

**NORFOLK AND WAVENEY
UNIVERSITY HOSPITALS GROUP**

**GROUP BOARD MEETING IN PUBLIC:
7 OCTOBER 2026**

SUPPLEMENTARY PAPERS

This pack contains additional material referenced within individual
Group Board papers for the meeting on 7 October 2026

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**NORFOLK AND WAVENEY
UNIVERSITY HOSPITALS GROUP**

**GROUP BOARD MEETING IN PUBLIC:
7 OCTOBER 2026**

**SUPPLEMENTARY PAPERS
FOR AGENDA ITEM 6**

Walker, Ian
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Lesley Dwyer
Chief Executive Officer
Norfolk & Waveney University
Hospitals Group

NHSE – East of England
2-4 Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

28 September 2026

Dear Lesley,

Norfolk & Waveney University Hospitals Group (NWUHG) Mid-Year Provider Review Meeting – 16 September 2026

Thank you to colleagues from NWUHG for their participation in the Mid-Year Review meeting held on 16 September 2026. The discussion focused on delivery against the 2026/27 operational and financial plan, preparedness for winter, and the actions required to ensure delivery during the second half of the year.

We recognised the progress made across the Group in elective recovery, cancer improvement and diagnostic performance, whilst noting the significant ongoing challenges associated with urgent and emergency care performance, ambulance handovers, discharge pathways and financial recovery, particularly at The Queen Elizabeth Hospital King's Lynn (QEHKL).

Meeting Summary and Key Points

Board Approved 2026/27 Annual Plan: Financial and Operational Delivery

The Group reported a generally positive position in delivery of elective recovery trajectories. All three trusts expressed confidence in achieving planned RTT waiting list and 18-week recovery trajectories by year end, with additional opportunities being explored through bids to the national waiting list reduction funding programme. Focus was placed on reducing long waits in orthopaedics, ENT, gynaecology and community paediatrics.

At James Paget University Hospitals NHS Foundation Trust (JPUH), delivery against RTT and waiting list trajectories remains on track, although winter pressures and reduced escalation capacity associated with the RAAC programme present a delivery risk.

Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) reported confidence in delivery of its elective recovery plan following a deterioration in performance earlier in the year. Recovery actions include independent sector provision, validation activity and targeted specialty interventions. The Trust expects to return to trajectory by the end of September and this is built into regional projections.

QEHKL reported confidence in delivery of RTT trajectories, supported by insourcing arrangements and additional operational support. Activity delivery is expected to return fully to plan by September.

Financially, the Group reported a £3.2m adverse variance to plan at Month 5. While NNUH and JPUH remain broadly on track to deliver their plans, the principal financial risk remains at QEHKL where a significant efficiency gap and financial recovery challenge persist. The Group highlighted concerns regarding Deficit Support Funding, recurrent efficiency delivery and the impact of no criteria to reside (NCTR) patients on costs and operational performance.

Performance

The Group reported improving performance across cancer pathways. Faster Diagnosis Standard (FDS) performance is improving across all three trusts, supported by pathway redesign, operational focus and Cancer Alliance support. with confidence in achieving the required year-end position. Monthly variability means that the Trust is not expected to meet the full year planning standard of 80% delivery across the whole year. NHSE remain concerned regarding 62- day performance particularly at QEHKL. Histology capacity continues to present a risk, particularly affecting delivery of cancer standards.

Diagnostic performance is also improving, with targeted interventions across MRI, echocardiography, audiology, endoscopy and ultrasound services. Significant recovery work is underway through insourcing, independent sector support and workforce initiatives.

The most significant operational concern remains urgent and emergency care performance. Whilst there was evidence of sustained improvement efforts across all three trusts, ambulance handover delays, 4-hour performance, 12-hour waits and patient flow remain significant challenges. The Group identified increasing attendances, rising demand and high numbers of patients who no longer meet criteria to reside as major contributors to deterioration in flow.

Concern was raised regarding social care capacity and discharge pathways. The Group reported substantial numbers of patients awaiting social care packages and highlighted concerns regarding the availability of community and care home capacity, particularly at JPUH.

NHSE and the ICB agreed that further system-level discussions would be required to address these issues.

The review also noted the positive impact of criteria-led discharge initiatives and improvements in length of stay across the Group. However, members agreed that these gains are currently being offset by increasing demand and discharge constraints.

Local Risks and Issues

The key risks identified during the review were:

- Deterioration in ambulance handover performance and emergency flow.
- Growth in patients with no criteria to reside driven by social care capacity constraints.
- Delivery of winter plans in the context of constrained bed capacity and RAAC-related impacts.
- Continued fragility of histology services and associated impact on cancer pathways.
- Workforce challenges affecting oncology, diagnostics and urgent care services.
- Financial recovery and delivery of efficiency savings, particularly at QEHL.
- Delay in implementation of the acute medicine operating model at QEHL and the associated impact on flow and performance.

Winter Preparedness

The Group provided assurance that winter planning is underway, including system testing exercises, discharge planning arrangements and urgent care improvement programmes. Concerns remain regarding discharge capacity, community service provision, ambulance handovers and the availability of escalation capacity during periods of peak pressure.

Actions and Next Steps

- Review discrepancies in provider segmentation and ranking data, including comparison with Model Hospital datasets, and provide clarification to the Group **(NHSE)**.
- Provide an assessment of the anticipated impact of elective recovery funding bids on RTT performance and waiting list reduction across all three trusts **(NWUH)**.
- Establish a targeted system-level review of ambulance handover performance involving providers, Norfolk and Suffolk ICB, East of England Ambulance Service NHS Trust

(EEAST) and NHSE to identify and implement further improvement actions **(NHSE / Norfolk and Suffolk ICB)**.

- Convene an executive-level discussion with local authority partners to address social care capacity constraints, NCTR growth and discharge challenges affecting delivery across the Group **(Norfolk and Suffolk ICB)**.
- Share further information regarding options and costs with temporary modular capacity and alternative solutions supporting RAAC mitigation and winter resilience **(JPUH)**.
- Continue development of the acute medicine operating model at QEHL and provide an updated implementation timeline **(QEHL)**.
- Submit the updated financial recovery plan for QEHL and continue engagement with NHSE regarding forecast delivery and Deficit Support Funding implications **(NWUHG)**
- Share details of the Urgent Community Response business case and associated system impacts with Group partners **(Norfolk and Suffolk ICB)**.

Additional for Consideration

Whilst not discussed in detail, NHSE would welcome continued assurance regarding:

- Delivery of winter plans in the context of infection prevention and control requirements.
- Oversight of diagnostic recovery programmes for audiology and imaging services.
- Continued monitoring of cancer workforce resilience and histology capacity.

Oversight During the Winter Period

NHSE recognises the progress made across NWUHG in strengthening elective recovery, cancer performance and diagnostic delivery. However, oversight during the winter period will continue to focus on urgent and emergency care performance, ambulance handovers, discharge pathways, financial recovery and delivery of agreed improvement plans, particularly where organisations remain subject to enhanced operational or financial scrutiny.

Next Steps

We will continue to work closely with the Group, individual trusts and system partners to support delivery over the remainder of 2026/27.

Thank you once again for your time, engagement and the openness of the discussion.

