Group Board (General Purpose Joint Committee) Meeting in Public

Wed 01 April 2026, 10:30 - 12:45

Lecture Theatre, Burrage Centre, James Paget University Hospital, Gorleston

Agenda

10:30 - 10:35 5 min

1. Welcome and Apologies

For information *Group Chair*

0 - Group Board in public - Agenda - 01.04.26 iw.pdf (3 pages)

10:35 - 10:35 0 min

2. Declarations of Interest

For information *Group Chair*

Those present to declare any actual, potential or perceived interests relating to items on the agenda

10:35 - 10:55 20 min

3. Reflections from Board Walk-rounds and Patient Story

For discussion *Group Chief Nurse*

10:55 - 11:00 5 min

4. Minutes of the Previous Meeting

For decision *Group Chair*

To approve the Minutes of the meeting held on 17 December 2025

Paper required

4 - Minutes of Group Board Meeting in Public.pdf (7 pages)

11:00 - 11:00 0 min

5. Action log and matters arising not covered by other agenda items

For discussion *Group Director of Governance*

Paper required

5 - Group Board in Public Action Log.pdf (1 pages)

11:00 - 11:10 10 min

6. Group Chief Executive's Report

For discussion *Group Chief Executive*

Paper required

6 - Group Chief Executives Report iw.pdf (7 pages)

11:10 - 11:40 30 min

7. Foundation Trust Update Reports

7.1. Queen Elizabeth Hospital King's Lynn NHS FT

For discussion *Executive Managing Director*

Paper required

7.1 - QEH EMD Group Board Report iw.pdf (6 pages)

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7.2. James Paget University Hospitals NHS FT

For discussion *Executive Managing Director*

Paper required

7.2 - JPUH EMD Group Board Report iw.pdf (5 pages)

7.3. Norfolk and Norwich University Hospitals NHS FT

For discussion *Executive Managing Director*

Paper required

7.3 - NNUH EMD Group Board Report iw.pdf (5 pages)

11:40 - 11:50
10 min

8. Reports from the Chairs of Board Committees

8.1. Group Risk Assurance Committee

For information *Committee Chair*

Paper required

8.1 - Group Risk Assurance Committee - Chair's report iw.pdf (5 pages)

8.2. Group Audit Committees in Common

For Information *Committee Chair*

Paper required

8.2 - Group Audit Committees in Common - Chair's report iw.pdf (2 pages)

8.3. Group Research, Innovation and Education Committee

For information *Committee Chair*

Paper required

8.3 - Group Research, Innovation and Education Committee - Chair's report iw.pdf (2 pages)

11:50 - 12:15
25 min

9. Performance Reports

9.1. Group Integrated Performance Report

For discussion *Group Chief Delivery Officer*

Paper required

9.1.1 - Group IPR cover sheet iw.pdf (4 pages)
9.1.2 - Group IPR - Feb 26 iw.pdf (61 pages)

9.2. Group Finance Report

For discussion *Group Chief Finance Officer*

Paper required

9.2.1 - Group Finance Report cover sheet iw.pdf (1 pages)
9.2.2 - Group Finance Report M11 iw.pdf (11 pages)

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9.3. One Recovery Programme

For discussion *Group Chief Delivery Officer and Executive Managing Directors*

Paper required

9.3 - One Recovery Group Board update March 2026 iw.pdf (8 pages)

12:15 - 12:20
5 min

10. Board Assurance Framework Report

For discussion *Group Director of Governance*

- 10.1 - Report to Group Board - BAF update March 2026 iw.pdf (3 pages)
- 10.2 - NWUHG BAF - March 2026 iw.pdf (40 pages)

12:20 - 12:30
10 min

11. Trust Charities

For decision *Group Chief Executive*

Paper required

- 11- Trust Charities iw.pdf (10 pages)

12:30 - 12:35
5 min

12. Group Governance Framework

Decision *Group Secretary*

- 12- Group Governance Framework iw.pdf (11 pages)

12:35 - 12:35
0 min

13. Group Committee Terms of Reference

13.1. Nomination and Remuneration Committees in Common

For approval *Group Director of Governance*

Paper required

- 13.1 - Group Nomination and Remuneration Committees in Common terms of reference iw.pdf (6 pages)

13.2. Research, Innovation, and Education Committee

For approval *Group Director of Governance*

Paper required

- 13.2 - Group Research, Innovation and Education Committee terms of reference iw.pdf (6 pages)

12:35 - 12:35
0 min

14. Committee Membership and NED Roles

For information *Group Director of Governance*

Consent items (not for discussion unless notified to the Group Chair in advance)

Paper required

- 14 - Board committee membership and NED roles iw.pdf (3 pages)

12:35 - 12:45
10 min

15. Any Other Business

Group Chair

12:45 - 12:45
0 min

16. Questions from Members of the Public

For discussion *Group Chair*

To respond to pre-submitted questions

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12:45 - 12:45
0 min

17. Meeting Review and Reflections

For discussion *Group Chair*

12:45 - 12:45
0 min

18. Date of the Next Meeting

For information

Wednesday 3 June 2026 at the Norfolk and Norwich University Hospital

12:45 - 12:45
0 min

19. Resolution

For decision

That representative of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of its business to be transacted, publicity on which would be prejudicial to the public interest (NHS Act 2006 as amended by the Health and Social Care Act 2012)

12:45 - 12:45
0 min

20. Close of Meeting

Walker,Ian
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Group Board (General Purpose Joint Committee)

Meeting in public on Wednesday 1 April 2026 at 10.30
in the Lecture Theatre, Burrage Centre, James Paget University Hospital, Lowestoft Road, Gorleston, Great Yarmouth, Norfolk NR31 6LA

AGENDA					
Time	**No.**	**Item**	**Purpose**	**Paper attached**	**Lead**
10.30	**1.**	**Welcome and apologies**			Group Chair
	2.	**Declarations of interest** Those present to declare any actual, potential or perceived interests relating to items on the agenda	For information	No	Group Chair
Patient story					
10.35	**3.**	**Reflections from Board walkrounds and Patient Story**	For discussion	No	Group Chief Nurse
Introductory items and reports					
10.55	**4.**	**Minutes of the previous meeting** To approve the Minutes of the meeting held on 17 December 2025	For decision	Yes	Group Chair
	5.	**Action log and matters arising not covered by other agenda items**	For discussion	Yes	Group Director of Governance
11.00	**6.**	**Group Chief Executive's report**	For discussion	Yes	Group Chief Executive
11.10	**7.** 7.1 7.2 7.3	**Foundation Trust update reports** Queen Elizabeth Hospital King's Lynn NHS FT James Paget University Hospitals NHS FT Norfolk and Norwich University Hospitals NHS FT	For discussion	Yes	Executive Managing Directors
11.40	**8.** 8.1 8.2	**Reports from the Chairs of Board Committees** Group Risk Assurance Committee Group Audit Committees in Common	For information	Yes	Committee Chairs

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	8.3	Group Research, Innovation and Education Committee			
Performance items					
11.50	**9.** 9.1	**Performance reports** Group Integrated Performance Report	For discussion	Yes	Group Chief Delivery Officer
	9.2	Group Finance Report		Yes	Group Chief Finance Officer
	9.3	One Recovery Programme		Yes	Group Chief Delivery Officer and Executive Managing Directors
Governance items					
12.15	**10.**	**Board Assurance Framework**	For discussion	Yes	Group Director of Governance
12.20	**11.**	**Trust charities**	For decision	Yes	Group Chief Executive
12.30	**12.**	**Group Governance Framework - Including Trust Constitutions, Standing Orders and Standing Financial Instructions**	For decision	Yes	Group Secretary
	13. 13.1 13.2	**Group Committee terms of reference** Nomination and Remuneration Committees in Common Research, Innovation and Education Committee	For approval	Yes	Group Director of Governance
Consent items (*not for discussion unless notified to the Group Chair in advance*)					
	14.	**Group Board committee membership and NED roles**	For information	Yes	Group Director of Governance

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Other items					
12.35	**15.**	**Any other business**		No	Group Chair
	16.	**Questions from members of the public** To respond to pre-submitted questions	For discussion	No	Group Chair
	17.	**Meeting review and reflections**	For discussion	No	Group Chair
	18.	**Date of the next meeting** Wednesday 3 June 2026 at the Norfolk and Norwich University Hospital.	For information		
	19.	**Resolution** That representative of the press and other members of the public be excluded for from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (NHS Act 2006 as amended by the Health and Social Care Act 2012)	For decision		
12.45	**20.**	**Close of meeting**			

Group Board (GPJC) Meeting in Public (Part A)

Wednesday 17 December 2025, 09:30 - 11:30

NNUH Boardroom located on Level 4 West Block, Colney Lane, Norwich NR4 7UY

Attendees

Board members

David Roberts (Interim Group Chair), Lesley Dwyer (Group Chief Executive), Stephen Javes (Group Non-executive Director), Marcus Thorman (Group Chief Finance Officer), Joanne Segasby (Group Chief Delivery Officer), Philip Baker (Group Non-executive Director), Sally Collier (Group Non-executive Director), Jack Bowman (Group Non-executive Director), Jo Churchill (Group Non-executive Director), Chris Bown (Executive Managing Director QEHKL), Jonathan Barber (Executive Managing Director NNUH), Rachael Cocker (Interim Group Chief Nurse), Shane Gordon (Executive Managing Director NNUH), William Van't Hoff (Group Non-executive Director), Robert Sherwin (Group Chief Medical Officer)

Absent: Nikki Gray (Group Non-executive Director)

In Attendance

Edward Prosser-Snelling (Group Director of Digital), Ian Walker (Interim Group Director of Governance), Jo Hannam (Group Communications Lead), Charlie Helps FRSA (Secretary)

The quorum for the General Purpose Joint Committee (GPJC), also referred to as the Group Board, is defined as follows:

1. **Minimum Attendance**: At least seven (7) voting members must be present for the meeting to be quorate.
2. **Composition**:
   - At least four (4) Non-Executive Directors must be in attendance.
   - At least three (3) Executive Directors must be present.
3. **Deputies**: Nominated deputies authorised by the Chair may count towards the quorum.

If the quorum is not met, the meeting may proceed if those attending agree, but no decisions can be made. This ensures that decisions are made with adequate representation from both Non-Executive and Executive Directors.

Meeting minutes

1. Chair's Welcome

Formalities

Chair

David Roberts, Group Chair, formally opened the inaugural meeting of the Group Board (General Purpose Joint Committee). He welcomed Board members, attendees, governors and members of the public, noting the significance of the meeting as a key milestone in the transition to Group governance and a new phase of collective leadership across the three Trusts.

The Group Chair emphasised the importance of establishing strong relationships, shared purpose and clarity of expectations at an early stage. He invited all members and attendees to introduce themselves, recognising the breadth of experience in the room and the need to foster open, constructive and respectful engagement as the Group Board developed its ways of working.

2. Apologies for Absence

Apologies were received from Nikki Gray, Group Non-Executive Director. The Chair advised that Jo Churchill, Group Non-Executive Director, was expected to join later in the meeting.

The meeting was confirmed as quorate in accordance with the Group Board quorum requirements.

3. Declarations of Interest

The Chair confirmed that all required declarations of interest had been received by the Group Secretary in advance of the meeting. Members were invited to declare any additional actual, potential or perceived interests relating to items on the agenda. No further declarations were made and existing declarations were confirmed as standing.

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4. Minutes of Previous Meetings

Information

Chair

The Chair explained that, given the establishment of the Group Board and changes in membership, the minutes of the previous meetings of the constituent NHS Foundation Trust Boards were presented for noting rather than approval. He clarified that this approach ensured continuity of record while recognising that the Group Board was not the approving body for those meetings.

He further confirmed that the Group Board would assume responsibility for ensuring that actions arising from the former Boards were appropriately consolidated, tracked and progressed through Group governance arrangements.

The minutes of the following meetings were noted for the record:

- James Paget University Hospitals NHS Foundation Trust Board of Directors
- Norfolk and Norwich University Hospitals NHS Foundation Trust Board of Directors
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust Board of Directors

Members emphasised the importance of maintaining a grip on legacy actions during the transition period to avoid any dilution of accountability.

The Group Board resolved to note the minutes of the previous meetings of the constituent Trust Boards of Directors.

Action

The Group Secretary to provide the composite list of all outstanding actions from the three constituent Boards for oversight by the Group Risk Assurance Committee and for implementation by the Group Executive.

5. Chair's Report

Information

Chair

The Group Chair advised that he would defer a substantive Chair's report until the next meeting, allowing time for further induction, site visits and engagement with key stakeholders across the Group. He confirmed that this would enable him to provide more informed reflections on culture, governance maturity and priorities for the Group Board.

6. Chief Executive's Report

Discussion

Chief Executive

Lesley Dwyer, Group Chief Executive, presented her report, setting out the current operational and strategic context facing the Group. She highlighted winter pressures, including the escalation of flu cases, sustained demand across urgent and emergency care, and the commencement of a five-day period of resident doctors' industrial action. She reassured the Board that detailed contingency arrangements were in place and reiterated that patient safety and service continuity remained the overriding priorities.

The Group Chief Executive updated the Board on the national maternity and neonatal investigation led by Baroness Amos, confirming that Queen Elizabeth Hospital King's Lynn was one of the Trusts included. She reported that the recent visit by the investigation team had been constructive, with strong engagement from staff, women and families, and that no immediate concerns had been identified requiring urgent intervention. She advised that the investigation team had expressed interest in the emerging Group governance model and would return for further engagement.

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The Board was also updated on NHS England's recent review of progress on the Group's transition arrangements. The Group Chief Executive advised that initial feedback had been received but that the formal report remained with the regional team. She confirmed that the report would be shared with Board members once finalised and scheduled for discussion at a future meeting.

Turning to oversight and performance, the Chief Executive confirmed that all three Trusts remained in segment four of the National Oversight Framework (NOF). She noted the relative national positioning of Queen Elizabeth Hospital King's Lynn and James Paget University Hospitals NHS Foundation Trusts and advised that limited movement was anticipated in the current quarter due to the annual nature of some NOF indicators, including the staff survey. She outlined plans for a Group-wide recovery and transformation programme, supported by an external partner, aimed at moving the Trusts from segment four through focused improvement in quality, safety, staff experience and operational delivery.

In discussion, the Group Chair and Group Non-Executive Directors asked about the latest staff survey. The Group Chief Executive acknowledged the impact of survey timing, financial recovery measures, redundancies and adverse media attention on staff sentiment. She outlined actions underway to strengthen engagement, including listening events, pulse surveys and the development of a clearer and more compelling Group vision and narrative.

The Interim Executive Managing Director of Queen Elizabeth Hospital King's Lynn (QEH) advised that, while the QEH response rate in the recent survey had been relatively high, the context suggested that results would be challenging. The Group Chair emphasised that high response rates provided valuable insight and reinforced the Board's responsibility to listen, respond and demonstrate visible leadership. He highlighted the importance of the National Oversight Framework as both an external accountability mechanism and an internal tool for prioritisation and improvement.
The Group Board resolved to note the Group Chief Executive's report.

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7. Board Committee Reports

7.1. Group Audit Committees in Common

Information

Committee Chair

A report was presented summarising the meeting of the Group Audit Committees in Common held on 19 November 2025. Members noted that the Committees continued to operate as sovereign and independent audit committees for each Trust, while meeting in common to promote consistency, shared learning and efficiency.

The Group Chief Finance Officer advised that work to align external audit contracts across the three Trusts was progressing and confirmed that formal approval rested with the respective Councils of Governors. The Group Director of Digital provided an update on cyber security, advising that a Cyber Security Task Force had been established to address gaps identified through Internal Audit and regulatory review. He highlighted the dynamic nature of cyber risk and the need for sustained investment and assurance.

The Group Chair stressed the importance of committees providing clear, outcome-focused reports to the Board, including explicit recommendations and resolutions, to support effective oversight.

The Group Board noted the report.

7.2. Group Risk Assurance Committee

Information

Committee Chair

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Sally Collier presented the report from the meeting of the Group Risk Assurance Committee held on 27 November 2025, advising that partial assurance had been provided due to the scale and cross-cutting nature of Group risks. She highlighted progress in defining principal risks with named owners and actions, while noting further work required on the development of the Group Board Assurance Framework, risk appetite, control effectiveness and cyber assurance.

The Committee had discussed mortality data across all three Trusts and requested further review, alongside discussion of risks associated with major programmes including the New Hospital Programme and the Electronic Patient Record.

Members emphasised the importance of clear risk flow between executive forums, committees and the Board, and the need for narrative explanation alongside quantitative data to support assurance.
The Group Board noted the report.

7.3. Group Executive

Information

Group Chief Executive

The Group Chief Executive outlined the role of the Group Executive Directors' Meeting as the principal executive decision-making forum, responsible for operational grip and delivery of the Group transition plan. She confirmed that actions were either complete, embedded within routine governance or would return to the Board only where formal approval was required.

The Board discussed the distinction between executive management and Board governance functions and agreed that in future any matters to be highlighted or escalated from the Group Executive Directors' meeting should be covered in the Group Chief Executive's report.

The Group Board noted the report.

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8. Performance Reports

8.1. Group Integrated Performance Report

Discussion

Group Chief Delivery Officer

The Group Chief Delivery Officer presented the Group Integrated Performance Report, noting that the data reflected October 2025 performance. She highlighted key areas of concern including sickness absence, elective waits over 65 weeks, cancer performance, ambulance handover delays and patient experience metrics.

Board members welcomed the move towards a Group-level report but raised concerns about variation in targets between Trusts, the risk of over-reliance on headline measures and the need to surface less visible risks. The Board emphasised the importance of linking performance reporting to recovery plans and national standards.

The Group Board reviewed and noted the report.

8.2. Group Finance Report

Discussion

Group Chief Finance Officer

The Group Chief Finance Officer presented the Group Finance Report, advising that the Group remained on track to deliver the financial plan for 2025/26, with a forecast outturn of approximately £5 million. He outlined ongoing pressures relating to redundancy costs, industrial action and capital constraints, including the Electronic Patient Record programme. He confirmed that income positions had been agreed with the Integrated Care Board and that discussions continued regarding capital funding and national programmes.

Board embers sought assurance regarding financial sustainability and the implications of Group working for future planning. It was agreed that a separate briefing session would be arranged for Group Non-Executive Directors.

The Group Board acknowledged the financial assurance provided.

Action:

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The Group Chief Finance Officer would arrange a separate briefing session on the financial position and plans for Group Non-Executive Directors ahead of the next Group Board meeting.

8.3. Constituent Foundation Trust Update Reports

Information

Updates were provided by the Executive Managing Directors (EMDs) for each Trust.

Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)

The EMD for NNUH highlighted a deterioration in ambulance handover performance and actions underway to address financial and operational challenges.

Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH)

The EMD for QEH noted reductions in long elective waits, improvements in urgent and emergency care performance and cancer pathways, alongside ongoing concerns regarding coding backlogs, industrial action risks and workforce vaccination rates.

James Paget University Hospitals NHS Foundation Trust (JPUH)

The EMD for JPUH noted workforce engagement challenges, senior leadership changes, the opening of the same-day emergency care unit and progress in neighbourhood development initiatives.

In discussion, Board members emphasised the need for a consistent purpose and format for Trust reports to support effective Board assurance and decision-making.

The Group Board resolved to note the Trust updates.

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9. Emergency Preparedness, Resilience and Response Core Standards

For Assurance

Group Chief Delivery Officer

The Group Chief Delivery Officer presented the Emergency Preparedness, Resilience and Response self-assessment, confirming that all three Trusts were assessed as substantially compliant, with regional assurance supporting this position. She highlighted Group-wide themes including infectious disease planning, cyber assurance and incident coordination arrangements.

Members discussed the consistency of self-assessment and the role of internal audit in strengthening assurance, particularly in relation to cyber resilience.

The Group Board resolved to acknowledge the assurance provided.

Actions:

- Include Emergency Preparedness, Resilience and Response and cyber assurance within discussions on the Internal Audit programme.

10. Board Governance Documentation

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10.1. NWUHG Directors' Code of Conduct

Adoption

Group Secretary

The Group Secretary presented the Directors' Code of Conduct, noting that it incorporated the Nolan Principles, the NHS Constitution and Institute of Directors standards. Members welcomed the clarity provided and the importance of setting shared expectations at Group level.

The Group Board resolved to approve and adopt the Directors' Code of Conduct.

10.2. Board Committee Terms Reference

Decision

The Terms of Reference for the Group Audit Committees in Common, the Group Nomination and Remuneration Committees in Common, and the Group Risk Assurance Committee were presented. Members noted the need for flexibility as governance arrangements matured.

The Group Board resolved to:

- Approve the terms of reference of the Group Audit Committees in Common and the Group Nomination and Remuneration Committees in Common, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust.
- Approve the terms of reference of the Group Audit Committees in Common and the Group Nomination and Remuneration Committees in Common, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.
- Approve the terms of reference of the Group Audit Committees in Common and the Group Nomination and Remuneration Committees in Common, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust.
- Approve the terms of reference of the Group Audit and Risk Committee.

11. Group Board Calendar

To Note

Group Secretary

The forward calendar of Board and Committee meetings was presented and noted.

Date	Location/Trust	Room
01 April 2026	JPUH	Lecture Theatre, Burrage Centre, JPUH
03 June 2026	NNUH	Board Room, NNUH
05 August 2026	QEHKL	Board Room, QEHKL
07 October 2026	JPUH	Lecture Theatre, Burrage Centre, JPUH
02 December 2026	NNUH	Board Room, NNUH
03 February 2027	QEHKL	Board Room, QEHKL
07 April 2027	JPUH	Lecture Theatre, JPUH

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12. Any Other Business

Discussion

Chair

A member of the public raised concerns regarding senior leadership costs, redundancies and outpatient letter backlogs. The Group Chief Executive responded, outlining the rationale for Group-level leadership, the importance of modernisation and efficiency, and actions underway to address backlogs and improve job planning.

13. Meeting Review

Discussion

Chair

The Chair reflected on the conduct of the meeting and invited feedback on agenda management and Board papers. He emphasised expectations regarding clarity, brevity and consistency, and encouraged constructive challenge as the Group Board matured.

Walker, Ian

14. Date of Next Meeting

Wednesday 1 April 2026 in the Lecture Theatre, Burrage Centre, James Paget University Hospital, Lowestoft Road, Gorleston, Great Yarmouth, Norfolk NR31 6LA.

15. Close of Meeting

The Chair thanked everyone for attending and formally closed the meeting.

The meeting was adjourned at 11:30.

Walker,Ian
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GROUP BOARD MEETING IN PUBLIC: ACTION LOG

Ref.	Meeting date	Agenda item	Action	Lead	Update	Status
1	17.12.25	Minutes of previous meetings	Provide composite list of legacy actions from constituent Boards for oversight by Group Risk Assurance Committee.	Group Secretary	Completed – tracking in place through Trust reporting to Executive Risk Assurance Group, with quarterly reporting to Group Risk Assurance Committee.	To close
2	17.12.25	Group Finance Report	Arrange a briefing session for Group NEDs on financial position and plans.	Group Chief Finance Officer	Completed – finance session took place on 28.01.26.	To close
3	17.12.25	Emergency Preparedness, Resilience and Response (EPRR) Core Standards	Include EPRR and cyber assurance in discussions on the Internal Audit programme.	Group Chief Finance Officer	To be considered as part of ongoing discussions on the 2026/27 Internal Audit Plan ahead of finalisation at April 2026 meeting of the Group Audit Committees in Common.	Open

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Report to the Group Board in public: 1 April 2026

Agenda item number	6		
Title	Group Chief Executive's Report		
Author(s)	Professor Lesley Dwyer, Group Chief Executive		
Executive sponsor	Professor Lesley Dwyer, Group Chief Executive		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

Strategic Progress
- One Strategy: Work completed to understand local health needs and service use.
- One Recovery: All three hospitals in our Group have improved their position in the NHS National Oversight Framework (NOF) ratings for Quarter 3.

Quality and Performance
- The Queen Elizabeth Hospital King's Lynn was placed into the National Provider Improvement Programme, and the Care Quality Commission (CQC) carried out an unannounced inspection of its Surgery services.

People and Culture
- NHS Staff Survey response: Following a Group-wide decline in staff experience, a coordinated improvement programme is being launched, including 18,000 Voices, increased leadership visibility and the Vanderbilt professional accountability programme.

Corporate Services Transformation
- Ongoing work to bring key corporate support services together across the Group.
- Progress continues on creating one Group-wide Human Resources function

Research and Partnerships
- The Research, Innovation and Education Committee held its first meeting.
- James Paget University Hospital supporting development of the local Community Collaborative.

National and Regional Context
- Resident Doctors plan Industrial Action from 07.00 on Tuesday 7 April until 06.59 on Monday 13 April.
- Meningococcal outbreak in Kent - the Group's hospitals remain alert and prepared through close regional coordination.
- Continued engagement with NHS England on Group progress and future plans.
- Local Government Review: Three unitary authorities announced for Norfolk and Suffolk from April 2028.

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Recommendations The Group Board is asked to note the content of this report.

Alignment to Board Assurance Framework risk(s)	All
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	Norfolk Health Overview and Scrutiny Committee (HOSC) Update Presentation

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Norfolk and Waveney University Hospitals Group

Group Board in public: 1 April 2026
Group Chief Executive's Report

1. Introduction and background

This report updates the Group Board (the General Purpose Joint Committee) on key recent developments from a Group perspective and should be read alongside the separate reports from the Executive Managing Directors of the three Trusts (agenda item 7).

Group and Trust Developments

2. One Strategy

Working with others, we have completed an analysis of population needs and current service use that also takes account of rapidly developing technologies. We will use it to design a model of care that delivers better integrated services closer to home and supports a sustainable, first-class acute system.

3. One Recovery

The One Recovery programme is a two-year plan focused on delivering rapid improvement across NHS Oversight Framework (NOF) measures, service access, financial sustainability and alignment with the Medium-term Plans. Aggregated Quarter 3 NOF rankings, published on 18 March 2026, show improvement across all three trusts:

- **Norfolk and Norwich University Hospitals NHS Foundation Trust** has risen to **91/134** from **108/134**, moving from Segment 4 to Segment 3.
- **James Paget University Hospitals NHS Foundation Trust** has improved to **127/134** from **129/134**, remaining in Segment 4.
- **The Queen Elizabeth Hospital Kings Lynn** has improved to **133/134** from **134/134**, remaining in Segment 4.

The scale of improvement effort across the Group should not be underestimated and is not yet fully reflected in overall NOF scores. Further detail is set out in agenda item 9.3.

4. The Queen Elizabeth Hospital King's Lynn

The Queen Elizabeth Hospital (QEH) was placed in the National Provider Improvement Programme (NPIP) at the beginning of March. Dr April Brown, Intensive Improvement Director at NHS England, has since met with Group Executives and the QEH Hospital Leadership Team. In addition, the Care Quality Commission (CQC) conducted a two-day unannounced visit to QEH in mid-March focused on Surgery.

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The Group continues to provide targeted support to QEH. Further detail is available in the QEH Executive Managing Director's report at agenda item 7.1.

5. Corporate Services Transformation

We are bringing together a number of corporate functions that support our three hospitals so they can work more effectively as single teams. This will help to reduce duplication, improve consistency and efficiency and ultimately contribute to better care for patients.

As part of this process, some staff are transferring to a single employing organisation under standard national employment protections (TUPE), with the Norfolk and Norwich University Hospital acting as the host organisation.

Phase 1
The first phase involves staff working in Digital, Finance and Communications teams across the three trusts. Those who are currently employed by the Queen Elizabeth Hospital King's Lynn and the James Paget University Hospital will transfer on 1 April 2026, following a full consultation process.

Phase 2

The second phase will bring together further corporate and operational services including Transformation, Corporate Governance and Estates and Facilities. Planning is underway and the final list of services is still being confirmed. We are also carrying out a lessons-learned review from Phase 1 to inform Phase 2. This work will help strengthen the support services across all three hospitals.

As part of this wider redesign, we are creating a Group-wide Human Resources (HR) function. This will include shared services such as recruitment, payroll, staff training records and workforce analytics, supported by local HR teams on each site. Specialist teams such as Equality, Diversity and Inclusion (EDI), Organisational Development (OD) and medical staffing will form Centres of Excellence. By operating in a more digital-first and coordinated way, the new HR model will improve consistency, reduce cost, enhance resilience and strengthen how we support our workforce across the Group.

6. NHS Staff Survey

The 2025 National Staff Survey results for all three trusts are disappointing. Engagement, morale and confidence have all fallen, and fewer staff would recommend the organisations as a place to work.

In response, the Group Chief Executive and the Executive Team have brought together leaders from HR, organisational development and communications to agree a clear plan of action.

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Key mandated actions include:
- launching the *18,000 Voices* programme so staff can quickly share concerns and see visible follow-up

- rolling out Vanderbilt, an internationally recognised cultural advocacy and professional advocacy programme

- and strengthening leadership by increasing leaders' regular presence across all areas of our hospitals through 'Gemba' visits and creating a network to support emerging leaders.

These actions aim to improve staff experience, rebuild trust in how the organisation responds to concerns, and create a more positive, supportive and aligned workplace.

7. Group Structure

Since the last Group Board meeting in December 2025, all Executive Managing Directors have now taken up post and are establishing themselves in role. A Group Director of Communications and Engagement has also been appointed and will join us in May 2026.

8. Research, Innovation and Education Committee

The Group's Research, Innovation and Education Committee met for the first time on 24 February 2026. This is an important step in making research, innovation and education a core part of how our hospitals work together in the future. The Committee will help the Group Board set the overall direction for this work and agree shared goals across all three hospitals. Its early priorities include creating consistent ways of measuring progress at each site and developing a new, Group-wide approach to how research, innovation and education are organised and supported. A summary of the first meeting is provided in the Committee Chair's report at agenda item 8.3.

National and Regional Developments

9. Resident Doctors' Industrial Action

The British Medical Association has announced that six days of industrial action by Resident Doctors will take place from 07.00 on Tuesday 7 April until 06.59 on Monday 13 April.

While each Trust has well-rehearsed plans for managing periods of industrial action, the timing of this action immediately following the Easter Bank Holiday weekend will create additional pressures on teams.

10. Invasive Meningococcal Disease Outbreak

At the time of writing, the UK Health Security Agency (UKHSA) is continuing to manage an outbreak of invasive meningococcal disease in Kent. There have been 20 confirmed cases and 2 probable cases, with more being investigated, and sadly two deaths. We offer our sincere condolences to the families and friends affected.

Walker,Ian
30/03/2026 09:59:08

The response includes contact tracing, clear public information, and quick access to antibiotics and MenB vaccinations for those at risk. Targeted

antibiotics have already been provided in key settings such as university accommodation.

This situation is understandably worrying for parents, students and university communities. Although the outbreak remains centred in Kent, given the large university population in Norfolk, we remain alert and prepared with updates and guidance from UKHSA and Regional Health Protection teams.

11. Meeting with the Chief Executive of NHS England (NHSE)

The Group Chief Executive and Group Chair met during March with the Chief Executive of NHSE to discuss progress on the Group formation. The discussion focused on the development of Group's future operating model and mobilisation of the One Recovery Programme.

12. Local Government Review

The Government has confirmed details of new single-tier unitary councils for Norfolk and Suffolk. These are planned to take effect from April 2028 subject to the required statutory and parliamentary steps to approve the legal change that creates the new councils.

We will consider the impact of these changes, noting that the models for both Norfolk and Suffolk will involve three new unitary authorities, each with their own new geographical area. It is acknowledged that a single authority had been proposed by Norfolk and Suffolk County Councils. The Group had also supported the single authority for Norfolk. The proposed structures are detailed below:

Norfolk

- West Norfolk Council (current local government areas of Breckland, King's Lynn and West Norfolk, and 9 parishes from South Norfolk).
- Greater Norwich Council (current local government areas of Norwich, 19 parishes from Broadland, and 16 parishes from South Norfolk).
- East Norfolk Council (current local government areas of Broadland (less 19 parishes), Great Yarmouth, North Norfolk, and South Norfolk (less 25 parishes)).

Suffolk

- West Suffolk
- East Suffolk
- South Suffolk and Ipswich

Throughout this period, all councils will continue to deliver business as usual services, meeting statutory responsibilities and with no immediate changes to service delivery.

Walker,Ian
30/03/2026 09:59:08

13. Norfolk Health Overview and Scrutiny Committee (HOSC)

13.1. Digital Transformation – Electronic Patient Record

The Group Digital Director and the Associate Director of Digital for Norfolk and Waveney Integrated Care Board (ICB) attended a formal HOSC meeting in March to provide an update on digital transformation across the Integrated Care System (ICS). This included an update on the Electronic Patient Record (EPR) programme, which is the Group's largest digital transformation initiative.

HOSC were advised of the revised go-live date for its shared Electronic Patient Record (EPR) system following a comprehensive review of Programme readiness. This decision reflects the Group's commitment to ensuring the solution fully meets clinical, operational, and safety requirements across all three acute trusts prior to implementation. The HOSC noted the importance of prioritising patient safety in agreeing the revised timeline.

13.2. New Hospital Programme

The Group Chief Delivery Officer and the Group Chief Medical Officer recently attended an informal meeting with the Lead of HOSC and the Norfolk and Waveney Integrated Care Board (ICB) to update on progress with the plans to build new hospitals for James Paget University Hospital and The Queen Elizabeth Hospital King's Lynn.

Both hospitals were built using Reinforced Aerated Concrete (RAAC), which is now known to have structural limitations and are part of the national programme to replace RAAC-built hospitals.

Since the formation of the Norfolk and Waveney Hospitals Group, the work is now being taken forward as a single programme for the whole area, with two linked hospital projects. The HOSC noted key milestones in the programme and that the programme is progressing as planned.

14. Partnerships

Colleagues at James Paget University Hospital (JPUH) continue to work with partners to shape the evolving role of Place. This includes the establishment of a Community Collaborative in Great Yarmouth and Waveney. Further detail is provided in the JPUH Executive Managing Director's report agenda item 7.2.

15. Recommendations

The Group Board is asked to note the content of this report.

Walker,Ian
30/03/2026 09:59:08

Report to the Group Board in public: 1 April 2026

Agenda item number	7.1		
Title	Foundation Trust update report: Queen Elizabeth Hospital King's Lynn NHS FT		
Author(s)	Michelle Arrowsmith, Executive Managing Director		
Executive sponsor	Michelle Arrowsmith, Executive Managing Director		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

This report is presented to the Group Board to provide an overview of key priorities and actions which are in train within the QEH.

The organisation continues to focus on operational resilience in light of the national Urgent and Emergency Care (UEC) and Elective sprints and ongoing General Surgery improvement. Improving leadership capability and strengthened culture in line with the development of the Group approach and the National Staff Survey results are a priority, alongside the immediate actions and response to the National Provider Improvement Programme (NPIP) and the unannounced Care Quality Commission (CQC) visit to Surgery in March 2026.

Recommendations

The Group Board is asked to receive and note the report.

Alignment to Board Assurance Framework risk(s)	Principal Risks 1, 2, 3, 4, 5
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

Walker,Ian
30/03/2026 09:59:08

Norfolk and Waveney University Hospitals Group

Group Board in public: 1 April 2026
Foundation Trust update report: Queen Elizabeth Hospital King's Lynn NHS FT

Site Leadership Team
Dawn Collins has started with the Trust as Interim Chief Nurse following the departure of Pippa Street. I would like to take the opportunity to formally thank Pippa for her support and leadership to the Trust and to welcome Dawn.

Defence Employer Recognition Scheme Gold Award
The Trust has been recognised nationally for its continued support to the Armed Forces community after securing revalidation of the Defence Employer Recognition Scheme (ERS) Gold Award for a further five years.

The award – the highest recognition presented by the Ministry of Defence to supportive employers – was presented by the HM Lord Lieutenant of Norfolk, Lady Dannatt, at an event held at Norwich Army Reserve Centre on 5 March.

The recognition reflects the Trust's sustained commitment to supporting veterans, reservists and their families, both as colleagues and as patients. This includes the Armed Forces Champions network, close partnerships with organisations including RAF Marham, a monthly Armed Forces Forum, and initiatives to support recruitment and opportunities for cadets and veterans.

Regulatory

National Provider Improvement Programme (NPIP)
The Trust has formally entered the NPIP with support from a National Improvement Director, Dr April Brown, and a wider team. An initial on-site visit took place on 17 March. This has been supported by a data request which has been responded to and includes a broad range of documents relating to both the Group and Trust's development and governance. Next steps include the development of an initial report by mid-April, followed by the final report by mid-July. Work will be required to ensure robust triangulation and alignment with other programmes.

CQC – Inspection of Surgery
On 17 and 18 March 2026, the Trust had an unannounced CQC inspection of Surgery. The inspectors reviewed all aspects of the surgical pathway visiting all key areas. The Performance Information Request has now been received and will be actioned. Alongside this, it has been confirmed that focused interviews will take place between the CQC team and key leaders as well as focus groups with broader nursing and medical staff. A final report will be received in due course.

Operational performance

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30/03/2026 09:55:08

Urgent and Emergency Care
Urgent and Emergency Care (UEC) performance during February showed modest improvement compared with January, with overall 4-hour performance increasing from 64.0% to 64.6%. This was driven by the admitted pathway, which improved from 26.0% to 28.5%, while non-admitted performance remained broadly stable.

Performance continues to be influenced by 12-hour delays for admitted patients, although the position remained broadly stable during the month. Ambulance handover performance also improved, with fewer delays exceeding one hour and more handovers completed within 30 minutes.

During March the Trust mobilised a UEC Sprint programme as part of the national Spring Reset to strengthen front-door flow and patient movement through the Emergency Department.

Cancer Performance

Cancer performance during February remained below the 62-day national standard, with pressures concentrated in a small number of tumour pathways.

Enhanced operational oversight has been introduced, including weekly recovery meetings led by the Deputy Chief Operating Officer and joint working with Norfolk and Norwich University Hospital (NNUH) to support pathway recovery.

A Cancer Sprint programme has been mobilised during March to strengthen pathway management, reduce backlog patients and increase diagnostic and treatment capacity within the most pressured tumour pathways.

Elective Performance

Elective performance remains under close regional scrutiny, with QEH currently the lowest performing organisation within the Norfolk system on 18-week Referral to Treatment (RTT).

Current forecasts indicate 18-week RTT performance finishing above 60%, with potential improvement towards approximately 62% as validation activity and additional elective activity flow through during March.

During March the Trust mobilised an Elective Sprint programme, including approximately 2,000 additional pieces of elective activity, expanded evening and weekend working and targeted validation programmes. Executive oversight is in place to track bookings, activity delivery and validation outputs weekly to ensure delivery of the planned March activity.

General Surgery

The Medical Director is leading the action plan to address recommendations from the Royal College of Surgeons, with an update due to the College and the public in early April, supported by ongoing work with the deanery on workforce education. This work is supported by daily huddles which are being used to assure safety of patient care, address issues, and support staff welfare.

