Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

NORTHAMPTON GENERAL HOSPITAL (NGH) NHS TRUST Annual Report 2025-26

Contents

All NHS organisations are required to publish an annual report and financial statements following the end of each financial year. This report provides an overview of the work of Northampton General Hospital NHS Trust between 1 April 2025 and 31 March 2026 (2025-26).

The report is made up of three parts:

Section 1: Performance Report

Glossary of terms

Throughout the report:

- ‘UHN’ refers to the University Hospitals of Northamptonshire NHS Group
- ‘UHL’ refers to the University Hospitals of Leicester NHS Trust
- ‘KGH’ refers to Kettering General Hospital NHS Foundation Trust
- ‘NGH’ refers to Northampton General Hospital NHS Trust

Chair's welcome

It is my privilege to present this year's annual report for NGH. As Chair, I remain deeply proud of the extraordinary commitment, resilience, and professionalism demonstrated by our colleagues across what has been another demanding year for the NHS.

Throughout the past year, our organisations have continued to operate in a complex and evolving healthcare landscape. Pressures on urgent and emergency care, workforce challenges, and increasing demand for services have tested our systems. Yet time and again, our teams have risen to these challenges with determination, compassion, and an unwavering focus on patient care.

We have made meaningful progress against our strategic priorities. Improvements in patient access, investment in digital infrastructure, and the strengthening of our clinical services are helping to create a more responsive and sustainable organisation. Our elective recovery programme has enabled us to treat more patients, while maintaining safety and quality as our foremost priorities.

Quality of care remains at the heart of everything we do. This year, we have continued to embed a culture of continuous improvement, learning from incidents, and listening closely to patient feedback. While we acknowledge that there is more to do to consistently meet all performance standards, we are encouraged by the progress made and remain firmly committed to delivering safe, effective, and compassionate care for all.

Our workforce is our greatest asset. I would like to extend my sincere thanks to every colleague, volunteer, and partner who contributes to our Trusts. We have taken steps this year to improve colleague. wellbeing, support recruitment, and foster a more inclusive and supportive working environment. These efforts are essential not only for our people but also for the patients and communities we serve.

This year also saw periods of industrial action by Resident Doctors, which presented additional challenges across our services. Our priority throughout was to minimise disruption to patients and ensure that safety and urgent care remained protected. I would like to express my sincere gratitude to colleagues across all professional groups who went above and beyond during these periods—adapting rotas, covering additional duties, and supporting one another to maintain continuity of care under considerable pressure. Their professionalism and collective effort ensured that we were able to continue delivering safe services to our patients during these challenging times.

Collaboration has been a defining theme of the year. Working closely with partners across the Northamptonshire system, we are strengthening integrated care pathways and improving outcomes for our population. In particular, our growing partnership with University Hospitals of Leicester has demonstrated the tangible benefits of closer collaboration between neighbouring trusts. By starting work on aligning clinical pathways, sharing expertise, and coordinating services across organisational boundaries, we are improving access to specialist care, reducing variation, and making better use of our collective resources. This collaborative approach not only enhances patient outcomes but also strengthens our ability to respond to system-wide challenges with greater resilience and flexibility.

Financial sustainability continues to be a significant challenge across the NHS. We have worked diligently to manage our resources responsibly, identifying efficiencies while protecting frontline services. Maintaining this balance will remain a key focus in the coming year.

Looking ahead, we are clear about the work still required. Reducing waiting times, improving access to services, and enhancing patient experience will remain central to our priorities. At the same time, we will

continue to invest in innovation, infrastructure, and our workforce to ensure the long-term resilience of our organisation.

In closing, I would like to thank our patients and communities for their trust and support, and our colleagues for their dedication and compassion. Together, we will continue to build a stronger, more sustainable healthcare service for the future.

Andrew Moore

Trusts' Chair (Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust)

24 June 2026

Chief Executive's Introduction

Introductory note: The University Hospitals Northamptonshire NHS Group (UHN) and the University Hospitals of Leicester NHS Trust (UHL) have come together to form the UHL-UHN Group - an ambitious and forward-looking collaboration designed to enhance patient care, improve population health, and make our Trusts exceptional places to work.

The last year in the NHS and at UHN and UHL has been a period of transformation. For me, four themes stand out: a gradual return of public confidence, the continuing strain on colleague experience, stronger financial discipline, and the rapid rise of digital and artificial intelligence (AI) transformation.

Public confidence in the health service is beginning to improve for the first time since before the pandemic. The annual British Social Attitudes poll has tracked attitudes towards the NHS since 1983 and has found that faith in the health service remains low but is slowly recovering, though Generation Z are less happy with the NHS than older people. Overall, 26 per cent of people said they were satisfied with the NHS last year, up from a record low of 21 per cent in 2024. Here at UHN and UHL, we have improved quality, safety and access and early verbal feedback from recent CQC visits is promising. Our Group Clinical Strategy, developed with involvement and insight from colleagues, partners, and communities across Leicester, Leicestershire, Rutland, and Northamptonshire, sets out how we will improve care, access, and outcomes for our population over the next decade, including reducing unwarranted variation and making better use of our collective expertise and capacity. Delivering this strategy requires us to work together more consistently across our hospitals and teams.

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

Financially, this has been a year of greater grip across the NHS: workforce growth has levelled out and there have been notable reductions in agency use and increases in productivity. Locally, UHN and UHL delivered the revised financial positions we agreed with NHS England, and at UHL we reduced the deficit compared to last year. Both UHN and UHL are forecasting further reductions in deficit next year. Of course, none of this removes the reality of inflation, rising demand and service resilience pressures, all of which mean significant financial challenge, and which contribute to the need for difficult choices. Our focus remains on protecting high-quality care, improving productivity and working closely with partners to reduce duplication and make best use of our collective resources.

In a modern NHS, digital technology and AI are essential for enhancing patient outcomes, increasing operational efficiency, and enabling proactive care management. They help improve communication, remote monitoring, and personalised treatments, shifting the focus from reactive to preventative care while boosting efficiency. Key tools with increasing influence over the last year include telehealth, wearable devices, and AI-driven diagnostics. At UHN and UHL we are investing heavily in digital technology and AI and I believe this is the biggest opportunity we have to improve patient care,

colleague experience and our finances over the next 10 years. Digital innovation, including ambient voice technology, is still at an early stage but being piloted thoughtfully across sites, spreading both cost and risk. UHL's Patient Administration System (PAS) could not have gone live without UHN colleagues stepping in to support and we are now able to share skills and knowledge across organisations in ways that simply were not possible before. At UHN and UHL, AI will create jobs, change jobs and mean some jobs will no longer be needed. We need to support colleagues as we respond to these changes, and no decisions about roles will be made without engagement and support.

I am grateful to the many colleagues who have contributed to the transformation over the last year. In the last 12 months, the conversations that stay with me are the simplest ones. When I ask colleagues why they work in the NHS, the answer is almost always the same: because I want to make a difference. UHN and UHL colleagues have done exactly that over the last 12 months.

Richard Mitchell

Chief Executive and Accountable Officer

24 June 2026

UHN Chief Executive's Overview

It is a privilege to present this year's Annual Report for Northampton General Hospital and to reflect on the progress we have made over the past 12 months.

This has been a year of both challenge and delivery. We have continued to operate in a demanding environment, with increased pressure across urgent and emergency care, elective services, alongside significant financial constraints. Despite this, our colleagues have remained focused on what matters most—delivering safe, high-quality and compassionate care for the people of Northamptonshire.

This year, we have continued to strengthen our clinical services and build on areas of recognised excellence. Achieving national accreditation as a specialist centre for advanced endometriosis care is a significant milestone and reflects the expertise within our teams. We have also expanded key programmes, including bowel cancer screening, and introduced new technologies that are supporting improved outcomes for patients.

Improving access to care has remained a clear priority. We have expanded diagnostic capacity, including through the Kings Heath Community Diagnostic Centre, and introduced a Rapid Assessment Centre to improve ambulance handovers and patient flow within our Emergency Department. Working closely across University Hospitals of Northamptonshire, we have made good progress in reducing long waits, eliminating 65-week waits for much of the year and supporting around 1,400 patients to be treated across our sites to improve equity for patients across the county. We have also seen early signs of recovery in cancer performance, with improvements of around 4% towards the end of the year. Alongside this, plans for a new Emergency Department entrance and Urgent Treatment Centre represent an important investment in the future of urgent and emergency care at our hospital.

We have continued to improve how the hospital operates day to day. We have made progress in improving patient flow, reducing delays and making better use of capacity in the context of sustained demand and this reflects the continued efforts of teams across the organisation.

Delivering high-quality, safe care remains fundamental. Our mortality indicators remain within the expected range, and we have strengthened our approach to quality through a new UHN Quality Strategy. We have also seen tangible improvements in areas such as stroke care, where collaborative work has contributed to a 65% improvement in outcomes and faster treatment times, and in sepsis management, where reliability of care has improved significantly. Alongside this, we have strengthened oversight and learning within urgent care services.

Supporting over 11,000 colleagues across UHN and strengthening our culture has been another important focus. In response to colleague feedback, we invested in leadership development, with over 700 colleagues completing leadership programmes, alongside the launch of our Health and Wellbeing Strategy. Our co-produced Belonging Strategy was introduced during the year, supported by practical actions to improve inclusion across the organisation. It has been encouraging to see strong engagement in recognising colleagues, with more than 450 nominations received for the UHN Excellence Awards. We were proud to receive national recognition through a second Pathway to Excellence designation, as well as the Ministry of Defence Gold Award. Alongside this, we have made significant progress in reducing agency spend by around 60% and reshaping our workforce, helping to build a more sustainable staffing model while improving recruitment in key areas.

We have also continued to deliver our digital and transformation programmes. This includes phase one of the introduction of Electronic Patient Records (EPR), with Phase 2 planned for 2026-27, the implementation of new maternity systems and early work to explore the use of AI to support clinical teams. We are also playing a leading role nationally through the Federated Data Platform programme, being one of the first organisations to deploy core products across a Group and helping to shape future developments.

Partnership working continues to be a key enabler of our progress. Our clinical divisional structure is now embedded across UHN, with closer alignment of services and leadership Kettering General Hospital. We have also made progress in our wider collaboration with the University Hospitals of Leicester NHS Trust, including the development of our Group Clinical Strategy and joint approaches to service delivery in areas such as spinal and plastics. Alongside this, our neighbourhood approach is supporting more joined-up care, with a focus on areas such as frailty, diabetes and cardiovascular disease to help reduce unnecessary hospital demand.

There are significant benefits in engaging patients in research activity, both for the development of our services and for the experience of those who take part. In 2025-26, we were pleased to achieve this for over 13,000 patients across both hospitals. Participation was delivered across 17 specialties, with recruitment exceeding planned targets and positioning the Trust among the highest recruiting organisations in the region.

While we can be proud of the progress we have made, we are clear that there is more to do. The challenges facing the NHS remain significant, and we must continue to adapt and innovate in response.

I would like to thank all of our colleagues, volunteers and partners for their continued dedication and support, and our patients and communities for the trust they place in us.

We will continue to build on this progress in the year ahead.

Laura Churchward

UHN Chief Executive

24 June 2026

Who we are and what we do

NGH provides general acute services for a population of 426,700 in West Northamptonshire (ONS Mid-Year 2021 estimates) and hyper-acute stroke, vascular and renal services to people living throughout the whole of Northamptonshire. The Trust is also an accredited cancer centre and provides cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire. In addition to the main hospital site, which is located close to Northampton town centre, the Trust also provides outpatient and day surgery services at Danetre Hospital in Daventry.

The principal activity of the Trust is the provision of free healthcare to eligible patients. The hospital provides the full range of outpatients, diagnostics, inpatient and day case elective and emergency care and also a growing range of specialist treatments that distinguishes their services from many district general hospitals It also provides a very small amount of healthcare to private patients. The Trust is constantly seeking to expand the portfolio of hyper-acute specialties and to provide services in the most clinically effective way. Examples are developments in both urological cancer surgery and laparoscopic colorectal surgery placing the Trust at the forefront of regional provision for these treatments.

The Trust trains a wide range of clinical staff, including doctors, nurses, midwives, allied health professionals therapists, scientists and other professionals. The training and development department offers a wide range of clinical and non-clinical training courses, accessed in a variety of ways through a range of media including e-learning. The Trust has excellent training facilities which were recently upgraded. Services are delivered from the main acute hospital site in Northampton or by staff in the community.

Introduction to the UHL-UHN Group

The University Hospitals of Leicester NHS Trust (UHL) and the University Hospitals Northamptonshire NHS Group (UHN) have come together to form the UHL-UHN Group - an ambitious and forward-looking collaboration designed to enhance patient care, improve population health, and make our Trusts exceptional places to work.

Together, KGH, NGH and UHL provide high-quality healthcare across five major hospital sites serving the populations of Leicester, Leicestershire and Rutland (LLR), and Northamptonshire. Each of our hospitals delivers essential general services, including three busy Emergency Departments (EDs), supporting some of the region's most pressing acute needs. In addition, we operate from 19 smaller community hospitals, delivering care closer to home. Increasingly, we are embracing virtual care models and delivering services in people's homes - supporting independence and preventing unnecessary hospital admissions.

With a combined annual spend of approximately £2.9 billion and a dedicated workforce of nearly 30,000 colleagues, we are one of the largest NHS Groups. Our size and scale bring opportunity: we are able to standardise and improve services, share learning, attract and retain talent, and build innovative pathways of care across the region.

We are part of a broader ecosystem of care. Our work is deeply connected with our local Integrated Care Systems (ICSs), community and mental health providers, primary care partners, local government, voluntary and charitable organisations, and the East Midlands Acute Provider Collaborative. As a Group, we are committed to collaboration, innovation and transformation - delivering better outcomes for our patients and communities and creating a healthier future for all.

UHN values:

UHN's core values directly reflect the most common themes shared by staff, patient representatives and other stakeholders during the engagement programme. The top aspirational values we need to nurture have been woven into the vision and mission statements and will form an important part of our Group organisational development plans.

Our priorities for 2025-26

The Trusts agreed three priorities for 2025-26 to transform patient care, strengthen our culture, and deliver our financial plan. Delivering these priorities will give rise to multiple benefits to patient care, and they must also save money. The priorities are underpinned by the following key deliverables, with a brief assessment of performance during 2025-26 for each:

Deliverable	**Progress (examples relate to UHN unless otherwise stated)**
Deliver national access targets in planned care and transform pathways with system partners to safely reduce the number of people accessing urgent and emergency care (UEC)	• Significant work across the year to deliver improved urgent and emergency care performance, with new **Rapid Assessment Unit** at NGH, new **Surgical Assessment Unit** in KGH, and implementation of rapid flow model to support ambulance handovers and ED flow. Both Trusts have achieved the 10% target for 12 hours in the department, and improvement trajectories across all UEC metrics, with a strong finish for NGH as part of the A&E sprint, finishing the year on 75% 4 hour performance.

	• Continued **strong performance on 52 weeks**, finishing the year on 0.8% of the waiting list, working collaboratively across UHN to reduce our longest waiting patients with **around 1,400 patients transferred** between KGH and NGH to support long-wait performance, **improving equity in long waits** across the county. • Encouraging **signs of improvement** giving assurance that action plans put in place in Breast, Gynae and Derm to recover from the dip in cancer performance in Q2/Q3 are having an impact, with a recovery to 74% and 67% in March, albeit below levels from March 25. • **Zero 65 week waits** achieved in **September** and at the year end position.
Deliver our quality priorities, including the Patient Safety and Incident Response Framework (PSIRF) and the perinatal safety programme	• NGH's **mortality metrics are showing an increase and are now in the 'above expected'** range, being impacted by Same Day Emergency Care changes and depth of coding, which is being reviewed. Alerts are being monitored to ensure safety.. • Developed and approved the **UHN Quality Strategy**, focusing on four key goals to improve patient experience, outcomes and equity, with work well underway to deliver. • Continued focus on quality within ED, with a new **Quality & Safety Group** within ED (twice monthly) to focus on quality issues within the department, review audit findings and formulate improvement actions and improved oversight of key quality metrics in ED. • Establishment of the **Group Perinatal Accountability Framework** to oversee quality of perinatal services and continued improvement work underway as part of the national maternity improvement programme. • **Improvements in the management of sepsis**, with screening on admission consistently above 90%, improved clinical review performance and UHN-wide sepsis audit. Well-established QI programme in place with trajectories to improve fluid balance monitoring and through 26/27.
Take action on the 2024 staff survey feedback, and deliver our People Plan prioritised actions for 2025, including tackling bullying, discrimination, and harassment	• Delivery of significant strands of our culture improvement work including a **comprehensive leadership development offer** which has had over 700 graduates to date, and the development and **launch of the Health and Wellbeing strategy**. • Co-produced with colleagues **our Belonging Strategy**, which was launched in the autumn to support inclusion in our organisation, alongside key practical elements including our Neuro-inclusion toolkit, reasonable adjustments SOP. • Record entries nominating over 450 colleagues for awards in our **UHN Excellence Awards** evening to recognise our excellent colleagues. • **Civility Matters at UHN campaign** launched with planning underway for the first pilot area in Maternity at KGH as part of the Maternity cultural improvement programme.

	• Successfully planned the transition to an independent service for Freedom To Speak Up to support our culture.
Deliver major digital change, aligning clinical systems across UHN and exploring automation of corporate systems	• **First tranche of new Electronic Patient Record** functionality successfully implemented in NGH in July in ED and inpatient services. • Implemented **Badgernet Maternity** system in both KGH and NGH, digitising maternity services • Conducted **Ambient AI procurement** across the UHLN Group, now being piloted ahead of full roll-out, to streamline and improve clinical administration processes, as the first Group-wide project in our ambitious AI and automation programme. • UHN is a **leading product incubator partner for the Federated Data Platform programme**, having implemented 4 of the 5 core national products, being the first Trusts to deploy core products across a Group, and pioneering future national products in partnership with the national team, including the Shared PTL (waiting list), Integrated Performance & Improvement, Diagnostic Imaging Scheduler, and Nursing Ward Excellence Accreditation Framework. • Consolidation of key corporate systems including incident and finance systems to reduce duplication.
Go further in integrating clinical and corporate services across UHN, delivering seamless pathways and improving safety and outcomes for our patients	• New Clinical Divisional Structure (implemented in April 2025) now **embedded across UHN.** • As of February 2026, **all Corporate services across UHN** have now restructured to form UHN-wide teams to support our UHN clinical divisions. • **Quality governance review** with refreshed UHN-wide governance strengthening oversight of quality measures. • Strengthened and aligned reporting across UHN, aligned metric definitions, supporting now fully embedded **Accountability and Continuous Improvement Framework**, which brings National Oversight Framework weightings through to divisional performance, improving oversight of divisional performance.
Develop our collaborative model with UHL, improving productivity and creating joint plans for clinical and corporate services where appropriate	• **Group Clinical Strategy (GCS) approved and implementation underway**, with joint models agreed in plastics, spinal services and nuclear medicine. • Exploring **options for the reconfiguration of major services** (e.g. maternity, neonatal & Children and Young People). • **Corporate consolidation workshops** held with corporate areas to identify opportunities for collaboration and integration.
Deliver our workforce plan as a key component of financial plan delivery	• **Agency spend reduced by 60%** in the past year, with agency usage targets set in planning achieved in both Trusts. • Early progress in right-sizing the workforce, with **a reduction of over 500 whole-time equivalent (WTE) between** March to September, with the largest decreases in temporary staffing, but this was challenging to maintain over the winter period, with an increase between October to March, **ending in March with a 276 WTE reduction** against the 781 plan.

	• Development of **full workforce metrics data pack** is providing substantially enhanced oversight of workforce. • Notable **change in our success in recruiting to some previously hard to recruit areas** such as oncology, strengthening our UHN workforce and reducing our reliance on temporary staffing, with a particularly notable fall in agency medics as recruitment succeeds.
Accelerate work to integrate patient care, removing barriers between secondary, community and primary care services	• UHN **Neighbourhood Health** group is now in place with a clinical lead. Priorities identified including diabetes, frailty, dermatology, CVD – to focus on reducing urgent and emergency care (UEC) demand and unnecessary elective referrals • **Corby Community Diagnostic Centre** has now opened and providing easier to access, high quality care in local communities • Significant work in Dermatology to develop opportunities for redesigning activity and provide clearer referral pathways. • Primary and secondary care interface work in 6 key specialties to review and streamline referral pathways with primary care clinicians in our clinics working collaboratively to improve the interface, developing shared guidelines and approach.
Increase our research and trial activities by 10%	• UHN is **research active in 17 specialties**, with the most active specialties being Gastroenterology, Obstetrics, ED and Oncology. • UHN (if it were counted as a single Trust) being the **highest participant recruiting Trust** in the East Midlands, with UHL being second, putting the wider collaborative group substantially ahead of others in the region. • **Strongly positive patient feedback** from the Research and Innovation team, with 100% positive FFT feedback in the last year.
Foster a learning culture, rolling out our 'Improving Together' continuous improvement methodology and giving teams the tools to improve care, experience and productivity	• Successfully ran UHN's **first four Rapid Improvement Events** "Improving Together Week" supporting improved working on our inpatient wards and improvements in how we could work together, resulting in **over 450 improvement ideas**, already **saving around 900 hours a week** for colleagues on wards. • Sustained **rise in the number of active QI projects**, increasing from 80 to 140 in the last year. • Embedded Quality Improvement into the Excellence Accreditation Framework for adult inpatient wards collaboratively with the nursing Quality Excellence team. • Since August, **18 cohorts have been trained in QI**, and training also now fully embedded in professional and leadership development courses. • Hosted the **annual Leicestershire and Northamptonshire Improvement Symposium**, and **established the East Midlands Improvement Directors network** to foster and share improvement ideas and best practice.

Our local health system

The Trusts are key partners in the Northamptonshire Integrated Care Board (NICB), which is the statutory body responsible for commissioning local NHS services and functions. The Group Chief Executive is a Partner Member of the ICB Board, which now operates as single Board for NICB and Leicester, Leicestershire and Rutland (LLR) ICB, representing acute providers within the Northamptonshire and Leicestershire (KGH, NGH and UHL), whilst the Trust Chair is invited to observe ICB meetings. The ICB is responsible for joining up care services to improve patient care in the community within the Integrated Care System (ICS). In bringing together hospitals and family doctors, physical and mental health, the NHS, local councils and community and voluntary services, the ICB allows for greater input from all those involved in delivering services, resulting in better care wrapped around individuals. The ICB ensures that the best possible care is available to people in our communities. It constantly assesses what needs to change to meet the level and complexity of care in the county. The ICB ensures that integrated care improves population health and reduces inequalities between different groups.

During 2025-26, NHS England's approach has increasingly emphasised a more devolved operating model alongside clearer, more direct accountability relationships with both ICBs and providers. For Northamptonshire, this means NICB and local trusts are expected to take greater ownership of planning and delivery against agreed priorities and performance requirements, with more direct engagement with NHS England to support assurance and improvement where required.

For 2026-27, plans were developed within new cluster arrangements between Northamptonshire Integrated Care Board (ICB) and Leicester, Leicestershire and Rutland (LLR) ICB commencing in September 2025. This arrangement is intended to strengthen joint planning and delivery across the wider system while maintaining local accountability for Northamptonshire priorities. UHN has also worked closely to align priorities and their approach to planning with University Hospitals of Leicester NHS Trust (UHL) under the Group arrangements.

Alongside the annual plan, NHS ICB's and providers have moved to a medium-term planning horizon, with each organisation submitting finance, workforce, and activity and performance plans aligned to national and system wide strategic priorities. This approach supports clearer accountability for delivery at provider level and ensures that the Trusts' operational, workforce and financial plans are consistent with the broader ICB strategy and system-wide performance requirements.

The deficit forecast outturn for University Hospitals Northamptonshire (UHN) in 2025-26 was £66.2m, including deficit support funding of £47.8m. This was a £56.2~~3~~m adverse variance to plan. The performance analysis below provides a detailed summary of performance against activity, workforce and financial plans, including the year-end outturn position.

Planning for 2026-27 onwards

The Group and NICB submitted a 3-year medium term plan to NHS England on 18 March 2026, covering 2026-27 to 2028-29. This plan identified a NGH planned deficit of £57.9m in 2026-27, £38.3m in 2027-28, and £19.7m in 2028-29. This plan position has been triangulated with the ICB and other Commissioners and is part of an overall UHN deficit plan of £102.3m for 2026-27, reducing to £36.2m in 2028-29. All plans exclude NHSE deficit support funding due to non-compliance with the breakeven position requirement. The Trust plan has been compiled taking account of known and anticipated cost pressures, an allowance for prioritised investments and the assumed delivery of an efficiency target of around 7% in all three years. The Trusts continue to work with ICB and NHS England to identify measures to reduce the overall deficit position.

Working together to tackle local health inequalities

Health inequalities continue to have a significant impact on the communities served by UHN. Differences in deprivation, ethnicity, age, sex and wider social factors can affect people's access to services, their experience of care and the outcomes they achieve. As acute trusts, UHN has an important role in understanding these differences and using the information available to us to support more equitable access, experience and outcomes across the services we provide.

During 2025-26, the Group continued to develop its approach to health inequalities in line with NHS England's Statement on Information on Health Inequalities. This work remains at an early stage in several areas, but it has provided an important opportunity to review the information currently available, identify gaps in our data and analysis, and begin to establish a clearer basis for future action.

NHS England statement requirements and key lines of enquiry

NHS England's revised statement for 2025/26 expects trusts to demonstrate how they have collected, analysed and published information on health inequalities, and how that information has been used to inform decision-making and improvement. The statement is supported by a set of Key Lines of Enquiry (KLOEs) covering five areas:

1. understanding health needs
2. improving data quality, collection and analysis
3. understanding healthcare access, experience and outcomes
4. using information to act on health inequalities; and
5. publishing information on health inequalities.

NHS England also expects trusts to include information on operational priorities, Core20PLUS5 (central framework used to identify and reduce healthcare inequalities) clinical priorities and ethnicity coding/data quality within or alongside annual reports.

This section of the annual report has therefore been structured to reflect those requirements. It summarises the Group's current position, the information reviewed during the year, and the areas where further development is needed to strengthen both reporting and delivery over time.

Understanding local need and current position

Our approach has drawn on a combination of local population insight, trust performance information, service-level intelligence and wider system understanding. In practice, this remains a developing area for the Group, particularly in relation to the routine breakdown of data and the use of that information to target action more consistently.

The Northamptonshire Health Inequalities Annual Report 2024/25, published by Northamptonshire ICB, highlights that our local population is both growing and ageing, with the number of people aged 80 years and over projected to increase significantly over the coming years, with corresponding implications for demand on urgent, elective and complex hospital services. It also shows that around 15% of Northamptonshire's population live within the 20% most deprived areas nationally, and that deprivation is associated with poorer health outcomes and higher health need. The analysis identifies cardiovascular disease, cancer and respiratory disease as the conditions contributing most to the life expectancy gap between the most and least deprived communities, making them particularly significant for acute healthcare planning and service delivery. The report also shows that people living in more deprived areas experience poorer access and outcomes across a range of measures, including higher emergency care use, poorer cancer outcomes and poorer chronic disease management, while racialised communities experience higher emergency care use and lower uptake of some preventative and planned care services. These inequalities are compounded by high levels of modifiable risk factors locally, including smoking and obesity, which continue to influence both population health and future demand for acute healthcare services.

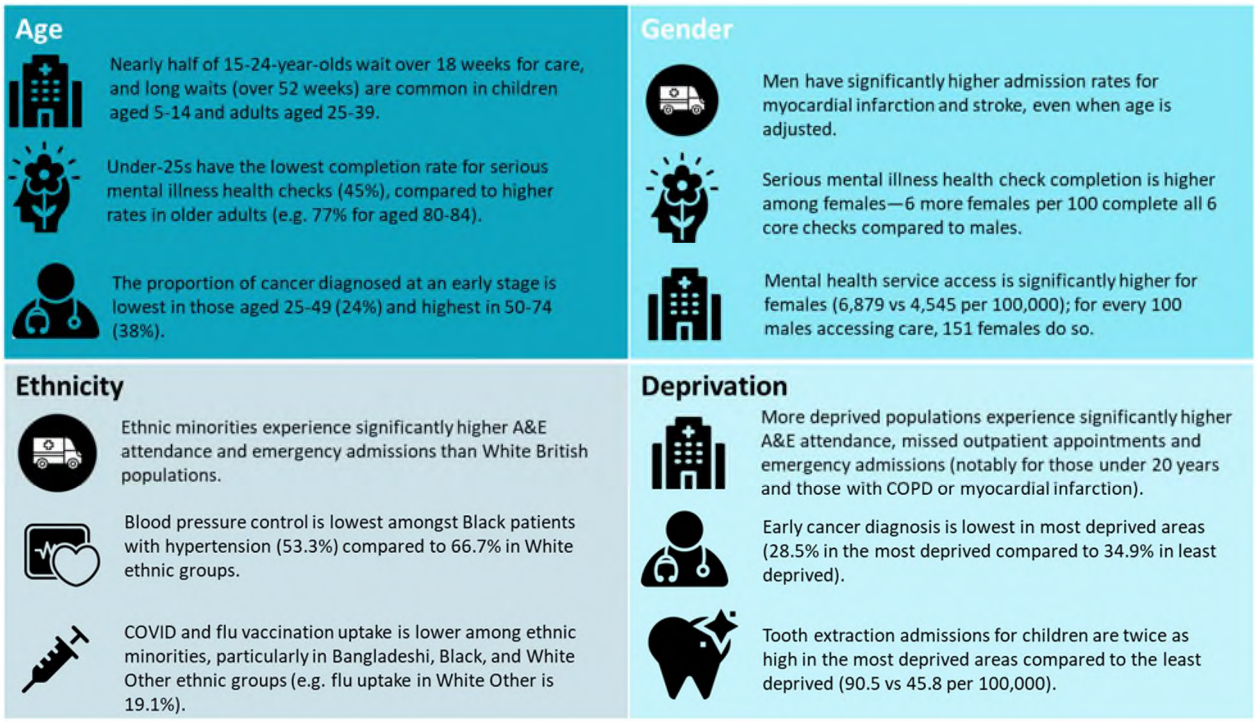


Figure 1 Key finding from the Northamptonshire Health Inequalities Annual Report 2024/25

Improving data quality, collection and analysis

The Group has implemented a targeted approach to improving the completeness and accuracy of demographic data to support health inequalities analysis. Routine data quality monitoring focuses on key fields such as ethnicity and demographic information, where completeness is critical to understanding variation in access and outcomes. Regular audits of demographic data across outpatient, inpatient and A&E services provide substantive assurance and enable targeted improvement activity where gaps are identified. Risks are escalated, and improvement actions are monitored and re-audited to ensure progress. These actions are aligned to expectations set by NHS England and reinforced through system controls and staff awareness.

Performance against data quality dashboards for ethnicity remains strong across both sites, exceeding national averages, providing a reliable foundation for health inequalities analysis. A breakdown by site is provided below for April 2025 – February 2026.

	Northampton General Hospital	Kettering General Hospital
Admitted Patient Care	97.7%	99%
Outpatient	96%	97.4%
Maternity	98.4%	98.9%
Emergency Care	96.2%	99.2%

Data Quality will continue to focus on strengthening the quality and completeness of demographic data captured within the Patient Administration System, recognising its critical role in supporting health inequalities analysis. Improving the recording of protected characteristics and deprivation-related information at the point of entry will enable more reliable linkage and a clearer understanding of patient pathways and service use across different groups. This will support better identification of underrepresented populations and gaps in access, experience and outcomes, enabling more targeted and practical actions to reduce inequalities.

Understanding healthcare access, experience and outcomes

During the year, the Group has begun to use available information to better understand variation in access, experience and outcomes across several priority areas. This includes consideration of operational priorities such as elective care and urgent and emergency care, together with selected Core20PLUS5 clinical priorities, including maternity and other areas where inequalities may contribute to poorer outcomes or access barriers.

This work also sits within the wider direction of travel of the UHN/UHL Group Clinical Strategy, which is intended to support more seamless, proactive and preventative care and stronger integration between primary, acute, community and local authority services. As neighbourhood models develop, this provides an opportunity to align future health inequalities work more closely with local population need and with the wider shift towards care that is delivered earlier, closer to home and through stronger place-based partnership working.

The Group has also recognised the importance of understanding healthcare experience as well as activity and outcomes. This includes areas such as patient experience, access to information and communication support, and other factors that can influence how people engage with services and how equitable that experience is across different groups.

The Group also completes an annual review against the NHS Equality Delivery System (EDS) 2022, which provides a structured assessment of equality across three domains: Commissioned or Provided Services (including patient experience), Workforce Health and Wellbeing (staff experience) and Inclusive Leadership. This helps to bring together evidence from across the organisation and stakeholder insight to identify priorities and track progress over time. EDS findings and actions are considered through group governance arrangements and are published in line with national guidance.

Using information to act on health inequalities

While the Group's use of health inequalities data is still developing, work during 2025-26 has begun to translate this agenda into practical service improvement and partnership activity.

During the year, this has included targeted actions to address maternity inequalities, including service user engagement and listening events, maternity specific translation services and promotion of staff diversity. Future collaborative work is planned to include a targeted quality improvement project to reduce late pregnancy bookings in specific patient groups. Other work this year has also included trust-wide action to improve patient experience and access, such as the introduction of the UHN Translation Service, helping to provide more consistent communication support for patients across Northamptonshire.

Case study – Addressing Sickle Cell Health Inequalities

The UHN Haemoglobinopathy Improvement Programme addresses the sickle cell health inequalities in Northamptonshire and demonstrates strong alignment with NHS England's Information on Health Inequalities KLOEs. Local work has focused on understanding population need, improving access and experience, and translating insight into practical action for a Core20PLUS population disproportionately affected by unequal outcomes.

UHN partnered with Northamptonshire Carers and Cole & Clay to form a Community Asset Group SickleWell, developed in response to long standing poor patient experiences, particularly delayed pain relief in emergency care and challenges transitioning from paediatric to adult services. Using lived experience and community co-production, the project has built a clearer understanding of both clinical and social needs, including isolation, mistrust of services, and barriers linked to geography, culture, and life stage.

SickleWell has strengthened this approach by providing a trusted, peer led community model that complements hospital care. SickleWell Connect groups offer structured education, peer support, and direct access to Clinical Nurse Specialists from across UHN and UHL, delivered flexibly through

online and rotating face to face sessions across Northamptonshire. This place-based approach improves accessibility and reflects population distribution, directly addressing inequality in access.

Insight gathered through community engagement, feedback, and expert by experience involvement has informed service improvements, digital alert flagging, education initiatives, and smoother service transition. Qualitative intelligence is used to fill gaps where traditional data may underrepresent sickle cell patients.

The programme demonstrates how inequalities data and lived experience are being used to redesign pathways, improve patient trust, and reduce avoidable hospital attendance. Learning has been shared regionally, with plans to embed patient voice into ongoing system planning and governance, supporting sustained action on health inequalities.

Health inequalities considerations have also informed the Group's contribution to the wider shift towards care closer to home. Over the past 18 months, two Community Diagnostic Centres have opened in Kings Heath (Northampton) and Corby, with locations taking into consideration local population needs to improve access and reduce barriers associated with travel and deprivation. Working with system partners, the Group will continue to develop the pathways and supporting services around these centres so that the benefits of earlier diagnosis and timely investigation are delivered equitably across communities. This approach will also shape future strategic estates developments, including plans for elective, diagnostic and urgent treatment centres.

The Group also recognises that health inequalities are shaped by the wider determinants of health, and that its contribution extends beyond the direct delivery of healthcare. Through its **role as an anchor institution** (large public sector organisations that are deeply rooted in their local communities), UHN has continued to work with the Northamptonshire Anchor Institution Network and local partners on areas including employment, sustainability and procurement/social value, recognising that these wider levers can contribute to healthier communities over time.

Alongside this, the Group has continued to strengthen the foundations for future action through work on improving governance processes and links with research and innovation. Taken together, these actions show the beginnings of a more joined-up approach in which health inequalities information can inform service development, improve patient experience and support the wider shift towards earlier intervention, neighbourhood working and more integrated place-based care.

Publishing information on health inequalities

NHS England guidance includes a set of guidelines for NHS bodies to use including a measurement framework which sets out a menu of good practice core and supporting measures that align with national policy priorities. These measures cover three key reporting sections - operational priorities, selected Core20PLUS5 (national NHS framework to reduce healthcare inequalities) clinical areas and data quality.

Table shows NHSE Health Inequalities Guidance recommended measurement framework aligning the national policy priorities:

Operational Priorities	Core20PLUS5 (Adults)	Core20PLUS5 (CYP)	Data Quality
• Elective Care • UEC	• Maternity • Mental Health • Respiratory & Smoking • Cancer • CVD • Vaccines • LD&A	• Asthma • Diabetes • SEND, LD&A and Epilepsy • Oral Health • Mental Health	• Ethnicity Recording

This report includes a small number of example graphs, using metrics recommended in national guidance, to show how variation in access and outcomes can be explored by deprivation and ethnicity. At this stage, the metrics included here provide baseline information to help identify where inequalities may exist and to shape priorities and actions over time; they do not represent a comprehensive assessment across all services. (An analysis of data quality and ethnicity recording is included above).

Several of the recommended metrics are available through national dashboards such as the NHS England Maternity and Neonatal Equalities Dashboard and Tobacco Dependence Services Dashboard, enabling analysis and benchmarking of locally collated data through national datasets.

During 2026-27, the Group will use the data available to refine the final set of measures for routine reporting and update the supporting narrative accordingly, alongside development of a dedicated Health Inequalities Report with the full suite of metrics and more detailed analysis that aligns to local priorities and can be utilised to develop plans to deliver change.

The Group will continue to strengthen its approach to health inequalities reporting and improvement. Priorities will include improving the completeness of demographic data as part of the rollout of new digital systems; embedding more routine analysis of access, experience and outcomes by deprivation, ethnicity, age and sex; and using the selected metrics more actively to shape actions and monitor progress over time. The Strategy, Transformation and Digital Committee of the Board of Directors will provide oversight of this important work.

Performance Management Framework

The Group Integrated Performance Report (IPR) is submitted to Boards of Directors at each meeting. The Trust uses Statistical Process Control exception reporting, using longitudinal data and statistical theory to inform judgement and provide greater assurance and trend analysis. The Trust uses an aligned suite of key performance metrics to monitor performance in the context of UHN, with consolidated reports to the Board of Directors on a bi-monthly basis.

The strategic priorities, as set out above, are a key part of our integrated business planning cycle to ensure that we create a single forward focused view of our priorities and goals that can be used to communicate and engage staff about what we are trying to achieve, with clear goals, deliverables and KPIs.

As part of the alignment of risk management arrangements across the group, links have been strengthened between the Group Board Assurance Framework (BAF) and key linked Corporate Risks within each Trust. This allows for the alignment and escalation of risks from ward through Directorate and Divisional risk registers up to the corporate risk register with the Risk Management and Audit Committees maintaining governance oversight and a reporting line to the Board; over 100 risk registers, identified from ward to board, are in place at KGH.

Links to the Integrated Governance Reports, considered by the Board of Directors during the year, are available on our public website: https://www.kgh.nhs.uk/board-of-directors-and-board-meetings

The Trusts implemented a new Accountability and Continuous Improvement framework in April 2025 across clinical and corporate teams to provide balanced scorecard measures which cascade from the Boards through divisions and directorates to team level, and provide weighted performance scores for each team. The Integrated Governance report was relaunched as an Integrated Performance Report as part of this process and provides:

- Clarity on metrics and targets, re-organised by CQC domains (Caring, Safe, Effective, Responsive, Well-Led, Use of Resources)
- Improved processing of organisational data via the data warehouse programme;
- A format that supports interpretation and discussion;
- Culture and behaviours that support the right discussions in committees;
- Links to internal organisational performance reporting.

Trust Performance analysis

1.3.1 NGH Highlights, 2025-26

April 2025

NGH is nationally accredited to deliver a high level of endometriosis care

NGH was approved as a top regional centre for the treatment of women with endometriosis.
It has recently been approved by the British Society for Gynaecological Endoscopy to provide treatment to patients suffering from advanced endometriosis. This means women with stage 3 or 4 rectovaginal endometriosis will no longer have to travel further afield for their treatment.

June 2025

NGH launches New Electronic Patient Record system

NGH went live with a brand-new Electronic Patient Record (EPR) system, marking a major step forward in modernising patient care.
The new system brings together patients' medical records into a single, secure digital format. It enables clinical teams to access real-time information about a patient's care, helping them make quicker, safer and better-informed decisions.

