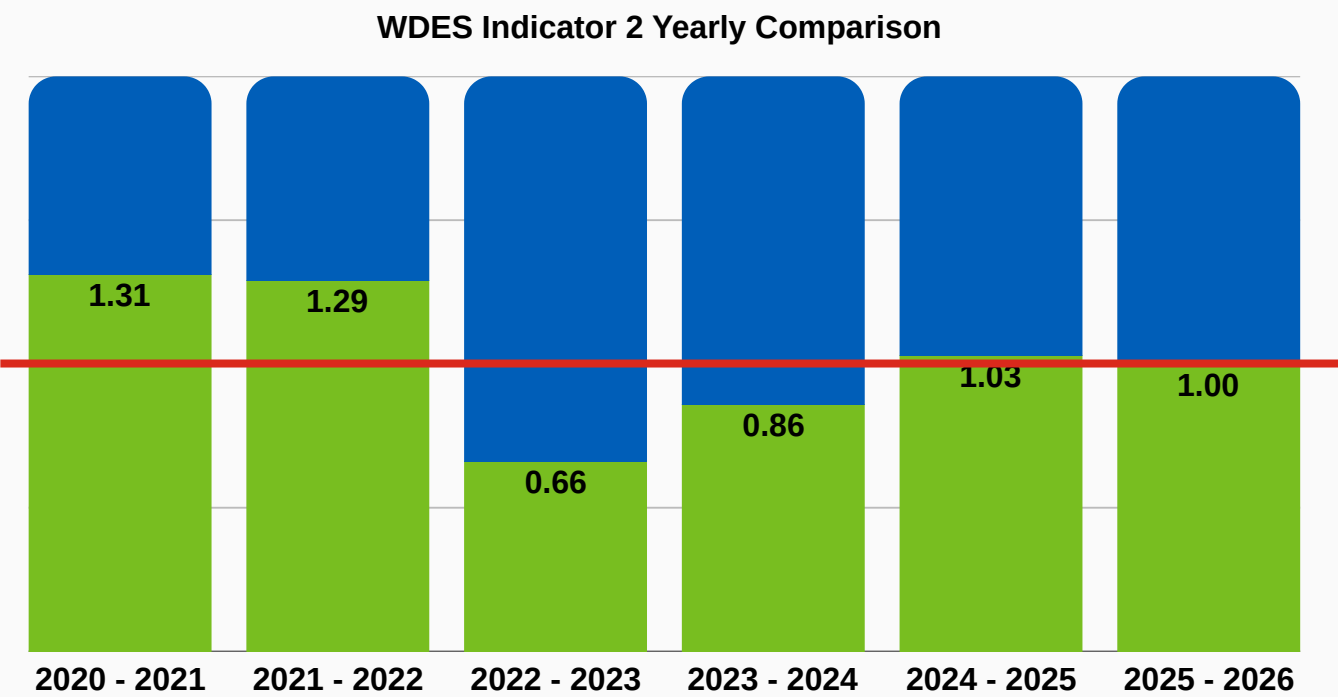


- Only within Consultant roles, do colleagues with disabilities remain above the national average for overall NHSE workforce, which is 2.7%
- Colleagues with disabilities working within Non- Consultant Career Grades and Trainee grade roles, represent less than 1% of the medical workforce.
- Work needs to be done to reduce the amount of Medical & Dental colleagues who have not declared their disability reporting



WDES Indicator 2

Relative likelihood of Non-Disabled applicants being appointed from shortlisting across all posts compared to applicants with disabilities



A relative likelihood below 1 indicates that non-disabled applicants are less likely to be appointed from shortlisting compared to applicants with disabilities



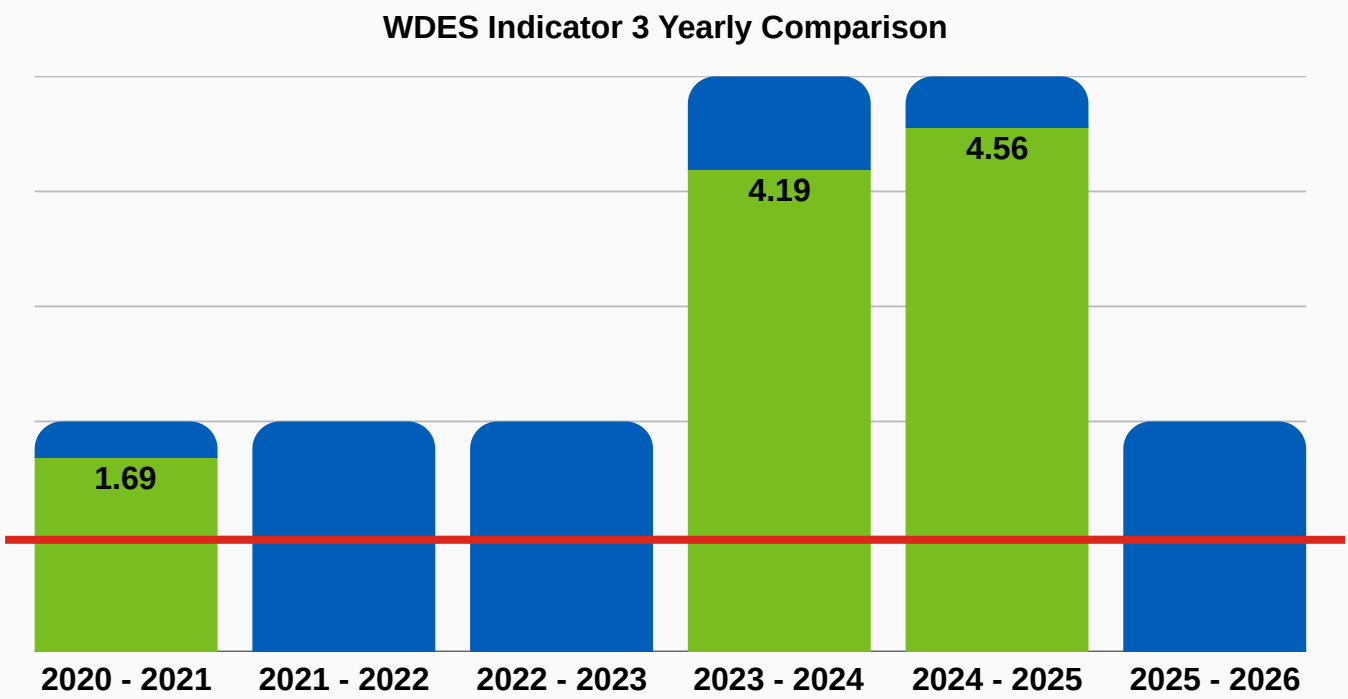
A relative likelihood above 1 means that non-disabled applicants are more likely to be appointed compared to applicants with disabilities.

A relative likelihood of 1 means that there is no difference and non-disabled applicants are just as likely to be appointed compared to applicants with disabilities.

2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
1.31	1.29	0.66	0.86	1.03	1.00

WDES Indicator 3

Relative likelihood of staff with disabilities entering formal capability process compared to Non-Disabled staff



A relative likelihood below 1 indicates that staff with disabilities are less likely to enter the formal capability process compared to non-disabled colleagues.



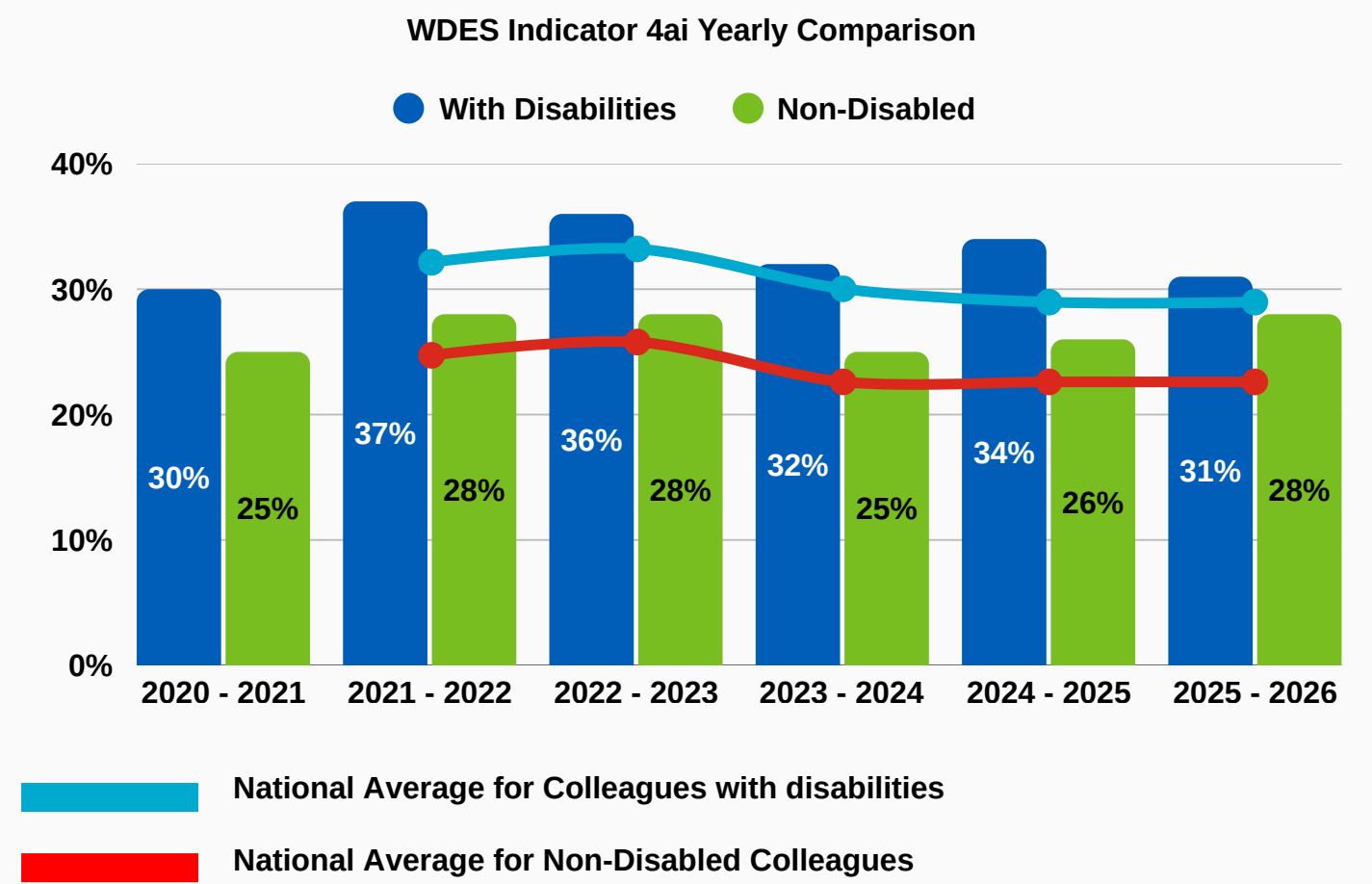
A relative likelihood above 1 means that staff with disabilities are more likely to enter the formal capability process compared to non-disabled colleagues.

A relative likelihood of 1 means that there is no difference and non-disabled colleagues are just as likely to enter the formal disciplinary process compared to colleagues with disabilities.

2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
1.69	0.00	0.00	4.19	4.56	0.00

WDES Indicator 4ai

Percentage of staff with disabilities experiencing harassment, bullying or abuse from Patients/Service users, their relatives or other members of the public in last 12 months

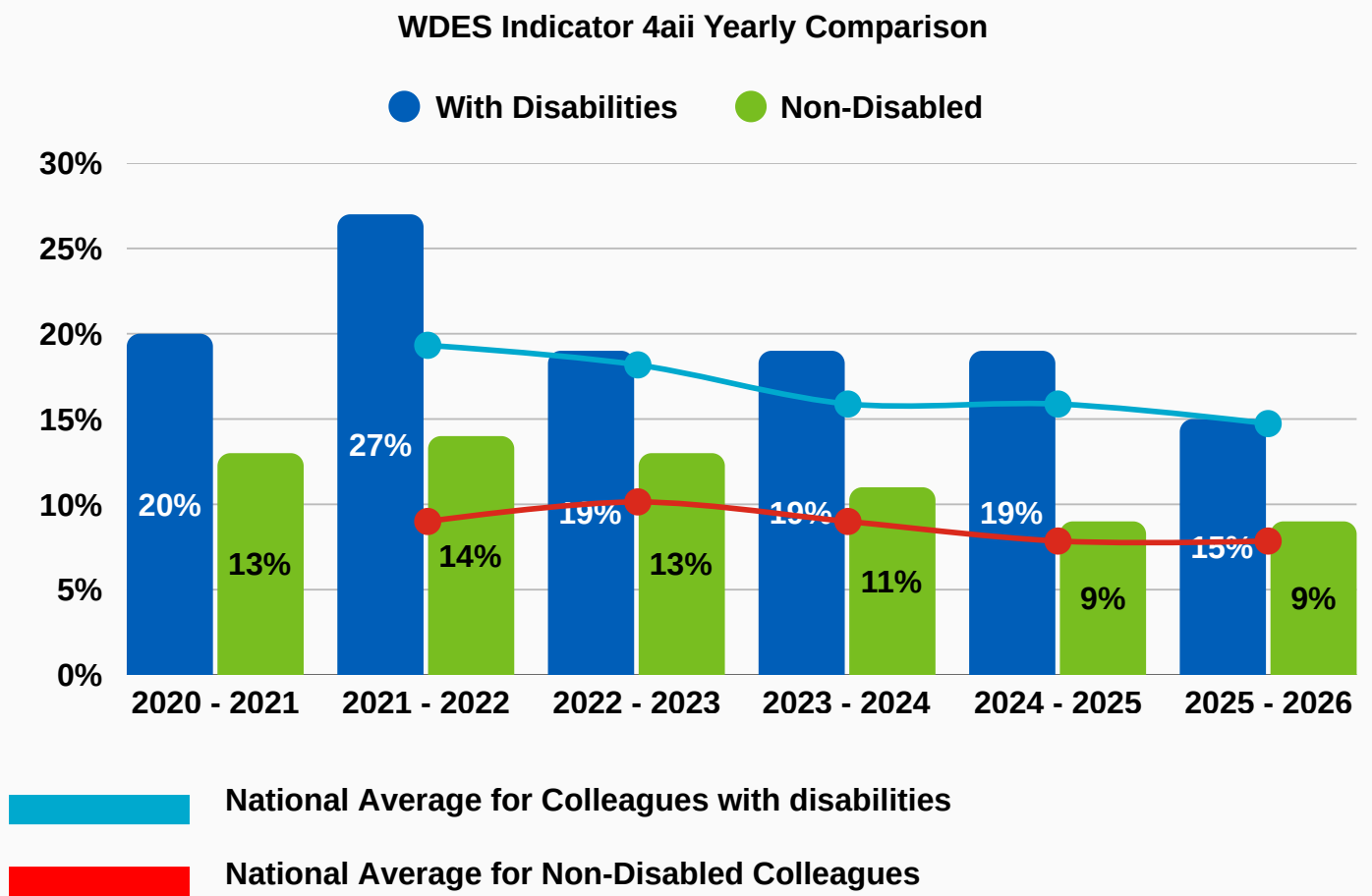


- Over a third of colleagues with disabilities within KGH have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- There has been an decrease of 3% of colleagues with disabilities experiencing harassment from patients, relatives and the public from 34% to 31% in 2025.

Overall KGH Workforce:	Non-Disabled	With Disabilities
	Overall: 4,414	Overall: 354
	NSS: 1,872	NSS: 633

WDES Indicator 4aii

Percentage of staff with disabilities experiencing harassment, bullying or abuse from managers in last 12 months

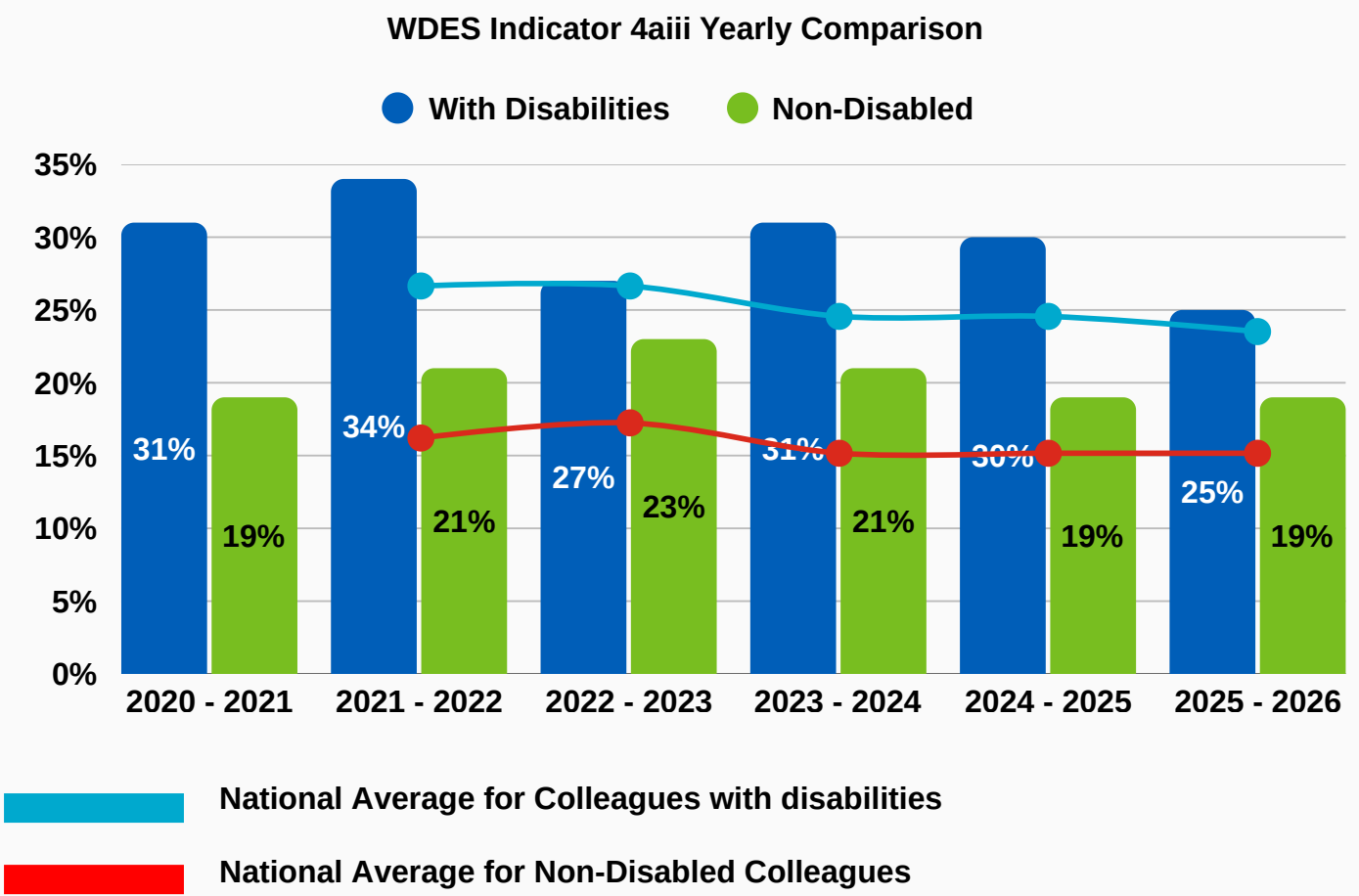


- Less than a fifth of colleagues with disabilities within KGH have experienced harassment, bullying or abuse from managers in the last 12 months.
- There has been a decrease of 4% of colleagues with disabilities experiencing harassment from managers from 19% to 15% in 2025.

Overall KGH Workforce:	Non-Disabled	With Disabilities
	Overall: 4,414	Overall: 354
	NSS: 1,872	NSS: 633

WDES Indicator 4aiii

Percentage of staff with disabilities experiencing harassment, bullying or abuse from other colleagues in last 12 months

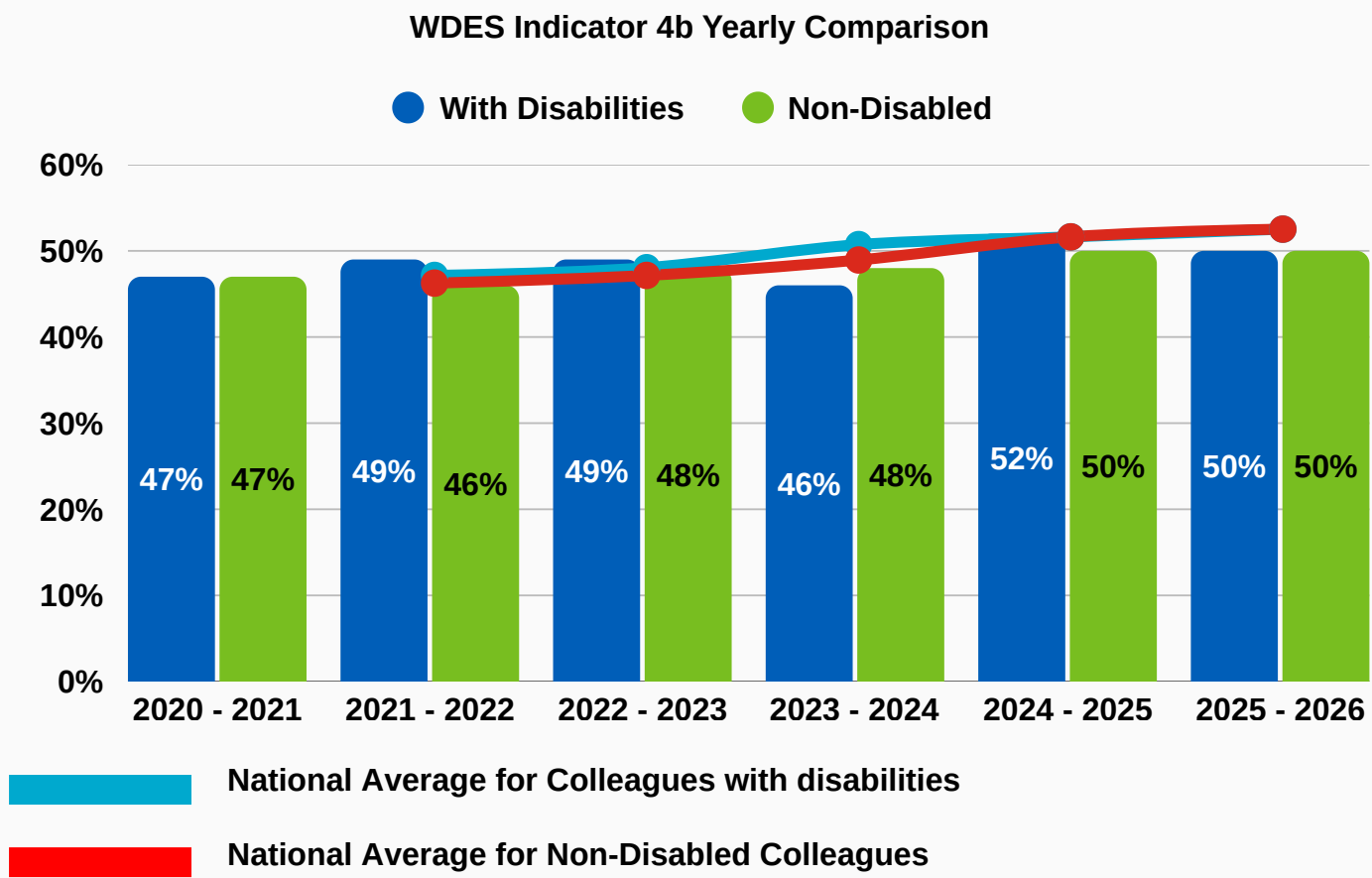


- A quarter of colleagues with disabilities within KGH have experienced harassment, bullying or abuse from other colleagues, in the last 12 months.
- There has been a decrease of 5% of colleagues with disabilities experiencing harassment from other colleagues from 30% to 25% in 2025.

Overall KGH Workforce:	Non-Disabled	With Disabilities
	Overall: 4,414	Overall: 354
	NSS: 1,872	NSS: 633

WDES Indicator 4b

Percentage of staff with disabilities saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months

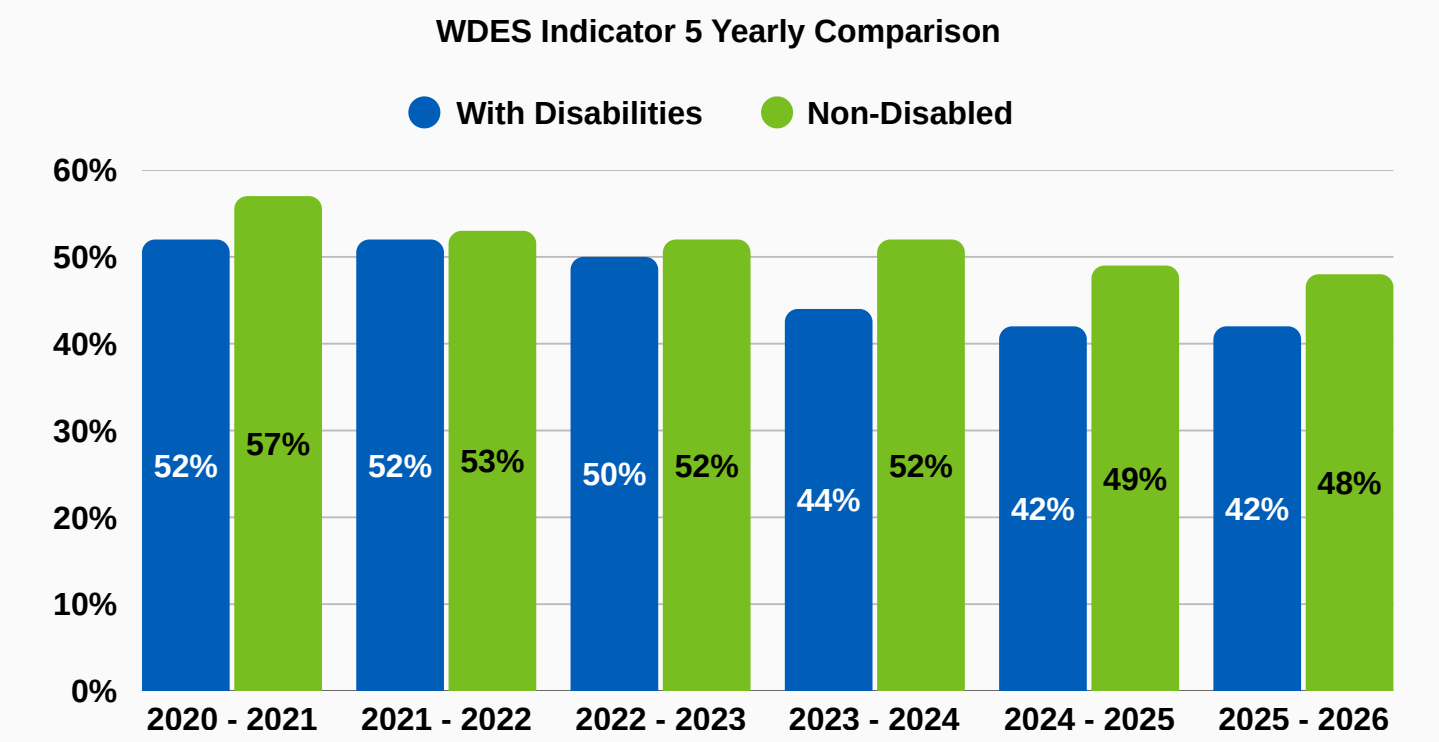


- Half of colleagues with disabilities within KGH say that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.
- There has been a decrease of 2% of colleagues with disabilities that say say the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it from 52% to 50% in 2025.

Overall KGH Workforce:	Non-Disabled	With Disabilities
	Overall: 4,414	Overall: 354
	NSS: 1,872	NSS: 633

WDES Indicator 5

Percentage of staff with disabilities believing that trust provides equal opportunities for career progression or promotion

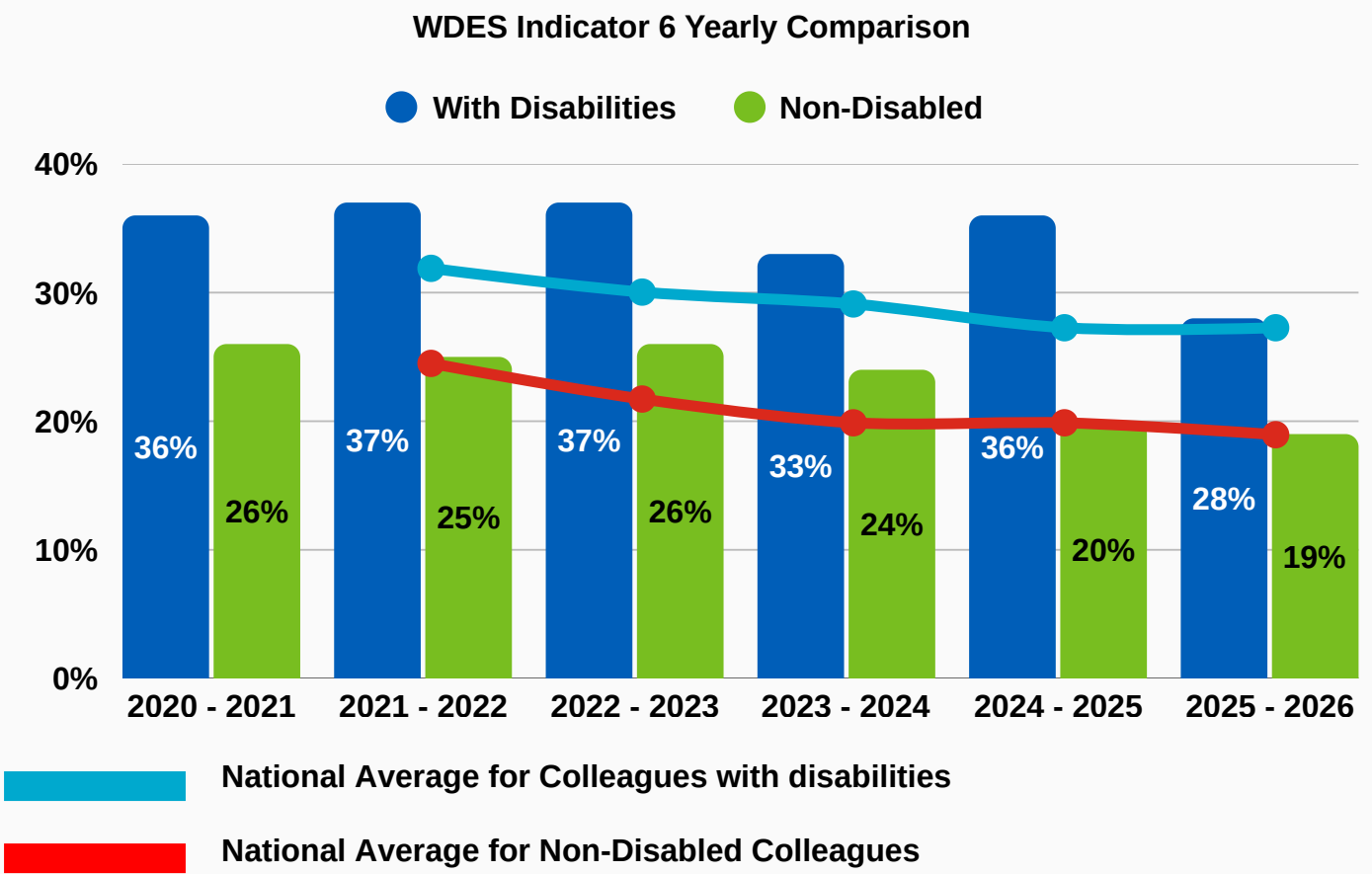


- Less than half of colleagues with disabilities within KGH believe that the trust provides equal opportunities for career progression or promotion
- There has been no change of colleagues with disabilities who believe that the trust provides equal opportunities for career progression or promotion from 42% in 2025.

Overall KGH Workforce:	Non-Disabled	With Disabilities
	Overall: 4,414	Overall: 354
	NSS: 1,872	NSS: 633

WDES Indicator 6

Percentage of staff with disabilities saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

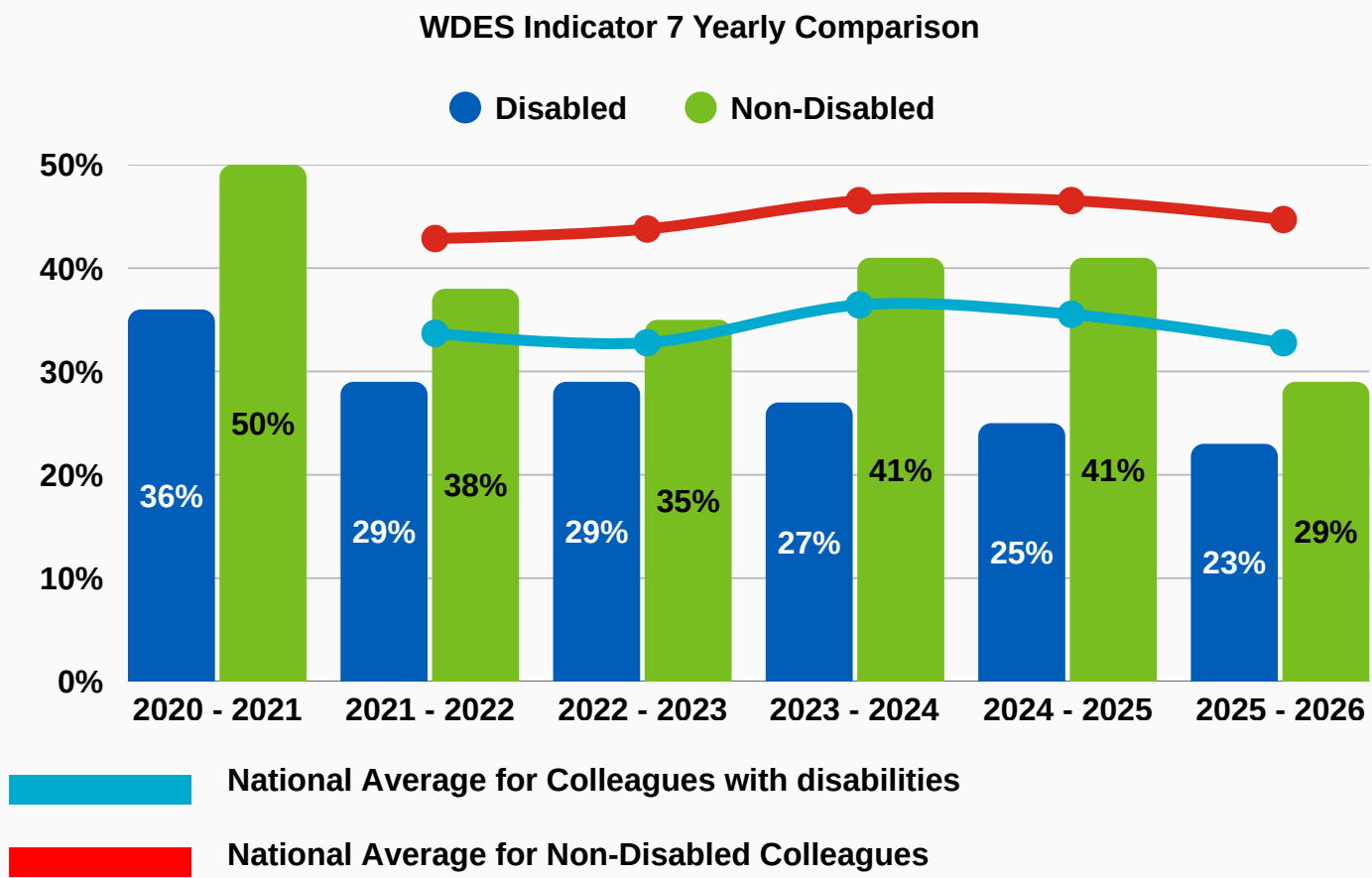


- Nearly a third of colleagues with disabilities within KGH say that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
- There has been an decrease of 8% of colleagues with disabilities say that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties from 36% to 28% in 2025.

Overall KGH Workforce:	Non-Disabled	With Disabilities
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

WDES Indicator 7

Percentage of staff with disabilities satisfied with the extent to which their organisation values their work

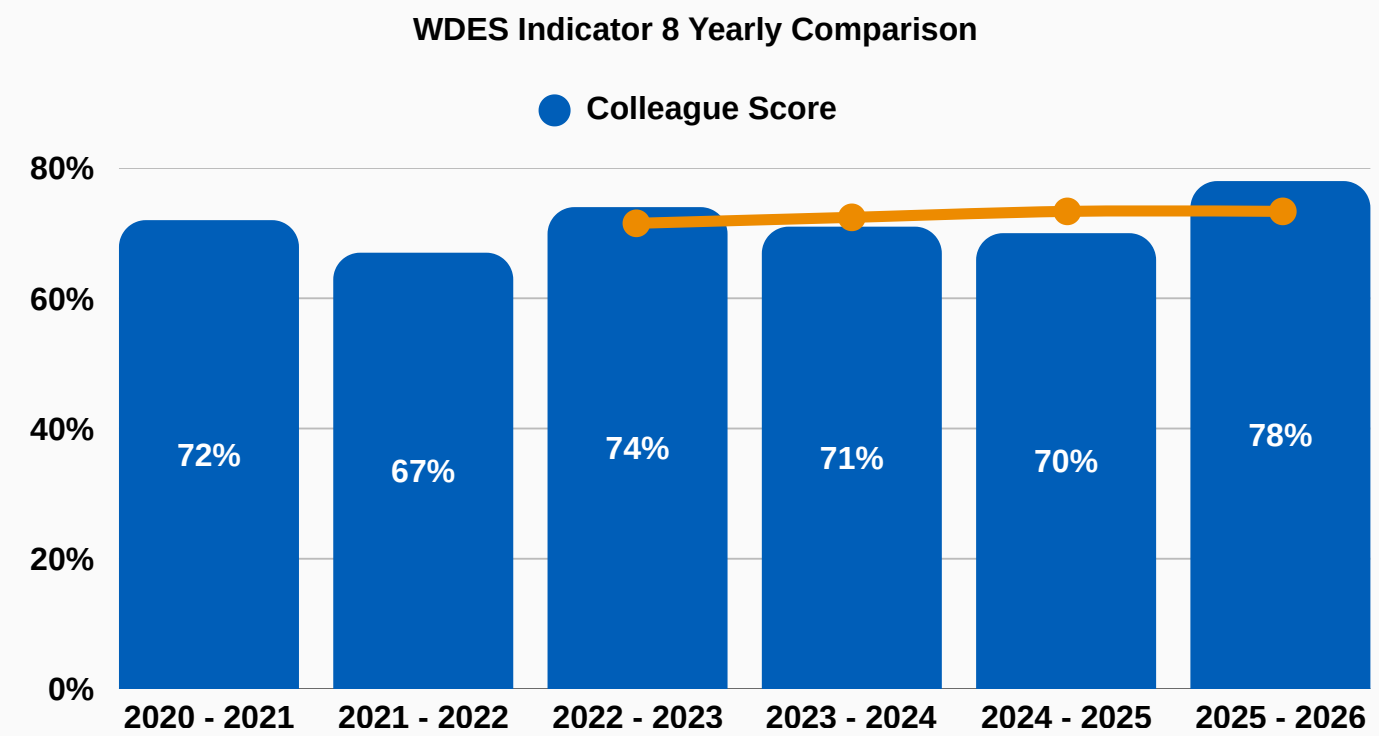


- Nearly a quarter of colleagues with disabilities within KGH are satisfied with the extent to which their organisation values their work
- There has been a decrease of 2% of colleagues with disabilities that are satisfied with the extent to which their organisation values their work from 25% to 23% in 2025.