A significant number of elective cases have been transferred to NNUH to decompress the service, managing patient follow-up and radiology support, alongside ongoing efforts to stabilise the workforce and service being managed collaboratively across the Trusts.

Work is in train to ensure the robust development and implementation of a clear stabilisation plan for the General Surgery Service.

Walker,Ian
30/03/2026 09:59:08

Finance – Month 11
At M11 the Trust has reported an in-month surplus of £1.3m against a planned surplus of £0.9m, this gives rise to a year-to-date position of £0.2m deficit against a planned deficit of £0.3m. CIP in M11 is showing a favourable variance to plan of £198k. NNUH continue to provide cash support to the Trust. A Cash Committee has now been established and is meeting fortnightly and is chaired by the Executive Managing Director (EMD) with oversight from the Group Chief Finance Officer.

Service updates

Maternity and Neonatal Inspection
The National interim report has been published. The Trust is fully compliant and engaged with the on-going process and awaits the final report.

10-point plan for Resident Doctors
QEH has seen a 34-percentage point improvement in our compliance with key recommendations from the baseline survey to the 12-week survey undertaken in December. The Medical Director meets monthly with our Resident Doctor Peer leads, and we have agreed priority areas for improvement. Additional lockers were installed in February. The focus remains on improving rostering and a co-produced Rota SOP has been agreed. Work continues to improve the foundation year teaching programme, induction and reward and recognition. Exception reporting is compliant with the new framework. The Trust has resident doctor representation on its staff survey group.

Pharmacy Services
Pharmacy services continue to operate under pressure, with the Trust's aseptic production unit currently paused due to the availability of authorised staff required to release aseptic products.

During this period the Trust has relied on external supply arrangements to maintain continuity of treatment for patients requiring chemotherapy and other aseptically prepared medicines.

Work is underway to stabilise local pharmacy leadership ahead of the planned appointment of a Group Chief Pharmacist, alongside addressing authorised staffing capacity required to support restoration of local aseptic services.

Audiology
Audiology remains one of the Trust's most operationally fragile diagnostic services, particularly within Paediatric Audiology. The recovery model which has been instigated relies largely on capacity at Norfolk and Norwich University Hospital, creating a group-level recovery challenge.

An external insourcing provider has been identified to support backlog reduction, with potential ICB funding to accelerate clearance of the waiting list. The Executive Managing Directors for QEH and NNUH are overseeing rapid improvement work to stabilise the service and strengthen group oversight of the recovery plan.

Walker, Ian
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Chronic Pain Service
The Chronic Pain service has now stabilised and is expected to continue stabilising with confidence following a period of workforce disruption. The service now has two

substantive consultants in post, with a further appointment progressing and interim locum support in place, restoring clinical leadership and clinic capacity.

Coding
Work continues to address the historic clinical coding backlog. Contract coding resource has been deployed and is ahead of the delivery trajectory. At the current rate of progress the Trust is close to catching up on the historic backlog, with the remaining activity expected to be cleared shortly. Work has been completed to secure additional external coding support for the next 3–6 months, while longer-term group coding arrangements are developed in line with the development of the Target Operating Model for finance.

National Staff Survey
The 2025 NSS were released publicly on 12 March 2026. While it was expected that there would be declines in scores across the NHS and acute sector the QEH has had a particularly challenging survey in 2025. QEH had its best ever response rate of 53.1% in 2025, however, nearly all metrics have declined compared to 2024.

Headline metrics such as recommending the Trust for treatment or as a place to work had declined and the Trust is also below average for all seven People Promise indicators and staff engagement.

Improving leadership and management competency, the Trust's response to incidents and dealing quickly, consistently and compassionately will be key to improving organisational culture. Leveraging Group wide leadership initiatives, 18,000 voices and Vanderbilt approaches in conjunction with local initiatives will be important in improving the experience of working at QEH for all our staff.

Place, Neighbourhood and partnership working

Place
There is a clear focus on ensuring that Place-based partnership activity across West Norfolk, Fenland and the wider Norfolk & Waveney system is generating meaningful progress across key themes including prevention, employment, discharge support and community wellbeing. Work is now at a stage where we can triangulate delivery across Place forums with the One Recovery priorities. Continued triangulation of Group led strategic work is in progress to ensure that work which has already been done at Place in relation to 'left shift' and future delivery models is built upon.

Neighbourhood
In line with the work on One Strategy, significant work is in train to develop the framework and roadmap for Neighbourhood delivery. Detailed discussions are in train via the West Place Board and in collaboration with wider Partners. Building upon the high-level principles discussed and agreed at the March N&W Health and Wellbeing Partnership and a discussion at ICS EMT a cross-partner workshop took place on 13 March with key leaders from within the System, supported by the external expertise commissioned from PPL.

Walker,Ian
30/03/2026 09:09:08

Health Inequalities
Progress is being made on the wider determinants of health through the King's Lynn & West Norfolk Health and Wellbeing Partnership. The next phase of the Marmot Programme, focusing on employment and skills, is being prepared. The first Marmot

Place Year 1 report has been published, focusing on early years and the inequalities affecting children and young people, providing an important evidence base for longer term population health improvement. Health Inequalities delivery requirements have been confirmed contractually by the ICB necessitating a step change in delivery approach including clear focus on data utilisation to inform proactive pathway changes and decision-making supported by staff training. Discussions are in train at Group level around an aligned approach to delivery.

Conclusion

The Trust remains focused on performance and productivity improvement and ensuring that services remain safe.

Recommendation

The Group Board is asked to receive and note the report.

Walker,Ian
30/03/2026 09:59:08

Report to the Group Board in public: 1 April 2026

Agenda item number	7.2		
Title	Foundation Trust update report: James Paget University Hospitals NHS FT		
Author(s)	Jonathan Gardner, Executive Managing Director		
Executive sponsor	Jonathan Gardner, Executive Managing Director		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

In the last quarter we strengthened the senior leadership with the appointment of a new **Chief Medical Officer, Chief Financial Officer and Director of People and Culture**. Despite two critical incidents, we **improved A&E performance**, **reduced long waits** and **maintained a forecast breakeven** position.

We **responded immediately** to two never events, completed Duty of Candour and **implemented organisational learning**. We also **reviewed and challenged** the draft Care Quality Commission (CQC) findings from the maternity visit through a factual accuracy process. Our leadership and culture work - including first-name culture, "My Name Is" badges and visible leadership - **aims to prevent recurrence** and **strengthen safety culture**.

We continue to hear from staff that wellbeing and morale need attention, especially in areas with low nursing fill rates. In response, we **launched the Top Leaders Programme**, **increased visible leadership** and **expanded opportunities for engagement** across teams.

Our relaunched **Length of Stay (LoS) (Time to Care) programme** is delivering results, **reducing LoS from 12.0 to 10.7 days** since November 2025. In elective care, we **accelerated recovery through a Q4 sprint**, booking, validating or transferring more than **4,300 patients**.

We **advanced neighbourhood and place-based care**, working with partners to design integrated models and mobilise proactive frailty-focused neighbourhood teams. Early testing shows that these teams can **better identify risk**, **coordinate multi-disciplinary teams (MDTs)** and **provide person-centred care**.

We also delivered several local achievements: we **expanded training opportunities** by converting clinical fellow posts; we **opened a new maternity triage and assessment unit**; we **recruited the UK's first patient** to an international immunotherapy study; we **secured conditional approval** for the new hospital SOC; and we **strengthened community engagement** through local health and wellbeing initiatives.

Walker,Tanya 30/03/2026 09:59:08

Overall, we **maintained operational resilience**, **developed leadership capability**, **strengthened culture**, and **progressed strategic transformation** across urgent care, electives, and neighbourhood working.

Recommendations

The Group Board is asked to receive and note the report.

Alignment to Board Assurance Framework risk(s)	Principal Risks 1, 2, 3, 4, 5
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

Norfolk and Waveney University Hospitals Group

Group Board in public: 1 April 2026
Foundation Trust update report: James Paget University Hospitals NHS FT

1. Site-specific updates

Site Leadership Team

I joined the Paget and the Group on the 12 January 2026. I would like to take this opportunity to thank Jon Barber for acting up between Shane Gordon leaving and my arrival. Since the last Board report, I am delighted to say we have appointed Rob Major as our site Chief Medical Officer, James Taylor as our site Chief Financial Officer and Deborah O'Hara as our Director of People and Culture. I have spent a large amount of my time so far focusing on listening and being visible. I am pleased to say I have now visited every area of the Trust at least once.

Safety
This month in other reports we are highlighting two never events over the last quarter. One was a wrong site surgery and the other was a retained instrument. The details have been reported elsewhere; however, both resulted in moderate harm to patients. Duty of candour was conducted immediately and learning has been applied straight away. The work we are doing on leadership (see below) and culture (e.g. first name terms, and my name is badges) will be one key to ensuring prevention of future events. We received the CQC draft report from their Maternity visit in September and sent back a factual accuracy response. We have carried out Well Led Interview practice with Capsticks.

Performance
The last quarter of this year has been a challenging one from a performance perspective with two separate critical incidents being declared due to industrial action and then poor flow in the hospital. Despite that, our A&E performance has continued to exceed previous year's performance by a long way. In addition, our long waits continue to reduce although not to the level we would like. We continue to forecast an end of year breakeven financial position.

Our people
We are hearing from staff that we have more to do to support their wellbeing and morale and sickness is slightly higher than we would expect. This is particularly true in areas where the nursing shift fill rate is low. Among other things we have implemented a new Top Leaders Programme for the top 250 leaders in the organisation. This will be a place for us to listen to them, empower them, invest in them and develop them to also listen and lead their teams effectively. We have also increased visible leadership through 'in your shoes', and an executive visit tracker.

Urgent and emergency care recovery
Walker, Jan
30/03/2026 09:59:08
The length of stay programme was relaunched in November last year with the aim to reduce the average length of stay across inpatient wards enabling improved flow and bed optimisation. Average length of stay at JPUH had consistently remained above the benchmarked national average sitting at 12.0 days against the national average of 10.5 days. The programme focusses on five key areas under the banner of Time to Care. This includes reviewing every patient over 14 days twice a week in executive

and system engaged meetings, implementing Criteria Led Discharge on every ward, reviewing case manager and Ward based discharge support, improving the training and use of OPTICA and leading on a red to green diagnostic process to reduce delays. Supporting these initial projects, has been the overarching focus on long term sustainability - teach, learn and hand over to the Divisions following a period of intensity. It is this element which will see the long-term step change required at JPUH. The programme with its engagement with system partners and teams across the Trust has a strong focus on long term improvements not just within the acute but also across health and social care whilst we aim to reduce the deconditioning of patients that we have seen within our organisation. JPUH has demonstrated through this programme a month-on-month improvement of the Length of Stay (LoS) performance since launch showing 10.7 days in February.

Elective care recovery

The elective care programme has been dominated by the sprint work during Q4, this has included a combination of weekend clinics, virtual clinics, additional typing support, insourcing and validation of waiting lists. To date, we have booked, transferred or validated 4,347 patients across a variety of initiatives with 2,059 patients seen at the time of writing. Support is ongoing from NHS England to ensure that we can appropriately record the activity in time for the end of March 2026.

Neighbourhoods

Jon Barber and I have been progressing work with our partners through numerous design and engagement events with GPs, council and community colleagues. This has included arranging a meeting of all partners (community partners / ICB / primary etc etc) and the three place chairs to define how the role of Place can evolve to meet the new approaches to health care and neighbourhoods. We are hopeful to be able to use 'left shift' ICB funding to start new models of care early in the new financial year, including multi agency anticipatory care teams and long-term condition consultant support into primary and community care at a neighbourhood level.

A Community Collaborative is established in Great Yarmouth & Waveney which reports to the Place Board. This partnership oversees the 'Test, Learn and Grow Neighbourhood Health Programme' in Great Yarmouth and Waveney. Partners are working together to test a shared, person-centred model of proactive care. Phase 1 focuses on a frailty cohort identified through Eclipse risk stratification, aiming to provide earlier, coordinated support for people with complex needs through a single neighbourhood team.

A well-engaged multi-agency Steering Group has established strong oversight, with early testing confirming that the cohort identification and validation process is effective. The programme is now moving into person-centred engagement, beginning assessments with 20 individuals and using "what matters to me" visits to inform MDT discussions across Suffolk and Norfolk.

Overall, the programme has established a functioning MDT, a validated cohort and early learning. A clear roadmap is in place to scale and embed neighbourhood teams over the next 24 months, supporting a sustainable model that improves coordination, experience and reduces avoidable escalation.

Walker,Ian
30/03/2026 09:59:08

2. Local developments

Resident Doctor 10-point Plan
The James Paget 10 Point plan was submitted by Chief Medical Officer to East of England region on 09/12/2025 after sign off by the Resident Doctor Lead. The East of England collective submission made the us equal first in the country, along with the West Midlands, in terms of our performance against the 10-point plan.

Better education offering for resident doctors
We were asked by The East of England (EoE) Deanery to convert five clinical fellow posts into training posts. We have agreed to do this with two from Medicine and three from surgery. We have also advertised three clinical training fellow posts to support resident doctor clinical training on the wards.

New maternity triage area and maternity assessment units open
James Paget's Maternity department opened its new triage area and maternity assessment units in January, providing care for those who are pregnant and those who have recently given birth, offering faster assessment and prioritisation of urgent or complex cases, as well as a calmer, welcoming environment and dedicated monitoring spaces.

First UK hospital to recruit to international immunotherapy drug study
James Paget has become the first hospital in the UK to recruit a patient to a study focused on a new way of administering Atezolizumab, an immunotherapy drug which has been used by the NHS to treat various cancers since 2017, via subcutaneous injection. More than 200 patients - including 10 from the James Paget – will be recruited to the study, which is running in hospitals across the UK and in European countries including Austria, Italy, Poland and Spain.

James Paget's new hospital SOC receives conditional approval
James Paget has received conditional approval of its Strategic Outline Case (SOC) from the Department of Health and Social Care (DHSC) Joint Investment Committee following its meeting on 19 February. The SOC is the first stage business case that establishes the importance of the new hospital, and how the scheme will be delivered.

JPUH co-leads health & wellbeing event for people experiencing homelessness
James Paget Hospital Research and Evaluation Associate Emma Stimpson helped coordinate 'A Roof Over Your Health', an event for the local homeless community in Great Yarmouth in January, aimed at connecting individuals experiencing homelessness to essential health and wellbeing services and information in a supportive, welcoming setting, and attended by over 35 people experiencing homelessness.

JPUH Heart Failure Specialist Nurse awarded 'Special Recognition' Award
Mickey Cox, Heart Failure Specialist Nurse at James Paget Hospital, has been awarded a 'Special Recognition' Award by Pumping Marvellous, the UK's heart failure charity, for helping to develop three community events in Great Yarmouth and Waveney and delivering over 500 free heart health checks to local residents.

Walker, Jan
30/03/2026 09:55:08

3. Recommendation

The Group Board is asked to receive and note the report.

Report to the Group Board in public: 1 April 2026

Agenda item number	7.3		
Title	Foundation Trust update report: Norfolk and Norwich University Hospitals NHS Foundation Trust		
Author(s)	Dr Shane Gordon, Executive Managing Director		
Executive sponsor	Dr Shane Gordon, Executive Managing Director		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

This report highlights progress in financial recovery, service improvement and innovation at NNUH, while recognising continued pressure in urgent and emergency care. Key developments include delivery of financial breakeven and exiting from enhanced regional expenditure controls, improving elective and cancer performance and National Oversight Framework ranking, as well as the doubling of robotic surgery capacity and the implementation of Martha's Rule across services.

Together, these developments demonstrate progress against our Ambition for Excellence, while also underlining the need for continued focus on operational resilience, culture and staff experience.

Recommendations

The Group Board is asked to receive and note the report.

Alignment to Board Assurance Framework risk(s)	Principal Risks 1, 2, 3, 4, 5
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

Walker,Ian
30/03/2026 09:59:08

Norfolk and Waveney University Hospitals Group

Group Board in public: 1 April 2026
Foundation Trust update report: Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)

1. Changes within Hospital Leadership Team

Shane Gordon joined NNUH as Executive Managing Director in December 2025. Also in December, Rachael Cocker, Chief Nurse was appointed to the position of Group Chief Nurse on a one-year secondment. Deputy Chief Nurse Lucy Weavers is acting up as Interim Chief Nurse at NNUH.

Louise Ludgrove joined NNUH as Interim Director of Human Resources in February 2026. Lorraine Hooper, Interim Director of Finance, has left the organisation to take up a role at Barking, Havering and Redbridge Hospitals NHS Trust. We thank Lorraine for her contribution in supporting the Trust to achieve a breakeven position for 2025/26.

Bernard Brett, Medical Director, will be taking up a new position leading key programmes of work across our hospitals Group, including developing our clinical strategy and leading the Vanderbilt Pursuing Professionalism programme. Tarnya Marshall, Deputy Medical Director, will be stepping up to Interim Medical Director.

2. Performance

Activity
Recent performance has been mixed but there are encouraging signs of improvement. In urgent and emergency care, 4 hour performance remained above the national standard in February (80.5% admitted, discharged or transferred from ED), although slightly below our plan.

12-hour waits and ambulance handover delays, remain off track, but each improved compared with January, suggesting some positive movement despite continued pressure across the urgent and emergency care pathway.

Elective and cancer performance has shown stronger progress. 18 weeks to treatment performance and 18 week time to first appointment both improved in February and achieved their best position of 2025/26 to date. The 52 week position also improved when compared to January but remains above the expected level overall. With 3.1% of waiting list waiting 52 weeks or more for treatment against a target of less than 1%.

In cancer, the 28 day Faster Diagnosis Standard is performing ahead of plan and has reached the highest level ever achieved by NNUH (84.3%). 62 day performance is improving and remains on trajectory.

Walker,Ian
30/03/2026 09:59:08

Overall, performance in elective and cancer pathways is moving in the right direction, while urgent and emergency care continues to require the greatest operational focus. Eradicating the use of temporary care spaces remains a top

priority for the organisation as does ensuring that ambulances are not delayed in responding to emergencies in the community.

Finance

As a result of significant organisational effort to achieve financial break-even during the financial year, NNUH was removed from the enhanced regional expenditure controls ("triple lock") on 1 March 2026. The Trust had originally entered the process in December 2024. Removal from triple lock restores greater local autonomy over recruitment and non-pay expenditure decisions, removing the requirement for external approval from the ICB and NHS England.

3. National Oversight Framework

In the most recent quarterly publication, the Trust has moved up in the National Oversight Framework (NOF) rankings from 108th to 91st (out of 134 acute trusts), and is now in Segment 3. This improvement reflects the progress outline above regarding improved cancer performance, waiting list reductions and delivering to our financial plan. While we welcome the improvement in our position, we are still not where we aspire to be. Work continues to embed the improvements and achieve a NOF ranking that aligns to the excellent services we provide and that we can be truly proud of.

4. Our Ambition for Excellence

Our vision is to deliver *"the best care for every patient".* To do this, we have set out our ambition for excellence. It reflects our ambition not only to maintain areas of strong performance, but to reduce unwarranted variation and ensure that high-quality care, timely access, effective use of resources, and a strong culture of learning and innovation are embedded across all services. In essence, is about being clear on what excellence looks like for our organisation and aligning our improvement efforts behind that shared ambition.

In order to deliver excellence, we are focusing on the practical changes needed. This includes improving quality and safety, strengthening flow and access to care, making better use of our workforce, estate and finances, and supporting education, research and innovation as core parts of how we improve services.

The aim is to bring greater consistency, accountability and pace to improvement, so that patients, staff and communities experience the benefits of a more effective, sustainable and high-performing organisation.

5. Celebrating 10 Years of Robotic Surgery and doubling robotic surgery capacity

The Trust has marked 10 years of robotic surgery, recognising the significant contribution that charitable support has made to the development of this service in Norfolk. The anniversary event brought together staff, patients, donors and supporters and highlighted the impact of robotic surgery across multiple specialties, including improvements in surgical precision, the ability to undertake less invasive procedures, reduced recovery times, and opportunities for further innovation in training and patient outcomes.

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This milestone follows the recent arrival of two additional da Vinci surgical robots, funded entirely through charitable donations and gifts in wills. The £3.2 million investment has already doubled the Trust's robotic surgery capacity and is expected to increase access to advanced surgical treatment for patients, while supporting faster recovery and enhanced clinical outcomes.

6. Community Diagnostics Centre one-year anniversary

Since opening in February 2025, the Community Diagnostics Centre (CDC) has improved imaging performance across MRI, CT, ultrasound and X-ray, delivering around 120,000 in its first full year. The CDC has increased diagnostic capacity, improved performance against the DM01 standard, reduced reliance on mobile units, and enhanced patient experience. Positive patient feedback and strong multidisciplinary support have underpinned a successful first year, with further work planned to respond to changing referral patterns and sustain improvement.

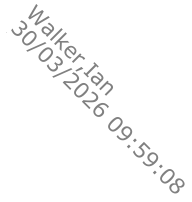
7. Implementation of Martha's Rule

The Trust has been a pilot site for Martha's Rule over the last year. This important new safety process has now been launched across all hospital services, including children's, maternity, neonatal and emergency care, strengthening arrangements for recognising and responding to patient deterioration. The initiative is intended to improve patient safety by ensuring patients and families are regularly asked about changes in condition, that staff can escalate concerns to another team where needed, and that clear escalation routes are available for patients, families and carers.

8. National Staff Survey Results

The National Staff Survey results for 2025 show a deterioration in overall staff experience compared with 2024, with declines across all People Promise themes as well as the additional themes of staff engagement and morale. The Inclusion sub-theme showed an improvement. Benchmarking against the national average for acute trusts shows that the organisation remains above average in the area of flexible working, but the overall position indicates a material worsening in how staff are experiencing work across a number of important domains.

The findings highlight the need for sustained organisational focus on leadership visibility, communication and support to line managers. Feedback indicates that a significant proportion of staff do not currently feel able to recommend the organisation either as a place to receive care or as a place to work, which is a matter of serious concern. The results have been received by the leadership team. These will inform further work with staff and leaders to ensure that colleagues voices are heard and ensuring are supported through ongoing organisational change.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9. New Clinical Associate Professors

Congratulations to Catherine Gooday, Principal Podiatrist, Marco Gasparetto, Consultant Paediatric Gastroenterologist, and Consultant Gynaecologist Thomas Gray who have been appointed as Clinical Associate Professors at the University of East Anglia. These appointments are key to continuing collaboration with our hospital to expand the level and impact of our research activity.

10. Recommendation

The Group Board is asked to receive and note the report.

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Report to the Group Board in public: 1 April 2026

Agenda item number	8.1		
Title	Group Risk Assurance Committee – Chair's report		
Author(s)	Nikki Gray, Committee Chair and Group Non-Executive Director William Van't Hoff, Group Non-Executive Director (chair of the GRAC meeting for the section on Quality and Outcomes)		
Executive sponsor	Not applicable		
Purpose of report	**For decision** ☐	**For discussion** ☐	**For information** ☒

Executive summary

The Group governance structure includes a Group Risk Assurance Committee which meets monthly.

The attached report summarises the key areas of discussion at the Committee's latest meeting which was held on 26 March 2026.

Recommendations

The Group Board is asked to note the report of the Group Risk Assurance Committee meeting held on 26 March 2026.

Alignment to Board Assurance Framework risk(s)	All BAF Principal Risks
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

Chair's Report from the Group Risk Assurance Committee (GRAC): 26 March 2026

In response to a challenge from the Group Chair that more attention needs to be given to matters of Quality and Outcomes, this Committee was co-chaired with William Van't Hoff (Non-Executive Director), who assumed Chair responsibilities for items 13 and 14 of the agenda. His report from that section of the meeting is set out below.

Matters for Board consideration

1. Committee members (and the wider Board) are invited to reflect on the effectiveness of how matters relating to Quality and Outcomes were discussed via the co-Chair route (see below) and whether this is a blueprint for future GRACs; I would welcome feedback on this matter.

2. The Committee discussed the management of the action log, noting that some items had been marked "to close", where the action would be dealt with elsewhere rather than the action had been completed. While noting that this approach was adopted to aid management of time in Committee, we agreed that the use of "not yet due" labels should be incorporated and that actions should remain open until complete, to ensure effective scrutiny.

3. The Committee welcomed the update that the Board Assurance Framework Principal Risk PR5 regarding 'workforce capacity and engagement' is now an area of priority focus and comprehensive review given widespread workforce challenges and recent National Staff Survey (NSS) results. It was noted that the Integrated Performance Report (IPR) does not provide data to enable sufficient understanding and effective scrutiny of actions to manage workforce risk.

4. The Committee noted that the 'Induction of Labour' paper, presented by the NNUH Executive Managing Director, provided an example of the Group's risk-based model working at pace. While the paper was inconclusive with recommendations still developing, it had been prepared and presented to the Executive Risk Assurance Group (ERAG) within four days of the issue being identified, enabling rapid scrutiny and consideration by the Group Executive.

5. The work over the year to deliver a breakeven financial position was acknowledged as a hugely significant achievement and it was also commendable to see that Cost Improvement Programme (CIP) identification is almost fully complete ahead of the start of the 2026/27 financial year. It was noted that this is a step change from where the three Trusts were with CIP identification at the start of 2025/26.

6. I believe that, as a Board, we need to spend more time scrutinising Group finances, including the cost of the new Group model and associated savings; consideration needs to be given to how we achieve this – within GRAC, via an additional Committee (e.g. Finance, Investments and Partnerships) or at full Board.

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7. The Committee noted 46 Principal and Significant risks (February 2026 GRAC: 39 risks), reflecting further work undertaken across all Trusts as a deeper understanding of risk and scoring continues to develop. The Committee discussed the need for cross-cutting risks to be more clearly identified. Cyber security risk was again used as an example; whilst a Group-wide risk, our process also needs to recognise that there may be site-specific consequences.

8. Similarly, when discussing the NNUH Quality Priorities paper, the Committee reflected on the benefits of undertaking this work at Group level, while recognising that there will additionally be site-specific matters that need to be addressed.

9. The New Hospital Programme was explicitly not discussed in detail noting that the programme has no risks of 12 and above. The paper includes a number of "Issues" scored via our 5+5+5 methodology and we need to consider if/how the Committee should scrutinise these.

10. The Electronic Patient Record papers included detailed risk registers, with four risks rated at 14 included within the summary of 46 risks from ERAG, but with an additional 33 risks rated at 12+. While not discussed in Committee, we should consider whether these additional 33 risks need to be scrutinised by GRAC.

Matters from the Quality and Outcomes section of the agenda

The following section reports on items principally pertaining to Quality and Outcomes on the GRAC agenda. The Executive Quality Standards Group is being convened by the Group Chief Medical Officer and Group Chief Nurse which will give further assurance on Quality and Outcomes across the Trusts.

Matters for Board Consideration

1. Committee members (and the Board) are invited to reflect on the effectiveness of how matters relating to Quality and Outcomes were discussed via the co-Chair approach and to consider how we can strengthen our assurance of these matters.

2. The Committee noted the Histopathology Reporting Recovery paper, highlighting the requirement for increased consultant histopathology capacity and the recovery plan for immunohistochemistry after the technical challenges encountered during an equipment update. NNUH, which hosts the service, is receiving the benefit of national input on best practice.

3. The Committee received reports including Quality issues from each Trust's Executive Managing Director, the Executive Risk Assurance Group and the Group Integrated Performance Report. After discussion, further assurance was requested in services and areas as listed below:

    a. Mortality statistics continue to be impacted by coding delays (especially at QEH). However, crude mortality rates are within control limits.

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b. Quality processes in Theatres are being reviewed in light of 'Never Events' at James Paget and QEH. A benefits paper is being drafted to identify ways of working which will standardise the way quality elements of care within the theatre environment are measured and reported. This paper will review national best practice standards and frameworks.

c. Paediatric Audiology (QEH) which has been supported by NNUH, continues to be challenged in service provision. A harm review is in place.

d. Cancer performance (especially 62-day treatment waits) requiring review of potential harm.

e. Diagnostics performance which has been impacted by increases in requesting activity for some investigations.

f. Urgent and Emergency Care – Trusts are making progress yet there is variability in the focus of their services between ambulance offloads and long waits.

g. Elective care - Long waits (65 weeks) are still evident (NNUH and JPUH) although Trusts are focused on these. The process for consistent and robust clinical harm review requires further assurance from each Trust.

h. Complaints, excessive delays in completing responses and the quality of the response continues to be a focus at all three Trusts. The Executive Managing Directors, along with their site-based teams, are focused on this with action plans and significant improvements in some areas.

i. Test result approvals at James Paget where a significant backlog was identified. This is being cleared yet has highlighted variability in the approach to approvals.

j. Maternity: Midwifery staffing fill rates have given cause for concern at NNUH – there are limited vacancy gaps and this therefore relates to leave. One-to-one care in labour is maintained; however, further analysis is required to understand the staffing model and the allocation of those midwives across the service. Low staff morale in Maternity across the whole multi-disciplinary team has been highlighted.

k. Mental health presentations through the Emergency Departments at all three Trusts remain a concern. Emergency Department presentations in the first instance requires collaborative working with the Mental Health Trust to signpost to services which support immediate need. Delays in gaining specialist support for service users not only increases the time individuals spend in the Emergency Department but has an impact on their care.

l. General Surgery at QEH – subsequent to the Royal College of Surgeons review there is senior, executive and Group oversight in place to support and manage the service.

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4. Positive assurance was available for several services listed below:

   a. James Paget University Hospital has received national accreditation for its Orthopaedic Centre.

   b. As part of the One Recovery work, a World Class Basics Programme is being rolled out across the Trusts, one element of which is Infection Prevention and Control. This will provide a programme of improvement which draws on best practice for all three Trusts. The One Recovery programme will monitor and support the changes through the governance structure.

   c. The National Provider Improvement Programme will enable a clinical governance review across QEH with reviews running in parallel for JPUH and NNUH starting in April 2026.

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Report to the Group Board in public: 1 April 2026

Agenda item number	8.2		
Title	Group Audit Committees in Common – Chair's report		
Author(s)	Stephen Javes, Committee Chair and Group Non-Executive Director		
Executive sponsor	Not applicable		
Purpose of report	**For decision** ☐	**For discussion** ☐	**For information** ☒

Executive summary
The Group governance structure includes a Group Audit Committees in Common which meets four times per year (with an additional meeting on the Annual Report and Accounts).

The attached report summarises the key areas of discussion at the Committee's latest meeting which was held on 23 February 2026.

Recommendations

The Group Board is asked to note the report of the Group Audit Committees in Common meeting held on 23 February 2026.

Alignment to Board Assurance Framework risk(s)	All BAF Principal Risks
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

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Chair's Report from the Group Audit Committees in Common: 23 February 2026

The Group Audit Committees in Common (ACiC) met on 23 February 2026 and noted positive assurance that core audit, financial reporting and counter fraud arrangements are robust and aligned across the Group.

External audit plans for 2025/26 are risk-based, proportionate and reflect sector expectations, with aligned timetables to support timely accounts sign-off.

Internal audit progress indicates year-end opinions are variable but note an appropriate focus on governance, workforce and digital risks.

Counter fraud arrangements meet NHS Counter Fraud Authority standards and demonstrate consistent, structured approaches across all Trusts.

Planning for the 2025/26 Annual Reports and Accounts is well advanced, with agreement on key accounting treatments, including the going concern basis.

Areas requiring Board attention include continued oversight of Group governance and value for money arrangements. A specific risk has been identified at JPUH relating to medical equipment controls, with corrective actions in progress.

An annual workplan for the Group ACiC has been established and agreed.

These matters align to strategic priorities on financial sustainability, governance and capital delivery.

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Report to the Group Board in public: 1 April 2026

Agenda item number	8.3		
Title	Group Research, Innovation and Education Committee – Chair's report		
Author(s)	Philip Baker, Committee Chair and Group Non-Executive Director		
Executive sponsor	Not applicable		
Purpose of report	**For decision** ☐	**For discussion** ☐	**For information** ☒

Executive summary

The Group governance structure includes a Board-level Research, Innovation and Education Committee, reflecting the central importance of research, innovation and education to the Group's strategic ambitions including as a University Hospital System.

The attached report summarises the key areas of discussion at the Committee's inaugural meeting which was held on 24 February 2026.

Recommendations

The Group Board is asked to note the report of the Group Research, Innovation and Education Committee meeting held on 24 February 2026.

Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 16
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

Chair's Report from the Group Research, Innovation and Education Committee: 24 February 2026

The first meeting of the Norfolk and Waveney University Hospitals Group (NWUHG) Research, Innovation and Education Committee took place on 24 February 2026, marking an important step in establishing research, innovation and education as core Group priorities. The Committee brings together executive and non-executive leadership from across the Group and its academic partners to guide the development of NWUHG as a University Hospital System.

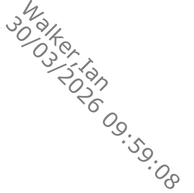
As a foundational meeting, the Committee discussed the Group's ambition to strengthen research, innovation and education across all three hospitals and to build a system that supports both academic excellence and high-quality patient care. This ambition is closely linked to the strengths of the Norwich Research Park and wider academic partnerships, with the long-term aim of developing the Group towards Academic Health Science Centre status anchored around the Norfolk and Norwich University Hospital.

Presentations from each Trust highlighted strong foundations across the Group, including growing research activity, strong educational programmes and important clinical partnerships. Members recognised that while capability and infrastructure vary between organisations, each site brings distinctive strengths that can be amplified through collaboration at Group level.

The Committee emphasised that research and innovation should be embedded across everyday clinical practice rather than confined to specialist academic roles. Developing a culture that supports curiosity, learning and research participation across the workforce was identified as central to achieving this ambition.

Looking ahead, the Committee agreed to develop a structured programme of work to support delivery of the Group's ambitions. This will include establishing a baseline assessment of research and education activity across the Group, defining key milestones over the next three years, and developing a Group-wide strategy to strengthen capability, reduce variation and build on existing strengths.

The next meeting of the Committee will take place in April 2026.



Report to the Group Board in public: 1 April 2026

Agenda item number	9.1		
Title	Group Integrated Performance Report		
Author(s)	Jo Segasby, Group Chief Delivery Officer		
Executive sponsor	Jo Segasby, Group Chief Delivery Officer		
Purpose of report	For decision ☐	For discussion ☒	For information ☐

Executive summary
The Group Integrated Performance Report provides a consolidated assessment of Group performance across the domains of Safe and Effective Care, People and Culture, Access and Flow, and Productivity and Efficiency.

The presentation of data in the pack is designed to allow a review of performance for each Trust and also across the Trusts, to enable consideration of key themes, actions or areas of best practice to inform improvement across the Group.

This report provides a summary of key performance issues for February 2026.

Recommendations
The Group Board is asked to receive and discuss the Group Integrated Performance Report for February 2026.

Alignment to Board Assurance Framework risk(s)	Principal Risks 1, 2, 3, 4, 5
Previously considered by	Group Risk Assurance Committee, 26 March 2026
Any background papers in Admin Control Reading Room	None

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Norfolk and Waveney University Hospitals Group

Group Board in public: 1 April 2026

Group Integrated Performance Report (IPR)

Overall Performance

The IPR provides a consolidated view of quality, workforce, operational performance and finance across the three Trust sites (NNUH, JPUH and QEH). Overall, there is clear operational pressure, particularly in elective care, urgent and emergency care, and workforce sickness, alongside financial control and recovery activity progressing broadly as planned.

There is clear evidence of improvement in several priority areas. Hospital flow continues to limit consistency in urgent and emergency care, but targeted sprint activity and strengthened executive oversight are beginning to deliver traction. Financial performance is broadly stable, with strong cost control in place.

1. Safe and Effective Care

1.1 Infection Prevention & Control (IP&C)

- All three sites continue to review IP&C data and implement actions to manage infections.
- A key focus is ensuring clarity of targets for 2026/27.
- IP&C policy and procedure reviews form part of the One Recovery Programme, supporting improvement oversight and shared learning.

1.2 Nursing, Quality & Complaints

- Registered Nurse fill rates are closely monitored, with QEH using the red flag and safe care process aligned with JPUH and NNUH.
- A Group-wide deep dive into pressure ulcer management has been completed, with improvement actions underway.
- Complaints handling remains a concern across all sites, particularly quality and timeliness of responses; learning from an NNUH complaints process trial will be shared.

1.3 Maternity

- Maternity units continue to monitor a wide range of quality metrics via the perinatal report.
- Midwifery staffing remains challenging due to sickness, maternity and study leave; however, one-to-one care in labour is maintained across all sites.
- Monthly maternity safety champion walkarounds support shared learning and quality improvement projects.

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2. People & Culture

Workforce availability remains a shared constraint across organisations. Recruitment and retention initiatives are ongoing, with targeted actions to support staff wellbeing and reduce reliance on temporary staffing.

Workforce performance is largely stable:

- Strong appraisal and mandatory training performance at NNUH and JPUH.
- Sickness interventions are having impact at JPUH, but sickness rates remain high at QEH.

3. Access and Flow

3.1 Elective Care

Elective performance remains extremely challenged across the Group. Two programmes within One Recovery are expected to support Referral to Treatment (RTT) improvement into 2026/27, with plans submitted to NHS England (NHSE).

- QEH is currently the lowest-performing organisation for 18-week RTT. Forecasts suggest performance finishing above 60%, with potential improvement to around 62% through validation and additional activity. An Elective Sprint in March delivered around 2,000 additional elective activities, supported by expanded evening and weekend working and weekly executive oversight.
- NNUH achieved its best elective performance of 2025/26 to date in February, with improvements in 18-week RTT, time to first appointment and the 52-week position, although patients waiting over 65 weeks remain above the expected level and unlikely to achieve zero in March.
- JPUH delivered a strong Q4 elective recovery sprint, with over 4,300 patients booked, transferred or validated, and more than 2,000 treated at the time of reporting, patients waiting over 65 weeks remains in the region of 100 patients and is unlikely to change significantly by end of March 2026 although all actions are in place to treat these patients as quickly as possible.

3.2 Cancer Performance

All three sites experienced performance deterioration following Christmas and New Year delays. One Recovery includes support for sustainable cancer delivery, including full rollout of tele-dermatology and a linked histopathology recovery plan.

- QEH, recovery actions include enhanced operational oversight, weekly recovery meetings, and the launch of a Cancer Sprint programme in March to strengthen pathway management and capacity.
- NNUH continues to perform strongly on the 28-day Faster Diagnosis Standard, achieving its highest ever level (84.3%), with 62-day performance improving and remaining on trajectory.

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- JPUH. detailed actions at body site are in place and March Sprint activity underway.

3.3 Urgent and Emergency Care (UEC)

Focused actions are in place to improve 4-hour and 12-hour performance. Ambulance handover plans are in place at all sites to address waits over 45 minutes, though sustained improvement remains difficult. Corridor care assessments have been completed in line with national guidance.