Yours sincerely,



Clare Panniker

Regional Director

NHSE – East of England

CC Jonathan Gardner, Managing Director, JPUH

Jo Segasby, Interim Managing Director, QEHL and Deputy CEO of NWUHG

Shane Gordon, Managing Director, NNUH

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**NORFOLK AND WAVENEY
UNIVERSITY HOSPITALS GROUP**

**GROUP BOARD MEETING IN PUBLIC:
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**SUPPLEMENTARY PAPERS
FOR AGENDA ITEM 12**

Walker, Ian
02/10/2026 14:20:39

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

21 September 2026

Thirlwall Inquiry report and recommendations

Dear colleagues,

Lady Justice Thirlwall's [report](#) is a sobering moment for all of us working in the NHS. From the devastating failure, both of individuals and the system, to act quickly enough to safeguard babies, to the questions it poses about the NHS culture that prevented this – the need for change goes beyond the walls of a single hospital ward. We must address these together now.

Our thoughts remain very much with the families affected who have experienced unimaginable loss and pain, and the NHS repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.

Recommendations

On Tuesday, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full.

Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this;
- Go further on [new guidance](#) on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death;
- Undertake a review of the 'Working Together to Safeguard Children' (April 2026) and safeguarding training nationally;
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities;
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting:** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children (SUDIC):** The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The [SUDIC protocol](#) is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably

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expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within neonatal units. **All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026.** It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

- **National Bereavement Care Pathway for stillbirth and neonatal death:** ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the [NHS Medium Term Planning Framework](#) (October 2025).
- **Insulin:** By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the [GIRFT neonatology Guide to safe insulin use](#). Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.
- **Safeguarding:** Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts are reminded that the [Insightful Provider Board guide](#) is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Health and wellbeing

We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.

We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

Next steps

The report firmly underlines why the urgent work we are doing through the Maternity and Neonatal Care 10-Point Plan must be a top priority for the NHS. As the Secretary of State has clearly set out, the safety, safeguarding and wellbeing of mothers and babies must never be treated as a side issue and must be a central priority for NHS boards.

The findings of this crucial report will be a key focus of our next CEO leadership event tomorrow. It is important that we challenge each other when we meet on whether we are all doing enough to ensure that babies and children are protected, no staff member is ignored when they raise concerns, and that we are consistently acting to the highest standards of governance and leadership.

Yours sincerely,



Duncan Burton

Chief Nursing Officer for England



Sarah-Jane Marsh

NHS England Chief Operating Officer

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UNIVERSITY HOSPITALS GROUP**

**GROUP BOARD MEETING IN PUBLIC:
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**SUPPLEMENTARY PAPERS
FOR AGENDA ITEM 14**

Walker, Ian
02/10/2026 14:20:39

Report to the People & Culture Management Group Tuesday, 14 April 2026

Title:	Freedom to Speak Up (FTSU) Guardian Report
Author:	Frances Dawson, Lead FTSU Guardian
Previous scrutiny:	
Purpose:	The paper is presented for Choose an item.
Relevant strategic themes:	☒ 1. Quality ☐ 2. Operational Performance ☐ 3. Financial Sustainability ☒ 4. Workforce Wellbeing
Impact assessments:	☐ Quality ☐ Equality ☐ GDPR and DPA ☒ Not applicable

Executive Summary

This paper presents information for assurance purposes to the People and Culture Management Group on the current effectiveness of the Freedom to Speak Up (FTSU) service and progress towards NNUH's wider speaking-up ambitions. It outlines FTSU activity and key themes, highlights emerging risks, and identifies actions to strengthen confidence and learning.

FTSU activity increased by 17% in 2025/26, with KPI performance remaining strong overall. While increases in matters raised may reflect improved awareness, the rise in anonymous concerns and staff survey findings indicating reduced confidence that concerns will be addressed, highlight the need for further action to strengthen organisational response.

Recommendations are made to agree interim executive arrangements, enhance Speak Up training, and seek assurance that actions are in place to prevent further decline in confidence and support its restoration across the organisation.

Recommendations

- **Agree an interim executive arrangement for the FTSU service**, appointing a named Executive or equivalent senior leader to provide continuity, senior oversight, and appropriate escalation until the substantive Director of People and Culture is in post.
- **Prioritise "Listen Up" training for line managers**, including consideration of delivering training to larger groups for maximum impact, or implementing an alternative or complementary approach to strengthen local capability and confidence.
- **Seek assurance that appropriate actions are in place to prevent further decline in confidence**, and review the effectiveness of current and planned NNUH actions aimed at restoring trust in the organisation's response to concerns.

Purpose of the Report

The report provides information to support the People and Culture Management Group to be able to consider assurance both in relation to the FTSU service and the wider NNUH speaking-up ambitions.

Interim arrangement for FTSU leadership

To comply with national guidance, the Freedom to Speak Up (FTSU) service requires a named executive, or recognised equivalent, to provide cover until the substantive Director of People and Culture commences in June 2026.

This role provides senior oversight and appropriate influence where a significant speak up matter or risk requires escalation and is typically highly sensitive.

Executive cover has been provided by interim post-holders for an extended period, which, while pragmatic, has introduced risks to continuity and consistency.

It is proposed that the Executive Medical Director (EMD) be considered as a suitable temporary executive, providing a brief period of cover, ensuring continuity and appropriate confidentiality should a matter extend beyond June 2026. All new matters would transfer to the incoming Director on appointment.

FTSU activity and trends.

In 2025/26, 244 matters had been discussed with an FTSU Guardian, compared to 208 in 2024, representing a 17% increase.

Anonymous concerns accounted for 11% of activity, returning to levels seen in 2022/23 following a reduction to 8% and then 3% in the previous year (fig 2).

While anonymity remains a vital safeguard, this increase is not fully aligned with the ambitions of the Trust's *Caring Together* strategy, which seeks to foster a culture of openness, psychological safety and confidence to speak up openly.

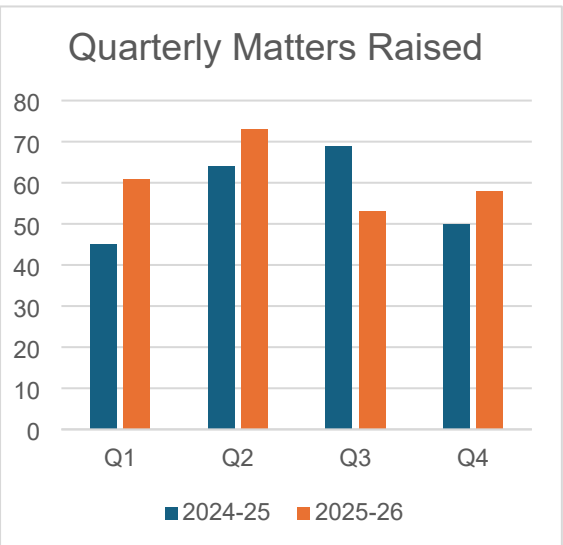


Fig 1.

