# UHN Boards of Directors Meeting in Public

*Thursday 10 September 2026, 09:30 - 12:45*

**Boardroom, Kettering General Hospital**

## Agenda

**09:30 - 09:30**
0 min

### 1. Welcome, apologies and declarations of interest

*Andrew Moore*

1. UHN Public Boards Agenda 100926.pdf (2 pages)

**09:30 - 10:00**
30 min

### 2. Patient Story - Steven's Story

*Presentation and Discussion* *Suzie O'Neill*

**10:00 - 10:05**
5 min

### 3. Minutes of the previous meeting held on 11 June 2026 and Action Log

*Decision* *Andrew Moore*

3.1 UHN and UHL Boards public mins 110626.pdf (15 pages)
3.2 Public action log updated after 110626 meeting.pdf (2 pages)

**10:05 - 10:15**
10 min

### 4. Chair's report (verbal)

*Information* *Andrew Moore*

**10:15 - 10:20**
5 min

### 5. UHN Chief Executive's Report

*Information* *Julie Hogg*

5. CEO report.pdf (4 pages)

**10:20 - 11:00**
40 min

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

*Assurance / Decision* *Julie Hogg / Becky Taylor / Executive Leads / Board Committee Chairs*

6. July 2026 Integrated Performance Report Cover Sheet Board.pdf (2 pages)
6. 2026 July IPR report.pdf (45 pages)
6. 2026 July IPR Financial tables.pdf (5 pages)
6.0 Board Committees upward report September 2026 (1).pdf (14 pages)

**11:00 - 11:15**
15 min

### 7. Perinatal Report (including KGH Maternity and Neonatal Improvement Support Team update)

*Assurance* *Julie Hogg*

Assurance

7. 2026_09_11__UHN Board of Directors_PUBLIC_ Perinatal Report.pdf (12 pages)

**11:15 - 11:25**
10 min

### *Break*

**11:25 - 11:40**
15 min

## 8. Response to the Amos National Maternity and Neonatal Investigation, Ockenden Review and NHS England 10-Point Plan (added 8 September 2026)

*Assurance / Decision* *Julie Hogg*

Assuraance

- 8. 2026_09_10 Board of Directors_Perinatal 10PP UHN Response.pdf (18 pages)

---

**11:40 - 11:50**
10 min

## 9. NGH CQC Well-Led final report and next steps

*Assurance* *Julie Hogg / Richard May*

- 9. Boards Cover sheet NGH Well Led 100926.pdf (4 pages)
- 9. Boards Appendix B delivery framework in response to NGH Well Led.pdf (3 pages)
- 9. Boards Appendix C RNS Report of FTSU actions.pdf (3 pages)

---

**11:50 - 12:00**
10 min

## 10. Progress report: 2025-26 Deliverables year-end review and 2026-27 progress review

*Assurance* *Rebecca Taylor*

- 10. UHN Deliverables Report Boards.pdf (5 pages)

---

**12:00 - 12:05**
5 min

## 11. Fit and Proper Persons Compliance

*Assurance* *Andrew Moore*

- 11. Fit and Proper Persons report.pdf (2 pages)

---

**12:05 - 12:15**
10 min

## 12. Board Capability Self-Assessment

*Decision* *Rebecca Taylor*

- 12. Provider Capability Self-Assessment (1).pdf (3 pages)

---

**12:15 - 12:30**
15 min

## 13. Board Assurance Framework

*Assurance* *Susan Clennett*

- 13. UHN BAF Qtr 1 Board September 2026.pdf (42 pages)

---

**12:30 - 12:45**
15 min

## 14. Annual Report of the Northamptonshire Healthcare Charitable Fund (NHCF)

*Presentation* *Jonathan McGee (NHCF Chief Executive)*

- 14. UHN Cover Sheet NHCF annual report cover.pdf (2 pages)
- 14. Northampton Health Charity UHN Board presentation 100926.pdf (10 pages)

---

**12:45 - 12:45**
0 min

## 15. Use of the Trusts' Seals

*Information* *Richard May*

- 15. UHN Cover Sheet Trusts' Seals 100926.pdf (1 pages)

---

**12:45 - 12:45**

## 16. Questions from the public

0 min

**12:45 - 12:45** 0 min

## 17. Any other business and close

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

| | |
|---|---|
| Meeting | Boards of Directors (Part II) Meeting in Public |
| Date & Time | 10 September 2026, 09:30-12:45 |
| Location | Boardroom, Kettering General Hospital |

| Purpose and Ambition |
|---|
| The Boards are accountable to the public and stakeholders; to formulate the Trusts' strategies; ensure accountability; and to shape the culture of the organisations. The Boards delegate authority to Board Committees to discharge their duties effectively and these committees escalate items to the Boards, where Board oversight, decision making and direction is required. |

| Item | Description | Lead | Time | Purpose | P/V/Pr |
|---|---|---|---|---|---|
| 1 | Welcome, Apologies and Declarations of Interest | Chair | 09:30 | - | Verbal |
| 2 | Patient Story – Steven's Story | Director of Communications and Engagement | 09:30 | Presentation | Pr. |
| 3 | Minutes of the Meeting held on 11 June 2026 and Action Log | Chair | 10:00 | Decision<br>Receive | Attached<br>Attached |
| 4 | Chair's report | Chair | 10:05 | Information | Verbal |
| 5 | UHN Chief Executive's Report | Managing Director | 10:15 | Information | |
| Operations | | | | | |
| 6 | Integrated Performance Report (IPR) and Board Committee Chairs' Reports | Managing Director, Executive Directors and Committee Chairs | 10:20 | Assurance | Attached |
| 7 | Perinatal Report (including KGH Maternity and Neonatal Improvement Support Team update) | Chief Nurse | 11:00 | Assurance | Attached |

| | | | | | |
|---|---|---|---|---|---|
| | BREAK: | | 11:15 | | |
| 8 | Response to the Amos National Maternity and Neonatal Investigation, Ockenden Review and NHS England 10-Point Plan | Chief Nurse | 11:25 | Assurance / Decision | Attached |
| 9 | NGH CQC Well-Led final report and next steps | Chief Nurse / Company Secretary | 11:40 | Assurance | Attached |
| Strategy | | | | | |
| 10 | Progress report: 2025-26 Deliverables year-end review and 2026-27 progress review | Director of Continuous Improvement | 11:50 | Assurance | Attached |
| Governance | | | | | |
| 11 | Fit and Proper Persons Compliance | Chair | 12:00 | Assurance | Attached |
| 12 | Board Capability Self-Assessment | Director of Continuous Improvement | 12:05 | Decision | Attached |
| 13 | Board Assurance Framework | Chief Nurse / Deputy Director of Risk and Legal Affairs | 12:15 | Assurance | Attached |
| 14 | Annual Report of the Northamptonshire Healthcare Charitable Fund (NHCF) | NHCF CEO | 12:30 | Presentation | Attached |
| 15 | Use of the Trusts' Seals | Company Secretary | 12:45 | Information | Attached |
| 16 | Questions from the Public | Chair | 12:45 | Information | - |
| 17 | Any Other Business and close | Chair | 12:45 | Information | - |

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

**MINUTES OF A MEETING OF THE BOARDS HELD ON 11 JUNE 2026 FROM 9.30-13:00 IN SEMINAR ROOMS 2-3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL**

**Voting Members present:**
Trevor Shipman, UHN Non-Executive Director & Vice Chair and UHN Strategy, Transformation and Digital Committee Chair (in the Chair)
Scott Adams – UHL Non-Executive Director and Operations and Performance Committee Chair
Lee Bond – UHL Chief Financial Officer
Ivan Browne OBE – UHL Non-Executive Director and People and Culture Committee Chair
Laura Churchward – UHN Chief Executive
Alice Cooper – UHN Non-Executive Director and Audit Committee Chair
Simon Gay – UHN Non-Executive Director (KGH voting member)
Helen Hendley – UHL Chief Operating Officer
Julie Hogg – Group Chief Nurse
Jill Houghton – UHL & UHN Non-Executive Director
Andrew Inchley – UHL Non-Executive Director and UHL Finance and Investment Committee Chair
Paula Kirkpatrick – UHN Chief People Officer (KGH voting member)
Richard Mitchell – UHL & UHN Group Chief Executive
David Moon – UHL Non-Executive Director and UHL Audit Committee Chair
Hemant Nemade – UHN Medical Director
Sarah Noonan – UHN Chief Operating Officer
Sarah Stansfield – UHN Chief Financial Officer
Damien Venkatasamy – UHN Non-Executive Director and UHN Finance, Investment and Performance Committee Chair (KGH voting member)
Chris Welsh – UHN Non-Executive Director and UHN Quality and Safety Committee Chair
Gang Xu – UHL Medical Director

**Non-Voting Members present:**
Ruw Abeyratne – UHL Director of Health Equality and Inclusion
Simon Barton – UHL Deputy Chief Executive
Becky Cassidy – UHL Director of Corporate and Legal Affairs
Emma Casteleijn – UHL Director of Communications and Engagement
Polly Grimmett – UHN Director of Strategy
Will Monaghan - Group Chief Digital Information Officer
Suzie O'Neill – UHN Director of Communications and Engagement
Clare Teeney – Chief People Officer

**Also present:**
Danni Burnett – Group Director of Midwifery
Sheela Kaya – Freedom to Speak Guardian (for minute 34/26/2)
Harsha Kotecha – Chair, Leicester and Leicestershire Healthwatch
Richard May – UHN Company Secretary
Derek McIlroy – Operations Manager, The Guardian Service (for minute 34/26/2)
Rachel Moss – Freedom to Speak Guardian (for minute 34/26/2)
Matthew Reeves – UHL Corporate and Committee Services Officer
Emma Roberts – Head of Nursing, Emergency and Specialist Medicine (ESM) (for minute 30/26)
Raunak Singh – Guardian of Safe Working (for minute 34/26/3)
Sharon Wilkinson – Senior Nurse, Patient Experience (for minute 30/26)

**Apologies for absence:**
Andrew Moore – Group Chair
Simon Baylis – KGH Lead Governor
Steve Harris – UHL Associate Non-Executive Director
Andy Haynes MBE – UHL Non-Executive Director & UHL Vice Chair and Quality Committee and Our Future Hospitals & Transformation Committee Chair
Denise Kirkham – UHN Non-Executive Director and UHN People Committee Chair
Tom Robinson – UHL Non-Executive Director and UHL Charitable Funds Committee Chair
Caroline Stevens – UHN Non-Executive Director

Becky Taylor – UHN Director of Continuous Improvement

| | | ACTION |
|---|---|---|
| **25/26** | **APOLOGIES AND WELCOME** | |
| | The Chair welcomed colleagues to the meeting and noted apologies for absence as listed above. | |
| **26/26** | **CONFIRMATION OF QUORACY** | |
| | The meeting was confirmed as quorate and able to proceed with business. | |
| **27/26** | **DECLARATIONS OF INTERESTS** | |
| | There were no declarations of interest regarding the business to be transacted at the meeting. | |
| **28/26** | **MINUTES** | |
| | Ms H Kotecha, Chair of Leicester & Leicestershire Healthwatch requested that reference be made to the questions she provided prior to the May Boards in Common meeting.<br><br>**Resolved –** that the Minutes of the Boards of Directors of Kettering General Hospital (KGH), Northampton General Hospital (NGH) the University Hospitals of Leicester (UHL) NHS Trust meeting held on 8 May 2026 be confirmed as a correct record, subject to the above amendment. | **UHN CoSec** |
| **29/26** | **ACTION LOG** | |
| | The Boards noted, the action log enclosed at Paper B, on which all actions were marked as complete or in progress, except for the action regarding oversight arrangements of the UHN Community Engagement Strategy which was on hold due to the ongoing review of committees. | |
| **30/26** | **PATIENT STORY: SEEING THE PERSON BEHIND THE PATIENT – SUSAN'S STORY** | |
| | The Group Chief Nurse introduced the patient story, which was Susan's story about her time as a cancer patient at Leicester Royal Infirmary and the Boards received a video where her son, Mr R Bradbury provided details of the care that his mother received.<br><br>In the video, Mr R Bradbury described the patient pathway that his mother followed during the development of her cancer illness, and different stages of treatment she had received. He also outlined aspects of his mother's personality and how staff took the time to learn this about his mother and adapted the care accordingly based on her as an individual person. He praised the approach taken by staff throughout his mother's care, and felt assured by the care she received, because of the time taken to get to know her.<br><br>In discussion the following points were raised:<br>- The team caring for the patient were clearly a high-performing team which left a very positive impression for the patient's family.<br>- Following a question regarding the coordination taken by the Team, it was reported that geriatric ward in question took a wholistic approach to individualised care, which considered the patients' spiritual, social and physical needs with good engagement with the family. This approach was taken across the entirety of the CMG's services.<br>- The story showed clearly that the care was focussed on the person at the centre. Further, other aspects such as hospital moves, establishing a care package and the challenges of accessing records at out of hours times demonstrated positive working from the team delivering care.<br>- Challenges in delivering care were noted such as having sufficient time to have important conversations with patients and their families, particularly when delivering palliative care.<br>- It was acknowledged that the Emergency Department was not the most suitable admission pathway for palliative patients and there needed to be better working with community partners.<br>- It was felt that more generally, patient stories had demonstrated that longer term relationships delivered better care that short term and queried whether lessons could be learned. In response, it was noted that the Fundamentals of Care programme and the Leicester Excellence Accreditation Framework, were both programmes that sought to deliver better care, and there would be a focus going forward on supporting patients in community settings. | |

| | | |
|---|---|---|
| | - Palliative care teams were supportive of community based care and the need for better working with community partners was reinforced.<br>- Improving end of life care was noted as area of focus with the need for better inter-team working highlighted.<br>- The patient story demonstrated the team's clear ability to deliver compassionate care whilst supporting families at a difficult time.<br>- The 3 weeks the patient spent as an inpatient receiving palliative care was queried as to whether this was the best place for the patient and their family, and UHL's role in such situations was also questioned, but it was acknowledged that some patients would need acute care. Further, it was felt that consideration should be given to the time provided to staff to engage with patients and families in palliative care, possibly through monitoring of data for time of interactions, to inform a balance between time spent with patients and the need for efficiency to provide clarity for teams.<br><br>The Chief Executive thanked Ms E Roberts, Head of Nursing, ESM for the care and services that she and her teams delivered.<br><br>The UHN Vice-Chair thanked Ms E Roberts for attending and asked that the positive feedback could be shared with her team. The importance of consistency when delivering care was felt to be evident from the story which had been received. | **GCN** |
| | **<u>Resolved</u> – that consideration to the role in delivery of care for palliative patients, and arrangements for working alongside community provision partners.** | **GCN** |
| **31/26** | **STANDING ITEMS** | |
| 31/26/1 | <u>Vice-Chair's Report</u> | |
| | The UHN Vice-Chairman highlighted the importance of the Boards' giving consideration to the needs of patients and colleagues in their deliberations. More specifically the need to support colleagues to deliver care at the appropriate time and to consider how governance could also support the delivery of care.<br><br>The UHN Vice-Chairman noted that Ms L Churchward, UHN Chief Executive noted that this would be her last Board meeting before she left her role and thanked her for all her efforts and delivery at UHN. | |
| 31/26/2 | <u>Group Chief Executive's report</u> | |
| | The Group Chief Executive presented paper D, and reported the following:<br><br><u>UHN Chief Executive</u> – Ms L Churchward was thanked for her leadership whilst in the role of Chief Executive of UHN and it was noted that it had improved as an organisation under her leadership. She was wished well for her future career within the NHS.<br><br><u>UHL-UHN Collaboration</u> – the collaboration had been growing in development at governance level with 3 Boards in Common meetings and 9 Joint Executive Team meetings having taken place, which had enabled strengthened governance and leadership arrangements.<br><br><u>UHL – UHN Priorities</u> – The Chief Executive and other Executive colleagues had recently attended a staff listening event. Part of the discussion had focussed on UHL / UHN priorities, which were; transforming patient care, strengthening our culture, and delivering our financial plans. There had been a general view arising from the event from colleagues that the most important priority for the Boards was delivering our financial plans. The importance of the Boards focussing on all 3 priorities was highlighted but acknowledged that finance could sometimes take over. The focus on culture to bind the organisation together, as well as improved patient should be part of Board interactions, and the Boards were asked to check if this was the case.<br><br>Mr S Adams, UHL Non-Executive Director stated that he personally felt that all three priorities were equally important but noted that if the financial plan was not met, then time or freedom would not be given to deliver changes to culture or improvements to care. | |

| | | |
|---|---|---|
| | The UHN Vice-Chair welcomed the discussion on priorities and noted that it set an important context for the meeting, and it was stressed that there also needed to be a focus on the long term as well as the short term. | |
| | **Resolved – that that report be received and noted.** | |
| 31/26/3 | Integrated Performance Report and Executive Summaries (Month 12, 31 March 2026) | |
| | The Group Chief Executive introduced the Integrated Performance Report (IPR), which provided a high-level assessment of themes – access, quality, safety and money, covering the organisations. The report provided details for April, but verbally a more up to date position was noted in regard to Urgent and Emergency Care (UEC), where the pathway was very challenged with demand at winter levels, which raised concerns for the forthcoming winter and wider impacts on access and patient quality. Following a recent meeting with Leicester, Leicestershire and Rutland Local Medical Committee, it was highlighted from the meeting that Leicester City had particular challenges due to the highest rates of infant mortality and tuberculosis in the country and second worst levels of access to General Practice in the country.<br><br>The UHN Chief Operating Officer highlighted the following points regarding access:<br>- For the 4 hour Emergency Department wait time, Kettering General Hospital (KGH) had exceeded the standard, with Northampton General Hospital (NGH) meeting the standard and there had been sustained improvement following sprint schemes.<br>- Ambulance handover times remained challenged at both sites.<br>- Length of stay and right to reside criteria targets also remained challenged, but June was showing signs of improvement.<br>- The frailty service had re-started at the beginning of June and the Length of Stay group had also been re-started.<br>- Cancer performance, particularly breast remained challenged, but April had shown some areas of improvement.<br>- Referral to treatment targets were broadly on plan following additionality being agreed.<br><br>The UHL Chief Operating Officer highlighted the following points regarding access:<br>- The 4 hour and 12 hour Emergency Department waiting time targets were improved compared to previous years, despite increased demand.<br>- Extended waits for hospital admission were impacting length of stay targets, with new capacity being brought online, but this had a financial impact.<br>- Performance improved in the 31 day and 62 day cancer referral to treatment targets, however performance deteriorated in the Faster Diagnosis Standard.<br>- Actions were in place to address wait challenges in breast cancer care.<br>- Elective wait times were still not at the required level, but assurance was provided that actions were in place to improve the position.<br>- It had been 1 year since the Hinckley Community Diagnosis Centre (CDC) had opened, with 60,000 patients served without the need to attend an acute site.<br>- Industrial action was due to start in the following week, assurance was provided that plans were in place, but there would still be an impact on services.<br><br>In discussion, the following points were raised and discussed:<br>- Noting the demand in the Emergency Departments, it was queried whether discussions had taken place with System partners to mitigate the demand. For UHL it was confirmed that the UEC collaborative had identified 5 ‘pillars’ to reduce demand, but further clarity was needed when actions would be put into place. It was also noted that general practice was facing similar demand pressures. For UHN, similar challenges were noted, but it was highlighted that a meeting of the ICB Health Executive was due to take place in the following week and consider summer demand pressures.<br>- The Group Chief Executive noted there were a number of discussions taking place across the System, but this appeared insufficient to address the high levels of attendance. The acute sector was at the centre of these challenges, facing high levels of accountability, but there was also a need to consider pre and post hospital care to address the problems, and as such community partners had been requested to maintain capacity. Due to current funding arrangements, the current demand would create a financial pressure for the ICB. Concern was expressed that Urgent Treatment Centres planned for NGH and Leicester Royal Infirmary (LRI) would open and only address unmet current demand. | |

| | | |
|---|---|---|
| | - In response to a question, the Group Chief Nurse agreed to provide an update regarding the roll out of Paediatric Early Warning System metrics.<br>- Performance in cancer screening was highlighted with the impact of wider determinants of health felt to be a key factor in low levels of screening. The need to discuss this issue with System partners to consider ways forward taking wider determinants into account was noted.<br>- There was an opportunity to improve medical productivity through a greater focus in the use of job plans. It was confirmed that job plan performance was now at 95%, with the focus on validity and delivery going forward, with further improvements through automation currently under discussion.<br>- Addressing UEC demand would require different ways of working to address, with solutions such as a single point of access, possibly via primary care being suggested.<br>- The reason for the increase in UEC demand needed to be determined in order to agree how the problem could be addressed, but it was noted that the increase was being seen nationally.<br>- Patients could often be confused about where the needed to go for the most appropriate care for their needs and this was felt to be partly driven by recent ICB communications. The UHL Director of Communications and Engagement agreed to discuss the matter further outside of the meeting with the Chair of Leicester and Leicestershire Healthwatch.<br>- Levels of service expectations had increased due to developments in other parts of the consumer economy.<br>- Anecdotal evidence from the Health and Wellbeing Board in Northampton was that there did not appear to be awareness of the levels of pressure that services were facing, possibly so as not to cause alarm.<br><br>Each of the Executive Director IPR leads were invited to provide an overview of the key aspects of paper E, relating to their portfolios as follows:-<br><br>**(1) Quality –** Commenting on UHL, the Group Chief Nurse highlighted the following:<br>- Gram negative bloodstream infections remained above target, but a plan had been considered by the Quality Committee for addressing this issue and it included enquiries into catheter and invasive line usage and a working group on microbial infections had also been convened.<br>- The UHL Medical Director reported 3 never events in the month of April with full investigation and review of procedures having taken place in response. An initiative had been developed to ensure clear focus to minimise future occurrence. It was assured that there was minimal patient harm.<br>- The Summary Hospital-Level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) levels were both below 100 which was positive due to the period covered in the report which included the early winter period.<br><br>Commenting on UHN, the Group Chief Nurse highlighted the following:<br>- Both KGH and NGH sites overall performed well regarding friends and family tests, but there was variation between wards and this was being reviewed in detail.<br>- The Fundamentals of Care programme and the Leicester Excellence Accreditation Framework (LEAF) were being developed and implemented.<br>- Complaints response performance was not at the required level, but an upward trajectory was now being seen.<br>- There had been a positive reduction in the number of mixed sex breaches.<br>- Similar challenges to UHL were being seen in respect of gram negative bloodstream infections.<br>- The UHN Medical Director noted the SHMI was increasing and above the expected level. A deep dive had been undertaken to consider relevant factors which included the depth of coding, methodology changes and the fact that palliative care was disproportionately provided at NGH, and this was reported to the Quality Committee.<br><br>In discussion, the following points were raised and discussed:<br>- Professor C Welsh, UHN Non-Executive Director commented that the mortality deep dive confirmed that there was no underlying increase in mortality at NGH.<br>- In response to a question about risks, it was felt that the biggest patient risk at UHN was likely to be those UEC risks around safety due to infection and poor quality patient experience due to long waits. A further risk element was noted due to the increase in unassessed patients being left at NGH due to a change in ambulance procedures, which was felt to be something that should be addressed with system partners. The Group Chief Executive confirmed that this would be raised at a forthcoming meeting with East Midlands Ambulance Service. | **GCN**<br><br>**DoC&E** |

**(2) People –** The UHN Chief People Officer noted the following points:

- A sickness absence rate of 4.9% was reported.
- Appraisal rates were variable with KGH good, but NGH well below target with variation in the level of quality, but a new process was being put in place to address the issue.
- Agency spend was less than 1% of the total pay bill, with virtually zero at KGH, but vacancies in the medical workforce were driving demand for agency staff.
- Meeting the targets of the workforce plan and associated Cost Improvement Plan (CIP) targets were an ongoing weekly focus.
- Formal cases at both sites, thought to be driven by new freedom to speak up arrangements had confirmed cultural issues to address.

In discussion, the following points were raised and discussed:

- It was confirmed that there were regional led plans in place to stabilise medical agency pay rates, but this became challenging when looking for staff to support fragile services.
- Work was ongoing to safely reduce UHN medical pay expenditure through engagement with Local Negotiating Committees (LNC), but fragile services such as Oncology required the use of agency staff. Use of medical bank staff was a further challenge, particularly due to increased front door demand, but despite these challenges, plan targets were being maintained.
- The attractiveness of UHN for medical recruitment was considered, in terms of its attractiveness as a place to work and whether closer working with UHL would improve this. The collaboration between KGH and NGH had improved recruitment, but changes in the medical recruitment market due to fewer temporary opportunities was also a factor. Closer working between UHN and UHL was planned regarding fragile services, but this would require shared working arrangements and standardisation.
- The development of a plan for workforce reductions was questioned, noting that whilst targets had been developed, it was felt that there was further work to do, to meet the targets.

The UHL Chief People Officer noted the following points:

- The Whole Time Equivalent (WTE) workforce numbers were slightly above plan mainly due to the use of bank staff, but substantive recruitment continued which provided greater stability and was better for patient care.
- Plans were in place to meet the targets of the workforce plan through effective rostering, utilisation of the workforce, and effective use of job plans. A plan outlining details would be presented to committees in the near future.
- Implementation of medical automation was providing data which would assist in effective utilisation of the workforce.
- Appraisal rates were below targets, but a new process was about to be introduced with a comprehensive training programme.
- Sickness absence had decreased in line with seasonal variation.
- A new leadership programme had been implemented which sought to address concerns raised as part of the staff survey.

In discussion, the following points were raised and discussed:

- The challenge of meeting CIP workforce target which were at a higher level towards the end of the financial year was highlighted.
- The need to recognise the achievements by the workforce on a daily basis, not just consider the costs was highlighted.
- Opportunities for improved achievement and delivery by the workforce was considered, noting there was a lack of visibility regarding rostering and deployment, but this had improved in nursing and Estates & Facilities, but a further focus was needed in respect of the medical workforce.
- Staff wellbeing was an issue which could hinder effective service delivery, where impacts such as verbal abuse, assault and racism were factors. Increased civil enforcement orders would be considered in future to protect and support staff. Concern was expressed that such incidents were underreported due to a general view that action would not be taken.

The UHL Chief Financial Officer noted the following points:

- The month 1 position was a deficit of £3.9m which was £0.8m adverse to plan, but the figure was impacted by the recent industrial action.
- The cash position was £20m, which was down on the previous month, but impacted by creditors from significant capital activity.
- Elective income performance was in line with plan.

| | | |
|---|---|---|
| | - Staff vacancies were contributing to the financial performance.<br>- Expenditure on bank and agency staff remained comparable to previous months at around £7m.<br><br>The UHN Chief Financial Officer noted the following points:<br>- The financial position was at plan in month 1, underspends in non-pay, over delivery in efficiency targets, income above plan, balancing out the negative impacts of industrial action.<br>- The Cost Improvement Plan (CIP) achieved £3.2m in April, which was 5% of the total. 90% of the schemes had now been identified for the CIP, but delivery risk remained high.<br>- Both KGH and NGH had submitted non compliant operational plans which meant monthly cash support was being relied upon and capital expenditure management.<br>- Underlying risks regarding the cash position and CIP delivery heightened the need to ensure the financial the financial plan was delivered.<br><br>In discussion, the following points were raised and discussed:<br>- In response to a question, it was confirmed that UHL were meeting local supplier payment terms at 98% of value and 92% volume. It was also confirmed that UHN prioritised Small/ Medium Enterprises for payment.<br>- Both UHL and UHN expressed a level of confidence that quarter 1 financial plan targets could still be met despite the forthcoming industrial action.<br>- Both UHL and UHN confirmed that they were not current making accruals for any overperformance.<br>- It was felt that there were opportunities to improve financial performance, such as improving theatre utilisation and reducing on the day cancellations. | |
| | **Resolved – that (A) an update be provided to Ms J Houghton, Non-Executive Director regarding the rollout of PEWS (Paediatric Early Warning System) metrics; and**<br><br>**(B) a meeting be held with the Chair of Leicester and Leicestershire Healthwatch to understand the concerns raised by Healthwatch regarding patient communications and progress outside of the meeting.** | **GCN**<br><br>**UHL DoC&E** |
| 31/26/4 | <u>Board Committee Escalation Reports</u> | |
| | <u>UHL Quality Committee – 28 May 2026</u><br>Ms J Houghton, UHL Quality Committee Member highlighted the following discussions:<br>- The Committee was considerably assured regarding the use of AI for responses to patient complaints.<br>- The Perinatal Accountability Framework was commended and approved.<br>- The Patient Safety Partner had commented that the Quality Account could be improved by making it more patient friendly and this was being developed.<br>- Discussions on the Mortality and Learning from Deaths report considered in detail the position with regard to infant mortality.<br>- The Quality Committee annual report was recommended for approval, but noted a recommendation that fragile services should be part of the committee's Terms of Reference.<br><br><u>UHN Quality and Safety Committee – 27 May 2026</u><br>Professor C Walsh, UHN Quality and Safety Committee Non-Executive Director Chair highlighted one item of limited assurance regarding Integrated Performance and Urgent and Emergency Care Standards update where concerns regarding patients with no right to reside and use of temporary escalation places was having a significant impact on patient quality and safety.<br><br><u>UHL Finance and Investment Committee – 27 May 2026</u><br>Mr A Inchley, UHL Finance and Investment Committee Non-Executive Director Chair outlined one item for approval, the Finance and Investment Committee annual report, noting that there had been discussion regarding the workplan, specifically the respective roles of the Finance and Investment Committee and the Our Future Hospitals and Transformation Committee with regard to approval of contracts and business cases.<br><br><u>UHN Finance, Investment and Performance Committee – 26 May 2026</u><br>Mr D Venkatasamy, UHN Finance, Investment and Performance Committee Non-Executive Director Chair presented the upward report, incorporating a request for approval of £5m Public Dividend Capital (PDC) cash support for Kettering General Hospital (KGH) and £1m for | |

| | | |
|---|---|---|
| | Northampton General Hospital (NGH), which was supported by the Finance, Investment and Performance Committee.<br><br>The KGH and NGH Boards confirmed their approval of the PDC request.<br><br>The UHN Finance, Investment and Performance Committee Non-Executive Director Chair highlighted the increasing challenge of meeting Cost Improvement Plan targets as the plan transitioned into quarter 2, specifically with regard to workforce targets.<br><br><u>UHL Operations and Performance Committee – 28 May 2026</u><br>Mr S Adams, Operations and Performance Committee Non-Executive Director Chair highlighted the following discussions:<br>- The revised Board Assurance Framework (BAF) risk which combined risks for Urgent and Emergency Care (UEC), elective care and cancer performance was felt to be a positive change.<br>- Current demand pressures were an ongoing challenge.<br>- Cancer performance improvements were noted in the 31 day treatment target and notable reductions in radiotherapy backlogs.<br>- The late notice withdrawal of the single insourcing provider was a matter of concern, but mitigations were being developed.<br>- The Operations and Performance Committee annual report was recommended for approval with overall strong assurance on effectiveness, but points raised regarding the visibility of the committee workplan and escalation processes.<br><br><u>UHL Our Future Hospitals and Transformation Committee – 27 May 2026</u><br>Mr D Moon, Our Future Hospitals and Transformation Committee Non-Executive Director Member recommended the Our Future Hospitals and Transformation Committee annual report for approval, noting that the committee was considered to be functioning well, but some points were raised regarding the need to review elements of the committee's Terms of Reference.<br><br><u>UHN Strategy, Transformation and Digital Committee – 28 May 2026</u><br>Mr T Shipman, UHN Strategy, Transformation and Digital Committee Non-Executive Director Chair confirmed that all items received reasonable assurance. Specific discussions regarding digital and cyber security risks were noted, but imminent national guidance may require a further review. The Group Chief Digital Information Officer confirmed that relevant Board committees would be provided with a position statement following any national announcements.<br><br><u>UHN People Committee – 21 May 2026</u><br>Mr T Shipman, UHN People Committee Non-Executive Director Member noted that the committee received limited assurance on some items of business, but noted that significant work was underway to address the concerns particularly with regard to greater control of the use of bank staff.<br><br><u>UHL People and Culture Committee – 28 May 2026</u><br>Professor I Brown, UHL People and Culture Committee Non-Executive Director Chair reported that most of the reports provided substantial assurance, with some moderate assurance in terms of delivery. The Freedom to Speak Up Q4 and 2025/26 Annual Report and Resident Doctors' Contract – Guardian of Safe Working Report were both recommended to the Boards as standalone items of business and the Annual Report on the Effectiveness of the People and Culture Committee was recommended for approval. | |
| | **<u>Resolved</u> – that the escalation reports from the UHL Quality Committee held on 28 May 2026, the UHN Quality and Safety Committee held on 27 May 2026, the UHL Finance and Investment Committee held on 27 May 2026, the UHN Finance, Investment and Performance Committee held on 26 May 2026; the UHL Operations and Performance Committee held on 28 May 2026; the UHL Our Future Hospitals and Transformation Committee held on 27 May 2026, the UHN People Committee held on 21 May; and the UHL People and Culture Committee held on 28 May 2026, be noted, and any recommendations within be endorsed or approved where necessary by the applicable Board, namely;**<br><br>**- UHL Committee annual effectiveness reports for Quality Committee, Finance and Investment Committee, Operations and Performance Committee, Our Future Hospitals and Transformation Committee and People & Culture Committee; and** | **UHL DCLA** |

| | | |
|---|---|---|
| | **- Public Dividend Capital (PDC) cash support of £5m for Kettering General Hospital (KGH) and £1m for Northampton General Hospital (NGH).** | **UHN CFO** |
| **32/26** | **STRATEGY: REVIEW OF DELIVERABLES** | |
| 32/26/1 | 2025-26 Deliverables: Year End Review | |
| | The UHL Deputy Chief Executive presented a summary of the UHL year end performance against the Trust's 2025/26 deliverables and outlined the approach to development of targets and initiatives in relation to 2026/27 annual priorities covering both UHL and UHN. The following points were highlighted:<br>- The year had some challenges, but also a considerable number of improvements which crossed the 3 organisational priorities; transforming patient care, strengthening our culture, and delivering our financial plans.<br>- Care and quality improvements were noted, particularly in maternity and health innovation developments.<br>- Digital developments were notable, particularly the implementation of the Nervecentre Patient Administration System and the Badgernet EPR in maternity and neonates.<br>- Work was ongoing to improve access, Referral to Treatment (RTT) and cancer performance.<br>- Culture was difficult measure, but the staff survey provided a guide, but it was noted that completion rates had reduced compared to the previous year, but compared well to peers.<br>- The financial plan did not meet its original targets but met the re-forecast targets. Positive aspects of the plan were reduction in agency staff use, improved productivity and better oversight of finance, balanced with expenditure challenges regarding bank staff.<br>- Development programmes such as those regarding the use Artificial Intelligence became further embedded with new programmes on commercial opportunities and corporate consolidation promising to deliver in the future.<br><br>Mr A Inchley, UHL Non-Executive Director welcomed the progress made and highlighted the need to recognise the achievements. The Group Chief Executive also acknowledged the positive achievements, but also stressed the need to ensure these were communicated effectively.<br><br>The UHN Vice-Chair in summary also spoke of the need to celebrate achievements, but also acknowledge that unforeseen challenges such as industrial action could have an impact. The need for transformation going forward was highlighted, but also focus on those challenged areas such as fragile services. He confirmed that the Boards approval for the deliverables targets for 2026/27. | |
| | **Resolved - that the approach to development of targets and initiatives in relation to 2026/27 annual priorities for UHL and UHN be approved.** | **UHL DCE/ UHN DoCI** |
| **33/26** | **HIGH QUALITY CARE FOR ALL** | |
| 33/26/1 | KGH Maternity and Neonatal Intensive Support Team Programme | |
| | The Group Chief Nurse introduced the KGH Maternity and Neonatal Intensive Support Team Programme report, and reported that a meeting had taken place with national Executive Team overseeing the programme where positive progress was noted with some minor escalations to address.<br><br>The Group Director of Midwifery presented the report and noted the following points:<br>- The overall programme was heading a positive direction.<br>- Metrics in the report demonstrated that there was a positive experience of care, improvements on workforce and culture such as low turnover and improved consultant establishment, with job planning an area of focus going forward.<br>- Bellwether metrics had now been identified, and a quality improvement plan was in place.<br>- Actions for improvement were in place, focusing on induction of labour, documentation consistency and utilising the full effectiveness of the BadgerNet patient record system.<br>- A community services and equity deep dive was awaited from NHSE.<br>- The monthly national level meetings were showing good progress, but it was not possible at this stage to move to a business-as-usual position.<br><br>In discussion, the following points were raised and discussed: | |

| | | |
|---|---|---|
| | - The sustainability of the improvements was questioned, but it was noted that the overarching perinatal safety programme would ensure that actions and milestones from the Care Quality Commission (CQC) and those arising from the National Maternity and Neonatal Investigation and the Ockenden Review into Nottingham were included. The System level partnership would also ensure assurance and oversight as well as ongoing audits and transformation improvements.<br>- The point at which the national oversight could be removed was discussed, noting that it was a 12 month programme which commenced in December 2025, but milestones and targets would need to be met at that point. | |
| | **Resolved – that the report be noted and assurance received.** | |
| 33/26/2 | Perinatal Report | |
| | The Group Director of Midwifery presented the Perinatal Report encompassing the Perinatal Assurance Committee highlight reports and Perinatal Scorecards. The following points were noted:<br>- Future reporting would be bi-monthly, with metrics included within the integrated performance report.<br>- The overall view of services was that they were safe, but were under a level of pressure, with evolving governance through the development of an accountability framework to provide grip to provide assurance across the group.<br>- Workforce capacity remained challenged, with risks regarding variation in terms of outcomes and patient flow, but assurance was provided that sufficient cover was in place. Assurance was provided that recruitment was ensuring a pipeline of Midwife staff, but Obstetric staffing remained challenging and was being managed through recruitment and job design.<br>- Rates of smoking were being monitored through enhanced surveillance at Perinatal Assurance Committees with the emphasis on intervention rather than diagnosis.<br>- Patient flow was felt to be moving in the right direction with support from NHSE.<br>- Scan capacity was a risk at all sites, but a business case was in development.<br>- Neonatal demand remained high at group sites and across wider networks.<br>- Friends and family test promoter rates remained high.<br>- The development of an equity focussed scorecard remained in development, with the expectation that this would be in operation in October.<br>- Action on equalities, particularly regarding infant deaths in Leicester City, prematurity, smoking and obesity would require a System level focus and priorities had been agreed in Leicester City.<br>- In summary care was felt to be responsive and safe, but under pressure, with one to one care being maintained and indicators going in the right direction tears and breast feeding, but pace and delivery needed to be maintained.<br>- Reports from the National Maternity and Neonatal Investigation and the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trus were anticipated, but assurance was provided that services were ready to positively respond.<br><br>In discussion, the following points were raised and discussed:<br>- Ms J Houghton, Group Non-Executive Director provided feedback from the recent regional network meeting; the issue of vacancies was noted, particularly where it arose due to maternity leave; the role of the Maternity and Neonatal Voices Partnership was due to part of a presentation at a future meeting and a presentation on MBRRACE from regional NHSE was also programmed to provide greater awareness for Non-Executive Directors.<br>- The position regarding unplanned leave was being worked through with finance colleagues and would be monitored through the safe staffing report.<br>- The report was welcomed, particularly as it covered the entire UHL / UHN Group, but it was noted there was variation in the different needs in different areas covered by the group.<br>- The variation between maternity vacancies in the Perinatal report and the Integrated Performance Report was highlighted, but it was noted that this reflected different reporting time periods, as well as different reporting methods. | |
| | **Resolved – that the report be received and noted.** | |
| 33/26/3 | Nursing and Midwifery Bi-Annual Establishment Review Reports 2026: UHL and UHN | |
| | The Chief Nurse presented the bi-annual nursing and midwifery establishment reviews for both UHL and UHN. The following points were noted: | |

| | | |
|---|---|---|
| | - Both UHN and UHL were in similar positions, with assurance provided that staffing was safe, effective and sustainable.<br>- There were ongoing challenges arising from sustained operational pressures, the need to use temporary staffing and increased acuity pressures.<br>- The Safer Nursing Care Tool had been utilised to provide assurance regarding staffing levels.<br>- Challenges were also noted with regard to fill rates for Health Care Support Workers, particularly during the winter period.<br>- Assurance was provided that strong daily oversight was in place, backed up by monthly reporting.<br>- Further assurance was noted in that both UHN and UHL had reduced their levels of staff turnover, but plans were in place to reduce the number of substantive staff.<br><br>In discussion, the following points were raised and discussed:<br>- The reports were welcomed and the effort to required to undertake the reviews was commended.<br>- The implementation of Enhanced Theraputic Observations and Care at UHN was considered, noting the more advanced position of KGH, but challenges were noted at NGH, but the next review report would provide greater clarity.<br>- It was noted that the requirements of some patients needing 2-1 or even 3-1 care increased staffing pressures and the difficulties regarding access to social care was highlighted. These challenges had been monitored and discussed at both the UHN and UHL Quality Committees, where particular concern was noted and it was felt the matter required consideration at System level. The Group Chief Executive confirmed that he was meeting with System partners in the following week and undertook to raise the concerns at that meeting. | |
| | **<u>Resolved</u> – that (A) the UHN and UHL Boards confirm they accept the recommendations of the Group Chief Nurse and are assured that staffing is safe, effective and UHN and UHL Medical Directors that staffing is safe, effective and sustainable; and**<br><br>**(B) concerns be relayed to ICB colleagues at the Health Executive meeting, regarding delayed transfers of care and provide a report back to the Boards in Common.** | **GCN**<br><br>**GCEO** |
| 33/26/4 | <u>Quality Accounts 2025-26: UHL and UHN</u> | |
| | The Group Chief Nurse presented the UHL and UHN Quality Accounts for approval. It was acknowledged that there were ongoing challenges to address, clear evidence of sustainable improvements was provided within the reports such as improvements in patient flow and access for UEC. Specific improvements highlighted were reductions in 12 hour Emergency Department wait times, the implementation of safe staffing approaches, reduced levels of methicillin-resistant Staphylococcus aureus infections at KGH, and reduced Clostridioides difficile at both UHN and UHL. There were also clear quality priorities and strategies and perinatal safety programmes.<br><br>The UHN Vice-Chair confirmed that the Boards approved or endorsed both Quality Accounts and delegated any final amendments to the UHN Quality Accounts to the Group Chief Nurse and UHN Medical Director. | |
| | **<u>Resolved</u> – that (A) the UHL Quality Account for 2025-26 be approved for publication, and**<br><br>**(B) the draft UHN Quality Account for 2025-26 be endorsed and any final sign off authority be delegated to the Group Chief Nurse and UHN Medical Director.** | **GCN**<br><br>**GCN / UHN MD** |
| **34/26** | **A GREAT PLACE TO WORK** | |
| 34/26/1 | <u>Response to the NHS Staff Survey 2025 and Staff Standards</u> | |
| | The UHL and UHN Chief People Officers presented a report which provided a response to the NHS Staff Survey 2025 and provided details of staff standards which were part of the national 10-year Workforce Plan.<br><br>The UHL Chief People Officer noted the following points:<br>- UHL reported a decline in the response rate, but this was in line with the national picture, but feedback had still been received from 11,500 staff. | |

| | | |
|---|---|---|
| | - A programme of work had been developed based on the feedback including a new leadership programme, and the programme had been monitored at the People and Culture Committee.<br>- Clinical Management Groups were engaged and empowered to drive delivery of response actions, through 3 identified priorities.<br>- The relationship between staff and their line manager was felt to be critical in determining views of the organisation as a whole.<br>- The new national six standards for staff would be measured as part of future staff surveys and through National Oversight Framework.<br>- There would also be recommendations arising from the Lord Mann review into antisemitism and racism to be adopted and responded to in future.<br><br>The UHN Chief People Officer noted the following points:<br>- A decline in the response rate and recommend as a place to work was reported. KGH was notably below the national average generally on scores, and low scores were noted on staff engagement and morale at NGH.<br>- Low scores regarding belonging, wellbeing and work pressures reinforced the need for compassionate leadership and visibility.<br>- The response to the results had informed a programme of cultural improvements which were informed by and alignment to the national staff standards.<br>- Future actions in response to the staff survey included shared UHN / UHL workstreams such as a joint EDI Steering Group, flexible working priorities, leadership development and joint planning for the next staff survey.<br><br>In discussion, the following points were raised and discussed:<br>- The report demonstrated improvements which should be rightly celebrated, but also some areas for improvement in order to be comparable with the best NHS organisations, particularly with regard to staff safety and wellbeing.<br>- The potential for improvement in the 2026 staff survey responses was considered, partly noting a likely further deterioration in scores due to ongoing change, pressures and uncertainty. It was also acknowledged that many thousands of staff took the time to respond in the current year and there would be a continual drive to improve and respond to feedback, particularly at a local level.<br>- The importance of a timely response discussion at Boards meetings was highlighted and it was agreed that the response report for the 2026 staff survey should be considered in February 2027.<br>- The level of uncertainty faced by employees was discussed, noting that there were necessary changes being made to some roles, particularly for administrative employees. This was however balanced by the fact that this uncertainty impacted a small number of employees, who may be at risk of losing their job, or that their role was going to change, and greater clarity should be communicated to address concerns about uncertainty, based on concerns raised in the survey responses.<br>- The report included details of uncomfortable feedback particularly in respect of poor and disrespectful behaviour, which should not be tolerated. There needed to be a response to unacceptable behaviour and ensuring psychological safety for staff.<br><br>In summary, the UHN Vice-Chair, noted that it was important to stress areas of positive performance as well as negative, and to encourage staff to become ambassadors for their organisation, and noted the importance of undertaking action to improve the lives of staff where possible. | **CPOs**<br><br>**CPOs**<br><br>**CPOs** |
| | **<u>Resolved</u> – that (A) the response to the 2026 staff survey be considered at Boards in February 2027;**<br><br>**(B) communication be undertaken with staff which appropriately reflected the job future comments in the staff survey; and**<br><br>**(C) focus be maintained on, and appropriate responses be developed to address unacceptable behaviour and improve psychological safety for staff.** | **CPOs**<br><br>**CPOs**<br><br>**CPOs** |
| 34/26/2 | <u>Freedom to Speak Up Reports: UHN 25-26 Q4 Report & UHL 25-26 Annual Report</u> | |
| | The UHN Chief Executive presented the UHN 2026 Freedom to Speak Up quarter 4 report and noted that the highest ever level of concerns had been reported in 2025/26, and the highest | |

| | | |
|---|---|---|
| | division area for concerns was Corporate. The Guardian Service had commenced working with the UHN Group in May 2026 and increases in the number of concerns had been seen since this point.<br><br>In discussion, the following points were raised and discussed:<br>- The differences that colleagues would see from the Guardian Service were noted and these included, 2 full time dedicated guardians, where there would be a clear focus on promotion of their service at all levels of the organisation with details of how to contact them being promoted. The Service would be very active and undertake regular engagement, taking part in meetings with teams, but also highlighting where teams did not want to engage.<br>- The reasons for high levels of concerns from the Corporate division were felt to be not entirely clear, as this division covered a range of service areas, but it was thought to be largely due organisational change processes.<br>- The issues around concerns being raised anonymously were considered, noting that the Guardian Service may need to remove anonymity where necessary such as in relation to patient safety, but generally those people raising concerns were encouraged to introduce themselves to the Guardian Service, but some people raising concerns did wish to remain anonymous even to the point of not using their own email address.<br><br>Ms R Moss, UHL Freedom to Speak Guardian presented the UHL 2025-26 Annual Report and noted the following points:<br>- It had been a busy year, but concerns were very slightly below the previous year and the level of concerns reflected a healthy confidence in being able to speak up.<br>- Management issues were the highest theme for concerns, with Renal, Respiratory and Cardiovascular (RRCV) being the highest Clinical Management Group (CMG) for concerns, with Estates and Facilities being highest in quarter 4 – these figures were felt to reflect areas of promotion and engagement, with assurance provided that senior management were engaging well with the Guardian Service.<br>- The 73% decline in red concerns was felt to be a positive indicator of the service's effectiveness, with the impartial nature of the service also noted as important in encouraging people to speak up.<br>- The issue of discrimination was a recurring theme in concerns and the Guardian Service was proactively working with the differently abled staff network which was generating further concerns.<br>- Assurance was provided that red concerns were responded to within the same day in 100% of cases.<br>- The report outlined recommendations with responses having been provided, and these were reviewed at the People and Culture Committee.<br>- National level changes were being introduced regarding speaking up and this had been reported to the People and Culture Committee with minimal changes required, but it was intended to report data to Performance Review Meetings (PRMs) for increased oversight.<br><br>In discussion, concerns regarding line managers being an important area of concerns being raised, but it was noted that a new leadership framework was being introduced and it was suggested that the People and Culture Committee consider the impacts. The Chair of the UHL People and Culture Committee confirmed that triangulation was a key area of focus for the Committee, including the impacts of management changes to concerns being raised.<br><br>The UHN Vice Chair highlighted that the UHN Disability Network was assured that the Guardian Service was not a phone only service. He further acknowledged the key role of network chairs being a channel for concerns to be raised. He thanked the presenters for their reports. | |
| | **<u>Resolved</u> – that the reports be received and noted.** | |
| 34/26/3 | <u>UHL Guardian of Safe Working Report: December 2025 to March 2026</u> | |
| | Dr R Singh, UHL Guardian of Safe Working presented the UHL Guardian of Safe Working report for the period December 2025 to March 2026 and noted the following points:<br><br>- The report was the first covering a four monthly period which was felt to provide more accurate data in line with doctor rotations, with data re-set in May 2026 to reflect the change. | |

| | | |
|---|---|---|
| | - Exception reporting reforms were implemented in February 2026 which had been a considerable undertaking, with thanks to the Medical Human Resources Manager for delivering the change.<br>- The local Standard Operating Procedure (SOP) for exception reporting was included in the report, developed from collaboration with relevant stakeholders and would evolve over time.<br>- The levels of access to exception reporting had been considered as part of the review following the changes, with this now detailed in the SOP.<br>- Some challenges had arisen from the new rules such as the need for approval from those raising the report to enable a response to be actioned, but some of the reforms had not been implemented, such as the need to provide location in order to simplify matters.<br>- Immediate safety concerns were not covered by the reforms, but details would be included in the reporting if necessary.<br>- Dr A Patwardhan would be leaving the role of Guardian of Safe Working and she was thanked for her time in the role. The role would now be advertised to fill the vacancy.<br><br>In discussion, the following points were raised and discussed:<br>- The UHL Medical Director sought confirmation as to whether the Guardian of Safe Working felt adequately supported and this was confirmed as well as appropriate support from the Chief People Officer.<br>- The number of exception reports regarding unscheduled late finishes was felt to be low as a percentage of the overall number of late finishes.<br>- There was a year on year growth in the number of exception reports which demonstrated a greater level of confidence in the process, but it was down to the individual to decide whether to make a report, but also issues could 'snowball' with increased reporting following an initial exception report on a particular issue.<br>- There was generally a lack of awareness of changes to exception reporting processes, but this was felt to be due to smooth transition. | |
| | **<u>Resolved</u> – that the report be received and noted.** | |
| **35/26** | **GOVERNANCE** | |
| 35/26/1 | <u>Board Assurance Frameworks: UHN and UHL</u> | |
| | The Group Chief Nurse presented the UHN Board Assurance Framework (BAF) Quarterly Review, noting that Board Committees (except for Audit) had received a recent update, with Executive owners of risks being invited to future discussions to provide further assurance. No changes to risk scores were being proposed, but the Strategy, Transformation and Digital Committee would be taking an in depth look at cyber security risks.<br><br>Comments were noted that the changes to BAF reporting had provided improved assurance and enabled Non-Executive Directors to effectively undertake their roles.<br><br>The UHL Director of Corporate and Legal Affairs presented the UHL Board Assurance Framework and Significant Risk Report which covered the quarter 4 and closedown period for the 2025/26 BAF. The recent Internal Audit review confirmed substantial assurance for the strong BAF processes and monthly oversight of key risks including the BAF focussed approach to escalation reports. The recent refresh of BAF risks had reduced the overall number of risk, but assurance was provided that risks were still captured as required. A further piece of work was being undertaken to ensure that actions for risks had appropriate timelines. It was also noted that deep dives into service area risks would continue as a key part of the Risk Committee activity. | |
| | **<u>Resolved</u> – that (A) the reports be received and noted; and**<br><br>**(B) the UHL Board approve the 2026/27 Board Assurance Framework, subject to the finalisation of the Activity risk.** | |
| **36/26** | **ANY OTHER BUSINESS** | |
| | The UHN Vice-Chair posed questions for the Boards, about whether there had been sufficient consideration during the meeting of the 3 UHL/UHN Group priorities, transforming patient care, | |

| | | |
|---|---|---|
| | strengthening our culture, and delivering our financial plans; and how a greater impact could be made in future meetings. The following comments were made in response:<br>- The 3 priorities had been discussed, but there had been little discussion about the levers between the priorities and how there could be prioritisation.<br>- There were interdependencies between the priorities, such as good finance made investment in care more possible. It was questioned whether there should be greater guidance on interdependencies.<br>- The meeting considered a number of update and assurance reports, with the level of actions arising from the discussions was felt to be limited, but this should be the focus of future Boards meetings.<br>- The way in which Board discussions were communicated was questioned as it was suggested there was a lack of awareness of the role of the Boards, with examples provided of senior Pathologists being unaware of Trust priorities.<br>- Examples of delivering good quality care with good financial management were felt to be key in terms of providing a way forward to becoming a high performing organisation.<br>- The patient story from the beginning of the meeting was discussed in terms of the balance between care provided and associated costs.<br>- The importance of balance between priorities going forward was highlighted with questions around the role of System partners and how change could be delivered, as well as a greater strategic focus. | |
| **37/26** | **QUESTIONS FROM THE PRESS AND PUBLIC** | |
| | There were no questions from the press or public. | |
| **38/26** | **DATE AND TIME OF NEXT MEETING** | |
| | The Boards noted that the next Public Boards meeting will be held on 7 August 2026 in the Boardroom, Northampton General Hospital at 9.30am. | |

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

| Name | Possible | Actual | % attendance | Name | Possible | Actual | % attendance |
|---|---|---|---|---|---|---|---|
| A Moore (Chair) | 3 | 2 | 67 | P Kirkpatrick | 3 | 3 | 100 |
| S Adams | 3 | 3 | 100 | R Mitchell | 3 | 3 | 100 |
| L Bond | 3 | 3 | 100 | D Moon | 3 | 3 | 100 |
| I Browne | 3 | 3 | 100 | H Nemade | 3 | 3 | 100 |
| L Churchward | 3 | 3 | 100 | S Noonan | 3 | 2 | 67 |
| A Cooper | 3 | 2 | 67 | T Robinson | 3 | 1 | 33 |
| S Gay | 3 | 3 | 100 | T Shipman | 3 | 3 | 100 |
| A Haynes | 3 | 2 | 67 | S Stansfield | 3 | 3 | 100 |
| H Hendley | 3 | 2 | 67 | C Stevens | 3 | 2 | 67 |
| J Hogg | 3 | 2 | 67 | D Venkatasamy | 3 | 1 | 33 |
| J Houghton | 3 | 3 | 100 | C Welsh | 3 | 3 | 100 |
| A Inchley | 3 | 3 | 100 | G Xu | 3 | 3 | 100 |
| D Kirkham | 3 | 2 | 67 | | | | |

**Non-Voting Members:**

| Name | Possible | Actual | % attendance | Name | Possible | Actual | % attendance |
|---|---|---|---|---|---|---|---|
| R Abeyratne | 3 | 3 | 100 | H Kotecha | 3 | 2 | 67 |
| S Barton | 3 | 3 | 100 | W Monaghan | 3 | 3 | 100 |
| B Cassidy | 3 | 3 | 100 | S O'Neill | 3 | 3 | 100 |
| E Casteleijn | 3 | 3 | 100 | B Taylor | 3 | 2 | 67 |
| P Grimmett | 3 | 2 | 67 | C Teeney | 3 | 3 | 100 |
| S Harris | 3 | 0 | 0 | | | | |

## Progress of UHN and UHN/UHL actions arising from the Boards' meeting held on 11 June 2026

| Item no. | Minute Ref: | Action | Lead | By When | Progress Update | RAG status* |
|---|---|---|---|---|---|---|
| **11 June 2026** | | | | | | |
| 1.4 | 28/26 | **Minutes of the previous meeting**<br>To update the minutes of the 8.5.26 to highlight the questions raised by Healthwatch. | **UHN CoSec**<br>**R May** | **Immediate** | Complete. | **5** |
| 3.3 | 31/26/3 | **Integrated Performance Report**<br>To provide an update to Ms J Houghton, Non-Executive Director regarding the rollout of PEWS (Paediatric Early Warning System) metrics. | **GCN**<br>**J Hogg** | **August 2026** | In progress | **4** |
| 5.3 | 33/26/3 | **Nursing and Midwifery Bi-Annual Establishment Review Reports 2026**<br>To relay concerns to ICB colleagues at the Health Executive meeting, regarding delayed transfers of care and provide a report back to the Boards in Common. | **CEO** | **HE 19.06.26 & BiC (n/a)** | Complete. | **5** |
| 6.1 | 34/26/1 | **Response to the NHS Staff Survey 2025 and Staff Standards**<br>To ensure that communication with staff appropriately reflected the job future comments in the staff survey. | **CPOs** | **July 2026** | Assurance provided to the July 2026 meeting of the People Committee (upward report refers) | **5** |
| 6.1 | 34/26/1 | To maintain focus on and develop appropriate responses to address unacceptable behaviour and improve psychological safety for staff. | **CPOs** | **July 2026** | Assurance provided to the July 2026 meeting of the People Committee (upward report refers) | **5** |
| **8 May 2026** | | | | | | |
| 3.3i | 22/26/3 | The Director of Continuous Improvement (UHN) undertook to work with Chief Operating Officers to review performance indicator definitions for length of stay to account for possible differences between UHN and UHL. | **B Taylor** | **August 2026** | Not required following decision to decouple UHN/UHL Group: close | **5** |
| 3.3ii | 22/26/3 | To provide a detailed projected timeline to bring NGH Mortality indicators within expected levels. | **H Nemade** | **August 2026** | Presented to the Quality and Safety Committee in July 2026: update report provides commentary | **5** |
| 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** |
| 6.1 | 25/26/1 | To clarify oversight arrangements for the UHN Community Engagement Strategy as part of the current review of committees being led by the Vice-Chairs | **B Cassidy** | **On hold** | Review of Committees discontinued following decision to decouple UHN/UHL group arrangements: close | **5** |
| **9 April 2026** | | | | | | |

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

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

| Item no. | Minute Ref: | Action | Lead | By When | Progress Update | RAG status* |
|---|---|---|---|---|---|---|
| 2a | 18/26/3 | To review and put in place improvements in the cancer pathway, relating to engagement with families. | **GpCN DoC&E (UHL & UHN) J Hogg, E Casteleijn, S O'Neill** | **July 2026 QC** | Built into the quarterly cancer report for Quality Committees. | **5** |
| 2c | 18/26/3 | To develop a single group Integrated Performance Report | **DoCI (UHN)/ COO (UHL) B Taylor** | **BiC 8.10.26** | Not required following decision to decouple UHN/UHL group: close | **5** |
| 2d | 18/26/3 | To consider how to incorporate more up to date data within the Integrated Performance Report. | **DoCI (UHN)/ COO (UHL) B Taylor** | **Boards 10.9.26** | Update provided at agenda item 5 | **5** |
| 4 | 19/26/1 | **Group Perinatal Report and Dashboards** To provide greater clarity on key, high level risks in future reports. | **GpCN J Hogg** | **June 2026** | Reflected from June 2026. | **5** |
| 5 | 20/26/2 | **Group Research and Innovation Report** To present a proposal to Boards in Common for a single group Research and Innovation framework. | **MD (UHN & UHL) / DoR&I H Nemade / G Xu / N Brunskill** | **10.9.26** | 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 / G Xu / N Brunskill** | **10.9.26** | 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 / G Xu / N Brunskill** | **10.9.26** | 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*** |
|---|---|---|---|---|---|---|---|---|---|---|

# 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 | 10 September 2026 |
| Agenda item | 5 |

| | |
|---|---|
| Title | Chief Executive's Report |
| Presenter | Julie Hogg, Interim Managing Director & Group Chief Nurse |
| Authors | Julie Hogg, Interim Managing Director & Group Chief Nurse & Richard Mitchell, Group Chief Executive |

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

| This paper is for | | | |
|---|---|---|---|
| ☐ Approval | ☐ Discussion | ☒ Note | ☐ Assurance |
| To formally receive and discuss a report and approve its recommendations OR a particular course of action | To discuss, in depth, a report noting its implications for the 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 |
|---|---|
| To update the Boards on significant organisational developments, strategic priorities, key achievements and matters of importance arising during the reporting period. | None |

## Executive Summary

**Chief Executive's Update**

This month has been one of significant achievement and important transition for University Hospitals of Northamptonshire NHS Group (UHN). Alongside continued focus on quality, operational performance and financial sustainability, we have reached several major

milestones that demonstrate both our ability to deliver large-scale transformation and our commitment to maintaining a compassionate, values-led culture.

**Organisational Arrangements**

Last month our boards announced the decision that UHN and University Hospitals of Leicester will move away from the current formal Group model arrangements. While this represents a change in organisational structure, it does not diminish the strong relationships that have been developed over recent years or our commitment to continued collaboration.