- QEH saw modest improvement in February, with 4-hour performance increasing to 64.6%, driven by better admitted pathway performance. 12-hour delays remain a concern, while ambulance handover performance improved, with fewer long delays. A UEC Sprint was mobilised in March as part of the national Spring Reset to improve front-door flow.
- NNUH maintained 4-hour performance above the national standard in February, although slightly below plan. Both 12-hour waits and ambulance handover delays improved compared with January, indicating early positive movement despite ongoing pressure.
- JPUH sustained A&E performance above the previous year, with long waits reducing, though not yet at the desired level. The opening of the Same Day Emergency Care (SDEC) and relaunched Length of Stay (Time to Care) programme has delivered sustained improvement, reducing average length of stay and supporting better flow.

4. Performance & Efficiency

- All three Trusts are forecasting a breakeven year-end position, with strong progress by month 11.
- Year-to-date performance is now favourable against plan.
- Cost Improvement Plans (CIPs) are on track for the current year, though reliance on non-recurrent schemes remains.
- Focus has shifted to CIP planning for 2026/27.
- Bank and agency reductions exceed NHSE trajectories, with further reductions planned for the new financial year.
- Productivity work is focusing on process improvements, including activity coding, which will also improve NHSE productivity data.

5. Conclusion

- Quality and safety oversight is active, with tangible improvement work underway, but complaints and staffing pressures remain areas of concern.
- Elective and UEC performance remain high risk, requiring continued intensive recovery support.
- Financial control is strong, with breakeven forecasts and progress on agency and CIP delivery.
- The transition from short-term recovery to sustainable improvement in 2026/27 is a central theme across all domains.

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Group Integrated Performance Report

Feb-26

Introduction

Feb-26

The Group Integrated Performance Report provides the Group with an consolidated focus on key performance indicators across the domains of:

Safe and Effective Care | People and Culture | Access and Flow | Productivity and Efficiency

The report is designed to enable the board to consider a range of metrics across each of the three Group hospitals to provide assurance and context for performance against nationally monitored standards. The presentation of data in the pack is designed to allow a review of performance for each individual site, but also across the three hospitals – to enable consideration of any themes, actions or areas of best practice to inform improvement across the Group.

Performance is measured using Statistical Process (SPC) charts to identify whether individual metrics are meeting target, performing within expected ranges and whether the trend is stable, improving or declining. Where SPC charts are not the appropriate way to display the data, alternative charts have been included. A summary of the symbols used in the report and what they represent is shown below, and a more detailed matrix can be found at the end of the report.

Compliance

Target being met

Target not met

No target

Variation

Common cause

Special cause of concerning nature

Special cause of improving nature

Assurance

Inconsistent achievement of target

Consistent achievement of target

Consistent failure of target

Escalation Status

Assure
Performing as expected

Advise
Ongoing monitoring/ negative assurance

Alert
Attention required/ not performing as expected

NHS James Paget University Hospitals NHS Foundation Trust

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

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Group Summary

Feb-26

James Paget University Hospitals NHS Foundation Trust

	P	?	F
H / L (improvement)	1	8	2
(common cause)	3	26	9
H / L (concern)	1	3	

Domain Assurance Level	
Safe and Effective Care	!
People and Culture	(eye)
Access and Flow	!
Productivity and Efficiency	(eye)

Norfolk and Norwich University Hospitals NHS Foundation Trust

	P	?	F
H / L (improvement)		11	2
(common cause)	4	18	6
H / L (concern)	1	1	1

Domain Assurance Level	
Safe and Effective Care	!
People and Culture	(eye)
Access and Flow	!
Productivity and Efficiency	(eye)

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

	P	?	F
H / L (improvement)		7	2
(common cause)	2	20	4
H / L (concern)	1	4	1

Domain Assurance Level	
Safe and Effective Care	!
People and Culture	!
Access and Flow	!
Productivity and Efficiency	(eye)

Annual Metrics

CQC Safe Domain Rating

Trust	Are services Safe?
James Paget University Hospitals NHS Foundation Trust	Requires improvement
Norfolk and Norwich University Hospitals NHS Foundation Trust	Requires improvement
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	Requires improvement

Inpatient Satisfaction

Trust	2024 Inpatient Satisfaction	Patient Response	Compared with other trusts
James Paget University Hospitals NHS Foundation Trust	Overall experience (Care Quality Commission)	8.3 / 10	About the same
Norfolk and Norwich University Hospitals NHS Foundation Trust	Overall experience (Care Quality Commission)	8.0 / 10	About the same
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	Overall experience (Care Quality Commission)	7.8 / 10	About the same

Staff Survey - We are Safe and Healthy

Trust	Score
James Paget University Hospitals NHS Foundation Trust	5.83
Norfolk and Norwich University Hospitals NHS Foundation Trust	5.69
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	5.75

National - 6.07

Staff Survey - Engagement Score

Trust	Score
James Paget University Hospitals NHS Foundation Trust	6.59
Norfolk and Norwich University Hospitals NHS Foundation Trust	6.17
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	6.17

National - 6.74

Staff Survey - Raising Concerns

Trust	Score
James Paget University Hospitals NHS Foundation Trust	6.09
Norfolk and Norwich University Hospitals NHS Foundation Trust	5.76
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	5.43

National - 6.30

Annual Metrics

Maternity Survey 2025

James Paget University Hospitals NHS Foundation Trust

Section	Patient Response	Compared with other trusts
Labour and birth	Not available	
Staff caring for you	8.1 / 10	About the same
Care in hospital after the birth	7.0 / 10	About the same

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Section	Patient Response	Compared with other trusts
Labour and birth	Not available	
Staff caring for you	8.7 / 10	About the same
Care in hospital after the birth	7.6 / 10	About the same

Norfolk and Norwich University Hospitals NHS Foundation Trust

Section	Patient Response	Compared with other trusts
Labour and birth	8.2 / 10	About the same
Staff caring for you	8.6 / 10	About the same
Care in hospital after the birth	7.5 / 10	About the same

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2024 | National Education and Training Survey — Overall Experience

Trust	Overall Experience
James Paget University Hospitals NHS Foundation Trust	72.7%
Norfolk and Norwich University Hospitals NHS Foundation Trust	73.4%
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	71.0%

Safe and Effective Care Domain Metrics

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Metric Summary Matrix - Safe and Effective Care

James Paget University Hospitals NHS Foundation Trust

	P	?	F
H / L			
	FFT	CDiff, Falls, CHPPD, PSII, Pr. Ulcers, SHMI, Readm, RN Fill Rate	Av Disch Delay, Complaints
H / L		EColi, MRSA	

Safe and Effective Care Assurance

- SHMI
- FFT Score
- MRSA
- CDiff
- Ecoli
- Average number of days between planned and actual discharge date
- Readmission Rate
- Complaints Received
- Pressure Ulcers
- Registered Nurse Fill Rate
- Care Hour Per Patient Day (CHPPD)
- Falls
- PSII Number

Norfolk and Norwich University Hospitals NHS Foundation Trust

	P	?	F
H / L		SHMI	
	MRSA, RN Fill Rate	CDiff, CHPPD, EColi, Falls, FFT	Av Disch Delay, Complaints, Pr. Ulcers, Readm
H / L			

Safe and Effective Care Assurance

- SHMI
- FFT Score
- MRSA
- CDiff
- Ecoli
- Average number of days between planned and actual discharge date
- Readmission Rate
- Complaints Received
- Pressure Ulcers
- Registered Nurse Fill Rate
- Care Hour Per Patient Day (CHPPD)
- Falls

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

	P	?	F
H / L		Pr. Ulcers	
	MRSA, PSII	CDiff, Falls, CHPPD, EColi, RN Fill Rate	
H / L		FFT, SHMI	Complaints

Safe and Effective Care Assurance

- SHMI
- FFT Score
- MRSA
- CDiff
- Ecoli
- Complaints Received
- Pressure Ulcers
- Registered Nurse Fill Rate
- Care Hour Per Patient Day (CHPPD)
- Falls
- PSII Number

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Metric Summary Matrix - Safe and Effective Care

	P	?	F
H / L			
~	FFT	CDiff, Falls, CHPPD, PSII, Pr. Ulcers, SHMI, Readm, RN Fill Rate	Av Disch Delay, Complaints
H / L		EColi, MRSA	

Safe and Effective Care Assurance !

James Paget University Hospitals NHS Foundation Trust

Metric	
SHMI	
FFT Score	✓
MRSA	
CDiff	
Ecoli	
Average number of days between planned and actual discharge date	!
Readmission Rate	
Complaints Received	!
Pressure Ulcers	
Registered Nurse Fill Rate	
Care Hour Per Patient Day (CHPPD)	
Falls	
PSII Number	

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	P	?	F
H / L			
~	MRSA, RN Fill Rate	CDiff, CHPPD, EColi, Falls, FFT	Av Disch Delay, Complaints, Pr. Ulcers, Readm
H / L	SHMI		

Safe and Effective Care Assurance !

Norfolk and Norwich University Hospitals NHS Foundation Trust

Metric	
SHMI	
FFT Score	
MRSA	✓
CDiff	
Ecoli	
Average number of days between planned and actual discharge date	!
Readmission Rate	!
Complaints Received	!
Pressure Ulcers	!
Registered Nurse Fill Rate	✓
Care Hour Per Patient Day (CHPPD)	
Falls	

	P	?	F
H / L		MRSA, PSII	
~		CDiff, Falls, CHPPD, EColi, RN Fill Rate	
H / L	Pr. Ulcers	FFT, SHMI	Complaints

Safe and Effective Care Assurance !

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Metric	
SHMI	
FFT Score	
MRSA	✓
CDiff	
Ecoli	
Complaints Received	!
Pressure Ulcers	
Registered Nurse Fill Rate	
Care Hour Per Patient Day (CHPPD)	
Falls	
PSII Number	✓

Safe and Effective Care Domain Summary

Feb-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
SHMI	Oct-25	1.17	1.15			
MRSA	Feb-26	0	1			
CDiff	Feb-26	3	3			
Ecoli	Feb-26	0	8			
Average number of days between planned and actual discharge date	Feb-26	2	6			
Readmission Rate	Jan-26	10.0%	10.48%			

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
SHMI	Oct-25	1.17	1.15			
MRSA	Feb-26	0	0			
CDiff	Feb-26	8	8			
Ecoli	Feb-26	0	5			
Average number of days between planned and actual discharge date	Feb-26	2	5			
Readmission Rate	Jan-26	10.0%	12.88%			

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
SHMI	Oct-25	1.17	1.35			
MRSA	Feb-26	0	0			
CDiff	Feb-26	4	2			
Ecoli	Feb-26	0	5			

Group Summary

All three sites continue to review IP&C data and whilst actions continue to be undertaken to manage infections the targets set need to be understood for the 26/27 year. The review of IP&C policies and procedures forms part of the Recovery programme which will provide intense improvement oversight and shared learning

Walker,Ian
30/03/2026 09:59:08

Safe and Effective Care Domain Summary

Feb-26

Metric	James Paget						Norfolk and Norwich						Queen Elizabeth					
	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance
FFT Score	Feb-26	95.0%	97.69%	✓		P	Dec-25	95.0%	91.83%	✗		?	Feb-26	95.0%	90.60%	✗	L	?
Complaints Received	Feb-26	0	17	✗		F	Feb-26	0	74	✗		F	Feb-26	0	49	✗	H	F
Pressure Ulcers	Feb-26	0	7.00	✗		?	Feb-26	0	35.00	✗		F	Feb-26	0	3.00	✗	L	?
Registered Nurse Fill Rate	Feb-26	90.0%	86.67%	✗		?	Feb-26	90.0%	95.25%	✓		P	Jan-26	90.0%	88.17%	✗		?
Care Hour Per Patient Day (CHPPD)	Feb-26	8.00	7.96	✗		?	Feb-26	8.00	7.73	✗		?	Feb-26	8.00	7.60	✗		?
Falls	Feb-26	67	71	✗		?	Feb-26	187	170	✓		?	Feb-26	54	60	✗		?
PSII Number	Feb-26	0	1	✗		?							Feb-26	0	0	✓		P

Group Summary

Registered Nurse fill rates are monitored closely with the QE utilising the red flag and safe care process which aligns with JPUH and NNUH.

The deep dive into pressure ulcer management for all three sites has been undertaken and shared at each site and improvement actions have been commenced.

Complaints continue to be raised as a concern by all sites in terms of quality of response and timeliness of the response. Learning from the NNUH complaints process trial will be shared.

Walker,Ian 30/03/2026 09:55:08

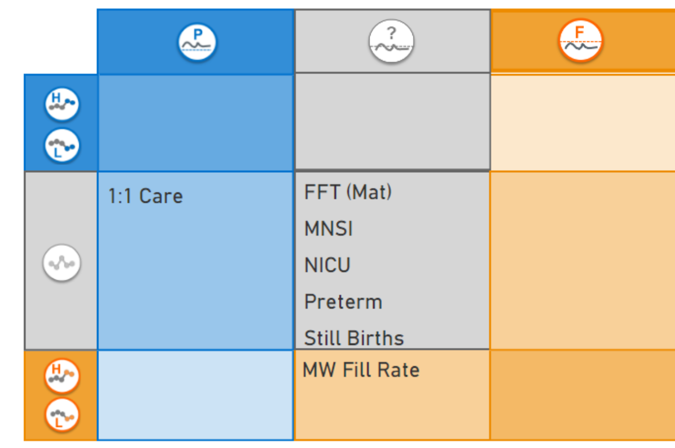
Metric Summary Matrix - Safe and Effective Care - Maternity

	P	?	F
H / L (improvement)	1:1 Care	MW Fill Rate Still Births	
Common cause	Complaints (Mat)	FFT (Mat) NICU Preterm	
H / L (concern)			

Safe and Effective Care Assurance

NHS James Paget University Hospitals NHS Foundation Trust

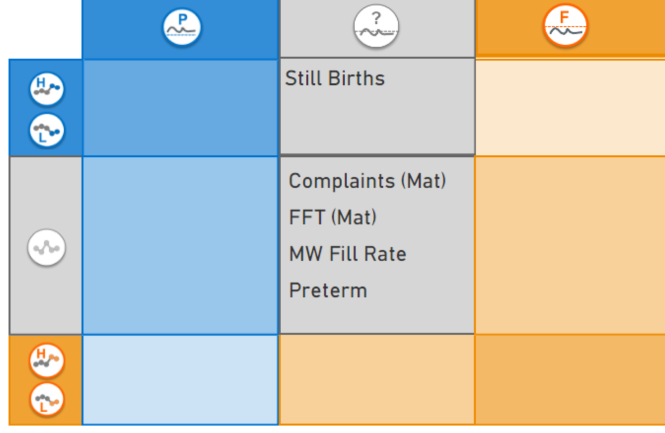
- Still Birth Rate
- Midwifery Fill Rate
- Preterm Birth Rate
- Maternity FFT
- Complaints Received - Maternity
- Unplanned Admissions to NICU
- MNSI
- 1:1 Care



Safe and Effective Care Assurance

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

- Still Birth Rate
- Midwifery Fill Rate
- Preterm Birth Rate
- Maternity FFT
- Unplanned Admissions to NICU
- MNSI
- 1:1 Care



Safe and Effective Care Assurance

- Still Birth Rate
- Midwifery Fill Rate
- Preterm Birth Rate
- Maternity FFT
- Complaints Received - Maternity

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Safe and Effective Care Domain Summary - Maternity

Feb-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Still Birth Rate	Feb-26	3.5%	0.00%			
Midwifery Fill Rate	Feb-26	90.0%	84.33%			
Preterm Birth Rate	Feb-26	6.0%	8.11%			
Maternity FFT	Feb-26	95.0%	90.63%			
Complaints Received - Maternity	Feb-26	0	0			
Unplanned Admissions to NICU	Feb-26	0	10			
MNSI	Feb-26	0	0			
1:1 Care	Feb-26	97.0%	100.00%			

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Still Birth Rate	Feb-26	3.5%	0.58%			
Midwifery Fill Rate	Feb-26	90.0%	85.23%			
Preterm Birth Rate	Feb-26	6.0%	6.94%			
Maternity FFT	Dec-25	95.0%	100.00%			
Complaints Received - Maternity						
Unplanned Admissions to NICU	Feb-26	0	13			
MNSI	Feb-26	0	1			
1:1 Care	Feb-26	97.0%	99.18%			

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Still Birth Rate	Jan-26	3.5%	2.37%			
Midwifery Fill Rate	Feb-26	90.0%	85.68%			
Preterm Birth Rate	Jan-26	6.0%	6.57%			
Maternity FFT	Feb-26	95.0%	98.48%			
Complaints Received - Maternity	Feb-26	0	3			
Unplanned Admissions to NICU						
MNSI						
1:1 Care						

Group Summary

The maternity units across the three sites continue to monitor quality against a broad number of metrics which are presented in the perinatal report. Midwifery staffing fill rates remain a challenge due to sickness, maternity, and study leave however one to one care in labour is maintained at all three sites.

The maternity safety champion walk arounds are undertaken monthly with the learning shared at an all-site meeting, this allows for quality improvement projects to be shared.

People and Culture Domain Metrics

Walker,Ian
30/03/2026 09:59:08

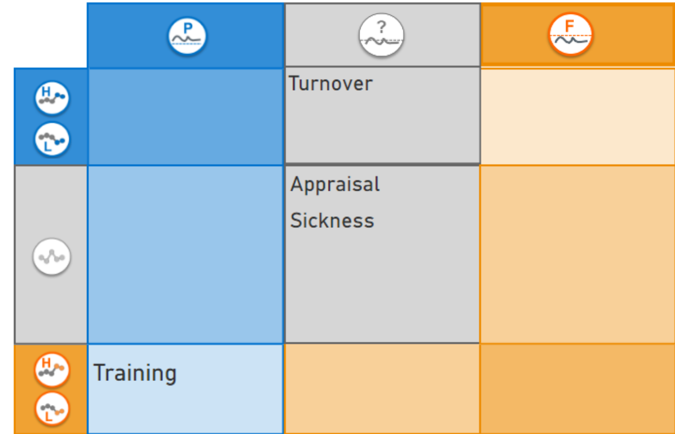
Metric Summary Matrix - People and Culture

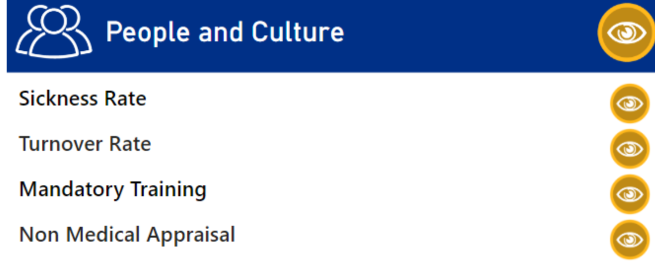
Feb-26

James Paget University Hospitals
NHS Foundation Trust

	P	?	F
H/L (improving)		Appraisal	Sickness
Common cause			
H/L (concerning)	Training	Turnover	

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust





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NHS Foundation Trust

	P	?	F
H/L (improving)		Appraisal Training	Turnover
Common cause			Sickness
H/L (concerning)			

People and Culture Domain Summary

Feb-26

Metric	James Paget Date	Target	Actual	Compliance	Variation	Assurance	Norfolk and Norwich Date	Target	Actual	Compliance	Variation	Assurance	Queen Elizabeth Date	Target	Actual	Compliance	Variation	Assurance
Sickness Rate	Feb-26	4.6%	5.73%				Jan-26	4.2%	5.22%				Feb-26	4.5%	6.27%			
Turnover Rate	Feb-26	10.0%	7.05%				Feb-26	10.0%	7.01%				Feb-26	10.0%	10.13%			
Mandatory Training	Feb-26	90.0%	91.64%				Feb-26	90.0%	91.93%				Feb-26	90.0%	80.43%			
Non Medical Appraisal	Feb-26	85.0%	89.66%				Feb-26	85.0%	92.36%				Feb-26	85.0%	85.85%			

Group Summary

Workforce metrics remain largely unchanged with strong performance on appraisal rates and mandatory training at NNUH and JPUH. Sickness interventions are impacting at JPUH but rates remain high at QEH.

Walker, Ian
30/03/2026 09:59:08

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Norfolk and Waveney
University Hospitals Group

Metric Summary Matrix - Access and Flow - Elective Care

Feb-26

James Paget University Hospitals NHS Foundation Trust

	P	?	F
H / L			Paed PTL Size
		1st Appt <18 52+ Waits Diagnostics RTT Incomp <18	65+ Waits Clearance PTL Size
H / L			

Access and Flow

- Total PTL Size
- RTT Incomplete Within 18 weeks
- 65+ Week Waits
- 52+ Week Performance
- First Attendance Within 18 Weeks
- 6 Week Diagnostics
- Under 18s elective waiting list size
- Estimated clearance times

Norfolk and Norwich University Hospitals NHS Foundation Trust

	P	?	F
H / L		1st Appt <18 Diagnostics Paed PTL Size PTL Size RTT Incomp <18	52+ Waits 65+ Waits
H / L			

Access and Flow

- Total PTL Size
- RTT Incomplete Within 18 weeks
- 65+ Week Waits
- 52+ Week Performance
- First Attendance Within 18 Weeks
- 6 Week Diagnostics
- Under 18s elective waiting list size

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

	P	?	F
H / L		65+ Waits	52+ Waits
		1st Appt <18 Diagnostics	PTL Size
H / L		RTT Incomp <18	

Access and Flow

- Total PTL Size
- RTT Incomplete Within 18 weeks
- 65+ Week Waits
- 52+ Week Performance
- First Attendance Within 18 Weeks
- 6 Week Diagnostics

Walker,Ian 30/03/2026 09:59:08

Access and Flow Domain Summary - Elective Care

Feb-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Total PTL Size	Feb-26	28,649	33,120			
RTT Incomplete Within 18 weeks	Feb-26	92.0%	53.97%			
65+ Week Waits	Feb-26	0	126			
52+ Week Performance	Feb-26	5.6%	4.90%			
First Attendance Within 18 Weeks	Feb-26	64.0%	60.64%			
6 Week Diagnostics	Feb-26	95.0%	69.83%			
Under 18s elective waiting list size	Feb-26	2,615	2,716			
Estimated clearance times	Feb-26	18	27			

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Total PTL Size	Feb-26	81,265	66,269			
RTT Incomplete Within 18 weeks	Feb-26	92.0%	59.87%			
65+ Week Waits	Feb-26	0	98			
52+ Week Performance	Feb-26	2.2%	3.47%			
First Attendance Within 18 Weeks	Feb-26	64.0%	73.39%			
6 Week Diagnostics	Feb-26	95.0%	85.00%			
Under 18s elective waiting list size	Feb-26	8,368	7,229			

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Total PTL Size	Jan-26	24,963	26,144			
RTT Incomplete Within 18 weeks	Jan-26	92.0%	53.90%			
65+ Week Waits	Jan-26	0	2			
52+ Week Performance	Jan-26	1.5%	1.53%			
First Attendance Within 18 Weeks	Feb-26	64.0%	56.45%			
6 Week Diagnostics	Jan-26	95.0%	58.59%			

Group Summary

Elective care across the group continues to be extremely challenged with local targets agreed for overall waiting times and RTT performance following the elective sprint activity commissioned in quarter four for all three sites for end of March 2026. Through these sprints NNUH have been able to significantly reduce their overall waiting list although delivery at both JPUH and NNUH remain high risk for no patients waiting over 65 weeks by 31st March. Review of clinical harm processes are under way by the GCNO and GCMO to ensure these are robust and consistent across the Group.
Two programmes within One recovery are expected to impact on RTT performance into 2026/27 as ambitious plans have been submitted to NHSE.

Benchmarking

Jan-26

RTT 52+ Weeks

Current Performance

JPUH	5.27%
NNUH	3.81%
QEH	1.53%

0.07% Top Decile

1.54% Median

Metric Name	Percentage of patients waiting over 52 weeks
Basis	End of period
Description	Of the total elective (RTT) waiting list, the percentage of patients who have been waiting more than 52 weeks.
Purpose	This metric allows us to track delivery of the 2025/26 priority to reduce 52 week waits to below 1%.

Walker,Ian 30/03/2026 09:59:00

RTT Within 18 Weeks

Median Performance — Top Decile Performance

100%
80%
60%
40%
20%
0%

Current Performance

JPUH	53.06%
NNUH	58.52%
QEH	53.90%

72.29%
Top Decile

61.43%
Median

Walker,Ian 30/03/2026 09:59:08

Metric Name	Percentage of patients waiting less than 18 weeks
Basis	End of period
Description	Of the total elective (RTT) waiting list, the number of patients who have been waiting less than 18 weeks.
Purpose	This allows absolute 18 week performance to be tracked to allow for direct performance comparisons on delivering the standard.

Benchmarking

Dec-25

6 Week Diagnostics

Median Performance
Top Decile Performance

100%
80%
60%
40%
20%
0%

Current Performance

JPUH	64.27%
NNUH	79.52%
QEH	58.19%

97.20%
Top Decile

79.46%
Median

Metric Name	Percentage of patients waiting less than 6 weeks for a diagnostic test
Basis	End of period
Description	Of the total number of eligible diagnostic appointments undertaken in the month, the percentage of patients who were seen within 6 weeks.
Purpose	This metric ensures that patients are receiving their diagnostic tests within 6 weeks to ensure delivery of the 18 week standard.

Walker,Ian
30/03/2026 09:59:08

Metric Summary Matrix - Access and Flow - Cancer

Jan-26

	P	?	F
H / L (improving)			
Common cause		62 Day FDS	
H / L (concerning)			

Access and Flow

- 28 Day Faster Diagnosis
- Cancer 62 Day Treatment

	P	?	F
H / L (improving)		FDS	
Common cause		62 Day	
H / L (concerning)			

Access and Flow

- 28 Day Faster Diagnosis
- Cancer 62 Day Treatment

NHS
The Queen Elizabeth
Hospital King's Lynn
NHS Foundation Trust

	P	?	F
H / L (improving)			
Common cause		62 Day FDS	
H / L (concerning)			

Access and Flow

- 28 Day Faster Diagnosis
- Cancer 62 Day Treatment

Walker,Ian
30/03/2026 09:59:08

Access and Flow Domain Summary - Cancer

Jan-26

Metric	James Paget Date	Target	Actual	Compliance	Variation	Assurance	Norfolk and Norwich Date	Target	Actual	Compliance	Variation	Assurance	Queen Elizabeth Date	Target	Actual	Compliance	Variation	Assurance
28 Day Faster Diagnosis	Jan-26	75.0%	69.17%				Jan-26	75.0%	73.75%				Jan-26	75.0%	60.90%			
Cancer 62 Day Treatment	Jan-26	85.0%	67.01%				Jan-26	85.0%	64.17%				Jan-26	85.0%	54.31%			

Group Summary

Performance deterioration evident for all three sites following delays over the Christmas and New Year period. NNUH remain close to plan for FDS. Activity sprints are in place at QEH to boost recovery and all three sites have clear plans in place to recover their position by end of March.
One recovery includes a programme to support sustainable cancer delivery into March 2026 including full roll out of tele dermatology with a corresponding histopathology recovery plan to improve turnaround times.

Walker,Tom 30/03/2026 09:59:48

Benchmarking

Oct-25

Cancer 28 Day FDS - Current

Median Performance — Top Decile Performance

100%
80%
60%
40%
20%
0%

Current Performance

JPUH	73.64%
NNUH	81.84%
QEH	67.74%

85.73%
Top Decile

78.01%
Median

Walker,Ian 30/03/2026 09:59:06

Metric Name	Percentage of urgent cancer referrals to receive a definitive diagnosis within four weeks.
Basis	End of Period
Description	Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat (FDS clock stops) within 28 days following an urgent cancer referral.
Purpose	This measures the percentage of patients seen in a timely way following urgent cancer referral.

Benchmarking

Oct-25

Cancer 28 Day FDS - Rolling 12 Months

Median Performance — Top Decile Performance

100%
80%
60%
40%
20%
0%

Current Performance

Trust	Performance
JPUH	75.76%
NNUH	74.59%
QEH	68.10%

82.85%
Top Decile
76.83%
Median

Metric Name	Percentage of urgent cancer referrals to receive a definitive diagnosis within four weeks.
Basis	Rolling 12-month
Description	Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat (FDS clock stops) within 28 days following an urgent cancer referral.
Purpose	This measures the percentage of patients seen in a timely way following urgent cancer referral.

Walker, Ian 20/03/2026 09:59:06

Cancer 62 Day Treatment - Current

Median Performance — Top Decile Performance

100% 80% 60% 40% 20% 0%

Current Performance

JPUH	65.94%
NNUH	63.79%
QEH	60.29%

85.57% Top Decile

72.11% Median

Walker,Ian 20/03/2026 09:59:08

Metric Name	Percentage of patients treated for cancer within 62 days of referral
Basis	End of period.
Description	Percentage of patients receiving a first treatment for cancer within 62 days following an urgent referral.
Purpose	This measures the percentage of patients beginning treatment in a timely way following urgent cancer referral.

Oct-25

Cancer 62 Day Treatment - Rolling 12 Months

Median Performance — Top Decile Performance

100% 80% 60% 40% 20% 0%

Current Performance

JPUH	68.32%
NNUH	55.91%
QEH	55.04%

81.83% Top Decile

71.26% Median

Walker, Ian 30/03/2026 09:59:06

Metric Name	Percentage of patients treated for cancer within 62 days of referral
Basis	Rolling 12-month
Description	Percentage of patients receiving a first treatment for cancer within 62 days following an urgent referral.
Purpose	This measures the percentage of patients beginning treatment in a timely way following urgent cancer referral.

Metric Summary Matrix - Access and Flow - UEC

Feb-26

James Paget University Hospitals NHS Foundation Trust

	P	?	F
H/L		4hr ED	
~		NE LoS	12hr ED % Handover >30 Handover >45 Handover >45%
H/L			

Access and Flow

- ED 4 Hour Performance
- ED 12 Hours in Department %
- Ambulance Handovers Over 30 Minutes
- Ambulance Handovers Over 45 Minutes
- Ambulance Handovers Over 45 Minutes %
- Non Elective LoS

Walker, Jan 30/03/2026 09:50:08

Norfolk and Norwich University Hospitals NHS Foundation Trust

	P	?	F
H/L			
~		12hr ED % 4hr ED	Handover >30 Handover >45
H/L			

Access and Flow

- ED 4 Hour Performance
- ED 12 Hours in Department %
- Ambulance Handovers Over 30 Minutes
- Ambulance Handovers Over 45 Minutes
- Ambulance Handovers Over 45 Minutes %

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

	P	?	F
H/L		4hr ED	
~		12hr ED % Handover >45% NE LoS	Handover >30 Handover >45
H/L			

Access and Flow

- ED 4 Hour Performance
- ED 12 Hours in Department %
- Ambulance Handovers Over 30 Minutes
- Ambulance Handovers Over 45 Minutes
- Ambulance Handovers Over 45 Minutes %
- Non Elective LoS

Access and Flow Domain Summary - UEC

Feb-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
ED 4 Hour Performance	Feb-26	78.0%	72.08%			
ED 12 Hours in Department %	Feb-26	2.0%	8.60%			
Ambulance Handovers Over 30 Minutes	Feb-26	0	649			
Ambulance Handovers Over 45 Minutes	Feb-26	0	525			
Ambulance Handovers Over 45 Minutes %	Feb-26	0.0%	36.04%			
Non Elective LoS	Feb-26	10	10.72			

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
ED 4 Hour Performance	Feb-26	78.0%	80.54%			
ED 12 Hours in Department %	Feb-26	4.0%	7.81%			
Ambulance Handovers Over 30 Minutes	Feb-26	0	2,015			
Ambulance Handovers Over 45 Minutes	Feb-26	0	1,664			
Ambulance Handovers Over 45 Minutes %	Feb-26	0.0%	63.93%			

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
ED 4 Hour Performance	Feb-26	78.0%	64.60%			
ED 12 Hours in Department %	Feb-26	12.1%	15.15%			
Ambulance Handovers Over 30 Minutes	Feb-26	0	749			
Ambulance Handovers Over 45 Minutes	Feb-26	0	590			
Ambulance Handovers Over 45 Minutes %	Feb-26	0.0%	33.77%			
Non Elective LoS	Feb-26	10	10.25			

Group Summary

All three trusts have focused actions for improved 4 hour and 12 hour performance in March. The SDEC at JPUH has had significant impact and changes to model at QEH are starting to take effect. All three trusts have developed ambulance handover plans to reduce number of ambulances waiting over 45 mins and achieve the required standard which has remained a difficult requirement to see sustained improvement in. At the same time assessment on elimination of corridor care has been undertaken by the GCNO and Chief Nurses in line with national guidance.   Improvements in Length of stay at JPUH should be noted.

Feb-26

ED 4 Hours - Current

Median Performance
Top Decile Performance

100%
80%
60%
40%
20%
0%

Current Performance

JPUH	71.75%
NNUH	80.54%
QEH	64.48%

83.01% Top Decile

74.09% Median

Metric Name	Percentage of emergency department attendances admitted, transferred or discharged within four hours
Basis	End of Period.
Description	Percentage of emergency department attendances managed within 4 hours
Purpose	This measures performance against the NHS constitutional pledge and is a key metric for showing pressure on the urgent and emergency care system.

Walker, Ian 30/03/2026 09:59:06

Norfolk and Waveney
University Hospitals Group

Benchmarking

Feb-26

ED 4 Hours - Rolling 3 Months

Current Performance

JPUH	72.40%
NNUH	80.02%
QEH	64.87%

81.09% Top Decile

72.45% Median

Metric Name	Percentage of emergency department attendances admitted, transferred or discharged within four hours
Basis	Rolling 3-month
Description	Percentage of emergency department attendances managed within 4 hours
Purpose	This measures performance against the NHS constitutional pledge and is a key metric for showing pressure on the urgent and emergency care system. In order to account for the different mechanisms of delivering urgent care, an acute trust footprint has been developed which apportions some or all of the lower acuity activity from surrounding type 3 providers to acute trusts. This takes into account redirection of lower acuity patients to a more appropriate setting.

Walker,Ian 30/03/2026 09:59:08

Ambulance Handovers - 30 Minutes Current

ʼmance — Median Performance — Top Decile Performance

100%
80%
60%
40%
20%
0%

Current Performance

JPUH	44.73%
NNUH	63.93%
QEH	44.61%

15.26%
Top Decile

51.34%
Median

Walker, Ian
30/03/2026 09:59:06

Metric Name	Percentage of ambulance handovers completed in over 30 minutes
Basis	End of Period
Description	Percentage of ambulance handovers completed outside of 30 minutes within the East of England
Purpose	This measures performance against the NHS constitutional pledge and is a key metric for showing pressure on the urgent and emergency care system.

Benchmarking

Feb-26

Ambulance Handovers - 30 Minutes Rolling 3 Months

Median Performance
Top Decile Performance

80%
60%
40%
20%
0%

Walker,Ian
30/03/2026 09:39:06

Current Performance

JPUH	43.65%
NNUH	59.05%
QEH	52.32%

15.92% Top Decile
52.93% Median

Metric Name	Percentage of ambulance handovers completed outside of 30 minutes
Basis	Rolling 3 months
Description	Percentage of ambulance handovers completed in over 30 minutes within the East of England
Purpose	This measures performance against the NHS constitutional pledge and is a key metric for showing pressure on the urgent and emergency care system.

Benchmarking

Feb-26

Ambulance Handovers - 45 Minutes Current

Median Performance — Top Decile Performance

100%
80%
60%
40%
20%
0%

Current Performance

JPUH
36.04%

NNUH
52.79%

QEH
32.76%

0.88%
Top Decile
34.48%
Median

Walker,Ian
30/03/2026 09:59:08

Metric Name	Percentage of ambulance handovers completed in over 45 minutes
Basis	End of Period
Description	Percentage of ambulance handovers completed outside of 45 minutes within the East of England
Purpose	This measures performance against the NHS constitutional pledge and is a key metric for showing pressure on the urgent and emergency care system.

Feb-26

Ambulance Handovers - 45 Minutes Rolling 3 Months

Median Performance | Top Decile Performance

50%
40%
30%
20%
10%
0%

Current Performance

JPUH 34.52%

NNUH 48.64%

QEH 41.32%

3.10% Top Decile

33.05% Median

Metric Name	Percentage of ambulance handovers completed outside of 45 minutes
Basis	Rolling 3 months
Description	Percentage of ambulance handovers completed in over 45 minutes within the East of England
Purpose	This measures performance against the NHS constitutional pledge and is a key metric for showing pressure on the urgent and emergency care system.

Walker,Ian 30/03/2026 09:39:08

Productivity and Efficiency Domain Metrics

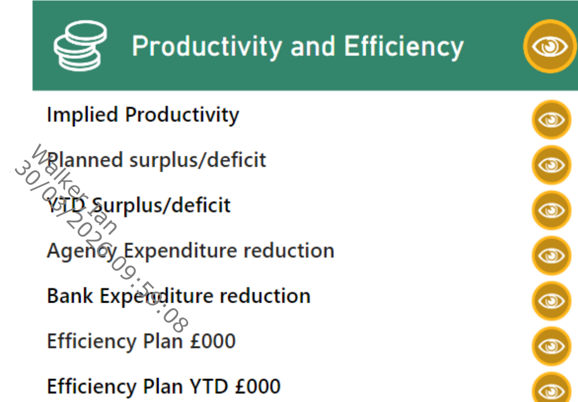
Walker, Ian
30/03/2026 09:59:08

JPUH Metric Summary Matrix - Productivity and Efficiency

Feb-26

James Paget University Hospitals NHS Foundation Trust

	P	?	F
H / L		Eff. Plan YTD YTD Sur/Def	
~		Agency Exp Bank Exp Eff. Plan Imp. Prod Plan Sur/Def	
H / L			



Productivity and Efficiency

- Implied Productivity
- Planned surplus/deficit
- YTD Surplus/deficit
- Agency Expenditure reduction
- Bank Expenditure reduction
- Efficiency Plan £000
- Efficiency Plan YTD £000

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Norfolk and Norwich University Hospitals NHS Foundation Trust

	P	?	F
H / L		Eff. Plan YTD Plan Sur/Def YTD Sur/Def	
~	Imp. Prod	Agency Exp Bank Exp Eff. Plan	
H / L			

Productivity and Efficiency

- Implied Productivity
- Planned surplus/deficit
- YTD Surplus/deficit
- Agency Expenditure reduction
- Bank Expenditure reduction
- Efficiency Plan £000
- Efficiency Plan YTD £000

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

	P	?	F
H / L		Eff. Plan YTD	
~		Eff. Plan Imp. Prod Plan Sur/Def YTD Sur/Def	
H / L	Bank Exp	Agency Exp	

Productivity and Efficiency

- Implied Productivity
- Planned surplus/deficit
- YTD Surplus/deficit
- Agency Expenditure reduction
- Bank Expenditure reduction
- Efficiency Plan £000
- Efficiency Plan YTD £000

Productivity and Efficiency Domain Summary

Feb-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Implied Productivity	Oct-25	3	-3.00	✗		?
Planned surplus/deficit	Feb-26	792	663	✗		?
YTD Surplus/deficit	Feb-26	-1,531	-338	✓	H	?
Agency Expenditure reduction	Feb-26	30.0%	46.74%	✓		?
Bank Expenditure reduction	Feb-26	10.0%	20.41%	✓		?
Efficiency Plan £000	Feb-26	2,546	2,800	✓		?
Efficiency Plan YTD £000	Feb-26	23,112	26,164	✓	H	?