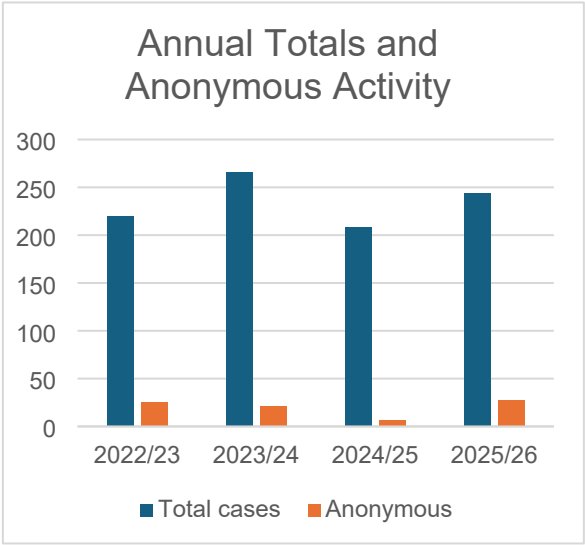


Fig 2.

FTSU KPI compliance.

	Jan	Feb	March
KPI 1	100%	94%	94%
KPI 2	95%	88%	tbc

KPI 1 = response from a Guardian, two working days. KPI 2 = Matter closed within 20 days for all care and safety matters, 30 days for all other matters. NB- Actions may still be ongoing but assurance has been acquired that, a lead is in place, progress as expected is being achieved. Matters can re-open if progress halts.

Ward
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FTSU January & February KPI 2 Exceptions; Delayed follow up, delay in ability to arrange an off-site suitable meeting venue, incorrect signposting (required post holder on sick leave).

Key Themes

Matters may span multiple themes. Key categories have been identified, including a new focus on development and training. All patient care and safety matters have senior oversight, and concerns relating to harassment or discrimination are escalated to HR colleagues, with consent, for appropriate support.

Discrimination matters included one case where escalation was not consented to and others relating to recruitment panels, possible disability-related discrimination, and detriment linked to protected characteristics. One case of sexual harassment was raised anonymously, with the care group responding promptly and demonstrating exemplar practice.

Learning from these cases is being shared through NNUH's ongoing diversity, inclusion and equality work.

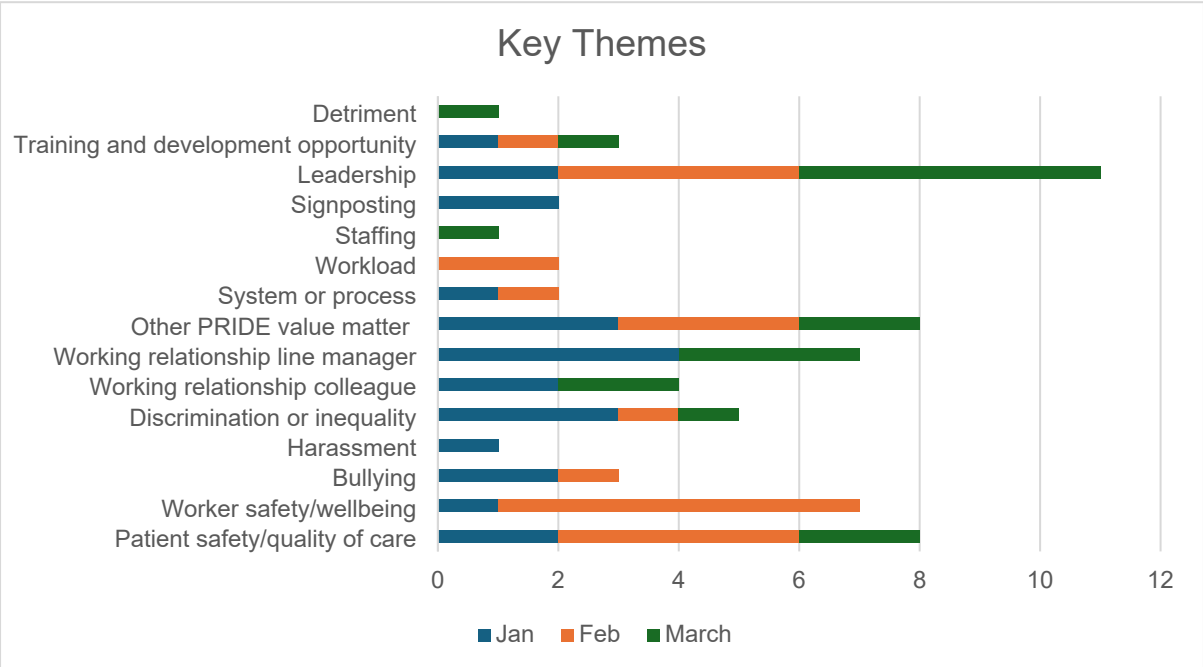


Fig 3.

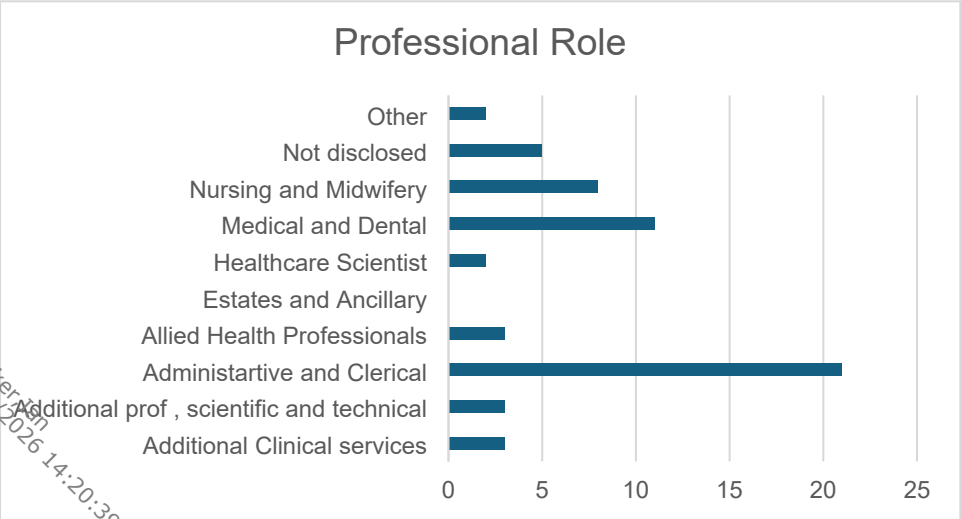


Fig 4.

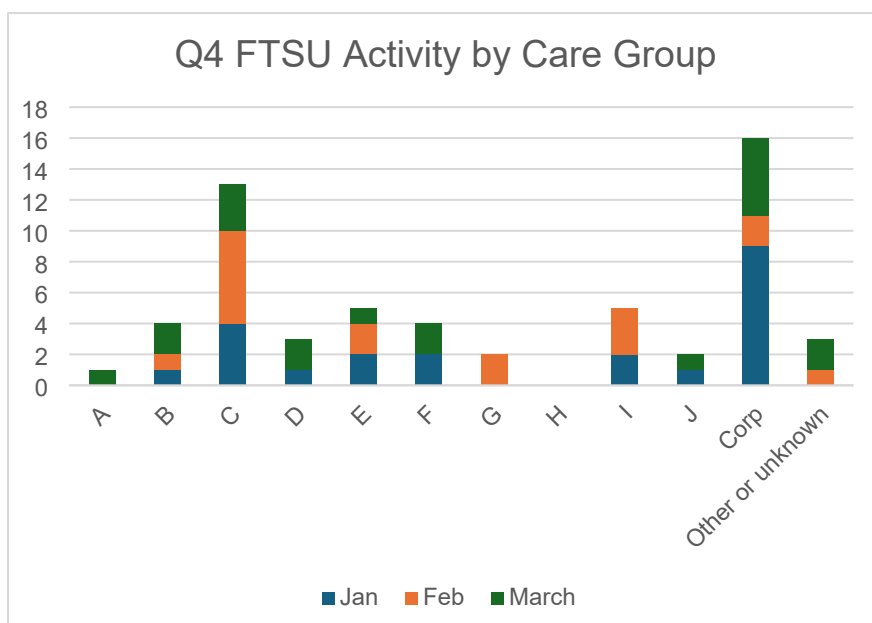


Fig 5.