May 2025

Competition winning nurse shows the benefits of cutting caffeine to improve patient wellbeing

A month-long trial involving switching patients and staff to decaffeinated tea and coffee, has shown promising results for elderly patients. Led by Infection Prevention and Control Nurse Jasmine Lowdon, the trial revealed significant findings including elderly patients experiencing better sleep and reduced incontinence.

July 2025

KGH and NGH achieve a national award for the way they support the armed forces' community

KGH and NGH both achieved a national recognition award for the way they support service and ex-service personnel.
The two hospitals both achieved the Gold Award from the Government's 2025 Ministry of Defence Employer Recognition Scheme.

The Gold Award reflects the outstanding efforts UHN has made at both hospitals to support veterans, reservists, military spouses or civil partners of current service personnel and Cadet Force Adult Volunteers (CFAV's).
.

August 2025

Unveiling major plans to improve emergency care experience

NGH announced plans for a new facility to create a new central entrance to all urgent and emergency care services. The designs show a modern environment where patients needing urgent and emergency care would access the most appropriate place for their care. The new building will replace the existing Springfield Urgent Treatment Centre, which opened in 2017 and temporary entrances to the Emergency Department which have been in place since 2023. The unit will be built on the Cliftonville Road and would join the existing Emergency Department with the Nye Bevan building.

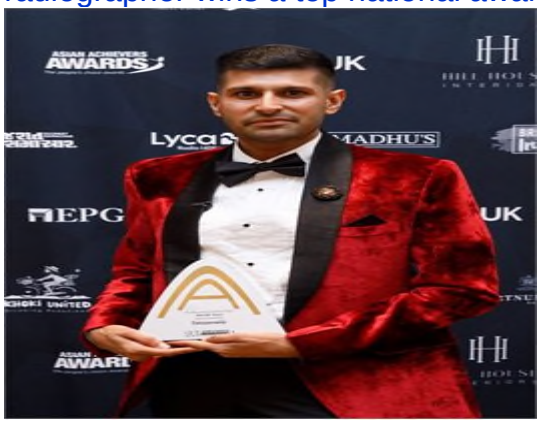
October 2025

UHN pioneers live-streamed robotic cancer operations as part of advanced medical education

UHN undertook two live-streamed robotic colorectal cancer operations to support the education of surgeons. Two local patients with colorectal cancer consented to support the event. They were operated on while their operations were live-streamed into the Cripps Education Centre at NGH.
The live-streamed operations formed part of a two-day robotic surgical symposium where consultants, colorectal surgeons, and senior doctors from Northamptonshire, the rest of the UK, and Portugal, met and took part in a range of events, lectures, discussions, and presentations.

September 2025

NGH consultant therapeutic radiographer wins a top national award



A consultant therapeutic radiographer has received a prestigious national award for his achievements and the way he supports patients. Maulik Darji has been named Professional of the Year at the prestigious national Asian Achievers Awards 2025.
He won the award for the contribution he is making to his profession and for the way he has championed head and neck cancer patients in the county and nationally.

November 2025

Local neonatal unit at NGH gets top marks in national quality of care audit

The unit that looks after premature and sick babies at Northampton General Hospital has achieved some top marks in a national quality audit. Gosset Ward - which supports more than 450 babies each year - has achieved nationally outstanding performances in two areas of care measured by the National Neonatal Audit Programme, published this month.

.

December 2025

NGH achieves a green award for its inspirational sustainability work

NGH won a national environmental award for the way it has encouraged other hospitals to find new ways to reduce carbon emissions and waste. It has been awarded Sustainability Influencer of the Year at the national Investors in the Environment (iiE) Awards 2025. The award goes to businesses that have changed behaviours to inspire change beyond their direct business activities.

February 2026

Radiotherapy team feature on BBC Radio 5 Live

As part of the World Cancer Day coverage, BBC Radio 5 Live asked their listeners to nominate their Cancer Stars – those teams and individuals who had a positive impact on their diagnosis, treatment and aftercare following a cancer diagnosis. On last Tuesday's breakfast show presenter Rachel Burden spoke to Carolyn, a cervical cancer patient at NGH, who had nominated the radiotherapy team as her Cancer Stars. Carolyn had her diagnosis in September 2025 and has undertaken five weeks of both chemotherapy and radiotherapy.

January 2026

Muslim Midwife of the Year Award for Hauwa

An NGH midwife has won Midwife of the Year at the first ever British Muslim Health Awards 2025. Hauwa Hamza has trained and worked at Northampton General Hospital as a midwife and for the last sixteen months has worked in the One Digital and Data team in the role of Digital Clinical Facilitator to help transform and modernise midwifery information systems.

March 2026

Special messages for special moments

NGH launched a new volunteer-led service that allows families and friends to send personalised messages to patients online – which are then delivered in person on a greeting card by hospital volunteers.

The initiative, designed to support patients who may feel lonely or anxious, enables messages of many kinds to be composed online and delivered for free directly to the patient's ward on a card which they can choose.

1.3.2 Performance Analysis: Caring, Safe and Effective

This section provides draw attention to the Trust's work to enhance the quality and safety of care provided to patients, including performance against key quality indicators including mortality, falls, infection prevention and control. It should be read in conjunction with the Annual Quality Report, which is available to view on the Trust's website here: NGH Quality Account

During 2025-26, NGH received multiple positive visits across Emergency and Children's Emergency Departments, children's and adult inpatient wards, and outpatient departments. These included formal peer reviews, Healthwatch engagement, Non-Executive Director walk rounds, ICB support visits, and structured accreditation observations. Feedback consistently highlighted welcoming teams, compassionate care, good clinical standards, and positive patient and family experience, with no significant safety concerns reported in the documented visits.

The following Performance Analysis provides a detailed performance summary for Northampton General Hospital against the headings of Caring, Safe, Effective, Responsive and Well-Led (including Use of Resources) (aligned to CQC domains and the Integrated Performance Report).

The analysis contains Statistical Process Control charts for a number of key indicators; these charts contain the following symbols:

The *dotted grey lines* on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

The *dotted orange lines* on SPC charts show the target.

The *straight lines* show acutal performance against target.

1.3.2.1 Nursing Midwifery and Allied Health Professionals (NMAHP) Strategy

During 2025–26, University Hospitals of Northamptonshire strengthened its approach to quality, safety and continuous improvement through the development and implementation of a refreshed Quality Strategy. This followed the completion of earlier strategies and reflected the need for a clear, shared direction across nursing, midwifery and allied health services.

The Quality Strategy, covering 2025–2028, was launched in summer 2025 following engagement with staff across clinical services. It sets out a clear focus on delivering excellent patient care, supporting staff to provide that care, and working in partnership to reduce variation and improve outcomes.

Improving patient safety remained a central priority. Sustained work continued to reduce avoidable harm, including falls, pressure damage and healthcare-associated infections. Alongside performance monitoring, there was an increased emphasis on learning from incidents and supporting teams to make practical, locally led improvements, helping embed a culture of safety and continuous improvement.

Investment in quality improvement capability continued throughout the year. More staff became involved in improvement activity, supported by training, coaching and clearer oversight. This has helped ensure that improvements are evidence-based, measurable and sustainable.

Staff experience was recognised as fundamental to delivering high-quality care. Shared decision-making approaches were further embedded, enabling staff to have a stronger voice in decisions affecting their

work and patient care. Education, training and professional development remained priorities, supporting staff wellbeing, retention and leadership at all career stages.

Digital developments also supported the Quality Strategy, including progress with electronic patient records, digital audits and standardised reporting. These changes have helped improve patient safety, reduce duplication and release staff time for direct care.

By March 2026, the organisation had established a clear and consistent approach to quality improvement, with the Quality Strategy actively embedded across services. This has created a strong foundation for continued improvement in patient safety, staff experience and care quality in the years ahead.

1.3.2.2 Patient Experience and Engagement

1. Supporting Patients and Families

During 2025-26, patient experience and involvement continued to be strengthened through structured listening, learning and improvement activity across nursing, midwifery and allied health professional services. Patient feedback and lived experience were actively used throughout the year to inform service improvement, with particular focus on maternity care, surgical pathways and coordination across services. Learning from patient experience was embedded into practice, with actions identified and implemented to improve communication, compassion and continuity of care.

2. Hearing the Voice of Our Patients

We are committed to ensuring that patients and carers can share positive experiences and areas of concern regarding their care. A range of structured feedback mechanisms are in place to capture these perspectives and support the ongoing development of our services. Key approaches are outlined below.

Patient Feedback

3. **Friends and Family Test (FFT)**
   The Friends and Family Test remains a core national measure of patient experience, inviting patients to indicate whether they would recommend our services, alongside providing qualitative feedback to explain their responses. The survey also includes questions relating to protected characteristics to support the monitoring of equity and inclusivity in care delivery.

   Feedback is collected at multiple points throughout the patients journey and is accessible through a variety of formats, including text messaging, automated telephone calls, QR codes, postcards, and online platforms, ensuring broad accessibility and ease of participation.

4. **CQC and NHS England National Surveys**
   A programme of national surveys mandated by the Care Quality Commission (CQC) is undertaken annually. The findings from these surveys are shared transparently both internally and externally and are routinely presented to the Patient Carer Experience and Engagement Committee (PCEEC) to inform oversight and drive quality improvement.

During 2025-26, CQC national survey results were published for the most recent surveys:

(i) **2025 Children and Young People Survey** Results published May 2025 for patients discharged in March through to May 2024. Responses were received from 249 parents and carers, which was a response rate of 20%. Detailed below are the top five results regarding the best patient experience and where this could be improved:

Where reported patient experience was best (top 5 scores)	Comparison to other Trusts	Where reported patient experience could improve (bottom 5 scores)	Comparison to other Trusts
Children and young people's questions			
1. **Hospital food**: Young people having access to hospital food outside mealtimes	better than expected	1. **Hospital ward**: Children and young people not being stopped from sleeping by noise from other patients	about the same
2. **Being looked after in hospital**: Staff playing or providing activities for children and young people	somewhat better than expected	2. **Operations and procedures**: Staff providing children and young people with clear explanations after operations or procedures	about the same
3. **Facilities**: Children and young people finding the hospital Wi-Fi meets their needs	better than expected	3. **Hospital ward**: Children and young people not being stopped from sleeping by the hospital environment	about the same
4. **The waiting area**: Children and young people being kept informed while in waiting areas	somewhat better than expected	4. **Talking to hospital staff**: Staff helping children and young people with their fears or worries	about the same
5. **The waiting area**: Children and young people not feeling bothered by anything in waiting areas	about the same	5. **Leaving hospital**: Staff providing information to children and young people about who to contact if they were worried about anything after discharge	about the same
Parents and carers' questions			
1. **Being looked after in hospital**: Staff taking parents / carers' concerns seriously	better than expected	1. **Operations and procedures**: Parents / carers feeling that staff explain well how the child or young person's operations or procedures have gone	worse than expected
2. **Hospital food**: Children having access to hospital food outside of mealtimes	about the same	2. **Operations and procedures**: Parents / carers feeling that staff explain well what will be done before the child or young person's operations or procedures	about the same
3. **Facilities**: Parents / carers having good access to food in hospital	about the same	3. **The waiting area**: Children having enough to do in waiting areas	about the same
4. **Facilities**: Parents / carers having good access to hot drinks in hospital	about the same	4. **Being looked after in hospital**: Parents / carers having confidence and trust in staff caring for their child	about the same
5. **Talking to hospital staff**: Staff providing consistent information about care		5. **Operations and procedures**: Parents / carers feeling that staff provide enough distraction	about the same

		for children and young people during operations and procedures	

(ii) **2024 Adult inpatients –** Results published in September 2025 for patients discharged in November 2024. Responses were received from 435 patients, which was a response rate of 37%. Detailed below are the top five results regarding the best patient experience and where this could be improved:

Where reported patient experience is best:	Comparison to other Trusts	Where reported patient experience could improve:	Comparison to other Trusts
1. Leaving hospital: Staff discussing with patients whether they would need any additional equipment in their home after leaving	about the same	6. Sleeping: Patients not being prevented from sleeping at night	worse than expected
2. Information while on waiting list: Quality of information given while on waiting list	about the same	7. Waiting in the hospital: Length of time waited (in another location) before admission to a ward	somewhat worse than expected.
3. Support from health or social care services: Patients getting enough support to recover/manage condition after leaving hospital	about the same	8. Individual needs: Staff taking into account patients' individual needs: Dietary needs	Benchmark data has not been provided for Q31 (individual needs) due to data quality issues
4. Waiting list: Length of time on waiting list before hospital admission		9. Help from staff to eat: Patients' getting enough help from staff to eat meals	worse than expected
5. Information while on virtual wards: Patients feeling they were given enough information about care and treatment on virtual ward	about the same about the same	10. Sleeping: Patients being prevented from sleeping at night due to noise from other patients	somewhat worse than expected

(iii) **NGH 2025 Maternity –** Results published in November 2025 for patients discharged in February 2025. Questionnaires were issued between April and July 2025, responses were received from 129 patients, which was a response rate of 44%. Detailed below are the top five results regarding the best patient experience and where this could be improved:

Where reported patient experience is best:	Comparison to other Trusts	Where reported patient experience could improve:	Comparison to other Trusts
1. **Antenatal care: During your pregnancy:** Relevant information provided from midwives about feeding their baby	much better than expected	1. **Care in the Ward:** Partner or someone else close to them being able to stay as much as they wanted	worse than expected
2. **Antenatal care: Antenatal check-ups:** Midwives or doctor aware of medical history	better than expected	2. **Labour and Birth: Your labour and birth:** Feeling that healthcare professionals did everything they could to help manage pain	about the same
3. **Antenatal care: Antenatal check-ups:** Being asked	better than expected	3. **Postnatal Care: Feeding your baby:** Decisions about	about the same

about mental health by midwives 4. **Antenatal care: During your pregnancy:** Having confidence and trust in the staff caring for them 5. **Antenatal care: During your pregnancy:** Concerns being taken seriously	better than expected better than expected	how to feed their baby respected 4. **Labour and Birth: Your labour and birth:** Partner or someone else close to them was able to be involved as much as they wanted 5. **Postnatal Care: Care at home after birth:** Frequency of seeing or speaking to a midwife	about the same about the same

Analysis of feedback and actions taken in response

The CQC Maternity and Children and Young People (CYP) survey results identified areas where patient experience was reported as worse than expected. The Trust recognises these findings and the importance of a clear, targeted response, including explicitly acknowledging these outcomes within reporting. In response, steps have been taken to strengthen patient and carer engagement by enhancing service user involvement, including close partnership working with the Maternity and Neonatal Voices Partnership (MNVP).

UHN Maternity Services co-produced an 8-point action plan with the MNVP, focusing on the lowest scoring areas across both KGH and NGH, to ensure that improvement activity is proactive and directly informed by patient and family experience across the county. This approach has already led to patient-informed service changes, including the introduction of partners staying overnight, demonstrating a clear link between feedback received and tangible improvements to care. Delivery of this work through multidisciplinary workstreams has further supported a collaborative approach to service improvement, ensuring that changes are meaningful and sustainable.

Ongoing improvement work is also underway in response to key themes identified in the survey. This includes enhancements to pain management, such as the introduction of scheduled drug rounds at KGH and the availability of Pethidine within the Birth Centre at NGH. Opportunities for self-administration of analgesia are also being explored across both sites, with the intention of implementation Trust-wide. Infant feeding has been identified as a further priority area, particularly in relation to the impact of tongue-tie. Both sites are therefore working towards the implementation of a maternity-led tongue-tie clinic to improve timely access to care and support for families. Strengthening patient engagement remains a core focus. This includes the continuation of biannual Maternity Roadshows, which provide families with opportunities to engage directly with midwifery, obstetric, and neonatal teams, alongside local charities, supporting ongoing co-production and responsiveness to patient feedback.

(5) Patient Experience Listening Events

Listening events are carried out across the Trust to enable clinical teams and services obtain direct feedback on positive outcomes and areas of improvements from a patient and carer perspective.

The Patient Experience and Engagement Team held the following events during 2025-26:

(6) Neonatal and Transitional Care:

The UHN Patient Experience & Engagement team facilitated two Neonatal and Transitional Care Listening Events, in conjunction with the Maternity and Neonatal Voices Partnership**.** These events were a follow up to events held at KGH and NGH last year building on the continuous improvement programme led by the UHN Neonatal Clinical Psychologist, the clinical and nursing leads for the units. There was some excellent positive feedback gathered at both events for the support and care received by the clinical teams. Themes that will form the improvement action plans include:

- Information and support to help parents understand medical feeding plans
- Greater support and inclusion for fathers.
- Out of hours access to Gosset Ward was problematic.
- Improved discussions with parents prior to discharge.

(7) Multiple Sclerosis

The Patient Experience & Engagement team in collaboration with the Quality Improvement Team, the Multiple Sclerosis team and the Multiple Sclerosis Society facilitated a Multiple Sclerosis listening event for patients with this condition who use NGH services. The event was attended by both patients and carers giving a great insight into their experiences and pathway journeys through the Emergency Department, inpatient wards, outpatient services and community support for patients. Generally, the feedback was very positive with the need for improvements to discharge planning for both patients and carers.

(8) Assistance Dogs Training Event

In May 2025, the Head of Patient Experience and Engagement facilitated a visit to Danetre hospital by the Infinity Dogs organisation and East Midlands Ambulance Service as part of the Assistance Dogs Training Event incorporating clinical areas and ambulances. This provided the opportunity for young assistance dogs and their owners to experience ambulance journeys and bringing their dogs into a hospital environment.

The feedback from members of the Infinity Dogs organisation members was overwhelming positive with appreciation for the opportunity, emphasising how much it helped dog owners and their dogs grow in confidence to use our services. This joint partnership has also assisted with the shaping the new UHN Assistance Dogs Policy.

(9) Children & Young People:

NGH conducted a Children's & Young People (CYP) 15 Steps Assessment with the assistance of five current and former CYP patients who visited Paediatric ED, the two children's wards, Paediatric Assessment Unit and the Activity Centre.



The outcome from this assessment visit has informed an improvement action plan with the key areas being noted below:

- Greater focus on an environment and activities more suitable for teenage patients.
- Improved signage around the Trust that is CYP focused
- Improvement in the Activity Centre Garden.
- Improved Wi-Fi and television availability in designated areas.

(10) UHN Operating Theatre Conference:

In October the Head of Patient Experience and Engagement arranged for a patient with autism to present their lived experiences of using both NGH and KGH theatres. The session also facilitated further learning for the whole multidisciplinary learning to raise awareness of Autism for future patients. The feedback from the conference attendees was overwhelmingly positive with a greater consideration gained for patients living with Autism.

(11) West Northamptonshire Healthwatch 'Enter & View' Visits:

During October 2025 NGH received two Enter & View visits by West Northamptonshire Healthwatch covering the Paediatric Departments and the Adult Emergency Departments. For the first of the two visits, the Healthwatch team visited the Children's Accident and Emergency (Paediatric ED) Unit, Paddington Ward, Disney Ward, Play Activity Centre, Paediatric Assessment Unit (PAU) and Children's Outpatient Department.

The findings from the first visit were:

Positives:

- Welcoming and child-friendly Spaces
- Strong Safety and Accessibility Measures in place
- Positive Engagement and Communication with patients and families

Recommendations for improvement:

- Raise awareness of the hospital passport system.
- Introduce sensory spaces on all wards, especially Disney and Paddington.
- Redevelop the outdoor space into an inclusive, accessible play environment with greenery, sensory paths and wheelchair-friendly equipment.

The Healthwatch team's second visit was to the A&E Streaming Hub and Minor Injuries, Springfield Minor Treatment Centre, rapid assessment area, Ambulance Pathways, Same Day Emergency Care (SDEC), Main Emergency Department, and the Clinical Observation Area (COA).

The findings from this visit were:

Positives:

- Passionate and dedicated staff
- Safe and secure wards, with dementia-friendly blue seating
- Notification of upcoming renovations to help the flow of patients and quality of care

Recommendations for improvement:

- Better communication with patients about what to expect and wait times

- Improving the environment where patients are waiting, with additional notices, display boards and decoration.
- Improvements to provide more privacy to patients

Outcomes from the listening events helped with the creation of action plans and strategy development for the areas involved. Positive feedback was received from the participants for holding the forums, enabling patients and carers the opportunity to have their experiences heard personally, in the knowledge that NGH genuinely recognised their contributions.

(12) **Haemoglobinopathy Quality Improvement Programme**

The UHN Equality and Inclusion Officer supported the Haemoglobinopathy Quality Improvement Programme throughout 2025-26. The improvement programme has focused on the following areas of improvement;

- Development and launch of Sickle Well Community Asset Group in partnership with Northamptonshire Carers and Cole
- Collaboration with East Midlands Thalassemia and Sickle Cell Network for support in advice and guidance to the patients attending Community Asset Group
- Review of data alongside ICB Population Health colleagues to identify and promote the community services to primary care and patients across Northamptonshire
- Developing evaluation tools for patient experience towards quality improvement cycles of the Community Asset Group and neighbourhood working
- Presentation accepted to the Core20Plus (addressing health inequalities) Ambassador Programme 2025-26 on the sickle cell community asset group development approach at UHN to improve awareness

(13) Patient Stories

The Patient Experience and Engagement team are regularly asked for patient stories to be shared and discussed at various meetings and committees; they are also used for training sessions or to celebrate events such as the Daisy Awards. The team work closely with the Trust's Digital Communications Office to produce video and digital patient stories.

Throughout the year, patient stories have provided essential insight into how our care is experienced day to day, complementing clinical outcomes, safety metrics and operational performance. Positive stories highlight what we should protect and replicate: compassionate interactions, clear communication, responsive teams and well-coordinated pathways. They also strengthen staff pride and reinforce a culture of person-centred care. Negative stories are equally valuable, helping us identify where harm, distress or avoidable delays may occur, and where processes do not work as intended (for example around listening and involvement, medicines information, discharge planning, accessibility and continuity between services). Taken together, patient stories, captured through feedback, compliments, complaints and engagement activity support transparent governance, guide quality improvement priorities and help us track whether changes made are improving experience and equity. Used responsibly, with confidentiality maintained and themes triangulated with other evidence, these accounts turn lived experience into learning and action.

(14) **Local Surveys**

The Trust utilises the Envoy platform, which also supports the Friends and Family Test, to design and deliver localised patient surveys. This flexible digital system enables the rapid development and deployment of multiple surveys, accessible via web links and QR codes.

(15) **Social media and Online Reviews**

Online platforms and social media play an important role in how patients, families and carers share feedback about their experiences of care. NGH actively monitors social media channels and online review platforms, providing real-time oversight of public feedback and sentiment. This

enables themes, concerns and positive feedback to be identified promptly, with comments reviewed, responded to and, where appropriate, escalated through established governance and incident management processes to ensure appropriate action is taken.

Insights gained through social media monitoring are considered alongside other sources of patient feedback to inform service improvement and strengthen patient engagement. Social media also acts as a key engagement tool, enabling the Hospital to maintain an open and visible dialogue with its local communities. Significant work has been undertaken to strengthen relationships with local Facebook groups, supporting effective two-way communication, promoting transparency and ensuring accurate information is shared directly with the communities the Hospital serves.

Through the use of a social media management platform, the Communications Team is able to monitor all social media channels, track emerging sentiment and proactively plan content throughout the year. Increased emphasis has been placed on sharing stories that reflect patients' and families' experiences of care, alongside colleague recognition content celebrating the work of staff and teams. This approach supports Well-Led objectives by demonstrating open listening, responsive leadership and clear routes for escalation, learning and improvement based on public feedback.

(16) Supporting patients to give feedback

Friends and Family Test Performance:
There is no overarching Trust wide target as FFT targets are separate for each service. Service level targets have been reviewed during this financial year and have been agreed across NGH and KGH aligning for a UHN target satisfaction as follows:

- Inpatient wards – 95%
- Maternity – 95%
- Emergency Departments – 80%
- Outpatients – 95%

During 2025-2026, the Patient Experience and Engagement team received and analysed 68,877 FFT responses across services provided to patients. The average monthly % satisfaction score achieved across the Trust for the year was 90.5% which was an overall increase of 0.3% against the performance in 2024-2025.

As can be seen in the table below, Inpatients Wards, Day Case Units and Outpatient Departments saw a decrease in their average FFT % patient satisfaction experience during the period. Maternity Services remained static and the Emergency Department saw an increase of 0.1%.

The number of responses received decreased across Inpatients Wards, Maternity Services, Emergency Department and Outpatient Departments. The only area to see an increase in the number of responses received was the Day Case Units which increased by 213.

Table: Patient satisfaction via the Friends & Family Test (FFT)

% Patient Satisfaction via the FFT Survey	2024/25	2024/25 No. of Responses	2025/26	2025/26 No. of Responses	% increase / decrease
Inpatient Wards	94.1%	9488	93.8%	9138	-0.2%
Day Case Units	96.3%	10448	95.9%	10661	-0.4%

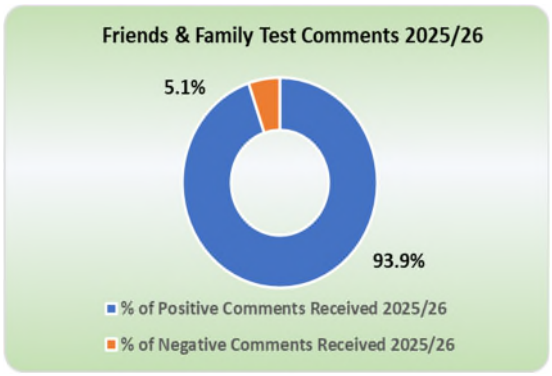
Maternity Services	95.9%	3205	95.9%	2596	0.0%
Emergency Departments	79.1%	21684	79.2%	16717	0.1%
Outpatient Departments	94.0%	32742	93.5%	29765	-0.5%
Trust wide	90.2%	77567	90.5%	68877	0.3%

Patient satisfaction performance in 2025-26 remained consistent with, and slightly more stable compared to 2024-25.

Friends and Family Test Narrative: In addition to satisfaction scores, patients and carers are asked for comments about their experiences and care received. These comments are analysed to enable us to record and celebrate positive feedback and theme negative narrative to enable us to formulate improvement strategies to employ.

Of the **68,877** responses collected from the Friends and Family Test **36,982** comments were received (compared with 42,238 the previous year). This was split into **34,717** positive and **1,902** negative comments. Detailed in the charts below is the split of positive and negative comments for 2025-26.

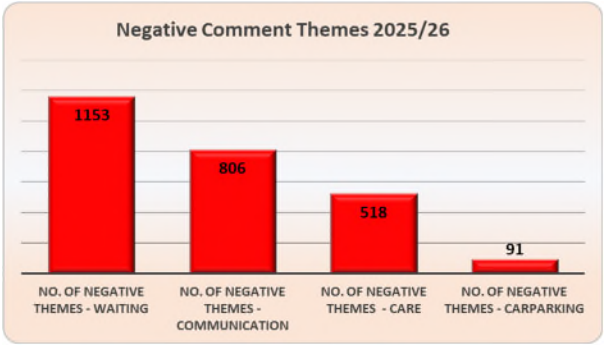
Diagram 2 – 2025-26



For all the 1,902 negative comments received, these were themed to inform areas of the most common reasons.

The 2024-25 (Diagram 1) and 2025-26 (Diagram 2) yearly comparison and breakdown of the top 4 negative feedback themes is as follows:

Diagram 1 – 2025/2026



(17) Moving forward:

During 2025-26 the activities of the Patient Experience and Engagement Team have been underpinned by strengthened collaborative working across the Trust and with external partners. This has enabled a more coordinated and systematic approach to capturing patient and carer experience, ensuring that feedback is translated into measurable service improvements. This enhanced focus has contributed to engagement, improved insight into patient needs, and more targeted quality improvement initiatives across services. A forward programme of engagement is currently being developed which will further support the identification of priority areas for improvement and ensure that patient voice continues to shape service design and delivery.

(18) Management of Complaints

The Trust recognises the effective management of complaints as a key component of its governance and assurance framework, supporting the delivery of safe, high-quality and patient-centred care. Feedback from patients, carers and the public, including complaints, is treated as a critical source of assurance and is systematically used to inform risk identification, service improvement and organisational learning.

A clear and accessible complaints process is in place, supported by established policies and procedures aligned to statutory requirements and national guidance. Complaints are managed through formal investigation by the Complaints Team or through local resolution supported by the Patient Advice and Liaison Service (PALS), ensuring a proportionate, consistent and timely approach.

Robust controls are in place to ensure that all complaints are appropriately recorded, triaged, investigated and responded to within agreed timescales, however, there have been challenges across NGH at times to achieve these. Defined escalation processes support the identification and management of complaints that meet the threshold for serious incidents, safeguarding concerns or potential legal claims. Compliance with these processes is monitored through routine audit and performance reporting.

Clear governance and reporting arrangements provide oversight of complaints management at divisional, executive and Board level. Regular reporting includes analysis of complaint volumes, themes, trends, response timeliness and outcomes, enabling the Board to gain assurance regarding the effectiveness of complaint handling processes and the quality of care provided.

The Trust is committed to embedding the Duty of Candour and promoting a culture of openness, transparency and accountability. Staff are supported through training and guidance to ensure they understand their responsibilities in relation to complaint handling and are empowered to respond effectively and compassionately to concerns raised.

Learning from complaints is systematically captured along with other sources of quality and safety intelligence, including incidents, claims and patient experience data. Action plans arising from complaints are subject to formal monitoring, with progress tracked to completion to ensure that improvements are embedded.

Through these arrangements, assurance can be provided to the Board that complaints are managed effectively, risks are identified and mitigated, and that continuous learning is driving measurable improvements in the quality and safety of services.

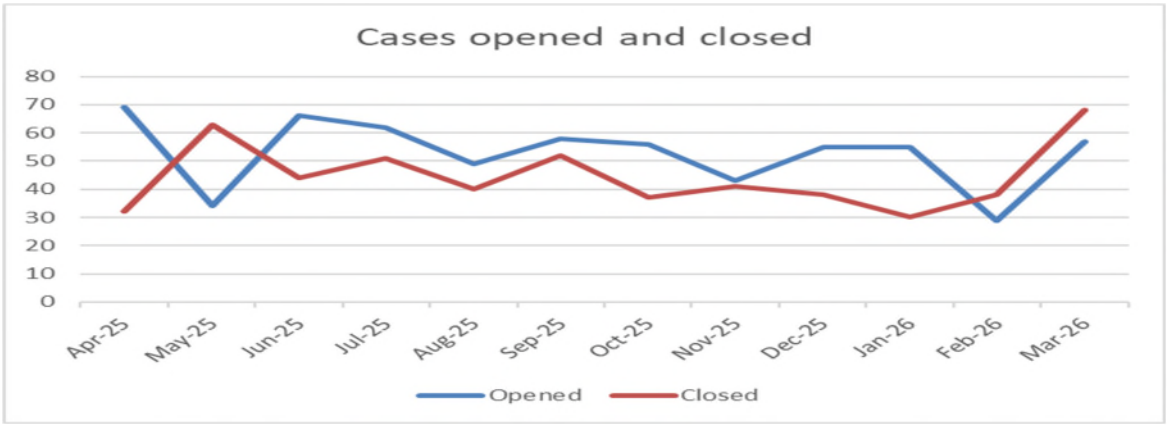
The information detailed below provides a summary of complaints received and investigated at NGH during 2025-26:

	NGH
Total number of complaints for the year **2025-26**	587
(Versus 2024-25)	(515)
Percentage change from 2024-25 to 2025-26	13%* increase
Total number of complaints responded to within 60 days	211
Total number of complaints responded to 61 days and above	309
Average response rate over the 12-month period	40%
Complaints that were still open at the time that the information was prepared (April 2026)	226
Total patient contacts/episodes*	940,621**
Percentage of complaints versus number of patient contacts/episodes	0.06%

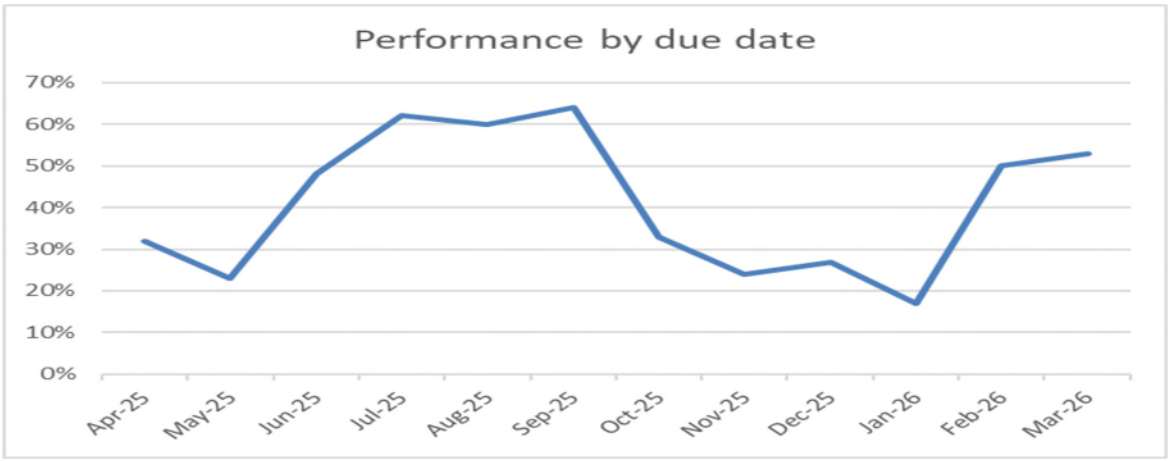
**13% increase is below the national average. Observed to be lower than other organisations.*
***Data extracted from the UHN Data Insights Portal*

Whilst it is acknowledged that there is significant improvement work required to improve the total number of complaints responded to within 60 days, there has been sustained improvements in compliance over the last two months of the year (February 50% and March 53%). The graphs below illustrate an improving position with an increase in complaints closed and overall percentage performance:

Graph 1- number of cases open and closed per month 2025-26



Graph 2- Performance against 60-day target per month 2025-26



Actions to maintain the improvement trajectory:

- Overdue meetings with leads (any cases over 60 days) introduced.
- Weekly divisional meetings between key divisional leads and complaints to be introduced.
- Streamlining templates for response and acknowledgement letters across site.
- Creation of a single complaints leaflet across NGH and KGH.
- Streamline our learning and actions and consider reviewing this alongside other specialties, i.e. clinical governance and patient safety.
- Focus on responding within set timeframes and ensuring no cases are open for longer than 120 days.
- Review the enrolment of one single email address / telephone number for complaints across the group.

(19) Learning from complaints

All complaints received are subject to a structured investigation aligned to the key lines of enquiry identified by the patient, their family, or representative. As part of this process, learning points are clearly identified and documented within the formal complaint response, alongside agreed outcomes and actions.

We are in the process of moving NGH complaints onto a new digital platform, which allows access to an actions module where evidence is uploaded and tracked for onward learning.

(20) You Said, We Did

Feedback, whether it is a compliment, concern or complaint helps us understand what it feels like to use our services and where we can do better. Over the year, we listened to what patients, families and carers told us, responded to concerns as quickly and clearly as possible, and used what we learned to improve communication, care processes and discharge planning through the “You said we did” framework. We also shared key themes through our governance and quality improvement teams so that learning leads to action. Taking feedback seriously supports safer care, a better experience, and trust in our hospital. An example of you said we did can be seen below;

NGH- Surgery and Same Day Escalation Centre (SDEC):
A patient attended the hospital and their relevant clinical information from the GP was not reviewed or acknowledged by the Surgical and SDEC team. Areas identified as learning focused on improving communication to the relevant teams and ensuring documentation from community partners are considered within clinical assessments.

1.3.2.3 Martha’s Rule

Implementing Martha’s Rule at Northampton

Martha’s Rule is a national patient safety initiative designed to strengthen the identification and response to clinical deterioration by combining routine clinical monitoring with a clear route for patients and families to raise urgent concerns and trigger structured escalation.

In April 2024, the project team at NGH transitioned from being one of the seven pilot sites for the national Worry and Concern collaborative (2022) to being one of the 143 sites for the phase one of the implementation of Martha’s Rule. We have continued to progress this project and have been putting Martha’s Rule into practice. This is about making it easier for patients and families to raise worries if someone in hospital seems to be getting worse, and ensuring staff respond in a clear and consistent way. We have focused on improving how we ask patients (and parents/carers) how they feel each day, how that information is recorded, and how concerns are acted on through a patient wellness questionnaire. In children’s wards, we have already included a question in our observation charts to help

parents and carers tell us if their child seems worse, and we are using what we learn to improve the process across more areas.

Achievements

- National external visit in December 2025 from NHS England to speak with the team about implementing Martha's Rule in paediatrics, neonatal and maternity services
- NGH Team spoke at regional celebration event in March 2026 in Birmingham about the implementation of Martha's rule

Continued Work for 2026-27

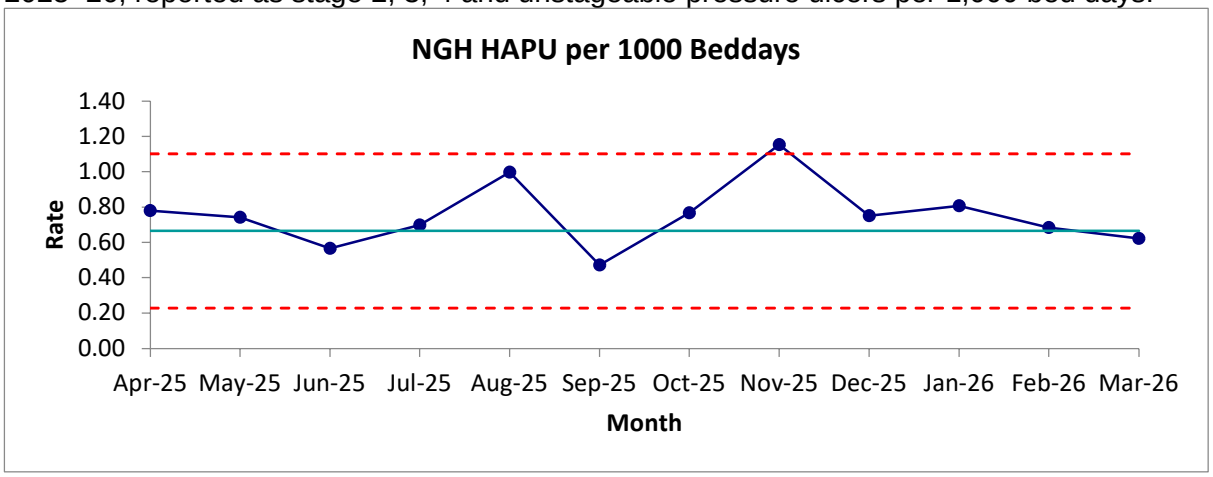
- To continue to process data from audit looking at service users' knowledge of Martha's Rule and whether they are confident to use 'Call for Concern' if required
- Meaningfully embed the Patient Wellness Questions (PWQ) in our adult areas with appropriate escalations and actions. This is being directed across our whole regions as part of a regional project with Nerve Centre
- Across UHN we are investigating how Martha's Rule could be adapted for use in our Emergency Departments.
- Introduce PWQ into neonates at NGH
- Introduce PWQ into maternity across UHN
- Further work is needed to ensure that Martha's Rule is accessible to all irrespective of language, culture and neurodiversity
- To provide mandatory training for all staff clinical and non-clinical staff.

1.3.2.4 Harm Free Care

Harm Free Care focuses on reducing avoidable harm to patients associated with patient falls, pressure ulcers, and nutrition and hydration across the hospital. During 2025–26, the Harm Free Care arrangements at NGH have continued to mature following the implementation of revised leadership and reporting structures established in the previous year.