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Implied Productivity	Oct-25	3	5.60	✓		P
Planned surplus/deficit	Feb-26	-636	7,968	✓	H	?
YTD Surplus/deficit	Feb-26	-26	6	✓	H	?
Agency Expenditure reduction	Feb-26	30.0%	65.15%	✓		?
Bank Expenditure reduction	Feb-26	10.0%	13.87%	✓		?
Efficiency Plan £000	Feb-26	4,005	3,766	✗		?
Efficiency Plan YTD £000	Feb-26	39,647	39,535	✗	H	?

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Implied Productivity	Oct-25	3	-5.00	✗		?
Planned surplus/deficit	Feb-26	849	1,237	✓		?
YTD Surplus/deficit	Feb-26	-321	-181	✓		?
Agency Expenditure reduction	Feb-26	30.0%	-6.43%	✗	L	?
Bank Expenditure reduction	Feb-26	10.0%	31.79%	✓	L	P
Efficiency Plan £000	Feb-26	1,757	1,629	✗		?
Efficiency Plan YTD £000	Feb-26	16,439	16,638	✓	H	?

Group Summary

All three Trusts are forecasting a breakeven position for year end with significant progress towards this in month 11 which means that all Trusts are now delivering a favourable variance to the year-to-date plan.

The CIPs are on track to deliver the plans for this financial year, although there is still a large amount of non-recurrent schemes in place. The focus is now on the CIP plans for next financial year.

Bank and agency reductions are above the trajectory required by NHSE and like CIPs the focus is now on the planned reductions for the new financial year.

The productivity is being addressed by looking at processes to identify the key areas to address that will impact the three Trusts. The data from NHSE is linked to the activity coding and therefore will automatically improve as this area is addressed.

Walker,Tom
30/03/2026 09:5?:08

Appendices

Walker,Ian
30/03/2026 09:59:08

Safe and Effective Care Domain Appendix - E-Coli, MRSA, CDiff

Feb-26

JPUH - Ecoli 8

JPUH - MRSA 1

JPUH - CDiff 3

NNUH - Ecoli 5

NNUH - MRSA 0

NNUH - CDiff 8

QEH - Ecoli 5

QEH - MRSA 0

QEH - CDiff 2

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	8				
NNUH	0	5				
QEH	0	5				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	1				
NNUH	0	0				
QEH	0	0				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3	3				
NNUH	8	8				
QEH	4	2				

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Safe and Effective Care Domain Appendix - SHMI, FFT, Complaints Received

Feb-26

JPUH - SHMI 1.15

JPUH - FFT Score 97.69%

JPUH - Complaints Received 17

NNUH - SHMI 1.15

NNUH - FFT Score 91.83%

NNUH - Complaints Received 74

QEH - SHMI 1.35

QEH - FFT Score 90.60%

QEH - Complaints Received 49

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	1.17	1.15				
NNUH	1.17	1.15				
QEH	1.17	1.35				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	95.0%	97.69%			P	
NNUH	95.0%	91.83%				
QEH	95.0%	90.60%		L		

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	17			F	!
NNUH	0	74			F	!
QEH	0	49		H	F	!

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Safe and Effective Care Domain Appendix - Readmission Rate, CHPPD & Discharge Delay

Feb-26

JPUH - Readmission Rate 10.48%

Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

JPUH - Care Hour Per Patient Day (CHPPD) 7.96

Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

JPUH - Average number of days between planned and actual discharge date

Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

6

NNUH - Readmission Rate 12.88%

Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

NNUH - Care Hour Per Patient Day (CHPPD) 7.73

Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

NNUH - Average number of days between planned and actual discharge date

Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

5

-

QEH - Care Hour Per Patient Day (CHPPD) 7.60

Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

-

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Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	10.0%	10.48%				
NNUH	10.0%	12.88%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	8.00	7.96				
NNUH	8.00	7.73				
QEH	8.00	7.60				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	2	6				
NNUH	2	5				

Safe and Effective Care Domain Appendix - Pressure Ulcers, Falls and RN Fill

Feb-26

JPUH - Pressure Ulcers 7.00

20, 0
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

JPUH - Falls 71

100, 50
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

JPUH - Registered Nurse Fill Rate 86.67%

100, 90, 80
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

NNUH - Pressure Ulcers 35.00

50, 0
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

NNUH - Falls 170

200, 100
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

NNUH - Registered Nurse Fill Rate 95.25%

95, 90
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

QEH - Pressure Ulcers 3.00

10, 0
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

QEH - Falls 60

100, 50
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

QEH - Registered Nurse Fill Rate 88.17%

90, 80
Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

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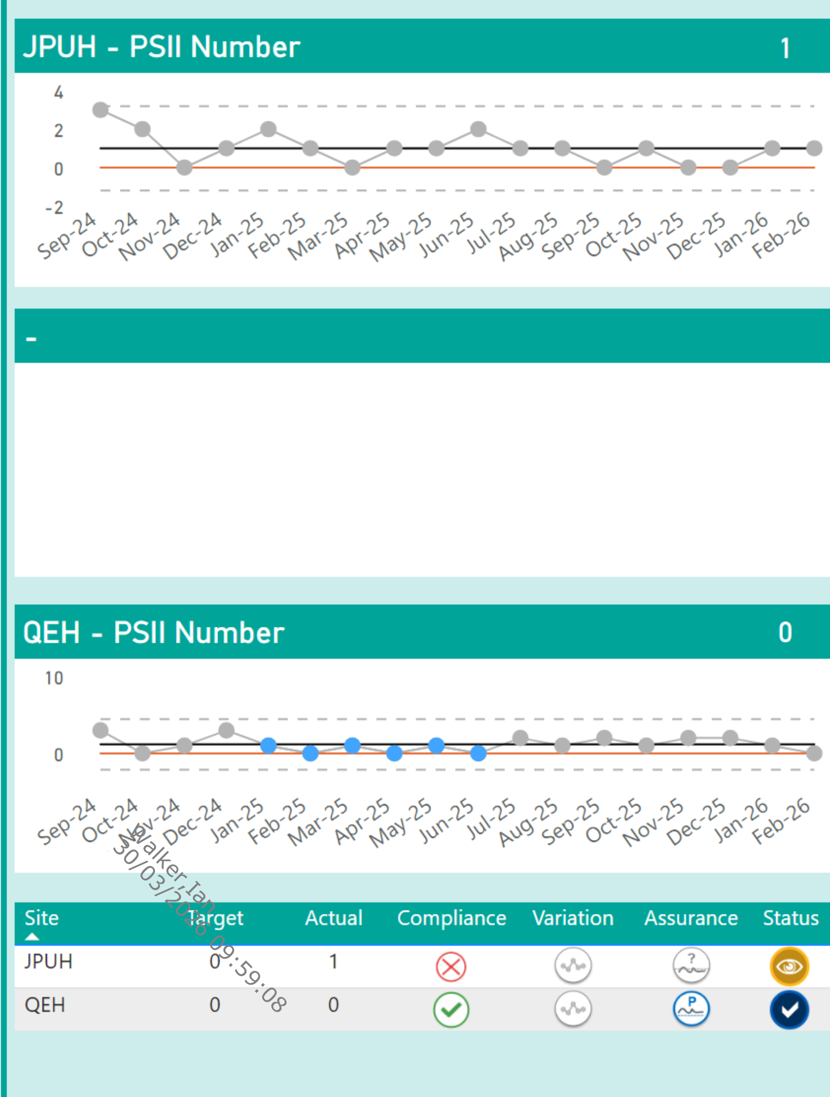
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	7.00				
NNUH	0	35.00				
QEH	0	3.00				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	67	71				
NNUH	187	170				
QEH	54	60				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	86.67%				
NNUH	90.0%	95.25%				
QEH	90.0%	88.17%				

Safe and Effective Care Domain Appendix - PSII

Feb-26



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	1				
QEH	0	0				

Walker Ian 30/03/2026 09:59:08

Safe and Effective Care Domain Appendix - Midwifery Fill Rate, Stillbirth Rate, Preterm Birth Rate

Feb-26

JPUH - Midwifery Fill Rate 84.33%

JPUH - Preterm Birth Rate 8.11%

JPUH - Still Birth Rate 0.00%

NNUH - Midwifery Fill Rate 85.23%

NNUH - Preterm Birth Rate 6.94%

NNUH - Still Birth Rate 0.58%

QEH - Midwifery Fill Rate 85.68%

QEH - Preterm Birth Rate 6.57%

QEH - Still Birth Rate 2.37%

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	84.33%				
NNUH	90.0%	85.23%				
QEH	90.0%	85.68%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	6.0%	8.11%				
NNUH	6.0%	6.94%				
QEH	6.0%	6.57%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3.5%	0.00%				
NNUH	3.5%	0.58%				
QEH	3.5%	2.37%				

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Safe and Effective Care Domain Appendix - FFT (Maternity) and Complaints (Maternity)

Feb-26

JPUH - Maternity FFT 90.63%

100
80
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

JPUH - Complaints Received - Maternity 0

4
2
0
-2
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

NNUH - Maternity FFT 100.00%

100
50
Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25

-

QEH - Maternity FFT 98.48%

100
95
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

QEH - Complaints Received - Maternity 3

10
0
Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26

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Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	95.0%	90.63%				
NNUH	95.0%	100.00%				
QEH	95.0%	98.48%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	0				
QEH	0	3				

Safe and Effective Care Domain Appendix - One to One Care, MNSI and Unplanned NICU Admissions

Feb-26

JPUH - 1:1 Care — 100.00%

JPUH - MNSI — 0

JPUH - Unplanned Admissions to NICU — 10

NNUH - 1:1 Care — 99.18%

NNUH - MNSI — 1

NNUH - Unplanned Admissions to NICU — 13

-

-

-

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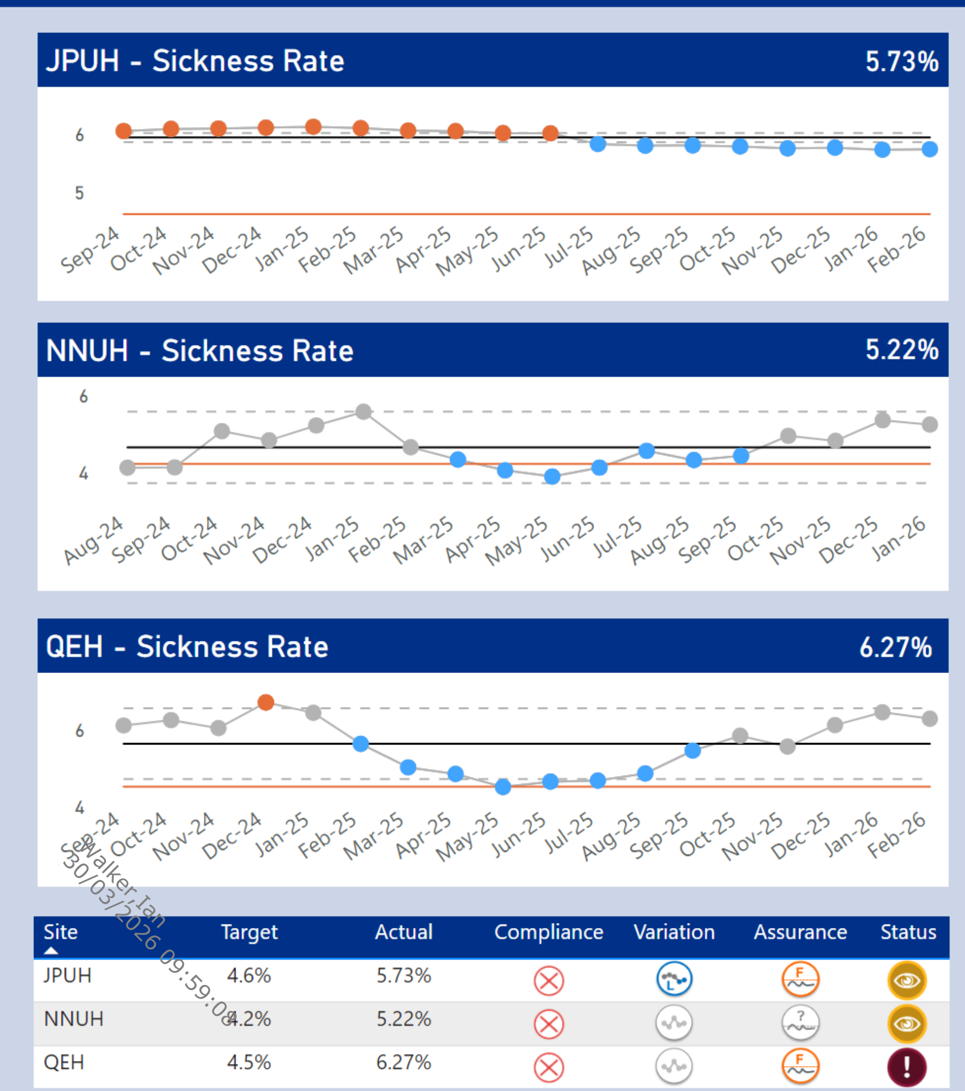
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	97.0%	100.00%				
NNUH	97.0%	99.18%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	0				
NNUH	0	1				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	10				
NNUH	0	13				

People and Culture Domain Appendix - Sickness and Turnover

Feb-26



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	4.6%	5.73%				
NNUH	4.2%	5.22%				
QEH	4.5%	6.27%				

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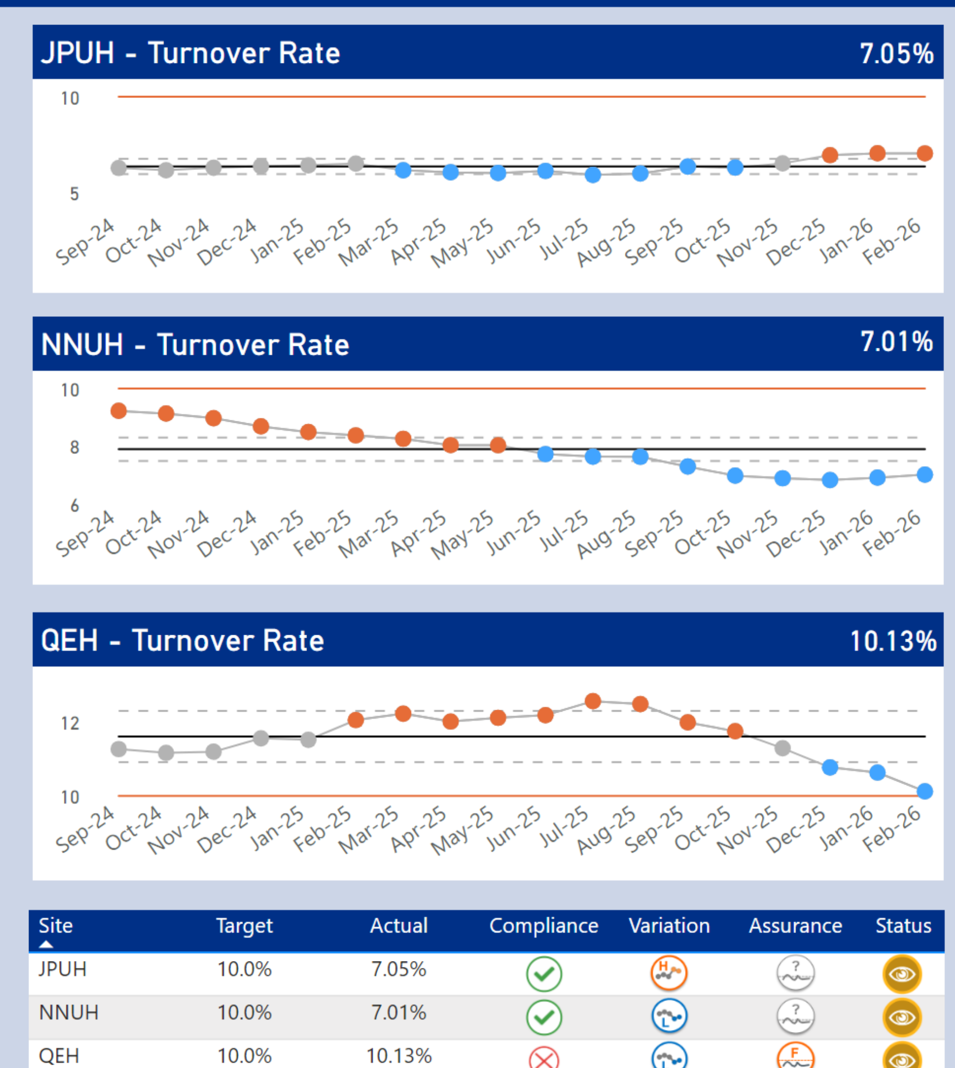
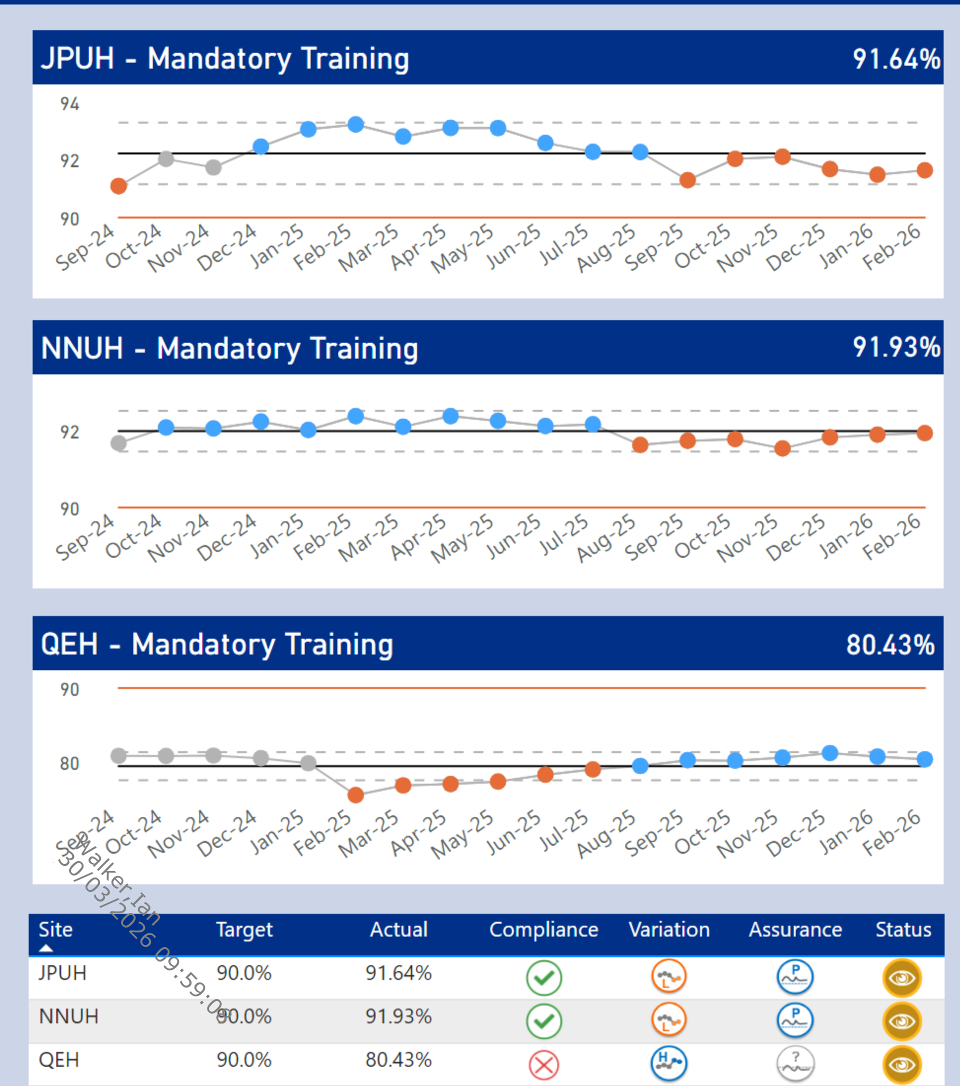


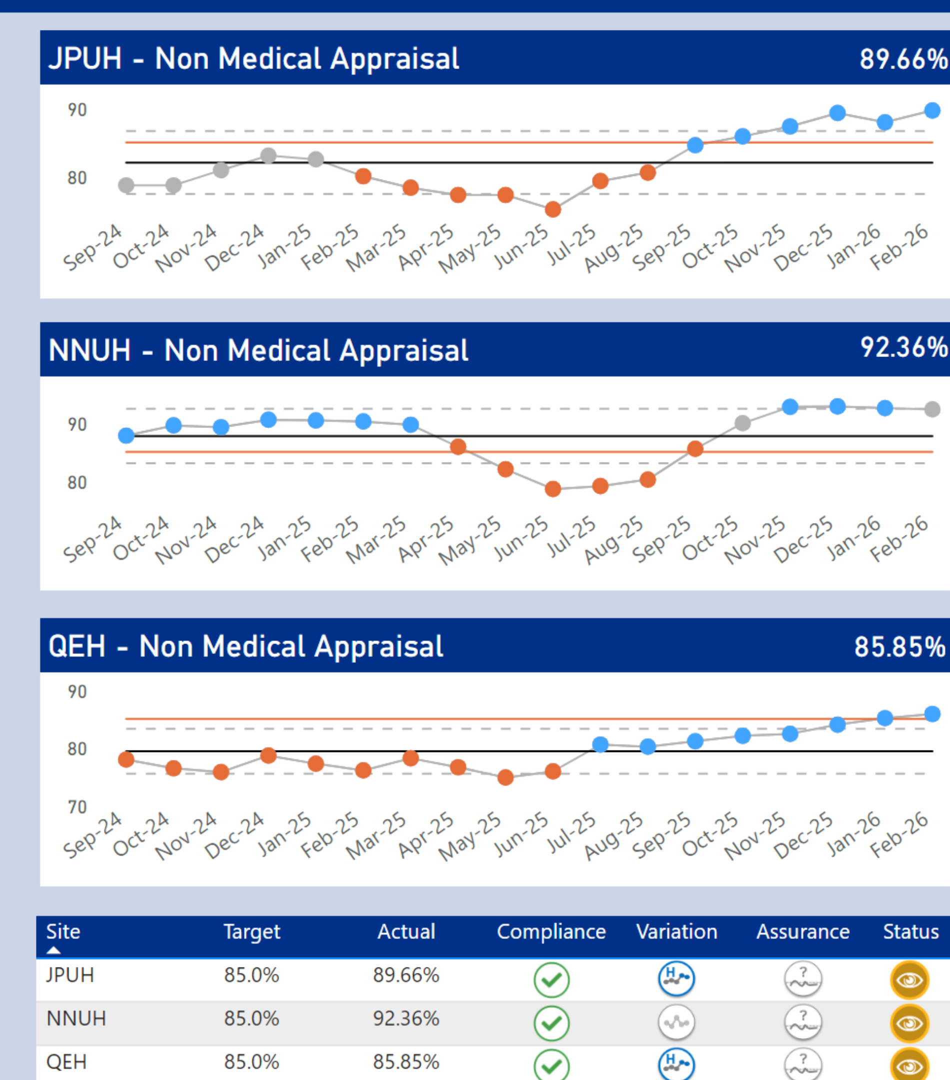
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	10.0%	7.05%				
NNUH	10.0%	7.01%				
QEH	10.0%	10.13%				

People and Culture Domain Appendix - Mandatory Training and Appraisals

Feb-26



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	91.64%				
NNUH	90.0%	91.93%				
QEH	90.0%	80.43%				



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	85.0%	89.66%				
NNUH	85.0%	92.36%				
QEH	85.0%	85.85%				

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Access and Flow Domain Appendix - RTT

Feb-26

JPUH - 65+ Week Waits 126

JPUH - 52+ Week Performance 4.90%

JPUH - 6 Week Diagnostics 69.83%

NNUH - 65+ Week Waits 98

NNUH - 52+ Week Performance 3.47%

NNUH - 6 Week Diagnostics 85.00%

QEH - 65+ Week Waits 2

QEH - 52+ Week Performance 1.53%

QEH - 6 Week Diagnostics 58.59%

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Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	126				
NNUH	0	98				
QEH	0	2				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	5.6%	4.90%				
NNUH	2.2%	3.47%				
QEH	1.5%	1.53%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	95.0%	69.83%				
NNUH	95.0%	85.00%				
QEH	95.0%	58.59%				

Access and Flow Domain Appendix - RTT

Feb-26

JPUH - Total PTL Size 33,120

JPUH - RTT Incomplete Within 18 weeks 53.97%

JPUH - First Attendance Within 18 Weeks 60.64%

NNUH - Total PTL Size 66,269

NNUH - RTT Incomplete Within 18 weeks 59.87%

NNUH - First Attendance Within 18 Weeks 73.39%

QEH - Total PTL Size 26,144

QEH - RTT Incomplete Within 18 weeks 53.90%

QEH - First Attendance Within 18 Weeks 56.45%

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	28,649	33,120				
NNUH	81,265	66,269				
QEH	24,963	26,144				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	92.0%	53.97%				
NNUH	92.0%	59.87%				
QEH	92.0%	53.90%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	64.0%	60.64%				
NNUH	64.0%	73.39%				
QEH	64.0%	56.45%				

Access and Flow Domain Appendix - Clearance Times

Feb-26

JPUH - Estimated clearance times 27

JPUH - Under 18s elective waiting list size 2,716

-

NNUH - Under 18s elective waiting list size 7,229

-

-

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	18	27				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	2,615	2,716				
NNUH	8,368	7,229				

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Access and Flow Domain Appendix - Cancer

Jan-26

JPUH - 28 Day Faster Diagnosis 69.17%

JPUH - Cancer 62 Day Treatment 67.01%

-

NNUH - 28 Day Faster Diagnosis 73.75%

NNUH - Cancer 62 Day Treatment 64.17%

-

QEH - 28 Day Faster Diagnosis 60.90%

QEH - Cancer 62 Day Treatment 54.31%

-

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	75.0%	69.17%				
NNUH	75.0%	73.75%				
QEH	75.0%	60.90%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	85.0%	67.01%				
NNUH	85.0%	64.17%				
QEH	85.0%	54.31%				

Site	Target	Actual	Compliance	Variation	Assurance	Status

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Access and Flow Domain Appendix - UEC

Feb-26

JPUH - ED 4 Hour Performance 72.08%

JPUH - ED 12 Hours in Department % 8.60%

JPUH - Ambulance Handovers Over 30 Minutes 649

NNUH - ED 4 Hour Performance 80.54%

NNUH - ED 12 Hours in Department % 7.81%

NNUH - Ambulance Handovers Over 30 Minutes 2,015

QEH - ED 4 Hour Performance 64.60%

QEH - ED 12 Hours in Department % 15.15%

QEH - Ambulance Handovers Over 30 Minutes 749

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	78.0%	72.08%	✗	H	?	
NNUH	78.0%	80.54%	✓		?	
QEH	78.0%	64.60%	✗	H	?	

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	2.0%	8.60%	✗		F	!
NNUH	4.0%	7.81%	✗		?	
QEH	12.1%	15.15%	✗		?	

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	649	✗		F	!
NNUH	0	2,015	✗		F	!
QEH	0	749	✗		F	!

NHS-Ker, Ian 26/03/2026 09:59:08

Access and Flow Domain Appendix - UEC

Feb-26

JPUH - Ambulance Handovers Over 45 Minutes 525

JPUH - Ambulance Handovers Over 45 Minutes % 36.04%

JPUH - Non Elective LoS 10.72

NNUH - Ambulance Handovers Over 45 Minutes 1,664

NNUH - Ambulance Handovers Over 45 Minutes % 63.93%

-

QEH - Ambulance Handovers Over 45 Minutes 590

QEH - Ambulance Handovers Over 45 Minutes % 33.77%

QEH - Non Elective LoS 10.25

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	525				
NNUH	0	1,664				
QEH	0	590				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0.0%	36.04%				
NNUH	0.0%	63.93%				
QEH	0.0%	33.77%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	10	10.72				
QEH	10	10.25				

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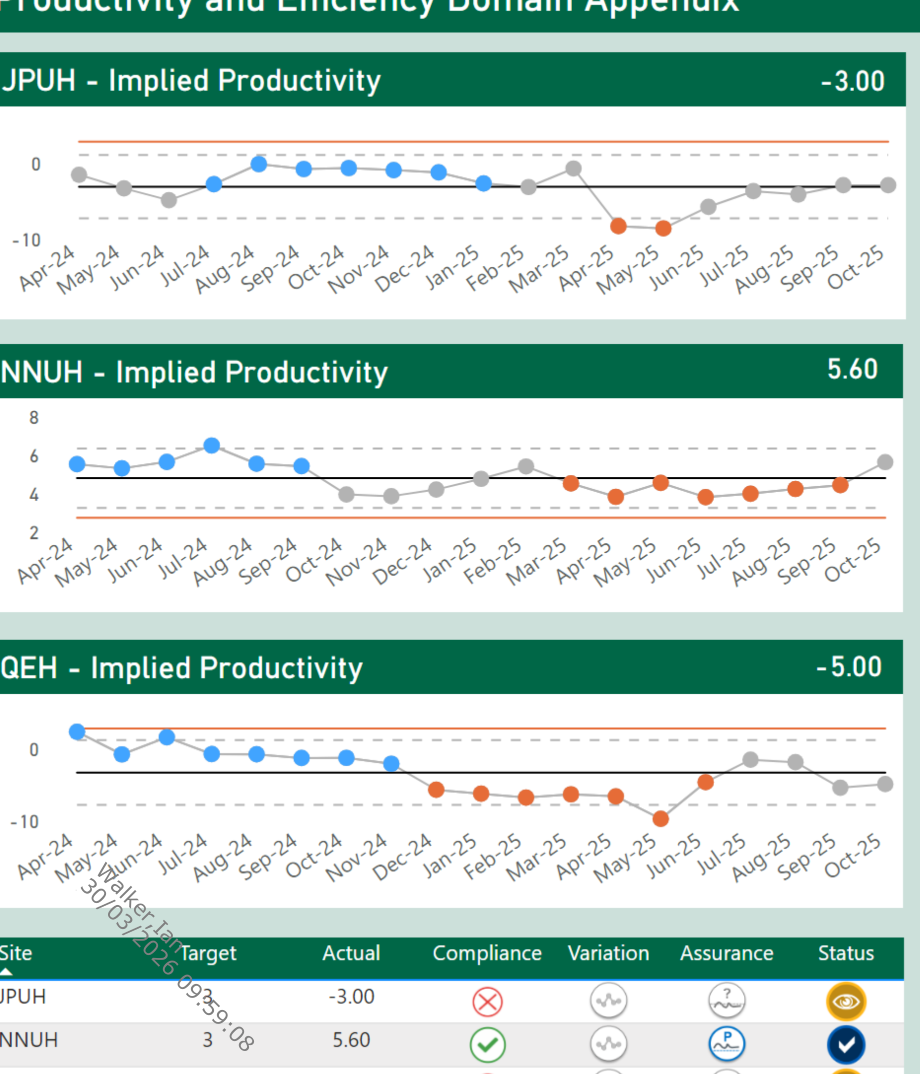
Norfolk and Waveney University Hospitals Group

Productivity and Efficiency Domain Appendix

Oct-25



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3	-3.00				
NNUH	3	5.60				
QEH	3	-5.00				

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Norfolk and Waveney University Hospitals Group

Productivity and Efficiency Domain Appendix

Feb-26

JPUH - Planned surplus/deficit 663

JPUH - YTD Surplus/deficit -338

NNUH - Planned surplus/deficit 7,968

NNUH - YTD Surplus/deficit 6

QEH - Planned surplus/deficit -1,237

QEH - YTD Surplus/deficit -2,655

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	792	663				
NNUH	-636	7,968				
QEH	849	-1,237				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	-1,531	-338				
NNUH	-26	6				
QEH	-321	-2,655				

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Norfolk and Waveney University Hospitals Group

Productivity and Efficiency Domain Appendix

Feb-26

JPUH - Agency Expenditure reduction 46.74%

JPUH - Bank Expenditure reduction 20.41%

NNUH - Agency Expenditure reduction 65.15%

NNUH - Bank Expenditure reduction 13.87%

QEH - Agency Expenditure reduction -6.43%

QEH - Bank Expenditure reduction 31.79%

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	30.0%	46.74%				
NNUH	30.0%	65.15%				
QEH	30.0%	-6.43%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	10.0%	20.41%				
NNUH	10.0%	13.87%				
QEH	10.0%	31.79%				

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NHS
Norfolk and Waveney
University Hospitals Group

Productivity and Efficiency Domain Appendix

Feb-26

JPUH - Efficiency Plan £000 — 2,800

JPUH - Efficiency Plan YTD £000 — 26,164

NNUH - Efficiency Plan £000 — 3,766

NNUH - Efficiency Plan YTD £000 — 39,535

QEH - Efficiency Plan £000 — 1,629

QEH - Efficiency Plan YTD £000 — 16,638

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	2,546	2,800				
NNUH	4,005	3,766				
QEH	1,757	1,629				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	23,112	26,164				
NNUH	39,647	39,535				
QEH	16,439	16,638				

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Icon Descriptions

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
H	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
L	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
H	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
L	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

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

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Understanding the Matrix

Variation/Performance (rows) × **Assurance** (columns)

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F
H	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Average** — **Investigate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.
L	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Average** — **Investigate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.
	Good — **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** — **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.
H	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change
L	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change

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Report to the Group Board in public: 1 April 2026

Agenda item number	9.2		
Title	Group Finance Report		
Author(s)	Marcus Thorman, Group Chief Finance Officer		
Executive sponsor	Marcus Thorman, Group Chief Finance Officer		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

The Group delivered a strong Month 11 financial position, reporting a £9.9m surplus against plan and a year-to-date deficit of £0.5m, £1.4m favourable to plan, despite £11.6m of non-recurrent redundancy costs at NNUH. Excluding these costs, the Group would be in a significant surplus, and the forecast outturn remains breakeven for the year. Clinical income has been resolved following agreement with the ICB, generating a £26.5m favourable year-to-date variance, while other income is £22.4m favourable overall but largely offset by adverse pay and non-pay expenditure reflecting pass-through costs. There are ongoing pay pressures at QEH as the planned reductions have not been delivered in year. The risk score for delivering the 2025/26 financial plan has reduced to 7, reflecting the agreed forecast outturn, although key risks remain around capital delivery, bank and agency controls and delivery of the Cost Improvement Programme (CIP). Looking ahead to 2026/27, financial risk increases due to higher CIP requirements arising from the phased withdrawal of deficit support and the increasing difficulty of further bank and agency reductions, meaning the overall financial sustainability risk score has not reduced.

The attached report provides additional detail, with an overall summary on page 3.

Recommendations

The Group Board is asked to:

- Note the reduction in risk score on delivering this year's financial plan and the continuation of forecasting a breakeven position for the 2025/26 financial year.
- Note the level of CIP risk within the Medium-term Plan and its impact on the overall Principal Risk score.

Alignment to Board Assurance Framework risk(s)	Principal Risk 4 – Financial sustainability
Previously considered by	Group Risk Assurance Committee, 26 March 2026
Any background papers in Admin Control Reading Room	None

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Norfolk and Waveney University Hospitals Group

Group Finance Report
February 2026

Group Board meeting: 1 April 2026

Marcus Thorman, Group Chief Finance Officer

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Contents

This report sets out the Group's financial performance and forms part of the Group's performance reporting suite.

The report has been structured to provide the reader with an overview of the Group's financial performance using the following framework.

1.0	Executive Summary/Dashboard	Page 3-4
2.0	Operational Performance	Page 5-6
3.0	CIP	Page 7
4.0	Cash	Page 8
5.0	Statement of Financial Position	Page 9
6.0	Capital	Page 10
7.0	Risk	Page 11

NHS Norfolk and Waveney University Hospitals Group

1. Executive Summary

Month 11 Financial Performance

The Group position in month 11 is a surplus of £9.9m against a planned surplus of £1.1m at the control total, a favourable variance of £8.8m. The position is predominantly driven by the additional surge funding from the ICB for quarter 4. The year-to-date (YTD) position is a deficit of £0.5m against a planned position of a deficit of £1.9m, a favourable variance of £1.4m. However, the YTD position includes the impact of the redundancies at NNUH of £11.6m and a much smaller value at JPUH, a non-recurrent cost in year, which if removed would mean the Group would have a significant surplus position for the year, albeit non recurrently.

The clinical income for the Group has been resolved following an agreement with the ICB as described to the Board in previous months. The YTD position is a favourable variance overall of £26.5m which relates to additional funding as well as the variable elements of the contract. Other income was a favourable variance in month of £0.3m, mainly due to the pass-through costs for drugs and devices with the commissioners, Cancer Alliance funding and Research & Development income. The total favourable variance to date is £22.4m which is offset by expenditure, in both pay and non-pay.

The pay expenditure in month was an adverse variance of £2.8m. The key issue moving forwards on pay is with QEH as they have not reduced the substantive workforce in line with the original financial and workforce plans and have invested in additional staffing for the Emergency Department. The non-pay was an adverse variance of £3.4m and YTD a total of £26.8m the majority of which is the equal and opposite the favourable variance in other income.

Each Trust has reviewed its forecast outturn and will deliver a breakeven position for the year hence the Group will deliver its fiduciary responsibility for 2025/26.

Productivity and Efficiency

The Cost Improvement Programme (CIP) target for the year is £87.9m and to date the three Trusts have identified £89.0m of approved schemes a favourable variance of £1.1m. As at the end of month 11 the Group has delivered £82.3m against a plan of £79.2m, a favourable variance of £3.1m. This is predominantly driven by over-performance on the programmes offset by a small target not yet identified. However, a significant proportion is still non-recurrent in nature and means there is a recurrent impact into 2026/27 albeit offset by the full year effect of the part year recurrent schemes.

The focus in the last few months has been identifying the programmes for the new financial year and as per the submission to NHSE the majority of the plan has been identified and work moves towards delivery of the schemes.

Cash and Capital

The cash position at QEH has been a key focus this financial year with a very low operational cashflow. The position was such that across Group it was agreed that QEH would hold the NNUH invoices until back into recurrent balance therefore by year end they will have almost £8m of debt with NNUH, hence the increase in debtors >90 days at NNUH. The cash position has also been impacted favourably by the underspend in capital in year with a total underspend against the plan of £63.8m.