Improving Speak Up Culture

Our ambition is to become an exemplar NHS organisation for speaking up. NNUH ranked 126 out of 134 in the *Raising Concerns* metric within the NHS Oversight Framework 2024, with an updated position awaited following publication of the 2025 NHS Staff Survey.

Encouragingly, staff survey results show improved scores in feeling safe to raise clinical concerns in all but two care groups and corporate services; however, this is offset by a more significant decline across all care groups and corporate services, in confidence that concerns would be addressed by the organisation if raised (Appendix I).

As most concerns are raised outside the FTSU service, it is essential that colleagues across NNUH recognise concerns early and understand their roles in fostering a healthy Speak Up culture. Although Speak Up training completion has increased since January, across all care groups, further improvement is needed to achieve sustained cultural impact (Appendix II).

Risk: Ongoing lack of confidence that concerns will be acted upon may further undermine Speak Up culture and introduce greater risks to safety and quality of care. Care groups are asked to consider whether alternative approaches, such as facilitated “Listen Up” training for larger groups of staff, may better support teams and whether this is a feasible option.

Conclusion

The FTSU service continues to provide a vital route for colleagues to raise concerns, with increased activity, strong KPI performance, and evidence of effective handling of sensitive matters. However, the ongoing decline in confidence that concerns will be addressed presents a clear cultural and patient safety risk that requires focused and sustained action.

Strengthening executive oversight, investing in impactful Speak Up training, particularly for line managers and ensuring organisational learning is consistently shared will be essential to rebuilding confidence and achieving NNUH’s ambition to become an exemplar organisation for speaking up. The recommendations set out in this paper provide a clear opportunity for the People and Culture Management Group to offer assurance, direction, and support for this critical agenda.

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Appendix I

Table 1. Feeling secure to raise a clinical concern. NNUH 2025 NHS staff survey findings.

Avg Acute %, % Scored Positively , 24 & 25 Diff

BY CARE GROUP, QUESTIONTEXT, PPELEMENTTHEME

Care Group	% Scored Positively	Avg Acute %	24 & 25 Diff
Care Group A			
We each have a voice that counts			
I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	68.4%	70.1%	0.1%
Care Group B			
We each have a voice that counts	60.4%	70.1%	2.2%
Care Group C			
We each have a voice that counts	68.1%	70.1%	2.3%
Care Group D			
We each have a voice that counts	75.1%	70.1%	-1.3%
Care Group E			
We each have a voice that counts	67.6%	70.1%	2.1%
Care Group F			
We each have a voice that counts	69.7%	70.1%	1.8%
Care Group G			
We each have a voice that counts	63.8%	70.1%	0.4%
Care Group H			
We each have a voice that counts	65.8%	70.1%	-0.7%
Care Group I			
We each have a voice that counts	75.5%	70.1%	1.5%
Care Group J			
We each have a voice that counts	68.3%	70.1%	0.4%
Corporate	55.5%	70.1%	-4.8%

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Table 2. Confidence in organisation to address matter raised. NNUH 2025 NHS staff survey.

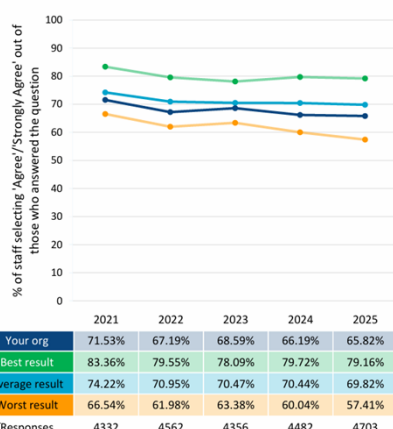
Avg Acute %, % Scored Positively , 24 & 25 Diff

BY CARE GROUP, QUESTIONTEXT, PPELEMENTTHEME

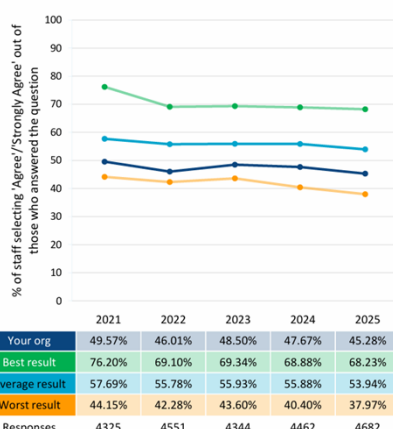
Care Group	% Scored Positively	Avg Acute %	24 & 25 Diff
Care Group A			
We each have a voice that counts If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	33.5%	46.6%	-4.9%
Care Group B			
We each have a voice that counts	24.6%	46.6%	-6.7%
Care Group C			
We each have a voice that counts	38.5%	46.6%	-1.5%
Care Group D			
We each have a voice that counts	36.5%	46.6%	-9.3%
Care Group E			
We each have a voice that counts	31.7%	46.6%	-2.3%
Care Group F			
We each have a voice that counts	26.3%	46.6%	-5.9%
Care Group G			
We each have a voice that counts	33.5%	46.6%	-0.1%
Care Group H			
We each have a voice that counts	37.8%	46.6%	-2.0%
Care Group I			
We each have a voice that counts	39.2%	46.6%	-3.0%
Care Group J			
We each have a voice that counts	39.6%	46.6%	-0.1%
Corporate	33.9%	46.6%	-8.9%



Q20a I would feel secure raising concerns about unsafe clinical practice.



Q20b I am confident that my organisation would address my concern.



Walker Ian
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Appendix II

Recorded completions of speak up training Feb 2026.

NB it is recognised this data is not exact, but it is sufficiently accurate to enable the NNUH to consider broad themes and track progress against actions.

Care Group Completions							
Care Group	000 Speak Up - core training for all workers	% Staff Group Completed Training	000 Listen Up - Training for all Managers	% Staff Group Completed Training	000 Follow Up - For Senior Managers	% Staff Group Completed Training	Headcount Sept 2025
234 Care Group A	76	6.6%	23	2.0%	8	0.7%	1154
234 Care Group B	30	5.0%	5	0.8%	0	0.0%	605
234 Care Group C	137	10.1%	25	1.8%	5	0.4%	1360
234 Care Group D	61	6.7%	14	1.5%	1	0.1%	912
234 Care Group E	147	10.6%	54	3.9%	2	0.1%	1386
234 Care Group F	163	29.4%	20	3.6%	5	0.9%	555
234 Care Group G	128	11.0%	12	1.0%	3	0.3%	1166
234 Care Group H	64	13.6%	1	0.2%	2	0.4%	469
234 Care Group I	48	12.0%	6	1.5%	1	0.2%	401
234 Care Group J	37	4.1%	4	0.4%	2	0.2%	902
234 Corporate Services	158	14.2%	35	3.1%	7	0.6%	1116
Total	1049	10.5%	199	2.0%	36	0.4%	10026

Care Group Totals Combined		
Care Group	Total	%Completed
234 Care Group A	107	9.3%
234 Care Group B	35	5.8%
234 Care Group C	167	12.3%
234 Care Group D	76	8.3%
234 Care Group E	203	14.6%
234 Care Group F	188	33.9%
234 Care Group G	143	12.3%
234 Care Group H	67	14.3%
234 Care Group I	55	13.7%
234 Care Group J	43	4.8%
234 Corporate Services	200	17.9%

Walker Ian
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Annual Report
1st April 2025 – 31st March 2026

Circulation:

Main point of contact

Deborah O'Hara – Director of People and Culture

Prepared by:
Jo Penniston
Guardian
The Guardian Service Ltd.