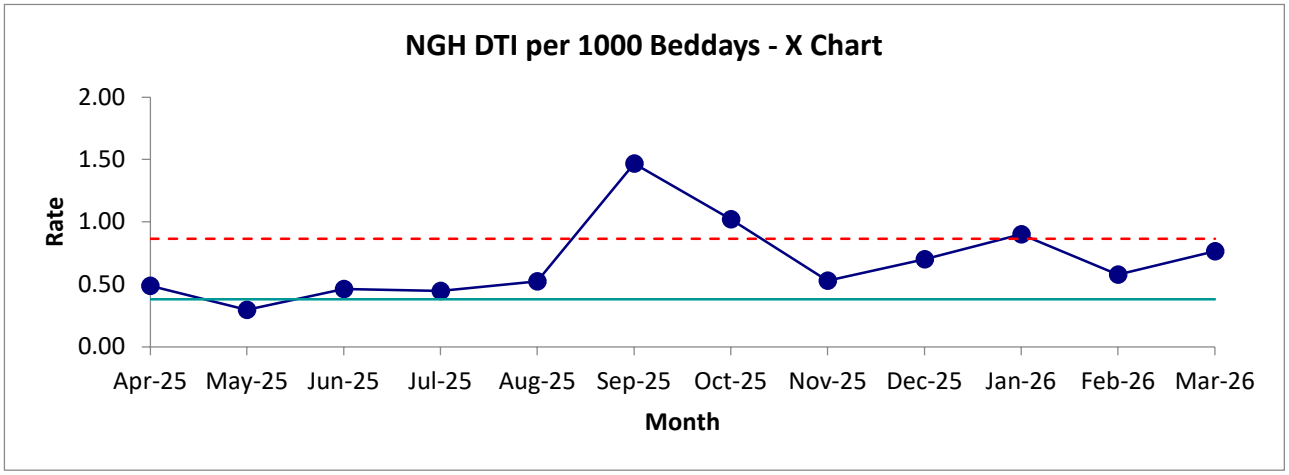
Hospital Acquired Pressure Ulcers

The chart below provides an overview of hospital acquired pressure ulcers (HAPUs) at NGH during 2025–26, reported as stage 2, 3, 4 and unstageable pressure ulcers per 1,000 bed days.



Significant effort was maintained to prevent hospital acquired pressure ulcers (HAPUs), supported by routine Harm Free Care audits, tissue viability expertise, and consistent use of national best practice standards. Most reported pressure damage remained at lower categories of harm. Learning from incidents was routinely reviewed through our structured incident review process, with actions taken to strengthen assessment, repositioning, equipment availability and staff education.

Table 2 demonstrates Deep Tissue Injury (DTI) per 1,000 bed days



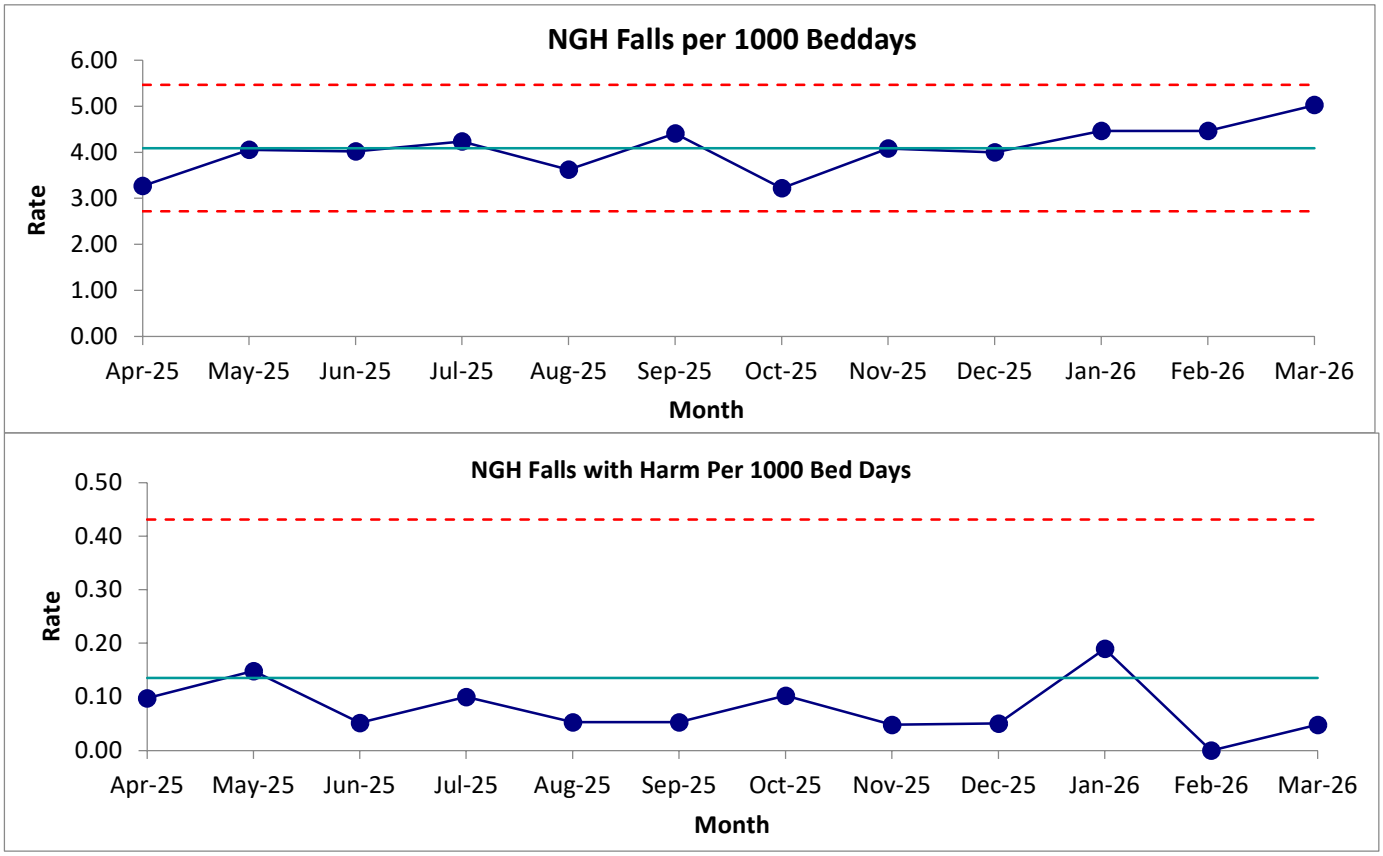
DTI's reporting during the year has highlighted periods of increased incidence, followed by improvement later in the reporting period. Ongoing review of DTI cases continues to inform targeted learning and supports earlier identification of deep tissue damage.

Work during 2025–26 focused on:

- Purpose T (pressure risk assessment form) fully implemented onto the new electronic patient record, replacing previous tools.
- Targeted education and validation sessions, particularly in the:
    - Emergency Department.
    - High incidence wards.
- Improved response to preventing unstageable and DTI related ulcers
- Focus on management of incontinence and prevention of moisture associated skin damage.

Inpatient Falls

The chart below provides an overview of inpatient falls at NGH during 2025–26. It shows a consistent rate throughout the year around a mean of 4.02 falls per 1000 bed days. See charts below;



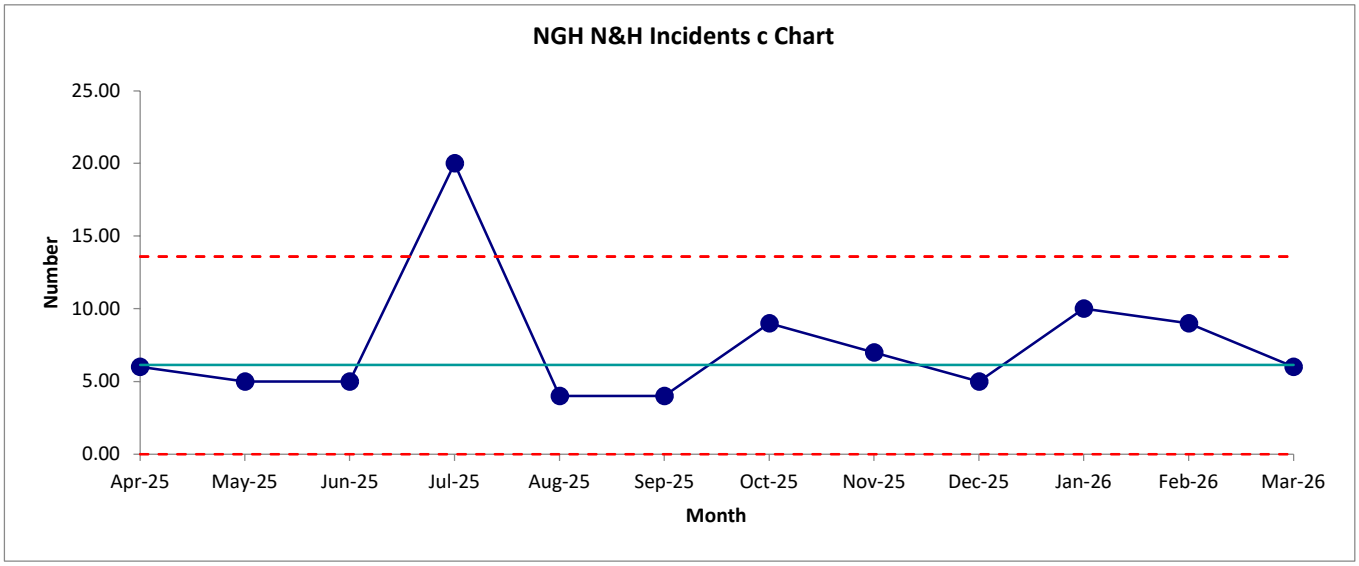
The chart above shows a continued focus on reducing harm associated with inpatient falls during 2025–26. Improvement has been supported by a range of patient safety interventions, including:

- Standardisation of observing patients who are at risk of falls (bay tagging) and supervision practices.
- Targeted training on:
    - Bedrail use.
    - Delirium management.
    - Post fall assessment.
- Harmful fall reviews informing thematic learning

These interventions remain embedded in practice and continue to be evaluated through incident review, audit and ward-level feedback.

Nutrition and Hydration

Continuous improvement work focuses on learning from reported incidents to strengthen clinical practice and maintain safe, person-centred care for patients at nutritional or hydration risk. In February 2026 the nutrition nurse specialists at NGH moved from the Surgical Division to the Harm free care team and there has been an increased focus on protected mealtimes, monitoring referrals to dietetics and speech and language therapy to ensure they are followed up, plus the launch of the UHN Food and Drink Strategy. See charts below;



A key development during 2025–26 was the continued alignment of Harm Free Care reporting, governance and improvement activity across NGH. Through the UHN Harm Free Care framework, collaborative work has continued at NGH and KGH with both hospitals adopted shared metrics, aligned audit tools, and a common approach to data presentation and assurance. This collaborative model improved visibility of performance supported cross site benchmarking and enabled shared learning and spread of good practice across both organisations. This culminated in the establishment of a single UHN Harm Free Care Team in February 2026.

Summary of Harm Free Care

Harm Free Care data for 2025–26 shows that NGH has maintained stability across all three harm domains (Falls, Pressure Ulcer Prevention and Nutrition & Hydration) with some increases seen through the winter period associated. Rates of falls and pressure damage resulting in serious harm remained low. Where harm did occur, incidents were subject to a structured review, Duty of Candour was applied where appropriate, and learning was translated into clear improvement actions. Together, this data demonstrates a maturing, learning focused approach to harm prevention, underpinned by strong clinical leadership and collaborative working across NGH and KGH.

1.3.2.5 Infection Prevention and Control

Infection prevention and control remained a key priority throughout 2025-26. During the year, work progressed to strengthen audit, assurance and improvement activity across services, alongside updated policies and refreshed training approaches. Improvements were made to the visibility and use of infection prevention data to support local action, with continued focus on hand hygiene, environmental cleanliness and adherence to national standards. Collaborative working across services supported a consistent approach to reducing healthcare associated infection risk.

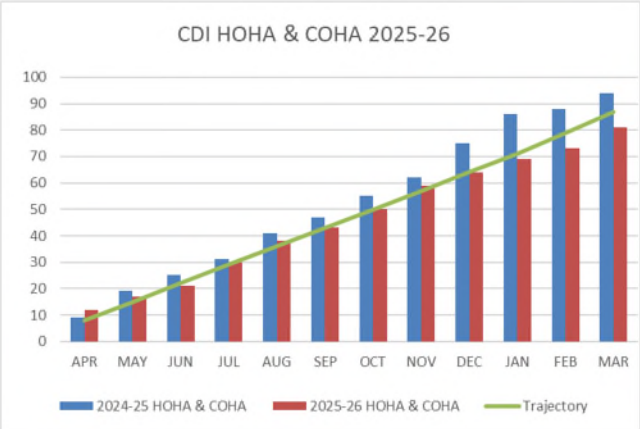
Healthcare associated infections

In 2025-26 the following Healthcare associated infections were identified (national standard in brackets):

- 81 patients developed a healthcare associated C.difficile infection (87)
- 66 patients developed an E. coli bloodstream infection (48)
- 32 patients developed a Klebsiella spp. bloodstream infection (19)
- 14 patients developed a Pseudomonas aeruginosa bloodstream infection (6)
- Two patients developed MRSA bloodstream infections (no national standard)
- 17 patients developed MSSA bloodstream infections (no national standard)

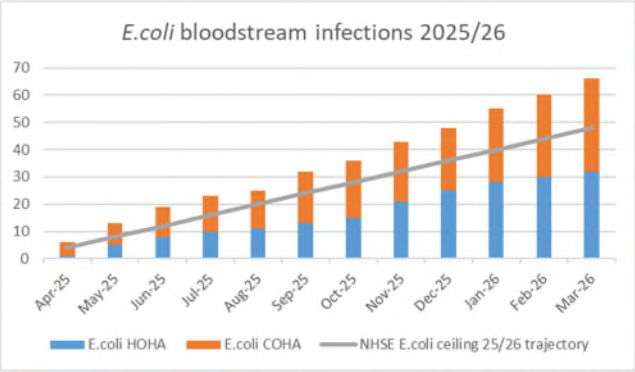
Each patient had a post-infection review completed and, where learning was identified, this was fed back directly to the ward team, to the wider directorate at governance meetings, and across the site at the Infection Prevention Operation Group (IPOG). The graphical representation in the graphs below identifies the prevalence of hospital and community acquired infection against the national ceiling target:

C.difficile



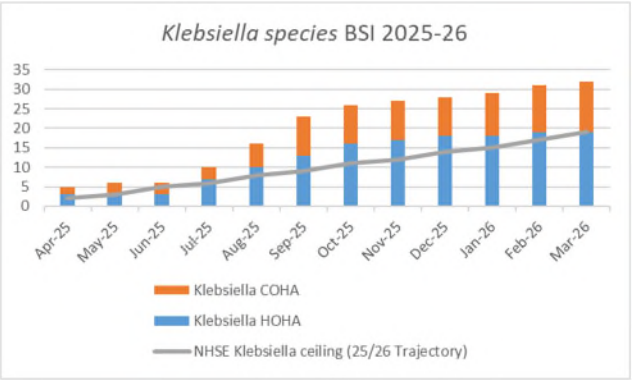
NGH noted a 14% reduction in the number of cases of C.difficile being achieved, compared to the previous year.

E.coli bloodstream infections



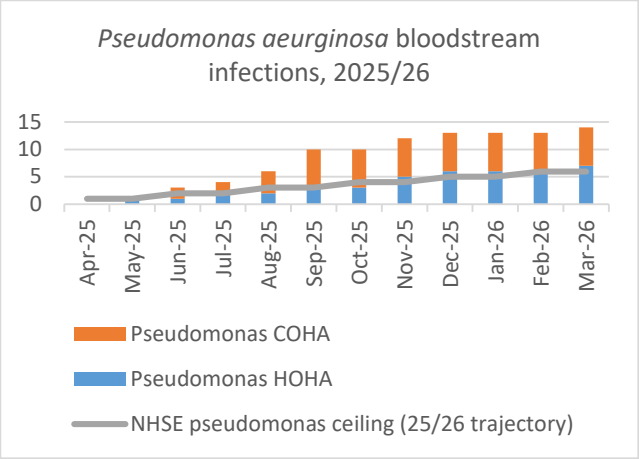
NGH noted a slight increase compared to the previous year.

Klebsiella species bloodstream infections



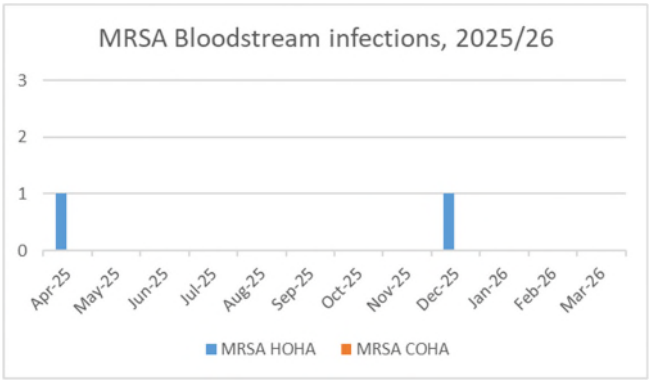
NGH noted a slight increase in Klebsiella species bloodstream infections

Pseudomonas aeruginosa bloodstream infections



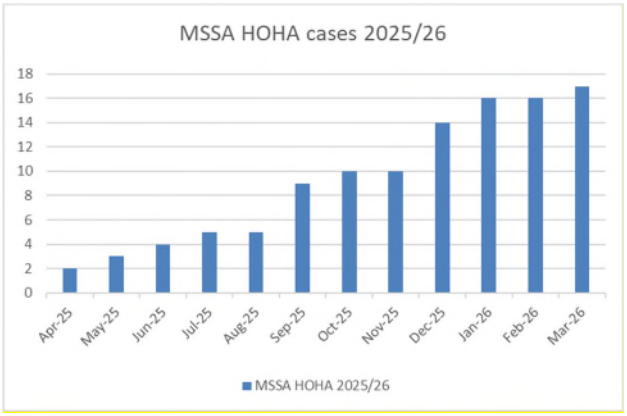
NGH noted a slight increase compared to the previous year.

MRSA bloodstream infections



NGH noted a 33% reduction in the number of cases being achieved, compared to the previous year.

MSSA bloodstream infections



This remained static compared to the number of MSSA cases the previous year.

On review of healthcare associated C.difficile infections, the key themes centred around antimicrobial stewardship, appropriate suspicion and timely isolation of patients with C.difficile infections. Antibiotic guidelines were reviewed and focused multidisciplinary ward rounds were conducted. In addition, amendments were made to the process for decontamination of mattresses, a Loose Stool Risk Assessment was implemented onto the specimen requesting system and the IPC Team worked to reduce Hospital Acquired Pneumonia through empowering early nurse-led patient mobilisation with the Therapies Team.

On review of Gram-negative bloodstream infections, analysis identified that most of the cases were not preventable due to the underlying clinical condition of the patient. The preventable cases identified themes associated around urinary catheter care, mouthcare and cannula care. Quality improvement work focused on Excellence in Infection Prevention Control study days which provided key clinical skills to staff. Next steps include 2026-27 campaigns around hand hygiene practices, and further collaboration and standardisation of IPC practices and products across UHN, including a Blood Culture Pathway Task and Finish Group.

IPC UHN / UHL Collaborative working

The IPC Team has embraced collaborative working in 2025-26 under the leadership of the UHN IPC Assurance Committee. The following collaborations have been successfully delivered this year:

- UHN IPC Annual Work Plan
- UHN IPC Quality Improvement plan
- UHN Safer Sharps & Indwelling Devices Group commenced April 2025
- UHN Infection Prevention Operational Group commenced June 2025
- UHN IPC audits were developed
- A UHN IPC Dashboard has been developed
- UHN Policies and Procedures have been developed including Standards for Cleanliness Policy, Hand Hygiene Code of Practice, Uniform Policy and Blood Culture Sampling Procedure
- The IPC team has restructured into one UHN IPC Team
- The IPC Team have collaborated with UHL to review the Antimicrobial Stewardship processes and practices and identify opportunities for collaboration, sharing and learning.
- The IPC Team collaborated with UHL and with LLR and Northamptonshire ICBs to develop a local health system-wide action card for Meningococcal Disease following the outbreak in Kent.

IPC achievements

During 2025-26 the IPC Team supported the Continence Specialist Nurse who won the Green Team competition in March 2026 for their work to implement intermitted self-catheterisation into UEC pathways and reduce the need for urinary catheterisation as this has a significant infection risk.

An IPC Nurse has completed the Non-Medical Prescribing Course and will use this development skill to support the Antimicrobial Stewardship Team in prevention Antimicrobial Resistance and C.difficile infections.

The NGH team also successfully piloted an Inpatient ‘Flu Vaccination Programme this year and plan to scale this up and across UHN next winter.

One member of the team sits on the national Sustainability Specialist Interest Group of the Infection Prevention Society and has been instrumental in organising a national annual sustainable IPC conference event, that had over 300 delegates attended in March 2026.

1.3.2.6 Workforce, Staffing and Professional Practice

The following section relates to specifically to staffing with nursing, midwifery and allied health professionals. These colleagues represent our largest staffing group, therefore it’s imperative that we describe what good practice looks like and show how we adhere to standards which ensure

safe and ethical care, underpinning public protection and professional credibility across our hospital and wider group and health system

NGH provides comprehensive educational support to both non-registered and registered practitioners across the site.

The NHS England Self-Assessment is a mandated annual, multi-professional, and nationally consistent assessment tool launched in 2022. It requires NHS placement providers (trusts) to evaluate the quality of healthcare learning environments against NHS England Education Quality Framework domains. Key purposes include benchmarking, identifying improvement areas, ensuring NHS Education Contract compliance.

The NGH NHSE Self-Assessment document was submitted in October 2025, for final sign off. NHSE required clarity around a pharmacy response, which has now been provided.

National Education and Training Survey (NETS)

- The NETS 2025 is a key initiative by NHS England to gather feedback from healthcare learners regarding their clinical placement experiences. This covers all student groups and providers. 2025 results were published in March 2026.

  Uptake was improved on the previous year. The following analysis of the NETS survey results, four emerging themes of concern were identified:

  1. Discrimination
  2. Bullying & undermining
  3. Sexual Safety
  4. Wellbeing

Work is in progress in collaboration with the University of Northampton to address the themes.

NGH CPD Spending

Continual Professional Development (CPD) allocation from NHSE has been fully utilised. CPD funding in the NHS is a national initiative (usually £333 annually per registrant) designed for registered nurses, midwives, and certain allied health professionals (AHPs) in England to maintain, improve, and broaden their skills. It covers course fees, conferences, and accredited university modules, enabling staff to deliver up-to-date, safe, and effective patient care

To ensure additional governance to the CPD funding application process, a CPD funding panel has been created that meets monthly to discuss and approve/decline applications. On some occasions further information is required. This meeting is held for both KGH and NGH sites, thus providing more robust challenge and equity.

Allocated	Spent	Number of programmes supported	Nursing	Midwifery	AHPs	Multi-disciplinary	Uptake by staff
£683,023.00	£676,404.11	255	161	31	30	33	570

- NHS East Midlands commissions confirmation – NGH was successful in securing:
  - 45 x non-medical prescribing attendees – uptake has been 25 staff
  - 6 x Nursing Associate to Registered Nurse top ups – all recruited
  - 4 x Senior Nursing Associate apprenticeships – all recruited
  - 4 x shortened MSc midwifery programme attendees – none were recruited due to visa issues

- The NHS England Safe Learning Environment Charter (SLEC) is a framework designed to ensure high-quality, safe, and supportive training environments for health learners. Launched in October 2023, it sets out 10 key priorities to foster a positive, inclusive culture, allowing learners to thrive. It is mandated for use by education providers from both a theoretical and clinical perspective. SLEC across UHN has set up a multidisciplinary operational group involving the planning and roll out of the 10 priorities of the charter. A launch of SLEC took place in September, to ensure Practice Assessors and Supervisors, students and clinical staff are aware of the student contribution and support required. The response was encouraging and though most areas of the charter are already in place, there is further work to be undertaken especially with the visibility of senior staff (band 6 and above) to the students.

- NGH UCAS & Apprentice student uptake remains buoyant. Recruitment is inconsistent, mostly due to graduates wanting to return to their hometowns. We have an improving relationship with our education providers to ensure that the student clinical experience is the best it can be.

- Compassly is an online competency tool which is currently being rolled out across UHN. At NGH Maternity is now using Compassly along with all Adult Nursing inpatient areas. As of February 2026, competencies will be paperless, except for CYP.

- The NHS England Multidisciplinary Quality Mark launch has been delayed until Spring 2026, with some uncertainty as to whether this timeline may be extended further. It has been confirmed that NHS England will allow organisations to retain the interim quality mark considering the delay. As the national preceptorship team has been disbanded, we are awaiting further guidance from the Department of Health regarding the timeline for launching the new multi-professional framework and the associated Quality Mark.

- Leadership update includes those programmes delivered and commissioned exclusively for Nursing. The programmes include:
  - Making Every Contact Count (MECC) – in partnership with local government – to be embedded into appropriate programmes
  - Educating with Empathy – in partnership with UHL and the University of Leicester
  - Strengths match career coaching training undertaken programme to be launched
  - CPD accreditation for Evidence Based Practice Course
  - Coaching with external providers
  - Evidence Based Practice Programme delivery

  The CNO fellows successfully completed their Clinical Leadership programme. One participant, subsequently presented at an overseas conference and two others submitted their posters for various conferences. All attendees evaluated the course well and successfully implemented change through their quality improvement projects.

- As of October 2025, one unified UHN Fundamentals of Care Health Care Support Worker (HCSW) programme has been delivered across sites, managed and delivered by NGH Practice Development.

- Post training education for Health Care Support Workers (HCSW) is being planned. Bedside Emergency Assessment Course for HCSWs (BEACH) is now being delivered at both sites from March 2026.

- New programmes delivered:
  - University of Northampton (UoN) collaboration - BSc top up programme for those Diploma Nurses with Level 5 study only. The first cohort commenced in September. They are about to complete the programme and the evaluation of the course is very good.
  - University of Northampton (UoN) collaboration - Bridging Modules for RNs - for those Diploma Nurses with Level 4 study only. UoN has produced two modules to top up to from level 4 to 5, enabling individuals to then top up to degree (level 6). The first cohort commenced in February 2026.
  - Radiographers training for Intramuscular injections for anaphylaxis
  - New Spinal Cord Injuries Day implemented which includes log rolling

- Celebration events for the Care certificate, Preceptorship and NVQ level 3 completion have taken place with good attendance from clinical leaders, matrons and the senior nursing team.

1.3.2.7 Assessment and Accreditation

Over the past 12 months, UHN successfully launched the Excellence Accreditation Framework (EAF) as a core component of its quality assurance and improvement approach. The programme provides a consistent, organisation-wide framework to support clinical teams in delivering high-quality, safe and compassionate care, while strengthening leadership capability and continuous improvement. EAF builds on the existing assessment and accreditation processes, it offers a structured and multidisciplinary approach that recognises the collective contribution of nursing, medical, allied health and wider clinical teams. By combining assurance, improvement and recognition within a single framework, EAF supports alignment with the Trust's overarching Quality and Excellence agenda, Quality Improvement strategy and CQC action plan.

During the year, the EAF training programme commenced for the first of six cohorts, bringing together staff from adult inpatient wards and the wider multidisciplinary workforce. These sessions have equipped teams with the knowledge, skills and practical tools to apply the framework confidently in practice. Feedback has been positive, with multiple Quality Improvement ideas identified, reflecting strong engagement and a growing culture of ownership and improvement.

The framework has increasingly been used as a developmental tool, supporting ward and departmental leaders to strengthen leadership practice, promote open and reflective team conversations, and develop meaningful, sustainable improvement plans. Where sustained improvement has been demonstrated, achievements have been recognised and shared, reinforcing positive behaviours and staff morale. In areas requiring further development, the Quality Excellence team has worked closely with divisional colleagues, Quality Improvement coaches and the Education team to provide targeted, supportive interventions.

First 2 completed cohorts:

1.3.2.8 Pathway to Excellence

The Pathway to Excellence® programme at NGH has continued to mature and embed as a core framework for excellence in nursing practice throughout 2025, with the organisation now midway through its second Pathway to Excellence ® designation. Since first achieving designation, NGH has demonstrated sustained progress across multiple domains, which has been supported by the development of a Quality Excellence team for the group. Throughout 2025, the team has actively engaged with the global Pathway to Excellence® community, including attendance at the ANCC conference, and in the past year has played a wider role in mentoring organisations 8 acute organisations from across the globe on their Pathway to Excellence journeys. This maturity is further evidenced by the development of internal expertise, including the first UK-based ANCC appraiser working at UHN, strengthening the organisation's ability to interpret standards, build evidence and support continuous improvement at both local and system level continuing their work as leaders within this feel.

The Organisational Demographic Form (ODF) submitted through the Pathway to Excellence in 2025 demonstrated clear, measurable impact, including sustained reductions in registered nurse vacancy rates from the initial programme entry point, alongside improvements in skill mix and education levels across the nursing workforce. These changes align with the well-established research of Linda Aiken and colleagues, which consistently shows that higher proportions of registered nurses and better-educated nursing workforces are associated with improved patient outcomes and safer care. Pathway to Excellence® has also acted as a catalyst for innovation and locally led improvement at NGH, with examples including the development of Chief Nursing Officer (CNO) Fellows, implementation of self-rostering, and a range of Shared Decision-Making (SDM) projects such as the oncology snack trolley and the Spencer Loss Room. In addition, the delivery of an evidence-based practice course has strengthened nurses' capability to translate research into practice. With plans for a third Pathway designation in 2027 already well underway, NGH continues to build on a strong foundation of engagement, professionalism and outcomes, demonstrating sustained commitment to nursing excellence.

Following on from lobbying by the Quality Excellence Team, accreditors have formally recognised the role of the midwife in their Pathway to Excellence® programme which has now formalised our approach to midwifery excellence across UHN. Midwives will now be able to contribute to the Pathway Standards document and take the Pathway to Excellence® survey which is a significant landmark given these were previously only open to nurses.

1.3.2.9 Professional Nurse Advocate (PNA) and Pastoral Support

The Professional Advocacy programme across UHN continues to support staff wellbeing, psychological safety and compassionate leadership across Nursing and Allied Health Professionals (AHPs), contributing directly to the Organisation's Well led, Safe and Caring priorities.

The service has had several key achievements in 2025-26. NGH became the first Trust in the region to achieve the national recommended ratio of Professional Nurse Advocate (PNA) to nurse ratio (1:20), placing it within the top 5% of Trusts nationally for Professional Advocate Nurse coverage. Other key achievements have included the introduction of a UHN Professional Advocacy Standard Operating Procedure (SOP) and the development of a UHN Professional Advocacy Strategy to provide clear governance, consistency and assurance for the delivery of Professional Advocacy across the organisation. The strategy has been shared with UHL colleagues to support wider collaboration and alignment.

The Professional Advocates have also continued to provide restorative clinical supervision (RCS), enabling staff to reflect on practice, manage the emotional impact of work and raise concerns safely. Feedback from staff accessing PNA support has been consistently strong, with colleagues reporting improved wellbeing, confidence and ability to navigate professional challenges. The Professional Advocacy team has also provided quality improvement (QI) support, helping translate learning from RCS sessions into practical improvements, strengthening learning cultures and assurance. Professional Advocates have also led ward based restoration days throughout the year, supporting teams to identify challenges affecting morale, safety and performance. Key themes from these sessions have informed divisional action plans, supported by Professional Advocates and divisional leadership teams.

Over 80 Professional Advocates attended the UHN Professional Advocate Away Day in March 2026, with 100% of attendees reporting learning they could take back into practice. UHN also led the system wide Professional Advocate Conference in partnership with the University of Northampton, expanding participation to include UHL colleagues.

Professional Advocate Away Day

International Pastoral Support

Pastoral support for internationally educated nurses, AHPs and healthcare support workers continues to be a key part of UHN's approach to workforce wellbeing, inclusion and retention. During 2025–26, this support was strengthened and formalised, reflecting the international workforce and the importance of providing compassionate, accessible and responsive support to our international educated colleagues.

From February 2026, pastoral support for internationally educated staff formally sits within the Professional Advocacy team, enabling closer alignment with restorative practice, staff voice and workforce wellbeing. A full time International Pastoral Support Nurse role is now established across UHN, providing a consistent and visible offer across both hospital sites. This role is new to KGH and builds on existing provision at NGH, supporting equity of access across the organisation.

The service has had a number of key achievements in 2025 including a Cultural Awareness Study Day which was well attended at NGH, supporting learning, reflection and understanding across teams. International colleagues were supported to share experiences and cultural perspectives, with learning taken back into clinical areas to strengthen inclusive practice. Further success has been achieved through increasing the profile of the service and the development of the service as clear first point of contact for internationally educated nurses and healthcare support workers, offering listening support,

guidance and signposting, with a focus on psychological safety, early identification of concerns and prevention of escalation to more formal processes.

Pastoral support has enabled internationally educated staff to engage with opportunities for shared decision making, helping colleagues feel heard and represented in decisions that affect their working lives. At NGH, this included awareness and engagement activity that promoted inclusion, participation and confidence among international educated staff.

NGH Cultural Awareness Study Day

1.3.2.10 Leading an Empowered Organisation (LEO)

The Leading an Empowered Organisation (LEO) course at Northampton General Hospital (NGH) has become a key enabler of colleague-led improvement, building capability and confidence across the workforce to lead meaningful change. Since its inception, over 450 delegates from a wide range of professional backgrounds have completed the programme, with all undertaking a quality improvement (QI) project as a core requirement. These projects demonstrate tangible impact on patient care, efficiency and staff wellbeing, with examples including improving compliance with sedation-hold guidelines within the Intensive Care Unit, introducing the reuse of urine bottles within community midwifery to reduce waste and improve sustainability, and the implementation of huddles to strengthen team connection and wellbeing. Collectively, the programme has embedded a culture of empowerment and shared leadership at NGH, ensuring staff are supported to translate learning into real-world improvement aligned to organisational priorities.

1.3.2.11 Shared decision making (SDM)

During 2025/26, SDM has continued to mature and develop, supporting staff involvement in shaping practice, driving improvement and engaging in local priorities. There is now an established quality excellence team across UHN who during the year have focused on strengthening consistency, supporting joint approaches across services and improving sustainability of councils within the organisations. Actions were identified to address challenges relating to protected time to undertake SDM and engagement, ensuring shared decision making remains meaningful and accessible to colleagues at NGH.

There are now over 70 Shared Decision-Making councils established across UHN with 44 of these being based at NGH. This represents an increase compared to 2024-25 and reflects continued organisational commitment to strengthening staff voice and involvement in decision making. The expansion of councils has supported wider staff representation and contributed to a more consistent approach to SDM, enabling staff to influence service development and quality improvement initiatives.

Shared decision-making councils have led meaningful, locally driven initiatives that have positively impacted both patient and staff experience. These include the creation of a patient day loss room to improve the experience of patients and their families when experiencing a loss in the gynaecology room, a snack trolley for haematology patients who spent long periods of their day hooked up to machines in

the day care unit and are high risk of malnourishment. Councils have also supported staff wellbeing through initiatives such as organised restorative days and local recognition schemes.

Collaboration has been a key theme, with ENT (ear, nose, throat)councils working together across both UHN sites to hold a joint away day, providing an opportunity to share learning, celebrate cultural diversity and strengthen team connections. Practical improvements to the working environment have also been introduced, including the use of low-level lighting to support more comfortable and less disruptive night-time care for patients. These examples represent a small number of the many initiatives delivered by councils across NGH during the year.

A shared decision-making showcase event was also held in collaboration with UHL in February 2026, bringing together teams to share learning and highlight the impact of council led initiatives. The event provided an opportunity to celebrate achievements, spread best practice and further strengthen collaborative working across organisations.

1.3.2.12 Enhanced Therapeutic Observation and Care (ETOC)

Enhanced care refers to an increased level of observation and one-to-one support provided to patients who may pose a risk to themselves or others, or whose needs are complex and require closer monitoring than standard care. It is a proactive approach focused on maintaining patient safety, while preserving dignity, privacy, and person-centred care.

A key purpose of enhanced care is to establish a therapeutic relationship with patients through active engagement, reassurance, and companionship, particularly when patients are at their most vulnerable. This includes individuals experiencing confusion, agitation, or an increased risk of falls, often within unfamiliar clinical environments. By providing consistent support and presence, ETOC aims to reduce distress, prevent harm, and promote a more positive patient experience.

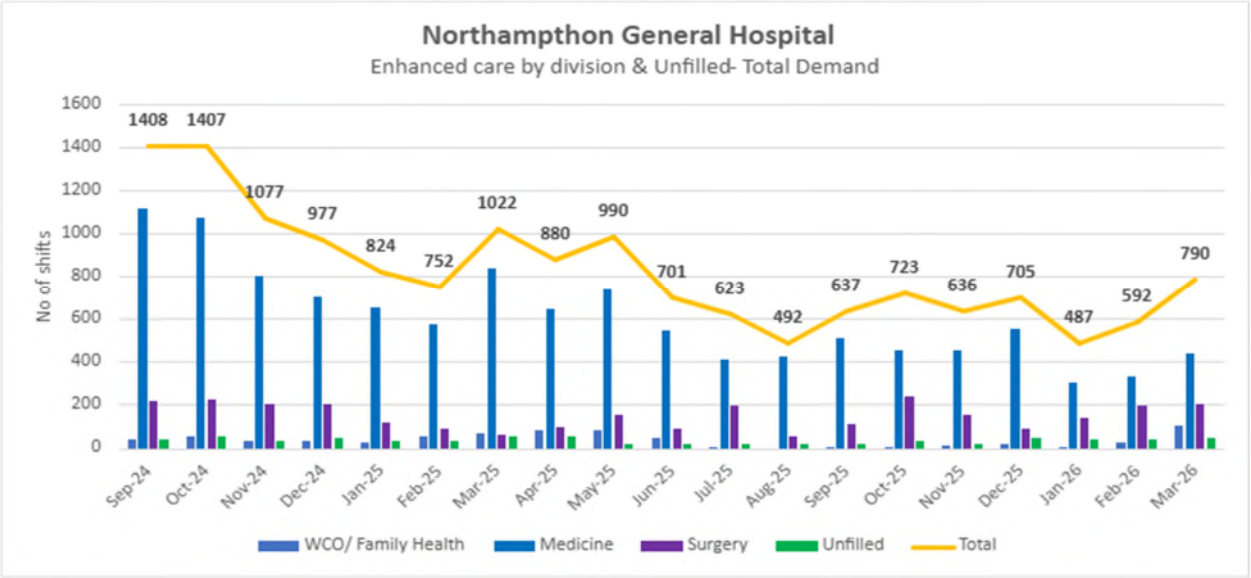
The ETOC service at NGH was established in April 2024, with formal processes for shift allocation and patient review commencing in May 2024. Prior to this, enhanced care provision was managed at ward level by the Nurse in Charge and Matron. This approach resulted in variability in decision-making, increased demand, and inconsistent application of observation levels. The introduction of ETOC has enabled a more standardised, evidence-based, and equitable approach to enhanced care delivery.

From October 2024, the University Hospitals of Northamptonshire (UHN) ETOC service has been further strengthened through collaboration with University Hospitals of Leicester NHS Trust Enhanced Patient Observation Team, supporting the development of a consistent strategic direction across the organisation.

Summary of Achievements

Operational Improvements

- Agency HCSW usage at NGH ceased as of September 2024, contributing to improved continuity of care and cost efficiency.
- Implementation of a structured referral and risk assessment process, improving the appropriateness and governance of ETOC utilisation.
- Achieved a 55.82% reduction in ETOC shifts, reflecting improved decision-making and demand management. See chart below



- Establishment of a UHN-wide ETOC model, providing standardised practice, consistent governance, and reporting at both Trust and national level.
- Improved quality of referrals, with clearer criteria and evidence-based decision-making (e.g. behavioural monitoring).
- Strengthened multidisciplinary team (MDT) collaboration, supporting more holistic and timely patient reviews.
- Enhanced patient safety outcomes, particularly in reducing risks related to falls, agitation, and deterioration in vulnerable patients.
- Increased staff awareness and education regarding appropriate use of enhanced care and alternatives to one-to-one support.

1.3.2.13DAISY/ ROSE Awards

The DAISY (Disease of the AutoImmune SYstem) award was established in the USA in 1999 by the family of J Patrick Barnes following his death from complications of the auto-immune disease ITP. The DAISY Foundation commemorates the appreciation Patrick's family had for the care and compassion shown to him and his family. The DAISY award is an opportunity for patients, family and carers to say thank you to a nurse or midwife for the difference they made in their experience.

The DAISY programme has been running at NGH since 2015. In 2025-2026 we presented **12 individual DAISY Awards**, **two DAISY Leader Awards** and **three DAISY In-Training Awards** to students across our Nursing and Midwifery workforce. We also presented **two DAISY Team** awards to the Maternity Immunisations Team and Maternity Practice Development.

The ROSE Awards were launched across UHN in 2024. ROSE stands for Recognising Our Staff Excellence (ROSE) and celebrates extraordinary care delivered by staff where they show empathy, compassion and dedication. A wide range of colleagues can be nominated, including clinical healthcare support workers and Allied Health Professionals. In 2025-2026, we awarded **11 individual** ROSE awards to staff working in a range of roles across NGH.

