NHS
Northampton General Hospital
NHS Trust

Proud to be a part of

University Hospitals of Northamptonshire
NHS Group

Northampton General Hospital (NGH) NHS Trust

Annual Report 2024/25

Dedicated to excellence

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 2024 and 31 March 2025 (2024-25).

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Section 3: Financial Statements (numbered separately from page 112)

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 write this opening statement to the 2024-25 KGH Annual Report. I am approaching the completion of my first year as Chair of both University Hospitals of Northamptonshire (UHN) and University Hospitals of Leicester (UHL) – and what a year it has been.

In this foreword, I want to reflect on the progress we've made, acknowledge the challenges we continue to face and reaffirm my commitments for the year ahead.

The NHS, like many organisations, is undergoing a period of profound transformation — arguably one of the most significant in its history. At UHN/UHL, we face this challenge with both confidence and realism. Everyone reading this report will be well aware of the challenges facing the NHS and we, at UHN and UHL, are not immune from this. We remain determined to respond with resilience, innovation, and purpose.

Our Boards are committed to exercising greater financial control in a safe and responsible manner to secure a more sustainable operating environment. We are transforming our hospitals into digitally-led and data-driven organisations. This is a game-changing priority for our teams and, while the scale of the challenge is clear, so too is the opportunity. We are already seeing how new systems will deliver efficiencies and improved levels of care for our communities. Equally important is our ongoing effort to foster a strong and healthy organisational culture - where colleagues work in safe, positive and inclusive working environments.

The complexity of our operating environment demands deep collaboration, not only within our hospitals, but across the UHN/UHL group and, critically, with our system partners. That includes local authorities, general practice and our wider community-based stakeholders. We know that only by working together can we deliver truly integrated, high-quality care.

Over the course of the year, I have been humbled by the dedication and compassion of our staff. Despite facing complex and often difficult circumstances, their unwavering commitment to delivering the best possible care is inspiring. I have had the privilege of visiting many services and teams across the Trust, as well as engaging with key community groups and stakeholders.

All of us have a role in meeting the diverse needs of our patients and delivering the best care. We haven't always got this right, and we deeply regret where we have let people down. I want to assure you that we are focused on making the necessary improvements. We are committed to listening to patients, their families and colleagues and learning from them so that we understand their different requirements and deliver quality care to everyone, despite the challenges.

We support the Government's commitment to focus on three strategic shifts, moving care from:

- hospital to community
- sickness to prevention
- analogue to digital

By actively pursuing these shifts our Boards believe we can make progress on cutting waiting times for care, tackling health inequalities and making the NHS sustainable for the long term.

I remain steadfast in my belief that we can, and must, continue to improve. We owe it to our patients, our staff, and our communities to keep striving for excellence in all that we do. I fully accept that there is always more to be done.

Thank you to everyone who plays a role in helping our Trusts deliver on our mission.

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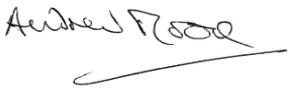

Andrew Moore

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

27 June 2025

Chief Executive's Introduction

2024/25 at University Hospitals of Leicester NHS Trust (UHL) and University Hospitals of Northamptonshire NHS Group has been a year of change. Andrew Moore, who is also UHL Chair, joined in the summer and has built on the foundations delivered by John MacDonald, his predecessor. Laura Churchward, UHN CEO, joined in the autumn.

UHL UHN is the largest provider of healthcare in the NHS, and we have a key role to play in overall NHS delivery – this is an opportunity and a responsibility. Local, regional and national colleagues are watching us with increasing interest and support. Improvements at UHL and UHN are not only important for the people who use our services, but they will have a material impact on the NHS.

UHL/UHN is a group formed from three statutorily separate hospitals, Kettering General Hospital Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) and University Hospitals of Leicester NHS Trust. We have been working together for 20 months and all three trusts are at different stages of their own change cycles. Patient care is improving but there is a huge amount to do to ensure all patients receive safe, timely, high-quality care. Progress has been made with planned care and emergency waiting times. Staff survey results are mixed with some areas reporting the highest engagement in their peer group, and some the lowest. Across the three trusts, the experience for all colleagues is not at the level we want it to be. There is a strong relationship between being a better employer for all and providing safe care to all. UHL UHN has a large deficit, and we are committed in 2025/26 to take actions to safely reduce it. A key part of this is working more effectively across the group and delivering actions which consistently improve productivity and efficiency.

UHL UHN has three priorities in 2025/26:

1. Transforming patient care
2. Strengthening our culture
3. Delivering our financial plan

And these priorities are underpinned by ten commitments:

1. **We will** 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) in our hospitals.
2. **We will** deliver our Quality priorities, which includes the Patient Safety and Incident Response Framework (PSIRF) and the perinatal safety programme.
3. **We will** take action on the 2024 staff survey feedback and deliver our People Plan prioritised actions for 2025, which includes action to tackle bullying, discrimination and harassment.
4. **We will** deliver major digital change, including the new Electronic Patient Record at NGH, aligning clinical systems across UHN and exploring automation of corporate systems.
5. **We will** go further in integrating clinical and corporate services across UHN, delivering seamless pathways and improving safety and outcomes for our patients.
6. **We will** further develop our collaborative model with UHL, improving productivity and creating joint plans for clinical and corporate services where appropriate.
7. **We will** accelerate work to integrate patient care, removing barriers between secondary, community and primary care services.
8. **We will** deliver our workforce plan as a key component of financial plan delivery.
9. **We will** increase our research and trial activities by 10%.

10. **We will** foster a learning culture, rolling out our 'Improving Together' continuous improvement methodology and giving teams the tools to improve care, experience, and productivity.

Whilst 2024/25 was a year of change, the pace of change in 2025/26 must increase for us to deliver our three priorities. The UHL UHN operating model will evolve and we also recognise the benefits of working more closely and effectively with general practice and community partners in Leicester, Leicestershire, Northamptonshire and Rutland.

I know we do not get everything right and colleagues are working under sustained pressure, but I am proud to work at UHL UHN. I would like to thank colleagues, patients, our communities and partner organisations for their support last year and this year.
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Richard Mitchell

Chief Executive and Accountable Officer

27 June 2025

UHN Chief Executive's Overview

It was a privilege to join University Hospitals of Northamptonshire (UHN) as Chief Executive on 1 October 2024. I have since been inspired by the dedication, compassion and professionalism of our teams across Northampton General Hospital (NGH) and the wider UHN Group.

I am therefore proud to present the 2024–25 Annual Report, which reflects a year of progress, innovation and resilience, delivered against the backdrop of some of the most severe financial pressures the NHS has ever faced. Despite these challenges, our teams have remained focused on what matters most: delivering safe, high-quality, and compassionate care to the people of Northamptonshire.

This year, we have seen achievements across every part of our organisation. From national and international recognition for our staff, to pioneering clinical innovations and expanded services, we have continued to push boundaries and improve outcomes for our patients.

We have led the way in clinical innovation-becoming the first UK hospital to implant next-generation leadless pacemakers, expanding our bowel cancer screening programme and opening the Kings Heath Community Diagnostic Centre. We have also been nationally accredited as a centre of excellence for endometriosis care and became the first UK organisation to receive a second Pathway to Excellence designation, reflecting our leadership in nursing and midwifery. Building work started on a new cancer support and information centre – Maggie's, which will open by the end of the year.

Operationally, we have made strides in urgent and emergency care, cancer pathways, and diagnostics. We have reduced long waits, improved patient flow, and introduced new models of care, all while managing increased demand and constrained resources.

Our teams have achieved a lot, but not everyone has had the best experience in our hospitals, and I want to apologise to anyone whose experience has fallen below the high standards we look to deliver. Although I cannot change what has happened, I do want to offer my commitment, on behalf of the Board, that we will listen to our communities and we will learn, making improvements so that we offer the best experience to everyone every time.

We employ 6,656 people, from frontline staff to support services, volunteers, to clinical leaders. This year we have we have focused on building a stable, supported and engaged workforce - achieving lower vacancy and turnover rates, improving training compliance and investing in wellbeing and career development.

In September, the UHN Excellence Awards provided an opportunity to recognise the outstanding contributions of our colleagues and volunteers- celebrating the compassion, accountability, respect, integrity and courage that underpin everything we do. Our volunteers continue to play an incredibly significant role supporting our patients, colleagues and visitors.

We have strengthened our commitment to patient and community engagement, welcoming over 90 new service users to the UHN Patient Engagement Pool and co-producing initiatives with local partners including Northamptonshire Carers, Northamptonshire Association for the Blind and Healthwatch. These efforts, supported by expanded feedback mechanisms, are helping us shape services around what matters most to those we serve.

This last year, we laid the foundation for a unified digital future with the launch of our 2025 - 2028 Group Digital and Data Strategy, bringing together University Hospitals of

and innovation, we are accelerating the delivery of digital solutions that improve patient care, empower staff, and drive efficiency.

We have modernised core technology across our hospitals and have been working towards the launch of electronic patient records at NGH and automated key communications to improve patient experience. Together, these steps mark real progress in transforming care through digital innovation.

Sustainability has remained a key priority. We have delivered major carbon reduction projects, improved waste management and maintained our Green accreditation for the 11th consecutive year. These efforts are not only good for the environment—they are essential to building a healthcare system that is fit for the future.

All of this has been achieved while navigating a financial landscape that continues to place immense pressure on NHS organisations. We are operating in an environment where every decision must balance quality, safety, and value for money. Yet, even in this context, our teams have continued to innovate, improve, and deliver for our patients.

As I look back on the past year, I want to acknowledge the contributions of our colleagues and our partners across Northamptonshire. Their collaboration and support have been essential in helping us deliver our objectives. Together, we are making steady progress toward a more resilient, efficient, and sustainable healthcare system for Northamptonshire.

I look ahead to the coming year with confidence in our people and optimism about what we can achieve together.

Laura Churchward

UHN Chief Executive

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.

University Hospitals of Northamptonshire

Northampton General Hospital NHS Trust (NGH) is part of University Hospitals of Northamptonshire (UHN) with Kettering General Hospital NHS Foundation Trust (KGH).

Both hospitals provide core services such as A&E and maternity services and are collaborating more closely on other clinical and support services with the aim of providing the best care possible for patients. Working together, we are developing innovative approaches to team working in support services such as digital, estates, corporate governance, and human resources. A common approach to transformation and quality improvement also remains a key priority for UHN.

Since forming in 2021 we have achieved University Hospital status, which has improved academic opportunities for staff and access to research and new treatments for patients and continue to scale and create opportunities for key clinical collaborations, with work already underway in Head & Neck, ENT and the delivery of the Cardiology Centre of Excellence for Northamptonshire.

Delivering a shared Vision for UHN

In 2021, we formed a hospital group with Kettering General Hospital NHS Foundation Trust (KGH), and appointed a Group Chief Executive of our hospitals. Under the Group model, both Trusts work collaboratively to improve the quality of the care we provide, enable more equitable access to services across the county, and make better use of our valuable resources.

As part of this work, we adopted (with KGH) a ‘Dedicated to Excellence’ Strategy, developed following extensive public engagement, articulating the group’s common vision and mission, supported by shared priorities and values.

The Strategy set out:

Our Group vision:

Dedicated to outstanding patient care and staff experience by becoming a university hospital group and a leader in clinical excellence, inclusivity and collaborative healthcare.

Our Group mission:

Provide safe, compassionate and clinically excellent patient care by being an outstanding employer for our people, creating opportunity and supporting innovation, and working in partnership to improve local health and care services.

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.

Compassion

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

Integrity

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

Respect

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

Courage

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

Accountability

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

Our Group Priorities

The Trusts agreed five priority areas of focus and improvement in respect of:

- Patient: excellent patient experience shaped by the patient voice;
- Quality: outstanding quality healthcare, underpinned by continuous, patient-centred improvement and innovation;
- Systems and Partnerships: seamless, timely pathways, working together with our partners;
- Sustainability: a resilient and creative University Hospital Group, embracing every opportunity to improve care
- People: an inclusive place to work where people are empowered to make a difference.

The Performance analysis below describes the Trust's performance against these priorities during 2024-25.

Our priorities for 2025-26

The Trusts have 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:

1. We will aim to 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) in our hospitals

2. We will deliver our Quality priorities, which includes PSIRF and the perinatal safety programme

3. We will take action on the 2024 staff survey feedback and deliver our People Plan prioritised actions for 2025, which includes action to tackle bullying, discrimination and harassment

4. We will deliver major digital change, including the new EPR, aligning clinical systems across UHN and exploring automation of corporate systems

5. We will go further in integrating clinical and corporate services across UHN, delivering seamless pathways and improving safety and outcomes for our patients

6. We will further develop our collaborative model with UHL, improving productivity and creating joint plans for clinical and corporate services where appropriate

7. We will accelerate work to integrate patient care, removing barriers between secondary, community and primary care services

8. We will deliver our workforce plan as a key component of financial plan delivery

9. We will increase our research and trial activities by 10%

10. We will foster a learning culture, rolling out our 'Improving Together' continuous improvement methodology and giving teams the tools to improve care, experience, and productivity

Each deliverable has been allocated to a responsible executive lead and Board Committee to ensure implementation.

The UHN/UHL Clinical Strategy

UHN is working with UHL to prepare a joint Clinical Strategy which to address the key challenges of urgent and emergency care, elective care, financial sustainability and the fragmentation of health care through cross-cutting areas of focus around seamless, proactive, preventative treatment. The strategy will be aligned with a new NHS 10-year plan provide a framework in which to develop complementary integration between primary, acute, community and local authority care within Northamptonshire, and more widely across county boundaries. The draft strategy is subject to extensive stakeholder co-design and engagement, before a final version is presented to Boards for consideration and adoption in summer-autumn 2025.

Our local health system

The Trusts are key partners in the Northamptonshire Integrated Care Board (ICB), which legally came into being in 2022 to replace the Northamptonshire Clinical Commissioning Group (CCG) and is the statutory body responsible for local NHS services, functions, performance and budgets. The UHN Chief Executive is a Partner Member of the ICB Board representing acute providers within the county (KGH and NGH), 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.

For 2024-25, UHN contributed to a single Operating Plan for the Northamptonshire Integrated Care Board (ICB), comprising the key elements of activity and performance, workforce, finance and accompanying narrative.

The final plan, submitted to NHS England in June 2024, set out targets to deliver elective activity recovery targets, key operational performance targets and a reduction in bank and agency usage across the local health system. The plan was for a £55m deficit financial position with a challenging efficiency target of £41.5m. The report to the Boards of Directors in October 2024 (Item 6) sets out more details regarding these targets and associated risks to delivery.

Due to a number of variances from plan driven by premium staffing costs, urgent and emergency care demand, inflation, non-pay pressures and the under-delivery of efficiency targets, the Trusts submitted a revised forecast showing a financial deficit of £100m in Q3 of 2024/25. The performance analysis below (see page 14 onwards) provides a detailed financial summary of performance against performance, workforce and financial targets, including the year-end financial outturn position.

Planning for 2025-2026

The Trusts and NICB submitted the final 2025/26 plan to NHS England on 30 April 2025. This plan identified a NGH gross planned deficit for the year of £35.7m against which £31.0m of plan deficit funding is being supplied by NHSE to arrive at a net deficit submission of £4.7m. This plan position has been triangulated with the ICB and other Commissioners and is part of an overall UHN deficit plan of £75m. 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 8.6% in year efficiency target. 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

(further information is available in the Health inequalities annual report 2023-24)

Our local population is older than, and growing faster than, the national average so the demand for good quality care and support will increase over the coming years. Some of our local populations have significantly poorer health outcomes and life expectancy than the national average, and many of these people do not get the access to the care they need in a timely way.

Where you are born in Northamptonshire makes a difference to how long you are likely to live. A male in Northamptonshire can expect to live an average of 80 years and a female an average of 83 years. This is in line with the national average; however, males born in the most deprived part of Corby in the north of the county have an average life expectancy of 73 years, compared to males born in the wealthier area of Spratton, who live to an average of 83 years. Similarly, females born in Corby Central live to an average age of 78, while others in Towcester Mill in South Northamptonshire, live to an average age of 87.

Patient referrals resulting in cancer diagnoses are significantly higher in Northamptonshire than the national average (7.8% of patients diagnosed with compared to 7.1% - two-week referral standard), 547 of the 1,385 deaths from cardiovascular diseases amongst those aged under 75 years were considered preventable, had effective public health and primary prevention interventions been delivered. North and West Northamptonshire have significantly higher death rates for respiratory disease in residents age under 75 years compared to the England average, 38 per 100,000 in North Northamptonshire compared to 34 per 100,000 for England); 24 of local deaths were considered preventable.

More detailed information on health inequalities in Northamptonshire is available to access online at icnorthamptonshire.org.uk/health-inequalities.

The Group's current Clinical Strategy (see above) sets out what we need to do to tackle these challenges, identifying key areas where our population will require care and treatment over the coming years. We are working within the Integrated Care System to transform how services are delivering through a collaborative for elective care, for which KGH and KGH have been designated as Lead Providers. This collaborative aims to transform services so that patients can access the right clinician in the right place, for example in community integrated diagnostic hubs and transformed outpatient services, supported by an ICS-wide patient waiting list to support equitable access. KGH has worked with partners to progress the redesign of **outpatient services** across the county, committing to a co-design approach to enable patients, communities and staff to create a county-wide blueprint for excellent outpatient pathways to reduce backlogs, improve health outcomes, remove unwarranted variation and ensure everyone can access the right care in the right place: co-design workshops took place between March to June 2024. UHN has also joined the Getting it Right First Time 'Further Faster' accelerator programme, which will enable us to draw directly on national guidance and support for the rapid adoption of best practice locally.

The Trusts participate in the ICS **'Supporting and Recovering Independence'** programme, which expanded its scope during the year to focus on 'Ageing Well' and further improvements and expansion of the virtual ward. KGH also progressed transformation workstreams linked to NHS England's high impact interventions, including work by the frailty team within the Emergency Department to fast-track vulnerable patients to therapy and social care to avoid hospital admission. The Trust plans to increase access to this service going forward. Operational teams also worked with North Northampton Council (NNC) to jointly open additional beds at Thackley Green Specialist Care Centre. The additional bedded capacity was provided for patients who no longer required acute care but were not quite ready to return home. These initiatives not only improved the timeliness of access and care for most of our most vulnerable patients, but also provided important mitigations which helped us to maintain services during the winter peak period.

We continued made significant progress in **community diagnostic** provision during the year, to increase testing capacity and reducing journeys to our hospitals, which are difficult to access for many people. Following approval by Regional and National panels in February 2023, we selected Corby and King's Heath (Northampton) as preferred sites, based on the following criteria:

- Future proofing (available land for future expansion or new build)
- Accessible by car or public transport within 30 minutes
- Size of population where Index of Multiple Deprivation is within the highest 20%.

The King's Heath centre fully opened in November 2024 and has offered over 25,000 additional scans to patients since opening. The centre is open 12 hours a day, seven days a week, for MRI and CT scans, and can receive referrals from patients from across the county for advanced imaging services.

The Corby centre will open during summer 2025 and offer core tests, whilst we are in the procurement phase for a further large centre whose location is yet to be determined.

The Trusts' endorsed the Integrated Care Northamptonshire Strategy (icnorthamptonshire.org.uk) in February 2023, setting out 10-year plan four our residents to have the best outcomes at every stage of their lives, and how we will work together with a shared responsibility to deliver these outcomes for our communities, which will improve the health of the population so that our services are reserved for the people most in need of them.

Northamptonshire Health Inequalities Plan

The Northamptonshire Health Inequalities Plan describes how we plan to work with communities so that everyone in our county has the chance to thrive and to access quality services providing excellent experiences and the best outcomes for all.

The long-term ambition set out in the Northamptonshire Health Inequalities Plan is to see:

- An increase in people's healthy life expectancies
- A reduction in health inequalities
- A reduction in early death
- Improved community cohesion

To achieve these ambitions, the plan outlines a set of guiding principles for how we need to work together as an integrated care system to understand and address health inequalities. These principles will be embedded across all our health and care organisations working across Integrated Care Northamptonshire.

Alongside these principles, specific actions are being developed at every level of our integrated care system – from county-wide down to local neighbourhoods – to address health inequalities. The plan is available to view here: Northamptonshire Health Inequalities Plan 2022/23-2025/26

Performance Management Framework

The UHN Integrated Governance Report is submitted to Board Committees and 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. UHN uses an aligned suite of key performance metrics to monitor performance in the UHN context, with consolidated reports to the Boards 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 Assurance and Risk 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.northamptongeneral.nhs.uk/About/Our-Trust-Board/Meeting-and-papers/Meeting-papers.aspx

During the year, UHN agreed a new Accountability and Continuous Improvement framework for implementation from April 2025. The framework will support improved oversight and assurance of performance and improvement across our divisional teams, creating a line of sight from services through directorate and divisional governance through to the Board committees and Boards of Directors. It will be a key part of our corporate governance feeding into the Integrated Leadership Team and Board committees. The Integrated Governance report will be relaunched as an Integrated Performance Report as part of this process and provide:

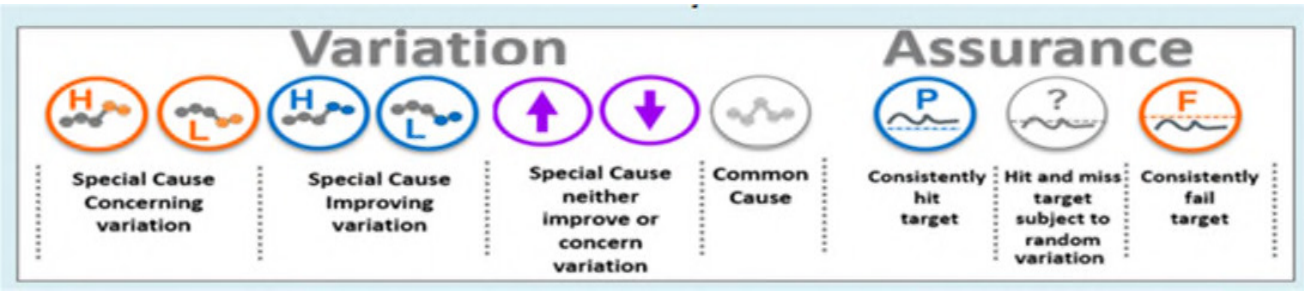
- Clarity on metrics and targets, re-organised by CQC domains (Caring, Safe, Effective, Responsive, Well-Led, Use of Resources)
- Improved processing of organisational data via the data warehouse programme;
- A format that supports interpretation and discussion;
- Culture and behaviours that support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

Trust Performance analysis

1.3.1 Introduction

The Performance Analysis provides a detailed performance summary for Northampton General Hospital against the Group objective headings of Patient, Quality, Sustainability, Systems and Partnerships and People.

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



NGH Highlights, 2024-25

April 2024

NGH restaurant worker wins her category in national 2024 Unsung Hero Awards

Alana Ricketts, who works as a Restaurant Food Service Assistant, was named as the winner of the Unsung Hero award's Estates and Ancillary Individual category for the compassion, kindness, and empathy she showed to a hospital visitor. Alana was nominated for the kindness and compassion she showed to a visitor who had been in the hospital daily to visit a loved one.

The hospital's Volunteer Services Team also made it to the finals of the awards.

June 2024

NGH nurse wins national award

Lead Dementia Liaison Nurse Rebecca Goadsby – who worked with colleagues from across the hospital - won a Healthcare Quality Improvement Partnership Clinical Audit Heroes Award in the Patient and Public Involvement category. The award recognized Rebecca's work with patients, carers, and hospital teams to improve dementia care.

May 2024

New generation of miniature leadless pacemakers being fitted at NGH

Northampton General Hospital became the first hospital in the UK to start to fit a new generation of leadless pacemakers. The miniature pacing device - which is less than 2 grams in weight – is implanted inside of the right ventricle of the heart and remains undetected to the human eye, unlike traditional pacemakers that are often seen under the surface of the skin.

July 2024

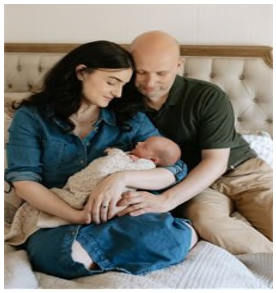
Cancer Charity Maggie's starts work on new Northampton support centre

National cancer support charity Maggie's started work on a new purpose-built support centre to provide expert care to people living with cancer from across the Northamptonshire area.

The centre is being built in the grounds of Northampton General Hospital. Maggie's plans to open the centre and be offering free expert psychological, emotional and practical support to people with cancer, as well as family and friends, by the end of 2025.

August 2024

New community support group for families who have had sick and premature babies



Additional specialist support for families who have been through the difficulties of having sick and premature babies is now being delivered in NGH and KGH though the work of a specialist Neonatal Clinical Psychologist supporting the neonatal units at both acute hospitals. The development follows the Ockenden Report which recommended hospitals do more to support families going through the many stresses, and often trauma, associated with having a sick or premature baby in hospital, for days, weeks, or even months.

October 2024

Healthcare Assistant wins international Pathway Nurse of the Year Award

Cancer and oncology nurse Samuel Dundas won the American Nurses Credentialing Center (ANCC) Pathway to Excellence Program Pathway Nurse of the Year Award – Direct Care Nurse. The award recognized Samuel's work as the chair of his ward's Shared Decision-Making Council - where staff get together to find ways to improve patient experience, staff wellbeing and recognition.

September 2024

Nurses receive awards for the way they support patients and families

Two nurses from NGH received nursing awards for the way they have supported patients and families with difficult issues. Staff Nurse Lauren Head received the award to mark her work in end-of-life-care and organ and tissue donation in the emergency department and Macmillan Head and Neck Clinical Nurse Specialist Flavia Taylor for the way she goes above and beyond to support patients with challenging life situations.

November 2024

Bowel cancer screening programme expanded to over 50s

A bowel cancer screening programme that helps detect cancers and pre-cancerous growths was extended to patients over 50 in Northamptonshire.

The expansion is part of national plans to roll out screening in stages to all patients over 50 by 2025 and allows all 50 and 52-year-olds registered with GPs have been added to the screening programme.

December 2024

NGH achieves a green award for its commitment to sustainability

NGH achieved a Green Accreditation with the national Investors in the Environment (iiE) scheme for the way it is working to reduce its carbon emissions and waste. Achieving a Green Accreditation means the hospital has demonstrated it is focused on sustainable development and carbon emission reduction and is committed to finding ways to achieve these goals.

February 2025

Kings Heath Community Diagnostic Centre officially opens its doors

The new Community Diagnostic Centre, located adjacent to the Kings Heath General Practice in Northampton, officially opened its doors. This state-of-the-art facility will transform access to diagnostic services in the community, offering cutting-edge technology to aid in early detection of serious conditions like cancer and heart disease, enabling patients to receive life-saving treatments quickly.

January 2025

Immunisation nurse receives leadership award

Lead Nurse for Maternity Immunisation Leigh-Anne Spinelli, and her team, were awarded for boosting the uptake of vital vaccinations. The team succeeded in boosting whooping cough vaccination uptake from as low as 39% in some months last year up to 70% - ten per cent above the national target of 60%.

March 2025

NGH nationally accredited to deliver a high level of endometriosis care

NGH has been 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.

1.3.2 Performance Analysis: Patient and Quality

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-2023-24.pdf

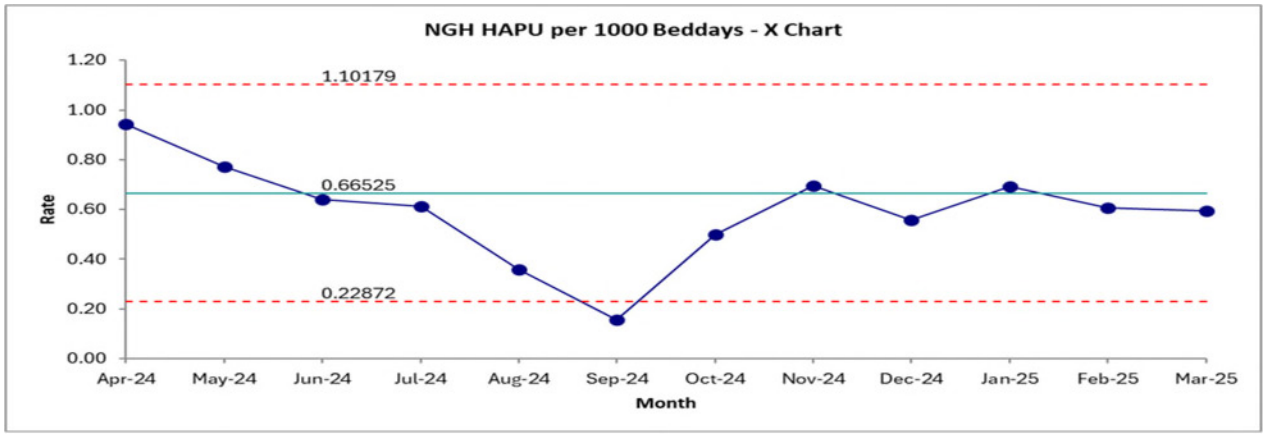
Harm Free Care

"Harm Free Care" is aimed at reducing avoidable harm to patients in hospitals and community settings. Through 2024-2025 reporting and leadership structures of specialist teams has been reviewed. This has led to the development of the Harm Free Care Team which brings together the specialities of Falls, Tissue Viability and Nutrition and Nutrition and Hydration. In addition to reviewing the structure at NGH, the reporting of these incidents across UHN as a group has been aligned across these specialities.