Date – 22/04/2026

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02/10/2026 14:20:39

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1. Executive summary

The Guardian Service Limited began providing the Freedom to Speak Up Service for James Paget University Hospital Trust on 1st May 2024.

Between the period of 1st April 2025 and 31st March 2026 112 concerns were raised by staff members.

The efforts by the Trust to help promote The Guardian Service, as well as colleagues sharing positive experiences and results of using the service, has contributed to the increased usage of this channel for speaking up.

43% of staff chose to speak to The Guardian Service because they wanted impartial support, 40% felt that they had raised the concern before and had not been listened to, 15% of staff were fearful of reprisal if they spoke up via other internal channels, and 2% felt that they wouldn't be listened to by using other internal channels.

Concerns received are recorded by GSL against specific themes which are Management Issues, System & Process, Bullying & Harassment, Discrimination & Inequality, Behaviour & Relationship, Patient Safety/Quality and Worker Safety and Sexual Misconduct

The top 3 job groups raising concerns were Nursing and Midwifery (44), Additional Clinical Services (18) and Admin and Clerical (17)

The 3 most common themes for new cases were Systems and Processes (36), Patient Safety/Quality (20) and Behaviour and Relationships (18)

It is important to note that there were cases recorded under other themes that had the potential to indirectly impact on the quality of patient care and safety.

Medicine and Surgery divisions have had the highest number of concerns. This should not be viewed negatively, but as encouragement that staff are comfortable to speak up.

(2) staff members reported that they suffered a detriment because of speaking up.

There are a number of recommendations detailed at the end of this report that the Trust is asked to consider. These relate to management training, processes and the Trust's action to concerns raised.

2. Purpose of the paper

This is an annual report to the Trust Board of Directors profiling the activities that have been carried out in the Trust as part of the Freedom to Speak Up (FTSU) work stream within the 2025/26 financial year, starting from 01 April 2025 and ending on 31st March 2026. The paper includes a thematic breakdown of concerns raised with the FTSU Guardian within the period, an analysis of case trends and data highlights to note from the National Guardian Office (NGO).

Data is provided in line with reporting guidance provided by the NGO. **Background to Freedom to Speak Up**

Following the Francis Inquiry¹ 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

¹ <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>

3. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the James Paget University Hospital as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in James Paget University Hospital Trust on 1st May 2024

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

4. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not JPUH employees and are external to the Trust.

5. Categorisation of Calls and Agreed Escalation Timescales

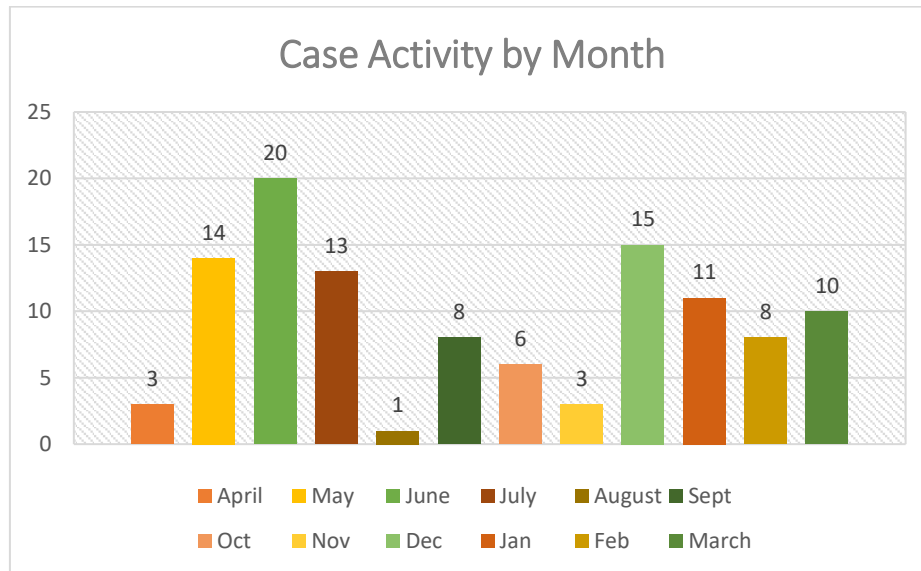
The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

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6. Number of concerns raised

Between 1st April 2025 and 31st March 2026 ,112 concerns were raised



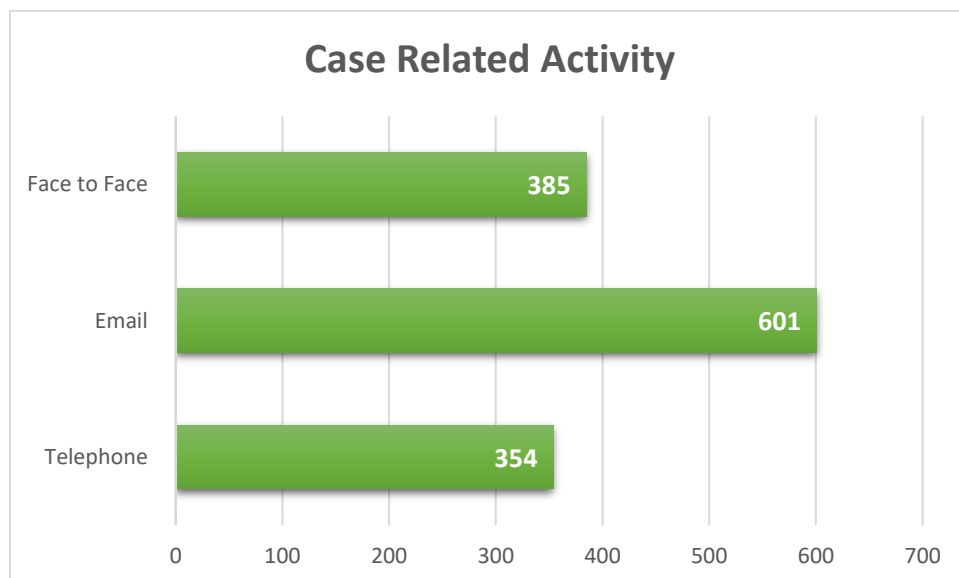
By the 31st of March 2026, 12 cases remained open and 100 have been closed.

Open cases are continually monitored, and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

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The number of emails, telephone calls (including text messages) and face to face visits engaged by the Guardians in responding to concerns are as follows:



There is often multiple contact points for every concern raised, therefore the numbers do not directly correlate with the number of concerns raised.

7. Confidentiality

The way in which cases are managed by The Guardian Service with respect to confidentiality and escalation routes is recorded cumulatively. A breakdown of this data covering the period of 1st April 2025 to 31st March 2026 is provided below.