Overall KGH Workforce:	Non-Disabled	With Disabilities
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

WDES Indicator 8

Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry on working

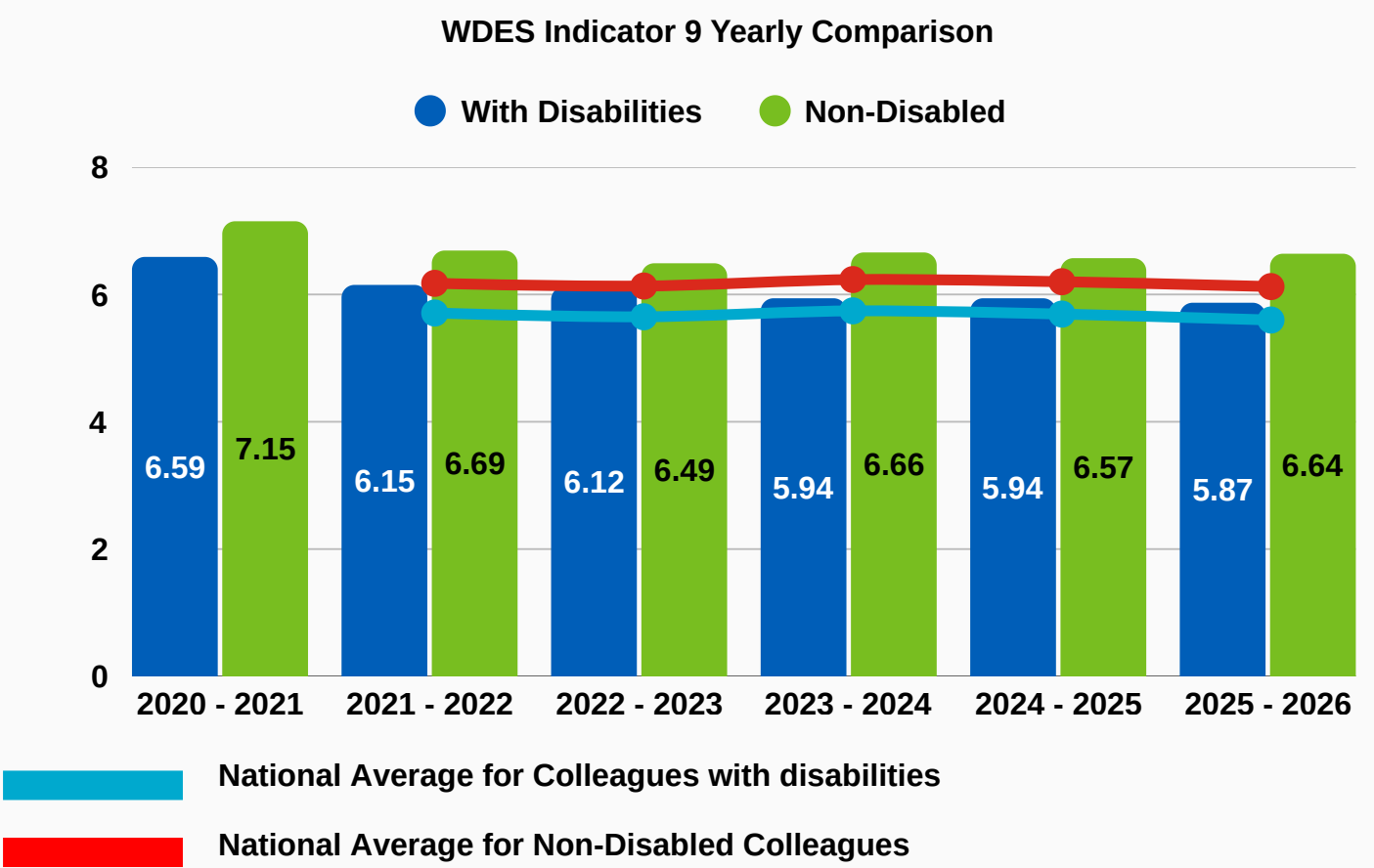


- National Average for Colleagues with disabilities**
- More than two - thirds of colleagues within KGH with a long lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry on working.
 - There has been a increase of 8% of colleagues with a long lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry on working from 70% to 78% in 2025.

Overall KGH Workforce:	Non-Disabled	With Disabilities
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

WDES Indicator 9

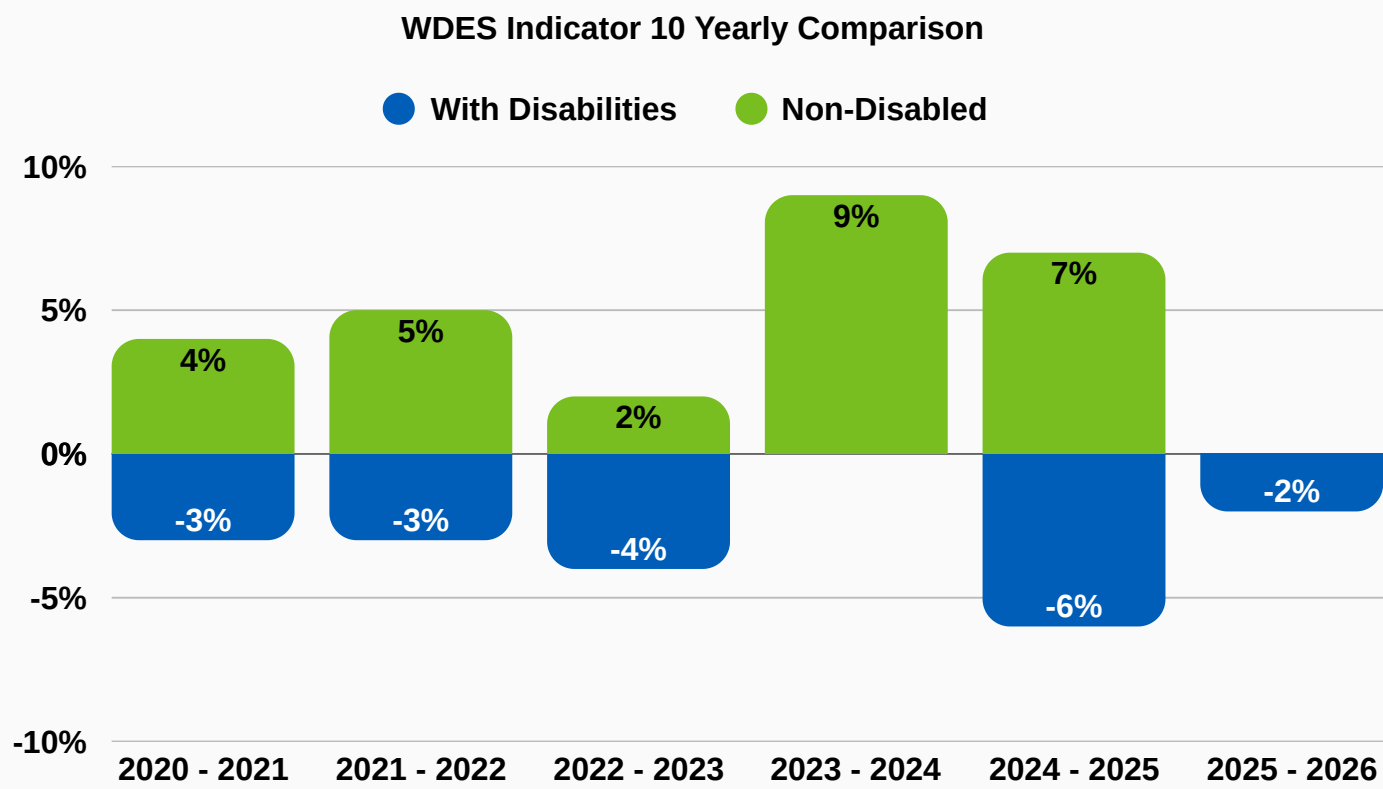
Staff engagement score for staff with disabilities from 0 - 10



- On average colleagues with a disability or long term condition have given KGH a score of 5.87 for engagement
- There has been decrease of 0.07 in the engagement score from colleagues with a disability or long term condition compared to 2025.
- For colleagues with a disability or long term condition, KGH's engagement scores remain below the national average.

Overall KGH Workforce:	Non-Disabled	With Disabilities
	Overall: 3,588	Overall: 2,828
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Percentage difference between the organisation’s Board membership and its organisation’s overall workforce (disabled)



- All board members have voting membership.
- The number of voting board members with disabilities has increased by 4%.
- Out of 20 board members only 1 has declared that they have a disability
- The percentage of members on the board of directors with disabilities is lower than in the workforce.

Year	Position	Non-Disabled	With Disabilities
2025	Exec	9	1
	Non Exec	8	0

1. Continue to work with colleagues with disabilities and the Disability, Accessibility, Wellbeing and Neuroinclusion Network (DAWN) to better understand the reasons why colleagues may not have declared a disability on ESR, with a view to closing the gap between ESR and National Staff Survey declaration rates.

2. Continue to work to reduce the number of colleagues with disabilities experiencing harassment, bullying and abuse from patients/public and staff. Working with disabled colleagues and DAWN Network members, we will:

- Continue to discuss experiences of harassment, bullying or abuse with colleagues with disabilities, ensuring that there is a safe person/space for any discussions
- Launch a communications campaign focused on reducing harassment, bullying and abuse
- In conjunction with unions, freedom to speak up guardians, and staff networks, review and improve support for staff who experience bullying, harassment or abuse. This will include access to specialist support for staff
- Working with system colleagues and DAWN members, review NHS England's Civility and Respect toolkit and adopt identified practices set out

3. The Trust will continue to strengthen governance arrangements, develop the Disability, Accessibility, Wellbeing and Neuroinclusion (DAWN) Network, and maintain and review the following support pathways:

- a. The Health Passports and Disability Leave,
- b. The UHN Neuroinclusion Toolkit, and
- c. The centrally overseen route for colleagues to access reasonable adjustments

4. Work with the Trust Board and DAWN Network Board Sponsors to produce a Board Charter alongside the DAWN Network.



Accountability

We take responsibility for our decisions, our actions and our behaviours. We do what we say we will do, when we say we will do it. We acknowledge our mistakes and we learn.



Respect

We value each other, embrace diversity and make sure everyone feels included. We take the time to listen to, appreciate and understand the thoughts, beliefs and feelings of others



Integrity

We are consistently open, honest and trustworthy. We can be relied upon, we stand by our values and we always strive to do the right thing.



Compassion

We care about our patients and each other. We consistently show kindness and empathy and take the time to imagine ourselves in other people's shoes.



Courage

We dare to take on difficult challenges and try out new things. We find the strength to speak up when it matters and we see potential failure as an opportunity to learn and improve.

NGH Workforce Disability Equality Standard (WDES) Report 2025 - 2026



EMPLOYER
RECOGNITION
SCHEME

GOLD AWARD

UHN Colleagues & Teams responsible for compiling this report are as follows:

Paula Kirkpatrick, UHN Chief People Officer

Brad Scott, Deputy Chief People Officer

Farhana Ahmedabadi-Patel, Head of Organisational Development & Inclusion

Jane Sanjeevi, Senior Diversity & Inclusion Specialist

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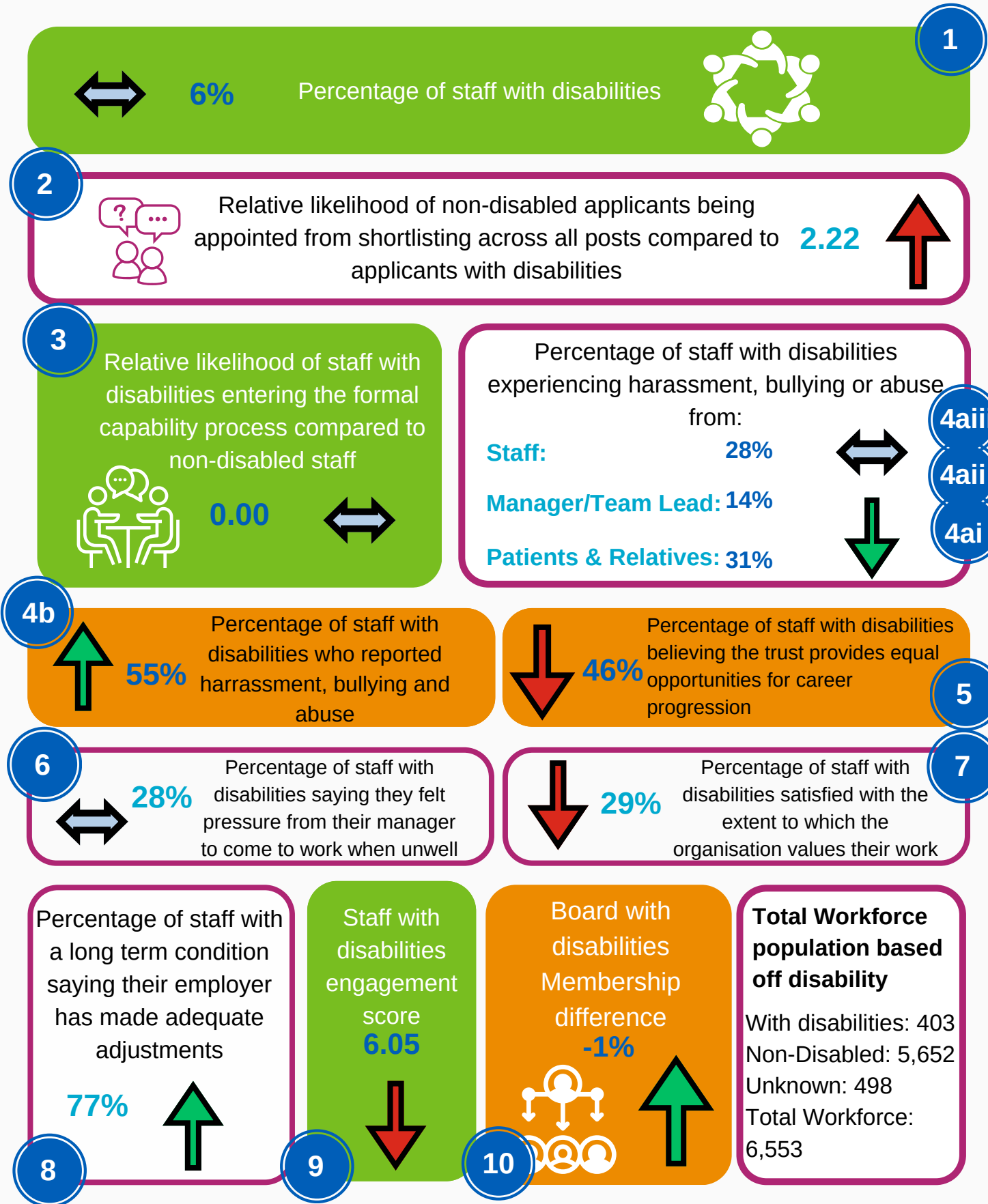
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Workforce Disability Equality Standard 2025/26



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of Northamptonshire
NHS Group

	WDES Indicator	NGH 2020-2021	NGH 2021-2022	NGH 2022-2023	NGH 2023-2024	NGH 2024 - 2025	NGH 2025 - 2026	Trend	RAG Rating
1	Percentage of staff with disabilities	5%	4%	5%	5%	6%	6%		Green
2	Likelihood of Non-Disabled applicants being appointed from shortlisting across all posts compared to applicants with disabilities	1.12	1.24	1.27	0.82	1.25	2.22		Red
3	Likelihood of staff with disabilities entering formal capability process compared to Non-Disabled staff	5.85	0.00	0.00	0.00	0.00	0.00		Green
4ai	Percentage of staff with disabilities experiencing harassment, bullying or abuse from Patients/Service users, their relatives or other members of the public in last 12 months	35%	33%	38%	32%	32%	31%		Red
4aii	Percentage of staff with disabilities experiencing harassment, bullying or abuse from managers in last 12 months	21%	23%	23%	15%	15%	14%		Orange
4aiii	Percentage of staff with disabilities experiencing harassment, bullying or abuse from other colleagues in last 12 months	31%	33%	32%	29%	28%	28%		Red
4b	Percentage of staff with disabilities saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	50%	45%	53%	53%	48%	55%		Green

Yearly Comparison

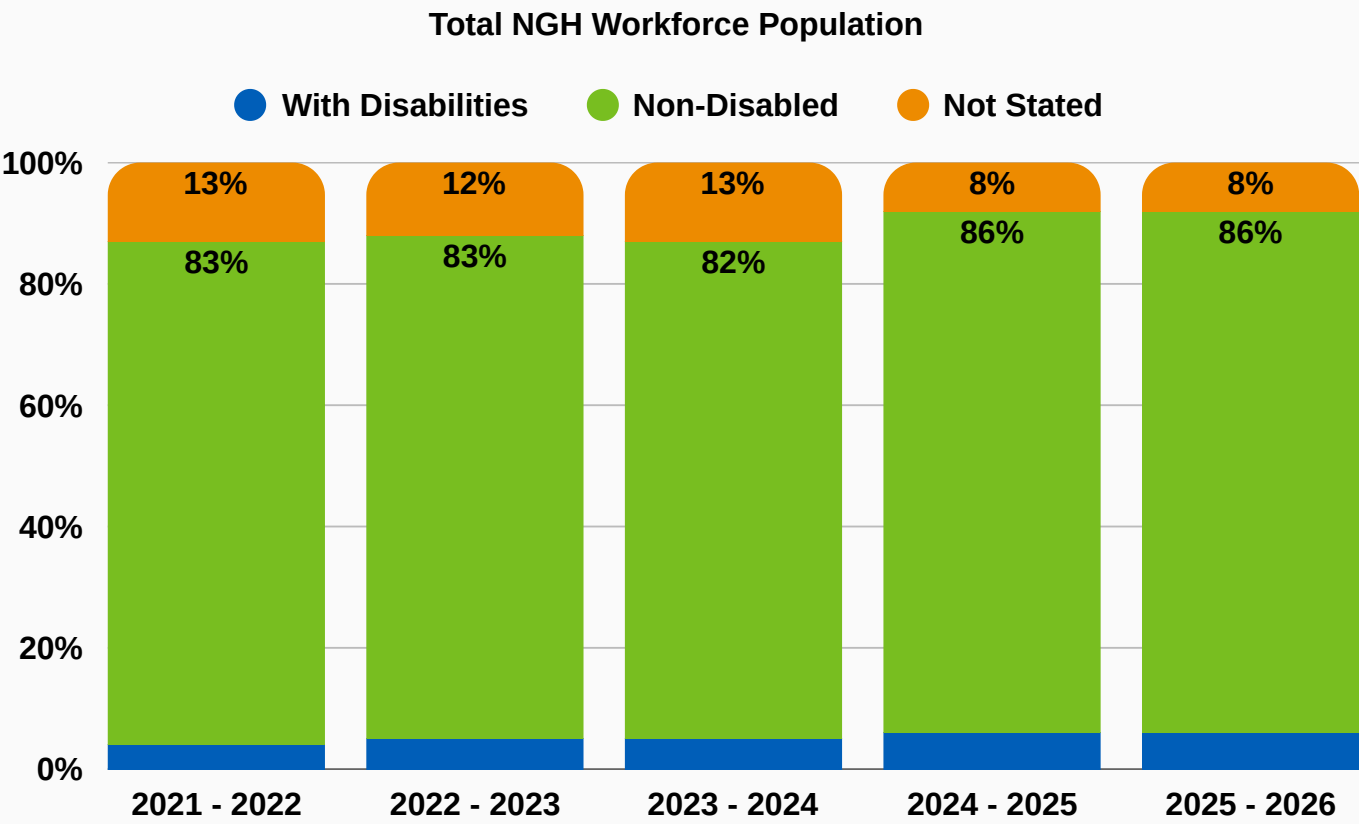


University Hospitals
of Northamptonshire
NHS Group

	WDES Indicator	NGH 2020-2021	NGH 2021-2022	NGH 2022-2023	NGH 2023-2024	NGH 2024 - 2025	NGH 2025 - 2026	Trend	RAG Rating
5	Percentage of staff with disabilities believing that trust provides equal opportunities for career progression or promotion	50%	51%	51%	51%	49%	46%		
6	Percentage of staff with disabilities saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	35%	33%	34%	29%	28%	28%		
7	Percentage of staff with disabilities satisfied with the extent to which their organisation values their work	36%	33%	33%	37%	33%	29%		
8	Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry on working	79%	72%	70%	75%	76%	77%		
9	Staff engagement score for staff with disabilities	6.66	6.39	6.19	6.49	6.25	6.05		
10	Percentage difference between the organisation's Board membership and its organisation's overall workforce (with disabilities)	-5%	-4%	-5%	-5%	-6%	-1%		

WDES Indicator 1

Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce



The overall headcount for the Trust is 6,553. This has increased from previous years with the number of staff declaring a disability remaining at 6%.

The number of colleagues who have not completed their disability reporting on ESR has remained the same at 8%. There has been an emphasis on the updating of ethnicity information on ESR (Electronic Staff Record)

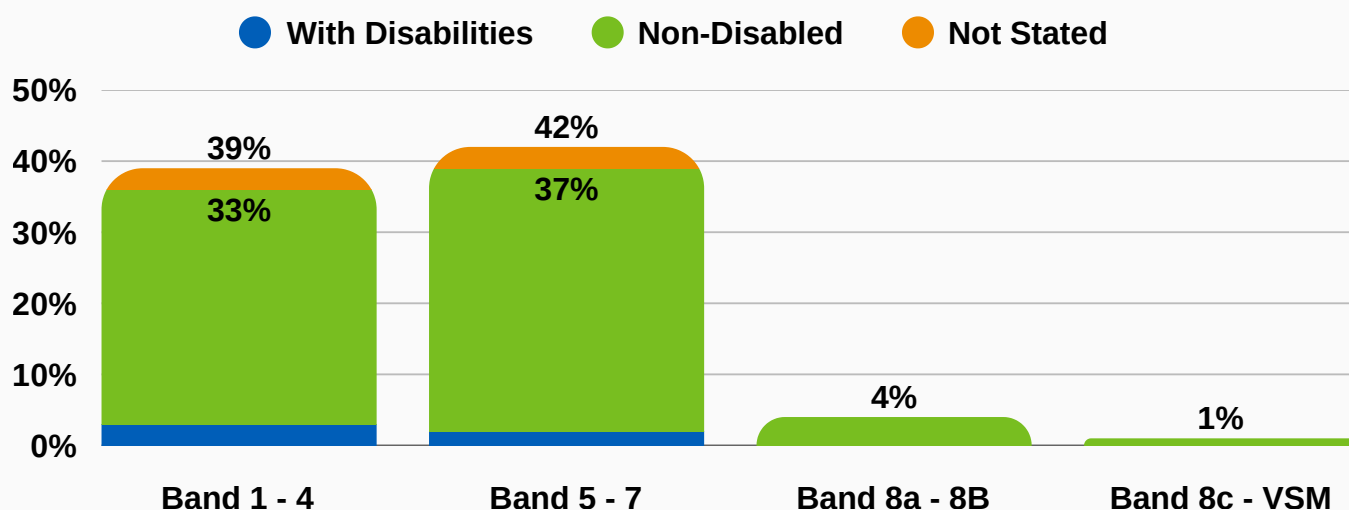
Overall Workforce Headcount at NGH

2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
5,973	5,805	5,913	6,158	6,617	6,553

WDES Indicator 1

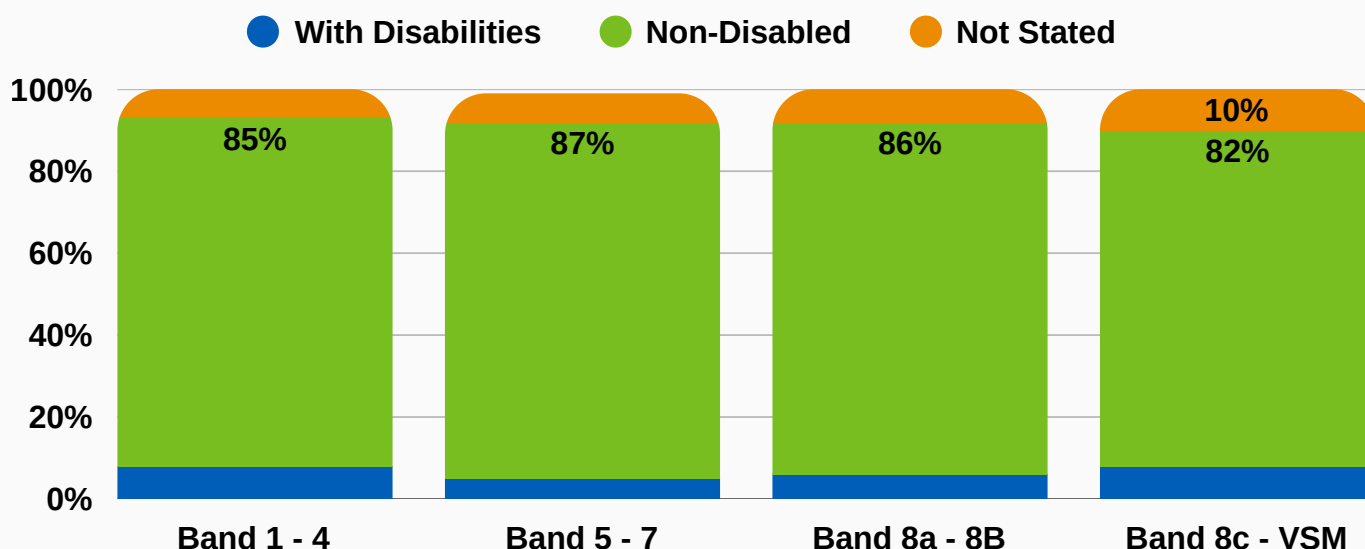
Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

Banding Population across Total NGH Workforce



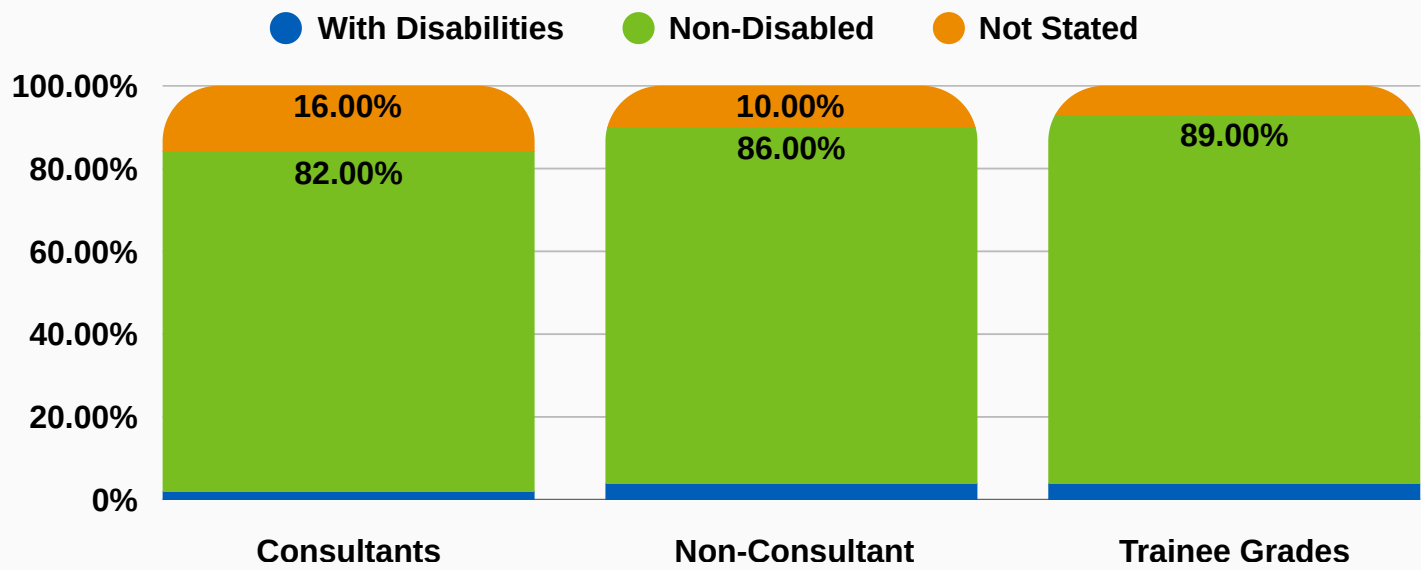
- Across most bands, except Bands 5 -7, our disability representation remains above the national average of colleagues with disabilities within NHSE, which was 5.7% in 2024.
- Within Bands 8a - VSM, NGH is sees a lower representation figure for colleagues with disabilities employed showing less than 1%.
- Bands 1 - 4, show the highest representation of colleagues with disabilities at NGH, at 3%

NGH Agenda for Change Population



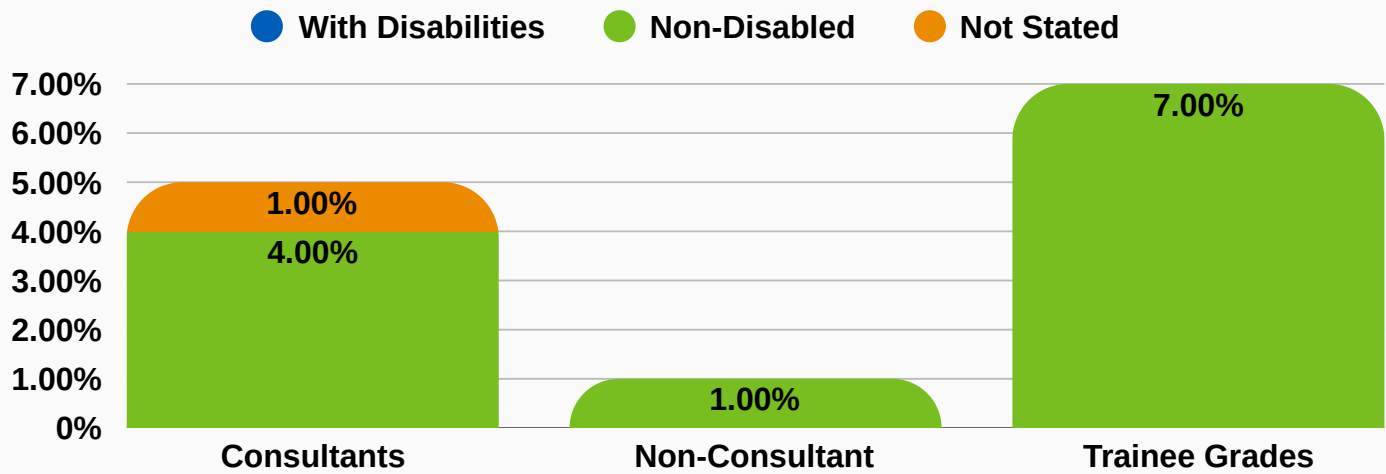
Percentage of staff in Medical and Dental subgroups compared with the percentage of staff in the medical workforce

NGH Medical & Dental Population



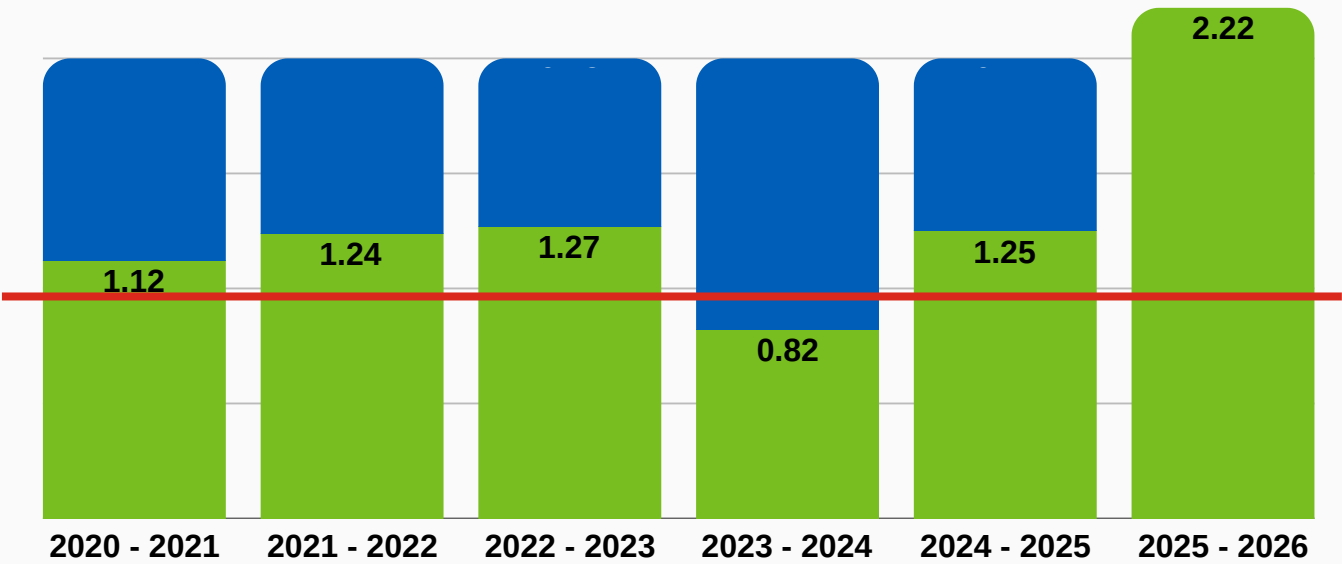
- Across most Medical & Dental roles, colleagues with a disability remain above the national average for overall NHSE workforce, which is 2.4% among the medical workforce.
- Compared to the rest of the NGH workforce, colleagues with disabilities within the medical workforce amount to less than 1% representation.
- Work needs to be done to reduce the amount of Medical & Dental colleagues who have not declared their disability reporting

Medical & Dental Population across Total NGH Workforce



Relative likelihood of Non-Disabled applicants being appointed from shortlisting across all posts compared to applicants with disabilities

WDES Indicator 2 Yearly Comparison



A relative likelihood below 1 indicates that non-disabled applicants are less likely to be appointed from shortlisting compared to applicants with disabilities



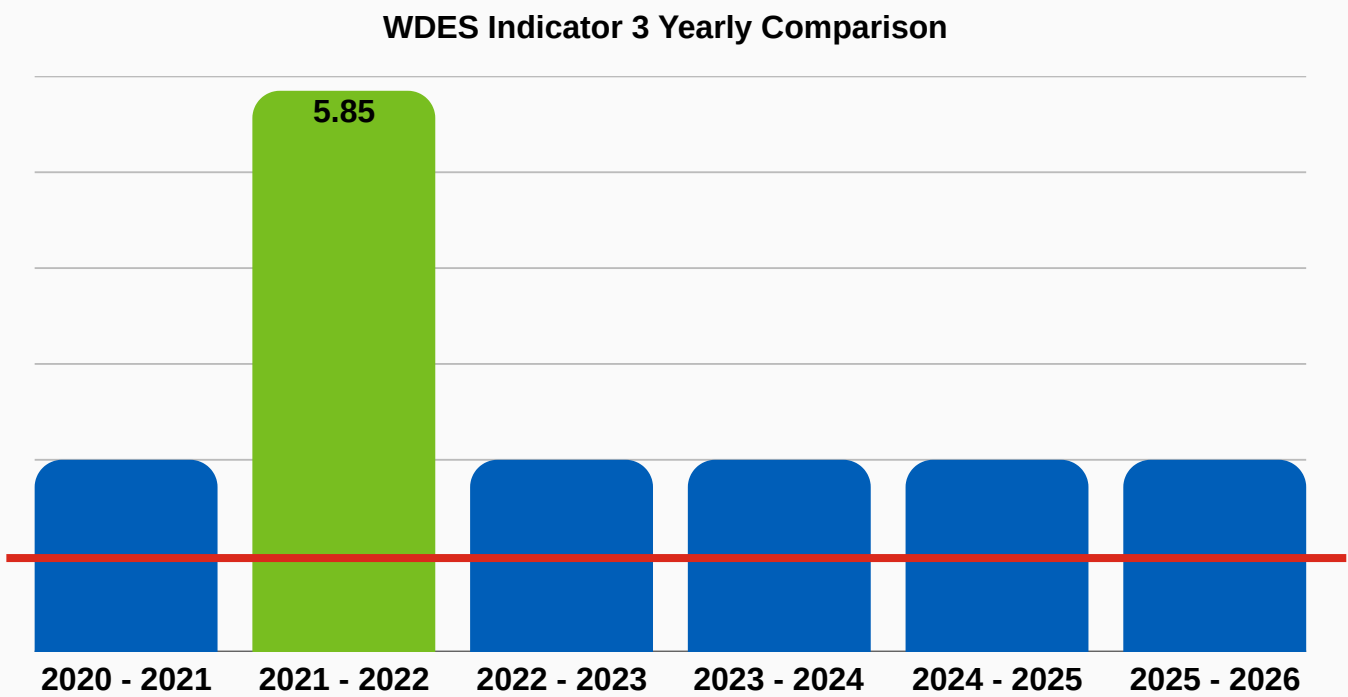
A relative likelihood above 1 means that non-disabled applicants are more likely to be appointed compared to applicants with disabilities.