Hospital Acquired Pressure Ulcers

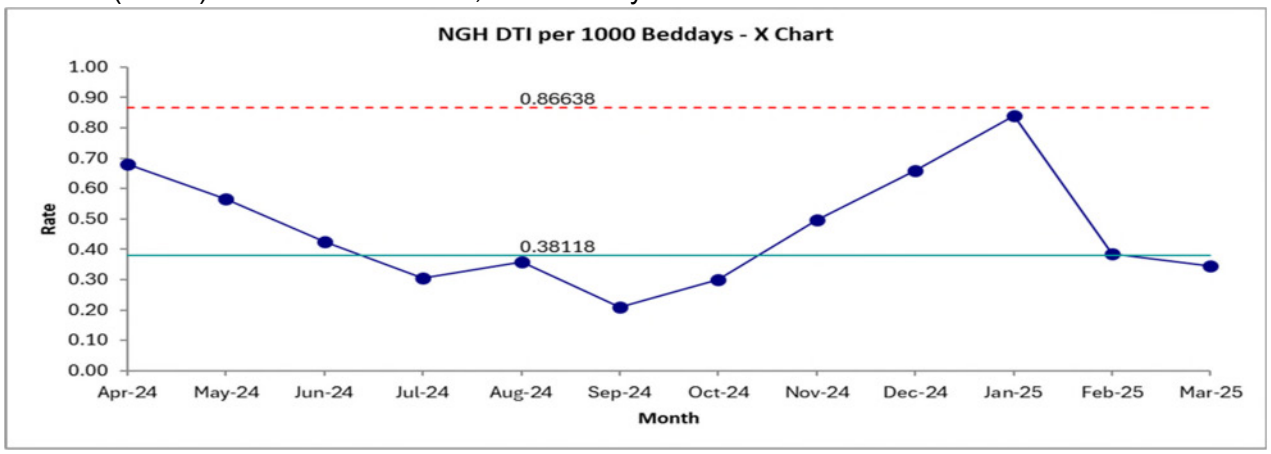
The below data provides oversight of the number of hospital acquired pressure ulcers (HAPUs) which are categorised as stage 2, 3, 4 and unstageable per 1,000 bed days sustained by patients at NGH through 2024-2025. Following alignment of reporting the monitoring of deep tissue injuries (DTIs) is now undertaken separately.

Table 1 (below) demonstrates HAPU's/ 1000 bed days



The above table illustrates a stabilising position of pressure ulcer prevention across NGH and a continued commitment to continue driving improvements to reduce harm.

Table 2 (below) demonstrates DTI/1,000 bed days



The above table illustrates an increase in DTI's over quarter 3 and an improving position in quarter 4.

Ongoing Improvement work focuses on improving staff knowledge of pressure ulcer prevention and implementing shared learning from pressure ulcer harm causation.

Inpatient Falls

The below data provides an oversight of inpatient falls incidents at NGH through 2024-2025. As part of the collaborative work to align reporting, the bed days used within this data has been amended to reflect on acute and adult bed days.

Table 3 below demonstrates all inpatient falls/ 1000 bed days

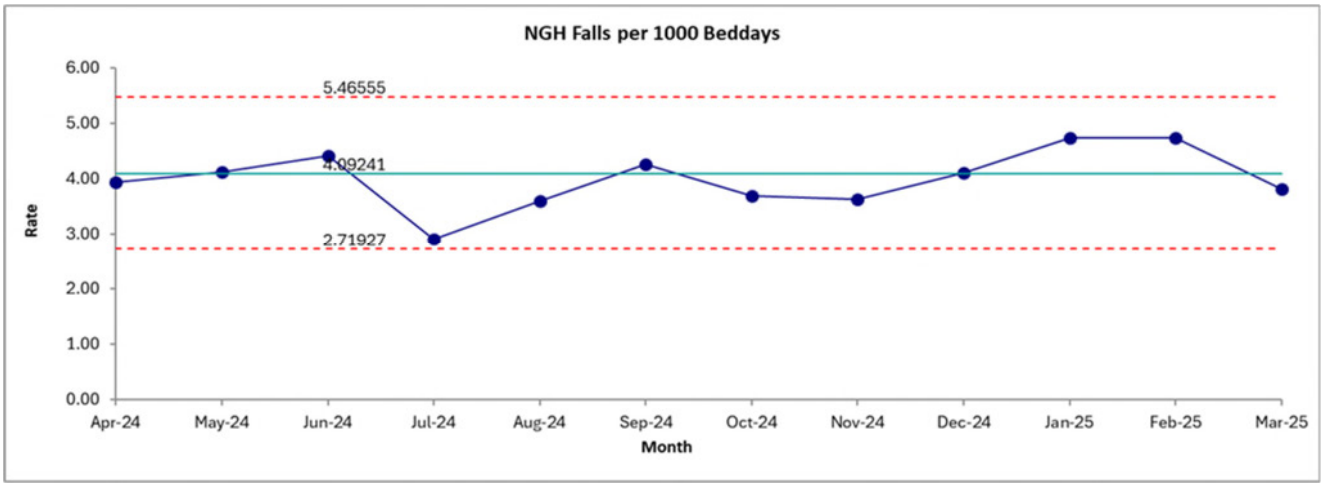
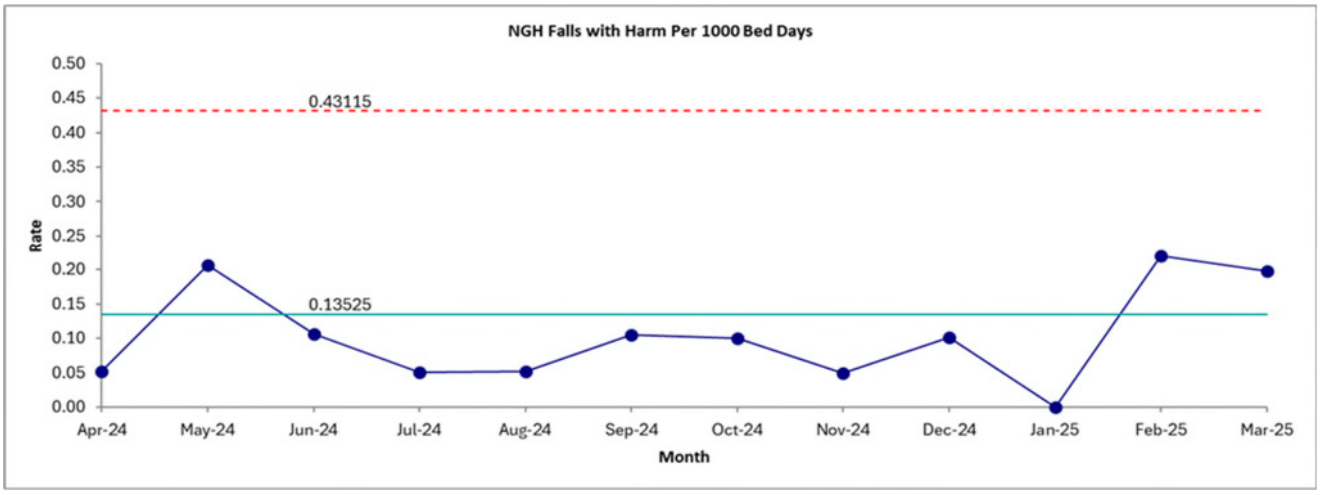


Table 4 below demonstrates falls with harm bed days through 2024-2025.

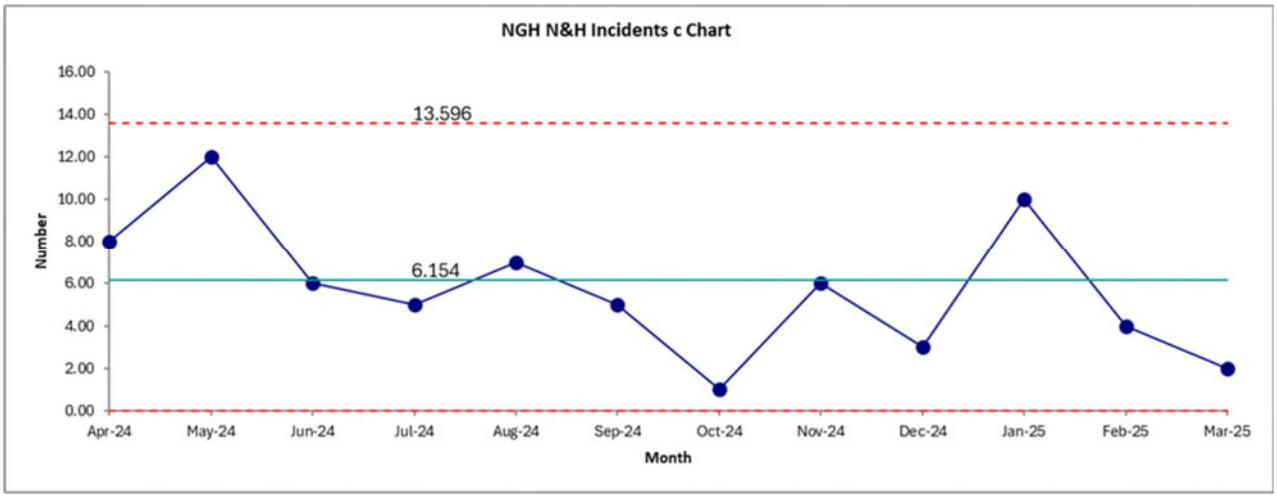


The above data in both tables demonstrates a reduction in harmful falls between June 2024 – January 2025. This improvement followed several patient safety improvements; changes to the care planning process, an introduction of yellow blankets and risk bands providing a visual prompt of patients at higher risk of falls and an improved training programme for clinical staff.

Nutrition and Hydration

The below data summarises the number of incidents per month reported for nutrition and hydration incidents at NGH. Reporting has remained in normal variance throughout 2024-2025.

Table 5 summarises the number of Nutritional and Hydration incidents per month.



Continued work is ongoing to improve nutrition and hydration to our patients and learning from incidents to drive improvements.

Infection Prevention and Control

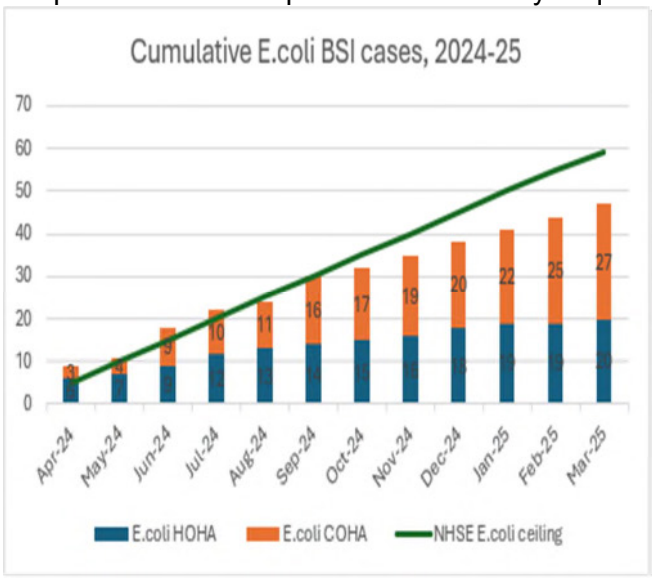
Healthcare associated infections

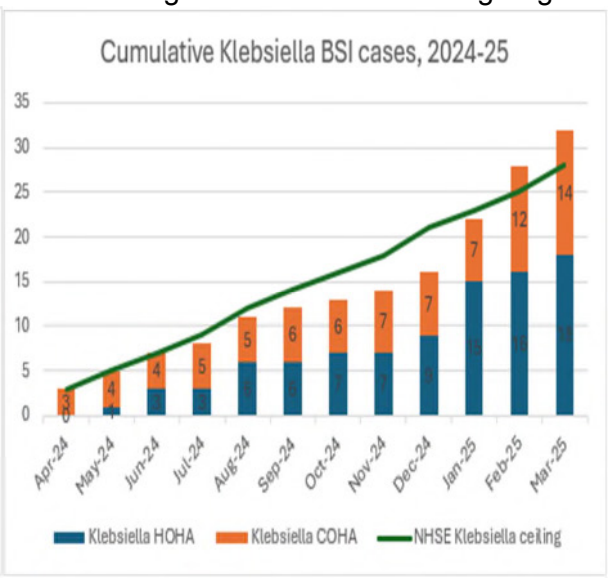
In 2024-25 the following Healthcare associated infections were identified (national standard in brackets):

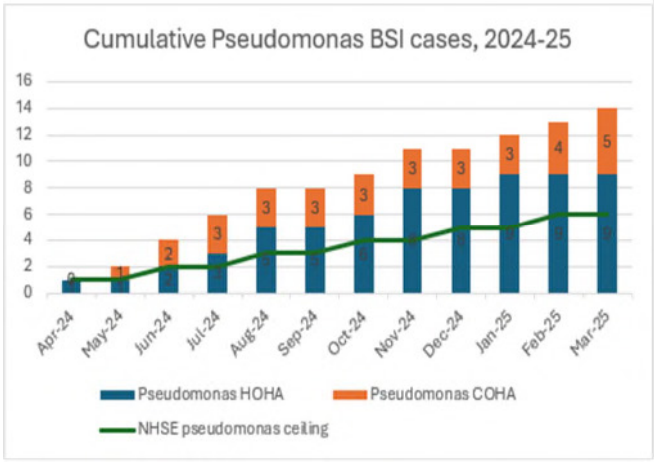
- 94 patients developed a healthcare associated C.difficile infection (93)
- 47 patients an E. coli bloodstream infection (59)
- 32 a Klebsiella spp. bloodstream infection (28)
- 14 a Pseudomonas aeruginosa bloodstream infection. (6)
- 3 MRSA (no national standard)
- 20 MSSA (no national standard)

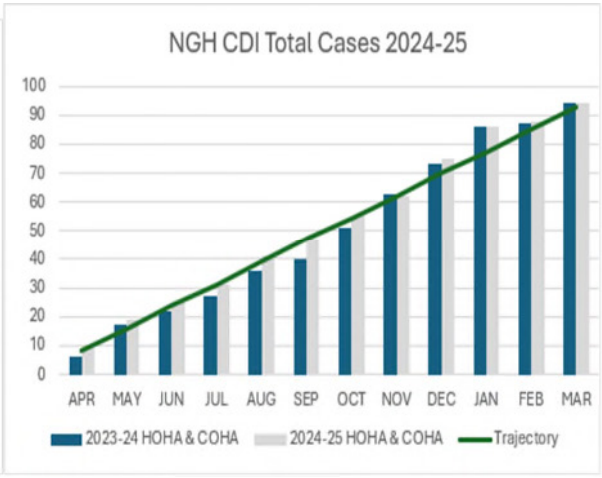
Each patient had a post infection review completed and where learning was identified this was fed back directly to the ward team, to the wider directorate at governance meetings, and across the site at the Infection Prevention Operation Group (IPOG). The graphical representation in the graphs below identify

the prevalence of hospital and community acquired infection against the national ceiling target:









On review of hospital acquired 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 implemented.

On review of Gram-negative bloodstream infections, analysis identified that over half 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.

In addition to the above interventions, an intensive cleaning programme of clinical areas within the Trust, were undertaken throughout the year, along with implementation of rolling UV decontamination of side rooms in Urgent Care. The site supported a visit from NHSE and Integrated care board infection prevention leads in March 2025. Whilst formal feedback is awaited, the peer review noted good patient care and infection prevention practices.

Next steps include the 2025-26 campaigns which will focus on hand hygiene practices and intravenous cannula management improvement strategies.

Performance against national targets

HCAI	National target	Actual number of cases
C.diff	93	94
E.coli	59	46
Klebsiella	28	32
Pseudomonas aeruginosa	6	14
MRSA	No national target	3
MSSA	No national target	20

UHN / UHL Collaborative working

The IPC Team has embraced collaborative working in 2024-25 and has developed the site-based IPC Steering Group into a UHN IPC Assurance Committee from September 2024. In quarter 3 and 4 the following site-based IPC documents have been developed into UHN documents:

- IPC Quality Improvement plan 2024-25
- IPC Quality Improvement plan 2025-26
- IPC Annual plan of work for 2024-25
- IPC Annual Plan of work for 2025-26
- IPC Annual Audit schedule for 2025-26
- Gram-negative bacteria IPC procedure
- Tuberculosis IPC procedure

Falls, IPC and Tissue Viability (FIT) Shared Decision-Making Council

The IPC Team won a Highly Commendation in the July 2024 Green Team competition for their work with the Falls and Tissue Viability Teams to implement the 'Have Confidence with Continence' improvement project to improve staff knowledge of continence aids and improve patient continence care on two elderly medical wards. The team undertook ward stock audits, observations of care, patient and staff engagement to trial new continence products and held a Confident Continence study day. As a result, staff knowledge and confidence in caring for patients' incontinence improved, patients' dignity, comfort and confidence improved and so did their experience of our hospital.

Chief Nurse Fellowship project

1. One of the IPC Nurses was successful in achieving a Chief Nurse Fellowship in November 2024. The focus of the fellowship was on evaluating the effect of decaffeinated beverages on an Elderly Medical ward over a period of six months. The results were overwhelmingly positive, illustrating significant health benefits to the patients.
2. The IPC Team have presented this work at a national IPC Sustainability conference in December 2024. The IPC Team are currently writing this work up as an article to be published in a national nursing journal and scoping out a Trust wide roll out of decaffeinated beverages.

Sustainable IPC practice

In 2024-25 the IPC Team have implemented several sustainable quality improvement initiatives:

- a new hand sanitiser across NGH that has a significantly lower carbon footprint than alcohol and a plethora of other benefits due to being alcohol-free, the main one being that it is effective against C.difficile and norovirus. This work was presented as a podium presentation at the annual national Infection Prevention Society conference in October 2024.
- The Team has also supported the innovation to implement UV-C decontamination for reusable anaesthetic masks successfully in theatres. 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 attend.
- At the end of 2024-25 the IPC Team have been instrumental in forming the Greener Nursing, Midwifery and AHP Group to work collectively to implement sustainable pathways and practices that maintain high standards of infection prevention whilst also having a positive impact on the environment. Initial projects include reusable silicone tourniquets.

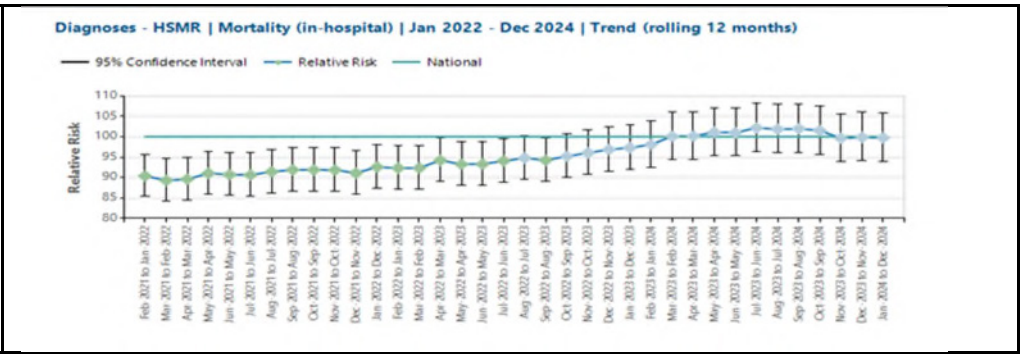
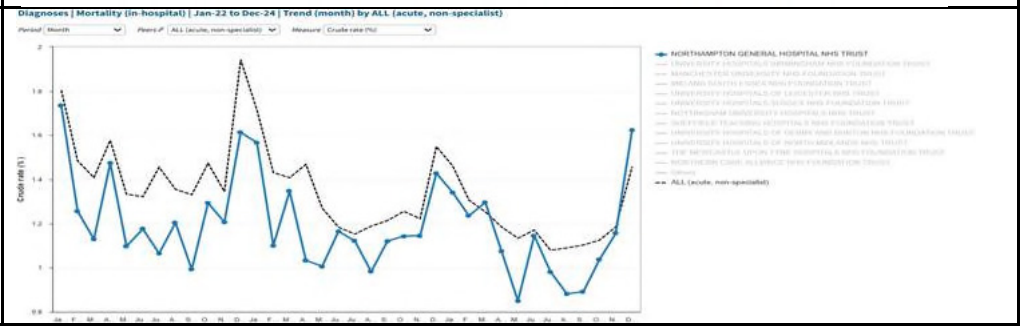
Mortality

In 2024-25 the national methodology for calculating our mortality performance metrics was updated:

- HSMR: Hospital Standardised Mortality Ratio
- SMR: Standardised Mortality Ratio
- SHMI: Summary Hospital-level Mortality Indicator

Specifically, there was a greater focus on comorbidity and frailty capture, while palliative care coding was excluded from the HSMR and SMR datasets. This had a perceived "negative" impact on our performance metrics, which increased from the "below expected" to the "as expected" range (**chart 1).**

Of note, our crude rate, except for a couple of isolated data points, has remained consistently below the national average for the past three years **(chart 2).** To provide further assurance, we triangulated our mortality data with other deteriorating patient metrics such as preventable cardiac arrests and ITU admission data. These confirmed there has been no recent change to other measures of Trust performance, and the changes are likely due to how our data is captured by clinical coding processes.

Chart 1 NGH HSMR 3 year trend (new 'HSMR+' methodology)	
Chart 2 NGH 3 year crude rate trend (blue) vs national (black)	

In October 2024 we commenced UHN Learning from Deaths meetings and now produce a monthly UHN mortality dashboard. We are in the process of aligning our respective mortality pathways and plan to rollout the mortality module (MaMR) on the AMaT database in 2025-26. Ongoing mortality reviews and a

pro-active learning from deaths / medical examiners group continue to address and investigate any mortality alerts or themes that are raised, and to share the thematic learning across the Trust at morbidity and mortality meetings.

Furthermore, in 2024-25 UHN Mortality Review Group commenced, aiming to triangulate mortality case referrals from the Medical Examiner for Structured Judgement Review (SJR), with Patient Safety Incident Referrals and Coroner referrals for Inquest.

Patient Experience and Engagement

Supporting patients and families

Patient Experience and Engagement activities and feedback mechanisms have continued to expand during 2024-25 with an increased drive to ensure the experience of patients and carers is captured and used to inform service improvements.

Hearing the voice of our patients

We offer patients and carers the opportunity to feedback both positive and more challenging experiences of their care. We employ several strategies to listen to feedback and drive improvements in the care and services we deliver. These are summarised in the following section.

Patient Feedback

The Friends and Family Test (FFT): This is a national standard survey asking patients whether they were satisfied with the care received, with a follow up question seeking reasons for the score given. The survey also asks questions relating to protected equality characteristics to ensure everyone is treated in a fair and equitable way. The question can be asked throughout any point in the patient's journey and is provided in many different formats within the Trust including, SMS text message, Automated calls, QR codes within posters and mini-postcards, postcards, and online surveys.

CQC/NHS England National Surveys: The CQC mandate a series of national surveys each year. All the published CQC surveys are shared both internally and externally. They are also presented at the Patient Carer Experience and Engagement Committee (PCEEC) meetings.

During 2024-25, CQC national survey results were published for the most recent surveys:

- The **Inpatient Survey** for patients discharged in November 2023.
- The **Urgent Care Survey** for patients attending Emergency Departments in February 2024.
- The **Maternity Survey** for patients receiving maternity services in January and February 2024.
- The **Children and Young Peoples Survey** for 2024 has been completed although the results will not be published until May 2025.

Inpatient Journey Survey (IPJ): In addition to the nationally mandated inpatient survey, the Trust also commissions its own Inpatient Journey Survey using questions from the national inpatient survey. The IPJ is sent out to 1,000 patients each month who have been treated as adult inpatients. The results are collated monthly Trust-wide, and quarterly at ward level.

Local Surveys*:* Local surveys are created through the Envoy system which is the same system used to collate the FFT. The online system allows us to create multiple surveys which can be shared via weblink and QR code. Initially, three surveys were set up to be issued via text message alongside the FFT, covering Discharge (Inpatients), the Emergency Department experience and the Outpatient experience. Subsequently, the local surveys have grown quickly, with new services participating each week.

Social Media and Online Reviews*:* Patients often look for ways to share feedback and an important communication channel is online. All feedback is reviewed and responded to.

Supporting patients to give feedback

Friends and Family Test Performance:
There is no overarching Trust wide target as the FFT targets are separate for each service. *Please note that these targets are currently under review for agreement of new aligned targets across the University of Northamptonshire Hospitals for 2025/26.*

- Inpatient wards – 89.5%
- Day case units – 98.0%
- Emergency Departments – 88.0%
- Outpatients – 94.0%

During 2024-25, the Patient Experience and Engagement team received and analysed 77,567 FFT responses across services provided to patients. The average monthly % satisfaction score achieved across the Trust for the year was 90.2% which was an overall increase of 0.4% against the performance in 2023-24.

As can be seen in the table below, every service saw an increase in their average FFT % patient satisfaction experience during the period. Additionally, the number of FFT responses has increased in all services.

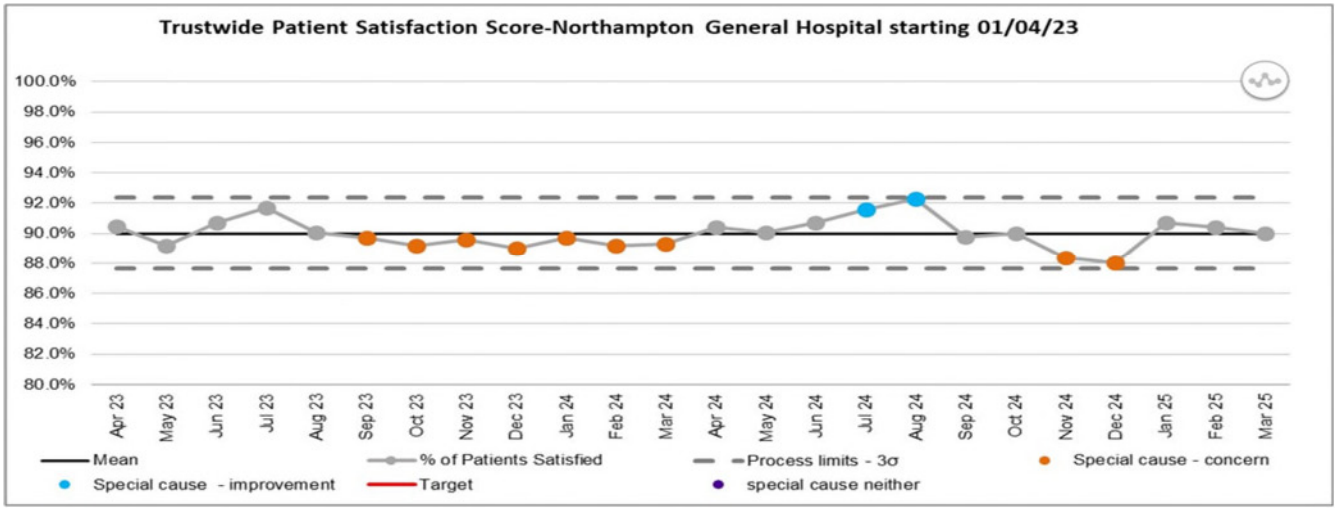
Table: Patient satisfaction via the Freedom to speak up survey.

% Patient Satisfaction via the FFT Survey	2023/24	2023/24 No. of Responses	2024/25	2024/25 No. of Responses	% increase / decrease
Inpatient Wards	92.5%	8718	94.1%	9488	1.6%
Day Case Units	96.3%	10144	96.3%	10448	0.0%
Maternity Services	95.7%	2787	95.9%	3205	0.2%
Emergency Departments	78.4%	20265	79.1%	21684	0.8%
Outpatient Departments	93.7%	32385	94.0%	32742	0.2%
Trust wide	89.8%	74299	90.2%	77567	0.4%

Satisfaction scores have remained between 88% - 92%. From April 2023 to date, satisfaction scores average 90.0%.

From September 2023 to March 2024, there is a run of 7 data points lying below the mean representing special cause concerning variation. From April 2024 to August 2024 the data points represent an upward trend in satisfaction scores. The remaining data points are lying within normal variation (common cause). However, it should be noted that the data points for November and December 2024 are lying on the lower process limit (LPL).

SPC chart Trust wide satisfaction scores:



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.

During 2024-25, the Patient Experience Team collected 42,238 comments from the Friends and Family Test responses, which is a slight decrease of 0.6% from the previous year. This was disseminated into 39,987 positive and 2,251 negative comments.

Detailed below is the split of positive and negative comments for 2023-24 (see diagram 1) and 2024-25 (see diagram 2) for comparison.

Diagram 1.