The capital programme has a total value for the year of £204m with a forecast outturn of £160m.The majority of the underspend is on national schemes, for which brokerage into 2026/27 has been agreed (with the exception of NNUH ED which is subject to ongoing discussion). For system internally funded capital there has been slippage of the stroke thrombectomy scheme due to delays in the PFI for which funding to complete in 2026/27 has now been awarded in principle.

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Risks

Across the Trusts, delivery risk remains significant in the new financial year as plans rely heavily on the CIP programmes, a material proportion of which are high risk and include non-recurrent elements, requiring sustained and close monitoring to achieve breakeven in 2026/27. Workforce cost reduction plans, particularly for bank and agency, become increasingly challenging due to a narrowing pool of agency usage, ongoing recruitment difficulties, sickness levels and continued reliance on escalation capacity. In addition, cash remains a critical risk, particularly for QEH, where failure to deliver the financial plan could place quarterly cash funding at risk.

NHS Norfolk and Waveney University Hospitals Group

1. Executive Dashboard

February position is a £9.9m surplus on a control total basis, £8.8m favourable to the planned £1.1m surplus.

The main drivers of the favourable variance are as a result of £8.3m of income due to contractual adjustments at NNUH and £2.3m of delayed investment, offset by non utilisation of reserves, £1.1m of planned release held, £0.4m associated with redundancy, and costs of escalation totalling £0.3m.

Year to date position is a £0.5m deficit on a control total basis, £1.4m favourable to the planned £1.9m deficit.

The main drivers of the favourable variance are surge funding £12.6m, over delivery of CIP of £3.1m offset by £12.4m of expenditure associated with the NNUH redundancy programmes, £0.4m as a result of Industrial Action and escalation costs of £1.5m of costs relating to escalation.

Forecast Outturn for the Group remains breakeven, no movement from the breakeven plan.

Cash: Cash held on 28th February was £130.4m, £54.1m favourable to the planned £76.3m.

Capital Expenditure: Year to date total capital spend is £118.9m, £63.8m behind the planned spend of £182.7m.

CIP: Year to date CIP delivery is £82.3m against a budgeted plan of £79.2m, a favourable variance of £3.1m, comprised of an adverse planning variance of £0.6m and a favourable performance variance of £3.7m. Identifying recurrent CIP remains the biggest challenge with NNUH £16.8m adverse to the planned recurrent CIP.

Activity: Value-based activity performance for February was favourable by £1.0m, YTD performance is £8.3m favourable.

	In Month			Year To Date		
	Plan	Actual	Variance	Plan	Actual	Variance
SOCI	£m	£m	£m	£m	£m	£m
Clinical Income	120.9	135.2	14.3	1,331.8	1,358.3	26.5
Other Income	15.3	15.6	0.3	159.5	181.9	22.4
TOTAL INCOME	**136.1**	**150.8**	**14.7**	**1,491.3**	**1,540.2**	**48.9**
Pay	(88.0)	(90.7)	(2.8)	(975.6)	(996.1)	(20.4)
Non Pay	(34.1)	(37.5)	(3.4)	(372.2)	(399.0)	(26.8)
Drugs (Net Expenditure)	(4.5)	(4.4)	0.1	(52.7)	(55.7)	(3.1)
TOTAL EXPENDITURE	**(126.5)**	**(132.6)**	**(6.1)**	**(1,400.5)**	**(1,450.8)**	**(50.4)**
Non Opex	(8.5)	(8.4)	0.2	(92.7)	(89.9)	2.8
Control Total Surplus / (Deficit)	1.1	9.9	8.8	(1.9)	(0.5)	1.4
Statutory Surplus / (Deficit)	1.6	9.5	7.9	1.9	(1.1)	3.1
Other Financial Metrics	£m	£m	£m	£m	£m	£m
Cash at Bank (before support funding)	76.3	130.4	54.1	76.3	130.4	54.1
Capital Programme Expenditure	17.8	21.5	3.7	182.7	118.9	(63.8)
CIP Delivery	8.3	8.2	(0.1)	79.2	82.3	3.1
Aligned Payment Incentive (API) contract performance	38.2	39.3	1.0	440.8	449.1	8.3

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Norfolk and Waveney University Hospitals Group

2.1 Financial Performance

February position is a £9.9m surplus on a control total basis, £8.8m favourable to the planned £1.1m surplus.

The main drivers of the favourable variance are as a result of £8.3m of income due to contractual adjustments at NNUH and £2.3m of delayed investment, offset by non utilisation of reserves, £1.1m of planned release held, £0.4m associated with redundancy, and costs of escalation totalling £0.3m.

Year to date position is a £0.5m deficit on a control total basis, £1.4m favourable to the planned £1.9m deficit.

The main drivers of the favourable variance are surge funding £12.6m, over delivery of CIP of £3.1m offset by £12.4m of expenditure associate with the NNUH redundancy programmes, £0.4m as a result of Industrial Action and escalation costs of £1.5m of costs relating to escalation.

Forecast Outturn for the Group remains breakeven, no movement from the breakeven plan.

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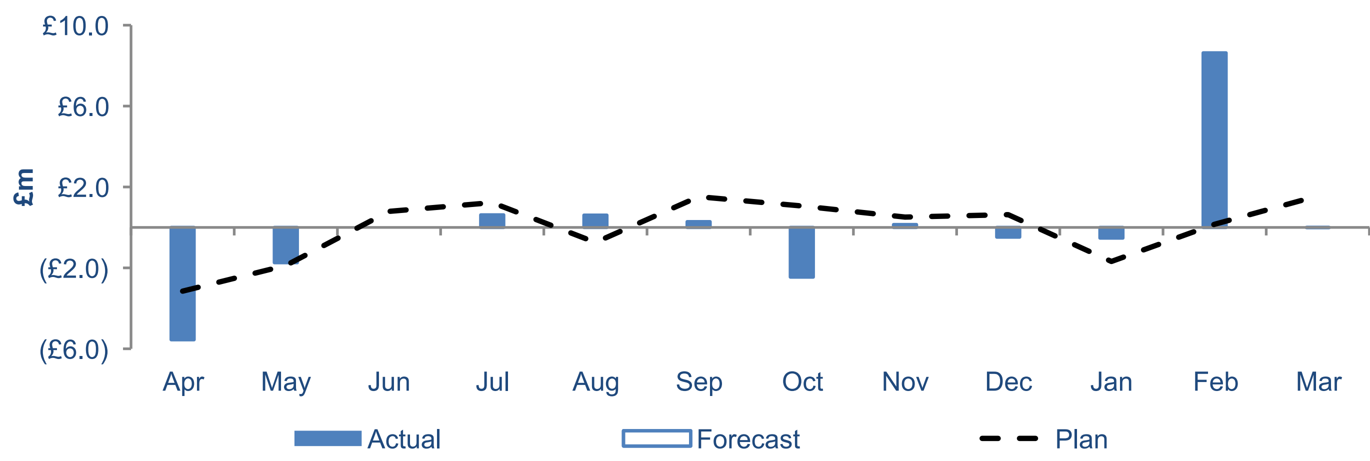
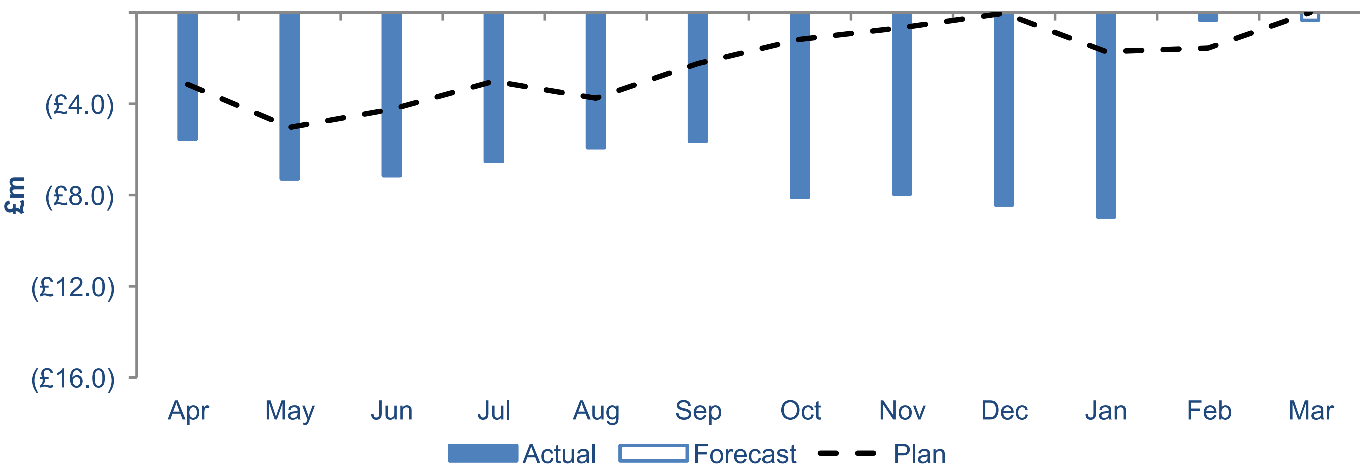




Norfolk and Waveney University Hospitals Group

2.3 Forecast Outturn

Forecast outturn for the Group remains breakeven, no movement from the breakeven plan.

❶The Group operational plan for FY25/26 was breakeven.

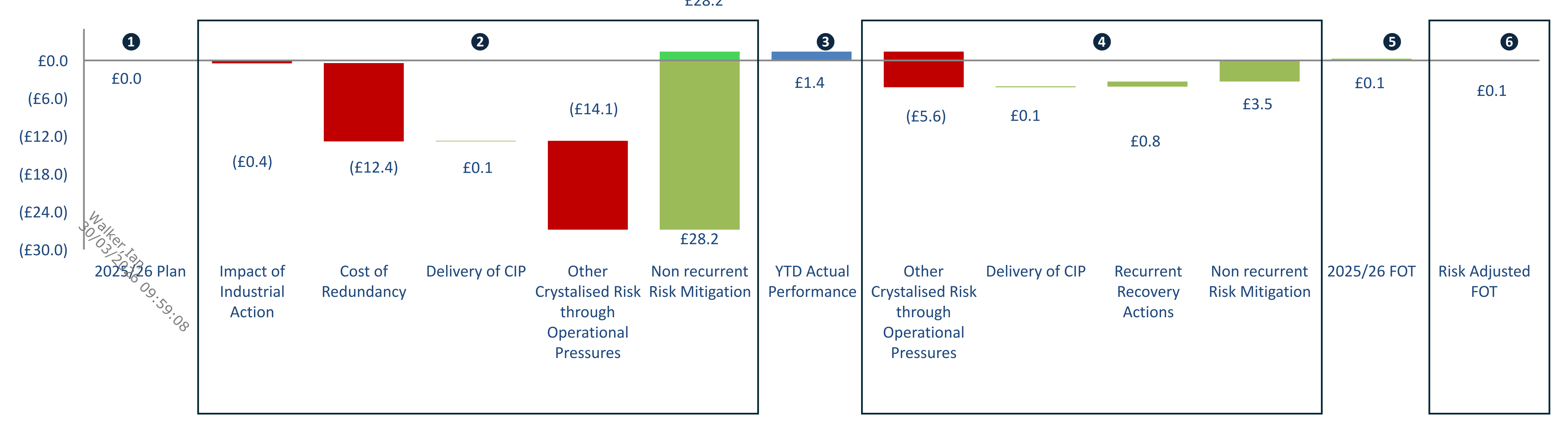
❷Year to date crystalised risks of £26.8m, of which £12.4m relates to cost of redundancy are offset by £28.2m of mitigations.

❸ YTD favourable performance to plan of £1.4m.

❹ Further run rate risk of £5.6m forecast to crystallise through remainder of the year based on current run rates. Offset by £0.8m of recurrent and £3.5m of non recurrent recovery actions.

❺Forecast outturn of breakeven, no movement from the breakeven plan.

❻There are no risks outside of the Forecast Outturn resulting a downside risk adjusted forecast outturn of breakeven



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3. CIP

Year to date CIP delivery is £82.3m against a budgeted plan of £79.2m, a favourable variance of £3.1m, comprised of an adverse planning variance of £0.6m and a favourable performance variance of £3.7m. Identifying recurrent CIP remains the biggest challenge with NNUH £16.8m adverse to the planned recurrent CIP.

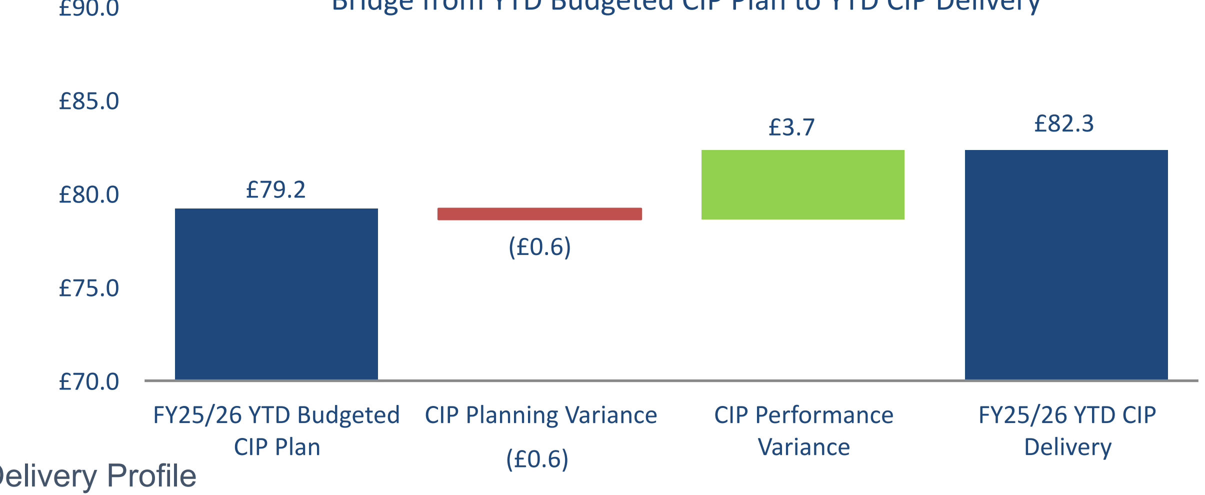
FY25/26 CIP Programme Delivery

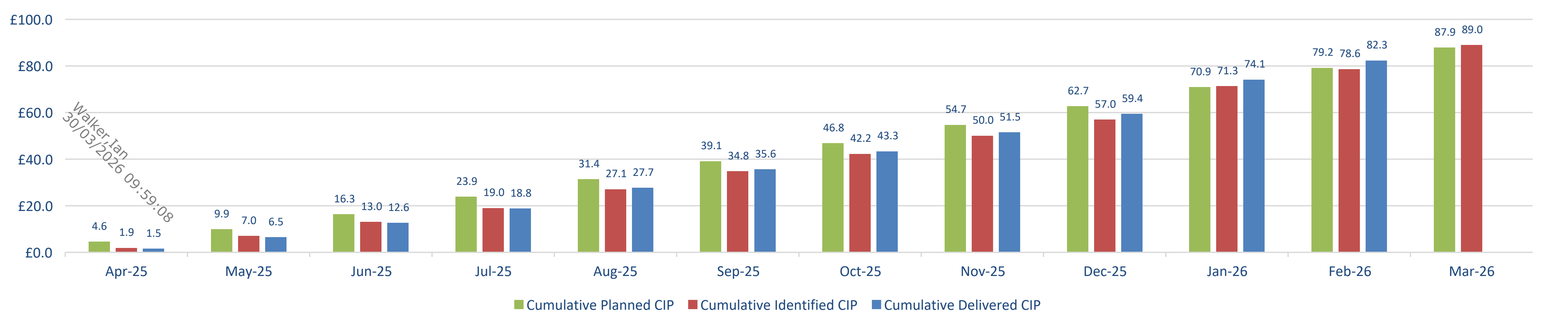
Year to date the Group has delivered £82.3m of CIPs against a budgeted plan of £79.2m, a favourable variance of £3.1m, comprised of (see bridge):

- An adverse planning variance of £0.6m; and
- A favourable performance variance of £3.7m.

FY25/26 CIP Programme Development

As at 4th Mar 2026, the programme consists of £89.0m of Gateway 2 approved schemes. This is £1.1m favourable to the planned £87.9m full year CIP requirement. Identifying recurrent CIP remains the biggest challenge with NNUH £16.8m adverse to the planned recurrent CIP.





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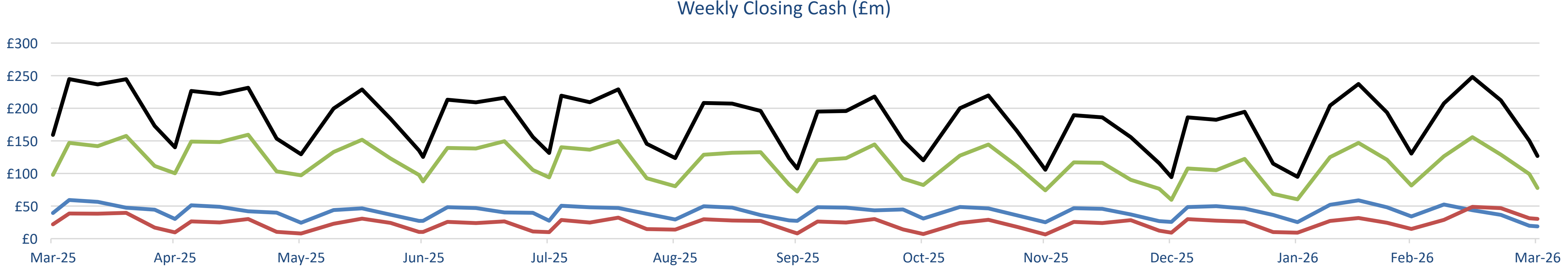
4. Cash

Norfolk and Waveney University Hospitals Group

Cash held on 28th February was £130.4m, £54.1m favourable to the planned £76.3m. Cash balances are forecast to drop by £3.7m by year end, a reduction of £32.4m since the beginning of the year.



Aged Debtors: Debtors on 28th February were £32m, £1.3m more than January 2026. £13.1m is over 90 days. Of the Non-NHS debt greater than 90 days £2.5m relates to an ongoing legal dispute. The Trusts continue to focus on resolving these debts and a bad debt provision of £10.0m is being held.

Debtors by Type	Total Debt			Debt > 90 days		
	Dec-25 £m	Jan-26 £m	Feb-26 £m	Dec-25 £m	Jan-26 £m	Feb-26 £m
NHS	18.1	19.7	21.6	4.6	5.5	5.9
Non NHS	9.0	11.0	10.4	6.0	6.2	7.3
Total	27.1	30.7	32.0	10.6	11.6	13.1

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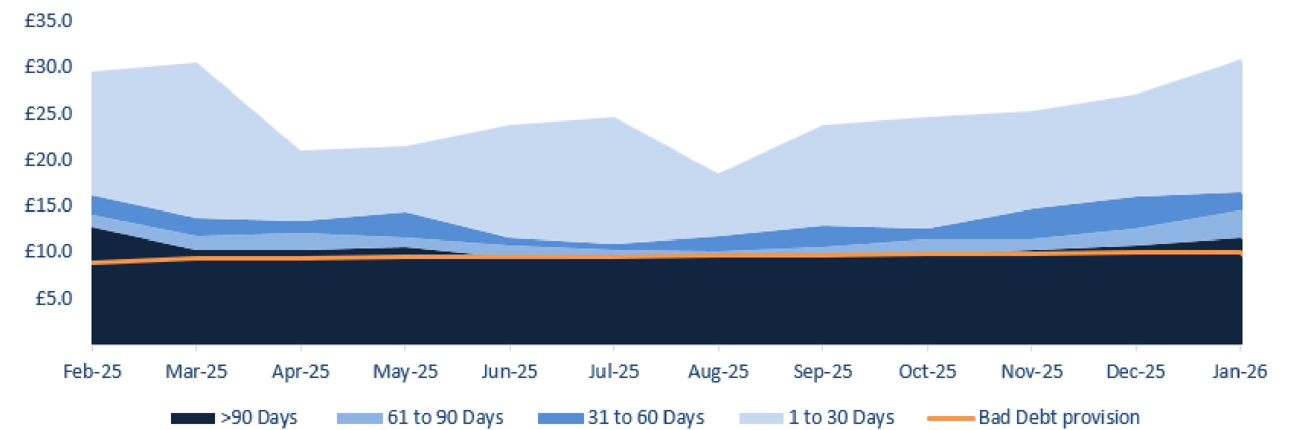

NHS Norfolk and Waveney University Hospitals Group

5. Statement of Financial Position

The Statement of Financial Position at the end of February has increased by £77.5m compared to the opening balance. This is a result of the Public Dividend Capital received by QEH and JPUH offset by the year-to-date statutory deficit.

	JPUH			NNUH			QEH			N&W GROUP		
	Mar-25 £m	Feb-26 £m	YTD Movement £m	Mar-25 £m	Feb-26 £m	YTD Movement £m	Mar-25 £m	Feb-26 £m	YTD Movement £m	Mar-25 £m	Feb-26 £m	YTD Movement £m
Property, plant and equipment	146.0	168.1	22.1	413.8	421.3	7.5	156.3	190.8	34.5	716.1	780.2	64.1
Right of use assets - leased assets	1.5	1.9	0.3	43.7	44.3	0.6	0.2	4.0	3.8	45.4	50.2	4.7
Receivables: due from DHSC group bodies	0.0	0.0	0.0	3.2	3.2	0.0	0.0	0.0	0.0	3.2	3.2	0.0
Receivables: due from non-DHSC bodies	0.6	0.5	(0.1)	60.5	58.3	(2.2)	0.4	0.4	0.0	61.5	59.2	(2.3)
Total non-current assets	**148.1**	**170.4**	**22.3**	**521.2**	**527.1**	**5.9**	**156.9**	**195.2**	**38.3**	**826.2**	**892.7**	**66.5**
Inventories	3.7	3.3	(0.4)	15.8	16.2	0.4	3.2	3.5	0.3	22.7	23.0	0.3
Receivables: due from DHSC group bodies	5.2	6.2	1.0	22.9	25.7	2.8	2.8	3.3	0.5	30.9	35.2	4.3
Receivables: due from non-DHSC group bodies	8.0	8.3	0.4	25.1	35.9	10.8	5.9	5.8	(0.1)	39.0	50.0	11.1
Cash and cash equivalents	39.4	34.1	(5.3)	93.4	76.9	(16.5)	21.9	14.8	(7.1)	154.7	125.8	(28.9)
Total current assets	**56.3**	**51.9**	**(4.4)**	**157.2**	**154.7**	**(2.5)**	**33.8**	**27.4**	**(6.4)**	**247.3**	**234.0**	**(13.3)**
Trade and other payables: capital	(17.3)	(5.5)	11.8	(16.6)	(17.2)	(0.6)	(3.4)	(4.1)	(0.7)	(37.3)	(26.8)	10.5
Trade and other payables: non-capital	(32.1)	(31.0)	1.2	(125.8)	(104.9)	20.9	(46.8)	(39.7)	7.1	(204.7)	(175.6)	29.2
Borrowings - PFI	0.0	0.0	0.0	(18.0)	(18.0)	0.0	0.0	0.0	0.0	(18.0)	(18.0)	0.0
Borrowings: leases current	(0.9)	(0.8)	0.2	(8.5)	(8.0)	0.5	(0.2)	(0.3)	(0.1)	(9.6)	(9.1)	0.6
Current provisions	(0.4)	(0.4)	0.0	(1.5)	(3.1)	(1.6)	(0.2)	(0.2)	0.0	(2.1)	(3.7)	(1.6)
Deferred Income	(3.7)	(4.2)	(0.5)	(23.4)	(37.5)	(14.1)	(1.8)	(5.5)	(3.7)	(28.9)	(47.2)	(18.3)
Total current liabilities	**(54.5)**	**(41.8)**	**12.7**	**(193.8)**	**(188.7)**	**5.1**	**(52.4)**	**(49.8)**	**2.6**	**(300.7)**	**(280.3)**	**20.4**
Total assets less current liabilities	**149.9**	**180.5**	**30.6**	**484.6**	**493.1**	**8.5**	**138.3**	**172.8**	**34.5**	**772.8**	**846.4**	**73.6**
Borrowings - PFI	0.0	0.0	0.0	(351.0)	(349.0)	2.0	0.0	0.0	0.0	(351.0)	(349.0)	2.0
Borrowings: leases non-current	(0.7)	(1.0)	(0.4)	(31.9)	(28.0)	3.9	(0.1)	(3.9)	(3.8)	(32.7)	(32.9)	(0.3)
Provisions	(0.7)	(0.6)	0.1	(6.5)	(3.9)	2.6	0.0	0.0	0.0	(7.2)	(4.5)	2.7
Deferred Income	0.0	0.0	0.0	(1.1)	(1.0)	0.1	(1.0)	(1.6)	(0.6)	(2.1)	(2.6)	(0.5)
Total non-current liabilities	**(1.4)**	**(1.7)**	**(0.3)**	**(390.5)**	**(381.9)**	**8.6**	**(1.1)**	**(5.5)**	**(4.4)**	**(393.0)**	**(389.1)**	**3.9**
Total assets employed	**148.5**	**178.8**	**30.3**	**94.1**	**111.2**	**17.1**	**137.2**	**167.3**	**30.1**	**379.8**	**457.3**	**77.5**
Financed by												
Public dividend capital	220.0	249.8	29.8	390.9	400.9	10.0	390.5	421.1	30.6	1,001.4	1,071.8	70.4
Retained Earnings (Accumulated Losses)	(73.6)	(73.1)	0.6	(323.1)	(315.3)	7.8	(256.4)	(256.9)	(0.5)	(653.1)	(645.3)	7.9
Revaluation reserve	2.1	2.1	(0.0)	26.3	25.6	(0.7)	3.1	3.1	0.0	31.5	30.8	(0.7)
Total Taxpayers' and others' equity	**148.5**	**178.8**	**30.3**	**94.1**	**111.2**	**17.1**	**137.2**	**167.3**	**30.1**	**379.8**	**457.3**	**77.5**

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6. Capital

Month 11 forecast outturn for Total CDEL is a £45.2m underspend compared to revised plan (£48.2m underspend prior month) of which £2.5m relates to system CDEL and £47.7m nationally funded programmes.

System CDEL £2.5m underspend: £3.3m relates to slippage in the NNUH Stroke Thrombectomy scheme due to delays with PFI legal process, which is now funded to complete in 2026/27 via RTCS UEC programme. The balance relates to small changes in disposals and other schemes. £5.6m of EPR slippage (self-financed element) confirmed by the programme in Month 9 is being managed through bringing forward 2026/27 spend.

Nationally funded programmes £47.7m underspend: New in month: New Hospital Programme forecast has increased by £2.0m across JPUH and QEH. Previously reported variances: NNUH elective hub has H2 delay recognised in FOT (£14.0m), JPUH Frailty Hub is no longer progressing in 2025/26 (£7.5m), NNUH ED redevelopment is working to a longer programme timeline (£4.9m), and QEH UTC is forecasting delay (£4.8m). Funding for 2026/27 to complete these programmes is now confirmed through planning allocations with the exception of NNUH ED which is subject to ongoing discussion. Final capital cash draws for 2025/26 have completed.

		25/26 Outturn: Month 11 FOT											
		NHSE Plan (Start Year Plan)				FOT				FOT Variance			
Month 11 FOT		JPUH	NNUH	QEH	N&WUHG	JPUH	NNUH	QEH	N&WUHG	JPUH	NNUH	QEH	N&WUHG
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Internally Funded	Owned	9,704	15,246	9,296	34,246	9,773	23,269	8,545	41,587	(70)	(8,023)	751	(7,342)
	Right of Use Asset	1,302	8,151	290	9,743	1,302	7,822	424	9,548	(0)	329	(134)	195
	Other Adjustments: grants/donations/peppercorn leases	(1,598)	(229)	0	(1,827)	(1,598)	(4,029)	0	(5,627)	0	3,800	0	3,800
	Disposals	0	0	0	0	0	(855)	0	(855)	0	855	0	855
Total System CDEL		**9,408**	**23,168**	**9,586**	**42,162**	**9,477**	**26,206**	**8,969**	**44,653**	**(69)**	**(3,038)**	**617**	**(2,491)**
Nationally Funded Scheme	Front Line Digitisation	6,351	14,412	6,100	26,863	5,140	12,520	5,150	22,810	1,211	1,892	950	4,053
	NHP	14,929	0	10,000	24,929	11,351	0	10,796	22,147	3,578	0	(796)	2,782
	RAAC Plank	9,848	0	36,223	46,071	11,820	0	31,736	43,556	(1,972)	0	4,487	2,515
	UEC	9,768	5,359	9,988	25,115	3,132	1,041	5,959	10,132	6,636	4,318	4,029	14,983
	Elective Recovery	0	27,750	0	27,750	186	2,849	0	3,035	(186)	24,901	0	24,715
	Diagnostics	210	3,940	250	4,400	2,532	2,092	227	4,851	(2,322)	1,848	23	(451)
	Estates Safety	1,410	2,992	2,992	7,394	1,742	2,080	3,037	6,859	(332)	912	(45)	535
	Other	0	289	0	289	630	411	715	1,756	(630)	(122)	(715)	(1,467)
Total Nationally Funded		42,516	54,742	65,553	162,811	36,533	20,993	57,620	115,146	5,983	33,749	7,933	47,665
Total CDEL		**51,924**	**77,910**	**75,139**	**204,973**	**46,011**	**47,199**	**66,589**	**159,799**	**5,913**	**30,711**	**8,550**	**45,174**

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7. Risk

Principal Risk 4: Financial sustainability - if a credible financial sustainability plan is not delivered, then regulatory action may ensue, autonomy may diminish, and the Group's capacity to provide appropriate care will be at risk. ***Risk score C5+L4+CE3=12***

Risks to in-year delivery

Risk	Metric	Consequence	Likelihood	Control Effectiveness	Total
1a	Risk of not delivering breakeven financial plan in 2025/26	5	1	1	7
1b	Risk of not delivering breakeven financial plan in 2026/27	5	4	3	12
2a	Risk of not delivering efficiency targets in line with the plan in 2025/26	5	1	1	7
2b	Risk of not delivering efficiency targets in line with the plan in 2026/27	5	4	4	13
3a	Risk of not delivering the NHSE bank and agency controls in 2025/26	4	2	2	8
3b	Risk of not delivering the NHSE bank and agency controls in 2026/27	4	4	3	11
4	Risks of failing to deliver a CDEL compliant capital programme	5	3	3	11

Commentary:

The table is split between performance for the remainder of 2025/26 and moving to focus on 2026/27 with the commentary predominantly on the plan for the new financial year.

- Financial Performance: for 2025/26 all Trusts are on plan to deliver breakeven and will achieve the CIP, albeit some being non recurrent. For 2026/27 the Trusts have set ambitious breakeven plans to deliver the reduction in deficit support monies. The CIP plans are the driver for delivery of the overall financial performance and although the plans are significantly advanced compared to previous years there is still a large proportion in the high-risk category and will require constant monitoring in order to deliver the overall plan. This is a key part of the One Recovery programme for the Trusts in 2026/27.
- Bank/Agency rate reduction: The plans will be broadly delivered for 2025/26 in all Trusts with significant savings in agency costs compared with 2024/25. The reductions become much harder in 2025/26 for agency as there are only a small number of hard to recruit roles that are now using agency. Bank reductions are reliant on reducing sickness levels across all Trusts as well as reducing the need for escalation space.
- Cash: this continues to be an issue with QEH and a cash committee has been set up chaired by the EMD to support the ongoing management of the position. Despite the reduction in deficit support money in 2026/27 there is still a significant amount, which if the financial plan is not delivered then the quarterly cash is at risk.

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Actions:

- Continued focus on identifying recurrent and non recurrent CIPs to deliver the 2026/27 financial plans.
- Continuation of the controls on the use of temporary staffing, with a focus on medical staffing.
- Ongoing discussions with NHSE on the revenue position to ensure the cash position does not deteriorate.

Report to the Group Board in public: 1 April 2026

Agenda item number	9.3		
Title	One Recovery		
Author(s)	Interim Transformation Director		
Executive sponsor	Group Chief Delivery Officer/Group Chief Finance Officer		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

The Norfolk and Waveney University Hospitals Group (NWUHG) has committed to ambitious Medium-Term Plans. These commit the three Trusts to returning to Constitutional standards, in line with NHS England planning guidelines. The NHS Oversight Framework (NOF) measures performance against Constitutional standards and other metrics covered in the Medium-Term Plans.

Significant improvement is required in NWUHG's NOF scores. Achieving the Medium-Term Plans will have a major impact on the scores, meaning that by Q4 2026/2027, James Paget University Hospitals NHS Foundation Trust and Queen Elizabeth Hospital King's Lynn NHS Foundation Trust achieve second quartile performance and Norfolk and Norwich University Hospitals NHS Foundation Trust achieves top quartile performance.

Given these ambitious targets, this paper sets out key delivery risks and how the Group's One Recovery programme will help to mitigate them. One Recovery consists of seven programmes of work which ensure disciplined focus on key NOF metrics, supporting Medium-Term Plan delivery.

Recommendations

The Group Board is asked to note the improvement trajectories against the NHS Oversight Framework which are committed to in the Trusts' Medium-Term Plans, supported by the One Recovery programme.

Alignment to Board Assurance Framework risk(s)	Principal Risks 1, 2, 3, 4, 5
Previously considered by	Executive Recovery Oversight Group
Any background papers in Admin Control Reading Room	No

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Norfolk and Waveney University Hospitals Group

Group Board in public: 1 April 2026

1. Introduction and background

The NHS Oversight Framework (NOF)

The NOF is NHS England's core mechanism for assessing provider performance and determining oversight intensity.

It assesses Trusts against a suite of metrics. Trusts are allocated a score of 1-4 (performance quartile) against each metric. NOF1 is the top performing quartile. Based on these scores, all 134 acute Trusts in England are ranked against each other.

A subset of the metrics tracked are summarised in the below table.

Domain	Sub-Domain	Example Metrics
Access to services	Cancer care	% patients with cancer diagnosed or ruled out within 28 days of an urgent referral
	Elective care	% patients waiting 18 weeks or less for elective treatment
	Urgent and emergency care	% emergency department patients admitted, transferred or discharged within 4 hours
Effectiveness and experience	Effective flow and discharge	Average number of days from ready for discharge to actual discharge
	Patient experience	CQC inpatient survey satisfaction rate
Finance and productivity	Finance	Variance year-to-date to financial plan
	Productivity	Implied productivity level
Patient safety	Patient safety	Infection prevention & control measures e.g. MRSA cases, E. coli
People and workforce	Retention and culture	Sickness absence rate

***Figure 1**: NOF Metrics (non-exhaustive)*

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Scores are released each Quarter. All metric scores are:

- Combined and averaged
- Benchmarked against other trusts (league table), assigned a quartile
- Overrides are applied (e.g. if a Trust receives deficit support funding, it is limited to NOF3)

- This produces a final score (1–4)

For Quarter 3 2025/26, the Trusts within our Group were ranked as follows:

- Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH): Segment 3, **91 of 134**
- James Paget University Hospitals NHS Foundation Trust (JPUH): segment 4, **127 of 134**
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH): segment 4, **133 of 134** and entered into the National Provider Improvement Programme (NPIP)

As the NOF uses a ranking system, unweighted metrics and plan-adherence effects, significant improvements can lead to no visible progress. It is therefore important to maintain close visibility of the measures that make up scores.

The NOF has a significant weighting towards financial plan adherence and Referral to Treatment (Elective Care access metrics) as these are the only domains to have both performance metrics and adherence to plan metrics.

Returning to Constitutional standards

NHS England has committed to returning to Constitutional standards by 2029, including the below targets for key NOF metrics.

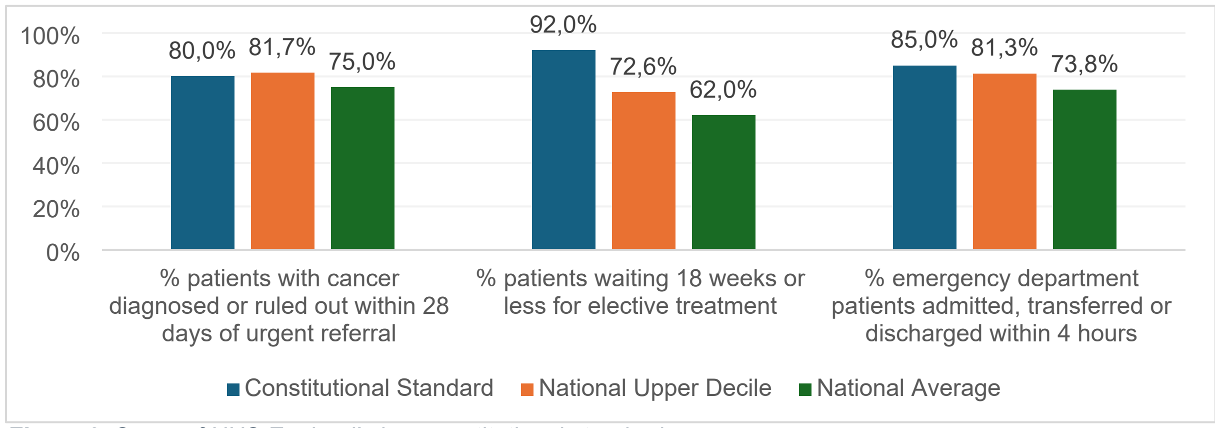

***Figure 2**: Some of NHS England's key constitutional standards*

These targets are ambitious, and the major challenge is the Elective Care 'Referral to Treatment' (RTT) target of 92%, which has not been achieved as a national average since 2015.

Medium-Term Plans

Trusts are required to submit Medium-Term Plans to NHS England which commit to achieving Constitutional standards by 2029, and to exit Deficit Support Funding. NWUHG is fully committed to these Plans, achievement of which will result in a major uplift in NOF scores, as laid out in the section below. Each Trust within NWUHG has submitted its Board-approved Medium-Term Plan.

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One Recovery

One Recovery is a NWUHG-wide set of seven programmes which aim to grip, support and accelerate each Trust's efforts to achieve its Medium-Term Plan, while maximising the opportunity of working within the Group and laying strong foundations for the future. One Recovery will align with the One Strategy and One Digital portfolios, maximising short and medium-term opportunities to impact NOF scores.

2. Our Medium-Term Plan commitment to NOF Improvement

The Trusts' Medium-Term Plans focus specifically on improving NOF metrics. Some commitments are achievable with incremental, short-term improvements, while others will require major service transformation, which is acknowledged in NHS England's Medium Term Planning Guidelines. This section breaks down the NOF improvement trajectories for each Trust, based on achievement of its Medium-Term Plan commitments each quarter. It highlights major areas of focus to ensure this achievement.