A relative likelihood of 1 means that there is no difference and non-disabled applicants are just as likely to be appointed compared to applicants with disabilities.

2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
1.12	1.24	1.27	0.82	1.25	2.22

WDES Indicator 3

Relative likelihood of staff with disabilities entering formal capability process compared to Non-Disabled staff



A relative likelihood below 1 indicates that staff with disabilities are less likely to enter the formal capability process compared to non-disabled colleagues.



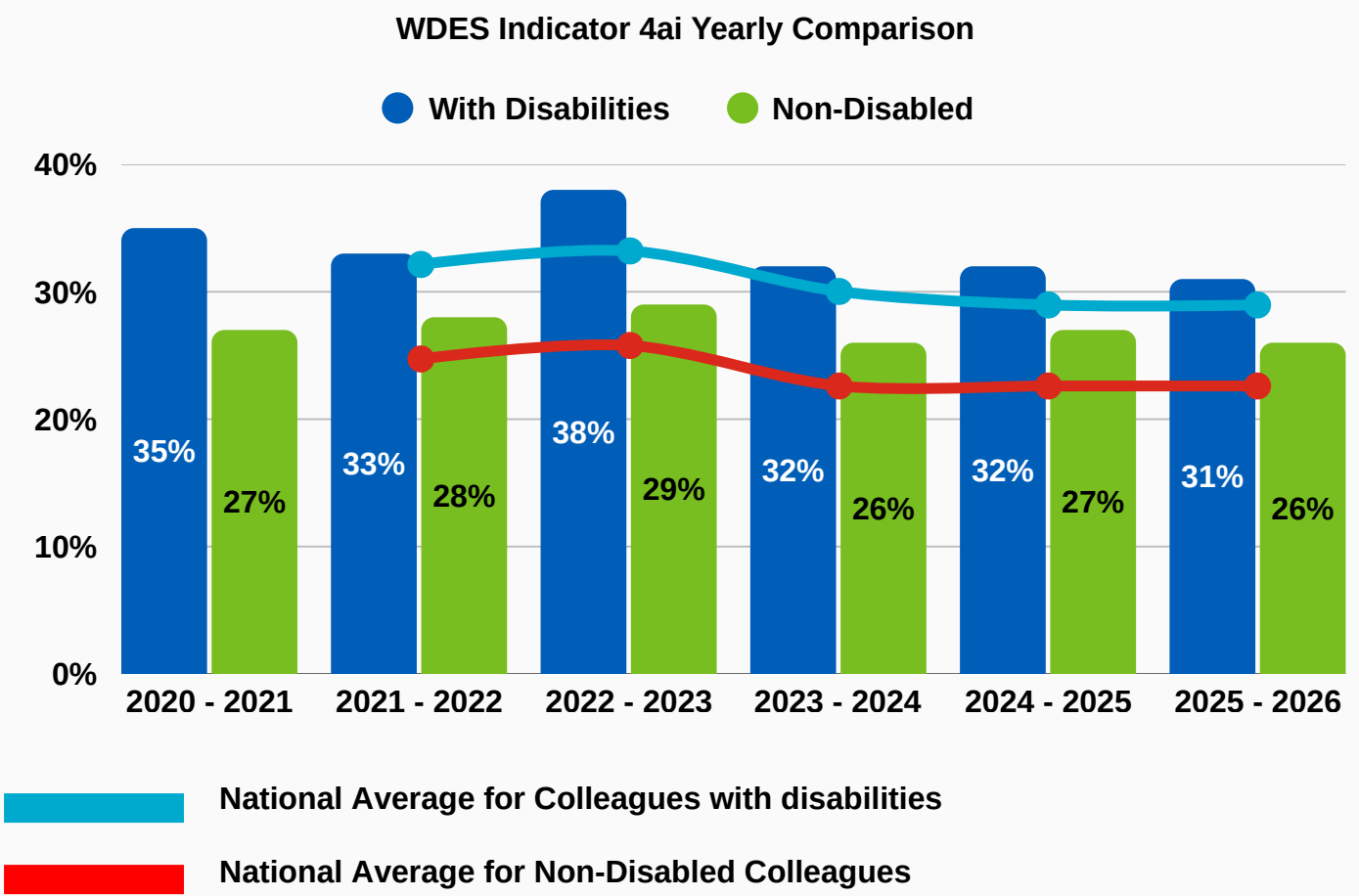
A relative likelihood above 1 means that staff with disabilities are more likely to enter the formal capability process compared to non-disabled colleagues.

A relative likelihood of 1 means that there is no difference and non-colleagues with disabilities are just as likely to enter the formal disciplinary process compared to colleague with disabilities.

2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026
5.85	0.00	0.00	0.00	0.00	0.00

WDES Indicator 4ai

Percentage of staff with disabilities experiencing harassment, bullying or abuse from Patients/Service users, their relatives or other members of the public in last 12 months

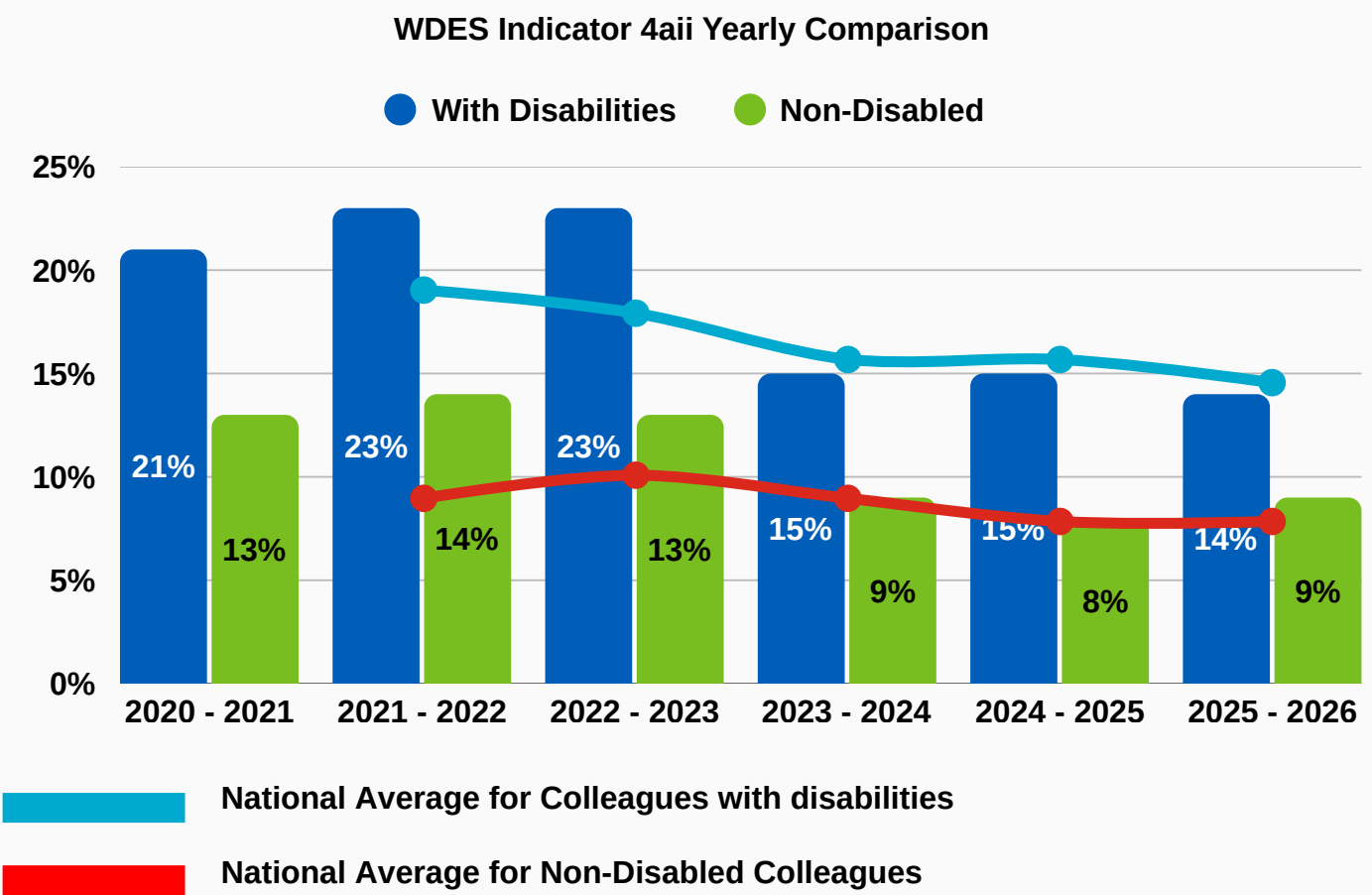


- Over a third of colleagues with disabilities within NGH have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- There has been an decrease of 1% of colleagues with disabilities experiencing harassment from patients, relatives and the public from 32% to 31% in 2025.

Overall NGH Workforce:	Non-Disabled	With Disabilities
	Overall: 5,652	Overall: 403
	NSS: 2,255	NSS: 789

WDES Indicator 4aii

Percentage of staff with disabilities experiencing harassment, bullying or abuse from managers in last 12 months

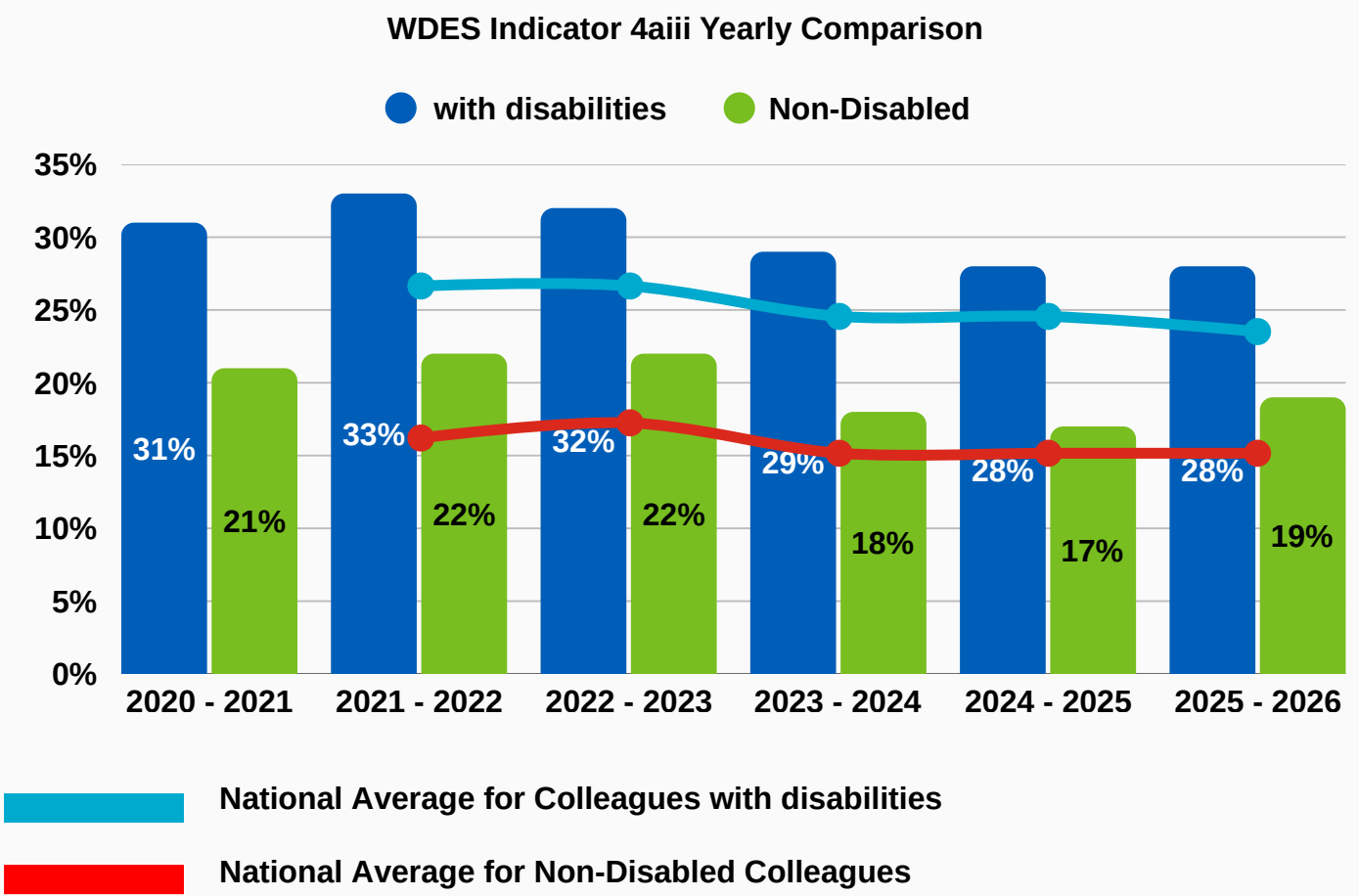


- Less than a fifth of colleagues with disabilities within NGH have experienced harassment, bullying or abuse from managers in the last 12 months.
- There has been a decrease of 1% of colleagues with disabilities experiencing harassment from managers from 15% to 14% in 2025.

Overall NGH Workforce:	Non-Disabled	With Disabilities
	Overall: 5,652	Overall: 403
	NSS: 2,255	NSS: 789

WDES Indicator 4aiii

Percentage of staff with disabilities experiencing harassment, bullying or abuse from other colleagues in last 12 months

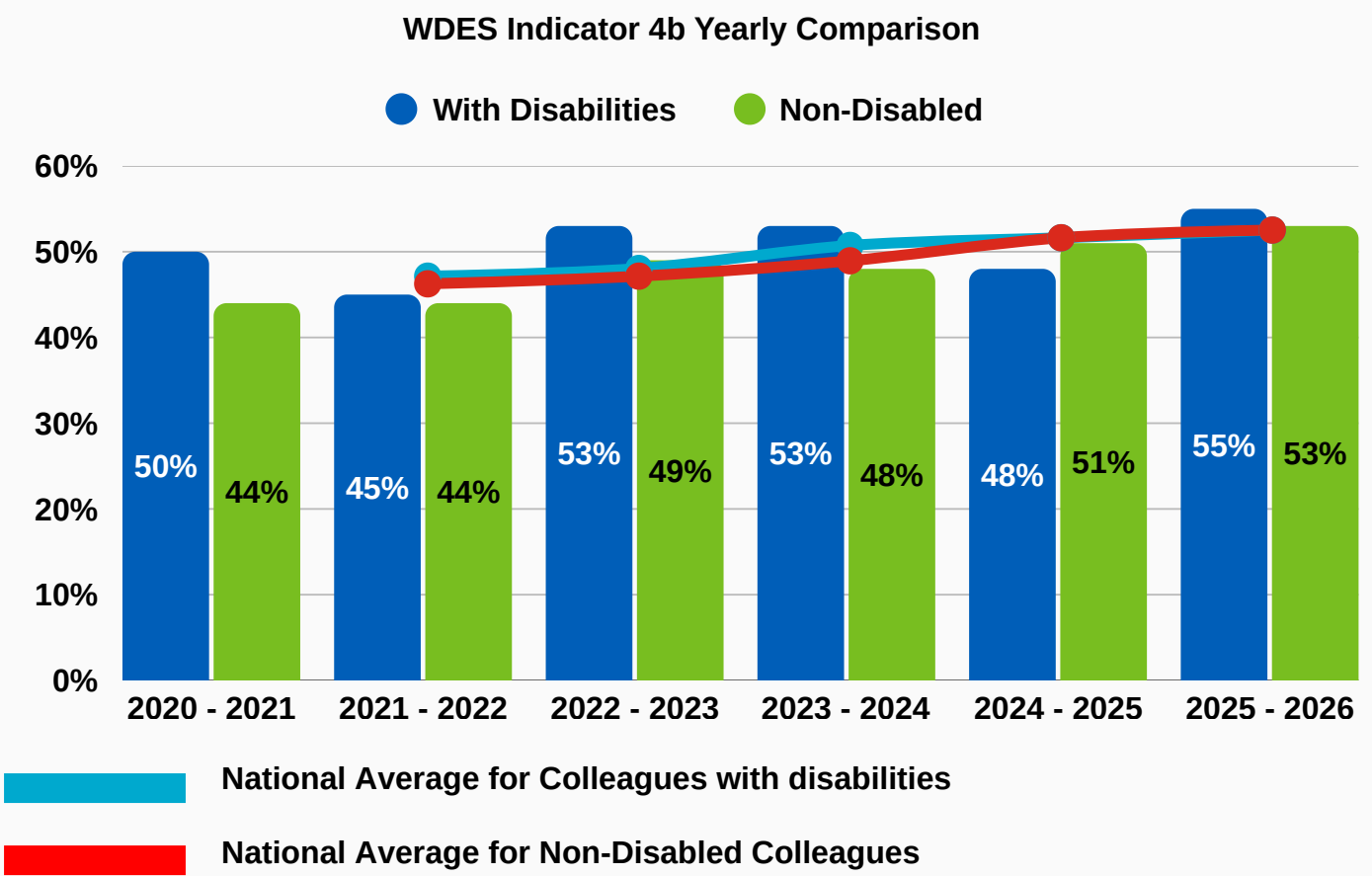


- Nearly a third of colleagues with disabilities within NGH have experienced harassment, bullying or abuse from other colleagues, in the last 12 months.
- There has been no change of colleagues with disabilities experiencing harassment from other colleagues from 28% in 2024.

Overall NGH Workforce:	Non-Disabled	With Disabilities
	Overall: 5,652	Overall: 403
	NSS: 2,255	NSS: 789

WDES Indicator 4b

Percentage of staff with disabilities saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months

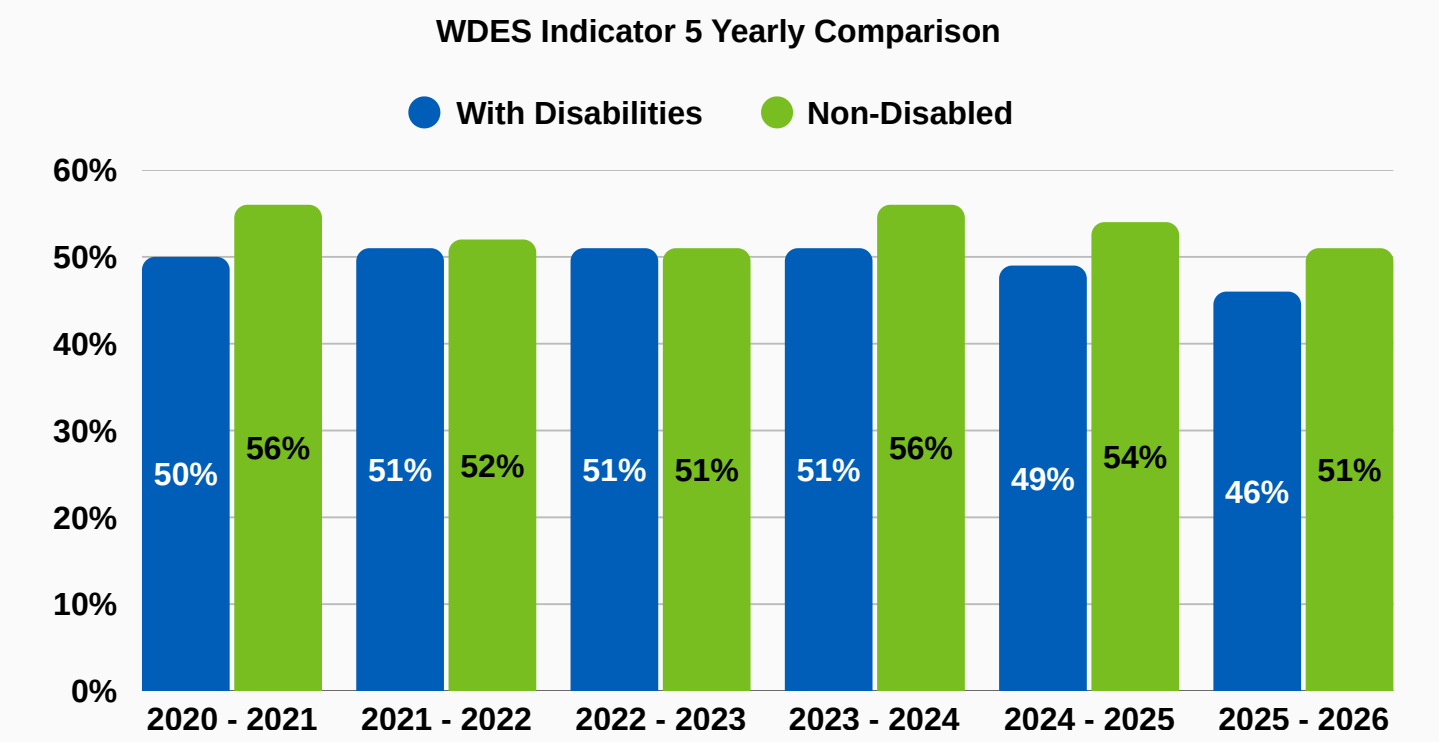


- Over half of colleagues with disabilities in NGH say that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.
- There has been a increase of 7% of colleagues with disabilities that say say the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it from 48% to 55% in 2025.

Overall NGH Workforce:	Non-Disabled	With Disabilities
	Overall: 5,652	Overall: 403
	NSS: 2,255	NSS: 789

WDES Indicator 5

Percentage of staff with disabilities believing that trust provides equal opportunities for career progression or promotion

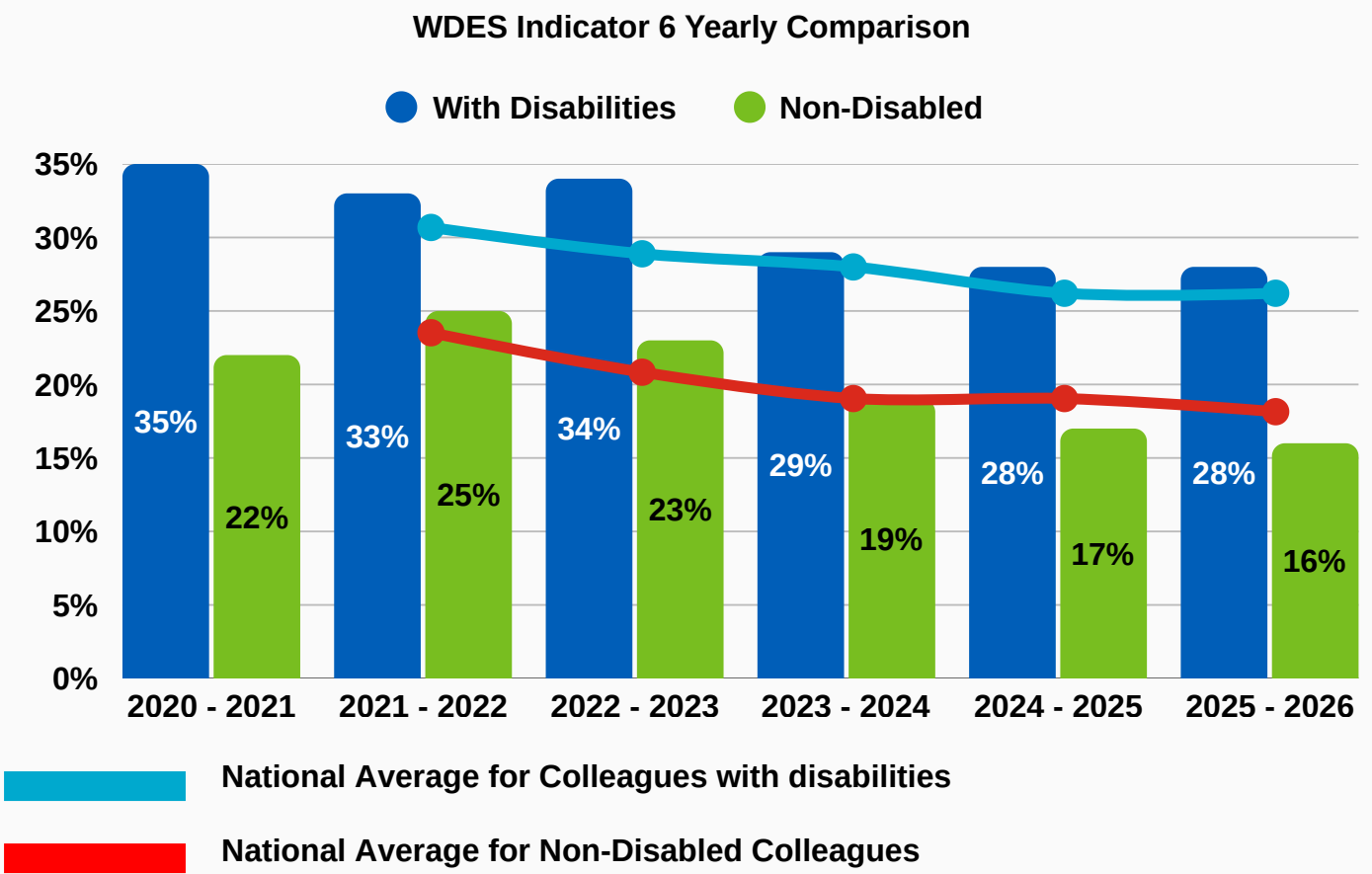


- Nearly half of colleagues with disabilities within NGH believe that the trust provides equal opportunities for career progression or promotion
- There has been a decrease of 3% of colleagues with disabilities who believe that the trust provides equal opportunities for career progression or promotion from 49% to 46% in 2025.

Overall NGH Workforce:	Non-Disabled	With Disabilities
	Overall: 5,652	Overall: 403
	NSS: 2,255	NSS: 789

WDES Indicator 6

Percentage of staff with disabilities saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

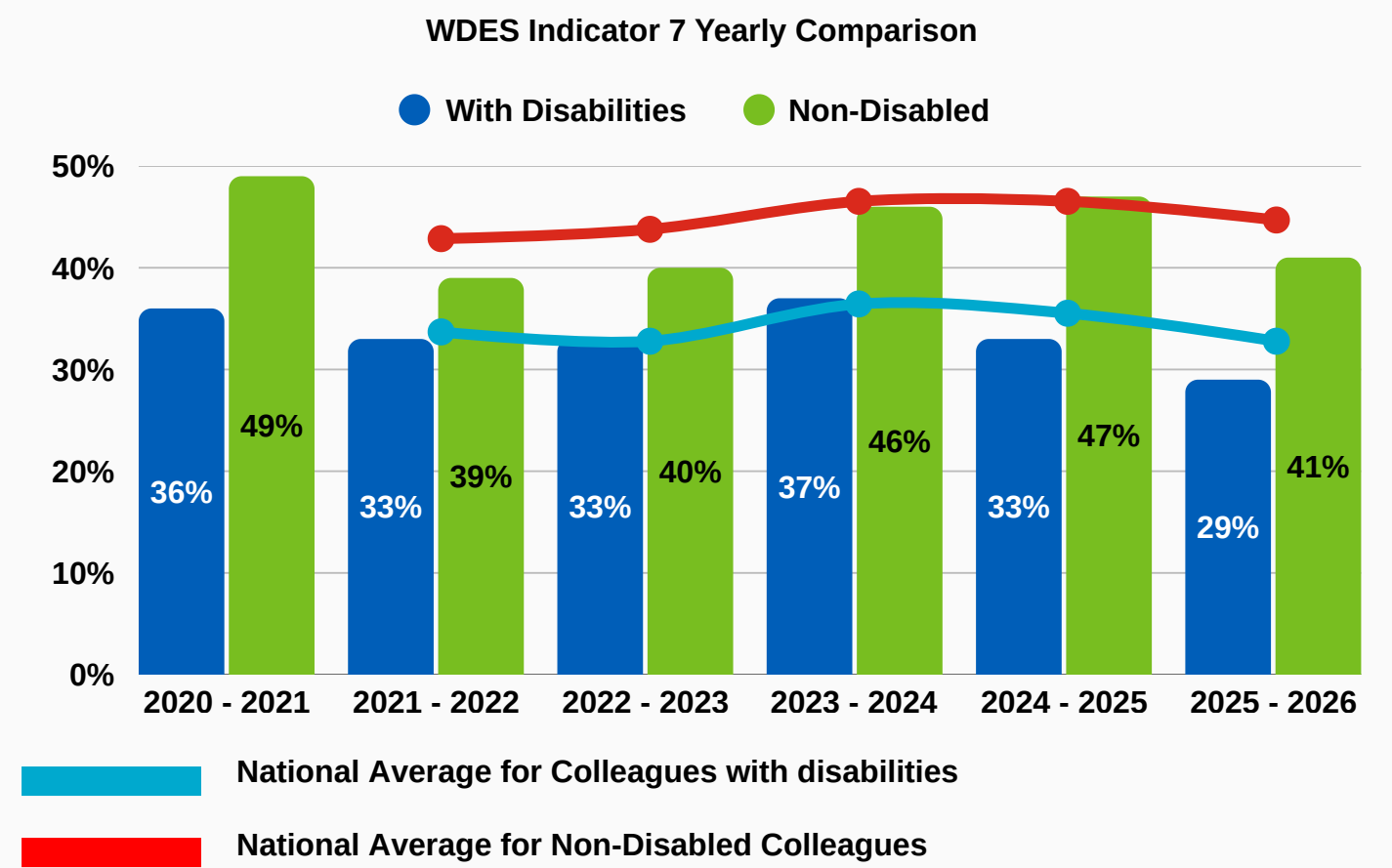


- Nearly a third of colleagues with disabilities within NGH say that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
- There has been no change of 28% of colleagues with disabilities say that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties from.

Overall NGH Workforce:	Non-Disabled	With Disabilities
	Overall: 5,652	Overall: 403
	NSS: 2,255	NSS: 789

WDES Indicator 7

Percentage of staff with disabilities satisfied with the extent to which their organisation values their work

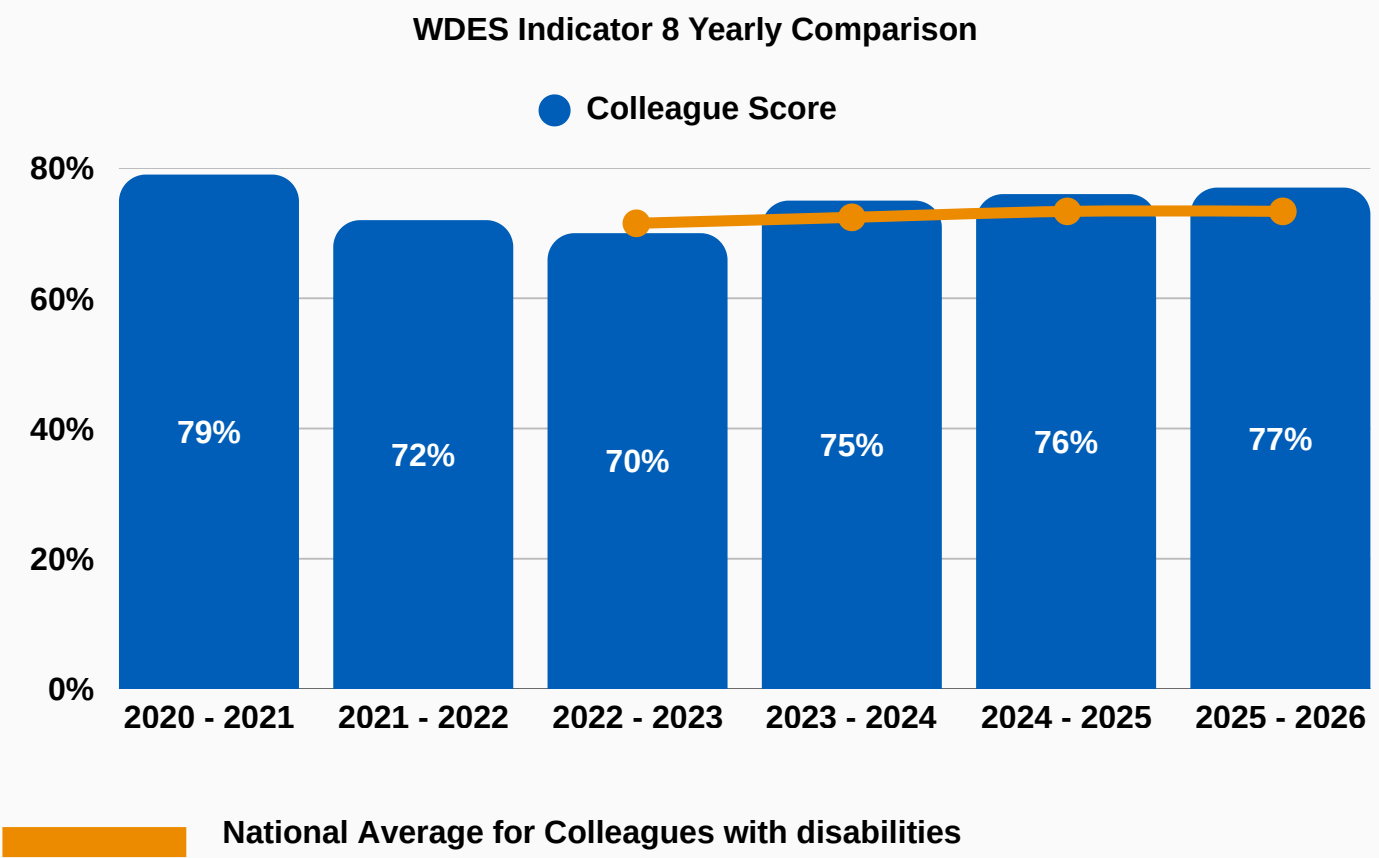


- Nearly a third of colleagues with disabilities within NGH are satisfied with the extent to which their organisation values their work
- There has been a decrease of 4% of colleagues with disabilities that are satisfied with the extent to which their organisation values their work from 33% to 29% in 2025.

Overall NGH Workforce:	Non-Disabled	With Disabilities
	Overall: 5,652	Overall: 403
	NSS: 2,255	NSS: 789

WDES Indicator 8

Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry on working

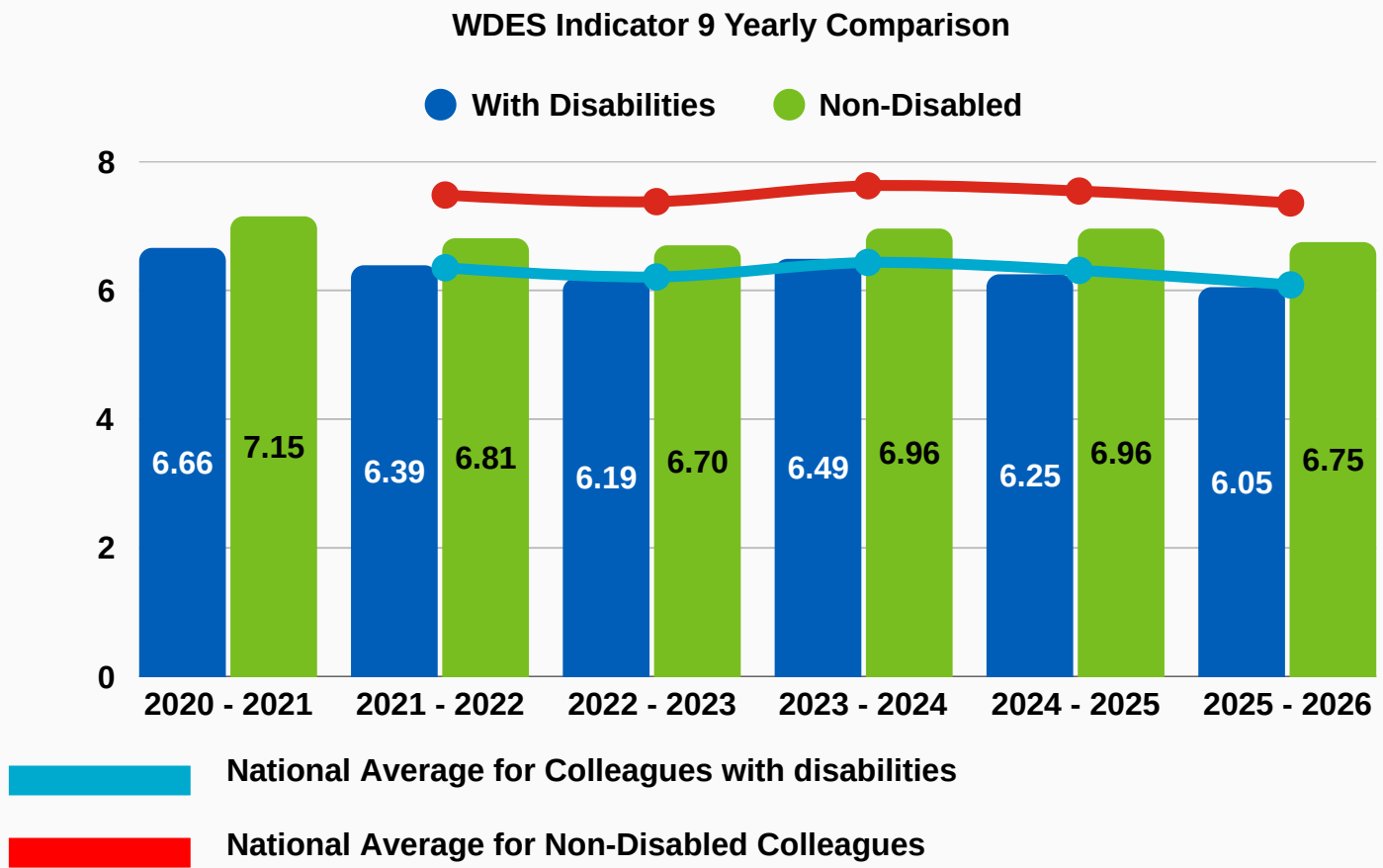


- More than two - thirds of colleagues within NGH with a long lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry on working.
- There has been a increase of 1% of colleagues with a long lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry on working from 76% to 77% in 2025.