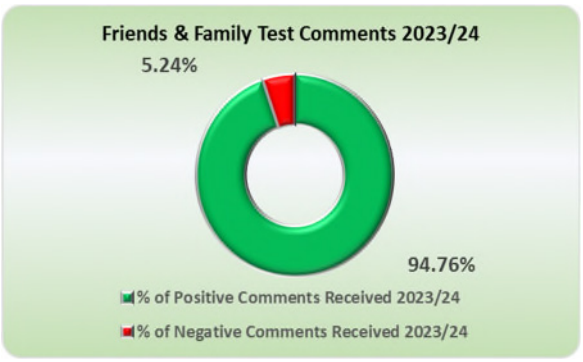
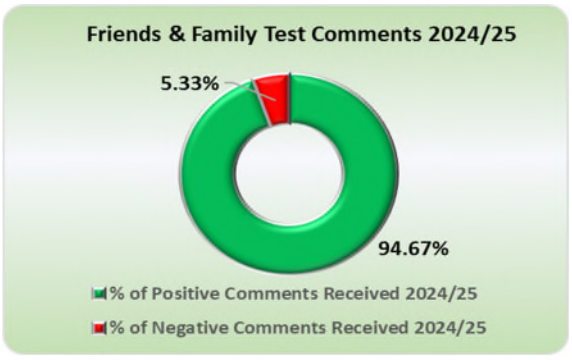


Diagram 2.



For all the 2,251 negative comments received, these were themed to inform areas of the most common reasons for this type of patient feedback.

The 2023-24 (Diagram 1) and 2024-25 (Diagram 2) yearly comparison and breakdown of the top 4 negative feedback themes is as follows:

Diagram 1

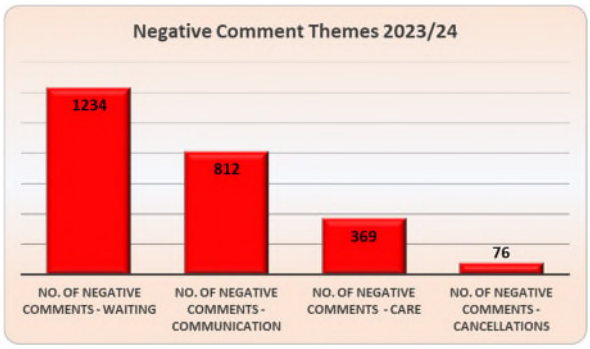
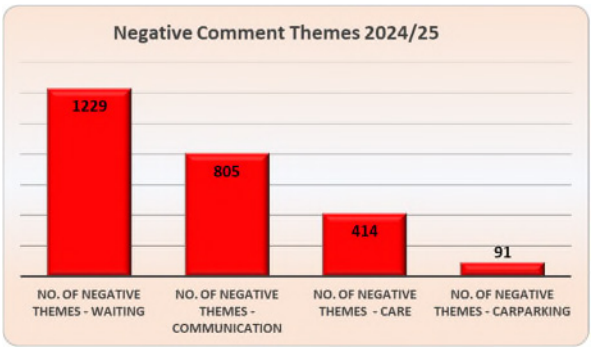


Diagram 2



Patient Experience Listening Events

Listening Events

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

Urgent Care

There was a steady increase in attendances through the year, during which COVID-19 cases required the retention of pathway changes and isolation rules within the Emergency Department (ED), and the situation exacerbated by increased ‘flu and respiratory cases.

Improvements to internal processes and collaborative working within the local health system contributed to the length of stay for patients awaiting community and social care, reducing by 12 days, comprising two days from internal processes and ensuring our patients were declared medically fit earlier in pathways, and 10 days from the system working. This was achieved through the early agreement of comprehensive packages to support pathways at the start of the year.

Additionally, the internal flow programme of activity supported the length of stay for those patients discharged home by focusing on:

- IV Antibiotics in the community
- Board rounds supporting next steps and escalating issues from doctors
- New dashboard reports, created to support visibility
- Frailty Same Day Emergency Care (SDEC) moving to extended days and
- Seven days per week working, alongside medical SDEC opening to midnight to support the ED

The winter period nevertheless saw extraordinarily high attendances in December, causing significant delays and the use of our elective capacity for the first time this calendar year (the Elective Orthopaedic Unit was used for 4 weeks this year, compared to over 10 weeks the year before).

The Trust has invested in patient safety throughout this period, including the daily deployment of medical consultants in ED to enable earlier patient assessment.

Haemoglobinopathy Quality Improvement Programme

The Head of Patient Experience and Engagement and the Equality, Diversity and Inclusion Patient Liaison Officer have supported the Haemoglobinopathy Quality Improvement Programme throughout 2024-25 with attendance at various events for patients and families affected by Sickle Cell. See events below:

- Attendance at the Northamptonshire Carers ICAN Patient Advisory Group meeting alongside other leads from NGH to provide a full update of progress to date and future planned actions.
- Meeting with the Trustee for Northamptonshire Carers and Governor for Northamptonshire Black Communities Together (NBCT)
- Representing NGH with a stand and participating in the 'Living Well with Sickle Cell Fun Day organised by Northamptonshire Carers organisation.
- Reaching out to join community events such as the Northamptonshire Carers Sickle Cell Youth Club event.
- Hospital Attendance at the World Sickle Cell Day staff awareness event held at Kettering General with representation by people living with Sickle Cell and their relatives.
- NGH EDI Patient Liaison Officer attendance at the 'Living Well with Sickle Cell 2024'
- Collaborate working with Health Watch, Northamptonshire Carers, Northamptonshire Integrated Care Board

Staff Training

- The Patient Experience and Engagement team have delivered 25 staff training sessions to 403 staff during 2024-25 to raise the awareness of the importance of improving patient experience. The sessions are tailored to the specific staff group and adapted as new themes occur during the year.
- This process also facilitates shared learning and celebrating successes.

See table summary below for Patient Training Experience Sessions for staff:

Training	Number of attendees
Student Nurse Induction	**152**
Preceptorship	**110**
Medical Development and Leadership	**45**
Evidence-based Practice	**41**
Shared Decision-making Council	**31**
Chief Nurse Fellowship	**13**
Royal College of Nursing Leadership	**11**
Total	**403**

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 these video and digital patient stories. During 2024-25 the following stories / videos were created and used:

- Jane's Story: An example of a positive maxillo-facial surgical experience
- Nigel's Story: An example of a success story of a patient using the Smoking Cessation team.
- Emergency Department. An example of patients experiences in the department over the winter.
- Gabby's Story: An example from a Trauma and Orthopaedic patient from their emergency admission to their recovery.

- Daniella's Story: An example of a patient staff member using NGH maternity services.
- Daniella's Story: An example of a patient staff member using NGH maternity services.
- Emma's Story: : An example of the support that the Play Activity Team provide to paediatric inpatients at NGH
- Jade's Story: Maternity Induction Experience.

The following patient experience videos are used as part of the Patient Experience training sessions for staff to raise awareness of the impact of both positive and negative experiences:

- Aimee's Story: An example of a negative experience for people living with autism.
- Kirstie's Story: An example of a positive experience for people living with autism.
- Pete's Story: A negative example of a patient living with Early Onset Dementia.
- Howard's Story: A negative example of the lack of pain relief support following an inpatient discharge.

Moving forward

The activities of the Patient Experience and Engagement team have expanded significantly during 2024-25 with greater collaborative working across UHN and external organisations. This is due to the increased focus on ensuring the experience of patients and carers is captured and used to inform service improvement. Further patient and carer listening events are already planned for April, May and June 2025.

Management of Complaints

We are committed to listening and responding to patients, encouraging a culture that seeks and uses their experiences to improve our services. We recognise the need for a clear and accessible process for patients, their families, and carers to provide feedback about their experiences. Compliments, comments, complaints and concerns from patients, carers and the public are encouraged and welcomed. Should patients, their relatives, carers or friends be dissatisfied with the care provided by NGH we ensure they these are reviewed, and their concerns are dealt with promptly, efficiently, and courteously.

When someone expresses dissatisfaction with the services provided by the Trust, with a request that the issue(s) are investigated, all such matters are managed either formally through the Complaints Teams, or through local resolution with the support of our Patient Advice and Liaison Service (PALS). We ensure that our teams know and comply with all relevant legislation, make information available in a format that people understand, make sure everyone knows when a complaint is stratified as a serious incident, legal issue or safeguarding and what action must be taken. All team members are strongly committed to duty of candour and there is a culture of being open and honest should something go wrong and that we listen and learn from complaints to improve services.

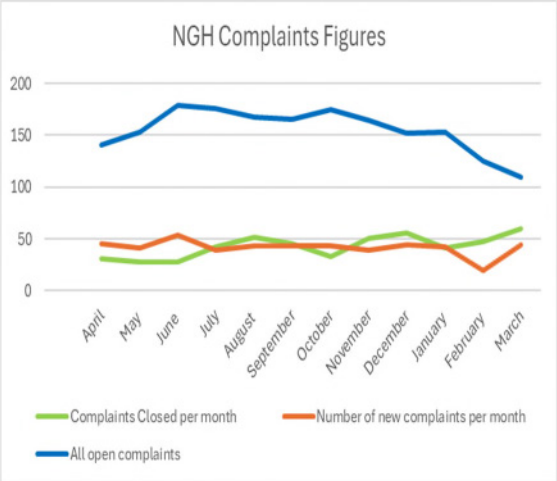
The information detailed below provides a summary of complaints received and investigated at NGH.

	NGH
Total no of complaints for the year **2024-25**	506
(Versus 2023-24)	(533)
Percentage change from 2023-24 to 2024-25	<6 %
Total % of complaints responded to within 60 days	12%
Total number of complaints responded to 61 days and above	444
Average response rate over the 12-month period	13%
Complaints that were still open at the time that the information was prepared (April 2025)	143
Total patient contacts/episodes*	957,069

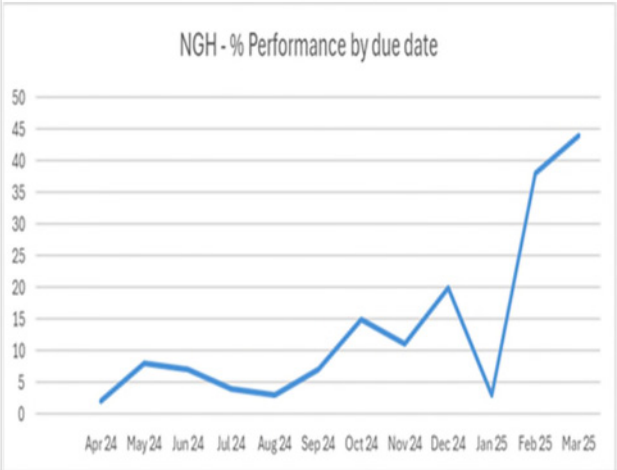
Percentage of complaints versus number of patient contacts/episodes	0.05%

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 improvemens in compliance over the last two months. The graphs below illustrate an improving position with an increase in complaints closed and overall percentage performance:

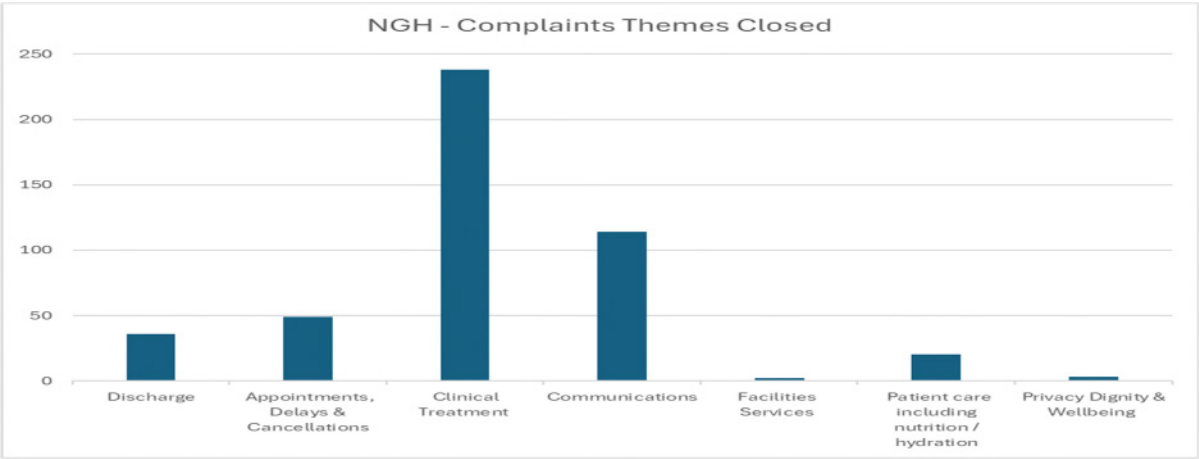
Graph 1



Graph 2



The table below illustrates complaint themes:



Clinical treatment and communication remain the main causes of complaints raised which are shared both locally and as a Trust for shared learning.

What we achieved in 2024/25 to improve complaints management:

Subject:	Commentary:
Joint working	The complaints teams have been working closely with KGH to streamline their internal processes. This includes: • Shared templates • Joint reporting • Use of Datix reporting system

Reporting / Committees	Complaints information is discussed / presented through the following committees: - UHN Nursing, Midwifery and AHP Committee - UHN Quality and Safety Committee - UHN Patient Carer Experience and Engagement Committee
Digital Letters Process	The Complaints teams across UHN have implemented a fully digitalised solution for letters of response which require Executive review and sign off. There has since been a significant improvement within the final sign off process.
Learning from Complaints	Datix is used to capture all learning from complaints. This information is then shared with the divisional teams for chasing updates on actions, process to continue to overcome any actions overdue (older than 3 months). A learning report has been created which is currently under review which will provide a UHN overview of the learning moving forwards.

Martha's Rule

Implementing Martha's Rule at Northampton

Introduction

In April 2024, the project team at NGH transitioned from being one of the seven pilot sites for the national Worry and Concern collaborative to being one of the 143 sites for the phase one of the implementation of Martha's Rule. The overarching aim of year one was that by March 2025 we would have tested and implemented systems and processes to meet all three components of Martha's Rule. Areas that are not mandated for phase one include Neonates, Maternity, and the Emergency Department (ED).

The project is overseen by Health Innovation East Midland (HIEM) and internally by the Deteriorating Patient Operational Group (DPOG) and we work very closely with our colleagues at KGH. The project team continue to showcase the work at NGH at both regional and national forums. This has included webinars and conferences including Confed.

Component One - The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist Trusts.

- A trial has been completed on five adult wards using a more simplified questionnaire. The potential deterioration of patients was not identified but themes such as pain management were identified and addressed.
- Separate Patient and Staff engagement events have influenced the design the next version to be used on all adult inpatient wards.
- The new National Paediatric Early Warning Score (NPEWS) charts include a prompt to discuss any concerns, have been used on the paediatric wards since November 2024.
- National Maternity Early Warning Score (NMEWS) – a project team support has been set up to support stakeholder meetings for rollout across maternity at NGH

Component two - All staff in NHS Trusts must have 24/7 access to a rapid review from a Critical Care Outreach Team (CCOT) who they can contact should they have concerns about a patient.

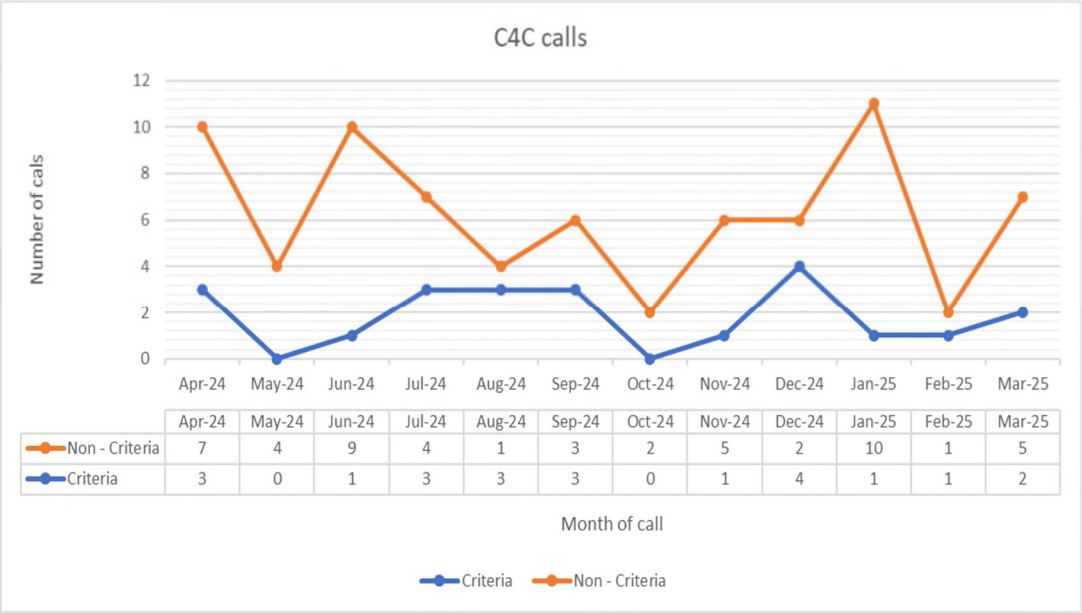
- Call for Concern© has been in all adult inpatient areas since May 2023 and introduced in Maternity and Paediatrics including neonates from July 2024

Component Three - All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a CCOT, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition.

- Call for Concern© was rolled out in May 2023 across all adult inpatient areas, excluding maternity. Patient and relatives or carers can call a mobile phone number that is held by our adult CCOT. There are inclusion criteria, such as the concern must relate to deterioration and have been raised to the ward staff prior to the call.

- Call for Concern© was launched in paediatrics and maternity on 22nd July 2024. There has so far been one call from paediatrics that met criteria with a good outcome. There have been no calls from neonates and maternity.

Graph below demonstrates the number of C4C calls



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Non - Criteria	7	4	9	4	1	3	2	5	2	10	1	5
Criteria	3	0	1	3	3	3	0	1	4	1	1	2

Next Steps

- To work closely with KGH, to continue to submit data to NHSE project portal and contribute to shared learning events
- Identify improvements and adaptations required for patients who may find communication a challenge.
- To await national guidance and consider the resources required to expand Call 4 Concern© into the Emergency Department,

Assessment and Accreditation

During 2024-25, significant progress has been made in the implementation of the Assessment and Accreditation (AandA) Programme at Northampton General Hospital (NGH). All adult and paediatric inpatient wards have now been successfully assessed, alongside several key outpatient areas including the Same Day Emergency Care unit (SDEC) and Discharge Suite. The Emergency Department continues to receive ongoing support through regular assessment and targeted development initiatives.

A major milestone during this period was the successful rollout of the Assessment and Accreditation framework to the Maternity Department, marking a crucial step in expanding the reach and influence of the programme across a broader range of clinical services.

The framework will be introduced to Theatres in 2025, further demonstrating our commitment to driving continuous quality improvement throughout the Trust.

Throughout the year, we've witnessed outstanding engagement from clinical teams and ward and department leaders. The framework has been embraced not just as a tool for assessment, but as a powerful driver for professional growth and service improvement. Many ward leaders have used it to strengthen their leadership skills, foster open communication with their teams, and develop meaningful, sustainable improvement plans. This proactive approach has already led to measurable improvements in both patient and staff experience, as departments use their accreditation outcomes to promote a culture of excellence and continuous development.

Where departments have demonstrated sustained improvements, their achievements have been recognised and celebrated across the organisation, with formal certificates awarded to acknowledge their success. In areas requiring further support, we have continued to work very closely with our Quality Improvement coaches, who collaborate with local leaders to develop comprehensive action plans. These plans are closely aligned with the Trust's overarching Quality Improvement agenda and the CQC action plan, ensuring our services remain safe, effective, and compassionate.

Looking to 2025, the Assessment and Accreditation Lead across University Hospitals of Northampton (UHN) will launch a new unified Assessment and Accreditation Programme in alignment with our partners at University Hospitals of Leicester (UHL).

Pathway to Excellence

Northampton General Hospital became the first UK organisation to achieve a second designation for Pathway to Excellence. The Pathway to Excellence model focuses on six standards, providing a cohesive framework for nurses and midwives which has been operationalised across NGH:

1. **Shared Decision-Making (SDM)**:
    - 63 SDM councils across UHN- 46 at NGH and 17 at KGH
    - Projects focusing on improving patients and staff experience
2. **Leadership**
    - Chief Nurse fellow programme now running across UHN
    - Leading an Empowered Organisation programme rolled out across UHN
3. **Safety**
    - Professional Nursing Advocate (PNA) support now offered to all staff who report incidence of violence and aggression
4. **Quality**
    - Roll out of N-LEAF (Northampton-Leicester Excellence Accreditation Framework) Programme across UHN to commence in 2025
    - Evidence Based practice course for Nursing, Midwifery and Allied Health Professionals continues
5. **Wellbeing**
    - PNA-to-Registered Nurse ratios at 1:37 at KGH and 1:26 at NGH
    - Continued roll out of the Daisy and Rose recognition Awards
6. **Professional Development**
    - Comprehensive portfolio of professional development supported internally and externally
    - CNO Fellow programme

As a result of the above, NGH has also been significant contributors to the DEFiNE study and published as an exemplar case study in the associated E-Book. The link to the e-book is as follows

DEFiNe Case Study e-book

NHS England Midlands

NHS University Hospitals Coventry and Warwickshire NHS Trust

Shared decision-making for staff empowerment: Promoting inclusion and demonstrating value at Northampton General Hospital

Overview

In 2016 Northampton General Hospital NHS Trust launched the shared decision-making (SDM) councillor model. Direct care staff can take part in unit-specific, specialty, or themed councils; as a council, they are empowered to make decisions improving care delivery, safety outcomes, and the care environment, for the benefit of teams, patients, and their families. Council membership has expanded from nurses and midwives to include multidisciplinary colleagues.

Successes and outcomes

Improving the environment

The Neonatal Council successfully obtained funding through the hospital charity and used this to develop a breastfeeding room for parents.

Improving sustainability

To support the sustainability agenda, the Falls, Infection Control, and Tissue Viability Council introduced new incontinence products. They visited ward areas and delivered training to support product roll-out.

Driving Equality, Diversity, and Inclusion (EDI)

The Internationally-Educated Staff Council introduced Cultural Awareness Day to celebrate diversity. The council is actively involved in driving forward EDI initiatives within the organisation.

Key enablers

- An SDM Facilitator delivers training which includes principles of organisational development, QI, and leadership. Council members have protected time each month for SDM. These experiences provide professional development opportunities and support career progression.
- The CNO is engaged. The CNO chairs the bi-monthly Leadership Council, a meeting with all council chairs across the Trust, and feeds council activity through the committee structure into Trust Board.
- Each Non-Executive Director of Trust Board joins a council as a member; they attend meetings and participate in projects. This increases the visibility of SDM, demonstrates its value in action to Board members, and promotes a non-hierarchical approach to decision-making.
- SDM is widely celebrated across the Trust and embraced in EDI initiatives. Because the Trust values SDM as a methodology for staff empowerment, staff from different roles and backgrounds feel psychologically safe to voice ideas and contribute to decision-making.

Key learning points

- Training integrating organisational development, QI, and leadership enables councils to work together to improve outcomes; these experiences support professional development and career progression.
- Engagement from the CNO and Trust Board is key in promoting the visibility and value of SDM.
- Through a culture of celebration and inclusion, staff feel safe using their voice to make decisions.

"SDM has really influenced our organisation's culture about the importance of staff empowerment … When we show staff that we value their voice, it creates psychologically safe spaces so staff can speak up and be involved in the decision-making process."

Strategy:

The previous Nursing, Midwifery, and Allied Health Professionals (NMAHP) strategy expired in late 2024, necessitating the development of a new strategic framework across UHN. The new strategy represents a unified commitment across UHN to delivering excellent care, fostering a positive working environment,

and strengthening partnerships for better health outcomes. This proposed strategy outlines key objectives for the 2025-2028 period, focusing on 4 key strategic themes:

1. Provide Excellent care for All
2. To create a positive practice environment for staff to work in
3. Partnerships for impact across UHN
4. To provide NMAHP's with an excellent educational experience

Within the strategy, each objective has been allocated a group of responsible persons to ensure their delivery in a timely manner. To ensure accountability and progress, governance will be maintained through a structured reporting framework.

Leading an Empowered Organisation (LEO)

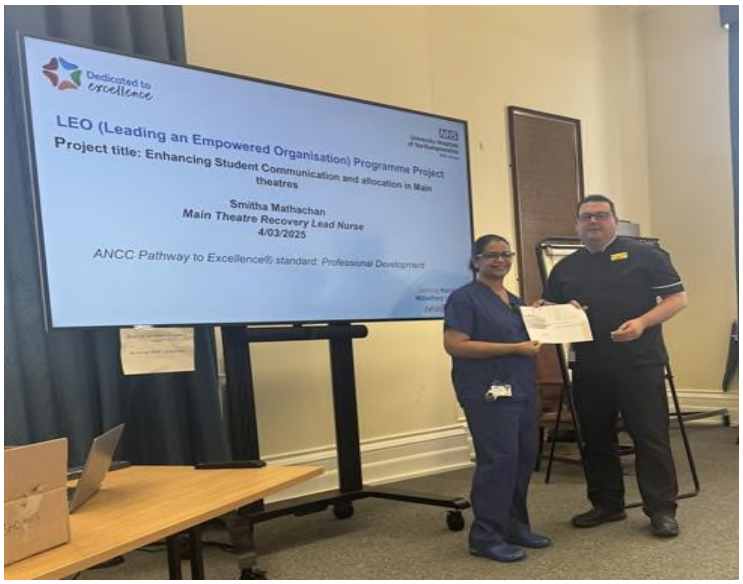
The Leading an Empowered Organisation (LEO) course at UHN is a dynamic leadership development programme designed to support individuals in fostering a culture of empowerment, accountability, and compassionate care within healthcare settings. By the end of 2025, Northampton General Hospital (NGH) will have trained 375 staff members through this impactful course, with six facilitators already fully signed off to deliver the programme. At Kettering General Hospital (KGH), six facilitators are currently progressing through the sign-off process, with plans to train 150 participants. The course combines practical leadership tools with reflective practice, equipping staff to lead with confidence and inspire positive change across their teams and departments.

The course is structured around key modules that build core leadership capabilities relevant to the NHS environment. These include: Understanding Empowerment, which explores the importance of autonomy and trust in teams; Leadership Styles and Emotional Intelligence, helping participants understand their impact as leaders; and Effective Communication, which focuses on active listening, assertiveness, and feedback. Other modules cover Decision-Making and Accountability, Coaching and Mentoring Skills, Conflict Resolution and Difficult Conversations, and Leading Through Change. Each session is interactive and grounded in real-world application, ensuring participants leave with tools and strategies they can immediately apply in their roles.

Participants undertake a project as part of the programme which includes:

- Improving patient identification checks in the outpatient setting
- Increasing safeguarding checks in the ED when English is an additional language
- Reduction of gossip through the introduction of the commitment to my colleague's card in Critical Care

- Improvement of post-natal handover



Shared decision making (SDM)

SDM is a fundamental standard in the Pathway to Excellence Framework, at which colleagues come together from a range of teams and clinical disciplines to make changes which enhance patient outcomes, staff engagement, professional autonomy, and interdisciplinary communication. UHN has committed to embedding SDM across the organisation to meet ANCC standards for Pathway to Excellence designation at both NGH and KGH.

Both organisations have developed SDM through a councillor model, establishing new clinical and non-clinical councils to strengthen collaboration and best practice sharing. NGH has operated SDM councils for eight years, with approximately 46 councils, while KGH launched SDM in 2022 and currently has 17 active councils, with plans for expansion.

Projects have included:

Patient Wellbeing and Environment:

- Stroke: Terrabike purchased to support patient mobility.
- Talbot Butler Ward: Garden project and streaming access in progress.
- Hawthorn and Althorp Wards: Quiet rooms completed/fundraised.
- Paediatric ED: Bay update for newborns; sunflower competition planned.
- Elderly Care: TV installation, stable tables to prevent falls, sunflower competition.

Staff Appreciation and Safety

- Practice Development: Wellbeing cards, keyrings, gift bags.
- Spencer Ward: Staff safety project (VARG) underway.

Fundraising and Awareness

- Maternity: Selling knitted items and running a tuck shop.
- Finedon Ward: World Kidney Day awareness.
- Eleanor Ward: Birthday Club for patient celebrations.

Facilities and Comfort Improvements

- ENT: Breastfeeding room development.
- Endoscopy: Microwave added, games for team engagement.

Learning and Leadership

- International shared decision making: Empowerment workshop.
- Student Midwifery Council: Student recognition award.

Professional Nurse Advocate (PNA)

The Professional Advocate programme at UHN continues to make significant progress, with both Northampton General Hospital (NGH) and Kettering General Hospital (KGH) advancing well towards the national target of a 1:20 Professional Nurse Advocate (PNA) to Registered Nurses ratio by March 2025. The programme has also taken important steps in integrating Allied Health Professionals (AHPs) into its scope, expanding the reach and impact of professional advocacy across disciplines.

Key Achievements

- **Exceeding Regional Progress**
  UHN is ahead of regional benchmarks, with current PNA-to-RN ratios at 1:37 at KGH and 1:26 at NGH. Both sites remain on track to achieve the national 1:20 target, demonstrating strong engagement and delivery.