As a Group organisation comprising Northampton General Hospital and Kettering General Hospital, UHN remains fully committed to working as one organisation, sharing expertise, resources and learning across our sites to deliver the best possible outcomes for patients and communities. We will continue to build on the benefits already achieved through closer working and maintain a relentless focus on improving quality, productivity and patient experience across UHN.

The immediate focus has been on ensuring stability for our staff and services, maintaining momentum against our organisational priorities and developing plans for a smooth transition. The Boards can be assured that patient care and operational delivery remain our primary focus throughout this period of change.

**Digital Transformation**

A major highlight this month has been the successful implementation of the Electronic Patient Record (EPR) at Northampton General Hospital. This represents one of the most significant transformation programmes undertaken by the organisation and marks an important step forward in our digital maturity.

The successful go-live reflects the commitment and resilience of colleagues across the Trust who have supported programme delivery, training, testing and implementation. The EPR provides a strong foundation for improved clinical workflows, enhanced patient safety and future service transformation. Focus is now turning towards optimisation and benefit realisation as the system becomes embedded in daily practice.

**Urgent and Emergency Care**

Good progress continues to be made with the development of the new Urgent Treatment Centre (UTC) at Northampton General Hospital. This important investment will strengthen the urgent and emergency care pathway, improve patient experience and support more effective patient flow across the hospital.

The UTC is a key component of our wider plans to improve access, resilience and operational performance and will be particularly important as we prepare for the pressures associated with the winter period. The UTC opens on 7th September 2026.

**Our People and Culture**

Thanks to the support of Northamptonshire Healthcare Charity, we were proud to unveil the Memory Tree at Kettering General Hospital. This staff-led initiative provides a permanent space for reflection and remembrance, honouring colleagues and patients who have died. The unveiling was a moving occasion and a powerful reflection of the compassion, kindness and sense of community that underpin our culture at UHN. It demonstrates our commitment to supporting colleagues through bereavement and

creating opportunities to remember those who have made a lasting impact on our hospitals and communities. Building on its success, plans are now being developed to create a similar space at Northampton General Hospital.

The month also saw the successful induction of more than 300 doctors joining UHN as part of the national August rotation, reflecting the considerable efforts of our workforce and education teams in supporting the next generation of healthcare professionals.

In addition, colleagues have received recognition for a number of quality improvement initiatives, including work in stroke and audiology services, with aspects of the audiology programme being recognised as potential national exemplar practice.

**Publication of the CQC Adult Inpatient Survey Results**

This month also saw publication of the latest Care Quality Commission (CQC) Adult Inpatient Survey, providing valuable feedback from more than 850 patients who received care at Northampton General Hospital and Kettering General Hospital. The results highlighted significant strengths across UHN, particularly in the kindness, compassion and professionalism of our staff, with patients reporting high levels of respect, dignity, privacy and confidence in nursing teams. While Kettering's overall patient experience score was in line with the national benchmark, Northampton's score was below average, reinforcing the need for continued focus on improving communication, involving patients and families in decisions about their care, discharge planning, and responding to individual needs. The Boards can be assured that improvement actions are already being progressed at both Trust and ward level, with the findings helping to shape our patient experience priorities for the year ahead. This will be overseen by the Quality and Safety Committee.

**Looking Ahead**

As we move into autumn, our priorities remain unchanged: delivering safe, high-quality care; improving operational performance and patient experience; supporting our people; delivering our financial plan; and ensuring the successful implementation of major transformation programmes.

I would like to thank colleagues across Northampton General Hospital and Kettering General Hospital for their continued professionalism, commitment and dedication during a period that has combined significant organisational change with major achievements for the Trust and the communities we serve.

**Recommendation**

The Boards are asked to receive and note the report.

| Appendices |
| --- |
| None |
| Risk and assurance |
| No direct implications |
| Financial Impact |
| None arising from this information report. |
| Legal implications/regulatory requirements |
| None arising from this information report. |
| Equality Impact Assessment |
| Neutral |

# 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 | 10th September 2026 |
| Agenda item | 6 |

| | |
|---|---|
| Title | Integrated Performance Report (IPR) |
| Facilitator | Julie Hogg, Managing Director and Group Chief Nurse |
| Authors | Julie Hogg, Managing Director and Group Chief Nurse<br>Robin Binks, Interim UHN Chief Nursing Officer<br>Hemant Nemade, Medical Director<br>Sarah Noonan, Chief Operating Officer<br>Paula Kirkpatrick, Chief People Officer<br>Sarah Stansfield, Chief Finance Officer<br>Becky Taylor, Director of Continuous Improvement |

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

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

| Reason for consideration | Previous consideration |
|---|---|
| The Integrated Performance Report (IPR) provides an overview of KGH and NGH's performance. | The IPR is produced on a monthly basis. |

## Executive Summary

The Integrated Performance Reports (IPR) for the September 2026 Boards are enclosed, which report on July 2026 performance. Executive Leads will draw the Board's attention to significant exceptions within the Caring, Safe, Effective, Responsive, Well-Led and Use of Resources domains.

**IPR Production and Development**

The Federated Data Platform (FDP)-enabled IPR continues to demonstrate stable and reliable functionality, supporting a consistent reporting process, with the reporting and approach now used across multiple other reports, particularly to report Quality data.

Following the go-live of the Electronic Patient Record at NGH, work can commence on the automation of core clinical system metrics and enhancements that had been paused pending work on national reporting. This will significantly improve the speed of production and eliminate the remaining manual steps in the process. In parallel, the Divisional Accountability Meeting reports that take the IPR metrics through the organisation are being automated with an aim to complete for data from the month of September, and an automated dashboard to support forecasting of the National Oversight Framework (NOF) position is under development. Consideration to be made as part of this development as to what views may be appropriate to share with Board members.

Features that were stood down from the IPR in the move to FDP including the benchmarking functionality and the provision of some data in tables, work will now re-commence on developing these into FDP, with a workplan and target dates to be agreed with the national team.

Future planned updates with target Board(s) dates:

- Addition of sepsis six compliance metrics – October 2026
- Change of pressure ulcer metric to be percentage of spells with a new pressure ulcer to align with the NOF definition – October 2026
- Addition of percentage of all patient safety incidents defined as resulting in harm to align with the NOF – October 2026
- Addition of 6-week diagnostic performance to align with the NOF – October 2026
- Addition of the delayed induction rate metric to align with the NOF – October 2026
- Addition of the number of patients in the period cared for in corridors to align with the NOF – October 2026
- Addition of the number of E. Coli infections to align with the NOF – October 2026
- Automation of core clinical system metrics – October 2026
- Automation of quality and workforce metrics – November 2026
- Addition of the 30-day re-admission rate – December 2026

The Board is asked to indicate assurance from the IPR on UHN performance.

## Appendices

Appendix 1: Integrated Performance Report, reporting period July 2026
Appendix 2: IPR Financial tables, reporting period July 2026
Appendix 3: Board Committees summaries from June, July and August 2026 meetings

## Risk and assurance

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

## Financial Impact

No direct implications relating to this assurance report.

## Legal implications/regulatory requirements

No direct implications relating to this assurance report.

## Equality Impact Assessment

Neutral

This report may be subject to disclosure under the Freedom of Information Act 2000, subject to the specified exemptions.

## Our overall performance

### Understanding performance against our key delivery metrics

- July's performance shows a mixed picture across key metrics.
- Serious harms remain stable following a decrease across UHN in April.
- Patient satisfaction has shown a dip in July, to 91.6% in KGH and 88% in NGH. Some notable areas including ED areas in NGH and outpatients at KGH have improved. There has been a lower than usual response rate in July which will likely be impacting on performance, which is likely to continue into August, particularly in NGH, with the switch off of SMS responses midway through the month.
- Both SHMIs have seen an increase, although KGH remains in the 'as expected' range. There has been an increase in SHMI in NGH in recent months, although remains in 'as expected' range, with the causes related to changes in SDEC and a reduction in coding depth. However there is no evidence of an increase in mortality with significant oversight from the relevant patient safety and mortality groups and quality committee has received an in-depth report on the impact of data changes on mortality metrics.
- A&E 4-hour performance remains stable at 79.8% (KGH). NGH performance has declined slightly to 71%, but this remains an 11% increase compared to July last year. There has been an increase in ambulance handover performance in NGH despite increased ambulance attendances, but ambulance handovers remain an area of challenge primarily as a result of high bed occupancy associated with high numbers of patients with no reason to reside, which has been decreasing in both Trusts since January, impacting flow.
- Cancer metrics remain stable, with plans in place to address challenges in breast and colorectal. 52 week waits continue to reduce across the Group and ahead of plan, continuing to be very low in KGH. RTT performance has improved significantly in KGH, but the plan remains challenging to achieve for the year. Mission RTT plans are in place for September with an aim to focus rapid improvements on productivity in support of the RTT target.
- Total WTE has increased in July, and remains above plan. Bank and agency spend have increased in July, with bank significantly above plan whilst agency remains below plan.
- Financial performance is £1m adverse to plan for M4, and YTD CIP delivery slightly ahead of plan. However as the efficiency requirement increased in M4, in-month delivery has fallen to 60% of target. Significant work is underway to mitigate the gaps in the financial plan delivery. There is a risk in the identification and then subsequent delivery of the full CIP delivery value for the year.

| METRIC | KGH | NGH | TARGET | STAR |
|---|---|---|---|---|
| **INCIDENTS** | | | | |
| Serious or moderate harms per 1000 bed days | 0.19 | 0.24 | — | |
| **PATIENT EXPERIENCE** | | | | |
| Friends and Family Test satisfaction score - Trustwide | 91.6 % | 88 % | 90 % | |
| **MORTALITY** | | | | |
| SHMI | 101.84 | 109.5 | 100 | |
| **UEC** | | | | |
| Ambulance handover 45 minute performance | 77.62 % | 69.5 % | 99 % | |
| A&E 4 hour performance | 79.8 % | 70.63 % | 78 % | |
| **CANCER** | | | | |
| 62-day wait for first treatment | 61.1 % | 63.7 % | 80 % | |
| **ELECTIVE** | | | | |
| 52 week waits as a % of the waiting list | 0.36 % | 0.9 % | 1 % | |
| **WORKFORCE FINANCIAL SUSTAINABILITY** | | | | |
| Total WTE (PWR figure) | 5,110.55 | 6,452.83 | — | |
| Bank Spend as % of Total Pay | 9.57 % | 12.78 % | 6.3 % | |
| Agency Spend as % of Total Pay | 1.33 % | 1.97 % | 2 % | |
| **FINANCE** | | | | |
| Surplus / deficit | -3,158 | -5,064 | — | |
| **PRODUCTIVITY AND EFFICIENCY** | | | | |
| CIP Delivery | 60.3 % | 65.7 % | 100 % | |

| | Consistently hit target | Not consistently achieved or failed | Consistently fail target | No target set |
|---|---|---|---|---|
| Special Cause Improvement | | • Agency Spend as % of Total Pay - NGH | • A&E 4 hour performance - NGH | |
| Common Cause | • 52 week waits as a % of the waiting list - KGH<br>• Agency Spend as % of Total Pay - KGH | • A&E 4 hour performance - KGH<br>• 52 week waits as a % of the waiting list - NGH<br>• CIP Delivery - NGH<br>• CIP Delivery - KGH | • Ambulance handover 45 minute performance - KGH<br>• Ambulance handover 45 minute performance - NGH<br>• 62-day wait for first treatment - NGH<br>• 62-day wait for first treatment - KGH<br>• Bank Spend as % of Total Pay - KGH<br>• Bank Spend as % of Total Pay - NGH | • Serious or moderate harms per 1000 bed days - KGH<br>• Serious or moderate harms per 1000 bed days - NGH<br>• Total WTE (PWR figure) - KGH<br>• Total WTE (PWR figure) - NGH |
| Special Cause Concern | • Friends and Family Test satisfaction score - Trustwide - KGH | • Friends and Family Test satisfaction score - Trustwide - NGH<br>• SHMI - KGH | • SHMI - NGH | • Surplus / deficit - KGH<br>• Surplus / deficit - NGH |

Signed off by **Rebecca Taylor** on 3 Sept 2026, 04:52

## Caring domain

### Good news

NGH saw similar scores in overall satisfaction scores (88.0% compared with 88.2% in June).

Notable increased patient satisfaction performance seen in July in the following areas:

NGH - A&E 77.5% (74.1% in June).

NGH - SDEC 79.8% (76.1% in June).

NGH - Eye Casualty 88.1% (79.3% in June).

NGH - Paediatric ED 85.2% (83.5% in June).

KGH - Postnatal Ward 100% (95.8% in June).

Total FFT responses for July:

KGH 3,691

NGH 5,131

### Areas of concern

KGH saw a decrease in overall satisfaction scores (91.6% compared with 93.4% in June).

Notable decrease in patient satisfaction performance seen in the following areas:

NGH - Postnatal Ward 91.0% (93.4% in June).

NGH - Springfield 87.9% (89.2% in June).

KGH - Medical SDEC 68.2% (78.9% in June).

KGH - Antenatal Community 28.6% (100% June).

Notification received that NGH FFT provider will cease to supply a system as of 31st August 2026.

### Improvement plans in place

Divisional FFT performance packs provided to Divisional Leads who then report performance and mitigate actions to the Patient Experience & Engagement Committee ( PCEEC).

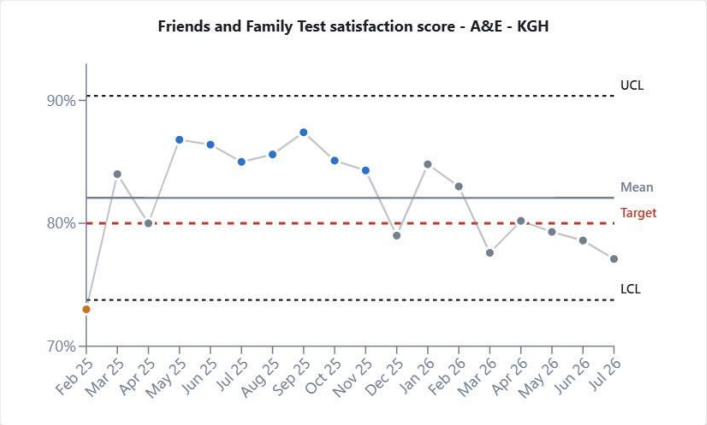
Steps undertaken with UHN Procurement Team to go out to tender for a new FFT survey supplier via the NHS framework. Interim plan in place to utilise a manual process during the period between suppliers. Project plan in place.

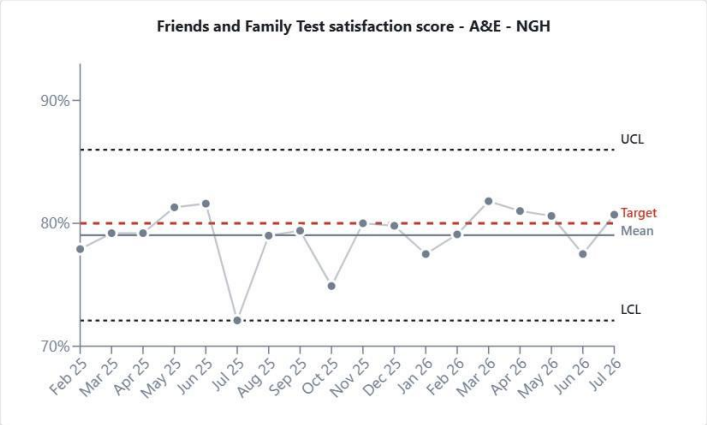
| METRIC | KGH | NGH | TARGET | STAR |
|---|---|---|---|---|
| Friends and Family Test satisfaction score - A&E | 77.1 % | 80.7 % | 80 % | |
| Friends and Family Test satisfaction score - inpatients | 91.8 % | 93.2 % | 95 % | |
| Friends and Family Test satisfaction score - maternity | 88.9 % | 95.1 % | 95 % | |
| Friends and Family Test satisfaction score - outpatients | 98.2 % | 91 % | 95 % | |
| Complaints response performance | 45 % | 20 % | 95 % | |
| Single sex breaches | — | 21 | 0 | |

| | Consistently hit target | Not consistently achieved or failed | Consistently fail target | No target set |
|---|---|---|---|---|
| Special Cause Improvement | | | | |
| Common Cause | | • Friends and Family Test satisfaction score - A&E - NGH<br>• Friends and Family Test satisfaction score - A&E - KGH<br>• Friends and Family Test satisfaction score - inpatients - NGH<br>• Friends and Family Test satisfaction score - maternity - NGH<br>• Friends and Family Test satisfaction score - outpatients - KGH<br>• Single sex breaches | • Complaints response performance - NGH | |
| Special Cause Concern | | • Friends and Family Test satisfaction score - inpatients - KGH<br>• Friends and Family Test satisfaction score - maternity - KGH<br>• Complaints response performance - KGH | • Friends and Family Test satisfaction score - outpatients - NGH | |

## Friends and Family Test satisfaction score - A&E

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




### Understanding the performance

KGH saw a further decrease in patient satisfaction within the ED services as a total, achieving 77.1% satisfaction (78.6% June, 79.3% May) - (target = 80%).

NGH saw an increase in patient satisfaction, and met target, within the ED services as a total, up from 77.5% in June, to 80.7% (target = 80%).

KGH Medical SDEC patient satisfaction continued on a downward trend at 68.2% (78.9% June and 83.0% May).

NGH – SDEC saw an increase from 76.1% in June to 79.8%.

### What are the issues impacting performance?

KGH – all services (A&E, SDEC, Paeds A&E) within ED unable to reach the 80% target, which have impacted the overall ED services score. SDEC was a particularly poor performer achieving 68.2% satisfaction.

NGH – Both SDEC and A&E satisfaction scores fell below the 80% satisfaction target which have impacted the overall ED score.

Challenging month with sustained pressures across the whole UEC pathway resulting in prolonged ambulance offloads and long waits in services affecting patient experience.

### What SMART actions are being taken to improve?

Divisional FFT performance packs provided to Divisional leads who then report performance and mitigating actions to the Patient & Carer Experience & Engagement Committee (PCEEC).

Focused Urgent care work in progress with both divisions.

### Risks

Notification received that NGH FFT supplier will cease from 31st Aug 2026. Steps undertaken with UHN Procurement team to go out to tender via the NHS Framework. Interim plan in place to utilise a manual process during the period between suppliers. Project plan in place.

DATA VALUES

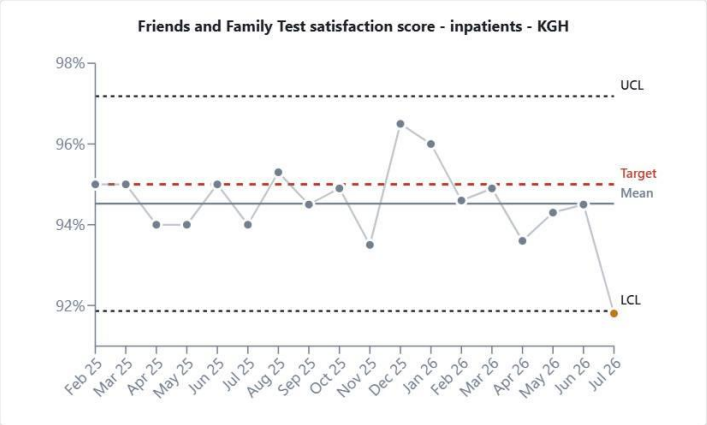
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 77.1 % | 82.07 % | 80 % | |
| NGH | 80.7 % | 79.03 % | 80 % | |

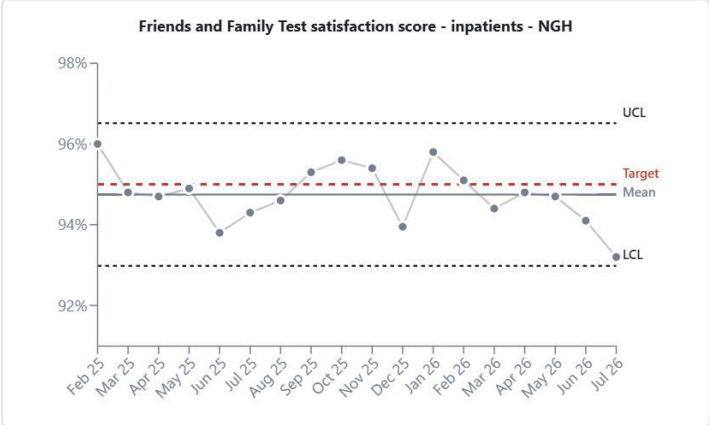
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Friends and Family Test satisfaction score - inpatients

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




## Understanding the performance

KGH remained below 95% target demonstrating a decrease in satisfaction scores, obtaining 89.4% compared with 93.6% in June.

NGH saw a slight decrease in inpatient satisfaction scores in July, with 92.6% compared with 93.6% in June, also failing to met the target of 95%.

886 Inpatient FFT responses received for KGH

675 Inpatient FFT responses received for NGH

## What are the issues impacting performance?

**Reviewing wards that had at least 10 responses:**

**KGH Wards showing the greatest decline**

Harrowden A decreased from 95.2% in June to 42.9% in July (-52.3%).

Barnwell C decreased from 89.5% in June to 72.7% in July (-16.%).

Naseby B decreased from 95.3% in June to 84.1% in July (-11.2%).

Gynaecology SDEC decreased from 76.2% in June to 66.7% in July (-9.5%).

Digestive Diseases Unit decreased from 97.1% in June to 90.5% in July (-6.6%).

**NGH Wards showing the greatest decline**

Willow Ward decreased from 90.9% in June to 60.0% in July (-30.9%).

Abington Ward decreased from 100.0% to 91.7% (-8.3%).

Compton Ward decreased from 100.0% to 91.7% (-8.3%).

Esther White Ward decreased from 100.0% to 94.9% (-5.1%).

Cedar Ward decreased from 93.2% to 88.2% (-5.0%).

## What SMART actions are being taken to improve?

Divisional FFT performance packs provided to Divisional leads who then report performance and mitigating actions to the Patient & Carer Experience & Engagement Committee (PCEEC)

Monthly performance data by ward provided to senior nursing leads to highlight specific areas for improvementa and delivery of divisional action plans.

## Risks

Notification received that NGH FFT supplier will cease from 31st Aug 2026. Steps undertaken with UHN Procurement team to go out to tender via the NHS Framework.

DATA VALUES

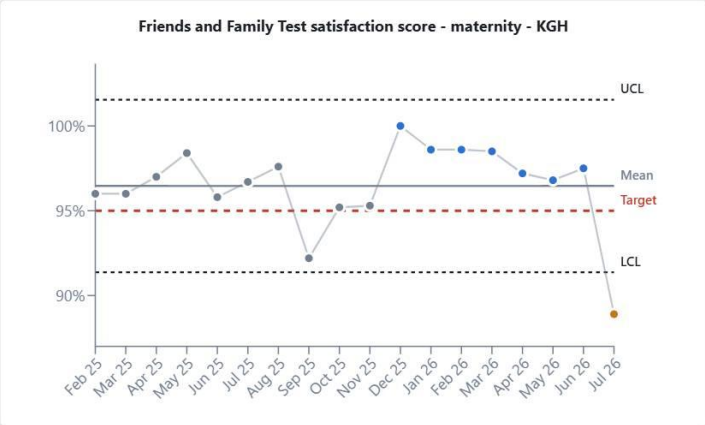
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 91.8 % | 94.52 % | 95 % | |
| NGH | 93.2 % | 94.75 % | 95 % | |

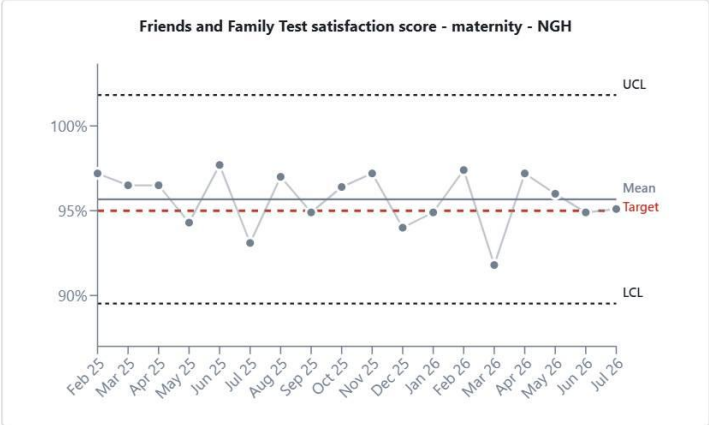
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Friends and Family Test satisfaction score - maternity

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




## Understanding the performance

KGH performance dropped with July scoring 88.9% compared with 97.5% in June (above 95% target).
NGH saw a slight increase in performance, up from 94.9% in June to 95.1% in July (under target).

54 FFT responses received for KGH.

197 FFT responses received for NGH.

KGH response dropped from 157 in June to only 54 in July.

## What are the issues impacting performance?

KGH - All areas achieved the 95% target or above, with the exception of Maternity Triage. However, the score for this area is believed to be artificially low due to issues with how responses have been categorised. A number of responses that should be linked to Antenatal Community services appear to have been recorded elsewhere, impacting the overall result. As such, the 'antenatal community' score should be interpreted with caution pending further review of the data.

NGH - All areas within NGH Maternity achieved the 95% target, with the exception of the Postnatal (PN) Wards, which achieved an overall score of 91.0%. This lower score appears to be largely attributable to Robert Watson Ward, which achieved 82.9%. In comparison, Balmoral Ward achieved 96.9%, while the Transitional Care (TC) Unit achieved 100%.

## What SMART actions are being taken to improve?

Divisional FFT performance packs provided to Divisional leads who then report performance and mitigating actions to the Patient & Carer Experience & Engagement Committee (PCEEC).

Monthly performance data by ward provided to senior nursing leads to highlight specific areas for improvement.

## Risks

Notification received that NGH FFT provider will cease to supply a system as of 31st Aug 2026. Steps undertaken with UHN Procurement team to go out to tender via the NHS Framework.

DATA VALUES

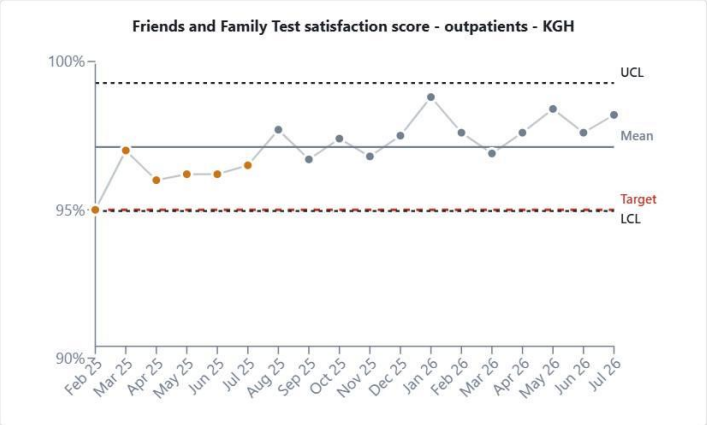
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 88.9 % | 96.46 % | 95 % | |
| NGH | 95.1 % | 95.67 % | 95 % | |

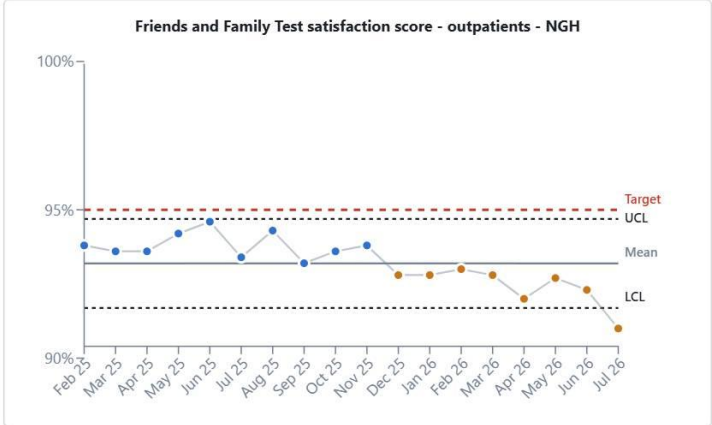
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Friends and Family Test satisfaction score - outpatients

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




## Understanding the performance

Slight improvement in KGH performance achieving 98.2% from 97.6% in June (95% target achieved).

NGH performance dropped slightly achieving 91%, compared with June scoring 92.3% (remains below the 95% target).

1,498 FFT responses received for KGH.

2,425 FFT responses received for NGH.

## What are the issues impacting performance?

Specialties showing the greatest decline (10 or more responses)

**NGH -** Blood Taking Unit decreased from 83.7% in June to 63.8% in July (-19.9%).

Anticoagulant Service decreased from 94.6% to 83.3% (-11.3%).

Rheumatology decreased from 90.6% to 84.0% (-6.6%).

Breast decreased from 96.1% to 93.9% (-2.2%).

Paediatrics decreased from 93.9% to 91.7% (-2.2%).

**KGH -** Cardiac Investigations decreased from 98.5% in June to 85.7% in July (-12.8%).

Pre-assessment decreased from 100.0% to 93.3% (-6.7%).

Outpatients - Nene Park decreased from 96.6% to 94.5% (-2.1%).

Breast Unit Treatment Centre decreased from 100.0% to 97.4% (-2.6%).

## What SMART actions are being taken to improve?

Divisional FFT performance packs provided to Divisional leads who then report performance and mitigating actions to the Patient & Carer Experience & Engagement Committee (PCEEC).

## Risks

Notification received that NGH FFT provider will cease to supply a system as of 31st Aug 2026. Steps undertaken with UHN Procurement team to go out to tender via the NHS Framework.

DATA VALUES

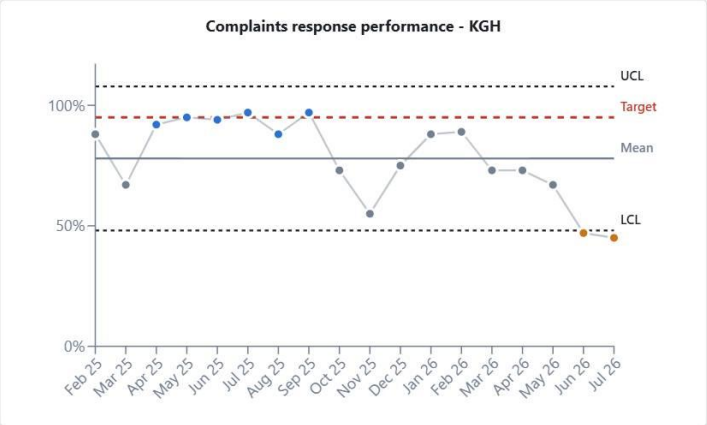
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 98.2 % | 97.12 % | 95 % | |
| NGH | 91 % | 93.19 % | 95 % | |

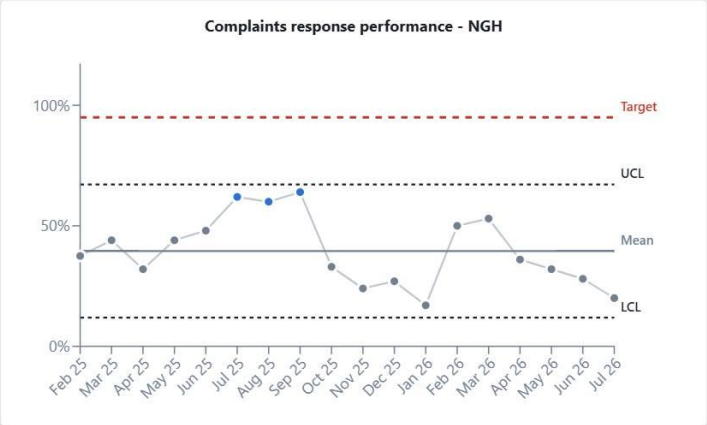
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Complaints response performance

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




## Understanding the performance

KGH performance dropping against 60 day target, due to teams assisting with NGH cases and unforeseen absence in team.

NGH has dropped against 60 day target but focused work on 120 day deadline.

## What are the issues impacting performance?

Unforeseen absence

Increased volume with cases being logged

## What SMART actions are being taken to improve?

Additional support within the team

New starter started in July

Focus on 120 day cases

Linking in with triumvirates for responses back

Team working across UHN and divisional based

## Risks

Ongoing absence within team

Continued increase in cases being logged

DATA VALUES

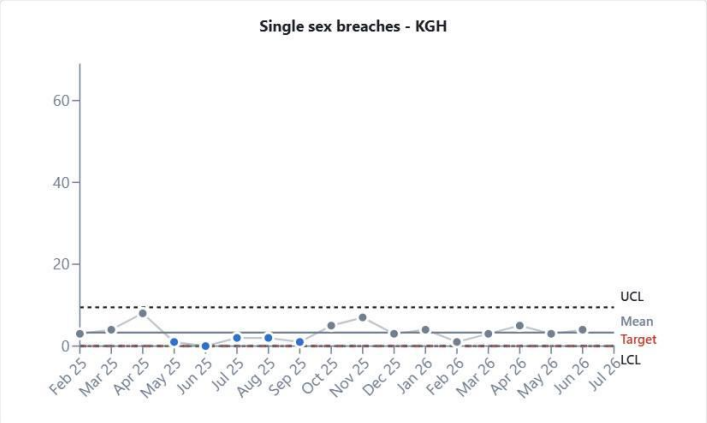
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 45 % | 77.94 % | 95 % | |
| NGH | 20 % | 39.53 % | 95 % | |

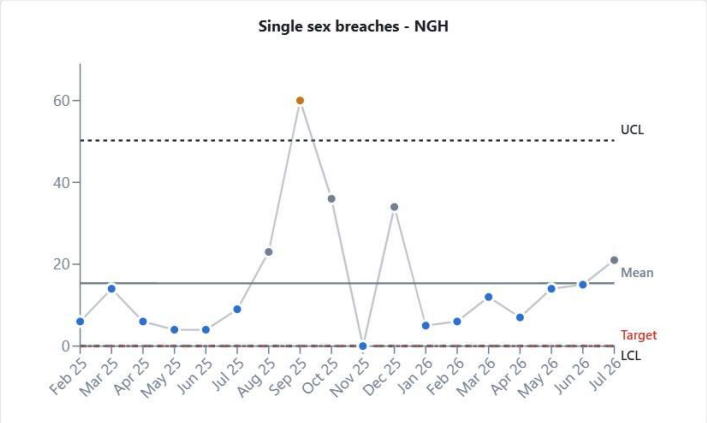
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

# Single sex breaches

The number of occasions where patients have to share sleeping accommodation, toilet or bathroom facilities with members of the opposite sex.




## Understanding the performance

0 breeches for KGH

Breeches occur due to the cardiology primary service and ITU when patients are delayed step down's

## What are the issues impacting performance?

Cardiology step down their patients once out of the acute phase but ITU are dependent on capacity especially within medicine

## What SMART actions are being taken to improve?

breaches were rectified when patients moved to discharge suite, datix and duty of candour completed by ward sister

KGH- Ensure step down beds are offered immediately if a mixed sex breech has occurred

## Risks

Poor patient experience

Increased risk of complaints

DATA VALUES

| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | — | 3.29 | 0 | — |
| NGH | 21 | 15.33 | 0 | |

DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

Signed off by **Joanne Smith** on 3 Sept 2026, 17:19

## Effective domain

### Good news

HSMR & SMR remains within 'as expected' for KGH.

SHMI remains 'as expected' for both NGH and KGH.

### Areas of concern

HSMR and SMR are both 'above expected' ranges for NGH.

NGH's rise in HSMR and SMR is multifactorial, with the following under review:

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

### Improvement plans in place

Monitored through monthly UHN Learning from Deaths Group, with upward reporting to Patient Safety Committee.

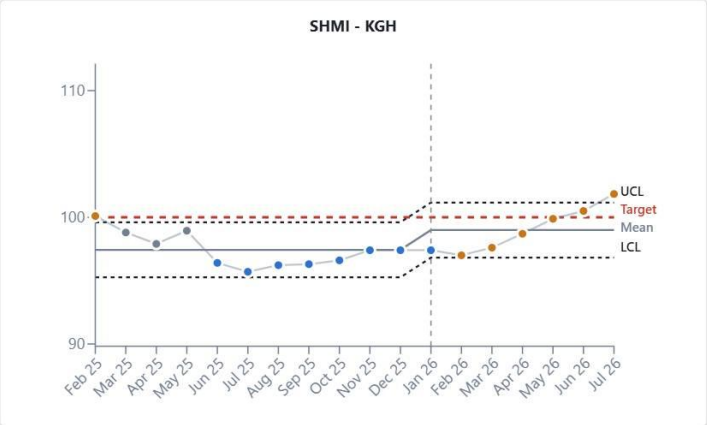
Working alongside Dr Foster representative and Clinical Coding to identify areas of concern amongst data accuracy issues relating to SDEC removal.

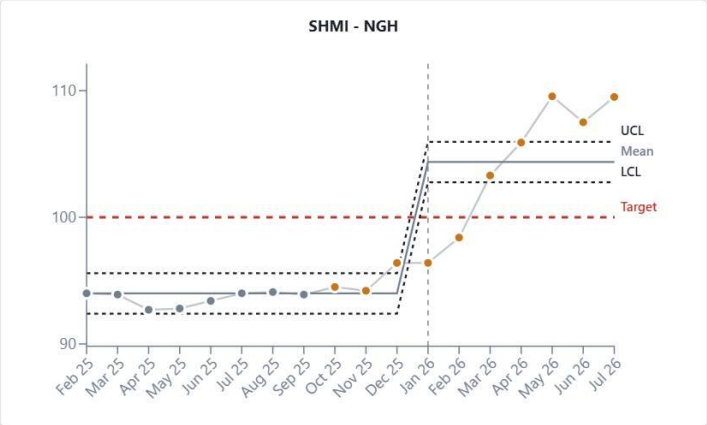
| METRIC | KGH | NGH | TARGET | STAR |
|---|---|---|---|---|
| SHMI | 101.84 | 109.5 | 100 | |
| HSMR | 98.8 | 112.5 | 100 | |
| SMR | 100.6 | 110.5 | 100 | |

| | Consistently hit target | Not consistently achieved or failed | Consistently fail target | No target set |
|---|---|---|---|---|
| Special Cause Improvement | | | | |
| Common Cause | | | • HSMR - NGH<br>• SMR - NGH | |
| Special Cause Concern | • SMR - KGH | • SHMI - KGH<br>• HSMR - KGH | • SHMI - NGH | |

## SHMI

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




## Understanding the performance

Despite SPC chart showing an increase above the target of '100' for NGH, Dr Foster methodology provide national bandings when comparing Trusts Nationally - Both KGH and NGH SHMI remain within 'as expected' banding.

## What are the issues impacting performance?

NGH's rise in SHMI is multifactorial, with the following under review:

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

## What SMART actions are being taken to improve?

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

## Risks

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

DATA VALUES

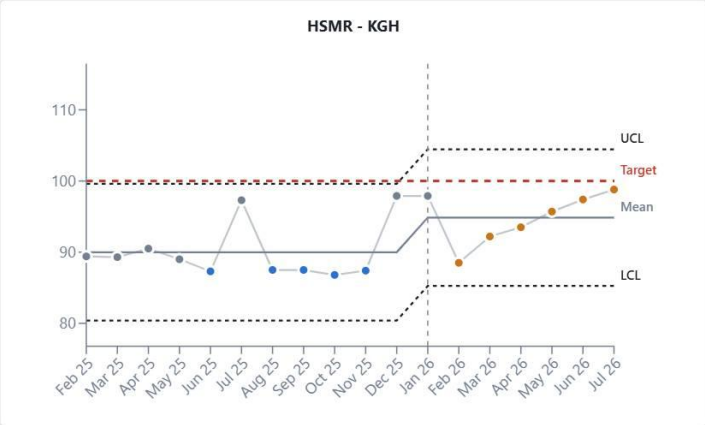
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 101.84 | 98.99 | 100 | |
| NGH | 109.5 | 104.36 | 100 | |

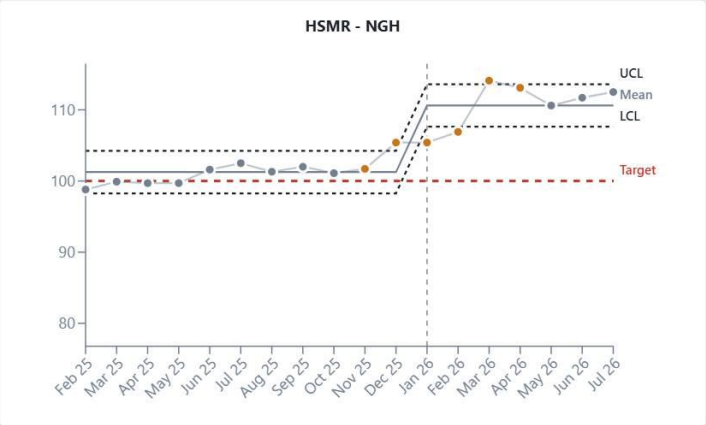
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## HSMR

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




## Understanding the performance

HSMR is now 'as expected' for KGH and 'above expected' for NGH.

## What are the issues impacting performance?

HSMR is 'above expected' ranges for NGH.

NGH's rise in HSMR is multifactorial, with the following under review:

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

## What SMART actions are being taken to improve?

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

## Risks

An increase in HSMR presents a reputational and regulatory risk; however, current analysis indicates that recent HSMR movement is driven primarily by data and methodological factors rather than an increase in observed mortality or evidence of deteriorating care quality.

This risk is being actively mitigated through triangulation with SHMI, Learning from Deaths, PSIRF, and coding assurance processes, with no current evidence of excess mortality requiring escalation.

DATA VALUES

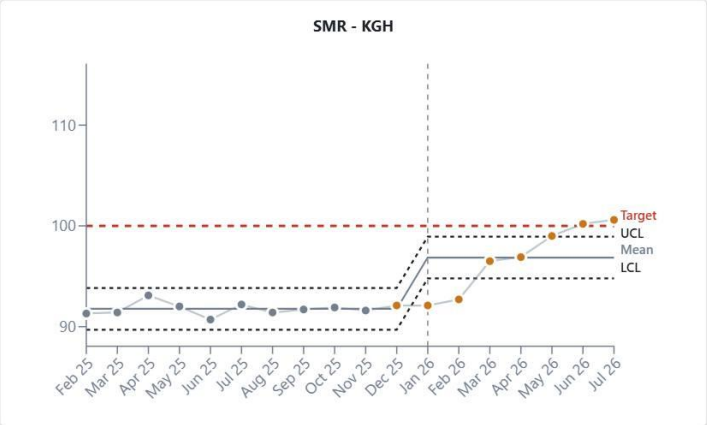
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 98.8 | 94.86 | 100 | |
| NGH | 112.5 | 110.61 | 100 | |

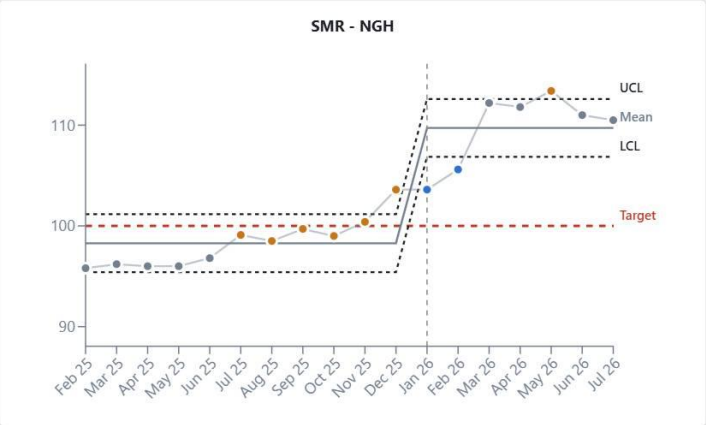
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## SMR

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




## Understanding the performance

SMR is now 'as expected' for KGH and 'above expected' for NGH.

## What are the issues impacting performance?

SMR is 'above expected' ranges for NGH.

NGH's rise in HSMR is multifactorial, with the following under review:

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

## What SMART actions are being taken to improve?

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

## Risks

An increase in SMR presents a reputational and regulatory risk; however, current analysis indicates that recent HSMR movement is driven primarily by data and methodological factors rather than an increase in observed mortality or evidence of deteriorating care quality.

DATA VALUES

| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 100.6 | 96.86 | 100 | |
| NGH | 110.5 | 109.73 | 100 | |

DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

Not signed off yet

## Safe domain

### Good news

There are no reported NEVER events this month

### Areas of concern

Themes of incidents reported as moderate and above

Falls with harm

Pressure tissue damage

Appropriate Decision making relating to use of ReSPECT forms.

### Improvement plans in place

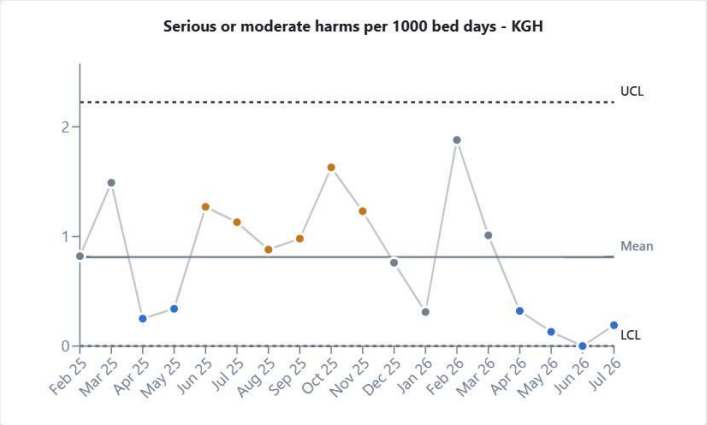
All validated moderate and above harms are discussed at IRG and proportionate responses are commissioned in accordance with PSIRF

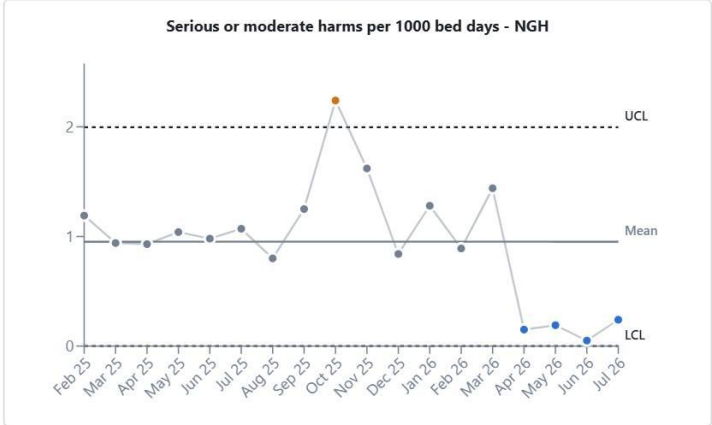
| METRIC | KGH | NGH | TARGET | STAR |
|---|---|---|---|---|
| **INCIDENTS** | | | | |
| Serious or moderate harms per 1000 bed days | 0.19 | 0.24 | — | |
| Never event incidence | 0 | 0 | 0 | |
| **INFECTION PREVENTION CONTROL** | | | | |
| Number of MRSA Bacteraemia | 0 | 0 | 0 | |
| C Diff per 100,000 bed days | 19.19 | 9.61 | — | |
| Number of MSSA Bacterium | 0 | 1 | 0 | |
| **SAFE CARE** | | | | |
| Care hours per patient day | 9.26 hours | 9.1 hours | 9 hours | |
| Serious or moderate harms - falls per 1000 bed days | 0 | 0.1 | — | |
| Serious or moderate harms - pressure ulcers per 1000 bed days | 0.13 | 0.34 | — | |

| | Consistently hit target | Not consistently achieved or failed | Consistently fail target | No target set |
|---|---|---|---|---|
| Special Cause Improvement | | • Never event incidence - KGH<br>• Number of MRSA Bacteraemia - NGH | | |
| Common Cause | • Number of MRSA Bacteraemia - KGH | • Never event incidence - NGH<br>• Number of MSSA Bacterium - NGH<br>• Number of MSSA Bacterium - KGH<br>• Care hours per patient day - KGH<br>• Care hours per patient day - NGH | | • Serious or moderate harms per 1000 bed days - KGH<br>• Serious or moderate harms per 1000 bed days - NGH<br>• C Diff per 100,000 bed days - KGH<br>• C Diff per 100,000 bed days - NGH<br>• Serious or moderate harms - falls per 1000 bed days - KGH<br>• Serious or moderate harms - falls per 1000 bed days - NGH<br>• Serious or moderate harms - pressure ulcers per 1000 bed days - KGH<br>• Serious or moderate harms - pressure ulcers per 1000 bed days - NGH |
| Special Cause Concern | | | | |

## Serious or moderate harms per 1000 bed days

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




### Understanding the performance

There was a total of 142 moderate and above patient harms reported for July. 14 have been validated as moderate and above through IRG 79 have been downgraded through IRG with 49 cases awaiting IRG

### What are the issues impacting performance?

All incidences reported with a harm level of moderate and above are validated through the IRG framework therefore the numbers reported will change.

### What SMART actions are being taken to improve?

1 PSII was declared in July unexpected Infant death

2 MNSI cases - Intrauterine death

Neonatal death

### Risks

49 moderate and above incidences have not yet been validated though the IRG process.

DATA VALUES

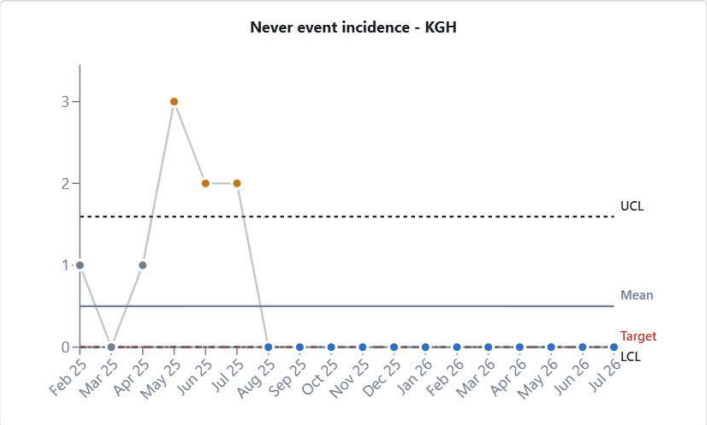
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 0.19 | 0.81 | — | |
| NGH | 0.24 | 0.95 | — | |

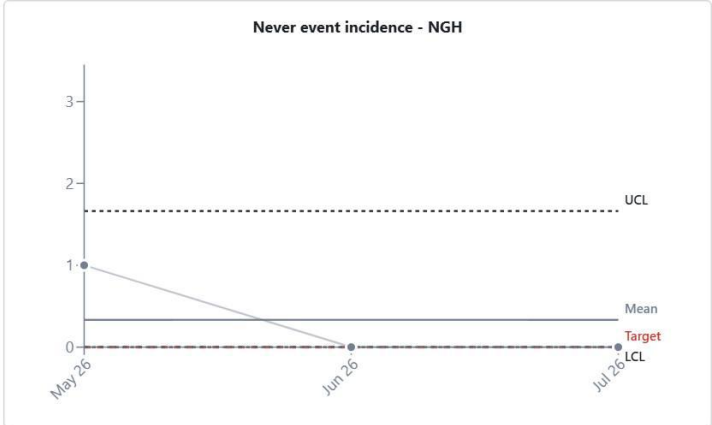
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Never event incidence

The number of never events.




### Understanding the performance

There are no NEVER events to report this month

### What are the issues impacting performance?

*No content yet*

### What SMART actions are being taken to improve?

*No content yet*

### Risks

*No content yet*

DATA VALUES

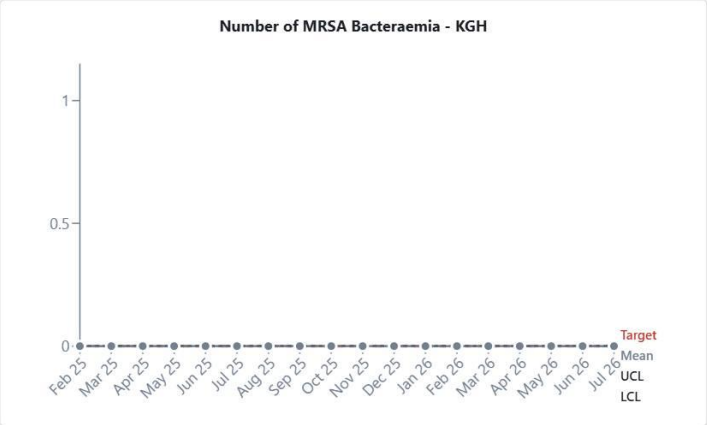
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 0 | 0.5 | 0 | |
| NGH | 0 | 0.33 | 0 | |

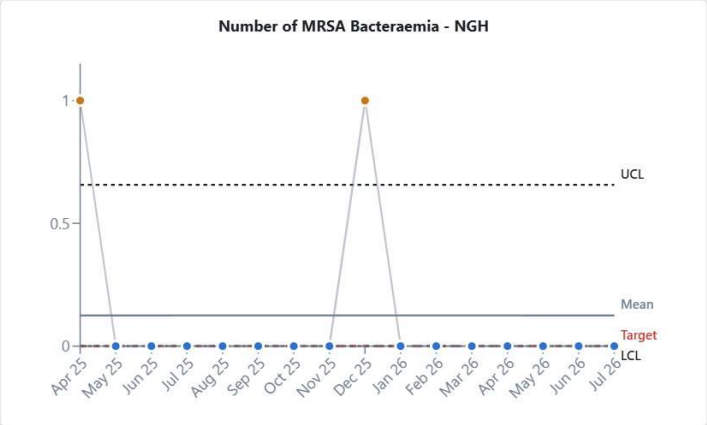
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Number of MRSA Bacteraemia

The number of methicillin-resistance staphylococcus aureus infections.




### Understanding the performance

0 cases this month.

### What are the issues impacting performance?

None identified

### What SMART actions are being taken to improve?

MRSA & MSSA section of the Annual IPC Plan being delivered and monitored by IPAC.

### Risks

None identified

DATA VALUES

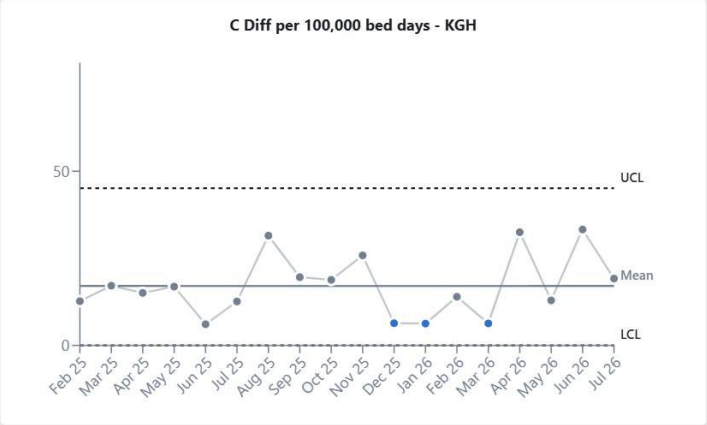
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 0 | 0 | 0 | |
| NGH | 0 | 0.13 | 0 | |

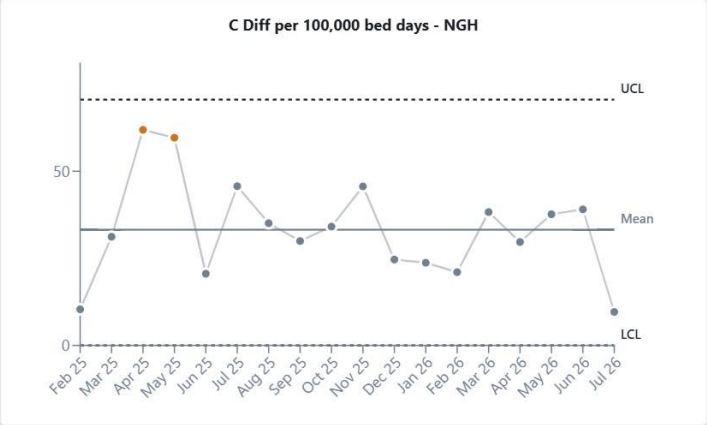
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## C Diff per 100,000 bed days

The number of Clostridioides difficile infections per 100,000 bed-days.




### Understanding the performance

3 cases at KGH, of which 2 are still under review and 1 was deemed preventable following inappropriate sampling.

2 cases at NGH, both unpreventable.

### What are the issues impacting performance?

SIGHT assessment compliance gap.

### What SMART actions are being taken to improve?

Targeted education and audit, learning shared widely in Infection Reflections bulletin.

To continue to implement the C.diff section of the IPC Quality Improvement Plan.

### Risks

The risk of exceeding the NHSE trajectory of 27 cases for 2026/27 at KGH with 15 cases year to date.

DATA VALUES

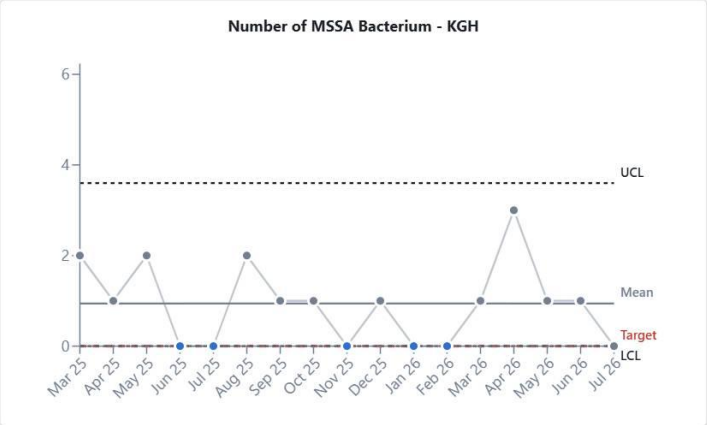
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 19.19 | 17.05 | — | |
| NGH | 9.61 | 33.21 | — | |

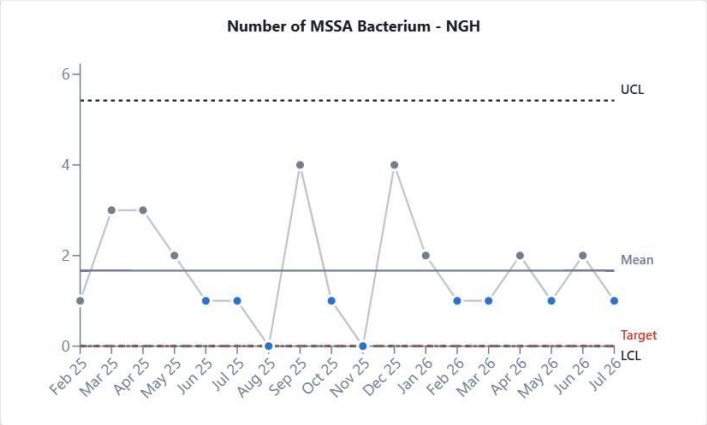
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Number of MSSA Bacterium

The number of methicillin-susceptible staphylococcus aureus infections.




### Understanding the performance

1 case this month in Medicine at NGH

### What are the issues impacting performance?

Case was deemed preventable following a midline-related infection.

Inaccurate and omitted documentation of vascular device relating to type and placement of line.

### What SMART actions are being taken to improve?

Lead PICC Nurse has agreed to undertake Line training on the ward.

MRSA & MSSA section of the Annual IPC Plan being delivered and monitored by IPAC.

Business case being developed for a Vascular Access Nurse to provide training and ward support for patients with Midlines and PICCs in situ.

### Risks

Increased number of Midlines being inserted with insufficient training provision for staff on how to identify, access, remove and document care regarding this device.

DATA VALUES

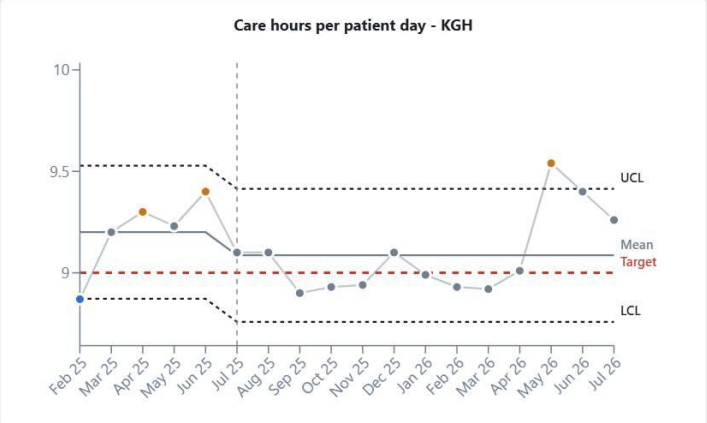
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 0 | 0.94 | 0 | |
| NGH | 1 | 1.67 | 0 | |

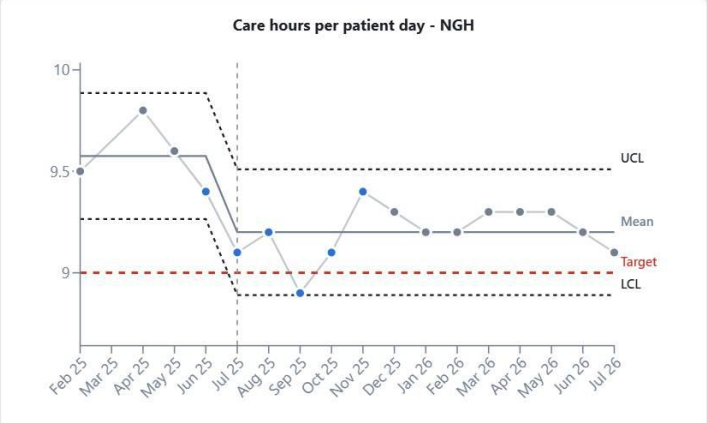
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Care hours per patient day

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




### Understanding the performance

KGH demonstrating improvement as the alignment of the reporting process is cleansed.
Ongoing work with working to planned template demonstrating a reduction in CHPPD at NGH.