Overall NGH Workforce:	Non-Disabled	With Disabilities
	Overall: 5,652	Overall: 403
	NSS: 2,255	NSS: 789

WDES Indicator 9

Staff engagement score for staff with disabilities from 0 - 10

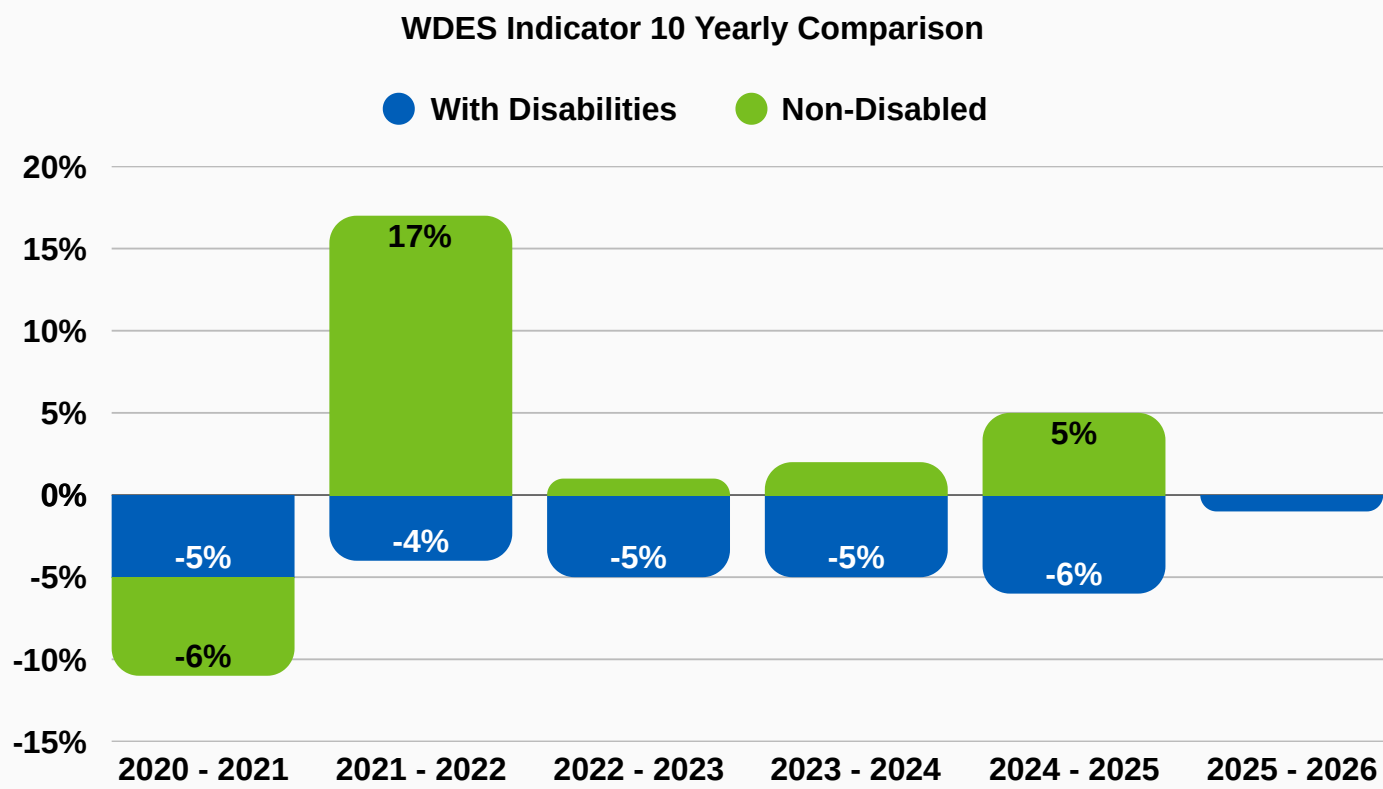


- On average colleagues with a disability or long term condition have given NGH a score of 6.05 for engagement
- There has been a decrease of 0.20 in the engagement score from colleagues with a disability or long term condition compared to 2025 from 6.25 to 6.05.
- For both colleagues with and without a disability of long term condition, NGH's engagement scores remain below the national average.

Overall NGH Workforce:	Non-Disabled	With Disabilities
	Overall: 3,588	Overall: 2,828
	NSS: 1,972	NSS: 1,095

WDES Indicator 10

Percentage difference between the organisation’s Board membership and its organisation’s overall workforce (with disabilities)



- All board members have voting membership.
- The number of voting board members with disabilities has increase by 5%.
- Out of 20 board members only 1 has declared that they have a disability
- The percentage of members on the board of directors with disabilities is lower than in the workforce.

Year	Position	Non-Disabled	With Disabilities
2025	Exec	9	1
	Non Exec	8	0

1. Continue to work with colleagues with disabilities and the Disability, Accessibility, Wellbeing and Neuroinclusion Network (DAWN) to better understand the reasons why colleagues may not have declared a disability on ESR, with a view to closing the gap between ESR and National Staff Survey declaration rates.

2. Continue to work to reduce the number of colleagues with disabilities experiencing harassment, bullying and abuse from patients/public and staff. Working with disabled colleagues and DAWN Network members, we will:

- Continue to discuss experiences of harassment, bullying or abuse with colleagues with disabilities, ensuring that there is a safe person/space for any discussions
- Launch a communications campaign focused on reducing harassment, bullying and abuse
- In conjunction with unions, freedom to speak up guardians, and staff networks, review and improve support for staff who experience bullying, harassment or abuse. This will include access to specialist support for staff
- Working with system colleagues and DAWN members, review NHS England's Civility and Respect toolkit and adopt identified practices set out

3. The Trust will continue to strengthen governance arrangements, develop the Disability, Accessibility, Wellbeing and Neuroinclusion (DAWN) Network, and maintain and review the following support pathways:

- a. The Health Passports and Disability Leave,
- b. The UHN Neuroinclusion Toolkit, and
- c. The centrally overseen route for colleagues to access reasonable adjustments

4. Work with the Trust Board and DAWN Network Board Sponsors to produce a Board Charter alongside the DAWN Network.



Accountability

We take responsibility for our decisions, our actions and our behaviours. We do what we say we will do, when we say we will do it. We acknowledge our mistakes and we learn.



Respect

We value each other, embrace diversity and make sure everyone feels included. We take the time to listen to, appreciate and understand the thoughts, beliefs and feelings of others



Integrity

We are consistently open, honest and trustworthy. We can be relied upon, we stand by our values and we always strive to do the right thing.



Compassion

We care about our patients and each other. We consistently show kindness and empathy and take the time to imagine ourselves in other people's shoes.



Courage

We dare to take on difficult challenges and try out new things. We find the strength to speak up when it matters and we see potential failure as an opportunity to learn and improve.

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	10 September 2026, 09:30-12:30	
Location	Boardroom, Kettering General Hospital	
Purpose and Ambition		
The Boards are accountable to the public, stakeholders and KGH Council of Governors to formulate the UHN Group’s strategy, ensure accountability and shape the culture of the group. The Boards delegate authority to Committees to discharge their duties effectively and these committees escalate items to the Boards where decision making, assurance and direction is required.		
Attendance	Name and Title	
Present		
	Andrew Moore	Trusts’ Chair
	Alice Cooper	Non-Executive Director
	Simon Gay	Non-Executive Director
	Polly Grimmett	Director of Strategy
	Julie Hogg	Group Chief Nurse and UHN Interim Managing Director
	Denise Kirkham	Non-Executive Director
	Will Monaghan	Chief Digital Information Officer
	Sarah Noonan	Chief Operating Officer
	Suzie O’Neill	Director of Communications and Engagement
	Sarah Stansfield	Chief Finance Officer
	Caroline Stevens	Non-Executive Director and Senior Independent Director
	Becky Taylor	Director of Continuous Improvement
	Damien Venkatasamy	Non-Executive Director
	Chris Welsh	Non-Executive Director
In Attendance		
	Robin Binks	UHN Interim Chief Nurse
	Susan Clennett	Deputy Director of Risk and Legal Affairs (Item 17)
	Andy Eagle-Weston	Deputy Chief People Officer
	John Evans	Deputy Medical Director
	Richard May	Company Secretary
	Jonathan McGee	Chief Executive, Northamptonshire Healthcare Charity (Item 14)
	Emma Mills	Head of Nursing, Cancer and Diagnostics (Item 2)
	Lauren Rothwell	Deputy Head of Nursing, KGH Medicine (Item 2)
	Rashmi Shah	KGH Public Governor
Apologies for absence		

	Simon Baylis	Lead Governor (KGH)
	Jill Houghton	Non-Executive Director
	Paula Kirkpatrick	Chief People Officer
	Richard Mitchell	Chief Executive, UHN/UHL
	Hemant Nemade	Medical Director
	Trevor Shipman	Vice-Chair and Non-Executive Director

Item	Discussion	Action Owner
1	Welcome, Apologies and Declarations of Interest The Chair welcomed colleagues and guests to the meeting, and noted apologies for absence as listed above. There were no declarations of interest relating to specific agenda items.	
2	Patient Story – Steven’s Story The Boards viewed a video in which Nicki Farr described the care of her brother Steven, who was diagnosed with squamous cell carcinoma of the lung. Nicki described poor communication with both Steven and herself, limited discussion with Steven about his deteriorating condition, and multiple ward moves that disrupted continuity of care. She spoke of the difficulty of explaining his diagnosis and prognosis during his final days while witnessing his suffering. The Boards extended their condolences and thanked Nicki for sharing her experience. The story highlighted failings in communication, continuity of care and the management of terminal agitation.¹ Colleagues from the Medicine and Cancer divisions outlined a comprehensive improvement plan developed with the family and clinical teams. Actions focused on improving communication with patients and families, communication between teams, end of life care training, escalation processes and access to specialist palliative care advice. No recurring complaint themes were identified. A review of Steven’s pathway concluded that, once cancer services became involved, he should have remained under the lung team with specialist support. Although he was assessed as too unwell for treatment, communication of this decision was not handled effectively. Improvements had since been made to communication, decision-making and visiting arrangements. Board(s) members sought assurance that lessons had been addressed robustly. They emphasised the importance of named clinical responsibility, effective communication, compassion and professional accountability. Concerns were raised that Steven appeared unaware of his diagnosis while others were informed, and that responsibility for communication had not been clearly owned. Boards reflected on wider cultural and structural issues, including	

¹ Subsequent digital prescribing logs have confirmed the delays and gaps in end-of-life medication.

	accountability, visiting arrangements and opportunities for relatives to engage with consultants. The Chief Nurse agreed these matters would be taken forward. The Group Chief Nurse emphasised that accountability rested with senior clinical leadership and that assurance would increasingly focus on patient and family experience measures through the Quality and Safety Committee. In closing, the Chair described the case as tragic and acknowledged that the organisation had failed the family in relation to process, communication and culture. While the actions taken provided reassurance, the Boards agreed that ongoing oversight was required to ensure improvements were effective and sustainable.	RB/HN
3	Minutes of the last meeting held on 11 June 2026 and Action Log The Minutes of the meeting held on 11 June 2026 were approved as a correct record. The Boards noted the action log, actions on which were closed or not yet due. With regard to Action 31/26/3, Boards were advised that there was currently no date for the Paediatric Early Warning System metrics to be available at KGH; the action therefore remained open. Paper processes continued to be used at NGH, pending digital updates linked to the Electronic Patient Record roll-out.	
4	Chair's Report The Chair welcomed colleagues and guests to the meeting and noted that this was the first meeting of the University Hospitals of Northamptonshire (UHN) Boards (only) since February 2026. Significant changes had taken place since, and the Chair expressed confidence that the governance decisions taken to decouple UHN/UHL group arrangements would ultimately benefit both patients and staff. Extensive engagement had been undertaken with a wide range of stakeholders regarding the decoupling arrangements, including Governors, MPs, local authority representatives and colleagues across partner organisations. Feedback received had been consistently positive and supportive. Reflecting on forthcoming leadership changes, the Chair recorded thanks to the Chief Finance Officer and Chief Operating Officer for their hard work, commitment and leadership during a particularly challenging period – both would be leaving UHN for new roles. The Chair also thanked the Interim Managing Director for the considerable impact she had made in her roles, providing stability and leadership. The Chair acknowledged the contribution of the Group Chief Executive over the past three years, recognising the leadership provided and the collaborative relationships that had been developed, particularly with the University Hospitals of Leicester NHS Trust (UHL). The resulting benefits for patients, services and the wider health system were noted and best wishes were extended for future endeavours.	

	The Boards were advised that Adam Carson had been appointed as Chief Executive Officer and Accountable/Accounting Officer of UHN and was due to join the organisation on 28 September 2026, subject to Remuneration and Appointments Committees' approval. The appointments of Tracey Cotterrill as Chief Financial Officer and Chris Dann as Chief Operating Officer, both on interim bases, were also noted. The Chair emphasised that, notwithstanding the organisational changes, UHN would continue to work closely with UHL on key strategic priorities and the Boards would receive updates later in the meeting regarding these collaborative arrangements. The Chair thanked colleagues for their cooperation and engagement with the recent rapid review process, noting that the overriding focus remained the delivery of the best possible care for patients and making UHN the best possible place to work. The importance of financial discipline, accountability and responsibility across the organisation was highlighted given the significant financial challenges facing the Trusts. Whilst progress had been made in strengthening individual accountabilities, it was emphasised that every part of the organisation would need to deliver its contribution to achieve the required improvement. Reference was made to Office for National Statistics data indicating that healthcare productivity remained approximately 6% below pre-COVID levels. UHN was currently reporting a position significantly off plan against a planned deficit of £100 million, which was considered unsustainable, and the Boards would receive reports setting out recovery actions later in the agenda. The Chair noted that even full delivery of the current financial plan would leave UHN with a deficit exceeding £100 million. Consequently, the strategic discussion scheduled for the meeting would be particularly important in setting out a credible route to financial sustainability and a balanced position within three years through innovation, transformation and creative approaches to service delivery. The Chair also highlighted the impressive progress made in relation to digital transformation, including the successful Electronic Patient Record implementation at NGH, and extended congratulations to all those involved. The forthcoming opening of the NGH Urgent Treatment Centre was welcomed and recognised as a development that would significantly improve services for patients. The Chair noted, however, that further difficult and potentially unpopular decisions would be required in the future. UHN would therefore need to continue strengthening its communication and engagement with staff, stakeholders and the public. Whilst UHN's past achievements demonstrated the significant talent and capability that existed within the organisation, the Chair stressed the importance of fostering the right culture to enable that potential to be fully realised. Finally, the Chair referred to the Council of Governors' engagement reports (discussed at the recent Council meeting), noting the key issues and concerns that had been raised. Thanks were extended to	
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	Governors for their continued commitment and constructive contribution, and it was noted that regular feedback from the Council would continue to be reviewed by the Board to ensure that the views and priorities of boards and the wider community informed decision-making.	
5.	Group Chief Executive's report The Managing Director presented the Group Chief Executive's report, drawing attention to the following specific items: <i>Digital Transformation</i> A major highlight was the successful implementation of the Electronic Patient Record (EPR) at NGH. This represented one of the most significant transformation programmes undertaken by the organisation and marks an important step forward in digital maturity. The successful go-live reflected the commitment and resilience of colleagues across the Trust who were supporting programme delivery, training, testing and implementation. The EPR provided a strong foundation for improved clinical workflows, enhanced patient safety and future service transformation. Focus was now turning towards optimisation and benefit realisation as the system became embedded in daily practice. <i>Urgent Treatment Centre (UTC)</i> The new NGH UTC opened on 7 September and was treating an average of 147 patients per day (over double the capacity of the previous facility), 99%-100% within four hours. The facility would strengthen the urgent and emergency care pathway, improve patient experience and support more effective patient flow across the hospital. The Boards extended thanks to colleagues for their work to bring the scheme to implementation, requesting recognition as appropriate. The Boards noted the report.	
6.	Integrated Performance Report (IPR) and Board Committee Summaries Executive leads highlighted the following significant items from the IPR contained within the agenda pack. Caring, Safe and Effective Domains (Chief Nurse and Deputy Medical Director) • Family and Friends Test (FFT) performance had deteriorated, largely due to operational pressures, particularly within the Paediatric Emergency Department. • Improvement work was underway to address underlying causes and enhance patient and family experience, supported by colleagues from the Leicestershire, Lincolnshire and Rutland Integrated Care Board. • A recovery plan had been implemented at NGH to improve	

	complaints response performance and ensure patients and families were kept informed throughout their care. • A new Group Head of Patient Experience had been appointed and was focused on reducing the complaints backlog and improving response times. • Boards noted continued challenges in complaint response performance. Work with the complaints team had identified opportunities to use AI-enabled support for high-volume administrative tasks, with further input expected from Microsoft specialists. • Preventative work was being targeted at complaint hotspot areas; however, increasing use of AI was also contributing to greater complexity in some complaints. • Cultural challenges within the complaints team following formation of the UHN team were being addressed through an organisational development programme. • Boards emphasised the importance of capturing learning from complaints and using this to drive service improvement. Work was underway to better understand root causes and recurring themes. • The fundamentals of care programme continued to bring together professional groups and improve communication across services. • The School of Empathetic Healthcare programme was being rolled out to support staff engagement with colleagues and patients. • Most single-sex accommodation breaches at NGH were linked to the discharge suite. Plans to relocate the facility were expected to significantly reduce breaches. • Mortality indices remained slightly above the desired level but broadly within expectations. • The Patient Safety Group had identified a potential national data reporting issue relating to Same Day Emergency Care activity. National guidance was awaited. • An independent review found no significant evidence that mortality rates were increasing as a result of the reported issue. Responsive Domain (Chief Operating Officer) • Boards expressed concern regarding continued ambulance handover delays at NGH. It was reported that delays reflected wider system pressures, with capacity equivalent to up to four wards of patients potentially being cared for elsewhere in the system. • Work was continuing with West Northamptonshire Council and system partners to improve discharge arrangements, increase discharge home rates and address transport challenges. • Length of stay reduction initiatives were being led by the Medical Director and supported by recommendations from UHN's financial recovery partner. • NGH had achieved the ambulance handover standard within 45 minutes for approximately 90% of arrivals during November and December 2025. Occupancy remained stable; however, there were now around 30 additional patients awaiting pathways of	
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	care and ambulance conveyances had increased by approximately 7%. • Cancer performance continued to improve, with targeted work within breast and skin cancer pathways contributing to positive results. • KGH continued to demonstrate strong Referral to Treatment (RTT) performance and was ranked third best in the region. • NGH RTT performance remained broadly static, although specialty improvement plans were in place to support progress towards the 73% target. • The waiting list position remained positive overall and the increase reported since EPR go-live was expected to remain within tolerance. • Following EPR implementation, priority had been given to completion of nationally required data returns. One national return had been missed due to a missing submission form but was subsequently completed. Reporting stability was expected to improve following further submissions and clinical validation work, with an update due to the Finance, Investment and Performance Committee in September. Well-Led Domain (Deputy Chief People Officer) • Mandatory training compliance continued to exceed target levels and remained stable. • High levels of formal employee relations cases continued to affect workforce experience and place pressure on HR resources. • UHN was recruiting an additional 100 volunteers and Boards requested further details to help promote the campaign. Use of Resources (Chief Finance Officer) • The Month 4 position (31 July 2026) was £1 million adverse to plan year-to-date, primarily due to industrial action variance. • Year-to-date cost improvement delivery totalled £16.4 million, £0.5 million ahead of trajectory. • Ninety-five per cent of the £73 million cost improvement target had been identified. • Cash remained the most immediate financial risk, with balances at £2.1 million, around £5 million below plan. No central deficit support funding was available and the Trusts remained reliant on Public Dividend Capital borrowing support. Robust working capital controls continued to be required. • Actions to strengthen cash management included earlier invoice raising, robust debt recovery processes and weekly cash management oversight meetings. • The capital programme had not been impacted by the cash position, although delivery remained behind plan. • The £97 million capital programme was approximately £17 million behind plan at Month 4, primarily due to delays in national programmes. No significant concerns regarding programme delivery were reported, and the position continued	
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	to be managed with NHS England. Committee Chairs' Reports Audit • Progress continued in addressing internal audit findings. • Particular focus had been placed on improving the management of declarations of interests and reinforcing individual accountability. Audit Committees intended to increase scrutiny of this area going forward. • Boards and senior leaders were reminded of their responsibility to declare and appropriately record interests, gifts and hospitality. Finance, Investment and Performance • Limited assurance had been reported due to a larger-than-anticipated gap in identified CIP schemes. • Boards noted the positive improvement from the earlier position, with 95% of schemes now identified. People • The new Culture Dashboard had been introduced and would be reviewed quarterly. • Some progress had been demonstrated, although uptake of the Rethinking Racism initiative amongst leaders remained below expectations. • The Committee emphasised that organisational culture must be led and role-modelled from the top of the organisation. • Workforce financial sustainability had deteriorated slightly at Month 3 in terms of whole-time equivalents and bank staffing. • A deep dive review was being undertaken, and a more strategic workforce planning approach was required. • Rising employee relations cases continued to create operational, legal and reputational risks. Although it was positive that staff felt able to raise concerns, the position remained a significant area of risk for the organisation. Quality and Safety • Continued deterioration in ambulance handover performance was reported, particularly at NGH. • Around 100 patients were awaiting supported discharge pathways, contributing to delays in ambulance handovers and emergency department flow. • The Committee expressed concern regarding the effectiveness of current system working arrangements and potential winter resilience implications. Improvements were recognised as requiring multiple incremental gains rather than a single solution. • Recent system round-table discussions had resulted in agreed actions, with focus now required on delivery	SN
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	• Quality improvement work in four wards at NGH had demonstrated reductions in length of stay and improvements in discharge processes. • Work was underway to assess how these improvements could be scaled across the organisation. Strategy, Transformation and Digital • The Rockingham development programme was subject to a temporary pause due to significantly increased projected costs and an extended timetable. • Staff, local residents, bereaved families and charity representatives were being kept informed of developments. • An options appraisal had been completed with Non-Executive Director and Governor involvement. • A Strategic Outline Case and preferred option would be presented to the Committee in October and Boards in November. • Boards recognised the concern and disappointment amongst staff and stakeholders regarding the delayed provision of the Bereavement Suite, and emphasised the need for transparent engagement. • Cost increases were primarily attributed to supply chain instability and site constraints. Boards noted the report and the updates provided across all performance domains and committee assurance reports.	
7.	Perinatal report (including KGH Maternity and Neonatal Improvement Support Team update) The Board received the Perinatal Report and noted that maternity and neonatal services remained broadly stable during July 2026, with 640 births, no Patient Safety Incident Investigations commissioned and no new Maternity and Newborn Safety Investigations referrals. Maternity Incentive Scheme Year 8 delivery remained on track and key quality indicators, including full-term neonatal admissions and severe perineal tears, remained within expected standards. The Boards noted that the pre-term birth rate remained above the national target at 9.65%, requiring continued focus through prevention, optimisation and improvement programmes. Workforce pressures persisted, with a midwifery vacancy rate of 10.9% across UHN (7.9% at KGH and 12.2% at NGH) alongside continued neonatal allied health workforce gaps. The Boards noted that maternity triage remained rated 'amber', with ongoing work to improve timely assessment, telephone access and workforce resilience. Operational pressures continued, with 207 reported red flags during July, including 179 relating to delayed or cancelled time-critical activity. Boards noted that delays in induction of labour remained a significant operational and patient experience risk, although performance had improved, with inductions delayed by more than 24 hours at NGH reducing from 18 cases in May to two in July. The Boards further noted progress within the KGH Maternity and Neonatal Improvement Support Team programme and endorsed the maternity triage assurance position and associated improvement	

	actions. Boards were advised that new IPR metrics were being developed to improve the visibility of outcome measures. The Managing Director advised that the Group Director of Midwifery, Danni Burnett, would shortly be returning to her substantive role at UHL; the Boards extended their thanks to Danni for her significant contributions to service improvement and looked forward to welcoming Sarah Jamieson as the new appointee. Boards sought assurance regarding the impact of recent leadership changes within maternity services. The Managing Director advised that significant investment had been made in developing teams across UHN and that, whilst some fragility remained at Matron and Obstetric leadership level given the complexity of these roles, overall leadership stability was stronger than previously due to the appointment of a strong Clinical Director. Boards noted the continued investment in a single Perinatal Improvement Programme, providing a clear framework through which completed actions and improvements could be evidenced. The Boards also recognised the valuable contribution of Jill Houghton in her role as Non-Executive Director Maternity and Perinatal Safety Champion. Boards welcomed the positive findings within the report, including the recent 'Good' CQC rating, and emphasised the importance of recognising the efforts of staff. The Managing Director confirmed that this would be supported through internal communications, Executive visits to clinical areas and local media activity. It was agreed that a message of thanks would be issued on behalf of the Boards, and that the achievement would also be highlighted through the UHN Forum and wider stakeholder communications, including ICB partners. The Boards sought clarification regarding reported telephone access delays, including a call which remained unanswered for 54 minutes. The Managing Director explained that a complaint investigation had identified that the call had been lost between handlers. The issue had been reviewed with technical teams and corrective actions implemented. Boards noted that further work was underway to meet national maternity triage standards, including strengthening arrangements for a consistent 24/7 point of contact for service users. Following discussion, the Boards: (1) Noted the stable July 2026 safety profile and the material operational, workforce and capacity pressures; (2) Endorsed the 'amber' maternity-triage assurance position and prioritised cross-site improvement plan and (3) Indicated support for the workforce, estates, digital, analytical, quality improvement and programme capacity required to deliver sustained improvement.	SON
8.	Response to the Amos National Maternity and Neonatal	

	Investigation, Ockenden Review and NHS England 10-point Plan The Boards RESOLVED to suspend Standing Orders (3.3) to enable this report to be considered; it had been issued within three days of the meeting due to the requirement to complete urgent mandated audit and costings work. The Boards received a report setting out UHN's response to the national maternity and neonatal recommendations arising from the Amos Investigation, Ockenden Review and NHS England 10-Point Plan. Boards noted that both KGH and NGH had assessed 26 deliverables, with 11 rated compliant and 15 partially compliant, providing reasonable but conditional assurance that core governance and safety arrangements were in place, whilst recognising that further work was required to evidence consistent implementation, sustainability and measurable impact. The Boards noted that key areas requiring improvement included Martha's Rule implementation, clinical leadership visibility, inequalities reporting, workforce sustainability, complaints learning and maternity triage. Maternity triage remained assessed as 'amber' following a cross-site review which identified gaps in timely assessment, protected workforce capacity, telephone access, estates, digital capability, data quality and equity reporting. Boards noted that unresolved telephone access issues, including unanswered and abandoned calls, represented a significant resilience and patient safety risk. The Boards further noted that delivery of the improvement programme would require continued executive oversight together with additional workforce, digital, analytical and programme management capacity. A minimum investment requirement of approximately £3.89m had been identified, subject to further validation. Following discussion, the Boards: (1) Noted the national shift from assurance that plans exist to evidence that change is embedded, reliable and improving experience and outcomes. (2) Approved the KGH and NGH NHS England 10-Point Plan baseline reporting templates, subject to final completion and validation of the evidence logs. Each site has assessed 26 deliverables: 11 compliant and 15 partially compliant, with none non-compliant or not applicable. (3) Endorsed the eight strategic improvement priorities and the proposed oversight route through the PSIP Programme Board, the separate UHN Perinatal Assurance Committee and quarterly Boards reporting, while maintaining structured cross-site learning through regional assurance routes and established collaborative programmes. (4) Endorsed the 'amber' maternity triage assurance position and a prioritised cross-site improvement plan with named leads, milestones and measures. The site benchmarking identifies a minimum planning requirement of approximately £3.89m; the final envelope remains subject to validation of currently	
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	uncosted workforce, accessibility and infrastructure requirements. (5) Indicated support for the workforce, analytical, digital, quality-improvement and programme capacity required for delivery, including the triage workforce, telephone-access, administrative, estate and data capability identified in the cross-site deep dive. (6) Requested quarterly assurance showing progress, risks, mitigations, impact and areas requiring corporate or Boards intervention, with immediate escalation of material safety, access, workforce, digital, analytical or delivery risks.	RM/JH
9.	NGH CQC Well-Led Report and follow up The Boards received a report setting out the outcome of the Care Quality Commission Well-Led assessment of Northampton General Hospital undertaken in September 2025. The inspection resulted in an overall rating of Requires Improvement and identified a breach of Regulation 17 (Good Governance), principally relating to Freedom to Speak Up (FTSU) arrangements and limited assurance that governance systems consistently supported organisational learning and risk mitigation. Boards noted that the assessment also recognised strengths in partnership working, environmental sustainability and leadership development. The Boards noted that the proposed UHN response focussed on five key organisational priorities: strengthening FTSU and psychological safety; improving culture, leadership visibility and staff experience; enhancing governance effectiveness and organisational learning; delivering measurable improvements in equality, diversity and inclusion outcomes; and embedding strategy and culture more consistently throughout the organisation. Particular emphasis would be placed on implementing actions arising from the external FTSU review, increasing guardian capacity, improving learning from incidents and complaints, strengthening leadership visibility and demonstrating the impact of improvement initiatives. The Integrated Leadership Team would oversee delivery of the response framework and receive quarterly assurance on progress, with a focus on addressing the causes of the Regulation 17 breach and demonstrating measurable improvements in culture, staff experience, inclusion and organisational learning. The Boards discussed the findings relating to FTSU and noted that additional capacity had been secured through outsourced support arrangements. It was reported that there was emerging evidence of increased utilisation of the service and that mandatory FTSU training was being introduced. The Boards emphasised that improvements to FTSU arrangements must be integrated with the wider cultural improvement programme, recognising that success would be measured not only through use of the formal FTSU process but also through staff confidence to raise concerns routinely as part of normal working practice. The Boards sought assurance regarding future regulatory activity and	

	were advised that further engagement with the CQC was anticipated following the NGH Well-Led assessment. It was also noted that a Well-Led inspection of KGH was likely during 2027-28, with Children and Young People's services expected to be inspected in the shorter term. The Boards heard that extensive communication and engagement activity was underway, including attendance by FTSU Guardians at staff forums, targeted communications campaigns and social media engagement. Boards stressed the importance of demonstrating visible action in response to concerns raised and supported the development of regular reports showing themes raised, actions taken and resulting improvements. It was agreed that this should be linked to wider "You Said, We Did" communications and incorporated within broader UHN delivery reporting. In considering how the organisation would assess progress in relation to culture and speaking up, the Boards noted the annual Provider Capability Assessment process, and requested a further external well-led peer review within the next 12 to 18 months. It was noted that maternity services already had a number of positive culture indicators, but additional mechanisms were required to assess organisational culture more frequently than through the annual NHS Staff Survey. The People Pulse Survey was highlighted as an important barometer of staff experience and culture. Assurance was provided that plans were in place to bring together existing culture, engagement and staff network initiatives and to introduce more frequent pulse surveys from Quarter 4 of 2026/27. The Boards emphasised that organisational culture was set from the top and underlined the importance of visible leadership and effective listening. Boards welcomed plans to reinstate Board visits from October and noted that the Engagement Strategy placed significant emphasis on Executive and Non-Executive Director visibility, staff engagement and listening events, including activity within the Emergency Department. Following discussion, the Boards noted and indicated assurance regarding the latest position.	
10.	UHN deliverables The Boards received a report setting out progress against the UHN strategic deliverables for both 2025/26 and Quarter 1 of 2026/27. The report highlighted significant achievements during 2025/26, including the implementation of UHN-wide clinical divisions, improvements in urgent and emergency care performance, reductions in long waiting patients and agency expenditure, implementation of major digital systems, improvements in patient experience and research participation, and progress in workforce and productivity measures. Challenges remained in delivery of the Cancer Faster Diagnosis Standard, mortality performance at NGH, workforce reductions, financial delivery and mandatory training compliance.	

	The Boards noted that the 2026/27 shared UHN/UHL deliverables built upon previous progress and supported delivery of national priorities. Quarter 1 achievements included further improvements in cancer performance, waiting-list reductions, efficiency delivery, agency spend, patient safety initiatives, quality improvement capability, digital transformation, research activity and development of community and elective care models. The Boards also noted a number of areas requiring continued attention, including mortality indicators at NGH, a slight deterioration in A&E performance and patient experience at NGH, increased non-elective length of stay, financial pressures, workforce productivity, and the need to finalise neighbourhood care operating arrangements. Overall, the Boards indicated assurance on progress against the strategic deliverables and noted the actions in place to address areas of underperformance. Boards requested that future reports incorporate prioritisation of the deliverables in the context of UHN's challenged finance and operating position, informed by risk appetite.	BT
11.	Fit and Proper Persons Annual Declarations (FPPT) The Boards considered a report providing a brief summary of FPPT checks undertaken for Board members, which had not given rise to any concerns about fitness or ability to carry out duties; the Audit Committees had confirmed this position at their June 2026 meeting, enabling a declaration, signed by the Chair, to be submitted to NHS England on 30 June 2026. The Boards noted the position and accepted the assurance of the Trusts' Chair that all Board Members continue to meet Fit and Proper Persons requirements	
12.	Provider Capability Self-assessment The Boards received a report setting out the requirements of the NHS England Provider Capability Self-Assessment process, which formed part of the National Oversight Framework and was used to assess organisational capability across six domains, including strategy, quality, workforce, operational delivery and financial performance. The Boards noted that the assessment would be submitted by 2 October 2026 and would be triangulated with regulatory and performance intelligence. The Boards noted that both Trusts were rated Amber/Red in the 2025 assessment and that, whilst challenges relating to performance and finance remained, improvements had been made during the year, including commissioning an independent Freedom to Speak Up service, strengthening quality governance arrangements and enhancing quality oversight methodologies. The Boards also noted that recent governance changes, including organisational decoupling arrangements, would be explained to NHS England in an accompanying covering letter. The Boards approved delegation of authority to the Chair and Chief Executive Officer to submit the completed self-assessment on behalf of the Boards, subject to	

	retrospective review in October.	
13.	Board Assurance Framework (BAF) The Boards received the BAF following review by Committees during Quarter 1 (the BAF would be received by Audit Committees on 22 September 2026). The Boards noted that the majority of risks remained within the significant range, with the financial risks (UHN16 and UHN17) remaining at the highest level of 25, whilst patient safety and activity risks (UHN11 and UHN15) remained at 20. Quality and Safety Committee had specifically reviewed the alignment between the patient safety culture risk (UHN11) and the workforce culture risk (UHN18), with further work commissioned between the Chief Nurse and Chief People Officer. The Boards noted that most risk scores remained unchanged from Quarter 4 2025/26; however, following committee review, two risks had increased. The estates and infrastructure risk (UHN14) increased from 15 to 20, reflecting escalating estate pressures, climate-related risks (inability to cool hospital buildings during heatwaves) and infrastructure challenges. The cyber security risk (UHN21) increased from 12 to 20 following reassessment of exposure relating to legacy infrastructure, cyber resilience, patching performance and digital asset management. No risks reduced during the quarter. The Boards noted ongoing mitigation actions across patient safety, workforce, activity, digital transformation, estates, finance and culture risks, together with plans to review the Board Risk Appetite during Quarter 3 and to further assess the alignment of strategic deliverables with the principal strategic risks. The Boards reviewed the BAF and were content that, whilst concerning, the risk scores appropriately reflected the challenges UHN faced across several domains. UHN was not considered to be an outlier in this regard; however, benchmarking against the BAFs of comparable organisations was requested as part of the next review. Following discussion, the Boards noted and indicated assurance regarding the latest position.	SC
14.	Report on the Activities of the Northamptonshire Health Charity (NHCF) The Boards welcomed the NHCF Chief Executive to present the report. The report highlighted the significant contribution of the NHCF to patient care, staff wellbeing and service improvement across UHN. During 2025/26, the Charity received 323 funding applications valued at £1.95m and approved 260 awards totalling £883k. Significant achievements included raising over £480k for the Prostate Cancer Focal Therapy Appeal, funding £430k of diabetes research, expanding the regular giving programme to over 1,100 donors, and supporting a range of patient, environmental and staff wellbeing initiatives across both hospital sites. The Boards noted progress against major appeals, including	

	completion of fundraising targets for the Daisy Maternity Bereavement Suite and the Charity's ambition to explore support for a future Cancer Centre Appeal. The Boards acknowledged challenges arising from a national decline in charitable giving and the impact this may have on unrestricted funding available in future years. Despite these pressures, the Charity reported continued growth in regular giving and legacy income and outlined a range of new fundraising initiatives. Priorities for 2026/27 included increasing community fundraising, closing existing appeals, launching a Cancer Appeal and further promoting the impact of charitable funding to patients, communities and staff. The Boards discussed the future Cancer Centre Appeal and sought clarification regarding the proposed £5m fundraising ambition. The NHCF CEO advised that the funding could potentially support either a new-build facility or the enhancement of existing facilities. The Boards emphasised the importance of agreeing a clear internal specification and vision before launching any significant fundraising campaign, recognising that prospective donors would need clarity regarding how funds would be used. The Boards also noted the need to ensure that major fundraising campaigns did not detract from support for smaller projects and highlighted the importance of careful public messaging, particularly where funds had already been raised for other schemes, the delivery of which remained dependent on wider capital developments. In response to questions, assurance was provided that staff wellbeing expenditure was now considered through an internal group responsible for determining funding priorities and reviewing requests originating from services. The NHCF CEO reported that the Charity continued to experience pressures on income generation and had reduced investment in underperforming fundraising activities, including corporate fundraising. Regular giving continued to grow, however, with approximately 1,200 regular donors now supporting the Charity, and work was underway to further expand fundraising activity within local communities. The Boards welcomed this progress, recognised the contribution of all charitable supporters and volunteers, and encouraged continued innovation in fundraising approaches. The Boards thanked the NHCF CEO and the Charity team for their ongoing support to patients, staff and services across UHN.	
15.	Trusts' Seals The Boards of Directors noted the use of the Trusts' Seals (as indicated in the report) in respect of: (1) The Project Agreement with Integrated Health Projects for the Energy Centre and Electrical Infrastructure Works on 24 February 2026, affixed by the Company Secretary and signed by the Director of	

	Strategy (KGH) (2) Lease relating to premises at Robinson Way, Kettering on 23 March 2026, affixed by the Company Secretary and signed by the Director of Strategy (KGH) (3) Lease between NGH and Boots UK Limited relating to part of Building 41, Northampton General Hospital on 24 February 2026, affixed by the Company Secretary and signed by the Director of Strategy (NGH) (4) Licence to Occupy relating to the Mortuary at Northampton General Hospital (both Trusts) on 27 April 2026, affixed by the Company Secretary and signed by the Chief Finance Officer and Director of Strategy. (5) Renewal to Lease by reference to an existing Lease relating to part of Northampton General Hospital (NGH and Alliance Medical Limited) on 14 July 2026, affixed by the Company Secretary and signed by the Director of Strategy (NGH).	
16.	Questions from the Public None	
17.	Any other business None	