DAISY Award winners:

- 
- 

- 

ROSE Award winners:

- 

- 

1.3.2.14 Tea with the Director of Nursing

Tea with the DoN (Director of Nursing) provides an important opportunity to recognise and celebrate staff from across our clinical areas who have gone above and beyond for patients, families and their teams. Staff nominations are open to all roles reflecting the commitment to meaningful recognition within our Nursing Midwifery and Allied Health Professionals (NMAHP) strategy. Successful nominees are invited to attend an informal session with the Director of Nursing, where they are personally thanked, share their experiences, and enjoy tea, coffee and cake with colleagues. Each recipient is presented with a certificate in recognition of their dedication, compassion and commitment to delivering high quality care. Tea with the DoN is a new initiative at NGH with over 60 colleagues being nominated across the three events held so far.

1.3.2.15 Digital and Service Improvement

Over the past year, NMAHP digital delivery has continued to strengthen professional practice and service improvement across UHN. Activity during 2025-26 focused on the safe implementation and adoption of digital systems, improvements to clinical documentation, and enhanced use of digital tools to support care delivery. Investment in digital capability and leadership has supported staff readiness and

the safe use of technology, contributing to improved efficiency, information quality and patient care. A key highlight was hosting the National Deputy Chief Nursing Information Officer (CNIO), Regional CNIO and National Chief Midwifery Information Officer on 19 February 2026, recognising strong clinical engagement, visible senior sponsorship and a clear “can-do” culture across UHN.

NGH – NMAHP digital progress and impact

At NGH, the year has been defined by the introduction and embedding of Nervecentre’s Electronic patient record (EPR), supporting a move away from paper and legacy systems towards a more joined-up Electronic Patient Record. NGH delivered the supplier’s largest single deployment to date. Optimisation has continued to help teams standardise documentation and improve the timeliness and accessibility of clinical information. Further phases are progressing to extend functionality across outpatient and administrative pathways.

NGH also delivered BadgerNet Maternity go-live on 19 November 2025, strengthening the digital maternity record and improving the quality and availability of information across the pathway. This included the implementation of BadgerNotes, supporting more timely documentation and improving the experience for women and families through clearer, more consistent information to support care, including enabling mothers to access their own digital records.

NMAHP Digital Strategy

During 2025-26 we developed and agreed an NMAHP Digital Strategy, setting out how digital will support professional practice, quality and safety, and service improvement across both sites. Key elements documented below:

Positive Stories

The following positive stories showcase selected highlights of the impact and success of the CCIO team across UHN, acting as the NMAHP multidisciplinary team (MDT) for digital delivery across both sites.

1.3.3 Performance Analysis: Operations (Responsive Domain)

Introduction

This section summaries the Trust's performance against key national operational standards for elective/planned care, including cancer treatment, and urgency and emergency care (including A&E).

Cancer

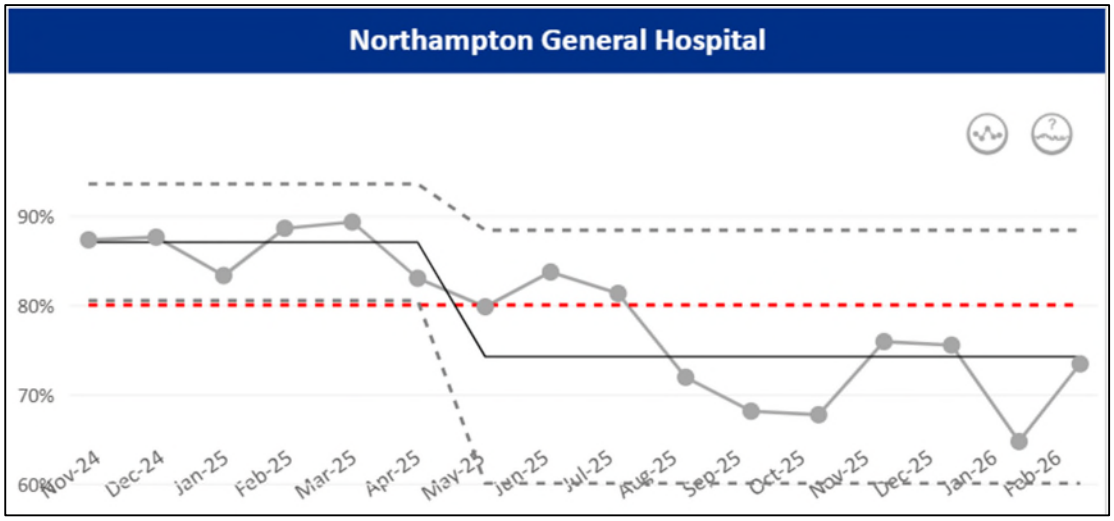
We aim to ensure patients are given a diagnosis to confirm or exclude cancer as quickly as possible (Faster Diagnosis: 80% within 28 days), to enable patients' treatment to be commenced within 62 days of referral (national target 70%).

There were some important improvements for Northampton Cancer patients this year. The Maggie's Centre opened in October 2025. Maggie's provides free practical, emotional and psychological support to people who are living with cancer, as well as their family and friends.

In April 2025, Northampton commenced the first NHS Focal Therapy Service for the Midlands, starting with a pioneering new soundwave treatment for prostate cancer. This was supported by a fundraising campaign launched in July 2024, which has resulted in significant private donations to the Northamptonshire Health Charity (NHC).

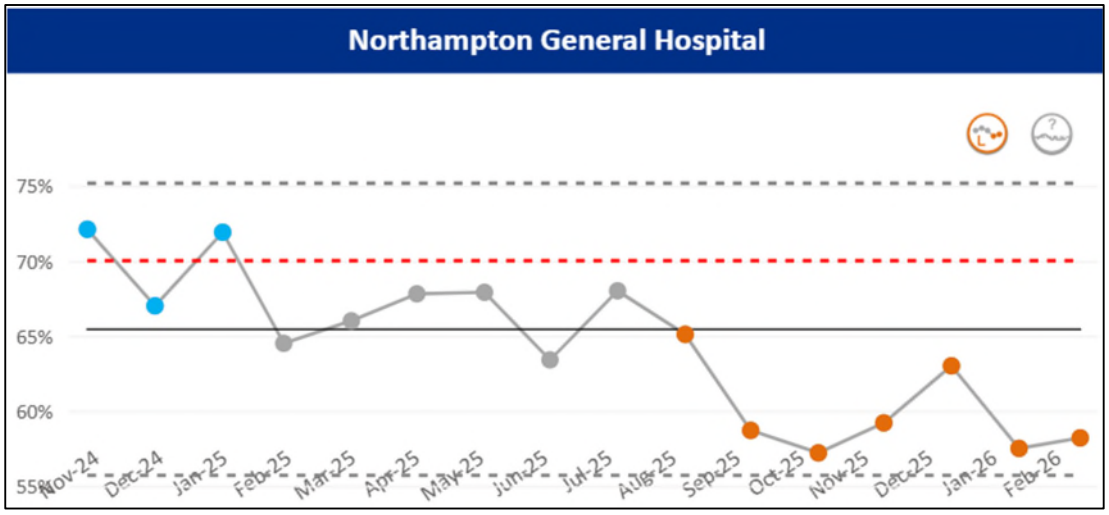
Cancer: Faster Diagnosis

This has been a challenging year to deliver this standard, with capacity challenges in the Breast pathway and working across the county to support the delivery of the standard for the Skin pathway. This was particularly challenging in the winter, but we are starting to see the recovery of the standard due to significant additional capacity in the Skin pathway.



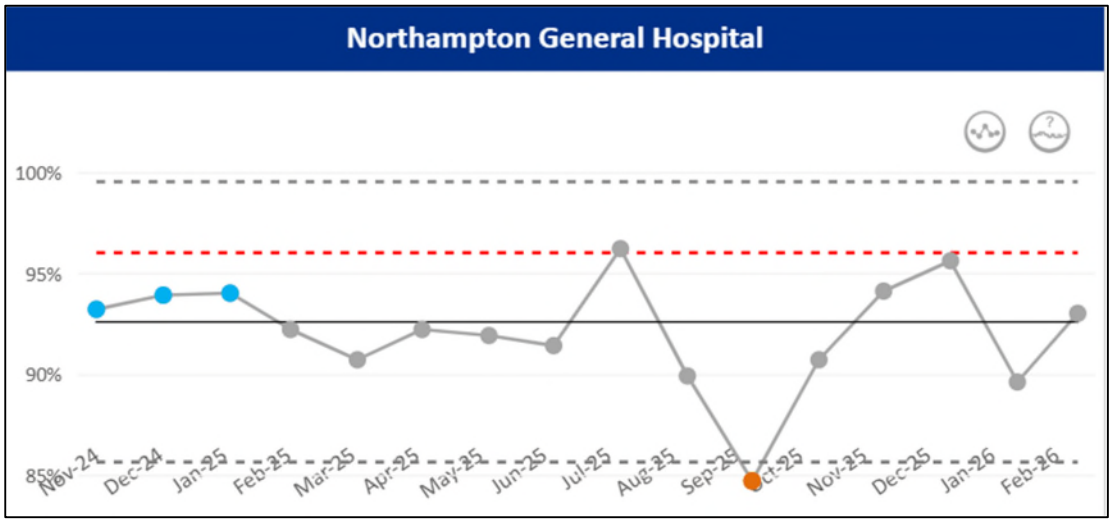
Cancer: 62-day Referral to First Treatments

The national target this year was to ensure 70% of patients who are referred urgently are diagnosed, and have their treatment initiated within 62 days of the referral. This has been challenging this year, particularly in Skin and Breast pathways. Changes are planned to support improvement of this performance, ensuring the patient cancer pathways progress as quickly as possible.



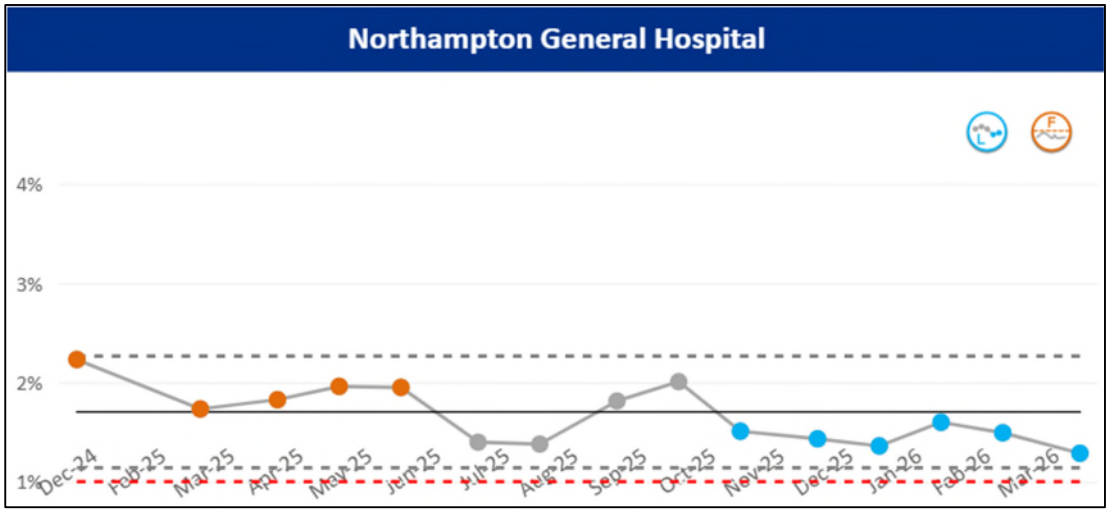
Cancer: 31-day Treatments

Once a patient is diagnosed and has agreed their preferred treatment option, we aim to ensure over 96% of patients initiate their treatment with 31 days of that agreement. This was not a national target in 2025-26, but is a good indicator of progress to meet the 62-day standard. Performance was challenged in the Autumn this year, but there has been good recovery in the final part of the year.



Referral to Treatment (RTT)

My March 2026, there were no patients waiting longer than 65 weeks and we had reduced the number of patients waiting more than a year from 742 on 31 March 2025 to 470 on 31 March 2026: this is 1.18% of the total waiting list. To ensure equity for patients across Northamptonshire, where patients consent to move their treatment between Northampton and Kettering, we have supported quicker treatment for those patients by treating them in Kettering where Kettering's performance is better. We have also received patients from Kettering where Northampton's performance is better. The national target for 2025-26 is to ensure that fewer than 1% of the RTT waiting list wait more than 52 weeks.



Note: Long waits targets are based on operational planning guidance for 2025/26: [NHS England » 2025/26 priorities and operational planning guidance](). *The data includes patients referred to consultant led pathways only.*

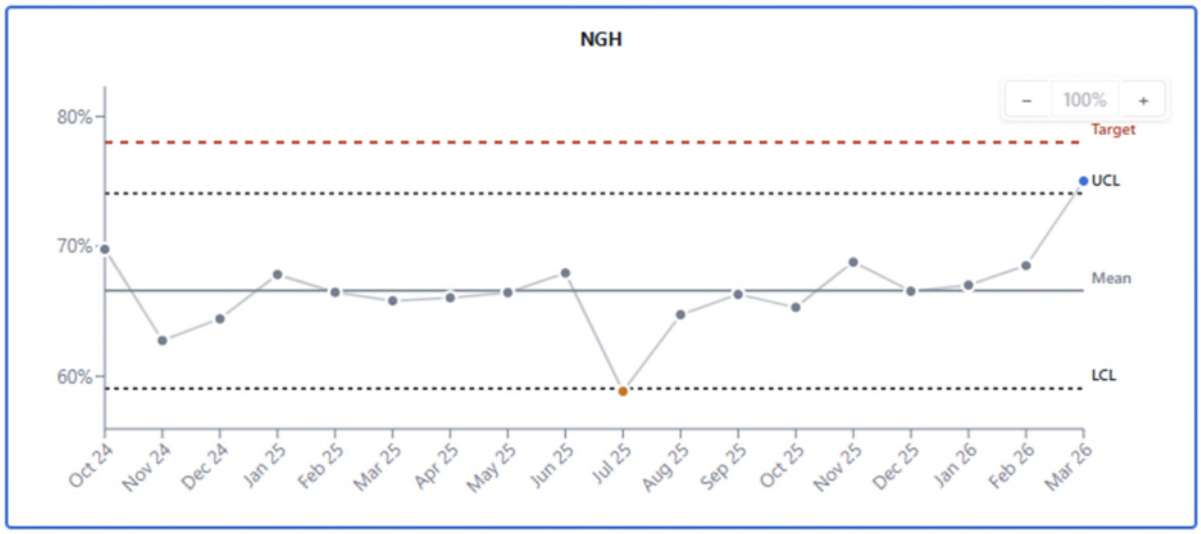
Wait List Size

The overall number of patients who have been referred and are awaiting their initial treatment to start, started and finished the year in a similar position. There was fluctuation over the year due to transfer of patients between Northampton and Kettering to support quicker treatment of patients.

Urgent Care

Attendances and Four-hour performance

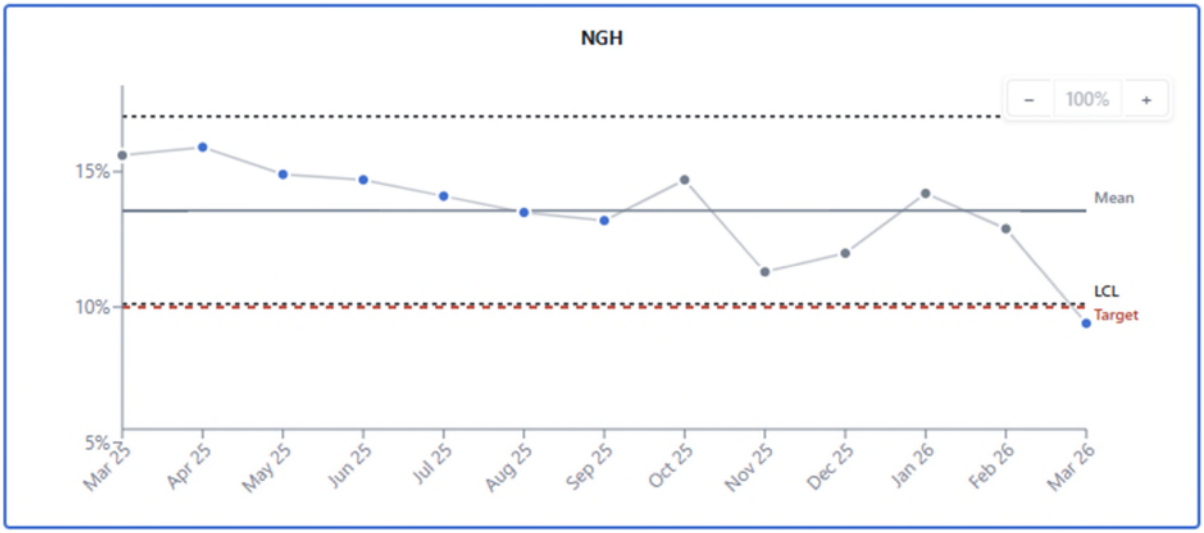
There has been an increase in A&E attendances by around 5% against plan during 2025-26 compared to 2024-25. Performance against the 4-hour standard by March 2026 was 75% against the National Standard of 78%. The four-hour standard refers to the percentage of patients admitted, transferred or discharged within four hours of arrival. This represents a significant 9.2% improvement from March 2025, delivered through improved patient pathways across the Emergency Department (ED), Same Day Emergency Care (SDEC), Urgent Treatment Centre and ED senior clinical decision makers as first points of contact.



A&E 4hr % Performance for NGH

12-hour Performance

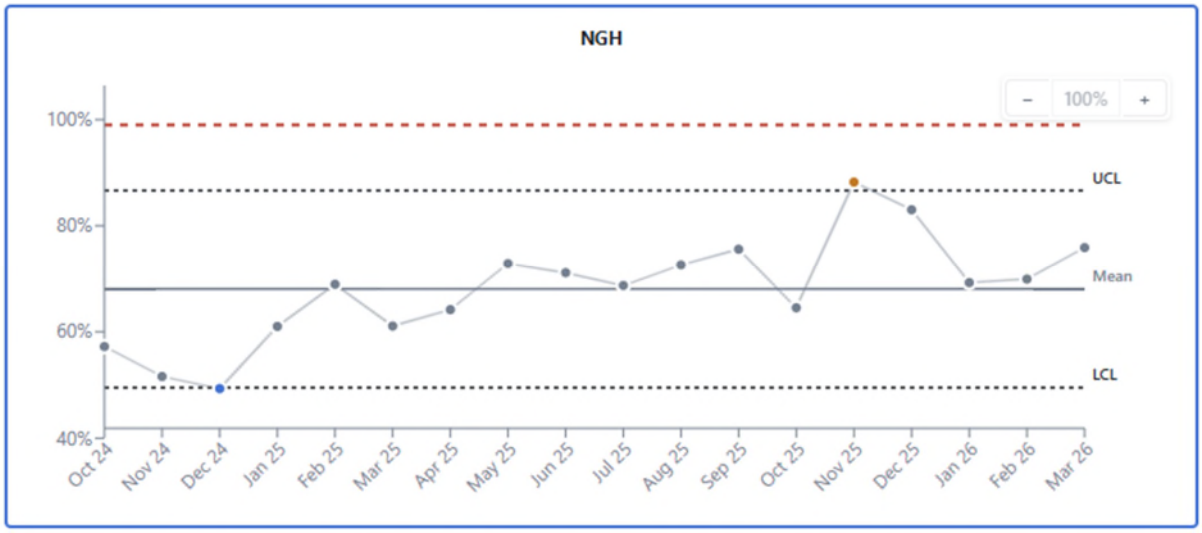
Improvements in UEC throughout the year and early planning for winter, supported by opening of the new rapid assessment unit (RAU), Acute assessment unit (AAU), extended hours of the Urgent Treatment Centre (UTC), increase in MRI capacity, and additional medical and therapy support improved 12-hour performance, with fewer than 10% of patients being discharged or admitted from the ED after waiting more than 12 hours in March 2026.



Percentage of patients waiting more than 12 hours in the ED at NGH

Ambulance Handovers

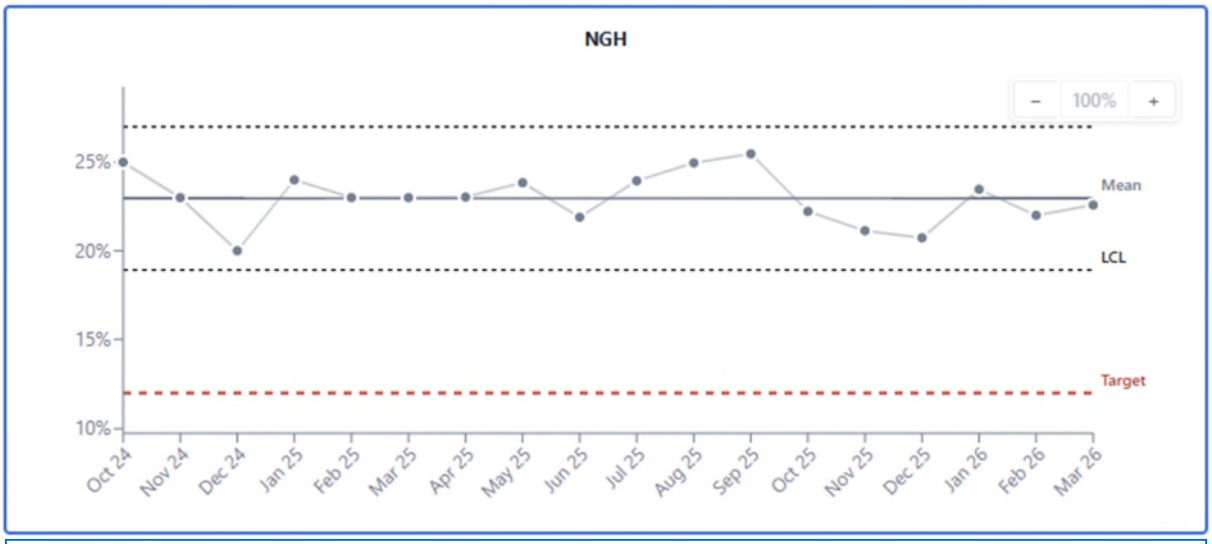
The number of patients arriving by ambulance to A&E at NGH/KGH increased from 2024-25 with a 3.5% increase against plan. We nevertheless achieved improvements throughout the year in ambulance handovers, with 76% achieved in under 45 minutes by March 2026. Capacity constraints in the ED affected performance, primarily due to demand and patients staying longer in ED waiting for patient flow 'downstream' and out of the hospital. Bed occupancy remains high at NGH at over 99%. We continue to work closely with local health system partners to reduce the number of patients who are fit for discharge but remain in hospital, and with the East Midlands Ambulance Service to ensure we continue to reduce delays in handover.



Percentage of ambulance handovers achieved in <45mins for NGH

Length of Stay

The number of 'super stranded' patients (patients with lengths of stay in hospital greater than 21 days) remained high, with around 150 super stranded patients on any given day. This is not only detrimental to patients' wellbeing but impacts on flow across the Trust and waiting times in the Emergency department. Throughout the year we ran several multi-agency discharge events (MADE) to reduce delayed discharges. We also focussed on internal processes to reduce the time taken for a patient's package of care requirements to be identified and agreed. Safe and timely discharge is a priority for the Trust, and we continue to work closely with our system partners to ensure that patients are discharged to appropriate destination, as quickly and safely as possible.



Super-stranded patients (21+ day length of stay) as a % of G&A bed occupancy at NGH

1.3.4 PERFORMANCE ANALYSIS: WELL-LED

Workforce Key Metrics (see also the analysis of UHN People Plan Delivery, Staff Survey results and Equality and Diversity analysis, set out in the Staffing Report below)

Data/Measure	NGH (target)
Total Headcount	6595
Whole Time Equivalent (WTE)	5865.44
Overall Vacancy Rate	9.38% (8%)
Nursing and Midwifery Vacancy Rate	7.60% (8%)
Medical and Dental Vacancy Rate	7.53% (8%)
Turnover Rate	5.77% (6.5%)
Sickness Absence Rate	4.93% (5%)
Appraisal	80.24% (85%)
Mandatory Training	89.41% (85%)

Note: The metrics referred to below are aggregated as they show the high-level performance of the Trust. There may, therefore, be higher or lower levels of performance at local level which will be monitored and acted upon accordingly.

Vacancy

Vacancy rates at NGH have improved by the end of the year, reflecting proactive and focused recruitment activities. The Trust has successfully recruited internationally educated nurses through dedicated pastoral care and onboarding programmes, significantly contributing to reducing nursing vacancies. Additionally, targeted recruitment of Health Care Assistants (HCAs) and hard-to-recruit areas such as Theatres (Operating Department Practitioners), supported by recruitment centres and apprenticeship pathways, has resulted in notable vacancy reductions. Overall, NGH ended the year with a vacancy rate of 9.38%.

Staff Turnover

Staff turnover rates at NGH have increased slightly in 2025/26, achieving 5.77% by year-end. Retention is underpinned by ongoing programmes aimed at enhancing employee experience and satisfaction, including a focus on individual wellbeing, career progression opportunities and cultivating an inclusive and compassionate working environment. The Trust has successfully extended self-rostering practices following positive feedback from initial pilots, empowering colleagues to better manage work-life balance and reducing managerial workload associated with roster preparation with particular focus on flexible working through the “Flex at UHN” programme. Continued investment in leadership development and tailored retention initiatives remain pivotal to NGH’s approach in maintaining a committed and engaged workforce.

Sickness absence

Sickness absence rates at NGH have remained stable at 4.89% under the 5% target rate. The primary drivers of absence have been mental health conditions (stress, anxiety, depression), flu and respiratory illnesses, and musculoskeletal (MSK) conditions. The Trust has implemented robust preventative and supportive measures to maintain colleague wellbeing, including centralised and ward-based vaccination clinics, enhanced occupational health support for management referrals and comprehensive mental health services including a dedicated Staff Psychological Wellbeing service, a “single point of access” referral service, a proactive trauma and risk (TRiM) management incident debriefing service and targeted early interventions for burnout and team health.

Appraisal

Appraisal completion at NGH has been consistent, ending the year at 80.24% although consistently below the 85% target. Our appraisal process incorporates a person-centred approach with a focus on colleague wellbeing as well as ensuring appraisals support our strategic priorities and provide meaningful developmental conversations aligned with personal objectives. The Trust continues to invest in training for appraisers to improve the quality of the appraisal discussion and support for our colleagues. Moving forward, the Trust is exploring how the newly proposed national NHS appraisal support tools can be embedded to enhance our appraisal process, aligning closely with the group's core aims.

Mandatory training

Compliance with mandatory training at NGH has consistently achieved above the 85% benchmark, finishing the year strongly at 89.41%. Throughout 2025 the organisation has worked to fully align with the National framework reducing the training burden for colleagues and releasing time to care. We have focussed on improving accessibility and engagement through multiple delivery methods, including e-learning modules, workbooks and practical videos and through the launch of a colleague mandatory training manual. We have supported the national direction of accepting and transferring training completion across NHS organisations with nationally elongated refresher periods working on the principle of "train once and then assess well" and and will significantly reduce the training burden. Mandatory training compliance for all colleagues is managed through an individualised training profile, which is easily accessible and enables colleagues to view their current requirements and status at any time. Supporting systems and processes are in place to provide timely reminders when training is due or overdue, helping colleagues to remain compliance. Compliance is actively monitored across all staff groups and competency areas.

1.3.5 Emergency Preparedness Resilience & Response (EPRR)

The EPRR team has been refreshed with a appointment of a group level manager overseeing the emergency preparedness of the sites. With this appointment, a recovery plan has been implemented to provide assurance to internal and external stakeholders of the preparedness of the organisation to deal with significant emergencies, with a focus on achieving an improved position regarding emergency planning. The NHS England Core Standards for EPRR submission for 2025 highlighted further areas for focus; however, with the work undertaken, a significantly improved position is anticipated for the 2026 submission.

The team have been involved in providing a wide range of educational sessions, from providing and directing the internationally recognised Hospital Major Incident Medical Management and Support (HMIMMS) courses, to delivering local level sessions covering Group staff induction, business continuity, and preparing strategic and tactical commanders with the relevant knowledge to manage incident responses.

The EPRR team continue to engage in Local Resilience Forum activities and have developed the relationships within the Local Health Resilience Partnership and the Health Emergency Planning Officers Group, with the EPRR Manager hosting as chair for six months of the year.

Internally, the EPRR team has engaged across the organisation with core stakeholders, taking part in Fire Safety, Health and Safety, Electronic Patient Record, Digital Asset, Estates and Facilities Capital Investment Teams Committees keeping preparedness on agenda across the group.

The EPRR Team has been involved in “planned” incidents, such as industrial action as well as with emergency response, with co-ordination and external liaison in business continuity incidents across the group.

1.3.6 Sustainability Report 2025-26

The Public Sector Decarbonisation (PSDS) scheme, which modernised the energy centre and removed steam from site, has delivered further carbon savings. Nitrous Oxide emissions have reduced to a lower than expected level following the removal of the manifolds to theatres in January 2025, removing over 200 tonnes of CO2e (equivalent). The Trust has run a fourth successful Green Team competition, delivering sustainable environmental and financial savings. NHS clinical waste segregation targets have been achieved and year on year financial savings realised.

Summary

- A new UHN Green Plan was approved by the Boards in August 2025.
- Carbon emissions from utilities have reduced by 8% compared to the previous financial year, although we are still above the targets required to reach the 2040 net zero target which will require significant investment and demand reduction.
- Water consumption has increased due to a water leak, but once this had been repaired returned to a level below that of last year.
- Emissions from both Entonox and Nitrous Oxide have reduced; nitrous oxide manifolds were removed in January 2025 with an even greater reduction in subsequent use than forecast.
- Clinical waste segregation has now almost reached NHS England Targets
- Recycling has increased slightly but overall levels of waste have decreased significantly.
- 227 new users have signed up to reuse Platform WarpIt to bring the total to 497 and a total of £47,000 and 8.9 tonnes of waste have been saved for NGH and its external partners. This has resulted in a reduction of 23.8 tonnes of CO2e.
- The Green Team Competition has resulted in projected savings of £250,000 and 15,000 kg CO2e;
- Awarded Sustainability Influencer in the Investors in the Environment annual awards.
- Investors in the Environment Green accreditation maintained for the 12th year and were one of a select group that were recognised for achieving Green accreditation for over ten years.
- Four members of staff now studying the Sustainability in Healthcare Apprenticeship, with two in their end point assessment period.

Carbon Emissions – NHS Net Zero Strategy

NGH is working to the net zero target for the items listed below by 2040, and for the remaining (scope 3) emissions by 2045.

	2021-22	**2024-25**	**2025-26**	**% change from 24-25 to 25-26**	**21-22 to 25-26 change%**
Energy (gas, electricity and renewables)	10,992	10,248	9,378	-8.4%	-14.6%
Anaesthetic gases including nitrous and Entonox	1539	1288	973	-42.5%	-24.5%
F-gases	131	44.5	401.4	+206%	+802%
Business mileage	186	232	195	+4.9%	-15.9%

Water	66	59	58	-12%	0
Waste	39	12	9	-77%	-25%
Metered Dose Inhalers	67 (8.27kg per inhaler)	85 (10.28kg per inhaler)	71 (9.37kg per inhaler)		-16%
TOTAL tCO_{2e}	**12,953 (Excluding inhalers)**	**11,884 (Excluding inhalers)**	**11,014 (Excluding inhalers)**		

All calculations, including waste, use DEFRA emissions factors published July 2024 Greenhouse gas reporting: conversion factors 2024 - GOV.UK Waste emissions have reduced significantly due to a change in the conversion factor compared with previous years.

The methodology for the reporting of the emissions from inhalers has been changed and is now calculated centrally for all Trusts. This year will be taken as the baseline against which we will report in future. Emissions factors taken from https://www.nhsbsa.nhs.uk/sites/default/files/2024-09/A1_Metric_11_GHG_EF_Inhalers.csv

Carbon Footprint Plus

NHS England has published calculations of the carbon footprint plus for all hospitals; however, this is up to the end of financial year 2024-25. This is shown below, but we do not currently calculate the carbon footprint plus.

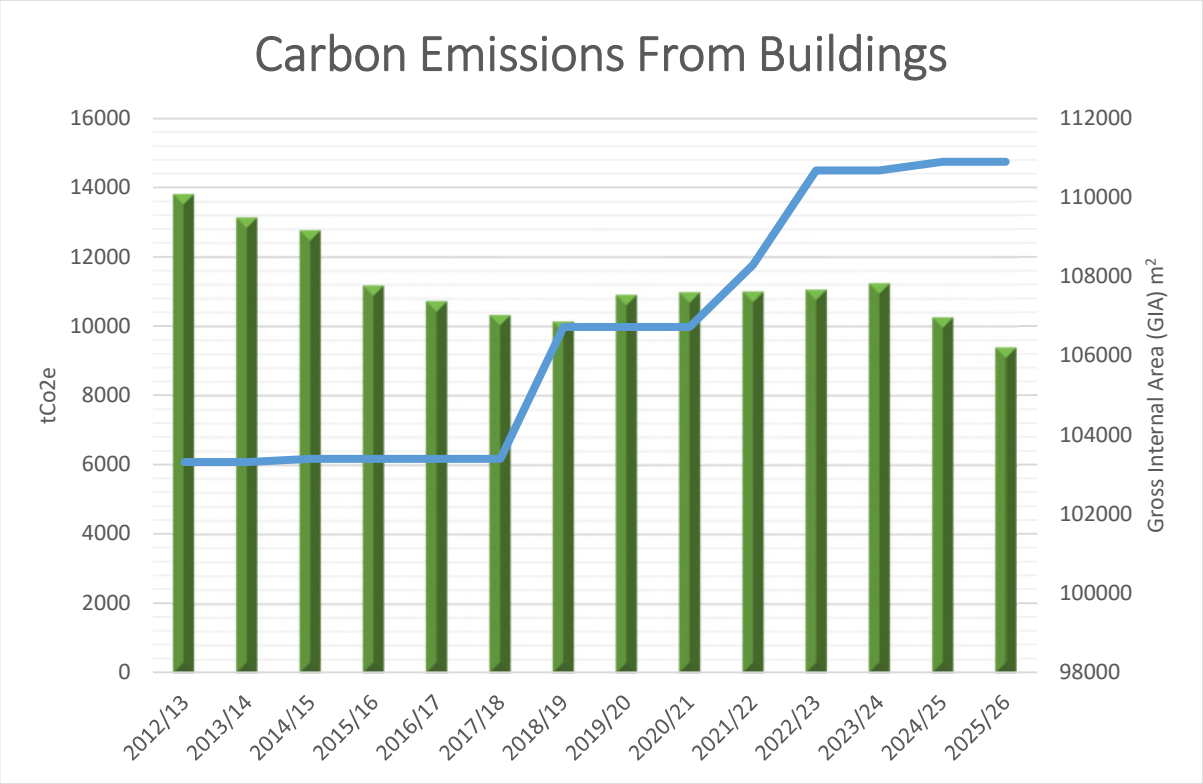
We had commissioned a calculation, based on expenditure, of our scope 3 emissions, excluding medicines, but were unable to obtain the required information relating to spend to complete the work.

Carbon Emissions from Buildings

The majority of the £21.6 million PSDS has been delivered and is showing a reduction in carbon emissions from the buildings making up the NGH Estate. The figure relates to capital expenditure spanning 2022-23, 2023-24 and 2024-25, representing a prior year scheme with benefits expected to be realised from 2025-26 onwards.

Management confirmed that the wording will be amended to more accurately reflect this and make it clear that this relates to multiple years (note we don't need to audit the figure as it is non monetary). The scheme removed steam across the site, added our first heat pumps as well as a number of energy efficiency measures. This is shown by the graph below indicating a further 8.5% reduction in absolute CO2e emissions over the last twelve months.

The Trust also received Critical Infrastructure funding from the Government to replace the final two steam boilers; these were commissioned in March 2026. These, along with the solar PV that is being commissioned are expected to reduce the carbon emissions from buildings by a further 200 tonnes per year.



Utility information for the last three years is shown below. Gas consumption has decreased as the new system has been commissioned. This is also partly due to a slightly warmer winter as shown by a reduced number of heating degree days (8.5% lower over the months January to March). Electricity consumption has slightly decreased despite the addition of the electric heating with the new heat pumps, but also due to a slightly lower number of patient appointments. Renewable energy generation has increased as our solar panels have been commissioned and started generating. Electricity costs are higher this year due to a reduction in the running hours of the Combined Heat and Power (CHP) process. Gas costs are lower due to the hours run by the heat pump, reduced CHP running and the slightly warmer winter, along with a full year impact of the de-steam of the site.

	2023-24	2024-25	2025-26
Consumption Data			
Gas kWh	55,147,673	48,413,762	43,792,725
**Electricity kWh	18,074,211	18,416,907	17,936316
Biomass kWh	4,780,740	3,833,073	1,627,505
Business Travel miles	904,680	953,799	821,829
Renewable Electricity Generated Solar PV kWh	49,008	40,275	113262
Electricity consumption per patient contact kWh	24.22	23.22	23.59
Water m^3	202,506	157,736	161,525
Water consumption per patient contact m^3	0.27	0.20	0.22
Financial Data £			
Gas	2,413,556	2,670,619	2,165,248
Electricity	1,577,715	1,887,817	2,209,727
*Biomass	171,453	255,068	104,345.4
Water	452,021	473,831	585,508
Business Mileage	377,630	418,049	395,250
*Renewable Heat Incentive	(165,137)	(105,633)	(73,160)

*Figures are approximate, pending validation from Ofgem and Energy Performance Certificate supplier

** includes electricity generated from the CHP and solar panels and imported from the grid

Business mileage figures do not include public transport. Although spend is available this does not include start and end points. Using an approximate distance from Northampton to London and approximate cost per ticket, a further 15,346 miles were travelled by train.

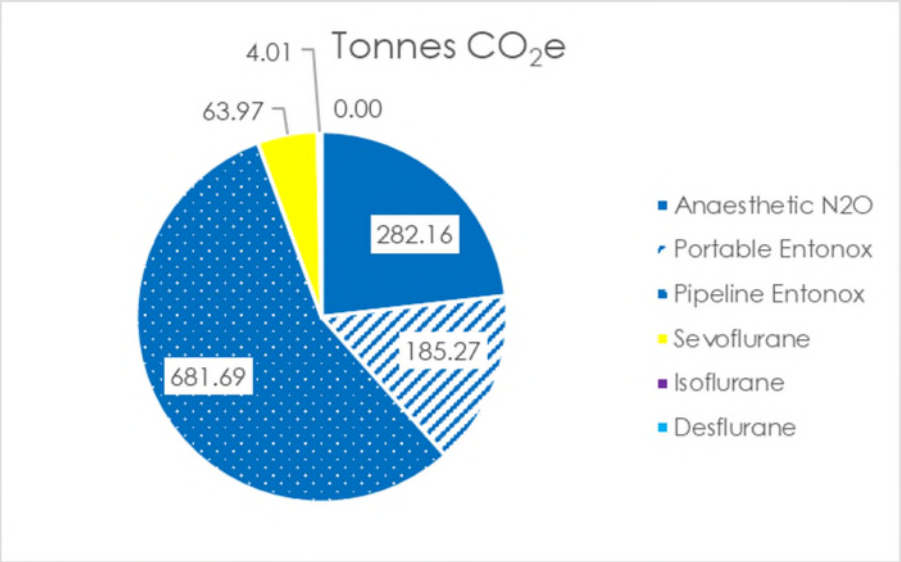
The spend of £10,141 on train tickets is included in this figure. No flights were paid for by NGH staff in 2025-26.

Anaesthetic Gases

The emissions from isoflurane and sevoflurane are shown below.