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	31	28%
Permission to escalate with names	38	34%
Permission to escalate without name	37	33%
Permission to escalate anonymously	6	5%
Total	112	

Within this reporting period, 33% of staff members asked for their concern to be escalated without their name and 34% with their names. This pattern suggests that some staff may feel anxiety about speaking up, which can be influenced by factors such as previous experiences of not feeling listened to, concerns about potential detriment or reprisal, the impact of formal processes, and a lack of confidence that concerns will lead to meaningful change.

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8. Themes

Concerns raised are broken down into the following categories.

Theme	Total
A Patient and Service User Safety / Quality	20
B Management Issue	14
C System Process	36
D Bullying and Harassment	5
E Discrimination / Inequality	4
F Behavioural / Relationship	18
G Sexual Misconduct	1
H Other (Describe)	0
I Worker Safety	14
Grand Total	112

9. Assessment of Themes

System & Process

This was the highest reported concern with 36 concerns raised in relation to this theme. Examples as described by staff:

- Staff receiving little or no updates during formal processes
- Unfair Recruitment Processes
- Staff only getting rota a few days ahead and unable to plan life around work
- Changes being implemented without consultation of managers and staff

Patient Safety/Quality

20 concerns were raised in relation to this theme. Examples of concerns described by staff:

- Lack of staffing on wards effecting patient care and quality and staff safety
- Unsafe practices within a team
- Concern over patient and staff safety within a ward
- Length of time patients remain on waiting lists
- Level of acuity and dependency on the ward and ability to maintain patient safety and experience

Behavioural & Relationship

18 concerns were raised in relation to this theme. Examples as described by staff:

- Staff shouting and swearing at colleagues
- Staff and managers acting in a way that does not promote the Trust Values
- Managers displaying preferential treatment towards staff
- Low morale within teams due to workload

Bullying & Harassment

5 concerns were raised in relation to this theme. Examples of concerns described by staff

- Staff ignoring colleagues and refusing to engage in any conversation with them
- Staff being given unmanageable workload compared to their colleagues
- Open episodes of verbal abuse and sarcastic comments
- Repeated reminders of errors and providing feedback in a manner that is not constructive

Discrimination / Inequality

4 concerns were raised in relation to this theme. Examples concerns described by staff:

- Discrimination and lack of support due to long term health condition
- Shifts being withdrawn due to a period of sickness absence
- Inappropriate comments made about culture
- Unfair treatment regarding shift allocation

Worker Safety or Wellbeing

14 concerns were raised in relation to this theme.

The cases recorded under this theme included the following example concerns described by staff:

- Concern for staff wellbeing through burnout and exhaustion
- Inappropriate Sexual Behaviours
- Inappropriate text messaging from a colleague
- Negative experience and impact on Mental Health due to long formal process
- Concerns of constant work-related communications having a negative impact on wellbeing
- Concerns of a leaky roof and potential of water getting in electrics
- Concerns regarding behaviours of a male towards female colleagues

Sexual Misconduct

1 concern was raised in relation to this theme.

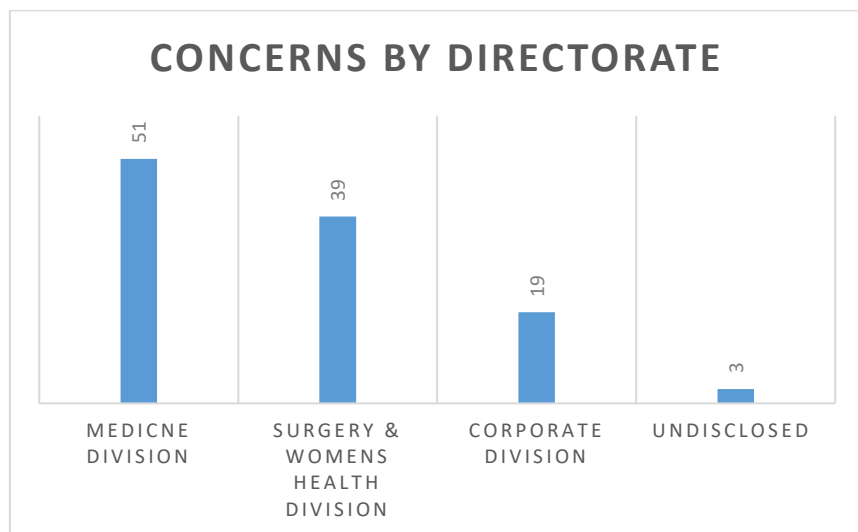
Concern of inappropriate language and touching from a male to female staff member

The Trust demonstrated effective arrangements for responding to concerns, with timely acknowledgment, proportionate action, appropriate escalation and senior oversight, providing assurance that risks were identified, managed and monitored appropriately.

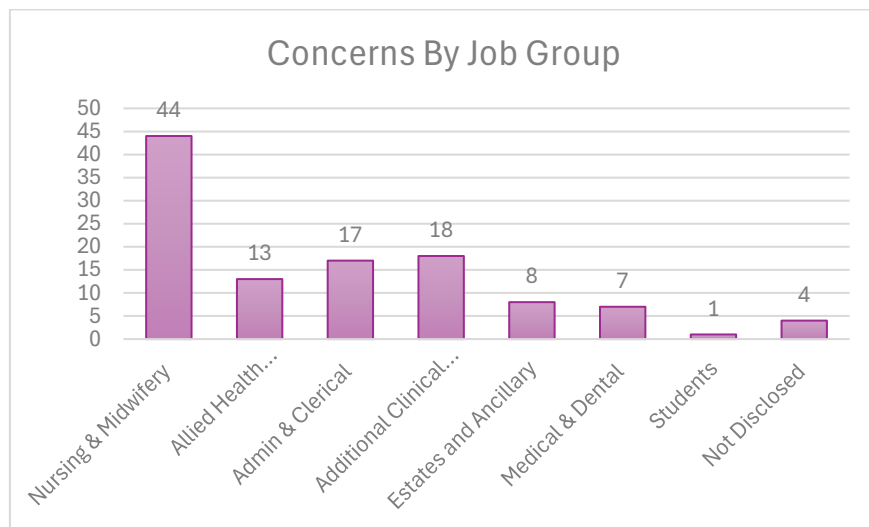
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10. Statistical Graphs

Concerns raised by Directorate



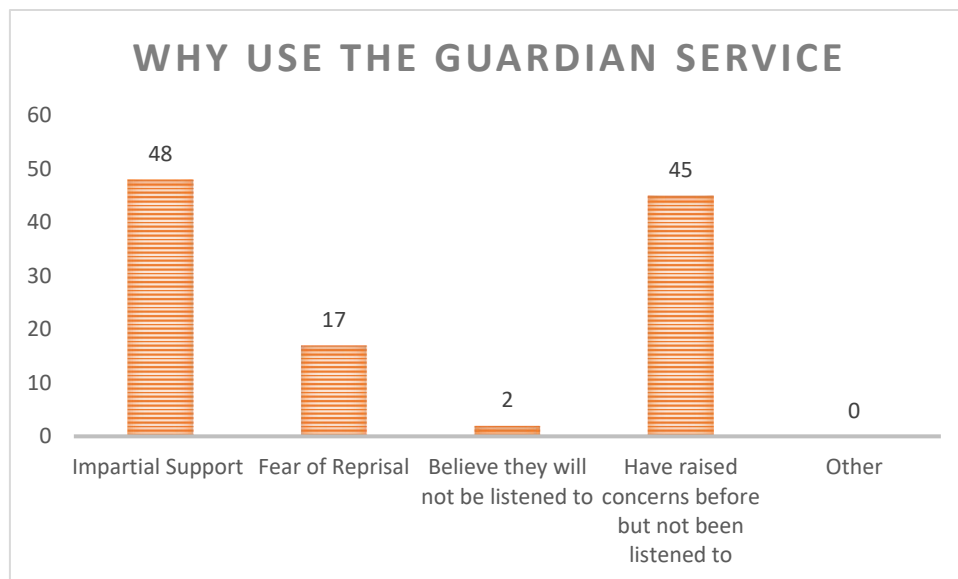
Concerns raised by Job Group



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11. Why do staff use The Guardian Service?