- **Expansion to Allied Health Professionals (AHPs)**
  The programme has successfully begun to include AHPs in advocacy initiatives, promoting multidisciplinary wellbeing and career development, despite the absence of national funding for AHP PNA training.
- **Positive Impact on Workforce**
  The programme is contributing to improved staff retention, reduced sickness rates, and stronger workplace culture. Regular restorative sessions and career conversations are actively supporting staff wellbeing and professional growth.
- **Collaborative Development**
  UHN is working across the local health system to develop a shared Professional Advocate strategy, establish standardised guidelines, and prepare for a Trust-wide Professional Advocate Conference in June 2025, further strengthening alignment and visibility.

Pastoral Support for the Internationally Educated Nurses

Professional development

To support staff professional development, Pastoral support services in collaboration with the International Shared Decision-Making Council; planned and facilitated a Career Day for international staff that was attended by 40 staff, empowering international staff on pathways to access available resources in the Trust for career development, an increased satisfaction in progressing, thereby improving patient safety and the ward/department environment.

Leadership:

Pastoral support services have supported international colleagues by co-facilitating the Levelling Up programme. This programme is designed to support international staff to develop their leadership skills, assist interview preparedness for leadership positions and signposting to development programmes to increase knowledge and competency.

Safety

Pastoral services support safety and well-being of staff by doing daily well-being checks on staff in their place of work and escalating common themes to the relevant management teams and giving staff support on how to address their concerns by planning and facilitating safe confidential spaces. Visible Pastoral support and awareness of accessible support encourages staff to feel safe to reach out and speak up; thereby receiving the necessary support. The pastoral service network and give input to staff networks and groups such as Violence and Aggression to ensure the safety of staff.

Wellbeing:

The Pastoral service supports the onboarding of international staff to feel welcome at NGH. They ensure that staff have airport pick-up, accommodation and essential groceries on arrival, orientating them to the town and hospital, GP registration, setting up bank accounts. This helps international staff to integrate, build strong foundations and community. In addition, staff were introduced and 'buddied' with substantiate staff from their country of origin and culture.

To encourage inter- hospital staff networking, Pastoral and Pathway to Excellence services facilitate 1st Christmas in UK celebration of NGH international recruits with international recruits from Leicester Glenfield Hospital. Some of the international staff have forged friendships from their visit.

To bridge the gap for staff integration and combat loneliness within the Trust, Pastoral Support services planned a Walk and Talk in the park event for all staff and their family at NGH in March 2025. The goal was to encourage friendships, share interests and hobbies, their children were able to interact and forge friendships. The event was successful, despite the cold weather and staff that attended, shared their experiences with other staff. Future events are being encouraged to build positive relationships and community.

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From October 2024, the UHN ETOC team have been supported by UHL's enhanced patient observation team, helping to steer the collaboration and strategic direction of ETOC across UHN.

Summary of achievements:

Operational Improvements

- Agency HCA usage at NGH ceased as of September 2024.
- Out-of-hours shift creation (19:30–07:00) discontinued.
- Implementation of a new referral and assessment process,
- Reduction in ETOC shifts by 55.82%

NHS England Collaborative

- NGH accepted on the NHSE ETOC Collaborative launch – October 2024.
- NHSE ETOC team visited NGH on 09/12/2024.
- UHN ETOC team presented to Sheffield NHS Trust during their site visit (February 2025).

Performance Analysis: Operations

Introduction

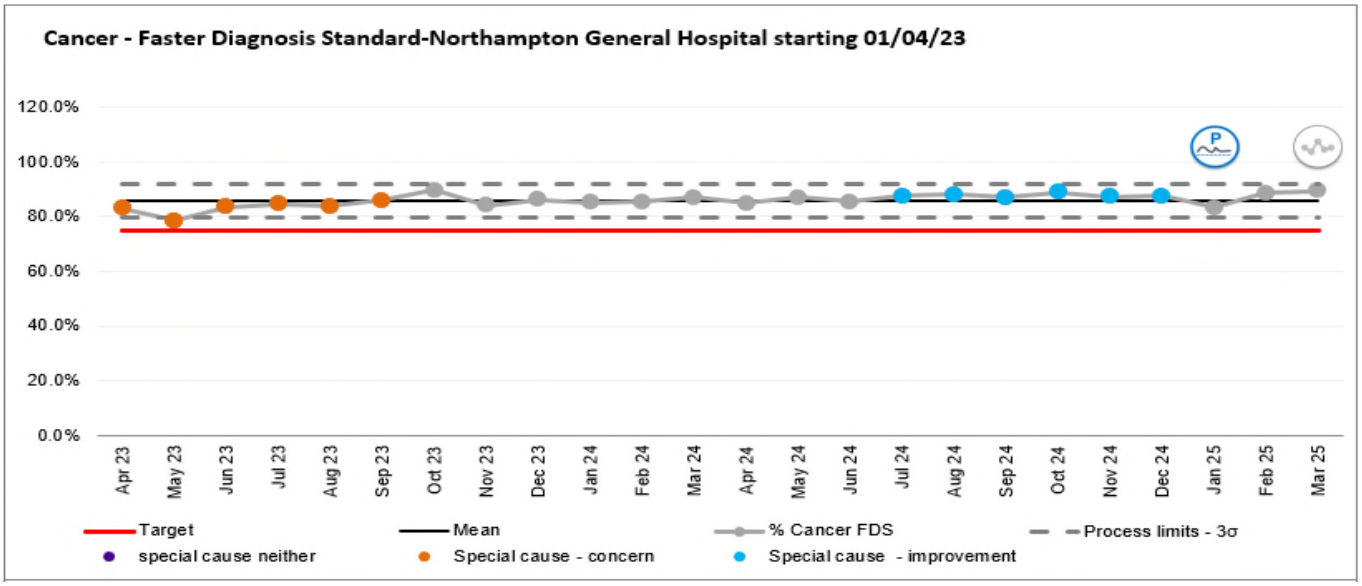
This section summaries the Trust's performance against key national operational standards for elective/planned care, including cancer treatment, and urgency and emergency care (including A&E).

Cancer

We aim to ensure patients are given a diagnosis to confirm or exclude cancer as quickly as possible (Faster Diagnosis: 77% within 28 days), to enable patients treatment to be commenced in less than 62 days from referral (national target 70%). NGH has frequently exceeded the national average across the three cancer standards this year, leading the country as a system for Faster Diagnosis and we have hosted conversations with other Trusts to share our success and learning this year.

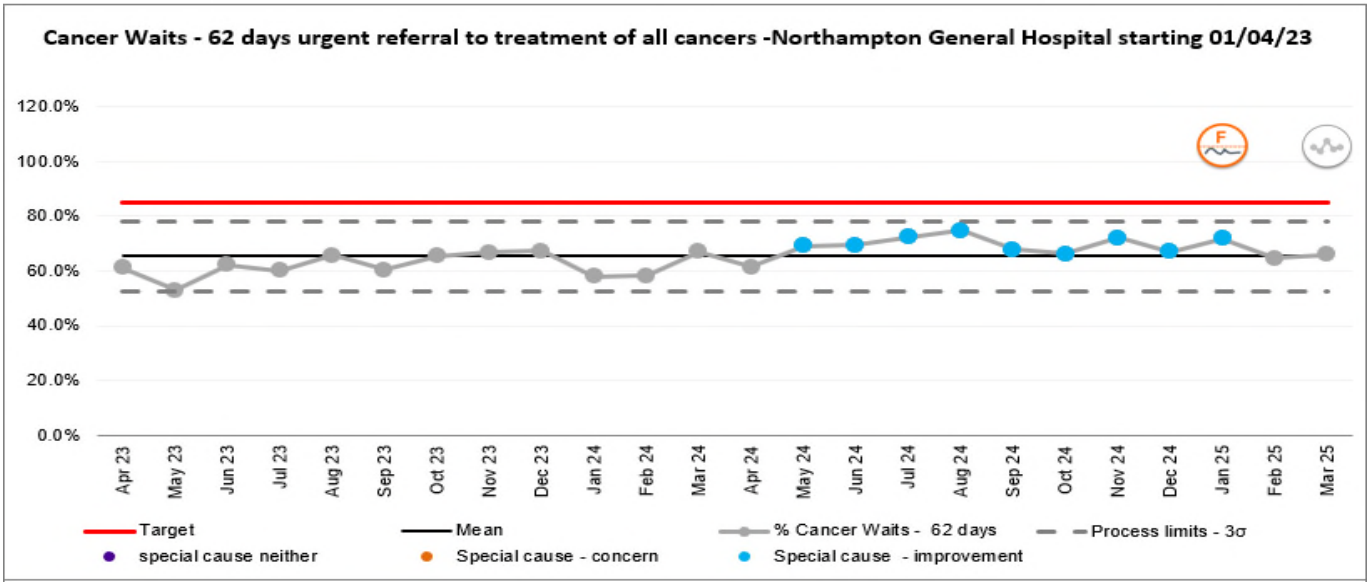
Cancer: Faster Diagnosis

We aim to ensure 80% of patients have a diagnosis or the all-clear within 28 days of referral; although the national target was 77%, we set a more ambitious internal target. We have consistently met this standard across the year, even through winter when performance is historically more challenged.



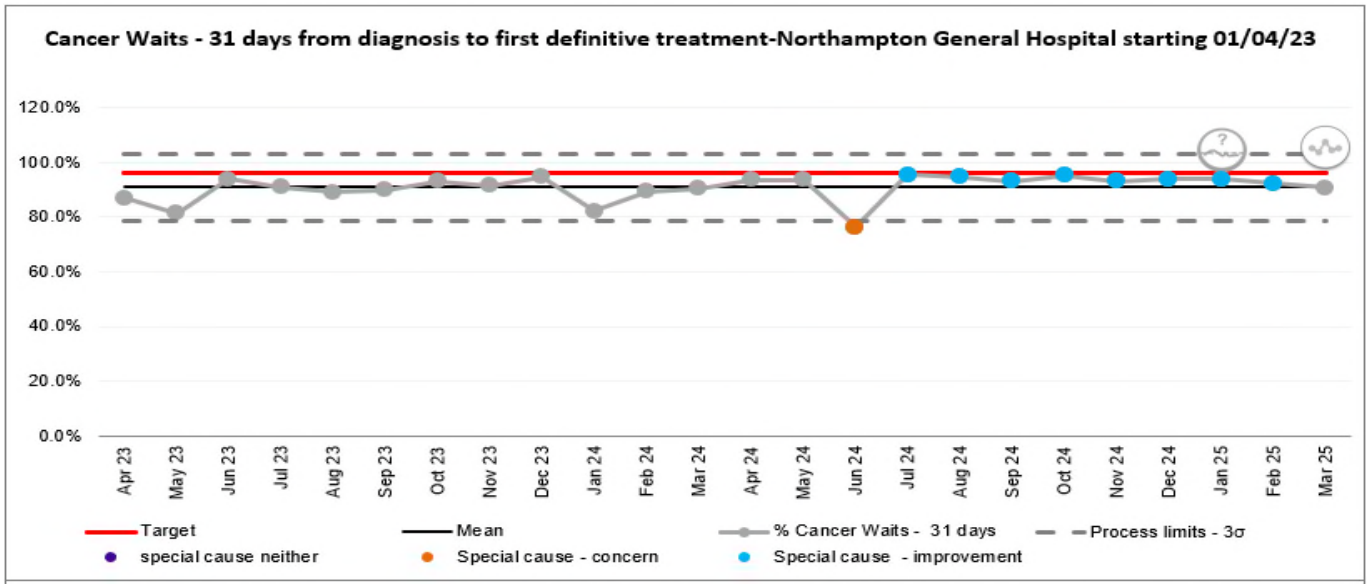
Cancer: 62-day Referral to First Treatments

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. NGH has achieved this target over the past year, which is a significant improvement from the previous year. This improvement has been supported by embedding national best practice timed pathways and a focus on reducing our long waiters. We have achieved a 42% reduction in patients waiting beyond 62 days for treatment in the past year, the Trust has also supported the Midlands with provision of robotically assisted radical prostatectomies and mutual aid for head and neck to UHL.



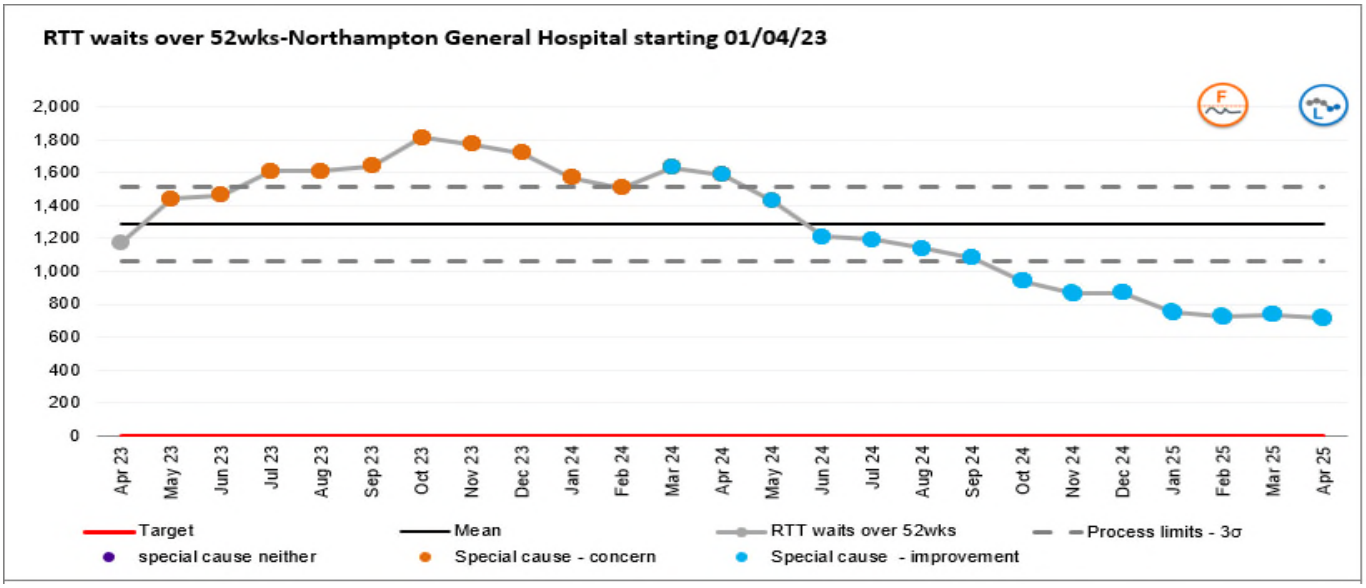
Cancer: 31-day Treatments

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 2024-25, but is a good indicator of progress to meet the 62-day standard. We have not been able to meet this target this year. Theatre availability and diagnosis of cancer times has impacted performance, but we have identified targeted improvement plans for 2025/26, as part of our oversight of theatre booking.



Referral to Treatment (RTT)

My March 2025, there were 27 patients waiting longer than 65 weeks and we had reduced the number of patients waiting more than a year from 1,633 on 31 March 2024 to 742 on 31 March 2025. To ensure equity for patients across Northamptonshire, from April 2024 we have transferred a number of long waiting patients to Kettering General Hospital. The national target for 2025/26 is to ensure that less than 1% of the RTT waiting list wait more than 52 weeks.



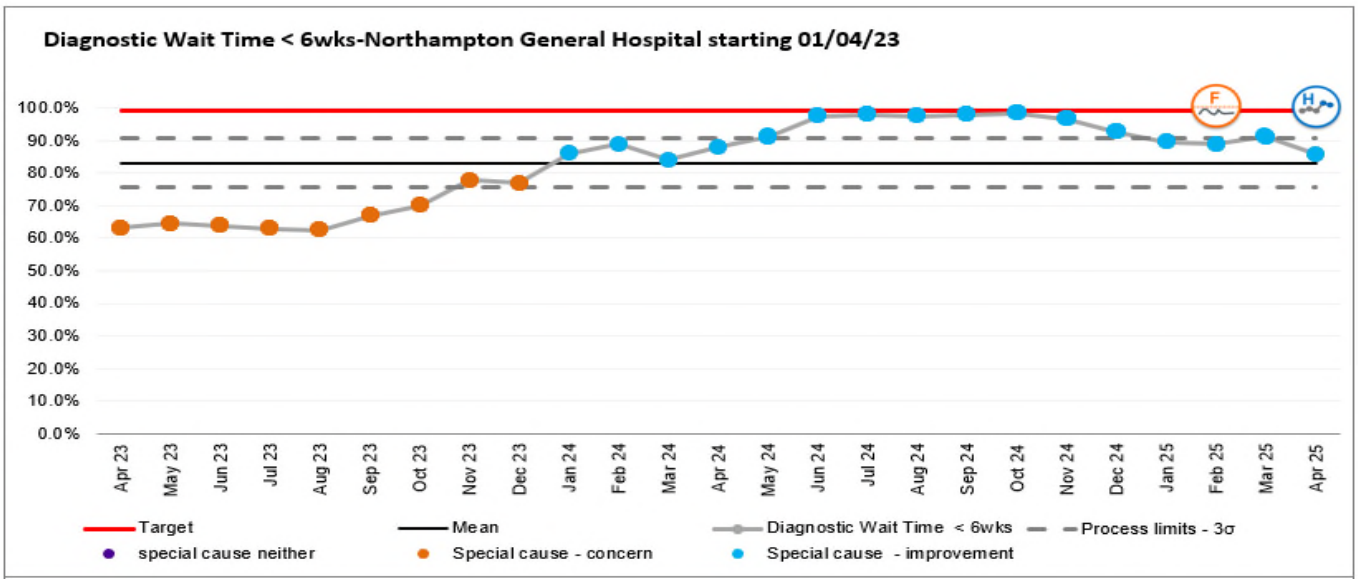
Note: Long waits targets are based on operational planning guidance for 2024/25: [NHS England » Priorities and operational planning guidance 2024/25](). The data includes patients referred to consultant led pathways only.

Wait List Size

The overall number of patients who have been referred and are awaiting their initial treatment to start has remained fairly stable over the year. In order to improve performance in 2025-26, we will need to see the size of the waiting list reduce, through looking at clinical productivity and greater work with primary care on advice and guidance and alternative pathways.

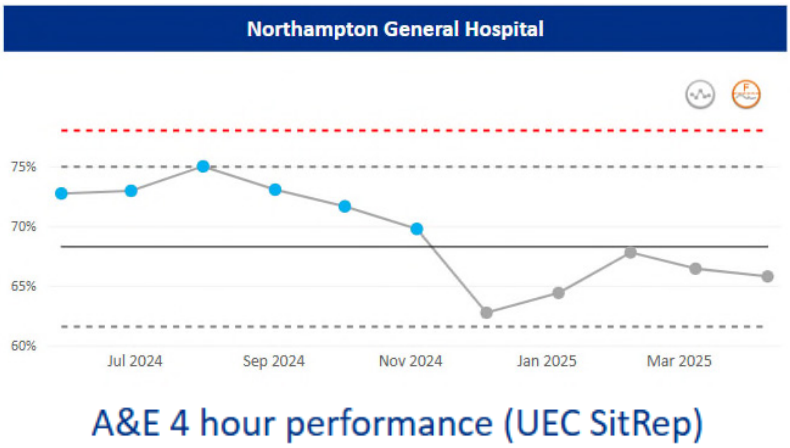
Diagnostics

The national expectation was 95% of patients having their diagnostic test in six weeks. We were meeting this target in the summer months, but have seen it impacted by winter pressures and continued increased demand for diagnostic services. We will take targeted action to mitigate this demand in 2025/26, whilst continuing to support the priority inpatient and urgent (e.g. cancer) demand.



Urgent Care

There has been an increase in A and E attendances by around 8% during 2024-25 compared to 2023-24. Performance against the 4-hour standard by 31 March 2025 was 66% against the National Standard of 78%. The standard refers to the percentage of patients admitted, transferred or discharged within four hours of arrival. The reduction in 4hr Performance in part impacted due to a counting change from Nov-24 and in part due to winter pressures and difficulties maintaining patient flow through the emergency department.

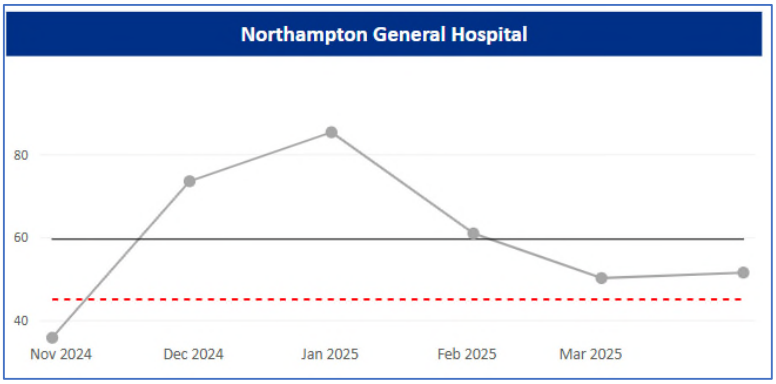


A&E 4 hour performance (UEC SitRep)

Note: 'y' axis shows the % of people arriving at an A&E Department who are admitted to hospital, transferred to a more appropriate care setting, or discharged home within four hours.

During winter, extending the hours of both the Urgent Treatment Centre (UTC) opening until 04:00, and Same Day Emergency Care (SDEC) extending until 02:00 supported the Emergency Department to reduce delays and improve the patient experience. Acute medicine short stay wards (Nye Bevan) initiated early board rounds to facilitate early discharges to aid with flow alongside several ward changes to increase bed capacity to improve flow.

The number of patients arriving by ambulance was similar to the previous year. Difficulties with ambulance handovers due to capacity constraints in the emergency department (ED) contributed to patients staying longer in ED waiting for patient flow 'downstream' and out of the hospital. This, alongside a peak in respiratory infections (flu and RSV) increased length of stay due to the need to maintain infection control processes for patients. We continue to work to work closely with system partners to reduce those 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.

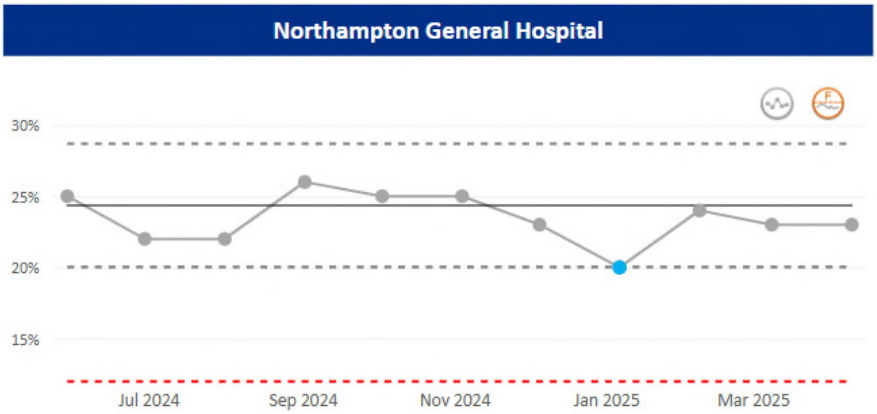


Average Ambulance handovers

(Note – 'y' axis: minutes)

Length of Stay

The number of 'super stranded' patients (patients with a length of stay in hospital greater than 21 days) continues to be a challenge, which at times 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 support expediting delays. We also focussed on internal processes to reduce the time it takes 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 Integrated Care System (ICS) partners to ensure that patients are transferred to their chosen destination, as quickly and safely as possible.



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

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
Total Headcount	6656
Whole Time Equivalent (WTE)	5887.68
Overall Vacancy Rate	8.41%
Nursing and Midwifery Vacancy Rate	8.31%
Medical and Dental Vacancy Rate	5.49%
Turnover Rate	5.27%
Sickness Absence Rate **Sickness Top 4 Reasons:** S13 Cold, Cough, Flu - Influenza S25 Gastrointestinal problems S98 Other known causes - not elsewhere classified S10 Anxiety/stress/depression/other psychiatric illnesses	4.93%
Appraisal	79.92%
Mandatory Training	89.19%

Vacancy*

Vacancy rates at NGH have shown steady improvement over 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 8.41%, remaining below national averages. Medical and Dental roles achieved particularly strong performance, with vacancy rates reducing further to just 5.49%, reflecting the effectiveness of sustained international recruitment efforts and targeted campaigns. Work continues to streamline recruitment processes through the ongoing Recruitment and Onboarding Transformation Programme, enhancing the candidate experience and facilitating quicker onboarding.

Staff Turnover*

Staff turnover rates at NGH have continued to decrease, achieving 5.27% by year-end, indicating increased workforce stability and retention. This 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 5.08%, slightly above the UHN target of 5%. 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 and comprehensive mental health

services. Specific interventions include a dedicated psychological support service, proactive trauma and stress management programmes and targeted support for managing physical and mental health issues.

Appraisal*

Appraisal completion at NGH has seen consistency, ending the year at 79.92%, marginally below the 85% target. In 2024 we relaunched our appraisal process to incorporate 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 has invested in training for appraisers to improve the quality of the appraisal discussion and support for our colleagues. Moving forward, the Trust will explore digital solutions to further streamline and enhance the appraisal process, aligning closely with the Group's core aims.

Mandatory training*

Compliance with mandatory training at NGH has steadily improved throughout the year, concluding at 89.19%, exceeding the Trust's target of 85%. The Trust has broadened access to training by diversifying delivery methods, including online modules, interactive workbooks, and video sessions. Specifically tailored sessions for senior medical staff have also been introduced to enhance engagement and compliance among this professional group. Additionally, mandatory training has been standardised across both Trusts within the UHN Group, supporting enhanced workforce mobility. Future alignment with national NHS Statutory and Mandatory programme, including the NHS Staff Passport, remains a strategic priority, aiming to facilitate smoother transitions and reduce duplication for staff moving across NHS organisations.

Medical compliance is broadly in line with other professions but fluctuates generally in line with rotations. Trust grade staff on both sites have the lowest overall compliance and with data integration to separate this group their overall compliance is 83.69%. It should be noted there are only a handful of requirements that are greater than six months adrift, and they are appropriately targeted and supported to complete.

The implementation of the new national mandatory training project will have a positive impact, and this is being enacted currently in the systems. The new requirement profiles have nationally elongated refresher requirements but also works on the principle of 'train once and then assess well', will significantly reduce the training burden. This project is expected to be fully completed in the systems in the next few weeks, but is dependent on national system support.

**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.*

Sustainability 2024-25

The Trust has delivered the £21 million Public Sector Decarbonisation Scheme (PSDS) scheme to de-steam the site and begin the electrification of the heating system. The work is in the final commissioning phase, but has already shown substantial carbon savings from the scheme. The nitrous oxide manifold supplying piped gas to theatres for anaesthetics was decommissioned in the final quarter but has already delivered significant carbon savings. The Trust has run a third successful Green Team competition, delivering sustainable environmental and financial savings.

Summary

- Carbon emissions have reduced by 8.8% 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 decreased by 14% following the identification of a major leak, although it still remains higher than in previous years.
- The installation of an air source heat pump, solar panels and a new heating network has been completed with final commissioning to be completed in the first quarter of 2025-26;
- The nitrous oxide manifolds in the Trust's theatres were removed towards the end of the year which is expected to show significant carbon savings in the coming years.
- Carbon emissions from anaesthetics have decreased despite increases in the number of procedures performed.
- Emissions from both Entonox and Nitrous Oxide have reduced.
- Clinical waste segregation is improving, with overall levels of clinical waste reduced by 9%
- Recycling has increased by 9%
- 221 new users have signed up to reuse Platform WarpIt and a total of £64,000 and 11 tonnes of waste have been saved for NGH and its external partners.
- Business Mileage (Scope 3) and therefore carbon emissions have increased.
- The Green Team Competition has resulted in projected savings of £100,000 and 27,000 kg CO2e;
- The Hand Therapy team, who were the Green Team winners in 23/24, were Highly Commended in the HSJ Awards;
- Investors in the Environment Green accreditation maintained for the 11th year
- Successful completion of a NHSE Greener apprentice through NGH

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	2022/23	% change from 21/22 to 22/23	2023/24	% change from 22/23 to 23/24	2024/25	% change from 23/24 to 24/25	21/22 to 24/25 change %
Energy (gas, electricity	10,992	11,045	+4.8%	11,231	+1.6%	10,248	-9.0%	-6.8%

and renewables)								
Anaesthetic gases including nitrous and Entonox	1539	1521	-1.16%	1611	+5.9%	1358	-15.7 %	-11.7%
F-gases	131	330	+251%	33.2	-90%	44.5	+34%	-34%
Business mileage	186	211	+13.4 %	236	11.8%	232	-1.7%	+24.7%
Water	66	67	+1.5%	77	+14.9 %	59	-23.4 %	-10.6%
Waste	39	39	No change	39	No change	12	-69.9 %	-69.9%
Metered Dose Inhalers	67 (8.27kg per inhaler)					85 (10.28kg per inhaler)		
TOTAL tCO_{2e}	**13,020 (Excluding inhalers)**	**13,213 Excluding inhalers**		**13,254 Excluding inhalers**		**11,707 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.