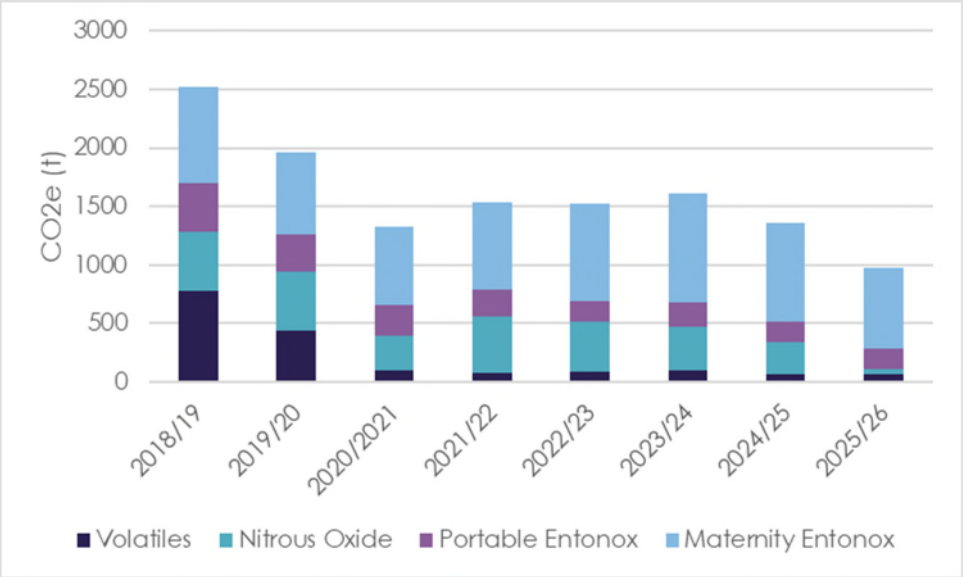
The Trust decommissioned the manifolds supplying nitrous oxide for anaesthesia to the theatres on site in January 2025. Portable cylinders are available for any anaesthetists wishing to use nitrous oxide. Although there has not been any use of manifold nitrous oxide during this financial year, there is still a reported use due to the delay in removing the bottles of nitrous oxide; this is the figure reported by Greener NHS. This results in a reported level 244 tonnes CO2e higher than that actually used. The two sets of figures are reported below for comparison and show the significant reduction in environmental impact – this is equivalent to replacing approximately 3,500 fluorescent lights with LED. This reduction in use was higher than originally anticipated and will deliver increased financial as well as environmental savings.

The use of Entonox in maternity has further reduced, although there has been no focussed work in this area.



	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Isoflurane	16	16	9	15	12	7	8	4
Sevoflurane	67	58	31	55	57	92	63	64
Desflurane	695	366	58	4	19	0	0	0
Total Volatiles	**778**	**440**	**98**	**74**	**88**	**99**	**71**	**68**
Anaesthetic N_2O	507	503	293	491	430	376	271	282 / 38
Portable Cylinders N_2O	410	316	264	230	176	201	170	185
Maternity Entonox	826	704	675	743	827	936	847	681
TOTAL CO2e (Tonnes)	**2521**	**1963**	**1330**	**1539**	**1521**	**1612**	**1288**	**1217/ 973**

This change in the carbon emissions from anaesthetic gases since focussed work commenced is illustrated below:



Water

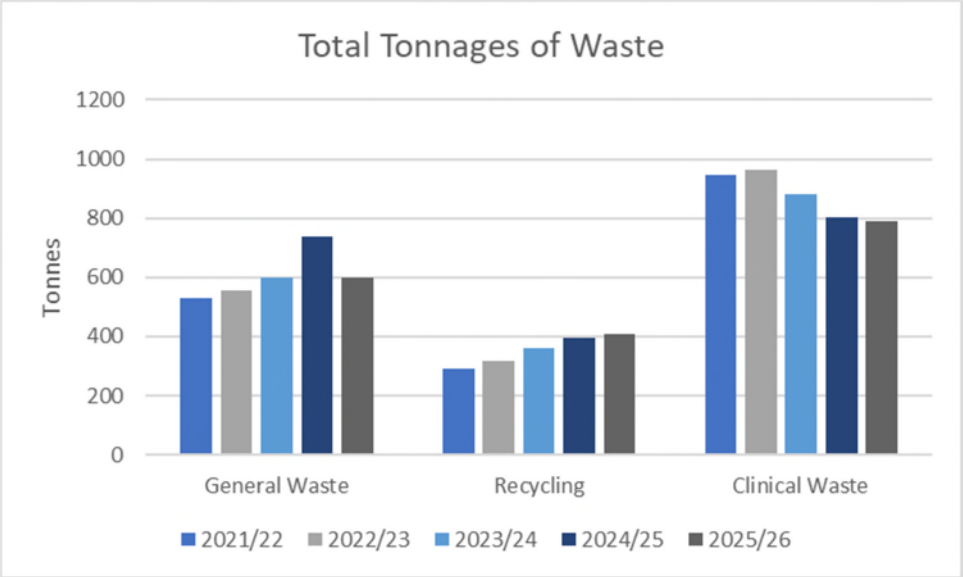
Water consumption increased in the year due to a water leak that took several months to locate. Water use from the other meters on site remained the same or decreased. The impact of removing the steam and therefore the impact of steam leaks has not been quantified. There was also an increase in water consumption due to the commissioning of the new boilers.

Waste

The NHS targets for the segregation of clinical waste are 20:20:60, and in the last twelve months the percentage of offensive waste has increased from 47 to 56%.

20:20:60 ratio	2020 - 2021	2021 - 2022	2022 - 2023	2023 – 2024	2024-25	2025-26	Target
Offensive waste	30	42	40	45	47	56	60
Alternative treatment	61	47	46	41	38	34	20
High temperature incineration	9	11	14	14	15	11	20

The overall levels of waste have reduced over the last twelve months. This has been due to a proactive approach to waste management with better segregation and a focus on reuse and repair being taken. As well as reducing the environmental impact, this has also significantly reduced costs to the Trust from waste management. This was highlighted by a positive audit from our waste management company and the change in the ratios of the clinical waste streams.



Circular Economy and Reuse

The creation of a separate Sustainability Co-ordinator has resulted in an increased focus on Circular Economy and Reuse projects. The Trust continues to subscribe to the WarpIt platform for reuse. In the last financial year there were 227 new members and £20,000 saved from internal reuse, with an

additional £27,700 saved for external charitable partners. This has reduced our waste by almost nine tonnes and saved 23.7 tonnes of CO2e.

We also promoted our walking aid collection and reuse scheme; we reissued 56 pairs of crutches, saving approximately £1,100 and nearly 0.5tonnes CO2e. We also donated over 100 crutches to a charity, which will refurbish them for reuse.

The Trust carried out the first of two repair workshops to determine the most cost-effective items for repair and reuse, saving nearly £2,000 in one morning after the cost of spare parts and labour were included. This will be repeated in April 2026.

After a successful trial period, NGH installed its first washer disinfector to replace a macerator and an estimated 36,800 pulp items (weighing 1.6 tonnes in total) in one ward, which would otherwise be sent to sewers. Plans are in place to roll these out to other wards.

In April 2026, we introduced UV decontamination to replace single use anaesthetic masks in the theatres with a reusable option.

After installing new waste bins to reduce handling requirements and litter across the site, the hospital donated the original bins to the Council's parks contractor for use across Northamptonshire.

The Trust uses an auction house for its unwanted equipment that is no longer used. In 2025-26, this generated almost £32,000 in income, and saved 4.86 tonnes from being disposed of through recycling and landfill, with only 0.25 tonnes sent but not sold, and therefore being recycled.

Travel and Transport

The updated Travel Plan was approved and issued in 2025. In 2025 the Trust reintroduced parking charges for staff, but on a pay per day basis as per best practice guidance from the NHS.

In November we held an event with Stagecoach to advertise the positives of bus travel and the 10% NHS discount for staff.

Information for patients and visitors about how to travel to the hospital using public transport has been updated on the external website. This includes the Spider Map commissioned via West Northamptonshire Council helping to show the routes to and from the hospital using the bus.

The hospital has also advertised any local offers from the Partnership working group with Stagecoach and West Northamptonshire Council to its staff base.

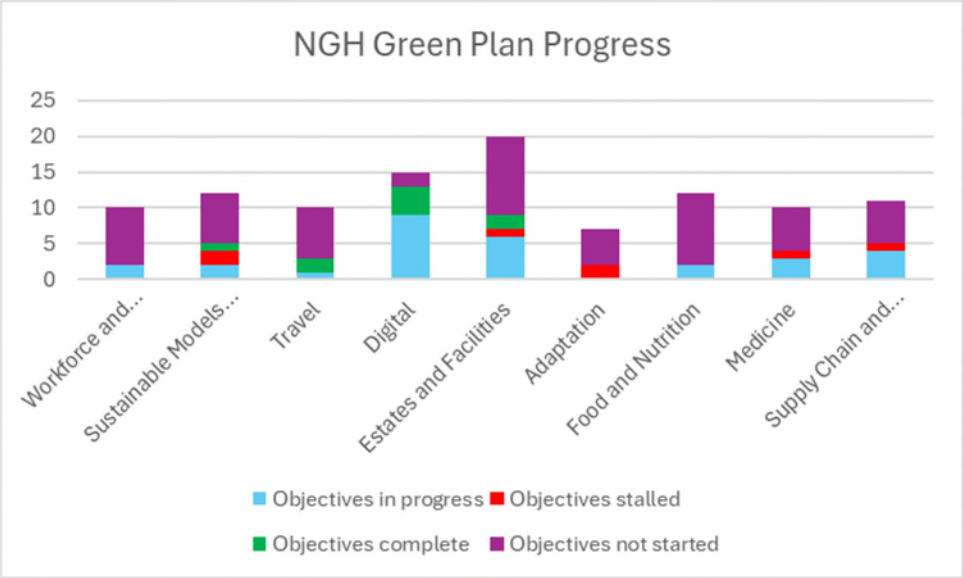
Electric Vehicles

The use of the EV chargers installed at NGH has remained largely static during the year. This use will remain static unless the charging point bays become dedicated EV parking spaces.

	Number of sessions	kWh Electricity	tCO2e avoided
2023-24	6925	98,027	65.15
2024-25	8246	146,859	115.8
2025-26	8128	142,131	28.42

Green Plan and Group and Integrated Care Systems (ICS) targets

The Trust's Green Plan forms the basis of the sustainability activities and covers a number of key themes determined by Greener NHS as shown below. The plan was refreshed and approved by the Boards on 1st August 2025.



Actions completed from the Green Plan in 2025-26

- Investors in the Environment Green Accreditation maintained
- Digital Meal Ordering commenced
- Seed library created with 192 packets of seeds taken since it opened in November
- Four members of staff undertaking a sustainability apprenticeship
- Several nursing-led projects completed; removal of couch roll, reuse of urine bottles, removal of single use blood pressure cuffs, reduction of single use tourniquets. Case studies for these will be created and carbon savings calculated.
- Green Team competition completed across UHN
- Walking Aid Reuse scheme in operation

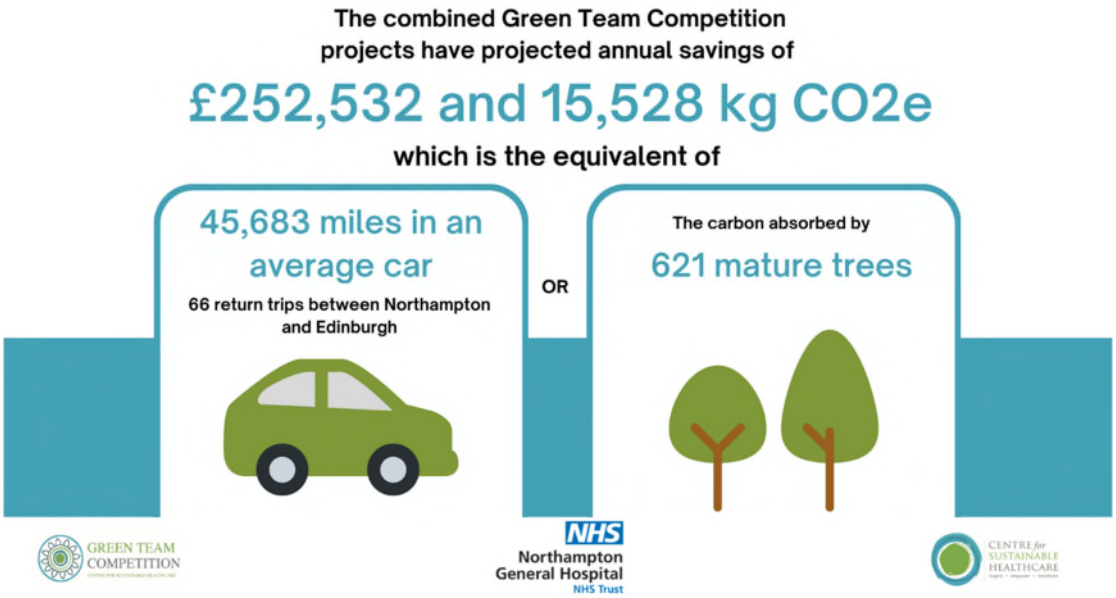
Innovation

In 2023 NGH partnered with Mackwell Health to obtain SBRI (Small Business Research Initiative) funding to reduce carbon emissions in the NHS. The trial to use UV to decontaminate anaesthetic masks and move to a reusable alternative was completed in 2024 and will be rolled out in 2026. This will form the basis of a new process that can be replicated across the NHS. Following this, trials were completed in the ENT department to replace the use of the Tristel 3 stage wipe with UV decontamination to clean nasal endoscopes. This resulted in the delivery of several UV boxes at NGH and an additional box in KGH to scale up the work. As well as being a better process for staff this first for the NHS will save an anticipated £20,000 a year and around 0.5 tonnes of CO2e. This will be presented as a poster at a major ENT conference this year.

NGH was also invited to join the Circular Economy Healthcare Alliance. This was started by UCL Hospitals and includes other members from across the NHS including Newcastle, Brighton and Sussex, and Cambridge.

Green Team Competition

Four teams from NGH, one from KGH and one group team competed in the Green Team Competition, run in conjunction with the Centre for Sustainable Healthcare. Entries from NGH were from IPC (self catheterisation), Critical Care (daily sedation holds), IPC (introduction of DiffX for cleaning in theatres) and Anaesthetics (removing unnecessary items from theatre packs). The winner was the self-catheterisation project from IPC. A summary of the projected annual savings are shown below.



Our People

Teaching sessions have been carried out with first year doctors joining the Trust. In addition, a teaching session was carried out with fifth year medical students at Leicester Medical School.

The Head of Sustainability presented at the Centre for Sustainability's annual conference.

The hospital's Associate Director of Infection Prevention, Dr Holly Slyne, runs the University Hospitals of Northamptonshire's Greener Nursing and Allied Health Professionals Group. She is also part of the steering committees for three infection prevention special interest groups and is co-authoring position statements about reducing disposable glove use and reusable theatre hats. She has co-organised three sustainability conferences, hosts the Centre for Sustainable Healthcare's Infection Prevention Network, and is helping them to write infection prevention guidance for green spaces in healthcare.

Head of Procurement, Rachel Pell, sits on the Department of Health and Social Care's Design for Life Product Advisory Group, and discusses our sustainability projects at both a regional and national level.

Critical Care Nurse, Leeanne Hardy, has organised sustainability workshops for the region to enable other hospitals to learn from each other as well as a full day sustainable critical care meeting. Her work was featured in the National Critical Care Sustainability Recipe Book, and she has gone on to help colleagues in her department and in other departments with their sustainability projects.

Renal Pharmacist Janeme Lam has presented her work to reduce medicine wastage online and presented posters at national conferences. She has since started further projects and has been talking to patients about medicine waste.

Infection Prevention and Control Nurse Jasmine Lowdon, has spoken about her project to reduce continence issues from caffeinated drinks and reduce carbon dioxide production at several online forums and locally, with GPs and Care Homes.

Four staff members are currently studying for a Level 4 Apprenticeship with the LDN Sustainable Healthcare Academy.

NGH was named a Sustainability Influencer at the Investors in the Environment awards for the work these colleagues have done to spread sustainable practices both internally and externally.

Governance and Compliance with legislation and NHS Targets

The climate related activities of NGH NHS Trust are reported annually in this report. In addition, they are audited each year by Investors in the Environment, and NGH was again awarded Green Accreditation during the year. The progress on the Green Plan and carbon targets is reported quarterly to the multidisciplinary Sustainable Development Committee. The risk of failing to meet net zero targets is detailed on the Board Assurance Framework and is updated quarterly. The Director of Strategy is the Board Lead for Sustainability.

Consumption and cost of utilities are put into the NHS Estates Returns Information Collection returns on an annual basis. The Premises Assurance Model (PAM) is also populated to show Trust position on aspects of sustainability. All progress is also reported to members of staff through a monthly newsletter sent to department heads and included in the Trust bulletins.

The relevant targets and measures are reported elsewhere in this Sustainability Section of the NGH report. Rather than report on Scope 1 and 2 emissions only, the Trust is reporting annual movement on the elements of the NHS Carbon Footprint included in the Net Zero Target of 2040. It is not currently possible to provide a measure of all Scope 3 emissions. These will be published externally by Greener NHS, with calculated emissions up to 2024-25 recently published for all scopes.

The Trust is compliant with the Simpler Recycling Legislation and has continued to roll out further food waste collections from staff and accommodation kitchens to augment the food waste collections already in place from the patient food and staff restaurant. This also incorporates the retail outlet food waste delivered by an external provider.

The Trust has an Adaptation Policy that lists the main risks to the trust, but this has not been widely adopted or disseminated and there has been no quantitative calculation or materiality assessment of the risks made. The risks are not incorporated into any strategies or financial plans and managers are not equipped to understand the risks to their service relating to climate change.

Heat-health and cold-health risks have been identified and assessed using Met Office models and based on NHS Midlands guidance on risk assessment. Any department specific climate related risks would be identified at a local level and reviewed at internal governance meetings. There are no locally based risks on risk registers.

The Trust includes a 10% weighting for social value in all tenders with questions set specifically for each contract depending on the scope of the contract and what is deemed an appropriate subject area. This inclusion is monitored via NHS England and reported regionally. All suppliers are expected to send their Carbon Reduction commitments and details of their Modern Slavery Statement.

Climate change and sustainability risks are reflected in our governance arrangements through the Board Assurance Framework (including the risk of not meeting net zero targets), quarterly reporting routes, and clear executive accountability. As set out above, the Director of Strategy is the Board lead for sustainability and climate-related activity is reported annually in this report, with utilities and estates sustainability returns completed through established national submissions (ERIC and PAM). While we continue to strengthen how climate-related considerations are embedded into wider strategic and operational decision-making, this is supported through the ongoing review of our decarbonisation plan, the planned sustainability initiatives for 2026–27, and the development of local and group-level arrangements (including Sustainability Champions and a UHN Waste Management Group). Where specific, department-level climate risks are identified, these will continue to be managed through local governance processes and escalated through risk registers as appropriate

Richard Mitchell

Chief Executive and Accountable Officer

24 June 2026

Section 2: Accountability Report

Corporate Governance Report

(prepared in accordance with guidance issued by NHS England and Improvement in compliance with sections 3.49-3.59 of the DHSC group accounting manual 2025 to 2026 - GOV.UK)

Chief Executive and Accountable Officer's governance statement

1. Scope of responsibility

1.1 As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

2. The purpose of the system of internal control

2.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The Head of Internal Audit's opinion in respect of the 2025-26 period is set out at paragraph 12.5 below, providing 'Reasonable' assurance.

2.2 The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control is in place and has been maintained in Northampton General Hospital NHS Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

2.3 Capacity to handle risk

Governance arrangements for risk management are as follows:

- **Group risk management:** The Trust and KGH are working together as part of the UHN Group to strengthen acute care service provision across Northamptonshire, under the leadership of a jointly appointed Chair and Chief Executive and Accountable/Accounting Officer for both Trusts.

  Collaborative working across both organisations enables us to prioritise acute pathway transformation and quality improvement. Working in a group maintains the statutory duties and responsibilities of two separate Boards of Directors.

  As part of the collaboration planning work, and to facilitate the seamless implementation of Group Priorities following previous approval by Boards, both Trusts established Finance, Investment and Performance, Quality and Safety, Strategy, Transformation and Digital and People Committees in Common.

  These meetings are a recognised governance approach that enables collaboration between organisations to take decisions together on projects that cross boundaries without

compromising the integrity of their own statutory requirements. They are responsible for reviewing and monitoring any strategic risks to both organisations.

UHN has adopted a shared Group Board Assurance Framework and shared Corporate Risk Register (significant operational risks)

The Audit and Remuneration and Appointments Committees remain constituted separately but meet together, with shared agenda and membership

- **The Group Chief Executive (and Accountable Officer)**: takes Board-level responsibility for governance, including risk management, and has overall responsibility for maintaining an effective risk management system and for meeting all statutory requirements. Executive directors and clinical directors have delegated responsibility for governance and risk management arrangements within their areas of control.

- **UHN Chief Executive:** leads the Executive Directors in the day-to-day running of the Trusts' business, including chairing Integrated Leadership Team meetings and communicating decisions / recommendations to the Boards. Ensures effective implementation of Boards' decisions.

- **Board of Directors:** The Board of Directors and Group Chief Executive ensure that the risk management arrangements are implemented, monitored and reviewed, and meet all legal and regulatory requirements. The Board receives reports from its Committees on the Trust's risk control measures.

- **Non-Executive Directors:** Non-executive directors are drawn from outside the organisation and bring to the Trust external expertise; they are appointed by NHS England. They are paid for their time but are not employees of the Trust. They do not have a managerial role and are particularly responsible for supporting and challenging the executive directors in the delivery of the Trust's strategy and objectives.

- **Audit Committee:** The Audit committee has overall responsibility for independently monitoring, reviewing and reporting to the Board on all aspects of governance, risk management and internal control. It is supported in this role by all Board Committees.

- **Finance, Investment and Performance Committee:** The Committee's overarching purpose is to assure the Boards, patients, visitors and staff of the UHN Group that there is oversight of the delivery of group objectives (including associated risk) in respect of finance and performance.

- **Quality and Safety Committee:** The Committee's overarching purpose is to assure the Boards, patients, visitors and staff of the UHN Group that services at Kettering and Northampton General Hospitals are safe and that they conform the required quality and safety standards required within a culture of learning and continuous improvement.

- **People Committee:** The Committee's overarching purpose is to assure the Boards, patients, visitors and staff of the UHN Group that there is oversight of the delivery of group objectives in respect of people.

- **Strategy, Transformation and Digital Committee:** The Committee's overarching purpose is to assure the Boards about the delivery of the Group's strategic transformation programmes and the strength of the underpinning infrastructure that supports them.

- **Risk Management Committee (RMC):** The RMC is chaired by the Deputy Director of Risk and Legal Services and provides executive oversight of risk management issues. UHN is responsible for ensuring the development and implementation of effective systems and processes for risk management at each level of the Trust.

- The Trust has a Governance team with a focus on integrated risk management. The team supports the process of identification, assessment, analysis and management of risks and incidents at every level of the organisation and aggregation of results at a corporate level.

- In each of the Clinical Divisions, the Divisional Director has lead responsibility for governance and risk issues and is responsible for coordinating risk management processes, including management of the Divisional risk register supported by the Divisional manager. The Divisional management groups have responsibility for monitoring, managing and, where necessary, escalating risks on their risk registers and significant risks are reviewed at monthly performance review meeting.

- **Data Risk & Governance Board**: The purpose of this group is to set a clear direction of travel in respect of Data Security and Information Governance and to provide the Board with the assurance that effective governance for cyber security, clinical safety and data protection is in place. The group is attended by key stakeholders across the Trust which includes clinical and operational leaders.

  The Trust's Senior Information Risk Owner (SIRO) during 2025-26 was the Chief Digital Information Officer and is responsible for taking ownership of information risk and advising the Chief Executive accordingly. The SIRO works closely with the Medical Director as Caldicott Guardian (the senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly) and the Head of Data Security and Protection.

- Risk management training is delivered to staff in accordance with the Trust's risk management training needs analysis. This begins at corporate induction, which all staff are required to attend.

3. The risk and control framework

3.1 Risk management is recognised as a fundamental part of the Trust's culture and is the business of everyone in the organisation. There is a Risk Management Strategy together with a Risk Register Policy and Improvement Workplan in place to ensure that risk management is integral to all aspects of the Trust's functioning. Within this, the organisational Risk Appetite is reviewed annually by the Board and is detailed below.

3.2 The risk appetite statement identifies statements across 11 key risk areas (domains). The statements and supporting definitions establish our capacity for risk.

3.3 In line with the Risk Management Strategy, the risk appetite was reviewed by the Board during 2025-26 and updated as shown below:

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.

Board committees have responsibilities for monitoring and leading on aspects of risk management across the Trust in accordance with their terms of reference. Committees consider the Board Assurance Framework (BAF) each quarter. Risks within the BAF are allocated to named committees of the board, alongside a named lead executive. The BAF is considered in its entirety alongside an in-depth review of the BAF risk(s) owned by the committee.

3.4 The Audit Committee considers the BAF on a quarterly basis and on a rotational basis each executive named against BAF risks attends Audit Committee to present on how risks are managed throughout their service and inform the BAF risk and management of the strategic risks.

The Board receives the BAF on a quarterly basis, seeking assurance from executives and chairs of its committees on the robust identification and management of strategic risks.

3.5 Escalation of risk issues takes place through the Divisional Governance structure that allows two-way communication from the Board and its Committees. Trust wide committees and operational groups report to Board via the Patient Safety Committee reporting to the Quality and Safety Committee. Monthly directorate and divisional governance meetings consider risk, quality and performance information alongside the risk registers for their service areas. Themes or specific significant / extreme issues requiring escalation are taken to the monthly Risk Management Committee for consideration and potential inclusion in the Corporate Risk Register. Significant or extreme risks each have an executive lead who has agreed the risk. The operational significant risks contained on the Corporate Risk Register are aligned to relevant strategic BAF risk(s).

3.6 Strategic risks are identified within the Board Assurance Framework and assurance that the risks are appropriately managed is sought from both external and internal sources as appropriate.

The Risk Management Strategy sets out the strategic direction, structures and processes for the identification, evaluation and control of risk, as well as the system of internal control. The Strategy has been developed to support the delivery of the Group's Strategic Aims and Objectives. Its priorities are to ensure all strategic risks are managed in line with the Board's risk appetite and to ensure that risks that could prevent objectives being achieved are proactively identified, quantified and managed to an

acceptable level and in doing so provide a robust risk management framework with appropriate reporting arrangements and individual responsibilities clearly identified.

The process of risk management begins with the systematic identification, assessment and prioritisation of risks throughout the organisation via structured risk assessments recorded on Datix (the Trust's integrated risk management system). The Trust uses an integrated approach to the identification and management of risk identified through a variety of mechanisms, both reactive and proactive. Pro-active identification may arise from local risk assessments, impact assessments and 'horizon scanning' of published reports on healthcare subjects. Re-active identification can be flagged as a result of a serious incident, a trend in incidents or complaints or following an audit, either internal or external.

Identified risks are and analysed to determine their relative importance using a standard risk scoring matrix. This is then utilised to populate the relevant division, directorate or ward risk registers via our online system. Responsibility for the management and control of a particular risk rests with the division, directorate or ward concerned.

3.7 The Trusts have adopted a shared BAF to overcome duplication and confusion from similar risks describing the same issues across the Group and provide clearer alignment with Group objectives and delivery strategies. Each Trust retains a Corporate Risk Register which will inform the Group BAF and provide oversight of key cross-cutting risks at an organisational level.

At 31 March 2026, there were 15 risks within the Group BAF

Strategic Priority	Risk Description	Domain	Risk Appetite
Transform Patient	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.	Quality / Patient Exp	**Open**
Transform Patient Care	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	Patient Safety	**Minimal**
Transform Patient Care	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	Quality / Patient Exp.	**Open**
Transform Patient Care	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.	Patient Safety	**Minimal**

Transform Patient Care	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.	Information	**Minimal**
Transform Patient Care	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.	Pt Experience/ Quality	**Open**
Transform Patient Care	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.	Information	**Minimal**
Transform Patient Care	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.	Activity	**Open**
Transform Patient Care / Strengthen Culture	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.	Innovation	**Open**
Strengthen Culture / Transform Patient Care / Finance	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.	Infrastructure	**Minimal**
Strengthen Culture	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.	Culture	**Minimal**
Deliver 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	Finance	**Minimal**
Deliver Financial 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.	Finance	**Minimal**
Deliver Financial Plan	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.	Workforce	**Open**
Deliver Financial Plan	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.	Net Zero	**Open**

The Group received a ‘Reasonable Assurance’ opinion from internal audit on the Board Assurance Framework and Risk during 2025-26.

3.8 Communication and consultation is undertaken with internal and external stakeholders when appropriate. The Trust has continued to develop communication channels with its partners, and internally. Regular reports are prepared for directorates and divisions on the incidents reported, both clinical and non-clinical, with escalation channels to the Board of Directors and its Committees when required.

3.9 There is an established Internal Audit programme approved by the Audit Committee. The Audit Committee receives reports which provide assurance of the Trust's key internal control objectives. The Internal Auditor presents an Internal Audit Annual Report and Head of Internal Audit Opinion to those charged with governance and the Audit Committee on the overall level of assurance for the system of internal control. Internal Audit recommendations are tracked in a system to record action taken and completed.

3.10 The Trust has an established Anti-Crime (Counter Fraud) Service provided by an anti-Crime Specialist. In addition to investigation work, this postholder carries out an agreed amount of proactive work. They regularly attend the Audit Committee, providing reports on any proactive or reactive work undertaken. They also provide feedback to the Freedom to Speak Up Guardian in regard to any referrals made from that route.

3.11 The Trust's External Auditors conduct an Annual review of the Trust's control environment and present an Annual Report to those charged with governance in the form of an External Audit Opinion, comprising financial and Value for Money elements.

3.12 The Trust has a range of approaches in place to ensure that short, medium, and long-term workforce strategies and staffing systems are in place which assures the Board that staffing processes are safe, sustainable and effective.

3.13 The Board receives assurance reports in respect to safer staffing to ensure adherence to National Quality Board requirements. This assurance includes the provision of monthly and six-monthly Safe Staffing Review of Inpatient Staffing Levels. Assurance against the requirements of the NHS England 'Developing Workforce Safeguards' guidance is reported and monitored through the People Committee.

3.14 The Trust uses a range of workforce-planning methods:

- Professional judgement method – multi- disciplinary teams (MDTs) of lead clinicians and managers consider workforce requirements. Using their professional judgement, MDTs will review the current performance standards, financial performance, patient feedback and commissioning intentions and consider the benefits/risks of alternative skill–mixes as part of this approach
- Workload quality method – the Trust uses evidence-based tools to calculate staffing levels based on a variety of inputs, including the Safer Nursing Care tool, Birth Rate plus for maternity services, and in addition the Trust uses the Allocate Acuity data, to ensure that the nursing establishment supports the staffing level and skill mix for each ward
- Triangulation of the above with quality, patient feedback, workforce, and workflow metrics is undertaken through the work of the Board committees
- Benchmarking internally and externally (where information is available and applicable)

3.16 The workforce planning approach detailed above informs the outputs of the annual business planning cycle. Divisions establish their future workforce requirements modelled against planned activity, service developments and financial planning.

3.17 Clinical teams have access to key performance data. Data sources for dashboard indicators include, amongst other information sources: staff HR metrics (e.g., staffing levels, sickness levels and

bank staff usage), patient feedback, numbers of complaints, audit outcomes and numbers of incidents reported.

3.18 The Board and its committees receive triangulated data in a number of key documents including the corporate dashboard, Group Board Assurance Framework and as part of Patient Safety, Safer Staffing, Workforce and Financial reports. The Trust uses the information in a number of ways, including to:

- assure the Board that the systems and processes are working to identify risk or good practice/outcomes
- challenge the data and request further information
- identify internally driven, focused pieces of quality work
- formulate ideas for change or for new ways of working
- review assurances available within the Corporate Risk Register and Board Assurance Framework
- identify new quality indicators aligned to transformational programmes
- promote quality across the organization, using key messages and focused themes

3.19 The People Committee has delegated responsibility for ensuring that any workforce/staffing changes are undertaken with the associated findings reviewed and discussed. The NHS England Developing Workforce Standards offer a framework for this to be undertaken.

3.20 The Trust was rated “Requires Improvement” by the Care Quality Commission (CQC) in 2019 and remains fully compliant with the registration requirements of the CQC and of the NHS provider licence (2023).

The received an unannounced CQC inspection of Urgent and Emergency Care (UEC) and medical services on 18 February 2025. The visit took place during a particularly busy period for the hospital, with high patient demand, extended stays in the Emergency Department and delays in ambulance handovers. The CQC recognised the compassion, commitment and professionalism of staff but also identified a number of concerns, requesting urgent actions in the following areas:

- The potential risk of harm to patients in the Emergency Department;
- Hospital flow issues affecting the timeliness of care;
- Ensuring the privacy and dignity of patients, particularly where Temporary Escalation Spaces are in use.

Following the Inspection, the Trust received a Section 29A Warning Notice from the CQC (Health and Care Act) on 21 March 2025. This notice highlighted areas where urgent improvements were required.

The Trust acted quickly following the inspection, taking immediate and short-term actions to improve safety, patient experience, and flow through the hospital. These included reviewing how and where patients are cared for in high-demand areas and enhancing senior clinical oversight in key areas of the hospital.

3.21 The Trust has published on its website an up-to-date register of interests, including gifts and hospitality. The Employee Self-Service (ESR) system is used to ensure that senior decision-making staff (defined at the Trust as Consultants and staff on Agenda for Change Band 8D and above or equivalent) submit annual declarations of interests, as required by group policy and the ‘Managing Conflicts of Interest in the NHS’ national guidance.

3.22 As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the

Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

3.23 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

3.24 The Trust has undertaken risk assessments included in its Adaptation Policy and has a sustainable development management plan in place which is currently being reviewed to take account of UK Climate Projections 2018 (UKCP18) and the Carbon Net Zero by 2040 NHS commitments. The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust complies with its obligations under the Climate Change Act and Adaptation Reporting guidelines through its annual report – see the Sustainability Report above for more details.

3.25 **Condition 7 (Continuity of Services) Availability of Resources - Declaration**

After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate; however, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services (CRS).

Rationale: The Board and its committees including the Audit Committee having reviewed the financial statements are satisfied that the Trust has the required resources, taking all factors into account; however, CRS remains the default position for all services, and the Trust continues to rely on cash support due to its deficit position.

4. Risk assessment and the NHS Oversight Framework

4.1 The Trust has adopted an approach to risk management with the structures and processes in place to successfully deliver the risk management objectives. Leadership arrangements are defined within the Trust and are supported by job descriptions, objectives, and annual appraisals.

4.2 Leadership has been further embedded at Divisional and Directorate level, where managers have responsibility for risk identification, assessment, and analysis. All staff are required to complete mandatory and role specific update training. All new members of staff are required to attend induction which covers key elements of risk management including Freedom to Speak up.

4.3 An Annual Governance Statement is in place (this report) and the Trust is compliant with the risk management and assurance framework requirements that support the statement pursuant to the most up to date guidance.

4.4 NHS England's NHS Oversight Framework is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) Its segment derived from scored metrics under five performance domains (access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)

b) considering financial override which may limit a segment to be no better than 3

c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and

d) capability assessments which consider the organisation's leadership and governance.

4.5 Based on the latest published data, the Trust's position for 2025-26 (Quarter 4) was in segment 4: low-performing. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/nhs-oversight-framework/segmentationand-league-tables/. The trust is included on the acute hospital trust dashboard.

4.6 The Trust is currently subject to Enforcement Undertakings from NHS England in relation to its financial position and Urgent and Emergency Care Performance; these were agreed by the Board in October 2023 and updated in October 2025. Details of the Undertakings are available here: 20250905-Northampton-General-Hospital-Undertakings.pdf.

4.7 The Board ensures that the Trust's governance operates effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the Board of Directors; and that all Board positions are filled, or plans are in place to fill any vacancies.

4.8 The Board is satisfied that all executive and Non-Executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability. All Board members complete a "Fit and Proper persons" declaration, and the Audit Committee confirmed compliance with the Fit and Proper regulations at its June 2026 meeting.

5. Review of economy, efficiency, and effectiveness of the use of resources

5.1 The Trust has a number of processes in place to ensure that resources are used economically, efficiently and effectively. The Trust has an established process in place for budget setting, monitoring and reporting. ,

5.2 The Trust has achieved productivity improvements in its clinical services through working more with health and social care partners and engaging with national productivity improvement programmes. The Trust, however, continues to experience emergency demand pressures, which together with key workforce challenges (high vacancy rates and agency spend) contributing to the deficit financial position.

5.3 The Board and Board Committees responsible for Audit and Performance, Finance and Resources regularly review the Trust's economy, efficiency and effectiveness in the use of resources.

6. Information governance and data security and protection

6.1 The Trust uses an online tool to measure its performance against data security and information governance requirements which reflect legal rules and Department of Health and Social Care policy, this is called the Data Security and Protection Toolkit (DSPT). Each Trust must complete the Toolkit independently; however, the majority of Teams are managed as a Group and therefore the evidence is broadly consistent.

6.2 All organisations that have access to NHS patient information must provide assurances that they are practicing good information governance and use the DSP Toolkit to evidence this by the publication of annual assessments. In September 2024, the DSPT changed to adopt the National

Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and information governance assurance.

6.3 In 2023 the health and care cyber security strategy committed to adopt the CAF as the principal cyber standard in order to:

- Emphasise good decision-making over compliance, with better understanding and ownership of information risks at the local organisation level, where those risks can most effectively be managed.
- Support a culture of evaluation and improvement, as organisations will need to understand the effectiveness of their practices at meeting the desired outcomes – and expend effort on what works, not what ticks a compliance box.
- Create opportunities for better practice, by prompting and enabling organisations to remain current with new security measures to meet new threats and risks.

6.4 The DSPT is split into a number of contributing outcomes, each of which are supported by indicators of good practice grouped into levels of achievement – 'Not Achieved,' 'Partially Achieved' or 'Achieved.'

6.5 There are 39 contributing outcomes of the CAF with a further eight contributing outcomes in a custom section on 'using and sharing information appropriately', to ensure that data protection, confidentiality, and other information governance disciplines such as clinical coding are covered, totalling 47 outcomes that we must self-assess our level of compliance against using the indicators of good practice as a guide.

6.6 The Data Security and Protection Team work closely with the Digital Team, to ensure a firm focus of Data Security and Protection and Cyber Security at the Trust. The Trust's auditors (TIAA) must complete the Trusts DSPT Audit which is in line with the standard audit criteria for nine nationally agreed outcomes plus three additional Trust chosen outcomes. The DSP Team has engaged fully with the auditors and received a 'standards fully met' outcome at the last audit.

6.7 For the 2025 DSP Toolkit submission, five objectives were assessed as not meeting the required standard, resulting in an overall status of Standards Not Met at that time. These related to gaps in asset management (A3.a), identity verification, authentication and authorisation (B2.a), identity and access management (B2.d), understanding data (B3.a), and managing records (E4.a). For each of these outcomes, a time-bound and resourced improvement plan was in place and subsequently reviewed and accepted by NHS England and DHSC, enabling the organisation's status to move to Approaching Standards pending full implementation of the agreed actions. The Trust expects that this will be reduced to one outcome (E4a) for the June 2026 submission.

6.8 NGH reported four information governance serious incidents to the Information Commissioner's Office (ICO) in 2025 (compared to one in 2024) all of which have been investigated fully with relevant actions identified and implemented (or planned to be implemented) as appropriate in line with Trust Policy and communications with the ICO.

6.9 We continue to develop tools to ensure compliance with General Data Protection Regulation (GDPR), the Data Protection Act and the Freedom of Information Act and have now procured the use of a Policy Management System which can enforce policies and training to relevant staff. We have a Privacy Notice which provides detailed information about how the Trust handles personal data.

6.10 The Trust is using robust tools to ensure compliance with Data Sharing and Data Protection Impact Assessments which ensure it operates in a clear and transparent manner, with Data Protection by

Design and Default at the forefront. We are responding to Subject Access Requests in a much improved and timely manner using a digital portal for patients to receive copies of their records, only a few which breach the one calendar month statutory requirement.

6.11 The Data Risk and Governance Board and the Data & Analytics Group meet monthly to ensure the Trust has adequate controls in place with reports presented by Clinical Coding, Health Intelligence, Data Quality, Clinical Safety, Cyber Security and Data Security and Protection which are scrutinised regularly. The Trust is proud to commit to high expectations for Data Security and Protection and has made excellent progress for a clear culture change towards Data Protection using education and reporting to promote best practice.

6.12 **Data Quality and Governance**

The quality and accuracy of our Referral to Treatment (RTT) data is assured through internal validation of patients pathway (over 12 weeks wait) every 12 weeks. The aim is to achieve 90% validation and, during March 2026, NGH was achieving 80%, replacing it within the ten highest performers in the region. Performance is reported monthly at the Patient Access Board.

Data quality is assured through 12-week cycles of Patient Validation, which are added to the weekly data submissions. Patients are asked whether they still require their appointment/treatment as part of this process.

Clinical review is also undertaken as appropriate.

The system allows us to drill down to specific cohorts causing concern, which removes the need to validate pathways where there is likely to be no change.

7. Going Concern

7.1 The Audit Committee, at its meeting in March 2026, confirmed its agreement with the positive going concern assessment supporting the conclusion that the Trust is a going concern, and formally approved Going Concern status for the completion of the accounts.