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
A Moore (Chair)	4	3	75	R Mitchell	4	3	75
A Cooper	4	3	75	H Nemade	4	3	75
S Gay	4	4	100	S Noonan	4	3	75
P Grimmett	4	3	75	T Shipman	4	3	75
J Hogg	4	3	75	S Stansfield	4	4	100
J Houghton	4	3	75	C Stevens	4	4	100
D Kirkham	4	3	75	D Venkatasamy	4	4	100
P Kirkpatrick	4	3	75	C Welsh	4	4	100
S O'Neill	4	4	100	B Taylor	4	3	75
W Monaghan	4	4	100				

(i) Progress of UHN and UHN/UHL actions arising from the Boards' meetings held between April to June 2026

Item no.	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
11 June 2026						
3.3	31/26/3	Integrated Performance Report To provide an update regarding the rollout of PEWS (Paediatric Early Warning System) metrics.	R Binks	Oct 2026	NGH adopted PEWS through its Electronic Patient Record in June 2025. KGH PEWS currently subject to testing. Expected timeframe for availability is summer 2027.	5
8 May 2026						
3.3iii	22/26/3	Updated Patient Safety and Incident Response Plans to be provided	H Nemade	December 2026	Scheduled for Quality and Safety Committee (November) and Boards (December)	4
9 April 2026						
5	20/26/2	Group Research and Innovation Report To present a proposal to Boards in Common for a single group Research and Innovation framework.	MD (UHN & UHL) / DoR&I H Nemade	9.10.26	Group research arrangements to be covered as part of Transition Plan report	4
5a	20/26/2	To include greater detail in future reports of trial / research outcomes.	MD (UHN & UHL) / DoR&I H Nemade	9.10.26	Group research arrangements to be covered as part of Transition Plan report	4
5b	20/26/2	To measure trial access across constituent populations across the Group area in order to inform possible approaches for wider inclusion in trials.	MD (UHN & UHL) / DoR&I H Nemade	9.10.26	Group research arrangements to be covered as part of Transition Plan report	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
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(ii) Progress of actions from University Hospitals of Northamptonshire NHS Group Boards

Meeting	UHN Boards of Directors Meetings in Private
Date & Time	Updated following 10 September 2026 meeting

Minute Ref.	Action	Owner	Due Date	Progress	Status
Sep 26 2	Steven's story: Quality and Safety Committee to continue to oversee delivery of the learning and monitor the impact of actions arising from the case.	JH/HN	Sep 26	Added to QSC work plan	5
Sep 26 6	Ensure progress and delivery of local health system actions to improve patient flow and discharge	SN	Oct 26	Item on private Boards agenda	5
Sep 26 7	Issue of message of thanks to reflect positive NGH CQC Maternity outcomes	SON	Sep 26	Messages sent from the Chief Executive and Non-Executive Maternity and Neonatal Safety Champion. Note from the Director of Midwifery published on website	5
Sep 26 8	Quarterly assurance reports to Boards regarding Amos/Ockenden 10-point plan implementation	RB/RM	Sep 26	Added to work plan: next update December 2026	5
Sep 26 10	Boards requested that future reports incorporate prioritisation of the deliverables in the context of UHN's challenged finance and operating position, informed by risk appetite.	BT	Nov 26	Incorporate into Q2 report	4
Sep 26 13	Undertake benchmarking of BAF risk scores	SC	Nov 26	Incorporate into next quarterly report	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
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Summary Balance Sheet - KGH

TRUST SUMMARY BALANCE SHEET						
MONTH 5 2026/27						
	Balance at 31-Mar-26 £000	Current Month		Forecast end of year		
		Opening Balance £000	Closing Balance £000	Movement (in month) £000	Closing Balance £000	Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	230,763	230,763	230,763	0	230,763	0
IN YEAR REVALUATIONS	0	0	0	0	0	0
IN YEAR MOVEMENTS	0	9,411	11,871	2,459	80,927	80,927
LESS DEPRECIATION	0	(5,616)	(7,020)	(1,404)	(17,343)	(17,343)
NET BOOK VALUE	230,763	234,558	235,613	1,055	294,347	63,584
NON CURRENT RECEIVABLES	1,180	1,021	1,033	12	956	(224)
CURRENT ASSETS						
INVENTORIES	7,211	6,974	6,879	(95)	7,243	32
TRADE & OTHER RECEIVABLES	12,330	17,837	18,942	1,105	14,870	2,540
CASH	3,126	1,009	1,195	186	1,707	(1,419)
TOTAL CURRENT ASSETS	22,667	25,819	27,016	1,196	23,820	1,153
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	41,204	43,825	46,124	2,299	28,714	(12,490)
LEASE PAYABLE under 1 year	1,345	852	793	(58)	793	(552)
DHSC LOANS	0	0	0	0	0	0
PROVISIONS under 1 year	1,292	1,126	983	(143)	890	(402)
TOTAL CURRENT LIABILITIES	43,841	45,803	47,901	2,098	30,397	(13,444)
NET CURRENT ASSETS / (LIABILITIES)	(21,174)	(19,983)	(20,885)	(902)	(6,577)	14,597
TOTAL ASSETS LESS CURRENT LIABILITIES	210,769	215,596	215,762	166	288,726	77,957
NON CURRENT LIABILITIES						
LEASE PAYABLE over 1 year	6,275	6,219	6,219	0	6,219	(56)
LOANS over 1 year	0	0	0	0	0	0
PROVISIONS over 1 year	532	527	527	0	527	(5)
NON CURRENT LIABILITIES	6,807	6,746	6,746	0	6,746	(61)
TOTAL ASSETS EMPLOYED	203,962	208,850	209,016	166	281,979	78,017
FINANCED BY						
PDC CAPITAL	357,509	379,627	382,794	3,167	457,044	99,535
REVALUATION RESERVE	41,154	41,200	41,200	0	41,200	46
I & E ACCOUNT	(194,701)	(211,978)	(214,979)	(3,001)	(216,265)	(21,564)
FINANCING TOTAL	203,962	208,850	209,016	166	281,979	78,017

Non-Current Assets

- Capital expenditure in the month totalled £2.3m, including £1.9m spent on the Energy Centre development, £0.1m on the Telephony Hardware Refresh and £0.2m on the Rockingham Wing Extension

Current Assets

- Cash balance has been kept to a bare minimum of £1m at each month end, reflecting the significant shortfall of £7m in PDC cash support received so far (£16m) against YTD financial plan of £23m.

Current Liabilities

- Payables increased by £2.2m in the month, with £3.8m of overdue creditors, including £2.0m NHS creditors, £0.5m PDC payable and £1.0m accruals.
- Cash constraints continue to require stringent working-capital management, including extending payment terms where possible and generally deferring NHS creditor payments except pass-through costs.
- BPPC performance has deteriorated significantly due to the cash-flow deficit, with YTD performance at 59% by invoice volume and 6% by value, against the 95% target.

Financing

- PDC Capital Increase of £3.2m in month includes Capital programme allocation of £1.2m plus £2m of Revenue Support PDC received.
- Income & Expenditure movement reflects in-month deficit of £3m.

Summary Balance Sheet - NGH

TRUST SUMMARY BALANCE SHEET MONTH 5 2026/27

	Balance at 31-Mar-26 £000	Current Month			Forecast end of year	
		Opening Balance £000	Closing Balance £000	Movement £000	Closing Balance £000	Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	288,332	288,324	288,324	0	288,332	0
IN YEAR REVALUATIONS	0	0	0	0	0	0
IN YEAR MOVEMENTS	0	7,975	9,930	1,955	33,223	33,223
LESS DEPRECIATION	0	(7,156)	(8,945)	(1,789)	(21,473)	(21,473)
NET BOOK VALUE	288,332	289,143	289,309	166	300,082	11,750
CURRENT ASSETS						
INVENTORIES	9,142	8,836	9,009	173	9,200	58
TRADE & OTHER RECEIVABLES	16,254	20,561	19,002	(1,559)	15,045	(1,209)
CLINICIAN PENSION TAX FUNDING	587	587	587	0	628	41
CASH	2,631	1,141	1,340	199	2,820	189
TOTAL CURRENT ASSETS	28,614	31,125	29,938	(1,187)	27,693	(921)
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	53,987	67,274	69,275	2,001	70,434	16,447
FINANCE LEASE PAYABLE under 1 year	3,027	3,041	3,045	4	1,335	(1,692)
SHORT TERM LOANS	41	39	39	0	18	(23)
PROVISIONS under 1 year	2,467	2,313	2,230	(83)	995	(1,472)
TOTAL CURRENT LIABILITIES	59,522	72,667	74,589	1,922	72,782	13,260
NET CURRENT ASSETS / (LIABILITIES)	(30,908)	(41,542)	(44,651)	(3,109)	(45,089)	(14,181)
TOTAL ASSETS LESS CURRENT LIABILITIES	257,424	247,601	244,658	(2,943)	254,993	(2,431)
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	9,918	9,011	8,774	(237)	10,399	481
LOANS over 1 year	18	0	0	0	0	(18)
PROVISIONS over 1 year	720	720	720	0	709	(11)
NON CURRENT LIABILITIES	10,656	9,731	9,494	(237)	11,108	452
TOTAL ASSETS EMPLOYED	246,768	237,870	235,164	(2,706)	243,885	(2,883)
FINANCED BY						
PDC CAPITAL	368,556	383,256	385,256	2,000	424,225	55,669
REVALUATION RESERVE	63,989	63,989	63,989	0	63,989	0
I & E ACCOUNT	(185,777)	(209,375)	(214,081)	(4,706)	(244,329)	(58,552)
FINANCING TOTAL	246,768	237,870	235,164	(2,706)	243,885	(2,883)

Non-Current Assets

- M5 Capital movements of £2m. The top sliced schemes account for the majority of spend in M5, including EPR tranche 2 £0.6m, the 33 bedded ward £0.3m, UTC Works £0.2m and Mortuary £0.1m. BAU spend includes Estates heat exchanger works £0.2m & Digital end user devices £0.2m

Current Assets

- Inventories increased by £0.2m, primarily driven by higher Pharmacy stock.
- Trade and other receivables reduced by £1.6m, mainly due to lower prepayments (£0.8m), NHS receivables (£0.5m) and VAT reclaim (£0.2m).
- Salary overpayments reduced slightly by £0.05m, with the outstanding balance at £0.4m and in-month overpayments broadly consistent with last year.
- Cash increased by £0.2m, reflecting PDC capital receipts and operating cash flows, offset by capital expenditure.

Current Liabilities

- Trade and other payables increased by £2.0m, mainly due to higher revenue (£1.3m), NHS (£1.1m) and accrued (£0.7m) payables, partly offset by a £1.2m release of education funding and lower Tax & NI.
- The increase includes high-value Boots and electricity invoices awaiting authorisation and additional NHS contract underperformance provisions.
- Provisions reduced by £0.08m, reflecting utilisation of the medical staff pay arrears provision.

Financing

- PDC Capital - £2m Revenue Deficit Support Funding made up of £1.6m Deficit Support and £0.4m Working Capital.
- I & E Account - £4.7m - In-month deficit.

Cash Flow - KGH

MONTHLY CASHFLOW	ANNUAL TOTAL 2026/27 £000s	ACTUAL APR £000s	ACTUAL MAY £000s	ACTUAL JUN £000s	ACTUAL JUL £000s	ACTUAL AUG £000s	SEP £000s	OCT £000s	NOV £000s	FORECAST			
										DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
Clinical Income	403,590	35,505	32,009	33,766	33,870	34,040	33,566	33,452	33,551	33,458	33,458	33,458	33,458
Health Education England	13,534	3,512	0	0	3,790	0	0	4,156	0	0	0	2,077	0
VAT	6,966	534	642	822	0	1,622	346	500	500	500	500	500	500
Other income	10,826	979	1,222	769	2,001	929	1,099	719	599	719	599	602	589
PDC - Capital	58,402	0	3,217	1,378	4,185	567	1,612	4,016	4,209	4,034	3,938	5,973	25,273
PDC - Revenue	49,028	3,949	4,000	2,000	3,600	2,600	7,596	3,600	3,600	3,600	3,600	3,600	7,283
Interest Receivable	787	89	75	57	58	65	63	64	69	66	59	56	67
TOTAL RECEIPTS	543,132	44,568	41,165	38,793	47,504	39,822	44,282	46,506	42,528	42,377	42,154	46,266	67,169
PAYMENTS													
Salaries and wages (incl agency)	325,608	27,048	26,438	26,936	27,539	26,488	27,509	27,597	27,117	27,517	27,117	27,117	27,185
Trade Creditors	125,152	8,689	10,645	8,261	14,847	8,922	9,578	13,405	8,834	8,426	8,681	13,421	11,444
NHS Resolution	15,336	1,534	1,534	1,534	1,534	1,534	1,534	1,534	1,534	1,534	1,534	0	0
Capital Expenditure	54,800	8,942	2,795	2,410	3,441	2,719	2,671	3,970	5,044	4,900	4,822	5,728	7,358
PDC Dividend	6,859	0	0	0	0	0	3,176	0	0	0	0	0	3,683
TOTAL PAYMENTS	527,755	46,213	41,411	39,141	47,359	39,662	44,468	46,506	42,528	42,377	42,154	46,266	49,669
Actual month balance	15,378	-1,646	-247	-348	145	160	-186	0	0	0	0	0	17,500
Cash in transit & Cash in hand adjustment	5	3	19	-31	-12	26	-9	0	0	0	0	0	0
Balance brought forward	3,126	3,126	1,483	1,255	876	1,009	1,195	1,000	1,000	1,000	1,000	1,000	1,000
Balance carried forward	18,509	1,483	1,255	876	1,009	1,195	1,000	1,000	1,000	1,000	1,000	1,000	18,500

What are the issues impacting the position?

- Closing cash balance in August was £1.2m an increase of £0.2m during August.
- Planned Revenue Support to Month 4 was £28.388m, actual support received is £16.149m, which represents a shortfall of £12.239m. This explains the deterioration in the BPPC indicator and increase in creditors.
- PDC Cash Support request of £7.6m for September is awaiting approval. The cash forecast shown above assumes that the Trust will receive £3.6m Revenue support each month putting a strain on the Trusts ability to meet payment terms and sustain the financial plan expenditure. A higher PDC support is required for September and March to ensure the Trust can pay PDC dividends.
- The Trust continues to use 30 days payment terms for most suppliers. The Trust has moved large Pharma companies to end of following month terms (their terms). NHSSC remains at 45 days to manage the cash position while deficit support is limited, and the Trust has stopped paying many NHS organisations.
- Capital PDC draw down matches September forecast. March 27 shows significant PDC drawdown but limited expenditure, resulting in a large balance for 27/28 capital creditors.
- VAT monies due in the September return have been offset by a repayment of £106k previously recovered VAT that were paid back to the Trust by Medicare.

Cash Flow - NGH

MONTHLY CASHFLOW	ANNUAL TOTAL	ACTUAL						FORECAST					
	2026/27 £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
RECEIPTS													
SLA Block Payments	499,717	42,770	40,483	42,329	42,330	41,700	41,590	40,789	41,107	42,107	41,504	41,504	41,504
Health Education Payments	18,559	4,744	0	0	5,037	0	0	5,990	0	0	0	2,788	0
Other NHS Income	17,001	1,716	1,652	594	2,369	1,921	2,004	2,294	850	1,050	850	850	850
VAT Claim	7,391	317	1,686	567	0	1,030	791	500	500	500	500	500	500
PP / Other	8,512	687	488	692	744	807	554	650	1,047	893	650	650	650
PDC - Capital	10,069	0	0	0	0	0	0	337	337	437	2,517	1,380	5,061
PDC - Revenue	57,888	5,000	5,000	1,600	3,100	2,000	8,300	10,102	4,349	4,909	4,633	4,455	4,440
Interest Receivable	783	94	71	57	69	63	70	60	60	60	60	60	60
TOTAL RECEIPTS	619,920	55,328	49,380	45,839	53,650	47,521	53,309	60,722	48,250	49,956	50,714	52,187	53,065
PAYMENTS													
Salaries and wages	396,283	33,750	33,466	33,947	34,061	33,575	33,066	33,328	32,700	32,591	32,200	31,900	31,700
Trade Creditors	146,916	11,783	9,720	8,062	14,490	9,267	11,604	20,092	10,339	12,007	12,709	15,364	11,479
NHS Creditors	35,205	4,354	2,545	2,651	2,986	2,466	3,031	4,956	2,781	2,781	2,531	2,065	2,060
Capital Expenditure	33,748	6,226	3,716	2,153	1,819	1,900	2,135	2,395	2,380	2,543	3,447	2,652	2,382
PDC Dividend	7,516	0	0	0	0	0	3,568	0	0	0	0	0	3,948
Repayment of PDC Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Salix loan	41	18	0	3	0	0	0	17	0	3	0	0	0
TOTAL PAYMENTS	619,709	56,130	49,447	46,816	53,356	47,207	53,404	60,788	48,200	49,925	50,887	51,981	51,569
Actual month balance	210	(803)	(67)	(978)	294	314	(95)	(66)	50	31	(173)	206	1,496
Cash in transit & in hand adjustment	(21)	15	24	(31)	55	(114)	30	0	0	0	0	0	0
Balance brought forward	2,631	2,631	1,843	1,800	792	1,141	1,340	1,276	1,210	1,260	1,291	1,119	1,324
Balance carried forward	2,820	1,843	1,800	792	1,141	1,340	1,276	1,210	1,260	1,291	1,119	1,324	2,820

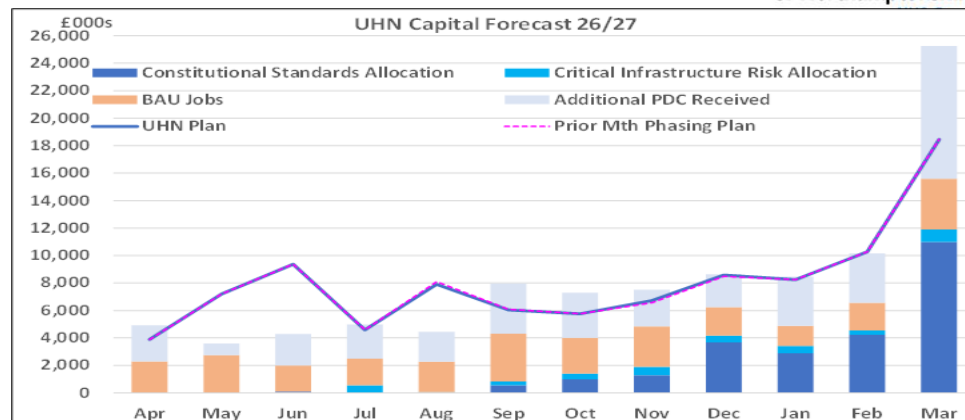
What are the issues impacting the position?

- Cash remains under significant pressure, closing August at £1.3m, £0.35m above forecast. Year-to-date Revenue Deficit Support is £10.0m below plan, restricting the Trust's ability to pay suppliers and contributing to deterioration in BPPC performance. August PDC Revenue Support was only £2.0m against £3.1m requested.
- Creditor pressures continue to build, with approved Trade Creditor invoices awaiting payment increasing by £2.6m to £11.0m overdue, including £3.0m over 90 days. September Revenue Support of £8.3m has been approved in full, which should enable some catch-up payments. The forecast assumes future deficit support is received in line with plan; without this, significant pressure on service delivery and supplier payments will continue.

Capital - UHN

UHN Capital Expenditure	YTD M5		
£000s	Revised Plan	Actual	Variance
BAU - Estates	1,637	1,266	371
BAU - Medical Equipment	731	152	579
BAU - Digital	392	572	(180)
KGH Cath Lab 3	35	2	33
KGH CT	150	0	150
NGH Maternity Bereavement Suite	29	31	(2)
Laparoscopic Stacks	0	0	0
Feasibilities	24	17	7
Mortuaries	520	375	145
SDEC / SSU KGH	40	271	(231)
ROU Renewals + Additions	849	35	814
33 Bed Winter Ward	2,428	1,872	556
NGH UTC	3,642	3,171	471
EPR System Implementation	2,907	3,168	(261)
Lin Acc Enabling Work + Eqp.	135	102	33
Charitable Funds	(100)	(11)	(89)
BAU Capital net of Disposals	13,419	11,023	2,396
Critical Infrastructure Risk Allocation	463	60	403
Const.Stds. Diagnostic Hub 3rd CDC	300	0	300
Const. Stds. UHN Elective Hub	180	156	24
Const. Stds. KGH UTC & UHN Majors ED	505	15	490
Rockingham Extension	941	1,036	(95)
Energy Centre	15,974	8,507	7,467
NHP Wave 2	405	427	(22)
NHP Enabling	50	126	(76)
MSCP Main Build	63	211	(148)
MSCP Utilities Diversion	420	0	420
Maternity Building Rebuild	221	163	58
Non BAU Capital Expenditure	19,522	10,701	8,821
Total Capital Expenditure	32,941	21,724	11,217

Year to Date Capital Spend	KGH	NGH	UHN
Capital Allocation	1,185	9,849	11,034
PDC Funded	10,633	68	10,701
Total CDEL	11,818	9,917	21,735
Grants Donations	0	-11	-11
Total Capital Expenditure	11,818	9,906	21,724



What are the issues impacting the position?

- .Month 5 – £11.2munderspend. The UHN Capital Plan is £97.0m, with £32.9m phased expenditure expected by Month 5 compared with £21.7m actual spend, resulting in an £11.2m underspend. The overall plan is weighted towards the second half of the year, largely due to Constitutional Standards projects.
- Of the £21.7m spent to date, £11.0m relates to BAU capital, with key projects including 33 Bed, NGH UTC and NGH EPR broadly on plan. Externally funded projects account for £10.7m of expenditure.
- The main driver of the underspend is the Energy Centre, £7.5m behind plan, with the gap increasing by £2.5m since last month. A full reforecast is being undertaken to determine how much of the £30.7m MOU funding may need to move into 2027/28. Constitutional Standards projects are also now contributing to the underspend, with revised expenditure profiles being requested for the £24.8m programme.

BOARD COMMITTEE SUMMARIES - BOARDS OF DIRECTORS 9 OCTOBER 2026

Audit: 22 September 2026

Quality and Safety: 23 September 2026

Strategy, Transformation and Digital: 24 September 2026

Finance, Investment and Performance: 29 September 2026

KGH/NGH Audit Committees (meeting together) Upward Report to Boards of Directors		Date of reporting group's meeting: 22 nd September 2026 (1 of 2)	
Reporting Chair: Alice Cooper			
Agenda Item	Description and summary discussion	Link to BAF Risk	Assurance level
Cyber/Digital Business Continuity Plans Assurance Report	The Committees received the very comprehensive report, noting the assurance given in key areas and areas where currently funding is not agreed, therefore assurance cannot be given at present.	UHN 21	Reasonable
Board Assurance Framework Focus (Risks 11,12, 13 & 20)	Updates were provided by the Chief Nurse/Interim Managing Director and Medical Director respectively. ▪ The changes to the Patient Experience Team were noted in the update on UHN 12 ▪ It was agreed that UHN20 (re collaboration with UHL) required revision in light of the new arrangements. ▪ The positive work in research was noted in the update on UHN 13. It was noted that the Boards were also due to revisit/reset its Risk Appetite (as it does at least annually) shortly. The Committees discussed that they continue to see a lack of significant risk reduction across the BAF, questioning the appropriateness of the appetite set currently.	UHN 11, 12, 13 & 20	Reasonable
Clinical Audit Compliance Report	The Committees warmly welcomed the first fully joint UHN report, and commended the approach taken and work carried out. Limited assurance was given, however, due to the number of actions as yet unclear given the stage of the integration of the two agendas.	UHN 11	Limited
Breaches of Standing Orders - Board and Committees	The Committees were understanding of the reasons behind what appeared to be an increase in late papers being provided to Boards and Committees over recent months; however, in order to retain strong and meaningful governance it was noted that it is essential that this is addressed going forward, particularly where material strategic matters are being raised for decision or scrutiny by the Boards.	N/A - Governance	N/A but raised at Board for awareness

Reporting Chair: Alice Cooper

Agenda Item	Description and summary discussion	Link to BAF Risk	Assurance level
Internal Audit Progress Report	The Committees were unable to give more than Limited Assurance due to the findings of the report into "Key Financial Controls: Budget Holder Training" which had received Limited Assurance. A broad discussion regarding clarity of ownership of financial controls followed.	UHN 16	Limited
Internal Audit: Escalatory Framework for Recommendations	The Committees were very welcoming of the new framework to escalate and track internal audit recommendations, and of the increased focus in this area seen from the external provider, and by Executives as a result.	N/A - Governance	Reasonable
Internal Audit: Anti-Crime Progress Report	The Committees continue to be significantly concerned about the time being taken to resolve investigations into staff, and the impact. This is having on both our ability to pursue/recover funds, but also as importantly, our employment law risk, and our ability to effectively reduce other risks and to allow departments to continue their work in the interim. The Committees have requested an additional meeting with representatives of the Anti-Crime team and the Chief People DOfficer to gain further assurance on the steps being taken.	UHN 19	Limited
External Audit: 25/26 Lessons Learnt Report	The Committees welcomed the extremely comprehensive report, and the assurance that plans for the 26/27 audit will take these findings into account.	N/A - Governance	Substantial
Financial Governance Report	The Committees welcomed the continued enhancements to the report, which now allows focus on the key issues at hand; however the concerns regarding the Better Payment Code compliance, and the other unplanned losses in areas such as the Overseas Visitor debt and Salary Overpayments prevented the Committees giving more than Reasonable assurance over this area.	UHN 16	Reasonable

UHN Quality and Safety Committee Upward Report to UHN Board of Directors Slide 1 of 3	Date(s) of reporting group's meeting(s): 23 rd September 2026
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Reporting Group Chair: Chris Welsh, Non-Executive Director

Agenda Item	Description and summary discussion The committee:	Link to Board Assurance Framework (BAF)	Assurance level *
Subgroup upward reports	- Received updates on fire and water safety including progress against actions arising from internal audit reviews and ongoing work to strengthen water safety governance arrangements. The committee will receive further updates on the delivery of outstanding actions, including the harmonisation of arrangements across both hospital sites, to support continued assurance and oversight. - Received assurance regarding the overall performance of Children's and Young People's services. Challenges relating to the timely transfer of children with complex needs to appropriate placements was discussed, together with the potential implications for service capacity during periods of increased demand. Actions are being progressed both locally and across the wider system to address these issues. - Noted plans for a future review of end-of-life care arrangements.	UHN11 Positive safety culture	Reasonable
EPR Tranche 2 Go-Live	- Welcomed the successful implementation of EPR Tranche 2 and commended staff involved in the programme. - Received assurance that no significant patient safety incidents had arisen following go-live and that robust arrangements remained in place to monitor and resolve reporting and operational issues during the stabilisation phase. - Noted ongoing work to improve reporting functionality, support users and prepare for future phases of implementation.	UHN24 Transform Patient Care: Deliver major digital change	Reasonable

UHN Quality and Safety Committee Upward Report to UHN Board of Directors Slide 2 of 3	Date(s) of reporting group's meeting(s): 23rd September 2026
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Reporting Group Chair: Chris Welsh, Non-Executive Director			
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Agenda Item	Description and summary discussion	Link to Board Assurance Framework (BAF)	Assurance level *
The committee:			
Medicines Optimisation	- Noted progress on strengthening medicines governance, pharmacy workforce capacity and assurance arrangements alongside ongoing quality improvement work focused on medication safety, antimicrobial stewardship and the standardisation of medicines management practices across UHN. - Noted ongoing challenges affecting aseptic and radiopharmacy services. Whilst assurance was received regarding the implementation of mitigating actions, strengthened governance oversight and the absence of reported moderate or severe patient harm arising from these pressures, members noted the continued fragility of these services and the importance of maintaining effective monitoring and escalation arrangements. The committee wishes to highlight to the Board the need for ongoing Board oversight of workforce, estate and service sustainability considerations to support the longer term resilience of these specialist services.	UHN11 positive safety culture	Limited
Clinical Negligence Claims and Organisational Learning	- Noted the organisation's claims portfolio. - Welcomed enhanced work to triangulate themes arising from claims, complaints, patient experience feedback, patient safety incidents and inquests, noting that recurrent themes, particularly relating to communication and patient care, continue to emerge across multiple sources. - Requested continued assurance that identified learning is being embedded across services and that actions taken are reducing the likelihood of recurrence.	UHN11 positive safety culture	Reasonable
PHSO complaint	- Received an update regarding a Parliamentary Health Service Ombudsman Complaint, noting the Ombudsman has upheld the complaint and an action plan is being implemented. - Noted the learning from the case is being embedded through the agreed action plan.	UHN11 Positive safety culture	Reasonable
Perinatal services	- Welcomed the significant progress within maternity services including the achievement of a 'Good' rating across all domains at NGH and improvements in key maternity outcome measures. - Highlighted ongoing concerns regarding maternity triage, delays in access to obstetric review and workforce requirements necessary to support a fully compliant 24 hour service. - Noted continuing work arising from the Thirlwall Inquiry, including strengthened oversight of neonatal deaths and review of pre-term birth and neonatal outcomes.	UHN11 positive safety culture	Reasonable

UHN Quality and Safety Committee

Upward Report to UHN Board of Directors

Slide 3 of 3

Date(s) of reporting group's meeting(s): 23rd September 2026

Reporting Group Chair: Chris Welsh, Non-Executive Director

Agenda Item	Description and summary discussion The committee:	Link to Board Assurance Framework (BAF)	Assurance level *
Patient Safety	- Received assurance regarding patient safety arrangements including implementation of PSIRF, learning from deaths processes and strengthening mortality review arrangements. - Received assurance that learning and corrective actions have been implemented following a never event which had occurred during the reporting period. - Highlighted concerns regarding end-of-life readmissions and the wider system capacity issues contributing to patients being admitted to hospital towards the end of life, noting the need for continued system wide action. - Noted ongoing challenges relating to non-emergency patient transport services, which are under review. The committee wishes to highlight this issue to the Boards due to the operational risks associated with this issue, due to the impact on discharge delays, patient experience and bed capacity.	UHN11 positive safety culture	Reasonable
Child death reviews	- Received an update on the multi-agency Child Death Review process established and noted the themes identified by the review. - Noted immediate improvement actions have been implemented and welcomed the commissioning of a wider system review to strengthen learning and governance across organisations. - Noted the importance of compliance with national requirements and embedding learning across the system.	UHN11 Positive safety culture	Reasonable
Infection Prevention and Control Annual Report	- Approved the IPC Annual Report. - Noted positive performance in several areas and continued organisational focus on antimicrobial stewardship, water safety, environmental cleanliness, reduction in Gram-negative bloodstream infections.	UHN11 Positive safety culture	n/a

**UHN Strategy, Transformation and Digital Committee
Upward Report to Board of Directors**

Date of reporting group's meeting: 24th September 2026
(slide 1 of 1)

Reporting Non-Executive Director: Trevor Shipman (Chair)

Agenda Item	Description and summary discussion	BAF references	Assurance level *
	The committee:		
Digital Roadmap delivery	- Received a detailed update on Electronic Patient Record (EPR) programme, noting successful implementation at NGH, continued system stabilisation activities and positive assurance regarding patient safety. - Noted progress against the wider digital roadmap including maternity digital developments. - Considered future digital investment priorities and requested an update on the longer term digital roadmap and planned developments across the organisation.	UHN24 Digital Transformation	Reasonable
Strategic Estates	- Received an update on the capital and infrastructure programmes, noting progress across a range of strategic developments including the New Hospital programme, estates modernisation initiatives and major capital schemes. - Reviewed key programme milestones, emerging planning considerations and funding arrangements and received assurance regarding ongoing governance and programme management.	UHN14 Estates and Infrastructure	Reasonable
Cyber Security	- Received an update on cyber security and digital resilience arrangements noting progress in the development of a Trust-wide cyber improvement programme and enhanced cyber governance. - Received assurance that work is progressing to strengthen both preventative controls and organisational recovery arrangements, alongside continued investment in cyber resilience.	UHN21 Transform Patient Care (Cyber Security)	Reasonable
Transition	- Received an update on clinical strategy collaboration with UHL, noting proposals to continue joint working in several areas. - Received a presentation on proposed future digital operating arrangements and governance structures designed to support continued collaboration whilst maintaining clear organisational accountability. The committee noted the direction of travel and supported further development of the model. No assurance rating is assigned at this stage pending further development and discussion.	UHN20 Transform Patient Care	n/a (on Boards' agenda 9 October)

Finance, Investment and Performance Committee Upward Report to Boards of Directors		Date of reporting group’s meeting: 29 September 2026	
Reporting Group Chair: Damien Venkatasamy			
Agenda Item	Description and summary discussion	Link to Board Assurance Framework (BAF)	Assurance level *
CFO Report Month 5	The Committee received a detailed update on the financial position, including ongoing cash pressures. The reported position was £1m adverse to plan year to date and there remained significant uncertainty regarding the underlying run rate, forecast outturn and delivery of the efficiency programme. A key priority over the coming weeks would be agreeing a realistic outturn position and financial trajectory with NHS England. The Committee agreed this should be escalated to Board as a significant issue requiring Board engagement and ownership.	UHN BAF 16 UHN BAF 17	Limited
Winter Assurance Statement	The Committee approved the Winter Assurance return, subject to strengthening of the narrative around discharge, system partner support and operational risks, and noted that Board should be informed that FIPC had exercised its delegated authority for approval.	UHN15	N/a
National reports for NGH post EPR go-live	The Committee highlighted concerns regarding the UHN's reporting capability and the challenges arising from post-go-live EPR reporting, operational reporting development and data quality issues. This should be flagged for the Boards’ attention given the significance of reliable reporting to decision-making and assurance.	UHN24	

*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

Cover Sheet

Meeting	Boards of Directors of the University Hospitals of Northamptonshire NHS Group (Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust) meeting together (public)
Date	9 October 2026
Agenda item	8

Title	UHN Perinatal Report October 2026 [August Data]
Presenter	Sarah Jamieson – UHN Interim Director of Midwifery
Author	Sarah Jamieson – UHN Interim Director of Midwifery

Link to Group Priorities (select all that apply):		
☒ Transform Patient Care	☒ Strengthen our Culture	☐ Deliver our financial plan
Improves safety, access, outcomes and experience across maternity and neonatal pathways, with focused action on triage, preterm birth, pelvic health and neonatal capacity.	Strengthens compassionate, inclusive and learning cultures through staff voice, leadership visibility, multidisciplinary working, training, complaints learning and MNVP co-production.	

Action — this paper is for:	Assurance
Assurance and Significant Risks	
Continued progress across UHN Maternity and Neonatal Services was demonstrated during August 2026, with workforce resilience and most training and quality indicators providing positive assurance. Operational pressures reduced, with services operating at the lowest escalation level for most of the month. There were 595 births, 1 PSII (KGH) and 1 MNSI referral (KGH). Key areas requiring continued focus include the MOSS safety response and perinatal outcomes, preterm birth, timely complaint resolution, NGH anaesthetic PROMPT compliance and workforce gaps, particularly neonatal AHP and psychology provision. Recruitment, strengthened safety surveillance and targeted improvement actions remain priorities, alongside the planned September KGH MOSS drill to test preparedness, escalation and organisational learning.	
Impact Assessment	
The paper considers impacts on patient safety, quality, access and experience; workforce capacity, wellbeing, training and culture; equality and health inequalities, including ethnicity, deprivation, language and vaccination uptake; system and partnership working with the ICB, regional teams and MNVP; and sustainability, estates, digital and financial requirements. Improvement actions prioritise equitable access, family voice, timely care and measurable outcomes. Detailed investment requirements remain subject to validation and appropriate business-case and governance processes.	
Appendices	
Appendix 1 - UHN Assurance and Priority Action Summary Appendix 2 - UHN August 2026 Perinatal Performance Summary Appendix 3 - UHN Perinatal Scorecard [August Data]	

Glossary

The following glossary and acronym guide is included to support readability and consistent interpretation of terms used throughout this report and its appendices.

Glossary	Meaning
Ward-to-Board assurance	A clear reporting route showing how risks, concerns and performance information are identified in clinical services and escalated through governance structures to Trust Boards.
Unwarranted variation	Differences in outcomes, experience or processes that cannot be explained by population need or case mix alone and may indicate improvement opportunities.
Case mix	The complexity, acuity and characteristics of the women and babies cared for by a service, which can influence outcomes and demand.
Care bundle	A set of evidence-based actions which, when delivered consistently together, improve the reliability and quality of care.
Deep-dive review	A focused review of an issue, outcome or service area to better understand causes, themes and required actions.

Acronyms

Acronym	Meaning
PACiC	Perinatal Assurance Committee in Common
PSIP	Perinatal Safety Improvement Programme
MIS	Maternity Incentive Scheme
PMRT	Perinatal Mortality Review Tool
MNSI	Maternity and Newborn Safety Investigations
FFT	Friends and Family Test
OPEL	Operational Pressures Escalation Level
ARM	Artificial Rupture of Membranes
MAU	Maternity Assessment Unit
ATAIN	Avoiding Term Admissions Into Neonatal units
EPR	Electronic Patient Record
FDP	Federated Data Platform
ODN	Operational Delivery Network
PPH	Postpartum Haemorrhage
OASI	Obstetric Anal Sphincter Injury
CTG	Cardiotocography
NNAP	National Neonatal Audit Programme
SPEN	Strategic Executive Information System for patient safety event notification
MatNeoIST	Maternity and Neonatal Improvement Support Team
MatNeoPREM	Maternity and Neonatal Patient Reported Experience Measure
PSII	Patient Safety Incident Investigation
MOSS	Maternity Outcome Signal System

BOARDS OF DIRECTORS 9 OCTOBER 2026 UHN PERINATAL REPORT — KETTERING AND NORTHAMPTON

PURPOSE OF THE REPORT

To provide the Boards with an up-to-date assessment of maternity and neonatal safety, quality, workforce, operational performance, experience, equity and improvement across Kettering General Hospital (KGH) and Northampton General Hospital (NGH).

UHN Perinatal Report — Board Summary | October 2026



August data shows improved operational stability and recruitment, while MOSS, preterm birth, PROMPT compliance and workforce gaps require continued Board oversight.