NNUH

Based on the recently improved RTT scores, NNUH will be in the NOF2 score range once they are back on financial plan by Q4 end.

Key points:

- **RTT performance:** NNUH's RTT performance has improved materially from Q3 to Q4 in 2025/26 and is now on plan. While current performance remains well below the 92% target by 2028/29 at 61%, it is now much closer to the 2026/27 target of 67% - giving a credible platform to achieve this with sustained improvement.
- **Cancer standard performance:** Improvement in 28-day cancer performance helped to mitigate the impact of the finance downgrade between Q2 and Q3. Cancer performance is currently on track for Q4, and continued delivery here supports the overall improvement in NNUH's NOF position.
- **Urgent and Elective Care (UEC) performance:** NNUH continues to hit the current NHS England 4-hour targets in UEC performance, a major contributor to the ongoing NOF improvement.
- **Finance / Productivity:** Finance remains the critical path for NNUH to improve fast in overall NOF score. With the trust currently on track to return to on plan in Q4, combined with the improved RTT performance, it would move NNUH into the NOF2 score range.

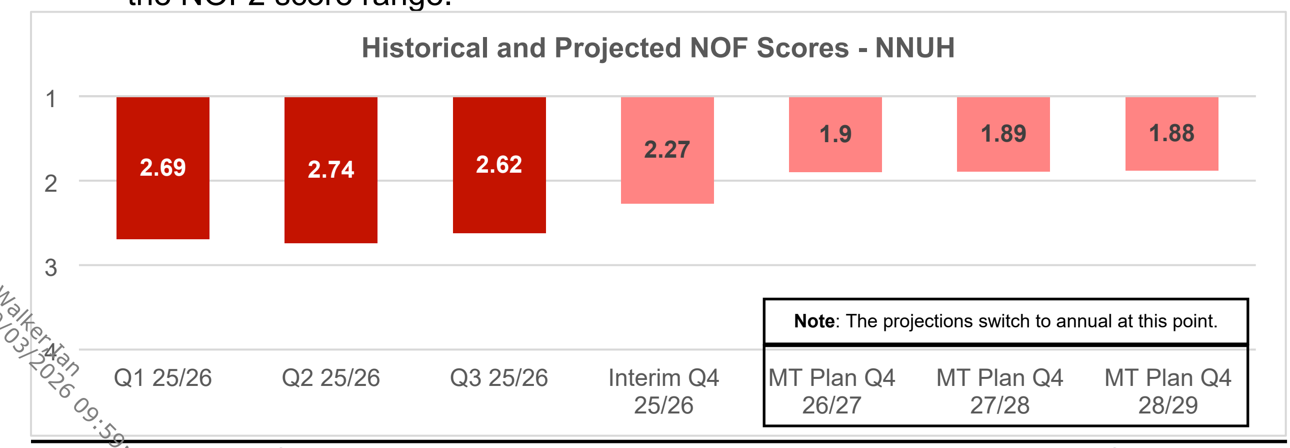

Figure 3: Illustrative NOF trajectory based on hitting all targets set in the Medium-Term Plan. Interim Q4 25/26 projection is based on the most recently posted data on the NHS Model Health System platform.

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JPUH

JPUH is projecting to maintain the current score in Q4 2025/26 but achieving Medium-Term Plan targets projects moving JPUH from 127th to near the top of the NOF2 quartile score range by 2028/29, highlighting both the scale of the opportunity and the consistency required to deliver it.

Key points:

- **RTT performance:** JPUH's RTT performance has improved in the latest Model Health System data, but at 55% it remains lower than peers and the recovery challenge more significant. While there is a clear path to improvement, the gap to the increasingly ambitious RTT trajectory through to 2028/29 means this will remain one of the biggest delivery challenges in moving JPUH up the NOF rankings.
- **Cancer standard performance:** Recent gains from RTT are being slightly offset by weaker 28-day cancer performance, leaving Q4 2025/26 broadly flat. January is a low-side outlier across all trusts in the NHS, so restoring cancer performance to target should be the immediate priority to unlock quicker NOF improvement before focus shifts more fully onto the tougher RTT challenge ahead.
- **UEC performance:** 4-hour performance is currently around 72% against a 78% target this year, 82% next year, and 85% by 2028/29, so there is also a meaningful improvement gap in this domain.
    - JPUH has additional complexity in this space as they operate as a community health and mental health provider, which contributes to their Access-to-Services score.
- **Finance / Productivity:** Finance is a slower-burn improvement area for JPUH and will require sustained delivery over the course of the next few years, particularly to ensure DSF ends by the end of 2028/29.

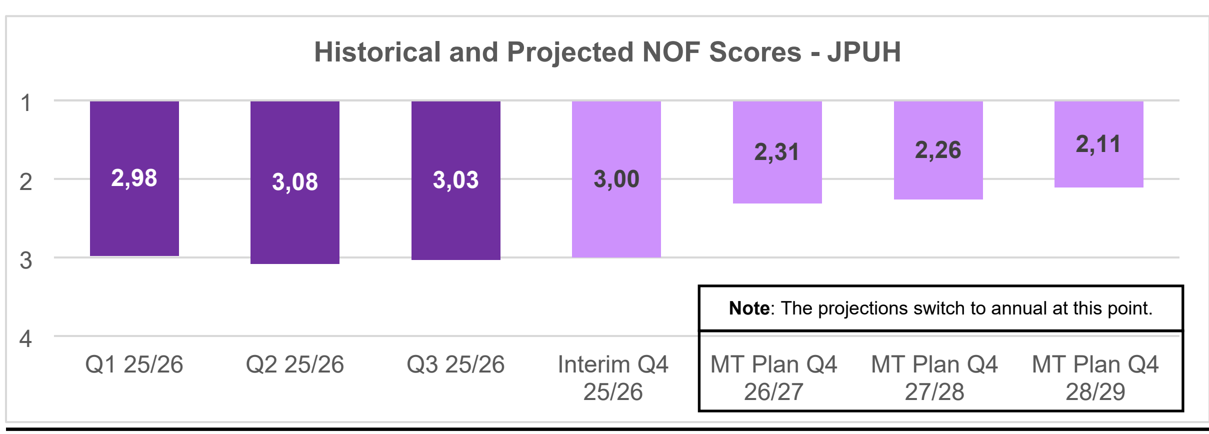

***Figure 4**: Illustrative NOF trajectory based on hitting all targets set in the Medium-Term Plan. Interim Q4 25/26 projection is based on the most recently posted data on the NHS Model Health System platform.*

QEH

There is huge NOF upside in achieving the MTP but only if QEH can deliver the highly ambitious RTT improvements alongside cancer and productivity recovery.

Key points:

- **RTT performance:** QEH has seen incremental improvement in RTT, which is expected to support a modest uplift in its Q4 2025/26 NOF score. However, the Medium-Term Plan assumes ambitious further gains, with around a 12% improvement in 18-week RTT performance each year on average, making RTT

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one of the biggest determinants of whether the trust can realise its projected NOF upside.

- **Cancer standard performance:** The Medium-Term Plan assumes substantial improvement, including a 13% increase in 28-day Faster Diagnosis Standard and 30% increase in 62-day cancer treatment performance, indicating that material recovery in cancer standards is essential if QEH is to achieve the scale of NOF improvement projected.
- **UEC performance:** 4-hour UEC performance is currently at 65%. While the main NOF upside is driven by recovery in RTT, cancer and productivity, improvement in UEC will also be important to support a broader strengthening of performance.
- **Finance / Productivity:** Productivity recovery is central to the case for improvement at QEH. The Medium-Term Plan assumptions imply a 4-10% annual productivity improvement on average across the planning period, which is highly ambitious. This, alongside continued finance position improvements, will require sustained effort to bring DSF close to ending by the end of 2028/29.

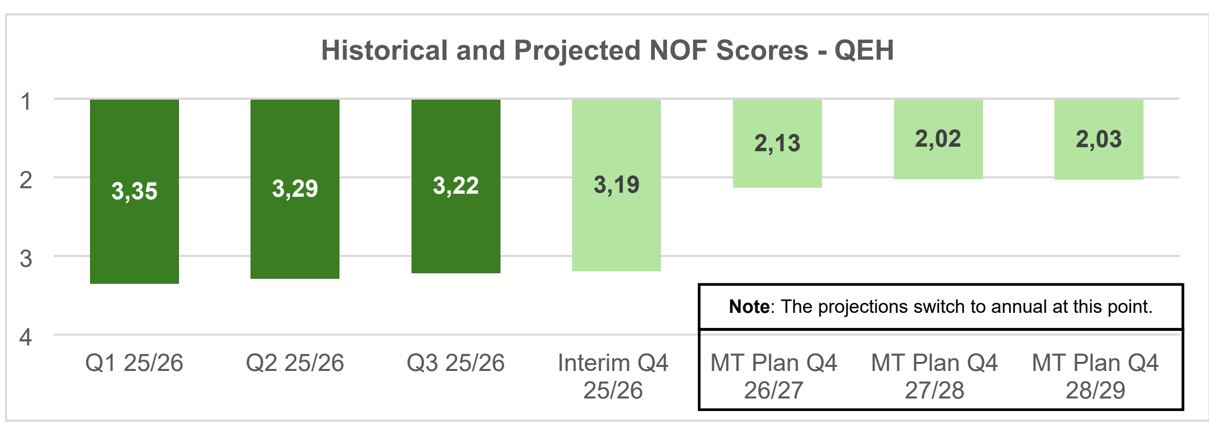

***Figure 5**: Illustrative NOF trajectory based on hitting all targets set in the Medium-Term Plan. Interim Q4 25/26 projection is based on the most recently posted data on the NHS Model Health System platform.*

3. One Recovery NOF Impact

To ensure each Trust achieves its Medium-Term Plan commitments, and to leverage the Group model in doing so, the One Recovery Plan was developed.

Each One Recovery programme has launched a Delivery Group, working across all three Trusts, joining up services and leveraging best practice wherever possible. This ensures disciplined focus on the NOF metrics and alignment.

The programmes are monitored by the One Recovery Oversight Group, which meets fortnightly.

Most programmes will implement both short-term solutions as well as medium-term transformations as part of their programmes.

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4. Risks to delivery

The Medium-Term Plan is highly ambitious and requires unprecedented improvements. Key risks include:

Risk	How One Recovery mitigates the risk
RTT Ambition: Achieving 92% patients waiting 18 weeks or less for elective treatment requires the most significant uplift, risking under-delivery against this target.	Two of the One Recovery programmes target this metric in particular: the 'Outpatient Reform' programme aims at maximising existing capacity, while the 'Elective Recovery and Redesign' programme seeks both productivity gains and demand reduction.
Scale, pace and complexity of change required: Transformation capability and capacity is low across the Group, risking under-delivery.	Most transformation team members have been assigned to support One Recovery programmes. They will be assessed and supported, with a development plan put in place. The 'World Class Basics' programme provides specific training to operational leaders.
Electronic Patient Record alignment (EPR): Delivering misaligned changes to operations could delay EPR implementation.	The EPR team have dedicated representatives to One Recovery programmes. The central Programme Management Office (PMO) maps interdependencies.
Cultural and behavioural change requirement: Cultural inertia may slow adoption of service changes.	The 18,000 Voices initiative targets culture change, enabling staff to influence the way care is delivered.
NOF scoring system: Missing planned performance by a small fraction can mean a significant NOF impact.	The One Recovery Oversight Group meets fortnightly to ensure focus on NOF metrics in addition to programme delivery.

5. Further information on RTT delivery

The Outpatient Reform programme aims to significantly reduce follow-up appointments by implementing a culture of 'no follow-up by default', and expanded patient-initiated follow-up. It will also undertake major waiting list validation exercises, standardising outpatient templates according to best practice and channelling released capacity into patients with the longest waits.

The Elective Recovery and Redesign programme is working with the most challenged specialties to establish clear NWUHG-wide leadership, develop patient treatment lists and drive operational grip while redesigning whole pathways, shifting care 'to the left', out of hospital and leveraging technological opportunities. This will result in significant productivity gains in addition to reduced demand.

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6. Other Recovery Programmes

All One Recovery Programmes target NOF improvements but are not covered in detail in this paper. The table below provides a very high-level summary of which domain is primarily targeted by each programme.

One Recovery Programme	Primary NOF Sub-Domains Targeted
Outpatient Reform	• Elective care
Elective Recovery & Redesign	• Elective care • Productivity
Cancer Recovery & Redesign	• Cancer care • Productivity
UEC Recovery & Redesign	• Urgent and emergency care • Effective flow and discharge • Patient experience
18,000 Voices	• Patient safety • Retention and culture • Patient experience
World Class Basics	• Patient safety • Retention and culture • Effective flow and discharge • Finance
Cost Improvement & Sustainability	• Finance • Productivity

While most programmes will impact many measures, and all programmes interact, they have been designed to ensure specific focus on a small number of priority metrics.

Report to the Group Board in public: 1 April 2026

Agenda item number	10		
Title	Group Board Assurance Framework (BAF)		
Author(s)	Ian Walker, Interim Group Director of Governance		
Executive sponsor	Ian Walker, Interim Group Director of Governance		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary
The Board Assurance Framework (BAF) is a strategic tool used by Boards to identify, assess and monitor the key (Principal) risks to achieving an organisation's strategic objectives. The Group BAF has been developed and populated over the past four months, based on an initial set of strategic objectives agreed by the Special Purpose Joint Committee in autumn 2025. It has been updated with the Executive lead for each risk and reviewed by the Executive Risk Assurance Group (ERAG) and the Group Risk Assurance Committee (GRAC). The paper documents the current risk profile and key risk movements since the last group Board meeting in December 2025. 9 of the 14 risks are currently rated as 'Significant' (12 and above). A summary of the overall risk profile is provided on the first page of the attached full Group BAF document.

The paper also describes further work planned to develop the BAF and the wider risk management framework, including the development of medium-term risk trajectories and most significantly the work to develop the Group's risk appetite statement and apply it to the BAF during May 2026, with external support.

Recommendations
The Group Board is asked to:

- Note and comment on the appended Group BAF.
- Note the further work planned to populate and develop the BAF in the period ahead.

Alignment to Board Assurance Framework risk(s)	All BAF risks
Previously considered by	n/a
Any background papers in Admin Control Reading Room	n/a

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Norfolk and Waveney University Hospitals Group

Group Board in public: 1 April 2026

Group Board Assurance Framework (BAF)

1. Introduction and background

1.1 The Board Assurance Framework (BAF) is a strategic tool used by Boards to identify, assess and monitor the key (Principal) risks to achieving an organisation's strategic objectives.

1.2 The Group BAF has been developed and populated over the past four months, based on an initial set of strategic objectives agreed by the Special Purpose Joint Committee in autumn 2025.

1.3 This paper presents the current version of the Group BAF. Each risk has been reviewed with the Executive risk lead as part of the monthly review cycle, ahead of monthly discussion at the Executive Risk Assurance Group (ERAG) and the Board's Group Risk Assurance Committee (GRAC). All risks have been populated with the exception of PR12 which it is not proposed to populate at this stage pending a review of the Group's strategic objectives and Principal Risks.

1.4 A summary of the Principal Risks, there current and target risk scores, and the overall assurance strength rating is provided on the first page of the BAF.

2. Principal Risks

2.1 Of the 14 Principal Risks (excluding PR12) currently on the Group BAF:

- 9 are rated as Significant (with scores of 12 or 13)
- 5 are rated as Serious (with scores of 10 or 11)

2.2 Over the past four months since the previous meeting of the Group Board, one Principal Risk - PR10 (Reinforced Autoclaved Aerated Concrete deterioration) – has been de-escalated from the BAF on the basis of having reached its target score of 7 (down from 8) due to the assessment of the effectiveness of the controls in place. It continues to be referenced as part of PR9 (Estate and infrastructure) and is a risk on both the QEH and JPUH risk registers.

2.3 The following movements in current risk scores have been agreed over the past four months:

- PR3 (access, flow and productivity): increase from 12 to 13 in December 2025.
- PR13 (New Hospitals Programme): decrease from 14 to 12 in December 2025.
- PR16 (research, innovation and education): decrease from 13 to 10 in December 2025.
- PR8 (cyber security): increase from 12 to 13 in March 2026.

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2.4 In addition, a number of target risk scores have been amended as the risks have been reviewed and reassessed; and further work is planned to define medium-term risk trajectories and associated actions to achieve the target risk scores.

3. Further work

3.1 The following areas of further work are now required as part of the ongoing development of the Group BAF:

- With the BAF now fully populated, through the monthly review cycle there is the need for a particular focus on defining in appropriate detail the actions required to address the gaps in control and to assign timeframes to these. As this matures, it will be possible to link these to the delivery of a risk trajectory towards the target risk score.

- Work is planned with the Group Board in May 2026 on reviewing the Principal Risks, following approval of a revised Group Strategy, and defining the Group's risk appetite. This will enable the risk appetite element of the BAF to be populated, providing visibility on the extent to which Principal Risks are currently outside the agreed risk appetite range and planned to return to within range, supporting challenge as to whether additional actions are required. Once the risk appetite has been defined, this should be a key trigger for focusing discussions on BAF risks which sit outside the Group's risk appetite range.

- Alongside the BAF, it is intended to develop a Group 'corporate' risk register of more operational risks which are being managed at Group level (for example, because they span multiple trusts or require Group support to take forward the mitigating actions).

4. Recommendations

4.1 The Group Board is asked to:

- Note and comment on the appended Group BAF.
- Note the further work planned to populate and develop the BAF in the period ahead.

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Group Board Assurance Framework: March 2026

Risk ID	Summary risk description	Assurance strength	Risk score (Consequence + Likelihood + Control Effectiveness)												
			3	4	5	6	7	8	9	10	11	12	13	14	15
PR1	Quality standards variation	Limited					T					C			
PR2	Maternity services improvement	Limited						T			C				
PR3	Access, flow and productivity	Limited ↑							T				C		
PR4	Financial sustainability	Limited						T				C			
PR5	Workforce capacity, capability and engagement	Limited						T		C					
PR6	Digital capability and data readiness	Very limited						T					C		
PR7	Electronic Patient Record programme and dependent change	Very limited						T					C		
PR8	Cyber security and information governance	Limited					T→			T		C→	C		
PR9	Estate and infrastructure	Limited						T		C					
PR11	Transformation capacity and programme discipline	Very limited							T				C		
PR12	*Transition to Group operating model*							*T*				C			
PR13	New Hospitals Programme – rebuild of QEH and JPH	Limited						T				C			
PR14	Corporate governance framework	Reasonable					T				C				
PR15	Public and stakeholder confidence	Limited						T				C			
PR16	Research, innovation and education	Limited					T			C					

C Current risk score **T** Target risk score Risk appetite range (to follow) PR = Principal Risk

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Principal Risk 1: Quality standards variation
If adherence to national standards and professional guidance varies across services and sites, then quality of care may deteriorate with adverse impact on outcomes, safety and experience of patients.

Risk lead	Group CMO/CN
Last update	March 2026
Group Aim and Enabling Objectives	A1: Quality of care EO 1, 2, 3, 4, 5

Assurance strength rating (1-5)
3. Limited assurance

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	4	4	4	**12**
Target	4	2	1	7
Risk appetite				
Within appetite range?				

Related Group/Trust significant risks (12 and above)
NNUH: 80 (mortality outliers); QEH: 3762 (Histopathology), 3194 (Mental Health Act), 3723 (general surgery); JPUH: 587 (complaints)

	Risk score trajectory																									
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		Target
Planned	12	12	12	12	12	12	12	12	12	12	12	12														7
Actual	12	12	12																							

Summary of monthly review/amendments:	**March 2026**

- Current risk score unchanged.
- Additional third line of assurance added relating to QEH inclusion in National Provider Improvement Programme.
- GA1: target date for establishment of Quality Standards Group amended from March to April 2026.
- Additional gap in assurance GA3 added relating to plans to enhance Board-level quality and outcomes assurance.

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Key controls	Assurances on effectiveness of controls		
	First line	**Second line**	**Third line**
C1. Patient safety framework and individual Trust policies on implementation of national quality standards and guidance.	AF1-7. Trust-level Quality Management Groups reporting to Hospital Management Groups.	AS1-7. Monthly Executive Performance Review meetings with each Trust. Reporting to Executive Risk Assurance Group. Reporting to Group Risk Assurance Committee and Group Board.	AT1-7. NHS England regional oversight meetings. CQC inspections. Regulatory accreditation visits. Inclusion of QEH in National Provider Improvement Programme.
C2. Clinical governance framework in place in individual trusts.			
C3. Monitoring of key quality metrics in the Integrated Performance Report.			
C4. Monitoring of patient feedback through surveys, complaints, etc.			
C5. Agreed quality improvement methodology and training programme.			
C6. Specialist clinical networks sharing best practice and providing peer challenge.			
C7. Clinical audit programmes in each Trust.			

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Group-wide clinical governance framework focusing on reducing quality variation and improving quality of care.	Clinical governance review mandated at QEH in response to General Surgery issues and to be extended to NNUH and JPUH to inform a Group-wide clinical governance framework, with standardised policy, process and reporting.	August 2026
GC2. Group-wide quality improvement function and programme.	Programme and function to be developed and implemented.	June 2026

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GC3. Monitoring quality data in real time on a consistent basis.	Development of Integrated Performance Report and supporting insight.	tbc
GA1. Executive Quality Standards Group to be established.	Terms of reference to be developed and meetings established.	April 2026
GA2. Development of Group-wide approach to patient and service user feedback and co-production.	Design, develop and implement a Group-wide patient and public involvement strategy.	tbc
GA3. Enhanced Board committee oversight of quality and outcomes to be put in place.	Specific section on Quality and Outcomes to be added to Group Risk Assurance Committee agenda ahead of moving to a separate Quality and Outcomes Committee.	June 2026

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Principal Risk 2: Maternity services improvement
If the pace of maternity improvement across the Group does not increase, there will be an adverse impact on outcomes, safety and experience of mothers and babies.

Risk lead	Group DoM
Last update	March 2026
Group Aim and Enabling Objectives	A1: Quality of care EO 1, 2, 3, 4, 5

Assurance strength rating (1-5)
3. Limited assurance

Risk rating	Consequence	Likelihood	Control Effectiveness	Risk score (C+L+CE)
Current	4	4	3	**11**
Target	4	2	2	8

Risk appetite	
Within appetite range?	

Related Group/Trust significant risks (12 and above)
n/a

	Risk score trajectory																									Target
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		
Planned	11	11	11	11	11	11	11	11	11	11	11	11														8
Actual	11	11	11																							

Summary of monthly review/amendments:	**March 2026**

- Current risk score unchanged.
- Updated to reflect decision on Meditech solution for electronic patient record and publication of Baroness Amos' interim report.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Site specific maternity improvement actions plans, including CNST Maternity Incentive Scheme (MIS) compliance. C2. Group-wide perinatal governance framework developed. C3. Monthly perinatal reporting in place. C4. National maternity outcomes signal system implemented. C5. Daily national OPEL reporting.	AF1-5. Reporting through Trust perinatal governance framework to Trust Quality Management Groups and Hospital Management Groups. Review of CNST MIS compliance through Trust Maternity Evidence Groups.	AS1-5. Monthly Executive Performance Review meetings with each Trust. Reporting to Executive Risk Assurance Group. Reporting to Group Risk Assurance Committee and Group Board. NED and Executive Perinatal Safety Champions in place. Group Perinatal Safety Champions meetings and monthly walkrounds. Group Board review and approval in February 2026 of MIS Year 7 full compliance.	AT1. Regional Maternity Oversight Group. Local Maternity and Neonatal System (LMNS) Programme Board. CQC user survey results (positive assurance for QEH and JPUH). National maternity support programme for JPUH.
C6. Future roadmap in place for perinatal services across the Group (Perinatal Clinical Strategic Network).	AF6. Perinatal strategic network meetings.	AS6. Reporting to Group Executive and Group Board.	

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Lack of end-to-end perinatal electronic patient record across Group.	Decision to proceed with Meditech solution as part of EPR programme.	April 2027
GC2. Group perinatal governance framework implementation.	Implementation plan to be developed and rolled out, including revised Group reporting.	March 2027
GA1. Regulatory notices in place for maternity services at QEH and JPUH.	JPUH; to be addressed through progress on GC1 above.	tbc

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	QEH: evidence on training compliance provided to CQC and awaiting outcome.	
GA2. Outcome for QEH of Baroness Amos Independent Maternity and Neonatal Investigation.	Second day visit completed and in process of interviewing staff and service users. Awaiting Trust feedback from investigation team. Interim report published and each Trust working through this.	Spring/summer 2026 – tbc
GA3. Maternity and Neonatal Voices Partnership (MNVP) not meeting current national standards for funded time allowance.	Awaiting resolution from Integrated Care Board (ICB).	tbc

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Principal Risk 3: Access, flow and productivity
If national and local access and flow requirements are not achieved within resource constraints, then outcomes, patient satisfaction and contract performance may deteriorate, resulting in poor patient outcomes and experience, penalties, and regulatory escalation.

Risk lead	Group CDO
Last update	February 2026
Group Aim and Enabling Objectives	A2: Access and flow EO 6, 7, 8, 9, 10, 11, 12

Assurance strength rating (1-5)
3. Limited assurance

Risk rating	Consequence	Likelihood	Control Effectiveness	Risk score (C+L+CE)
Current	4	5	4	13
Target (by Dec 26)	4	3	2	9
Risk appetite				
Within appetite range?				

Related Group/Trust significant risks (12 and above)
NNUH: 131 (RTT), 216 (UEC/ambulance offloads); QEH: 2244 (mental health community beds); JPUH: 675 (surgical activity)

	Risk score trajectory																								
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27	Target
Planned	13	13	13	13	13	11	11	11	11	11	11	9	9	9	9	9	9	9	9	9	9	9	9	9	9
Actual	13	13	13																						

Summary of monthly review/amendments:	February 2026

- Current risk score unchanged.
- From Feb 26: proposed change in overall assurance rating from 4. Very limited to 3. Limited to reflect agreement of Medium-term Plan.
- Additional assurance added in relation to establishment of twice monthly One Recovery Oversight Group meetings.
- Additional gap in control G2 added on review and refresh of Performance and Accountability Framework.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Access and flow policies and processes at Trust level for elective and non-elective care, including escalation arrangements.	AF1. Oversight at Hospital Management Groups and relevant sub-groups, with review of site Integrated Performance Reviews (IPRs) and trajectories.	AS1. Risk-based oversight and assurance at Executive Risk Assurance Group (ERAG), Group Risk Assurance Committee (GRAC) and Group Board, with review of Group IPR. Monthly Executive Performance Review meetings. One Recovery Oversight Group meeting twice monthly.	AT1. NHS England (NHSE) Regional and National tiering calls.
C2. Trust recovery and delivery plans with agreed trajectories against targets.			AT2. Monthly Regional Oversight and Scrutiny meeting with NHSE.
C3. Work of Trust operational and clinical teams with regular rhythm of daily/weekly meetings to manage access and flow.			
C4. Board-approved Medium-term Plans for 2026/27 and beyond.			

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Group Recovery Plan to be finalised and implemented.	Work following December 2025 workshop to agree Group Recovery Plan for receipt by Group Executive and Group Board.	Draft Recovery Plan in place. Final Plan by April 2026, followed by continued implementation.
GC2. Performance and accountability framework due for review.	Review, refresh and embed Performance and Accountability Framework.	End June 2026
GA1. Monitoring approach to Recovery and Medium-term Plans to be developed.	Working with analytical support to develop monitoring approach.	End March 2026
GA2. Limited sources of external assurance in place.	Group Executive to agree potential inclusion of relevant reviews as part of 2026/27 Internal Audit Plan.	April 2026

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Principal Risk 4: Financial sustainability
If a credible financial sustainability plan is not delivered, then regulatory action may ensue, autonomy may diminish, and the Group's capacity to provide appropriate care will be at risk.

Risk lead	Group CFO
Last update	February 2026
Group Aim and Enabling Objectives	A4: Financial sustainability EO 17-23

Assurance strength rating (1-5)
3. Limited assurance

Risk rating	Consequence	Likelihood	Control Effectiveness	Risk score (C+L+CE)
Current	5	4	3	12
Target (by 2030)	5	2	1	8
Risk appetite				
Within appetite range?				

Related Group/Trust significant risks (12 and above)
NNUH: 480 (breakeven 2026/27); QEH: 3676 (financial sustainability/CIP delivery), 3223 (cash availability); JPUH: n/a Finance in-year risk 4 (delivery of compliant capital programme)

	Risk score trajectory																								
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27	Target
Planned	12	12	12	12	12	12	12	12	12	12	12	12	12	12	11	11	11	11	11	11	11	11	11	11	8
Actual	12	12	12																						

Summary of monthly review/amendments:	February 2026

- Current risk score unchanged.
- Aim to achieve target risk score by March 2030 on the basis that financial sustainability will only be secured once Deficit Support Funding is removed (March 2029 for JPUH and March 2030 for QEH). Aim to reduce risk score to C5+L4+CE2=11 by March 2027 based on increased control effectiveness and delivery of the 2026/27 financial plan.
- Gap in assurance added on CIP programme delivery and initial deep dive to GRAC planned for April 2026.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Planning environment – Board-approved Medium-term Plan for 2026/27 and beyond. C2. CIP plans for 2026/27 and 2027/28 in development. C3. Bank and agency controls in line with NHSE reductions. C4. Capital plan for 2026/27.	AF1-4. Trust Finance and Performance meetings reporting to Hospital Management Groups.	AS1-4. Monthly Executive Performance Review meetings with each Trust. Reporting to Executive Risk Assurance Group, Group Risk Assurance Committee and Group Board. Review of controls in place through Annual Governance Statement.	AT1-4. Monthly financial reporting to NHSE. Monthly NHSE Oversight meetings. Head of Internal Audit Opinion annually. Value for Money review/ conclusion from External Audit.
C5. Triple lock for substantive staff and key non-pay contracts at all three Trusts.	AF5. Triple lock review panel at each Trust.	AS5.	AT5. NHSE Triple Lock review panel

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Finalise CIP programmes for 2026/27.	All three Trusts in the process of identifying CIP schemes.	End March 2026
GC2. Implementation of 2026/27 CIP programmes.	Agree resources, programme management arrangements for delivery of each scheme and oversight of CIP programmes in each Trust.	Ongoing to end of March 2027
GA1: Additional assurance on delivery of 2026/27 CIP programme.	Initial deep dive on CIP programme to be undertaken and presented to Group Risk Assurance Committee.	April 2026

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Principal Risk 5: Workforce capacity, capability and engagement
If workforce planning is not effective and/or there are recruitment, retention and engagement challenges, then staffing may become unsafe, care may be compromised, and staff wellbeing may be adversely affected.

Risk lead	Trust HRDs
Last update	March 2026
Group Aim and Enabling Objectives	A3: People and culture EO 13, 14, 15, 16

Assurance strength rating (1-5)
3. Limited assurance

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	4	3	3	**10**
Target (date?)	4	2	2	8
Risk appetite				
Within appetite range?				

Related Group/Trust significant risks (12 and above)
NNUH: 82 (staff morale and engagement); JPUH: 744 (inadequate workforce capacity), 758 (staff engagement/morale); QEH: 3848 (staff experience), 3723 (General Surgery)

	Risk score trajectory																									
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		Target
Planned	10	10	10	10	10	10	10	10	10	10	10	10														8
Actual	10	10	10																							

Summary of monthly review/amendments:	**March 2026**

- Current risk score unchanged but will be further reviewed in April 2026 cycle, taking account of 2025 National Staff Survey results which were published in mid-March 2026.

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Key controls	**Assurances on effectiveness of controls**		
	First line	**Second line**	**Third line**
C1. Trust-level workforce plans as part of Medium-term Plan.		AS1-7. Risk-based oversight and assurance at Executive	AT1-5. NHS England monthly oversight meetings.

	AF1-2. Trust oversight at People and Culture Management Groups reporting to HMGs.	Risk Assurance Group (ERAG), Group Risk Assurance Committee (GRAC) and Group Board, with review of Group IPR.	
C2. Short staffing protocols.			
C3. For nursing, safe staffing levels – twice yearly review and proposed changes.	AF3-4. Trust oversight at Quality Management Groups reporting to HMGs.		
C4. Daily tracking of nurse staffing levels against minimum level templates.			
C5. Sickness absence reduction plans and oversight.	AF5-7. Trust oversight at People and Culture Management Groups reporting to HMGs.		
C6. Temporary staffing deployment.			AT6. Temporary staffing controls - internal audit report awaited (JPUH).
C7. Staff survey improvement plans.			AT7. Staff survey and quarterly Pulse surveys.

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Group-level plans for shortage specialties/staff groups to be developed.	Develop Group strategies for addressing high-risk specialty/staff group shortages including Memorandum of Understanding for cross-Trusts working; making it easier to move and work across sites (e.g. digital access); agreement on approach to cross-Trusts resource sharing; and plan for shared Bank covering all three Trusts.	tbc
GC2. Sickness rates above national average (particularly at JPUH and QEH).	Review and enhance sickness reduction plans.	Plans at JPUH and QEH due to be signed off by end Mar 2026
GC3. Staff engagement and morale (particularly recommender scores).	Review approach to staff engagement following 2025 survey results publication in March 2026.	May 2026

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Principal Risk 6: Digital capability and data readiness
If digital maturity, data quality assurance and analytics capability are not improved at sufficient pace, then modern clinical practice and operational transformation will be inhibited and decision confidence reduced.

Risk lead	Group DD
Last update	March 2026
Group Aim and Enabling Objectives	A2: Access and flow EO 6, 7, 8, 9, 10, 11, 12

Assurance strength rating (1-5)
4. Very limited assurance

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	4	5	4	13
Target	4	2	2	8

Risk appetite	
Within appetite range?	

Related Group/Trust corporate risks
NNUH: 14 (digital infrastructure vulnerabilities); QEH: 3089 (image vault failure)

	Risk score trajectory																									
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		Target
Planned	13	13	13	13	13	13	13	13	13	13	13	13														8
Actual	13	13	13																							

Summary of monthly review/amendments:	**March 2026**

- Current risk score unchanged.
- Key controls C1 and C3 combined.
- GC1: updated to reflect work on costed digital roadmap.
- GC4: updated to reflect activation in March 2026 of additional MS Office functionality to enable greater data sharing across Trusts.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Digital strategy and data science strategy to tackle legacy technical shortfall.	AF1-3. Shared Digital Committee reporting.	AS1-5. Group Executive Board and Group Board.	AT1.
C2. Data Taskforce to deliver infrastructure improvements.			AT2. AT3.
C3. Single Digital Team to improve specialist capability.	AF4.Corporate Services Transformation Group.		AT4.
C4. Electronic Patient Record (EPR) preparatory work to improve data quality.	AF5.EPR Programme Board.		AT5. NHS England EPR Gateway Reviews.

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Costed digital roadmap in development.	Annual planning and prioritisation of elements of the Digital Strategy. Use of in-year capital funding to support agreed elements. Use of regional funding where available to remediate legacy infrastructure.	Costed roadmap due at Digital Board in May 2026 and Group Board in June 2026.
GC2. Skills debt relating to digital immaturity.	Creation of digital skills academy.	tbc
GC3. Enterprise architecture and processes to support modern ways of working digitally.	Migration to a single national Microsoft tenant. Adoption of industry standard working practices (Information Technology Infrastructure Library (ITIL), Service Desk Plus).	March 2027
GC4. Ability to work seamlessly across sites with a single digital environment.	Alignment of digital contracts for services, infrastructure and solutions. Stage 1 completed with activation of MS Office functionality in March 2026 to increase data sharing capability.	Stage 2 in progress – completion date tbc following Single Digital Team go-live.
GC5. Data analytics capability.	Develop and implement plans for a Group-wide Business Intelligence, Analytics and Data Quality function.	July 2026 (with interim arrangements from April 2026).

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Principal Risk 7: Electronic Patient Record programme and dependent change
If the Electronic Patient Record (EPR) implementation, with its cut over, migration and process redesign is not sufficiently planned and executed without adequate protections, then service continuity may be disrupted, and our reliance on outdated and unsupported software may be prolonged, impairing safe, effective and reliable care.

Risk lead	Group DD
Last update	March 2026
Group Aim and Enabling Objectives	A4: Financial sustainability EO 17-23

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	4	5	4	**13**
Target	4	2	2	8
Risk appetite				
Within appetite range?				

Assurance strength rating (1-5)
4. Very limited assurance

Related Group/Trust significant risks (12 and above)
EPR programme: 6216 (financial consequences of delay), 6217 (impact on operational performance), 6202 (multi-Trust convergence complexity)

	Risk score trajectory																								
	Jan 26	**Feb 26**	**Mar 26**	**Apr 26**	**May 26**	**Jun 26**	**Jul 26**	**Aug 26**	**Sep 26**	**Oct 26**	**Nov 26**	**Dec 26**	**Jan 27**	**Feb 27**	**Mar 27**	**Apr 27**	**May 27**	**Jun 27**	**Jul 27**	**Aug 27**	**Sep 27**	**Oct 27**	**Nov 27**	**Dec 27**		**Target**
Planned	13	13	13	13	13	13	13	13	13	13	13	13														8
Actual	13	13	13																							

Summary of monthly review/amendments:	**March 2026**

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- Current risk score unchanged.
- No amendments.

Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. EPR programme and associated risk management.	AF1. EPR Programme Board.	AS1-5. Group Executive, Group Risk Assurance Committee and Group Board.	AT1. NHS England Gateway Reviews.
C2. Emergency Preparedness, Resilience and Response (EPRR) simulations prior to go-live.	AF2. EPRR Group.		
C3. Staff Training in EPR.	AF3-5. EPR Programme Board		AT3-5. NHS England Gateway Reviews.
C4. End-to-end User Acceptance and Pathway testing.			
C5. Technical Stability, Connectivity and Wireless Network testing.			

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Requirement to re-set and reprofile EPR programme with delay to implementation start timetable of March 2026.	Work underway with partners to reset programme, negotiate funding requirements and reprofile phasing of delivery.	Update to Group Board in April 2026.
GC2. Trusts' ability to commit to large scale change programmes during intense periods of activity or recovery.	Go-live approach to be further developed to avoid periods of heightened pressure, to minimise operational disruption and to maintain clinical safety.	Ongoing
GC3. Suppliers' ability to smoothly migrate data across multiple live environments.	Work on data migration and stabilisation with external and internal partners.	Ongoing
GC4. Need to appoint delivery partner.	Undertake procurement exercise and appoint experienced delivery partner.	April 2026

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Principal Risk 8: Cyber security and information governance
If cyber defences, information security controls, and incident response capabilities are not developed, maintained and tested to national standards across the Group, then a cyber-attack, data breach or ransomware incident may compromise patient safety, disrupt critical services, breach statutory data protection obligations under the UK General Data Protection Regulation (GDPR) and Data Protection Act 2018, and damage public trust.