8. External Auditor

The Board of Directors approved the re-appointment of Grant Thornton as external auditors for a three-year period commencing on 1 April 2025. The Trust is estimated to incur external audit costs of £245,000 (plus VAT) for the 2025-26 audit. The Audit Findings Report for 2025-26 sets out independence considerations linked to the secondment of Grant Thornton employees to NHS England's Financial Improvement Programme, in which NGH is participating.

9. External Auditor's Reports 2024-25 to 2025-26

Auditor's report 2024-25: Key recommendations giving rise to significant control issues

The Annual Auditor's report for the year ended 31 March 2025 identified the following significant weaknesses, which the Audit Committee considered that to represent significant control issues to address during 2025-26.

(1) Significant weakness in arrangements identified in relation to delivering savings and a key recommendation raised that there should be a specific focus on delivering planned productivity improvements and efficiency savings.

Progress: The Target Cost Improvement Plan (CIP) in 2025-26 was £47.1m (8% of expenditure) which was an ambitious target. £36.4m (6%) was delivered which was good progress against a prior year delivery of £22.8m. The target for 2026/27 is £39.8m which appears more realistic.; however, whilst performance is indicating a positive trajectory, arrangements to deliver this have been enhanced by NHS England funded support. The 2025-26 contract is ending, and the Trust is being supported by NHS England to retender for another year of support. This process has (at the time of the Audit Findings report) not yet concluded. This annual support is not building internal capacity for the Trust to develop embedded and sustained improvement in its efficiency delivery. More work required to understand the position.

Current status: In progress / partially implemented

Further action: Re-raised and updated as part of Key Recommendation 2 (see below)

(2) *Significant weakness in arrangements identified in relation to responding to Urgent & Emergency Care department demand and a key recommendation raised that the Trust should ensure its quality assurance processes regularly assure the Board that completed regulatory improvements are achieving the required impact and are embedded and sustained across services. Lessons from the recent Section 29A warning notice should be shared across services to prevent similar future issues*

Progress: The Trust responded quickly and improved performance, but stronger governance and follow-up is required to ensure changes are fully embedded and sustained, but needs stronger governance and follow through to ensure changes are fully embedded and sustained

Current status: In progress / partially implemented

Further action: Key recommendation closed and an improvement recommendation raised

2025-26 assessment of arrangements

The Annual Auditor's report for the year ended 31 March 2026 identified significant weakness in arrangements identified for both financial planning and delivering savings, with two key recommendations made:

(1) The Trust must strengthen its medium-term financial planning arrangements so that it produces an NHS England-compliant multi-year plan and can demonstrate that it is credible and deliverable.
(2) The Trust must strengthen its arrangements for identifying and delivering savings and planned productivity improvements through its Cost Improvement Programme (CIP).

The Audit Committee considers that the above issues represent significant control issues to address during 2026-27.

10. Review of effectiveness

10.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, group clinical quality, safety and

performance committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

10.2 All relevant Board Committee Terms of Reference have been updated, with revised Terms of Reference being agreed by the Board of Directors at its August 2025 meeting.

11. Board Reporting

11.1 During 2025-26, the Boards of NGH and KGH met nine times in public, and held joint development sessions in the intervening months. A performance report is received each meeting with performance overviews provided by the director responsible for performance in each area and risks reviewed. The Board receives updates from the chair of each Board committee following individual committee meetings highlighting the key points discussed and any issues which require escalation.

12. Board effectiveness

12.1 The Board approved changes to the governance operating model at its August 2025 meeting, following consultation with Committees.

12.2 The Board has been assured that there are robust mechanisms to ensure that the evidence to support compliance is in place and available and is routinely monitored and reported upon within the Trusts governance and performance framework. The process that has been applied to maintain the effectiveness of a system of internal control follows.

12.3 The Trust's Audit Committee approved an Internal Audit programme and received all Internal Audit Reports. The committee has reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the organisation's activities both clinical and non- clinical that supported the achievement of the organisation's objectives.

12.4 The Group's Patient Safety Committee oversees the Trust's participation in local and national clinical audit and national confidential enquiries, and reports to the Quality and Safety Committee. Divisions receive an update report from the Clinical Audit and Effectiveness Department as part of the governance structure. This update gives highlights by exception of audit progression, findings and actions. This enables the Divisional and directorate management team oversight and ownership of their elements of the Trust audit programme.

12.5 The Trust's Internal Auditor's conclusion for the year specified:

'TIAA is satisfied that, for the areas reviewed during the year, the Trust has reasonable and effective risk management, control and governance processes in place. This opinion is based solely on the matters that came to the attention of TIAA during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or your ability to meet financial obligations which must be obtained by the Trust from its various sources of assurance.'

12.6 The Local Counter Fraud Specialist (LCFS) has supported the Trust to ensure that investigations are carried out promptly and efficiently. In addition, the LCFS has continued to carry out proactive work at the Trust in order to prevent, detect and deter fraud and bribery within the NHS and to also raise awareness of the role of the counter fraud specialist within the Trust and the NHS as a whole. This proactive work has helped to establish an effective anti-fraud culture and zero tolerance approach within the Trust that is fully supported by the Board.

12.7 In accordance with the Government Functional Standard 013 Counter Fraud, the Trust is required to complete a Counter Fraud Functional Standard Return (CFFSR). The Audit Committee

Chair has reviewed and confirmed the contents of the CFFSR to support the primary authorisation of the Chief Finance Officer, while maintaining the appropriate division between the operational and non-executive functions. The Trust received an overall Green rating for the submission.

Patient Safety

12.8 During 2025-26, UHN continued to strengthen its arrangements for identifying, reviewing and learning from patient safety incidents,. Our approach is underpinned by the Patient Safety Incident Response Framework (PSIRF), which promotes compassionate engagement, systems-based learning, proportionate responses and supportive oversight with a clear focus on learning, improvement and being fair.

12.9 Strong executive and Board oversight was maintained for PSIRF delivery, with executive leadership and established governance routes providing assurance that incidents are reviewed consistently, learning responses are commissioned proportionately, and actions are monitored through to completion. Oversight includes the Incident Review Group (IRG) and escalation through established patient safety governance and reporting arrangements.

12.10 UHN's Patient Safety Incident Response Plan (PSIRP) remained the basis for prioritising learning responses and investigations, supporting a flexible range of approaches (for example, after action reviews and other proportionate methods) to maximise learning and improvement. The PSIRP is intended to be kept under review and applied with flexibility, reflecting the circumstances of the incident and the needs of those affected. We have commenced preparations to review and refresh the trusts PSIRP within the next six months, recognising that an 18-month to 2-year review point is appropriate.

12.11 We continued to strengthen compassionate engagement with patients, families and staff following patient safety incidents, including improving how people are kept informed and supported through learning responses, and reinforcing openness and transparency. This aligns with our wider safety culture ambition to build openness, compassion and psychological safety across the Group

12.12 UHN remains committed to meeting the requirements of the statutory Duty of Candour, supported by clear process guidance and monitoring arrangements. Performance is tracked against a locally agreed internal standard for completion of statutory Duty of Candour within 10 working days. In Quarter 4, we saw a significant improvement in performance against this internal standard

12.13 Throughout the year, we enhanced our commitment to translating learning into actionable steps that drive measurable outcomes. We initiated the documentation of PSIRF actions within the AMaT system and established a governance framework designed to deliver robust, outcome-oriented evidence for timely closure and assurance via the PSIRF governance structure. These efforts facilitate the transition from merely tracking activities to demonstrating the real impact of learning and achieving sustained improvements.

12.14 In the coming year we will further strengthen organisational capability by progressing recruitment to the specialist Human Factors role to support the cultural shift towards systems thinking and learning, and by developing the Patient Safety Partner role so that it is embedded in key safety governance forums and strengthens co-production in our oversight arrangements.

13. Code of Governance for NHS Provider Trusts

13.1 Northampton General Hospital NHS Trust has applied the principles of the Code of Governance for NHS Provider Trusts on a comply or explain basis. The Code, which came into effect in April 2023, is based on the principles of the UK Corporate Governance Code, and is available to view here: https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/.

Provisions requiring supporting explanations	***Code of Governance* Reference**	**Disclosure**
The board of directors should assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the **ICP and ICB, and place-based partnerships**. The board of directors should ensure the Trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as **provider collaboratives**. The Trust should describe in its annual report how opportunities and risks to future **sustainability** have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	A.2.1	As set out in Performance Report and Accountability Report
The board of directors should assess and monitor **culture**. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the Trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the Trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	A.2.3	As set out in Performance Report, Staffing Report and Accountability Report
The board of directors should describe in the annual report how the interests of **stakeholders**, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the Trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	A.2.8	As set out in Performance Report and Accountability Report

Board: independence of non-executive directors	B 2.6	As set out in Accountability Report
The annual report should give the number of times the board and its committees met, and individual director attendance.	B2.13	As set out in Accountability Report
If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the Trust or individual directors.	C 2.5	As set out Accountability Report
The board of directors should include in the annual report a description of each director's skills, expertise and experience.	C 4.2	As set out in Accountability Report
All Trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the Trust or individual directors.	C 4.7	Undertaken during 2022-23 and referenced in Accountability Report
Work of the nomination committee (Remuneration and Appointments Committee)	C 4.13	As set out in Accountability Report
Audit Committee / control environment	D 2.4	As set out in Accountability Report
Directors: annual report	D 2.6	As set out in Performance Report and Accountability Report
Risk assessment	D 2.7	As set out in Performance Report and Accountability Report
Monitoring of risk management and internal control systems	D 2.8	As set out in Performance Report and Accountability Report
Going Concern	D 2.9	As set out in Accountability Report
Where a Trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	E 2.3	Not applicable
'Comply or explain' requirements where the Trust has departed from the code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the code.		
The board of directors should report on its approach to **clinical governance** and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	A 2.6	Duties in this regard are shared between the Quality and Safety and Audit Committees.
Both the appointment and removal of the company secretary should be a matter for the whole board.	B 2.15	Company Secretary is appointed by the Chief Executive and Trust Chair on the Board's behalf. Postholder is subject to standard contractual obligations with regard to performance in the role.
Legislation requires an NHS Trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation Trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.	D 2.5	Disclosed within Annual Accounts. Trust does not have a separate policy.

14. Conclusion

I am pleased to report that, based on the opinion of Internal Audit and the evidence presented within this report; that Northampton General Hospital NHS Trust has a reasonable and effective system of internal control that supports the achievement of its policies, aims and objectives.

Significant internal control issues have been identified during 2025-26 relating to the Trust's medium financial planning arrangements, and to its arrangements for identifying and delivering savings and planned productivity improvements through the Cost Improvement Programme. The Board and Committees are providing oversight of specific actions to improve the Trust's position, as described in Section (9) above, as a result of which it is considered that our stakeholders can be assured that robust plans and processes are in place to address the issues identified.

Appropriate arrangements are in place for discharge of the Trust's statutory functions. These ensure that any potential issues are highlighted to the Board and that the Trust is legally compliant with its statutory responsibilities.

Richard Mitchell

Chief Executive and Accountable Officer – 24 June 2026

Report from the Chief Finance Officer

The Trust's financial position, in line with the NHS England Oversight Framework, showed an adjusted financial performance deficit of £(37.7)m in line with the updated financial forecast notified to and agreed with NHSE in January 2026. This forecast was produced following internal review of known operational and cost pressures and a range of mitigations under development at the time and was approved by the Board of Directors.

Included within the financial performance was Deficit Support Funding of £22.8m. Our operating expenses in delivering services to patients and the population of Northamptonshire incur costs of £1.7m every day.

Capital investment to improve and replace our property, plant, equipment and digital assets was £43.3m.. Investment was made on safety and infrastructure works across the site in accordance with estates plans, development of an Urgent Treatment Centre and medical and other equipment. We continue to support our digital plans to improve infrastructure and equipment for staff alongside the security features.

Forward look

As a result of the deficit financial position in previous financial years, NHS England Enforcement undertakings are in place and any failure to comply with the undertakings may result in NHS England taking further regulatory action. This could include giving formal directions to the Trust under section 27B of the National Health Service Act 2006.

The Trust has set a deficit budget for the year ended 31 March 2027 of £(57.9)m, and we will continue to work across the Trust, through the Board and with partners to manage our public money more effectively and in the best interests of patients and our staff.

Sarah Stansfield

Chief Finance Officer

24 June 2026

Statement of Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the Trust.

The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Richard Mitchell

Chief Executive and Accountable Officer

24 June 2026

Statement of Directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

Each director: knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy

By order of the Board

Richard Mitchell
Chief Executive and Accountable Officer, 24 June 2026

Sarah Stansfield
Chief Finance Officer, 24 June 2026

Remuneration and Staff Reports

Remuneration report

A remuneration and appointments committee meets regularly and is comprised of non-executive directors. The duties of the remuneration and appointments committee are set out in its terms of reference. The primary role of the remuneration and appointments committee is to establish a formal process for developing policy on executive remuneration and to oversee the appointment process for executive directors.

The remuneration and appointments committee determines the remuneration and terms of service for the chief executive and executive directors, acting in accordance with the scheme of delegation and reservation of powers to the Board and approve any non-contractual benefits in relation to the termination of employment for executive directors.

The remuneration and appointments committee oversees the process for the appointment of new executive members to the Trust board of directors, ensuring that there is a formal, lawful procedure in place. The committee will also ensure that systems and processes are in place for the development of the Board members where appropriate. The Committee can confirm that the Trust is compliant with the national framework for 'Very Senior Managers', introduced during 2025-26.

Pay multiples –has been subject to audit

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of total remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The annualised highest paid director was the former Hospital Chief Executive Officer. The banded remuneration of the highest paid director in Northampton General Hospital NHS Trust in the financial year 2025-26 was £115 - 120k (2024-25, £185 – 190k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

For clarity, a ratio of 7.07 means that the director receives 7.07 times the relevant salary/remuneration of employees.

2025-26	25th percentile	Median	75th percentile
Total remuneration (£)	28,994	39,733	54,506
Pay ratio information	4.06	2.96	2.16
2024-25			
Total remuneration (£)	26,530	36,937	51,234
Pay ratio information	7.07	5.08	3.66

2025-26	25th percentile	Median	75th percentile
Salary component of total remuneration (£)	26,598	37,796	47,810
Pay ratio information	4.42	3.11	2.46
2024-25			
Salary component of total remuneration (£)	25,674	32,324	46,148
Pay ratio information	7.30	5.80	4.06

The movement in ratios between 2024-25 and 2025-26 is due to changes in the overall mix of the wider workforce and the impact of the 2025-26 pay award for all staff groups

All ratios also reflect the increase in both the total remuneration and the salary component of total remuneration paid to the organisation's workforce.

The Trust believes the median pay ratio for the relevant financial year is consistent with the pay policy and the reward and progression policy for the entity's employees taken as a whole.

Percentage change in remuneration of highest paid director

The percentage change from the previous financial year in respect of the highest paid director was 37% (decrease) (2024-25, 16% (decrease)). The decrease reflects a change in the highest paid director, from Hospital Chief Executive to UHN Medical Director.

Calculation is based on the mid-point of the band of the highest paid director's salary and reflects a 50% share of total salary.

The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole, was 3% (increase) (2024-25, 2% (increase)).

Calculation is based on the total for all employees on an annualised basis, excluding the highest paid director, divided by the FTE number of employees (also excluding the highest paid director and non-executive directors).

In 2025-26, 340 (2024-25, 68) employees received remuneration higher than the highest-paid director. Remuneration ranged from £14 to £348,524 (2024-25 £14-£397,455).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The employees counted for this purpose and the method of calculating their remuneration are:

- Permanent staff - the full time equivalent basic contracted pay plus enhancements, overtime, shift allowances etc.
- Bank staff – as for permanent staff but excludes bank staff who already have a permanent post and only includes bank staff paid in March.
- Agency staff – the annualised cost of agency staff working on the 31 March. The costs used by the Trust include Agency premium costs as these are not readily separable to identify the remuneration paid to the individual.

Salary and Pension Entitlements of Senior Managers Remuneration – has been Subject to audit

Name	Title	Salary (in bands of £5,000) £000	Expense payments (taxable) to nearest £100* £	All Pension-related Benefits (in bands of £2,500) £000	Total - Salary & Benefits (in bands of £5,000) £000
Exeutive Directors					
R Mitchell	Chief Executive Officer (UHN & UHL)	75 - 80	0	70 - 72.5	150 - 155
L Churchward	Chief Executive (UHN)	100 - 105	100	27.5 - 30	130 - 135
S Noonan	Chief Operating Officer	85 - 90	0	112.5 - 115	200 - 205
H Nemade	Medical Director	115 - 120	0	2.2 - 5.0	115 - 120
J Hogg	Chief Nurse (UHN & UHL)	50 - 55	0	0	50 - 55
S Stansfield	Chief Finance Officer	90 - 95	0	27.5 - 30	120 -125
W Monaghan	Chief Digital Information Officer	40 - 45	100	0	40 - 45
R Taylor	Director of Continous Improvement	70 - 75	0	17.5 - 20	85 - 90
P Grimmett	Director of Strategy	65 - 70	0	42.5 - 45	110 - 115
P Kirkpatrick	Chief People Officer	75 - 80	0	7.5 - 10	85 - 90
S Finn	Director of Estates and Facilities	25 - 30	0	15 - 17.5	40 - 45
R Apps	Director of Governance	10 - 15	100	17.5 - 20	30 - 35
S O'Neill	Director of Communications and Engagement	60 - 65	0	15 - 17.5	75 - 80
Non-Exeutive Directors					
A Moore	Chair	20 - 25	300	0	20 - 25
A Cooper	Non-Executive Director	10 - 15	100	0	10 - 15
C Welsh	Non-Executive Director	5 - 10	400	0	5 - 10
J Houghton	Non-Executive Director	10 - 15	0	0	10 - 15
C Stevens	Non-Executive Director	5 - 10	0	0	5 - 10
D Kirkham	Non-Executive Director	5 - 10	0	0	5 - 10
T Shipman	Vice Chair and Non-Executive Director	10 - 15	100	0	10 - 15
D Venkatasamy	Non-Executive Director (non-voting)	5 - 10	0	0	5 - 10
S Gay	Non-Executive Director	5 - 10	0	0	5 - 10

Salary Notes 2025-26

1. *The amount paid or payable by the Trust relates only to the period during which the senior manager held office. All pension-related benefits arise from participation in the pension scheme during that year. Where a full year has not been served, these are calculated on a pro rata basis.*
2. *As Non-Executive members do not receive pensionable remuneration; there are no entries in respect of pension related benefits.*
3. *We have staff sharing arrangements across UHN entities for all Directors / Senior officers and we have disclosed their total salaries proportionately in these tables.*
4. *All the Executive officers held joint roles with Kettering General Hospital NHS Foundation Trust (KGH), therefore only 50% of their total remuneration is shown above, with the remaining 50% recharged to KGH.*
5. *Richard Mitchell, Julie Hogg and Will Monaghan hold roles across three Trusts: University Hospitals of Leicester (UHL), Northampton General Hospital (NGH), and Kettering General Hospital (KGH). Accordingly, their total remuneration has been apportioned on a 50:25:25 basis respectively.*
6. *Jill Houghton was appointed to the Board of University Hospitals of Leicester NHS Trust on 1st January 2025. The associated salary has been recharged to UHL.*
7. *Andrew Moore holds a role across three Trusts: University Hospitals of Leicester (UHL), Northampton General Hospital (NGH), and Kettering General Hospital (KGH). Therefore, the total remuneration has been apportioned on a 50:25:25 basis respectively.*
8. *Stuart Finn left during the year, his earnings are part of salary notes and table above and exit packages notes and tables at section 3.2.9.*
9. *All current Non-Executive Directors hold joint roles with Kettering General Hospital NHS Foundation Trust (KGH). Accordingly, only 50% of their total remuneration is shown above, with the remaining 50% recharged to NGH.*

TOTAL SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS ACROSS ALL EMPLOYING ORGANISATIONS 2025-26 (has been subject to audit)

Name	Title	Salary (in bands of £5,000) £000	Expense payments (taxable) to nearest £100* £	All Pension-related Benefits (in bands of £2,500) £000	Total - Salary & Benefits (in bands of £5,000) £000
Exeutive Directors					
R Mitchell	Chief Executive Officer (UHN & UHL)	315 - 320	0	285 - 290	605 - 610
L Churchward	Chief Executive (UHN)	200 - 205	200	55 - 60	260 - 265
S Noonan	Chief Operating Officer	175 - 180	0	225 - 230	405 - 410
H Nemade	Medical Director	230 - 235	0	5 - 10	240 - 245
J Hogg	Chief Nurse (UHN & UHL)	215 - 220	0	0	215 - 220
S Stansfield	Chief Finance Officer	185 - 190	0	55 - 60	240 - 245
W Monaghan	Chief Digital Information Officer	175 - 180	200	0	175 - 180
R Taylor	Director of Continous Improvement	140 - 145	0	35 - 40	175 - 180
P Grimmett	Director of Strategy	135 - 140	0	85 - 90	220 - 225
P Kirkpatrick	Chief People Officer	155 - 160	0	15 - 20	175 - 180
S Finn	Director of Estates and Facilities	50 - 55	0	30 - 35	85 - 90
R Apps	Director of Governance	20 - 25	200	35 - 40	60 - 65
S O'Neill	Director of Communications and Engagement	120 - 125	0	30 - 35	155 - 160
Non-Exeutive Directors					
A Moore	Chair	85 - 90	1,200	0	85 - 90
A Cooper	Non-Executive Director	20 - 25	200	0	20 - 25
C Welsh	Non-Executive Director	15 - 20	800	0	15 - 20
J Houghton	Non-Executive Director	25 - 30	0	0	25 - 30
C Stevens	Non-Executive Director	15 - 20	0	0	15 - 20
D Kirkham	Non-Executive Director	15 - 20	0	0	15 - 20
T Shipman	Vice Chair and Non-Executive Director	25 - 30	200	0	25 - 30
D Venkatasamy	Non-Executive Director (non-voting)	15 - 20	0	0	15 - 20
S Gay	Non-Executive Director	15 - 20	0	0	15 - 20

Salary and Pension Entitlements of Senior Managers Remuneration 2024-25

Name and Title	2024-25					
	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100* £	Performance Pay and Bonuses (bands of £5,000) £000	Long term Performance Pay and Bonuses (bands of £5,000) £000	All Pension-related Benefits (bands of £2,500) £000	Total - Salary and Benefits (bands of £5,000) £000
Andrew Moore - Chair (from 1st July 2024)	15- 20					15- 20
John MacDonald - Chair (to 30th June 2024)	5 - 10					5 - 10
Richard Mitchell - Chief Executive Officer	75 - 80				25 - 27.5	100 - 105
Laura Churchward - Hospital Chief Executive Officer (from 1st October 2024)	45 - 50				205 - 207.5	255 - 260
Heidi Smoult - Hospital Chief Executive Officer (to 18th September 2024)	115 - 120				112.5 - 115	230 - 235
Palmer Winstanley - Interim Hospital Chief Executive Officer and Chief Operating Officer/Deputy Hospital Chief Executive Officer (to 30th Sept 2024)	80 - 85				22.5 - 25	105 - 110
Sarah Noonan - Chief Operating Officer (from 1st October 2024) and Interim Chief Operating Officer (to 30th June 2024 NGH/1st July 24-30th Sept UHN)	85 - 90				0	85 - 90
Hemant Nemade - Medical Director (to 30th June 2024 NGH/from 1st July 2024 UHN)	135 - 140				30 - 32.5	165 - 170
Julie Hogg - Chief Nurse (from 8th November 2024) and Interim Chief Nurse (from 8th July to 8th November 2024)	35 - 40				0	35 - 40
Nerea Odongo - Chief Nurse (to 7th July 2024)	35 - 40				92.5 - 95	130 - 135
Sarah Stansfield - Interim Chief Finance Officer (from 20th December 2024)	25 - 30				25 - 27.5	50 - 55
Helen Ellis - Interim Chief Finance Officer (19th December 2024)	0 - 5				40 - 42.5	40 - 45
Richard Wheeler - Chief Finance Officer (to 18th December 2024)	65 - 70				80 - 82.5	145 - 150
Will Monaghan - Chief Digital Information Officer (from 9th August 2024)	25 - 30				95 - 97.5	120 - 125
Natasha Chare - Chief Digital Information Officer (to 9th August 2024)	25 - 30				12.5 - 15	40 - 45
Stuart Finn - Director of Estates, Facilities and Sustainability (from 1st June 2024) and Director of Estates and Facilities/Interim Director of Operational Estates (to 31st May 2024)	65 - 70				5 - 7.5	70 - 75
Rebecca Taylor - Director of Continuous Improvement (from 1st June 2024) and Director of Transformation and Quality Improvement (to 31st May 2024)	65 - 70				17.5 - 20	85 - 90
Polly Grimmett - Director of Strategy	70 - 75				12.5 -15	80 - 85
Richard Apps - Director of Corporate and Legal Affairs (from 1st June 2024) and Director of Governance (to 31st May 2024)	65 - 70				10 - 12.5	75 - 80
Paula Kirkpatrick - Chief People Officer	75 - 80				20 - 22.5	95 - 100
Suzie O'Neill - Director of Communications and Engagement	40 - 45				15 - 17.5	55 - 60
Sam Holden - Interim Director of Communications and Engagement (to 13th August 2024)	20 - 25				10 - 12.5	30 - 35
Alice Cooper - Non-Executive Director (from 1st September 2024)	5 - 10					5 - 10
Jill Houghton - Non-Executive Director	10 - 15					10 - 15
Caroline Stevens Non-Executive Director	10 - 15					10 - 15
Denise Kirkham - Non-Executive Director	10 - 15					10 - 15
Christopher Welsh - Non-Executive Director	10 - 15					10 - 15
Trevor Shipman - Non-Executive Director (from 1st September 2024)	5 - 10					5 - 10
Damien Venkatasamy - Non-Executive Director (from 4th October 2024)	0 - 5					0 - 5
Natalie Armstrong - Non-Executive Director (from 1st September to 31st December 2024)	0 - 5					0 - 5
Simon Gay - Non-Executive Director (from 1st January 2025)	0 - 5					0 - 5
Elena Lokteva - Non-Executive Director (to 31st August 2024)	5 - 10					5 - 10
Rachel Parker - Non-Executive Director (to 31st August 2024)	10 - 15					10 - 15
Ghulam Ng - Associate Non-Executive Director (to 31st August 2024)	5 - 10					5 - 10

Salary notes 2024-25:

1. The amount paid or payable by the Trust relates only to the period during which the senior manager held office. All pension-related benefits arise from participation in the pension scheme during that year. Where a full year has not been served, these are calculated on a pro rata basis.
2. As non-executive members do not receive pensionable remuneration; there are no entries in respect of pension related benefits.
3. Andrew Moore, Laura Churchward, Julie Hogg, Sarah Stansfield, Will Monaghan, Alice Cooper, Trevor Shipman, Damien Venkatasamy, Natalie Armstrong and Simon Gay were appointed to the Board in 2024-25. There is therefore no salary information for 2023-24.
4. Laura Churchward, Sarah Noonan, Richard Wheeler, Helen Ellis, Sarah Stansfield, Natasha Chare, Stuart Finn, Becky Taylor, Polly Grimmett, Paula Kirkpatrick, Suzie O'Neil and Sam Holden all held joint roles with Northampton General Hospital NHS Trust (NGH). Therefore, only 50% of their total remuneration is shown above, with the remaining 50% recharged to NGH.
5. The following executives Richard Mitchell, Julie Hogg and Will Monaghan hold roles across three Trusts: University Hospitals of Leicester (UHL), Northampton General Hospital (NGH), and Kettering General Hospital (KGH). Accordingly, their total remuneration has been apportioned on a 50:25:25 basis respectively.
6. John MacDonald held a role across three Trusts: University Hospitals of Leicester (UHL), Northampton General Hospital (NGH), and Kettering General Hospital (KGH). Therefore, the total remuneration has been apportioned on a 50:25:25 basis respectively.
7. Jill Houghton was appointed to the Board of University Hospitals of Leicester NHS Trust on 1st January 2025. The associated salary has been recharged to UHL.
8. The non-executive Andrew Moore holds a role across three Trusts: University Hospitals of Leicester (UHL), Northampton General Hospital (NGH), and Kettering General Hospital (KGH). Therefore, the total remuneration has been apportioned on a 50:25:25 basis respectively.
   All other current Non-Executive Directors hold joint roles with Northampton General Hospital NHS Trust (NGH). Accordingly, only 50% of their total remuneration is shown above, with the remaining 50% reported at KGH.
9. Heidi Smoult, Hospital Chief Executive Officer, received a redundancy payment during 2024/25. This was subject to the appropriate HMRC regulations for PAYE and National Insurance. The anticipated cost was provided for and reported as an exit package in 2023/24. 2024/25 salary includes pay award arrears and pay in lieu of annual leave relating to 2023/24 (£15-20k).

Notes – all pension-related benefits

All pension related benefits represent the annual increase in total pension benefits entitlement. This represents the values payable at the beginning and end of the financial year, adjusted for inflation, irrespective of whether or not the position was held for full or part year and length of NHS service. Where this value is negative a nil balance is shown.

All pension-related benefits include the cash value of payments (whether in cash or otherwise) in lieu of retirement benefits, and all benefits in year from participating in pension schemes. These are the aggregate input amounts, calculated using the method set out in section 229 of the Finance Act 2004

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:
A change in role with a resulting change in pay and impact on pension benefits
A change in the pension scheme itself
Changes in the contribution rates
Changes in the wider remuneration package of an individual

Pension benefit report –has been subject to audit

Pension Benefits 2025-26

Financial Year 2025 / 26		Real increase in pension at Pension Age (in bands of £2,500)	Real increase in pension lump sum at Pension Age (in bands of £2,500)	Total accrued pension at Pension Age at 31 March 2026 (bands of £5,000)	Lump sum at Pension Age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2025	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026	Employer's contribution to stakeholder pension
Name	**Title**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
R Mitchell	Chief Executive Officer (UHN & UHL)	2.5 - 5.0	5.0-7.5	20 - 25	45 - 50	304	61	380	N/A
L Churchward	Chief Executive (UHN)	0 - 2.5	2.5 - 5.0	30 - 35	82.5 - 85	595	33	644	N/A
S Noonan	Chief Operating Officer	5.0 - 7.5	10 - 12.5	20 - 25	50 - 55	317	97	431	N/A
H Nemade	Medical Director	0	0	15 - 20	0	240	6	246	N/A
J Hogg	Chief Nurse (UHN & UHL)	0	0	0	0	0	0	0	N/A
S Stansfield	Chief Finance Officer	0 - 2.5	0	20 - 25	0	298	17	332	N/A
W Monaghan	Chief Digital Information Officer	0	0	10 - 15	0	174	0	154	N/A
R Taylor	Director of Continous Improvement	0 - 2.5	0	5 - 10	0	53	8	70	N/A
P Grimmett	Director of Strategy	0 - 2.5	2.5 - 5	20 - 25	45 - 50	367	41	423	N/A
P Kirkpatrick	Chief People Officer	0 - 2.5	0	5 - 10	0	119	8	138	N/A
S Finn	Director of Estates and Facilities	0 - 2.5	0	15 - 20	35 - 40	337	17	363	N/A
R Apps	Director of Governance	0 - 2.5	0 - 2.5	15 - 20	40 - 45	351	22	380	N/A
S O'Neill	Director of Communications and Engagement	0 - 2.5	0	5 - 10	0	56	8	72	N/A

- *J Hogg chose not to be covered by the pension arrangements during the reporting year.*

Pension Benefit Notes

1. As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.
2. For UHN group posts, the CETV and related increases have been apportioned based on the recharge allocations to Kettering General Hospital and University Hospitals of Leicester.
3. CPI is 1.7% in 2025/26.
4. The 2024-25 CETV values for Sarah Noonan and Hemant Nemade have been restated to allow a like for like comparison for the real increase in CETV.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowa made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the ben membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transf benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme and end of the period.

The Public Service Pension Scheme Remedy – (McCloud)
1995/2008 Scheme members moved to the 2015 Scheme on either 1 April 2015, or if affected by McCloud remedy, 1 April 2022. Members will have a final salary link to their 1995/2008 scheme benefits unless a break of over 5 years has occurred.

Members of the NHS Pension scheme are entitled to claim payment of their benefits early from any age on or after their minimum pension age up to their normal pension age (this differs dependant on scheme). When taking actuarially reduced early retirement, pensio

The inflation applied to the accrued pension, lump sum (if applicable) and CETV is the percentage (if any) by which the Consumer Prices Index (CPI) for the September before the start of the tax year is higher than it was for the previous September.
We have staff sharing arrangements across UHN entities for all Directors / Senior officers and we have disclosed their total salaries proportionately in these tables.

The Consumer Prices Index up to September 2024 was 1.7%. Therefore, for pensions and CETV calculation purposes CPI is 1.7%.

HM Treasury published updated guidance on the basis for setting the discount rates for calculating cash equivalent transfer values (CETV) payable by public service pension schemes on16 October 2024. This guidance on discount rates for calculating unfunded publ
2025-26 CETV figures.

No lump sum is shown for senior managers who only have membership in the 2015 Scheme or 2008 Section (unless they chose to move their 1995 Section benefits to the 2008 Section under the Choice exercise).

No CETV is shown for pensioners or senior managers over NPA. Age 60 in the 1995 Section, age 65 in the 2008 Section or SPA or age 65, whichever is the later, in the 2015 scheme.

No values are shown for senior managers that have opted out of the NHS Pension scheme.

Pension Benefits 2024-25

Name and Title	Real increase in pension at Pension Age (bands of £2,500)	Real increase in pension lump sum at Pension Age (bands of £2,500)	Total accrued pension at Pension Age at 31 March 2025 (bands of £5,000)	Lump sum at Pension Age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Richard Mitchell - Chief Executive Officer	0 - 2.5	0 - 2.5	15 - 20	35 - 40	259	18	304	N/A
Laura Churchward - Hospital Chief Executive Officer (from 1st October 2024)	2.5 - 5	10 - 12.5	30 - 35	75 - 80	389	86	596	N/A
Heidi Smoult - Hospital Chief Executive Officer (to 18th September 2024)	5 - 7.5	10 - 12.5	45 - 50	115 - 120	791	109	967	N/A
Palmer Winstanley - Interim Hospital Chief Executive Officer and Chief Operating Officer/Deputy Hospital Chief Executive Officer (to 30th Sept 2024)	0 - 2.5	0	20 - 25	0	248	3	289	N/A
Sarah Noonan - Chief Operating Officer (from 1st October 2024) and Interim Chief Operating Officer (to 30th June 2024 NGH/1st July 24-30th Sept UHN)	0 - 2.5	0	20 - 25	50 - 55	369	0	397	N/A
Hemant Nemade - Medical Director (to 30th June 2024 NGH/from 1st July 2024 UHN)	0 - 2.5	0	20 - 25	0	250	17	301	N/A
Julie Hogg - Chief Nurse (from 8th November 2024) and Interim Chief Nurse (from 8th July to 8th November 2024)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nerea Odongo - Chief Nurse (to 7th July 2024)	0 - 2.5	0	30 - 35	0	387	15	485	N/A
Sarah Stansfield - Interim Chief Finance Officer (from 20th December 2024)	0 - 2.5	0	20 - 25	0	260	3	298	N/A
Helen Ellis - Interim Chief Finance Officer (19th December 2024)	0 - 2.5	0 - 2.5	20 - 25	50 - 55	384	0	450	N/A
Richard Wheeler - Chief Finance Officer (to 18th December 2024)	2.5 - 5	5 - 7.5	35 - 40	95 - 100	740	65	891	N/A
Will Monaghan - Chief Digital Information Officer (from 9th August 2024)	2.5 - 5	0	10 - 15	0	100	40	174	N/A
Natasha Chare - Chief Digital Information Officer (to 9th August 2024)	0 - 2.5	0	5 - 10	0	47	0	60	N/A
Stuart Finn - Director of Estates, Facilities and Sustainability (from 1st June 2024) and Director of Estates and Facilities/Interim Director of Operational Estates (to 31st May 2024)	0 - 2.5	0	15 - 20	35 - 40	304	5	337	N/A
Rebecca Taylor - Director of Continuous Improvement (from 1st June 2024) and Director of Transformation and Quality Improvement (to 31st May 2024)	0 - 2.5	0	0 - 5	0	35	7	53	N/A
Polly Grimmett - Director of Strategy	0 - 2.5	0	15 - 20	40 - 45	326	12	367	N/A
Richard Apps - Director of Corporate and Legal Affairs (from 1st June 2024) and Director of Governance (to 31st May 2024)	0 - 2.5	0	15 - 20	40 - 45	313	8	351	N/A
Paula Kirkpatrick - Chief People Officer	0 - 2.5	0	5 - 10	0	88	15	119	N/A
Suzie O'Neill - Director of Communications and Engagement	0 - 2.5	0	0 - 5	0	39	7	56	N/A
Sam Holden - Interim Director of Communications and Engagement (to 13th August 2024)	0 - 2.5	0	5 - 10	0	55	6	67	N/A

Pension Benefit Notes 2024-25

1. As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.
2. For UHN group posts, the CETV and related increases have been apportioned based on the recharge allocations to Kettering General Hospital and University Hospitals of Leicester.
3. CPI is 6.7% in 2024/25.
4. The 2023/24 CETV values for Sarah Noonan and Hemant Nemade have been restated to allow a like for like comparison for the real increase in CETV.

Richard Mitchell, Chief Executive and Accountable Officer
24 June 2026

Sarah Stansfield, Chief Finance Officer
24 June 2026

Off Payroll Report Finance team please update

Table 1: Off-Payroll Engagements longer than 6 months

For all off-payroll engagements as of 31 March 2026, for more than £245 per day* and that last longer than six months:

Narrative	Number
Number of existing engagements as of 31 March 2026	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between 1 and 2 years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245* per day:

Narrative	Number
Number of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	0
Of which, the number	
not subject to off-payroll legislation**	0
subject to off-payroll legislation and determined as in-scope of IR35**	0
subject to off-payroll legislation and determined as out of scope of IR35**	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which : number of engagements that saw a change to IR35 status following review	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

**A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

Table 3: Off-Payroll board membership / senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	**0**

Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure must include both on payroll and off-payroll engagements	**22**

STAFF REPORT

Our Board of Directors

Northampton General Hospital NHS Trust is governed by a Board of Directors. The Board is made up of Executive Directors, appointed to specific roles within the organisation, and Non-Executive Directors, who bring a range of external expertise with them.

CHAIR AND NON-EXECUTIVE DIRECTORS (at 31 March 2026)

Andrew Moore, Trust Chair (First Term to 30 June 2027, Voting)

Andrew's commercial background is in retail where he held a variety of senior positions including Directorships at Marks and Spencer, Chief Merchandising Officer at Asda-Walmart and Chief Commercial Officer at Wilko. He has also worked in South Africa where he started his own Retail Consultancy and partnered with Woolworths SA. He retains a close connection with the retail sector through his advisory work with corporate investor institutions.

In 2019 he joined the board of Breast Cancer Now charity as a Trustee where served as Vice Chair, helping the charity navigate the many challenges faced by the Not-For-Profit sector and contributing to its strategic development and operational efficiency. Andrew believes his business experience in focusing on quality, value and service can help support the KGH team in the next chapter of the hospital's development.

Andrew joined Kettering General Hospital as a Non-Executive Director in 2023 and was appointed Group Chair of UHN and University Hospitals of Leicester from July 2024.

During 2025-26, Andrew chaired the Boards of Directors and the Council of Governors. .

Trevor Shipman, Vice-Trust Chair, Non- Executive Director (Second term to 30 April 2027, Voting)

Trevor was appointed in February 2017, and reappointed for a second term in 2020 and third term in 2023. Governors appointed Trevor for an additional 12-month term to April 2027, to assist with continuity and succession planning as collaborative arrangements with UHL develop.

Trevor lives in Northamptonshire and has extensive experience in the NHS and was Finance Director of Central and North West London NHS Foundation Trust. He is a member of the Association of Certified Chartered Accountants and brings a wealth of experience in audit and finance to the Board.

Trevor is the Trust's Vice-Chair, chairs the Strategy, Transformation and Digital Committee and is a member of the Audit and Finance, Investment and Performance Committees. Trevor is also the Non-Executive Lead for Security.

Alice Cooper, Non-Executive Director (first term to 31 August 2027, Voting)

After studying Psychology, Alice started her professional career at KPMG, qualifying as a Chartered Accountant and later joining the specialist Financial Services Audit team. She later moved to working directly for a large Building Society Group, holding a variety of senior roles in the areas of Risk, Information, Strategy and Planning. Having always enjoyed the people development and engagement side of her work, Alice also qualified as an Executive and Career Coach, and now combines freelance coaching and development work with a non-executive director role at a financial services company, as well as her role at UHN.