Governance & Assurance	Quality & Safety	Workforce & Culture
• NGH MOSS Level 1 response submitted; KGH drill planned for September • UHN-wide investigation guideline will <u>standardise</u> review and shared learning • Priority: reduce overdue Datix cases and strengthen safety-data triangulation	• Most incidents caused low/no harm; 1 new MNSI, 2 ongoing cases and 1 PSII • Four August stillbirths plus one neonatal death triggered the NGH MOSS <u>alert</u> • Preterm birth: 9.65% vs 6% target; KGH PPH rose; APGAR <7 improved	• Midwifery vacancies: KGH 7.8% (13.10 WTE); NGH 9.84% (28.40 WTE) • Eleven graduate midwives secured; neonatal vacancies are reducing • Neonatal AHP+P is 19% funded; a 5.43 WTE gap remains after recruitment
Operational Resilience	Equity, Experience & Family Voice	Strategic Risks
• OPEL 1 for 85% of August; OPEL 2 for 15% • 202 red flags; 179 (89%) involved delayed or cancelled time-critical activity • One-to-one labour care reached 100%; no obstetric-led service suspensions	• FFT promoter rates were at or above target across UHN • 42 open complaints (23 KGH / 19 NGH); 5 overdue; 8 under enhanced oversight • Most women booked before 10 weeks; vaccine uptake varies by site and community	• Priority risks: MOSS response, stillbirth and preterm birth • NGH anaesthetic PROMPT is 76% vs the 90% requirement • AHP/psychology gaps, time-critical delays and complaints need sustained action

RECOMMENDATIONS

The Boards are asked to:

- (1) **Note the positive assurance** provided by improvements in operational performance, training compliance, recruitment, patient experience and the CQC rating for NGH maternity services;
- (2) **Note the significant and emerging risks** relating to the NGH MOSS safety alert and perinatal mortality, preterm birth, major postpartum haemorrhage, workforce and neonatal AHP/psychology gaps, delayed complaints and NGH anaesthetic PROMPT compliance;
- (3) **Endorse the priority improvement and recovery actions** described in the report, including continued enhanced safety surveillance and delivery of the MatNeolST programme;
- (4) **Support the completion of a Trust-wide gap analysis and action plan in response to the Thirlwall Inquiry (see also item 8.1)**, with clear executive ownership, timescales, resource implications and governance oversight; and
- (5) **Request** that progress, exceptions and evidence of sustained improvement are reported through the UHN Perinatal Assurance Committee and escalated to the Boards where required.

1. PERINATAL SERVICES SUMMARY

August demonstrated continued progress across UHN Maternity and Neonatal Services, with workforce resilience and most training and quality indicators providing positive assurance. Operational pressures reduced, with services operating at the lowest escalation level for most of the month. There were 595 births, 1 PSII (KGH) and 1 MNSI referral (KGH). Key areas requiring continued focus include the MOSS safety response and perinatal outcomes, preterm birth, timely

complaint resolution, NGH anaesthetic PROMPT compliance and workforce gaps, particularly neonatal AHP and psychology provision. Recruitment strengthened safety surveillance and targeted improvement actions remain priorities, alongside the planned September KGH MOSS drill to test preparedness, escalation and organisational learning.

2. PERINATAL SURVEILLANCE HIGHLIGHTS

Clinical Quality and Safety: August data shows most incidents resulted in low or no harm, with ongoing MNSI and PSII activity requiring continued oversight. A MOSS Level 1 safety alert was received at NGH following four stillbirths and one neonatal death in the preceding three months. A Perinatal MDT review has been completed and a formal response submitted to NHSE. Improvement is required in timely incident investigation, learning, maternity pathway delivery and strengthened triangulation of safety and mortality intelligence across UHN. To support preparedness and organisational learning, a MOSS drill is planned at KGH during September, providing assurance that escalation and response arrangements are effective and embedded.

Operational & Capacity: Operational performance improved during August, with UHN maternity services operating at the lowest escalation level for 85% of the reporting period. However, workforce and capacity pressures remain, particularly delays or cancellations of time-critical activity and occasions where coordination staff were required to support clinical care. One-to-one care in labour was maintained across both sites, and no obstetric-led maternity services were suspended. Midwifery recruitment continues to progress, supporting workforce stabilisation. Improvement priorities remain reducing red flag events, strengthening rota resilience and workforce deployment, maintaining coordinator supernumerary status, and sustaining recruitment, retention and staff wellbeing to support safe, high-quality maternity care.

Patient Experience: Patient feedback remains positive, with Friends and Family Test promoter rates at or above target across UHN. Complaint management remains an area of focus, particularly timely progression, clear ownership and consistent responses. A revised maternity complaints process is being embedded to strengthen oversight and learning. Staff feedback highlights workforce capacity and environmental pressures, alongside positive multidisciplinary working. Priorities remain improving complaint resolution, addressing workforce and estate concerns, and ensuring patient and staff feedback drives measurable improvements across maternity and neonatal services.

Outcomes:

Escalate: Stillbirths / MOSS signal, preterm birth

Exception Review: KGH PPH ≥ 1500 ml

Watch: Smoking at booking and smoking at birth

Assurance: APGAR <7 , severe perineal trauma, breastfeeding initiation.

Clinical surveillance identifies stillbirths, preterm birth and PPH ≥ 1500 ml as the key areas for focused oversight. The UHN stillbirth position requires continued surveillance alongside the MOSS response. Preterm birth remains above the 6% target at 9.65%. While overall PPH performance has improved, the August increase at KGH requires review. Other indicators are broadly stable or improving, with smoking remaining under continued surveillance.

Training Compliance:

Escalate: NGH anaesthetic PROMPT compliance, currently 76% against the 90% requirement.

Exception Review: Recovery plan and additional PROMPT capacity for anaesthetic staff ahead of MIS submission.

Watch: Sustained compliance across all professional groups and alignment of training with safety priorities.

Assurance: Overall PROMPT attendance is 98%, with obstetric consultants, doctors and maternity support workers achieving 100% in August. Fetal monitoring compliance is 98–100%, and neonatal life-support training remains 95–97%, demonstrating strong compliance across most areas. Overall training compliance remains strong, with focused improvement required in NGH anaesthetic PROMPT attendance to achieve sustained MIS compliance and assurance.

Workforce:

Workforce resilience continues to improve across UHN Maternity and Neonatal Services, supported by active recruitment and new starters. Midwifery vacancies remain a key focus, particularly at NGH, while recruitment is underway to address higher maternity support worker vacancies at KGH. Obstetric consultant stability has improved at KGH, with recruitment progressing at NGH to address remaining gaps.

Neonatal nursing vacancies are reducing and medical staffing is broadly stable, although some gaps remain. The most significant neonatal workforce risk is AHP and psychology provision, where staffing remains below recommended standards and recruitment and business case development continue.

3. KGH MatNeoIST IMPROVEMENT PROGRAMME

The NHS England Maternity and Neonatal Improvement Support Team (MatNeoIST) programme is aligned within a single PSIP assurance framework bringing together CQC, Ockenden and emerging AMOS themes. The NHS England Quality Improvement Group received evidence on 23 September 2026, the MatNeoIST and Perinatal Safety Improvement Programmes continue to make demonstrable progress, with improved assurance ratings, stronger governance arrangements, implementation of PSIRF, enhanced service-user engagement and development of a number of clinical pathways. Progress is evident in community midwifery, induction of labour, homebirth services, neonatal improvement and workforce planning. Key delivery risks remain in relation to elective caesarean pathways, diabetes services, workforce resilience, OPEL training and guideline harmonisation, all of which continue to receive focused executive oversight.

Assurance increased by 4.3% to 21%. Progress is strongest in governance and workforce, while targeted recovery remains focused on elective caesarean pathways, cross-site processes and operational resilience. Delivery is progressing across clinical pathways, governance, workforce, service-user voice and neonatal improvement. The immediate focus is converting established plans into implemented, measurable and sustained practice.

Priorities for the next 30-60 days are to Fast-track elective CS pathway finalisation and align delivery with demand and capacity plans, prioritise multi-site manager on-call and OPEL training to strengthen out-of-hours resilience. Progress will continue through QIG, PSIP, UHN PAC and Board-level reporting.

APPENDIX ONE — UHN Assurance and Priority Action Summary

CQC Report	The CQC has upgraded Northampton General Hospital's maternity services rating from Requires Improvement to Good. The inspectors, who visited in March, recognised the "real and meaningful improvements" made across the service since their previous inspection. The report praises the care, compassion, teamwork and professionalism seen throughout the service, alongside improvements in leadership, safeguarding and staff engagement, and recognises how learning, feedback and data are used to drive improvement. The report also highlights positive feedback from women and families, who told inspectors they felt listened to, cared for and supported throughout their maternity journey.
MOSS Safety Alert	MOSS Safety Alert template completed for Northampton General Hospital, combining the first alert received on 30 August and the subsequent second alert on 6 September. This has had input from our multi-disciplinary team and oversight from the MNVP. Executive sign off provided by UHN Chief Nurse/ Interim Managing Director. At this stage, initial reviews have not identified any acts or omissions in care that are considered to have contributed to the outcome. However, investigations remain ongoing under the PSIRF framework. We have summarised the outcome of this safety check as GREEN/AMBER - there is at least one known safety issue in our intrapartum service, with a plan of action already in place and progressing as planned.
The Thirlwall Inquiry	The Thirlwall Inquiry highlights significant NHS-wide lessons relating to patient safety, safeguarding, leadership accountability and organisational culture, following failures to act on concerns, weaknesses in governance arrangements and insufficient support for challenge and escalation. The Inquiry makes recommendations across 17 areas, including safeguarding, mortality review, data reporting, employment practices, staff training, bereavement care, system interoperability and stronger regulatory oversight. UHN's initial assessment indicates that many of the themes align with existing work already underway, including perinatal safety improvements, PSIRF, Freedom to Speak Up, Martha's Rule and cultural improvement programmes. However, the report reinforces the need for leaders to listen, respond and act decisively when concerns are raised. Approximately 13 of the 17 recommendation areas are expected to have direct implications for UHN, with a Trust-wide gap analysis planned to identify required changes, resource implications and governance arrangements. The key message is that the Inquiry extends beyond neonatal care and serves as a reminder that effective patient safety depends on robust escalation processes, clear accountability and a culture where concerns are heard, challenged and acted upon.
Martha's Rule	In response to the death of Martha Mills, and other cases related to the management of deterioration, the then Secretary of State for Health and Social Care and NHS England committed to implement 'Martha's Rule' – a patient safety initiative as part of a wider NHS strategy to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon. The 3 components of Martha's Rule are as follows: 1. Patients will be asked, at least daily, about how they are feeling and if they are getting better or worse, this information will be acted on in a structured way 2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to 3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital

Patients, family, carers and staff close to the patient can often notice early and subtle signs of deterioration that may be missed by hospital teams that are not as familiar with the patient. NHS England's 'Martha's Rule' project, aims to ensure that there is robust guidance and processes for in-patient-carer escalation.

UHN currently have Martha's Rule components 2 & 3 imbedded in maternity. With regards to component 1, a working group is to be established to consider MEWS and Patient Wellbeing Questionnaire (PWQ) on NerveCentre.

APPENDIX TWO — UHN August 2026 Perinatal Performance Summary

Activity	595 births; induction rate 22.2%; OPEL 1 for 85% and OPEL 2 for 15%; no suspensions and one obstetric led divert
Safety and outcomes	One PSII and one MNSI referral (both KGH); ten moderate or above-harm incidents under review; four SPEN referrals; one MOSS level 1 safety alert was received at NGH at the end of August due to 4 stillbirths and 1 neonatal death in the last three months; tears 1.4%; major PPH 2.5%
Workforce and training	Midwifery vacancy 12.9% - 10.9% KGH and 6.3% NGH; safe staffing 98.5%; neonatal AHP gaps of 5.81 WTE at KGH and 3.8 WTE at NGH; NGH neonatal QIS compliance 68% against the 70% BAPM standard; NGH anaesthetic PROMPT compliance remains at 76% against the 90% requirement
Triage and flow	UHN maternity triage performance continues to improve, with BSOTS well embedded and documentation compliance remaining strong across both sites. KGH has demonstrated sustained improvement across most ongoing-care measures, while NGH achieved target for midwifery Yellow reviews (80.8%) and exceeded target for medical Green reviews (96.5%). The principal areas requiring further improvement are initial assessment within 15 minutes and timely Orange-category reviews, particularly during periods of high demand, workforce pressure and increased clinical acuity. Mitigating actions include reviewing breaches, reducing scheduled activity within triage, strengthening alternative pathways, workforce and demand modelling, and continued monthly governance oversight.
Experience and equity	Patient and staff feedback highlights pressures from workforce capacity, rising acuity and estate constraints, alongside positive consultant engagement and multidisciplinary working. At the end of August there were a total of 51 open complaints with four opened for over 120 days. The highest areas of pressure were complaints with the division for investigation, cases awaiting information or local resolution, and responses moving into drafting / LOR progression. There are eight complaints requiring high-risk or enhanced oversight, indicating that the key issues continues to be timely progression, clear ownership and active oversight.

Positive Assurance	Priority Actions and Escalations
• Low five-minute APGAR rates, severe perineal trauma and breastfeeding initiation all performed favourably against thresholds • UHN operated at OPEL 1 for 85% of August and maintained one-to-one care in labour across both sites • Overall training compliance remains strong, including 98% PROMPT attendance and 98–100% fetal-monitoring compliance • Most Maternity Incentive Scheme evidence requirements are on track, complete or assured at both sites • Recruitment is improving maternity and neonatal workforce resilience, supported by new starters and the Graduate Promise scheme • Patient feedback and multidisciplinary engagement remain positive, while maternity-triage performance is improving across both sites	• Continue enhanced surveillance and delivery of actions following the NGH MOSS Level 1 alert associated with recent perinatal mortality • Address preterm births at 8.9% against a 6% target and PPH ≥1,500ml at 5.92% against 3.7%, including focused review of KGH performance • Recover NGH anaesthetic PROMPT compliance, currently 76% against the 90% requirement, ahead of the MIS submission • Progress recruitment and the business case for neonatal AHP and psychology provision, where a 5.43 WTE residual gap is forecast • Reduce maternity red flags—particularly delayed or cancelled time-critical activity—and strengthen rota resilience and workforce deployment • Improve complaint progression and oversight; • Validate and improve emergency caesarean, induction-of-labour and triage response times, with particular focus on higher-acuity pathways

Perinatal Quality Assurance Scorecard

September 2026 (August 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	Clinical Quality and Safety - Neonates	

11	Maternity Workforce	
12	Neonatal Workforce	
13	Operational and Capacity	
14	Training and Compliance	
15	Safety Actions	
16	Experience and Feedback	
17	Spotlight on...	
18	Appendices	



The month in review:

August demonstrated continued progress across maternity and neonatal services, with recruitment strengthening workforce resilience and most training and quality indicators providing positive assurance. Operational pressures reduced, with services operating at the lowest escalation level for most of the month. Key areas requiring continued focus include the MOSS safety response and perinatal outcomes, preterm birth, timely complaint resolution, NGH anaesthetic PROMPT compliance and workforce gaps, particularly neonatal AHP and psychology provision. Recruitment, strengthened safety surveillance and targeted improvement actions remain priorities, alongside the planned September KGH MOSS drill to test preparedness, escalation and organisational learning.

Clinical Quality and Safety:

- Escalate: NGH MOSS Level 1 safety alert / stillbirths
- Exception review: Incident investigation timeliness and maternity pathway delivery
- Watch: MNSI / PSII activity and UHN safety-mortality triangulation
- Assurance: Perinatal MDT review completed; KGH MOSS preparedness.

Clinical safety surveillance A MOSS Level 1 safety alert was received at NGH following the surveillance signal of four stillbirths and one neonatal death within the relevant MOSS review period. The Perinatal MDT review is complete and a formal response has been submitted. Focus is required on timely investigation and learning, maternity pathway delivery and strengthened UHN-wide triangulation of safety and mortality intelligence. Most incidents resulted in low or no harm. A September MOSS drill at KGH will provide further assurance of organisational preparedness and escalation arrangements.

Operational & Capacity:

- Escalate: Delays/cancellations of time-critical activity
- Exception review: Coordinator deployment to clinical care / red flag events
- Watch: Rota resilience, workforce capacity and deployment
- Assurance: 85% at lowest escalation level; 1:1 care maintained; no service suspensions.

Operational surveillance shows improved performance in August, with maternity services operating at the lowest escalation level for 85% of the period. Workforce and capacity pressures remain, particularly time-critical activity and maintaining coordinator supernumerary status. One-to-one care in labour was maintained, and no obstetric-led services were suspended. Recruitment continues to support workforce stabilisation. Priorities remain reducing red flags, strengthening rota resilience and maintaining recruitment, retention and staff wellbeing.

Patient Experience:

- Escalate: None identified
- Exception review: Complaint timeliness and ownership
- Watch: Workforce and environmental pressures
- Assurance: Positive FFT performance and multidisciplinary working.

Experience surveillance shows positive patient feedback, with FFT performance at or above target. Complaint management remains a priority, with the revised process strengthening oversight, timeliness and learning. Staff feedback highlights workforce and environmental pressures alongside positive multidisciplinary working. Focus remains on improving complaint resolution, addressing workforce and estate concerns, and translating patient and staff feedback into measurable service improvement.

Outcomes:

- Escalate: Stillbirths / MOSS signal, preterm birth
- Exception review: KGH PPH $\geq 1500\text{ml}$
- Watch: Smoking at booking and smoking at birth
- Assurance: APGAR <7 , severe perineal trauma, breastfeeding initiation.

Clinical surveillance identifies stillbirths, preterm birth and PPH $\geq 1500\text{ml}$ as the key areas for focused oversight. The UHN stillbirth position requires continued surveillance alongside the MOSS response. Preterm birth remains above the 6% target at 8.9% although this has improved from 9.65% in July. PPH $\geq 1500\text{ml}$ increased to 5.92% across UHN in August, above the 3.7% target, driven particularly by the KGH increase to 7.66%; focused review and continued surveillance are required. Other indicators are broadly stable or improving, with smoking remaining under continued surveillance.

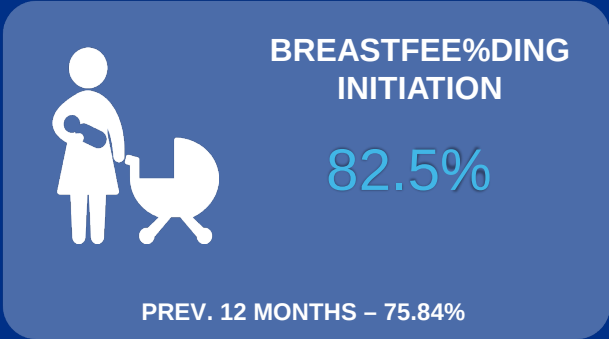
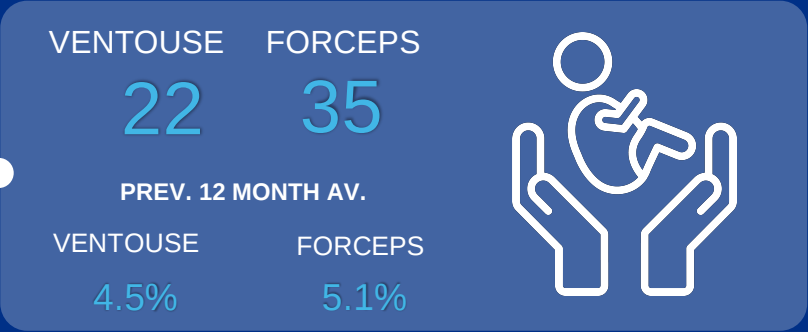
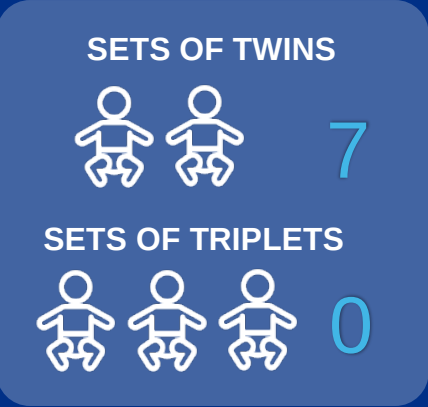
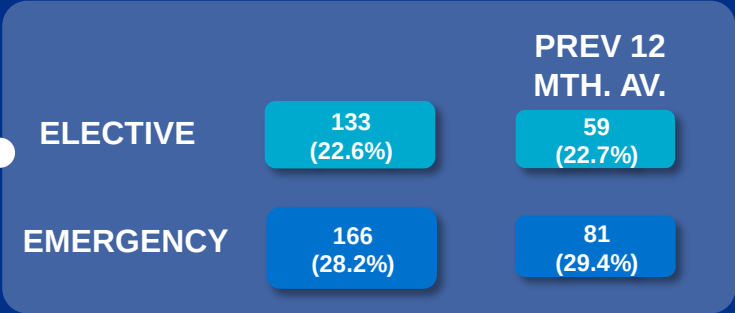
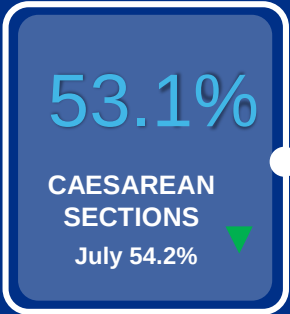
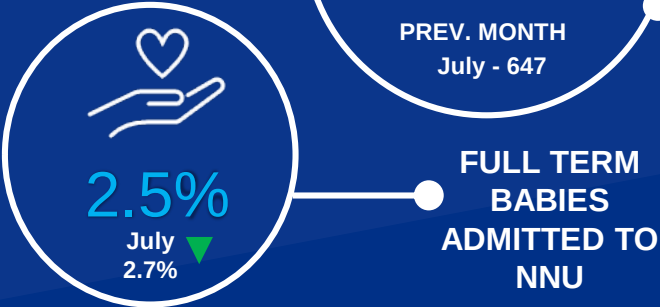
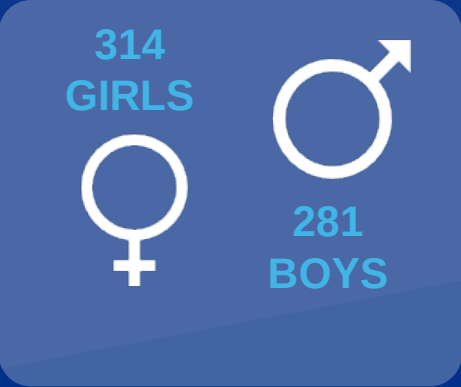
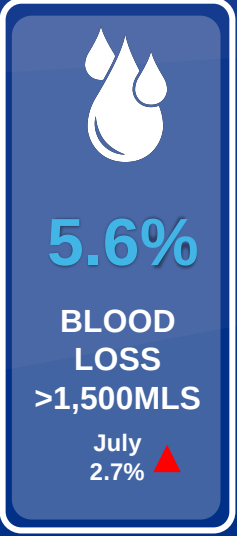
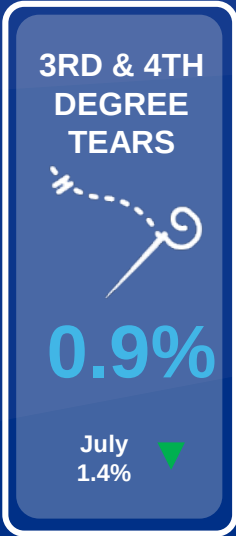
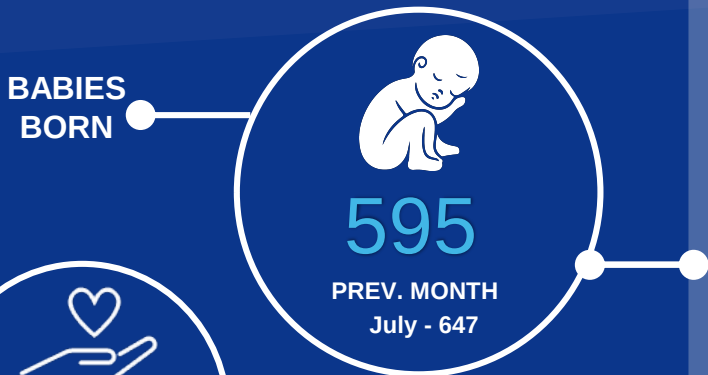
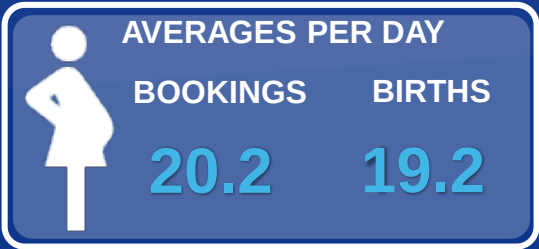
Training compliance:

- Escalate: NGH anaesthetic PROMPT compliance, currently 76% against the 90% requirement.
- Exception review: Recovery plan and additional PROMPT capacity for anaesthetic staff ahead of MIS submission.
- Watch: Sustained compliance across all professional groups and alignment of training with safety priorities.
- Assurance: Overall PROMPT attendance is 98%, with obstetric consultants, doctors and maternity support workers achieving 100% in August. Fetal monitoring compliance is 98–100%, and neonatal life-support training remains 95–97%, demonstrating strong compliance across most areas. Overall training compliance remains strong, with focused improvement required in NGH anaesthetic PROMPT attendance to achieve sustained MIS compliance and assurance.

Workforce:

- Escalate: Neonatal AHP and psychology provision
 - Exception review: NGH midwifery and obstetric vacancies
 - Watch: KGH maternity support worker vacancies
 - Assurance: Recruitment progressing; neonatal nursing vacancies reducing
- Workforce surveillance** shows improving resilience, supported by recruitment and new starters. Midwifery vacancies remain a focus at NGH, with KGH recruitment targeting maternity support worker gaps. Obstetric staffing has improved at KGH, with recruitment continuing at NGH. Neonatal staffing is broadly stabilising; however, AHP and psychology provision remains the key workforce risk, with staffing below recommended standards and recruitment and business case development ongoing.

August 2026 UHN AT A GLANCE



August 2026 AT GLANCE



AVERAGES PER DAY

BOOKINGS

KGH 9.3
NGH 10.9

BIRTHS

KGH 8.0
NGH 11.2

BABIES BORN



595

KGH 249
NGH 346

July UHN : 647



BIRTH LOCATION

KGH
(Labour Ward)

221

OOA

23

HOME

5

NGH
(Labour Ward)

320

BIRTH
CENTRE

16

HOME

10

3RD & 4TH DEGREE TEARS

KGH

0.4%

July

1.1%

NGH

2.6%

July

1.7%

BLOOD LOSS

>1,500MLS

KGH

7.7%

July

2.5%

NGH

4.5%

July

2.8%

GIRLS

KGH 140
NGH 174



BOYS

KGH 109
NGH 172



KGH 2.4%
NGH 2.6%

FULL TERM BABIES ADMITTED TO NNU

INDUCTION OF LABOUR (IOL)

KGH 23.4%
NGH 21.8%

PREV. 12 MONTHS - 30.4%

PREV. 12 MONTHS - 24.0%



UHN CAESAREAN SECTIONS

53.1%

KGH 51.2%
NGH 53.3%

ELECTIVE

KGH

49

(19.8%)

55

(23.5%)

NGH

83

(24.9%)

78

(22.8%)

EMERGENCY

KGH

75

(30.2%)

178

(22.8%)

NGH

95

(28.4%)

90

(26.3%)

PREV 12 MTH. AV.

SETS OF TWINS



KGH 1
NGH 6

SETS OF TRIPLETS



KGH 0
NGH 0

ASSISTED BIRTHS

KGH 28
NGH 29

VENTOUSE

KGH 14
NGH 8

PREV. 12 MONTH AV.

VENTOUSE
KGH 8
NGH 4

FORCEPS

KGH 14
NGH 21

FORCEPS
KGH 14
NGH 24



BREASTFEEDING INITIATION



KGH 76.7%

NGH 86.7%

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

August 2026 UHN AT A GLANCE

NGH 98%

MDT CLINICAL
SIMULATION
TRAINING
COMPLIANCE (YTD)



97% July

YEAR 8 PROGRESS
MATERNITY INCENTIVE
SCHEME
SAFETY ACTIONS ON TRACK
KGH **6** SAFETY ACTIONS
NGH **5** SAFETY ACTIONS



1

MNSI
REPORTABLE
CASES &
REFERRED

August 2026

MATERNITY FRIENDS &
FAMILY TEST
(PROMOTER %)

98%



VACANCY RATE
(August DATA)

MIDWIVES **10.48%**

CONSULTANT
OBSTETRICIAN **TBC WTE**

NEONATAL NURSES **8.5%**

NEONATOLOGISTS **1 WTE**

NEWBORN LIFE
SUPPORT TRAINING
COMPLIANCE (YTD)

NGH 96%



95% July

10

MODERATE
INCIDENTS
10 July



1

PATIENT SAFETY
INCIDENT
INVESTIGATIONS
(PSII)

0 July

0

CORONER'S
REGULATION 28

0 July

MINIMUM SAFE STAFFING
MET (LABOUR WARD ONLY)

98.5%

95% July



1:1 CARE IN
LABOUR

100%

99% July



August 2026 AT A GLANCE

KGH 96%
NGH 98%

MDT CLINICAL
SIMULATION
TRAINING
COMPLIANCE (YTD)



YEAR 8
MATERNITY INCENTIVE
SCHEME

SAFETY ACTIONS ON TRACK
KGH 6 SAFETY ACTIONS
NGH 5 SAFETY ACTIONS



KGH 1
NGH 0

MNSI
REPORTABLE
CASES &
REFERRED

August 2026

MATERNITY FRIENDS &
FAMILY TEST
(SATISFACTION %)

KGH 92.2%
NGH 98.3%



VACANCY RATE
(November DATA)

MIDWIVES

KGH 7.8%
NGH 9.84%

CONSULTANT
OBSTETRICIAN

KGH TBC WTE
NGH TBC WTE

NEONATAL NURSES

KGH 10.9%
NGH 6.3%

NEONATOLOGISTS

KGH 1 WTE
NGH 0 WTE

NEWBORN LIFE
SUPPORT TRAINING
COMPLIANCE (YTD)

KGH 95%
NGH 97%



KGH 4
NGH 6

MODERATE
INCIDENTS



KGH 1
NGH 0

PATIENT SAFETY
INCIDENT
INVESTIGATIONS
(PSII)

KGH 0
NGH 0

CORONER'S
REGULATION 28

MINIMUM SAFE STAFFING
MET (LABOUR WARD ONLY)

KGH 100%
NGH 97%



1:1 CARE IN
LABOUR

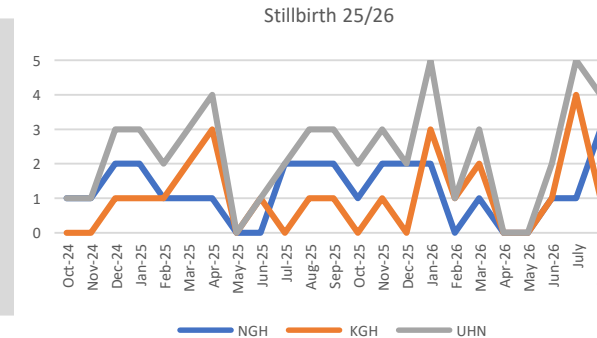
KGH 100%
NGH 100%

Summary

Clinical quality surveillance highlights a mixed but actively managed position across UHN. Stillbirths remain a key area of focus following recent increases and the NGH MOSS Level 1 alert, with enhanced review, monitoring and learning underway. PPH $\geq 1500\text{ml}$ increased to 5.92% across UHN in August, above the 3.7% target, driven particularly by the KGH increase to 7.66%; focused review and continued surveillance are required. APGAR scores below 7 at five minutes demonstrate sustained improvement and are a positive exception, providing assurance on immediate newborn outcomes. Priorities remain early identification of emerging trends, robust multidisciplinary review, shared learning and delivery of targeted improvement actions across both maternity services.

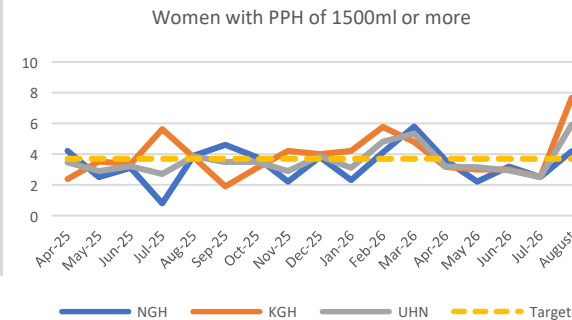
Stillbirths

Stillbirth numbers continue to fluctuate across UHN, with a recent increase requiring enhanced surveillance and review. The NGH MOSS Level 1 alert has prompted multidisciplinary review and a formal response, with learning and actions being closely monitored. All stillbirths undergo established review processes to identify potential contributory factors and opportunities for improvement. Perinatal mortality, incidents and wider safety intelligence will continue to be triangulated across both maternity services to identify emerging themes early. A planned MOSS drill at KGH in September will further test escalation arrangements, strengthen preparedness and support shared learning across UHN to improve safety and outcomes.



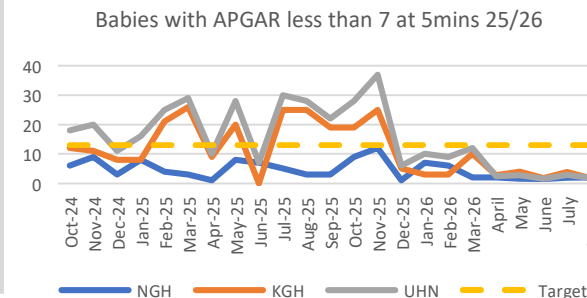
Post Partum Haemorrhage

PPH $\geq 1500\text{ml}$ shows month-to-month variation across UHN, with the overall position generally close to the 3.7% target. August shows a notable increase at KGH, while NGH remains around target, requiring focused review to understand whether this represents isolated variation or an emerging trend. PPH cases will continue to be reviewed for common themes, including risk assessment, prevention, recognition, escalation and management. Site-level performance will be closely monitored and triangulated with incident and safety data. Learning from case reviews will inform targeted improvement actions, with escalation through maternity governance if sustained deterioration or recurrent themes are identified.

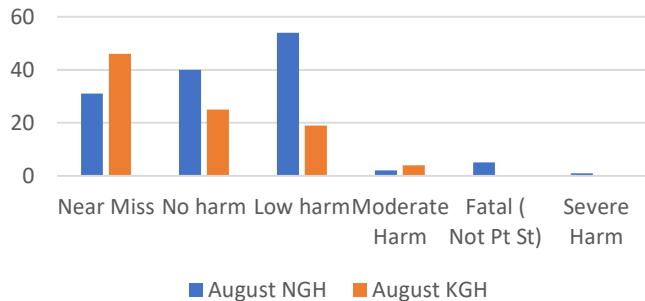


Babies with APGAR less than 7 at 5 mins of birth

APGAR scores below 7 at five minutes are a positive exception, with performance showing sustained improvement across UHN. Following higher levels and variation during 2025, the number of babies with a low five-minute APGAR has reduced markedly during 2026 and remained consistently below the target threshold in recent months. This provides positive assurance regarding immediate newborn outcomes. Performance will continue to be monitored at both sites to ensure improvement is sustained, with any deterioration or emerging variation reviewed alongside neonatal outcomes, incidents and other maternity safety intelligence to identify learning and opportunities for further improvement.

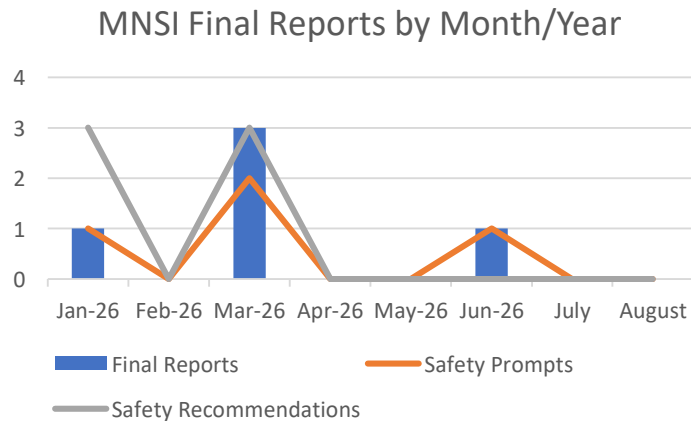


Incidents and Events
August



MNSI Cases	Current Month	Prior Month
Referred	1	0
Accepted	1	0
On going	2	2

PSII Casses	Current Month	Prior Month
Commissoned	1	0



What the data is telling us

August data demonstrates that most reported incidents resulted in low or no harm, although variation in the incident profile between KGH and NGH requires continued triangulation. Maternity safety investigation activity remains ongoing, with one new MNSI referral accepted, two cases ongoing and one PSII commissioned. Perinatal mortality surveillance has identified an emerging signal at NGH, with a MOSS Level 1 alert following four August stillbirths and one neonatal death in the preceding three months; a Perinatal MDT response to be submitted by 16 September. Continued oversight of incident, mortality and investigation data is required to identify themes early and ensure learning is translated into improvement.

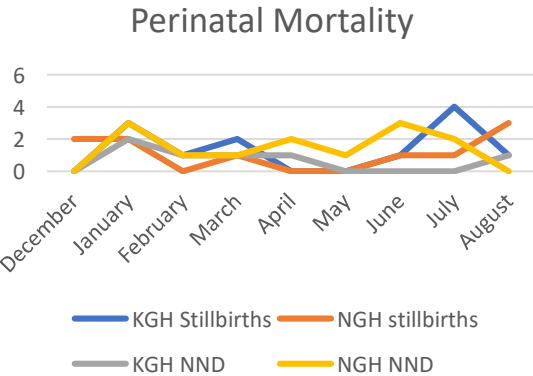
Areas of Focus

- Analysis of August data highlights a growing concern regarding the number of overdue Datix Investigations. This remains a challenge across the Group and requires continued focus to ensure timely review, closure and dissemination of learning from reported incidents.
- The recent NGH Level 1 Maternity Outcome Signal System (MOSS) response has identified two key areas requiring targeted improvement. These include improving Category 1 and 2 caesarean section decision to birth times, and reducing delays between admission for Induction of Labour and commencement of the IOL pathway.
- Ongoing triangulation of incidents, complaints, mortality reviews and wider safety intelligence remains essential to ensure emerging risks are identified early and acted upon appropriately.