Risk lead	Group DD
Last update	March 2026
Group Aim and Enabling Objectives	A4: Financial sustainability EO 17-23

Assurance strength rating (1-5)
3. Limited assurance

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	5	4	4	**13**
Target	5	3	2	10
Risk appetite				
Within appetite range?				

Related Group/Trust significant risks (12 and above)
NNUH: 12 (data protection breaches), 7 (cyber security); QEH: 3449 (cyber security/MFA)

	Risk score trajectory																									
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		Target
Planned	13	13	13	13	13	13	13	13	13	13	13	13	13	13	13	13	13	13	13	13	13	10	10	10		10
Actual	13	13	13																							

Summary of monthly review/amendments:	**March 2026**

- From Feb 26: Proposal following re-assessment of the Consequence (from 4 to 5) to increase the current risk score from 12 to 13.
- From Feb 26: Proposal following re-assessment to increase the target risk score from C4+L2+CE1=7 to C5+L3+CE2=10.
- Required work programme indicates an 18-month trajectory to reduce the risk from 13 to 10.
- GC1: updated to reflect that there is a costed and prioritised plan in place at NNUH; with business cases for QEH and JPUH completed and going through approvals processes.
- GC3: planned date brought forward from July to June 2026.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Data Protection and Security Toolkit (DPST) Improvement Plan.	AF1-3. Digital Group.	AS1-3. Executive Risk Assurance Committee, Group Risk Assurance Committee and Group Board.	AT1. Annual audit of DPST.
C2. Cyber Security Action Plan overseen by Cyber Security Task Force.			AT2. Internal Audit programme on cyber security.
C3. Layered technical controls, user education and supplier contractual clauses for cyber risk management.			AT3 Annual DSPT/Cyber Assessment Framework (CAF) audit; ISO27001 and CE (JPUH only); IT Health Checks/PEN tests.

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Adequate resources for cyber remedial and development work.	Group business case to be developed to define and right size investment and sourcing of cyber security service.	Costed and prioritised plan in place for NNUH. April 2026 for JPUH and QEH business cases.
GC2. Infrastructure refresh programme.	Strategic approach to asset management and refresh to be established across the Group and move to a sustainable footing, aligned to maximise support for DPST/CAF compliance.	April 2026
GC3. Information Governance and Cyber Security governance and policy alignment.	Alignment of policy and decision making for Information Governance across the Group. Approach agreed at Executive Directors' meeting in February 2026 to be implemented on an interim basis from March 2026 and on a substantive basis from July 2026 following creation of a Single Digital Team.	June 2026
GC4. DPST/CAF compliance.	Cyber security strategic outline cases to be developed to highlight tools and resources required to achieve compliance.	April 2026 for QEH and JPUH (NNUH complete and approved)

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Principal Risk 9: Estate and infrastructure
If the aging estate, critical infrastructure, and backlog maintenance are not addressed, then the ability to innovate, transform and provide safe, effective services will be undermined.

Risk lead	Group CFO
Last update	March 2026
Group Aim and Enabling Objectives	A4: Financial sustainability EO 17-23

Assurance strength rating (1-5)
3. Limited assurance

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	4	3	3	**10**
Target (date?)	4	3	1	8
Risk appetite				
Within appetite range?				

Related Group/Trust significant risks (12 and above)
NHP programme: 0074 (RAAC impact on NHP)

	Risk score trajectory																								
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27	Target
Planned		10	10	10	10	10	10	10	10	10	10	10													8
Actual		10	10																						

Summary of monthly review/amendments:	**March 2026**

- Risk score unchanged.
- No amendments.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. NNUH PFI Annual Lifecycle plan and joint fire safety survey.	AF1. Environmental monitoring team check progress and compliance. Safety groups for fire, water, ventilation, electrical, medical gases.	AS1-2. Monthly review of funded backlog schemes via Capital Committee. Reporting to NNUH Finance and Performance, Health and Safety and Quality and Safety Groups. Annual Premises Assurance Report to Hospital Management Group (HMG).	AT1-4. Authorising Engineers' reviews of progress and participation in committees. Annual ERIC data returns.
C2. NNUH Retained Estate Condition Survey 2023 and five-year plan to address backlog and lifecycle requirements.	AF2. FM Team monitoring. Safety groups for fire, water, ventilation, electrical, medical gases. Monthly review of FM contract performance.		
C3. JPUH Six Facet full survey 2016 and annual desktop review exercise.	AF3. Estates and Facilities Programme Delivery Group monitoring. Safety groups for fire, water, ventilation, electrical, medical gases.	AS3. Reporting to JPUH Health and Safety, Infection Control and Finance and Performance Committees. Annual Premises Assurance Report to HMG.	
C4. QEH Six Facet full survey 2025 with priority areas for maintenance assessed monthly.	AF4. Monthly monitoring of priority maintenance areas. Safety groups for fire, water, ventilation, electrical, medical gases.	AS4. Reporting to QEH Health and Safety, Infection Control, Medical Devices and Finance and Performance Committees. Annual Premises Assurance Report to HMG.	
C5. Reinforced Autoclaved Aerated Concrete (RAAC) mitigation plans for JPUH and QEH.	AF5. Tracking through respective Estates Groups.	AS5. Reporting to Hospital Management Groups.	AT5. NHS England regional monitoring. National Mott Macdonald report – December 2025.

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Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. JPUH Six Facet Survey requires updated.	New Six Facet Survey to be procured and completed.	March 2027
GC2. More detailed information required on Electrical and Biomedical Engineering (EBME) and Planned Preventative Maintenance (PPM).	Information and data being collated, RAG rated and reviewed.	April 2026
GC3. NNUH PFI – confirmation of lifecycle plan.	Working through timetable to programme works by areas/wards.	April 2026
GC4. NNUH retained estate – condition survey to be repeated.	Working through planned activity.	April 2027

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Principal Risk 11: Transformation capacity and programme discipline
If transformation capacity, skills and portfolio management discipline are insufficient for the Group's scale of change, then intended benefits may not be realised and sustainability may be jeopardised.

Risk lead	Group CDO
Last update	March 2026
Group Aim and Enabling Objectives	A2: Access and flow EO 6, 7, 8, 9, 10, 11, 12

Assurance strength rating (1-5)
4. Very limited assurance

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	4	5	4	**13**
Target	4	3	2	9

Risk appetite	
Within appetite range?	

Related Group/Trust significant risks (12 and above)
n/a

	Risk score trajectory																									
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		Target
Planned	13	13	13	13	13	13	11	11	11	11	11	9	9	9	9	9	9	9	9	9	9	9	9	9		9
Actual	13	13	13																							

Summary of monthly review/amendments:	**March 2026**

- Current risk score unchanged.
- GC1 updated to reflect appointment to Group Transformation Director post.
- Additional gaps in control GC2 and GC3 added in relation to development of a formal improvement methodology and development and implementation of an associated training programme.

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Key controls	Assurances on effectiveness of controls		
	First line	**Second line**	**Third line**
C1. Transformation teams in three trusts working on site priorities.	AF1. Overseen by Hospital Management Groups.	AS1. Reporting to Group Executive and Group Board.	AT1.
C2. Acute Clinical Strategy team supporting clinical strategy work.		AS2. Reporting to Group Executive and Group Board.	
C3. Group operating model for transformation agreed by Group Executive in December 2025.		AS3-4. Group Transformation Board (to be established).	
C4. External consultancy support in place.			
C5. Work plan in place through One Recovery programme.			

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Group Transformation resourcing and team structure.	Work to be undertaken to confirm and recruit to team structure. Appointment made in February 2026 to Group Transformation Director role. Transformation function to be included in Phase 2 of Corporate Services restructuring.	April 2026
GC2. Improvement methodology not yet formalised and rolled out.	Work with Transformation Team to agree formal methodology and implementation plan.	May 2026
GC3. Training programme on improvement programme required.	Develop and roll out training programme for Transformation Team and across the three Trusts.	March 2027
GA1. Transformation programme reporting.	Develop transformation governance framework and associated reporting.	April 2026

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Principal Risk 12: Transition to Group operating model
If the transition to the Group operating model coincides with complex harmonisation across the ICS/ICB/NHSE Regional and National without clear parameters, then gaps in oversight and management may arise, impairing continuity, creating inconsistent standards, inability to address health inequalities and increasing risks to outcomes.

Risk lead	Group CEO
Last update	February 2026
Group Aim and Enabling Objectives	A6: Partnerships A7: Governance EO 27-29, 30-33

Assurance strength rating (1-5)

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	4	5	3	**12**
Target	4	3	1	8
Risk appetite				
Within appetite range?				

Related Group/Trust significant risks (12 and above)

	Risk score trajectory																									
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		Target
Planned	12																									8
Actual	12																									

Summary of monthly review/amendments:	**February 2026**

- Population of this risk paused on the basis that the transition to the Group Operating Model is largely complete. Following completion of the current Group Strategy work, consideration will be given as to whether an alternative strategic risk is required.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1.	AF1.	AS1.	AT1.
C2.	AF2.	AS2.	AT2.
C3.	AF3.	AS3.	AT3.
C4.	AF4.	AS4.	AT4.
C5.	AF5.	AS5.	AT5.

Gap in control/assurance	Action to address gap in control/assurance	Due date

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Principal Risk 13: New Hospitals Programme (NHP) – rebuild of QEH and JPH
If the two new hospital schemes, with changes to health care delivery model, enhanced digital provision and modern facilities are not sufficiently ambitious and executed, then services will not transform and patient and financial benefits will not be realised, impairing on long-term health care provision for the population.

Risk lead	Group CDO
Last update	March 2026
Group Aim and Enabling Objectives	A4: Financial sustainability EO 17-23

Risk rating	Consequence	Likelihood	Control Effectiveness	Risk score (C+L+CE)
Current	5	4	3	**12**
Target	5	2	1	8
Risk appetite				
Within appetite range?				

Assurance strength rating (1-5)
3. Limited assurance

Related Group/Trust significant risks (12 and above)
NHP programme: 0075 (cost assumptions and contingency), 0074 (RAAC impact on NHP), 0007 (revenue affordability), 0076 (alignment between design briefs and templates)

	Risk score trajectory																									
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		Target
Planned	12	12	12	12	12	12	12	12	10	10	10	10														8
Actual	12	12	12																							

Summary of monthly review/amendments:	**February 2026**

- Current risk score unchanged.
- Updates to various assurances.
- GC1: closed and key control C1 updated to reflect approval of JPUH SOC.

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Key controls	Assurances on effectiveness of controls		
	First line	**Second line**	**Third line**
C1. Strategic Outline Cases (SOCs) approved for both schemes.		AS1-6. Monthly New Hospitals Programme Board meetings. Reporting to Executive Risk Assurance Group, Group Risk Assurance Committee and Group Board. Group Board approval of business cases.	AT1. National approval process for SOC and Outline/Full Business Cases, including independent Gateway Reviews.
C2. SOCs include detailed design and clinical services configuration, backed by demand and capacity modelling.			AT2-6. NHS England and national NHP attendance at monthly programme board. Independent Gateway Review assurance.
C3. NHP programme infrastructure and funding in place.			
C4. Anchor and strategic milestones agreed with NHP, supported by programme plans and milestones.	AF4-6. Programme Delivery group chaired by Strategic Programme Director.		
C5. Risk registers and benefits realisation plans in place.			
C6. Stakeholder engagement programmes in place for both schemes.			

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Clinical strategy for Group.	Ongoing work to review and develop Group clinical strategy to inform further work on specification of schemes.	July 2026 - tbc
GC2. No public engagement plan.	Develop and implement engagement plan on Clinical Strategy and impact on services and hospital design.	End of May 2026
GA1. Internal Audit plan work on NHP	Identify priority areas related to NHP for inclusion in 2026/27 Internal Audit Plan.	April 2026

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Principal Risk 14: Corporate governance
If a robust corporate governance and risk management framework is not developed, implemented and embedded across the Group, then decisions may be ultra vires, regulatory action may follow and public trust may be impaired.

Risk lead	Group DG
Last update	March 2026
Group Aim and Enabling Objectives	A7: Governance EO 30-33

Assurance strength rating (1-5)
2. Reasonable assurance

Risk rating	Consequence	Likelihood	Control Effectiveness	Risk score (C+L+CE)
Current	4	4	3	**11**
Target	4	2	1	7

Risk appetite	
Within appetite range?	

Related Group/Trust significant risks (12 and above)
n/a

	Risk score trajectory																								
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27	Target
Planned	11	11	11	11	11	11	9	9	9	9	9	9	7	7	7	7	7	7	7	7	7	7	7	7	7
Actual	11	11	11																						

Summary of monthly review/amendments:	March 2026

- No amendments to risk scores.
- Due dates for GC1 and GC2 amended from April to June 2026 (and embedding dates amended from October to December 2026) to reflect further work still required on establishment of Board committees and risk appetite in the context of revised strategic risks. Risk trajectory amended accordingly.
- Additional gap in control GC3 added on recruitment to NED/Associate NED vacancies.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Group Model Mobilisation Plan.	AF1. Tracking of progress through Executive Directors' Group.	AF2. Progress reporting to Group Board.	AT1. NHS England review of Group Model Mobilisation Plan – report received in January 2026.
C2. Governance framework at Group and Trust levels (including Provider Collaboration Agreement; FT Constitutions; Standing Orders; Schemes of Reservation and Delegation; committee structure with agreed terms of reference).	AF2. Corporate Governance function supports Group Board and committees, Executive Directors' Group and Hospital Management Groups to operate within Governance Framework and terms of reference.	AS2. Audit Committees in Common seek assurance on governance, risk and internal control effectiveness (*ongoing*). Annual Governance Statements agreed by Group Board (*due May 2026*).	AT2. NHS England review of Group Model Mobilisation Plan (December 2025). CQC Well-Led reviews (*not yet undertaken*). Annual Head of Internal Audit Opinion (*due in May 2026*).
C3. Annual review of Board and committee effectiveness.	AF3. Groups and committees to complete effectiveness reviews annually.	Group Board receives annual review of Board and committee effectiveness (*not yet undertaken*).	
C4. Risk management framework and policy, Board Assurance Framework (BAF) and Trust risk registers.	AF4. Ongoing review by Executive Risk Assurance Group.	AS4. Audit Committees in Common seek assurance on governance, risk and internal control effectiveness (*ongoing*). Annual Governance Statements agreed by Group Board (*due May 2026*).	AT4. Annual Internal Audit review of effectiveness of risk management system (*due May 2026*). CQC Well-Led review (*not yet undertaken*).

Gap in control/assurance	Action to address gap in control/assurance	Due date
G1. Group governance structure not fully implemented.	A1. Remaining Board committees to be established; Constitutions, SOs and SFIs to be finalised. Arrangements then to be embedded.	June 2026 (December 2026 for embedding)
G2. Risk management framework remains in development.	A2. BAF to be fully populated; principal risks to be reviewed by Group Board as Group Strategy finalised; Group Board to review and agree risk appetite statement. Then to be embedded.	June 2026 (December 2026 for embedding)
G3. NED vacancy and three Associate NED vacancies.	A3. Competitive recruitment process being undertaken. Appointment and induction to roles.	June 2026

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Principal Risk 15: Public and stakeholder confidence
If external scrutiny, performance challenges, infrastructure concerns (including Reinforced Autoclaved Aerated Concrete), or service disruption undermine public, patient, and stakeholder confidence in the Group's hospitals then recruitment and retention may suffer, patient choice may shift to alternative providers, partnership relationships may weaken, staff morale may decline, and regulatory intervention may intensify.

Risk lead	Group CEO
Last update	March 2026
Group Aim and Enabling Objectives	A6: Partnerships EO 27-29

Assurance strength rating (1-5)
3. Limited assurance

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	4	4	4	**12**
Target	4	3	1	8

Risk appetite	
Within appetite range?	

Related Group/Trust significant risks (12 and above)
n/a

	Risk score trajectory																								
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		Target
Planned		12	12	12	12	12	12	12	12	12	12	12														8
Actual		12	12																							

Summary of monthly review/amendments:	**March 2026**

- Risk scores unchanged.
- GC1 updated to reflect appointment of new Group Director of Communications and Engagement commencing in post in May 2026.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Appointment of part-time, interim strategic communications resource.	AF1. Reporting to Group Chief Executive.	AS1.	AT1.
C2. Strategic Communications Oversight of key reputational issues.	AF2. Reporting to Group Chief Executive and Executive Directors' Group.	AS2. Reporting to Group Board.	AT2.
C3. Trust and Group level communications work plans – narrative and key messages, tactical communications plan, project-specific plans, stakeholder management grids, etc.	AF3. Oversight at each Trust's Hospital Management Group.	AS3. Oversight at Executive Director's Group.	AT3.
C4. Regular briefing of key stakeholders.	AF4. Oversight at each Trust's Hospital Management Group.	AS4. Oversight at Executive Director's Group.	AT4. Stakeholder feedback.
C5. Targeted communications activities on reputational issues.	AF5. Oversight at each Trust's Hospital Management Group.	AS5. Oversight at Executive Director's Group.	AT5. Stakeholder feedback.
C6. Strategic review of communications and engagement services.	AF6. Reporting to Group Chief Executive.	AS6. Corporate Services Programme Board.	

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Lack of permanent strategic leadership.	Appointment of new Group Director of Communications and Engagement completed; takes up post in May 2026.	May 2026
GC2. Single Group Communications team.	Communications is part of Phase 1 of Corporate Services restructuring with service structure consultation due to commence in March 2026.	June 2026
GC3. Lack of Group Communications and Engagement Strategy.	Strategy to be developed following recruitment of new Group Director and implementation of new team.	September 2026

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Principal Risk 16: Research, innovation and education
If we do not enhance our capability and capacity for research, innovation and education through the establishment of a university hospital system with our strategic partners, then our ability to improve the care we offer to patients will be constrained, our access to new knowledge, insight and resources to improve hospital performance will be limited, and the development of skills, expertise and experience across our workforce will be slowed.

Risk lead	Group CMO
Last update	March 2026
Group Aim and Enabling Objectives	A3: People and culture A5: Research and education EO 13-16, 24-26

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	3	4	3	**10**
Target	3	2	2	7
Risk appetite				
Within appetite range?				

Assurance strength rating (1-5)
3. Limited assurance

Related Group/Trust significant risks (12 and above)
n/a

	Risk score trajectory																									Target
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		
Planned	10	10	10	10	10	10	10	10	10	10	10	10														7
Actual	10	10	10																							

Summary of monthly review/amendments:	**March 2026**

- No amendments to risk scores.
- No amendments in month.

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Group Board Assurance Framework: March 2026

Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Existing Trust strategies.	AF1. Oversight and assurance of strategy position and delivery through existing Trust management mechanisms.	AS1. Escalation to Executive Risk Assurance Group and Group Risk Assurance Committee for strategic risks concerning Research, Innovation and Education.	AT1. Independent measures of success and compliance set by key partners, funders and the NHS, e.g. grant income, contractual compliance, ethics/protocol compliance.
C2. Research Operations Management – Delivery of Strategy.	AF2. Management and delivery oversight and assurance of strategy delivery through existing Trust management mechanisms.	AS2. Operational issues impacting delivery against existing strategy to be escalated through existing, pre-Group, management structures into Group Executive and Group Board structures.	AT2. External audit, funder reporting, shared management and governance structures with external partners e.g. supporting joint resource, e.g. Quadram Institute Clinical Research Facility.
C3. Education and Training Partnerships.	AF3. Existing Trust:Partner educational and training agreements and integration into Trust management structures.	AS3. Escalation of items representing a strategic risk to be escalated through existing, pre-Group, management structures into Group Executive and Group Board structures.	AT3. External audit, reporting, shared management and governance structures with external education partners.

Gap in control/assurance	Action to address gap in control/assurance	Due date
GA1. Oversight and assurance remain within legacy Trust structures, with no agreed Group-level framework defining objectives, risks, performance measures or escalation.	Establish the Group Research, Innovation and Education (RIE) Committee and approve a Group RIE control and assurance framework, including University Hospitals Association (UHA) commitments as core assurance measures.	March 2026

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GA2. There is no routine, consolidated Group-level view of performance, delivery risks or compliance across Trusts; escalation is largely reactive.	Introduce interim Group-level RIE performance and risk reporting using a standardised dashboard, with clear escalation thresholds to the Group Executive.	April 2026
GA3. External assurance (funders, regulators, partners) is not consistently consolidated or reviewed at Group level, including arrangements with the University of East Anglia (UEA).	Approve the Group–UEA Memorandum of Understanding and implement a consolidated Group approach to monitoring external compliance, partnership delivery and assurance reporting through the RIE Committee.	March 2026

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Appendix 1: Risk and assurance scoring matrices

Risk score = Consequence (1-5) + Likelihood (1-5) + Control Effectiveness (1-5)
e.g. 5+5+5=15, using the descriptors below

	Consequence	Likelihood / Frequency	Control Effectiveness
1	Negligible	Remote / Not expected to occur for years	Fully Effective
2	Minor	Unlikely / Expected to occur at least annually	Largely Effective
3	Moderate	Possible / Expected to occur at least monthly	Partially Effective
4	Major	Likely / Expected to occur at least weekly	Planned but not in place
5	Catastrophic	Almost certain / Expected to occur at least daily	Absent

Risk score
Significant 12-15
Serious 10-11
Moderate 6-9
Low 3 - 5

Sources of assurances on the effectiveness of controls

1st line	Management assurance at site/Trust level
2nd line	Management and Board level assurance at Group level
3rd line	Independent assurance external to the Group/individual Trusts

Risks escalated to the Board Assurance Framework (BAF) also receive an assurance score (1-5)

1	2	3	4	5
Substantial Assurance	Reasonable Assurance	Limited Assurance	Very Limited/ Minimal Assurance	No Assurance

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Appendix 2: Risk appetite [DRAFT – to be developed with Group Board in March/April 2025]

Risk appetite level	Likelihood / Frequency	Risk score range
Minimal	Very low tolerance. Risks must be rare and tightly controlled.	3-8
Moderate	Some risks accepted if aligned with strategic goals and managed effectively.	9-11
Open	Higher risk accepted in pursuit of innovation and transformation.	12-15

Appendix 3: Glossary and abbreviations

Glossary	
Aims	The Group Aims define what the Group Board intends to achieve to discharge its statutory purpose and fulfil its responsibilities to the population it services. These aims are supported by a set of Enabling Objectives.
Assurance	Assurance is the process for building confidence that services and systems are working as intended and that risks are being managed effectively provides certainty through triangulated evidence and brings confidence that systems are working effectively. a process for building confidence that services, systems, and standards are working as intended and that risks are being managed effectively
Board Assurance Framework (BAF)	A strategic tool used by Boards to identify, assess and monitor the key (principal) risks to achieving the organisation's strategic objectives.
Consequence	The outcome or impact of an event affecting objectives. (ISO 31000:2018).
Controls	A measure that modifies risk. (ISO 31000:2018) Controls are a dynamic and iterative framework of processes, policies, procedures, activities, devices, practices or other conditions and/or actions that maintain and/or modify risk.
Control effectiveness	An assessment of the effectiveness of the controls in place to manage a risk.
Current risk score	The risk score (the summation of the Consequence, Likelihood and Control Effectiveness ratings) based on the controls currently in place in the organisation.
Enabling objectives	These define what must be done to achieve the Group Aims. They set the boundaries for action, assign responsibility for creating the right conditions for success and establish progress expectations.
Likelihood	Refers to the chance of something happening - can be expressed qualitatively or quantitatively. (ISO 31000:2018).

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Three lines of defence	The three lines of evidence the organisation gains on the effectiveness of the controls in place to mitigate a risk. *First line*: teams, managers and leaders in operational or service delivery functions and in support functions (*Trust level*) *Second line*: the oversight of management activity, separate from those responsible for delivery but not independent of the organisation's management chain (*Group level*) *Third line*: functions that provide independent and objective assurance regarding the integrity and effectiveness of risk management and related controls in the organisation (*External*)
Principal risks	Group-level strategic risks which would threaten the achievement of the Group's Aims.
Risk appetite	The amount and type of risk that an organisation is willing to pursue or retain.
Target risk score	The risk score (the summation of the Consequence, Likelihood and Control Effectiveness ratings) which the organisation aims to achieve once all identified and planned controls have been implemented.

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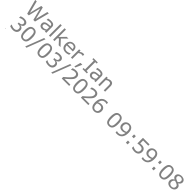
Abbreviations	
CDO	Chief Delivery Officer
CEO	Chief Executive
CMO	Chief Medical Officer
CFO	Chief Financial Officer
CN	Chief Nurse
DG	Director of Governance
DD	Digital Director
DoM	Director of Midwifery
EMD	Executive Managing Director
EO	Enabling Objective
HRD	Human Resources Director
JPUH	James Paget University Hospital
NNUH	Norfolk and Norwich University Hospital
PR	Principal risk
QEH	Queen Elizabeth Hospital, King's Lynn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Report to the Group Board in public: 1 April 2026

Agenda item number	11		
Title	Trust Charities		
Author(s)	Ian Walker, Group Director of Governance		
Executive sponsor	As above		
Purpose of report	**For decision** ☒	**For discussion** ☐	**For information** ☐

Executive summary

The three NHS foundation trusts within the Norfolk and Waveney University Hospitals Group each act as the Corporate Trustee for their associated NHS charity. Their Boards of Directors retain ultimate responsibility for safeguarding charitable assets, ensuring legal compliance, approving strategy and key financial decisions, and overseeing governance and performance. While certain duties can be delegated, overall accountability cannot be transferred.

To maintain robust governance and avoid conflicts of interest, the paper recommends that each Board of Directors continues to delegate specific responsibilities to its own Charitable Funds Committee (CFC).

It is recommended that the CFCs, which have not met since the Group's formal establishment in autumn 2025, should now be re-established with standardised terms of reference and a consistent core membership, including Group Non-Executive Directors and Executive leaders at Trust level. Each CFC would meet quarterly and approve expenditure up to £250,000 (NNUH Charity) and £125,000 (QEH and JPUH Charities), with higher-value decisions escalated to the Group Board acting as the relevant foundation trust Board of Directors.

This paper proposes that the three hospital charities explore opportunities to combine and rationalise support functions – such as finance, HR, communications and governance – to reduce duplication and strengthen resilience. Given the maturing Group model, it is also timely to assess whether maintaining three separate charities continues to offer the greatest charitable impact, or whether closer alignment, including the potential creation of a single organisation, would deliver greater benefit while retaining links with each hospital community. A 12-month options appraisal and business case is proposed, drawing on wider NHS experience and building on the previously endorsed work to assess whether the Norfolk and Norwich Hospitals Charity could become an independent charity.

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Recommendations

The Group Board is asked to:

- Approve the establishment of a Charitable Funds Committee (CFC) for the Norfolk and Norwich University Hospitals NHS Foundation Trust, delegated authority for the CFC to approve expenditure up to £250,000 and the core terms of reference attached at Appendix 1, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust (as the Corporate Trustee).

- Approve the establishment of a Charitable Funds Committee (CFC) for the James Paget University Hospitals NHS Foundation Trust, delegated authority for the CFC to approve expenditure up to £125,000 and the core terms of reference attached at Appendix 1, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust (as the Corporate Trustee).

- Approve the establishment of a Charitable Funds Committee (CFC) for the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, delegated authority for the CFC to approve expenditure up to £125,000 and the core terms of reference attached at Appendix 1, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (as the Corporate Trustee).

- Note that initial work will be undertaken to examine the scope to combine and rationalise support functions such as finance, human resources and communications, across the three charities.

- Agree that work should be undertaken over the next 12 months on a business case for potentially both bringing together the three charities into a single organisation and/or moving to independent status.

Alignment to Board Assurance Framework risk(s)	n/a
Previously considered by	n/a
Any background papers in Admin Control Reading Room	n/a

Group Board in public: 1 April 2026

Trust Charities

1. Introduction and background

Each of the three foundation trusts[1] has an associated charity:

- Norfolk and Norwich Hospitals Charity (Charity no.1048170)
- The Queen Elizabeth Hospital King's Lynn Charitable Fund (Charity no.1051327)
- James Paget University Hospitals Charitable Fund (Charity no.1050406)

Each charity is an NHS charity for the purposes of NHS legislation and is registered with the Charity Commission.

Under the NHS charity model, each foundation trust is the sole corporate trustee of its associated charity and in this capacity must fulfil a variety of charity law duties and responsibilities.

These duties and responsibilities are exercised by the Board of Directors of the respective foundation trust. The Board of Directors of each foundation trust can delegate specific powers as a trustee as it sees fit but it cannot delegate the overall responsibility of charity trusteeship.

The corporate trustee is ultimately responsible for:

- Safeguarding charitable assets.
- Ensuring compliance with charity law and regulations.
- Approving strategy, policy and key financial decisions.
- Receiving assurance on governance, risk and performance.

2. Delegation of duties

While the Boards of Directors of the three foundation trusts could delegate specific powers and duties to the Group Board (General Purpose Joint Committee), which could in turn delegate to a Charitable Funds Committee, this would potentially create issues under charity law. Specifically, if the Group Board was taking material decisions in relation to all three charities, the management of conflicts of interest and loyalty could become difficult to manage.

As such, it is proposed that compliance with charity law is best achieved by each Board of Directors delegating specific powers and duties to a Charitable Funds Committee for its respective charity, and that Charitable Funds Committee reporting to its respective foundation Trust Board of Directors. In practice, this means that the Group Board will take decisions in respect of each of the three charities by acting in the capacity of the Board of Directors of the respective foundation trust.

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[1] Norfolk and Norwich University Hospitals NHS Foundation Trust, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and James Paget University Hospitals NHS Foundation Trust.

Consistent with this, the Scheme of Reservation and Delegation adopted by the three Trusts at the establishment of the Norfolk and Waveney University Hospitals Group specifically reserves to each of the three Boards of Directors "*approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust, such as charitable funds…*".

3. Charitable Funds Committees

Each Board of Directors has historically established a Charitable Funds Committee (CFC) to exercise delegated authority on behalf of the Board as corporate trustee. The role of the CFC typically incudes day-to-day management of charitable funds, overseeing the management, investment and disbursement of these funds in accordance with Charity Commission guidance and ensuring compliance with the law governing charitable funds.

The CFCs for each of the three charities have not met since autumn 2025, when the Group was established, and this now needs to be addressed to enable the charities to progress with effective decision making.

It is proposed, however, to take the opportunity to standardise the core role and composition of the three CFCs in line with the draft terms of reference attached at Appendix 1. These have been developed drawing on best practice from the previous CFCs.

It is proposed that the core voting membership of each CFC comprises:

- One Group Non-Executive Director (Chair of the CFC).
- One Associate Non-Executive Director (Vice Chair of the CFC).
- Charity Director.
- Executive Managing Director of the Trust to which the charity is aligned.
- Director of Finance of the Trust to which the charity is aligned.
- One additional member of the Hospital Leadership Team with a clinical background to which the charity is aligned.
- One Governor from the Trust to which the charity is aligned.

Beyond this, it is proposed that each CFC will be able to determine additional non-voting attendees to reflect local circumstances.

It is proposed that each CFC will meet quarterly and will report to the Group Board (acting respectively as the Board of Directors of each foundation trust in its capacity as corporate trustee).

It is proposed that the CFCs will have delegated authority to approve charitable funds expenditure up to £250,000 for the Norfolk and Norwich Hospitals Charity and up to £125,000 for the other two charities. This is an increase from previous delegated limits of £100,000 and £50,000 respectively. Above this level, approval will need to be sought from the Group Board (acting as the Board of Directors of the relevant foundation trust in its capacity as corporate trustee).

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4. Charities alignment and independence

Looking ahead, it is proposed that the three charities and CFCs should examine options for combining and rationalising their support functions such as finance, human resources, communications and governance where possible and appropriate. This has the potential to reduce duplication and increase resilience.

More broadly, and in the context of the Group model, it is proposed that consideration should be given as to whether the model of three separate charities remains the best way to maximise charitable impact; or whether there is a case for bringing the three charities more closely together, potentially as a single organisation, while retaining strong links with each hospital community.

A detailed options appraisal would be required to assess the strategic, operational and cultural advantages and disadvantages of these approaches, drawing on experience from other parts of the NHS and consulting with a wide range of stakeholders.

This work could be combined with the programme of work previously endorsed by the Board of Directors of the Norfolk and Norwich University Hospitals NHS Foundation Trust and the Special Purpose Joint Committee (SPJC) to develop a business case for the Norfolk and Norwich Hospitals Charity potentially becoming an independent charity. (A copy of the paper discussed by the SPJC has been added to the Resource Library on Admin Control.)

It is proposed that the Group Board confirms support for the development over the next 12 months of a business case for potentially both bringing together the three charities into a single organisation and/or moving to independent status. Any future decision on changes to the status of the three charities would require the approval of the respective foundation trust Boards of Directors.

5. Recommendations

5.1 The Group Board is asked to:

- Approve the establishment of a Charitable Funds Committee (CFC) for the Norfolk and Norwich University Hospitals NHS Foundation Trust, delegated authority for the CFC to approve expenditure up to £250,000 and the core terms of reference attached at Appendix 1, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust (as the Corporate Trustee).

- Approve the establishment of a Charitable Funds Committee (CFC) for the James Paget University Hospitals NHS Foundation Trust, delegated authority for the CFC to approve expenditure up to £125,000 and the core terms of reference attached at Appendix 1, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust (as the Corporate Trustee).

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- Approve the establishment of a Charitable Funds Committee (CFC) for the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust,

delegated authority for the CFC to approve expenditure up to £125,000 and the core terms of reference attached at Appendix 1, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (as the Corporate Trustee).

- Note that initial work will be undertaken to examine the scope to combine and rationalise support functions such as finance, human resources and communications, across the three charities.

- Agree that work should be undertaken over the next 12 months on a business case for potentially both bringing together the three charities into a single organisation and/or moving to independent status.

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Appendix 1: Outline terms of reference for Charitable Funds Committees

[*INSERT CHARITY NAME*] CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1. Authority/Constitution

1.1 The Committee is constituted as a standing committee of the Board of Directors of [*insert Trust name*] NHS Foundation Trust, acting as the Corporate Trustee.

1.2 The Committee is authorised by the Corporate Trustee to act within these terms of reference. It has no executive powers other than those specifically delegated in these terms of reference.

1.3 All members of staff are directed to cooperate with any request made by the Committee.

1.4 The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

2. Purpose

2.1 The purpose of the Committee is to exercise delegated authority on behalf of the Board of Directors of [*insert Trust name*] NHS Foundation Trust, acting as the Corporate Trustee, overseeing the management, investment and disbursement of the charitable funds according to the requirements of the Charity Commission and other relevant regulatory and statutory frameworks.

3. Membership and attendance

3.1 The members of the Committee will be appointed by the Board of Directors and comprise:

- One Group Non-Executive Director (Chair of the CFC)
- One Associate Non-Executive Director (Vice Chair of the CFC)
- Charity Director
- Executive Managing Director of the Trust
- Director of Finance of the Trust
- One additional member of the Hospital Leadership Team with a clinical background
- One Governor of the Trust

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3.2 A quorum shall be three members including the Chair or Vice Chair and the Executive Managing Director or another member of the Hospital Leadership Team.

3.3 The following shall be invited to attend meetings of the Committee on a standing basis, in a non-voting capacity:

- [*CFC to agree locally the list of additional attendees*]

4. Secretariat

4.1 The Committee will be supported by [*insert support arrangements*]. This will include agreement of the agenda with the Chair, collation and circulation of papers, producing the minutes of the meetings, recording agreed actions and follow up, and advising the Chair and members as appropriate.

5. Frequency of meetings

5.1 Meetings will ordinarily be held four times per year.

5.2 The Chair may convene additional meetings of the Committee if necessary to consider business requiring urgent attention.

6. Reporting

6.1 A report will be presented to the next meeting of the Board of Directors following each meeting of the Committee to draw attention to any matters that require disclosure or escalation to the Board.

7. Duties and responsibilities

7.1 Specific duties and responsibilities of the Committee are to act on behalf of the Corporate Trustee to:

Management and expenditure of the Charity's funds

7.2 Receive reports concerning the Charity which should include the following information:

- Number and value of charitable and endowment funds
- Spend in period
- Total spent to date*
- Comparative figures for the previous financial year*
- Budget for year*
- List of large or unusual transactions
- List of significant donations
- Use of Chair's (or other officers') discretionary and delegated authority
- Summary investment report
- Report on slow moving or overdrawn funds
- Compliance with any restrictions on use of funds.

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** broken down to fund or budget heading*

7.3 Receive such reports from individual fund advisers as it considers appropriate, which may include fundraising or spending plans.

Investment of the Charity's funds

7.4 Engage and take such advice from professional investment managers as the Committee thinks fit and:

- Agree an investment strategy for the Charity, including the appointment and monitoring of investment managers.
- Oversee and approve investment transactions of the Charity.
- Consider and monitor the risk profile of the Charity's investments such that any necessary and appropriate recommendations may be made to the Corporate Trustee.

7.5 Ensure that, where the Committee delegates discretionary powers in respect of investments:

- The investment policy and scope of the power delegated is clearly set out in writing, communicated to the person or persons who will exercise it and kept under review.
- Adequate internal controls and procedures are in place to ensure that the delegated power is being exercised properly and prudently.
- The person(s) exercising the delegated power are subject to appropriate regulation and their performance is regularly reviewed.

Strategic Overview and Development of the Charity

7.6 Review and agree as appropriate:

- Relevant strategy, policies and procedures relating to the Charity.
- Major fundraising and expenditure plans.
- Publicity material and literature relating to the Charity for potential donors.
- Guidance for individual fund advisers.
- Relevant reports of the internal and external auditors.
- The Annual Accounts and Annual Report of the Trustee, ahead of seeking approval of the Board of Directors as Corporate Trustee.
- The Charity's Annual Plan and Budget.

7.7 Review grant applications and approve expenditure of funds in accordance with delegated authority (under [£250,000] or [£125,000]), making recommendations to the Corporate Trustee where approval is required.

7.8 Monitor key risks and escalate as required to the Board of Directors.

7.9 Promote a clear and effective approach to supporting equality, diversity and inclusion in the Charity's policies and practice.

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8. Review of effectiveness

8.1 The Committee will undertake an annual review of its effectiveness which will inform the review of the terms of reference and the work programme of the Committee.

9. Review of terms of reference

9.1 The terms of reference will be reviewed by the Committee and approved by the Boards of Directors of [*insert Trust name*] NHS Foundation Trust at least every two years.