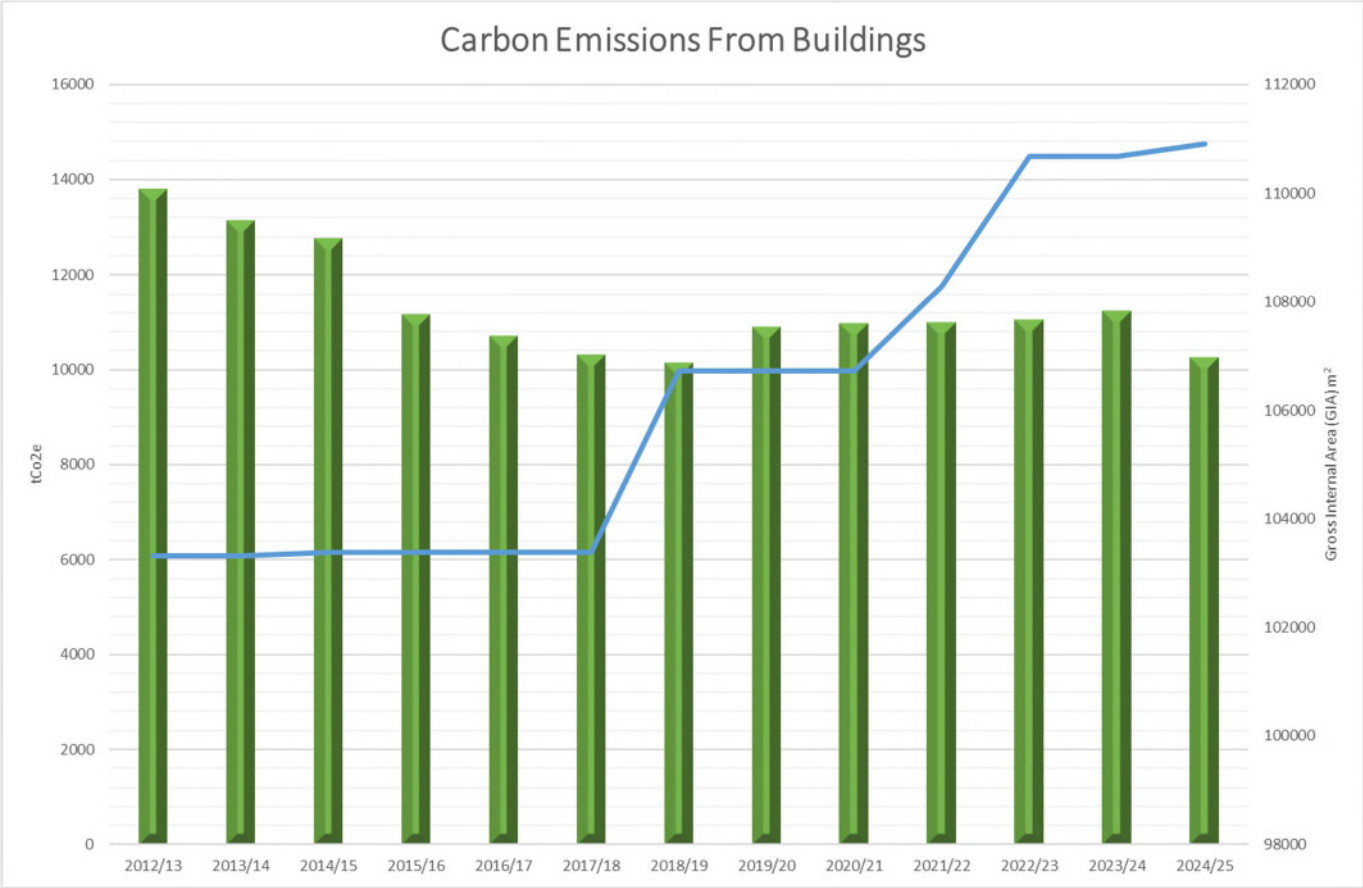
The methodology for the reporting of the emissions from inhalers has been changed and is now calculated centrally for all Trusts. This year will be taken as the baseline against which we will report in future. Emissions factors taken from https://www.nhsbsa.nhs.uk/sites/default/files/2024-09/A1_Metric_11_GHG_EF_Inhalers.csv

We have commissioned a calculation, based on expenditure, of our scope 3 emissions, excluding medicines but are still awaiting the report from finance.

Public Sector Decarbonisation Scheme (PSDS)

The Trust has delivered, in partnership with Vital Energi, year 2 of the government funded PSDS scheme (3a). Final commissioning is underway and is expected to be complete in May 2025. This has removed steam from most of the site, replacing it with low temperature hot water (LTHW). One of the 50+ year old steam boilers has been replaced by an air source heat pump, with a more efficient gas boiler providing back up. The Combined Heat and Power (CHP) unit and biomass boiler will remain as the leading heat sources. 500kWp of solar power has been installed on rooftops and will begin generating on site renewable energy in the summer months. The expected carbon savings are predicted to be in the region of 3,000 tonnes, or 30% of current carbon emissions from buildings which will put us back in-line with our

reduction plan. Carbon savings from the use of the low temperature hot water boiler and heat pump have already been realised in this financial year as shown in the graph below.



This is despite a 7% increase in the area of the buildings, the addition of electric charging points and the additional patient contacts. Emissions per m2 have decreased by 30.8% over this time period.

The carbon management plan has been used as a basis of a number of feasibility studies which have indicated the potential for carbon and energy savings from changes to the remaining boilers and the chilled water ring. In the next year more detailed work will look at options for further renewable energy generation on the site.

Utility information for the last three years is shown below. Gas consumption has decreased as the new system has been commissioned. This is despite a slightly colder year and reduced running of the biomass boiler. Electricity use has increased in part due to the increased EV charger use and also the addition of electric heating with the new heat pumps. The increase in electricity is less than that additional load from the heat pumps. Utility costs have increased significantly in the last year as gas costs have risen by 49% per kWh. Electricity costs are higher as there was a significant reduction in the CHP use due to several weeks where it was inoperable. Water consumption is lower following the repair of a water leak.

	2022/23	2023/24	2024/25
Consumption Data			
Gas kWh	53,407,600	55,147,673	48,413,762
**Electricity kWh	17,676,059	18,074,211	18,416,907
Biomass kWh	4,158,866	4,780,740	3,833,073
Business Travel miles	786,611	904,680	*953,799

Renewable Electricity Generated Solar PV kWh	28,264	49,008	40,275
Electricity consumption per patient contact kWh	25.03	24.22	23.22
Water m^3	160,137	202,506	157,736
Water consumption per patient contact m^3	0.23	0.27	0.20
Financial Data £			
Gas	2,338,641	2,413,556	2,670,619
Electricity	1,331,605	1,577,715	1,887,817
*Biomass	198,514	171,453	255,068
Water	383,331	452,021	473,831
Business Mileage	345,004	377,630	418,049
*Renewable Heat Incentive	(112,888)	(165,137)	(105,633)

*Figures are approximate pending validation from Ofgem and EPC 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 36,314 miles were travelled by train.

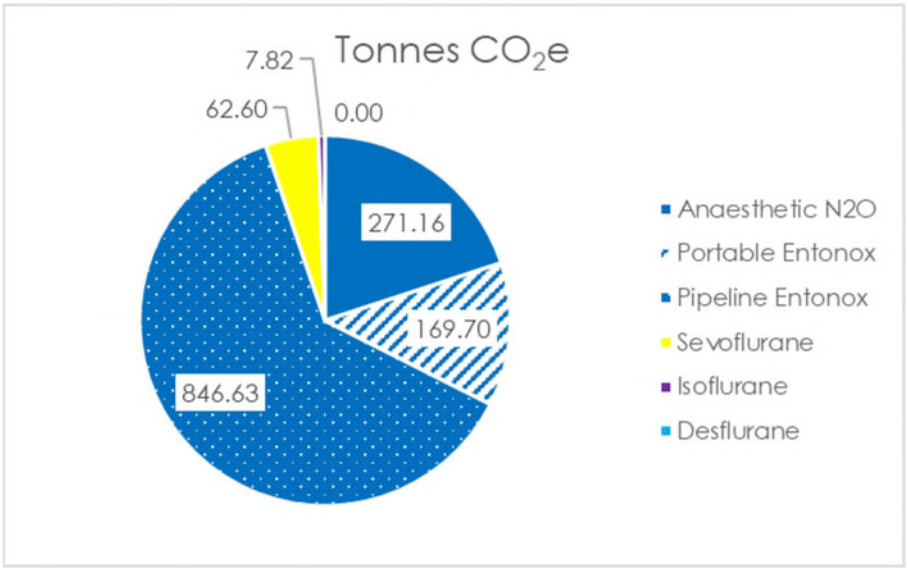
Additional spend of £23,998 on train tickets is not included in this figure.

Anaesthetic Gases

All desflurane was removed from use at the end of the 2023-24 year. The emissions from isoflurane and sevoflurane are shown below. The Trust also decommissioned the manifolds supplying nitrous oxide for anaesthesia to the theatres on site. Portable cylinders will be available for any anaesthetists wishing to use nitrous oxide. The work was completed at the end of January 2025 and therefore the full impact will not be realised until the end of the 2025-26 financial year, although the emissions from nitrous oxide have reduced to the lowest levels recorded.

The use of Entonox in maternity has returned to the levels seen prior to the change in manifold and cylinder size which showed a spike in 2023-24 as unused cylinders were returned. This will be the focus of carbon reduction work in the next year.

The use of Penthrox for pain relief in place of Entonox in the Emergency Department was approved in 2024 which will reduce the emissions from portable cylinders; a reduction in carbon emissions has already been seen, despite an increase in attendances in AandE, one of the higher use areas.



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

Water

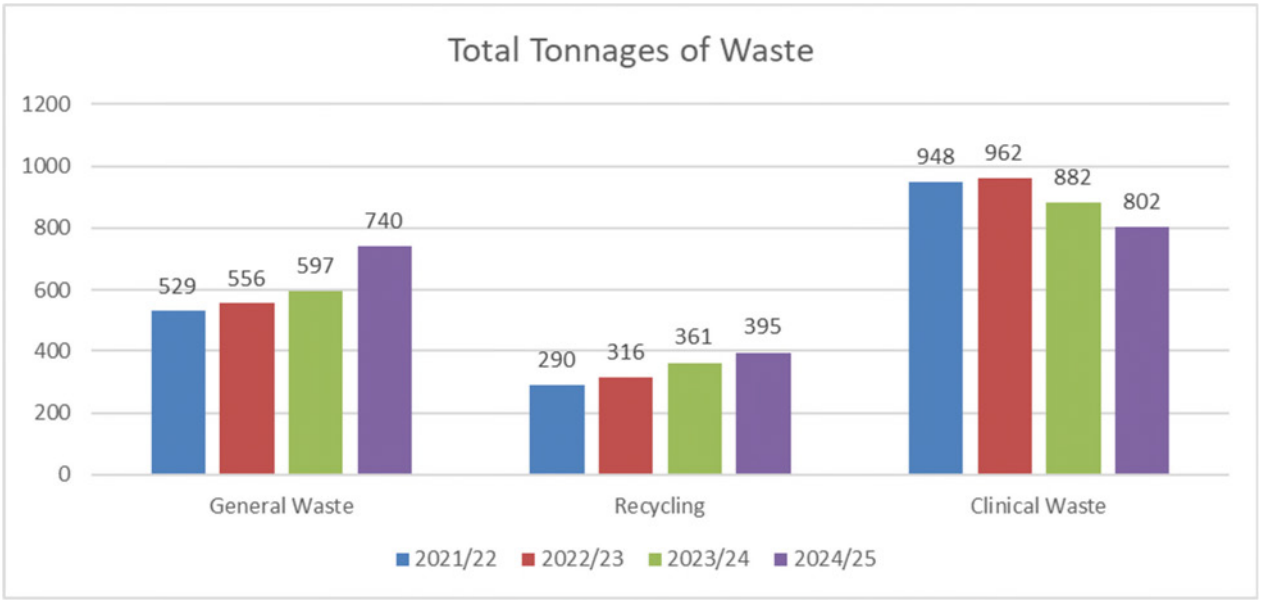
A major leak from the main incomer to site was found and repaired early in the year, restoring water use levels closer to those previously seen for the site. A survey to install more metering across the site was delayed, but will be carried out early in the new financial year. A trial of more water efficient toilets in a high use area has been successful, and options will be considered to install them in other high use areas across the site.

Waste

The NHS targets for the segregation of clinical are 20:20:60, and in the last twelve months the percentage of offensive waste has increased from 45 to 47%.

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

The overall levels of waste have increased in the last twelve months by slightly over one hundred tonnes, although about half of this is due to additional metal that has been sent for disposal due to the completion of the decarbonisation work. This was segregated and an income generated commensurate with market rates for recycled metal; however, the amount sent to clinical waste has reduced by 80 tonnes as waste is diverted to the appropriate waste streams; this is responsible for some of the increase in general waste tonnages. The amount of waste recycled has also increased by 34 tonnes compared to the previous year and is 35% of non-clinical waste, this is a lower percentage, which reflects the increased level of non-clinical waste. This has been due to a regime of auditing areas and targeting those that can move their waste to a more appropriate waste stream.



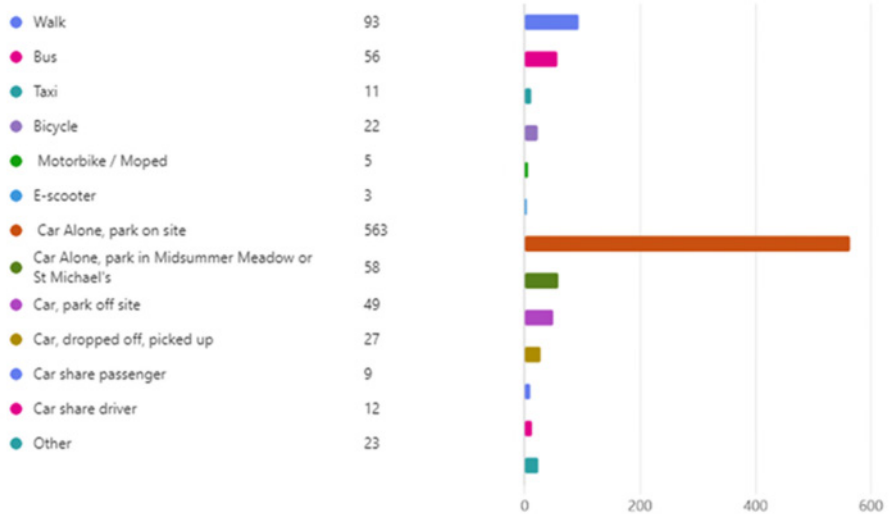
In 2024-25 NGH, within the existing budget structure, created the post of Sustainability and Waste co-ordinator. Part of the role's responsibility is to increase engagement around reuse and reduce the amount of reusable equipment and furniture sent out as waste. This is primarily done through the WarpIt platform. Over the last financial year there have been 221 new users on the system, £19,295 saved through internal reuse and claims from external partners, £45,156 saved for external charitable partners. This has reduced 11 tonnes of waste and saved 35 tonnes of CO2e. In addition to these donations,

NGH also arranged for the collection and reuse of unwanted uniforms that were in a suitable condition following the implementation of the new NHS Uniform. We worked with a local charity that has used them in a clinic in Kenya. This has saved the uniforms from being discarded as textile waste for which there is no suitable outlet. In addition, the Trust uses an auction house for disposal of some medical equipment which generates revenue; in 2024-25 8.9 tonnes of equipment was sold and 1 tonne recycled.

Travel and Transport

The Travel Plan is now in draft form and has been sent for consultation. This is expected to be published in July 2025. The installation of ANPR is complete and vehicle information systems have also been installed to enable visitors to know where spaces are available which should help reduce pollution and idling.

The annual staff travel survey was conducted between September and December, 931 people responded. Of these 71% commuted alone and parked on or off site. This is a reduction of 6% on the previous year. This is the first time the percentage has decreased, with an increase in bus use from 4% to 6% seen. Of those driving to work, there has been an increase in the number of staff using Electric Vehicles (EVs) from 5% to 9%. The results are shown below. Staff were also asked about their attitudes to active travel and public transport. The results were also used to calculate an approximate carbon footprint for the staff commute 2,462 $tCO2_e$ – which NGH has committed to reducing to net zero by 2045. (Conversion figures used were the average for each type of car according to Defra guidelines.)



Patient Travel Survey

For the months September to December all outpatients were asked two questions about their travel to NGH at the end of the routine patient survey:

- Which mode of transport did you take?
- If you travelled by car where did you park?

75% of patients came in the car, with only half parking on site, the remainder either being dropped off or parking off site.

Partnership working.

In 2024 West Northamptonshire Council funded GoTravel Solutions to undertake a review of options to increase bus usage by NGH staff. The result of this work has been added into the Travel Plan, and will be used as a basis for a number of initiatives promoting bus usage in the next financial year. It highlighted that up to one third of staff could potentially switch to bus usage with little impact to journey times as well as several changes that the Trust could make internally to provide better information about bus use. The work with WNC and Stagecoach will be ongoing as part of a wider piece of work across major employers in Northampton.

We have also commissioned a "spider map" of the bus routes around the hospital which will be added to the website and also made available in hard copy form. This highlights all of the bus routes that pass by the hospital in an easy-to-read format showing the routes and where each of them stops outside NGH.

Electric Vehicles

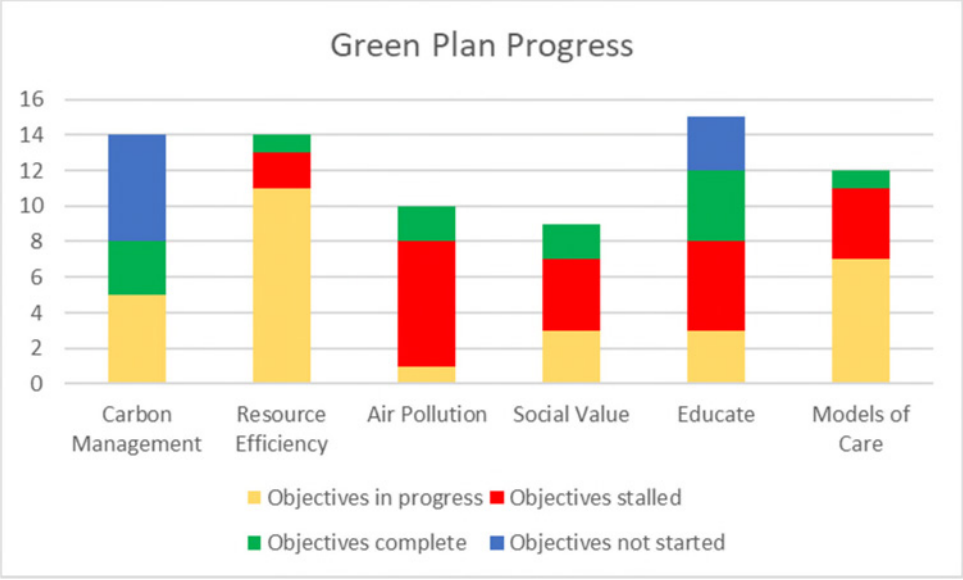
The use of the EV chargers installed at NGH has increased during the year. This reflects the increase in the number of electric vehicles owned by NGH staff.

NGH has the 2nd highest number of available EV chargers (79) of the 135 acute organisations as declared via ERIC (FY 23/24).

	Number of sessions	kWh Electricity	tCO2e avoided
2023/24	6925	98,027	65.15
2024/25	8246	146,859	115.8

Green Plan and Group Targets / ICS targets

The Trust's Green Plan forms the basis of the sustainability activities and covers six key themes below. The plan is due to be refreshed and will be presented to the Board in the summer. A number of the projects are ongoing and will be added to the new plan that is under development. The remainder of the projects have been reviewed and will either be carried over or removed from the new Green Plan.



Actions completed from the Green Plan in 2024/25

- Removal of piped nitrous oxide to the theatres;
- Green Team competition completed – four teams competed;
- Investors in the Environment Green Accreditation maintained;
- Innovative solutions being trialled to reduce single use items in theatres;
- Review of single use items to determine options for reuse or reduction such as blood pressure cuffs and couch roll underway;
- Carbon footprint calculation of inhalers completed;
- UHN Director of Estates and Facilities chairing the Sustainability group for the Anchor Institution work;
- Partnering with external organisations to submit bids for sustainability research funding.
- Information about carbon emissions of meals introduced onto menus in the restaurant;
- Walking aid reuse / recycling scheme introduced.

Innovation

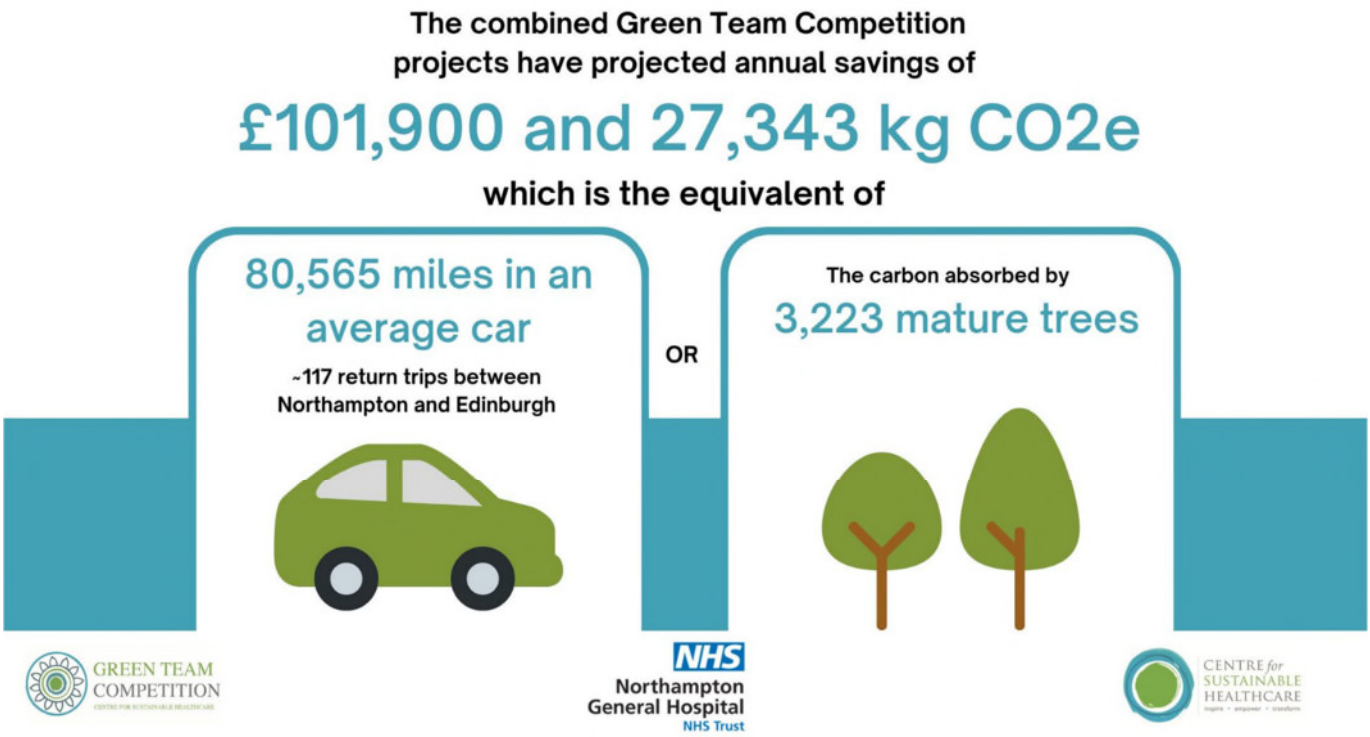
NGH partnered with Mackwell Health to obtain SBRI (Small Business Research Initiative) funding to reduce carbon emissions in the NHS. The trial to use UV to decontaminate anaesthetic masks and move to a reusable alternative was completed in 2024. This will form the basis of a new process that can be replicated across the NHS. Following on from this are trials with decontamination of other products in use across different departments.

NGH is also a partner with a consortium led by the University of Exeter that has received funding from EPSRC for a three-year programme to investigate the use of digital technologies and approaches to accelerate the transition to a more sustainable and resilient healthcare system using circular innovation. The work commences in the first quarter of 2025-26 and NGH will be on the Advisory Group along with Cambridge and Manchester University Hospitals and NHS Scotland.

NGH is also contributing to the development of an online platform to accelerate the uptake of more sustainable solutions within the NHS by providing stakeholder feedback on a range of products and processes.

Green Team Competition

Four teams completed the full ten-week Green Team competition in 2024. Entries were from Surgery, changing a process from an elective theatre session to a same day clinic, a review of unnecessary cannulation in the Emergency Department, a reduction in food waste on Holcot's elderly medicine ward and a review of caffeinated drinks to reduce falls and continence issues.



Previous years' Green Team entries have been featured in the Department of Health's Design for Life publication and the Critical Care Sustainability Recipe book and have resulted in long term changes in continence care outcomes.

Our People

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

The Hand Therapy Team's change in the care pathway for patients was Highly Commended in the Net Zero Category at the HSJ Awards.

Our Critical Care Ward Sister organised a full day sustainability event 'Critical Sustainability' for the East Midlands Critical Care Network Quality Service Improvement Group.

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

Governance and Compliance with legislation and NHS Targets

The climate related activities of NGH NHS Trust are reported annually in this report, and reviewed on an annual basis by the Finance and Investment Committee. In addition, they are audited each year by Investors in the Environment, and NGH NHS Trust were awarded their Green Accreditation again during this financial year. The progress on the Green Plan and carbon targets is reported quarterly to the NGH multidisciplinary Sustainable Development Committee, as well as to the UHN Group Sustainability Meetings and the ICS Sustainability Meetings; also on a quarterly basis.

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. In 2024 a measure of Scope 3 emissions from procurement was requested; once the reports are issued, Scope 3 emissions will be calculated and used to target high areas.

The change in waste legislation relating to Simpler Recycling has been incorporated into Trust activities. The Trust already collected and reported on food waste from the patient meal services, but now has additional collections and data from the restaurant and retail units and will commence in accommodation areas. The Trust already segregated cardboard, dry mixed recycling (plastic, cans and paper/card), metal and glass at source prior to sending off site for disposal.

To date the Board has not considered climate related risks in any strategic or local decision-making processes. However, work is underway to ensure sustainability as a broader theme is included in business planning templates. The risks to the Trust from changes in weather patterns expected through climate change are outlined in the Trust's Adaptation Policy which was updated and approved in April 2024. Further work relating to adaptation will be undertaken over the next twelve months utilising the NHS Flood Risk toolkit, as well as the Sustainability West Midlands NHS Adaptation planning tool. The main risks identified relate to extreme weather related events, particularly the impact of flooding on the local community, rather than at the Trust premises, as well as impacts on the supply chain and food supply from global climate related changes.

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.

In 2024-25 a new post (within the existing budget) of Waste and Sustainability Co-ordinator was created to reduce waste, increase reuse and support teams in their sustainability projects.

Richard Mitchell

Chief Executive and Accountable Officer

27 June 2025

Section 2: Accountability Report

Corporate Governance Report

(prepared in accordance with guidance issued by NHS England and Improvement in compliance with sections 3.43-3.48 of the DHSC group accounting manual 2024 to 2025https://assets.publishing.service.gov.uk/media/659e7951e8f5ec000d1f8ad4/dhsc-group-accounting-manual-2023-2024-january-2024.pdf .)

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 2024-25 period is set out at paragraph 11.5 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 Northampton General Hospital NHS 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 2025 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 and Investment, Quality and Safety, Operational Performance and People Committees in Common; the Boards agreed changes to Board Committees at their meeting together on 9 April 2024. Committee in Common 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. These committees are responsible for reviewing and monitoring any strategic risks to both organisations; UHN has adopted a shared Group Board Assurance Framework but the Trusts retain separate Corporate Risk Registers.

The Audit Committees remain constituted separately but have been meeting together, with a shared agenda and membership, since September 2024.

- **The Chief Executive**: 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.

- **Board of Directors:** The Board of Directors and 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 challenging the executive directors in decision making and on the Trust's strategy.

- **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 and Investment Committee:** The Committee assures the stewardship of the organisation's finances and investments, including planning, financial performance, capital expenditure, and the delivery of the financial plan and annual capital programme. It also approves revenue and capital business cases in accordance with limits set out in approved schemes of delegation

- **Operational Performance Committee:** The Committee seeks and provides assurance that the Trusts meet and surpass key local and national performance indicators in respect of urgent, emergency and elective care, whilst maintaining and enhancing quality, safety and the patient and staff experience.

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

- **People Committee:** The Committee oversees an aligned and integrated approach to ensure 10,000 colleagues across NGH and KGH are engaged and supported through the successful delivery of the UHN People Plan.

- **Assurance, Compliance and Risk Group (ARC):** The ARC Group is chaired by the Deputy Director of Governance 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 Trust's 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 Security and Protection Group**: The purpose of UHN is to set a clear direction of travel in respect of Data and Information Governance and to provide the Trust Board with the assurance that effective governance for data quality and protection is in place. UHN is attended by key stakeholders across the Trust which includes clinical and operational leaders

  The Trust's Senior Information Risk Owner (SIRO) during 2024-25 was the Director of Corporate and Legal Affairs 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 The Trust has adopted an integrated framework for risk management supported by policies and procedures. This provides a comprehensive framework for the management of principal risks and is mapped to the Trust's strategic objectives. These are in turn mapped to the risk register to assess the potential risks that threaten the achievement of the Trust's objectives, the existing control measures, and assurances in place.