Improvement Actions

- Develop and implement a UHN wide Maternity Incident Investigation guideline to ensure a consistent approach to incident investigation, learning identification and dissemination of all learning across maternity services
- Implement and monitor actions arising from the MOSS response to improve Category 1 and 2 caesarean section decision to birth timings, including a review of theatre availability, workforce deployment, escalation processes and MDT responsiveness.
- Strengthen oversight of IOL pathways, focussing on reducing delays from admission to commencement of induction through improved capacity management, flow co-ordination, and escalation of delays.
- Ensure timely staff debrief and wellbeing support following MNSI referrals and PSII cases, facilitating learning, reflective practice and staff engagement throughout the investigation process.
- Reduce the number of overdue Datix investigations through strengthened governance oversight, clear accountability and regular monitoring of investigation completion times

Perinatal Mortality



	Moss Signals	SPEN Referrals
KGH	0	2
NGH	1	2

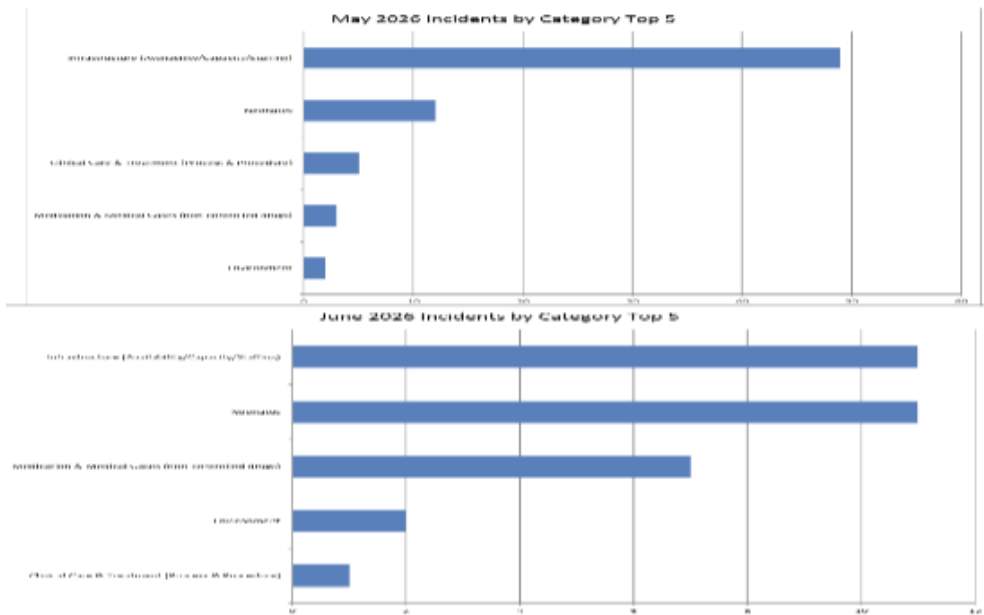
- In August there was 4 SPEN referral across UHN, a decrease from July 2026
- A MOSS level 1 safety alert was received at NGH at the end of August due to 4 stillbirths and 1 neonatal death in the last three months. A Perinatal MDT response has been submitted

CQC Maternity Rating

	2023 KGH	2022 NGH
Are services safe?	●	●
Are services effective?	●	●
Are services caring?	●	●
Are services responsive?	●	●
Are services well-led?	●	●
Overall	●	●

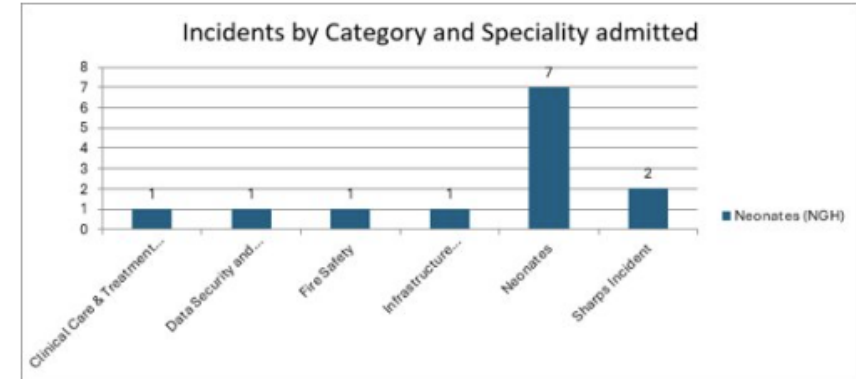
★ Outstanding ● Good ● Requires Improvement ● Inadequate

KGH

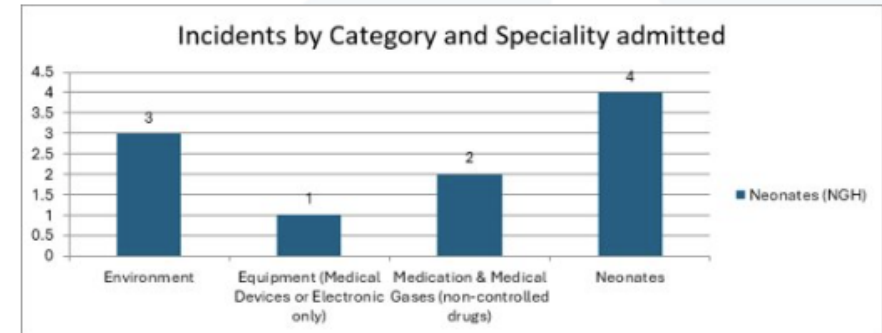


Total of 73 incidents reported in May and 33 incidents reported in June. The drop is due to Transitional Care staffing unavailability being reported as a single incident at month-end rather than daily. Neonates reported 1 moderate, 2 severe and 1 severe psychological harm. 1 case related to a baby transferred for therapeutic cooling who sadly died on day two and has been reported as an MNSI. The remaining 3 harms related to a single extremely preterm infant (26+6 weeks gestation) requiring resuscitation and transfer to a tertiary centre. The baby has since been repatriated and is progressing well on the neonatal unit. The case has been to IRG and is awaiting further information for harm grading confirmation.

NGH May



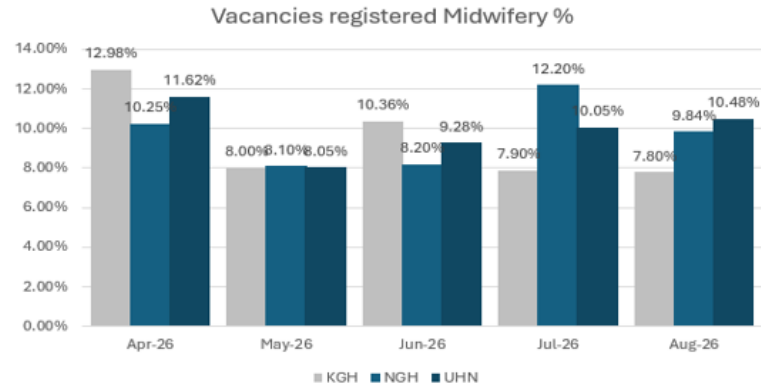
June



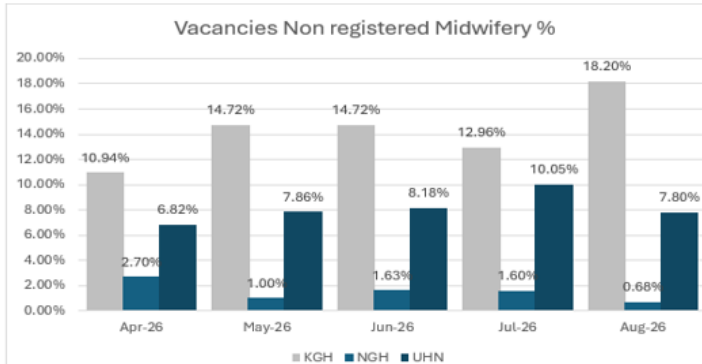
23 datix reports for May and June 2026

- No moderate harm or above datix
- There were no identified themes
- No AAR's or patient safety investigations declared or ongoing.

Midwifery vacancy



MSW VACANCY



Midwifery Workforce

UHN continues to make positive progress in midwifery recruitment to support workforce resilience across both sites. At KGH, the vacancy rate reduced to 7.8%, (13.10 WTE) with new starters joining the service and interviews planned to fill vacant posts. At NGH, the vacancy rate is 9.84% (28.40 WTE) following an increase in the funded establishment, with additional recruits progressing through pre-employment checks and professional registration. UHN has also secured a successful bid for 11 WTE newly qualified midwives through the national Graduate Promise scheme, with recruitment due to commence shortly. These initiatives are expected to further strengthen workforce capacity and support safe and sustainable maternity services across the Trust. MSW Vacancies remain high at KGH recruitment is underway

Obstetrician Consultant Workforce

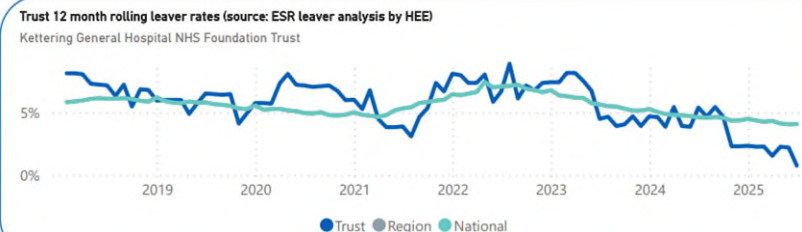
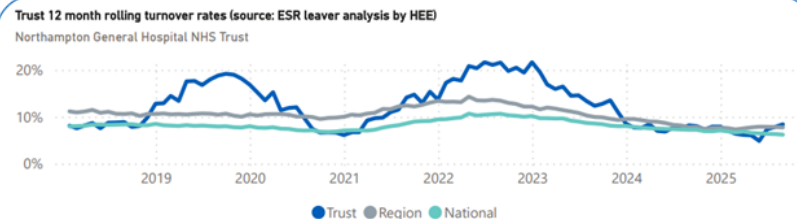
Kettering General Hospital

Consultant workforce stability at KGH has improved, with two fixed term NHS Consultants in post. Further substantive recruitment planned to strengthen capacity. Obstetric anaesthetic services remain fully staffed, and the neonatal medical workforce is compliant with BAPM standards following recent recruitment activity. Overall, the service is in a stronger position, with workforce planning focused on maintaining resilience and supporting sustainable service delivery.

Northampton General Hospital

Recruitment activity continues within the obstetric consultant workforce at NGH, with one recently appointed consultant now in post and additional vacancies progressing through recruitment processes. Whilst temporary rota gaps remain due to annual leave, LT sickness and locum turnover, plans are in place to secure substantive appointments and improve long-term workforce sustainability.

UHN 12 month rolling leaver rate

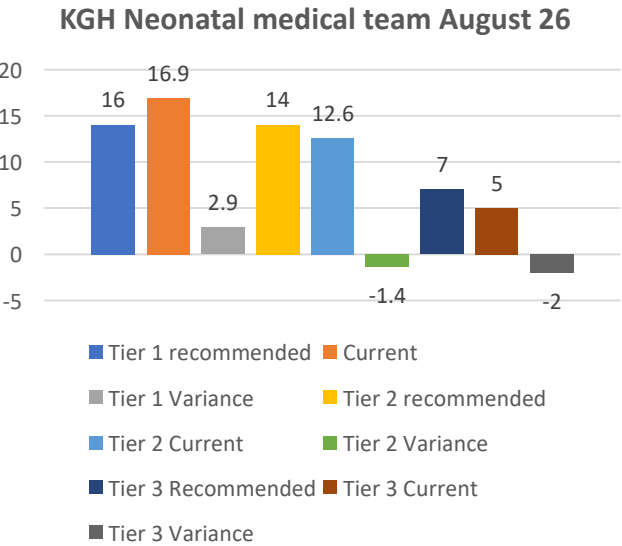


WORKFORCE – Neonates and AHP&P

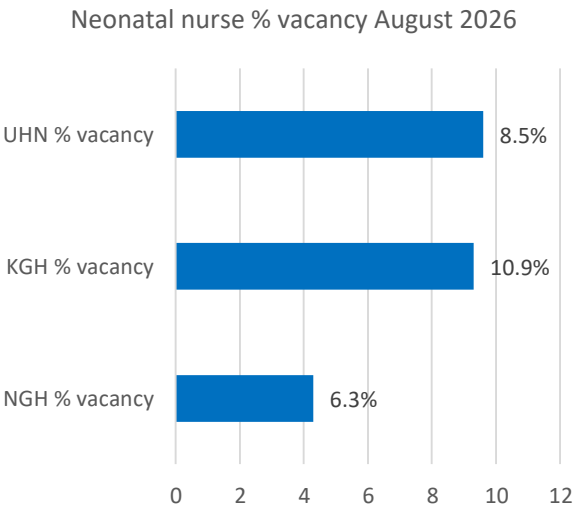
Neonatal medical vacancy

NGH Neonatal Medical Workforce

- Tier 1: BAPM compliant; 24/7 dedicated cover maintained
 - Tier 2: 16 WTE funded; recruitment ongoing; temporary cover supporting rota resilience
 - Tier 3: 7 WTE; BAPM compliant
- Key focus: Secure substantive Tier 2 recruitment and reduce reliance on locum/bank cover while maintaining dedicated neonatal medical cover.



Neonatal vacancy



Neonatal Nurse Staffing

Neonatal nursing vacancies are 6.3% at NGH and 10.9% at KGH, with a combined UHN position of 8.5%. Recruitment is progressing across both sites, with KGH vacancies forecast to reduce to 7.3% following recruitment/new starters. Staff turnover remains low. QIS compliance is improving at 68% NGH and 69.7% KGH, just below the 70% standard, with further QIS training planned for October 2026.

Neonatal AHP&P Workforce

KGH	Band	Recommended WTE	Current WTE Budget	Proposed WTE budget	Current Gap	Proposed gap
Dietitian	7	0.9	0.25	0	0.65	0.65
Physiotherapist	7	1	0	0.7	1	0.3
Occupational Therapist	7	0.88	0	0.2	0.88	0.68
Speech & Language Therapist	7	0.7	0	0.4	0.7	0.3
Psychologist	8b	1.1	0.4	0	0.7	0.7

NGH	Band	Recommended WTE	Current WTE Budget in post	Proposed WTE budget	Current Gap	Proposed gap after Ockenden monies
Dietitian	7	1.1	0.8	0.8	0.3	0.3
Physiotherapist	7	1.4	0.00	0.6	1.4	0.8
Occupational Therapist	7	1.2	0.00	0.2	1.2	1.0
Speech & Language Therapist	7	0.8	0.2	0.4	0.6	0.2
Psychologist	8b	1.4	0.4	0.6 (8a)	1.0	0.4
Pharmacy	8a/7	0.9	0.16	0	0.74	0.74
Advanced Neonatal nurse practitioners	8a	N/A	1.0	N/A	N/A	N/A
	8b	N/A	3.0	N/A	N/A	N/A

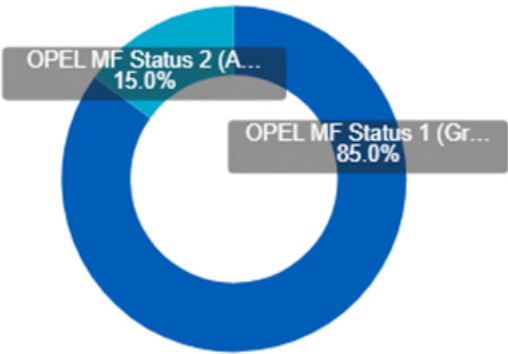
AHP&P Staffing

Both KGH and NGH remain non-compliant with national AHP and Psychology workforce standards, with gaps recorded on the risk register. Current funded establishment is 1.95 WTE against 10.38 WTE recommended. Recruitment to a further 3.0 WTE, funded through recurrent Ockenden monies, is underway. This will leave a 5.43 WTE gap, for which a recurrent funding business case is in progress. No funded physiotherapy or occupational therapy provision is currently available across either neonatal unit.

Key Information

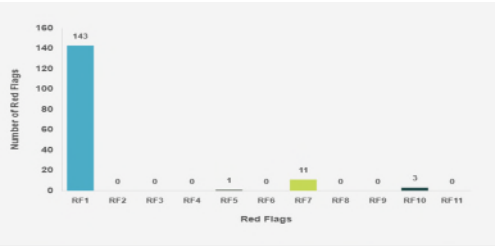
Operational Pressures Escalation Levels

University Hospitals on Northamptonshire
OPEL Maternity Status

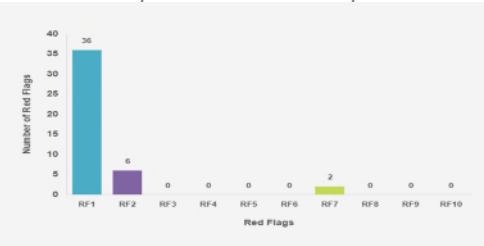


Midwifery Red Flag Events

Kettering General Hospital



Northampton General Hospital



What the data is telling us

In August, University Hospitals Northamptonshire operated at OPEL 1 for 85% of the reporting period and OPEL 2 for 15%. This data suggests that operational pressures improved in August compared to July, with UHN spending more time at the lowest escalation level. A total of 202 maternity red flags were reported across UHN during August. The majority (179) related to RF1: delayed or cancelled time-critical activities. Despite these challenges, 1:1 care in labour was achieved 100% of the time at both NGH and KGH, demonstrating continued compliance with national standards for safe intrapartum care. There were no occasions across UHN where the Labour Ward Coordinator lost supernumerary status while providing 1:1 care. However, at KGH, the Labour Ward Coordinator was required to undertake clinical duties on three occasions, resulting in a loss of supernumerary status when not providing 1:1 care.

What we need to focus on

Whilst operational performance improved during August, with UHN operating at OPEL 1 for 85% of the reporting period, the primary area requiring continued focus is the reduction of RF1 red flags relating to delayed or cancelled time-critical activities, which accounted for 89% of all red flags reported. 1:1 care in labour was maintained 100% across both sites. Coordinator supernumerary status was generally maintained; however, at KGH the coordinator undertook clinical duties on three occasions, requiring continued focus on workforce resilience and deployment. Further work is required to minimise occasions where coordinators undertake clinical duties due to workforce pressures and to address factors contributing to delays in time-critical maternity care activities. Priorities include effective rota management and equitable workforce deployment, alongside a sustained focus on recruitment, retention, and workforce wellbeing to support the delivery of safe, high-quality maternity care.

Performance Levels

Obstetric-led maternity services suspended:

Count: 0 0.0%

Obstetric-led maternity services diverted:

Count: 1 1.7%

Homebirth services suspended:

Count: 2 3.3%

MLU suspended:

Count: 1 1.7%

In-Utero Transfers – extreme preterm births (Northamptonshire)

KGH 0

NGH 0

HB services suspension reported, due to being in soft launch mode only – reporting changed 14 July to reflect being able to meet full provision

What is going well

UHN continues to make positive progress in midwifery recruitment to support workforce resilience across both sites. At KGH, the vacancy rate reduced to 7.8%, (13.10 WTE) with new starters joining the service and interviews planned to fill remaining posts. At NGH, the vacancy rate is 9.84% (28.40 WTE) following an increase in the funded establishment, with additional recruits progressing through pre-employment checks and professional registration. Alongside improved rota oversight, effective workforce planning, and strong financial governance, sustained recruitment activity will help to improve workforce stability, maintain safe staffing levels, and support the delivery of high-quality maternity care across UHN.

Training compliance

Attendance – All Staff

Module 3: Maternity emergencies and multiprofessional training:

Kettering General Hospital

	APR	MAY	JUNE	JULY	AUG
Prompt Midwives	95%	94%	90%	96%	96%
Prompt Doctors Cons	93%	100%	100%	100%	100%
Prompt Doctors Reg	100%	100%	100%	100%	100%
Prompt Anaesc Cons	71%	86%	100%	100%	100%
Prompt Anaes Reg	88%	88%	89%	100%	100%
Prompt MSW	98%	93%	93%	98%	98%

Northampton General Hospital

PROMPT	June	July	August
All Staff	97%	95%	98%
Anaesthetists	83%	76%	76%
Obstetric Consultants	100%	100%	100%
Obstetric Doctors	100%	87%	100%
Midwives	99%	99%	100%
Maternity Support Workers	99%	97%	100%

Module 6: Neonatal Basic Life Support:

	APR	MAY	JUNE	JULY	AUG
NLS Midwives	95%	94%	90%	95%	95%
NLS MSW	95%	93%	93%	96%	96%

NBLS/NLS	June	July	August
Midwives	97%	95%	96%
Maternity Support Workers	95%	97%	97%

Element 4: Fetal monitoring and surveillance:

	APR	MAY	JUNE	JULY	AUG
CTG Day Midwives	94%	94%	92%	98%	98%
CTG Day Consultants	92%	85%	85%	92%	92%
CTG Day Reg	100%	100%	100%	100%	100%
CTG Competency Midwives	94%	94%	92%	98%	98%
CTG Competency DR	98%	96%	96%	98%	98%

Fetal Monitoring	June	July	August
All Staff	99%	98%	99%
Obstetric Consultants	100%	100%	100%
Obstetric Doctors	100%	96%	100%
Midwives	99%	98%	99%

What the data is telling us

Overall compliance is strong across most staff groups, with consistent achievement of 90–100%. However, anaesthetic PROMPT compliance remains below target at NGH, representing a key risk area. Compliance is over the 90% requirement for CNST MIS Year 8 for KGH. Compliance with Obstetric and Anaesthetic teams has been escalated extensively to relevant leads, awaiting actions.

What we need to focus on

The primary area of focus is to accelerate anaesthetic engagement and compliance in PROMPT training at NGH, to mitigate the risk to MIS Safety Action B requirements. This will require targeted scheduling by anaesthetics, strengthened clinical leadership oversight, and clear accountability for delivery. Drop in compliance raised as a risk at Directorate and Divisional Quality and Safety meetings. Work is also required to link training compliance to escalation and safety priorities will be key.

What is going well

Demonstration of forward planning from Practice Development, with allocating additional training places for the backlog of out of date anaesthetic staff into future PROMPT sessions to recover compliance ahead of the November MIS submission. Continued rollout of national programmes such as ABC, supporting further strengthening of team response and patient safety. We had an additional Impacted fetal head training session at KGH in preparation for full implementation.

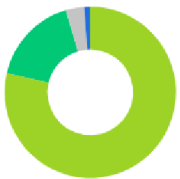
SAFETY ACTIONS

Maternity Improvement Scheme

MIS Safety Action – Year 8	KGH Status	NGH Status
A – Workforce and capacity	In progress	In progress
B - Training	In progress	In progress
C – Learning from reviews and investigations	In progress	In progress
D – Service-user voice and equity	In progress	In progress
E – Care Bundles	In progress	In progress
F – Board Oversight, Governance, Culture and Leadership	In progress	In progress

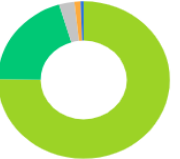
Summary

KGH – all SA evidence



On Track: 78.6%
Complete: 16.8%
Not Yet ... : 3.5%
Assured: 1.2%

NGH – all SA evidence



On Track: 75.1%
Complete: 20.2%
Not Yet ... : 2.9%
At risk: 1.2%

Maternity Incentive Scheme

KGH is progressing all 27 CNST MIS Year 8 standards, with 96.6% of evidence requirements currently on track, complete or assured. Good progress has been made across Workforce & Capacity, Training & Learning from Reviews and Investigations. The current focus is on reviewing the 'not yet evidenced' items and progressing assurance activities ahead of submission. No standards are currently rated as off-track or at risk.

NGH is demonstrating progress across all 27 CNST MIS Year 8 standards, with 95.9% of evidence requirements currently on track, complete or assured. 1.2% was updated to at risk due to a decline in training percentages across Anaesthetic emergency training and Obstetric fetal monitoring. Progress has strengthened by 11.4% within Learning from Reviews & Investigations. Assurance activity will be focused on closing remaining evidence gaps and progressing completed actions through the formal assurance pathway. No standards are currently rated as off-track.

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

Delivery of the Saving Babies' Lives Care Bundle (SBLCB) continues to be monitored through PSIP and MIS. Overall compliance remains strong, particularly for fetal growth restriction and intrapartum fetal monitoring, although variation persists in reduced fetal movements, smoking cessation and diabetes pathways. Work is underway to improve consistency across sites, supported by an updated quarterly report that will identify key areas for improvement and targeted actions. The Quarter two report will have a different reporting approach due to the care bundle no longer being verified by the LMNS.

EXPERIENCE FEEDBACK

Patient Experience

Complaints and Concerns

	Apr-26	May-26	Jun-26	Jul-26	Trend
Maternity KGH	3	3	6	0	↘
Neonatal KGH	0	0	0	0	
Maternity NGH	10	10	12	0	↘
Neonatal NGH	0	0	0	0	

Friends and Family Test (FFT)

Kettering General Hospital

	Target	National	Jun-26	Jul-26	Aug-26	YTD
FFT % Responses	20%	12%	9%	N/A	N/A	9%
FFT % Promoters	96%	93%	98%	89%	92%	96%

Northampton General Hospital

	Target	National	Jun-26	Jul-26	Aug-26	YTD
FFT % Responses	25%	13%	15%	13%	20%	13%
FFT % Promoters	96%	93%	95%	95%	98%	96%



KGH: Staff were very professional, caring, and down to earth. The environment was clean, safe, and tidy. No question was too difficult, and staff genuinely cared about their patients. I felt very safe, protected, and calm, and I never once felt like a burden. I'm so grateful to have been cared for by this Trust and its excellent staff.



NGH: It was good, my consultant was amazing, he ensured my care was looked after, and every member of the team was on top of. Every midwife, student nurse, support worker, consultant, registrar and doctor I come across did their job amazingly.

What the data is telling us

- At the end of August there were a total of 51 open complaints with four opened for over 120 days. The highest areas of pressure were complaints with the division for investigation, cases awaiting information or local resolution, and responses moving into drafting / LOR progression. There are eight complaints requiring high-risk or enhanced oversight, indicating that the key issues continues to be timely progression, clear ownership and active oversight .

What we need to focus on

- The immediate focus is to embed the revised UHN maternity complaints process so that all complaints are visible through the generic mailbox, reviewed at the weekly multidisciplinary complaints meeting, and allocated with clear KLOEs, owners and timescales. This will support stronger grip on outstanding complaints, reduce delays, improve the quality and consistency of responses, and ensure themes from complaints are translated into visible learning and improvement across both KGH and NGH.

Staff Experience

What are staff telling us?	What actions are we taking?
Workforce capacity and increasing patient acuity remain key concerns.	Reviewing workforce models and staffing resilience
Estate and environmental constraints continue to impact staff experience.	Lead for area to complete an environmental risk assessment of fetal medicine and scanning areas and implement agreed mitigations to improve staff and patient experience.
Positive consultant engagement and multidisciplinary working reported. Staff feel listened to and recognise actions arising from Safety Champion feedback.	

What is going on?



5 reasons to have your flu vaccine

1. It has been given to millions of pregnant women worldwide
2. You can have it at any stage of pregnancy
3. It helps to reduce the risk of premature birth
4. It helps to protect the baby in the first few months of life
5. It helps to reduce severe complications during pregnancy



Flu i mmunisation
Helping to protect you against flu

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Product code: 218407TEN001. 1p 50K SEP (APS). To order more copies of this
asset, please visit: <https://find-public-health-resources.service.gov.uk/>
or call 0300 123 1002.

Where can I get my flu vaccination at NGH?

 Maternity Day Unit, Area L,
NGH Monday to Friday, 08:30–
15:30

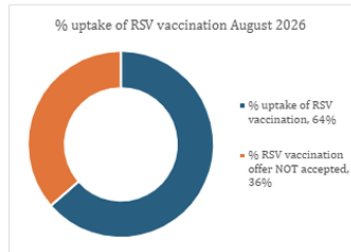
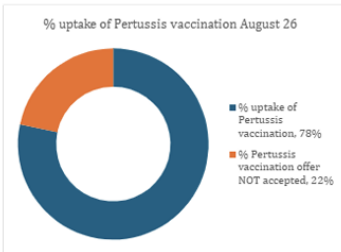
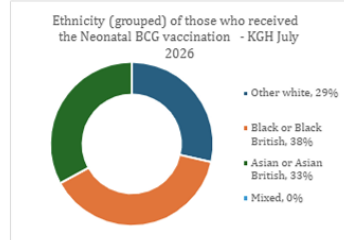
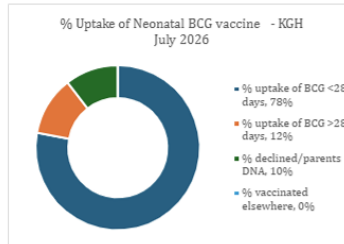
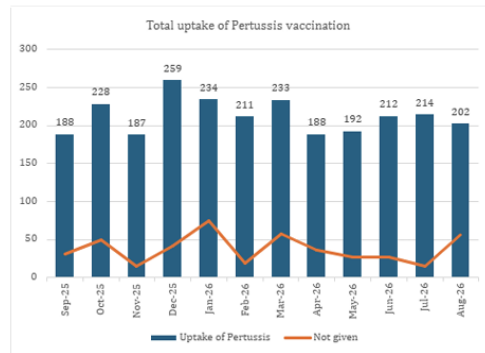
 Far Cotton Maternity Hub Flu
vaccination clinic every Monday,
subject to staff availability.

Flu vaccination can be given at any
stage of pregnancy. Please speak to
your midwife if you have questions
about flu, pertussis or RSV
vaccination during pregnancy.

APPENDICES

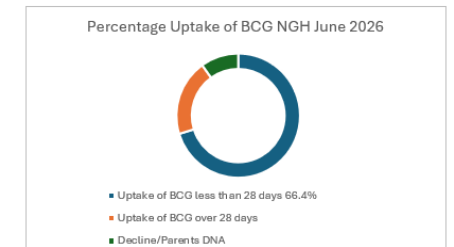
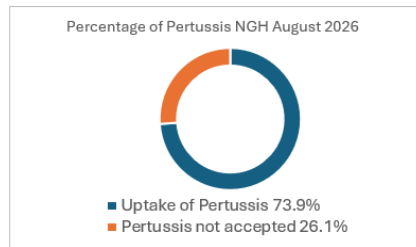
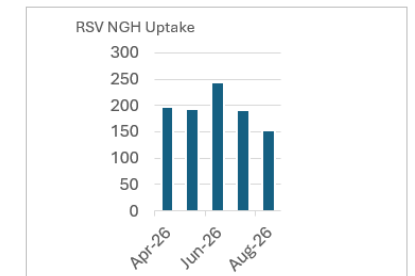
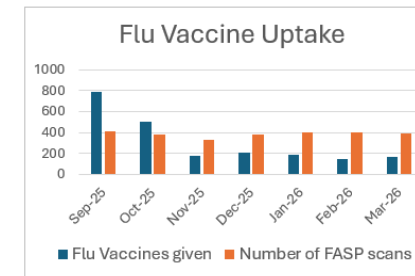
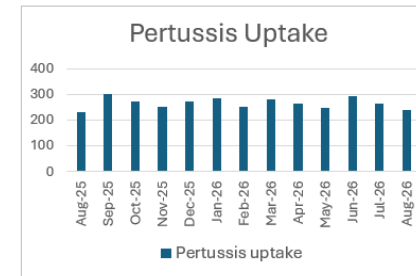
Kettering General Hospital

Immunisation Summary Antenatal Pertussis, RSV, FLU & Neonatal BCG Immunisations – JULY 2026



Northampton General Hospital

Immunisation Summary NGH – August 2026

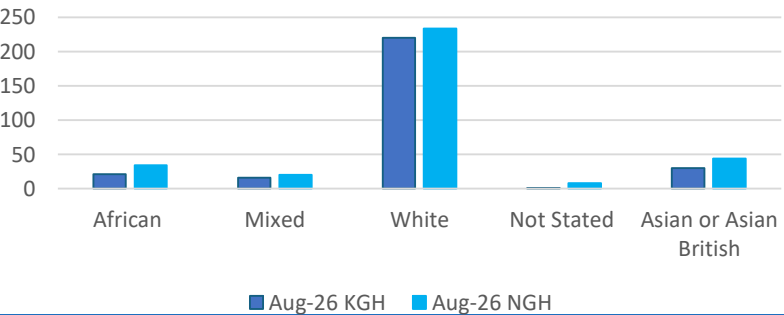


Immunisation remains an important part of protecting pregnant women and babies from serious infection. NGH pertussis uptake was 73.9% in August, with continued focus on improving flu and RSV vaccination. With flu season underway, women & birthing people are being encouraged to discuss vaccination throughout pregnancy and are being signposted to available vaccination clinics. Vaccination conversations will continue at appropriate points in pregnancy, giving women time to make informed choices and access recommended vaccinations. Neonatal BCG vaccination continues for eligible babies. KGH August data has been delayed and will be included in the next scorecard, alongside the updated UHN position.

EQUITY AND POPULATION – August 2026

Ethnic profile and variations

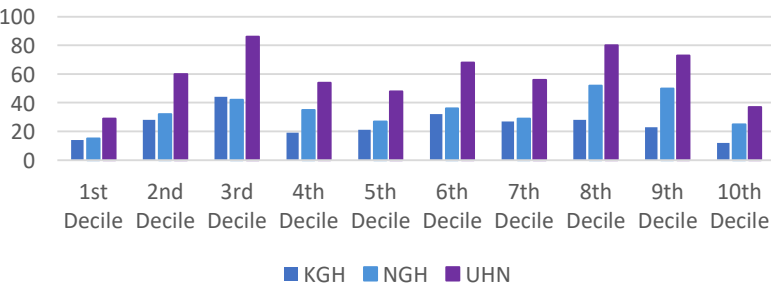
Population profile at booking



August booking data shows a broadly consistent ethnic profile across KGH and NGH, with White ethnicity representing the largest group and smaller African, Asian or Asian British and Mixed populations. Ethnicity recording is well completed, with few 'Not Stated' records. Continued monitoring is required to identify variation in access, experience and outcomes between population groups and support targeted action where inequalities emerge.

Deprivation

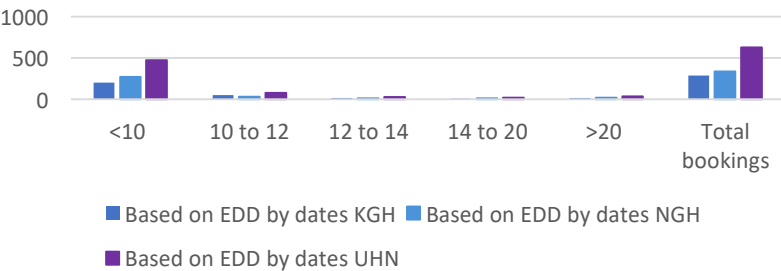
Population profile at delivery



Women accessing UHN maternity services are represented across all deprivation deciles, demonstrating a diverse socioeconomic population. Activity is distributed across both more and less deprived communities, with variation between deciles and sites. Continued triangulation of deprivation with access, clinical outcomes and experience measures will support identification of inequalities and enable targeted interventions for communities experiencing poorer outcomes or barriers to care.

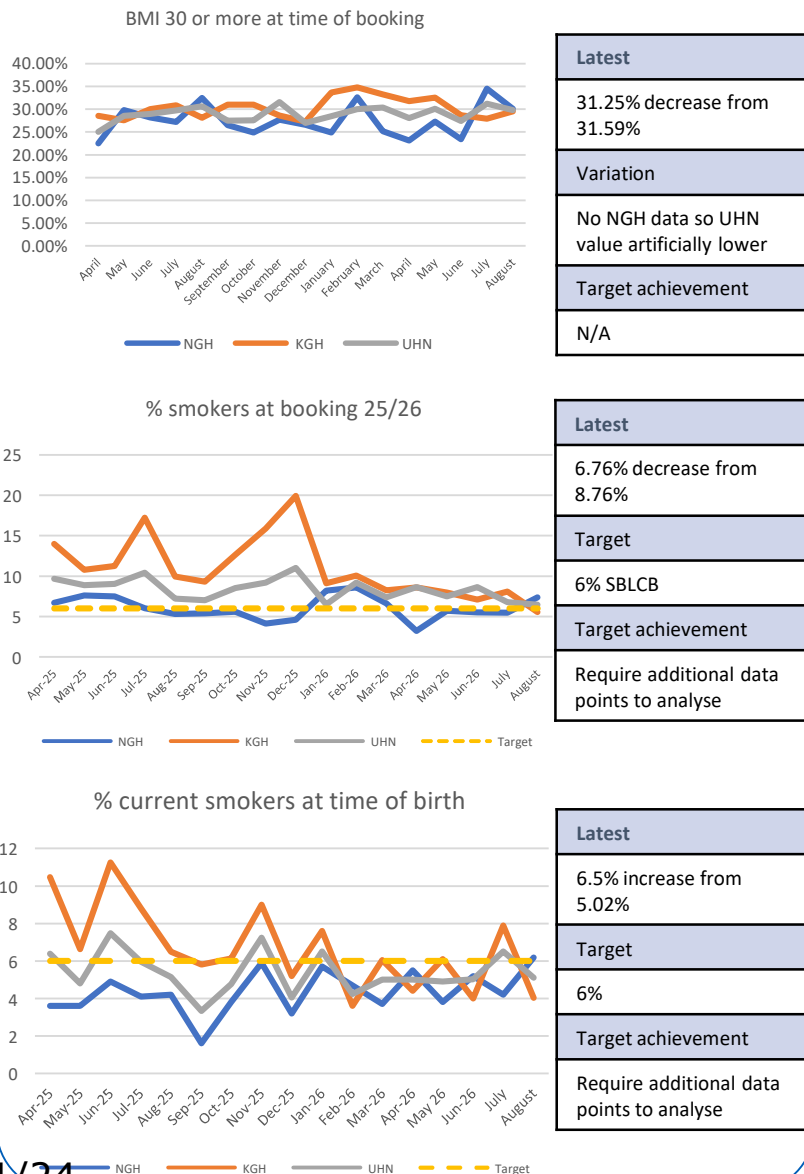
Gestational Age

Gestational age at booking

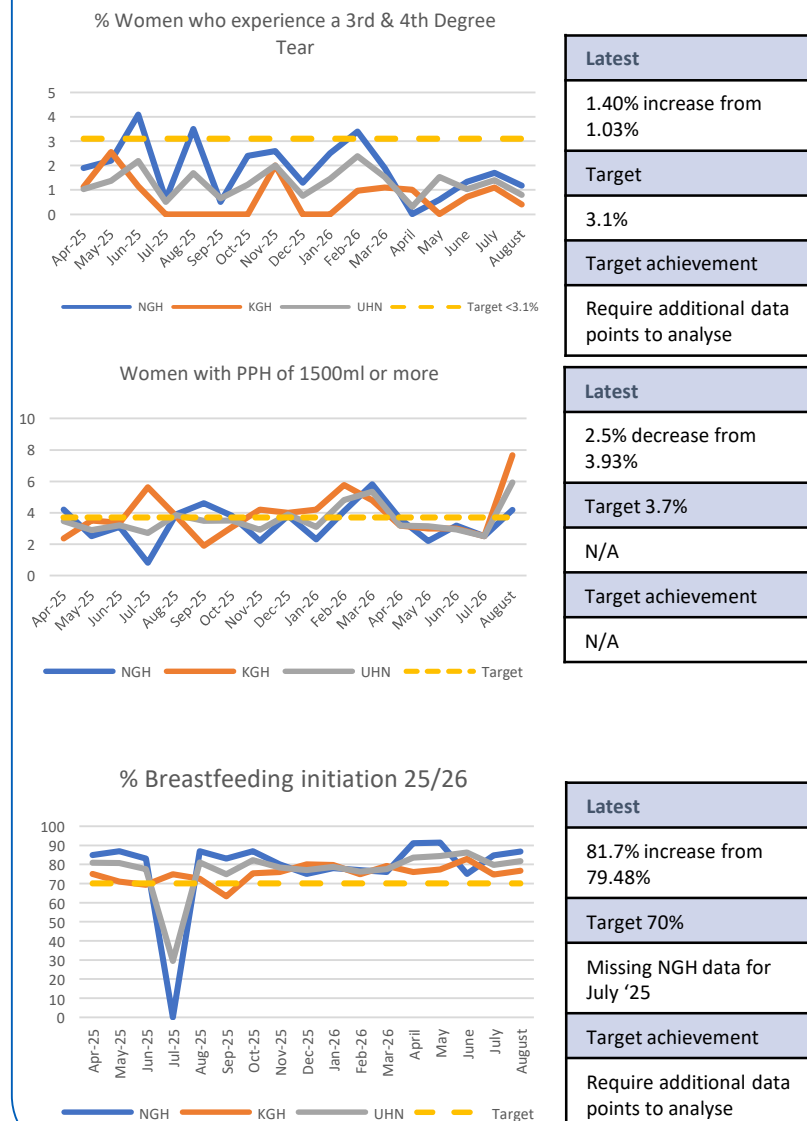


Most women across KGH and NGH book before 10 weeks' gestation, providing early opportunity for risk assessment, screening and personalised care planning. A smaller cohort books later in pregnancy, including after 20 weeks. Continued surveillance of late booking, particularly alongside ethnicity and deprivation, will help identify potential inequalities in access and inform targeted action to improve early engagement with maternity services.