Staff who make contact with The Guardian Service are routinely asked why they chose this route to raise a concern. The responses provided are demonstrated in the chart below.



12. Detriment

During this reporting period, two staff members reported that they believe they have suffered detriment as a result of speaking up. In one case, the staff member has since left the Trust. The second case remains ongoing, with the staff member currently progressing a formal detriment claim.

Detriment remains a significant concern associated with speaking up and has a substantial influence on Freedom to Speak Up (FTSU) culture. The Guardian Service continues to encourage staff to speak up, while reinforcing the principle that individuals should not suffer any detriment as a result of doing so. The FTSU Guardian does not close cases without the agreement of the staff members and encourages ongoing communication throughout the case and following closure. Any perceived detriment is actively signposted to the Guardian for support and appropriate action.

13. Action taken to improve the Freedom to Speak Up Culture

- **Monthly meetings with the Director of People & Culture and Head of HR** to review Freedom to Speak Up activity, including themes and case outcomes. Discussions are conducted at a thematic level to maintain staff confidentiality.
- **Regular meetings with the FTSU Non-Executive Director (NED)** to review activity, themes and outcomes, with discussions anonymised to protect confidentiality. Following the appointment of the new Group NED, this oversight will continue on a quarterly basis.
- **Monthly attendance at the People and Culture Management Group**, providing a summary of Freedom to Speak Up activity and emerging themes. All discussions are anonymised to maintain confidentiality.
- **Bi-monthly walkarounds with the FTSU NED** to target hotspot areas and engage directly with staff to promote speaking up, with arrangements in place to continue this engagement following the appointment of the Group NED.

- **Quarterly meetings with the Executive Managing Director** to discuss emerging themes, learning points and areas for organisational improvement.
- **Proactive staff engagement activities**, including walkabouts across wards, sites and offices, distribution of promotional materials, team briefings and attendance at meetings, both in person and via Teams, to increase awareness of the Guardian Service and encourage speaking up.
- **Attendance at staff induction sessions**, both virtually and in person, to introduce new starters to the Guardian Service and Freedom to Speak Up arrangements.
- **A total of 116 engagement visits** (in person and via Teams) were undertaken by the Guardian between 1 April 2025 and 31 March 2026, with ongoing visits continuing.
- **Engagement with the National Guardian Office (NGO)** through attendance at Eastern regional meetings, workshops, events and conferences, supported by regular NGO bulletins, ensuring practice remains up to date and aligned with national guidance.
- **Ongoing professional development**, including annual refresher training provided by the NGO, to ensure best practice and awareness of changes within the Freedom to Speak Up landscape.
- **Mental Health First Aid capability**, enabling the Guardian to recognise signs of poor mental health and appropriately signpost staff to relevant support services.
- **Structured support for staff raising concerns**, promoting early and informal resolution through facilitated discussions, peer support and guidance on communication and meeting preparation, reducing reliance on formal grievance procedures where possible.

14. Learning and Improvements

There are cases where staff did not wish to escalate issues through GSL. Reasons for this are more complex than they appear as each person has different reasons for speaking to a Guardian. Staff conversations with the Guardians indicate work could be undertaken by the organisation to try and understand why employees feel they cannot escalate an issue internally and what the organisation could do to remove barriers to speaking up.

Some staff choose to speak up through the Guardian because they have previously raised concerns but felt they were not listened to and, in some cases, fear reprisal. Confidence in speaking up can be strengthened by promoting positive staff experiences across all available speaking up routes within JPUH. Consideration could be given to sharing anonymised case studies to demonstrate how concerns have been effectively addressed, helping staff feel more confident and reassured about raising issues.

There are staff at all levels of the organisation who are experiencing challenges, including the impact of low staffing levels, strained working relationships, and burnout or exhaustion. Consideration could be given to how JPUH identifies staff who may be struggling and ensures appropriate, timely support is in place to meet their needs.

Poor communication is a key barrier to identifying staff wellbeing concerns. Experience from the Guardian Service indicates that proactive engagement, encouragement and support can enable staff to speak up, as reflected in the number of concerns raised following direct contact with the service.

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15. Comments & Recommendations

The Trust is commended for the increasing confidence of staff to speak up, the high level of engagement with the Guardian Service, and the consistently positive feedback from staff who report feeling listened to, supported, and reassured through an independent route.

To further strengthen an open, transparent and learning culture, the Trust is asked to consider the following actions:

1. **Leadership and Culture**

Continue to reinforce visible leadership commitment to Freedom to Speak Up, ensuring leaders and managers role-model openness, listen actively to concerns, and respond in line with Trust values.

2. **Management Capability and Capacity**

Further develop management confidence and capability through mandatory NGO *Speaking Up, Listening Up, Follow Up* training and targeted support for managers handling concerns and sensitive conversations.

3. **Freedom from Detriment**

Maintain clear assurance that staff will not suffer detriment as a result of speaking up, with ongoing Board-level oversight of detriment themes and proactive support for staff where concerns are identified.

4. **Learning, Improvement and Feedback**

Use intelligence from speaking up themes to inform organisational learning and improvement, particularly around systems, processes and communication, and ensure feedback is provided to staff wherever possible.

5. **Staff Engagement and Wellbeing**

Continue to prioritise staff wellbeing and psychological safety, particularly for those involved in formal processes, with timely access to support and appropriate aftercare.

These actions will support the Trust in demonstrating strong, compassionate leadership; an inclusive and learning culture; effective governance; and a continued commitment to listening to staff and acting on their concerns, in line with CQC Well-Led expectations

16. Staff Feedback

Feedback received from staff who have accessed the Guardian Service has been consistently positive. Staff report feeling listened to, supported and reassured throughout the process, with particular value placed on the Guardian's independence, professionalism and ongoing communication. The feedback highlights the importance of the service in helping staff feel safe to speak up, explore options openly, and raise concerns with confidence.

- I felt listened to and despite my worries about any effect my contact with the service would have on me personally, I was reassured it wouldn't
- I think it is important to ensure that staff can feel confident to speak up about concerns in the workplace.
- The Guardian was brilliant. She was kind, professional, understanding and knowledgeable. The Guardian took quick action and kept me informed throughout the entire process.
- I believe this a very important and valuable resource to have within the Trust. It allows fairness, safe environment for people to be able to discuss and raise concerns.