3.2 The Trust has a single integrated BAF report with KGH, which overcomes duplication and confusion from similar risks describing the same issues across UHN and provides clearer alignment with Group objectives and delivery strategies. Each Trust retains a Corporate Risk Register which will inform the UHN BAF and provide oversight of key cross-cutting risks at an organisational level.

3.3 The Trust has also adopted a Group Risk Management Strategy with KGH. The strategy sets out the Trusts' commitment to continuously improving risk management and patient safety within the organisation through annual targets for improvements, against which progress will be assessed by the Assurance with Risk Group. The UHN strategy was reviewed and updated to comply with legal and statutory requirements, assist in compliance with national standards, promote proactive risk management and improve the safety and quality of patient care.

3.4 The strategy seeks to:

- Ensure that UHN meets its statutory requirements to ensure compliance with the relevant legislation such as Health and Safety at Work etc. Act (1974) and the Regulatory Reform (Fire Safety) Order 2005
- Provide a consistent and integrated approach to the management of risk that reflects the UHN Risk Management Strategy
- Achieve improved recognition and prediction of risk and minimisation of adverse outcomes
- Encourage safe working practices and deliver a safe environment for patients, staff, contractors, volunteers, and visitors

- Ensure integration of risk management into business planning, objective setting and performance management
- Support an environment of continuous improvement through the risk management processes and framework, improving quality and safety of care delivery and working practices, and
- Embed the UHN risk appetite in decision making.

3.5 There is an established governance framework for risk management which includes high level committees, the Board of Directors, Board Committees and the Assurance, Risk and Compliance Group (ARC) (a sub-group of the Quality and Safety Committee) to divisional governance committees and department level risk groups.

3.6 The ARC Group continues 'deep dive' reviews into the Divisional Risk Registers in year to provide support and guidance with regard to content and identify best practice to improve clarity of the risk register content. Feedback is also provided to UHN from Internal Audit Reviews and standard templates for reports are provided.

3.7 The risk management system is continually reviewed to ensure that robust systems are in place at all levels within the Trust. The risk register is an integral part of the system. Amendments to the risk register are generated and actioned at directorate, division, and corporate level.

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 within the Trust. 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 a Local 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 People Committee regularly 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 Trust's 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. The final CQC report is awaited and will be received by the Boards following publication.

With KGH, the Trust undertook an externally-facilitated self-assessment exercise against the CQC Well-Led domain in early 2023, which included an assessment of Trust-level assurance within the context of the Group model. This complemented an independent external review of the Group Model, with a number of common themes/areas for attention emerging from the two pieces:

- Communication and Engagement
- Governance, Roles and Accountabilities
- Corporate Strategy and Integration Plans
- Clinical Collaboration
- Culture

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 the Managing Conflicts of Interest in the NHS 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

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 The Trust policy on the development of policies ensures that all Trust policies must be equality impact assessed before seeking approval.

4.4 The UHN Board Assurance Framework (BAF) identifies and mitigates risks to UHN objectives as articulated within the UHN Dedicated to Excellence Strategy and its enabling strategies. It identifies the principal risks to the achievement of those objectives, the key controls in place to manage those risks and the sources of assurance about the effectiveness of those controls.

4.5 The UHN BAF details any gaps in control and assurance in relation to the risks, including strategic objectives related to service delivery, workforce, finance, service transformation, and infrastructure and information systems, together with actions to address them. The actions include identifying additional resources, putting in place new systems, processes, operating procedures and monitoring arrangements, strengthening project and programme management, and effective working with partners.

4.6 The BAF is updated by the Executive Director leads with a full review at the end of each quarter which is then presented to the relevant Board Committee to review their assigned risks and a full Board review quarterly. It is also crossed referenced to risks on the Corporate Risk Register.

At 31 March 2025, the BAF contained the following risks (risk appetite in brackets for each risk):

- Challenges in our ability to attract, recruit, develop and retain colleagues means we are unable to deploy the right people to the right role at the right time resulting in potential detriment to patient care (moderate)
- Failure to deliver the UHN Clinical Strategy and clinical collaboration may result in some areas of clinical and financial unsustainability (low)
- Deterioration in patient outcomes and experience as a result unwarranted variation in the provision of patient care (low)
- Failure of the Integrated Care Board (ICB) to deliver transformed care will result in an impact on the quality of service provided across the group (high)
- Risk of failing estate buildings and infrastructure due to age and suitability and, failure to deliver Group strategic estates plans, may prevent delivery of key Group strategies, e.g. Clinical Strategy (high)
- Failure to deliver the long-term Group Academic Strategy may result in University Hospitals Northamptonshire's (UHN) ability to attract high calibre staff and research and education ambitions. Recognition of impact on financial income to the Group (low)
- Failure to deliver the Group Digital Strategy may result in our staff and patients not having the tools or information they need to deliver, and receive safe, high quality patient care (high)
- Failure to deliver a Group Medium Term Financial Plan results in an inability to deliver Trust, Group and system objectives (high)

4.7 Each risk and its actions are owned by an Executive Director and they are held to account for progress at respective Board Committees and the Board.

4.8 The Trust received a 'Reasonable Assurance' opinion from internal audit on the Board Assurance Framework and Risk Management in March 2023, with the final report issued in June 2023.

4.9 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.

4.10 The Board is satisfied that plans in place are sufficient to ensure work towards compliance with all existing targets as set out in the NHS Oversight framework; and a commitment to comply with all known targets going forward. The Trust's position at 31 March 2025 was in segment 3: 'Mandated support needs identified in Quality of care. Targeted support needs identified in Finance and use of resources and Operational performance.' Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/. The Trust is currently subject to Enforcement Undertakings from NHS England in relation to its financial position; these were agreed by the Board in October 2023. The Audit Committee considered a report at its March 2024 meeting, which provided oversight and assurance in respect of the Trust's response to the Undertakings, aligned to common issues also flagged in the External Auditor's report and referred to in the Annual Governance Statement at paragraph 8.2 below.

4.11 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.

4.12 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 Board confirmed compliance with the Fit and Proper regulations at its June 2025 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

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 IG assurance.

In 2023 the national 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.

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'. There are 39 contributing outcomes of the CAF with a further 8 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.

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 Trust's DSP Toolkit Audit which is in line with the standard audit criteria for 8 nationally agreed outcomes plus 4 additional Trust chosen outcomes. The DSP Team has engaged fully with the auditors and received a 'standards fully met' outcome at the last audit. The Trust is confident that it will submit a toolkit for 2025 albeit some outcomes may not be at the expectation achieved this year. The Trust will have met an estimated 45 outcomes to the required expectation and have an approved plan in place for the two remaining.

The Trust reported one Information Governance serious incident to the Information Commissioner's Office in 2024 (compared to five in 2023) 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.

We continue to develop tools to ensure compliance with 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. Furthermore, 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 SARS in a much improved and timely manner using a digital portal for patients to receive copies of their records.

The Data Security and Protection Group meets monthly to ensure the Trust has adequate controls in place with reports presented by Clinical Coding, Health Intelligence, Data Quality, 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.

Data Quality and Governance

The quality and accuracy of our Referral to Treatment (RTT) data is assured via four routes (see also the Performance Report above):

1. Internal validation of each pathway (over 12 weeks wait) every 12 weeks. The aim is to achieve this 90% and at 31 March 2025, we were achieving 97%. This is reported monthly at the Patient Access Board
2. Auditing of specific pathways where previous root cause analysis has raised a higher risk of data issues - this is undertaken monthly. This is reported monthly at the Patient Access Board
3. Developing and utilising the RTT validation tool as part of the Federated Data Platform which supports quick identification of issues to resolve.
4. Use of the national data tool (LUNA) to provide assurance as to overall data quality.

7. Going Concern

7.1 The Audit Committee, at its meeting in March 2025, 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 2024-25 (including the audit of the 2024-25 annual report and accounts), exercising the option of a one-year extension specified in the 2020 contract award. The Trust is estimated to incur external audit costs of £208,000 (plus VAT) for the 2024-25 audit. The Audit Findings Report for 2024-25 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 Report 2023-24

Auditor's report 2023-24: Key recommendations giving rise to significant control issues

The Annual Auditor's report for the year ended 31 March 2024 identified a significant weakness in arrangements for financial sustainability and a key recommendation that the efficiency programme needed to be underpinned by robust planned savings schemes and a clear pipeline of delivery within recorded timescales. Auditors also identified an improvement opportunity that the Medium-Term Financial Plan should show more detail in years three to five to better illustrate the Trust's financial pressures over the medium term.

The Audit Committee considered that this issue represented a significant control issue to address during 2024-25.

The Trust has taken action to strengthen governance arrangements which has enhanced oversight and monitoring, but more work is required to identify and develop savings at the scale required. This is supported by the Trust's planned deficit position for 2025/26 which includes a significant savings target. As such, the Trust's External Auditors have raised a key recommendation again (see below)

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 key

(1) For the Trust to have a specific focus on delivering planned productivity improvements and efficiency savings. The Trust's efficiency programme therefore needs to:
    - Be underpinned by robust planned savings schemes, with a clear pipeline of delivery within recorded timescales;
    - Contain multi-year detailed plans for saving schemes that reflect efficiency savings for service redesign and establishment reviews, as a continual project management process that feeds into the Trust's medium term financial plan, and
    - Reported with enhanced detail to the Board, given its critical part in meeting the Trust's financial target.

(2) In March 2025, the Care Quality Commission (CQC) issued the Trust with a Section 29A warning notice, over the Trust's arrangements for Urgent and Emergency Care (UEC), in relation to potential patient harm, privacy and dignity of patients and systems and processes to manage patient flow. The Trust also moved into tier two for UEC services. This notice indicates gaps in arrangements during 2024/25 for internal oversight of quality assurance within UEC services that were not identified or addressed in the year.

Key recommendation: The Trust should ensure its quality assurance processes regularly assure the Board that improvements to meet regulatory requirements 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.

The Audit Committee considers that the above issues represent significant control issues to address during 2025-26.

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 April 2024 meeting.

11. Board Reporting

11.1 During 2024-25, the Boards of NGH and KGH met bi-monthly together throughout the year in private and also 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 has processes in place to review the effectiveness with which it operates annually and received the results of its annual self-evaluation in October 2023. The Board approved changes to the governance operating model at its April 2024 meeting, following consultation with Committees. The Board's next self-evaluation will take place during May-June 2025.

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 Trust's Patient Safety Committee (now aligned with KGH) 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 element 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 Internal audit carried out 15 reviews during the year, which were designed to ascertain the extent to which the internal controls in the systems were adequate to ensure that activities and procedures were operating to achieve the Trust's objectives. These included a number of joint internal audits with KGH. Three reviews gave rise to findings of 'Substantial' assurance, nine reviews gave rise to findings of 'reasonable' assurance, one of 'Limited' Assurance and of 'No' Assurance. Lead Executives attended the Audit Committee in respect of 'Limited' and 'No' Assurance reviews.

12.7 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.

12.8 The Audit Committee received a report to its April 2025 meeting setting out the results of the annual self-assessment against the national Counter Fraud Function Standard Return. The 2024-25 assessment indicated full compliance against 12 components and partial compliance against one: fraud, bribery and corruption risk assessment, and anti-bribery and corruption training. The report identified work in progress to achieve full compliance in these areas.

12.9 The Trust places patient safety at the heart of what we do: we constantly strive to learn from incidents to deliver the best possible care. Incidents are discussed at a number of forums, including the Incident Review Group, Patient Safety Committee and Board Quality and Safety Committee.

Learning from serious harms – action and assurance

In 2019 the Patient Safety Incident Response Framework ('PSIRF') was launched and, in December 2024 the group adopted an aligned Patient Safety and Incident Response Plan (PSIRP). PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRF replaces the Serious Incident (SI) Framework and removes the 'serious incident' classification and threshold for it. It embeds patient safety incident responses within a wider system of learning and improvement and prompts a significant cultural shift towards systematic patient safety management.

How is PSIRF different from the previous investigation process?

The Serious Incident Framework (SIF) was introduced in 2015. This process provided a narrow opportunity to learn from harm, and particularly those that did not reach the 'serious' threshold, additionally, the SIF process could be long and drawn out, and patients sometimes reported feeling 'shut out' from investigations.

PSIRF aims to provide a more flexible, transparent and compassionate approach to learning responses and investigations, focused on understanding the different factors that contributed to incidents and ensuring organisations learn from them.

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement**.**

We have published our own Patient Safety Incident Response Plan (PSIRP). This outlines which patient safety incidents should be reviewed and investigated and which approach should be applied in different scenarios. For example, in 2024-25, we focussed on harm caused within our Children and Young Peoples (CYP) pathways to identify improvement projects, ensuring that we are listening and acting upon what our patients and families are telling us about their care, and embedding Martha's Rule within the Trust. We reviewed cases where there were potential missed radiological diagnoses to identify areas for improvement. There will be a continued focus on delays in ED care and sub-optimal care of the deteriorating patient.

The development of the patient safety partner role is a key priority for the year ahead which will strengthen our culture of transparency and ensuring that the patient's voice is heard.

We are doing more with our data and have begun to triangulate mortality, claims, complaints and inquest data using the Datix reporting system and our own learning outputs to give us a clearer picture of emerging issues. We are also challenging and enhancing the range and quality of actions derived from these types of review.

We are awaiting responses from NHSE around changes to the Just Culture Framework and Never Events and have been proactive in sharing our views with the review teams.

Family engagement is a priority for the rust and our approach. We have recruited a full time Family Liaison Practitioner who is actively engaging with families and patients who are involved in a patient safety review. This role will oversee our Duty of Candour responses and begin to draw patients and families into safety reviews such as the after-action review as participants in learning.

The team is actively supporting and demonstrating a positive safety culture and working with clinical teams towards making sure we make it easier to learn from patient safety incidents, support psychologically safe teamwork and that we enable and empower our colleagues to speak up.

Our work will then seek to enhance our analysis of patient safety reviews, building more reliable intelligence and generating more effective, sustainable safety actions to support improvement and quality of care.

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, applying to NHS Trusts for the first time, 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 Clinical Quality Safety and Performance and Audit Committees.
Both the appointment and removal of the company secretary should be a matter for the whole board.	B 2.15	Trust Board Secretary is appointed by the Director of Corporate and Legal Affairs 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 2024-25 relating to the Trust's financial position and following the receipt of a Section 29 Warning Notice following the CQC inspection of UEC. The Board and Committees are providing oversight of specific actions to improve the Trust's position, as described in Section 3.5.12 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 – 27 June 2025

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 £(17.006)m in line with the updated financial forecast notified to and agreed with NHSE in January 2025. 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 local and national financial support added to our contract with commissioners of £(38.6)m and in year cash support of £14.6m. Our operating expenses in delivering services to patients and the population of Northamptonshire incur costs of £1.5m every day, and we have seen substantive staff numbers grow by 5% to 5,653 during the year.

Capital investment to improve and replace our property, plant, equipment and digital assets was £31.5m, with £0.5m funding through donations including the Public Sector Decarbonisation Scheme supporting our plan to reduce our carbon footprint. Investment was made on safety and infrastructure works across the site in accordance with estates plans, development of Community Diagnostic Centres, Chest Clinic development medical and other equipment. We continue to support our digital plans to improve infrastructure and equipment for staff alongside the security features.

Forward look

Each NHS Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account.

This duty is known as the 'break even duty'. The phrase 'taking one financial year with another' has been interpreted by the Department of Health and Social Care and HM Treasury as meaning that the duty is met if income equals or exceeds expenditure over a three-year rolling period, or exceptionally a five-year rolling period with the agreement of NHS Improvement.

Northampton General Hospital NHS Trust reported in-year deficits of £15.425m in 2022-23, £15.803m in 2023-24 and £13.476m in 2024-25, resulting in a cumulative breakeven rolling assessment of £142.299m at 31 March 2025, with deficits first occurring in 2014-15.

As a result of the financial position 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 2026 of £(4.7)m assuming £31m of assumed planned deficit funding and 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.

Charitable funds

We are supported by the Northamptonshire Health Charity. Its primary purpose is to support our work by providing grant funding, making use of the many generous donations and legacies they receive from the general public and from fund raising activities.

To ensure local governance of funds, our senior nurses and managers are heavily involved as fund advisors, actively recommending the specific projects where funds should be spent.

During the financial year the charity paid £0.486m as grants, of specific note:

- Capital investment in High-Intensity Focused Ultrasound system for Urology £0.25m, Bespoke Welcome Desk for Critical Care and Child Health projects including the Robert Watson garden.

- Contribution to expenditure for building works and maintenance £0.07m, furniture and fittings £0.03m, staff training and events £0.02m.

Sarah Stansfield

Chief Finance Officer

27 June 2025

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

27 June 2025

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, 27 June 2025

Sarah Stansfield
Chief Finance Officer, 27 June 2025

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.

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 2024-25 was £185 – 190k (2023-24, £220 – 225k). 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.

2024-25	25th percentile	Median	75th percentile
Total remuneration (£)	26,530	36,937	51,234
Pay ratio information	7.07	5.08	3.66
2023-24			
Total remuneration (£)	25,331	35,395	50,762
Pay ratio information	8.78	6.29	4.38

2024-25	25th percentile	Median	75th percentile
Salary component of total remuneration (£)	25,674	32,324	46,148
Pay ratio information	7.30	5.80	4.06
2023-24			
Salary component of total remuneration (£)	22,816	30,639	43,742
Pay ratio information	9.75	7.26	5.09

The movement in ratios between 2023-24 and 2024-25 is due to changes in the overall mix of the wider workforce and the impact of the 2024/25 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 16% (decrease) (2023-24, 10% (increase)). The decrease reflects the change in highest paid director from the Medical Director (which is now a shared post across UHN) to the former Hospital Chief Executive Officer.

Calculation is based on the mid-point of the band of the highest paid director's salary.

The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole, was 2% (increase) (2023-24, 8% (increase)).

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The 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).

In 2024/25, 71 (2023-24, 38) employees received remuneration in excess of the highest-paid director's total remuneration.

The range of staff remuneration in 2024-25 was from £14 to £397,455 per annum. In 2023-24 this was £6 to £343,475.

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 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 24/25

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
e.
ension benefit table provides further information on the pension benefits accruing to the individual.

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

Remuneration 2023-24

Name and Title	2023-24					
	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
John MacDonald - Chair (from 1st July 2023)	20 -25					20 - 25
Rachel Parker - Interim Chair (1st April - 30th June 2023) and Non-Executive Director (from 1st July 2023)	30 - 35					30 - 35
Richard Mitchell - Chief Executive Officer (from 30th October 2023)	25 - 30				0	25 - 30
Heidi Smoult - Interim Chief Executive Officer (1st April - 30th October 2023) and Hospital Chief Executive Officer (from 1st November 2023)	180 - 185				15 - 17.5	195 - 200
Palmer Winstanley - Interim Hospital Chief Executive Officer (from 27th November 2023) and Chief Operating Officer/Deputy Hospital Chief Executive Officer	150 - 155				32.5 - 35	185 - 190
Sarah Noonan - Interim Chief Operating Officer (from 8th January 2024)	30 - 35				27.5 - 30	55 - 60
Hemant Nemade - Medical Director	220 - 225				125 - 127.5	345 - 350
Nerea Odongo - Chief Nurse (from 3rd April 2023)	120 - 125				150 - 152.5	270 - 275
Debra Shanahan - Director of Nursing, Midwifery and Patient Services (to 2nd April 2023)	0 - 5				0	0 - 5
Richard Wheeler - Chief Finance Officer (from 19th September 2023)	45 - 50				30 - 32.5	75 - 80
Jon Evans - Chief Finance Officer (to 16th July 2023)	25 - 30				0	25 - 30
Helen Ellis - Interim Chief Finance Officer (27th July – 31st August 2023)	5 - 10				25 - 27.5	30 - 35
Natasha Chare - Chief Digital Information Officer	70 - 75				17.5 - 20	90 - 95
Stuart Finn - Director of Estates and Facilities/Interim Director of Operational Estates	65 - 70				0	65 - 70
Rebecca Taylor - Director of Transformation and Quality Improvement	60 - 65				15 - 17.5	80 - 85
Polly Grimmett - Director of Strategy	60 - 65				0	60 - 65
Karen Spellman - Director of Integration and Partnerships (to 7th May 2023)	10 - 15				0	10 - 15
Richard Apps - Director of Corporate and Legal Affairs	60 - 65				0	60 - 65
Paula Kirkpatrick - Chief People Officer	70 - 75				17.5 - 20	90 - 95
Suzie O'Neill - Director of Communications and Engagement	35 - 40				15 – 17.5	50 - 55
Sam Holden- Interim Director of Communications and Engagement (from 2nd October 2023)	25 - 30				7.5 - 10	35 - 40
Jill Houghton - Non-Executive Director	10 - 15					10 - 15
Caroline Stevens - Non-Executive Director (from 1st January 2024)	0 - 5					0 - 5
Denise Kirkham - Non-Executive Director	10 - 15					10 - 15
Elena Lokteva - Non-Executive Director	10 - 15					10 - 15
Ghulam (Andre) Ng - Associate Non-Executive Director	10 - 15					10 - 15
Christopher Welsh - Non-Executive Director (from 8th December 2023)	0 - 5					0 - 5
Anette Whitehouse - Associate Non-Executive Director (to 31st January 2024)	10 - 15					10 - 15

Salary Notes 2023-24

John MacDonald, Richard Mitchell, Sarah Noonan, Nerea Odongo, Richard Wheeler, Helen Ellis, Suzie O'Neill, Sam Holden, Caroline Stevens and Christopher Welsh were appointed to the Board in 2023-24. There is therefore no salary information for 2022-23.

Richard Wheeler, Jon Evans, Helen Ellis, Natasha Chare, Rebecca Taylor, Richards Apps, Paula Kirkpatrick, Suzie O'Neill, Sam Holden and Christopher Welsh are/were employed by Kettering General Hospital NHS Foundation Trust. Richard Wheeler was employed by Northamptonshire Healthcare NHS Foundation Trust (NHFT) until 18th March 2024 when his secondment ended and he took up the position on a permanent basis.
Suzie O'Neill's management role in the year covered the period from 1 April to 31 July 2023
John MacDonald and Richard Mitchell are employed by University Hospitals of Leicester NHS Trust
Helen Ellis was considered to be covering the senior manager CFO role in the period from 17 July to 27 July in her Deputy CFO capacity.
Sarah Noonan is employed by East Suffolk and North Essex NHS Foundation Trust

UHL has recharged 25% of total salaries for the respective months for the appointments of Chair (JM- total salary £90 - 95k), and Chief Executive Officer (RM - total salary £115 - 120k)

KGH has recharged 50% of total salaries for the respective months for the appointments of Chief Finance Officer (RW total salary £90 -95k, JE - total salary £50 -55k, HE - total salary £10 - 15k), Chief Digital Information Officer (NC - total salary £145 - 150k), Director of Transformation and Quality Improvement (RT - total salary £125 - 130k), Director of Strategy (PG £125 - 130k), Director of Governance (RA - total salary £125 - 130k), Chief People Officer (PK - total salary £145 - 150k), Director of Communications and Engagement (SO - total salary £75 - 80k, SH - total salary £55 - 60k) and Non-Executive Director (CW - total salary £5 - 10k)

NHFT has recharged 100% of the total salary of the Chief Finance Officer to KGH for the secondment period (19th Sept 2023 - 18th March 2024)

East Suffolk and North Essex NHS Foundation Trust has recharged 100% of the total salary of the Interim Chief Operating Officer for the secondment period beginning 8th January 2024.

50% of the salary for Director of Estates and Facilities/Interim Director of Operational Estates has been recharged to KGH (SF total salary £130 - 135k). Salary includes pay arrears relating to 2022-23 (£0-5k)

50% of the salary for Jill Houghton, Non-Executive Director, since dual appointment on 15th Dec 2023 has been recharged to KGH (JH total salary £15 -20k)

Medical Director's salary above includes clinical work (£5 - 10k) and Clinical Excellence Award (£5 -10k)

Shanahan - Director of Nursing, Midwifery and Patient Services salary includes pay arrears relating to 2022-23 (£0 - 5k)

– *all pension-related benefits*

nsion 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 on was held for full or part year and length of NHS service. Where this value is negative a nil balance is shown.

nsion-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, ated using the method set out in section 229 of the Finance Act 2004.

alue 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 rease due to a transfer of pension rights.

alue 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 e.
ension benefit table provides further information on the pension benefits accruing to the individual.

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

Pension benefit report – Has been subject to audit

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

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.

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 allowable beneficiary's) pension payable from the scheme. A CETV is a payment 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 benefits that the individual has accrued as a consequence of their total 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 transferred to the NHS pension scheme. They also include any additional pension 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 or arrangement) and uses common market valuation factors for the start 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, pension is reduced to allow for the fact that it is being paid earlier than expected.

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.

The Consumer Prices Index up to September 2023 was 6.7%,. Therefore for pensions and CETV calculation purposes CPI is 6.7%.

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 on 27 April 2023. This guidance on discount rates for calculating unfunded public service pension contribution rates has been used in the calculation of 2024-25 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.

Off Payroll Report

Table 1: Off-Payroll Engagements longer than 6 months

For all off-payroll engagements as of 31 March 2024, for more than £245 per day* and that last longer than six months:

Narrative	Number
Number of existing engagements as of 31 March 2024	0
Of which, the number that have existed:	
for less than one year at the time of reporting	
for between 1 and 2 years at the time of reporting	
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	

*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 2023 and 31 March 2024, for more than £245* per day:

Narrative	Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	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 2022 and 31 March 2023:

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	**28**

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 2024)

John MacDonald, Chair (Voting)

John joined UHN on 1st July 2023 as Chair, alongside this role he retained his role as Chair of University Hospitals of Leicestershire, a role he has held since April 2021.

John has been a Chair in various NHS and Foundation Trust organisations for a number of years bringing a wealth of experience. This includes the role of Chair in an ICB setting, where John has linked with system partners to address challenges. John has worked more closely with our system partners, to bring us together to create a better service for the patients of Northamptonshire.

Prior to joining the NHS, John worked overseas in Africa and the Indian sub-continent as an agricultural and rural development economist on projects for the British Government, the World Bank and the International Fund for Agricultural Development.

John has announced his retirement and will be leaving his positions on 26 June 2024.

Rachel Parker (second term, expires 31 December 2025) (Voting)

Rachel Parker was appointed as a non-executive director in January 2020 and, during 2023-24, was the Trust's Vice-Chair and Senior Independent Director. She has several years' board level experience of managing operations and improving performance through a combination of leadership and strategic planning.

Rachel co-chaired the Finance and Performance and Group Transformation Committees with KGH. Following Alan Burns's retirement, Rachel fulfilled the role of Interim Trust Chair from between April-June 2023.

Jill Houghton (third term, expires 30 April 2026) (Voting)

Jill has been a non-executive director NGH since May 2018 with her term of office renewed in April 2024. Jill was also appointed to the 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

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 2024 (bands of £5,000)	Lump sum at Pension Age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Richard Mitchell - Chief Executive Officer (from 30th October 2023)	0	2.5 - 5	10 - 15	35 - 40	183	21	259	N/A
Heidi Smoult - Interim Chief Executive Officer (1st April - 30th October 2023) and Hospital Chief Executive Officer (from 1st November 2023)	0	40 - 42.5	35 - 40	95 - 100	513	204	791	N/A
Palmer Winstanley - Interim Hospital Chief Executive Officer (from 27th November 2023) and Chief Operating Officer/Deputy Hospital Chief Executive Officer	2.5 - 5	0	20 - 25	0	156	59	248	N/A
Sarah Noonan - Interim Chief Operating Officer (from 8th January 2024)	0 - 2.5	5 - 7.5	30 - 35	80 - 85	375	37	591	N/A
Hemant Nemade - Medical Director	7.5 - 10	0	30 - 35	0	219	129	400	N/A
Nerea Odongo - Chief Nurse (from 3rd April 2023)	7.5 -10	0	25 - 30	0	243	103	387	N/A
Debra Shanahan - Director of Nursing, Midwifery and Patient Services (to 2nd April 2023)	0	0	55 - 60	160 - 165	1,333	0	17	N/A
Richard Wheeler - Chief Finance Officer (from 19th September 2023)	0 - 2.5	12.5 - 15	30 - 35	80 - 85	526	79	740	N/A
Jon Evans - Chief Finance Officer (to 16th July 2023)	0	5 - 7.5	20 - 25	50 - 55	273	23	389	N/A
Helen Ellis - Interim Chief Finance Officer (27th July – 31st August 2023)	0 - 2.5	0 - 2.5	15 - 20	45 - 50	296	5	384	N/A
Natasha Chare - Chief Digital Information Officer	0 - 2.5	0	0 - 5	0	22	13	47	N/A
Stuart Finn - Director of Estates and Facilities/Interim Director of Operational Estates	0	15 - 17.5	10 - 15	30 - 35	217	57	304	N/A
Rebecca Taylor - Director of Transformation and Quality Improvement	0 - 2.5	0	0 - 5	0	15	10	35	N/A
Polly Grimmett - Director of Strategy	0	12.5 - 15	15 - 20	40 - 45	245	48	326	N/A
Karen Spellman - Director of Integration and Partnerships (to 7th May 2023)	0	0 - 2.5	35 - 40	100 - 105	746	5	891	N/A
Richard Apps - Director of Governance	0	12.5 - 15	15 - 20	35 - 40	216	67	313	N/A
Paula Kirkpatrick - Chief People Officer	0 - 2.5	0	5 - 10	0	53	20	88	N/A
Suzie O'Neill - Director of Communications and Engagement	0 – 2.5	0	0 - 5	0	23	8	39	N/A
Sam Holden- Interim Director of Communications and Engagement (from 2nd October 2023)	0 - 2.5	0	0 - 5	0	43	0	55	N/A

Pension benefit notes 2023-24

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

In 2023-24 Jon Evans, Helen Ellis, Natasha Chare, Rebecca Taylor, Polly Grimmett, Richards Apps, Paula Kirkpatrick, Suzie O'Neill and Sam Holden were fully remunerated by Kettering General Hospital Foundation Trust (KGH) as their primary employer.