Date approved by the Boards of Directors:
Next review date:

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Report to the Group Board in public: 1 April 2026

Agenda item number	12		
Title	Group Governance Framework		
Author(s)	Charlie Helps, Group Secretary		
Executive sponsor	Ian Walker, Group Director of Governance		
Purpose of report	**For decision** ☒	**For discussion** ☐	**For information** ☐

Executive summary

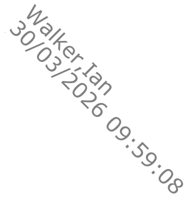
This report presents the remaining governance instruments, together with updates, completing the full statutory governance set for formal approval and adoption by each of the three Trust's Board of Directors, enabling lawful delegation to the General Purpose Joint Committee (the Group Board).

The Group Governance Framework established that governance is defined strictly through statutory instruments, namely Schedule 7 of the NHS Act 2006, the Constitutions and Standing Orders. The Provider Collaboration Agreement (PCA) established the mechanism for joint exercise of functions through the General Purpose Joint Committee (GPJC).

The statutory governance set is now complete and aligned across the three Trusts. It comprises the Constitutions, Standing Orders, Standing Financial Instructions and the previously approved Scheme of Reservation and Delegation, and defines the lawful authority of each Trust Board. The Boards, in each approving and adopting this set, effect delegation to the GPJC within defined limits. The terms of reference of the GPJC, an annex to the PCA, have also been updated to ensure full alignment across the documents.

These instruments have been developed and refined with legal input to ensure statutory compliance. Risk management, internal control, and assurance arrangements operate as operational control systems beneath this set to support the discharge of those duties.

Copies of these documents are included in the Admin Control Reading Room and the accompanying pack of additional papers.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Recommendations

The Group Board is asked to:

- Approve the Constitution, Standing Orders and Standing Financial Instructions of Norfolk and Norwich University Hospitals NHS Foundation Trust and the Variation to the Provider Collaboration Agreement in relation to the terms of reference for the GPJC, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust.
- Approve the Constitution, Standing Orders and Standing Financial Instructions of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and the Variation to the Provider Collaboration Agreement in relation to the terms of reference for the GPJC, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.
- Approve the Constitution, Standing Orders and Standing Financial Instructions of James Paget University Hospitals NHS Foundation Trust and the Variation to the Provider Collaboration Agreement in relation to the terms of reference for the GPJC, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust.
- Note that the statutory governance set defines authority, and that risk management, internal control, and assurance arrangements operate as operational control systems to support its discharge.
- Note the Group Scheme of Reservation and Delegation, approved in October 2025, which illustrate the governance instrument cascade.

Alignment to Board Assurance Framework risk(s)	PR14 (corporate governance)
Previously considered by	Group Audit Committees in Common, 23 February 2026 (SFIs)
Any background papers in Admin Control Reading Room	Yes – full copies of the governance documents referenced in the paper.

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Norfolk and Waveney University Hospitals Group

Group Board in public: 1 April 2026

Group Governance Framework

1. Introduction and background

1.1 The Group Governance Framework established the statutory basis for governance within the Group model, confirming that governance is exercised solely through the instruments defined in Schedule 7 of the NHS Act 2006, Foundation Trust Constitutions and Standing Orders.

1.2 The Provider Collaboration Agreement (PCA) established the General Purpose Joint Committee (GPJC or Group Board) as the mechanism for the joint exercise of functions, while preserving the sovereignty of each of the three Trust Boards and the requirement that Reserved Functions remain with those Boards.

1.3 NHS England's follow-up review in November 2025 recognised progress in establishing the Group model and its governance framework, while identifying the need to ensure that scrutiny, particularly by Non-executive Directors, remains effective and that governance arrangements are robustly implemented in practice.

1.4 The governance instruments presented in this report complete the statutory Board governance provisions required to support that model.

2. What has changed in the statutory Board governance instrument set

2.1 The statutory governance instruments presented in this report do not introduce new statutory powers. The powers of each Foundation Trust Board remain as defined in the NHS Act 2006 and each Trust Constitution.

2.2 What has changed is how those powers are exercised in practice within a Group model.

2.3 Prior to the establishment of the Group:

- Each Trust Board exercised its functions independently, supported by its own Constitution, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.
- Decision-making, accountability and scrutiny were contained within each sovereign organisation.
- Governance instruments differed across the three Trusts.

2.4 Under the Group model, the three Trust Boards retain full statutory authority but now exercise certain functions jointly through the General Purpose Joint Committee, within the limits defined in the Provider Collaboration Agreement and the Scheme of Reservation and Delegation.

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2.5 The statutory governance set has therefore been aligned and standardised across the three Trusts to enable:

- Consistent application of Constitutions, Standing Orders and Standing Financial Instructions.
- A single, coherent Scheme of Reservation and Delegation defining Reserved and Joint Functions.
- Clear and lawful delegation to the General Purpose Joint Committee.
- Consistent interpretation of governance instruments across the Group.

2.6 Prior to alignment, governance instruments differed across the three Trusts; these have now been standardised where appropriate to support consistent operation of the Group model. This alignment does not create a new legal entity or transfer statutory authority. Each Trust Board remains the sole statutory decision maker for its organisation. The General Purpose Joint Committee acts only as a mechanism through which delegated functions are exercised on behalf of those Boards.

2.7 In practical terms, the key changes are:

- Alignment of governance instruments across the three Trusts.
- Introduction of a shared delegation framework through the Scheme of Reservation and Delegation.
- Establishment of the General Purpose Joint Committee as the forum for joint exercise of delegated functions.
- Clarification of the boundary between Board governance and executive management.

2.8 These changes enable coordinated decision-making at Group level while preserving the sovereignty and statutory duties of each Trust Board.

3. Statutory governance instruments and operational control systems

3.1 The statutory governance instruments define the lawful authority of the Boards. Risk management, internal control and assurance arrangements operate as operational control systems beneath this set to support the discharge of those duties. These systems provide the control, evidence, and intelligence required for directors to exercise board governance effectively.

3.2 The statutory governance set comprises:

FT Constitutions

Each Trust Constitution establishes the Trust as a statutory corporation and confirms that all powers are exercised by its Board of Directors. The three Constitutions have been aligned around the NHS Model Core Constitution, with the only variation relating to the currently distinct composition of each Trust's membership constituencies and Council of Governors. Subject to approval of the Constitutions by the three Boards, approval is required from each Council of Governors. This will be sought during April 2026, ahead of scheduled Governor elections this spring. The Constitutions also include the provision to increase the number of Non-Executive Directors of each Trust from the current maximum of 8 to a maximum of 11.

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Scheme of Reservation and Delegation
The Scheme of Reservation and Delegation, approved in October 2025, defines those matters reserved to each Trust Board and those delegated to the General Purpose Joint Committee and establishes the boundary for lawful delegation.

Standing Orders
Standing Orders regulate the conduct of Board business, including meetings, quora, decision making and the exercise of Reserved Functions. These have been aligned across the three Trusts.

GPJC terms of reference
The General Purpose Joint Committee (Group Board) terms of reference have been updated to align with the content and coverage of the Standing Orders and provide greater clarity. None of the amendments involve any material change to the roles and responsibilities of the Group Board. This requires a Variation to the PCA, as the GPJC terms of reference are an annex to the PCA.

Standing Financial Instructions
Standing Financial Instructions establish the framework for financial control, stewardship of public funds, regularity, propriety and value for money, and apply to all persons acting on behalf of a Trust, including where functions are exercised through the General Purpose Joint Committee. These have been aligned across the three Trusts, with any variations in financial delegations across the Trusts explicitly specified.

A previous draft of these Standing Financial Instructions was reviewed by the Group Audit Committees in Common in February 2026. Since then, additional sections have been added on business case approval thresholds for investments fully backed by NHS income (8.2.5); capital spend backed by in-year NHS England Public Dividend Capital funding (8.3.4); payments between Trusts within the Group (8.4.7); and charitable funds (8.9). For ease of reference, Appendix 1 details Section 8 of the Standing Financial Instructions, setting out the proposed financial approval thresholds.

3.3 Together, these instruments form the complete statutory board governance instrument set.

4. Legal compliance and assurance

4.1 The statutory governance instruments have been developed with support from the Group's external legal advisers.

4.2 Legal review confirms that:

- The instruments comply with the NHS Act 2006 and associated statutory provisions.
- Delegation arrangements are lawful and do not extend beyond permitted limits.
- The Constitutions, Provider Collaboration Agreement, Standing Orders, Standing Financial Instructions, and Scheme of Reservation and Delegation operate as a coherent legal framework.

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4.3 This provides reassurance that the board governance arrangements are lawful, consistent and capable of external scrutiny.

5. Implementation of the Group Governance Framework

5.1 The Group Director of Governance has continued the work started by the Group Chief Delivery Director to lead the implementation of the Group Governance Framework as originally set out by the Group Secretary for the Special Purpose Joint Committee (SPJC) in 2025.

5.2 This has included:

- Alignment of statutory governance instruments across the three Trusts.
- Establishment of the G-line separating governance and management functions.
- Development of delegation and escalation arrangements.
- Embedding consistent terminology and legal interpretation.

5.3 This work has enabled the transition to the General Purpose Joint Committee and the establishment of a coherent governance model.

6. Statutory approval and decision making

6.1 As noted above, each Trust Board remains the sole statutory authority for its organisation. The General Purpose Joint Committee is a joint committee established under statute and the Provider Collaboration Agreement. It does not hold independent authority. The GPJC may exercise only those functions delegated to it by the Trust Boards.

6.2 In exercising those functions, the GPJC, its committees and all persons acting on its behalf must comply with each Trust's:

- Constitution
- Standing Orders
- Standing Financial Instructions
- Scheme of Reservation and Delegation

6.3 Reserved Functions remain with each Trust Board.

6.4 This establishes a governance model in which sovereignty is retained and joint action is lawfully structured.

6.5 Approval of the statutory governance instruments is a matter reserved to each of the three Trust Boards. Each Trust Board approves its own Constitution, Standing Orders and Standing Financial Instructions. The Group Scheme of Reservation and Delegation remains in force as approved in October 2025.

6.6 Where the Boards meet contemporaneously, reserved decisions are taken by each Trust Board in its own right and are recorded separately in the minutes.

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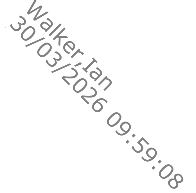
7. Conclusion

7.1 Approval and adoption of this set establishes a lawful, coherent and auditable framework for Board governance across the Norfolk and Waveney University Hospitals Group. It preserves the sovereignty of each Trust Board, enables effective delegation and strengthens clarity, accountability, and scrutiny.

8. Recommendations

8.1 The Group Board is asked to:

- Approve the Constitution, Standing Orders and Standing Financial Instructions of Norfolk and Norwich University Hospitals NHS Foundation Trust and the Variation to the Provider Collaboration Agreement in relation to the terms of reference for the GPJC, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust.
- Approve the Constitution, Standing Orders and Standing Financial Instructions of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and the Variation to the Provider Collaboration Agreement in relation to the terms of reference for the GPJC, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.
- Approve the Constitution, Standing Orders and Standing Financial Instructions of James Paget University Hospitals NHS Foundation Trust and the Variation to the Provider Collaboration Agreement in relation to the terms of reference for the GPJC, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust.
- Note that the statutory governance set defines authority, and that risk management, internal control, and assurance arrangements operate as operational control systems to support its discharge.
- Note the Group Scheme of Reservation and Delegation, approved in October 2025, which illustrate the governance instrument cascade.



Appendix 1: Section 8 of the Standing Financial Instructions

8 FINANCIAL APPROVAL THRESHOLDS AND NON-PAY EXPENDITURE

8.1 STATUS OF FINANCIAL THRESHOLDS

8.1.1 The financial approval thresholds set out in this section define the maximum levels of financial authority delegated by each Trust Board through the Scheme of Reservation and Delegation.

8.1.2 No officer or committee may approve expenditure, capital investment, contractual commitment, write-off or other financial transaction above the limits specified in this section.

8.1.3 These thresholds may be amended only by formal approval of each Trust Board.

8.2 INVESTMENT

8.2.1 Outline Business Cases and Full Business Cases for investment above £5,000,000 shall require approval by the General Purpose Joint Committee acting as the Group Board, subject to NHS England approval where applicable.

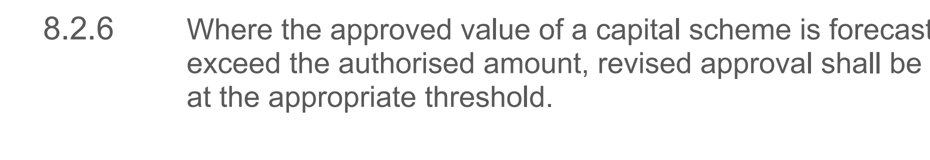
8.2.2 Investment between £3,500,000 and £5,000,000 may be approved by the Chief Executive Officer, subject to NHS England approval where applicable.

8.2.3 Investment between £2,000,000 and £3,500,000 may be approved by the Chief Finance Officer or Chief Delivery Officer, subject to NHS England approval where applicable.

8.2.4 Investment up to £2,000,000 may be approved by the relevant Executive Managing Director.

8.2.5 Business cases for investment fully backed by NHS England income will be subject to the following higher approval limits:

a) Above £20,000,000 – approval by the General Purpose Joint Committee
b) Between £15,000,000 and £20,000,000 – approval by the Chief Executive Officer
c) Between £10,000,000 and £15,000,000 – approval by the Chief Finance Officer or Chief Delivery Officer
d) Up to £10,000,000 – approval by the relevant Executive Managing Director



8.2.6 Where the approved value of a capital scheme is forecast to exceed the authorised amount, revised approval shall be obtained at the appropriate threshold.

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8.3 CAPITAL PLAN

8.3.1 The General Purpose Joint Committee acting as the Group Board is responsible for approving the Capital Plan at the start of the financial year.

8.3.2 The Trust Hospital Management Group has delegated authority to reallocate spend across capital schemes within the Group Board approved total plan value.

8.3.3 For specific NHS England funded schemes identified and agreed by the Group Board at the start of the year, authority is delegated to the Chief Finance Officer or the Chief Delivery Officer to authorise commitments in excess of the Group Board approved plan insofar as those commitments are fully funded by NHS England.

8.3.4 For capital spend that is backed by in year NHS England Public Dividend Capital funding, authority to increase the capital plan is delegated as follows:

(a) Between £15,000,000 and £20,000,000 – approval by the Chief Executive Officer

(b) Between £10,000,000 and £15,000,000 – approval by the Chief Finance Officer or Chief Delivery Officer

(c) Up to £10,000,000 – approval by the relevant Executive Managing Director

8.4 EXPENDITURE AND CONTRACTUAL COMMITMENTS

8.4.1 Expenditure or contractual commitments above £5,000,000 shall require approval by the General Purpose Joint Committee acting as the Group Board.

8.4.2 Expenditure or contractual commitments between £3,500,000 and £5,000,000 may be approved by the Chief Executive Officer.

8.4.3 Expenditure or contractual commitments between £2,000,000 and £3,500,000 may be approved by the Chief Finance Officer or Chief Delivery Officer.

8.4.4 Expenditure or contractual commitments up to £2,000,000 may be approved by the relevant Executive Managing Director.

8.4.5 Where a contract has been explicitly included within a previously approved Full Business Case, further approval is not required and the Full Business Case approval will be sufficient to evidence appropriate authority to proceed.

8.4.6 All commitments must be within approved budgets unless separately authorised by the appropriate approving body.

8.4.7 Approval for individual payments between members of the Norfolk and Waveney University Hospitals Group, where supported by a

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formal agreement or primary records (e.g. signed NHS contract, ICB income schedules, etc.) will be delegated as follows:

(a) Above £40,000,000 – Chief Executive Officer or Chief Finance Officer or Chief Delivery Officer

(b) Between £25,000,000 and £40,000,000 – relevant Director of Finance or relevant Executive Managing Director

(c) Up to £25,000,000 – relevant Director of Finance or formally named delegate

8.5 LOSSES AND SPECIAL PAYMENTS

8.5.1 Proposals for write-off of losses or making of special payments above the delegated limits to the Chief Executive Officer and Chief Finance Officer shall require approval by the General Purpose Joint Committee acting as the Group Board.

8.5.2 Delegated limits for losses and special payments shall comply with HM Treasury and NHS England requirements and shall be those approved by each Trust Board through the Scheme of Reservation and Delegation. The Finance Operating Manual may reproduce those limits for operational use, but shall not amend, override, or extend them.

8.5.3 All losses and special payments shall be reported to the Audit Committees in Common in accordance with applicable guidance.

8.6 VIREMENTS AND BUDGET TRANSFERS

8.6.1 The Chief Finance Officer may approve budget virements within the overall revenue limit approved by the Group Board.

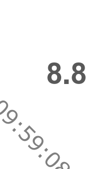
8.6.2 Detailed virement procedures and sub-delegated limits shall be set out in the Finance Operating Manual.

8.6.3 Virements that materially alter service delivery, strategic intent or risk exposure shall be reported to the Group Board.

8.7 TRANSPARENCY AND REPORTING OF SIGNIFICANT APPROVALS

8.7.1 All approvals of investment, expenditure or contractual commitments above £2,000,000 shall be reported to the next meeting of the General Purpose Joint Committee acting as the Group Board.

8.7.2 Such reporting shall be for transparency and oversight and shall not imply retrospective approval where authority has been exercised in accordance with these Standing Financial Instructions.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8.8 AGGREGATION AND ANTI-AVOIDANCE

8.8.1 Financial limits apply to the total value of a scheme, contract or transaction.

8.8.2 Artificial splitting, phased structuring, or other arrangements designed to avoid approval thresholds are prohibited.

8.9 FUNDS HELD ON TRUST

8.9.1 Approval of expenditure on Charitable Funds above £250,000 (for Norfolk and Norwich University Hospitals NHS Foundation Trust) and above £125,000 (for Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and James Paget University Hospitals NHS Foundation Trust) shall require approval by the respective Trust Board. Approval of expenditure below these levels will require the approval of the respective Charitable Funds Committee, unless otherwise delegated by the Committee.

8.10 RELATIONSHIP TO FINANCE OPERATING MANUAL

8.10.1 The Chief Finance Officer shall issue and maintain a Finance Operating Manual setting out detailed financial procedures, documentation standards, sub-delegated authority levels and operational controls.

8.10.2 The Finance Operating Manual:

(a) must operate within the authority and limits established by these Standing Financial Instructions and the Scheme of Reservation and Delegation;

(b) may be amended by the Chief Finance Officer with the approval of the Chief Executive Officer;

(c) shall not amend, override or extend any financial threshold or reserved authority established by the Trust Boards.

8.10.3 Material amendments to the Finance Operating Manual shall be reported to the Audit Committees in Common for scrutiny.

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Report to the Group Board in public: 1 April 2026

Agenda item number	13.1		
Title	Group Nomination and Remuneration Committees in Common terms of reference		
Author(s)	Ian Walker, Group Director of Governance		
Executive sponsor	Ian Walker, Group Director of Governance		
Purpose of report	**For decision** ☒	**For discussion** ☐	**For information** ☐

Executive summary

The Group Board received and approved at its meeting in December 2025 terms of reference for the Group Nomination and Remuneration Committees in Common. These terms of reference established the Committees in Common with a variable membership covering responsibilities for the appointment and remuneration of both Executive Directors and Non-Executive Directors. For greater simplicity and transparency, it is now proposed that there should be separate committee arrangements for the appointment and remuneration of Executive Directors and Non-Executive Directors. As such, the attached terms of reference have been produced for a Group Nomination and Remuneration Committees in Common with specific responsibility for Executive Director appointments and remuneration. Separate Governor Nomination and Remuneration Committees will be established for matters relating to the Chair and Non-Executive Directors.

The establishment of terms of reference, composition and reporting arrangements for the Nomination and Renumeration Committee are matters reserved to the three statutory Boards of Directors under the Scheme of Reservation and Delegation. As such, the Board of each Trust is required to approve these terms of reference.

Recommendations

The Group Board is asked to:

- Approve the terms of reference of the Group Nomination and Remuneration Committees in Common, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust.
- Approve the terms of reference of the Group Nomination and Remuneration Committees in Common, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.
- Approve the terms of reference of the Group Nomination and Remuneration Committees in Common, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust.

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Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 14
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

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GROUP NOMINATION AND REMUNERATION COMMITTEES IN COMMON

TERMS OF REFERENCE

1. Introduction

1.1 The Norfolk and Waveney University Hospitals Group (NWUHG) Nomination and Remuneration Committees in Common is established under the Provider Collaboration Agreement (PCA)[1].

2. Accountability and authority

2.1 The Boards of each of the three Trusts[2] have agreed and arranged for their Nomination and Remuneration Committees to operate together as Committees in Common.

2.2 In operating as Committees in Common, each Trust's Nomination and Remuneration Committee shall continue at all times to be directly accountable to its respective Board of Directors but shall routinely report its activities and decisions to the Group Board (the General Purpose Joint Committee).

2.3 Decisions of the Group Nomination and Remuneration Committees in Common regarding delegated joint functions are binding on each of the Trusts. Resolutions legally reflect the simultaneous decision of the Nomination and Remuneration Committees of all three Trusts.

2.4 The Committees in Common is authorised by the Group Board to act within these terms of reference. It has no executive powers other than those specifically delegated in these terms of reference.

2.5 All members of staff of the three Trusts are directed to cooperate with any request made by the Committees in Common.

2.6 The Committees in Common are authorised by the Group Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trusts with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

3. Purpose

3.1 The purpose of the Committees in Common is to approve and oversee the arrangements for the appointment, termination and remuneration of the Group Chief Executive and the Group Executive Directors (defined as those Executives reporting to the Group Chief Executive). In addition, the Committees in Common will, on an annual basis, receive information on the

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[1] Provider Collaboration Agreement for the purpose of establishing Norfolk and Waveney University Hospitals Group joint working arrangements and appointment of a General Purpose Joint Committee to exercise joint functions, 23 October 2025.
[2] Norfolk and Norwich University Hospitals NHS Foundation Trust, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and James Paget University Hospitals NHS Foundation Trust.

appointment and remuneration of any other Very Senior Manager (VSM) roles within the Group and its constituent Trusts.

3.2 The appointment and remuneration of the Group Chair and Group Non-Executive Directors are matters for the Councils of Governors of the three Trusts.

4. Membership and attendance

4.1 The members of the Group Nomination and Remuneration Committees in Common will be appointed by the Boards of Directors of the three Trusts and comprise three Group Non-Executive Directors.

4.2 One Group Non-Executive Director will be appointed as the Chair of the Committees in Common by the Boards of Directors of the three Trusts.

4.3 The Group Chief Executive will identify a link Executive Director for the Committees in Common.

4.4 A quorum shall be two Group Non-Executive Directors.

4.5 The Group Chief Executive and the Group Chief People Officer will attend all meetings except in relation to any items relating to their own positions, performance or remuneration. Other staff will be invited to attend for specific agenda items with the agreement of the Chair of the Committees in Common.

5. Secretariat

5.1 The Group Director of Governance will act as Secretary to the Committees in Common and provide administrative support to the Chair and members. This will include agreement of the agenda with the Chair and Executive lead, collation and circulation of papers, producing the minutes of the meetings, recording agreed actions and follow up, and advising the Chair and members as appropriate.

6. Frequency of meetings

6.1 Meetings will be held at least twice a year, the timings to be agreed by the Committees in Common Chair in liaison with the link Executive Director and the Secretary.

6.2 The Chair may convene additional meetings of the Committees in Common if necessary to consider business requiring urgent attention.

7. Reporting

7.1 A report will be presented to the next meeting of the Group Board following each meeting of the Committees in Common to draw attention to any matters that require disclosure or escalation to the Group Board.

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7.2 A section of the Trusts' Annual Reports will describe the work of the Committees in Common in discharging its responsibilities.

8. Duties and responsibilities

Appointments

8.1 Keep under review the structure, size and composition of the Boards of Directors of the three Trusts and make recommendations to the Group Board where appropriate.

8.2 Consider succession planning and talent management arrangements for the Group Chief Executive and Group Executive Directors, taking into account the opportunities and challenges facing the Group and its Trusts and the skills and expertise which are therefore required in the future.

8.3 Agree and oversee the recruitment and selection process for the Group Chief Executive, including the preparation of a description of the role and capabilities required and the composition of the appointments panel, in consultation with the Councils of Governors of the three Trusts.

8.4 Agree a recommendation to the Councils of Governors of the three Trusts on the appointment of the Group Chief Executive.

8.5 Receive updates on the recruitment and selection process for Group Executive Directors and endorse the appointment of Group Executive Directors based on the recommendation of the Group Chief Executive.

8.6 The Committees in Common may delegate the duties outlined in paragraph 8.5 and the agreement of salaries for newly advertised and appointed Group Executive Director posts to the Committee Chair and the Group Chief Executive (working with the Group Chief People Officer). Where such actions are taken, these will be reported to the next meeting of the Committees in Common.

8.7 Seek assurance that the Group Chief Executive and all Group Executive Directors meet the Fit and Proper Person requirements in accordance with national regulations and guidance.

Performance and objective setting

8.8 Receive and review a report from the Group Chair on the annual appraisal of the Group Chief Executive in relation to their objectives for the past year and comment on the objectives of the Group Chief Executive for the forthcoming year.

8.9 Receive and review a report from the Group Chief Executive on the annual appraisal of the Group Executive Directors in relation to their objectives for the past year and comment on the objectives of the Group Executive Directors for the forthcoming year.

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Remuneration

8.10 Determine the Group's remuneration policy for the Chief Executive and Group Executive Directors, having due regard to the NHS England VSM Pay

Framework, national benchmarking information and all other relevant laws, regulations, national policy requirements and guidance.

8.11 Within this framework, and taking account of the annual review of performance, review and agree on an annual basis the remuneration and terms and conditions of office of the Group Chief Executive and Group Executive Directors, including:

- Contractual and/or non-contractual remuneration, including any performance-related pay or bonus.
- Provisions for other benefits, including pensions and allowances.
- Any termination and/or severance payments.

8.12 Have oversight of the application and level of responsibility allowances for medical staff undertaking senior leadership roles at Group and Trust levels.

8.13 Review the pay framework and its outputs from a gender and other protected characteristics pay gap perspective.

Other

8.14 On an annual basis, receive information on the appointment and remuneration (including termination and/or severance payments) of any other Very Senior Manager (VSM) roles within the Group and its constituent Trusts.

9. Review of effectiveness

9.1 The Committees in Common will undertake an annual review of its effectiveness which will inform the review of the terms of reference and the work programme of the Committees in Common.

10. Review of terms of reference

10.1 The terms of reference will be reviewed by the Committees in Common and approved by the Boards of Directors of the three Trusts at least every two years.

Date approved by the Boards of Directors:
Next review date:

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Report to the Group Board in public: 1 April 2026

Agenda item number	13.2		
Title	Group Research, Innovation and Education Committee terms of reference		
Author(s)	Ian Walker, Group Director of Governance		
Executive sponsor	Ian Walker, Group Director of Governance		
Purpose of report	**For decision** ☒	**For discussion** ☐	**For information** ☐

Executive summary
The Group governance structure includes a Board-level Research, Innovation and Education Committee, reflecting the central importance of research, innovation and education to the Group's strategic ambitions including as a University Hospital System. The inaugural meeting of the Committee was held on 24 February 2026 and a report of the meeting is included on the agenda. The meeting considered draft terms of reference for the Committee and these are now attached for Group Board approval.

Recommendations

The Group Board is asked to approve the terms of reference of the Group Research, Innovation and Education Committee.

Alignment to Board Assurance Framework risk(s)	BAF Principal Risks 14, 16
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

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GROUP RESEARCH, INNOVATION AND EDUCATION COMMITTEE

TERMS OF REFERENCE

1. Introduction

1.1 The Norfolk and Waveney University Hospitals Group (NWUHG) Research, Innovation and Education Committee is a formally constituted committee of the Group Board of Directors (the General Purpose Joint Committee), established under the Provider Collaboration Agreement and the Constitutions of the three NHS Foundation Trusts[1].

1.2 The Committee has no powers other than those specifically stipulated in these Terms of Reference.

2. Purpose and function

2.1 The Committee will provide the Group Board with assurance that NWUHG's Research, Innovation and Education Strategy is and remains aligned with the Group's strategy and is being implemented in a timely, efficient and effective manner in pursuit of the Group's stated ambitions and objectives for research, innovation and education.

2.2 Notably these ambitions include:

- Establishment and further development of NWUHG as a University Hospital System.
- Securing group wide co-ordinated and high value investment into research, education and innovation (for example, the National Institute for Health Research (NIHR) Biomedical Research Centre programme).
- NWUHG achieving Academic Health Science Centre status.

2.3 The Committee's purpose extends to ensuring that appropriate and effective systems of governance, risk management and internal control relevant to the delivery of research, education and innovation activity are in place across the Group.

2.4 The Committee may request and expect to be provided with reports and assurance from directors and managers as appropriate in relation to systems of governance and management of research, innovation and education, and indicators of their effectiveness. In addition, the Committee may request and expect to be provided with reports documenting the Group's performance in relation to research, innovation and education.

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[1] James Paget University Hospitals NHS Foundation Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.

3. Authority and accountability

3.1 The Committee is authorised by the Group Board to:

- Investigate any activity that relates to research, innovation and education to provide assurance to the Group Board regarding the effectiveness, and appropriateness of these activities occurring within the Group.
- Seek any information it requires from any officer of the Group or the three Trusts that relates to the purpose of providing assurance to the Group Board relating to research, innovation and education activities.
- Obtain independent professional advice as it deems necessary, should such advice not be available within the Group.
- Request the attendance of individuals from within or outside the Group and the Trusts where necessary.

3.2 The Committee is accountable to the Group Board.

4. Membership and attendees

4.1 The members of the Committee will be appointed by the Group Board and will comprise:

- Three Group Non-Executive Directors
- Group Chief Medical Officer
- Group Chief Nurse
- One representative Executive Managing Director, to be rotated by agreement of the Group Board after a minimum term of 12 months
- Group Chief Executive-identified Executive Lead/s (one or two)
- Standing members to provide subject matter expertise (up to three)

4.2 One of the Group Non-Executive Director members will be appointed by the Group Board as the Chair of the Committee. In their absence, another Group Non-Executive Director may chair the Committee.

4.3 The Group Chief Executive will identify an Executive lead or leads for the Committee, of which there will be no more than two persons.

4.4 Members of the Committee should aim to attend all scheduled meetings, and if not attending a formal apology should be submitted to the Committee Secretariat.

4.5 The Group Chair and the Group Chief Executive will hold a standing invite to attend all meetings of the Committee but will not contribute to the quorum.

4.6 External representatives may be invited to attend the Committee on a standing basis to provide expertise in key domains and support the Committee in exercising its duties. This will be agreed by the Committee Chair, Group Chair and Group Chief Executive and documented accordingly.

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4.7 Other Executive Directors and other Group or Trust staff may be invited to attend for specific agenda items with the agreement of the Chair of the Committee.

5. Quorum

5.1 The quorum necessary for the transaction of business will be four members, comprising two Group Non-Executive Directors and two Group Executive Directors. In exceptional circumstances, an Executive Director member may send an appropriate nominated deputy in their place and this will count towards the quorum.

5.2 A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee as a whole.

6. Frequency of meetings

6.1 Initially, meetings will be held every two months.

6.2 The Chair may convene additional meetings from time to time if business relating to the Committee requires urgent consideration.

7. Secretariat functions

7.1 The Group Director of Governance will ensure the provision of a Secretary to the Committee and appropriate administrative support to the Committee Chair and members in line with the Group standard. This will include:

- Agreement of the agenda with the Committee Chair and Executive lead(s)
- Collation and circulation of papers
- Producing minutes of the meetings
- Keeping a record of agreed actions and follow up
- Advising the Committee Chair and members of the Committee as appropriate

7.2 Agendas will be circulated at least three clear working days in advance of each meeting, accompanied by supporting papers.

8. Meeting transparency and probity

8.1 The Committee Chair will ascertain, at the beginning of each meeting, the existence of any actual, potential or perceived conflicts of interest with matters on the agenda or related matters.

8.2 Such conflicts of interest will be managed by the Committee Chair and recorded in the minutes and, if appropriate, the Register of Declarations of Interest.

9. Duties and responsibilities

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9.1 The Committee will seek assurance on behalf of the Group Board that:

- Areas of strategic priority for research, innovation and education are aligned with the overall NWUHG strategy.
- Research, innovation and education are established as core Group activities across all Trusts and sites in the Group.

- Research and innovation are embedded into patient care pathways and Models of Care in line with the Group's overall strategy.
- There are appropriate arrangements in place to strengthen capability, capacity and quality across research, innovation and education.
- The Group has adequate infrastructure, environment and systems to support research, innovation and education activities.
- Appropriate career pathways and professional development opportunities are in place across clinical, academic and non-clinical staff for engagement in research, innovation and education.
- Arrangements are in place to enhance the Group's ability to compete successfully for major external funding, including NIHR and other research funding, including through expert input and scrutiny that such applications are co-ordinated across the Group.
- There is a focus on fostering effective collaboration and partnership working to deliver and amplify impact.

9.2 In relation to Innovation, the Committee will additionally oversee the development of a sustainable Group-wide governance, management and delivery model, fully integrated with research and core Trust operations, and support the development of skills, partnerships (commercial and non-commercial) and workforce capability required to deliver innovation at scale.

9.3 In relation to Education, the Committee will oversee the development of aims and objectives that strengthen undergraduate, postgraduate and continuing professional education across medical and non-medical professions, aligned to workforce sustainability, service need and the Group's research and innovation ambitions.

9.4 In fulfilling its strategic role, the Committee will:

- Have regard to relevant ethical, scientific, regulatory, funder and partnership considerations.
- Promote an inclusive, curiosity-led and learning culture consistent with a university hospital system.
- Actively encourage and incentivise engagement in research, innovation and education activity across the Group.
- Support the external promotion and profile of NWUHG's research, innovation and education activity.
- Support the development, embedding and demonstration of meaningful patient and public involvement across the research, innovation and education portfolios.

9.5 The Committee will provide assurance to the Group Board that the Group has appropriate, effective and proportionate governance, management, planning and enabling arrangements in place for research, innovation and education, and that these remain fit for purpose. Where the Committee identifies that such things are not in place, or are not performing to the standard that is to be expected, the Committee may request an action plan to address deficiencies and inform the Group Board accordingly.

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9.6 In providing this assurance, the Committee will review evidence relating to:

- Programmes of work aimed at developing research, innovation and education across the Group and its Trusts and to support the Group in fulfilling its objectives.
- Whether work aimed at developing research, innovation and education is appropriately managed and resourced.
- Whether work aimed at developing research, innovation and education is being delivered in an efficient, effective and timely manner.
- The effectiveness of governance and management arrangements for research, innovation and education.
- Key research, innovation and education risks and mitigations across the Group.
- Equity, diversity and inclusion within research, innovation and education activity across the Group.
- Performance against externally-set research, innovation and education requirements and indicators.
- Performance against internally-defined indicators that support effective decision-making by the Group Board across the research, innovation and Education portfolio.

9.7 Where required, the Committee may commission more detailed reviews and assign members to oversee the development, delivery and reporting of such reviews in line with requirements set by the Committee.

9.8 In exercising its duties and responsibilities, the Committee will have due regard to the work of the Group Board and other Board Committees; and may also examine any matters within its remit referred to the Committee by the Group Board or other Board Committees.

10 Reporting arrangements

10.1 The Committee Chair will provide a report to the Group Board after each meeting drawing attention to any matters that require disclosure or escalation to the Group Board.

10.2 The minutes of the Committee's meetings will be available for information to all members of the Group Board.

10.3 The Committee will produce an annual report to the Group Board detailing how it has discharged its responsibilities and met its terms of reference.

11 Review of terms of reference

11.1 The Terms of Reference will be reviewed by the Committee and approved by the Group Board at least once a year.

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Date approved by the Boards of Directors:
Next review date:

Report to the Group Board in public: 1 April 2026

Agenda item number	14		
Title	Group Board Committee membership and NED roles		
Author(s)	Ian Walker, Group Director of Governance		
Executive sponsor	Ian Walker, Group Director of Governance		
Purpose of report	**For decision** ☐	**For discussion** ☐	**For information** ☒

Executive summary

This paper documents the appointment of Group Non-Executive Directors (NEDs) to Board committees and a number of specific roles and responsibilities: the Senior Independent Director (SID), the Board Perinatal Safety Champion and the designated NED roles in relation to Maintaining High Professional Standards (MHPS) and Freedom to Speak Up.

As additional planned committees are established in the coming months, their membership will be confirmed.

Recommendations

The Group Board is asked to:

- Note the appointment of Sally Collier as Senior Independent Director.
- Note the appointments to Board committees.
- Note the appointment of Group NEDs to designated roles for Perinatal Safety, Maintaining High Professional Standards and Freedom to Speak Up.

Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 14
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

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Norfolk and Waveney University Hospitals Group

Group Board in public: 1 April 2026

Group Board Committee membership and NED roles

1. Introduction and background

1.1 This paper documents the appointment of Group Non-Executive Directors (NEDs) to Board committees and a number of specific roles and responsibilities.

2. Senior Independent Director

2.1 The Trusts' Constitutions provide for the appointment of a Senior Independent Director from among the NEDs. Following consultation with the Lead Governors, Sally Collier has been appointed as the Senior Independent Director of each of the three Trusts.

3. Board committees

3.1 The following Board committees have been established to date:

- Group Audit Committees in Common
- Group Nomination and Remuneration Committees in Common
- Group Risk Assurance Committee
- Group Research, Innovation and Education Committee

3.2 The membership of these committees with effect from 28 January 2026 is as follows:

Board committee	Membership
Group Audit Committees in Common	Stephen Javes (Chair) Jo Churchill Nikki Gray
Group Nomination and Remuneration Committees in Common	Sally Collier (Chair) Philip Baker Nikki Gray
Group Risk Assurance Committee	Nikki Gray (Chair) Sally Collier William Van't Hoff
Group Research, Innovation and Education Committee	Philip Baker (Chair) Jack Bowman William Van't Hoff Group Chief Nurse Group Chief Medical Officer Executive Managing Director (x1)

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3.3 As additional planned committees are established in the coming months, their membership will be confirmed.

4. NED roles and responsibilities

4.1 The Group Chair has allocated specific NED roles and responsibilities as follows:

- NED Board Perinatal Safety Champion: Jo Churchill
- Designated NED for Maintaining High Professional Standards (MHPS): Sally Collier
- Designated NED for Freedom to Speak Up: William Van't Hoff

4.2 Following the planned appointment of additional NEDs to the Group Board, each with an alignment to one of the three Trusts, it is planned that they will support the above NEDs in undertaking these roles and responsibilities.

5. Recommendations

5.1 The Group Board is asked to:

- Note the appointment of Sally Collier as Senior Independent Director.
- Note the appointments to Board committees.
- Note the appointment of Group NEDs to designated roles for Perinatal Safety, Maintaining High Professional Standards and Freedom to Speak Up.