Alice was born in Kettering and has lived in the area for much of her life. Outside of work and looking after a young family, she is a keen singer, and is also active in her local church and is a trustee and the audit committee chair for the Peterborough Diocesan Board of Finance.

Alice chairs the Audit Committees and is a member of the Remuneration and Appointments and Strategy, Transformation and Digital Committees.

Professor Simon Gay, Non-Executive Director (first term to 1 January 2028, Voting)

Simon joined the Boards in January 2025 as the nomination of the University of Leicester. A graduate of St. George's, London in 1988, Simon completed GP training in Leicestershire in 1992, spending 18 months of that training in various UHL locations, then working at various times as a GP partner, retainer, salaried doctor and locum.

In 2005, Simon joined Keele Medical School, holding various roles including co-lead of Final Year and Director of Curriculum and more recently was a Clinical Associate Professor at Nottingham Medical School, before finally completing his circular trip back to Leicester when appointed as a Chair in 2019 and where he has been Head of School since July, 2023.

Simon is also a GMC Education Associate Team Leader (contributing to the quality assurance of new medical schools), former Treasurer of the International Clinical Skills Foundation (an Australian Registered Charity set up to improve the clinical education of health professionals in low-middle income countries), Editor-in-Chief of the journal Education for Primary Care, a past Chair of the Association for the Study of Medical Education's Educator Development Committee, and a co-founder and former Treasurer of the UK Clinical Reasoning in Medical Education group.

An ASME Medical Education Innovation Award winner, Simon has more than 200 academic outputs in the form of peer reviewed publications, book chapters, presentations, workshops and seminars at regional, national and international conferences, and higher education institutions.

His research interests include clinical reasoning and the transition to qualified practice.

Jill Houghton, Non-Executive Director (third term to 7 December 2026, Voting)

Jill has been a non-executive director of Northampton General Hospital NHS Trust (NGH) since May 2018 with her term of office renewed in April 2024. Jill was appointed to the Kettering General Hospital NHS Foundation Trust (KGH) Board in December 2023 as part of work to further collaboration between the hospitals. She is a registered nurse and has worked as a midwife and health visitor. Jill has had experience in all sectors of healthcare, clinically and managerially within primary and secondary care. Jill has served several boards as a Director of Nursing/Chief Nurse over a period of 12 years. Jill was previously Chief Nurse for Cambridgeshire and Peterborough CCG and has been a Maternity Clinical Lead within the national Maternal and Neonatal Health Safety Collaborative.

Jill is a member of the Quality and Safety and Audit Committees for both KGH and NGH and is the Non-Executive Champion for Maternity and Neonatal Services. Jill is also a Trustee of the Trust's Charity, the Northamptonshire Healthcare Charitable Fund (NHCF)..

Denise Kirkham, Non-Executive Director (second term to 12 September 2026, Voting)

Denise joined the NGH Board in February 2020 and was appointed as a Non-Executive Director for UHN from 1st September 2024.

As an Executive Resourcing and OD professional, Denise is highly experienced at working with Boards and Executive teams in an advisory and developmental capacity. Qualified to Level A and B in Occupational Testing, Myers Briggs and ILM 7 Executive coaching studies, Denise has held posts at Director level across sectors.

Throughout her consultancy career, Denise has led and delivered on executive and NED recruitment, major Culture Change projects, organisational structure reviews and Executive coaching. Through her earlier career in the private sector, Denise developed strong business development and commercial skills, and a clear understanding of Customer Focus.

Denise chairs the People Committee and Remuneration and Appointments Committees and is the Non-Executive Freedom to Speak Up Champion.

Caroline Stevens, Non-Executive Director and Senior Independent Director (first term to 6 February 2027, Voting)

Caroline started her career as a community pharmacist in Leicestershire and Northamptonshire, moving into hospital pharmacy management. She later became an operating theatre manager and hospital Managing Director.

In 2009 she moved in the charity sector as a senior director at The British Lung Foundation, then Chief Executive at a children's disability charity. Since 2019 she has been the Chief Executive at The National Autistic Society, a UK wide charity supporting autistic people and their families.

Caroline lives in Northamptonshire. She is a mother of three adult sons, including Jack who is autistic, has severe learning disabilities, and has complex support needs requiring full support 24 hours per day. The experience of being a carer and securing appropriate health and care services for her disabled son has shaped many aspects of her life and career. This makes her determined to strive for safe, high quality health services that are accessible to all.

Caroline was appointed as a Non-Executive Director for UHN from 1st September 2024, is the Trust's Senior Independent Director and is a member of the People and Finance, Investment and Performance Committees.

Damien Venkatasamy, Associate Non-Executive Director (first term, to 30 June 2027, Non-Voting)

Damien was appointed to the KGH Board in June 2018 and to the NGH Board in September 2024. Damien has over 20 years' experience in the IT service industry. He has lots of experience in delivering services to public sector organisations and uses the opportunity to work in the public sector and share his experience of delivering complex and challenging change projects.

Damien is a member of the Remuneration and Appointments Committees and chairs the Finance, Investment and Performance Committee.

Professor Chris Welsh, Non-Executive Director (first term to 8 December 2026, Voting)

Chris was appointed to a third term in March 2024 and to the NGH Board of Directors in December 2023. Chris has extensive experience within the NHS as a former vascular surgeon; he was the Medical Director for NHS Yorkshire and Humber, and Medical Director and Chief Operating Officer at Sheffield Teaching Hospitals NHS Foundation Trust.

Chris chairs the Quality and Safety Committee and is a member of the Strategy, Transformation and Digital Remuneration and Appointments Committees.

Terms of Office

All Non-Executive Directors are appointed initially for 3-year terms. On review by NHS England, this can be extended for a further term of office of 3 years. Following a six-year period, NHS England will review each request for re- appointment on a yearly basis up to a maximum of nine years.

The process for terminating the appointment of the Non-Executive Directors is set out in the Trust's Standing Orders, which can be viewed on the Trust's public website.

Executive Directors (at 31 March 2026)

Richard Mitchell, Group Chief Executive (Voting)

Richard joined as joint Chief Executive of UHN and University Hospitals of Leicester NHS Trust (UHL) in October 2023.

He has been Chief Executive of UHL since 2021 and is the also the Chair of the East Midlands Cancer Alliance and Midlands Regional Talent and Leadership Board.

Richard is proud to work in his local hospitals and he and his family live in South Leicestershire.

Laura Churchward, UHN Chief Executive (Voting)

Laura joined UHN as Chief Executive on 1st October 2024 from University College London Hospitals NHS Foundation Trust (UCLH), where she was Director of Strategy for seven years.

Laura leads UHN across its two hospitals, working closely with Richard Mitchell, the Joint Chief Executive of UHN and University Hospitals of Leicester (UHL) to deliver improvements to patient care, employment, research, education, and finances.

Laura has delivered many achievements across her NHS career. At UCLH, she was responsible for the build and commission of two major new hospitals, including the commission of a proton beam therapy (PBT) service (one of only two for NHS patients in the UK). Laura has extensive experience in service redesign, business case development and project management. Prior to moving into strategy in 2014, she held several senior operational roles at UCLH, including the management of stand-alone sites. Laura is a Northamptonshire resident and has three primary-school aged children who were all born at UHN.

Polly Grimmett, Director of Strategy (Non-Voting)

Polly joined KGH in 2017, and has responsibility for leading its strategic development, including the redesign and rebuild of the site. The role also includes developing the Trust's relationships with other partners, to ensure patients in North Northamptonshire receive an integrated approach to all their care needs and remain as well as possible. Polly also has responsibility for strategic estates across UHN.

Polly spent much of her career in operational management roles in different acute providers, and also worked in commissioning and community services. Before joining KGH, she was part of the merger team at North West Anglia Foundation Trust and led the redevelopment of the Stamford hospital site.

Julie Hogg, Chief Nurse (Voting)

Julie was appointed UHN Chief Nurse in July 2024 whilst keeping her Chief Nurse role at University Hospitals of Leicester (UHL).

Julie joined UHL in May 2022 from Sherwood Forest Hospitals (SFH), where she served as Chief Nurse since 2019. At the time the Trust was voted Health Service Journal Acute and Specialist Trust of the Year. It became a recognised centre for best practice in women and children's care and laid the foundations for the Nursing and Midwifery Pathway to Excellence accreditation scheme. Prior to her role at SFH, she held the role of Deputy Chief Nurse at the University College London Hospitals for five years.

Paula Kirkpatrick, Chief People Officer (Non-Voting)

Paula joined KGH in 2019 after a career in HR spanning both public and private sectors, latterly including 15 years in policing where she was half of a job share partnership working in a number of senior roles. Whilst working for Cambridgeshire Constabulary Paula was part of the HR leadership team that developed a collaborated HR service across Bedfordshire, Cambridgeshire and Hertfordshire police forces. Initially joining KGH as Deputy Director HR and OD in September 2019, Paula was appointed as Director HR and OD in 2020 and Chief People Officer in 2022.

Paula's areas of interest include health and wellbeing and equality, diversity and inclusion. She believes leadership is about supporting teams and individuals to be the best they can be: by ensuring people are healthy and well in the broadest sense; are able to be themselves in

the workplace, bringing all their skills and expertise to their role; and are supported and developed to reach their potential.

Will Monaghan, Chief Digital Information Officer (Non-Voting)

William joined University Hospitals of Leicester and UHN in August 2024, after previously being the CDIO at University Hospitals of Derby and Burton. He has 16 years of NHS experience across acute Trusts, NHS England and NHSX. William's expertise has seen him lead digital transformation from complex acute environments to national programmes. His particular focus on ensuring the voice of colleagues and patients drives what and how technology is used in the organisation. William is focussed on delivering the digital and data strategy across the group and leading the use of new digital technologies and approaches to better support colleagues and patients. Outside the Trust, Will lectures for Imperial College London on the NHS Digital Academy as a Leading Digital Health Practitioner. He is also the digital lead for the East Midlands Acute Provider collaborative (EMAP).

Hemant Nemade, Medical Director (Voting)

Hemant joined NGH in 2017 as a Consultant Urologist. Since then, he has worked in a number of roles from Regional Director for the Royal College of Surgeons to the Trust Clinical Director for Cancer Performance.

Following his appointment as Deputy Medical Director in 2020, Hemant has supported the organisation with some key initiatives from Governance to starting robotic assisted surgical services in Northamptonshire. He was appointed as Medical Director in July 2022, Hemant was appointed as UHN Medical Director in July 2024.

Sarah Noonan (Chief Operating Officer, Non-Voting)

Sarah has worked in the NHS for over 20 years and her career has spanned community and acute providers, as well as working for both an integrate care board and the regional NHS England team.

Before joining UHN, she worked as a Director of Operation for East Suffolk and North Essex NHS Foundation Trust covering Urgent and Elective Care.

Sarah joined UHN in January 2024 as Interim Chief Operating Officer. In September 2024, Sarah became UHN Chief Operating Officer.

Suzie O'Neill, Director of Communications and Engagement (Non-Voting)

Suzie joined the Trust in February 2023 and has responsibility for corporate communications and engagement.

Suzie, who is a former journalist, has years of experience of leading communications in both the public and charity sector. Most recently she was Deputy Director of Communications and Engagement at Nottingham University Hospitals NHS Trust.

Suzie is passionate about staff engagement, honest and open communication, empowering teams to deliver continuous improvement and putting the patient at the heart of what we do.

Sarah Stansfield (Chief Finance Officer, Voting)

Sarah joined UHN in December 2024 from the Northamptonshire Integrated Care Board, having held the position of Deputy Chief Executive for Northamptonshire Clinical Commissioning Groups. Her role oversaw all aspects of contracting, performance and organisational development.

Before joining the Northamptonshire Clinical Commissioning Group, Sarah was the Executive Director of Finance for Gloucestershire Hospitals NHS Foundation Trust.

Becky Taylor, Director of Continuous Improvement (Non-Voting)

Becky joined Kettering and Northampton Hospitals in October 2021, and has responsibility for leading the Transformation and Quality Improvement agenda across UHN. This includes being the executive lead for large-scale transformation programmes across KGH and NGH, supporting and enabling a culture of quality improvement, and the monitoring and tracking of programmes and projects.

Becky spent much of her career in management consultancy supporting different acute providers, community providers, local authorities and NHS national bodies to develop strategies and transform services. She is a Health Foundation Q Community Fellow and is passionate about supporting staff to make things work better for both our patients and our staff.

Attendance at Board and Board Committee Meetings, 2025-2026

Name	Title	Boards of Directors (9)	QSC* (8)	OPC* (2)	STDC* (3)	FIC* (3)	FIPC* (7)	People (5)	RAC (9)	Audit (7)
Andrew Moore	Chair	8	-	-	-	-	-	-	-	-
Richard Mitchell	Group Chief Executive Officer	9	-	-	-	-	-	-	-	-
Richard Apps	Director of Corporate and Legal Affairs (to 31 May 2025)	2/2	1 / 2	-	-	1	3/3	1/1	-	1/1
Sarah Stansfield	Interim Chief Finance Officer	9	-	-	-	3	6	-	-	6
Will Monaghan	Chief Digital Information Officer	9	-	0	3	-	-	-	-	-
Hemant Nemade	Medical Director	9	8	0	3	-	3	2	-	-
Laura Churchward	UHN Chief Executive	9	-	-	2	-	-	-	9	-
Sarah Noonan	Chief Operating Officer	9	5	1	-	-	5	3	-	-
Polly Grimmett	Director of Strategy	9	-	1	3	2	6	-	-	-
Julie Hogg	Chief Nurse	8	7	0	0	-	-	1	-	-
Paula Kirkpatrick	Chief People Officer	9	-	-	-	2	6	5	7	-
Becky Taylor	Director of Continuous Improvement	9	5	2	2	3	6	2	-	-
Suzie O'Neill	Director of Communications and Engagement	8	-	-	-	-	-	2	-	-
Stuart Finn	Director of Estates, Facilities and Sustainability (to 31 August 2025)	3 / 4	-	-	-	-	-	-	-	-
Alice Cooper	Non-Executive Director	9	-	-	2	-	-	3/3	9	7
Simon Gay	Non-Executve Director	6	3	-	-	-	-	-	-	-
Jill Houghton	Non-Executive Director	9	8	-	-	-	-	-	-	7
Denise Kirkham	Non-Executive Director	7	-	-	-	-		5	9	-
Trevor Shipman	Non-Executive Director/Vice Trust Chair	7	-	2	3	3	6	-	9	6
Caroline Stevens	Non-Executive Director	9	-	2	-	3	6	1 / 2	-	-

Name	Title	Boards of Directors (9)	QSC* (8)	OPC* (2)	STDC* (3)	FIC* (3)	FIPC* (7)	People (5)	RAC (9)	Audit (7)
Damien Venkatasamy	Associate Non-Executive Director	8	-	-	-	3	6	-	8	-
Chris Welsh	Non-Executive Director	9	8	2	3	-	7	-	6	-

***Key:**

QSC – Quality and Safety

FIC – Finance and Investment (to July 2025)

FIPC – Finance, Investment and Performance (from September 2025)

OPC – Operational Performance Committee (to July 2025)

STDC – Strategy, Transformation and Digital (from December 2025)

RAC – Remuneration and Appointments

Notes: 1.Attendance based on Committee Membership therefore attendance as a Deputy or discretionary observation not counted within the above figures.

2. The UHN/UHL Partnership Committee did not meet during 2025-26

Staff costs and numbers –has been subject to audit

	Permanent	Other	2025/26 Total	2024/25 Total
			£000	£000
Salaries and wages	316,396	1294	317,690	302,439
Social security costs	41,964		41,964	33,225
Apprenticeship levy	1,562		1,562	1,508
Employer's contributions to NHS pension scheme	32,939		32,939	31,001
NHSE contributions to NHSE pension scheme	21,545		21,545	20,192
Pension cost - other	44		44	62
Termination benefits	1,282		1,282	231
Temporary staff - agency/contract staff		9345	9345	21,367
Total gross staff costs	**415,732**	**10,639**	**426,371**	**410,025**
Recoveries in respect of seconded staff	(1,277)		(1,277)	(1,730)
Total staff costs	414,455	**10,639**	**425,094**	**408,295**
Costs capitalised as part of assets	(3,305)	(87)	(3,392)	(2,485)
Total employee benefits excl. capitalised costs	**411,150**	**10,552**	**421,702**	**405,810**

Analysis of average staff numbers

	Permanent	Other	2025/26 Total	2024/25 Total
Medical and dental	811	102	913	888
Ambulance staff				
Administration and estates	1071	77	1,148	1,715
Healthcare assistants and other support staff	1356	230	1,586	1,036
Nursing, midwifery and health visiting staff	1658	240	1,898	1,905
Scientific, therapeutic and technical staff	698	36	734	782
Healthcare science staff			0	75
Total average numbers	**5,594**	**685**	**6,279**	**6,401**
Total	**5,594**	**685**	**6,279**	**6,401**
Of which				
Costs capitalised as part of assets	54	1	55	39

Exit packages –has been subject to audit

There were 58 exit packages agreed during 2025-26 with total value of £1,374k (two in 2024-25 with total value of £200k)

One payment was made in year to a Senior Manager for loss of office, which was provided for in 2025-26.

No other payments were made to past Senior Managers in this reporting period.

Reporting of compensation schemes - exit packages 2025-26 (2024-25)

Financial Year 2025-26								
Exit package cost band (including any special payment element)	Compulsory Redundancies		Other departures		Total		Where Special Payments made	
	Number	£'000	Number	£'000	Number	£'000	Number	£'000
<£10,000	3	17	18	112	**21**	**129**		
£10,000 - £25,000	1	13	18	317	**19**	**330**		
£25,001 - £50,000	1	49	9	296	**10**	**345**		
£50,001 - £100,000	1	52	6	419	**7**	**471**		
£100,001 - £150,000	1	101			**1**	**101**		
£150,001 - £200,000					**0**	**0**		
>£200,000					**0**	**0**		
Total	**7**	**232**	**51**	**1144**	**58**	**1376**		

Financial Year 2024-25								
Exit package cost band (including any special payment element)	Compulsory		Other departures		**Total**		Where Special	
	Number	£'000	Number	£'000	Number	£'000	Number	£'000
<£10,000								
£10,000 - £25,000								
£25,001 - £50,000								
£50,001 - £100,000	1	80			**1**	**80**		
£100,001 - £150,000	1	120			**1**	**120**		
£150,001 - £200,000								
>£200,000								
Total	**2**	**200**			**2**	**200**		

Analysis of Other Departures

Type of other departures	Agreements	Total value of agreements
	Number	£000s
Mutually agreed resignations (MARS) contractual costs	51	1144
Total	51	1144

- *Other departures include £80,000 mutually agreed resignation payment to one director, S Finn, who left during the year. The termination agreement stated the amount after withholding tax deductions, whereas he was paid without the deduction of tax.*

There were no “Special Payments” in 2025-26 (nil in 2024-25). Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension’s scheme. Ill-health retirement costs are met by the NHS pension’s scheme and are not included in the table.

Staff sickness absence

Sickness absence rates at NGH have remained stable at 4.89% under the 5% target rate. The primary drivers of absence have been mental health conditions (stress, anxiety, depression), flu and respiratory illnesses, and musculoskeletal (MSK) conditions. The Trust has implemented robust preventative and supportive measures to maintain colleague wellbeing, including centralised and ward-based vaccination clinics, enhanced occupational health support for management referrals and comprehensive mental health services including a dedicated Staff Psychological Wellbeing service, a “single point of access” referral service, a proactive trauma and risk (TRiM) management incident debriefing service and targeted early interventions for burnout and team health.

Note: Figures below are for January to December 2025

Average FTE	Adjusted FTE days lost to Cabinet Office Definitions	Average sick days per FTE
5,840	64,552	11.1

National, regional and NGH sickness absence data is available on the NHS Digital website using this link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates.

Early retirements due to ill health

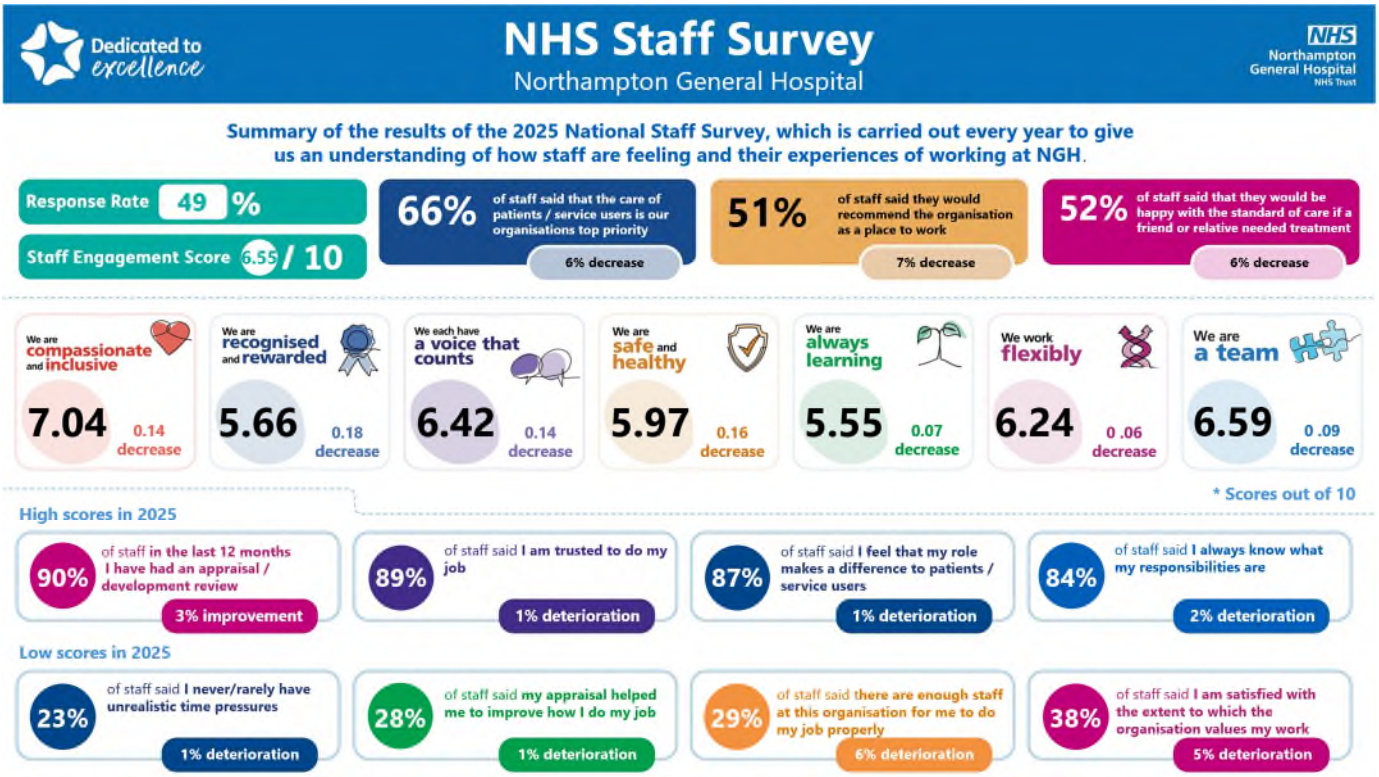
	2025-26	2025-26	2024-25	2024-25
	£000s	Number	£000s	Number
No of early retirements on the grounds of ill-health	8	1	215	5

Staff Survey Results

Staff engagement is well recognised as being key to delivering high quality, compassionate care. We seek feedback from colleagues through a variety of mechanisms, including listening events run by the Senior Leadership Team, Staff Network Groups and our Shared Decision-Making Councils.

In addition, the annual NHS National staff survey is a key source of information to understanding how colleagues are feeling and to gather their views about working at NGH. The most recent survey ran between October and November 2025 with 3,155 colleagues taking part, representing 49% of the NGH workforce. There was a significant decrease in the number of colleagues who took part compared to the previous survey;, however our 2025 response rates are higher than the national average for Acute Trusts, which was 47%.

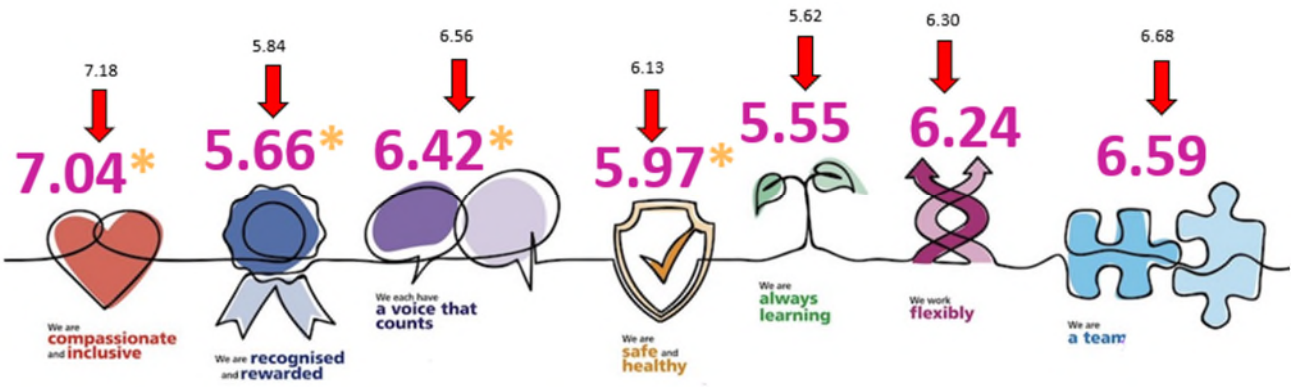
The National Results are available on the National NHS Survey website.



For the People Promise Themes, we have seen declines at NGH for all themes; with the first four being statistically significant declines. The Staff Engagement and Staff Morale themes have also declined from the 2024 results.

When comparing the theme results to the National Average we are below the National Average for all themes, except 'We work flexibly', which is higher.

The results highlight a need to focus on the following themes – Leadership and Visibility; Behaviours and Values; Engagement and Communication; Health and Wellbeing; Career Development and Continuous Improvement; and Belonging at UHN. Results have been shared with the organisation, with specific presentations given to staff networks, operational leadership groups and staff side colleagues. Work is underway to establish the organisational priorities and activities to improve colleague experience.



Equality, Diversity and Inclusion (EDI)

During 2025-26, we successfully launched our UHN We Belong Strategy 2025 - 2030. This strategy was codesigned by our workforce to reflect the needs and expectations of UHN colleagues. Influenced by our Staff Survey results; this strategy aims to improve the culture and inclusion of our workforce. We plan to ensure that by embedding a culture of belonging within UHN so that we have a workforce that is compassionate, accountable, respectful, empathetic, and courageous, and will be empowered to make the changes needed to address inequality.

We have met each of our statutory reporting duties and an annual Equality report will be produced and published on our website in line with the Public Sector Equality Duties (PSED).

The key areas of work and actions are linked to and driven by:

- Equality, Diversity and Inclusion Workforce Steering Group
- Inclusion Networks
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Gender Pay Gap Reporting
- National Staff Survey results
- Freedom to Speak Up
- Promotion of equality, diversity and inclusion to increase awareness and cultural competence across all staff groups

Some of our key achievements and activities included:

- Continued support of our Staff Networks, these are as follows:
    - REACH (Race, Ethnicity and Cultural Heritage) Network
    - DAWN (Disability and Wellbeing Network)
    - Pride (LGBTQ+) Network
    - Gender Equality Network
    - Veterans Network
- Completed a year of our Rethinking Racism Education Programme Training from April 2025 to March 2026. This year saw the training become mandatory for all senior managers.
- Collaborated with system partners for cultural celebrations across Northamptonshire such as Holi, Christmas, Black History Month, South Asian History Month and LGBTQ+ History Month.
- Creation of toolkits to support colleagues: Supporting Neurodiversity Toolkit, Reasonable Adjustments SOP, and Honouring my Name Toolkit
- Attended Northampton Pride in July 2025 to show our support and engage with our LGBTQ+ community.
- Had a ‘Wear your Pride’ day in which colleagues dressed in rainbow colours to show support for the LGBTQ+ community.
- Held ‘fireside chats’ for Black History Month/Freedom to Speak Up month/Disability History Month and LGBTQ+ History Month
- Hosted our own Menopause and Andropause presentation through the Gender Equality Network.
- Participated in Ward Walks, UHN Welcome Days, Recruitment Days and Training Days with information on EDI and the Networks.

- Had a stand in the Cyber Cafe at NGH and in the main reception at KGH, to celebrate Women's History Month.
- Continued to support and distribute the Sunflower Badge scheme for those with hidden disabilities.
- Support for the NHS Rainbow Badge charity that supports our LGBTQ+ community.
- Attended the British Indian Nurses Association Conference
- Co-facilitated the Northamptonshire Community of Practice which sees collaboration between public bodies across Northamptonshire.
- Achieved a Gold Standing with the Armed Forces Covenant and begun submission for the Fighting for Pride accreditation
- Created, published and hosted our We Belong Launch Event at the Recreation Hall at KGH and Cripps Postgraduate Centre at NGH.
- Launched the first cohort of reciprocal mentoring aimed at developing senior leaders for future executive roles.
- Attended maternity development days and THRIVE sessions at KGH & NGH, to provide EDI training and staff network awareness.
- Renewed and retained our Disability Confident Leader status
- Created the UHN Gender Inclusion Working Group, aimed at reviewing policies, processes and facilities across UHN to ensure that these services are inclusive to cisgender and transgender individuals following the Supreme Court Ruling 2025.
- Attended the Northamptonshire Healthcare NHS Foundation Trust REACH Event, a celebration of our IENs across the county as an annual event started by KGH in 2022

Workforce Race Equality Standard (WRES)

Each year we submit Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data to NHS England and create an action plan to address any disparities reported.

WRES reports data across nine metrics and has been part of the NHS Standard Contract since 2015. Four of the metrics focus on workforce data, four on NHS National Staff Survey results and one metric focuses on Board representativeness in comparison to the overall workforce.

You can read a detailed account of our WRES data and actions to improve performance here:

WRES NGH Final 2025

Workforce Disability Equality Standard (WDES)

The Trust has satisfied the NHS England requirement to publish Workforce Disability Equality Standard (WDES) on an annual basis. There are 10 metrics comparing the experiences of disabled colleagues at NGH to the experiences of those who are not disabled.

WDES has been part of the NHS Standard Contract since 2019. Three of the metrics focus on representation across pay bands, recruitment and the application of the process for unsatisfactory work performance, six on NHS National Staff Survey results and one metric focuses on disabled representation of the Board in comparison to the overall workforce.

You can read a detailed account of our WDES data and actions to improve performance here:

WDES NGH

Pay Gap Reporting

UHN has published pay gap reports for gender, ethnicity and disability. The pay gap audit obligations are outlined in The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017. Organisations employing more than 250 people and listed in Schedule 2 of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, must publish and report specific information about the gender pay gap. The report is retrospective based on the legal reporting requirements and information presented, relates to data from the previous financial year.

The pay gap can be defined as the difference between the median hourly earnings of:

- men and of women,
- white colleagues and BAME colleagues,
- non-disabled and disabled colleagues.

This is distinct from equal pay, which refers to earners in the same job earning an equal wage. Median is the middle value of the arranged set of data. Mean is the total of the numbers divided by how many numbers there are.

Our Gender pay gap report is available on the Government website at: Gender pay gap for Northampton General Hospital Nhs Trust - GOV.UK - GOV.UK (gender-pay-gap.service.gov.uk)

Our UHN Pay Gap report is available on our website here: UHN Gender Pay Gap

Modern slavery statement

This statement is made in pursuant to section 54 of the Modern Slavery Act 2015 and sets out the steps that Northampton General Hospital NHS Trust has taken and continues to take to ensure that modern slavery or human trafficking is not taking place within our business or supply chain.

Northampton General Hospital NHS Trust provides general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to people living throughout whole of Northamptonshire, a population of 692,000.

The organisation is also an accredited cancer centre and provides cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire.

The principal activity of the organisation is the provision of free healthcare to eligible patients.

Northampton General Hospital NHS Trust's position on modern slavery is to:

- Comply with legislation and regulatory requirements
- Make suppliers and service providers aware that we promote the requirements of the legislation
- Develop an awareness of human trafficking and modern slavery within our workforce
- Consider human trafficking and modern slavery issues when making procurement decisions in accordance with the Trust's Policies on Modern Slavery

The Trust fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it and supporting victims.

We are committed to ensuring that there is no modern slavery or human trafficking in any part of our business and in so far as is possible, to requiring our supplies hold a corresponding ethos.

To identify and mitigate the risks of modern slavery and human trafficking in our own business, Northampton General Hospital has established robust recruitment procedures, details of which are found in its Recruitment, Selection and Retention Policy.

The policy supports compliance with national NHS Employment Checks and CQC standards. In addition, all other external agencies providing staff have been approved through Government Procurement Suppliers (GPS). Modern slavery is incorporated within Northampton General's Safeguarding Children and Safeguarding Adults policies. In addition, modern slavery is reference within the Safeguarding Children and Adult

mandatory training from levels 1 -3, which applies to all staff employed by Northampton General Hospital as per the Safeguarding Training Strategy.

Staff must:

- Confirm their identities as new employees and their right to work in the United Kingdom
- Undertake safeguarding training appropriate to their roles and responsibilities to identify those who are victims of modern slavery and human trafficking
- Raise any concerns about working or clinical practice
- Work with the Procurement Department when looking to work with new suppliers so appropriate checks relating to modern slavery can be undertaken.

Working with Suppliers

The Trust's Procurement Department will ensure its supplier base and associated supply chain, which provides goods and / or services to Northampton General Hospital have taken the necessary steps to ensure modern slavery is not taking place. The Procurement Department have committed to ensuring that this is monitored and reviewed with its supplier base via the Trust's 3 Year Procurement Strategy. The Trust follows good practice, ensuring all reasonable steps are taken to prevent slavery and human trafficking and will continue to support the requirements of the Modern Slavery Act 2015 and any future legislation.

Richard Mitchell

Chief Executive and Accountable Officer

24 June 2026

Section 3: Financial Statements

Independent auditor’s report

Annual accounts

Independent auditor's report to the directors of Northampton General Hospital NHS Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Northampton General Hospital NHS Trust (the 'Trust') for the year ended 31 March 2026, which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers' equity, the statement of cash flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except that, on 10 June 2024, we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to the Trust's breach of its breakeven duty for the year ended 31 March 2026.

Responsibilities of directors

As explained more fully in the Statement of directors' responsibilities in respect of the accounts, the directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions and for being satisfied that they give a true and fair view, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud, is detailed below.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- We enquired of management and the audit committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and the presumed risk of fraud in some elements of revenue and expenditure recognition. We determined that the principal risks were in relation to:
  - journal entries that impacted on the financial position
  - recognition of expenditure between capital and revenue
  - recognition of expenditure in the correct period
  - recognition of income in the correct period
  - potential management bias in determining accounting estimates, especially in relation to:
    - the valuation of the Trust's land and buildings,
    - completeness of expenditure and payables, and
    - right of use assets and lease liabilities
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on journal entries posted by senior members of the finance team or those with superuser capabilities, journal entries with no description, journals that have not been appropriately authorised and significant journal entries at the end of the financial year which impacted on the Trust's financial performance;
  - capital additions testing, with a focus on year-end transactions;
  - testing receipts and payments after the financial year to ensure that income and expenditure have been recognised in the correct period;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations, right of use assets and accruals of income and expenditure at the end of the financial year;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further

removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to revaluation of land and buildings, depreciation, accruals and right of use assets and leases. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in respect of the above matter except on 21 June 2026 we identified two significant weaknesses in how the Trust plans and manages its resources to ensure it can continue to deliver its services, in relation to the Trust's arrangements for medium-term financial planning and delivering savings programmes. We identified;

- The Trust does not have sufficiently robust arrangements to produce an NHS England-compliant multi-year plan that is credible and deliverable. We recommended the Trust strengthen its medium-term financial planning arrangements to achieve this.
- Weaknesses in the Trust's arrangements for identifying, developing and delivering savings, and planned productivity improvements through its Cost Improvement Programme (CIP). We recommended the Trust strengthen these arrangements to establish a sustainable and effective model for CIP delivery.

Responsibilities of the Accountable Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust, the Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(2A)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Northampton General Hospital NHS Trust for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's directors as a body, for our audit work, for this report, or for the opinions we have formed.

Helen Lillington

Helen Lillington, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham
26 June 2026

Northampton General Hospital NHS Trust

Annual accounts for the year ended 31 March 2026

Statement of Comprehensive Income

	Note	2025/26 £000	2024/25 £000
Operating income from patient care activities	3	534,769	540,334
Other operating income	4	36,993	34,298
Operating expenses	7,9	(603,766)	(593,575)
Operating surplus/(deficit) from continuing operations		**(32,004)**	**(18,943)**
Finance income	11	1,108	1,337
Finance expenses	12	(513)	(372)
PDC dividends payable		(6,914)	(6,548)
Net finance costs		**(6,319)**	**(5,583)**
Other gains / (losses)	13	(38)	26
Surplus / (deficit) for the year from continuing operations		**(38,361)**	**(24,500)**
Surplus / (deficit) for the year		**(38,361)**	**(24,500)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(61)	(5,651)
Revaluations	17	3,725	5,802
Total other comprehensive income for the period		**3,664**	**151**
Total comprehensive income / (expense) for the period		**(34,697)**	**(24,349)**

Statement of Financial Position

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	14	18,019	11,587
Property, plant and equipment	15	250,807	230,583
Right of use assets	18	19,365	20,742
Receivables	20	702	753
Total non-current assets		**288,893**	**263,665**
Current assets			
Inventories	19	9,142	9,138
Receivables	20	16,279	21,836
Cash and cash equivalents	22	2,631	2,011
Total current assets		**28,052**	**32,985**
Current liabilities			
Trade and other payables	23	(51,269)	(38,556)
Borrowings	25	(3,069)	(3,214)
Provisions	26	(2,467)	(3,612)
Other liabilities	24	(2,712)	(2,775)
Total current liabilities		**(59,517)**	**(48,157)**
Total assets less current liabilities		**257,428**	**248,493**
Non-current liabilities			
Borrowings	25	(9,937)	(12,466)
Provisions	26	(721)	(768)
Total non-current liabilities		**(10,658)**	**(13,234)**
Total assets employed		**246,770**	**235,259**
Financed by			
Public dividend capital		368,556	322,348
Revaluation reserve		63,991	60,400
Income and expenditure reserve		(185,777)	(147,489)
Total taxpayers' equity		**246,770**	**235,259**

The notes on pages 7 to 54 form part of these accounts.

Name Richard Mitchell
Position Chief Executive and Accountable Officer
Date 24 June 2026

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	**322,348**	**60,400**	**(147,489)**	**235,259**
Surplus/(deficit) for the year	0	0	(38,361)	**(38,361)**
Other transfers between reserves	0	(73)	73	**0**
Impairments	0	(61)	0	**(61)**
Revaluations	0	3,725	0	**3,725**
Public dividend capital received	46,208	0	0	**46,208**
Taxpayers' equity at 31 March 2026	**368,556**	**63,991**	**(185,777)**	**246,770**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	**295,633**	**60,334**	**(123,074)**	**232,893**
Surplus/(deficit) for the year	0	0	(24,500)	**(24,500)**
Other transfers between reserves	0	(85)	85	**0**
Impairments	0	(5,651)	0	**(5,651)**
Revaluations	0	5,802	0	**5,802**
Public dividend capital received	26,715	0	0	**26,715**
Taxpayers' equity at 31 March 2025	**322,348**	**60,400**	**(147,489)**	**235,259**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(32,004)	(18,943)
Non-cash income and expense:			
Depreciation and amortisation	7.1	20,415	18,416
Net impairments	8	(246)	10,956
Income recognised in respect of capital donations	4	(235)	(622)
(Increase) / decrease in receivables and other assets		5,439	(4,390)
(Increase) / decrease in inventories		(4)	(1,414)
Increase / (decrease) in payables and other liabilities		8,986	2,456
Increase / (decrease) in provisions		(1,203)	701
Other movements in operating cash flows		(5)	1
Net cash flows from / (used in) operating activities		**1,143**	**7,161**
Cash flows from investing activities			
Interest received		1,125	1,337
Purchase of intangible assets		(11,063)	(4,222)
Purchase of PPE and investment property		(27,688)	(21,365)
Sales of PPE and investment property		1,413	29
Initial direct costs or up front payments in respect of new right of use assets		(63)	(89)
Receipt of cash donations to purchase assets		0	1,504
Finance lease receipts (principal and interest)		7	6
Net cash flows from / (used in) investing activities		**(36,269)**	**(22,800)**
Cash flows from financing activities			
Public dividend capital received		46,208	26,715
Movement on other loans		(163)	(217)
Capital element of lease rental payments		(3,169)	(3,125)
Other interest		0	(1)
Interest paid on lease liability repayments		(348)	(431)
PDC dividend (paid) / refunded		(6,782)	(7,133)
Net cash flows from / (used in) financing activities		**35,746**	**15,808**
Increase / (decrease) in cash and cash equivalents		**620**	**169**
Cash and cash equivalents at 1 April - brought forward		**2,011**	**1,842**
Cash and cash equivalents at 31 March	22.1	**2,631**	**2,011**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

In preparing the financial statements the Directors have considered the Trust's overall financial position and expectation of future financial support. The Trust reported a deficit of £38,361k (£37,683k adjusted financial performance) for 2025/26 and has sought additional cash support of £19,991k from NHS England (NHSE) for the year. Cash support will also be required for 2026/27, and the Trust will follow the NHSE process to apply for revenue support. The Trust has agreed contracts with local commissioners for 2026/27, and services will continue to be commissioned in the same manner in the future. There are no discontinued operations.