### What are the issues impacting performance?

Working above template due to opened escalation and corridor care.

### What SMART actions are being taken to improve?

Roster cleansing to differentiate between non-inpatient activity from inpatient rosters.

### Risks

falsely elevated CHPPD whilst roster cleanse is ongoing.

DATA VALUES

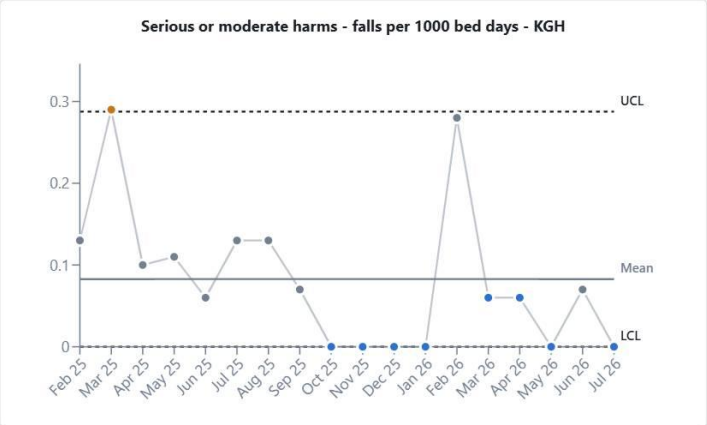
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 9.26 hours | 9.09 hours | 9 hours | |
| NGH | 9.1 hours | 9.2 hours | 9 hours | |

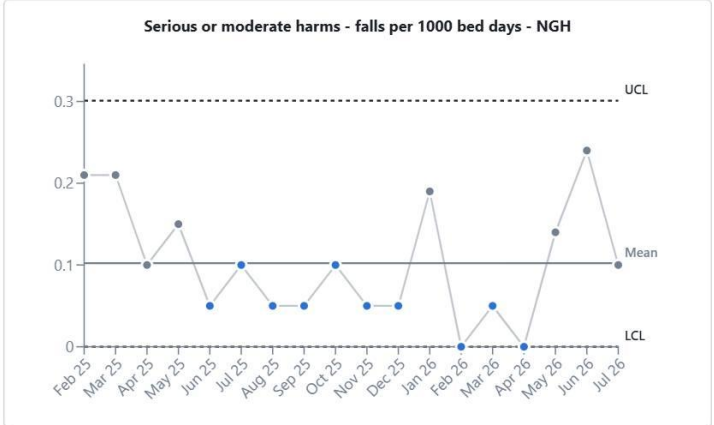
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Serious or moderate harms - falls per 1000 bed days

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




### Understanding the performance

No falls with harm at KGH with rate of harm remaining below 0.1. Rate of harm at NGH shows normal variation with a rate in July of 0.1 which equates to 2 harmful falls

### What are the issues impacting performance?

Increased acuity and frailty of patients remains a challenge.

### What SMART actions are being taken to improve?

Strengthening the tagging of bays across the group

Introduction of a systematic post fall protocol

### Risks

Increase in numbers of falls overall could lead to more falls with harm

DATA VALUES

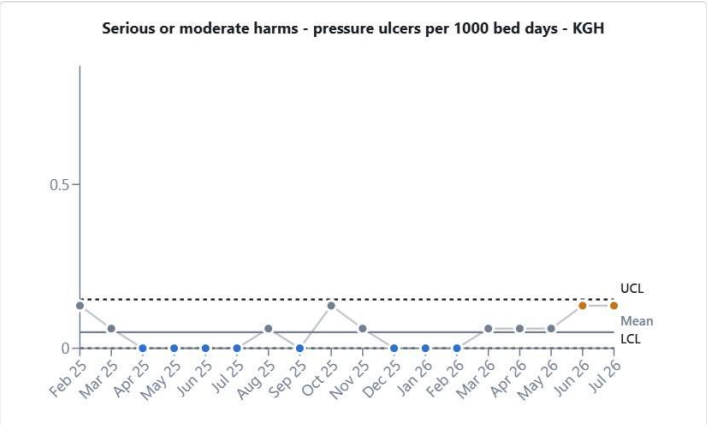
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 0 | 0.08 | — | |
| NGH | 0.1 | 0.1 | — | |

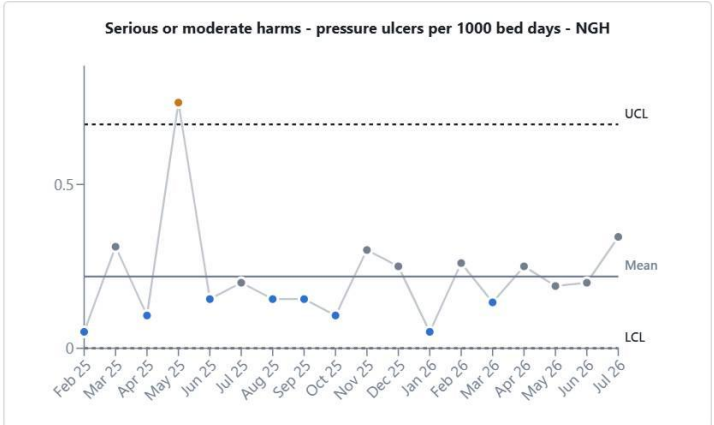
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Serious or moderate harms - pressure ulcers per 1000 bed days

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




### Understanding the performance

There has been an increase in the rate of pressure ulcers with harm at both sites in July more particularly at NGH.

### What are the issues impacting performance?

The main drive for the increase is the raised level of acuity with which patients are presenting combined increasing numbers of frail patients with poor skin integrity.

### What SMART actions are being taken to improve?

Review of staffing within budget to repurpose available resources to target support for tissue viability services.

Additional targeted training

### Risks

Increased regulatory scrutiny

reduced patient satisfaction

Litigation claims associated with inadequate care

DATA VALUES

| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 0.13 | 0.05 | — |  |
| NGH | 0.34 | 0.22 | — |  |

DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

```
Not signed off yet
```

## Responsive domain

### Good news

We continue to reduce the number of patients waiting 52 weeks or more for treatment, and both Trusts are ahead of plan this month.

KGH RTT performance continues to improve, and the transfer of long waiting patients from NGH to KGH is taking place to support performance.

TTIA within 15mins performance is being maintained.

8% improvement in ambulance handovers at NGH in July despite an increase of 7% in demand.

NGH 4hr at 71% in July, representing an 11% improvement in 4hr from July of 2025 despite an increase in attendances 6.5%.

### Areas of concern

The KGH waiting list size is higher than plan, some actions have been identified but further analysis is required.

NGH RTT performance is static and with EPR change at the end of August, will be challenged from a capacity perspective into September.

Continued growth in ED attendances across UHN including growth in conveyances.

Ambulance handover performance primarily as a result of high bed occupancy and associated high number of non-criteria to reside impacting flow.

Increase in non criteria to reside patients since January, particularly at NGH.

### Improvement plans in place

"Mission RTT" is running in September and October in the biggest 14 specialties, to drive improvement in RTT ahead of Winter. Services have been asked to drive productivity workstreams and also to identify specialty specific sprint activities.

EMCA money has been secured to support improvements in Breast, to implement a Breast pain pathway across the county (currently there is only a pathway in KGH).

UEC GIRFT Further Faster actions being completed.

A&E 4hr delivery improvement plans across UHN.

MDO led LoS improvement group launched.

Frailty assessment bay planned expansion.

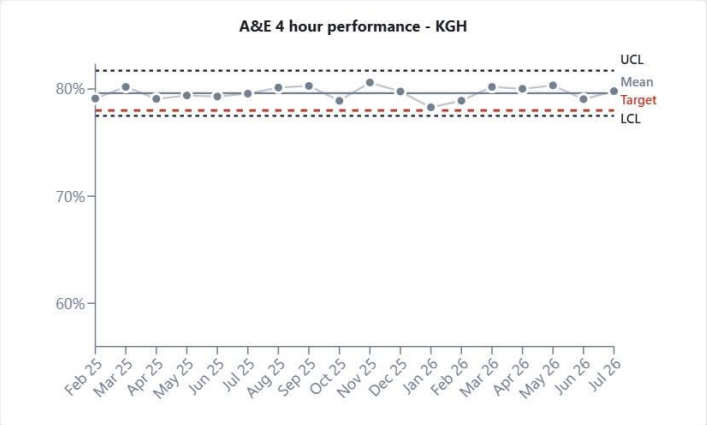
Growth in general medicine hot clinic to support discharge confidence

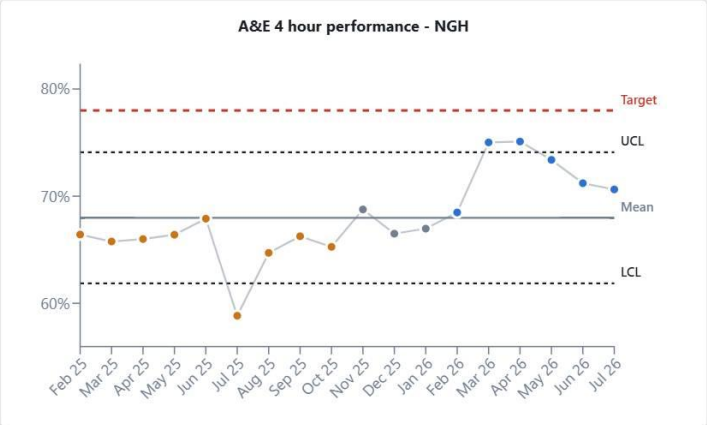
| METRIC | KGH | NGH | TARGET | STAR |
|---|---|---|---|---|
| **UEC** | | | | |
| A&E 4 hour performance | 79.8 % | 70.63 % | 78 % | |
| Ambulance handover 45 minute performance | 77.62 % | 69.5 % | 99 % | |
| Time to initial assessment | 11.34 | 11.26 | 15 | |
| 12 hour wait in the department | 11.8 % | 11.1 % | 10 % | |
| Non-elective length of stay | 10 days | 10 days | — | |
| Bed utilisation | 97.32 % | 99.53 % | 92 % | |
| Stranded patients (7+ day length of stay) | 51.94 % | 57.81 % | 42 % | |
| Super-Stranded patients (21+ day length of stay) | 17.82 % | 24.53 % | 12 % | |
| Patients with a reason to reside | 73.34 % | 65.84 % | 80 % | |
| **CANCER** | | | | |
| Cancer Faster Diagnostic Standard | 76.8 % | 78.6 % | 80 % | |
| 31-day wait for first treatment | 93.5 % | 93.2 % | 96 % | |
| 62-day wait for first treatment | 61.1 % | 63.7 % | 80 % | |
| **ELECTIVE** | | | | |
| RTT performance | 66.58 % | 58.43 % | 70 % | |
| Size of RTT waiting list | 31,124 | 41,439 | — | |
| 52 week waits as a % of the waiting list | 0.36 % | 0.9 % | 1 % | |
| Percentage of patients waiting no longer than 18 weeks for a first appointment | 71.37 % | 57.6 % | 72 % | |
| **PRODUCTIVITY** | | | | |
| Theatre utilisation | 82 % | 77.4 % | 85 % | |
| Average cases per list | 2.41 cases | 2.08 cases | 2.5 cases | |
| Outpatient appointments per consultant FTE | 144 | 138 | 116 | |

| | Consistently hit target | Not consistently achieved or failed | Consistently fail target | No target set |
|---|---|---|---|---|
| Special Cause Improvement | | • Time to initial assessment - NGH | • A&E 4 hour performance - NGH<br>• 12 hour wait in the department - NGH<br>• Bed utilisation - KGH<br>• Stranded patients (7+ day length of stay) - KGH<br>• Super-Stranded patients (21+ day length of stay) - KGH<br>• RTT performance - KGH<br>• Percentage of patients waiting no longer than 18 weeks for a first appointment - KGH | • Non-elective length of stay - KGH |
| Common Cause | • Time to initial assessment - KGH<br>• 52 week waits as a % of the waiting list - KGH | • A&E 4 hour performance - KGH<br>• 12 hour wait in the department - KGH<br>• Cancer Faster Diagnostic Standard - NGH<br>• Cancer Faster Diagnostic Standard - KGH<br>• 31-day wait for first treatment - NGH<br>• 31-day wait for first treatment - KGH<br>• 52 week waits as a % of the waiting list - NGH<br>• Theatre utilisation - KGH<br>• Average cases per list - NGH<br>• Outpatient appointments per consultant FTE - NGH<br>• Outpatient appointments per consultant FTE - KGH | • Ambulance handover 45 minute performance - KGH<br>• Ambulance handover 45 minute performance - NGH<br>• Bed utilisation - NGH<br>• Stranded patients (7+ day length of stay) - NGH<br>• Super-Stranded patients (21+ day length of stay) - NGH<br>• 62-day wait for first treatment - NGH<br>• 62-day wait for first treatment - KGH<br>• RTT performance - NGH<br>• Theatre utilisation - NGH<br>• Average cases per list - KGH | • Non-elective length of stay - NGH<br>• Size of RTT waiting list - NGH |
| Special Cause Concern | | | • Patients with a reason to reside - NGH<br>• Patients with a reason to reside - KGH<br>• Percentage of patients waiting no longer than 18 weeks for a first appointment - NGH | • Size of RTT waiting list - KGH |

## A&E 4 hour performance

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




## Understanding the performance

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

KGH at 80% in July, almost 1% improvement from June.

NGH at 71% in July, representing an 11% improvement in 4hr from July of 2025 despite an increase in attendances 6.5%.

## What are the issues impacting performance?

Admitted flow through ED.

Increase in attendances adverse to plan of ~6% at both sites.

## What SMART actions are being taken to improve?

4hr improvement plans including senior clinical decision maker as first point of contract, paediatric pathways to PAU and maximising use of SDECs.

UTC opening early September at NGH.

## Risks

Overcrowding risk in the ED(s).

Poor patient experience.

High bed occupancy >99% impacting flow and 4hrs.

DATA VALUES

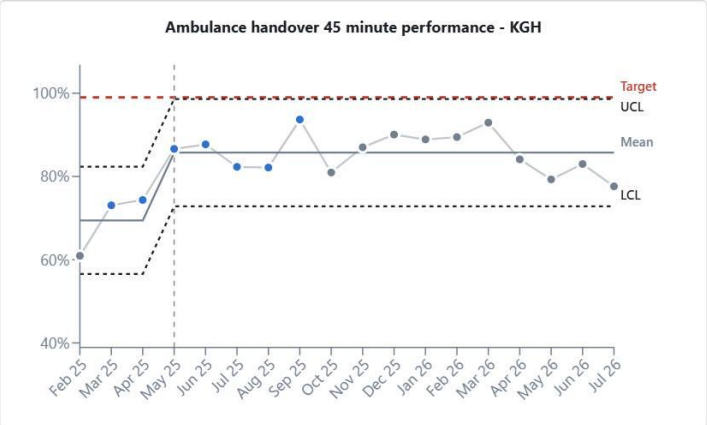
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 79.8 % | 79.61 % | 78 % | |
| NGH | 70.63 % | 67.98 % | 78 % | |

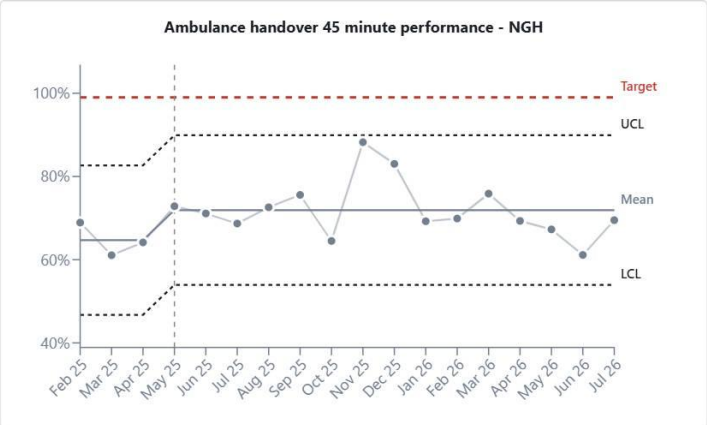
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Ambulance handover 45 minute performance

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




## Understanding the performance

Continued focus on improving ambulance handover times.

KGH performance has declined by 3% in July delivering 79% of handovers in <45mins.

Despite a 7% rise in demand during July, NGH improved ambulance handover performance by 8%, with 70% of handovers completed within 45 minutes.

## What are the issues impacting performance?

Admitted patient flow through ED.

Increase in numbers of non-criteria to reside.

Increase in ED attendances and conveyances across Northants. Conveyances with YTD adverse to plan at KGH 2% and 5% at NGH.

## What SMART actions are being taken to improve?

Ensuring NyeBevan LoS is delivered in line with an AMU / Medical Short Stay ward.

Boardround QI and GIRFT long length of stay improvement work has launched.

Frailty assessment at NGH has commenced from 1st June.

Ambulance challenge initiative - review of alternative pathways

Continued review of R2R procedures.

## Risks

Ambulance handover delays can contribute to C2 community response delays.

Poor patient experience.

DATA VALUES

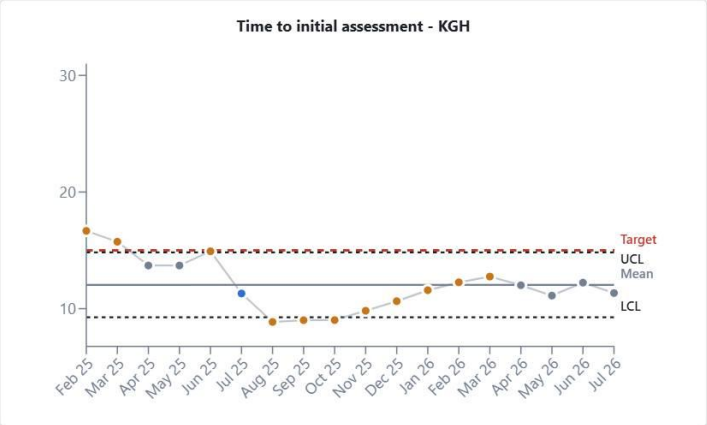
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 77.62 % | 85.72 % | 99 % | |
| NGH | 69.5 % | 71.92 % | 99 % | |

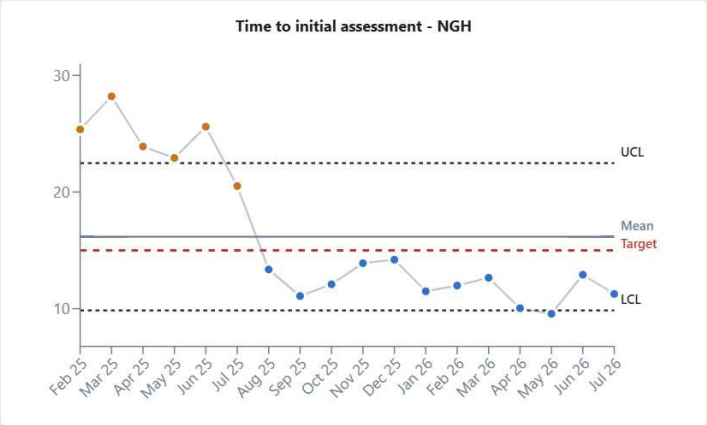
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Time to initial assessment

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




### Understanding the performance

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

### What are the issues impacting performance?

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

### What SMART actions are being taken to improve?

Introduction of the new acuity model at NGH has seen significant improvement in initial assessment times.

Regular safety huddles at both sites with ED NIC/EPIC and clinical site manager.

### Risks

Delays to assessment increases risk within the ED waiting room for undifferentiated patients.

Risk mitigation of regular staffing reviews via staffing cell with staff re-deployed from other areas to support safe ED staffing.

DATA VALUES

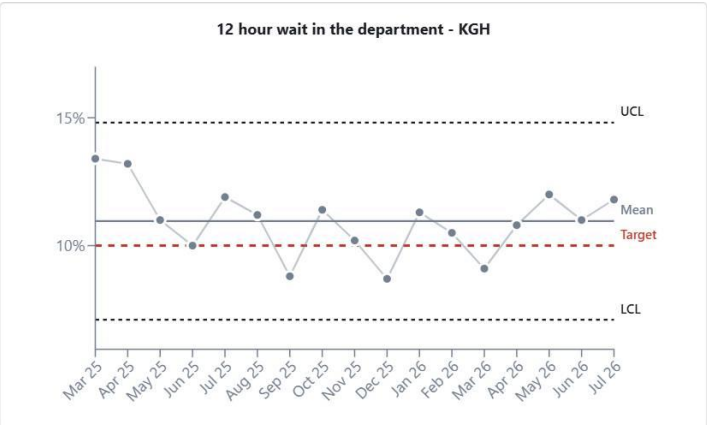
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 11.34 | 12.04 | 15 | |
| NGH | 11.26 | 16.17 | 15 | |

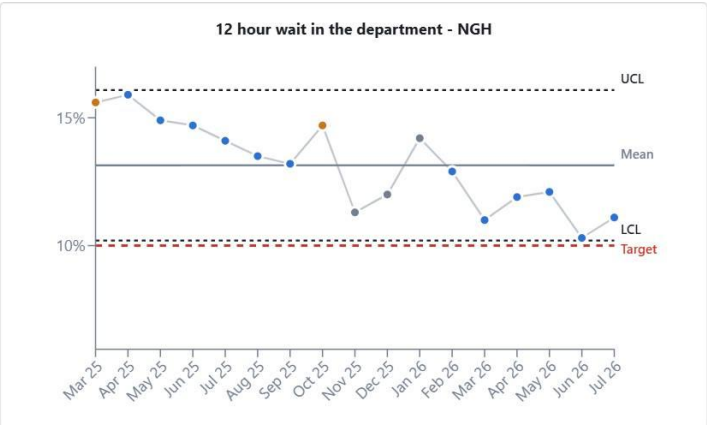
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## 12 hour wait in the department

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




### Understanding the performance

12hr performance across UHN has seen a slight reduction in performance by <1% in July.

### What are the issues impacting performance?

Primarily delays in admitted patient flow.

### What SMART actions are being taken to improve?

Reduction in length of stay that includes QI support into Boardrounds.

UEC Improvements including surgical assessment unit review.

Expansion of planned care flows at KGH.

### Risks

ED overcrowding.

Poor patients experience.

DATA VALUES

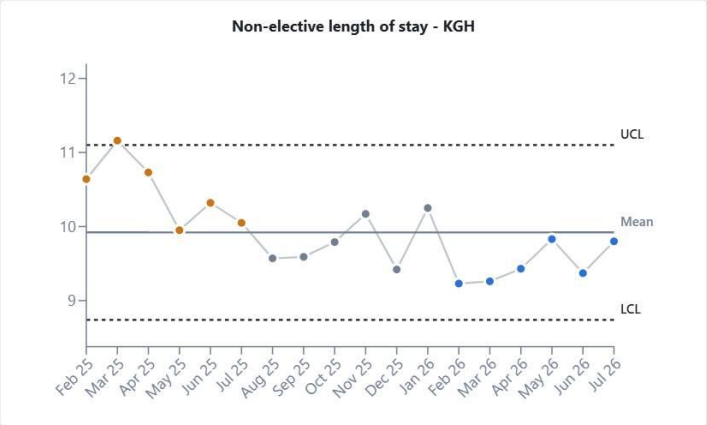
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 11.8 % | 10.96 % | 10 % | |
| NGH | 11.1 % | 13.14 % | 10 % | |

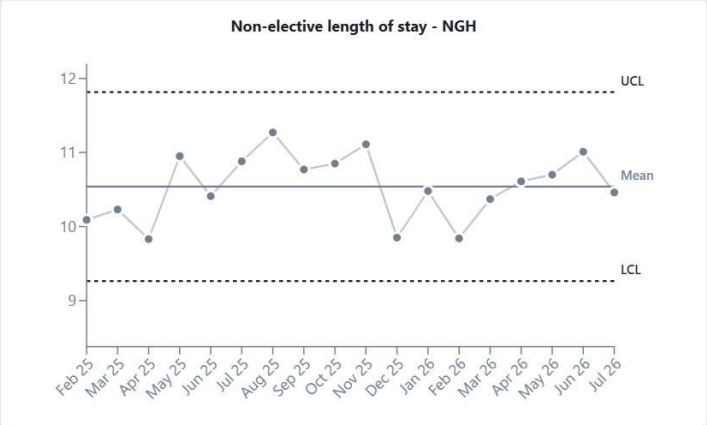
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Amber |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Red |

## Non-elective length of stay

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




### Understanding the performance

Reduction in LOS at NGH noted in July by 0.4 days.

Slight increase in LOS at KGH of 0.4 days in July .

### What are the issues impacting performance?

Continue to see high numbers of non-criteria to reside and supported pathway delays.

Clinical teams reporting an increase in complexity of patients.

### What SMART actions are being taken to improve?

GIRFT Further Faster Actions across UHN.

Boardround quality improvement work supported by GIRFT underway including launch of LLOS initiative from late Aug - teams to adopt SHOP approach, all resident doctors to access NC during boardrounds and internal referrals to be responded to same day.

Integrated discharge hub planning.

### Risks

Admitted patient flow through ED.

Ambulance handover delays.

Patient experience.

DATA VALUES

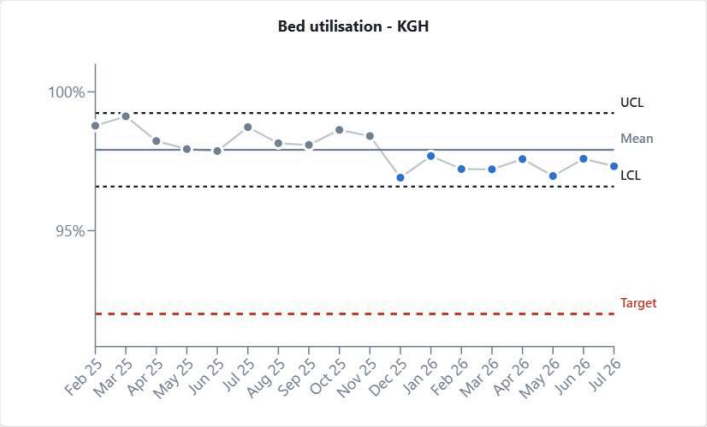
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 10 days | 10 days | — | |
| NGH | 10 days | 11 days | — | |

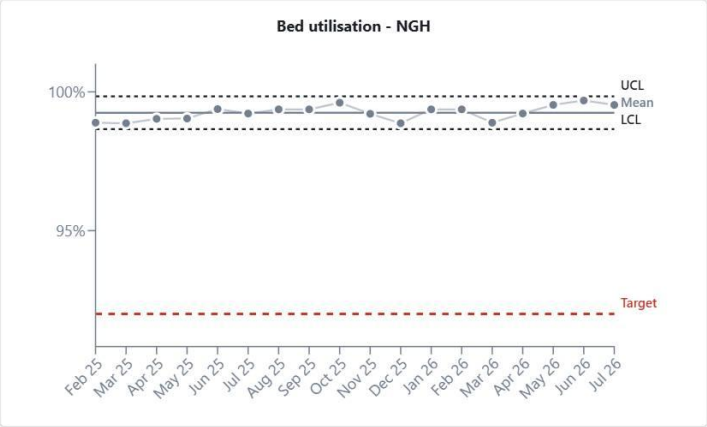
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Bed utilisation

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




## Understanding the performance

Bed occupancy remains high across UHN - KGH at 97% and NGH at >99%.

## What are the issues impacting performance?

Supported discharge pathway delays.

Stranded and super stranded position.

## What SMART actions are being taken to improve?

Reduction in LoS plans across UHN to reduce bed occupancy and improve flow.

Continued use of release 2 respond to support capacity and risk across the organisation.

Maximise use of SDECs as admission avoidance.

System planning around supported discharge turnaround times.

Utilisation of Optica for discharge planning.

## Risks

Poor patient experience due to ED delays.

Impact on 12hr/24hr performance.

ED overcrowding.

Ambulance handover delays.

Reliance on corridor care to maintain flow.

DATA VALUES

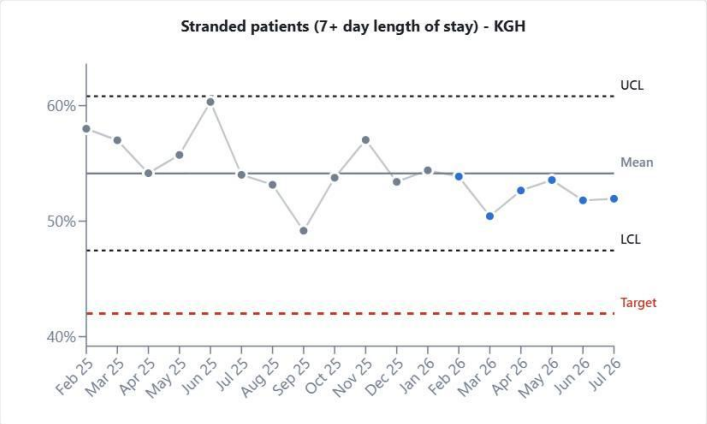
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 97.32 % | 97.91 % | 92 % | |
| NGH | 99.53 % | 99.25 % | 92 % | |

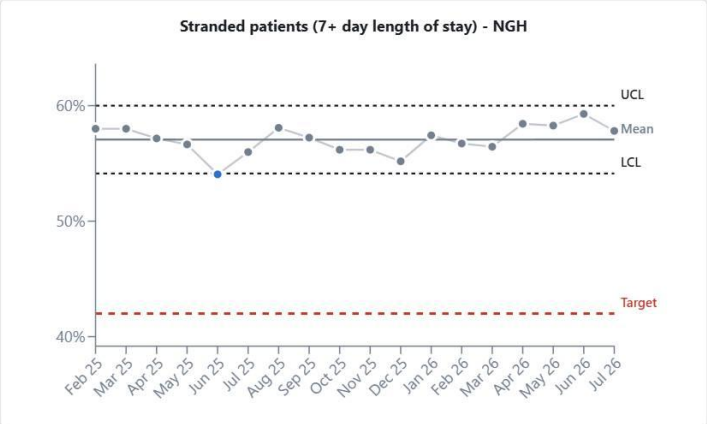
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

# Stranded patients (7+ day length of stay)

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




## Understanding the performance

No change in the stranded position at KGH.

Slight reduction in 7 day stranded position at NGH by 1%.

## What are the issues impacting performance?

Inpatient acuity, complexity and demand.

High demand for patient transport can lead to delays.

## What SMART actions are being taken to improve?

Boardrounds and focus on SHOP model.

Internal and external escalation delays to discharge.

Maximising use of discharge lounge.

Maximising use of SDEC.

P1 working group to reduce NEL LOS.

## Risks

Delay to discharge impacting admitted flow through ED across all pathways.

All community beds are full.

DATA VALUES

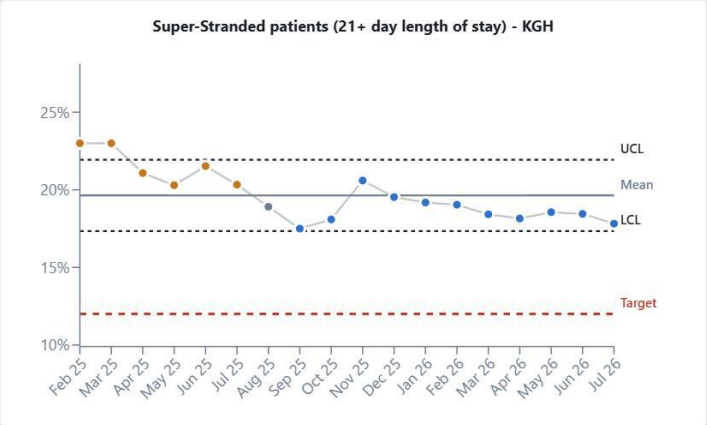
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 51.94 % | 54.13 % | 42 % | |
| NGH | 57.81 % | 57.06 % | 42 % | |

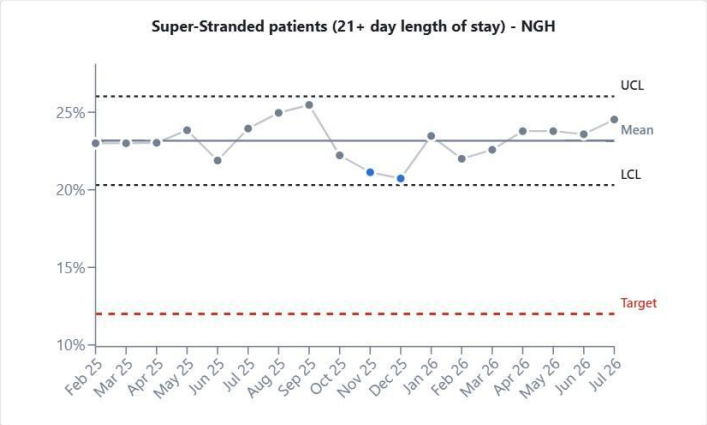
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Super-Stranded patients (21+ day length of stay)

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




### Understanding the performance

No significant change in the 21 day LOS position - there has been a slight increase at NGH of 1%.

### What are the issues impacting performance?

P2/3 supported discharge waits across UHN.

Complexity of patients.

Housing delays.

### What SMART actions are being taken to improve?

Escalation group for patients who do not have a supported discharge plan.

Working with partners to reduce P2 and P3 delays to discharge – particularly for DTA beds.

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

Top 20 MOFD and Top 20 MFFD meetings.

### Risks

Bed occupancy remains high impacting patient flow.

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

DATA VALUES

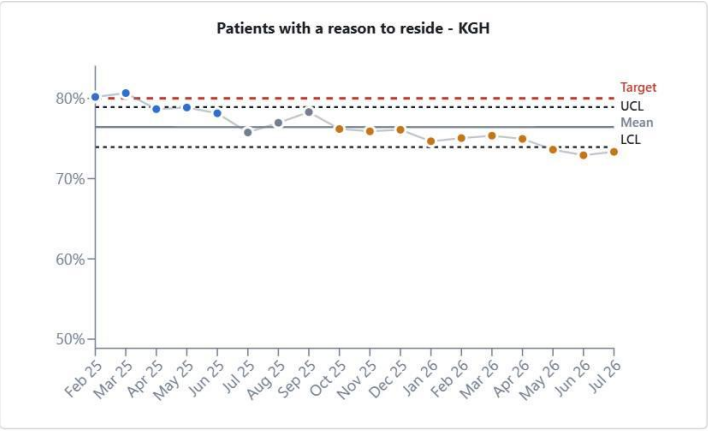
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 17.82 % | 19.64 % | 12 % | |
| NGH | 24.53 % | 23.16 % | 12 % | |

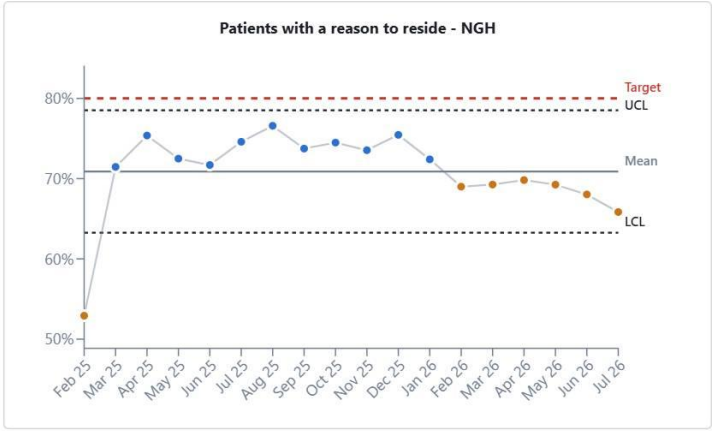
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Patients with a reason to reside

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




## Understanding the performance

Average percentage of beds meeting CtR in the Midlands (w/e 24th Aug) 86.9%, compared to KGH at 86.6% and NGH at 75.9%.

Significant increase in patients who do not meet criteria to reside at both sites since January, particularly NGH.

## What are the issues impacting performance?

Number of patients waiting supported discharge across all pathways.

Housing / house clean / awaiting equipment.

Complex patients who require mental health team support or a mental health community bed.

## What SMART actions are being taken to improve?

Weekly escalation group for supported discharge with system partners.

Trusted assessor at NGH.

Working with local authorities for housing pathway.

Integrated discharge hub planning.

Supported discharge turnaround times being agreed with system partners.

## Risks

Significant impact on high bed occupancy 99-100%, use of corridor care and 4hr/12hr performance in the ED.

DATA VALUES

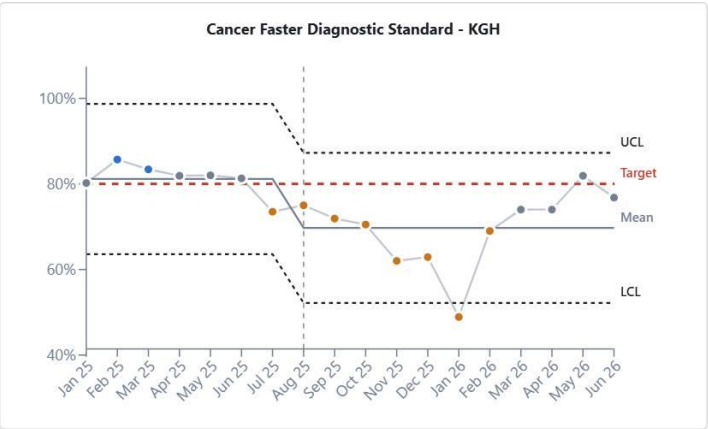
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 73.34 % | 76.42 % | 80 % | |
| NGH | 65.84 % | 70.89 % | 80 % | |

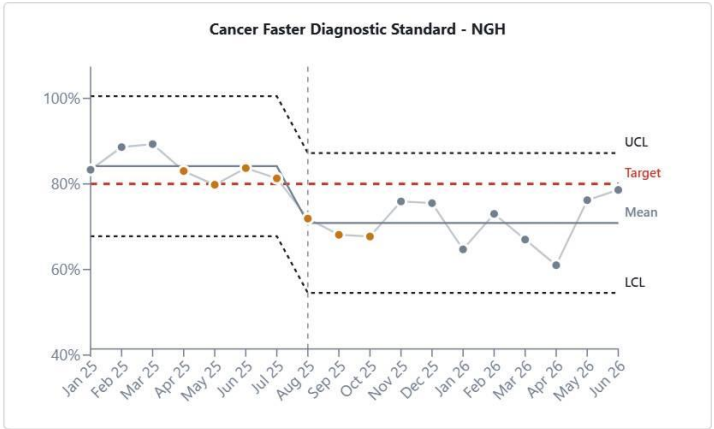
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Red |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Red |

## Cancer Faster Diagnostic Standard

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




## Understanding the performance

NGH achieved 78.6%, an increase of 2.4% from May. Breast, colorectal, gynae, Upper GI and Urology achieved the standard and skin met their trajectory, under plan overall by 1.4%.

KGH saw a reduction in performance to 76.8%. This was impacted by capacity challenges to first OPA for Breast and Skin. Other sites remained largely stable

## What are the issues impacting performance?

Seasonal increase in skin referrals impacting on already challenged capacity

Capacity challenges for first OPAs due to workforce (radiology in breast and retirement in Skin)

## What SMART actions are being taken to improve?

NGH Patients referred on skin being transferred to KGH if possible. Funding received from EMCA for additionality.

KGH additionality in skin clinics.

EMCA money for a Breast pain pathway for Northampton, to divert referrals which do not need to be on a cancer pathway.

## Risks

Patient Choice at this time of year

Fragile Skin service at NGH

Increase in referrals throughout summer

DATA VALUES

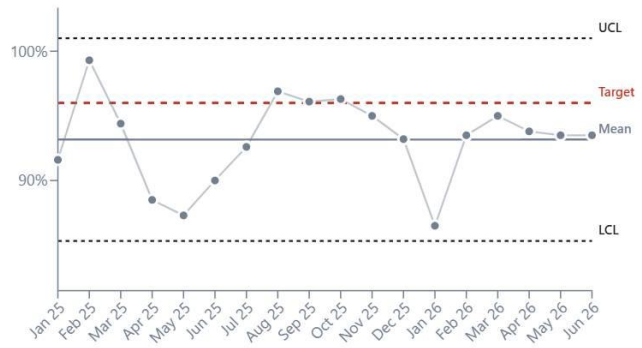
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 76.8 % | 69.72 % | 80 % | |
| NGH | 78.6 % | 70.87 % | 80 % | |

DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## 31-day wait for first treatment

The percentage of cancer patients who start treatment within 31 days of a decision to treat.





### Understanding the performance

NGH-· In June 93.2% was achieved, 2.5% decrease from May, colorectal and Urology achieved the standard, breast, gynae and skin achieved their trajectory, above plan by 1.3%.

KGH - performance remained stable for 31 day at 95.2%

### What are the issues impacting performance?

Gynaecology saw a deterioration in performance due to challenges with MDT capacity and deferrals

Surgical capacity in Breast, Skin and Colorectal at KGH

### What SMART actions are being taken to improve?

Established escalation process with weekly lists provided to all Tumour Sites with patients at risk of breaching to date in target, capacity reliant

Increase capacity once all surgeons fully trained in robotics

### Risks

Surgical capacity

DATA VALUES

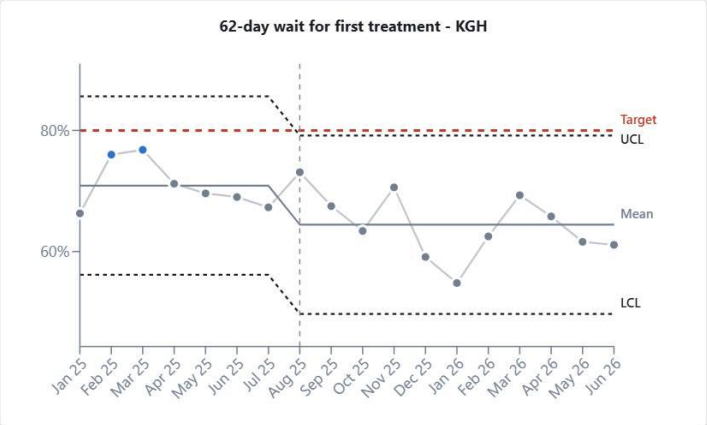
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 93.5 % | 93.17 % | 96 % | |
| NGH | 93.2 % | 92.34 % | 96 % | |

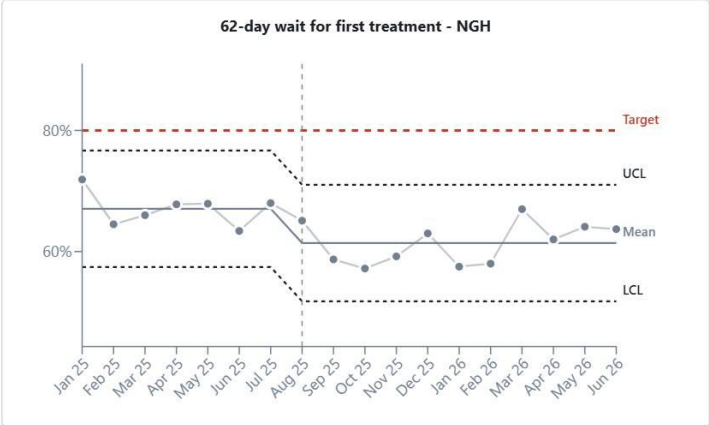
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## 62-day wait for first treatment

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




## Understanding the performance

NGH--In June we achieved 63.7%, marginal decrease, skin only site to achieve the standard, breast, haem and lung achieved trajectory, 3% under overall trajectory

KGH - a slight reduction in performance was seen off 0.05% achieving at 61.1%

## What are the issues impacting performance?

Head and Neck capacity for both outpatients and Theatres

Gynaecology pathway delays due to MDT deferral and outpatient capacity

Breast continue to struggle to meet the standard due to constraints earlier in the pathway (first appointment taking place at ~day 24).

## What SMART actions are being taken to improve?

A number of funding streams secured for additional activity and exploring long term solutions for sustainable services

Weekly PTLs and patient access group to maintain oversight, identify opportunities for improvement

Deep dive into colorectal services at KGH and NGH, working collaboratively with clinicians to share good practice, identify improvement opportunities, and implement changes that could improve performance

## Risks

Workforce,

No capacity to reduce the backlog of patients waiting more than 62 days

Patient choice and loss of activity during summer period

Increase in referrals overall.

Vacancies within tracking teams

DATA VALUES

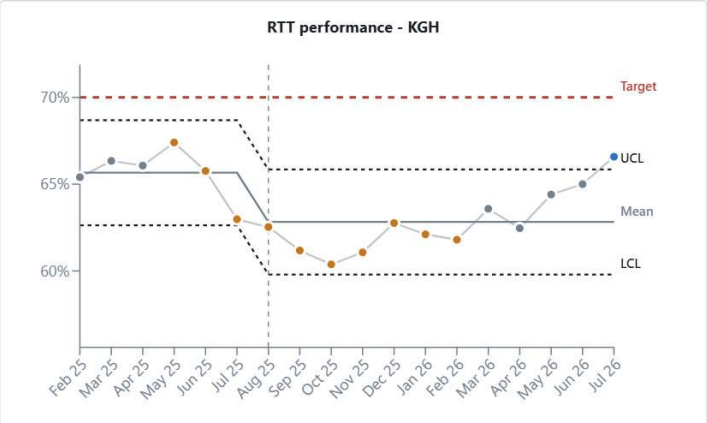
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 61.1 % | 64.44 % | 80 % | |
| NGH | 63.7 % | 61.41 % | 80 % | |

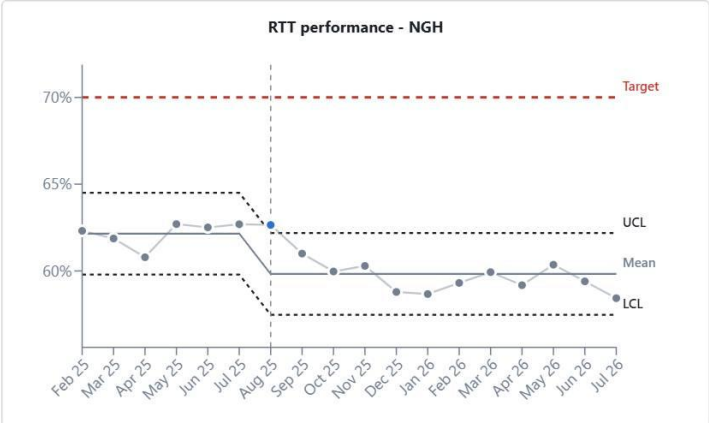
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## RTT performance

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




## Understanding the performance

We are seeing continued month on month improvement at KGH, towards the aim of 73%

NGH performance is flat and wait to first appointment is challenged

## What are the issues impacting performance?

At NGH, there has been a reduction in validation activities due to the capacity needed for the EPR change.

At KGH, the lift on of patients awaiting booking has supported performance improvement.

## What SMART actions are being taken to improve?

A "Mission RTT" sprint programme is being run in September and October, to drive performance ahead of winter in the 14 largest specialties. This combines progress on the productivity actions for services, as well as sprint activity, such as first only fortnights or focused discharge activities.

## Risks

Reduction in activity at NGH due to EPR go live

Theatre capacity

DATA VALUES

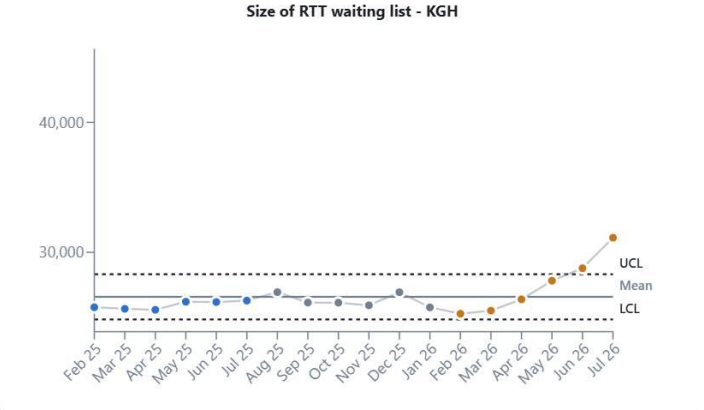
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 66.58 % | 62.82 % | 70 % | |
| NGH | 58.43 % | 59.83 % | 70 % | |

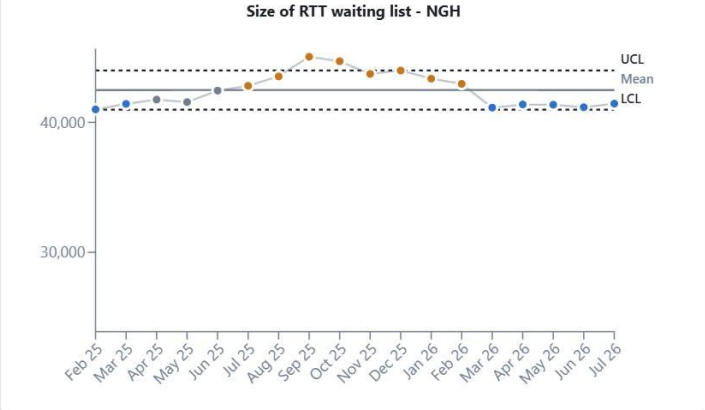
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Size of RTT waiting list

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




### Understanding the performance

The NGH waiting has been holding steady, under plan year to date,. We expect to see growth following the EPR go live as all referrals awaiting triage will be lifted on to the PTL.

KGH has seen continued growth following the lift on of referrals.

### What are the issues impacting performance?

NGH will see a growth in waiting list size following the EPR change. A growth of 5,500 was planned for in the trajectory, with recovery by the end of the financial year.

### What SMART actions are being taken to improve?

We have identified target action to reduce ~1k at KGH and further analysis is taking place to identify recovery actions.

### Risks

EPR go live

IPTs to KGH impacting on total waiting list size

DATA VALUES

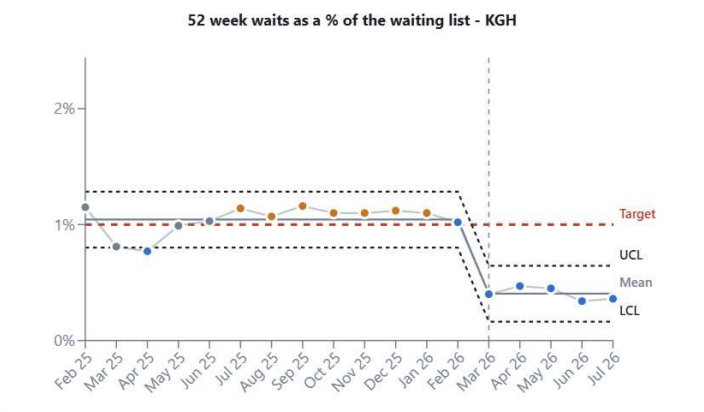
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 31,124 | 26,575.06 | — | |
| NGH | 41,439 | 42,485.72 | — | |

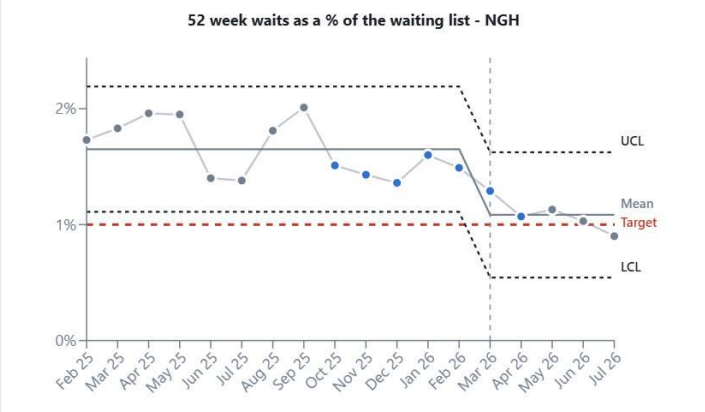
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## 52 week waits as a % of the waiting list

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




### Understanding the performance

Both Trusts are ahead of target as at July.

### What are the issues impacting performance?

We have seen a reduction in ENT 52w+ following the commencement of additional capacity. T&O patients are also been transferred from NGH to KGH to support treatment.

### What SMART actions are being taken to improve?

IPT of focussed cohorts of patients

Additional actiivyt in challenged specialties

### Risks

Theatre cancellations

Winter plans

DATA VALUES

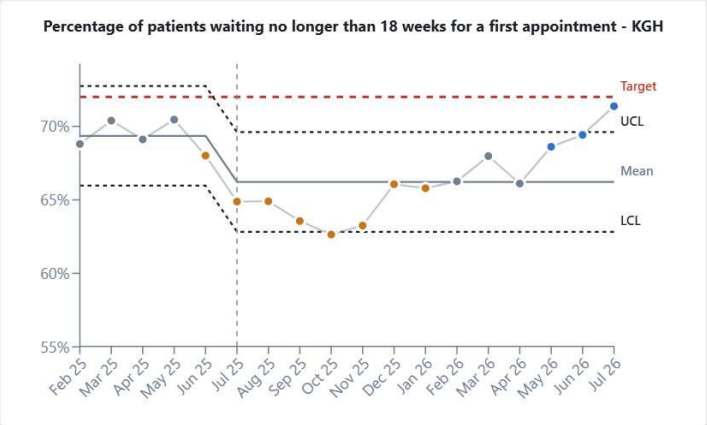
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 0.36 % | 0.4 % | 1 % | |
| NGH | 0.9 % | 1.08 % | 1 % | |

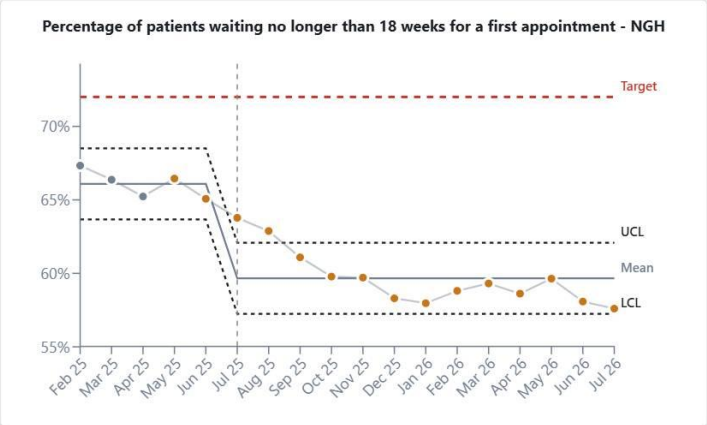
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Percentage of patients waiting no longer than 18 weeks for a first appointment

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




### Understanding the performance

Good progress is being made at KGH, with a reduction in the wait to first appointment. NGH remains challenged in this metric.

### What are the issues impacting performance?

Clinic capacity

There is an opportunity to reduce the first to follow up ratio in a number of specialties to support reduction in the wait to first appointment.

### What SMART actions are being taken to improve?

Mission RTT actions should support a reduction in the wait to first appointments

### Risks

Reduction in activity at NGH due to EPR go live

Clinic capacity

DATA VALUES

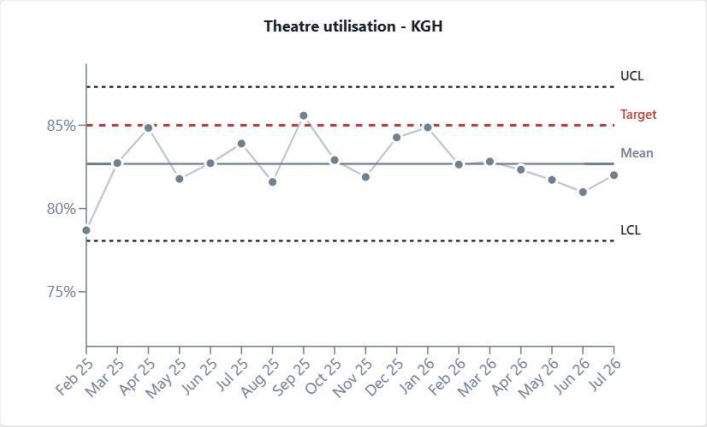
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 71.37 % | 66.22 % | 72 % | |
| NGH | 57.6 % | 59.66 % | 72 % | |

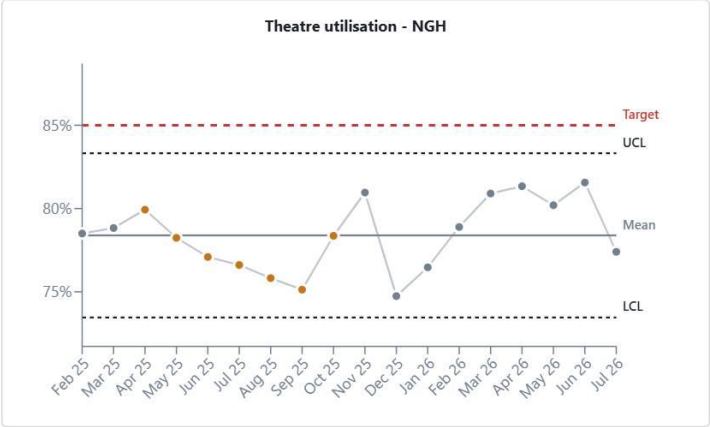
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Amber |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Theatre utilisation

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




## Understanding the performance

Performance declined in NGH due to the repeated cancellations and sessions lost in T&O who are high performers. Cancellation before and one the day also saw an increase (~14%) which also drives the drop in utilisation.

KGH saw an increase in performance following several months of declined performance.

## What are the issues impacting performance?

At NGH T&O proportion significantly impacts due to the amount of cases per list allocated to this specialty alone.

On the day cancellations and early finishes would reflect in declined utilisation.

Paediatric bed capacity at KGH (capped at 5 beds) is impacting the flow of cases.

Patient fitness has also impacted performance at both sites as short time turnarounds from listing to booking impacts quality of patient work-up.

## What SMART actions are being taken to improve?

Specialty leave review of timetables have been requested with support from Deloitte.

6-4-2 Model has been commended so focus will be on the front end of the process.

Winter pressures and plans will need to be looked into to mitigate impact to performance.

Paediatric bed allocation increase to 5 at KGH would support the ability to utilise lists. Plans being developed to support this.

## Risks

Winter pressures and Trauma will continue to be a risk for utilisation

DATA VALUES

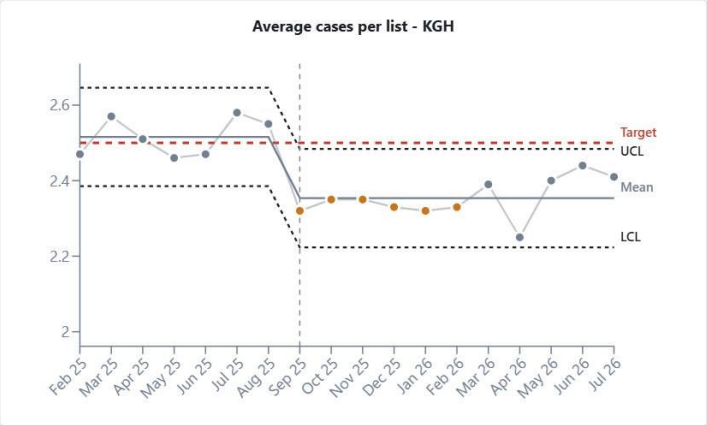
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 82 % | 82.68 % | 85 % | |
| NGH | 77.4 % | 78.39 % | 85 % | |

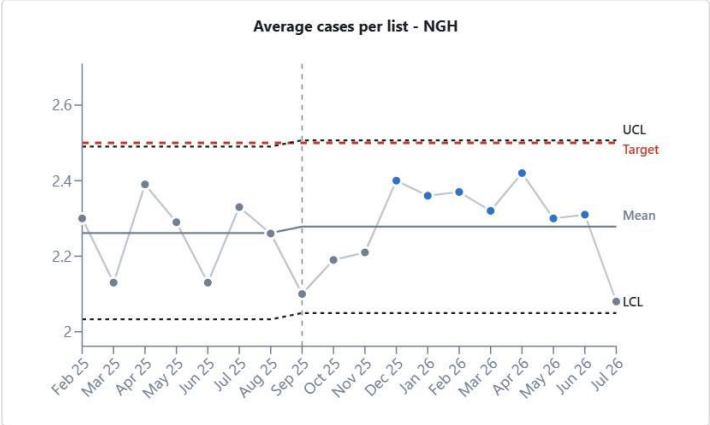
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Average cases per list

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




## Understanding the performance

Over summer there were changes to workforce which impacts the types of cases allocated to lists.

## What are the issues impacting performance?

Complexity of procedures can mean a list may look under utilised or short on cases. There has been a challenge with clinical buy-in to push the boundaries of lists.

## What SMART actions are being taken to improve?

Standby lists for Gynaecology to support with allocation of patients should spaces become available.

Consistent review of Model Hospital to review against peer performance.

Scoping a review of Ophthalmology Preoperative processes to see if there can be any learning or opportunities for improvement.