Richard Wheeler was fully remunerated by Northamptonshire Healthcare Foundation Trust as his primary employee for 6 months prior to transferring to KGH. During this 6 month period 100% of costs were recharged to KGH.

Northampton General Hospital reimbursed KGH 50% of costs for the period that a group role was held and as such NGH shows only 50% of pay and pension details for the relevant period with KGH disclosing the remaining 50%.

Richard Mitchell was fully remunerated by University Hospitals of Leicester NHS Trust (UHL) as his primary employer. Northampton General Hospital reimbursed UHL for 25% of his costs for the period that he held a group role and as such NGH shows only 25% of pay and pension details for the relevant period with KGH disclosing 25% and UHL the remaining 50%.

Stuart Finn was fully remuneration by NGH as his primary employer. 50% of his costs for the full year have been recharged to KGH and as such NGH only show 50% of pay and pension details. Stuart Finn, whilst in a Group Director role, is not considered to be a KGH Board Member.

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 allowable beneficiary's) pension payable from the scheme. A CETV is a payment 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 benefits that the individual has accrued as a consequence of their total 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 transferred to the NHS pension scheme. They also include any additional pension 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 or arrangement) and uses common market valuation factors for the start and end of the period.
The benefits and related CETVs in the above table do not allow for a potential future adjustment arising from the McCloud judgement.

The Public Service Pension Scheme Remedy – (McCloud)
On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called 'rollback'.
For those members affected by the Public Service Pensions Remedy, their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero. We have confirmation that Heidi Smoult, Nerea Odongo, Debra Shanahan, Stuart Finn, Helen Ellis, Richard Apps, Polly Grimmett had membership rolled back as a result of the McLoud judgement. Information is not available for Senior Managers recharged by other Trusts or those which have left the Trust during 2023/24.

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, pension is reduced to allow for the fact that it is being paid earlier than expected.

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.

The Consumer Prices Index up to September 2022 was 10.1%. Therefore for pensions and CETV calculation purposes CPI is 10.1%.

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 on 27 April 2023. This guidance on discount rates for calculating unfunded public service pension contribution rates has been used in the calculation of 2023- 24 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.

Richard Mitchell, Chief Executive and Accountable Officer
27 June 2025

Sarah Stansfield, Chief Finance Officer
27 June 2025

Trevor is the Trust's Vice-Chair, chairs the Operational Performance Committee and is a member of the and Audit 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 People 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. As a Northampton board member, she is the Maternity and Neonatal non-executive board champion and has also been the lead for safeguarding and complaints. 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.

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 and Remuneration and Appointments Committee 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 Finance and Investment and Operational Performance Committees.

Damien Venkatasamy, Associate Non-Executive Director (first term, to 30 June 2027, 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 and Investment 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 Remuneration and Appointments Committee.

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 2025)

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 recently worked with the boards of both Kettering General Hospital (KGH) and Northampton General Hospital (NGH) as the Senior Responsible Officer for Collaboration.

He 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.

Richard Apps, Director of Corporate and Legal Affairs (Non-Voting)

Richard joined KGH in July 2018 and moved into a group role with Northampton General Hospital in January 2022. He has lead responsibility for ensuring effective systems for managing risk and integrating governance across the Trust's divisions. He has a strong academic interest in patient safety and quality improvement, having worked at the Universities of Loughborough and Leicester. Richard also worked at NHS Improvement focussing on quality and performance improvement across a range of NHS Trusts.

Stuart Finn, Director of Estates, Facilities and Sustainability (Non-Voting)

Stuart's career began in electrical engineering. He has worked in both technical and senior management roles in several industries including airports, automotive manufacturing, semi-conductor manufacturing and facilities management. He joined NGH in December 2006 and prior to his current role he was the Head of Estates and Deputy Director of Facilities. Stuart has responsibility for both hard and soft services facilities management as well as our procurement and sterile services departments.

Stuart was appointed UHN Director of Estates, Facilities and Sustainability from July 2024.

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 June 2020 and Acting Chief People Officer in July 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.

In September 2022 Paula was appointed as Group Chief People Officer.

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

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, 2024-2025

Name	Title	Boards of Directors (13)	QSC* (11)	OPC* (11)	FIC* (10)	People (9)	Partnership (4)	RAC (11)	Audit (6)
John MacDonald	Chair (to June 2024)	3/4	-	-	-	-	1/1	-	-
Andrew Moore	Chair (from July 2024)	7/7	-	-	-	-	3/3	-	-
Richard Mitchell	Group Chief Executive Officer	10	-	-	-	-	4	-	-
Richard Apps	Director of Corporate and Legal Affairs	11	10	6	8	9	4	11	6
Sarah Stansfield	Interim Chief Finance Officer (from December 2024)	4 / 4	-	-	3/3	-	1/1	-	2/2
Richard Wheeler	Chief Finance Officer (to December 2024)	8 / 9	-	-	6/6	-	3/3	-	4/4
Natasha Chare	Chief Digital Information Officer (to August 2024)	5 / 6	-	-	-	-	-	-	-
Will Monaghan	Chief Digital Information Officer (from August 2024)	6 / 7	-	6/6	-	-	-	-	-
Hemant Nemade	Medical Director	10	9	5	-	4	2/3	-	-
Heidi Smoult	Hospital Chief Executive (to September 2024)	0/6	-	-	-	-	-	-	-
Laura Churchward	UHN Chief Executive (from October 2024)	6 / 6	-	-	-	-	0/2	6/6	-
Palmer Winstanley	Interim Hospital Chief Executive (to September 2024)	2 / 4	-	5/5	5/5	4/4	-	-	-
Sarah Noonan	Chief Operating Officer	9/9	8	9	-	3	-	-	-
Polly Grimmett	Director of Strategy (from June 2024)	6/7	-	3/5	7	-	4	-	-
Nerea Odongo	Chief Nurse (to July 2024)	2 / 3	3 / 3	-	-	3 / 3	0/1	-	-
Julie Hogg	Chief Nurse (from July 2024)	9 / 10	7/8	-	-	3/7	3/3	-	-
Paula Kirkpatrick	Chief People Officer	12	-	-	-	9	-	11	-
Becky Taylor	Director of Continuous Improvement	12	-	10	7	-	-	-	-
Suzie O'Neill	Director of Communications and Engagement (from October 2024)	6 / 6	-	1	-	5/5	-	-	-
Sam Holden	Director of Communications and Engagement (to September 2024)	7 / 7	-	3/5	-	1 / 4	-	-	-

Name	Title	Boards of Directors (13)	QSC* (11)	OPC* (11)	FIC* (10)	People (9)	Partnership (4)	RAC (11)	Audit (6)
Stuart Finn	Director of Estates, Facilities and Sustainability	9	-	-		-	-	-	-
Andre Ng	Associate Non-Executive Director (to August 2024)	2/6	-	-	-	-	-	-	-
Alice Cooper	Non-Executive Director (from September 2024)	6/7	-	-	-		-	5/6	4/4
Simon Gay	Non-Executve Director (from January 2025)	4/4	-	-	-	-	-	-	-
Jill Houghton	Non-Executive Director	12	11	-	-	3/3	-	-	6
Denise Kirkham	Non-Executive Director	9	-	-		9	-	11	-
Elena Lokteva	Non-Executive Director (to August 2024)	4/6	-	-	-	1 / 4	-	-	2/2
Rachel Parker	Non-Executive Director (to August 2024)	4/6	-	-	1/1	-	-	-	1 / 2
Trevor Shipman	Non-Executive Director/Vice Trust Chair (from September 2024)	6/7	3/4	-	-	3/4	4	-	3/4
Caroline Stevens	Non-Executive Director	11	-	11	4	-	-	-	1 / 2
Damien Venkatasamy	Associate Non-Executive Director (from September 2024)	6/7	-	-	6/6	-	-	4/6	-
Chris Welsh	Non-Executive Director	13	11	10	-	-	-	10	-

***Key:**

QSC – Quality and Safety

FIC – Finance and Investment

OPC – Operational Performance

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. Remuneration and Appointments Committees' attendance reflects membership from September 2024, prior to which all Non-Executive Directors were invited to meetings

Staff costs and numbers – Has been subject to audit

Staff costs

	Permanent £000	Other £000	2024/25 Total £000	2023/24 Total £000
Salaries and wages	301,040	1,399	**302,439**	266,500
Social security costs	33,225	0	**33,225**	30,360
Apprenticeship levy	1,508	0	**1,508**	1,389
Employer's contributions to NHS pension scheme	51,193	0	**51,193**	38,347
Pension cost - other	62	0	**62**	82
Other post employment benefits	0	0	**0**	0
Other employment benefits	0	0	**0**	0
Termination benefits	231	0	**231**	175
Temporary staff	0	21,367	**21,367**	26,063
Total gross staff costs	**387,259**	**22,766**	**410,025**	**362,916**
Recoveries in respect of seconded staff	0	(1,730)	**(1,730)**	0
Total staff costs	**387,259**	**21,036**	**408,295**	**362,916**
Of which				
Costs capitalised as part of assets	1,968	517	**2,485**	1,467

Average number of employees (WTE basis)

	Permanent Number	Other Number	2024/25 Total Number	2023/24 Total Number
Medical and dental	755	133	**888**	872
Ambulance staff	0	0	**0**	0
Administration and estates	1,559	156	**1,715**	1,216
Healthcare assistants and other support staff	776	260	**1,036**	1,439
Nursing, midwifery and health visiting staff	1,624	281	**1,905**	1,808
Nursing, midwifery and health visiting learners	0	0	**0**	0
Scientific, therapeutic and technical staff	721	61	**782**	656
Healthcare science staff	75	0	**75**	153
Social care staff	0	0	**0**	0
Other	0	0	**0**	0
Total average numbers	**5,510**	**891**	**6,401**	**6,144**
Of which:				
Number of employees (WTE) engaged on capital projects	33	6	**39**	15

Exit packages – Has been subject to audit

There were two exit packages agreed during 2024-25 with a total value of £200k

Reporting of compensation schemes - exit packages 2024-25 (2023-24)

	2024/25							
	Compulsory Redundancies		Other Departure		Total		Where special payments have been made	
	Number	£000	Number	£000	Number	£000	Number	£000
Exit package cost band (including any special payment element)								
<£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 by type	2	200			2	200		

	2023/24							
	Compulsory Redundancies		Other Departure		Total		Where special payments have been made	
	Number	£000	Number	£000	Number	£000	Number	£000
	1	15			1	15		
	1	160			1	160		
	1	160			1	160		

There were no “Special Payments” in 2024/25 (nil in 2023/24). 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 data is available on the NHS Digital website using this link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates
The Performance Analysis section above provides further commentary regarding the Trust’s sickness absence levels during 2024-25.

Average FTE for 2024	Adjusted FTE days lost to Cabinet Office Definitions	Average sick days per FTE
5,609	64,581	11.5

Early retirements due to ill health

	2024-25 £000s	2024-25 Number	2023-24 £000s	2023-24 Number
No of early retirements on the grounds of ill-health	215	5	21	1

Our Trade Union activity

Information regarding Facilities Time can be found on the Trust’s website here: https://www.northamptongeneral.nhs.uk/About/Policies-Reports-and-strategies/Annual-Reports/Annual-Reports.aspx.

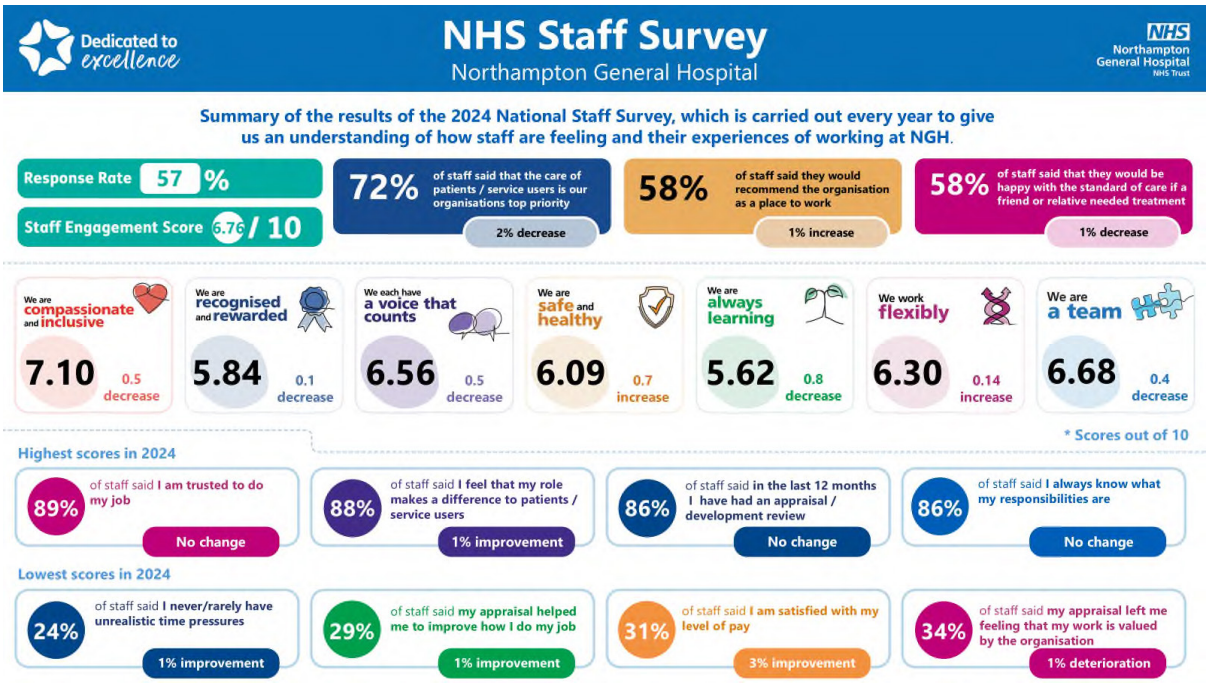
Staff Survey Results

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 the

National Quarterly Pulse Survey, 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 September and November 2024 with 6,183 colleagues taking part across the two organisations, representing 57% of the NGH workforce. There was a decrease in the number of colleagues who took part compared to the previous survey, however our 2024 response rates are higher than the national average for Acute Trusts in 2024 which was 49%.

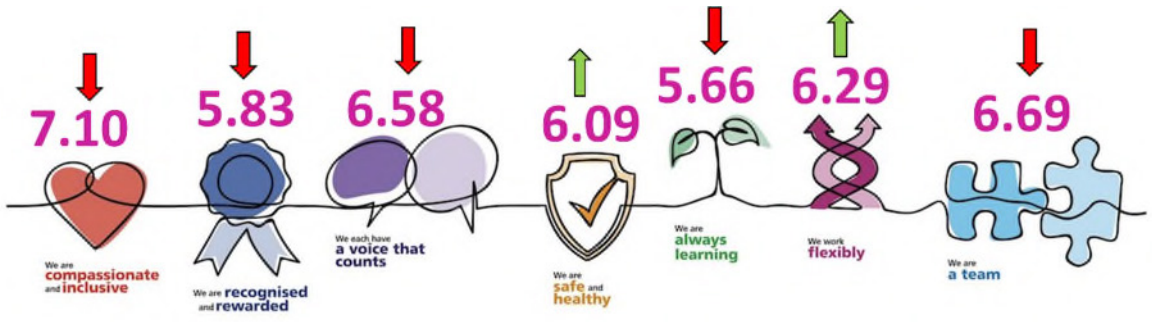
The National Results are available on the National NHS Survey website.



For the People Promise Themes we have seen improvements at NGH for the ‘We are safe and healthy’ and ‘We work flexibly’ themes and the result was noted as a statistically significant improvement. For the other themes, along with Staff Engagement and Staff Morale theme there has been a drop in the scores from the 2023 results.

When comparing the theme results to the National Average we are below the National Average however we are the same or higher for the ’We are safe and healthy’, ‘We work flexibly’ and ‘Staff morale’.

The results highlight a need to focus on 3 key themes – behaviours, safety and health and wellbeing. Results have been shared with the organisation, with specific presentations given to (amongst others) staff networks, operational leadership groups and staff side colleagues. Work will be done to establish the organisational priorities and activities, with divisions then working on their own priorities at all levels within their structures.



Equality, Diversity and Inclusion (EDI)

We were delighted to win the Gold ENEI (Employers Network for Equality and Inclusion) Award in 2024. This was testament to the significant focus our Equality, Diversity and Inclusion (EDI) team and Staff Networks placed on building a truly equitable organisation for our colleagues and patients.

In 2024 several of our UHN colleagues were shortlisted for the National BAME Health and Care Awards. These awards are aimed at recognising BAME Healthcare staff as well as allies who have demonstrated strong commitment to race equality and have implemented changes to help address healthcare inequalities within healthcare services. Our shortlisted nominees were as follows:

- Tracey Robson, Deputy Chief People Officer – Ally of the Year Award
- Hildah Matiashe, Midwife – BAME Midwife of the Year
- Jane Sanjeevi, FTSU Guardian – BAME Nurse of the Year and Inclusion Achievement of Year
- Maria Sagucio – BAME Nurse of the Year
- Palmer Winstanley, Interim CEO, Compassionate and Inclusive Leader
- Farhana Ahmedabadi-Patel, Senior Diversity and Inclusion Specialist – Inspiring Diversity Lead

We are proud that Hildah Matiashe was the winner in her category and won BAME Midwife of the Year
Our focus on EDI will continue and we are committed to providing the EDI team and Staff Networks the necessary support to continue the invaluable work they do to build a truly great place to work and receive care.

During 2024-25, we continued to review our progress against our Equality, Diversity and Inclusion Strategy 2021-2024. 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 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 by bringing them together as UHN Networks:
  - REACH (Race, Ethnicity and Cultural Heritage) Network
  - DAWN (Disability and Wellbeing Network)
  - Pride (LGBTQ+) Network
  - Gender Equality Network
  - Veterans Network
- Completed the pilot phase of our Rethinking Racism Education Programme Training from June 2024 to March 2025
- Collaborated with system partners for a celebration event for our REACH and Overseas staff in October 2024 as part of South Asian Heritage Month and Black History Month
- Creation of toolkits to support colleagues: Tackling Racism, Extended Leave Guidance, LGBTQ+, Why Pronouns Matter, Use of Language other than English in the Workplace, Microaggressions, REACH Allyship, Passover Guidance and Ramadan Guidance.
- Attended Northampton Pride in July 2024 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 and Disability History Month.
- Participated in Ward Walks, Induction, Recruitment Days and Training Days with information on EDI and the Networks.
- Had a stand in the hospital Main Reception to celebrate Women's History Month.
- Responded to the national civil unrest in the summer and provided ongoing support via monthly Listening Events and the creation of a dynamic risk assessment.
- 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
- Facilitated the NHS England Gender Inclusion Maternity Training, with 50 midwives trained across UHN.

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 BAME representation of the Board in comparison to the overall workforce.

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

https://www.northamptongeneral.nhs.uk/About/Equality-and-diversity-information/Downloads/Workforce-Race-Equality-Standard-WRES/Final-WRES-NGH-Report-2023-24-INTERNET.docx

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:

https://www.northamptongeneral.nhs.uk/About/Equality-and-diversity-information/Downloads/Workforce-Disability-Equality-Standard/Final-WDES-NGH-Report-2023-24-Internet.docx

Gender Pay Gap Reporting

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)

Gender Distribution of Staff (as at 31 March 2025)

Staff Type	Female	Male
Exec Directors	3	2
Senior Manager	254	82
All Other Employees	*4761*	1517

Senior Managers by Gender:

Band (Agenda for Change)	Female	Male	Grand Total
Band 8 - Range A	158	47	205
Band 8 - Range B	59	19	78
Band 8 - Range C	26	9	35
Band 8 - Range D	7	3	10
Band 9	4	4	8
Grand Total	**254**	**82**	**336**

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

27 June 2025

Section 3: Financial Statements

Independent auditors report and Certificate

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 2025, 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 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 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 2024-25; 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 2024-25 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 and accounts, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report and accounts. 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 Annual Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual 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 2024-25; 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 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 period ended 31 March 2025.

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 2024-25).
- 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, journal entries with no description, 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 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 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 2025.

We have nothing to report in respect of the above matter except on 5 June 2025 we identified two significant weaknesses in respect of:

- how the Trust plans and manages its resources to ensure it can continue to deliver its services. As set out in the Trust's undertakings, there should be a specific focus on delivering planned productivity improvements and efficiency savings. The Trust's efficiency programme therefore needs to be:

  - underpinned by robust planned savings schemes, with a clear pipeline of delivery within recorded timescales.

  - multi-year detailed plans for saving schemes that reflects efficiency savings for service redesign and establishment reviews, as a continual project management process, that feeds into the Trust's medium-term financial plan.

  - reported with enhanced detail to the Board, given its critical part in meeting the Trust's financial target.

- and, how the Trust uses information about its costs and performance to improve the way it manages and delivers its services. In March 2025, the Care Quality Commission (CQC) issued the Trust with a Section 29a warning notice, over the Trust's arrangements for Urgent & Emergency Care. We recommend that the Trust should ensure its quality assurance processes regularly assure the Board that improvements to meet regulatory requirements 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.

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

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 November 2024. 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 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the Trust's consolidation schedules, and 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 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

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
27 June 2025

Northampton General Hospital NHS Trust

Annual accounts for the year ended 31 March 2025

Statement of Comprehensive Income

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	3	540,334	479,575
Other operating income	4	34,298	46,679
Operating expenses	7,9	(593,575)	(526,381)
Operating deficit from continuing operations		**(18,943)**	**(126)**
Finance income	11	1,337	1,224
Finance expenses	12	(372)	(337)
PDC dividends payable		(6,548)	(6,387)
Net finance costs		**(5,583)**	**(5,500)**
Other gains / (losses)	13	26	(58)
Deficit for the year from continuing operations		**(24,500)**	**(5,684)**
Deficit for the year		**(24,500)**	**(5,684)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(5,651)	0
Revaluations	17	5,802	2,760
Total comprehensive income / (expense) for the period		**(24,349)**	**(2,924)**

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	14	11,587	9,367
Property, plant and equipment	15	230,583	228,789
Right of use assets	18	20,742	21,902
Receivables	20	753	756
Total non-current assets		**263,665**	**260,814**
Current assets			
Inventories	19	9,138	7,724
Receivables	20	21,836	18,328
Cash and cash equivalents	22	2,011	1,842
Total current assets		**32,985**	**27,894**
Current liabilities			
Trade and other payables	23	(38,556)	(36,272)
Borrowings	25	(3,214)	(3,056)
Provisions	26	(3,612)	(2,450)
Other liabilities	24	(2,775)	(2,455)
Total current liabilities		**(48,157)**	**(44,233)**
Total assets less current liabilities		**248,493**	**244,475**
Non-current liabilities			
Trade and other payables	23	0	0
Borrowings	25	(12,466)	(10,374)
Provisions	26	(768)	(1,208)
Total non-current liabilities		**(13,234)**	**(11,582)**
Total assets employed		**235,259**	**232,893**
Financed by			
Public dividend capital		322,348	295,633
Revaluation reserve		60,400	60,334
Income and expenditure reserve		(147,489)	(123,074)
Total taxpayers' equity		**235,259**	**232,893**

The notes on pages 7 to 55 form part of these accounts.

Name Richard Mitchell
Position Chief Executive and Accountable Officer
Date 27 June 2025

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' and others' 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' and others' equity at 31 March 2025	**322,348**	**60,400**	**(147,489)**	**235,259**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**273,256**	**57,666**	**(117,482)**	**213,440**
Prior period adjustment	0	0	0	**0**
Taxpayers' and others' equity at 1 April 2023 - restated	**273,256**	**57,666**	**(117,482)**	**213,440**
Surplus/(deficit) for the year	0	0	(5,684)	**(5,684)**
Other transfers between reserves	0	(92)	92	**0**
Revaluations	0	2,760	0	**2,760**
Public dividend capital received	22,377	0	0	**22,377**
Taxpayers' and others' equity at 31 March 2024	**295,633**	**60,334**	**(123,074)**	**232,893**

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	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(18,943)	(126)
Non-cash income and expense:			
Depreciation and amortisation	7.1	18,416	17,425
Net impairments	8	10,956	(915)
Income recognised in respect of capital donations	4	(622)	(9,890)
(Increase) / decrease in receivables and other assets		(4,390)	9,736
(Increase) / decrease in inventories		(1,414)	(1,001)
Increase / (decrease) in payables and other liabilities		2,456	(14,808)
Increase / (decrease) in provisions		701	527
Other movements in operating cash flows		1	(7)
Net cash flows from / (used in) operating activities		**7,161**	**940**
Cash flows from investing activities			
Interest received		1,337	1,204
Purchase of intangible assets		(4,222)	(3,198)
Purchase of PPE and investment property		(21,365)	(25,340)
Sales of PPE and investment property		29	27
Initial direct costs or up front payments in respect of new right of use assets		(89)	0
Receipt of cash donations to purchase assets		1,504	13,792
Finance lease receipts (principal and interest)		6	7
Net cash flows from / (used in) investing activities		**(22,800)**	**(13,508)**
Cash flows from financing activities			
Public dividend capital received		26,715	22,377
Movement on other loans		(217)	(271)
Capital element of lease rental payments		(3,125)	(3,001)
Other interest		(1)	(1)
Interest paid on lease liability repayments		(431)	(314)
PDC dividend (paid) / refunded		(7,133)	(6,217)
Net cash flows from / (used in) financing activities		**15,808**	**12,573**
Increase / (decrease) in cash and cash equivalents		**169**	**5**
Cash and cash equivalents at 1 April - brought forward		**1,842**	**1,837**
Cash and cash equivalents at 31 March	22.1	**2,011**	**1,842**

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 2024/25 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 £24,500k (£17,006k adjusted financial performance) for 2024/25 and has sought additional cash support of £14,606k from NHS England (NHSE) for the year. Cash support will also be required for 2025/26, and the Trust will follow the NHSE process to apply for revenue support. The Trust has agreed contracts with local commissioners for 2025/26, 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.

In 2024/25 fixed contract elements were set at a level that includes a nationally derived fair share allocation to support the delivery of elective activity targets as part of the Elective Recovery Fund (ERF) process. ERF targets are set for providers and commissioners as a required level of increase over 2019/20 activity levels. Providers and systems are then assessed against these targets and commissioner allocations and payments to providers are increased or decreased in accordance with the resultant performance.

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 Best Practice Tariff (BPT) schemes. Delivery under these schemes 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. The Trust is not receiving any variable payments in respect of Commissioning for Quality Innovation (CQUIN) schemes in 2024/25

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £500k), 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 service potential 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 service potential 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 service potential, 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 service potential 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 service potential 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 service potential, which is assumed to be at least equal to the cost of replacing that service potential. 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 service potential 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 service potential 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

8 **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.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued 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.

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.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

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.
CRU (Injury cost recovery) will be provided for at the nationally advised rate in the GAM which is 24.45% for 24/25

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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

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 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

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 2024/25.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance

No insurance contracts have been identified to date. The Trust therefore does not anticipate the adoption of the new standard to have any impact.

IFRS 18 Presentation and Disclosure in Financial Statements - 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.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

•Withdrawal revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.

• Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

• A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.

•Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed, but may have an impact on PPE measurement in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £212,627k as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £212,627k at 31 March 2025.

Note 1.23 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

• Accruals, – financial staff, in preparing the accounts, need to exercise their best judgement of local factors to ensure tha the most reliable estimation and resultant accruals are included in the accounts. Guidance is considered to provide efficient month and year end closure. Methods include: trend analysis and historic cost analysis considering current year factors; professional judgement based on detailed working papers; information gleaned from the Agreement of Balance exercise between Whole of Government bodies.

Note 1.24 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 Gerald Eve LLP carried out a full 5 yearly inspection of the site in Marc 2025 to ascertain the quality of the accommodation, its condition and the state of the locality in which it is situated. 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 2025, in accordance with the Department of Health Group Manual for Accounts (GAM) 2024/25, the Government Financial Reporting Manual (FReM) 2024-2025 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 replacemer 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 2.3% has been used in the valuation of the building assets. In order for a material misstatement of the accounts to occur (£10,000k), a BCIS cost indices or a Northamptonshire location factor movement of 4.9% would need to be applied to the carrying value of buildings which as at 31st March 2025 is £203,925k.