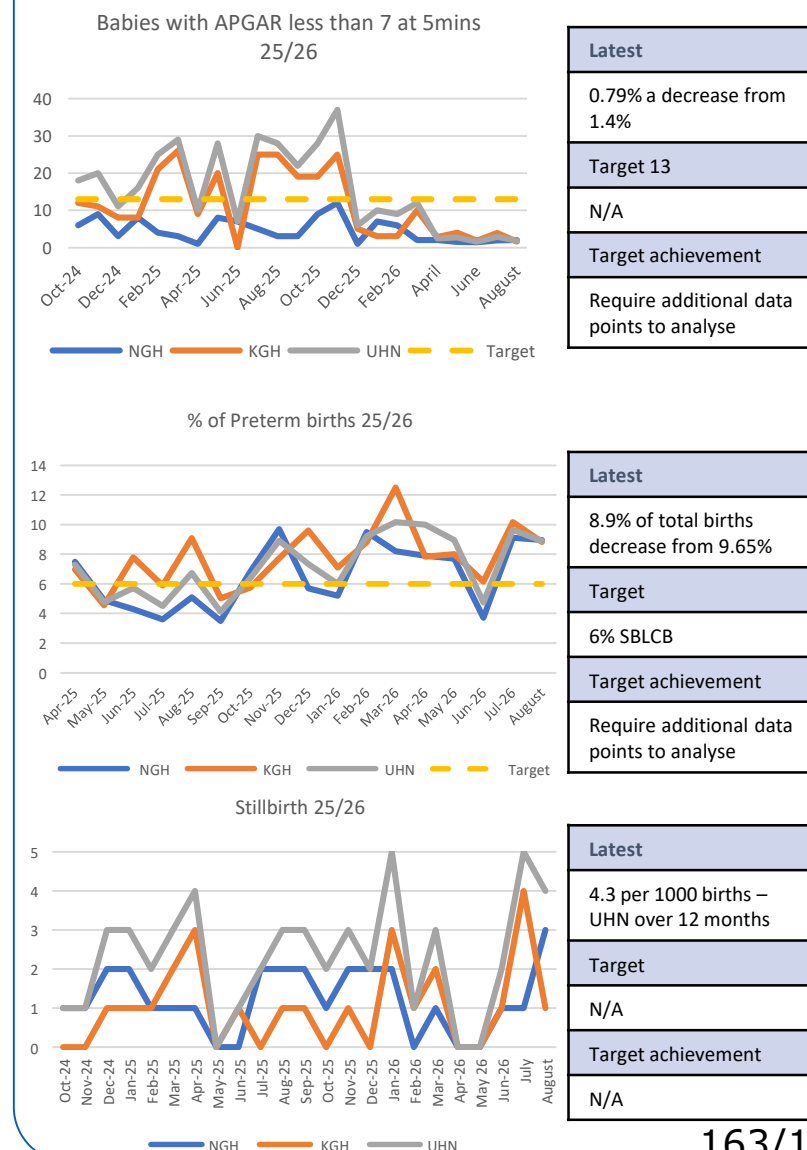
Antenatal



Intrapartum



Outcomes



KGH (June 2026) Data	
Antenatal Steroids	• 100%
Magnesium Sulphate	• 100%
Intrapartum Antibiotics	• 75% (Locally validated data is 100%, being clarified with network data Analyst)
Delayed Cord Clamping (DCC)	• 100%
Temperature on Admission	• 100%
Breastmilk within first two days	• 100% compliance
Breastmilk within first 6 hours:	• 100%
Parental Consultation	• 100% compliance.(ongoing QI project to sustain the compliance within 6 hours of birth)
Parental Inclusion in Ward Rounds	• 45-48%(This is slightly lower than previous month but still remains above average with special cause from Feb 2025. New Hybrid system is being developed and approved by IT to improve the outcome)
ROP	• 100% compliance.
Area of celebration	• KGH has been identified for x3 positive outliers for the NNAP data (ROP, Parent consultation and Magnesium sulphate) with plans in place to improve position by the end of February 2026
NIV	• To be confirmed
Caffeine	• To be confirmed
Hydrocortisone	• Use is variable nationally and is not currently standard practice within EMNODN or at LRI. UHN will review implementation should the lead centre adopt this intervention.

NGH (June 2026) Data	
Antenatal Steroids	• 100%
Magnesium Sulphate	• No eligible mothers
Intrapartum Antibiotics	• 50%
Delayed Cord Clamping (DCC)	• 100%
Temperature on Admission	• 50% (2 eligible babies) one baby was 36.4 degrees
Breastmilk within first two days	• 100% compliance, this stays above the average. QI project for buccal EBM within 6hrs of birth is ongoing.
Breastmilk within first 6 hours:	• 100%
Parental Consultation	• 100% compliance. All had a prompt consultation.
Parental Inclusion in Ward Rounds	• 5% compliance, a slight dip on previous month but has still been above the average since November 2023 with a special cause. Currently getting staff signed up for 'Accurx' parents can then log in to view messages and take secure video calls. Once all staff signed up and trained – will launch the system
ROP	• 100% compliance.
Area of celebration	• NNAP positive outliers for ROP and parent consultation
NIV	• To be confirmed
Caffeine	• 100%
Hydrocortisone	• Use is variable nationally and is not currently standard practice within EMNODN or at LRI. UHN will review implementation should the lead centre adopt this intervention.

Glossary

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

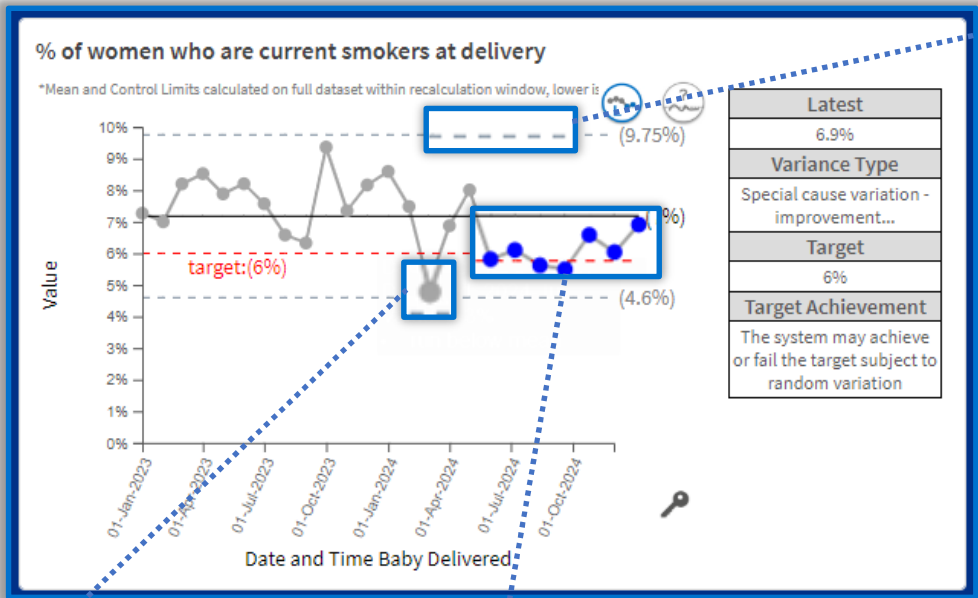
INTERPRETING DATA

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

SPC charts are widely used across the NHS to measure changes in data over time.

There is **strong evidence** that these provide a **better basis for decision making** versus isolated data points.

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**

Cover Sheet

Meeting	Boards of Directors of the University Hospitals of Northamptonshire NHS Group (Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust) meeting together (public)
Date	9 October 2026
Agenda item	8.1

Title	UHN Maternity Services – Thirlwall Inquiry Update
Presenters	Sarah Jamieson, UHN Interim Director of Midwifery
Authors	Sarah Jamieson, UHN Interim Director of Midwifery

Link to Group Priorities (select all that apply)		
Transform Patient Care <i>By strengthening patient safety, safeguarding, clinical oversight, and family escalation routes</i>	Strengthen our Culture <i>By promoting openness, speaking up, visible leadership and clear accountability</i>	Deliver our Financial Plan <i>By identifying potential capital, digital, workforce and recurrent costs through a coordinated Trust-wide gap analysis and options appraisal, enabling prioritised and affordable implementation</i>

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

Reason for Consideration	Previous consideration
The Thirlwall Inquiry highlights significant NHS-wide lessons relating to patient safety, safeguarding, leadership accountability, and organisational culture, following failures to act on concerns, weaknesses in governance arrangements and insufficient support for challenge and escalation. Approximately 13 of the 17 recommendation areas are expected to have direct implications for UHN, with a Trust-wide gap analysis planned to identify required changes, resource implications, and governance arrangements.	N/A

Executive Summary
The Thirlwall Inquiry highlights significant NHS-wide lessons relating to patient safety, safeguarding, leadership accountability, and organisational culture, following failures to act on concerns, weaknesses in governance arrangements and insufficient support for challenge and escalation. The Inquiry makes recommendations across 17 areas, including safeguarding, mortality review, data reporting, employment practices, staff training, bereavement care, system interoperability, and stronger regulatory oversight. UHN's initial assessment indicates that many of the themes align with existing work already underway, including perinatal safety improvements, Patient Safety and Incident Response Framework (PSIRF), Freedom to Speak Up, Martha's Rule and cultural improvement

programmes. However, the report reinforces the need for leaders to listen, respond and act decisively when concerns are raised.

Approximately 13 of the 17 recommendation areas are expected to have direct implications for UHN, with a Trust-wide gap analysis planned to identify required changes, resource implications, and governance arrangements. The key message is that the Inquiry extends beyond neonatal care and serves as a reminder that effective patient safety depends on robust escalation processes, clear accountability, and a culture where concerns are heard, challenged, and acted upon.

Recommendation

The Boards are requested to receive and note the report and to indicate assurance regarding the UHN position and next steps identified.

Appendices
None
Risk and Assurance
UHN11 Positive Safety Culture UHN12 Culture of compassionate, responsive and inclusive care
Financial Impact
No confirmed cost estimate is currently available. Initial screening identifies potentially material capital, digital, workforce and recurrent resource implications. These may include biometric access controls or CCTV for insulin storage, livestreaming baby-monitor technology, improvements to Wi-Fi and system interoperability, enhanced safety-data capability, specialist pathology and medical examiner capacity, safeguarding and bereavement resources, staff training, mortality review, PMA/PNA support, clinical leadership and staff wellbeing provision. Finance, Digital, Estates, Workforce, HR, Medicines Governance, Safeguarding and relevant clinical services will contribute to the gap analysis and options appraisal. Detailed costs and implementation timescales will be determined once the required changes, national guidance, funding arrangements, and dependencies are clearer.
Legal Implications / Regulatory Requirements
The Inquiry makes recommendations across 17 areas and is expected to lead to new or strengthened national requirements for NHS providers. Relevant areas include safeguarding training and employment arrangements; immediate precautionary action where deliberate harm is suspected; medicines security and audit trails; mortality and SUDIC processes; data reporting; bereavement care; medical examiner scrutiny; CQC oversight; and the future regulation and barring of NHS managers. Specific proposed deadlines include GIRFT-compliant neonatal insulin controls by 31 March 2027 and implementation of the National Bereavement Care Pathway for neonatal death by 31 August 2027. At the time of the report, UHN had not received formal provider-specific implementation requirements or additional regulatory assurance requests. The Trust will therefore need to monitor emerging NHS England and regulatory guidance and demonstrate governance, accountability, and evidence of implementation through the agreed assurance framework.
Equality Impact Assessment
A formal Equality Impact Assessment is not included in the report and should be completed as part of the Trust-wide gap analysis. The assessment should consider whether proposed changes are accessible and equitable for families and staff, including people with disabilities, communication or language needs, various levels of digital access, and those experiencing bereavement or requiring psychological support. Consideration should be given to equitable access to safeguarding and escalation routes, Martha’s Rule, family communications, livestreaming technology, bereavement services and staff training and wellbeing support. Engagement with families, staff and the Maternity and Neonatal Voices Partnership should inform the assessment and help identify and mitigate any disproportionate impacts.

THIRLWALL INQUIRY: KEY RECOMMENDATIONS AND IMPLICATIONS FOR UHN

The publication of the Thirlwall Inquiry report on 15 September 2026 is a significant moment for the NHS. Whilst the events occurred within one organisation, the recommendations are directed at the wider health system and focus on strengthening patient safety, safeguarding, leadership accountability, and organisational culture. The report identifies failures to act on concerns, weaknesses in safeguarding processes, inadequate governance arrangements and a culture that did not sufficiently support challenge and escalation.

Key Recommendations

The Inquiry makes recommendations across 17 distinct areas:

1. CCTV and monitoring: fit all neonatal cots and incubators with livestreaming baby monitors for remote parental viewing; NHS England is to publish a centrally funded, ring-fenced implementation roadmap by 31 March 2027.
2. Insulin safety: introduce biometric controls and audit trails for insulin storage; neonatal units must meet GIRFT requirements by 31 March 2027, use CCTV on storage until biometric controls are available, retain recordings for at least 28 days and apply national laboratory guidance for insulin and C-peptide testing.
3. Bereavement care: implement the National Bereavement Care Pathway for neonatal death nationally and in every Trust by 31 August 2027.
4. Safeguarding and employment: provide role-appropriate safeguarding training for all colleagues and Board members, including Non-Executive Directors, covering concerns or suspicions of deliberate harm by staff; ensure contracts and processes support immediate precautionary action while concerns are investigated.
5. Interoperable operating systems: strengthen the ability of clinical, incident, laboratory, and other safety-critical systems to exchange information so that warning signals are visible and can be acted on promptly.
6. Monitoring deaths in hospitals: improve systematic monitoring and review of deaths, particularly deaths of babies and children, so that unusual patterns, clusters, and unexplained deterioration trigger timely scrutiny and escalation, including board level involvement.
7. Data reporting: improve the quality, consistency and timeliness of mortality and safety data, with clearer routes for reporting, analysis and escalation at provider, regional and national level.
8. Sudden Unexpected Death in Infancy and Childhood (SUDIC): strengthen and clarify national SUDIC processes where a baby or child dies unexpectedly in hospital, including coordination between healthcare, safeguarding, police, pathology, and other agencies.
9. Suspicion of Deliberate Harm Protocol: develop national, practical guidance for responding when deliberate harm by a healthcare worker is suspected, including immediate protection, evidence preservation, escalation, safeguarding, and referral to the police.
10. Panel of experts: establish access to an independent expert panel able to advise organisations rapidly when unexplained deaths, collapses or suspected deliberate harm require specialist multidisciplinary review.
11. Medical examiners: strengthen independent scrutiny of deaths of babies and children and ensure medical examiners have the information, training and escalation routes needed to identify concerns and patterns.
12. Paediatric and perinatal pathologists: address shortages and improve access to specialist paediatric and perinatal pathology, recognising its importance in explaining deaths and identifying possible harm.
13. Accountability and regulation of managers: introduce a barring system for clinical and non-clinical NHS managers by September 2027, review it in 2030, and move towards full statutory regulation by September 2032.

14. Care Quality Commission: strengthen how CQC inspections assess leadership, safeguarding, clinical risk, staff concerns and the response to emerging safety intelligence, with more effective escalation and follow-up.
15. Assessment of CQC performance: introduce stronger independent scrutiny of whether the regulator is identifying and responding effectively to risks within providers.
16. Parliamentary and Health Service Ombudsman: strengthen the Ombudsman's role and effectiveness in handling complaints and identifying wider patient-safety learning, including concerns that have not been resolved locally.
17. Implementation of inquiry recommendations: give the National Audit Office responsibility for auditing implementation of recommendations from statutory NHS inquiries, with additional staffing and funding so that this work can begin by September 2027.

Initial Assessment for UHN

Many of the themes within the report align with work already underway across UHN, including the perinatal safety improvement programme, safeguarding governance, PSIRF, Freedom to Speak Up arrangements, Martha's Rule, workforce engagement, and cultural improvement. However, the Inquiry reinforces that compliance with processes alone is insufficient: concerns must be heard, routes for escalation must be understood and leaders must act promptly when risks emerge.

On first review, approximately 13 of the 17 recommendation areas appear to have direct implications for UHN. Around eight may require changes to clinical practice, systems, or local assurance arrangements, and a further five may require strengthened pathways, governance or partnership working. The remaining four are primarily directed at national bodies or regulators but may still generate future requirements for providers. These figures are an initial screening assessment rather than a confirmed compliance position and will be validated through the Trust-wide gap analysis.

Potential changes and investment: Initial screening indicates that several areas may have material capital, digital, workforce or recurrent resource implications. The insulin-storage recommendation will require a Trust-wide review rather than a neonatal-only response, including current storage locations, access controls, audit trails, CCTV or biometric options and medicines-governance assurance across all relevant services. Employment contracts, job plans, and associated HR processes will also need to be reviewed to ensure they support clear safeguarding responsibilities, escalation expectations, and immediate precautionary action where deliberate harm is suspected. Livestreaming baby-monitor technology and wider system interoperability may require investment in devices, infrastructure, and information governance; existing Wi-Fi coverage and resilience are recognised constraints and will need to be assessed across the relevant clinical areas. Further implications may include safety-data reporting capability; access to specialist pathology, medical examiner, or independent expert capacity; safeguarding and bereavement resource and training; mortality review; PMA/PNA support; clinical leadership; and staff wellbeing. No cost estimate or compliance conclusion is yet available. Finance, Digital, Estates, Workforce, HR, Safeguarding, Medicines Governance, and relevant clinical services will contribute to the Trust-wide gap analysis and options appraisal.

How this connects to existing UHN oversight and action

- **Executive oversight:** The UHN perinatal executive oversight arrangements on behalf of ILT will coordinate the initial review, consider immediate implications for maternity and neonatal services, and align relevant actions with the NHS England 10-Point Plan. It will provide an interim route for review, tracking and escalation while the Trust-wide governance and assurance framework is agreed.
- **Safety and culture:** Relevant actions will align with UHN patient safety and cultural improvement programmes so that learning is translated into measurable safety and cultural improvement rather than managed as a standalone perinatal response. The initial review will identify where existing arrangements provide sufficient assurance and where matters require referral into the Trust-wide governance framework.

- **Immediate colleague communication:** Communication is to be prepared for maternity, neonatal and children's services, acknowledging the impact of the report, reinforcing speaking-up and safeguarding routes, and signposting staff to support. A supporting FAQ will provide practical information on what the report means, how concerns can be raised and where help is available.
- **Staff support:** PMA and PNA visibility and support will be increased. We will also seek additional support from UHN staff wellbeing services and neonatal psychology support, including consideration of accessible drop-in sessions for staff affected by the report.
- **Families, reassurance, and engagement:** Specific actions are also required to ensure families are informed, reassured and able to raise concerns. As part of leadership walkarounds, we will speak directly with families and listen to any questions or concerns. We will work with the Maternity and Neonatal Voices Partnership (MNVP) to shape clear and accessible messaging, reinforce Martha's Rule, and ensure families understand how to access the nurse in charge, senior clinical team, and the relevant senior matron. Staff will be reminded through safety huddles and handovers to check in proactively with families, explain escalation routes and respond promptly when something does not feel right. This will build on our established family-integrated care approach and family-inclusive handovers, with further action informed by feedback from families and the MNVP.
- **Visible leadership:** Executive and senior clinical leadership walkarounds will take place across maternity, neonatal and children's services to listen directly to staff, reinforce safeguarding and escalation routes, and identify any immediate concerns requiring action.

Proposed Next Steps

The UHN perinatal executive oversight arrangements on behalf of ILT will coordinate the initial review of all 17 recommendations, identify any immediate actions for maternity and neonatal services, and align relevant work with the 10-Point Plan, UHN patient safety and cultural improvement programmes. This is an interim route for consideration and coordination, not the governance structure for the full organisational response. At the time of this briefing, UHN has not received any formal implementation requirements, however, UHN is in receipt of an NHSE letter dated 21 September, setting out some immediate actions required of all Trusts and Boards. The first deadline of the 28 September; relates to the immediate action that *'All Trusts with a Neonatal Unit must urgently communicate to all relevant staff and the Board that the SUCIC process applies as set out (above). This must be completed by the 28 September'*; is now complete. Inevitably, additional assurance requests or provider-specific guidance from NHS England or its regulators will follow; therefore, we remain prepared to respond to further national or regulatory asks as they emerge.

Next steps include:

- Work through the implementation of the immediate actions as set out in the NHSE letter 21 September.
- Complete a Trust-wide gap analysis against all 17 recommendation areas, identifying current controls, evidence, gaps, interdependencies, and any immediate risks requiring action.
- Confirm the full organisational scope of the response, including the implications for safeguarding, paediatrics, medicines governance, digital systems, workforce, mortality review and corporate leadership.
- Agree the appropriate Trust-wide governance structure and the committee or forum responsible for coordinating delivery, managing interdependencies and escalating risks.
- Appoint a designated executive lead and assign a responsible corporate or clinical owner to each action, with agreed milestones, timescales and evidence of completion and impact.
- Establish a clear reporting and assurance cycle so that progress, exceptions, risks, and evidence of impact are subject to executive scrutiny and visible to the Board and its relevant committees.

An initial gap analysis, including immediate risk actions, provisional resource implications and a recommended governance route, will be brought back through the agreed executive forum and

relevant Board committee. Detailed implementation timescales will then be set once national guidance, funding arrangements and dependencies are clearer.

Key Message

The central lesson from the Inquiry extends beyond neonatal care and concerns how the organisation listens, challenges and acts. The report shows the consequences when concerns are not heard, professional challenge is not acted upon and organisational reassurance outweighs curiosity. Alongside delivery of the NHS Perinatal 10-Point Plan, the Board should use the Trust-wide gap analysis to test whether UHN's arrangements provide timely escalation, clear accountability, and evidence that concerns result in action. Progress, risks, and investment requirements should remain visible through the agreed Executive and Board assurance routes.

Cover sheet

Meeting	Boards of Directors of the University Hospitals of Northamptonshire NHS Group (Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust) meeting together (public)
Date	9 October 2026
Agenda item	9

Title	Guardians of Safe Working: Consolidated report for April to August 2026
Presenters	Sarika Goel (NGH) and Mustafa Raza (KGH), Guardians of Safe Working
Authors	Sarika Goel (NGH) and Mustafa Raza (KGH), Guardians of Safe Working

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

Reason for consideration	Previous consideration
This report seeks to provide assurance to Boards that resident doctors are safely rostered, and working hours comply with the 2016 Terms and Conditions of Service (TCS), with exception reporting monitored and well-being initiatives in place.	None
Executive Summary	
Background The Guardians of Safe Working are responsible for monitoring resident doctors' working hours and ensuring they do not exceed safe limits. Exception reports are submitted when doctors work beyond rostered hours, miss breaks, or experience unsafe workloads. Analysis of these reports, alongside work schedule reviews and rota monitoring, informs actions to protect doctors and patients and ensures adherence to contractual and legal requirements.	

KGH Summary

1. During the reporting period, a pattern of **late finishes** has continued. The reported reasons include delays in handover, staffing shortages and last-minute rota gaps, management of complex patients, busy theatre lists, and high workload during on-call shifts. These factors have contributed to delays in completing duties and finishing within the rostered hours.
2. In **Urology**, specialist registrars (SPR) continue to report being called to A&E for complex procedures that FY2 doctors do not yet feel confident performing independently. This has led to frequent interruptions and breaches of the required five-hour continuous rest period between 10:00 p.m. and 7:00 a.m. The Guardian engaged directly with the Urology resident doctors, including through an extensive face-to-face meeting, to understand the key concerns and explore practical measures to address them. Following this meeting, a further discussion was held with the Surgery Division Clinical Director, Urology Clinical Lead and LNC Lead. Several actions were discussed and agreed to address the identified concerns, with further measures to be implemented if the current arrangements continue not to provide an effective solution.
3. Exception reports were received from Foundation Doctors working in **General Surgery**, raising concerns regarding the level of available senior support, delays in handover, and associated late finishes. The Guardian arranged one-to-one meetings with several resident doctors to better understand the concerns and identify the underlying issues. These concerns were subsequently discussed with the Clinical Lead for General Surgery across three separate meetings, with a focus on ensuring that appropriate measures are put in place to provide adequate senior support, improve handover arrangements, and minimise avoidable late finishes.
4. The Guardian also took prompt action on several exception reports related to **inefficient handover processes** and insufficient support for resident doctors on the medical wards. These concerns were raised with the relevant consultants and leads, resulting in improvement in support and handover process.
5. During the reporting period, a total of 110 exception reports were received at KGH. The majority (89) related to hours of working, reflecting concerns around late finishes, additional hours worked and breaches of safe working hours. A further 15 exception reports related to service support available to the doctor, highlighting issues such as staffing levels, availability of senior support and service pressures. Four reports related to patterns of work, while two related to educational opportunities. One exception report was initially reported as an immediate patient safety concern (ISC); however, following review, it was determined that the issue did not meet the criteria for classification as an ISC.
6. The Guardian continues to provide **visible and accessible support** through multiple channels, including communications via the dedicated email inbox, attendance at Trust inductions, support for the Resident Doctors' Committee and Chief Registrar, chairing of the Resident Doctors' Forum (RDF) meetings, and active contribution to the updated Safe Working Hours Trust Policy, incorporating key changes to the Terms and Conditions of Service. The Guardian also presents exception reporting trends and key concerns at Local Negotiating Committee meetings and works in close collaboration with the Medical Education team, including presentations at the Educational and Clinical Supervisors' Forum.

NGH Summary

1. During the reporting period, **360 exception reports** were submitted across the Trust. The majority of reports related to **unscheduled late finishes**, highlighting continued operational pressures across several specialties.

2. Foundation Year 1 doctors continue to account for the largest proportion of exception reports, **149**, representing **41%** of all submissions.
3. General Medicine remains the specialty generating the highest number of reports, accounting for, **145**, **40%** of all exception reports submitted during the reporting period.
4. The predominant themes identified were workload pressures resulting in delayed finishes, **258**, **71.6%**, and challenges in achieving contractual rest and break requirements, **42**, **11.7%**
5. **32 financial penalties** were issued during the reporting period because of breaches of safe working hours.
6. **13 Immediate Safety Concerns (ISCs)** were raised by doctors. The three concerns relating to breaches of rest requirements occurred within Trauma and Orthopaedics and have been addressed through specialty-level interventions. The five concerns relating to excessive workload highlighted significant rota gaps and delays in patient management. Active mitigation plans remain in place to address staffing gaps and reduce risks associated with excessive workload. The remaining five did not meet the criterion for ISC following review.
7. A recurring theme identified within **Trauma and Orthopaedics** was failure to achieve the contractual requirement of **five hours continuous rest during Non-Resident On-Call (NROC) shifts**. Following extensive discussions with resident doctors, departmental leadership and management teams, a series of face-to-face meetings were undertaken to review the sustainability of the current working arrangements.
As a result, a plan has been agreed to transition resident doctors from the current **NROC model to a full shift rota** from the next rotation.
8. Multiple exception reports relating to inability to take contractual breaks were submitted, particularly from: General Medicine and Obstetrics and Gynaecology. Individual meetings were held with reporting doctors to understand contributing factors and identify local barriers. In response, enhanced consultant support has been requested to facilitate and oversee protected contractual breaks for doctors working in these areas. Ongoing monitoring will continue to assess the effectiveness of these interventions.
9. A significant number of delayed finish reports were associated with doctors completing mandatory training outside their scheduled working hours. Following engagement with management teams, arrangements have been made to provide doctors with appropriate time off in lieu (TOIL) for mandatory training undertaken beyond rostered hours.
10. During the latter part of the reporting period, the Guardian team proactively identified several doctors who did not have access to the exception reporting system.
Working collaboratively with Human Resources colleagues, access issues were resolved and reporting functionality was restored for affected doctors.
11. Wellbeing Walks: Regular wellbeing walks were conducted across the hospital, with visits to clinical wards and departments. These visits provided opportunities to: Engage directly with resident doctors, promote awareness of exception

reporting, offer support regarding wellbeing concerns, Encourage timely escalation of safe working issues.

Exception reporting posters have been displayed across multiple clinical and non-clinical areas throughout the hospital. Additional posters are scheduled for installation in further locations to increase visibility and awareness of reporting processes.

Risks and Assurance

Common Themes / Risks and Issues Identified:

- Persistent late finishes and additional hours.
- Rest breaches in NROC settings.
- Workload pressures and rota gaps.
- Insufficient senior support and inefficient handovers.
- Breaks not being taken.
- Training outside rostered hours.
- System access issues affecting reporting accuracy.

Assurance Measures:

- Strong Guardian engagement and escalation.
- Structural rota changes and consultant support interventions.
- Improved handover processes.
- Enhanced visibility and communication.
- Strengthened governance and alignment with national reforms.

Summary

Between April and August 2026, 470 exception reports were submitted across KGH (110) and NGH (360), with the principal themes being persistent late finishes and additional hours, workload and rota pressures, missed breaks, insufficient senior support, inefficient handovers and breaches of continuous-rest requirements in non-resident on-call arrangements. The Guardians of Safe Working have responded through direct engagement with resident doctors and clinical leaders, strengthened escalation and monitoring, improvements to handover and consultant support, resolution of reporting-system access issues, time off in lieu for mandatory training completed outside rostered hours, and planned rota redesign, including moving Trauma and Orthopaedics at NGH from a non-resident on-call model to a full shift rota.

Although 13 immediate safety concerns were raised at NGH, five did not meet the criteria following review and mitigation remains in place for the remainder; 41 financial penalties were imposed across the two trusts for breaches of safe working hours. Overall, the report provides assurance that concerns are being identified and acted upon, while recognising that sustained oversight is required to address continuing pressures and ensure compliance with safe working requirements.

Recommendation

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

Appendix

None

Risk and assurance

As set out in the executive summary above. Board Assurance Framework Risk UHN18 refers: If we fail to put in place sufficient support for colleagues and/or processes that fail to create a safe working environment where people feel valued, included and supported, then this will lead to increased sickness absence, poor staff engagement, poor retention, a negative impact on morale and potential impact on patient care.

Financial Impact

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

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

Cost centres have been created to facilitate fine payment.

Legal implications/regulatory requirements

No contract breaches identified during the reporting period.

Equality Impact Assessment

No equality concerns raised during the reporting period.

Cover sheet

Meeting	Boards of Directors of the University Hospitals of Northamptonshire NHS Group (Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust) meeting together (public)
Date	9 October 2026
Agenda item	11

Title	Report from the KGH Council of Governors meeting
Presenter	Andrew Moore, Chair of Boards and Council
Author	Richard May, Company Secretary

Link to Group Priorities (select all that apply):

☒ Transform Patient Care	☒ Strengthen our Culture	☒ Deliver our financial plan
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This paper is for

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

Reason for consideration	Previous consideration
For the Boards' awareness of key issues raised by the KGH Governors. NGH is an NHS Trust and therefore has no Council of Governors. The report nevertheless raises priority themes for the group.	KGH Council of Governors, 2 September 2026

Executive Summary

The KGH Council of Governors met on 2 September 2026. The Governors, in pursuance of their statutory duties to represent the views of their communities (staff and public), and to hold the Non-Executive Directors to take account for the Trust's performance, discussed the following issues and concerns. The meeting was attended by the Chair, Non-Executive Directors, Managing Director and Director of Strategy.

Questions and concerns raised with the Managing Director of Director of Strategy

- **Patient experience and complaints:** Governors raised concerns about delayed, inaccessible and insufficiently empathetic complaint responses. UHN's new Head of Patient Experience will review the process to strengthen timeliness, communication and organisational learning, with appropriate Board support.
- **Community phlebotomy:** Governors raised concerns about appointment capacity, non-attendance and delays. The Managing Director undertook to provide a written response on the appointment model, and an ICB representative will be invited to a future governors' meeting to outline future plans for service provision within the county.
- **Kettering staff shuttle bus:** The replacement minibus has been repaired following a recall and is expected to restart within approximately one month as part of the car-parking strategy (the new service commenced on 28 September 2026).
- **New Hospital Programme and single rooms:** The Governors received a presentation setting out the requirements for single en-suite rooms within the KGH hospital redevelopment, offering privacy, dignity, infection-control and family-access benefits. Risks include reduced observation, isolation and different staffing and workflow requirements, particularly for rehabilitation, dementia and longer-stay care; layouts, communal space, proactive rounding and digital monitoring will therefore be important.
- **Rockingham Wing redevelopment:** The phased extension and rebuild was paused after validated costs and timescales proved unacceptable to NHS England. Alternative options are being assessed through a strategic outline case due by the end of October, followed by governor engagement before a full business case. It could open around two years earlier than the phased scheme but delay the provision of the bereavement suite, funded by the Twinkling Stars Appeal; staff, bereaved families and fundraisers will be engaged on interim solutions.
- **Medicines resilience and wastage: Medicines Resilience**
There are well established processes in place nationally and regionally to manage stock levels to minimise disruption to patient care. These include regional stock management to ensure available product is used effectively, nationally co-ordinated information sharing and supplier reports. At UHN, the Pharmacy teams have systems in place to react to both known national and local issues. Pharmacy stores escalate issues to specialist pharmacists who liaise with clinical colleagues to understand the impact of any supply challenges and what actions are needed. Risk assessments are carried out where necessary for product changes and product change/advice posters are widely circulated. Oversight is provided by Medicines Safety Group.

Currently, wastage on medicines is reduced through use of patient's own medicines, minimising resupply requests, returning higher cost items into stock if no longer needed, regular review of ward stock lists and stock rotation.

Future engagement model

Work is ongoing to a successor governor model retaining challenge, accountability, legitimacy and community representation, in anticipation of the removal of statutory references to Governors proposed within the NHS Modernisation Bill from April 2027.

Formal approvals

The Chair, Vice-Chair and Non-Executive Directors' annual appraisal summaries were received, and the outcomes of the process endorsed.

The Council approved the reappointment of Denise Kirkham as a Non-Executive Director for a further 12-month period to 30 September 2027.

Summary of Governors' engagement reports

- **Overall engagement:** Governors used community forums, webinars, staff networks, hospital visits, patient conversations, volunteering and local groups to gather feedback.
- **Recurring access issues:** Common concerns were difficulty obtaining blood tests, hospital parking, cancelled or missed follow-up appointments, and appointment letters arriving late.
- **Communication and administration:** Several reports highlighted unclear communication, delayed responses—particularly from the Patient Advice and Liaison Service—and weaknesses in appointment administration.
- **Staff concerns:** Themes included confidence in Freedom to Speak Up, information governance, workload and capacity pressures, leadership visibility, organisational culture, and communication about change.
- **Patient flow:** Ambulance handover delays and emergency-care pressures remain concerns, although effective teamwork and patient-safety processes were observed.
- **Positive examples:**
 - Excellent patient experiences following cataract, hip and maxillofacial treatment.
 - Efficient, reassuring Sunday CT services at Corby Diagnostic Centre.
 - Strong pharmacy support, hospital volunteers, and collaborative working between ambulance and acute teams.
 - Community engagement through patient groups, veterans' organisations, cancer-support networks, careers events and Age UK.

Recommendation

The Boards are recommended to receive and note the reports, including the further actions and assurances provided within it.

Appendices

None

Risk and assurance

No direct implications for the Board Assurance Framework

Financial Impact

No direct implications – information/assurance report.

Legal implications/regulatory requirements

The Governors' statutory duties are described above.

Equality Impact Assessment

No direct implications – information/assurance report.