There are no transfers of services or significant amendments to the structure of the organisation in the coming year. The Board of Directors also has a reasonable expectation that the Trust and its group will have access to adequate resources, including support from the Department of Health and Social Care (NHS Act 2006, s42a), to continue delivering the full range of mandatory services for the foreseeable future.

The Public Audit Forum 'Practice Note 10' was revised in 2022. This note confirms that the anticipated continued provision of services is a sufficient basis for going concern. This means that it is highly unlikely that NHS organisations would have any material uncertainties over going concern to disclose.□

The Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Payment terms are standard reflecting cross government principles.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.
Providers and Commissioners currently have a level of flexibility to determine whether they will utilise the options to operate some of the variable elements in that manner or opt to include them in the contract as a further fixed or "block" element.

Where the variable processes are used, income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.
Monthly payments are made to providers equating to 1/12th of the agreed fixed contract elements and baseline variable elements for each contract. These payments are then accompanied by a variable-element to adjust income for actual activity delivered on elective services as described above.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.
Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.
Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants. The grant received from Salix for the Public Sector Decarbonisation Scheme and grants from Northamptonshire Health Charity are treated in line with this policy.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or operational capacity be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or operational capacity deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or operational capacity, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their operational capacity and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their operational capacity but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining operational capacity, which is assumed to be at least equal to the cost of replacing that operational capacity. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of operational capacity in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of operational capacity is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised.
Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	8	79
Dwellings	62	62
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	10
Furniture & fittings	5	5

Note 1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	4	10
Software licences	2	10

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using a number of different cost methods.

Drugs are valued using the average cost method. Consumables managed using the Genesis stock system are valued using the standard costing method. Fuel oil is valued at the lower of cost and net realisable value, recognising that it has limited commercial value. All other consumables are valued at current replacement cost; this is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

A full review has been undertaken by invoice type which includes general, private patient, overseas visitors, salary overpayments and NHS organisations. This has been analysed by levels of aged debt to determine a level of anticipated loss in relation to these. The overseas visitors assumes an average recovery level on an overall rate of 10%. This does not include outstanding debt with other NHS organisations.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.
The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 26.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Should any contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) be identified they will not be recognised as assets, but disclosed where an inflow of economic benefits is probable.

Should any contingent liabilities be identified, they will not be recognised, but disclosed, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.18 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s *FReM*.

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted: Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £218m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, Trusts and their valuers can currently adopt an 'alternative site' assumption for [some / all] of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. This option is not curently used by the Trust and will therefore have no impact.

Note 1.23 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

•Valuation of property, external valuers, Newmark carried out a desktop valuation at 31st March 2026 with targeted inspections for those assets that were commissioned during 2025/26. The valuations are based, for the most part, on floor areas provided by the Trust.

The purpose of the valuation is to assess the capital value of the Trust's tangible fixed assets (land and buildings) for inclusion within the Trust's financial statements as at 31 March 2026, in accordance with the Department of Health Group Manual for Accounts (GAM) 2025/26, the Government Financial Reporting Manual (FReM) 2025-26 and International Financial Reporting Standards (IFRS).

•The net book value of the land and buildings of the Trust are all specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential. The BCIS index of 3.7% has been used in the valuation of the building assets. In order for a material misstatement of the accounts to occur (£12,200k), a BCIS cost indices or a Northamptonshire location factor movement of 5.8% would need to be applied to the carrying value of buildings which as at 31st March 2026 is £209,337k.

Note 2 Operating Segments

The Trust Board considers all of its operations to be the provision of Healthcare operated as a single segment.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	2025/26 £000	2024/25 £000
Acute services		
Income from commissioners under API contracts - variable element*	106,026	102,170
Income from commissioners under API contracts - fixed element*	360,159	376,166
High cost drugs income from commissioners	40,490	34,375
Other NHS clinical income	4,220	4,205
All services		
Private patient income	421	415
National pay award central funding***	0	1,403
Additional pension contribution central funding**	21,545	20,192
Other clinical income	1,908	1,408
Total income from activities	**534,769**	**540,334**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2025/26 £000	2024/25 £000
NHS England	50,510	50,556
Integrated care boards	481,722	487,579
Other NHS providers	336	268
Non-NHS: private patients	421	415
Non-NHS: overseas patients (chargeable to patient)	352	409
Injury cost recovery scheme	1,220	1,107
Non NHS: other	208	0
Total income from activities	**534,769**	**540,334**
Of which:		
Related to continuing operations	534,769	540,334
Related to discontinued operations	0	0

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	352	409
Cash payments received in-year	133	105
Amounts added to provision for impairment of receivables	196	213
Amounts written off in-year	222	169

Note 4 Other operating income

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,156	0	**1,156**	1,048	0	**1,048**
Education and training	19,853	1,235	**21,088**	18,357	574	**18,931**
Non-patient care services to other bodies	2,139		**2,139**	2,013		**2,013**
Income in respect of employee benefits accounted on a gross basis	332		**332**	428		**428**
Receipt of capital grants and donations and peppercorn leases		235	**235**		622	**622**
Charitable and other contributions to expenditure		264	**264**		176	**176**
Revenue from finance leases (variable lease receipts)		0	**0**		0	**0**
Revenue from operating leases		224	**224**		224	**224**
Other income	11,555	0	**11,555**	10,856	0	**10,856**
Total other operating income	**35,035**	**1,958**	**36,993**	**32,702**	**1,596**	**34,298**
Of which:						
Related to continuing operations			36,993			34,298
Related to discontinued operations			0			0

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	1,611	1,387
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0	0

Note 5.2 Fees and charges

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1,000k and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2025/26	2024/25
	£000	£000
Income	2,629	2,516
Full cost	(2,922)	(2,920)
Surplus / (deficit)	**(293)**	**(404)**

Services include Catering and Car Parking.

Note 6 Operating leases - Northampton General Hospital NHS Trust as lessor

This note discloses income generated in operating lease agreements where Northampton General Hospital NHS Trust is the lessor.

The following operate on the Trust's site under operating leases :
Boots Chemist
Nene Valley Day Nursery (Childbase Partnership Limited)

Compass Contract Services (UK) Ltd - Retail outlets (Costa Coffee, M & S Food, Subway and Stock shop)

A Maggie's Cancer Centre has been constructed on land leased at a peppercorn rent. At the end of the lease in 2050, consideration will be made to extend/renew the lease at the current peppercorn lease arrangement.

Note 6.1 Operating lease income

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	174	174
Variable lease receipts / contingent rents	50	50
Total in-year operating lease income	**224**	**224**

Note 6.2 Future lease receipts

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	72	72
- later than one year and not later than two years	72	72
- later than two years and not later than three years	72	72
- later than three years and not later than four years	72	72
- later than four years and not later than five years	72	72
- later than five years	186	258
Total	**546**	**618**

Note 7.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	176	122
Purchase of healthcare from non-NHS and non-DHSC bodies	1,818	1,224
Staff and executive directors costs	419,183	405,579
Remuneration of non-executive directors	73	100
Supplies and services - clinical (excluding drugs costs)	53,128	53,115
Supplies and services - general	5,830	6,115
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	47,846	45,369
Inventories written down	231	174
Establishment	3,937	3,347
Premises	18,770	20,544
Transport (including patient travel)	579	822
Depreciation on property, plant and equipment	17,463	16,589
Amortisation on intangible assets	2,952	1,827
Net impairments	(246)	10,956
Movement in credit loss allowance: contract receivables / contract assets	1,028	1,100
Change in provisions discount rate(s)	(3)	3
Fees payable to the external auditor - statutory audit	294	246
Internal audit costs	142	119
Clinical negligence	16,385	15,419
Legal fees	452	14
Insurance (as a policy holder)	159	165
Research and development	1,126	0
Education and training	3,942	2,311
Expenditure on short term leases	18	203
Expenditure on low value leases	51	45
Redundancy	105	231
Car parking & security	746	771
Hospitality	6	23
Other services, eg external payroll	2,731	2,077
Other	4,844	4,965
Total	**603,766**	**593,575**
Of which:		
Related to continuing operations	603,766	593,575
Related to discontinued operations	0	0

Note 7.2 Audit fee payable to auditor

The fee payable to Grant Thornton for the audit is £245k plus VAT of 20% (2024/25: £205k plus VAT of 20%)

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1,000k (2024/25: £1,000k).

Note 8 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	0	1,773
Abandonment of assets in course of construction	0	1,757
Changes in market price	(246)	7,426
Total net impairments charged to operating surplus / deficit	**(246)**	**10,956**
Impairments charged to the revaluation reserve	61	5,651
Total net impairments	**(185)**	**16,607**

The 25/26 valuation exercise was completed by the valuation company, Newmark as at 31 March 2025. This resulted in an overall site valuation increase of £3,909k.

	2025/26
	£000
Increase in Impairment balance	1,160
Decrease in the Impairment balance	(1,406)
	(246)
Increase in Revaluation Reserve	(3,724)
Decrease in the Revaluation Reserve (Impairment)	61
	(3,909)

For further details please refer to Note 17 Revaluations of Property, Plant and Equipment

Note 9 Employee benefits

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	317,690	302,439
Social security costs	41,964	33,225
Apprenticeship levy	1,562	1,508
Employer's contributions to NHS pensions *	54,484	51,193
Pension cost - other	44	62
Termination benefits	1,282	231
Temporary staff (including agency)	9,345	21,367
Total gross staff costs	**426,371**	**410,025**
Recoveries in respect of seconded staff	(1,277)	(1,730)
Total staff costs	**425,094**	**408,295**
Of which		
Costs capitalised as part of assets	3,392	2,485

* Included in the above is £21,545k (£20,192k in 2024/25) relating to the recent revaluation of public sector pensions schemes amounting to 9.4% (9.4% 2024/25) (increase from 14.3% to 23.7% (23.7% 2024/25)) in the employer contribution rate. In line with DHSC guidance, the Trust contributed 14.3% and the balance of 9.4% was paid on its behalf by DHSC. However the full cost of 23.7% is included on a gross basis in the accounts as entities are required to account for this as notional funding.

Note 9.1 Retirements due to ill-health

During 2025/26 there was 1 early retirement from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £8k (£215k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

National Employment Savings Trust (NEST)

The National Employment Savings Trust (NEST) Corporation is the Trustee of the NEST occupational pension scheme. The scheme, which is run on a not-for-profit basis, ensures that all employers have access to suitable, low-charge pension provision. The Trust is required to comply with workplace pension legislation and to auto enrol employees into a pension scheme. Where employees are ineligible to join the NHS Pension Scheme the Trust enrols the employee into NEST. NEST is a defined contribution scheme
As 31 March 2026, 134 employees were enrolled in this scheme, 58% of which paid a monthly contribution.

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,108	1,337
Total finance income	**1,108**	**1,337**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on lease obligations	495	343
Interest on late payment of commercial debt	0	1
Total interest expense	**495**	**344**
Unwinding of discount on provisions	11	21
Other finance costs	7	7
Total finance costs	**513**	**372**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	0	1

Note 13 Other gains / (losses)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	0	29
Losses on disposal of assets	(38)	(3)
Total gains / (losses) on disposal of assets	**(38)**	**26**

Note 14.1 Intangible assets - 2025/26

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**10,761**	**345**	**7,418**	**18,524**
Additions	1,351	0	7,768	**9,119**
Reclassifications	10,491	(52)	(9,962)	**477**
Disposals / derecognition	(404)	(293)	0	**(697)**
Cost at 31 March 2026	**22,199**	**0**	**5,224**	**27,423**
Amortisation at 1 April 2025 - brought forward	**6,592**	345	0	**6,937**
Provided during the year	2,952	0	0	**2,952**
Reclassifications	264	(52)	0	**212**
Disposals / derecognition	(404)	(293)	0	**(697)**
Amortisation at 31 March 2026	**9,404**	**0**	**0**	**9,404**
Net book value at 31 March 2026	**12,795**	**0**	**5,224**	**18,019**
Net book value at 1 April 2025	**4,169**	**0**	**7,418**	**11,587**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 14.2 Intangible assets - 2024/25

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**14,101**	**345**	**3,755**	**18,201**
Additions	1,046	0	6,532	**7,578**
Impairments	(1,773)	0	(1,757)	**(3,530)**
Reclassifications	1,112	0	(1,112)	**0**
Disposals / derecognition	(3,725)	0	0	**(3,725)**
Valuation / gross cost at 31 March 2025	**10,761**	**345**	**7,418**	**18,524**
Amortisation at 1 April 2024 - as previously stated	**8,489**	**345**	**0**	**8,834**
Provided during the year	1,827	0	0	**1,827**
Disposals / derecognition	(3,724)	0	0	**(3,724)**
Amortisation at 31 March 2025	**6,592**	**345**	**0**	**6,937**
Net book value at 31 March 2025	**4,169**	**0**	**7,418**	**11,587**
Net book value at 1 April 2024	**5,612**	**0**	**3,755**	**9,367**

Note 15.1 Property, plant and equipment - 2025/26

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**8,679**	**187,176**	**280**	**2,584**	**57,715**	**140**	**20,215**	**37**	**276,826**
Additions	0	7,109	0	14,157	9,851	32	2,395	0	**33,544**
Impairments	0	(1,220)	0	0	0	0	0	0	**(1,220)**
Reversals of impairments	0	1,365	0	0	0	0	0	0	**1,365**
Revaluations	1	(3,657)	(37)	0	0	0	0	0	**(3,693)**
Reclassifications	0	2,864	0	(2,759)	17	0	242	0	**364**
Disposals / derecognition	0	0	0	0	(4,153)	0	(1,059)	0	**(5,212)**
Valuation/gross cost at 31 March 2026	**8,680**	**193,637**	**243**	**13,982**	**63,430**	**172**	**21,793**	**37**	**301,974**
Accumulated depreciation at 1 April 2025 - brought forward	0	0	0	0	**34,360**	**107**	**11,738**	**37**	**46,243**
Provided during the year	0	6,531	37	0	5,771	12	3,164	0	**15,515**
Revaluations	0	(6,620)	(37)	0	0	0	0	0	**(6,657)**
Reclassifications	0	89	0	0	0	0	(264)	0	**(175)**
Disposals / derecognition	0	0	0	0	(2,700)	0	(1,059)	0	**(3,759)**
Accumulated depreciation at 31 March 2026	**0**	**0**	**0**	**0**	**37,431**	**119**	**13,579**	**37**	**51,167**
Net book value at 31 March 2026	**8,680**	**193,637**	**243**	**13,982**	**25,999**	**53**	**8,213**	**0**	**250,807**
Net book value at 1 April 2025	**8,679**	**187,176**	**280**	**2,584**	**23,355**	**33**	**8,476**	**0**	**230,583**

Note 15.2 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**7,444**	**168,876**	**322**	**22,777**	**56,274**	**140**	**17,690**	**37**	**273,560**
Additions	0	5,377	0	6,100	4,961	0	2,301	0	**18,739**
Impairments	0	(11,339)	0	0	0	0	0	0	**(11,339)**
Reversals of impairments	1,235	1,759	0	0	0	0	0	0	**2,994**
Revaluations	0	(285)	(42)	0	0	0	0	0	**(327)**
Reclassifications	0	22,788	0	(26,293)	779	0	2,726	0	**0**
Disposals / derecognition	0	0	0	0	(4,299)	0	(2,502)	0	**(6,801)**
Valuation/gross cost at 31 March 2025	**8,679**	**187,176**	**280**	**2,584**	**57,715**	**140**	**20,215**	**37**	**276,826**
Accumulated depreciation at 1 April 2024 - as previously stated	**0**	**0**	**0**	**0**	**33,254**	**92**	**11,387**	**37**	**44,771**
Provided during the year	0	5,918	42	0	5,403	15	2,853	0	**14,231**
Revaluations	0	(5,918)	(42)	0	0	0	0	0	**(5,960)**
Disposals / derecognition	0	0	0	0	(4,297)	0	(2,502)	0	**(6,799)**
Accumulated depreciation at 31 March 2025	**0**	**0**	**0**	**0**	**34,360**	**107**	**11,738**	**37**	**46,243**
Net book value at 31 March 2025	**8,679**	**187,176**	**280**	**2,584**	**23,355**	**33**	**8,476**	**0**	**230,583**
Net book value at 1 April 2024	**7,444**	**168,876**	**322**	**22,777**	**23,020**	**48**	**6,302**	**0**	**228,789**

Note 15.3 Property, plant and equipment financing - 31 March 2026

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	8,680	170,862	243	13,982	24,949	51	8,213	0	**226,980**
Owned - donated/granted	0	22,775	0	0	1,050	2	0	0	**23,827**
Total net book value at 31 March 2026	**8,680**	**193,637**	**243**	**13,982**	**25,999**	**53**	**8,213**	**0**	**250,807**

Note 15.4 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	8,679	163,919	280	2,584	22,160	28	8,476	0	**206,126**
Owned - donated/granted	0	23,257	0	0	1,195	5	0	0	**24,457**
Total net book value at 31 March 2025	**8,679**	**187,176**	**280**	**2,584**	**23,355**	**33**	**8,476**	**0**	**230,583**

Note 16 Donations of property, plant and equipment

The table below details donations of plant and equipment received during 2025/26 from Northamptonshire Health Charity.

Description	Department	2025/26
		£000
Equipment		
Accuvein Handheld Vein Viewing Sys	Oncology - Chemo Suite	6
3Shape Trios intra-oral scanner & Laptop + software	Maxillo Facial	18
Sprintray 3D Printer	Maxillo Facial	13
3Shape F8 Desktop Scanner & Shining 3D Metismile Facial Scanner	Maxillo Facial	19
LumenEye Device	Endoscopy	23
3D Prostrate Integrated Sys inc MR Imaging Pack and articulated arm	Urology	148
Buildings		
Room expansion works	Haematology	8
Total Donated Assets		**235**

Note 17 Revaluations of property, plant and equipment

Valuation company Newmark Gerald Eve LLP carried out an annual desktop valuation as at 31st March 2026 with a site visit to witness those assets that had been commissioned in year. Those being the Rapid Assessment Unit, Pharmacy extension and Steam boiler works.
The valuation was based on floor areas and information regarding in year spend was provided.
The valuations have been prepared to comply with IFRS, specifically with regard to IAS 16 Property Plant and Equipment, IAS40 Investment Properties.

As per the definitions in the current standard the Trust's property is identified as 'specialised property' and therefore valued on a Depreciated Replacement Cost (DRC) method.

The land value of the hospital site has remained the same £8,680k, no change year on year. The valuer has commented that after a thorough review of land sales in the area, residential land values may have marginally fallen, though they do not regard land for hospital use to have reduced.

Buildings increased by an average of 2.7% to £209,337k across the site. The remaining life of all assets has been reduced by 1 year and updated the valuation with reference to the BCIS locationally adjusted TPI costs.
As this is an update valuation (with targeted inspections), the valuer has applied TPI indexation to the 2025 adopted costs.
For Northampton this represented a 3.73% increase on last year’s costs. The building values have also been adjusted for obsolescence as the estate becomes one year older.

The land and building closing NBV of £214,345k compared to the valuation of £218,254k has resulted in an upward movement of £3,909k.
This has increased the Revaluation Reserve by £3,663k and decreased the Impairment balance by £246k

Asset Type	Total Adjustment £000s	Revaluation Adjustment £000s	Impairment Adjustment £000s
Land	2	0	2
Building	3,907	3,663	244
Total Valuation	**3,909**	**3,663**	**246**
Equipment Historic Cost adjustment	(73)	(73)	0
Total Adjustment	**3,836**	**3,590**	**246**

There is also a historic cost charge of £73k taken to the Revaluation Reserve for equipment, this is the adjustment made to write down the indexation that has been applied to equipment in previous years.

The Gross carrying amount of fully depreciated assets still in use for plant and equipment is £22,643k (£17,520k in 2024/25) and for intangible assets it is £3,654k (£3,517k in 2024/25).

Note 18 Leases - Northampton General Hospital NHS Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust leases buildings for the provision of clinical services. The Trust leases property, medical, non-medical equipment and vehicles.

Note 18.1 Right of use assets - 2025/26

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**17,280**	**5,811**	**206**	**0**	**23,297**	**637**
Additions	122	1	66	129	**318**	0
Remeasurements of the lease liability	158	126	0	0	**284**	33
Impairments	(1)	0	0	0	**(1)**	0
Reversal of impairments	41	0	0	0	**41**	6
Revaluations	761	0	0	0	**761**	0
Reclassifications	(893)	0	0	0	**(893)**	0
Disposals / derecognition	0	(453)	(23)	0	**(476)**	0
Valuation/gross cost at 31 March 2026	**17,468**	**5,485**	**249**	**129**	**23,331**	**676**
Accumulated depreciation at 1 April 2025 - brought forward	**270**	**2,204**	**82**	0	**2,556**	0
Provided during the year	1,004	870	74	0	**1,948**	335
Reclassifications	(89)	0	0	0	**(89)**	0
Disposals / derecognition	0	(425)	(23)	0	**(448)**	0
Accumulated depreciation at 31 March 2026	**1,185**	**2,649**	**133**	**0**	**3,967**	**335**
Net book value at 31 March 2026	**16,283**	**2,836**	**116**	**129**	**19,365**	**341**
Net book value at 1 April 2025	**17,010**	**3,607**	**124**	**0**	**20,742**	**637**

Net book value of right of use assets leased from other NHS providers	0
Net book value of right of use assets leased from other DHSC group bodies	341

Note 18.2 Right of use assets - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**20,917**	**4,034**	**246**	**0**	**25,197**	**2,310**
Additions	2,958	2,614	101	0	**5,673**	0
Remeasurements of the lease liability	(8)	104	0	0	**96**	(8)
Impairments	(4,732)	0	0	0	**(4,732)**	(316)
Revaluations	(1,855)	0	0	0	**(1,855)**	(1,349)
Disposals / derecognition	0	(941)	(141)	0	**(1,082)**	0
Valuation/gross cost at 31 March 2025	**17,280**	**5,811**	**206**	**0**	**23,297**	**637**
Accumulated depreciation at 1 April 2024 - brought forward	1,057	2,122	117	0	**3,296**	873
Provided during the year	1,237	1,023	98	0	**2,358**	476
Revaluations	(2,024)	0	0	0	**(2,024)**	(1,349)
Reclassifications	0	0	0	0	**0**	0
Disposals / derecognition	0	(941)	(133)	0	**(1,074)**	0
Accumulated depreciation at 31 March 2025	**270**	**2,204**	**82**	**0**	**2,556**	**0**
Net book value at 31 March 2025	**17,010**	**3,607**	**124**	**0**	**20,742**	**637**
Net book value at 1 April 2024	**19,860**	**1,912**	**129**	**0**	**21,902**	**1,437**

Net book value of right of use assets leased from other NHS providers	0
Net book value of right of use assets leased from other DHSC group bodies	637

Note 18.3 Revaluations of right of use assets

Included within Note 18. Revaluation of PPE is an overall upward valuation of £801k which is relevant to right of use assets.

	2025/26	2024/25
Right of Use Assets	**£000**	**£000**
Nye Bevan Building	722	107
Car Park Decking	0	12
South Entrance - Communal Area	39	49
Danetre Hospital	6	(316)
Springfield GP Streaming Hub	(1)	(2,514)
CDC Kings Heath	35	(1,902)
Total ROU Revaluation at 31 March	**801**	**(4,564)**

Note 18.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 25.1.

	2025/26	2024/25
	£000	**£000**
Carrying value at 1 April	**15,457**	**12,990**
Lease additions	255	5,584
Lease liability remeasurements	284	96
Interest charge arising in year	495	343
Early terminations	(28)	0
Lease payments (cash outflows)	(3,517)	(3,556)
Carrying value at 31 March	**12,946**	**15,457**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 18.5 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	**31 March 2026**	**31 March 2025**	**31 March 2025**
	£000	**£000**	**£000**	**£000**
Undiscounted future lease payments payable in:				
- not later than one year;	3,305	529	3,492	512
- later than one year and not later than five years;	5,505	0	7,442	511
- later than five years.	6,859	0	7,535	0
Total gross future lease payments	**15,669**	**529**	**18,469**	**1,023**
Finance charges allocated to future periods	(2,723)	(9)	(3,012)	(40)
Net lease liabilities at 31 March 2026	**12,946**	**520**	**15,457**	**983**
Of which:				
Leased from other NHS providers		0		0
Leased from other DHSC group bodies		520		983

Note 19 Inventories

	31 March 2026	31 March 2025
	£000	£000
Drugs	3,336	2,714
Consumables	5,787	6,412
Energy	19	12
Total inventories	**9,142**	**9,138**
of which:		
Held at fair value less costs to sell	0	0

Inventories recognised in expenses for the year were £87,349k (2024/25: £82,698k). Write-down of inventories recognised as expenses for the year were £231k (2024/25: £174k).

Note 20.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	11,090	15,269
Allowance for impaired contract receivables / assets	(2,686)	(2,120)
Prepayments	5,983	6,656
Interest receivable	91	108
Finance lease receivables	7	7
PDC dividend receivable	238	370
VAT receivable	1,533	1,526
Other receivables *	23	20
Total current receivables	**16,279**	**21,836**
Non-current		
Finance lease receivables	138	145
Other receivables *	564	608
Total non-current receivables	**702**	**753**
Of which receivable from NHS and DHSC group bodies:		
Current	4,826	8,356
Non-current	702	753

* Other receivables - Clinician pension tax provision reimbursement funding from NHS England

Note 20.2 Allowances for credit losses

	2025/26		2024/25	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**2,120**	0	**1,686**	0
New allowances arising	1,034	0	1,100	0
Reversals of allowances	(6)	0	0	0
Utilisation of allowances (write offs)	(462)	0	(666)	0
Allowances as at 31 Mar 2026	**2,686**	**0**	**2,120**	**0**

Note 21 Finance leases (Northampton General Hospital NHS Trust as a lessor)

This note discloses future lease payments receivable from lease arrangements classified as finance leases where the Northampton General Hospital NHS Trust is the lessor.

Northampton General Hospital NHS Trust has a lease arrangement with NHS Property Services for Battle House. Northamptonshire Healthcare NHS Foundation Trust occupies the building.

Note 21.1 Reconciliation of the carrying value of finance lease receivables (net investment in the lease)

	2025/26	2024/25
	£000	£000
Finance lease receivables at 1 April	**152**	**158**
Lease receipts (cash payments received)	(7)	(6)
Finance lease receivables at 31 March	**145**	**152**

Note 21.2 Finance lease receivables maturity analysis

	Total	Of which leased to DHSC group bodies:	Total	Of which leased to DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease receipts receivable in:				
- not later than one year;	7	7	7	7
- later than one year and not later than two years;	7	7	7	7
- later than two years and not later than three years;	7	7	7	7
- later than three years and not later than four years;	7	7	7	7
- later than four years and not later than five years;	7	7	7	7
- later than five years.	110	110	117	117
Total future finance lease payments to be received	**145**	**145**	**152**	**152**
Net investment in lease (net lease receivable)	**145**	**145**	**152**	**152**
of which				
Leased to other NHS providers		0		0
Leased to other DHSC group bodies		145		152

Note 22.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2025/26	2024/25
	£000	£000
At 1 April	**2,011**	**1,842**
Net change in year	620	169
At 31 March	**2,631**	**2,011**
Broken down into:		
Cash at commercial banks and in hand	16	18
Cash with the Government Banking Service	2,615	1,993
Total cash and cash equivalents as in SoFP	**2,631**	**2,011**
Total cash and cash equivalents as in SoCF	**2,631**	**2,011**

Note 22.2 Third party assets held by the trust

Northampton General Hospital NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2026	31 March 2025
	£000	£000
Bank balances	74	74
Total third party assets	**74**	**74**

Note 23.1 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	10,328	5,393
Capital payables	11,029	7,365
Accruals	14,756	12,036
Social security costs	9,766	8,435
Pension contributions payable	4,579	4,387
Other payables	811	940
Total current trade and other payables	**51,269**	**38,556**
Of which payables from NHS and DHSC group bodies:		
Current	3,039	1,565

Note 23.2 Early retirements in NHS payables above

There were no early retirements included in the payables note above (2024/25 - Nil)

Note 24 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	2,712	2,775
Total other current liabilities	**2,712**	**2,775**

Note 25.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Other loans - Salix	42	163
Lease liabilities	3,027	3,051
Total current borrowings	**3,069**	**3,214**
Non-current		
Other loans - Salix	18	60
Lease liabilities	9,919	12,406
Total non-current borrowings	**9,937**	**12,466**

The Trust has taken advantage of participating in the Energy Efficiency Loan Scheme operated by Salix Finance Ltd.

The Trust has agreed 13 schemes since 2013/14, of which 11 have been fully repaid.

Each of the loans are subject to zero interest and the remaining outstanding loans are repayable over 5 years in equal instalments. Repayment commences 6 months after completion of the scheme.

Note 25.2 Reconciliation of liabilities arising from financing activities

	Other loans	Lease Liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2025	**223**	**15,457**	**15,680**
Cash movements:			
Financing cash flows - payments and receipts of principal	(163)	(3,169)	**(3,332)**
Financing cash flows - payments of interest	0	(348)	**(348)**
Non-cash movements:			
Additions	0	255	**255**
Lease liability remeasurements	0	284	**284**
Application of effective interest rate	0	495	**495**
Early terminations	0	(28)	**(28)**
Carrying value at 31 March 2026	**60**	**12,946**	**13,006**

	Other loans	Lease Liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2024	**440**	**12,990**	**13,430**
Cash movements:			
Financing cash flows - payments and receipts of principal	(217)	(3,125)	**(3,342)**
Financing cash flows - payments of interest	0	(431)	**(431)**
Non-cash movements:			
Additions	0	5,584	**5,584**
Lease liability remeasurements	0	96	**96**
Application of effective interest rate	0	343	**343**
Carrying value at 31 March 2025	**223**	**15,457**	**15,680**

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Redundancy	Clinician's Pension Re-imbursement	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**141**	**213**	**628**	**3,398**	**4,380**
Change in the discount rate	(3)	0	(45)	0	**(48)**
Arising during the year	0	255	0	2,110	**2,365**
Utilised during the year	0	(247)	(23)	(1,735)	**(2,005)**
Reversed unused	(18)	(156)	(10)	(1,368)	**(1,552)**
Unwinding of discount	11	0	37	0	**48**
At 31 March 2026	**131**	**65**	**587**	**2,405**	**3,188**
Expected timing of cash flows:					
- not later than one year;	18	65	23	2,361	**2,467**
- later than one year and not later than five years;	74	0	81	44	**199**
- later than five years.	39	0	483	0	**522**
Total	**131**	**65**	**587**	**2,405**	**3,188**

Pensions: injury benefits provisions are based on expected lives and current levels of payment.

Clinician pension tax reimbursement

Clinicians who are members of the NHS Pension Scheme and face an annual allowance tax charge for work undertaken in 2019/20 can elect to have this charge paid by the NHS Pension Scheme. The employing trust will make a contractually binding commitment to pay a corresponding compensated amount on retirement, therefore the provider has a future obligation upon the individual’s retirement.

NHS England have provided Trust's with an updated calculation for provision liabilities arising from the 2019/20 clinicians' pensions compensation scheme based on the latest available information on actual uptake of the scheme. The values are derived from combining information on applications to join the 2019/20 scheme under the policy, together with information in the scheme pays election form where present, and with averages assumed where these forms are absent or clearly an estimate (values less than £100). Future liabilities based on individual member data and scheme rules are then discounted to give totals for each Trust.

This payment will be nationally funded therefore the provision recognised is matched with a receivable from NHS England (Note 20.1).

Other Provisions

Other Provisions relate to employment claims and estimated medical staff pay arrears

Note 26.2 Clinical negligence liabilities

At 31 March 2026, £229,256k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Northampton General Hospital NHS Trust (31 March 2025: £216,468k).

Note 27 Financial Guarantee

In 2021/22 the Trust entered into a Financial Arrangement with Noviniti and Compass for the Front Entrance and Retail Development. Subsequently Noviniti have transferred the lease to Prudential Assurance with CBRE acting as the managing agents.
Under this arrangement Compass has a 15 Year Lease to occupy this Footprint. The Trust has step in rights under this arrangement should Compass default to the value of £283k per annum. This is considered a guarantee which would be accounted for under IFRS9 Financial Instruments. It is Trust management's assessment of risk that the likelihood of this happening in the foreseeable future is minimal therefore the guarantee value disclosed is £nil.

Note 28 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	6,850	1,023
Intangible assets	3,938	5,019
Total	**10,788**	**6,042**

Included in the above capital commitments are orders worth £3,917k which relate to the Electronic Patient Records (EPR) digital scheme, £2,827k relating to the 33 bedded ward scheme and £2,378k relating to the Urgent Treatment Centre (UTC).

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Integrated Care Boards and the way those Integrated Care Boards are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS England. Interest rates are confirmed by the Department of Health & Social Care (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust 's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with primary care, Integrated Care Boards, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	8,427	**8,427**
Cash and cash equivalents	2,631	**2,631**
Total at 31 March 2026	**11,058**	**11,058**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	13,169	**13,169**
Cash and cash equivalents	2,011	**2,011**
Total at 31 March 2025	**15,180**	**15,180**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	12,946	**12,946**
Other borrowings	60	**60**
Trade and other payables excluding non financial liabilities	35,852	**35,852**
Total at 31 March 2026	**48,858**	**48,858**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	15,457	**15,457**
Other borrowings	223	**223**
Trade and other payables excluding non financial liabilities	25,045	**25,045**
Total at 31 March 2025	**40,725**	**40,725**

Note 29.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2026	31 March 2025
	£000	£000
In one year or less	39,199	28,700
In more than one year but not more than five years	5,523	7,502
In more than five years	6,859	7,535
Total	**51,581**	**43,737**

Note 29.5 Fair values of financial assets and liabilities

The carrying value of financial assets and financial liabilities is a reasonable approximation of their fair value

Note 30 Losses and special payments

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses *	18	5	300	90
Bad debts and claims abandoned	113	310	95	179
Total losses	131	315	**395**	**269**
Special payments				
Compensation under court order or legally binding arbitration award	1	4	1	24
Ex-gratia payments	38	94	37	84
Total special payments	39	98	**38**	**108**
Total losses and special payments	**170**	**413**	**433**	**377**
Compensation payments received				

*Cash losses relate to uncollectable Salary Sacrifice scheme balances

Note 31 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northampton General Hospital NHS Trust.

The Department of Health & Social Care is regarded as a related party. During the year Northampton General Hospital NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

These entities include :

NHS England, Northamptonshire, Leicester, Leicestershire and Rutland ICB and Bedfordshire, Luton and Milton Keynes Integrated Care Boards, Northamptonshire Healthcare NHS Foundation Trust, Kettering General Hospital Foundation Trust, University Hospitals of Leicester NHS Trust, Oxford University Hospitals Foundation Trust, NHS Resolution and NHS Blood and Transplant.

Group Transactions with Kettering General Hospital Foundation Trust were £943k for Total Income and £778k for Total Expenditure. Receivables balance £1,075k, Payables balance £392k. Staff recharges are reported gross.

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with West Northamptonshire Council (Business Rates and Pathology Services) and HM Revenue & Customs (Employers National Insurance contribution), National Health Service Pension Fund Scheme and NHS Business Services Authority.

The Trust has also received revenue and capital payments from Northamptonshire Health Charity.

Grants which were received from the Charity have been treated in the Trust's Accounts as income and have primarily contributed towards staff and patients welfare. The Charity also funded Building Works & Medical Equipment. Total grant income was £499k, of which £235k related to Capital.

The Charity owns Springfield House, part of which is being leased to the Trust. The facility is being utilised to provide a GP streaming service. The Trust pays an annual lease charge and also facilities costs. Total expenditure was £52k. Payable balance £0

Note 32 Events after the reporting date

There are no material events after the reporting date of 31 March 2026 which effect the financial position.

Note 33 Better Payment Practice code

Non-NHS Payables	2025/26 Number	2025/26 £000	2024/25 Number	2024/25 £000
Total non-NHS trade invoices paid in the year	66,969	191,224	73,248	192,108
Total non-NHS trade invoices paid within target	62,145	180,052	71,939	184,654
Percentage of non-NHS trade invoices paid within target	92.8%	94.2%	98.2%	96.1%
NHS Payables				
Total NHS trade invoices paid in the year	1,473	31,704	1,551	29,835
Total NHS trade invoices paid within target	1,387	31,204	1,449	29,000
Percentage of NHS trade invoices paid within target	94.2%	98.4%	93.4%	97.2%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Better payment compliance reporting includes a level of estimation uncertainty and judgement due to the tracking of supporting information related to compliance with the 30 days as required by the code, particularly where invoices are in dispute. As a result, the performance as stated above could be overstated.

Note 34 Capital Resource Limit

	2025/26 £000	2024/25 £000
Gross capital expenditure	43,265	32,086
Less: Disposals	(1,481)	(11)
Less: Donated and granted capital additions	(235)	(622)
Charge against Capital Resource Limit	**41,549**	**31,453**
Capital Resource Limit	42,432	32,159
Under / (over) spend against CRL	**883**	**706**

Note 35 Adjusted financial performance

	2025/26 £000	2024/25 £000
Surplus / (deficit) for the period per SOCI	(38,361)	(24,500)
Remove net impairments not scoring to the departmental expenditure limit	(246)	7,426
Remove I&E impact of capital grants and donations	924	47
Remove net impact of DHSC centrally procured inventories	0	21
Adjusted financial performance surplus / (deficit)	**(37,683)**	**(17,006)**

Net impairments, relates to the valuation of the site which included a decrease in impairment of £246k which scores as an Annually Managed Expenditure (AME). Detailed in Note 8 - Impairment of Assets. Resulting in £246k excluded from retained and statutory break even in accordance with the DHSC Group Accounting Manual (GAM) Note 17 refers.

The capital grant and donated asset adjustment of £924k (consisting of £1,136k donated depreciation and £23k Right of use assets - peppercorn leases depreciation, less £235k donated additions) is excluded from retained surplus and statutory breakeven duty in accordance with the DHSC Group Accounting Manual.

Note 36 Breakeven duty financial performance

	2025/26 £000	2024/25 £000
Adjusted financial performance surplus / (deficit)	(37,683)	(17,006)
Remove impairments scoring to Departmental Expenditure Limit	0	3,530
Breakeven duty financial performance surplus / (deficit)	**(37,683)**	**(13,476)**

Note 37 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		2,081	1,109	504	399	197	(16,525)	(20,151)	(13,847)
Breakeven duty cumulative position	2,892	4,973	6,082	6,586	6,985	7,182	(9,343)	(29,494)	(43,341)
Operating income		227,805	236,260	255,481	271,295	276,894	270,358	273,562	298,240
Cumulative breakeven position as a percentage of operating income		2.2%	2.6%	2.6%	2.6%	2.6%	(3.5%)	(10.8%)	(14.5%)

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(23,339)	(14,432)	(19,055)	2,789	(217)	(15,425)	(15,803)	(13,476)	(37,683)
Breakeven duty cumulative position	(66,680)	(81,112)	(100,167)	(97,378)	(97,595)	(113,020)	(128,823)	(142,299)	(179,982)
Operating income	304,760	326,571	359,129	430,786	461,833	490,190	526,254	574,632	571,762
Cumulative breakeven position as a percentage of operating income	(21.9%)	(24.8%)	(27.9%)	(22.6%)	(21.1%)	(23.1%)	(24.5%)	(24.8%)	(31.5%)