## Risks

Complexity of cases

Ophthalmology internal Preoperative challenges

DNA rate (~10%)

DATA VALUES

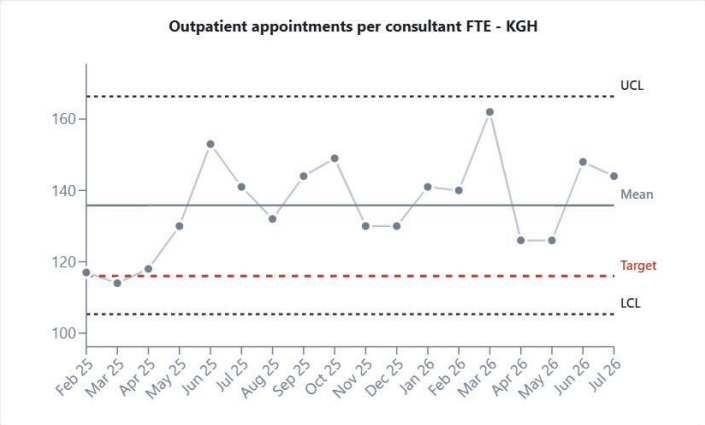
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 2.41 cases | 2.35 cases | 2.5 cases | |
| NGH | 2.08 cases | 2.28 cases | 2.5 cases | |

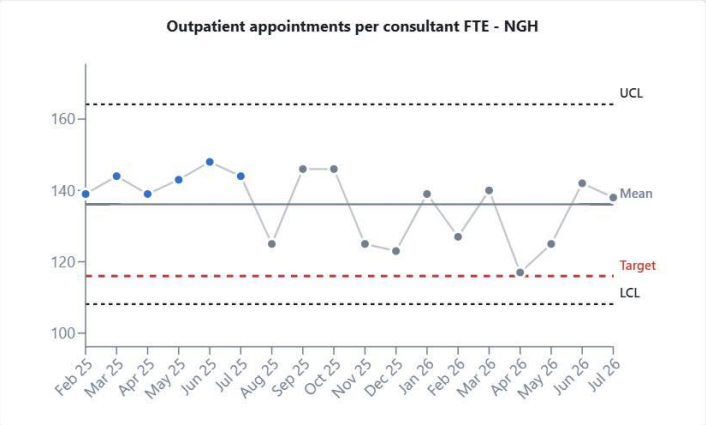
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Outpatient appointments per consultant FTE

The number of outpatient appointments carried out per whole time equivalent consultant in the Trust.




### Understanding the performance

Both Trusts are ahead of target for this metric

### What are the issues impacting performance?

Performance is good and is supported by the use of wider clinical staff to support outpatient activity

### What SMART actions are being taken to improve?

*No content yet*

### Risks

No significant risks identified.

DATA VALUES

| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 144 | 135.83 | 116 | |
| NGH | 138 | 136.11 | 116 | |

DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

Signed off by Sarah Noonan on 3 Sept 2026, 12:05

## Well Led domain

### Good news

- Staff turnover remains below target across both hospitals, indicating good workforce stability and retention.
- Mandatory training compliance continues to exceed the organisational target and remains stable overall.
- Volunteer hours increased during July, reflecting continued community engagement and volunteer contribution.

### Areas of concern

- High levels of formal employee relations cases continue to impact workforce experience and place pressure on HR capacity.
- Mental health and musculoskeletal absence remain significant contributors to lost working time and workforce resilience challenges.

### Improvement plans in place

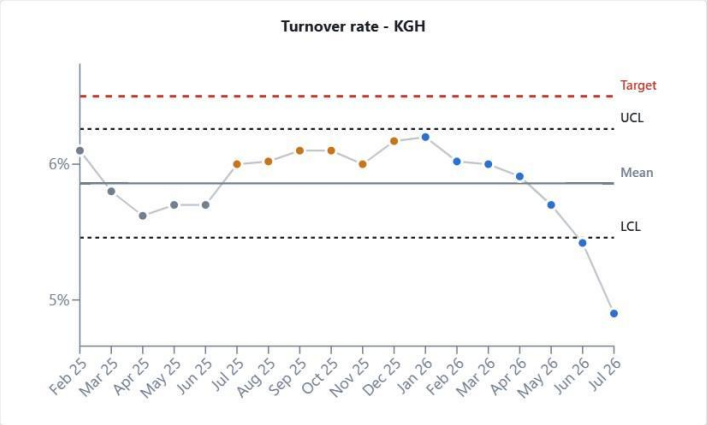
- Targeted workforce planning and recruitment initiatives are being progressed to sustain turnover performance and reduce vacancies.
- Quarterly ER case reviews, investigator development and leadership learning interventions are being introduced to support earlier resolution of workplace issues

| METRIC | KGH | NGH | TARGET | STAR |
|---|---|---|---|---|
| **CULTURE AND SAFETY** | | | | |
| Turnover rate | 4.9 % | 5.2 % | 6.5 % | |
| Appraisal completion rates | 83 % | 80.3 % | 85 % | |
| Mandatory training compliance | 91.1 % | 89.2 % | 85 % | |
| Sickness and absence rate | 5 % | 5 % | 5 % | |
| Number of volunteering hours | 3,065 hours | 3,919 hours | — | |
| **WORKFORCE FINANCIAL SUSTAINABILITY** | | | | |
| Vacancy rate | 8 % | 10.6 % | 8 % | |
| Time to hire (days) | 84.5 | 74.1 | 65 | |
| Employee relations formal cases | 38 | 39 | — | |
| Total WTE (PWR figure) | 5,110.55 | 6,452.83 | — | |
| Bank Spend as % of Total Pay | 9.57 % | 12.78 % | 6.3 % | |
| Agency Spend as % of Total Pay | 1.33 % | 1.97 % | 2 % | |

| | Consistently hit target | Not consistently achieved or failed | Consistently fail target | No target set |
|---|---|---|---|---|
| Special Cause Improvement | • Turnover rate - KGH | • Time to hire (days) - NGH<br>• Agency Spend as % of Total Pay - NGH | • Vacancy rate - KGH | |
| Common Cause | • Turnover rate - NGH<br>• Mandatory training compliance - NGH<br>• Mandatory training compliance - KGH<br>• Agency Spend as % of Total Pay - KGH | • Appraisal completion rates - KGH<br>• Sickness and absence rate - NGH<br>• Sickness and absence rate - KGH<br>• Vacancy rate - NGH | • Appraisal completion rates - NGH<br>• Bank Spend as % of Total Pay - KGH<br>• Bank Spend as % of Total Pay - NGH | • Number of volunteering hours - NGH<br>• Number of volunteering hours - KGH<br>• Employee relations formal cases - NGH<br>• Total WTE (PWR figure) - KGH<br>• Total WTE (PWR figure) - NGH |
| Special Cause Concern | | • Time to hire (days) - KGH | | • Employee relations formal cases - KGH |

## Turnover rate

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





### Understanding the performance

Turnover remains within target across both Trusts, with a continued downward trend. Performance was 4.9% at KGH and 5.8% at NGH against the 6.5% target, indicating sustained workforce stability and retention across UHN.

### What are the issues impacting performance?

Turnover continues to remain below target across both KGH and NGH. While overall trends are positive, recruitment and retention challenges persist in a number of specialist clinical and operational roles, influenced by wider NHS labour market pressures and organisational change.

### What SMART actions are being taken to improve?

- Continue targeted retention initiatives focused on staff groups and departments experiencing higher levels of turnover.
- Monitor turnover trends through monthly divisional workforce reviews, triangulating findings with exit interview feedback and workforce intelligence.
- Strengthen retention by promoting career development, wellbeing and progression opportunities across the organisation.
- Ensure vacancies resulting from turnover are addressed in a timely manner through effective workforce planning and robust recruitment oversight.

### Risks

Increased turnover in key clinical or specialist roles could affect service delivery, increase temporary staffing costs, and place additional pressure on remaining teams.

Continued competition within the NHS employment market may impact retention and recruitment in hard-to-fill roles.

DATA VALUES

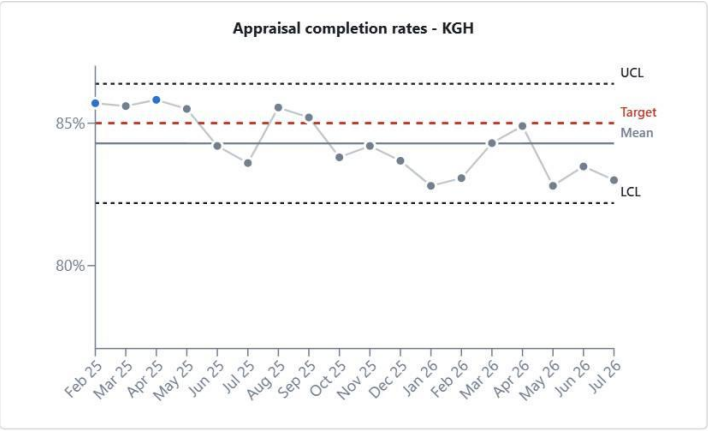
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 4.9 % | 5.86 % | 6.5 % | |
| NGH | 5.2 % | 5.81 % | 6.5 % | |

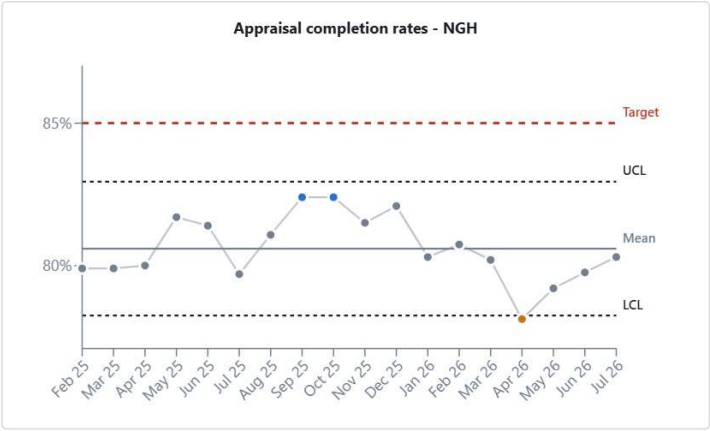
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Appraisal completion rates

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




## Understanding the performance

Site appraisal rates of compliance are consistent but remains below the expected organisational standard and indicates that approximately one in eight colleagues do not have a current appraisal in place. While there is evidence of sustained appraisal activity, variation persists across divisions and staff groups, indicating that further improvement is required to achieve the organisational standard.

## What are the issues impacting performance?

Operational pressures and competing service priorities continue to impact the time available for both managers and colleagues to undertake appraisals. Organisational change, manager turnover and changes in reporting structures have affected local ownership of appraisal completion in some areas. Inconsistent understanding of appraisal recording and submission processes also continues to contribute to delays, particularly amongst newer managers.

## What SMART actions are being taken to improve?

Monthly appraisal compliance reports continue to be shared with managers and reviewed through divisional performance meetings. ESR notifications and targeted communications are being used to remind managers and colleagues of outstanding appraisals. The recently launched Appraisal Toolkit is being promoted to improve consistency of approach, and work continues to align appraisal documentation with the developing NHS Leadership and Management Framework and future ESR functionality.

## Risks

Continued appraisal non-compliance may impact assurance against CQC Well-Led standards and the organisation's ability to demonstrate effective performance management and staff development. Delayed appraisals reduce opportunities to identify learning and development needs, support career progression and address performance concerns. Sustained levels below target may also negatively impact staff experience, engagement and organisational culture.

DATA VALUES

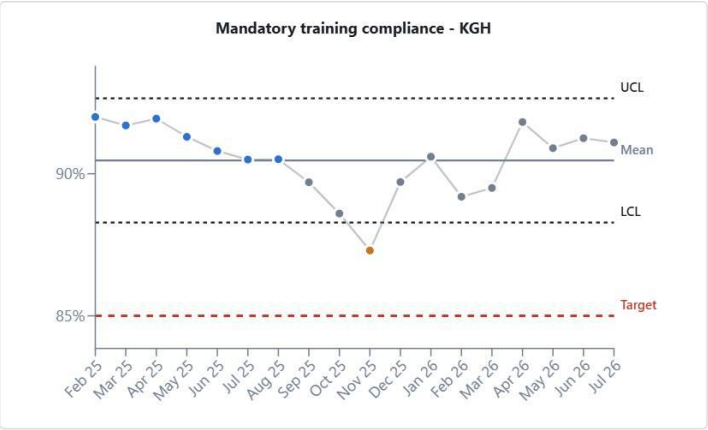
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 83 % | 84.29 % | 85 % | |
| NGH | 80.3 % | 80.59 % | 85 % | |

DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

# Mandatory training compliance

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





## Understanding the performance

Mandatory training compliance remains above the organisational target of 85% at both sites and continues to demonstrate a stable level of performance. KGH remains above its long-term mean at 91.1%, whilst NGH performance remains stable around its expected range. Month-to-month variation is evident but there is no indication of sustained deterioration in performance.

## What are the issues impacting performance?

Whilst overall compliance remains above target, variation continues across divisions, staff groups and training subjects. Medical staff compliance remains more challenging than other cohorts, and lower compliance continues to be seen in face-to-face and competency-based training requirements. Information Governance remains below the national benchmark of 95% and recurring gaps continue within Oliver McGowan and Freedom to Speak Up training but these are new to profiles.

## What SMART actions are being taken to improve?

Continue monthly compliance reporting and divisional review meetings, with targeted follow-up for teams below expected levels. ESR reminders and manager communications will be used to support completion of overdue training, particularly Information Governance, Oliver McGowan and other lower-performing subjects. Access to face-to-face training will continue to be reviewed to improve completion of competency-based requirements

## Risks

Persistent non-compliance within specific staff groups and training subjects may affect assurance against CQC and statutory training requirements. Ongoing gaps in competency-based training, Information Governance and safeguarding-related competencies may reduce assurance that staff maintain the knowledge and skills required to deliver safe and effective care.

DATA VALUES

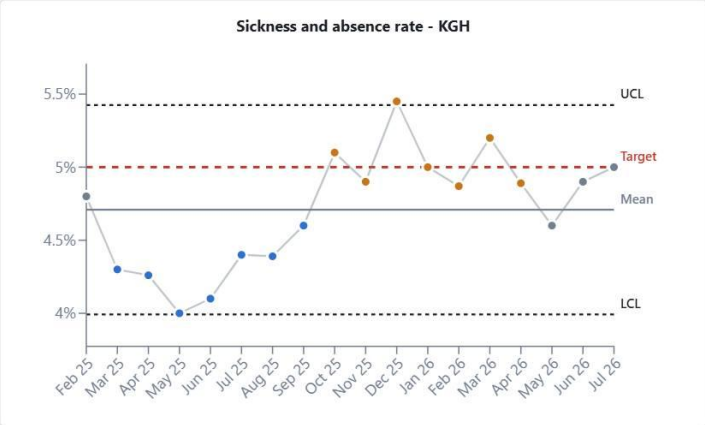
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 91.1 % | 90.47 % | 85 % | |
| NGH | 89.2 % | 89.4 % | 85 % | |

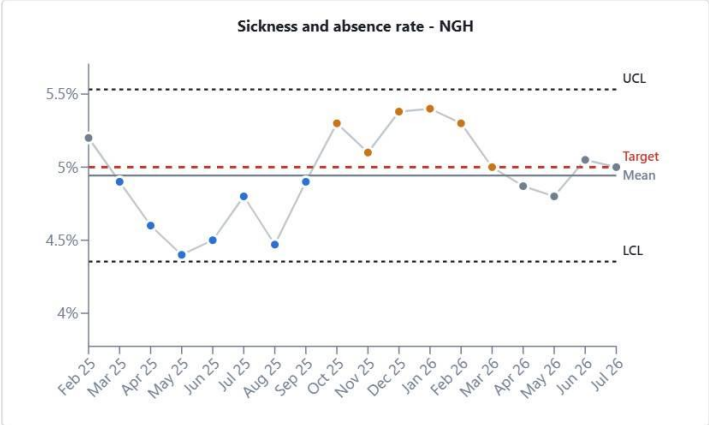
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Sickness and absence rate

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




### Understanding the performance

July sickness absence data for KGH and NGH remains on target and workforce absence continues to be driven by a combination of short-term illness and longer-term health conditions. Whilst cold, cough, flu and gastrointestinal illnesses account for a high volume of sickness episodes across many services, the largest impact on workforce capacity is being caused by mental health-related absence, musculoskeletal (MSK) conditions and pregnancy-related absence. The highest levels of FTE days lost are concentrated within frontline operational services including UEC, Acute Medicine, Elderly Care, Obstetrics, Theatres and Trauma & Orthopaedics, indicating that sickness absence is having its greatest effect in areas already managing significant clinical demand. This data identifies sickness absence as a major contributor to workforce unavailability, service pressure and staffing resilience challenges.

### What are the issues impacting performance?

Mental health absence remains a significant contributor to days lost, particularly within Obstetrics, UEC, Theatres, Cardiology, Paediatrics, Radiology and Outpatients. The organisational stress risk assessment identifies workload pressures, operational demands, limited control over work, organisational change and psychological safety concerns as factors that can contribute to stress-related absence. In addition, MSK conditions continue to generate substantial lost working time, particularly within Hotel Services, Trauma & Orthopaedics, Gastroenterology and Respiratory services, suggesting ongoing physical workload and ergonomic challenges. The data also highlights the impact of pregnancy-related absence in a number of clinical areas, alongside seasonal illness and gastrointestinal conditions which continue to affect staffing levels across the organisation. Collectively, these findings indicate that sickness absence is being influenced by a combination of workforce wellbeing, workplace pressures, long-term health conditions and service demands rather than any single cause.

### What SMART actions are being taken to improve?

UHN is implementing a range of targeted actions through the Sickness Improvement Plan, Absence Reduction Strategy and the Occupational Health & Wellbeing Service strategy and service provision. Priority actions include the monthly review of long-term sickness cases to ensure appropriate management plans with Occupational Health case discussion, targeted interventions within hotspot areas experiencing high levels of mental health and MSK absence, and enhanced manager training on sickness management, wellbeing conversations, reasonable adjustments and return-to-work planning. The organisation is also strengthening its data-led approach through divisional sickness dashboards, hotspot analysis and regular monitoring of high-risk areas. Performance measures include achieving 95% completion of return-to-work interviews, ensuring all identified hotspot services have documented action plans and maintaining monthly divisional reviews of absence trends. Alongside this, the organisational stress risk assessment process is being embedded to identify workplace stressors earlier, support psychological wellbeing and ensure local actions are implemented and monitored through a new stress at Work SOP.

### Risks

The primary risk is that continued high levels of mental health, MSK and long-term sickness absence within key clinical services will reduce workforce resilience, increase operational pressure on teams and affect the organisation's ability to achieve its sickness absence improvement ambitions if targeted preventative interventions are not embedded, maintained and strengthened.

DATA VALUES

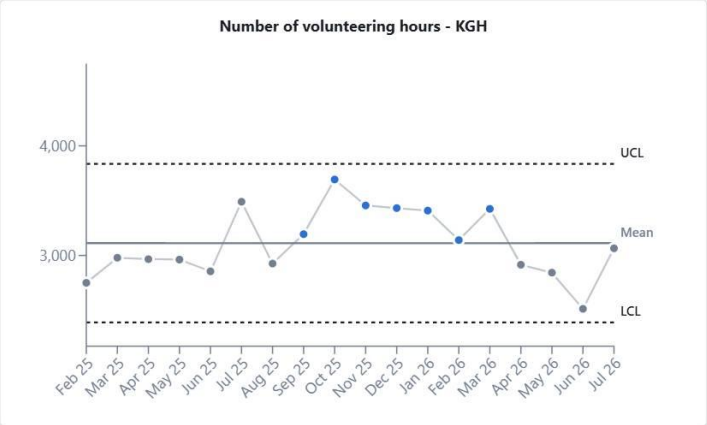
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 5 % | 4.71 % | 5 % | |
| NGH | 5 % | 4.94 % | 5 % | |

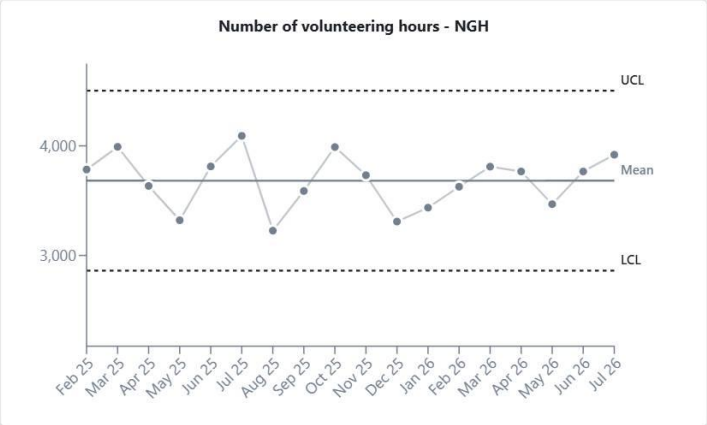
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Number of volunteering hours

The number of hours volunteered in the organisation.




### Understanding the performance

Volunteer hours in July increased by 10.2% compared to June.

### What are the issues impacting performance?

- During July we experienced an increase in the level of sickness and last minute holidays.

### What SMART actions are being taken to improve?

- A recruitment campaign will launch during August to recruit 100 volunteers across UHN, focusing on high-impact roles including Emergency Department, Theatre and Ward Volunteers.
- The team will continue to promote volunteering opportunities within the community and raise awareness of volunteer-led support services, including the Meet & Greet Service and Special Patient Moment Cards.
- A new 3-Month Volunteer Review Plan will be implemented for all new starters to strengthen early engagement, provide additional support and improve volunteer retention.

### Risks

- There is a risk that volunteer numbers will continue to decline in the short term due to seasonal reductions in volunteer availability and the loss of student volunteers returning to education.
- As recruitment activity takes place during August and interviews begin in September, there will be a period before newly recruited volunteers are processed, inducted and deployed into roles.
- August is traditionally a challenging month for volunteer attendance, with many volunteers taking annual holidays and some older volunteers reducing their availability during the school summer holidays to support grandchildren and family commitments.

DATA VALUES

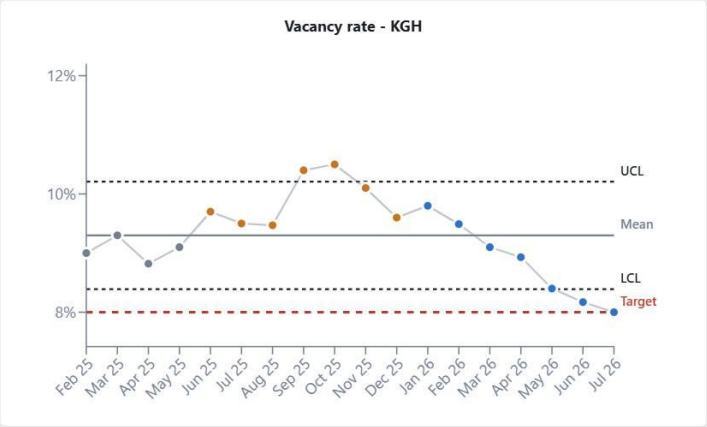
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 3,065 hours | 3,111.83 hours | — | |
| NGH | 3,919 hours | 3,681.61 hours | — | |

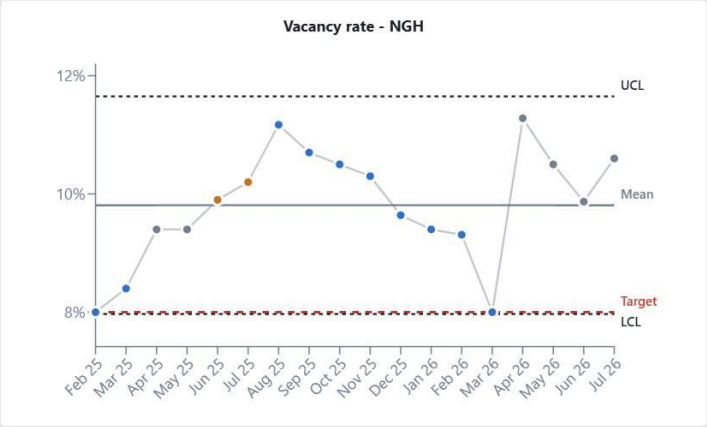
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Vacancy rate

The percentage of established posts which are currently vacant.




### Understanding the performance

Vacancy rates continues to decrease at KGH and is at target. Vacancy rate remains above target at NGH.

### What are the issues impacting performance?

Volume of vacancies to be progressed. Hard to attract posts. Delays in recruitment due to VCP processes.

### What SMART actions are being taken to improve?

New VCP process.

Removal of vacancies to recurrent which will reduce the establishment

### Risks

Hard to recruit specialties. Recruitment team capacity. Balancing flow of new starters with incresed temp staff use.

DATA VALUES

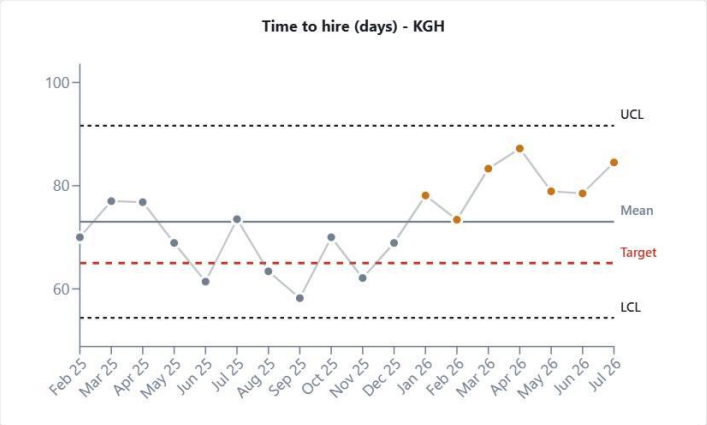
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 8 % | 9.3 % | 8 % | |
| NGH | 10.6 % | 9.81 % | 8 % | |

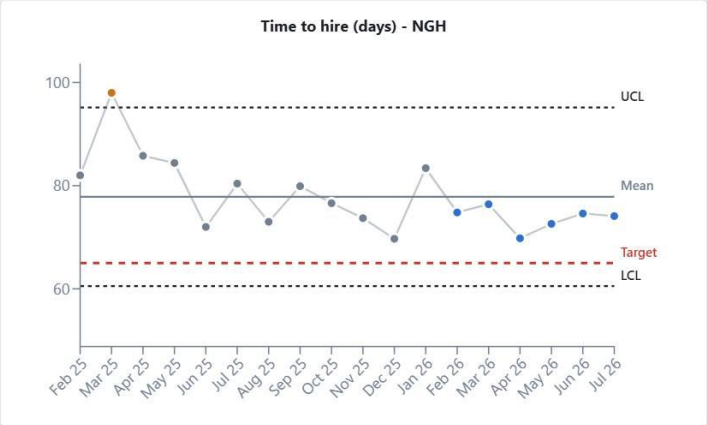
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Time to hire (days)

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




### Understanding the performance

Time to hire is above target

### What are the issues impacting performance?

VCP controls are elongating TTH

### What SMART actions are being taken to improve?

Exploring automated short listing

### Risks

Elongated TTH drives increased or sustained temporary staff use

DATA VALUES

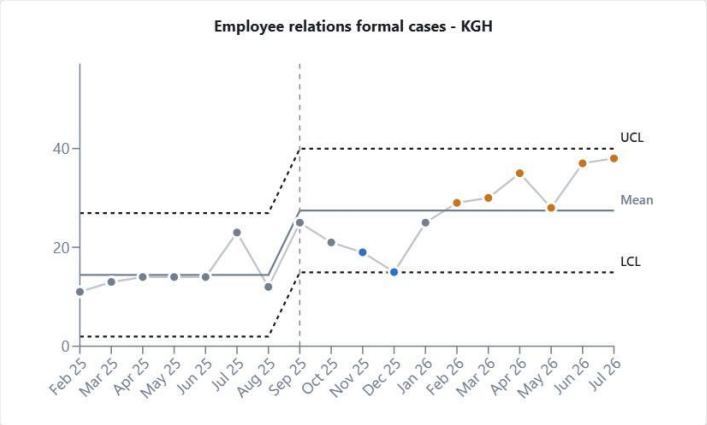
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 84.5 | 73.01 | 65 | |
| NGH | 74.1 | 77.84 | 65 | |

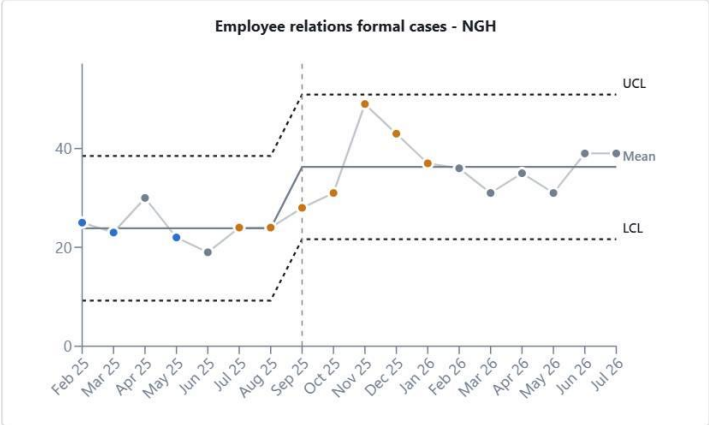
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Employee relations formal cases

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




### Understanding the performance

- There has been a sustained high volume of formal ER cases in both KGH and NGH, particularly in disciplinary and resolution (grievance) ; 29 of each case in month.
- Case closure rates are being monitored with a strong performance in month (18 cases closed in July).

### What are the issues impacting performance?

- Capacity of the team to deal with volume and complexity of existing and new cases alongside supporting efficiency workstreams and organisational change
- Identification and capability of case investigators
- Capacity of Trade Union representatives to accompany colleagues.

### What SMART actions are being taken to improve?

- Implementation of a quarterly case review to review themes, unblock barriers for completion and adopt organisational learning (scheduled Sept 26).
- Investigation Training - development of updated resources and approach, to be co-delivered with Legal partners to increase pool and competence of investigating managers.
- Development of bite size learning, focussed on specific staff groups, to support leaders to tackle poor behaviours, have difficult conversations and promote early resolution.

### Risks

- Unsettled workforce with the number of formal resolution cases impacting colleague satisfaction.
- Increased reputational and financial risk to the organisation with the number of formal and external cases, reflective of a wider NHS position.

DATA VALUES

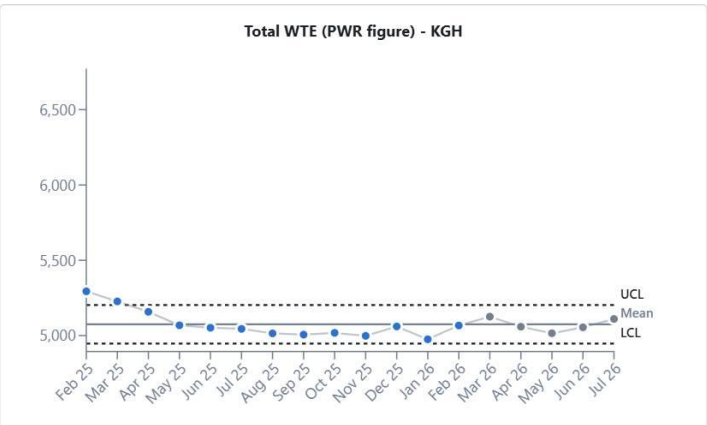
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 38 | 27.45 | — | |
| NGH | 39 | 36.27 | — | |

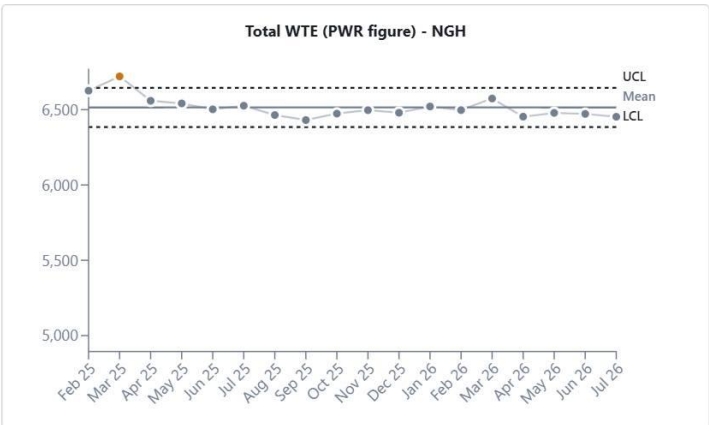
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Total WTE (PWR figure)

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




### Understanding the performance

*No content yet*

### What are the issues impacting performance?

*No content yet*

### What SMART actions are being taken to improve?

*No content yet*

### Risks

*No content yet*

DATA VALUES

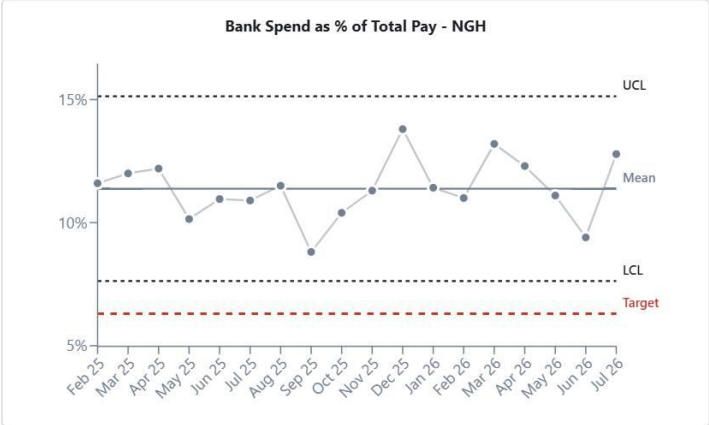
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 5,110.55 | 5,075.05 | — | |
| NGH | 6,452.83 | 6,515.06 | — | |

DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Bank Spend as % of Total Pay

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


### Understanding the performance

- Bank spend has slightly increased since last month, usage also remains above plan in both Trusts.
- The primary reason for increased usage is the current vacancy rates.

### What are the issues impacting performance?

- UHN is currently operating with 538 WTE above its bank plan. 437 WTE can be attributed to NGH and the remaining 101 to KGH.
- Usage and spend are highest in Estates and Facilities, UEC and Acute Medicine and Elderly and General Medicine across both sites, with the highest number of bookings being received from Nursing and Midwifery, Administrative and Clerical and Estates and Facilities staff groups.
- The primary reasons for increased usage are: 1) Budgeted Vacancy (VCP approved), 2) Sickness Absence (short term approved), 3) Maternity/Paternity (VCP approved) and 4) Sickness Absence (long term VCP approved)

### What SMART actions are being taken to improve?

- Plans are in place to recruit to substantive positions in nursing through student intake in September and recent assessment centres.
- Additional recruitment plans in place behind positions regularly filled by bank workers.
- 0% vacancy rate target for HCSW, Housekeeping and Portering roles.
- Introduction of enhanced vacancy and temporary workforce controls to prevent usage and spend over plan, including review of reasons for booking.

### Risks

- Delays with or inability to recruit to vacancies resulting in ongoing or increased requirement for bank utilisation.
- Projected increases in requests in Q3 and Q4 to cover winter demands and/or further Industrial Action.
- Potential implications of ERA changes on use of zero hour contracts.

DATA VALUES

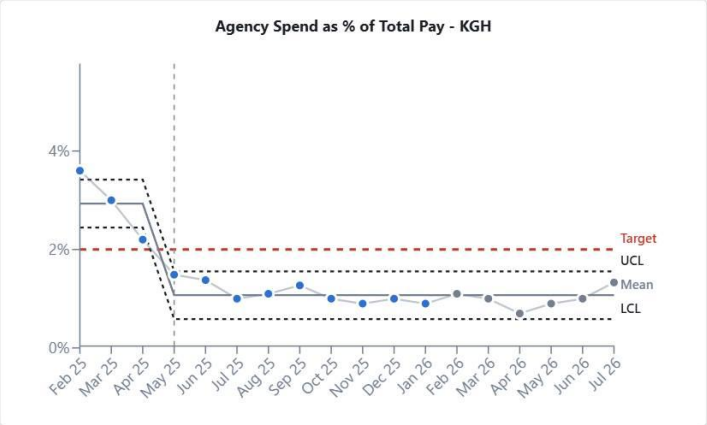
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 9.57 % | 9.7 % | 6.3 % | |
| NGH | 12.78 % | 11.38 % | 6.3 % | |

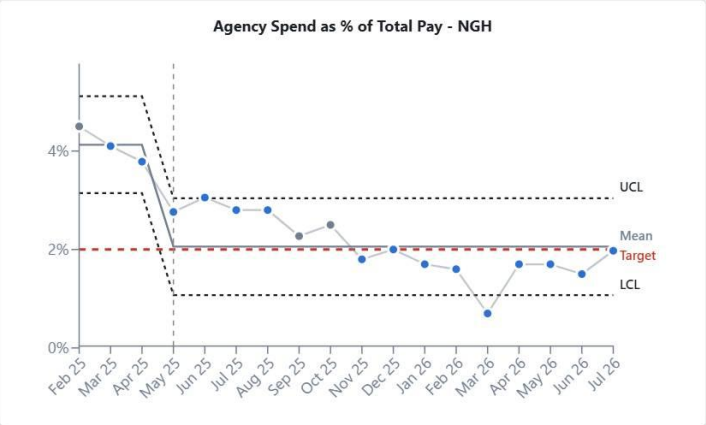
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Agency Spend as % of Total Pay

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




### Understanding the performance

- Agency usage remains below plan
- There has been a slight increase at KGH & NGH since the start of the financial year.
- Main reasons for agency usage are hard to fill medical roles, nursing vacancies, sickness and annual leave cover.

### What are the issues impacting performance?

- Year to date, UHN organisations are currently 4.6 WTE below plan on agency usage.
- Off framework usage and Admin and Clerical agency work has ceased.
- Cap compliance continues to improve alongside this.
- The highest usage of agency remains is for Nursing and Midwifery and Medical and Dental roles.

### What SMART actions are being taken to improve?

- Review of recruitment pipeline to ensure there are active plans to substantively fill positions currently occupied by long-term agency workers.
- Introduction of enhanced temporary workforce controls to prevent usage and spend over plan, including review of reasons for booking.

### Risks

- Adverse impact on financial position.
- Ability to recruit to hard to fill roles/shortage occupations.

DATA VALUES

| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 1.33 % | 1.07 % | 2 % | |
| NGH | 1.97 % | 2.06 % | 2 % | |

DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

Signed off by **Paula Kirkpatrick** on 1 Sept 2026, 20:40

## Use of Resources domain

### Good news

At month 4 financial performance is £1m adverse to plan YTD (which is purely the industrial action variance from earlier in the financial year), with YTD CIP delivery slightly ahead of trajectory.

### Areas of concern

Identification of CIP to support the increased efficiency requirement from Q2 remains a concern and will require increased and focused attention on temporary staffing spend in particular.

### Improvement plans in place

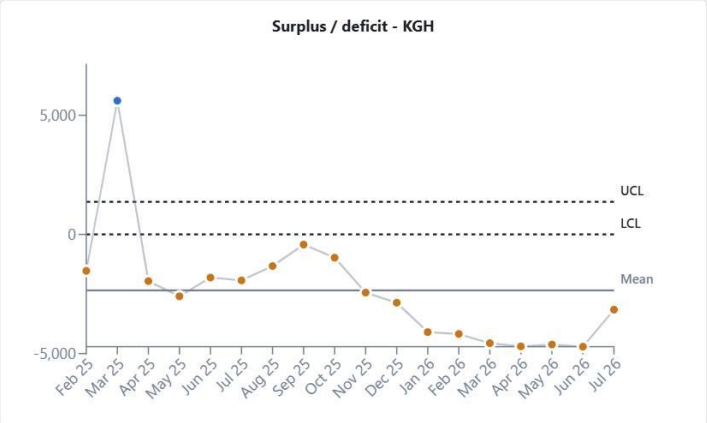
Work with clinical divisions, corporate functions and the delivery partner to reduce the run-rate remains ongoing.

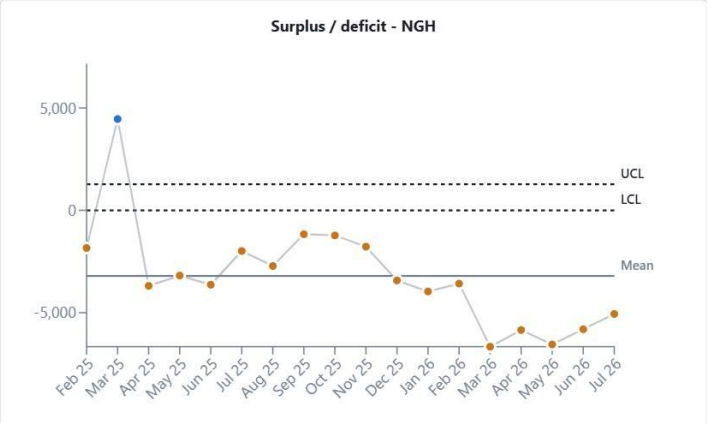
| METRIC | KGH | NGH | TARGET | STAR |
|---|---|---|---|---|
| **FINANCE** | | | | |
| Surplus / deficit | -3,158 | -5,064 | — | |
| Cash | 1,009 | 1,141 | — | |
| **PRODUCTIVITY AND EFFICIENCY** | | | | |
| CIP Delivery | 60.3 % | 65.7 % | 100 % | |

| | Consistently hit target | Not consistently achieved or failed | Consistently fail target | No target set |
|---|---|---|---|---|
| Special Cause Improvement | | | | |
| Common Cause | | • CIP Delivery - NGH<br>• CIP Delivery - KGH | | • Cash - KGH<br>• Cash - NGH |
| Special Cause Concern | | | | • Surplus / deficit - KGH<br>• Surplus / deficit - NGH |

## Surplus / deficit

Monthly financial position – total income vs total expenditure.




### Understanding the performance

At month 4, UHN are on £1m adverse to plan YTD which represents the unfunded industrial action costs from earlier in the financial year. UHN's delivery of the month 4 plan in aggregate is bolstered by a slight over delivery of efficiencies.

### What are the issues impacting performance?

£1.0m of costs due to industrial action (Apr-26) have been offset by a small amount of efficiency over delivery, income slightly above plan and a range of non pay underspends.

### What SMART actions are being taken to improve?

Work is ongoing to ensure schemes are in place to deliver full year efficiency target.

### Risks

Further industrial action, pay awards and other inflationary pressures may exceed available funding, operational pressures and ability to identify remaining efficiency requirement.

DATA VALUES

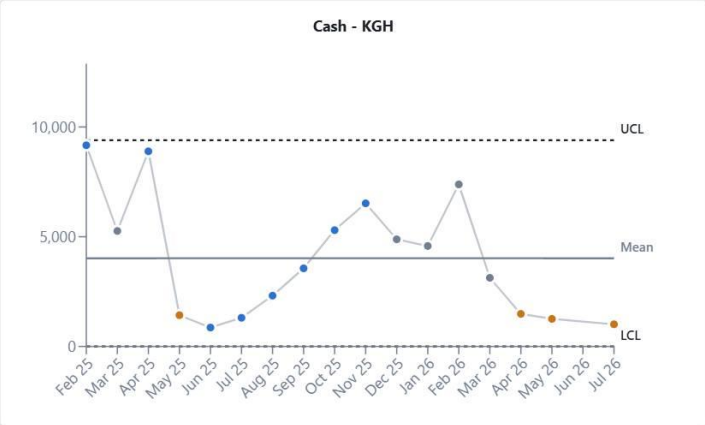
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | -3,158 | -2,349.67 | — | |
| NGH | -5,064 | -3,204.28 | — | |

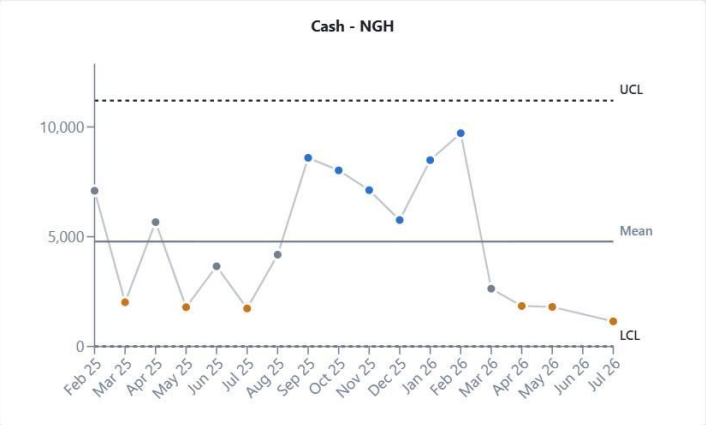
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## Cash

Cash balance




### Understanding the performance

- KGH: Cash remains tightly managed, with an August closing balance forecast at c.£1.0m. The position is broadly balanced month-to-month, but relies on careful management of income, creditor payments and capital expenditure.
- NGH: Cash is constrained, with an August closing balance forecast at c. £1.1m. Monthly cash movements remain volatile, including several forecast deficit months.

### What are the issues impacting performance?

- KGH: The key pressure is the high level of expenditure, particularly pay of c.£26–27m per month and variable trade creditor/capital requirements. Income is also uneven, with reliance on PDC revenue and capital funding at points during the year.
- NGH: Similar pressures are evident, with pay of c.£32–33m per month, significant trade/NHS creditor requirements and variable capital expenditure. Several months show expenditure exceeding income, creating continued pressure on underlying liquidity.

### What SMART actions are being taken to improve?

Continue weekly cash flow monitoring and active payment management, prioritising critical payments while aligning creditor and capital payment profiles with available cash. Forecasts should be refreshed monthly to reflect the latest income, PDC and expenditure assumptions, with any emerging deterioration escalated promptly.

### Risks

The principal risk remains limited cash headroom, with balances generally being maintained at around £1m, leaving little capacity to absorb unexpected movements. Delays in income/PDC receipts, higher-than-forecast pay or creditor payments, or acceleration of capital expenditure could therefore create an in year requirement for additional cash support.

DATA VALUES

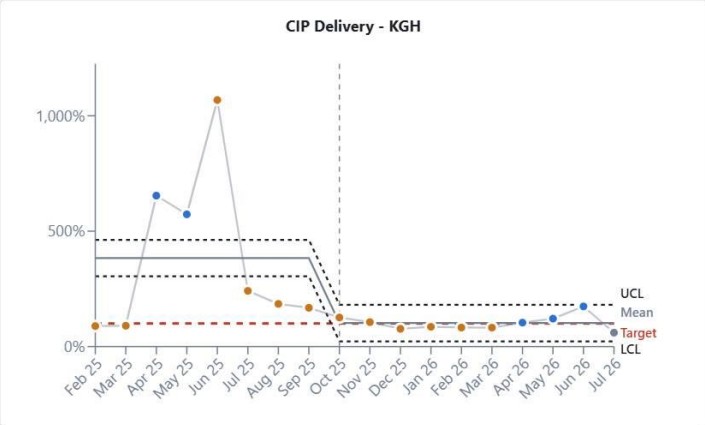
| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 1,009 | 4,018.24 | — | |
| NGH | 1,141 | 4,778.59 | — | |

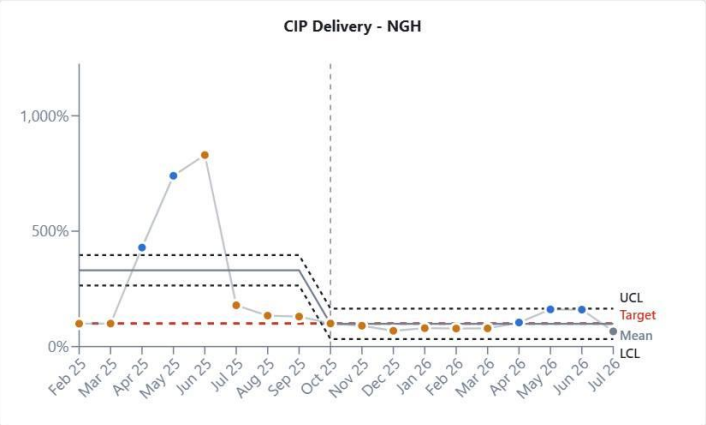
DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

## CIP Delivery

The percentage of our planned cost improvement plan that has been delivered in-month against the in-month target




## Understanding the performance

•£4.5m of efficiencies have been delivered across UHN for the year (£1.9m KGH, £2.5m NGH), against a Month 4 plan of £7.1m.

•A number of the 2025/26 schemes will have a beneficial full year effect into 2026/27.

## What are the issues impacting performance?

•The efficiency plan is phased to deliver 13% of required savings in quarter 1, and 29% in each of Q2, Q3 and Q4.

## What SMART actions are being taken to improve?

•Ongoing identification of efficiencies within divisional and corporate teams to meet the required targets.

•Cross-cutting programmes including workforce established and in place across the group.

•Implementation of findings from grip and control review across divisions.

## Risks

•Rising efficiency targets make savings increasingly hard to deliver.

•The full scope of the efficiency programme has not been identified yet for 2026/27, work is underway to fully develop the programme.

•Efficiency plans face development gaps and delivery risks, even where fully scoped.

DATA VALUES

| TRUST | VALUE | MEAN | TARGET | SPC |
|---|---|---|---|---|
| KGH | 60.3 % | 101.76 % | 100 % | |
| NGH | 65.7 % | 98.6 % | 100 % | |

DATA QUALITY

| DIMENSION | DESCRIPTION | STATUS |
|---|---|---|
| S | Signed off and validated | Green |
| T | Timely and complete | Green |
| A | Audit and accuracy | Not rated |
| R | Robust systems and data capture | Green |

Signed off by **Sarah Stansfield** on 3 Sept 2026, 08:52

# Summary Balance Sheet - KGH

NHS University Hospitals of Northamptonshire NHS Group

TRUST SUMMARY BALANCE SHEET
MONTH 4 2026/27

| | Balance at 31-Mar-26 £000 | Current Month Opening Balance £000 | Current Month Closing Balance £000 | Current Month Movement (in month) £000 | Forecast end of year Closing Balance £000 | Forecast end of year Movement £000 |
|---|---|---|---|---|---|---|
| **NON CURRENT ASSETS** | | | | | | |
| OPENING NET BOOK VALUE | 230,763 | 230,763 | 230,763 | 0 | 230,763 | 0 |
| IN YEAR REVALUATIONS | 0 | 0 | 0 | 0 | | 0 |
| IN YEAR MOVEMENTS | 0 | 6,246 | 9,411 | 3,165 | 80,985 | 80,985 |
| LESS DEPRECIATION | 0 | (4,212) | (5,616) | (1,404) | (17,343) | (17,343) |
| **NET BOOK VALUE** | **230,763** | **232,797** | **234,558** | **1,761** | **294,405** | **63,642** |
| **NON CURRENT RECEIVABLES** | **1,180** | **1,092** | **1,021** | **(71)** | **956** | **(224)** |
| **CURRENT ASSETS** | | | | | | |
| INVENTORIES | 7,211 | 6,954 | 6,974 | 20 | 7,243 | 32 |
| TRADE & OTHER RECEIVABLES | 12,330 | 16,496 | 17,837 | 1,341 | 14,870 | 2,540 |
| CASH | 3,126 | 877 | 1,009 | 132 | 1,707 | (1,419) |
| **TOTAL CURRENT ASSETS** | **22,667** | **24,327** | **25,819** | **1,492** | **23,820** | **1,153** |
| **CURRENT LIABILITIES** | | | | | | |
| TRADE & OTHER PAYABLES | 41,204 | 44,989 | 43,825 | (1,164) | 28,714 | (12,490) |
| LEASE PAYABLE under 1 year | 1,345 | 899 | 852 | (47) | 852 | (493) |
| DHSC LOANS | 0 | 0 | 0 | 0 | 0 | 0 |
| PROVISIONS under 1 year | 1,292 | 1,121 | 1,126 | 5 | 890 | (402) |
| **TOTAL CURRENT LIABILITIES** | **43,841** | **47,009** | **45,803** | **(1,206)** | **30,456** | **(13,385)** |
| **NET CURRENT ASSETS / (LIABILITIES)** | **(21,174)** | **(22,682)** | **(19,983)** | **2,699** | **(6,636)** | **14,538** |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | **210,769** | **211,207** | **215,596** | **4,389** | **288,725** | **77,956** |
| **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 | 532 | 527 | (5) | 527 | (5) |
| **NON CURRENT LIABILITIES** | **6,807** | **6,751** | **6,746** | **(5)** | **6,746** | **(61)** |
| **TOTAL ASSETS EMPLOYED** | **203,962** | **204,456** | **208,850** | **4,394** | **281,979** | **78,017** |
| **FINANCED BY** | | | | | | |
| PDC CAPITAL | 357,509 | 372,053 | 379,627 | 7,574 | 457,044 | 99,535 |
| REVALUATION RESERVE | 41,154 | 41,200 | 41,200 | 0 | 41,200 | 46 |
| I & E ACCOUNT | (194,701) | (208,797) | (211,978) | (3,181) | (216,265) | (21,564) |
| **FINANCING TOTAL** | **203,962** | **204,456** | **208,850** | **4,394** | **281,979** | **78,017** |

Dedicated to excellence

## Non-Current Assets

- Capital expenditure in the month totalled £3.1m, including £2.0m spent on the Energy Centre development, £0.5m on the Replacement LV Panels (CIR) project, and £0.2m on the Rockingham Wing Extension

## Current Assets

- Cash balance has been kept to a minimum of £1.0m at each month end, reflecting the significant shortfall of £12.3m in PDC cash support received so far (£13.3m) against YTD financial plan of £25.7m.
- Trade and other receivables have Increased in month by £1.3m. This includes £0.5m VAT recoverable, £0.6m prepayments and £0.2m accruals

## Current Liabilities

- Payables & working capital: Trade and other payables reduced by £1.1m in-month, with overdue creditors of £3.0m (£1.0m NHS; £2.0m trade). Stringent cash management continues, including extending creditor terms where possible and generally withholding NHS payments except pass-through costs.
- BPPC performance: Cash-flow pressures have reduced YTD BPPC performance to 58% by invoice volume and 64% by value, significantly below the 95% target.

## Financing

- PDC Capital Increase of £7.7m in month includes Capital programme allocation of £4.1m plus £3.6m of Revenue Support PDC received.
- Income & Expenditure movement reflects in-month deficit of £3.1m.

# Summary Balance Sheet - NGH

| TRUST SUMMARY BALANCE SHEET MONTH 4 2026/27 | Balance at 31-Mar-26 | Current Month Opening Balance | Current Month Closing Balance | Current Month Movement | Forecast end of year Closing Balance | Forecast end of year Movement |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| NON CURRENT ASSETS | | | | | | |
| OPENING NET BOOK VALUE | 288,332 | 288,332 | 288,324 | (8) | 288,332 | 0 |
| IN YEAR REVALUATIONS | 0 | 0 | 0 | 0 | 0 | 0 |
| IN YEAR MOVEMENTS | 0 | 6,130 | 7,975 | 1,845 | 33,223 | 33,223 |
| LESS DEPRECIATION | 0 | (5,367) | (7,156) | (1,789) | (21,473) | (21,473) |
| NET BOOK VALUE | 288,332 | 289,095 | 289,143 | 48 | 300,082 | 11,750 |
| CURRENT ASSETS | | | | | | |
| INVENTORIES | 9,142 | 8,699 | 8,836 | 137 | 9,200 | 58 |
| TRADE & OTHER RECEIVABLES | 16,254 | 19,533 | 20,561 | 1,028 | 15,045 | (1,209) |
| CLINICIAN PENSION TAX FUNDING | 587 | 587 | 587 | 0 | 628 | 41 |
| CASH | 2,631 | 792 | 1,141 | 349 | 2,820 | 189 |
| TOTAL CURRENT ASSETS | 28,614 | 29,611 | 31,125 | 1,514 | 27,693 | (921) |
| CURRENT LIABILITIES | | | | | | |
| TRADE & OTHER PAYABLES | 53,987 | 63,395 | 67,274 | 3,879 | 70,434 | 16,447 |
| FINANCE LEASE PAYABLE under 1 year | 3,027 | 3,037 | 3,041 | 4 | 1,335 | (1,692) |
| SHORT TERM LOANS | 41 | 39 | 39 | 0 | 18 | (23) |
| PROVISIONS under 1 year | 2,467 | 2,383 | 2,313 | (70) | 995 | (1,472) |
| TOTAL CURRENT LIABILITIES | 59,522 | 68,854 | 72,667 | 3,813 | 72,782 | 13,260 |
| NET CURRENT ASSETS / (LIABILITIES) | (30,908) | (39,243) | (41,542) | (2,299) | (45,089) | (14,181) |
| TOTAL ASSETS LESS CURRENT LIABILITIES | 257,424 | 249,852 | 247,601 | (2,251) | 254,993 | (2,431) |
| NON CURRENT LIABILITIES | | | | | | |
| FINANCE LEASE PAYABLE over 1 year | 9,918 | 9,215 | 9,011 | (204) | 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 | 9,935 | 9,731 | (204) | 11,108 | 452 |
| TOTAL ASSETS EMPLOYED | 246,768 | 239,917 | 237,870 | (2,047) | 243,885 | (2,883) |
| FINANCED BY | | | | | | |
| PDC CAPITAL | 368,556 | 380,156 | 383,256 | 3,100 | 424,225 | 55,669 |
| REVALUATION RESERVE | 63,989 | 63,989 | 63,989 | 0 | 63,989 | 0 |
| I & E ACCOUNT | (185,777) | (204,228) | (209,375) | (5,147) | (244,329) | (58,552) |
| FINANCING TOTAL | 246,768 | 239,917 | 237,870 | (2,047) | 243,885 | (2,883) |

Dedicated to excellence

## Non-Current Assets

- M4 Capital movements of £1.8m. The top sliced schemes account for the majority of spend in M4, including EPR tranche 2 £0.7m, UTC Works £0.6m and the 33-bed ward £0.3m

## Current Assets

- Working capital: Inventories moved by £0.1m, while trade and other receivables increased by £0.35m, mainly driven by higher NHS income accruals for C&V (£1.3m) and LVA funding (£0.1m), partly offset by lower NHS receivables.
- Salary overpayments & cash: Salary overpayments remain at £0.5m, with in-month overpayments of £0.082m across 22 cases, above last year (£0.029m/14 cases). Cash increased by £0.3m, reflecting PDC capital receipts net of capital and operating outflows.

## Current Liabilities

- Trade and Other Payables – Overall increase of £3.9m includes £1.5m for Patient Care Contract under-performance, £0.9m accruals for pharmacy & pathology supplies, £0.7m accrual for PDC dividends, and £0.4m increase in other creditors.
- Note that total creditors have increased by £13.4m since being of this year, due to the cash-deficit resulting from £7.7m shortfall in the cash support received to date against plan. This is also beginning to show in the BPPC performance to date.

## Financing

- PDC Capital - £3.1m Revenue Deficit support made up of £1.6m Deficit Support and £1.5m Working Capital.
- I & E Account - £5.1m - 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 | FORECAST AUG £000s | SEP £000s | OCT £000s | NOV £000s | DEC £000s | JAN £000s | FEB £000s | MAR £000s |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **RECEIPTS** | | | | | | | | | | | | | |
| Clinical Income | 400,393 | 35,505 | 32,009 | 33,766 | 33,870 | 33,902 | 33,049 | 33,049 | 33,049 | 33,049 | 33,049 | 33,049 | 33,049 |
| Health Education England | 14,394 | 3,512 | 0 | 0 | 3,790 | 0 | 0 | 4,728 | 0 | 0 | 0 | 2,364 | 0 |
| VAT | 6,620 | 534 | 642 | 822 | 0 | 1,622 | 500 | 500 | 400 | 400 | 400 | 400 | 400 |
| Other income | 11,243 | 979 | 1,222 | 769 | 2,001 | 1,195 | 1,240 | 719 | 597 | 723 | 607 | 602 | 589 |
| PDC - Capital | 62,029 | 0 | 3,217 | 1,378 | 4,185 | 567 | 5,486 | 4,216 | 4,499 | 4,039 | 3,643 | 6,193 | 24,606 |
| PDC - Revenue | 45,345 | 3,949 | 4,000 | 2,000 | 3,600 | 2,600 | 7,596 | 3,600 | 3,600 | 3,600 | 3,600 | 3,600 | 3,600 |
| Interest Receivable | 794 | 89 | 75 | 57 | 58 | 65 | 63 | 66 | 68 | 69 | 60 | 57 | 68 |
| **TOTAL RECEIPTS** | **540,819** | **44,568** | **41,165** | **38,793** | **47,504** | **39,951** | **47,934** | **46,878** | **42,213** | **41,880** | **41,358** | **46,265** | **62,312** |
| **PAYMENTS** | | | | | | | | | | | | | |
| Salaries and wages (incl agency) | 323,097 | 27,048 | 26,438 | 26,936 | 27,539 | 26,638 | 27,455 | 27,340 | 26,660 | 27,060 | 26,660 | 26,660 | 26,663 |
| Trade Creditors | 129,347 | 8,689 | 10,645 | 8,261 | 14,847 | 9,041 | 10,935 | 13,072 | 9,076 | 8,754 | 8,805 | 13,877 | 13,345 |
| 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 | 56,970 | 8,942 | 2,795 | 2,410 | 3,441 | 2,765 | 5,014 | 4,932 | 4,943 | 4,532 | 4,360 | 5,728 | 7,108 |
| PDC Dividend | 6,692 | 0 | 0 | 0 | 0 | 0 | 2,996 | 0 | 0 | 0 | 0 | 0 | 3,696 |
| **TOTAL PAYMENTS** | **531,441** | **46,213** | **41,411** | **39,141** | **47,359** | **39,977** | **47,934** | **46,878** | **42,213** | **41,880** | **41,358** | **46,265** | **50,812** |
| Actual month balance | 9,378 | -1,646 | -247 | -348 | 145 | -26 | 0 | 0 | 0 | 0 | 0 | 0 | 11,500 |
| Cash in transit & Cash in hand adjustment | 5 | 3 | 19 | -31 | -12 | 17 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Balance brought forward | 3,126 | 3,126 | 1,483 | 1,255 | 876 | 1,009 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 |
| **Balance carried forward** | **12,509** | **1,483** | **1,255** | **876** | **1,009** | **1,000** | **1,000** | **1,000** | **1,000** | **1,000** | **1,000** | **1,000** | **12,500** |

**What are the issues impacting the position?**

- Closing cash balance in July was £1.0m an increase of £0.1m during July.
- Planned Revenue Support to Month 4 was £25.66m, actual support received is £13.34m, which represents a shortfall of £12.32m. This explains the deterioration in the BPPC indicator as well as the low cash balance at end of Q1.
- PDC Cash Support request of £3.6m for August was approved but limited to £2.6m. 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 to ensure the Trust can pay PDC dividends as well as outstanding and overdue supplier invoices.
- The Trust continues to use 30 days payment terms for most suppliers.
- Capital PDC draw down in August was lower than forecast, offsetting the additional funds in July. The July variance of £1.7m was used to pay revenue suppliers to maintain a £1m closing balance . Revenue funds will be used to fund capital expenditure in month
- VAT monies due for the July return are to be paid in August due to the deadline of 2025/26 recoveries. £1.1m due for June return and £0.5m due for July return, both receivable in August.