• Clinical income outturn values – at the time of completing draft accounts in April, the Trust will still be in the process finalising the clinical coding of March activity. There is therefore a level of estimation required over the final income due in respect of that activity. This may require the use of average pricing for any remaining uncoded activity or use of previous trends. Values derived from these processes will be part of a year end outturn reconciliation with commissioners and may require acceptance of estimated values and a process of finalisation in the following financial year when definitive outcomes are confirmed.

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)	2024/25 £000	2023/24 £000
Income from commissioners under API contracts - variable element*	102,170	93,815
Income from commissioners under API contracts - fixed element*	376,166	334,393
High cost drugs income from commissioners	34,375	33,628
Other NHS clinical income	4,205	3,810
All services		
Private patient income	415	423
National pay award central funding***	1,403	211
Additional pension contribution central funding**	20,192	11,630
Other clinical income	1,408	1,665
Total income from activities	**540,334**	**479,575**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023 - 2025 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 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the 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:	2024/25 £000	2023/24 £000
NHS England	50,556	76,310
Integrated care boards	487,579	400,847
Other NHS providers	268	329
Non-NHS: private patients	415	423
Non-NHS: overseas patients (chargeable to patient)	409	586
Injury cost recovery scheme	1,107	1,080
Non NHS: other	0	0
Total income from activities	**540,334**	**479,575**
Of which:		
Related to continuing operations	540,334	479,575
Related to discontinued operations	0	0

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2024/25	2023/24
	£000	£000
Income recognised this year	409	586
Cash payments received in-year	105	136
Amounts added to provision for impairment of receivables	213	249
Amounts written off in-year	169	211

Note 4 Other operating income

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,048	0	**1,048**	235	0	**235**
Education and training	18,357	574	**18,931**	15,538	598	**16,136**
Non-patient care services to other bodies	2,013		**2,013**	2,003		**2,003**
Income in respect of employee benefits accounted on a gross basis*	428		**428**	4,221		**4,221**
Receipt of capital grants and donations and peppercorn leases		622	**622**		9,890	**9,890**
Charitable and other contributions to expenditure		176	**176**		297	**297**
Revenue from finance leases (variable lease receipts)		0	**0**		0	**0**
Revenue from operating leases		224	**224**		175	**175**
Other income	10,856	0	**10,856**	13,722	0	**13,722**
Total other operating income	**32,702**	**1,596**	**34,298**	**35,719**	**10,960**	**46,679**
Of which:						
Related to continuing operations			34,298			46,679
Related to discontinued operations			0			0

*in 2024/25 Salary recharges to other organisations have been reported as 'Recoveries in respect of seconded staff' under Note 9 Employee benefits

	2024/25	2023/24
	£000	£000
Other contract income includes :		
Development and project related funding income	3,376	7,332
Patient Portal Funding	0	752
Clinical Services Funding	317	41
Clinical Tests	733	800
Medical Examiner Funding	415	301
Inter-hospital recharges	350	417
Catering	1,376	1,150
Car Parking Income	1,099	982
Pharmacy Sales	226	260
Accommodation Charges	189	279
VAT Audit Claim	310	74
Sterile Services Sales	42	47
Non-Contract Income:		
Receipt of capital grants and donations		
Northamptonshire Health Charity	292	309
Salix	330	9,581
Charitable and other contributions to expenditure		
Northamptonshire Health Charity	176	179
DHSC for Covid Response - Consumables (PPE)	0	118

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2024/25	2023/24
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,387	1,446
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.

	2024/25	2023/24
	£000	£000
Income	2,516	2,174
Full cost	(2,920)	(2,444)
Surplus / (deficit)	**(404)**	**(270)**

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 is currently being 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

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	174	131
Variable lease receipts / contingent rents	50	44
Total in-year operating lease income	**224**	**175**

Note 6.2 Future lease receipts

	31 March 2025	31 March 2024
	£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	258	330
Total	**618**	**690**

Note 7.1 Operating expenses

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	122	73
Purchase of healthcare from non-NHS and non-DHSC bodies	1,224	646
Staff and executive directors costs	405,579	361,274
Remuneration of non-executive directors	100	131
Supplies and services - clinical (excluding drugs costs)	53,115	52,561
Supplies and services - general	6,115	5,140
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	45,369	40,204
Inventories written down	174	258
Establishment	3,347	3,983
Premises	20,544	18,572
Transport (including patient travel)	822	655
Depreciation on property, plant and equipment	16,589	15,343
Amortisation on intangible assets	1,827	2,082
Net impairments	10,956	(915)
Movement in credit loss allowance: contract receivables / contract assets	1,100	919
Change in provisions discount rate(s)	3	(5)
Fees payable to the external auditor		
audit services- statutory audit	208	118
additional fee for prior year audit	19	4
Internal audit costs	119	107
Clinical negligence	15,419	13,322
Legal fees	14	1,327
Insurance	165	182
Research and development	0	0
Education and training	2,311	2,389
Expenditure on short term leases	203	125
Expenditure on low value leases	45	41
Variable lease payments not included in the liability	0	0
Redundancy	231	175
Car parking & security	771	418
Hospitality	23	5
Losses, ex gratia & special payments	0	0
Other services, eg external payroll	2,077	1,823
Other	4,984	5,424
Total	**593,575**	**526,381**
Of which:		
Related to continuing operations	593,575	526,381
Related to discontinued operations	0	0

Other expenditure includes:	2024/25	2023/24
	£000	£000
Professional Fees & Services including Virtual Ward in the Community	3,387	3,587
Translation and Interpreting Services	363	415
Home Oxygen Service	356	355
Professional Subscriptions	395	417

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1,000k (2023/24: £1,000k).

Note 8 Impairment of assets

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	0	(264)
Over specification of assets	1,773	0
Abandonment of assets in course of construction	1,757	0
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Changes in market price	7,426	(651)
Other	0	0
Total net impairments charged to operating surplus / deficit	**10,956**	**(915)**
Impairments charged to the revaluation reserve	5,651	0
Total net impairments	**16,607**	**(915)**

The Trust recognised intangible asset impairments of £3,530k. These are all software assets that have not resulted in digital solutions, hence the resulting impairment has been recognised in 2024/25.

	2024/25
	£000
Over specification of assets	
Robotic Process Automations (RPA)	1,233
Surgical Hub - Process mining software	376
Outpatient Solution module	164
	1,773
Abandonment of assets in course of construction	
Electronic Prescribing and Medicines Administration (EPMA) software	979
Outpatient Solution platform + 2 modules	778
	1,757
	3,530

The 5 yearly valuation exercise was completed by the valuation company, Newmark Gerald Eve LLP as at 31 March 2025. This resulted in an overall site valuation decrease of £7,275k.

	2024/25
	£000
Increase in Impairment balance	10,420
Decrease in the Impairment balance	(2,994)
	7,426
Increase in Revaluation Reserve	(5,802)
Decrease in the Revaluation Reserve (Impairment)	5,651
	7,275

For further details please refer to Note 17 Revaluations of Property, Plant and Equipment

Note 9 Employee benefits

	2024/25 Total £000	2023/24 Total £000
Salaries and wages*	302,439	266,500
Social security costs	33,225	30,360
Apprenticeship levy	1,508	1,389
Employer's contributions to NHS pensions **	51,193	38,347
Pension cost - other	62	82
Termination benefits	231	175
Temporary staff (including agency)	21,367	26,063
Total gross staff costs	**410,025**	**362,916**
Recoveries in respect of seconded staff***	(1,730)	0
Total staff costs	**408,295**	**362,916**
Of which		
Costs capitalised as part of assets	2,485	1,467

* Included in the above is £1,403k Medical staff pay award (£211k 2023/24). Please see note 3.1 for further details.

** Included in the above is £20,192k (£11,630k in 2023/24) relating to the recent revaluation of public sector pensions schemes amounting to 9.4% (6.3% 2023/24) (increase from 14.3% to 23.7% (20.6% 2023/24)) 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.

***in 2023/24 Salary recharges to other organisations were reported as 'Recoveries in respect of seconded staff' under Note 4 Other operating income

Note 9.1 Retirements due to ill-health

During 2024/25 there were 5 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £215k (£21k in 2023/24).

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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

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 2025, 231 employees were enrolled in this scheme, 35% of which paid a monthly contribution.

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2024/25	2023/24
	£000	£000
Interest on bank accounts	1,337	1,224
Total finance income	**1,337**	**1,224**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on lease obligations	343	309
Interest on late payment of commercial debt	1	1
Total interest expense	**344**	**310**
Unwinding of discount on provisions	21	20
Other finance costs	7	7
Total finance costs	**372**	**337**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2024/25	2023/24
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	1	1

Note 13 Other gains / (losses)

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	29	13
Losses on disposal of assets	(3)	(71)
Total gains / (losses) on disposal of assets	**26**	**(58)**

Note 14 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 - brought forward	**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 - brought forward	**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 14.1 Intangible assets - 2023/24

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023	**17,444**	**345**	**2,472**	**20,261**
Additions	784	0	1,301	**2,085**
Reclassifications	18	0	(18)	**0**
Disposals / derecognition	(4,145)	0	0	**(4,145)**
Valuation / gross cost at 31 March 2024	**14,101**	**345**	**3,755**	**18,201**
Amortisation at 1 April 2023	**10,552**	**345**	**0**	**10,897**
Provided during the year	2,082	0	0	**2,082**
Disposals / derecognition	(4,145)	0	0	**(4,145)**
Amortisation at 31 March 2024	**8,489**	**345**	**0**	**8,834**
Net book value at 31 March 2024	**5,612**	**0**	**3,755**	**9,367**
Net book value at 1 April 2023	**6,892**	**0**	**2,472**	**9,364**

Note 15.1 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 - brought forward	**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 - brought forward	**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**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
Revaluations	0	(5,918)	(42)	0	0	0	0	0	**(5,960)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
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 15.2 Property, plant and equipment - 2023/24

	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 2023	**7,837**	**164,823**	**362**	**9,795**	**59,658**	**142**	**23,174**	**157**	**265,948**
Additions	0	5,427	0	14,387	5,895	18	1,311	0	**27,038**
Impairments	(393)	(294)	0	0	0	0	0	0	**(687)**
Reversals of impairments	0	1,338	0	0	0	0	264	0	**1,602**
Revaluations	0	(3,501)	(40)	0	0	0	0	0	**(3,541)**
Reclassifications	0	1,083	0	(1,405)	230	0	92	0	**0**
Disposals / derecognition	0	0	0	0	(9,509)	(20)	(7,152)	(120)	**(16,800)**
Valuation/gross cost at 31 March 2024	**7,444**	**168,876**	**322**	**22,777**	**56,274**	**140**	**17,690**	**37**	**273,560**
Accumulated depreciation at 1 April 2023	**0**	**62**	**0**	**0**	**37,888**	**99**	**15,858**	**157**	**54,064**
Provided during the year	0	5,662	40	0	4,790	13	2,681	0	**13,186**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
Revaluations	0	(5,724)	(40)	0	0	0	0	0	**(5,764)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(9,424)	(20)	(7,152)	(120)	**(16,715)**
Accumulated depreciation at 31 March 2024	**0**	**0**	**0**	**0**	**33,254**	**92**	**11,387**	**37**	**44,771**
Net book value at 31 March 2024	**7,444**	**168,876**	**322**	**22,777**	**23,020**	**48**	**6,302**	**0**	**228,789**
Net book value at 1 April 2023	**7,837**	**164,761**	**362**	**9,795**	**21,770**	**43**	**7,316**	**0**	**211,884**

Note 15.3 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 15.4 Property, plant and equipment financing - 31 March 2024

	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	7,444	160,682	322	4,772	21,759	40	6,300	0	**201,318**
Owned - donated/granted	0	8,194	0	18,005	1,262	8	3	0	**27,471**
Total net book value at 31 March 2024	**7,444**	**168,876**	**322**	**22,777**	**23,020**	**48**	**6,302**	**0**	**228,789**

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 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
Subject to an operating lease	0	151	0	0	0	0	0	0	**151**
Not subject to an operating lease	8,679	187,025	280	2,584	23,355	33	8,476	0	**230,432**
Total net book value at 31 March 2025	**8,679**	**187,176**	**280**	**2,584**	**23,355**	**33**	**8,476**	**0**	**230,583**

Note 15.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

	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
Subject to an operating lease	0	158	0	0	0	0	0	0	**158**
Not subject to an operating lease	7,444	168,718	322	22,777	23,020	48	6,302	0	**228,631**
Total net book value at 31 March 2024	**7,444**	**168,876**	**322**	**22,777**	**23,020**	**48**	**6,302**	**0**	**228,789**

Note 16.1 Donations of property, plant and equipment

The table below details donations of plant and equipment received during 2024/25 from Northamptonshire Health Charity.

Description	Department	2024/25
		£000
Equipment		
Critical Care Bespoke Welcome Desk	Critical Care	17
Sonoblate HIFU System	Urology	250
Buildings		
Robert Watson Garden	Child Health	22
Parents Accomodation	Child Health	3
Total Donated Assets		**292**

Note 16.2 Granted Assets

Below details the category of asset additions, which are included in Note 15.1 and 15.2 which are funded by the Salix Grant for the Public Sector Decarbonisation Scheme (PSDS).

Description	2024/25	2023/24
	£000	£000
Buildings	0	0
Assets Under Construction	330	9,581
Plant & Machinery	0	0
Total Granted Assets	**330**	**9,581**

Note 17 Revaluations of property, plant and equipment

Valuation company Newmark Gerald Eve LLP carried out a full 5 yearly valuation as at 31st March 2025, the last full 5 yearly valuation was at 31st March 2020, interim yearly valuations have been carried out based on floor areas and information 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.

In addition to the properties included in previous valuations, the Trust has included the additional leasehold properties, Right of Use (ROU) assets at Danetre Hospital, Springfield House and the Community Diagnostic Centre (CDC) at Kings Heath, which comprises of land and buildings.

The land value has risen by 17% to £8,679k, the main reason for this is that the Gross Internal Area (GIA) has increased since 2020 and based on a Modern Equivalent Area (MEA), the hospital would require a larger site.

Buildings increased by an average of 10% to £203,925k across the site, for the following reasons:
- An increase in build costs relating to the increase in Tender Price Index from 390 (2024) to 399 (2025).
- The full 5 yearly valuation means the Building Cost Information Service (BCIS) rates have been applied individually to each block rather than indexing forward previous costs.

Previously all the ROU assets were valued using the 'cost model' valuation. As at 31st March 25 Danetre, Springfield and the CDC were included in Newmark Gerald Eve LLP year end valuation. This has resulted in a total impairment of £4,723k.

Although the land and buildings valuation has increased year on year as per the external valuation, the closing NBV of land and building assets totalled £219,902k compared to the valuation total of £212,627k, therefore a downward movement of £7,275k.

Overall the movement on the Revaluation Reserve and the Impairment balance relating to Land and Buildings has been funded by an increase in the Revaluation Reserve of £151k and an increase in the Impairment balance of £7,426k

Asset Type	Total Adjustment £000s	Revaluation Adjustment £000s	Impairment Adjustment £000s
Land	1,226	0	1,226
Building	(8,501)	151	(8,652)
Total Valuation	**(7,275)**	**151**	**(7,426)**
Equipment Historic Cost adjustment	(85)	(85)	0
Digital	(3,530)	0	(3,530)
Total Adjustment	**(10,890)**	**66**	**(10,956)**

There is also a historic cost charge of £85k 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. Plus the £3,530k assessment made of the impairment of intangible assets as detailed in Note. 8.

The Gross carrying amount of fully depreciated assets still in use for plant and equipment is £17,520k (£20,437k in 2023/24) and for intangible assets it is £3,517k (£5,367k in 2023/24).

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 - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**20,917**	**4,034**	**246**	**25,197**	**2,310**
Additions	2,958	2,614	101	**5,673**	0
Remeasurements of the lease liability	(8)	104	0	**96**	(8)
Impairments	(4,732)	0	0	**(4,732)**	(316)
Revaluations	(1,855)	0	0	**(1,855)**	(1,349)
Disposals / derecognition	0	(941)	(141)	**(1,082)**	0
Valuation/gross cost at 31 March 2025	**17,280**	**5,811**	**206**	**23,297**	**637**
Accumulated depreciation at 1 April 2024 - brought forward	**1,057**	**2,122**	**117**	**3,296**	**873**
Provided during the year	1,237	1,023	98	**2,358**	476
Revaluations	(2,024)	0	0	**(2,024)**	(1,349)
Disposals / derecognition	0	(941)	(133)	**(1,074)**	0
Accumulated depreciation at 31 March 2025	**270**	**2,204**	**82**	**2,556**	**0**
Net book value at 31 March 2025	**17,010**	**3,607**	**124**	**20,742**	**637**
Net book value at 1 April 2024	**19,860**	**1,912**	**129**	**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 18.2 Right of use assets - 2023/24

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023	**20,289**	**3,995**	**93**	**24,377**	**1,972**
Additions	504	146	153	**803**	338
Revaluations	124	0	0	**124**	0
Disposals / derecognition	0	(107)	0	**(107)**	0
Valuation/gross cost at 31 March 2024	**20,917**	**4,034**	**246**	**25,197**	**2,310**
Accumulated depreciation at 1 April 2023	**478**	**1,135**	**46**	**1,659**	**394**
Provided during the year	992	1,094	71	**2,157**	479
Revaluations	(413)	0	0	**(413)**	0
Disposals / derecognition	0	(107)	0	**(107)**	0
Accumulated depreciation at 31 March 2024	**1,057**	**2,122**	**117**	**3,296**	**873**
Net book value at 31 March 2024	**19,860**	**1,912**	**129**	**21,902**	**1,437**
Net book value at 1 April 2023	**19,811**	**2,860**	**47**	**22,718**	**1,578**

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	1,437

Note 18.3 Revaluations of right of use assets

Included within Note 18. Revaluation of PPE is an overall impairment of £4,564k which is relevant to right of use assets.

	2024/25	2023/24
Right of Use Assets	**£000**	**£000**
Nye Bevan Building	107	358
Car Park Decking	12	149
South Entrance - Communal Area	49	31
Danetre Hospital	(316)	0
Springfield GP Streaming Hub	(2,514)	0
CDC Kings Heath	(1,902)	0
Total ROU Revaluation at 31 March	**(4,564)**	**538**

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.

	2024/25	2023/24
	£000	**£000**
Carrying value at 1 April	**12,990**	**15,193**
Lease additions	5,584	803
Lease liability remeasurements	96	0
Interest charge arising in year	343	309
Early terminations	0	0
Lease payments (cash outflows)	(3,556)	(3,315)
Other changes	0	0
Carrying value at 31 March	**15,457**	**12,990**

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 2025	**31 March 2025**	**31 March 2024**	**31 March 2024**
	£000	**£000**	**£000**	**£000**
Undiscounted future lease payments payable in:				
- not later than one year;	3,492	512	2,909	489
- later than one year and not later than five years;	7,442	511	7,044	978
- later than five years.	7,535	0	4,706	0
Total gross future lease payments	**18,469**	**1,023**	**14,659**	**1,467**
Finance charges allocated to future periods	(3,012)	(40)	(1,669)	(18)
Net lease liabilities at 31 March 2025	**15,457**	**983**	**12,990**	**1,449**
Of which:				
Leased from other NHS providers		0		0
Leased from other DHSC group bodies		983		1,449

Note 19 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	2,714	2,626
Consumables*	6,412	5,086
Energy	12	12
Total inventories	**9,138**	**7,724**
of which:		
Held at fair value less costs to sell	0	0

* includes £0k (2023/24: £21k) Department of Health and Social Care centrally procured personal protective equipment

Inventories recognised in expenses for the year were £82,698k (2023/24: £76,005k). Write-down of inventories recognised as expenses for the year were £174k (2023/24: £258k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £118k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 20.1 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables*	15,269	13,181
Capital receivables (Salix Grant Funding)	0	1,174
Allowance for impaired contract receivables / assets	(2,120)	(1,686)
Prepayments	6,656	4,381
Interest receivable	108	108
Finance lease receivables	7	7
Operating lease receivables	0	0
PDC dividend receivable	370	0
VAT receivable	1,526	1,140
Other receivables**	20	23
Total current receivables	**21,836**	**18,328**
Non-current		
Finance lease receivables	145	151
Other receivables**	608	605
Total non-current receivables	**753**	**756**
Of which receivable from NHS and DHSC group bodies:		
Current	8,356	6,445
Non-current	753	756

*Contract receivables includes £0k Medical staff pay award finding (2023/24 £211k)

**Other receivables - Clinician pension tax provision reimbursement funding from NHS England

Note 20.2 Allowances for credit losses

	2024/25		2023/24	
	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	**1,686**	**0**	**1,335**	**0**
New allowances arising	1,100	0	919	0
Utilisation of allowances (write offs)	(666)	0	(568)	0
Allowances as at 31 Mar 2025	**2,120**	**0**	**1,686**	**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)

	2024/25	2023/24
	£000	£000
Finance lease receivables at 1 April 2024	**158**	**165**
Lease receipts (cash payments received)	(6)	(7)
Finance lease receivables at 31 March 2025	**152**	**158**

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 2025	31 March 2025	31 March 2024	31 March 2024
	£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.	117	117	123	123
Total future finance lease payments to be received	**152**	**152**	**158**	**158**
Estimated value of unguaranteed residual interest	0	0	0	0
Unearned interest income	0	0	0	0
Allowance for uncollectable lease payments	0	0	0	0
Net investment in lease (net lease receivable)	**152**	**152**	**158**	**158**
of which				
Leased to other NHS providers		0		0
Leased to other DHSC group bodies		152		158

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.

	2024/25	2023/24
	£000	£000
At 1 April 2024	**1,842**	**1,837**
Net change in year	169	5
At 31 March2025	**2,011**	**1,842**
Broken down into:		
Cash at commercial banks and in hand	18	31
Cash with the Government Banking Service	1,993	1,811
Total cash and cash equivalents as in SoFP	**2,011**	**1,842**
Total cash and cash equivalents as in SoCF	**2,011**	**1,842**

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 2025	31 March 2024
	£000	£000
Bank balances	74	74
Total third party assets	**74**	**74**

Note 23.1 Trade and other payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	5,393	3,904
Capital payables	7,365	7,002
Accruals*	12,036	15,398
Social security costs	8,435	8,082
PDC dividend payable	0	215
Pension contributions payable	4,387	706
Other payables	940	965
Total current trade and other payables	**38,556**	**36,272**
Of which payables from NHS and DHSC group bodies:		
Current	1,565	1,821

*Accruals includes £0k Medical staff pay award (2023/24 £211k)

Note 23.2 Early retirements in NHS payables above

There were no early retirements included in the payables note above (2023/24 - Nil)

Note 24 Other liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income: contract liabilities	2,775	2,455
Total other current liabilities	**2,775**	**2,455**

Note 25.1 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Other loans - Salix	163	217
Lease liabilities	3,051	2,839
Total current borrowings	**3,214**	**3,056**
Non-current		
Other loans - Salix	60	223
Lease liabilities	12,406	10,151
Total non-current borrowings	**12,466**	**10,374**

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 10 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 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**

	Other loans	Lease Liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2023	**711**	**15,193**	**15,904**
Prior period adjustment	0	0	**0**
Carrying value at 1 April 2023 - restated	**711**	**15,193**	**15,904**
Cash movements:			
Financing cash flows - payments of interest	0	(314)	**(314)**
Non-cash movements:			
Additions	0	803	**803**
Application of effective interest rate	0	309	**309**
Carrying value at 31 March 2024	**440**	**12,990**	**13,430**

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Redundancy	Clinicians' Pension Re-imbursement	Other	Total
	£000	£000		£000	£000
At 1 April 2024	**135**	**160**	**628**	**2,735**	**3,658**
Change in the discount rate	3	0	(6)	0	**(3)**
Arising during the year	0	213	17	2,739	**2,969**
Utilised during the year	(18)	(160)	(42)	(988)	**(1,208)**
Reversed unused	0	0	0	(1,088)	**(1,088)**
Unwinding of discount	21	0	31	0	**52**
At 31 March 2025	**141**	**213**	**628**	**3,398**	**4,380**
Expected timing of cash flows:					
- not later than one year;	18	213	20	3,361	**3,612**
- later than one year and not later than five years;	72	0	83	37	**192**
- later than five years.	51	0	525	0	**576**
Total	**141**	**213**	**628**	**3,398**	**4,380**

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 a potential liability relating to the early exit of a digital contract.

Note 26.2 Clinical negligence liabilities

At 31 March 2025, £216,468k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Northampton General Hospital NHS Trust (31 March 2024: £205,286k).

Note 27 Financial Guarantee

During 2021/22 the Trust entered into a Financial Arrangement with Novinti and Compass for the Front Entrance and Retail Development. Under this Arrangement Compass has a 15 Year Lease with Novinti 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 2025	31 March 2024
	£000	£000
Property, plant and equipment	1,023	3,647
Intangible assets	5,019	1,430
Total	**6,042**	**5,077**

Included in the above capital commitments are orders relating to the Electronic Patient Records (EPR) digital capital scheme of £4,402k.

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 Integracted 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 2025 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 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**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	12,692	**12,692**
Cash and cash equivalents	1,842	**1,842**
Total at 31 March 2024	**14,534**	**14,534**

Note 29.3 Carrying values of financial liabilities

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**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	12,990	**12,990**
Other borrowings	440	**440**
Trade and other payables excluding non financial liabilities	26,020	**26,020**
Total at 31 March 2024	**39,450**	**39,450**

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 2025 £000	31 March 2024 £000
In one year or less	28,700	29,146
In more than one year but not more than five years	7,502	7,267
In more than five years	7,535	4,706
Total	**43,737**	**41,119**

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

	2024/25		2023/24	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses*	300	90	2	0
Bad debts and claims abandoned	95	179	123	247
Total losses	**395**	**269**	**125**	**247**
Special payments				
Compensation under court order or legally binding arbitration award	1	24	0	0
Ex-gratia payments	37	84	42	66
Total special payments	**38**	**108**	**42**	**66**
Total losses and special payments	**433**	**377**	**167**	**313**
Compensation payments received				

*Cash losses in 2024/25 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 1,513k for Total Income and £857k for Total Expenditure. Receivables balance £836k, Payables balance £131k. Staff recharges are reported net.

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 £469k, of which £292k related to Capital. Receivables balance £36k.

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 2025 which effect the financial position.

Note 33 Better Payment Practice code

Non-NHS Payables	2024/25 Number	2024/25 £000	2023/24 Number	2023/24 £000
Total non-NHS trade invoices paid in the year	73,248	192,108	71,896	194,474
Total non-NHS trade invoices paid within target	71,939	184,654	68,334	180,208
Percentage of non-NHS trade invoices paid within target	98.2%	96.1%	95.0%	92.7%
NHS Payables				
Total NHS trade invoices paid in the year	1,551	29,835	1,486	26,712
Total NHS trade invoices paid within target	1,449	29,000	1,316	25,023
Percentage of NHS trade invoices paid within target	93.4%	97.2%	88.6%	93.7%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 34 Capital Resource Limit

	2024/25 £000	2023/24 £000
Gross capital expenditure	32,086	29,926
Less: Disposals	(11)	(85)
Less: Donated and granted capital additions	(622)	(9,890)
Charge against Capital Resource Limit	**31,453**	**19,951**
Capital Resource Limit	32,159	23,046
Under / (over) spend against CRL	**706**	**3,095**

Note 35 Breakeven duty financial performance

	2024/25 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(17,006)
Remove impairments scoring to Departmental Expenditure Limit	3,530
Breakeven duty financial performance surplus / (deficit)	**(13,476)**

Note 36 Breakeven duty rolling assessment

	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
	£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)
Breakeven duty cumulative position	(66,680)	(81,112)	(100,167)	(97,378)	(97,595)	(113,020)	(128,823)	(142,299)
Operating income	304,760	326,571	359,129	430,786	461,833	490,190	526,254	574,632
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%)

Note 37 Adjusted Financial Performance

	2024/25	2023/24
	£000	£000
Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	(24,500)	(5,684)
Remove net impairments not scoring to the Departmental expenditure limit	7,426	(651)
Remove I&E impact of capital grants and donations	47	(9,227)
Remove net impact of inventories received from DHSC group bodies for COVID response	21	24
Adjusted financial performance deficit	**(17,006)**	**(15,539)**

Net impairments, relates to the valuation of the site which included an impairment of £10,956k which scores as an Annually Managed Expenditure (AME) and the intangible impairment of £3,530k which scores as a Departmental Expenditure Limit (DEL). Both detailed in Note 8 - Impairment of Assets. Resulting in £7,426k 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 £47k (consisting of £647k donated depreciation and £22k Right of use assets - peppercorn leases depreciation, less £292k donated additions and £330k cash grants for the purchase of capital assets) is excluded from retained surplus and statutory breakeven duty in accordance with the DHSC Group Accounting Manual.

NHS

Northampton General Hospital

NHS Trust

Proud to be a part of

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NHS Group

September 2025