# Cash Flow - NGH

| MONTHLY CASHFLOW | ANNUAL TOTAL 2026/27 £000 | ACTUAL APR £000 | MAY £000 | JUN £000 | JUL £000 | FORECAST AUG £000 | SEP £000 | OCT £000 | NOV £000 | DEC £000 | JAN £000 | FEB £000 | MAR £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **RECEIPTS** | | | | | | | | | | | | | |
| SLA Block Payments | 499,364 | 42,770 | 40,483 | 42,329 | 42,330 | 41,421 | 41,501 | 41,421 | 41,421 | 41,421 | 41,421 | 41,421 | 41,421 |
| Health Education Payments | 18,241 | 4,744 | 0 | 0 | 5,037 | 0 | 0 | 5,672 | 0 | 0 | 0 | 2,788 | 0 |
| Other NHS Income | 16,319 | 1,716 | 1,652 | 594 | 2,369 | 2,350 | 2,537 | 850 | 850 | 850 | 850 | 850 | 850 |
| VAT Claim | 7,000 | 317 | 1,686 | 567 | 0 | 1,030 | 400 | 500 | 500 | 500 | 500 | 500 | 500 |
| PP / Other | 7,811 | 687 | 488 | 692 | 744 | 650 | 650 | 650 | 650 | 650 | 650 | 650 | 650 |
| PDC - Capital | 10,069 | 0 | 0 | 0 | 0 | 0 | 432 | 337 | 337 | 437 | 2,517 | 1,380 | 4,629 |
| PDC - Revenue | 45,600 | 5,000 | 5,000 | 1,600 | 3,100 | 2,000 | 8,300 | 3,100 | 3,100 | 3,100 | 3,100 | 1,600 | 6,600 |
| Interest Receivable | 770 | 94 | 71 | 57 | 69 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 |
| **TOTAL RECEIPTS** | **605,173** | **55,328** | **49,380** | **45,839** | **53,650** | **47,511** | **53,880** | **52,591** | **46,918** | **47,018** | **49,098** | **49,249** | **54,710** |
| **PAYMENTS** | | | | | | | | | | | | | |
| Salaries and wages | 396,094 | 33,750 | 33,466 | 33,947 | 34,061 | 33,320 | 33,350 | 32,700 | 32,200 | 32,700 | 32,200 | 32,200 | 32,200 |
| Trade Creditors | 132,942 | 11,783 | 9,720 | 8,062 | 14,490 | 9,444 | 10,969 | 13,197 | 10,738 | 10,185 | 10,522 | 12,017 | 11,815 |
| NHS Creditors | 32,845 | 4,354 | 2,545 | 2,651 | 2,986 | 2,531 | 3,031 | 3,031 | 2,531 | 2,531 | 2,531 | 2,065 | 2,060 |
| Capital Expenditure | 34,531 | 6,226 | 3,716 | 2,153 | 1,819 | 2,282 | 2,391 | 2,826 | 2,342 | 1,614 | 3,844 | 2,949 | 2,369 |
| PDC Dividend | 8,510 | 0 | 0 | 0 | 0 | 0 | 4,136 | 0 | 0 | 0 | 0 | 0 | 4,374 |
| 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** | **604,964** | **56,130** | **49,447** | **46,816** | **53,356** | **47,577** | **53,877** | **51,771** | **47,811** | **47,033** | **49,097** | **49,231** | **52,818** |
| Actual month balance | 210 | (803) | (67) | (978) | 294 | (65) | 3 | 820 | (892) | (14) | 2 | 18 | 1,892 |
| Cash in transit & in hand adjustment | (21) | 15 | 24 | (31) | 55 | (83) | (1) | 0 | 0 | 0 | 0 | 0 | 0 |
| Balance brought forward | 2,631 | 2,631 | 1,843 | 1,800 | 792 | 1,141 | 992 | 994 | 1,814 | 922 | 907 | 909 | 927 |
| **Balance carried forward** | **2,820** | **1,843** | **1,800** | **792** | **1,141** | **992** | **994** | **1,814** | **922** | **907** | **909** | **927** | **2,820** |

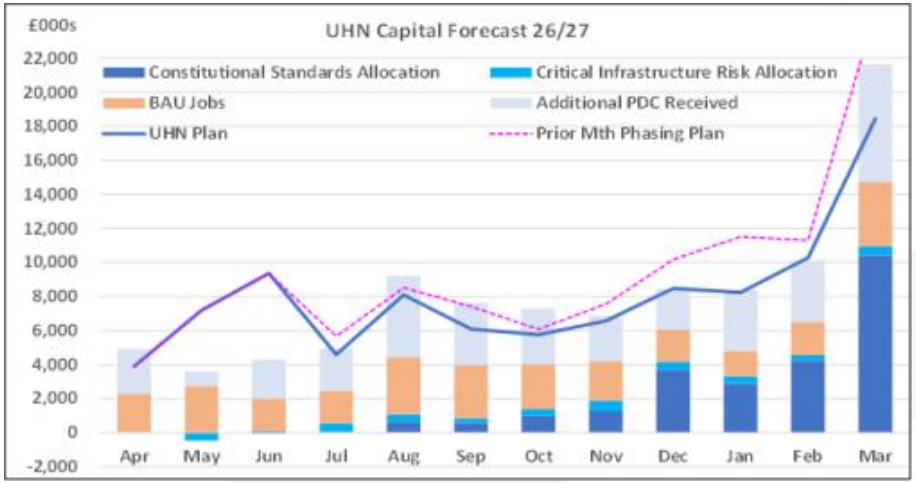
**What are the issues impacting the position?**

- Cash remains constrained: July closed at £1.1m, in line with forecast. Revenue support received YTD is £14.7m vs £22.4m planned, a £7.7m shortfall.
- Revenue support remains critical: £3.1m PDC support was received in July, but only £2.0m of the £3.1m requested for August has been approved, increasing pressure on creditor payments and BPPC performance.
- Creditor management: July saw higher creditor payments as previously held invoices were cleared, resulting in significant BPPC non-compliance. Weekly creditor reviews and prioritised payments will continue while cash pressures remain.
- Outlook: The forecast assumes ongoing monthly £1.6m deficit support plus working capital support; any reduction in support will further constrain the Trust's ability to meet payment terms and planned expenditure.

# Capital - UHN

| UHN Capital Expenditure | YTD M4 | | |
|---|---|---|---|
| £000s | Revised Plan | Actual | Variance |
| BAU - Estates | 1,277 | 967 | 310 |
| BAU - Medical Equipment | 344 | 143 | 201 |
| BAU - Digital | 392 | 51 | 341 |
| KGH Cath Lab 3 | 0 | 2 | (2) |
| NGH Maternity Bereavement Suite | 28 | 25 | 3 |
| Laparoscopic Stacks | 0 | 0 | 0 |
| Feasibilities | 0 | 0 | 0 |
| Mortuaries | 390 | 233 | 157 |
| SDEC / SSU KGH | 20 | 267 | (247) |
| ROU Renewals + Additions | 849 | 0 | 849 |
| 33 Bed Winter Ward | 1,753 | 1,573 | 180 |
| NGH UTC | 3,501 | 2,935 | 566 |
| EPR System Implementation | 2,323 | 2,575 | (252) |
| Lin Acc Enabling Work + Eqp. | 0 | 58 | (58) |
| Charitable Funds | (100) | 0 | (100) |
| **BAU Capital net of Disposals** | **10,777** | **8,830** | **1,947** |
| Critical Infrastructure Risk Allocation | 23 | 29 | (6) |
| Const.Stds. Diagnostic Hub 3rd CDC | 200 | 0 | 200 |
| Const. Stds. UHN Elective Hub | 0 | 135 | (135) |
| Const. Stds. KGH UTC & UHN Majors ED | 320 | 1 | 319 |
| Rockingham Extension | 864 | 861 | 3 |
| Energy Centre | 11,801 | 6,606 | 5,195 |
| NHP Wave 2 | 328 | 365 | (37) |
| NHP Enabling | 25 | 126 | (101) |
| MSCP Main Build | 63 | 211 | (148) |
| MSCP Utilities Diversion | 420 | 0 | 420 |
| Maternity Building Rebuild | 221 | 123 | 98 |
| **Non BAU Capital Expenditure** | **14,265** | **8,457** | **5,808** |
| **Total Capital Expenditure** | **25,042** | **17,287** | **7,756** |

| Year to Date Capital Spend | KGH | NGH | UHN |
|---|---|---|---|
| Capital Allocation | 939 | 7,891 | 8,830 |
| PDC Funded | 8,420 | 37 | 8,457 |
| **Total CDEL** | **9,359** | **7,928** | **17,287** |




**What are the issues impacting the position?**

- The £97.0m Capital Plan is phased to deliver £25.0m by Month 4, with expenditure weighted towards the second half of the year due to Constitutional Standards projects.
- Month 4 YTD expenditure is £17.3m, including £8.8m BAU and £8.5m externally funded schemes. Key top-slice projects remain broadly on plan.
- Overall expenditure is £7.8m behind plan, with the Energy Centre accounting for £5.2m (67%) of the variance. Its 2026/27 forecast has been revised to £29.4m, against £30.7m MOU funding, and will continue to be monitored for potential slippage.
- Further slippage against the original Constitutional Standards profile is also anticipated.

# BOARD COMMITTEE SUMMARIES

Audit: 2 June and 24 June 2026

Finance, Investment and Performance: 23 June, 28 July and 21 August 2026

People: 22 July 2026

Quality and Safety: 29 July 2026

Strategy, Transformation and Digital: 4 August 2026

| Audit Committees<br>Upward Report to Boards of Directors | Date(s) of reporting group's meeting: 24 June 2026 |
|---|---|

**Reporting Group Chair: Alice Cooper**

| Agenda Item | Description and summary discussion | Link to Board Assurance Framework (BAF) | Assurance level * |
|---|---|---|---|
| BAF UHN15 – Demand and Capacity | The committees received a full review of the current status of the risk, and related mitigations from the COO. | UHN15 | Reasonable |
| Tracking and governance over findings of (non-clinical) external reviews | The committees received an update from the interim Managing Director on the process being implemented, and also on key external reports currently being tracked and acted upon. Given that this had been a longstanding concern of the committee, the progress and clarity was particularly welcomed. | - | Reasonable |
| Internal Audit | The committees received both the final annual opinion relating for 2025-26, and also an update of work completed since the last meeting, against the plan for the year. Whilst positive signs of an improvement to the operation of the internal audit processes are being seen, it is still early days. The committees also received the equivalent reports in respect of the Anti-Crime work completed by the team. Concerns remained regarding the long time taken to progress investigations in this area, as reflected in the assurance level given.<br>Assurance (anti-crime) Overall Reasonable, but with Limited assurance in the area of the investigations | - | Limited |
| External Audit | The committees received the year end items relating to the finalisation of the external audit process for both trusts. It was noted that despite the short delay to completion of the fieldwork (which was ongoing and expected to be managed by the national deadline or very shortly after) the audits had been generally clean, and not significant concerns regarding process had been raised. | UHN16 Deliver Financial Plan | Reasonable |
| Fit and Proper Persons Compliance Process | The committees received an update on the enhancements/additional clarity being implemented to the existing process following the consideration of feedback from the NGH Well-Lead review. These enhancements were welcomed. Boards will be asked to accept the Chair's assurance regarding fit and proper compliance for Board(s) members at the 10 September 2026 meeting. | - | Reasonable |

| Audit Committees<br>Upward Report to Boards of Directors | Date(s) of reporting group's meeting: 24 June 2026 |
|---|---|

**Reporting Group Chair: Alice Cooper**

| Agenda Item | Description and summary discussion | Link to Board Assurance Framework (BAF) | Assurance level * |
|---|---|---|---|
| Register of Interests and Declarations of gifts and hospitality | The committees reviewed the annual registers of interest and gifts and hospitality, welcoming the UHN CEO to answer questions regarding a subset of the declarations regarding Executives. These questions were being followed up in more detail in conjunction with the UHL audit committee, and the committees also requested consideration of improvements which may be needed to the education of directors and decision-making employees regarding the national guidance, the UHN policy, their responsibilities, and also how declarations should be made and approved (where this is required). | N/A | Limited |

| Finance, Investment and Performance Committee<br>Upward Report to Board of Directors | Date(s) of reporting group's meeting(s): 23rd June 2026 |
|---|---|

**Reporting Group Chair: Damien Venkatasamy**

| Agenda Item | Description and summary discussion | Link to Board Assurance Framework (BAF) | Assurance level * |
|---|---|---|---|
| CFO Report Month 2 | The committee noted a £21.7m deficit compared to plan but highlighted cash pressures with a £5m monthly shortfall and potential need to pause capital spending. The forecast showed a possible £30m gap if current trends continued. Efficiency savings of 7% cost improvement must be delivered in cash terms. Audit work was ongoing with no misstatements reported. There were significant concerns on the financial run rate gap and ongoing cash shortfall with potential capital expenditure pause. | UHN16 & UHN17 | Limited |
| 2026/27 Planning – Referral to Treatment (RTT) Plan Changes | The Committee was informed of a mandated increase in RTT delivery from 70% to 73% which presented unfunded additional activity, loss of plan triangulation, and affordability challenges. Engagement with NHSE and ICB was ongoing to explore mitigation. | UHN15, UHN16 & UHN17 | Revised projection agreed by Boards 24 June 2026 |

| Finance, Investment and Performance Committee<br>Upward Report to Boards of Directors | Date of reporting group's meeting: 28 July 2026 |
|---|---|

**Reporting Group Chair: Damien Venkatasamy**

| Agenda Item | Description and summary discussion | Link to Board Assurance Framework (BAF) | Assurance level * |
|---|---|---|---|
| CFO Report Month 3 | The Committee noted that UHN remained on plan at Month 3, but the underlying position was highly challenging, with a potential adverse variance of c.£27m if no further action was taken. Key risks related to unidentified CIP, failure to reduce the run rate, increasing workforce numbers, and the sustainability of current offsets from non-pay and income benefits. Cash remained materially challenged, although additional support had been approved.<br><br>The Committee agreed to recommend Board ratification of the Quarter 2 cash drawdown requests submitted through NHS England processes (ratified by Boards 4 August 2026).<br><br>It was proposed to consider an extraordinary meeting in August to review the Deloitte findings and financial recovery programme in greater detail (this took place on 21 August 2026) | UHN16 & UHN17 | Limited |
| Capital Plan | The Committee approved the refreshed Capital Plan for delivery and monitoring, noting that it had been updated to reflect prior-year slippage, clinical prioritisation and emerging requirements from external reviews. Key risks remained around limited contingency, reduced BAU capital funding and year-end deliverability, although opportunities to release and reallocate funding in-year were identified.<br><br>The Committee also approved the Laparoscopic Stack System and Cath Lab 3 schemes, and requested continued oversight of capital phasing, BAU pressures and progress on the Sterile Services proposal. | UHN16 & UHN17 | N/a |
| Business Cases | KGH Data Centre Relocation Business Case – approved, with Board reporting to clarify the potential £2.1m revenue impact.<br>Elective Hub and CDC Land Purchase Heads of Terms – approved to proceed to Heads of Terms/due diligence, noting this was not final land purchase approval. | UHN24 Major Digital Change | N/a |
| UHN Winter Plan | The Committee approved the UHN Winter Plan, including the proposed winter actions, governance arrangements and financial assumptions, noting that financial provision had been included within the approved planning assumptions. Members recognised ongoing risks around capacity, patient flow, paediatric cover, domestic staffing and reliance on system partnership working. The Committee noted that additional actions from the recent national UEC visit would be incorporated into existing winter governance once formal feedback was received. | UHN15 Demand and capacity | N/a: On Boards agenda 10 September |

| Finance, Investment and Performance Committee<br>Upward Report to Boards of Directors | Date of reporting group's meeting: 21 August 2026 |
|---|---|

**Reporting Group Chair: Damien Venkatasamy**

| Agenda Item | Description and summary discussion | Link to Board Assurance Framework (BAF) | Assurance level * |
|---|---|---|---|
| Efficiency Programme and Financial Recovery | The Committee received a presentation on UHN's efficiency programme and the recovery support partner's review of further opportunities to improve the financial position. Some opportunities were already reflected in forecasts, while others remained under development. An Executive Financial Recovery Board had been established to oversee significant cross-cutting initiatives and drive delivery.<br><br>Progress against programme delivery would be reported through future Committee and Board meetings. It was further noted that proposals to strengthen financial improvement governance, programme management capability and divisional accountability would be developed and implemented during September. | UHN16 & UHN17 | Limited |

| People Committee<br>Upward Report to Boards of Directors | Date(s) of reporting group's meeting(s): 22nd July 2026 (1 of 2) |
|---|---|

**Reporting Group Chair: Denise Kirkham**

| Agenda Item | Description and summary discussion | Link to Board Assurance Framework (BAF) | Assurance level * |
|---|---|---|---|
| Strengthening our Culture | A paper was presented to provide People Committee with assurance on progress of the Strengthening our Culture plan which was endorsed by ILT in April 2026. The new Culture dashboard was presented which provides useful oversight of all activity, and some progress is being made. The dashboard will come to People Committee quarterly moving forward. Concerns remain however, including in respect of the Rethinking Racism initiative where uptake by the leadership cohort is below expectations. The point was made strongly at committee that culture is set from the very top of the organisation - consistent role modelling of behaviours is required from the Boards down. | UHN 18 | Limited |
| National Staff Survey approach for 2026 | A paper was presented to provide assurance to the committee that we have a sound plan to maximise uptake and improve communication around the steps that have been taken over the last 12 months to improve areas of concern. It was agreed by all executive and non-executive colleagues that the plan was sound. | UHN 18 | Substantial |
| Freedom to Speak Up (FTSU) | The Committee met one of the new UHN Guardians. Early signs are encouraging in terms of take up and reporting. The Communications plan will be critical in ensuring full understanding of the role of the Guardians - dedicated support has been provided to FTSU. It was acknowledged that a 'ramp-up' of manager training is required. | UHN 18 | Reasonable |
| Mann Review | The Committee received assurance around the UHN approach to the Mann review, which has been accepted in full by the government. It was agreed that activity in respect of the review is incorporated and aligned to our Strengthen our Culture plan, and also the NHS Staff Standards, to avoid duplication of activity. | UHN 18 | Substantial |
| Resident Doctor Ten Point Plan | Overall assurance has improved since the last report as progress is made across a range of the points, as overseen by the Ten Point Plan working group. Some issues still remain over Rotas. Whilst this is in the main a national issue, it is felt that further improvement could be made at KGH in this regard. | UHN13 | Reasonable |

| People Committee<br>Upward Report to Boards of Directors | Date(s) of reporting group's meeting(s): 22nd July 2026 (2 of 2) |
|---|---|

**Reporting Group Chair: Denise Kirkham**

| Agenda Item | Description and summary discussion | Link to Board Assurance Framework (BAF) | Assurance level * |
|---|---|---|---|
| Health and Wellbeing Strategy Year 1 Update | The annual update was provided to provide the People Committee with assurance regarding strategy deliverables. A huge amount of work has taken place under the umbrella of the Strategy, and the high quality provision of health and wellbeing initiatives at UHN was acknowledged and praised. | UHN 13 | Substantial |
| Workforce Financial Sustainability | It was acknowledged that at Month 3 (30 June 2026) the situation had worsened slightly in terms of whole time equivalents and Bank. At the time of the meeting a deep dive was taking place with the new Interim Deputy CPO, Medical Director and Chief Nurse. A more strategic approach to workforce planning is required, led by the CPO. | UHN 19 | Limited |
| Volunteers Annual Report | The impact of our Volunteer service was acknowledged by the Committee. The service supports UHN through improving patient experience, strengthening flow, reducing isolation, and providing additional capacity to frontline staff. We could not operate without them! | UHN12<br>UHN13 | Substantial |
| Employee Relations Case Update (ER) | The report came to committee to provide assurance on the ER plans to mitigate the rising employee relations position and enhance early intervention. Whilst it is acknowledged that it is positive that more colleagues feel able to speak up and raise concerns, this results in increased risks in terms of operational capacity for the people team, legal costs and potential reputational impact. It is an aera of significant concern to the CPO. The committee acknowledged the pressure on leaders and the tea, and endorsed the action being taken, but this remains an area of risk. | UHN 18 & 19 | Limited |

| UHN Quality and Safety Committee<br>Upward Report to Boards of Directors<br>Slide 1 of 3 | Date(s) of reporting group's meeting(s): 29th July 2026 |
|---|---|
| **Reporting Group Chair: Chris Welsh** | |

| Agenda Item | Description and summary discussion | Link to Board Assurance Framework (BAF) | Assurance level * |
|---|---|---|---|
| Subgroup upward reports | Antimicrobial stewardship programme: The committee reviewed progress. Whilst improvement work is underway, further development is required to strengthen compliance with national standards and provide greater assurance regarding workforce capacity and service arrangements. | UHN11 Positive safety culture | Limited |
| | Medicines Optimisation: The committee noted continued ongoing improvement in medicines management processes, including safe storage, documentation and quality assurance oversight. Positive progress is being demonstrated across both hospital sites, with targeted support continuing in areas where further improvement opportunities are identified. | | Reasonable |
| | The committee received an update on the actions arising from a recent Health and Safety Executive inspection. Good progress is being made against the agreed action plan and the committee was assured that arrangements are in place to address the recommendations within the required timescales. An HSE improvement notice had been issued following inspection of the CL3 laboratory which resulted in an improvement notice being received. Work is underway to address the recommendations arising from this with the responsible teams confident the required deadline of 10th September will be met. | | Reasonable |
| Digital Update | The committee received assurance regarding continued progress across the digital transformation programme including Electronic Patient Record Implementation, digital prescribing developments and wider technology improvements. Preparation for forthcoming implementation milestones remain on track supported by governance and oversight arrangements | UHN24 Transform Patient Care: Deliver major digital change | Reasonable |
| Mortality deep dive | The committee received a detailed review of mortality indicators. Independent analysis indicates that recent changes in mortality metrics are associated with coding, data capture and methodology changes rather than evidence of deterioration in clinical care outcomes. Work continues to strengthen clinical documentation and coding processes, alongside ongoing monitoring of patient safety indicators. | UHN11 positive safety culture | Reasonable |

| UHN Quality and Safety Committee<br>Upward Report to Boards of Directors<br>Slide 2 of 3 | Date(s) of reporting group's meeting(s): 29th July 2026 | | |
|---|---|---|---|
| **Reporting Group Chair: Chris Welsh** | | | |
| **Agenda Item** | **Description and summary discussion**<br><br>**The committee:** | **Link to Board Assurance Framework (BAF)** | **Assurance level *** |
| Perinatal services | Reviewed the latest perinatal assurance report and noted continued progress in strengthening governance, workforce planning and quality improvement arrangements across maternity and neonatal services. The committee considered the implications of recent national maternity reviews and received assurance that a coordinated programme of work is in place to address local and national priorities | UHN11 positive safety culture | Reasonable |
| Ockenden/ National Maternity Investigation | Noted the evolving national maternity and neonatal assurance landscape and received assurance that existing governance arrangements and the Perinatal Safety Improvement Programme would provide the framework for delivery of the Trusts' response to the national maternity and neonatal investigations including the Ockenden recommendations and the Amos report. The committee will receive ongoing updates regarding progress against national recommendations and local improvement priorities. | UHN11 Positive safety culture | Reasonable |
| Patient Experience | Noted increasing complexity within formal complaints received, with the growing use of AI tools by complainants contributing to significantly longer and more detailed complaints, often containing a substantially larger number of individual questions and issues requiring investigation. Whilst complaint response performance remains under close review, the committee was advised that increased response times are partly attributable to the greater complexity and volume of information now requiring consideration in the response. The Boards are asked to note the emerging impact of AI on complaint complexity and the associated implications for complaint investigation workload, response times and organisational capacity. | UHN12 Transform patient care | Reasonable |
| Urgent and Emergency Care Standards report | Noted continued deterioration in ambulance handover performance particularly at Northampton General Hospital, driven by sustained pressures within discharge pathways and reduced patient flow through the organisation. Approximately 100 patients were awaiting supported discharge pathways which represents a significant increase compared with winter 2025/26 and is contributing directly to delays in ambulance handovers and emergency department flow. Despite ongoing engagement with system partners, the committee is concerned about the current effectiveness of system working arrangements and the potential implications for organisational resilience ahead of winter. | UHN15 demand and capacity | Limited |

| UHN Quality and Safety Committee<br>Upward Report to Boards of Directors<br>Slide 3 of 3 | Date(s) of reporting group's meeting(s): 29th July 2026 | | |
|---|---|---|---|
| **Reporting Group Chair: Chris Welsh** | | | |
| **Agenda Item** | **Description and summary discussion**<br><br>**The committee:** | **Link to Board Assurance Framework (BAF)** | **Assurance level *** |
| External review of patient safety governance | Received an update on delivery of actions arising from the external review of patient safety governance. Significant progress has been made in strengthening patient safety leadership, risk management and organisational learning arrangements, with the remainder of actions progressing through established governance processes. | UHN11 Positive safety culture | Reasonable |
| Post-death care and Fuller Inquiry Compliance | Reviewed compliance against the national Board Assurance Statement requirements and was assured that the organisation is compliant in most areas assessed and actions are underway to achieve full compliance with the Fuller recommendations (received by Boards 20 August 2026) | UHN11 Positive safety culture | Reasonable |

| UHN Strategy, Transformation and Digital Committee Upward Report to Boards of Directors | Date of reporting group's meeting: 4th August 2026 (slide 1 of 2) | | |
|---|---|---|---|
| **Reporting Non-Executive Director: Trevor Shipman (Chair)** | | | |
| **Agenda Item** | **Description and summary discussion**<br><br>**The committee:** | **BAF references** | **Assurance level *** |
| Digital Roadmap delivery | 1. Received a comprehensive update on delivery of the Digital Roadmap.<br>2. Noted progress across the programme remains broadly on track, noting key risks around EPR go-live readiness, particularly staff training completion rates.<br>3. Discussed the importance of benefits realisation from digital investments, maintaining focus on optimisation of existing systems at Kettering General Hospital and ensuring strong governance and procurement, contractual and legal risks associated with digital transformation.<br>4. Welcomed the transparent reporting of programme risks and emphasised that success would be measured through improvements in patient care, staff experience and operational performance. | UHN24 Digital Transformation | Reasonable |
| Strategic Estates | 1. Received an update on the strategic estates and capital programme, including the Energy Centre, New Hospital Programme, Northampton Urgent Treatment Centre, Elective Hub and Community Diagnostic Centre developments.<br>2. Noted progress in relation to discussions with national New Hospital Programme leadership and emerging opportunities for schemes to progress.<br>3. Discussed the importance of effective communication and engagement with staff, governors and stakeholders regarding major strategic capital investments. | UHN14 Estates and Infrastructure | Reasonable |
| Strategic Transformation | 1. Noted an update on the review of transformation programmes being undertaken with external support. Early findings suggest opportunities to strengthen the use of data, improve benefits realisation arrangements and place greater emphasis on clinical pathway redesign and service integration across UHN. | UHN15 demand and capacity | Reasonable |
| Rockingham Rebuild programme | 1. Received an update on the Rockingham Wing rebuild programme, noting that options are currently being reviewed to inform the next phase of the programme. Further work is underway to support future decision-making through the Trust's governance processes. | UHN14 Estates and infrastructure | Reasonable |

| UHN Strategy, Transformation and Digital Committee<br>Upward Report to Board of Directors | Date of reporting group's meeting: 4th August 2026<br>(slide 2 of 2) | | |
|---|---|---|---|
| **Reporting Non-Executive Director: Trevor Shipman (Chair)** | | | |
| **Agenda Item** | **Description and summary discussion**<br><br>**The committee:** | **BAF references** | **Assurance level *** |
| Board Assurance Framework | 1. Considered cultural and system working risks within the BAF.<br>2. Discussed Net Zero, sustainability and climate resilience, including the operational and patient safety impacts of recent periods of extreme heat.<br>3. Noted that significant sustainability work is underway and that the UHN Sustainability Committee would be establishing its work programme.<br>4. Welcomed proposals to develop a more integrated approach to climate adaptation, sustainability and resilience planning and noted the financial implications associated with climate change mitigation measures. | UHN14/21/22/ 23/24 | Reasonable |
| UHN-UHL Clinical Strategy | 1. Received an update on the need to refresh the Group Clinical Strategy in light of recent Board discussions, organisational transition planning and emerging strategic reviews.<br>2. Noted that existing workstreams particularly in maternity and cancer services will form part of the future strategy.<br>3. Noted that future clinical strategy development will need to align closely with estate configuration and site planning work to ensure an integrated approach to service transformation and long term organisational development. | UHN20 collaborative working | Reasonable |

*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 | 10 September 2026 |
| Agenda item | **7** |

| | |
|---|---|
| Title | Perinatal Report (including KGH Maternity and Neonatal Improvement Support Team update) |
| Presenter | Julie Hogg, Group Chief Nurse |
| Author | Danni Burnett, Group Director of Midwifery and Deputy Chief Nurse |

| 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 and decision |
| **UHN priorities** | Patient; Quality; Systems and Partnerships; Sustainability; People |
| **Where discussed previously** | Final UHN/UHL Perinatal Assurance Committee, 2 September 2026, ahead of transition to organisation-specific UHN and UHL governance. |
| **Assurance and significant risks** | |
| July 2026 performance was broadly stable, with no PSIIs or new MNSI referrals, MIS Year 8 remaining on track and established governance and escalation arrangements. Risks requiring sustained Boards' oversight relate to maternity triage and telephone access; workforce sustainability, neonatal QIS and allied health capacity; preterm birth and delays in time-critical care; NGH emergency caesarean responsiveness pending validation; KGH MatNeoIST and CQC actions; pelvic health, neonatal and estate capacity; and digital, analytical and programme-delivery capability. Each site has 15 partially compliant 10-Point Plan deliverables requiring evidence of delivery and measurable impact. | |
| **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 July 2026 Perinatal Performance Summary |

## 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 |

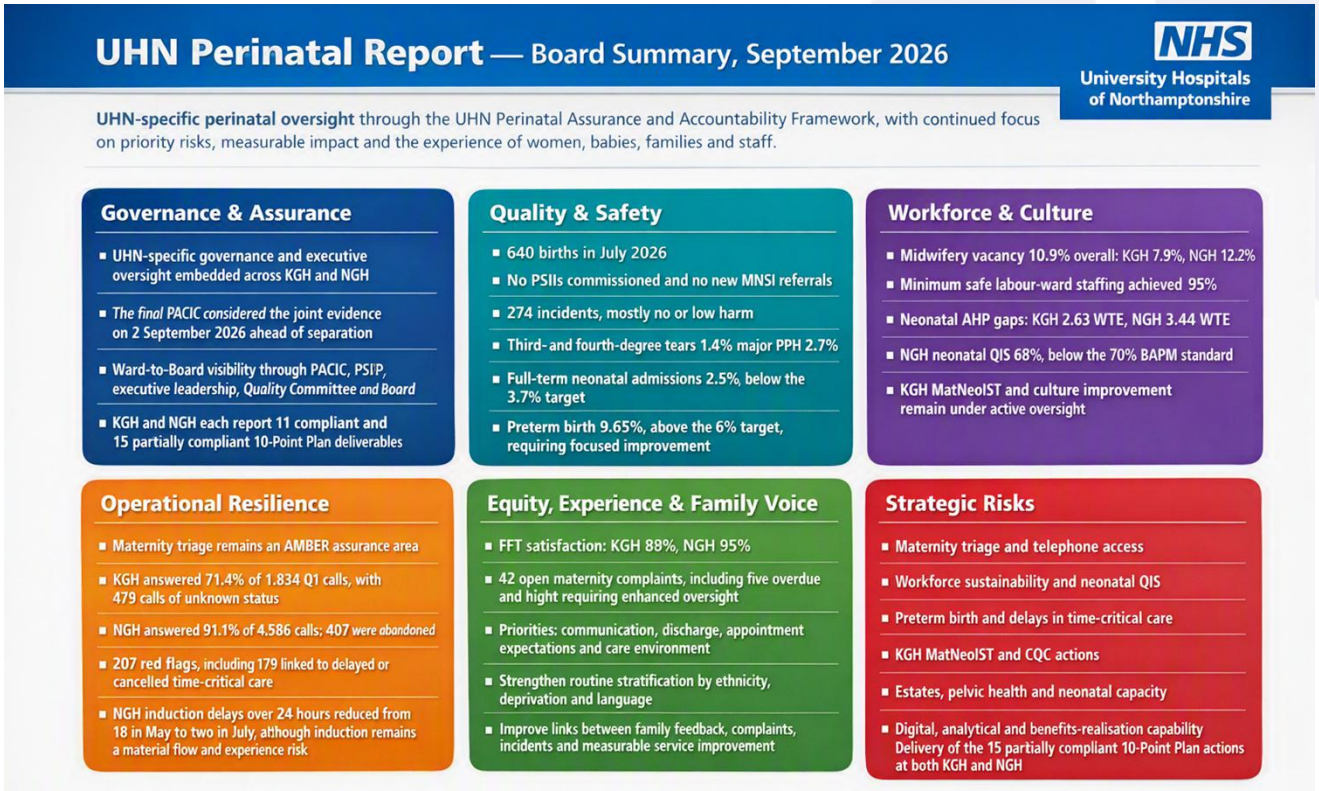
**UHN BOARDS OF DIRECTORS**

**10 SEPTEMBER 2026**

# UHN PERINATAL REPORT — KETTERING AND NORTHAMPTON GENERAL HOSPITALS (KGH/NGH)

## 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 KGH and NGH. The paper brings together the UHN 10-Point Plan response, the July 2026 UHN Perinatal Scorecard and the evidence considered at the final Perinatal Assurance Committee in Common on 2 September 2026, ahead of transition to organisation-specific UHN governance.




## RECOMMENDATION

The Boards are asked to **note** UHN's stable July 2026 safety profile and the material operational, workforce and capacity pressures; **endorse** the AMBER maternity-triage assurance position and prioritised cross-site improvement plan; and **support** the workforce, estates, digital, analytical, quality-improvement and programme capacity required to deliver sustained improvement.

## 1. PERINATAL SERVICES SUMMARY

UHN's July 2026 position remained broadly stable. There were 640 births, no PSIIs commissioned and no new MNSI referrals. The latest scorecard reported 274 incidents. Most incidents resulted in no or low harm, while ten moderate or above-harm incidents remain under governance review. Six SPEN referrals were recorded, and no MOSS signals were identified. Full-term neonatal admission reduced to 2.5%, third- and fourth-degree tears were 1.4%, and breastfeeding initiation was 82.1%. Preterm birth increased to 9.65%, above the 6% Saving Babies' Lives target, and remains a principal quality-improvement priority.

The final UHN/UHL Perinatal Assurance Committee in Common met on 2 September 2026. It considered UHN's 10-Point Plan response, Regional Perinatal Quality Group return, maternity-triage deep dive, homebirth resumption, care outside guidance, pelvic health, July scorecard, PSIP, MIS Year 8, Safety Champion intelligence, neonatal peer review and workforce assurance. PACiC supported the move to separate UHN and UHL governance from September to October 2026, with continued reciprocal learning and benchmarking where this adds value.

UHN will maintain organisation-specific executive and Board oversight through a refined perinatal assurance and accountability approach, with clear routes from KGH and NGH clinical services through divisional governance and PSIP to the UHN PACiC, executive leadership, Quality Committee and Board. UHN will also continue to participate in the joint perinatal quality surveillance group and regional and cluster forums, supporting quarterly assurance returns, benchmarking, shared learning and escalation following governance separation.

The 10-Point Plan baseline provides reasonable but conditional assurance. KGH and NGH each assessed 26 deliverables: 11 compliant and 15 partially compliant, with none non-compliant or not applicable. The mandatory baseline return is due by 25 September 2026, subject to completion and checking of the supporting evidence logs, with a further progress submission required by 31 December 2026. (See Separate Board Paper). Delivery, risks and readiness are monitored through the joint executive oversight group meeting fortnightly. AMOS actions are not included in the current baseline and will be incorporated separately when the NHS England task-force requirements are published.

## 2. PERINATAL SURVEILLANCE HIGHLIGHTS

### a. Workforce and Culture

UHN's midwifery vacancy rate was 10.9% in July: 7.9% at KGH and 12.2% at NGH. Minimum safe labour-ward staffing was achieved on 95% of occasions. Consultant obstetric workforce stability has improved, although rota limitations, locum use and further capacity requirements remain under review. Both neonatal services remain non-compliant with neonatal allied health professional workforce standards, with establishment gaps of 2.63 WTE at KGH and 3.44 WTE at NGH recorded on risk registers. NGH neonatal QIS

compliance has improved to 68%, just below the 70% BAPM standard, and requires continued training and recruitment.

Staff feedback remains positive about multidisciplinary working and leadership visibility, but workforce capacity, acuity, estate constraints and facilities continue to affect experience. Kettering remains under the highest level of regional oversight and MatNeoIST support following its July CQC inspection. Separately, the Trust has received the CQC maternity inspection report relating to NGH only for factual-accuracy checking and expects publication in the near future**.** The final published NGH findings and any resulting actions will be incorporated into PSIP and reported through the relevant UHN governance and Board assurance routes.

**b. Operational Performance and Flow**

**Maternity triage remains an AMBER assurance area.** Both sites provide 24/7 emergency access and have embedded BSOTS, audit and governance. Initial assessment within 15 minutes and timely higher-acuity Orange review remain variable. Scheduled activity within triage affects capacity for unscheduled emergency assessment and patient flow.

Telephone access is a focus. KGH access data require further validation due to the current system combining internal and external calls which relies partly on manual counting. A system fault also resulted in some callers remaining in a loop; IT support has been requested to establish reliable call-volume, unanswered-call and queue reporting. NGH recorded 4,586 calls and answered 91.1%, with 407 calls abandoned and a longest recorded wait of 54 minutes 9 seconds. UHN is developing a cross-site single point of telephone access, aligned measures, protected staffing and improved queue visibility.

Further work is required as part of the gap analysis of the newly published service specification to quantify and validate the full medical, midwifery, allied health, estates, digital and analytical requirements, including estate constraints, extended assessment-unit provision, separation of fetal-health staffing and additional medical cover.

**Operational pressure remains material.** UHN operated at OPEL 1 for 67.2% and OPEL 2 for 31.1% of July. There were 207 midwifery red flags, 179 relating to delayed or cancelled time-critical activity, and one isolated occasion when one-to-one care in established labour was not achieved. NGH required one maternity suspension and divert because of neonatal cot capacity. Induction of labour accounted for 26.3% of births; NGH delays exceeding 24 hours reduced from 18 episodes in May to two in July, but induction remains a material flow and experience risk and requires validation of outliers, daily oversight, proactive capacity management and timely escalation.

**c. Experience and Engagement**

Patient feedback remained positive overall, with FFT satisfaction of 89% at KGH and 95% at NGH. Response rates remain below target. Key themes in complaints raised during this

reporting period were communication, discharge, appointment expectations and the care environment.

The Northamptonshire MNVP is now hosted within a local charity and is establishing governance, recruitment, listening events, online forums, walk-the-patch activity and thematic analysis. UHN will continue to strengthen links between MNVP intelligence, complaints, FFT, incident learning and service improvement, with routine reporting of what was heard, what changed and the impact.

**d. Quality and Outcomes**

Clinical outcomes remained broadly stable. No PSIIs or new MNSI referrals were recorded in July. Third- and fourth-degree tears were 1.4%, below the 3.1% national threshold; major PPH was 2.7%; and full-term neonatal admissions were 2.5%, below the 3.7% target. Smoking at booking improved to 6.8% but remains above the 6% target. Preterm birth was 9.65%, above the 6% target, and remains the key outcome requiring focused improvement across prediction, prevention, optimisation and place-of-birth review.

UHN remains on track for MIS Year 8. NGH had 86.7% and KGH 78.6% of evidence requirements on track, complete or assured, with no standards rated off track. Training compliance was strong across most groups; anaesthetic PROMPT attendance at NGH was 76% in July, below the 90% requirement, and remains the principal training risk. Recovery actions include targeted scheduling, escalation to clinical leads and strengthened oversight ahead of MIS submission. Saving Babies' Lives compliance was 94% at KGH and 100% at NGH by self-assessment, with continued work on smoking, reduced fetal movements, diabetes and preterm birth.

Neonatal services remained safe, with staffing broadly within BAPM recommendations. Continued oversight is required for QIS compliance, neonatal capacity and consistent reporting of caffeine, probiotics and intrapartum antibiotics across KGH and NGH. The KGH neonatal peer review was broadly positive following redesignation, recognising clinical quality and collaborative working. Its action plan remains under oversight and includes the immediate safety action, transitional care, allied health recruitment, medical workforce, family facilities, parent communication, medicines management and estate challenges.

UHN's equity profile shows activity across all deprivation deciles and good ethnicity-data completeness. Most women book before 10 weeks, supporting timely risk assessment and screening. The Trust must now strengthen routine stratification of access, experience and outcomes by ethnicity, deprivation, language and other relevant characteristics, particularly for triage access, smoking, preterm birth, immunisation, pelvic health and neonatal outcomes.

## 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 25 August 2026 of measurable progress since KGH entered MatNeoIST with new milestones agreed in January 2025. Immediate safety risks are being actively mitigated and governance grip has strengthened across culture, workforce, triage, induction of labour, caesarean responsiveness and fetal monitoring.

MatNeoIST milestone delivery remains largely on track. The programme expanded from 24 to 33 milestones following inclusion of neonatal priorities, with 105 sub-items and 138 total actions. Overall assurance and progress increased from 13.9% to 16.7%, with most milestones on track and increasing numbers complete or assured. Workforce, escalation and OPEL arrangements, specialist-role reviews, the community model, equity and pathway implementation remain the main areas requiring recovery. Competing operational demand and parallel CQC, PSIRF and evidence requirements continue to affect delivery capacity.

Priority clinical pathways show improving control. Daily induction-of-labour monitoring, risk assessment and escalation are established; the revised NICE-aligned guideline and prioritisation arrangements require completion and audit of consent, delay and experience. Elective caesarean demand-and-capacity work is complete, with the booking-to-discharge standard operating procedure awaiting approval and implementation. Diabetes process mapping and workforce modelling have informed a business case, while triage BSOTS audit, response-time review and staff feedback are complete or assured.

The Q1 fetal-monitoring deep dive indicated targeted improvement required. Recurring learning relates to CTG classification, theatre and delivery delay, documentation, escalation and senior review. Immediate actions are to embed checklist audit, improve second-stage review reliability, refresh classification learning and strengthen documentation and escalation standards.

Priorities for the next 30–60 days are to complete the UHN escalation framework and MOSS exercise; conclude workforce and specialist-role reviews; implement induction, elective caesarean and diabetes pathway actions; strengthen equity and co-production measures; and align evidence standards across CQC, MatNeoIST and PSIP. Progress will continue through IOAG, PSIP, UHN PACiC and Board-level reporting.

## 4. ADDITIONAL PERINATAL HIGHLIGHTS

PACiC supported full resumption of the countywide UHN Homebirth Service subject to continued workforce-resilience monitoring, completion of residual actions and agreement of the public communications approach with the Northamptonshire MNVP. The strengthened model includes named leadership, eligibility and escalation criteria, emergency-transfer arrangements, training, documentation, MNVP oversight and three months of enhanced surveillance. UHN is aligned with regional care-outside-guidance expectations, with further standardisation required across the group of a unified guideline, MDT processes, legal escalation, ambulance notification and workforce sustainability.

UHN has a significant pelvic-health service gap and is not yet able to demonstrate full compliance with the NHS England Perinatal Pelvic Health Service specification. Prevention,

education, OASI pathways and consultant-led perineal review are established, but there is no dedicated specialist physiotherapy workforce or complete pathway for women following third- or fourth-degree tears, nor an integrated multidisciplinary clinic, single point of access, routine outcome monitoring or countywide rehabilitation pathway. A demand-and-capacity review is informing a business case for a specialist physiotherapist, assistant practitioner and specialist pelvic health midwife. Indicative recurrent workforce costs remain subject to validation and clarification of ICB commissioning responsibility and previous baseline funding; formal escalation may be required if the gap is not resolved.

PACiC requested review of the reduction in RSV vaccination uptake across UHN against regional performance, with the findings and associated winter-plan actions included in Board assurance reporting. The July scorecard also identifies variable influenza uptake, delays and missed opportunities in neonatal BCG delivery, and variation between sites and population groups. Improvement should therefore include consistent antenatal messaging, easier access across care settings and targeted engagement with communities experiencing lower uptake.

A consolidated view of UHN capital and revenue requirements is being developed.

## 5. PERINATAL SURVEILLANCE AND ASSURANCE FOR ESCALATION

The following was highlighted by PACiC as requiring oversight and continued Board visibility. These are not presented as new concerns, but as the areas where sustained grip, assurance and evidence of impact are required:

- delivery of the KGH and NGH 10-Point Plan baseline actions, particularly Martha's Rule, analytical and inequalities reporting, workforce deployment, complaints learning, compassionate debriefing and maternity triage;
- maternity triage, including the 15-minute standard, Orange-category review, KGH overnight telephone access, cross-site single point of access, workforce, administration, estates, data and equity intelligence;
- workforce sustainability, including midwifery vacancies, consultant capacity, neonatal QIS compliance, allied health provision and the completion of Birthrate Plus reviews;
- operational flow, including 207 red flags, induction-of-labour delay, elective and emergency theatre timeliness, neonatal capacity and service suspension;
- NGH emergency caesarean responsiveness, including completion of retrospective data validation by the end of September 2026 and implementation of any resulting clinical, documentation, theatre-access or operational actions;
- quality and experience, particularly preterm birth, complaints timeliness, anaesthetic training, smoking, parent communication and evidence that learning changes practice;
- KGH MatNeoIST delivery, including completion of workforce and escalation milestones, induction and elective caesarean pathway implementation, and targeted fetal-monitoring improvements; separately, factual-accuracy review and incorporation of the final published CQC maternity inspection findings for Northampton General Hospital only;
- corporate enablers around estate, pelvic health investment, digital infrastructure, business intelligence and programme capacity.

These risks will be overseen through UHN's organisation-specific perinatal governance, including PSIP, UHN PACiC, divisional governance, executive leadership, Quality Committee and quarterly Board reporting. The transition from the joint PACiC arrangement will be monitored to maintain continuity of oversight, reciprocal learning and immediate escalation where evidence does not support confidence or local mitigation is insufficient.

**APPENDIX ONE — UHN Assurance and Priority Action Summary**

| | |
|---|---|
| **10-Point Plan** | KGH and NGH each report 11 compliant and 15 partially compliant deliverables. Priority gaps include Martha's Rule, real-time outcomes and inequalities reporting, clinical leadership visibility, PEADP participation, workforce deployment, complaints learning, compassionate debriefing and maternity triage. The baseline return is due by 25 September 2026 following completion and checking of evidence logs; a progress return is due by 31 December 2026. Delivery is overseen fortnightly through the executive oversight group. |
| **Maternity triage** | AMBER assurance. Core pathways and BSOTS are established, but timely review, telephone access, protected workforce, estates, digital, data, equity and administrative capacity require improvement. Current costs are provisional, capturing investment in estates, medical cover, workforce, digital and analytical support, and must be validated by clinical, medical and operational leads. KGH telephone data also require cleansing, and IT action is needed following a system fault that left some callers in a loop. |
| **Workforce and specialist services** | Midwifery, neonatal QIS, allied health and consultant capacity remain material priorities. Both neonatal services are non-compliant with allied health workforce standards, with gaps of 2.63 WTE at KGH and 3.44 WTE at NGH. NGH neonatal QIS compliance is 68%, just below the 70% BAPM standard. NGH anaesthetic PROMPT compliance was 76% in July against the 90% requirement. Homebirth resumption is supported subject to workforce monitoring, residual actions and an agreed MNVP communications approach. Pelvic health remains a significant service gap requiring a demand-and-capacity business case, clarification of ICB commissioning and funding responsibility, and possible formal escalation. KGH neonatal peer-review actions and alignment of neonatal reporting remain under oversight. Immunisation work should address low RSV uptake, variable influenza uptake, missed BCG opportunities and inequalities in access. A consolidated capital and revenue view is required for triage, neonatal development, workforce, pelvic health and wider estates requirements. |

**APPENDIX TWO — UHN July 2026 Perinatal Performance Summary**

| | |
|---|---|
| **Activity** | 640 births; induction rate 26.3%; OPEL 1 for 67.2% and OPEL 2 for 31.1%; one NGH suspension and divert linked to neonatal capacity. |

| | |
|---|---|
| **Safety and outcomes** | No PSIIs or new MNSI referrals; ten moderate or above-harm incidents under review; six SPEN referrals; no MOSS signals; tears 1.4%; major PPH 2.7%; full-term neonatal admissions 2.5%; preterm birth 9.65%. |
| **Workforce and training** | Midwifery vacancy 10.9% overall—7.9% KGH and 12.2% NGH; safe staffing 95%; neonatal AHP establishment gaps of 2.63 WTE at KGH and 3.44 WTE at NGH; NGH neonatal QIS compliance 68% against the 70% BAPM standard; NGH anaesthetic PROMPT compliance 76% against the 90% requirement. |
| **Triage and flow** | KGH telephone and call-volume data require further validation. NGH answered 91.1% of 4,586 calls; 407 were abandoned and the longest wait was 54 minutes 9 seconds. NGH induction delays over 24 hours reduced from 18 in May to two in July, subject to validation of outliers. Reported emergency caesarean breaches require retrospective validation: six Category 1 breaches were recorded in July and Category 2 breaches increased from 17 in May to 26 in July. |
| **Experience and equity** | FFT satisfaction was 89% at KGH and 95% at NGH. There were 42 open complaints across UHN, including five overdue and eight requiring enhanced oversight. Priorities are communication, discharge, the care environment, equitable access and routine outcome stratification. |

| Positive Assurance | Priority Actions and Escalations |
|---|---|
| • Stable July safety profile and strong incident reporting culture.<br>• No PSIIs or new MNSI referrals.<br>• MIS Year 8 remains on track at both sites.<br>• Homebirth full resumption supported with enhanced surveillance.<br>• Positive fetal medicine and ANNB workforce assurance from NHS England. | • Deliver the 15 partially compliant 10-Point Plan actions at each site.<br>• Implement the AMBER triage improvement plan and cross-site telephone model.<br>• Reduce preterm birth and delays in time-critical care.<br>• Validate NGH Category 1 and Category 2 emergency caesarean breaches by the end of September and implement resulting actions.<br>• Complete neonatal AHP, QIS, pelvic health, neonatal peer-review and estate actions, and recover NGH anaesthetic PROMPT compliance.<br>• Strengthen complaints, immunisation, equity, data quality and benefits-realisation reporting, including reconciliation of the draft incident total. |

| 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** | 10 September 2026 |
| **Agenda item No.** | 8 |
| **Title** | Response to the Amos National Maternity and Neonatal Investigation, Ockenden Review and NHS England 10-Point Plan |
| **Presenters** | Julie Hogg, Group Chief Nurse and Interim Managing Director |
| **Author** | Danni Burnett, Group Director of Midwifery<br>Angela Boyce, Head of Perinatal Governance and Quality Improvement |

**This paper is for**

The Boards are asked to indicate reasonable but conditional assurance that core governance and safety controls are established across KGH and NGH, while recognising that 15 of 26 deliverables at each site remain only partially compliant and maternity triage is assessed as AMBER.

The Boards are asked to **approve** the KGH and NGH baseline submissions, subject to final evidence-log validation; endorse the eight strategic priorities and AMBER maternity triage position; confirm executive sponsorship and oversight; support the required business cases; and require quarterly assurance on delivery, impact, inequalities, investment and residual risk.

**SUPPORTING PAPERS**

NHS England 10PP Kettering General Hospital Template
NHS England 10PP Northampton General Hospital Template
UHN Triage ¼ Service Review Summary

**KEY NATIONAL PUBLICATIONS**

Ockenden Review into maternity services at Nottingham University Hospitals NHS Trust: final report — published 24 June 2026.
National Maternity and Neonatal Investigation: final report and Trust reports — published 30 June 2026.
NHS England response and Maternity and Neonatal 10-Point Plan — published 1 July 2026.
National Maternity Triage Specification — published July 2026.
Maternity and Neonatal 10-Point Plan assurance process, reporting template and benchmarking tool — published 12 August 2026.

| Reason for consideration | Previous consideration |
|---|---|
| To provide the BoardS with a clear, evidence-based assessment of UHN's response to the AMOS National Maternity and Neonatal Investigation, the Ockenden Review and the NHS England 10-Point Plan. The paper presents the validated KGH and NGH baseline position, incorporates the cross-site maternity triage deep dive and AMBER assurance assessment, identifies the principal assurance gaps and strategic risks, seeks approval | Perinatal Assurance Committee (PAC) 2 September 2026 |

| | |
|---|---|
| of the baseline returns and triage improvement approach, and sets out the corporate support required to deliver and evidence sustained improvement across both hospitals. | |

## Executive Summary

The NHS England 10-Point Plan, arising from the AMOS National Maternity and Neonatal Investigation and Ockenden Review, requires Boards to demonstrate not only compliance with national recommendations, but evidence that improvements are embedded, sustained and resulting in better outcomes and experiences for women, babies, families and staff. NHS England requires Board-approved baseline assessments by 25 September 2026 and progress updates by 31 December 2026.

The KGH and NGH baseline assessments each cover 26 deliverables. Both sites record 11 compliant and 15 partially compliant deliverables, with no non-compliant or not-applicable requirements. PACiC supported progression of the baseline submissions to the Boards, subject to consistent completion and final validation of the evidence logs. This provides reasonable but conditional assurance that core controls and governance routes are established. The increased number of partially compliant deliverables reflects a more rigorous assessment of whether arrangements are fully implemented, consistently evidenced, sustainable and delivering measurable impact.

Established strengths include:

- Joint executive accountability through the Chief Nurse, Medical Directors and Director of Midwifery.
- Mature Patient Safety Incident Response Framework arrangements.
- Established consultant presence, locum governance, neonatal workforce planning, midwifery establishment and anaesthetic cover.
- Completion of the homebirth review and delivery of associated improvements.
- Strong governance through the Perinatal Assurance Committee, Perinatal Safety Improvement Programme and Board reporting.
- Established family engagement, Maternity and Neonatal Voices Partnership and patient-experience routes.
- Completion of the post-death care assurance statement and established mortuary oversight arrangements.

The revised baseline identifies broader assurance gaps than previously reported. Partial compliance is concentrated in:

1. Martha's Rule implementation and alignment with maternity digital systems.
2. Real-time experience, outcomes, clinical audit and inequalities reporting.
3. Consistent clinical leadership participation in Board discussions.
4. Full multidisciplinary participation in the Perinatal Equity and Anti-Discrimination Programme.
5. Workforce acuity, cross-site escalation and formal resource-deployment review.
6. Thematic complaints learning, compassionate debriefing and evidence of impact.
7. All three maternity-triage requirements remain partially compliant; the cross-site deep dive provides an AMBER assurance position because protected workforce capacity, telephone

access, estates, digital and data capability, equity reporting and administrative support are not yet consistently assured.

8.

The principal challenge for UHN is therefore to convert established governance and improvement activity into reliable, consistently evidenced implementation across NGH and KGH. This will require stronger analytical capability, clearer clinical accountability, completion of workforce and triage reviews, improved benefits-realisation measures and sustained corporate support.

## Board Decisions Required

The Boards are asked to:

1. **NOTE** the national shift from assurance that plans exist to evidence that change is embedded, reliable and improving experience and outcomes.
2. **RECEIVE AND APPROVE** 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. **ENDORSE** the eight strategic improvement priorities and the proposed oversight route through the PSIP Programme Board, the separate UHN Perinatal Assurance Committee and quarterly Board reporting, while maintaining structured cross-site learning through regional assurance routes and established collaborative programmes.
4. **ENDORSE** 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 uncosted workforce, accessibility and infrastructure requirements.
5. **SUPPORT** 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. **REQUIRE** quarterly assurance showing progress, risks, mitigations, impact and areas requiring corporate or Board intervention, with immediate escalation of material safety, access, workforce, digital, analytical or delivery risks.

## Risk and assurance

Failure to deliver the national recommendations and demonstrate sustained improvement could compromise UHN's strategic objectives and result in poorer outcomes and experiences for women, babies and families, increased regulatory scrutiny, workforce pressure, financial exposure and reputational damage. The principal residual risks relate to Martha's Rule, clinical leadership visibility, workforce sustainability and deployment, and maternity triage, where the cross-site deep dive concludes an AMBER assurance position because timely assessment, telephone access, protected staffing, estates, digital and data capability, equity reporting and administrative support are not yet consistently assured. Further risks relate to analytical capability, inequalities intelligence, compassionate learning, post-death care oversight, programme capacity and the ability to demonstrate measurable impact. Separation of the joint UHN/UHL assurance committee also creates a transition risk if accountability, escalation routes or shared learning become unclear; this will be controlled through the separate UHN Perinatal Assurance Committee, confirmed executive routes and continued regional and cross-site collaboration.

| Financial Impact |
| --- |
| The site benchmarking identifies a minimum planning requirement of approximately £3.89m: £2.49m at KGH and £1.40m at NGH. This includes £1.10m recurrent Tier 2 medical investment across the two sites and £1.46m KGH capital estates investment. The remaining quantified costs support analytical, digital, telephony, administrative and service-model development. As some workforce, accessibility and infrastructure requirements remain uncosted, consolidated business cases will confirm the final recurrent, non-recurrent and capital envelope. |
| **Legal and Regulatory Implications** |
| This paper supports compliance with the NHS England Maternity and Neonatal 10-Point Plan, the recommendations arising from the Amos National Maternity and Neonatal Investigation and Ockenden Review, NHS Resolution Maternity Incentive Scheme requirements, the Patient Safety Incident Response Framework, Care Quality Commission expectations and wider national maternity and neonatal safety programmes. The maternity triage deep dive provides the Board-level assessment required against the NHS England National Maternity Triage Specification; failure to address the identified gaps may limit UHN's ability to demonstrate consistent compliance for timely assessment, workforce resilience, telephone access, estates, equity and performance measurement. |
| **Equality Impact Assessment** |
| No adverse equality impact is anticipated from the proposed assurance approach. However, the baseline and maternity triage deep dive identify material gaps in the routine segmentation of maternity and neonatal access, outcomes and experience by ethnicity, deprivation and other relevant characteristics. UHN will address this through improved data quality, a perinatal inequalities dashboard, strengthened analytical support, PEADP participation, targeted community engagement and routine oversight through PSIP, PAC and the BoardS. The triage improvement plan should also strengthen translation and accessibility support, culturally appropriate communication and monitoring of variation in access, waiting times, experience and outcomes. Progress should be judged by evidence that identified disparities lead to targeted action and measurable reduction in variation. UHN will also develop a formal Perinatal Health Equity Partnership, aligned with existing Northamptonshire community and MNVP arrangements, to bring together women, families, community partners, equity leads and clinical teams. The partnership will provide a visible route for communities to shape service design and improvement priorities, with clear feedback on how their insight has influenced decisions and whether identified inequalities are reducing. |

## UHN BOARD ASSURANCE REPORT: AMOS, OCKENDEN AND NHS ENGLAND 10-POINT PLAN

*Can the Board evidence that improvement is reliably implemented, sustained and experienced by women, babies, families and staff across NGH and KGH?*

**PURPOSE:** To provide the Board with an integrated overview of UHN's response to the AMOS National Maternity and Neonatal Investigation, the Ockenden Review and the NHS England 10-Point Plan. The paper outlines the current assurance position across KGH and NGH, highlights the principal areas requiring further improvement and seeks Board approval, oversight and support for the actions needed to deliver sustained improvements in safety, quality and experience for women, babies, families and staff.

### 1. BACKGROUND, NATIONAL LEARNING AND UHN'S INITIAL RESPONSE

This is the first report to the UHN Board bringing together the organisation's response to the Ockenden Review into maternity and neonatal services at Nottingham University Hospitals, the Amos National Maternity and Neonatal Investigation and the NHS England 10-Point Plan. Although these reports arose through different routes, their findings are closely aligned. Together, they describe a national maternity and neonatal system in which repeated recommendations have not always been implemented consistently or sustained, and where failures to listen, escalate, learn and act have contributed to avoidable harm.

This report is UHN's interim response and baseline stocktake under the NHS England 10-Point Plan assurance process. UHN will continue local delivery at pace and, when the national maternity and neonatal taskforce action plan is published, will complete a formal read-across, update the integrated programme and return any material changes in risk, resource or assurance through the appropriate committee and Board route.

While UHN will continue to reflect on the full Amos and Ockenden findings, the immediate national priority is delivery of the NHS England 10-Point Plan. This should remain the principal focus of local leadership, improvement activity and Board oversight while the national maternity and neonatal taskforce develops the comprehensive action plan expected by the end of 2026.

The central learning for Boards is that assurance can no longer rely on the existence of policies, committees or improvement plans. Boards must be able to evidence that core safety processes are reliable, concerns from women, families and staff are acted on, workforce and operational risks are visible, inequalities are treated as safety issues, learning changes practice and improvements are experienced consistently at the frontline. This requires triangulated oversight of safety, experience, workforce, culture, equity, estates, digital capability and operational performance.

| Report or requirement | What it found or requires | Learning and ask for the Board | UHN's initial response |
|---|---|---|---|
| **Ockenden Review** | The review identified longstanding systemic failures in safety, leadership, | Maintain direct line of sight to frontline risk; test whether concerns are | Use the 18 actions as one improvement framework, mapped |

| | | | |
|---|---|---|---|
| | governance and culture, including avoidable harm, unreliable clinical processes, workforce pressure, failure to listen and weaknesses in learning and Board oversight. It set out 18 Immediate and Essential Actions. | acted on; require reliable delivery of triage, escalation, deterioration, staffing, training and clinical standards; and evidence that learning reduces recurrence. | to PSIP, PAC, CQC and existing governance, with named owners, milestones, evidence, risks and escalation. |
| **Amos National Maternity and Neonatal Investigation** | AMOS concluded that the central problem is no longer a lack of recommendations, but inconsistent implementation and sustainability. Its eight recommendations call for whole-system reform spanning family voice, investigation and learning, a modern service framework, equity, accountability, culture, workforce, estates and digital systems. | Treat women's and families' voices, maternity triage, racism, discrimination, inequality, culture and infrastructure as patient-safety issues; demonstrate that improvement is felt by women, babies, families and staff. | Align PSIP, family engagement, staff voice, equity, workforce, governance and infrastructure work to the AMOS recommendations and participate in AMOS Into Action. |
| **NHS England 10-Point Plan** | The Plan converts the national learning into immediate provider and Board requirements: Martha's Rule; real-time experience, outcomes and audit data; joint executive accountability; staff listening; perinatal equity; 24/7 safe and responsive services; homebirth review; compassionate incident response; maternity triage; and post-death care. | Approve the baseline position, maintain visible ownership, complete time-critical assurance work and require evidence of implementation, sustainability and measurable impact. | Complete the baseline assessment; prioritise eight strategic gaps; maintain PAC, PSIP and Board oversight; and report progress, risks and impact quarterly. |
| **UHN initial response** | UHN has established governance and improvement routes, but evidence of operational maturity, cross-site consistency, analytical insight and benefits realisation requires strengthening. | Move from reporting activity to demonstrating reliable implementation, reduced variation and measurable benefit across NGH and KGH. | Use one integrated programme and tracker; confirm executive and clinical accountability; align Martha's Rule; strengthen maternity-triage assurance, |

| | | | |
|---|---|---|---|
| | | | workforce sustainability and equity intelligence; and implement a recommendation-to-impact framework. Establish a visible listening-to-action cycle for families and staff, with quarterly thematic review, named owners, published feedback, direct testing of change and escalation where recurring concerns or psychological-safety risks persist. |

**The shift in scrutiny:** The Board is being asked to move from assurance that plans are in place to assurance that implementation is reliable, risks are reduced and women, babies, families and staff experience measurable improvement. Assurance should demonstrate that UHN listens to women, families and staff; escalates deterioration and concerns promptly; triangulates safety, experience, workforce, culture and equity intelligence; and closes the loop by evidencing that learning changes practice, reduces recurrence and is experienced consistently across KGH and NGH.

## 2. NATIONAL ASK AND LOCAL IMPLICATIONS

| National requirement | What it means for UHN Board assurance |
|---|---|
| **One integrated response** | Map Amos, Ockenden and the 10-Point Plan to PSIP, PAC, MIS Year 8 and existing improvement work, avoiding duplicate plans and fragmented reporting. The assurance process should evidence progress without creating a standalone reporting burden: where evidence already exists in Board papers, committee minutes, dashboards, audits or MIS documentation, it should be referenced rather than reproduced. |
| **Visible ownership** | Maintain clear executive, clinical and operational ownership across both hospitals, with defined escalation and decision-making routes. |
| **Evidence of impact** | Triangulate safety, experience, workforce, culture, equity and operational data to demonstrate measurable benefit. |

| | |
|---|---|
| **Rapid delivery timetable** | Complete Board-approved baseline assurance and maintain readiness for the December 2026 progress return. |
| **Board-level triage oversight** | Keep the completed maternity triage benchmarking and deep dive under active Board oversight, including timeliness, staffing, capacity, escalation, outcomes and inequalities. The improvement plan should deliver against the National Maternity Triage Specification within 12 months, with milestones, evidence and material risks reported through routine governance. |
| **Women's and families' voice** | Use MNVP insight, targeted community outreach, complaints, PALS, patient stories, incident and PMRT family involvement, Friends and Family Test, birth-reflections feedback and Martha's Rule contacts as safety intelligence. Require quarterly thematic reporting that shows the concern raised, action agreed, named owner, timescale, feedback to families and measurable impact, with direct engagement to test whether change is experienced in practice. |
| **Staff listening** | Participate actively in Amos Into Action and support staff to contribute to the national conversation, which builds on feedback from more than 9,000 maternity and neonatal staff. Strengthen routine local listening through team-based sessions, Freedom to Speak Up intelligence, pulse surveys, staff survey, sickness, turnover, exit feedback and employee-relations themes. Local learning and any recommendations arising from the national exercise should be governed through culture, workforce and improvement arrangements, with named owners, published 'you said, we did' responses, protected time for participation and evidence that themes result in safety, culture or workforce action. |

## 3. INTEGRATED BOARD ASSURANCE POSITION

The completed NHS England baseline templates for KGH and NGH, included as Appendices 2 and 3, form the detailed evidence base for this report. Each template assesses 26 deliverables. Both sites record 11 compliant and 15 partially compliant deliverables, with no non-compliant or not-applicable requirements. This supports a judgement of reasonable assurance: fundamental controls and governance routes are established, but significant work remains to demonstrate that implementation is complete, consistent and sustainable.

Within the overall reasonable-assurance judgement, maternity triage is assessed separately as AMBER. Established pathways, BSOTS, audit and governance provide a foundation, but material gaps remain in timely initial and higher-acuity review, protected workforce and telephone capacity, estate compliance, cross-site digital and data reporting, equity intelligence and administrative support. Section 5 sets out the detailed findings, required actions and investment implications.

The updated position confirms that fundamental controls are present, but provides a more cautious assessment of whether arrangements are fully embedded and consistently evidenced. Partial compliance extends across Martha's Rule, analytical capability, complaints and maternity triage,

clinical leadership attendance, multidisciplinary PEADP participation, workforce acuity and resource deployment, compassionate debriefing and continuing post-death care oversight. Appendix 4 converts these findings into a single delivery view showing risk, required action, corporate support, accountability and the next assurance point.

## 4. PROPOSED ASSURANCE AND REPORTING FRAMEWORK

UHN should maintain one integrated assurance framework for AMOS, Ockenden, the 10-Point Plan, PSIP and related regulatory requirements, retaining the granular operational requirements from Ockenden and AMOS rather than allowing these to be diluted by the less detailed 10-Point Plan. Each action should record the national requirement, local baseline, accountable executive and senior responsible owner, milestones, evidence, outcome measure, equity impact, risk, mitigation, decision and escalation route. The framework must include a defined listening-to-action cycle: systematic capture of women's, families' and staff experiences; triangulation with safety, workforce, culture and outcome data; named ownership and timescales; feedback to those who raised concerns; and measures showing whether action changed care or working experience. Delivery should be reviewed through operational and PSIP routes, challenged through the separate UHN Perinatal Assurance Committee, escalated to executive leadership where corporate action or resource is required, and reported quarterly to the Board. Structured cross-site learning should continue through the Regional Perinatal Quality Group, regional surveillance routes and established collaborative programmes, with immediate escalation of material safety, workforce, digital, analytical or delivery risks.

The integrated tracker should also capture emerging national maternity and neonatal taskforce outputs. A time-limited portfolio review should use a common template to identify early warning signals across safety, experience, workforce, culture and equity, with particular attention to risks that are repeated, recent, fragile or difficult to evidence under operational pressure.

From the next reporting cycle, agreed maternity and neonatal metrics should be incorporated into the Integrated Performance Report and complemented by quarterly triangulated assurance. Reporting should include evidence-confidence ratings, benefits measures and examples of feedback leading to change. It should test variation by KGH and NGH, pathway, shift, ethnicity, deprivation and language so that positive averages do not conceal poorer access, experience or outcomes. Each update should answer: what changed, how do we know, who experienced the change, where variation remains, and what decision or support is required?

## 5. MATERNITY TRIAGE: DEEP-DIVE ASSURANCE AND REQUIRED ACTION

The cross-site maternity triage deep dive and benchmarking against the NHS England National Maternity Triage Specification result in an **AMBER assurance position**. Both sites have established clinical pathways, embedded BSOTS processes and governance oversight; however, neither can yet demonstrate that the specification is consistently implemented, protected and evidenced. The principal cross-site dependencies are workforce capacity, separation of urgent and scheduled activity, reliable telephone access, suitable estates, interoperable digital systems, analytical capability, equity reporting and administrative support. The site-level findings and required Board response are set out below.

The cross-site review draws on each site's completed assessment against the National Maternity Triage Specification. KGH reports against 82 standards, while NGH reports its findings through the specification's ten principles and associated standards. Appendix 5 provides a summary of the findings and these should therefore be interpreted as site-specific baselines within one integrated improvement programme, rather than as directly comparable counts.

| Assurance area | Current position | Board interpretation and required action |
|---|---|---|
| **Clinical performance** | BSOTS is embedded and ongoing-care performance is improving. Initial assessment within 15 minutes and timely higher-acuity Orange review remain variable at both sites. | Continue monthly analysis and governance oversight; link performance to demand, acuity, workforce and patient flow; demonstrate sustained improvement in initial and urgent review times. |
| **Service model and capacity** | Both sites provide 24/7 emergency maternity access. Scheduled activity within triage reduces capacity for unscheduled emergency assessment and affects flow. | Develop a protected 24/7 multidisciplinary triage model; establish a cross-site, ring-fenced single point of contact; extend NGH Maternity Day Unit provision; separate scheduled from urgent activity at both sites; and align staffing and capacity to demand. |
| **Telephone access** | During Q1, KGH recorded 8,134 calls and a 71.4% answer rate; the deep dive identified 47%–51% of overnight calls as unanswered. These figures are provisional and do not yet provide full assurance because internal and external calls may be combined, manual counting is used and a telephone-system fault may have left some women in an automated loop. NGH recorded 4,586 calls and a 91.1% answer rate, but 407 calls were abandoned and the longest recorded wait was 54 minutes 9 seconds. | Telephone access is a material safety and resilience risk, particularly overnight at KGH. Complete IT-supported validation of call volume, unanswered calls, abandonment and waiting times; resolve the identified call-loop fault; establish a cross-site, ring-fenced single point of contact staffed by trained individuals; review overnight coverage; protect telephone capacity; align systems and measures; and re-audit impact. |
| **Workforce and administration** | Current staffing does not consistently provide protected triage and telephone response. Redeployment, acuity and overnight arrangements reduce resilience, while administrative | Develop a sustainable multidisciplinary workforce model aligned to demand, including the additional Tier 2 medical staffing identified for KGH; secure protected midwifery and overnight |

| | | |
|---|---|---|
| | tasks draw clinical capacity away from care. | telephone capacity; provide administrative support; and monitor redeployment, closures and relocation as operational pressure indicators. |
| **Estates** | Current environments do not fully meet the national specification. KGH requires a fit-for-purpose triage area; NGH requires improved waiting, privacy and separation of scheduled care. | Develop prioritised and costed estate solutions, with interim mitigations for privacy, flow, clinical assessment and separation of urgent care. |
| **Digital, data and equity** | Different telephone systems, incomplete KGH waiting-time and call data, unavailable equity datasets and gaps in national metric reporting limit reliable cross-site assurance. KGH also requires improved interoperability and discharge communication; NGH requires dedicated analytical capacity and automated BadgerNet reporting. Interpretation, accessible information and systematic service-user feedback are not yet consistently embedded. | Standardise answer, abandonment, wait-time, longest-wait, overnight and closure metrics; automate BadgerNet and cross-site reporting; improve interoperability, call-data capture, discharge communication and data quality; routinely stratify access, experience and outcomes by equality measures; strengthen interpretation and accessible information; and establish a consistent service-user feedback and involvement cycle. |
| **Investment** | The site assessments identify a minimum planning requirement of approximately £3.89m: £2.49m at KGH and £1.40m at NGH. This includes £1.10m recurrent Tier 2 medical investment (£660k KGH; £440k NGH) and £1.46m KGH capital estates investment. The balance supports analytical, digital, telephony, administrative and service-model development. Site workforce costs are additive, while shared enabling costs must not be duplicated. The total remains a minimum estimate because several workforce, accessibility, infrastructure and estates requirements are uncosted or subject to validation. | Require one consolidated investment case that preserves site-level requirements, separates recurrent, non-recurrent and capital costs, avoids duplication of shared enabling work and confirms the remaining uncosted elements. |

The Boards are asked to endorse the **AMBER** cross-site assurance position; confirm executive sponsorship for an integrated maternity triage improvement programme; support development of the required workforce, digital, analytical, estates and service-model business cases; and require quarterly assurance on implementation, access and timeliness, inequalities, investment, benefits and residual risk. Material safety, access, workforce or telephone risks should be escalated immediately through the established governance route.

## 6. SUMMARY AND CONCLUSION

UHN has established the core governance, quality and safety arrangements required to respond, supporting reasonable but conditional assurance. However, 15 of 26 deliverables at each site remain partially compliant and maternity triage is assessed as AMBER. The immediate priority is to convert established activity into reliable implementation and measurable benefit across KGH and NGH, with particular focus on Martha's Rule, clinical leadership, workforce sustainability, experience and inequalities intelligence, complaints and compassionate learning, maternity triage and post-death care oversight.

Quarterly Board assurance should show movement against each partially compliant deliverable, the strength of supporting evidence, measurable changes in outcomes and experience, progress against the maternity triage improvement plan and any decisions required. Material safety, access, workforce, digital, analytical or delivery risks must be escalated immediately.

**Key milestones:** by 25 September 2026, submit the Board-approved baseline and completed evidence logs; during September and October 2026, confirm the revised assurance routes, metric set, evidence-confidence approach, formal equity-partnership arrangements and priority triage actions; by December 2026, submit the national progress return and demonstrate movement from baseline, including validated investment requirements and measurable impact; and quarterly thereafter, provide integrated Board assurance on progress, variation, evidence, risks and unresolved barriers.

## 7. RECOMMENDATIONS

The Boards are asked to:

1. **NOTE** the national shift from assurance that plans exist to evidence that change is embedded, reliable and improving experience and outcomes.
2. **RECEIVE AND APPROVE** 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. **ENDORSE** the eight strategic improvement priorities and the proposed oversight route through the PSIP Programme Board, the separate UHN Perinatal Assurance Committee and quarterly Board reporting, with structured cross-site learning continuing through regional assurance routes and established collaborative programmes.
4. **ENDORSE** 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 uncosted workforce, accessibility and infrastructure requirements.

5. **SUPPORT** 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. **REQUIRE** quarterly assurance showing movement against each partially compliant deliverable, progress against the maternity triage improvement plan, risks, mitigations, impact and areas requiring corporate or Board intervention, with immediate escalation of material safety, access, workforce, digital, analytical or delivery risks.

## APPENDIX 1 COMBINED KGH AND NGH 10-POINT PLAN BASELINE SUMMARY

This schedule summarises the formal NHS England Submission A baseline assessments for Kettering General Hospital and Northampton General Hospital. The full reporting templates, including evidence logs, gaps, mitigations and supporting commentary, accompany this paper as Appendix 2 and Appendix 3.

| 10-Point Plan action | KGH | NGH | Updated Board interpretation |
|---|---|---|---|
| **1. Martha's Rule** | 1 partial | 1 partial | Established escalation routes require national alignment, digital integration and stronger monitoring. |
| **2. Real-time outcomes, experience and clinical audit** | 3 partial | 3 partial | Scorecards and governance are established; population-level, inequalities and benefits evidence remain incomplete. |
| **3. Dual Board-level accountability** | 1 compliant; 1 partial | 1 compliant; 1 partial | Joint executive accountability is established; consistent clinical-leadership attendance and evidence in Board minutes require strengthening. |
| **5. Inequalities** | 1 compliant; 2 partial | 1 compliant; 2 partial | The Maternal Care Bundle is established; multidisciplinary PEADP completion and inequalities-dashboard scrutiny require further work. |
| **6. 24/7 safety and responsiveness** | 5 compliant; 2 partial | 5 compliant; 2 partial | Core clinical workforce standards are met; workforce acuity, cross-site escalation and the consolidated deployment review remain incomplete. |
| **7. Homebirth review** | 2 compliant | 2 compliant | Review and action plan are established, with continued monitoring required. |
| **8. Humanity and candour** | 1 compliant; 2 partial | 1 compliant; 2 partial | PSIRF is embedded; complaints benefits realisation and compassionate-debriefing evidence require strengthening. |
| **9. Maternity triage** | 3 partial | 3 partial | Benchmarking and operational oversight are established; implementation plans, outcomes, inequalities and pathway interfaces remain incomplete. |
| **10. Post-death care** | 1 compliant; 1 partial | 1 compliant; 1 partial | The assurance statement is complete; continuing Board oversight and residual inspection or review actions require evidence. |
| **Total** | **11 compliant; 15 partial** | **11 compliant; 15 partial** | **No non-compliant or not-applicable deliverables.** |

**Appendix 2:** KGH 10 Point Plan Reporting Template.xlsx – full Submission A baseline assessment, evidence log and improvement actions.
**Appendix 3:** NGH 10 Point Plan Reporting Template.xlsx – full Submission A baseline assessment, evidence log and improvement actions.

## APPENDIX 4. INTEGRATED DELIVERY AND ASSURANCE VIEW

| Priority | Position / risk | Current assurance and gap | Required action and control | Executive / corporate support | Accountability and next assurance |
|---|---|---|---|---|---|
| **Martha's Rule** | **Partial / High** | Escalation arrangements exist, but maternity-system alignment, digital interoperability and Patient Wellbeing Questionnaires require further development. | Align the emerging national model with maternity systems; complete the operating model, communications, training, monitoring and benefits measures. | Digital development, deteriorating-patient infrastructure and national-programme alignment. | Lead: Director of Clinical Governance and Quality Assurance. Progress to be presented through PAC and quarterly Board assurance by December 2026. |
| **Workforce sustainability** | **Partial / High** | Core standards are met; recruitment, retention, specialist resilience and future responsiveness remain material risks. | Complete Birthrate Plus; deliver the Perinatal Workforce Strategy (including safe staffing reviews), Cultural Improvement Plan and workforce dashboard; sustain recruitment and retention action. | People and OD, medical leadership, operational support and investment decisions. | Chief Nurse, Director of Midwifery, Medical and People leadership. Strategy and capacity assurance by December 2026. |
| **Analytical capacity and equity** | **Partial / Moderate** | Dashboards are developing, but segmented analysis and evidence of inequity and impact measures remain constrained. | Dedicated BI and population-health support; agree definitions; develop an inequalities dashboard and segmented outcomes analysis; revised integrated performance reports to include key perinatal metrics to complement the current scorecards | Dedicated analytical resource, data ownership and population-health intelligence. | PAC and Board to receive strengthened equity and impact reporting from September–December 2026. |
| **Benefits realisation** | **Partial / High** | Improvement activity is evident, but measurable benefit across outcomes, experience, workforce and equity requires greater focus. Current assurance does not yet consistently demonstrate that women, families and staff recognise the changes made or that recurring concerns have reduced. | Continue to use Monday.com and develop FDP benefits-realisation metrics as part of PSIP. Introduce a quarterly listening-to-action report that triangulates complaints, PALS, MNVP and community insight, patient stories, incident and PMRT family involvement, Martha's Rule contacts, birth-reflections feedback, staff survey, pulse checks, Freedom to Speak Up, sickness, turnover, exit and employee-relations themes. For each material theme, | Quality-improvement, patient-experience, workforce and analytical support. | PAC to oversee the PSIP Programme Board and receive the first integrated listening-to-action and impact report by December 2026, with recurring themes, overdue actions or unresolved psychological-safety concerns escalated immediately. |

| | | | | | |
|---|---|---|---|---|---|
| | | | record the action, owner, timescale, feedback provided and outcome measure; undertake direct follow-up with women, families and staff to test whether change is visible and sustained. | | |
| **Maternity triage** | **Partial / High** | The cross-site deep dive concludes an AMBER assurance position. Benchmarking, BSOTS and daily oversight are established, but timely initial and higher-acuity review, protected workforce and telephone capacity, estates, cross-site reporting, equity intelligence and administrative support are not yet consistently assured. | Deliver a prioritised, costed cross-site improvement plan covering the operating model, demand and capacity, telephone access, workforce, administration, estates, digital and data alignment, equity reporting, service-user voice and measurable outcomes. | Operations, BI, quality-improvement and demand-and-capacity expertise. | Director of Midwifery, operations and clinical leads. Implementation assurance September–December 2026. |
| **Organisational capacity** | **Partial / High** | Leadership, governance, programme and analytical capacity may be diverted from implementation to assurance production. | Use one tracker, prioritise evidence, reduce duplicate reporting and strengthen programme management, governance and leadership resilience. | Executive sponsorship, programme resource, governance capacity and protected leadership time. | Executive ownership and corporate resource decisions; quarterly Board review with immediate escalation of constraints. |

Dedicated to excellence

NHS
University Hospitals of Northamptonshire
NHS Group

**APPENDIX 5 – TRIAGE BENCHMARKING SUMMARY**

## Final KGH maternity triage benchmarking position

| Maternity Triage Specification Benchmarking Audit Tool Dashboard | | Fully in place | Partially in place | Not in place | Not relevant | Data not complete | Estimated cost to progress compliance of specification standard |
|---|---|---|---|---|---|---|---|
| **Principle 2: Recognition as urgent care** | Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such. | 18% | 73% | 9% | 0% | 0% | £514,645.00 |
| **Principle 3: Assessment and care of women** | Every woman receives timely assessment, prioritisation and a clear plan of care. | 20% | 70% | 10% | 0% | 0% | £20,000.00 |
| **Principle 4: Clear information for women** | Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried. | 0% | 80% | 0% | 20% | 0% | £0.00 |
| **Principle 5: Telephone maternity triage** | A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward. | 0% | 100% | 0% | 0% | 0% | £0.00 |
| **Principle 6: Service user voice and experience** | Women's feedback must shape service design, improvement and experience. | 0% | 100% | 0% | 0% | 0% | £0.00 |
| **Principle 7: Facilities and estates** | Triage needs safe, visible, fit-for-purpose space designed for urgent care. | 0% | 60% | 20% | 20% | 0% | £0.00 |
| **Principle 8: Staffing** | Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed. | 0% | 80% | 20% | 0% | 0% | £0.00 |
| **Principle 9: Equity and equality** | Services must use data and targeted action to identify and reduce inequalities. | 8% | 83% | 8% | 0% | 0% | £660,000.00 |
| **Principle 10: Data and measurement** | Data must drive oversight, learning from incidents and continuous improvement. | 0% | 60% | 40% | 0% | 0% | £0.00 |
| | | 0% | 86% | 14% | 0% | 0% | £58,000.00 |

KGH has completed benchmarking against all 82 standards in the Maternity Triage Specification. Five standards (6%) are fully implemented, 65 (79%) are partially implemented, ten (12%) are not in place and two (2%) are not relevant. The resulting position is that 75 standards (91%) require further action before KGH can demonstrate consistent, fully evidenced compliance. Priority action is required to provide a fit-for-purpose triage environment; separate urgent assessment from scheduled activity; secure ring-fenced medical, midwifery and telephone-triage capacity; improve digital interoperability, call-data capture and discharge communication; and strengthen accessibility, equity analysis and service-user feedback. The currently identified minimum investment is approximately £2.493 million. This comprises £1.460 million for the triage estate, £660k recurrently for six additional Tier 2 doctors, £58k for analytical capacity and £314,645 for digital, administrative and pathway developments. Further accessibility, education and workforce requirements remain uncosted, so the total should be treated as a minimum planning figure. KGH therefore has a foundation on which to build, but substantial improvement and investment are required before full assurance can be provided.

## Final NGH maternity triage benchmarking position

| NGH Maternity Triage Specification Benchmarking Audit Tool Dashboard | | Fully in place | Partially in place | Not in place | Not relevant | Data not complete | Estimated cost to progress compliance of specification standard |
|---|---|---|---|---|---|---|---|
| Principle 2: Recognition as urgent care | Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such. | 0% | 100% | 0% | 0% | 0% | £65,000.00 |
| Principle 3: Assessment and care of women | Every woman receives timely assessment, prioritisation and a clear plan of care. | 10% | 80% | 10% | 0% | 0% | £239,920.00 |
| Principle 4: Clear information for women | Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried. | 40% | 40% | 0% | 20% | 0% | £0.00 |
| Principle 5: Telephone maternity triage | A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward. | 0% | 100% | 0% | 0% | 0% | £0.00 |
| Principle 6: Service user voice and experience | Women's feedback must shape service design, improvement and experience. | 25% | 75% | 0% | 0% | 0% | £0.00 |
| Principle 7: Facilities and estates | Triage needs safe, visible, fit-for-purpose space designed for urgent care. | 20% | 60% | 0% | 20% | 0% | £0.00 |
| Principle 8: Staffing | Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed. | 50% | 30% | 20% | 0% | 0% | £0.00 |
| Principle 9: Equity and equality | Services must use data and targeted action to identify and reduce inequalities. | 50% | 42% | 8% | 0% | 0% | £440,000.00 |
| Principle 10: Data and measurement | Data must drive oversight, learning from incidents and continuous improvement. | 0% | 60% | 40% | 0% | 0% | £0.00 |
| | | 14% | 29% | 57% | 0% | 0% | £55,000.00 |

NGH has completed its self-assessment against the ten principles of the National Maternity Triage Specification. Many service elements are in place, but 11 standards are not implemented and 50 are only partially implemented; arrangements are therefore not yet sufficiently consistent, protected or evidenced to demonstrate full compliance. Priority action is required to establish a protected 24/7 multidisciplinary triage model and cross-site ring-fenced single point of contact; extend Maternity Day Unit provision to separate scheduled and urgent activity; secure dedicated analytical capacity and automated BadgerNet reporting; and address estates, interpretation, accessible information, inequalities, system pathways and service-user involvement. The currently identified minimum investment is approximately £1.4m. This includes £440k recurrently for a 4.0 WTE Tier 2 medical uplift, £55k for analytical capacity and £904,920 for service-model, access, digital and other enabling requirements. This is a separate site requirement and should be added to, not offset against, the KGH workforce investment. Estates, accessibility and infrastructure requirements remain subject to options appraisal and detailed business cases. NGH is actively improving, but sustained Board sponsorship and investment are required to deliver a safe, equitable and resilient 24/7 maternity triage service.

# 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 | 10 September 2026 |
| Agenda item | 9 |

| | |
|---|---|
| Title | CQC Well-Led report of Northampton General Hospital (NGH): findings and response |
| Presenter | Julie Hogg, Interim Managing Director |
| Author | Richard May, Company Secretary |

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

| This paper is for | | | |
|---|---|---|---|
| ☐ Decision | ☐ Discussion | ☐ Note | ☒ Assurance |
| To formally receive and discuss a report and make a decision/decisions based on the option/options recommended | To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it | For the intelligence of the recipients without the in-depth discussion as above | To reassure the recipients that controls and assurances are in place |

| Reason for consideration | Previous consideration |
|---|---|
| To receive the final CQC report (enclosed at **Appendix A)** following the Well-Led Inspection of NGH which took place between 16-18 September 2025, incorporating a framework for Integrated Leadership Team (ILT) oversight of the proposed actions in response **(Appendix B)** and Regulation 17 response in respect of Freedom to Speak Up arrangements **(Appendix C)**.<br><br>Whilst, the focus of the inspection was on NGH as a discrete provider, many of the findings reflect group-wide issues and priorities. The report therefore refers to, and proposes, a UHN response. | ILT, 27 July 2026 |

## Executive Summary

*Purpose*

The Care Quality Commission (CQC) undertook a Trust-wide Well-Led assessment of Northampton General Hospital (NGH) in September 2025, assessing performance against the eight Well-Led Quality Statements under the Single Assessment Framework. The Trust was rated Requires Improvement overall, with a breach of Regulation 17 (Good Governance) relating to weaknesses in Freedom to Speak Up (FTSU) arrangements and

limited assurance that governance systems consistently drive organisational learning and risk mitigation.

The assessment identified a number of strengths, including partnership working, environmental sustainability and improvements in leadership structures; however, the CQC concluded that progress in some critical areas had not yet translated into consistent improvements in staff experience, culture and organisational learning

This report summarises the priority themes, which will be subject to ILT oversight over the next 12 months, aligned to new and ongoing areas of focus specified as a delivery framework in **Appendix B** attached. The purpose of this framework is capture existing and identify new and updated actions and initiatives, recognizing that many of the issues are known and understood and reflecting time elapsed between the inspection and the issue of the final report. ILT is the sponsoring group to receive oversight and assurance each quarter, to ensure an effective and comprehensive response.

*Overall Strategic Priorities*

Whilst actions are required across all eight quality statements, the report indicates that five organisational priorities should form the core of the UHN response:

*1. Freedom to Speak Up and Psychological Safety*

The most significant finding of the assessment relates to staff confidence in speaking up. The CQC concluded that some staff remain fearful of raising concerns, confidence in FTSU processes is variable, guardian capacity is insufficient and there is limited evidence that concerns consistently lead to visible change. This contributed directly to the Regulation 17 breach. NGH was required to submit a report on planned actions by 21 July 2026, details of which are enclosed at **Appendix C** attached.

Priorities include:

- Implementing all recommendations arising from the external FTSU review.
- Developing and approving a comprehensive FTSU Strategy.
- Increasing dedicated FTSU Guardian capacity.
- Introducing mandatory FTSU training.
- Strengthening detriment monitoring and reporting.
- Embedding routine Board oversight of themes, actions and outcomes.

*2. Culture, Leadership Visibility and Staff Experience*

Whilst the CQC found that leaders understood the strategic direction of the organisation and were committed to improvement, staff feedback identified continuing concerns regarding visibility, listening behaviours and consistency of leadership experience below executive level. The disconnect between Board intention and frontline experience remained evident.

Priorities include:

- Embedding the Leadership Development Framework.
- Expanding executive and Non-Executive Director visibility programmes.
- Strengthening middle-management capability.

- Implementing regular culture and engagement pulse surveys.
- Demonstrating visible actions resulting from staff feedback.

*3. Governance Effectiveness and Organisational Learning*

The CQC found that, although governance structures are largely in place, there were gaps in demonstrating how learning from incidents, complaints, mortality reviews and other governance processes resulted in measurable improvement.

Priorities include:

- Completing implementation of PSIRG
- Establishing a Trust-wide learning framework.
- Strengthening reporting of lessons learned and associated improvements.
- Enhancing Board oversight of incident themes and learning outcomes.
- Continuing to evolve and improve the Board Assurance Framework.

*4. Equality, Diversity and Inclusion (EDI) Outcomes*

The CQC recognised significant Board commitment to EDI and acknowledged positive developments through staff networks and targeted initiatives; however, disparities remained evident in workforce experience, career progression, bullying and discrimination indicators. The challenge is increasingly one of demonstrating measurable impact rather than introducing additional initiatives.

Priorities include:

- Launching and monitoring delivery of the We Belong Strategy.
- Strengthening oversight of workforce race and disability equality (WRES/WDES) and Gender Pay Gap action plans.
- Focusing interventions on a smaller number of measurable objectives.
- Improving representation and progression outcomes.
- Enhancing assurance regarding workplace culture and inclusion.

*5. Embedding Strategy and Culture Across the Organisation*

The CQC found broad agreement on strategic priorities at Board level but noted inconsistent understanding and ownership at operational levels. Further work is required to translate organisational ambitions into everyday practice.

Priorities include:

- Refreshing and communicating strategic priorities.
- Strengthening staff understanding of how individual roles contribute to Trust objectives.
- Increasing engagement with patients, communities and staff in service development.
- Monitoring cultural indicators alongside operational and financial metrics.

*6. Conclusion*

The CQC assessment largely validated themes already identified through the Group's own self-assessment process (which immediately preceded the formal inspection), demonstrating a good level of organisational insight; however, the report concluded that greater emphasis must now be placed on evidencing impact and embedding improvements consistently across the organisation. ILT and the Boards' immediate focus should therefore be on addressing the underlying causes of the Regulation 17 breach through strengthening Freedom to Speak Up arrangements, improving organisational learning, and delivering measurable improvements in culture, staff experience and inclusion. These actions will be fundamental to achieving sustainable improvement in the Trust's overall Well-Led rating, and will place KGH in a stronger position to demonstrate good practice and continuous improvement ahead of its next Well-Led Inspection.

*7. Recommendation*

Boards are requested to receive:

(1) The final report of the CQC following the Well-Led Inspection of NGH which took place on 16-18 September (Appendix A);
(2) The group's response to the inspection, as set out in Appendices B-C, as endorsed by ILT.

## Appendices

A – final Well-Led report: Northampton General Hospital NHS Trust HTML report "Well-led" for assessment AP14973 - Care Quality Commission
B – Draft Delivery Framework
C – Regulation 17 response (Freedom to Speak Up)

## Risk and assurance

The CQC found that there needed to be further development of the Board assurance framework (BAF), which was revised in December 2025. This is reflected in the Delivery Framework at Appendix B.

## Financial Impact

No direct implications arising from this report and recommendations

## Legal implications/regulatory requirements

NGH provided a written report setting out actions in response to the identified breach of Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Appendix C).

## Equality Impact Assessment

As summarised in Section (4) of the CQC report and Appendix B.

.

| APPENDIX B – Delivery Framework by quality statement in response to NGH Well-Led Inspection published report, agreed by ILT, 27 July 2026 | | | | | |
|---|---|---|---|---|---|
| **Quality Statement** | **Actions and areas of foucs** | **Lead Exec (key below)** | **Current Position – (a) in place (b) under development (c) not started?** | **Which individual or group is overseeing delivery?** | **Success Measures** |
| **1. Shared Direction and Culture** | 1. Refresh and relaunch organisational strategy<br>2. Strengthen staff engagement and communication;<br>3. Increase executive and divisional listening events;<br>4. Implement culture and engagement dashboards;<br>5. Establish a visible "You Said, We Did" programme (in place?);<br>6. Improve staff understanding of how individual roles contribute to Trust objectives (strengthen the 'golden thread' linking organisational to team and individual objectives) | PG<br><br>SON/PK<br><br>SON<br>PK/BT<br><br>SON<br><br>SON | 1. Options appraisal for development completed: report to September Boards (b)<br>2. New internal engagement strategy is in sign-off. The key priority is re-engaging our workforce, supporting the overall priorities of strengthening our culture and transforming patient care (b)<br>3. Leadership Visibility Plan is in progress. In-person engagement sessions and divisional celebration sessions are in the plan for the coming year (b)<br>4. In place (a)<br>5. In place – being enhanced. Feedback loop engagement is a key feature of the new internal engagement strategy. We are rolling this out under the Together We Can campaign. (a)<br>6. Deliver as part of (2) above | 1. Boards of Directors<br>2. SON, Communications Team<br>3. SON, Communications Team<br>4. Cultural Assurance Group and People Committee<br>5. SON, Communications Team<br>6. SON, Communications Team | Improved Staff Survey scores for staff voice, inclusion and engagement;<br><br>Increased staff understanding of organisational priorities;<br><br>Improved staff participation in engagement activities;<br><br>Reduction in reports relating to leadership and culture concerns. |
| **2. Capable, Compassionate and Inclusive Leaders** | 1. Implement Leadership Development Framework;<br>2. Strengthen middle-management capability (linked to (1));<br>3. Expand executive and NED visibility programmes (ED 'offer' to visit in place, need more systematic NED visit programme, feeding back to PSC?);<br>4. introduce structured succession planning (in place for EDs);<br>5. Embed behavioural expectations linked to Trust values;<br>6. introduce regular leadership feedback mechanisms. | PK<br><br>PK<br><br>JH<br><br>PK<br><br>PK<br><br>JH / SON | 1. Ongoing (a)<br><br>2. Ongoing (a)<br><br>3. Visibility plan developed (a)<br><br>4. To be initiated (c)<br><br>5. Behavioural framework in draft (b)<br><br>6. Visibility plan developed (a) | 1. People Committee<br><br>2. People Committee<br><br>3. ILT<br><br>4. Remuneration and Appointments Committees / People Committee<br>5. People Committee<br>6. ILT | • Improved leadership visibility scores;<br>• improved staff perceptions of leadership;<br>• improved psychological safety indicators;<br>• reduced concerns regarding management behaviours;<br>• stronger succession pipelines. |
| **3. Freedom to Speak Up (FTSU)** | 1. Develop and implement a Trust-wide FTSU Strategy;<br>2. Implement all recommendations from the external FTSU review;<br>3. Increase Guardian capacity and independence (complete: independent service launched 26th May);<br>4. Introduce mandatory FTSU training (complete: Speak Up for all staff, Listen Up for Band 6 and above, Follow up for Band 8b and above);<br>5. Strengthen detriment monitoring;<br>6. Improve reporting of actions arising from concerns; | BT | As specified in Appendix C (Regulation 17 response) | People Committee and Boards of Directors (all) | • Improved Staff Survey FTSU indicators<br>• Increased staff confidence in raising concerns<br>• Reduction in anonymous speaking-up cases<br>• Timely closure of concerns<br>• Reduction in detriment concerns<br>• Evidence of organisational learning from FTSU cases. |

| | | | | | |
|---|---|---|---|---|---|
| | 7. Enhance Board oversight of FTSU themes and outcomes. | | | | |
| **4. Workforce Equality, Diversity and Inclusion** | 1. Deliver the We Belong Strategy (ongoing);<br>2. Strengthen WRES, WDES and Gender Pay Gap action plans e.g. improve career progression and representation (e.g. Shadow Board proposal)<br>3. strengthen anti-discrimination and anti-bullying interventions; improve communication of actions taken. | PK | We belong strategy in place and actions ongoing | People Committee | • Improved WRES and WDES metrics;<br>• reduction in bullying and discrimination indicators;<br>• improved Staff Survey inclusion measures;<br>• improved representation in leadership roles; narrowing of workforce inequalities. |
| **5. Governance, Management and Sustainability** | 1. Complete PSIRF implementation (2026 review);<br>2. Strengthen incident and complaint learning systems;<br>3. Redevelop and align the Board Assurance Framework;<br>4. Strengthen assurance regarding governance effectiveness; improve dissemination of lessons learned | HN / JH | 1. Planned for 2026 (b)<br>2. Group Head of Patient Experience conducting review (b)<br>3. Re-aligned BAF in place; work underway on Corporate Risk Registers (b)<br>4. As (2) above | 1. Quality and Safety Committee (QSC)<br>2. QSC<br>3. Boards of Directors<br>4. QSC | • Closure of Regulation 17 concerns;<br>• evidence of trust-wide learning from incidents;<br>• improved Board assurance;<br>• stronger risk management and BAF oversight;<br>• measurable improvements arising from governance reviews. |
| **6. Partnerships and Communities** | 1. Maintain strong system partnerships;<br>2. Expand patient and public involvement;<br>3. Increase co-production in service redesign;<br>4. Improve documentation of community engagement;<br>5. Strengthen demonstration of how feedback influences decisions. | JH/RM<br><br>(2) – (5) SON | 1.Ongoing (b)<br>2–5 covered in Public Engagement Strategy (b) | 1. Boards of Directors<br>2. Quality and Safety Committee<br>(3)-(5) ILT | • Increased evidence of co-production;<br>• positive stakeholder feedback;<br>• improved patient engagement measures;<br>• stronger evidence that community involvement influences service development. |
| **7. Learning, Improvement and Innovation** | 1. Refresh and strengthen the Improving Together strategy;<br>2. Establish a formal organisational learning framework;<br>3. Strengthen sharing of learning across sites and services; improve learning from complaints;<br>4. Expand quality improvement capability;<br>5. Improve benefit realisation reporting from improvement programmes. | BT<br><br>PK/BT<br><br>SH / SON<br><br>BT<br><br>BT | 1. NHS Impact self-assessment & review of delivery planned for Q2 (b)<br>2. Tbc<br>3. In progress – Together We Can Be Proud' learning campaign (b)<br>4. QI training capacity doubled in 26/27 (a)<br>5. Ongoing from Q3 following improvements in data (b) | Quality and Safety Committee (1)-(4)<br><br>Finance, Investment and Performance Committee | • Increased staff participation in improvement activities;<br>• Increased proportion of QI projects utilising QI methodology<br>• evidence of cross-site learning;<br>• measurable outcomes from QI projects;<br>• improved learning from complaints and incidents;<br>• stronger assurance regarding implementation of lessons learned. 12<br>• improved proportion of benefits realised from business case / programmes |

| | | | | | |
|---|---|---|---|---|---|
| **8. Environmental Sustainability** | 1. Continue delivery of the Green Plan;<br>2. Strengthen sustainability awareness amongst staff and leaders;<br>3. Embed sustainability into business cases and decision-making;<br>4. Develop departmental green plans;<br>5. Align sustainability with service redesign and health inequalities work. | PG<br><br>SON<br><br>PG<br><br>PG<br><br>PG | 1. Green plan approved at Board, delivery in progress (b)<br>2. Deliver as part of leadership objectives at (2) above<br>3. Plan in place (a)<br>4. Being planned (b)<br>5. Being planned (b) | Strategy, Transformation and Digital Committee | • Achievement of Green Plan milestones;<br>• increased staff awareness of sustainability;<br>• measurable carbon reduction;<br>• increased departmental participation in sustainability initiatives;<br>• evidence of sustainability being incorporated into routine planning. |

## Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

| | |
|---|---|
| **Account number** | <Provider ID> (if applicable – NHS inspections only) |
| **Our reference** | AP14973 |
| **Location ID** | <Location ID> (if applicable – IHC inspections only) |
| **Trust / Location name** | Northampton General Hospital NHS Trust<br>Cliftonville<br>Northampton<br>NN1 5BD |

**(For regulations requiring actions: Require one page per regulation)**

| **Regulated activity(ies)** | **Regulation** |
|---|---|
| Treatment of disease, disorder or injury | **17: Good Governance** |
| | **How the regulation was not being met:** |
| | During our assessment we found a lack of an effective system and process for Freedom to Speak Up to assess, monitor and improve the quality and safety of the services provided; and limited assurance of learning from governance processes to mitigate risk |
| **Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve** | |
| From 26th May 2026, the Freedom to Speak Up service has been transferred from an internal colleague-led service to the independent provider, The Guardian Service, in order to build confidence of colleagues in the independence of the service.<br><br>Communications strategy in place to support FTSU, including:<br>• New communications material on speaking up and how to contact the Guardian Service have been distributed throughout the Trust – from June 26<br>• Materials in Trust communications distribution channels, including screensavers, newsletters and in every Friday leadership blog – ongoing<br>• Updated materials in the induction and managers handbook – August 2026<br>• Regular focus on the Guardians in communications – from August 2026<br><br>Targeted support to specific areas:<br>• Engagement plan with staff networks and staff network leads – from August 2026 | |

- Triangulation of other 'red flag' data from HR, and informal feedback mechanisms, to inform areas of focussed engagement, agreed by the executive leadership team – from August 2026

FTSU training rolled out for all colleagues from 1st April 2026, at the following levels:

- Speak Up: all colleagues
- Listen Up: Band 6 and above
- Follow Up; Band 8b and above

Completion of the remainder of the NHSE action plan to strengthen FTSU services, including addition of the FTSU self-reflection tool and Board Development session following the introduction of the Guardian Service.

| | |
|---|---|
| **Who is responsible for the action?** | Becky Taylor, Director of Continuous Improvement and FTSU Executive Lead |

**How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?**

Regular reporting from The Guardian Service on numbers of colleagues speaking up and the themes they speak up about will be shared in a number of forums, including:

- Monthly reporting to Integrated Leadership Team Meeting – new from July 26
- Quarterly reporting to People Committee
- Quarterly reporting to Trust Board

Reports from the Guardian Service include feedback from colleagues speaking up on their experience and their reasons for using the service – these measures should give an indication as to trends in motivation and experience of speaking up in NGH

New reporting on the responsiveness / timeliness of responding to concerns on a RAG-rated scale based on the seriousness of the concern are now in place, providing for the first time visibility on compliance of the organisation responding to colleague concerns

National Staff Survey questions relating to speaking up will give an annual view of how colleagues in the organisation feel

Informal visit feedback from Board members collated by the Executive Assistant team

| | |
|---|---|
| **Who is responsible?** | Becky Taylor, Director of Continuous Improvement and FTSU Executive Lead |

**What resources (if any) are needed to implement the change(s) and are these resources available?**

Northampton General Hospital made an investment in 26/27 in The Guardian Service to transfer the service to an independent provider.

| Date actions will be completed: | New service started 26th May 2026, to be fully embedded by end August 2026 |
|---|---|

| How will people who use the service(s) be affected by you not meeting this regulation until this date? |
|---|
| Colleagues have been experiencing a fear of speaking up in the organisation, driven by a lack of trust in both the confidentiality and effectiveness of the process. Colleagues describe that they fear detriment from speaking up in the organisation.<br><br>A culture where colleagues do not feel safe to speak up creates a risk to patient safety, and risks entrenching poor behaviours or cultures in teams. |

| | |
|---|---|
| **Completed by:**<br>(please print name(s) in full) | Becky Taylor |
| **Position(s):** | Becky Taylor, Director of Continuous Improvement and FTSU Executive Lead |
| **Date:** | 20th July 2026 |

# 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 | 10 September 2026 |
| Agenda item | 10 |

| | |
|---|---|
| Title | UHN Deliverables Update |
| Presenter | Becky Taylor, Director of Continuous Improvement |
| Authors | Becky Taylor, Director of Continuous Improvement<br>Jono Roseveare, PMO Programme Manager |

| Link to Group Priorities (select all that apply): | | |
|---|---|---|
| ☒ Transform Patient Care | ☒ Strengthen our Culture | ☒ Deliver our financial plan |
| *Our UHN deliverables underpin the delivery of our three strategic priorities. This report provides assurance to the Board on the delivery of all three priorities.* | | |

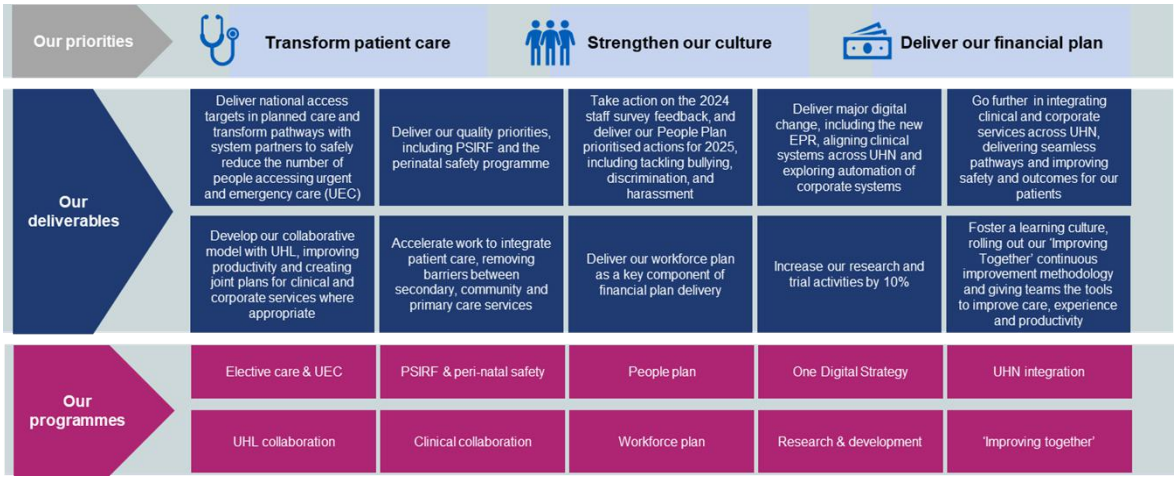
| This paper is for | | | |
|---|---|---|---|
| ☐ Approval | ☐ Discussion | ☐ Note | ☒ Assurance |
| To formally receive and discuss a report and approve its recommendations OR a particular course of action | To discuss, in depth, a report noting its implications for the Boards or Trust(s) without formally 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 |
|---|---|
| To provide Boards with assurance on the delivery of the UHN deliverables, encompassing both the 25/26 annual report and the 26/27 Q1 report | UHN Deliverables have previously been considered through Board for approval in April 2026. |

| Executive Summary |
|---|
| |

**25/26 Annual Review of UHN Deliverables**

The Ten Strategic Deliverables for UHN in 25/26 were agreed to support the delivery of our Three Strategic Priorities of Transforming Patient Care, Strengthening Our Culture and Delivering Our Financial Plan.




This paper provides a report on the annual delivery of the workstreams that support the strategic deliverables, and the key metrics that were agreed to track delivery.

In 25/26 year, we have made notable progress against our deliverables, including:

- The implementation of UHN-wide clinical divisions
- Improvements in mortality in KGH
- Improvements in patient experience, particularly over the winter period
- Improving trend for infections
- The development of the UHN / UHL Group Clinical Strategy
- The implementation of Nervecentre at NGH and Badgernet across UHN
- Improvement in all UEC metrics, particularly ambulance handover performance
- Improvement in A&E performance in Q4 in NGH with the sprint supporting a significantly improved position
- Continued reduction of 52 week patients, achieving a year-end position of 0.8%
- If listed as UHN, achieving the highest patient participation rate in research in the East Midlands
- Improvements in appraisal rate and reduction in sickness / absence rate
- Successful launch of Improvement Weeks
- Acceleration of our automation and AI programme with ambient voice technology and corporate automation
- 60% reduction in agency staffing spend
- Increasing run-rate of efficiency delivery, particularly in M12

There are also areas where we have not made as much progress as we would have liked:

- Challenges in Skin, Dermatology, Breast and Gynaecology with the Cancer Faster Diagnosis Standard resulted in deteriorating position in Q2 and Q3, which has been partially recovered, but remains challenged
- Increasing SHMI in NGH, which is now 'above expected', impacted by both coding depth and changes to the recording in SDEC activity. Mortality alerts continue to be monitored.
- The financial delivery for the year, whilst in line with revised forecasts, was below the initially agreed plan for the year, predominantly driven by under-delivery of the CIP target

- Initial early workforce reductions of 500 WTE were unable to be maintained all year, ending with a reduction in workforce of 276 against the 781 plan
- Mandatory training compliance has shown a downward trend, although remain above target

Details are included in Appendix 1: 2526 UHN Deliverables Annual Report

**26/27 Q1 Update on UHN / UHL Deliverables**

In April 2026, the UHL / UHN Group launched a new set of annual priorities and deliverables for 2026/27.

The deliverables for 2026/27 aim to build upon our progress in 2025/26 and focus on delivery of key national ambitions reflected in the 10 Year Plan for Health, such as the development of neighbourhood care models, and enhancing NHS efficiency and productivity. In recognition of the closer working and governance, for 2026/27 these were established as Shared Deliverables, which increases the number to 11.


For each deliverable, lead executives have set out a plan for the year for delivery, and identified KPIs to track progress on delivery, which will be reported quarterly through Board. It had been intended to align the reporting to the publication of the National Oversight Framework, but the timetable for the NOF release has not yet been consistent, so this month the quarterly report on deliverables progress stands alone.

The only deliverable for which there is not a delivery plan is the to 'Raise the profile of our Innovation Hub' which is a predominantly UHL initiative. It is proposed that the Strategy, Transformation and Digital Committee considers on the occasion of it's meeting in September how best to progress an innovation agenda in UHN.

In Q1 of 26/27, we have made notable progress against our deliverables, including:

- Nervecentre PAS, OrderComms and Care Planning completing UAT and entering go-live planning for 21 August
- Enhanced frailty pathways commencing in June across both sites
- Additional SDEC services implemented in medicine, surgery and gynaecology

- A strong start on the Cancer Faster Diagnosis Standard, improving in both Trusts to 81.9% in NGH and 76.8% in KGH
- Continued reduction in long waiting patients, with 52 week waits at 1.0% in NGH and 0.3% in KGH
- Strong Q1 delivery on CIP, above plan at 174% and 161% of plan for M3
- A sustained reduction in agency spend, with a steady position of 1.5% and 1.0% of pay in Q1
- Roll-out of the new Excellence and Accreditation Framework to all adult inpatient areas across both sites
- PSIRF and Human Factors leads now in post, with the Local Patient Safety Incident Response Plan reviewed and updated
- Development of the new QI Inspire project tool on FDP, with positive user testing
- A significant step up in Level 2 QI training across clinical areas of high priority
- Agreement of a single nuclear medicine service as part of the Group Clinical Strategy
- Continued improvement of the ambient voice technology pilot in response to clinician feedback, ahead of full roll-out
- Identification of local authority land in Wellingborough for an elective hub and large Community Diagnostics Centre
- Participant recruitment and commercial trial activity both on track against 10% growth targets
- Improvement in Q1 in appraisal rate, mandatory training compliance and turnover in KGH
- A reduction in falls across UHN in Q1, with falls causing serious or moderate harm decreasing

However, there are also areas where we have not made as much progress as we would have liked:

- SHMI in NGH has increased across Q4 25/26 and Q1 26/27 to 107.5, related to SDEC and coding, although both Trusts remain within the 'as expected' band
- A&E performance in NGH dipped slightly in Q1 to 71.2% following a strong Q4
- Non-elective length of stay in NGH increased in Q1 to 11.0 days
- Patient experience in NGH decreased slightly to 88.2%, impacted by pressures in the emergency department
- A slight increase in pressure ulcer incidence in Q1, in line with historical variation, although Category 3 and 4 pressure ulcers remain low in number
- The I&E position has remained largely flat across both Trusts at -£4.7m and -£5.8m
- Worked WTE reduced in NGH in Q1 but remained flat in KGH
- Appraisal rates and mandatory training compliance have both declined slightly across the 18 month trend, despite the Q1 improvement
- Priority cohorts, baselines, delivery plans and the operating model for neighbourhood care are not yet fully agreed

A full report covering all deliverables, KPIs and workstream updates is included in Appendix 2: 2627 UHN Deliverables Q1 Report.

**Recommendation**

It is recommended that the Boards note the latest position and indicate assurance on the delivery performance against the deliverables

| |
|---|
| **Appendices – available in the 'documents' section of the Boards portal, and from the Corporate Governance Team: kgh-tr.Corporate@nhs.net** |
| Appendix 1: 2526 UHN Deliverables Annual Report<br>Appendix 2: 2627 UHN Deliverables Q1 Report |
| **Risk and assurance** |
| The strategic deliverables and associated workstreams are a control against all BAF risks. |
| **Financial Impact** |
| One of our strategic priorities is around delivering the financial plan. |
| **Legal implications/regulatory requirements** |
| Delivering on these priorities supports our regulatory and legal requirements as two NHS Trusts. |
| **Equality Impact Assessment** |
| All workstreams have had a QIA or EIA completed where applicable |

# Cover sheet

| | |
|---|---|
| Meeting | Boards of Directors of Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) meeting together in Public |
| Date | 10 September 2026 |
| Agenda item | 11 |

| | |
|---|---|
| Title | Fit and Proper Persons Annual Declarations (FPP) |
| Presenter | Andrew Moore, Chair |
| Author | Richard May, Company Secretary |

| This paper is for | | | |
|---|---|---|---|
| P Decision | ☐Discussion | ☐Note | P 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 |
|---|---|
| For the Boards of Directors to accept the Chair's assurance that all Board Members continue to meet the Fit & Proper Persons requirements | Audit Committees, June 2026<br><br>Remuneration and Appointments Committees, June 2026 (executive director appraisals)<br><br>KGH Council of Governors, September 2026 (Chair and non-executive director appraisals) |

## Executive Summary

Board members have submitted yearly declarations satisfying Care Quality Commission (CQC) Regulations for the Trust to be able to demonstrate that all Directors are of good character and meet the CQC's Fit and Proper Persons Regulation. Completed Declaration Forms are retained by the Company Secretary.

The Company Secretary has also undertaken the following checks, from which no issues have emerged:

- Individual Insolvency Register;
- Companies House Register of Directors, and of Disqualified Directors;
- Register of Disqualified Charity Trustees
- Register of Employment Tribunals

- Web search

Assurance in respect of Board members' annual appraisals forms part of the evidence base for assessing competence, skills and experience for the purpose of FPP, and has been reported as follows:

- Chair and Non-Executive Directors to the Council of Governors on 2 September 2026 (KGH only), and to NHS England (UHN Chair, 30 June 2026, non-executive directors, by 30 September 2026)
- Executive Directors to the Remuneration and Appointments Committees on 16 June 2026.

The Audit Committees, at the meeting on 24 June 2026, indicated assurance that appropriate processes and checks were in place and had been followed with no concerns arising about board members' continuing status as fit and proper persons to hold office. The Committees further noted and welcomed enhancements to existing processes in response to the NGH CQC Well-Led review, undertaken in September 2025.

The Trust Chair is ultimately responsible for discharging the requirements placed on the Trust to ensure that all Directors meet the fitness test and do not meet any of the "unfit" criteria.

No concerns about relevant Directors' fitness or ability to carry out their duties or information about a Director not being of good character are required to be brought to the Boards' attention. The Trusts' Chair is therefore able to provide the Boards with assurance that all members of the Board of Directors continue to meet the Fit & Proper Persons requirements.

**RECOMMENDATION -** The Boards are asked to accept the assurance that all Members continue to meet the Fit & Proper Persons requirements, and to authorise the Chair and Vice-Chair to submit the annual declaration of compliance to NHS England.

| Appendices |
| --- |
| None |
| Risk and assurance |
| No direct implications for the Board Assurance Framework. |
| Financial Impact |
| None. |
| Legal implications/regulatory requirements |
| As set out above. |
| Equality Impact Assessment |
| Neutral |

# 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 | 10 September 2026 |
| Agenda item | 12 |

| | |
|---|---|
| Title | Provider Capability Self-Assessment |
| Presenter | Becky Taylor, Director of Continuous Improvement |
| Author | Becky Taylor, Director of Continuous Improvement |

| Link to Group Priorities (select all that apply): | | |
|---|---|---|
| ☒ Transform Patient Care | ☒ Strengthen our Culture | ☒ Deliver our financial plan |
| *The National Oversight Framework of which the Provider Capability Self-assessment is a part, outlines a consistent and transparent framework to assessing NHS providers against a focused set of metrics across five domains; access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity. Our strategic priorities as an organisation align to these domains and metrics.* | | |

| 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 |
|---|---|
| Following the launch of the 2026 Provider Capability Self Assessment process, this paper is to brief the Boards on the process and seek approval to delegate the sign-off of the submission to the Chair and CEO. | The 2025 Provider Capability Self-Assessment was considered by Boards in November 2025 |

## Executive Summary

The National Oversight Framework (NOF) describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation

trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

The framework sets out how NHS England will assess providers and ICBs, alongside a range of agreed metrics, promoting improvement while helping us identify quickly where organisations need support.

Each Trust is assessed against a range of metrics reflecting key NHS priorities, such as reducing waiting times in elective care and emergency departments. A Trust's financial position also impacts its segment rating: any Trust operating in deficit cannot be rated higher than Segment 3. The ratings will be refreshed every three months with the performance from the previous quarter. The ratings for Q1 of 26/27 have not yet been released and are expected soon.

Alongside the metrics in the NOF, providers are asked to self-assess their capability using the criteria outlined in the Insightful Provider Board guidance. This is intended to both strengthen board assurance and help regional oversight teams take a view of boards' grip and awareness of the challenges their organisations face and their track record of addressing them, and will be used to identify providers who will be placed into Segment 5, the Provider Improvement Plan.

The criteria and domains cover:

- strategy, leadership and planning
- quality of care
- people and culture
- access and delivery of services
- productivity and value for money
- financial performance and oversight

Regional and ICB oversight teams will triangulate provider self-assessments with the trust's recent operational history and track record of delivery and third-party intelligence including from NHS England, the CQC, other regulatory bodies and system partners.

The self-assessment is expected to provide a consistent framework for regional oversight teams to engage with NHS trusts, identify key risks and, over time, assess management's track record in delivering performance and/or identifying and addressing issues to ensure strong, sustainable organisations able to deal with challenges as they emerge. This will be an annual self-assessment, due to be submitted by Friday 2nd October.

In the 2025 Provider Capability Assessment, we submitted partial compliance in all categories apart from Productivity and Value for Money, and subsequently both KGH and NGH were rated as **Amber / Red**. Formal feedback on individual domains was not provided.

This is the second year of the Provider Capability Self-Assessment, and refreshed guidance has been shared, with Trusts asked to provide our rating for each domain against this scale, with examples provided for what each looks like in practice:

- Green - High confidence in management
- Amber / Green - Some minor issues that should be addressed
- Amber / Red - Material issue needs addressing or failure to address major issues over time
- Red - Significant and persistent concerns

Where providers are unable to make a positive self-assessment, the Board should provide the reasons for concerns, mitigating actions and plans to improve.

Many of our strengths from last year remain the same:

- Alignment of provider annual plans and priorities with system annual plans and priorities
- Collaborative working across organisational boundaries
- Approach to continuous improvement
- Approach to risk management
- Visibility of quality metrics at Board level and detailed reports through Quality Committee
- Board sponsorship for staff networks

Some of the challenges that are reflected in our oversight and tiering arrangements around finance and performance remain in place.

There have been a number of improvements since the submissions that we made last year, with significant changes made in areas of partial compliance:

- Commissioning of the independent FTSU service
- Strengthening quality governance and oversight through the implementation of the recommendations of the external quality governance review and embedding of SPC charts and improvement methodology through quality oversight

There have also been a number of changes in Board level governance, and the recent de-coupling will change arrangements again. In discussion with the region, and in line with the principle of 'no surprises' outlined in the guidance we will therefore seek to additionally submit a covering letter explaining the changes made in year and the plans for transition.

The Boards are asked to:

1. Note the expectation of submission of the provider capability self-assessment, and
2. **Delegate authority** to the Chair and CEO to submit the provider self-assessment, when completed, on behalf of the Boards, with a retrospective review in the October Board(s) meeting.

## Appendices

None

## Risk and assurance

The Provider Capability self-assessment assure progress against the delivery of a number of our BAF risks.

## Financial Impact

An improved position in the provider capability assessment in the Financial Performance and Oversight domain should support improved financial oversight and performance.

## Legal implications/regulatory requirements

NHS Providers are expected to complete a provider capability self-assessment annually.

## Equality Impact Assessment

Neutral.

| | |
|---|---|
| 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 | 10 September 2026 |
| Agenda item number | 13 |
| Title | Quarter 1 26/27 Board Assurance Framework (BAF) Report |
| Presenter | Susan Clennett, UHN Deputy Director of Risk and Legal Services |
| Author | Susan Clennett, UHN Deputy Director of Risk and Legal Services |

**Group Priorities**

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

Identification of strategic risks and management of those risks.

**This paper is for**

| ☐ Decision | ☒ Discussion | ☐ Note | ☒ Assurance |
|---|---|---|---|
| To formally receive and discuss a report and make a decision/decisions based on the option/options recommended | To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it | For the intelligence of the recipients without the in-depth discussion as above | To reassure the recipients that controls and assurances are in place |

| Reason for consideration | Previous consideration |
|---|---|
| To receive and be assured:<br>1. That the identification and management of strategic risks within the BAF is robust.<br>2. That Executive Directors and Committees of the UHN Boards of Directors ensure that strategic risks are dynamically managed and integral to delivery of UHN's objectives. | Committees of the Boards, June-July 2026 |

**Executive Summary**

The BAF has been to Committees of the Board during June-July 2026.

Quality and Safety Committee considered the patient safety risk linked to culture of workforce and questioned alignment of scoring on the culture risk owned by Chief People Officer, UHN18. A meeting is being arranged between the Interim UHN Chief Nurse and the Chief People Officer.

Consideration of the BAF has also included:

- The majority of risks within the BAF are within the "significant" range, noting that the two financial risks are scored as "extreme" (score of 25);
- Patient safety and activity risks are scored at 20, remaining at the top end of significant scoring;

The Risk Management Committee continues to consider corporate risks presented by risk owners, together with how corporate level risks inform the BAF.

A review of the Boards' Risk Appetite will take place during quarter three of 26/27, together with assessment of key deliverables linked to strategic risks.

**Appendices**

BAF Report Qtr 1 26/27 Report

| Risk and assurance |
| --- |
| The Risk Management systems and processes up to and including the BAF support a well-led organisation and evidence ownership, continual assessment of and assurance on the management of risks. Risks are assessed quarterly (or more frequently as required). |
| Financial Impact |
| None |
| Legal implications/regulatory requirements |
| Supports CQC Well-led requirements |
| Equality Impact Assessment |
| Neutral |

## Summary of BAF Risks

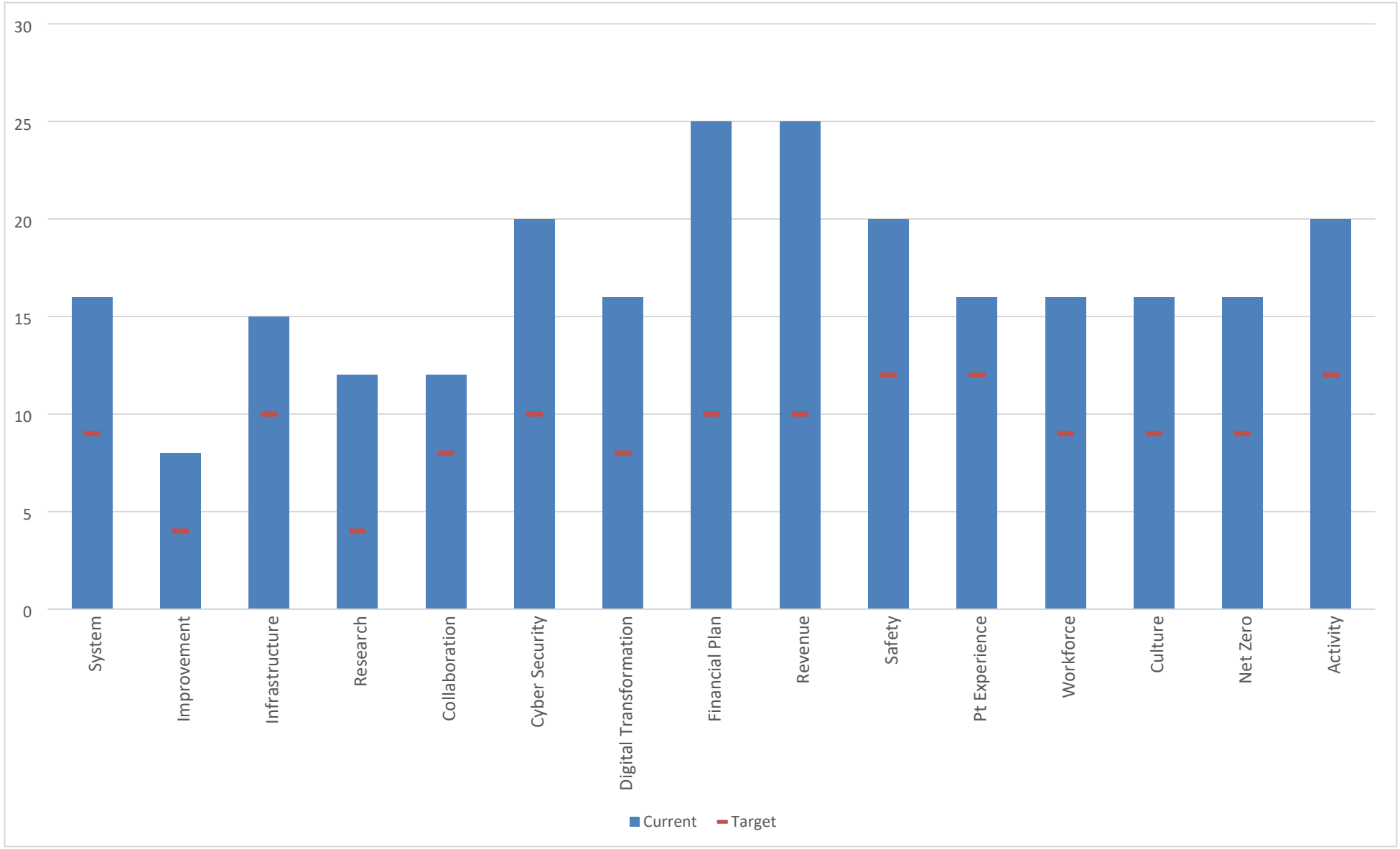
| Risk ID | Strategic Priority / Deliverable | Risk Description | Lead and Committee | Current Score | Current Tolerance | Domain Risk Appetite |
|---|---|---|---|---|---|---|
| UHN10 | **Transform Patient Care**<br>Learning Culture/Continuous Improvement | If UHN does not progress with continuous improvement plans, we will not have the capability and capacity to deliver the level of patient care that we wish to achieve, resulting in impact on the quality of care, efficiencies and staff morale impacted by potential restrictions on working in an autonomous organisation, supporting individuals to thrive. | Director of Continuous Improvement<br><br>Quality and Safety | **8**<br>**C4xL2** | **4**<br>**C2xL2** | Quality / Patient Exp<br>**Open** |
| UHN11 | **Transform Patient Care**<br>Improved clinical outcomes, experience and effectiveness | If we do not have a positive safety culture consistently embedded across our services there is a risk that we will fail to continuously learn and improve and that: Healthcare acquired infections and harm do not reduce as planned; families and carers will not be fully engaged in service development; care for all patients and especially those with mental health needs, learning disabilities, autism, dementia, or at end of life will remain inconsistent; patients from underserved groups continue to experience poorer access, communication, and outcomes | Chief Nurse / Medical Director<br><br>Quality and Safety | **20**<br>**C4xL5** | **12**<br>**C3xL4** | Patient Safety<br>**Minimal** |
| UHN12 | **Transform Patient Care**<br>Patient voice strengthened and improved patient and carer exp. | If we do not consistently embed a culture of compassionate, responsive, and inclusive care across all services, there is a risk that we will fail to deliver a positive and equitable patient experience. This may result in: Patients and families feeling disengaged or unheard, leading to reduced trust and satisfaction; Continued variability in the quality of fundamental care, especially for patients with complex needs or communication barriers; Poor compliance with accessible information standards, limiting patients' ability to understand and participate in their care; Delays or inconsistencies in responding to complaints and feedback, missing opportunities for service improvement; Patients from underserved groups continuing to experience inequitable access, communication, and outcomes; Reduced ability to meet national and regulatory expectations for patient involvement and experience | Chief Nurse / Medical Director<br><br>Quality and Safety | **16**<br>**C4xL4** | **12**<br>**C3xL4** | Quality / Patient Exp.<br>**Open** |
| UHN13 | **Transform Patient Care / Strengthen Culture**<br>10% Increase Research Activities/Trials | If UHN is unable to attract and retain high calibre staff then this may result in UHN being unable to deliver on our research and Development ambitions, resulting in UHN being unable to increase our research and clinical trial activities by 10% and where support to take an innovative role in healthcare research will not achieve the best possible outcomes for our patients. | Medical Director<br><br>Quality and Safety | **12**<br>**C4xL3** | **4**<br>**C4xL1** | Innovation<br>**Open** |
| UHN14 | **Strengthen Culture / Transform Patient Care / Finance**<br>Deliver our quality priorities | If estate buildings and infrastructure continue to deteriorate and/or fail, then delivery of services may be impacted resulting in delayed or sub-optimal patient care, safety of all persons and an inability to deliver key UHN strategies. | Director of Strategy Strategy, Transformation and Digital | **15**<br>**C5xL3** | **10**<br>**C5xL2** | Infrastructure<br>**Minimal** |
| UHN15 | **Transform Patient Care**<br>Deliver national access targets | If there is insufficient capacity to meet the demand on services patients will wait longer for urgent and emergency care, elective care and cancer care leading to patient harm, compromised clinical outcomes and experience. | Chief Operating Officer Finance, Investment and Performance | **20**<br>**C4xL5** | **12**<br>**C4xL3** | Activity<br>**Open** |
| UHN16 | **Deliver Financial Plan**<br>Development of a medium term robust financial plan | The risk of impacts on patients and services of increased regulatory intervention (NHSE) and medium-term financial penalties (revenue and capital) arising from failure to deliver improvement in the underlying revenue position and delivery of a break-even financial position over the medium term | Chief Finance Officer<br><br>Finance, Investment and Performance | **25**<br>**C5xL5** | **10**<br>**C5xL2** | Finance<br>**Minimal** |

| | | | | | | |
|---|---|---|---|---|---|---|
| UHN17 | **Deliver Financial Plan**<br>Delivery of 25/26 financial/workforce plan | The risk of impacts on patients and services because of increased regulatory intervention (NHSE) and loss of deficit support funding resulting from non-delivery of the 2025/26 financial plan. | Chief Finance Officer<br>Finance, Investment and Performance | **25**<br>**C5xL5** | **10**<br>**C5xL2** | Finance<br>**Minimal** |
| UHN18 | **Strengthen Culture**<br>Take action on 2024 staff survey / deliver people plan actions for 2025 | Failure to address poor behaviours in the workplace or to provide key components of a safe workplace culture will lead to a culture in which colleagues feel unsafe and under-valued, unsupported or excluded, resulting in poor staff engagement, retention and morale, elevated sickness absence and will ultimately impact patient care. | Chief People Officer<br>People Committee | **16**<br>**C4xL4** | **9**<br>**C3xL3** | Culture<br>**Minimal** |
| UHN19 | **Deliver Financial Plan**<br>Workforce plan as component of financial plan delivery | A robust resourcing and workforce controls strategy in support of our workforce plan is required to ensure the provision of safe patient care whilst managing workforce numbers and costs. Failure to deliver the workforce plan will lead to inefficient use of resources (skill gaps in areas covered by bank or agency or over-establishment use driving inefficiency) creating financial pressures and constraints and having a negative impact on the quality of patient care. | Chief People Officer<br>People Committee | **16**<br>**C4xL4** | **9**<br>**C3xL3** | Workforce<br>**Open** |
| UHN20 | **Transform Patient Care**<br>Go further in integrating clinical and corporate services across UHN, delivering seamless pathways and improving safety and outcomes for our patients. | If there are delays in the delivery of the collaborative working model with UHL this will impact on improving productivity and creating joint plans which will impact on the trust being able to deliver seamless pathways and improve patient safety and outcomes for our patients. | Medical Director<br>Quality and Safety | **12**<br>**C4xL3** | **8**<br>**C4xL2** | Patient Safety<br>**Minimal** |
| UHN21 | **Transform Patient Care**<br>Cyber security | Failure to maintain robust cyber security and information systems infrastructure may result in service disruption, data breaches, or compromise of patient safety and organisational operations. This includes risks from cyber-attacks, network instability, inadequate data protection measures, and failure to meet national security standards and impact on patients. | Group Chief Digital Information Officer<br>Strategy, Transformation and Digital | **20**<br>**C5xL4** | **10**<br>**C5xL2** | Information<br>**Minimal** |
| UHN22 | **Deliver Financial Plan**<br>Deliver our quality priorities | If we do not eliminate our greenhouse gas emissions, limit our impact on the environment and take action to achieve our net zero targets then we will fail to be compliant with UK legislation, NHS targets, and our own publicly declared ambitions leading to potential patient harm to patients and staff through pollution and service outages, an increase in waste, inefficiency and spend and potential regulatory action from failing to meet Trust, NHS and legislative targets. | Director of Strategy<br>Strategy, Transformation and Digital | **16**<br>**C4xL4** | **9**<br>**C3xL3** | Net Zero<br>**Open** |

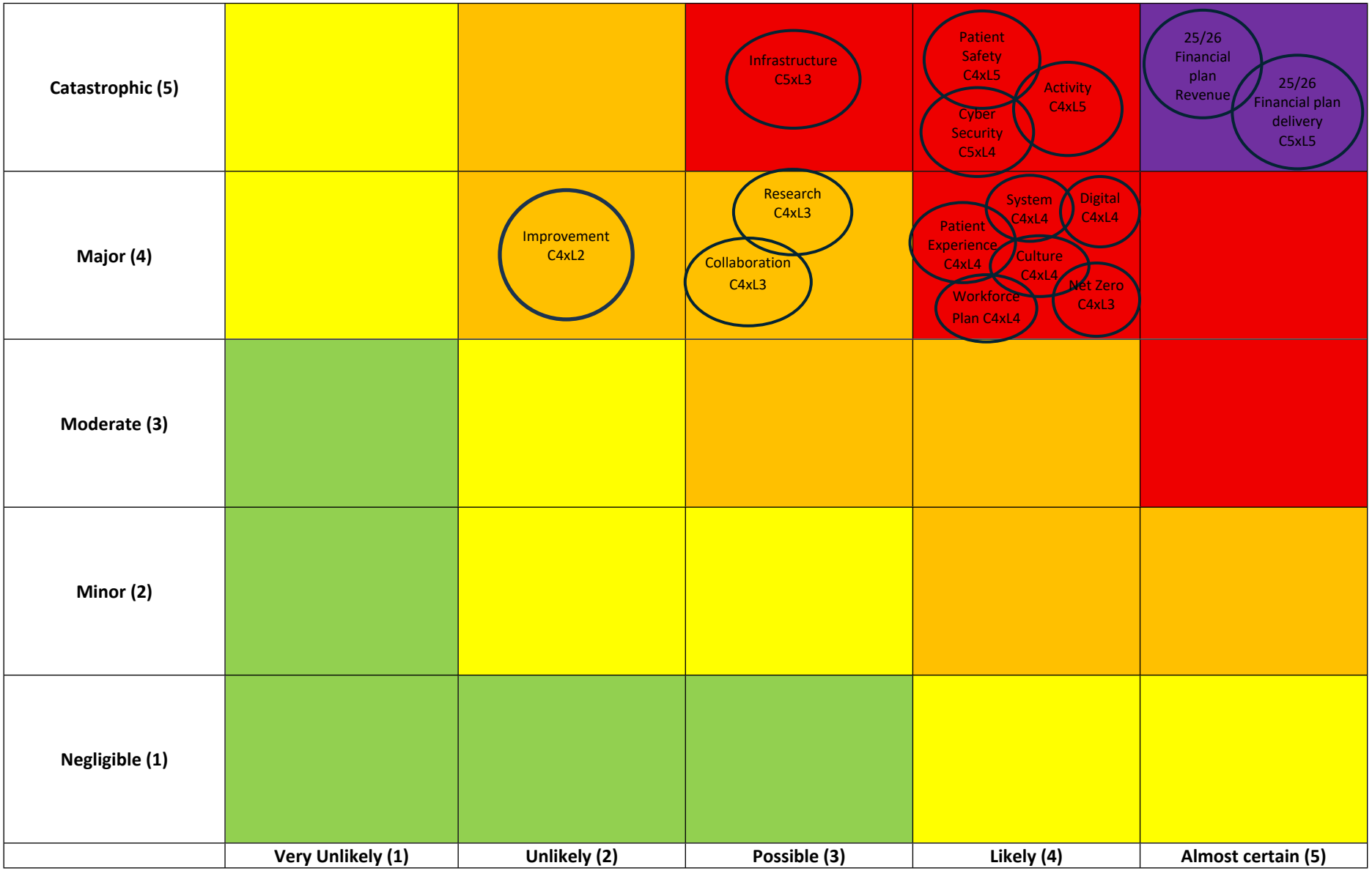
| | | | | | | |
|---|---|---|---|---|---|---|
| UHN23 | **Transform Patient Care**<br>Accelerate work to integrate patient care, removing barriers between secondary, community and primary care services | If integrated working with wider partners in our county or region is not sufficiently mature, our ability to deliver key elements of the NHSE 10 yr plan, realise our Anchor Institution ambitions or address demand from population health longer term, becomes compromised, impacting on high quality patient care and experience. | Director of Strategy<br><br>Strategy, Transformation and Digital | **16**<br>**C4xL4** | **9**<br>**C3xL3** | Pt Experience/ Quality<br><br>**Open** |
| UHN24 | **Transform Patient Care**<br>Deliver major digital change | Failure to deliver the Group's digital transformation agenda may result in continued operational inefficiencies, inability to standardise care delivery across sites, and failure to realise productivity benefits. This specifically includes risks to EPR implementation, automation programmes, and the broader digital strategy delivery impacting our ability to transform services and achieve digital maturity. | Group Chief Digital Information Officer<br>Strategy, Transformation and Digital | 16<br><br>C4xL4 | 8<br><br>C4xL2 | Information<br><br>**Minimal** |

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

## Overview of current risk v target risk



## Board Assurance Framework Heatmap



**BAF DETAIL**

| | |
|---|---|
| **Risk ID:** | UHN10 |
| **Strategic Priority:** | Transform Patient Care |
| **Risk Description:** | If UHN does not progress with continuous improvement plans, we will not have the capability and capacity to deliver the level of patient care that we wish to achieve, resulting in impact on the quality of care, efficiencies and staff morale impacted by potential restrictions on working in an autonomous |
| **Key Deliverable:** | Build a culture of continuous improvement to enhance patient experience :Foster a learning culture, rolling out our "Improving Together" continuous improvement methodology |
| **Executive Lead:** | Becky Taylor, Director of Continuous Improvement |
| **Assurance** | Quality and Safety Committee |

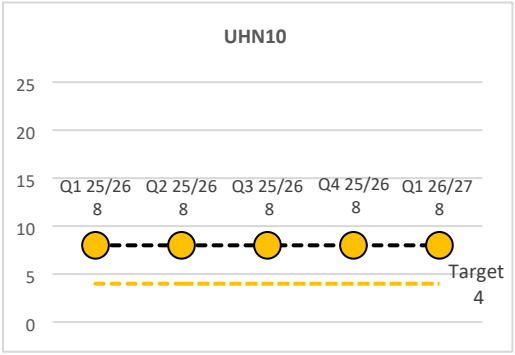
| Key Controls | Key Assurance |
|---|---|
| Improving together five year strategy | Monthly assurance reporting to Patient Safety Committee |
| Annual workplan aligned to strategy | Self assessment (NHSE Impact Framework) |
| Metrics for delivery | Quarterly update to Quality and Safety Committee |
| Annual schedule of quarterly events (Improvement Weeks, QI awards, | Forward calendar of events reporting to QI Steering Group |
| Excellence Accreditation Framework | EAF dashboard and QI tool performance metrics |
| QI Training Programmes | Training delivery metrics and before / after participant feedback |
| Corporate Accountability Meetings | Corporate accountability metrics/reporting |
| Regular communications and | Weekly communications posting |

**Gaps in control or assurance**

Schedule of annual self assessments (NHSE Impact Framework) – agreed delay due to organisational restructure, sessions booked for August 26

**Risk Scores**

| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain and Risk Appetite |
|---|---|---|---|---|
| **Consequence** | 4 | 4 | 2 | Innovation<br>Open |
| **Likelihood** | 2 | 2 | 2 | |
| **Risk Scores** | **8** | **8** | **4** | |




**Planned Actions (by due date)**

Reporting from new Quality Improvement software commencing from August 2026 following development
QI training schedule set out for the year including incorporation in all relevant programmes – Ongoing
QI training in KGH resident doctor induction for the first time – August 2026
Launch of EAF dashboard – September 2026
NHS Impact self-assessment – August-September 2026
LNR Improvement symposium – September 2026

| Q1 26/27 executive commentary |
| --- |
| Key successes in Q1 26/27 of the Improving Together strategy:<br>• Development of the EAF metrics and QI tooling – co-design work for the Federated Data Platform work completed between QI and corporate nursing – design signed off and transition for QI projects complete with EAF metrics to follow in August<br>• Further UHN Rapid 'Improving Together' Weeks held to support improved culture, with planning underway for Theatres<br>• QI training planned to be included in KGH Resident Doctor induction for the first time as<br>• QI module developed for EAF received positive feedback from participants with 7 times more participants reporting understanding QI 'Well' or 'Very Well' after training than before<br><br>Key challenges and risks in Q4 25/26: |

| | |
|---|---|
| **Risk ID:** | UHN11 |
| **Strategic Priority:** | Transform patient care |
| **Risk Description:** | If we do not have a positive safety culture consistently embedded across our services there is a risk that we will fail to continuously learn and improve and that:<br>- Healthcare acquired infections and harm do not reduce as planned<br>- Families and carers will not be fully engaged in service development<br>- Care for all patients especially those with mental health needs, learning disabilities, autism, dementia, or at end of life will remain inconsistent<br>- patients from underserved groups continue to experience poorer access, communication, and outcomes |
| **Key Deliverable:** | Deliver our Quality Priorities including PSIRF, Perinatal Safety Improvement Programme and fundamentals of care.<br>Transform UEC and improve planned care access, working with partners to deliver care in the right place at the right time.<br>Build a culture of continuous improvement |
| **Executive Lead:** | Group Chief Nurse & Medical Director |
| **Assurance Committee:** | Quality and Safety Committee |

| Key Controls | Key Assurance |
|---|---|
| Implementation of the patient safety incident response framework | Quality and Safety Committee oversight<br>Regular updates on incident trends, divisional risks, and improvement actions are reviewed, with triangulation of claims, inquests, and audit data. |
| Clinical policies and guidelines | Policies and guidelines are in date and compliance with monitoring reporting through PSC<br>Compliance with Statutory and mandatory training programme |
| Clinical audit and improvement programme | Regular audits and thematic reviews (e.g., VTE, sepsis, antimicrobial stewardship) drive targeted improvements and accountability across divisions.<br>Nursing metrics and medicines management reports to NMAHP committee |
| NLEAF assessment and accreditation programme | Ward to board oversight of key metrics and accreditation ratings |
| Freedom to speak up independent service (The Guardian Service) in place and reporting | Quarterly thematic updates on freedom to speak up service including fear of detriment monitoring |
| Targeted improvement plans for key domains of the quality strategy | Quarterly update on implementation of the quality strategy |
| Duty of Candour and Family Engagement | Thematic reviews of concerns, complaints, national surveys and the friends and family test<br>Compliance with duty of candour |
| Subject matter experts and specialist teams employed across the organisation | Annual reports from relevant teams such as Infection prevention, safeguarding, patient safety and patient experience |
| CQC improvement programmes | Organisational and service level CQC ratings /external validation<br>Peer review outcomes<br>Quality assurance visit outcomes<br>Compliance with Maternity Incentive Scheme |

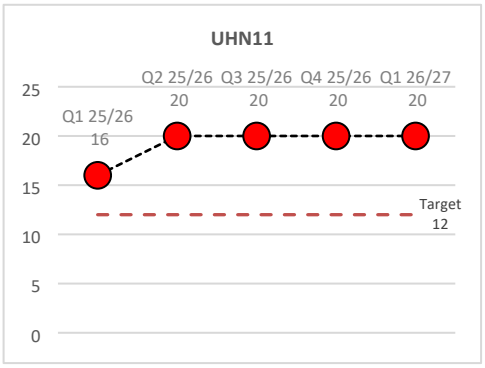
**Gaps in control or assurance**

- Concerns about effective learning from incidents and adoption of PSIRF across the group
- Neither maternity service has full compliance with the Maternity Incentive Scheme
- We did not meet all nationally set trajectories for healthcare acquired infection in 2025/26 Increasing ambulance handover delays; Crowding within the ED and normalisation of boarding; Delayed supported discharges; Delays to planned care. NGH in tier 1 for the provision of UEC
- Kettering General Hospital remains on the maternity safety support programme due to safety and cultural concerns
- Concern about team working and uncivil behaviours impacting on the safety culture
- CYP urgent and emergency care remain under regional oversight due to safety concerns
- The financial position at UHN is significantly challenged - leading to a £80million CIP programme with proposed headcount reductions. Pressure to deliver savings rapidly could result in rushed implementation of CIPs without robust clinical engagement or risk mitigation, heightening risk of harm

- Deterioration in Staff Wellbeing and Psychological Safety: Ongoing uncertainty about job security and workload increases may lead to presenteeism, rising sickness, and reluctance to speak up - masking early signs of harm or dysfunction.
- ICS Financial Pressures Impacting Shared Services: Financial recovery plans across the ICS could reduce support services (e.g. community capacity, mental health input, diagnostics), intensifying acute pressures at UHN
- The estate is aged and doesn't meet modern standards for healthcare including ventilation, water and lifts
- Fundamental care compliance not consistently embedded
- Timely response to complaints and engagement with patients, families and carers and variability in engagement and accessibility
- Compliance with accessible information standards
- Implementation of the risk management policy across the group
- Medicine safety management and optimisation compliance is not consistently embedded
- Increasing concern from the regional team about our organisation
- Deterioration in culture metrics following staff survey

**Risk Scores**

| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain and Risk Appetite |
|---|---|---|---|---|
| **Consequence** | 4 | 4 | 3 | Patient Safety Minimal |
| **Likelihood** | 5 | 5 | 4 | |
| **Risk Scores** | **20** | **20** | **12** | |




**Proposed Actions (by due date)**

1. PSIRF lead now in post and is currently reviewing PSIRF implementation gap analysis to develop action plan October 2026
2. CQC rapid improvement programme in place for UEC and medicine – Rapid programme now complete. Sustainability in progress
3. Infection prevention and control 2026/27 Annual Plan of Work and Quality Improvement Plan in place – o
4. Robust QIA process in place to ensure safe delivery of CIP Programme. Clinical representation in place on all groups – Ongoing
5. Launch of civility saves lives programme – Initiated
6. Development of the EAF assessment and accreditation programme with fundamentals of care – Sept 2026
7. Accessible information standards working group developing a road map to compliance –September 2026
8. Review of the corporate risk register across UHN – Commenced and due for completion 31st August 2026
9. Strengthening of freedom to speak up guardian services –Plan approved by ILT, implementation in progress.
10. Implementation of the recommendations from the "what good looks like" review for quality governance – April 2026
11. CQC published the NGH Well Led report with a rating of requires Improvement**.** Inspectors identified concerns around organisational culture, leadership behaviours, and staff confidence in speaking up. Whistle blower feedback highlighted issues with communication, discharge planning and involvement in care. The Trust is implementing actions to strengthen leadership visibility, governance processes and cultural improvement. – August 2026

**Q1 26/27 executive commentary**

The risk score remains unchanged at 20 in Q1, reflecting the continued presence of systemic patient safety and safety culture risks across UHN. While multiple improvement programmes are in place, these have not yet been embedded consistently to reduce the likelihood of harm.

During Q1 26/27, the Trust has continued to operate in a high risk environment for patient safety, characterised by sustained operational pressure, workforce instability, regulatory intervention and financial constraint. These pressures continue to affect the reliability of core safety processes and the consistent embedding of a positive safety culture across the organisation.

While progress has been made in strengthening safety governance structures, concerns remain regarding the effective embedding of learning from incidents and the consistent adoption of the Patient Safety Incident Response Framework (PSIRF)

across the group. Although training and support are in place, uptake and maturity vary, limiting the Trust's ability to use harm reviews and thematic learning to drive sustained improvement.
Clinical compliance remains variable in several high risk domains. Delivery of the Sepsis Six care bundle has been inconsistent, though early improvement is emerging following renewed clinical focus a Sepsis improvement group continues with aim of early identification and treatment of sepsis. Compliance with medicines safety and optimisation standards also remains variable and requires continued oversight. In maternity services, neither site has achieved full compliance with the Maternity Incentive Scheme, and Kettering General Hospital remains within the Maternity Safety Support Programme due to ongoing safety, cultural and leadership concerns.
The Trust did not meet all nationally set healthcare acquired infection (HCAI) trajectories in 2025/26. While focused infection prevention actions are now in place and early improvement is emerging, sustained delivery is required before risk reduction can be evidenced.2026/27 trajectories are still awaited from NHSE at the end of Q1. Nationally HCAIS have increased, UHN remains the 3rd lowest ICS in the Midlands region.
During quarter one operational pressures remain; ambulance handover delays, emergency department crowding, corridor care, delayed discharges and prolonged waits for planned care continue to constrain patient flow and increase safety risk.
During Q1 an NHG/KGH Medicine group was established focusing on improving length of stay group was established with the ambition of improving flow through and out of the organisation
Fundamental care compliance, timeliness of complaint responses, accessibility standards, and implementation of the corporate risk management framework remain inconsistently embedded. Implementation of the risk management policy across the group this has generally now been achieved and a single risk management database in use across UHN providing a consistent approach in support of the Risk Management Policy and Strategy.
Culture metrics, including psychological safety and civility, have deteriorated, further increasing the risk that early warning signs are not escalated or addressed promptly.
Despite these challenges, core quality outcomes remain broadly stable when viewed through the Integrated Performance Report. However, the breadth, depth and inter-connected nature of the risks require sustained executive focus, strengthened clinical leadership, improved data reliability and disciplined delivery of priority safety actions to reduce risk over time.
The following actions are prioritised as having the greatest leverage on reducing likelihood and consequence:

- Embed PSIRF consistently across all divisions, including assurance on quality of harm reviews and learning uptake
- Strengthen sepsis, medicines safety and infection prevention reliability, supported by improved data quality and clinical oversight
- Address safety culture and psychological safety, including Civility Saves Lives and strengthened Freedom to Speak Up services
- Apply robust Quality Impact Assessment (QIA) to the CIP programme to mitigate unintended safety consequences

All other actions remain important but are secondary to the above in terms of direct patient safety risk reduction.
We are in the process of reviewing Ockenden and Amos reviews, once completed we will develop a programme of work to implement any recommendations.

| | |
|---|---|
| **Risk ID:** | UHN12 |
| **Strategic Priority:** | Transform patient care |
| **Risk Description:** | If we do not consistently embed a culture of compassionate, responsive, and inclusive care across all services, there is a risk that we will fail to deliver a positive and equitable patient experience. This may result in:<br>- Patients and families feeling disengaged or unheard, leading to reduced trust and satisfaction<br>- Continued variability in the quality of fundamental care, especially for patients with complex needs or communication barriers<br>- Poor compliance with accessible information standards, limiting patients' ability to understand and participate in their care<br>- Delays or inconsistencies in responding to complaints and feedback, missing opportunities for service improvement<br>- Patients from underserved groups continuing to experience inequitable access, communication, and outcomes<br>- Reduced ability to meet national and regulatory expectations for patient involvement and experience |
| **Key Deliverable:** | Deliver our quality priorities including PSIRF, perinatal safety improvement programme and fundamentals of care programme.<br>Build a culture of continuous improvement to enhance patient experience<br>Transform UEC and improve planned care access working with partners to deliver care in the right place at the right time. |
| **Executive Lead:** | Group Chief Nurse & Medical Director |
| **Assurance Committee:** | Quality and Safety Committee |

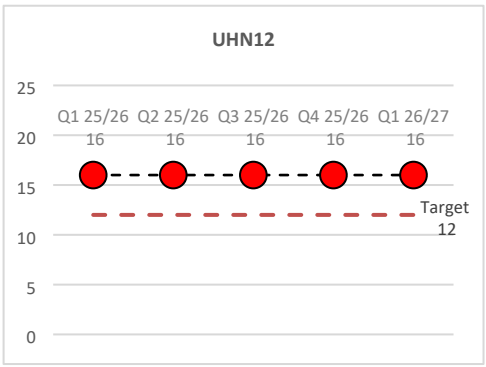
| Key Controls | Key Assurance |
|---|---|
| Patient experience strategy | Quality and Safety Committee oversight<br>Regular reporting on patient experience metrics, complaints, and engagement activities, with triangulation against safety and workforce data. |
| Accessible information standards compliance | Policies, training and technology in place to ensure patients receive information in formats that meet their communication needs, including easy-read, large print, and translation services. |
| Fundamental Care Audits supporting NLEAF assessment and accreditation programme | Routine audits of nutrition, hydration, hygiene, and dignity standards to ensure consistent delivery of fundamental care across all wards and departments.<br>Ward to board oversight of key metrics and accreditation ratings |
| Complaint and feedback handling | Quality and Safety Committee oversight<br>Regular reporting on patient experience metrics, complaints, and engagement activities, with triangulation against safety and workforce data. |
| Freedom to speak up service independent provider in place (Guardian Service) and | Quarterly thematic updates on freedom to speak up service including fear of detriment monitoring |
| Family and carer engagement | Patient stories, co-design workshops, and involvement in service reviews to ensure families and carers are active partners in care improvement. |
| Equity and inclusion framework | Targeted actions to reduce disparities in access and outcomes for patients from underserved communities, supported by data monitoring and staff training.<br>Mandatory training on communication, equality, and person-centred care embedded into induction and ongoing development programmes. |
| Patient experience surveys | Monthly reporting of patient experience indicators, including FFT scores, complaint response times, and accessibility compliance.<br>Benchmarking of national surveys with appropriate action plans |
| CQC Improvement Programmes | Organisational and service level CQC ratings/validation<br>Peer review outcomes<br>Quality assurance visit outcomes |
| Ockenden/Amos reports | We are currently reviewing the reports and recommendations, once completed we will develop a programme of work to implement any recommendations |

**Gaps in control or assurance**

- Concerns about effective learning from complaints and patient experience surveys
- Ongoing concerns about response time to PALS concerns and formal complaints
- Regulatory breaches identified by the CQC across UEC and medicine (NGH) and maternity (KGH) in relation to the safe and caring domains.
- Increasing ambulance handover delays; Crowding within the ED and normalisation of boarding; Delayed supported discharges; Delays to planned care. NGH in tier 1 for the provision of UEC
- Kettering General Hospital remains on the maternity safety support programme due to safety and cultural concerns
- CYP urgent and emergency care remain under regional oversight due to safety concerns
- The financial position at UHN is significantly challenged - leading to a £80million CIP programme with proposed headcount reductions. Pressure to deliver savings rapidly could result in rushed implementation of CIPs without robust clinical engagement or risk mitigation, heightening risk of harm
- Deterioration in Staff Wellbeing and Psychological Safety: Ongoing uncertainty about job security and workload increases may lead to presenteeism, rising sickness, and reluctance to speak up - masking early signs of harm or dysfunction.
- Fundamental care compliance not consistently embedded
- Timely response to complaints and engagement with patients, families and carers and variability in engagement and accessibility
- Compliance with accessible information standards
- Implementation of the risk management policy across the group

**Risk Scores**

| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain and Risk Appetite |
|---|---|---|---|---|
| **Consequence** | 4 | 4 | 3 | Quality/Patient Experience Open |
| **Likelihood** | 4 | 4 | 4 | |
| **Risk Scores** | **16** | **16** | **12** | |




**Proposed Actions (by due date)**

- Perinatal safety programme in development to support delivery of MSSP exit criteria and expected enforcement notice from the CQC– April 2027
- CQC rapid improvement programme in place for UEC and medicine – Complete and sustainability programme in progress.
- UEC improvement programme alongside KGH/NGH Medicine length of stay oversight meeting is in place to improve flow in, through and out of the organisation - Oct 2026
- Robust QIA process in place to ensure safe delivery of CIP Programme. Clinical representation in place on all groups – Ongoing
- Launch of civility saves lives programme and ongoing roll out – launched April 2026 ongoing implementation
- Development of the EAF assessment and accreditation programme with fundamentals of care – Ongoing
- Accessible information standards working group developing a road map to compliance – Commenced March 2026
- Review of the corporate risk register across UHN – commenced and due for finalisation 31st August 2026
- Development of a patient experience strategy – Delayed September 2026, awaiting Head of Patient experience to start in August 2026
- Refresh of consent training for KGH maternity colleagues following CQC – Ongoing

**Q1 26/27 executive commentary**

During Q4 25/26, the Trust has continued to operate within a period of heightened regulatory scrutiny and operational pressure, with ongoing risks to the delivery of a consistently positive patient experience across UHN.
The Trust remains in a period of high regulatory activity overall. We are still awaiting the report following the CQC's revisit NGH maternity services following the failure of Quality Assurance processes identified during the previous inspection. Kettering General Hospital maternity services were inspected on 1 and 2 July 2026, with colleague engagement events occurring w/c 6 July. In addition, the KGH homebirth service remains suspended following a gap analysis, reflecting the Trust's commitment to safety while required improvements are implemented. These factors continue to contribute to regulatory and reputational risk and require sustained executive oversight.

In June 2026 the CQC published the NGH Well Led report with a rating of requires Improvement**.** Inspectors identified concerns around organisational culture, leadership behaviours, and staff confidence in speaking up. Whistle blower feedback highlighted issues with communication, discharge planning and involvement in care. The Trust is implementing actions to strengthen leadership visibility, governance processes and cultural improvement.

Patient experience metrics remain variable, particularly across urgent and emergency care (UEC). Friends and Family Test (FFT) performance shows inconsistency between services, with the most significant volatility seen in areas experiencing sustained crowding, ambulance handover delays and flow constraints. These pressures continue to affect privacy, dignity and timeliness of care, and align with CQC findings relating to patient experience within urgent care pathways, particularly at NGH.
Internal audit findings provide reasonable assurance that complaints are being managed in line with policy, with improvements in timeliness and responsiveness evident in several divisions. However, concerns persist regarding the consistency and depth of learning from complaints and patient feedback, limiting the Trust's ability to embed improvement uniformly at pace. We have recently appointed a new Head of patient Experience who will commence with the trust in August who will further develop and take forward improvement plans.
Children and Young People's urgent and emergency care services remain under regional oversight, following a coroner's verdict in 2024 and a comprehensive cultural review that identified issues relating to leadership, psychological safety and team functioning. While improvement activity is underway, these services continue to represent an area of heightened risk.
Notwithstanding these challenges, the Trust has completed the corporate nursing consultation, enabling the establishment of a single, unified Patient Experience Team across UHN. This new structure strengthens governance, improves consistency across complaints, PALS, bereavement and accessible information standards, and provides a more resilient platform to support divisions during periods of operational pressure.
In summary, while there is evidence of positive progress and areas of good practice. The Trust continues to face significant pressures that impact patient experience. The pace and consistency of improvement are not yet sufficient to reduce the overall risk score. Sustained leadership focus, disciplined delivery of priority actions, and continued cultural alignment are required to move the risk towards the target position.
The following actions are prioritised as having the greatest impact on reducing likelihood and consequence:

- Deliver and embed the unified Patient Experience operating model - Strengthens governance, consistency and learning across complaints, PALS, bereavement and engagement.
- Implement NLEAF assessment and accreditation for fundamentals of care - Directly addresses variability in basic care, dignity and experience.
- Complete and sustain CQC rapid improvement programmes (UEC, Medicine, Maternity) - Targets areas of regulatory breach and highest patient experience risk.
- Strengthen Freedom to Speak Up and psychological safety at ward and divisional level - improves early identification of risk, staff confidence and learning culture.
- Apply robust QIA and clinical assurance to the CIP programme - Mitigates risk of unintended harm arising from rapid cost-improvement delivery.

All other actions remain important but are secondary to the above in terms of risk reduction leverage.

| | |
|---|---|
| **Risk ID:** | UHN13 |
| **Strategic Priority:** | Strengthen our Culture/Transform Patient Care |
| **Risk Description:** | If UHN is unable to attract and retain high calibre staff then this may result in UHN being unable to deliver on our research and Development ambitions, resulting in UHN being unable to increase our research and clinical trial activities by 10% and where support to take an innovative role in healthcare research will not achieve the best possible outcomes for our patients. |
| **Key Deliverable:** | Take part in more research and commercial trials and studies to benefit patients |
| **Executive Lead:** | Medical Director |
| **Assurance Committee:** | Quality & Safety Committee |

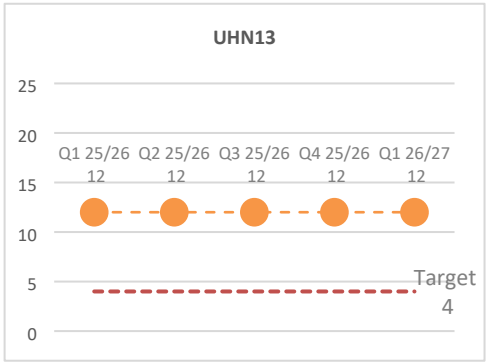
| Key Controls | Key Assurance |
|---|---|
| Agreed UHN UHL workstream on growing and developing | Academic research strategy oversight through UHN ILT |
| Research and trials portfolio. | Oversight through Quality and safety committee and UHN/UHL partnership board |
| Agreement of 11 workstreams | |

**Gaps in control or assurance**

Academic strategy has expired and requires review
Financial deficits
Impact of industrial actions

**Risk Scores**

| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain and Risk Appetite |
|---|---|---|---|---|
| **Consequence** | 4 | 4 | 4 | Innovation Open |
| **Likelihood** | 3 | 3 | 1 | |
| **Risk Scores** | **12** | **12** | **4** | |




**Proposed Actions (by due date)**

Progress the standardisation of academic and research governance, operational structures, and recruitment to key joint posts, while expanding opportunities for cross-organisational research and clinical trials. Planned completion: Q2 2026/27.
Undertake a review of clinical capacity and capability to ensure sufficient leadership and resource to support and accelerate service transformation and organisational change**.** Planned completion: Q2 2026/27.

**Q1 26/27 executive commentary**

- Joint **Research and Innovation Strategy** is currently being developed across UHN and UHL.
- **Director of Research and Innovation** has been appointed at UHN and is leading the implementation of the research agenda.
- **Director of Research** has also been appointed at UHL and is working collaboratively with the UHN Director to progress the joint research strategy and strengthen cross-organisational research delivery.
- Consultant job plans are being aligned across both organisations to provide protected time for research, supporting increased research participation, collaboration, and innovation.

| | |
|---|---|
| **Risk ID:** | UHN14 |
| **Strategic Priority:** | Improving Culture, Transforming Patient Care and Deliver our Financial Plan |
| **Risk Description:** | If estate buildings and infrastructure continue to deteriorate and/or fail, then delivery of services may be impacted resulting in delayed or sub-optimal patient care, safety of all persons and an inability to deliver key UHN strategies. |
| **Key Deliverable:** | Deliver our quality priorities (Safe and efficient physical infrastructure within which our staff can effectively treat patients). |
| **Executive Lead:** | Director of Strategy |
| **Assurance Committee:** | Strategic, Transformation and Digital Committee |

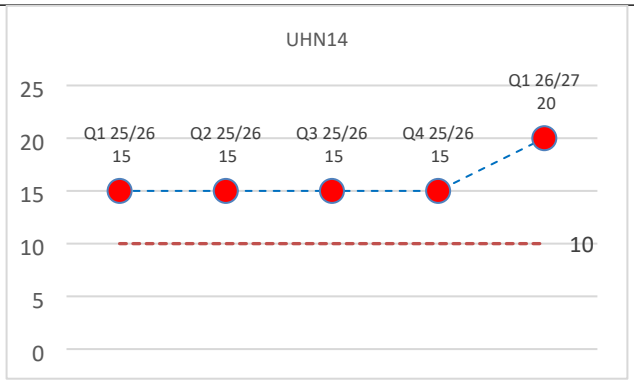
| **Key Controls** | **Key Assurance** |
|---|---|
| Kettering Hospital have a full Development Control Plan for the site and Northampton Hospital has a site masterplan. A Local Development Order has been signed with Kettering Planning Authority to cover all developments. | Kettering are part of the New Hospital Programme which will replace 70% of the Trust estate and 100% of the estate over 25 years old that is used for patients or staff. |
| NGH energy systems and aged steam infrastructure, Approval of KGH Energy Centre plans. Both these schemes reduce the hospitals reliance on fossil fuels. | KGH continues to engage with national and regional NHP meetings to regularly confirm its place and priority on the NHP programme. |
| Rockingham Wing at KGH have had funding to failsafe prop all RAAC concrete panels and have plans approved to build a decant extension. | Funding received for failsafe propping<br>SFBC submitted and approved in for the decant extension subject to Target Cost confirmation.<br>Funding received for Option Appraisal for RAAC removal. |
| All key estates infrastructure elements have independent AE (authorising engineers) appointed, annual audits and action plans in place; technical and trust meetings in place. | Monthly estates assurance report for each hospital is presented at Health and Safety Committee.<br>Technical meetings in place to review progress against audit plans (internal). |
| Business continuity plans and infrastructure resilience/backup systems are in place. | Estates infrastructure is regularly tested (internal).<br>Risk rated capital backlog plans in place (internal). |
| UHN estates backlog capital programme in place with applications for national funds to address critical safety issues made annually. | UHN capital committee (internal) oversees progress with agreed capital schemes. |
| Group Clinical Strategy approved which forms the basis of understanding what a UHN estates strategy needs to look like. | GSC Oversight group chaired by Joint CEO on a monthly basis that oversees progress. |

**Gaps in control or assurance**

- Many areas do not have an ability to effectively cool the environment with patient risk increasing in terms of their experience or access to treatment due to some areas being unable to continue care. Significant capital would be required to install adequate ventilation.
- NGH need to develop a full Development Control Plan to include how a sequence of developments over a time period will address the highest priority areas for our clinical services.
- NGH is not on the New Hospital Programme and has no secured funding route to develop the site.
- Whilst KGH is in wave 2 of NHP, there is not confirmed start date for the build.
- There is no financially approved plan to remove RAAC panels from Rockingham Wing.
- UHN Estates have had an initial meeting with EPRR and have committed to BCP workshop in Q1/Q2 2026/27. BCP plans to be formulated or reviewed with UHN EPRR manager.

**Risk Scores**

| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain and Risk Appetite |
|---|---|---|---|---|
| **Consequence** | 5 | 5 | 5 | Infrastructure Minimal |
| **Likelihood** | 3 | 4 | 2 | |
| **Risk Scores** | **15** | **20** | **10** | |




**Planned Actions (by due date)**

Funding secured relating to RAAC at KGH for the extension, and support given for an OBC for its entire removal.
NGH has completed the full site de-steam and are now seeing reductions in gas input (utility spend).
This is being tracked to enable us to quantify the value.
KGH have had their Energy Centre plans approved and have begun to replace their energy infrastructure. Due to complete September 2027.

**Q1 26/27 executive commentary**

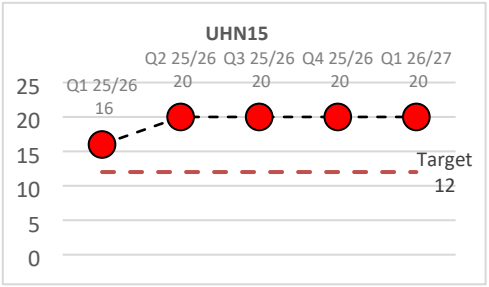
Climate change related heatwaves are increasing with our third so far in 2026. This has led to some patient cancellations and increased reported risks to our neonatal babies.
Full risk register overhaul at KGH and NGH complete, so a full and thorough understanding of the risk on both sites as relates to our estate is now known and documented.
NGH UTC scheme is due to complete in Q2 which releases the pressure in the current ED and start to allow for refurbishment in 2026. KGH and NGH have additional national capital allocation to refurbish their estate over the next 3 years including a new UTC at KGH.
C£25m award for a new Elective hub (subject to business case) will release some pressure and allow for theatres refurbishment programme on site.
KGH energy centre is on track.
NHSE national and regional meeting regarding the KGH site masterplan in order to further their support for continued work on Rockingham Wing, of which we are entering RIBA 4.
Critical infrastructure works and all BAU capital estates schemes are on track for delivery. NGH energy centre- NHSE CRIS scheme to replace steam boilers is complete. New LTHW boilers installed and operational. Efficiency savings are being achieved, with a significant reduction in gas input.
NGH Energy centre for CHP waste LTHW heat plate exchanger. Capex £860k Delivery Q4 25/26- Q1 26/27. This scheme has entered construction stage following in depth technical design and equipment manufacture. The scheme is later in actual delivery then the initial plan. This may affect the overall savings projections for 2026/27 due to heat load profiles.
09/04/2026- initial audits complete. Awaiting a couple of reports to progress further. Realign to Q1/Q2 2026/27.

| | |
|---|---|
| **Risk ID:** | UHN15 |
| **Strategic Priority:** | Transform Patient Care |
| **Risk Description:** | If there is insufficient capacity to meet the demand on services patients will wait longer for urgent and emergency care, elective care and cancer care leading to patient harm, compromised clinical outcomes and experience. |
| **Key Deliverable:** | Transform UEC and improve planned care access, working with partners to deliver care in the right place at the right time. |
| **Executive Lead:** | Chief Operating Officer (COO) |
| **Assurance Committee:** | Finance, Investment & Performance Committee |

| **Key Controls** | **Key Assurance** |
|---|---|
| Clinical prioritisation of patients and increased focus on specialties with high volumes of 52-week waiters and where forecast to be high waiting list growth. | ➢ Weekly tracking of clearance of long waiting patients in relation to national standards<br>➢ Monthly monitoring of performance against waiting time standards and other access metrics<br>➢ Clinical harm and root cause analysis reviews for patients who have waited too long on cancer or RTT patients<br>➢ External review of management of waiting lists conducted by the Elective Intensive Support Team; good assurance relating to longer waiting patients.<br>➢ Harm reporting through patient safety committee |
| Clinical prioritisation of cancer patients, regular pathway tracking of cancer patients and dissemination of reports | |
| Demand and capacity modelling to generate forecasts in performance and waiting list size to agree nature and level of intervention needed. | |
| Continued delivery and increase of virtual and face to face appointments, patient-initiated follow-ups and advice and guidance to release capacity and help reduce waiting times. | |
| Delivering the GIRFT recommendations including adoption of standardised clinical templates. | |
| Continued focus on theatre utilisation and cases per list to maximise use of available capacity. | |
| All patients who are not treated with their clinically timed pathway have a thematic review of their pathway and long waiters have a harm review through MDT | |
| Delivering the GIRFT recommendations including the implementation of the clinical operational standards. | ➢ Daily, weekly, monthly tracking of ambulance handover and time in department metrics<br>➢ Clinical harms and root cause analysis reviews for patients who have waiting too long on an ambulance or in the department<br>➢ Adherence to the UHN red lines<br>➢ UEC Delivery Board for system performance oversight |
| Continued improvement in length of stay across non-elective inpatient wards. | |
| Rapid Assessment Unit - new ambulance handover unit at NGH. | |
| Continued work to maximise admission avoidance opportunities such as SDEC | |
| Embedding the adherence to Internal Professional Standards | |
| Establishment of UHN red lines and maintain a zero tolerance to these | |
| Proactively engage in System transformation work to make improvements to patient pathways and demand management | |

| **Gaps in control or assurance** |
|---|
| Elective block contract means that we where we have a demand and capacity mismatch we currently to not have the income to mitigate the gap. We are moving to an activity based plan for 26/27.<br>Financial challenge means that we cannot use premium capacity to mitigate the gap.<br>No opportunity to expand G&A core bed capacity in support of UEC pathway.<br>No additional capacity available across DTA pathways resulting in delays to discharge.<br>Increase seen in emergency department attendances including conveyances against plan.<br>Initiatives and system ambitions in support of UEC delivery and winter are for partners to enact. |

| Risk Scores | | | | |
|---|---|---|---|---|
| | **Qtr 4 25/26** | **Qtr 1 26/27** | **Target Score** | **Risk Domain and** |
| **Consequence** | 4 | 4 | 4 | Activity Open |
| **Likelihood** | 5 | 5 | 3 | |
| **Risk Scores** | **20** | **20** | **12** | |




**Proposed Actions (by due date)**

- WLI policy in place for WLIs if there is a risk to cancer or long waits performance. This will be reviewed for the next financial year. Update on 26/27 plan ILT 20 April.
- Cancer Quality Improvement approach for 62 day being established to bring teams together around the pathway – to start with a tumour site at each hospital site. To commence April/May.
- UEC Steering Group providing oversight of performance against plan, 26/27 Divisional plans, further faster recommendations and service developments.
- Medicine LOS group setup since May led by CMO/CNO.
- Moulton Ward (33 bed escalation ward) opening at NGH from end of December 2026.
- UTC at NGH opens from September 2026
- Early winter planning with board approval of UHN winter plan in August 2026

**Q1 26/27 executive commentary**

- Strengthened data oversight in Divisional Accountability meetings for the key performance metrics, this is now in place
- Cancer performance is challenged currently, with significantly higher waiting lists and reduced performance. Recovery plans are in place for key tumour sites (Skin, Breast, Head and Neck) and we are engaging in MDT streamlining programmes.
- We delivered zero 65 week waits at year end and at a UHN level, less than 1% of the waiting list at 52 weeks or more.
- RTT performance remained behind plan for year end but we have agreed an ambitious yet deliverable plan for 2026/27 and we are on track for April performance.
- ED attendances are adverse to plan by up to 5% YTD, including conveyances up by almost 6%.
- Ambulance handovers across Northamptonshire have at times been significantly challenging during Q1 26/27, NGH delivering 61% in <45mins and KGH 83%.
- NGH 4hr (all types) performance YTD is 1% ahead of plan at 71%, KGH 4hr (all types) performance delivery YTD is 80%, 1% variance to plan.
- Adult G&A bed occupancy remains consistently high at 99-100%.
- Delivery of supported discharges remains adverse to system target impacting admitted flow from ED.

| | |
|---|---|
| **Risk ID:** | UHN16 |
| **Strategic Priority:** | Deliver our Financial Plan |
| **Risk Description:** | The risk of increased regulatory intervention (NHSE) and medium-term financial penalties (revenue and capital) arising from failure to deliver improvement in the underlying revenue position and delivery of a break-even financial position over the medium term. |
| **Key Deliverable:** | Achieve our financial plan targets, improving efficiency and productivity:<br>Under strategic priority to deliver financial plan - Development of a medium term robust financial plan (MTFP) with a focus on recurrent improvement |
| **Executive Lead:** | Chief Finance Officer |
| **Assurance Committee:** | Finance, Investment and Performance Committee |

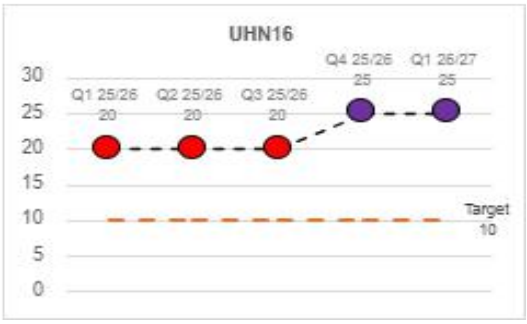
| Key Controls | Key Assurance |
|---|---|
| Business Planning framework to support budget setting, investment decisions and understanding of cost pressures over time | • NHS England revised planning guidance and timetable – NHSE will review and sign off plans in line with their national timetable |
| Assumptions on inflation and efficiency requirements to inform the MTFP time horizon | |
| Weekly Financial Recovery Group (chaired by the CFO) with all clinical and corporate divisions in attendance | • Weekly tracking of the gap in efficiency programme |
| Weekly Executive only Financial Recovery Group (chaired by the UHN managing Director) | • Weekly tracking of the corporate actions required to assure CIP delivery |
| Delivery Partnering team deployed across UHN to de-risk the in-year CIP programme | • Weekly assurance meeting with NHS England and CFO to monitor and manage the team |
| Business Partnering resource in place to support Directorates with financial management. | |
| External reporting to NHSE and Northamptonshire Integrated Care Board / System | • Annual External Audit Value for Money report |

**Gaps in control or assurance**

- A detailed 3-year plan which triangulates finance, activity and workforce based on the current underlying financial position
- Pipeline efficiency plans for future years
- Capacity of Divisional Teams to focus on the recovery agenda when faced with competing priorities

**Risk Scores**

| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain and Risk Appetite |
|---|---|---|---|---|
| **Consequence** | 5 | 5 | 5 | Finance Minimal |
| **Likelihood** | 5 | 5 | 2 | |
| **Risk Scores** | **25** | **25** | **10** | |




**Action updates (by due date)**

1. Development of a 3-year planning model which triangulates finance, activity and workforce – the three year model has been developed at a high level – this does not currently deliver the NHSE target trajectory
2. Engagement with the national NHSE workstreams on medium term planning - ongoing
3. Development of pipeline reporting for 2027/28 and 2028/29 efficiency programmes

**Q1 26/27 executive commentary**

The current 3 year planning exercise was submitted to NHS England in March. The position that NHS England have requested for UHN is challenging and will require a savings target well in excess of that within the published guidance in order to deliver. The current submission does not deliver the requested trajectory and discussions with NHS England remain ongoing.

| | |
|---|---|
| **Risk ID:** | UHN17 |
| **Strategic** | Deliver our Financial Plan |
| **Risk Description:** | The risk of increased regulatory intervention (NHSE), cash impacts and financial penalties arising from non-delivery of the 2026/27 financial plan. |
| **Key Deliverable:** | Achieve our financial plan targets, improving efficiency and productivity:<br>Strategic Priority: Deliver our Financial Plan - Delivery of our 26/27 financial plan and our workforce plan as a key component of financial plan delivery |
| **Executive Lead:** | Chief Finance Officer |
| **Assurance Committee:** | Finance, Investment and Performance Committee |

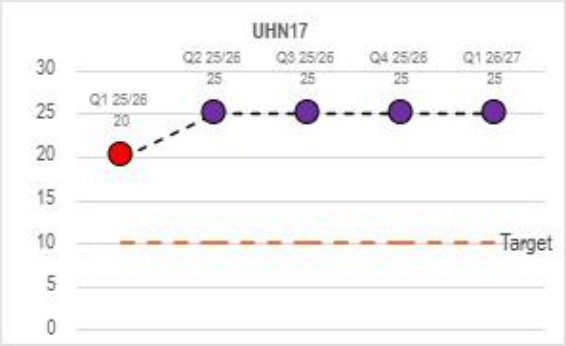
| Key Controls | Key Assurance |
|---|---|
| Monthly finance report to ILT, Finance, Investment and Performance Committee and as part of the IPR, to Board | • 2026/27 Financial Plan approved by UHN Board<br>• Submission of financial plan to ICB and NHSE<br>• Annual External Audit of Accounts and Value for Money report. |
| Monthly efficiency reporting to ILT, Finance, Investment and Performance Committee and as part of the IPR, to Board | • Monitoring delivery of efficiency plans by Finance Team |
| Weekly Financial Recovery Group (chaired by the CFO) with all clinical and corporate divisions in attendance | • Weekly tracking of the gap in efficiency programme |
| Weekly Executive only Financial Recovery Group (chaired by the UHN managing Director) | • Weekly tracking of the corporate actions required to assure CIP delivery |
| Delivery Partnering team deployed across UHN to de-risk the in-year CIP programme | • Weekly assurance meeting with NHS England and CFO to monitor and manage the team |
| SFIs, SO's and Scheme of Delegation, supported by detailed budgets | • Audit Committee reporting and review of all exceptions (waivers, mavericks etc.) |
| Revised Budget Holder Training implemented across UHN | • Use of the Budget Holder Power BI dashboard |
| Business Partnering resource in place to support Directorates with financial management. | |
| Monthly Divisional Accountability Meetings | • Reported regularly to Integrated Leadership Team |
| Programme of internal audit review of financial management arrangements | • Head of Internal Audit Opinion |
| External reporting to NHSE and Northamptonshire Integrated Care Board / System | • Annual External Audit of Accounts and Value for Money report |

## Gaps in control or assurance

- The plans for both Trusts are considered non-compliant and sign-off is still awaited from NHS England
- Cash impacts of lack of DSF manifesting in working capital controls for both Trusts
- Efficiency programme not fully identified for the 2026/27 financial year
- Triangulation of finance budgets with workforce establishment and activity
- Capacity of Divisional Teams to focus on the recovery agenda when faced with competing priorities
- Finance and Procurement teams currently have capacity gaps within the function due to sickness and recruitment / retention

## Risk Scores

| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain and Risk Appetite |
|---|---|---|---|---|
| **Consequence** | 5 | 5 | 5 | Finance Minimal |
| **Likelihood** | 5 | 5 | 2 | |
| **Risk Scores** | **25** | **25** | **10** | |




## Action updates (by due date)

1. Delivery partner to focus on reductions in run-rate, with a particular focus on workforce.
2. Ensure capacity issues addressed as part of team structure review – Restructuring will begin in July 2026.
3. Use of the One NHS Finance development tools to support professional development and talent management across finance – Ongoing
4. Reduce use of exceptions in relation to procurement, locally described as maverick and waivers, only use direct awards where appropriate and drive value through documented outcome-based specifications – ongoing

## Qtr 1 26/27 executive commentary

The financial position of UHN at Month 2 reports a deficit of £21.7m (£9.3m KGH, £12.4m NGH) which was substantively a break-even against plan at this point in the year. It should remain noted that the plan is non-compliant and as such not approved.

| | |
|---|---|
| **Risk ID:** | UHN18 |
| **Strategic Priority:** | Strengthen our culture |
| **Risk Description:** | Failure to address poor behaviours in the workplace or to provide key components of a safe workplace culture will lead to a culture in which colleagues feel unsafe and under-valued, unsupported or excluded, resulting in poor staff engagement, retention and morale, elevated sickness absence and will ultimately impact patient care. |
| **Key Deliverable:** | Address staff survey feedback though our People Plan, focusing on compassionate and inclusive behaviours. |
| **Executive Lead:** | Chief People Officer |
| **Assurance Committee:** | People Committee |

| Key Controls | Key Assurance |
|---|---|
| UHN induction programme (UHN Welcome day) | Numbers attending, qualitative feedback |
| Learning and development programmes for all professional groups incl. mandatory training and leadership development | Mandatory training rates course uptake rates, qualitative feedback |
| UHN values-based appraisal | Appraisal completion rates, qualitative feedback |
| Belonging strategy and associated plans | WRES and WDES and gender/race pay gap reports |
| Health and wellbeing strategy | Absence rates (IPR), Turnover rate (IPR) |
| People Promise culture programme including Civility, Flex @ UHN and sexual safety | Turnover rates (IPR), Report and Support concerns raised |
| Safe staffing processes, use of acuity tools, and prioritised workforce deployment. QIA process | Safe staffing report to Board |
| Exit interview and local intelligence | Exit interview analysis and creation of new SOP |
| Freedom to speak up service | FTSU quarterly and annual reports to People Committee |
| Violence and aggression reduction group | Reports of violence and aggression to colleagues, Staff survey feedback |
| Staff engagement and Reward and Recognition strategies | Staff engagement score reported to People Committee. Culture Assurance Group oversight to People Committee |
| Resident Doctor Ten-Point Plan actions | Ten-point plan assurance report to People Committee. |
| Leadership visibility | Leadership and Visibility delivery plan in place via the Strengthening our Culture programme |
| Strengthening Our Culture plan | A plan with associated metrics that is reported to People Committee that brings together initiatives covering Leadership visibility, engagement and communications, behaviours and values, health & wellbeing, belonging and career development and CI. |

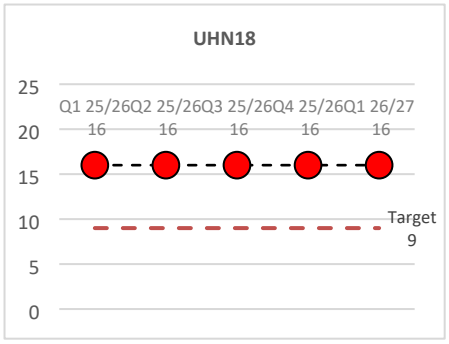
**Gaps in control or assurance**

Staff engagement score is low, but stabilised at KGH and reducing at NGH
Although some improvement has been seen in equality data, levels of discrimination remain too high.
Exit interview completion rates are low and the data is not used to inform improvements.
Appraisal rates below target in some areas, particularly in NGH
Medical and dental compliance with mandatory training reports consistently below threshold
Freedom to Speak up service requires strengthening with c.50% of colleagues with confidence in FTSU
Theme of anonymous reporting of concerns/pattern of whistleblowing through anonymous letters to executive and board members.
Delays in Occupational Health Service time to clear pre-employment screening and time to 1st management referral appointment from triage.

**Risk Scores**

| | Qtr. 4 25/26 | Qtr. 1 26/27 | Target Score | Risk Domain and Risk Appetite |
|---|---|---|---|---|
| **Consequence** | 4 | 4 | 3 | Culture minimal |
| **Likelihood** | 4 | 4 | 3 | |

| Risk Scores | 16 | 16 | 9 | |
|---|---|---|---|---|




## Planned Actions (by due date)

- **We Belong:** NSS aligned reporting and We Belong delivery plan 2026 actions (due dates in plan)
- **Staff survey response/Strengthening our Culture Plans**: Corporate and divisional 2026 delivery plans (due dates in plan).
- **NSS** fieldwork plans for 2026 to be created and delivered with an increased field work window to maximise opportunities for colleagues to have their voice heard (November 2026)
- **Civility –** roll out programme. Continue to embed within maternity
- **Leadership Development**: Develop Leadership Strategy linked to the new national Leadership and Management Framework. October 2026.
- **Health & Wellbeing:** development and monitoring of the unified UHN clinical referral and triage system automation, monitor engagement and impact (July 2026).
- **Preventative health measures** - Training for the Menopause Policy, H&WB at Work Policy and the Stress at Work management processes and completion of organisational stress risk assessment by August 2026.
- **OH system** - Implement a new OH management system (Feb 2027)
- **Appraisal** – focus on aligned reporting, training and embedding new staff standard MALF assessments by September 2026
- **Speaking up** –Monitor FTSU volume through new provider to maintain assurance that it is working appropriately September 2026.
- **Metrics**- development of the Culture Dashboard to Bellwether metrics August 2026.
- **Sexual safety** – improvement actions and assessment against programme due by end of July 2026
- **Management of change** – continuation of MOC programmes with expected commencement of Innovating Care processes MoC between August-Dec 2026.
- **Medical Mandatory training compliance** – implement new process with the MD office to support compliance September 2026
- **NHS Staff Standards** - Complete a self-assessment against the NHS Staff Standards to identify gaps and create an action plan through Strengthening Our Culture work (Sept 2026)

## Qtr. 1 26/27 Executive Commentary

- **Civility Launch**: Programme Delivery of phase 2
- **Maternity Support**: Targeted interventions supporting maternity teams at both NGH & KGH. This includes leadership development, 'Stay & Thrive' retention programme, Healthy Teams programme and cultural support.
- **Sexual Safety Audit**: plans aligned to address audit gaps scoped.
- **Reasonable Adjustments**: Pilot monitoring of requests for 12 months underway
- **NSS Engagement**: Responses received, Corporate plans completed and Divisional plans underway with ongoing support and assurance via Strengthening our Culture Group.
- **Management of Change (MoC) Support**: Continued support to teams undergoing MoC programmes and service redesign including Innovating Care Processes and redesigning new admin model
- **Freedom to speak up training** applied to all colleagues' profiles. Reset for KGH and newly for NGH.
- **Strengthening our Cultural Group (SOCG)**: refreshed TOR and workstream delivery plans
- **Culture Dashboard**: key metrics refreshed, quarter 4 position (as baseline) with end of May position used as first upward report on progress

| | |
|---|---|
| **Risk ID:** | UHN19 |
| **Strategic Priority:** | Deliver the workforce plan in support of our financial plan |
| **Risk Description:** | A robust resourcing and workforce controls strategy in support of our workforce plan is required to ensure the provision of safe patient care whilst managing workforce numbers and costs. Failure to deliver the workforce plan will lead to inefficient use of resources (skill gaps in areas covered by bank or agency or over-establishment use driving inefficiency) creating financial pressures and constraints and having a negative impact on the quality of patient care. |
| **Key Deliverable:** | Achieve our financial plan targets, improving efficiency and productivity |
| **Executive Lead:** | Chief People Officer |
| **Assurance Committee:** | People Committee |

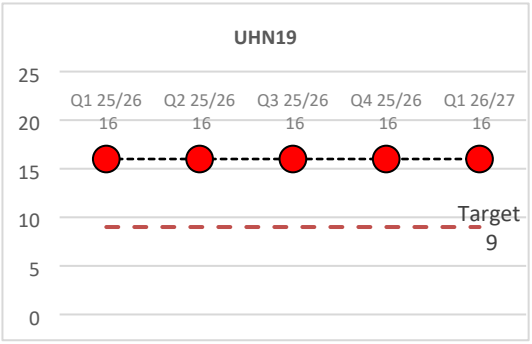
| Key Controls | Key Assurance |
|---|---|
| Establishment control | Planned and Actual WTE and progress against target reductions monitored by Finance and Investment and People Committees |
| Vacancy control | Vacancy rates, Time to Hire and progress against targets monitored by Finance and Investment and People Committees and Divisional Assurance Meetings. |
| Temporary staffing controls | Bank and Agency usage and progress against target reductions reported to and monitored by Finance and Investment and People Committees and Divisional Assurance Meetings. |
| Safe Staffing reviews | Safe Staffing report to Board. Daily staffing huddles to mitigate gaps and regular monitoring of safe staffing oversight at NMWAHP Performance and Productivity Board |
| Targeted recruitment activity | Progress monitored by People Committee and Workforce Programme Board |
| Roster optimisation | SNCT, establishment and workforce controls built into rostering tools |
| Minimising pay leakage | Workforce controls aligned with terms and conditions built into roster tools. Monitor progress to Finance & Investment, People Committee and Workforce Programme Board |
| Sickness Absence Improvement Plans | Progress with initiatives and impact on sickness absence rates reported to People Committee |
| Focus on improved ER Case Management | Progress with initiatives and impact on case management reported to People Committee |
| Development of strategic workforce plans | Monitoring delivery of Divisional/corporate workforce plans at Divisional Assurance Meetings and Workforce Programme Board |
| Delivering workforce change/transformation initiatives | Progress on people related change and transformation initiatives reported to People Committee and Workforce Programme Board |
| Use of apprenticeship levy | Take up of apprenticeships for new starters and as development pathways |
| Programmes of work to improve retention | Progress with initiatives and impact on turnover and vacancy rates reported to People Committee |

**Gaps in control or assurance**

- There is a significant gap in our workforce plan to deliver the required reduction in WTE in 2026/27
- Workforce analytics and forecasting tools need strengthening to inform decision-making
- Workforce planning is a “once a year” process (IBP) which misses the opportunity to create multi-year workforce plans
- Transformation plans are required to deliver the magnitude of improvement required
- Establishment control in ESR needs to be strengthened (focus NGH)
- Vacancy control compliance to be strengthened alongside targets for workforce reduction
- Time to Hire (TTH) target 60 days is not met.

- Rostering is not fully embedded across the organisation resulting in inconsistent application of Terms and Conditions

| Risk Scores | | | | |
|---|---|---|---|---|
| | **Qtr. 4 25/26** | **Qtr. 1 26/27** | **Target Score** | **Risk Domain and Risk Appetite** |
| **Consequence** | 4 | 4 | 3 | Workforce Open |
| **Likelihood** | 4 | 4 | 3 | |
| **Risk Scores** | **16** | **16** | **9** | |




**Planned Actions (by due date)**

- Establishment control – implement new protocols August 2026 – February 2027
- Vacancy control – review and tighten controls, introduce compliance measures August 2026
- Zero vacancy rate on HCA, Housekeepers and Porters through targeted attraction strategies. September 2026
- Strengthen temporary staffing controls to minimise use, ensuring aligned with establishment and vacancy control measures September 2026
- Switch on collaborative medical bank across UHN and UHL August 2026
- Review end to end recruitment process to reduce TTH to 60 days. Optimise OH screening, automate shortlisting and onboarding March 2027
- Roster utilisation – SNCT, establishment and workforce controls need to be reflected in the Trust's rostering software, and accurate application of T&C. Phased review to ensure rosters fully optimised March 2027
- Pay leakage – programme of work to ensure payments aligned to T&C. Scope and prioritise opportunities August 2026
- Sickness absence improvement plan – implement plan to reduce sickness to 4.5% March 2027
- ER case management improvement plan – map caseload and develop plan including prevention measures October 2026
- Workforce analytics and forecasting tools need strengthening to inform decision making October 2026

**Qtr. 1 26/27 executive commentary**

- Development of full workforce metrics data pack and instigation of Workforce Programme Board reporting to Finance Recovery Group to provide data to support evidence based decisions and formal governance and oversight
- Focus on strengthening and reinforcing workforce controls, ensuring we manage turnover by controlling the numbers of new starters (prioritisation to those that replace bank/agency).
- Collaborative bank UHL and UHN open to doctors. Onboarding processes underway
- Commenced centralisation of annual leave within rostering team to strengthen control and availability at NGH.
- Significant change programme in both corporate teams and divisional teams delivering both integration and CIP benefit. Additional resource approved to support People Services facilitation of change processes.
- Significant focus on nursing recruitment resulting in reduction in vacancy rate from 10% to 5% at KGH YOY
- Support to divisions to identify workforce plans 2026/27 with c.50% reductions identified by end Q1
- Development of sickness absence improvement plan
- KGH OH service recovery following service impacts Q4.

| | |
|---|---|
| **Risk ID:** | UHN20 |
| **Strategic Priority:** | Transform patient care |
| **Risk Description:** | If there are delays in the delivery of the collaborative working model with UHL this will impact on improving productivity and creating joint plans which will impact on the trust being able to deliver seamless pathways and improve patient safety and outcomes for our patients. |
| **Key Deliverable:** | Deliver our Group Clinical Strategy and Corporate Plans – realising group benefits through service reconfiguration and shared care pathways/Work with partners to provide proactive neighbourhood care across communities/Bring KGH and NGH services closer together to create safer, more seamless patient care:<br>1. Further strengthen the integration of clinical and corporate services across UHN to deliver seamless patient pathways, enhance patient safety, and improve clinical outcomes.<br>2. Build on the collaborative partnership with UHL to improve productivity, maximise shared opportunities, and develop aligned clinical and corporate service plans where these deliver greater value for patients and the organisation.<br>3. Accelerate the integration of patient care across secondary, community and primary care settings, removing organisational barriers to deliver more coordinated, person-centred care closer to home. |
| **Executive Lead:** | Medical Director, Hemant Nemade |
| **Assurance Committee:** | Quality and Safety Committee |

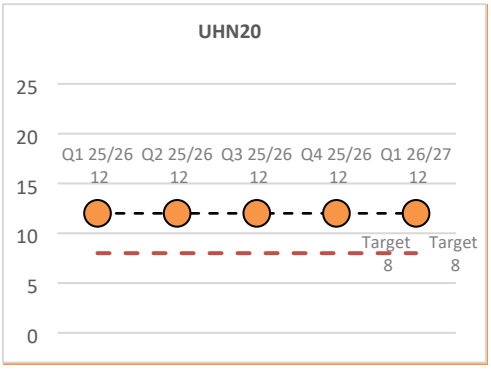
| Key Controls | Key Assurance |
|---|---|
| Clinical strategy group initiated across UHN / UHL | UHN Board Governance updates |
| Oversight through UHN Integrated Leadership Team (ILT) | ILT updates and assurance |
| Clinical strategy | UHN/UHL Partnership Board |
| Phased work that focuses on integration of specific services. | External reviews |

**Gaps in control or assurance**

Resource constraints – clinical and project resource (Industrial action, financial deficit.
Ability to influence systemwide patient pathway changes

**Risk Scores**

| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain and Risk Appetite |
|---|---|---|---|---|
| **Consequence** | 4 | 4 | 4 | Patient Safety<br>Minimal |
| **Likelihood** | 3 | 3 | 2 | |
| **Risk Scores** | **12** | **12** | **8** | |




**Action updates (by due date)**

**Spinal, Plastics and Haematology**

- **By September 2026:** Increase spinal capacity to improve access for urgent and complex UHN patients while reducing waiting times for Plastics and Haematology services.
- **By December 2026:** Streamline referral and triage pathways, including development of an MSK Hub, to improve consistency of access across both organisations.

- **By April 2027:** Deliver integrated and sustainable service models that enhance patient experience, improve clinical outcomes and strengthen service resilience.

**Nuclear Medicine**

- **By September 2026:** Complete the Nuclear Medicine TUPE transfer.
- **By March 2027:** Establish a more resilient and sustainable Nuclear Medicine service, improving continuity and quality of care for patients.

**Frailty**

- Undertake a joint UHL-UHN online survey and workforce mapping exercise to identify opportunities for service improvement.
- Identify potential 2026/27 financial efficiency opportunities through a collaborative workshop to review and agree the proposed Frailty Target Operating Model.
- Develop a shared improvement programme to support more consistent, integrated frailty services across the Group.

**Neighbourhoods and Population Health**

- Share learning from existing neighbourhood pilots and develop a joint approach to population health management.
- **Q2–Q3 2026/27:** Agree targeted UHL-UHN neighbourhood plans with partners for priority populations and geographical areas.
- **From Q4 2026/27 onwards:** Implement agreed "left-shift" interventions to reduce urgent and emergency care demand.
- **Patient benefit:** More timely care delivered closer to home, improved access to community-based services and better flow through urgent care pathways.

**Maternity, Neonatal and Children & Young People's Services**

- Complete a comprehensive review of current services, including strengths, weaknesses, opportunities and threats, workforce gaps, service pressures, geographical provision, outpatient demand and capacity modelling.
- Engage clinicians across the Group through surveys and co-design workshops to develop a shared vision and future service configuration.
- The outputs will inform sustainable models of care that improve access, workforce resilience and patient outcomes across maternity, neonatal and children's services.

**Cancer Services**

- A joint Cancer Strategy Conference held successfully in Lutterworth on **24 April** to showcase early achievements from the Group Clinical Strategy and agree future priorities.
- Oncology proposals will be reviewed collaboratively with tumour site leads, diagnostics, nursing, cancer teams, primary care, corporate services and commissioners to support delivery of a consistent, high-quality cancer service across the Group.

**Improving Access to Elective Care**

- Planned Care leads across UHL and UHN have established shared priorities for outpatient transformation.
- Initial focus areas include:
  - Greater use of digital technology and AI to improve outpatient productivity.
  - Enhanced advice and guidance services and referral pathways.
  - Pathway redesign for priority specialties.
  - Development of elective and neighbourhood hubs.
- **From Q4 2026/27:** Patients are expected to benefit from improved outpatient efficiency, more streamlined referral pathways and enhanced digital solutions.
- **From 2027/28 onwards:** Longer-term service redesign, including neighbourhood hubs and redesigned clinical pathways, will provide care closer to home, improve access and reduce waiting times.

**Q1 26/27 executive commentary**

The Group Clinical Strategy has now been published, and implementation is underway with dedicated Senior Responsible Officer (SRO) leadership and Programme Management Office (PMO) support.
Project leads have been appointed across all six strategic domains and are working collaboratively with the Strategy Team to identify and deliver opportunities for joint working that will improve patient care and outcomes.
Detailed implementation plans have already been developed in several priority areas, including Haematology, Plastics, Spinal Services and Nuclear Medicine. Other workstreams are progressing their plans through collaborative clinical engagement. For example, the Cancer programme will bring together regional and local commissioners, oncology teams and wider stakeholders to develop a comprehensive implementation plan. Similarly, the Maternity, Neonatal and Children & Young People's programme is convening multidisciplinary teams from across UHL and UHN to co-design future service models that improve quality, access, sustainability and patient outcomes across the Group.

| | |
|---|---|
| **Risk ID:** | UHN21 |
| **Strategic Priority:** | Transform Patient Care |
| **Risk Description:** | Failure to maintain effective cyber security and digital resilience across UHN may result in cyber-attack, malware infection, unauthorised access to data, disruption to critical digital services, regulatory action, reputational damage and potential impact to patient care.<br>The current risk position is driven by legacy infrastructure, patching performance, supplier assurance, identity and access controls, asset visibility, SOC/SIEM transition to business as usual, and the maturity of cyber response and recovery arrangements. |
| **Key Deliverable:** | Continue our Group One Digital Journey to become more data and digitally driven<br>(Maintain and improve UHN cyber resilience through effective cyber risk management, CAF-aligned assurance reporting, SOC/SIEM operationalisation, legacy infrastructure remediation, patching improvement, supplier assurance, identity and access governance, asset visibility, and continued development of a sustainable group cyber operating model). |
| **Executive Lead:** | Group Chief Digital Information Officer |
| **Assurance Committee:** | Operational Performance Committee (to transfer to new committee) |

| **Key Controls** | **Key Assurance** |
|---|---|
| Defence-in-depth cyber controls are in place across UHN, including endpoint protection, security monitoring, vulnerability response, identity and privileged access controls, supplier assurance, cyber awareness activity and incident response arrangements. | DSPT and CAF evidence, audit actions and cyber risks are tracked through monthly cyber governance arrangements, CDSOM reporting and board assurance activity. |
| Rapid7 SOC/SIEM capability is operational at MVP level, with active monitoring for agreed sources. Further work continues to complete service readiness, ownership arrangements, evidence packs and transition into business as usual. | CDSOM upward reporting confirms improving cyber risk visibility through CAF alignment, with further work required to strengthen review discipline, reporting consistency and UHN/UHL alignment. |
| Microsoft Defender for Endpoint, CareCERT / NHS CSOC alerting, vulnerability monitoring, firewall controls and agreed log-source monitoring provide operational visibility of cyber threats and vulnerabilities. | UHN Cyber Board assurance reporting identifies the main areas of residual risk as legacy technology, third-party and supplier exposure, patching consistency, access control maturity, asset visibility and cyber response and recovery arrangements. |
| Cyber risk is reviewed through established governance routes, including monthly CDSOM reporting, upward reporting to DRGB, CAF-aligned risk reporting. | The CAF-aligned cyber risk register provides a clearer view of risks across Digital, Cyber, Data Security, Infrastructure and operational domains, with ongoing work to rationalise duplicate or legacy risk entries. |
| Supplier and project cyber assurance is supported through the Digital Front Door and cyber pre-assessment process, helping ensure cyber, DSP and clinical safety requirements are identified before implementation. | Updates via established governance reporting routes provide regular assurance on key cyber activity, including SOC/SIEM transition, legacy infrastructure risk reduction, supplier assurance, Information Asset Register and asset visibility, DSPT evidence, CAF alignment and board assurance activity. |
| Legacy infrastructure remediation is being progressed through lifecycle planning, submission of group wide Digital Work Request 3065, PMO engagement, ownership mapping and planning for Windows Server 2016 and wider unsupported technology risks. | The NHSE Frontline Productivity cyber initiatives and funding submission supports the development of a more unified cyber capability, including SOC/SIEM maturity, threat detection, response capability and reduction of critical/high vulnerabilities. |
| Patch management improvement activity is in place to standardise KGH and NGH processes, review device scope and exclusions, improve off-network patching, and adopt a consistent deployment model. | The patch management action plan provides a defined route to improve patch compliance across KGH and NGH through process standardisation, deployment ring testing, scope validation and ongoing performance monitoring. |
| Frontline Productivity cyber investment and Target Operating Model work is progressing to support a more sustainable, risk-led cyber operating model across Security Operations, Governance Risk and Compliance, Vulnerability and Threat Management, and wider operational cyber capability. | The proposed Group Cyber TOM supports the move from a compliance-led model to a more operationally owned, risk-led cyber function aligned to One Digital and the wider ICS “Defend as One” direction. |

**Gaps in control or assurance**

**1) Overarching cyber risk alignment**

The BAF position should continue to align with the current corporate cyber risk profile, while also reflecting the latest operational assurance, CAF reporting and Group cyber governance position.

Unsupported and end-of-life software remains an ongoing and recurring risk as systems and applications naturally reach end of support over time.

**2) SOC/SIEM transition**

Rapid7 capability is operational at MVP level; however, full transition into business as usual remains dependent on completion of service acceptance, ownership arrangements, escalation processes, evidence packs and support model agreement.

**3) Legacy infrastructure**

Unsupported and ageing server infrastructure remains as a high cyber risk across UHN, with Windows Server 2016 lifecycle pressure and remediation capacity/ownership dependencies requiring continued executive focus.

**4) Patching**

Endpoint patching remains variable. A standardised KGH/NGH process, deployment ring model, exclusion review and remote connectivity improvements are being developed to improve compliance

**5) Asset visibility**

Information Asset Register Platform improvements and wider asset visibility remain key dependencies for incident response, DSPT evidence, ownership mapping and resilience planning.

**6) Supplier and project assurance**

Cyber, DSP and clinical safety checks are not yet consistently triggered through the one digital front door route.

The end-to-end governance pathway requires further embedding across projects, suppliers and operational teams.

**7) Operating model and capacity**

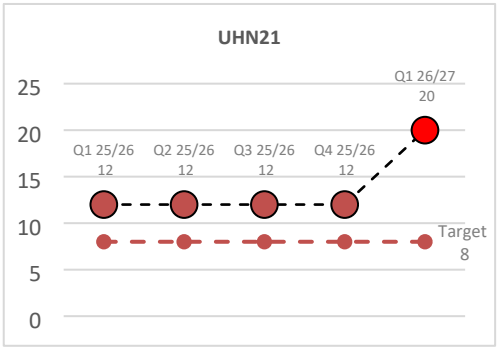
Current cyber capability is improving but remains dependent on successful Cyber TOM progression, NHSE Frontline Productivity cyber funding decisions, role development and sustainable service ownership.

**8) UHN/UHL alignment**

Cyber BAF and risk positions require alignment across UHN and UHL to support a consistent Group cyber assurance position.

**Risk Scores**

| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain and Risk Appetite |
|---|---|---|---|---|
| **Consequence** | 4 | 5 | 5 | Information<br>Minimal |
| **Likelihood** | 3 | 4 | 2 | |
| **Risk Scores** | **12** | **20** | **10** | |




**Risk Score Rationale**

The Q1 26/27 score is recommended to increase to **20**, reflecting the current corporate cyber risk position and the continued exposure from legacy infrastructure, SOC/SIEM transition, patching performance, supplier assurance, identity and access controls, asset visibility, and cyber response and recovery maturity.

The score reflects the potential impact of a significant cyber incident on patient care, operational continuity, sensitive data, regulatory compliance and organisational reputation. Although governance and assurance have strengthened, the residual risk remains significant until the key control improvements and remediation activities are further embedded.

**Planned Actions (by due date)**

1) Complete SOC/SIEM service acceptance and BAU transition for Rapid7, including defined ownership, escalation model, evidence packs, support arrangements and service readiness sign-off. Q2 2026/27
2) Progress the legacy server lifecycle programme, including IT Work Request 3065, Windows Server 2016 planning, ownership mapping, PMO support and consolidated UHN/UHL remediation planning. Q2 2026/27
3) Deliver the patch management improvement plan across KGH and NGH, adopting a standardised SOP, deployment rings, exclusion review and improved remote connectivity for off-network devices. Q2 2026/27
4) Continue rationalisation of the UHN cyber risk register aligned to CAF objectives, reducing duplication, improving ownership, separating cyber/DSP/operational risks, and strengthening review date discipline. Q2 2026/27
5) Progress Information Asset Register / Galileo and asset visibility activity, including ownership, milestones and evidence routes for DSPT, incident response and resilience planning. Q3 2026/27
6) Embed the Digital Front Door and cyber pre-assessment process so supplier, project, clinical safety and DSP checks are consistently triggered before implementation. Q2 2026/27
7) Continue monthly CDSOM reporting and CAF-aligned board assurance updates, ensuring the same cyber risk narrative flows through operational, executive and BAF reporting. – In Progress
8) Progress Frontline Productivity cyber funding and TOM activity, including role development, implementation planning and alignment with ICS executive paper development. Q2 2026/27
9) Continue Human Risk Programme, Digital Champions and cyber awareness activity to support behavioural risk reduction and staff engagement. – In Progress

**Qtr 1 26/27 executive commentary**

- UHN21 has been reviewed and updated to reflect the current UHN cyber risk and assurance position, including the latest position on SOC/SIEM transition, legacy infrastructure, patching performance, supplier and project assurance, asset visibility, and the wider cyber operating model.
- The Q1 26/27 risk score is recommended to increase to 20, reflecting the current corporate cyber risk profile and the continued exposure from legacy infrastructure, SOC/SIEM transition to business as usual, patching performance, supplier assurance, identity and access controls, asset visibility, and cyber response and recovery maturity.
- Governance and reporting have strengthened through monthly CDSOM reporting, CAF-aligned risk reporting, board assurance activity and regular updates through established executive reporting routes. This provides a clearer and more consistent view of cyber risk, controls, assurance and delivery progress.
- SOC/SIEM capability is operational at MVP level through Rapid7, with active monitoring in place for agreed sources. The priority for Q2 2026/27 is to complete service acceptance and transition into business as usual, including ownership, escalation arrangements, evidence packs, support model and service readiness sign-off.
- Legacy infrastructure remains a significant area of residual cyber risk. The priority for Q2 2026/27 is to progress the legacy server lifecycle programme, including IT Work Request 3065, Windows Server 2016 planning, ownership mapping, PMO support and consolidated UHN/UHL remediation planning.
- Patch management remains a core control improvement area. The priority for Q2 2026/27 is to deliver the KGH and NGH patch management improvement plan, including standardised processes, deployment rings, exclusion review and improved remote connectivity for off-network devices.
- CAF-aligned cyber risk reporting continues to mature. The priority for Q2 2026/27 is to continue rationalising the UHN cyber risk register, reducing duplication, improving ownership, separating cyber, DSP and operational risks, and strengthening review date discipline.
- Supplier and project assurance remains an important area of focus. The priority for Q2 2026/27 is to further embed the Digital Front Door and cyber pre-assessment process so that cyber, DSP and clinical safety checks are consistently triggered before implementation.
- Asset visibility remains a key dependency for cyber assurance, incident response, DSPT evidence, ownership mapping and resilience planning. The Information Asset Register / Galileo asset management project is planned to address and progress this through Q3 2026/27.
- Frontline Productivity cyber funding and Target Operating Model activity remain key enablers for a sustainable cyber operating model. The priority for Q2 2026/27 is to continue role development, implementation planning and alignment with the wider ICS Cyber TOM.
- Human Risk Programme, Digital Champions and cyber awareness activity will continue as an ongoing control to support behavioural risk reduction and staff engagement.
- Overall focus for Q2 2026/27 is therefore on completing SOC/SIEM BAU transition, progressing legacy server remediation, improving patching controls, rationalising the cyber risk register, embedding supplier and project assurance routes, and progressing the group cyber-TOM.

Asset visibility and Information Asset Register improvements remain a key dependency and are planned to progress through Q3 2026/27.

| | |
|---|---|
| **Risk ID:** | UHN22 |
| **Strategic Priority:** | Deliver our Financial Plan |
| **Risk Description:** | If we do not eliminate our greenhouse gas emissions, limit our impact on the environment and take action to achieve our net zero targets then we will fail to be compliant with UK legislation, NHS targets, and our own publicly declared ambitions leading to potential patient harm to patients and staff through pollution and service outages, an increase in waste, inefficiency and spend and potential regulatory action from failing to meet Trust, NHS and legislative targets. |
| **Key Deliverable:** | Deliver our Group Clinical Strategy and Corporate Plans – realising group benefits through service reconfiguration and shared care pathways (Reduction in wasted resources and carbon emissions) |
| **Executive Lead:** | Director of Strategy |
| **Assurance Committee:** | Strategic Transformation and Digital Committee |

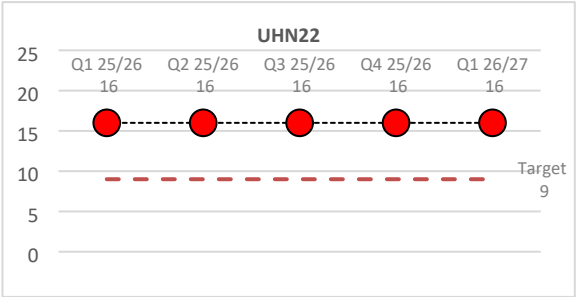
| **Key Controls** | **Key Assurance** |
|---|---|
| Carbon footprint reported annually through Annual Report and ERIC data | NGH – third party verification of data through Investors in the Environment |
| Board approved sustainability plans; submitted to Greener NHS | NGH – monitored via SD Committee |
| Carbon management plans commissioned from external consultant for NGH and KGH | Strategy, Transformation and Digital Committee |
| Task force for climate related financial disclosure in annual report | Strategy, Transformation and Digital Committee |
| Energy scheme at NGH | Carbon emissions monitored through Carbon Energy Fund – relates to items under the two energy schemes only |
| New Energy Centre at KGH planned for commissioning in 2027 | Energy Centre Project Board |
| Programme of environmental projects | NGH - Monitored through the SD Committee, Sustainable Surgery and Greener Nursing and AHP group. |
| Renewable energy projects | NGH – metering and annual reporting (iiE and UHN Board), also monitored through the CEF contract |

**Gaps in control or assurance**

- The high level data for Scope 3 carbon emissions has been released by Greener NHS but does not give the granularity required to target specific areas and spends – this would require further reports from finance and an additional spend on an external review.
- There has been no sustainability resource utilised at KGH and there have been gaps in the reporting for some of the carbon emissions.
- KGH carbon management plans revolved around the New Hospital Programme; if this is not forthcoming then targets are likely to be missed as much of the reduction projected relates to demolition and replacement of buildings.
- UHN still uses gas boilers for heating and hot water. Carbon emission reductions are at risk from the additional installation of further fossil fuel boilers using the Critical Infrastructure funding, albeit, these will be more efficient and therefore reduce carbon emissions. The nature of the two estates means that there is limited room for onsite renewable production and will be reliant on further grid decarbonisation. In the case of NGH, most buildings are poorly insulated; to remedy this will cost several million pounds. Funding constraints make this difficult to remedy.
- Changes to carbon emissions from business mileage have not been tackled, these may increase with expected working across sites
- The majority of work to reach net zero will require changes in the way that care is delivered. This requires more education and engagement – currently there is no mandated sustainability training, although it is available on ESR, and it has not been yet been included in any QI training. Limited resource within the Sustainability team reduces the direct influence.

There is resistance to the removal of nitrous oxide manifolds at KGH from the anaesthetists – the Royal College and Association of Anaesthetists have issued a position statement advocating the removal. There is no reason that the successful implementation at NGH cannot be repeated.

| Risk Scores | | | | |
|---|---|---|---|---|
| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain and Risk Appetite |
| Consequence | 4 | 4 | 3 | Net Zero Open |
| Likelihood | 4 | 4 | 3 | |
| Risk Scores | 16 | 16 | 9 | |




**Proposed Actions (by due date)**

1. Create streamlined reporting system for UHN and determine reporting and governance frameworks (Dec 2025 – Overdue)
2. Create and install UHN metering strategy (2027)
3. Feasibility study for UHN relating to renewables and battery storage with Greater South East Energy Hub (appointed by DESNZ to review public sector requirements for renewables) (2026)
4. Update Carbon Management plans for UHN to include proposed infrastructure changes (2026)
5. Remove KGH nitrous oxide manifolds (2025-Overdue)
6. Remove UHN maternity manifolds and move to bottled nitrous (2026)
7. Include Sustainability impact assessment in all business plans and capital plans (2026)
8. Get accurate baseline of scope 3 emissions and set reduction targets for different procurement categories (2026)
9. Make reuse first choice for all procurements (2030)
10. Review business mileage and fleet and create a plan to reduce all transport related emissions (2027)
11. Increase staff training and introduce requirement for sustainability into all senior management objectives and recruitments (2027)
12. Reduce carbon emissions from medicines through reduction of wastage and use of lower carbon alternatives e.g. DPIs to MDIs, IV to oral switches (2030)
13. Remove fossil fuel boilers from the UHN estate (2038)
14. Establish joint sustainability committee and write longer term Sustainability Strategy for UHN linking with Estates and Clinical Strategies (2028)

**Q1 26/27 executive commentary**

The Q1 position shows positive progress in targeted areas; however, the overall risk score remains unchanged at 16. This reflects continuing uncertainty around estates decarbonisation, sustainability governance, resource capacity and the funding route required to deliver the scale of change needed across UHN.

Progress in Q1:

- Two members of NGH staff have completed their Level 4 Apprenticeship with the LDN Sustainable Healthcare Academy. Both were awarded a distinction. A Pharmacy Technician identified a reduction in medicine stockholding from the aseptic unit saving £30k and 7 tonnes of CO2e per month. The Sustainability Co-ordinator held two half day repair workshops demonstrating a saving of £7k and 1.6 tonnes of CO2e and 0.5 tonnes of waste.
- Greener NHS has released high level Scope 3 emissions data for all providers.
- The switch from IV to oral paracetamol within NGH Day Surgery is progressing through the appropriate governance structures.
- Presentation made to QI team to increase awareness of how sustainability fits within the QI framework.
- The Lancet has published a new tool that will make calculation of carbon savings easier for commonly used items.

Remaining key challenges:

- No further progress has been made yet in removing nitrous oxide from KGH which had a 2025 date in our Green Plan.
- Delays to the E&F seniors restructure and leadership bandwidth has slowed expected progress on new UHN governance overseeing delivery of the Green Plan.
- There remains no overall costed or funded plan for removing NGH reliance on fossil fuels.
- KGH Energy Centre will reduce carbon emissions from buildings by approximately 50%, and progress on this build remains on track. However, there is some uncertainty about future decarbonisation options.
- The ICB has reduced its involvement with Greener initiatives and it is currently to be determined how they will incorporate sustainability and net zero into their workstreams, and how they will influence local sustainability.

Plans for Q2 2026/27:

- Begin new governance model and complete E&F seniors restructure to release more capacity into this agenda.
- Investigate alternative funding models for renewable technologies.
- Commence the NHS Climate Change Risk Assessment framework review.
- Determine options for hybrid laparoscopic instruments in surgery.
- Reinvigorate the Sustainability Anchor Institution Network.
- Procurement of new energy metering software provider.
- Finalise the updated Carbon Reduction Plan for KGH to include the GB Energy Funded Solar and Energy Centre.
- Finalise the sustainability targets in the new NMAHP strategy.

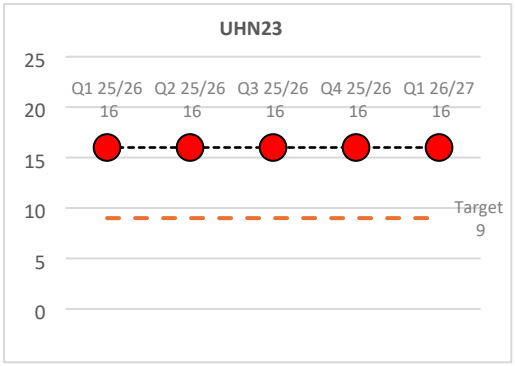
| | |
|---|---|
| **Risk ID:** | UHN23 |
| **Strategic Priority:** | Transform patient care |
| **Risk Description:** | If integrated working with wider partners in our county or region is not sufficiently mature, our ability to deliver key elements of the NHSE 10 yr plan, realise our Anchor Institution ambitions or address demand from population health longer term, becomes compromised, impacting on high quality patient care and experience. |
| **Key Deliverable:** | Work with partners to provide proactive neighbourhood care across communities (Accelerate work to integrate patient care, removing barriers between secondary, community and primary care services) |
| **Executive Lead:** | Director of Strategy |
| **Assurance Committee:** | Strategy, Transformation and Digital Committee |

| **Key Controls** | **Key Assurance** |
|---|---|
| Effective working across the ICS and the wider partners including the Northamptonshire Integrated Care Board and the Northamptonshire Integrated Care Partnership | ➢ New Board committee to have dedicated time to track progress and assess risks against delivery.<br>➢ ICS governance architecture tracks progress of the outcomes of integrated working.<br>➢ Establishment of Place Delivery Boards alongside Health and Wellbeing Boards to deliver improved outcomes in population health and healthcare (Internal / External)<br>➢ Population Health Board in place that produces single sets of integrated data and information on health inequalities.<br>➢ Delivering the GIRFT recommended pathways are end to end and include system partners.<br>➢ Primary care to attend UHN Clinical Senate. |
| Implementation of the ICS operating model to deliver good quality care, financial balance and improved outcomes. | |
| UHN leaders (Executives, non-executives and senior divisional clinical leaders) as members throughout the ICS governance system to ensure strong development and delivery against plans. | |
| Proactively engage in System transformation work to make improvements to patient pathways and demand management | |
| UHN Anchor Institution Strategy to clearly set out our ambitions and actions to deliver them, including to address health inequalities. | |

**Gaps in control or assurance**

Limited assurance on delivery of effective and transparent place and neighbourhood working – still in development.
Unknown impact of Cluster arrangements and reduced headcount across the system to work on these programmes
Consistent and contemporaneous board understanding of ICS operating model at UHN
Robust SMART delivery plan in agreement with all partners

| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain /Risk Appetite |
|---|---|---|---|---|
| **Likelihood** | 4 | 4 | 3 | **Pt Exp/Quality Open** |
| **Consequence** | 4 | 4 | 3 | |
| | **16** | **16** | **9** | |



| Actions (by due date) |
| --- |
| Drive the establishment of the Northants system architecture for Neighbourhoods end Q1 26/27 – still in progress<br>Ensure UHN Senior team have a consistent understanding of roles and responsibilities to drive delivery of actions end Q1 26/27 – still in progress<br>Agree UHN priorities for tackling health inequalities based on local need, data and national guidance – plan to complete by September 2026 |
| **Qtr 1 26/27 executive commentary** |
| Progress has continued during Q1 in the development of UHN's Anchor Institution, Health Inequalities and Neighbourhoods programmes. The UHN Health Inequalities Steering Group has been established and completed its first meeting, bringing together clinical and operational representatives. This group will establish UHN evidence-based priorities in line with local need, oversee delivery and provide greater organisational focus on reducing inequalities, providing a focus point for linking with external partners and supporting local initiatives.<br><br>The Northamptonshire Anchor Institution Network has been reset with refreshed governance arrangements and work is underway across priority themes of employment, social value and sustainability. UHN continues to provide leadership for the Sustainability Anchor workstream and is working with partners to identify opportunities for collaborative delivery and shared impact.<br><br>Neighbourhood development remains a key system priority. Partners have continued to support development of a LNR Neighbourhood Strategy, with arrangements aligned to national guidance and wider Integrated Care Partnership priorities. Work has also progressed to strengthen the alignment between health inequalities priorities, population health intelligence and neighbourhood delivery. Specific discussions have also commenced with system partners on co-design of Neighbourhood Health Centre models and transformation of specialty specific elective pathways, although plans are still in development. Governance around place-based delivery and partnership forums is also being refreshed, ensuring groups roles and purpose are being updated in line with new neighbourhood models and NHS bodies changing roles.<br><br>Whilst governance structures, partnerships and strategic direction have continued to be strengthened during the quarter, delivery remains at an early stage and there is limited assurance at this point regarding the scale of impact on demand management, patient outcomes and wider population health measures. Consequently, the risk score is recommended to remain unchanged this quarter pending further evidence of the LNR neighbourhood strategy, UHN priorities and delivery plans. |

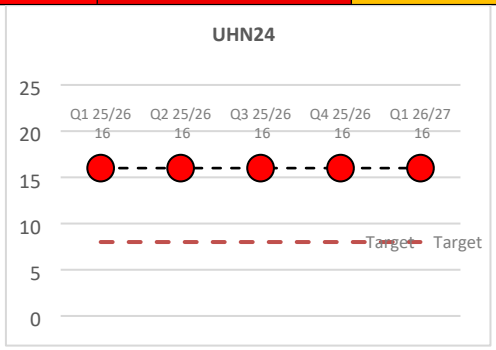
| | |
|---|---|
| **Risk ID:** | UHN24 |
| **Strategic Priority:** | Transform Patient Care |
| **Risk Description:** | Failure to deliver the Group's digital transformation agenda may result in continued operational inefficiencies, inability to standardise care delivery across sites, and failure to realise productivity benefits. This specifically includes risks to EPR implementation, automation programmes, and the broader digital strategy delivery impacting our ability to transform services and achieve digital maturity. |
| **Key Deliverable:** | Continued implementation of One Digital Strategy - unified digital transformation across UHL and UHN including EPR, automation, ongoing system rationalisation and review of our digital governance structures |
| **Executive Lead:** | Will Monaghan, CDIO |
| **Assurance Committee:** | Strategic Transformation and Digital Committee |

| **Key Controls** | **Key Assurance** |
|---|---|
| One Digital Strategy approved by Board | Monthly Digital Hospitals Board oversight reports (Internal) |
| Dedicated EPR programme teams with defined budgets and milestones (Internal) | Digital Maturity Assessment annual review (External) – results in Q1 26 showcase positive increase in DMA results across UHL and UHN |
| Programme Management Office providing oversight and benefits tracking (Internal) | NHSE EPR Gateway reviews (External) – NGH have had their Stage 4.5 Gateway review in Q1 |
| Digital Demand Panel | Processes our requests from our wider organisation for digital (Internal) |
| One Digital Risk Management Committee established | New committee reviewing all risks across UHL and UHN and feeds into One Digital Risk and Governance Board (Internal) |
| Digital transformation governance structure including programme boards | ICS Digital Board alignment and reporting (External) |
| Upward Reports from OneDigital Service and Operational Delivery Board and OneDigital Hospital Board | Regular reporting to ILT and Board committees |
| Revised One Digital Governance structures in flight | One Digital Hospitals Board (Internal) |

**Gaps in control or assurance**

1) UHN/UHL governance process not fully embedded - collaborative working arrangements still maturing
2) 25/26 DMA results were a big improvement on the previous ones, with all Trusts above average in many domains.
3) System fragmentation - ambition to reduce number of systems by 50% by April 2027
4) EPR not implemented at KGH - business case in development for post-merger alignment and work underway to review early implementation of Nervecentre EPMA
5) Resource constraints in digital teams affecting delivery capacity
6) Clinical and operational pressures impacting staff availability for digital transformation
7) Dependency on capital funding reliability for future phases
8) Cultural change management programme needs strengthening – Wellbeing and Culture Assurance action plan created for Digital Department

| Risk Scores | | | | |
|---|---|---|---|---|
| | Qtr 4 25/26 | Qtr 1 26/27 | Target Score | Risk Domain and Risk |
| **Consequence** | 4 | 4 | 4 | Information Minimal |
| **Likelihood** | 4 | 4 | 2 | |
| **Risk Scores** | **16** | **16** | **8** | |




**Action updates (by due date)**

1) Implement NGH EPR Tranche 2 (PAS, Outpatients, Investigations, Careplans) by August 2026. SRO Hemant Nemade / Will Monaghan

2) Implement NGH EPR Tranche 3 (Theatres, Critical Care, Patient Centre app, Paediatrics and Outpatients EPMA) by April 2027. SRO Hemant Nemade/ Will Monaghan

3) Complete KGH EPR strategy and alignment plan for UHN by July 2026. SRO Chris Evans

4) Achieve 25% reduction in number of systems by April 2027 (50% by April 2028). SRO Will Monaghan

5) Complete unified data platform implementation (FDP) by September 2026. SRO Will Monaghan

**Qtr 1 26/27 executive commentary**

Executive update (Q1 26/27):

- NGH EPR delivery — governance and stability. Planning and delivery of Tranche 2 is well underway and is scheduled for delivery on 21st August 2026.
- Pathology Order Comms go live at KGH successfully rolled out in ED and Inpatients. Further work planned for outpatient settings.
- BadgerNet EPAGU pre-implementation is underway, and plans scheduled for delivery in Summer 2026 for KGH and Autumn 2026 for NGH.
- The UHL/UHN AI academy is progressing well, with additional cohorts.
- Ambient AI / AVT pilot continues although there is due to be an organisational led MOC, which is an interdependency of rollout
- Digital Engagement with colleagues continues across UHN and Digital Roadshow held at NGH in June 2026. KGH scheduled for July 2026.
- Data platform (FDP) — scope and governance ongoing
- Focus for Q2 26/27: ensure delivery of NGH Tranche 2 EPR, establish governance for T3 NGH delivery and KGH Nervecentre EPMA, monitor AVT programme and continue rollout where appropriate, continue automation waves, embed revised digital governance processes and continue ongoing digital engagement.

**Appendix 1 DUE FOR REVIEW DURING QUARTER 2 26/27**

# UHN Risk Appetite 25/26


| Risk Appetite Levels | |
|---|---|
| 1 | None |
| 2 | Minimal |
| 3 | Open |
| 4 | Seek/ Significant |

The Board recognises that UHN's long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners, including our staff, wherever possible.

The risk appetite statement has individual statements across 11 key risk areas (domains). The statements and the supporting definitions seek to establish our capacity for taking and absorbing risk and will act as guiding principles for the management of risk across UHN.

Our image of risk appetite set against domains denotes the level of risk appetite within the maximum range.

In assessing risks, there will be recognition of levels of tolerance that may sit outside of the overarching risk appetite.

# Strategic Domains: Risk Appetite 25/26

1. **Patient Safety: Minimal**
Although the preference is for risk avoidance for safety, decisions may be taken that might have the possibility of improved patient outcomes where appropriate controls are in place.

2. **Patient Quality/Experience: Open**
Any risks to patient experience that might be required to achieve quality improvements or where there are longer-term gains. Some individual patient care and treatment experiences that may achieve improved clinical outcomes or innovation in emerging fields.

3. **Finance: Minimal**
Any risk that UHN may be required to take to mitigate risk to patient safety or quality of care, with value for money still being the main concern. Price may not always be the overriding factor if appropriate controls are in place.

4. **Reputation: Open**
Any risk that may result in improvements in the design or delivery of healthcare services through collaboration or innovation.

5. **Net Zero: Open**
Any risks that may result in increasing overall achievement of the net zero targets through collaboration or innovation but that result in short-term delays.

6. **Information: Minimal**
Any risk that may impact the availability of systems that support critical business functions and for threats to its assets arising from external malicious attacks.

7. **Activity: Open**
Due to operational pressures, it may be necessary to take a more open approach to risks except where there are implications for a safe delivery of care.

8. **Infrastructure: Minimal**
Limited action may be taken which may impact on operational service delivery only where it is essential to deliver safe and effective patient care and outcomes. Decision making authority held by senior management.

9. **Workforce: Open**
Appetite to take workforce management decisions which may have short term implications for our workforce for potential longer-term gains.

10. **Culture: Minimal**
Prepared to take limited risk with regards to culture as long as this could yield opportunities elsewhere within the UHN for longer team cultural and leadership development.

11. **Innovation: Open**
Any risk that may result in improvements in the design or delivery of services through innovation, creativity, external income or clinical research. We will pursue innovation where there is the potential for significant longer-term rewards and improvement on quality and safety outcomes.

Dedicated to excellence

NHS
University Hospitals of Northamptonshire
NHS Group

# 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 | 10 September 2026 |
| Agenda item | 14 |
| Title | Report on the activities of the Northamptonshire Health Charity (NHCF) |
| Presenter | Jonathan McGee, Chief Executive, NHCF |
| Author | Richard May, UHN Company Secretary |

This paper is for

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

| Reason for consideration | Previous consideration |
|---|---|
| The Terms of Nomination require the submission of annual reports on the NHCF's activities on an annual basis. | None |

## Executive Summary

The NHCF acts as trustee for the Trusts' charitable funds, following asset transfer by NGH and KGH in 2018 and 2021 respectively.
Jonathan McGee from the NHCF will attend the meeting to present a review of the Charity's activities during the past year, as set out in the **attached** report.
The presentation is for the Board's receipt, information and consideration.

## Appendix

Charity's annual report

## Risk and assurance

No direct implications

## Financial Impact

No direct implications

## Legal implications/regulatory requirements

As set out in 'Reason for consideration' above

## Equality Impact Assessment

The charity's activities generate positive equality impacts, as specified in the

presentation.

# Report from Northampton Health Charity to UHN Board

August 2026


## Jonathan McGee
Chief Executive


Northamptonshire Health Charity

Data compiled July 2026. E&OE.

# Improving your hospitals for patients and staff: April 2025 to March 2026

We had 323 applications for charitable expenditure to the value of £1.95 million

260 applications for funding were approved worth £883,000

Northamptonshire Health Charity

# Significant activity

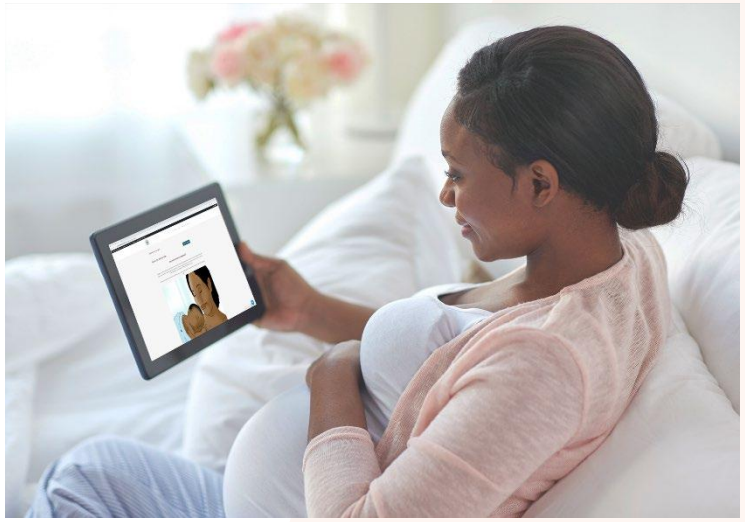
- Raised over £480k for Focal Therapy for our Prostate Cancer appeal – already this has seen the successful treatment of nearly 80 patients.
- Funded £430k of diabetes research across the county.
- Expanded our regular giving programme to KGH. Across Trusts we have now recruited 1,165 regular donors with an average gift of £7 per month (excluding gift aid worth 25%).
- Launched ‘free wills’ initiative with two local law firms for patients who want to say thank you and leave a gift in their will. We have seen significant uptake from Trust staff.
- New consolidated staff lottery (KGH, NGH, NHFT) with bigger prizes
- First year of our 12 London Marathon places raising over £40k
- Launch of the Oncology Café at NGH providing free hot drinks for patients


Northamptonshire Health Charity

# Funding: Patient pathway examples


**Integrated Surgery Outpatients - LumenEye X1 Digital Endoscope System**


**Books for children facing bereavement of a parent**



**NGH Maternity - The Real Birth Company Digital Birth Preparation workshop**

Northamptonshire Health Charity

# Funding: Environments and enhancements examples

Interactive Moving Sky Tiles, Skylark Ward, KGH


Oncology Café at NGH – providing free hot drinks for patients

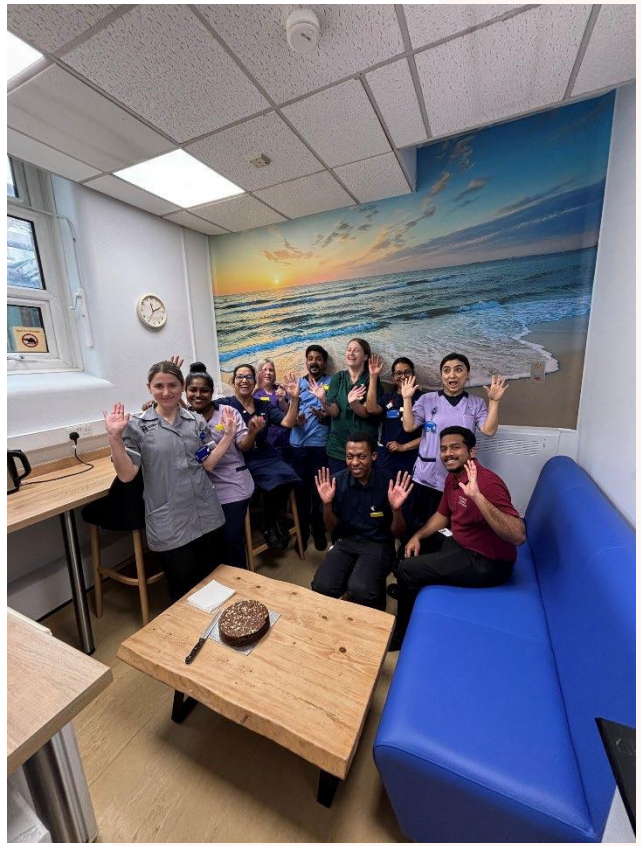
Enhancing a clinic room in the Child Development Centre at NGH

Northamptonshire Health Charity

# Funding: Staff Wellbeing & Development examples

Enabled the KGH Eye Team to attend a national conference as finalists for a Diabetes Excellence Award, recognising their innovative one-stop ophthalmology service.


Memory Tree at KGH offering a lasting tribute to patients and staff



Enhancements to Althorp Ward Staff room

Northamptonshire Health Charity

# Appeal updates

- **Children's garden appeal**: the Charity has committed £250,000 with the remaining costs funded by UHN.  Works were due to commence this summer. However, works are currently delayed and we are discussing mitigations with NGH.
- **Daisy maternity bereavement suite appeal:** we successfully exceeded our fundraising target of £150,000. The suite is now *in situ* and being fitted out later this year.
- **Twinkling Stars baby loss suite appeal:** We have almost **reached our fundraising target of £375,000**. However, this suite is to be located in the Rockingham Wing extension, and due to delays, implementation may be delayed.
- **Sensory rooms appeal:** This £80,000 appeal is predominantly across NHFT, but has already supported a paediatric A&E sensory room at Kettering.
- **Cancer Centre appeal:** We are conducting a fundraising feasibility study to ascertain whether the Charity can support a £5m+ capital campaign

Northamptonshire Health Charity

# Challenges

- Charitable Donations have decreased by 10% over the last 10 years across all charitable sectors (UK Giving Report 2026 Charitable Giving Insights | CAF).
- While we are seeing growth in areas and demographics largely unimpacted by cost of living (regular giving and legacy pledges), other areas, including direct corporate support are down.
- As a consequence, we are reviewing resources and expenditure.
- We have successfully spent down a large number of our existing funds on charitable purposes. However, unrestricted programme budgets for the next financial year are likely to be reduced, with a focus instead on allocating restricted funds.

Northamptonshire Health Charity

# Opportunities – new fundraising initiatives

- **Power up for Patients** launching in the Autumn - a biannual gaming fundraising event, working with local college and the University
- Launch of **Steps of Hope** in the October, virtual challenge to raise money in support of bereavement services
- **Public Lottery**, in partnership with NHS Charities Together, launching in August
- **The Heart** supporter magazine – distributed across our Trusts, we are asking local companies to advertise in our publication
- **Cancer Centre Appeal** conducting feasibility study to ascertain support for £5m campaign

Northamptonshire Health Charity

# Priorities this year

- Continue the focus on unrestricted and regular income
- Increase community-based fundraising
- Close existing appeals
- Launch Cancer appeal
- Continue increased communication of the impact of Charitable funding to both patients, communities, and to staff.

Northamptonshire Health Charity

greenheart@nhcf.co.uk
www.nhcf.co.uk

Dedicated to excellence

NHS
University Hospitals of Northamptonshire
NHS Group

# Cover sheet

| | |
|---|---|
| Meeting | Boards of Directors of Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) Meeting together in Public |
| Date | 10 September 2026 |
| Agenda item | 15 |
| Title | Use of the Trusts' Seals |
| Presenter | Richard May, Company Secretary |
| Author | Richard May, Company Secretary |

| This paper is for | | | |
|---|---|---|---|
| ☐ Approval | ☐Discussion | ✓ Note | ☐Assurance |

| Reason for consideration | Previous consideration |
|---|---|
| The Trusts' procedures require uses of the Seals to be reported to the Boards of Directors. | None |

## Executive Summary

The Boards of Directors are requested to note the use of the Trusts' Seals (as indicated) 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).

## Appendices

None

## Risk and assurance

None

## Financial Impact

None

## Legal implications/regulatory requirements

As specified in 'reason for consideration' section above.

## Equality Impact Assessment

Neutral