- The Guardian listened to me, and I felt very much supported. The Guardian contacted me regularly to check in, which I really appreciated and I felt heard.
- I felt comfortable throughout and reassured.
- This is the second time I have contacted The Guardian and they dealt with my concern promptly. They kept me updated regularly and I can't thank them enough.
- Felt safe and respected the entire process
- It was very helpful and a positive way of discussing issues. The Guardian discussed all options available equally and fairly, making sure I knew it was my decision.
- I have gone on to recommend the service to colleagues within our department and in other departments as a way to voice concerns and get appropriate help to find solutions.
- Nothing was too much trouble for The Guardian; they went above and beyond to help and support me. I will be forever grateful for their support at this time.
- The Guardian was absolutely crucial when we raised our concerns, very empathetic without taking sides. Thank you.
- The Guardian was amazing throughout at making me feel comfortable and able to speak freely. I would even say they go above and beyond within their role :-)
- I have already recommended the Guardian service to a colleague who confided in me with an issue within the workplace.

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Report to the People & Culture Management Group updated Thursday, 14 May 2026

Title:	Freedom to Speak Up - Annual Overview 2025-26	
Author:	Keighley Evans	
Sponsor	John Syson, Director of People	
Previous scrutiny:	People & Culture Management Group	
Purpose:	The paper is presented for Discussion	
Relevant strategic themes:	☐ 1. Quality & Safety	☐ 2. Operational Performance
	☐ 3. Financial Sustainability	☒ 4. Workforce Wellbeing
Impact assessments:	☐ Quality	☐ Equality
	☐ GDPR and DPA	☒ Not applicable

Executive Summary

2025–26 has been a year of transition for the Freedom to Speak Up service. Sustained demand, rising case volumes in the second half of the year and significant changes to the team have all tested the resilience of a function operating at reduced capacity. That the service has remained accessible and responsive throughout is a credit to everyone involved.

134 cases were recorded across the year, rising steadily from 26 in Q1 to 45 in Q4. Worker safety and wellbeing remained the dominant theme throughout, with bullying, harassment and patient safety concerns increasing notably in the second half. When adjusted for capacity, overall activity is broadly proportionate to 2024–25, demonstrating sustained demand and complexity despite reduced resource.

This paper reflects on the year as a whole and closes with themes for the group's consideration.

Purpose of the Report

To provide an annual overview of the Freedom to Speak Up service for 2025–26, drawing together case volumes, themes and key observations from across all four quarters. The paper is presented for Discussion.

Background

The Freedom to Speak Up service supports all NHS workers employed by or working on behalf of the Trust, promoting safe practice, fairness, staff wellbeing and organisational learning. All contacts are logged regardless of whether action is required, and the service aims to acknowledge all contacts within 48 hours. Concerns are received via email, telephone, MS Forms, in-person conversations and referrals from FTSU Champions.

2025–26 saw significant change in the staffing of the service. The Independent FTSU Guardian, Vivien John, retired in October 2025 following 2.5 years in post. Keighley Evans joined on a six-month internal secondment from October 2025, operating at 15 hours per week, compared to the full-time lead, part-time colleague and independent Guardian that had supported the service in 2024–25. Jenifer Saravanan joined as a full-time assistant in March 2026, providing additional capacity during a particularly active final quarter. Keighley Evans concludes her secondment at the end of April 2026.

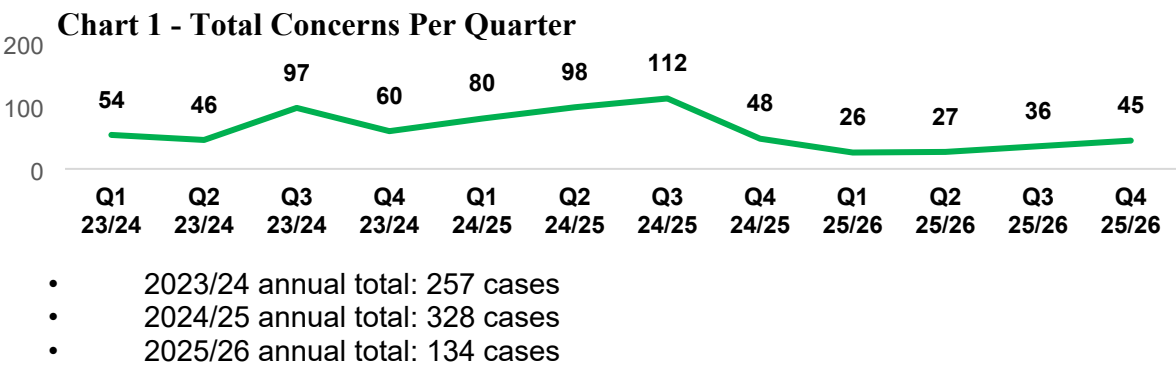
The 14 FTSU Champions remain in post, providing local visibility and signposting alongside their substantive roles.

Main Content of the Report

The following section draws together the full picture of FTSU activity across 2025–26, covering case volumes, the nature and outcomes of concerns raised, the divisional spread and the key themes emerging from a year of practice. Taken together, this data tells a consistent story about the experience of staff who speak up and the conditions that either support or complicate that process.

Case Volumes

Case volumes rose consistently across the year:



There were significantly higher headline volumes in 2024–25, when the service was more substantially resourced. Adjusted for capacity, the picture is broadly proportionate, reflecting sustained demand throughout the year.

Type and Outcome of Cases

Across the year, cases resulted in three categories of outcome. Escalation, where the Guardian acted directly on behalf of the individual. This accounted for the largest share in most quarters. Guidance, where individuals were supported to progress matters themselves, accounted for a consistent proportion. And a smaller number required no action, most often where individuals sought pastoral support or simply needed to be heard.

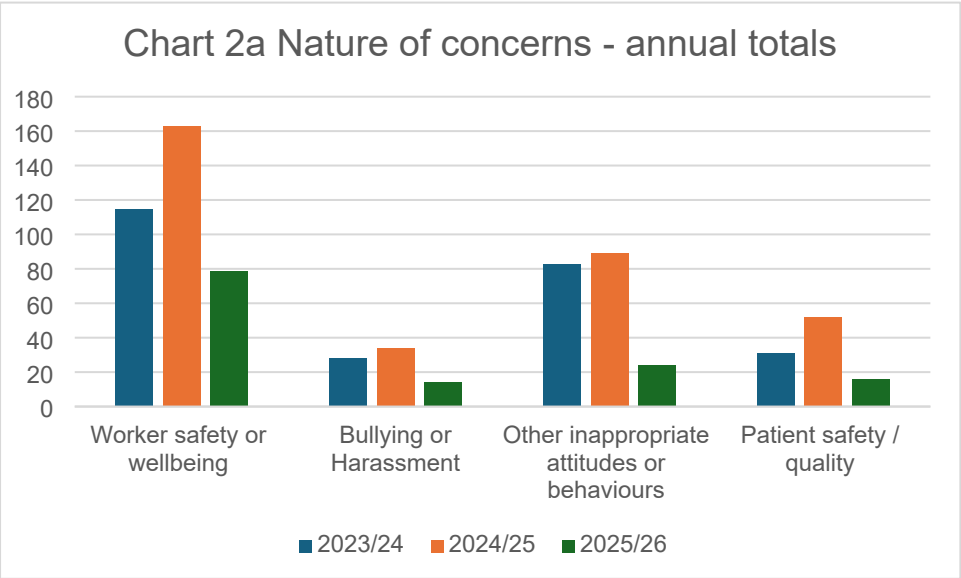
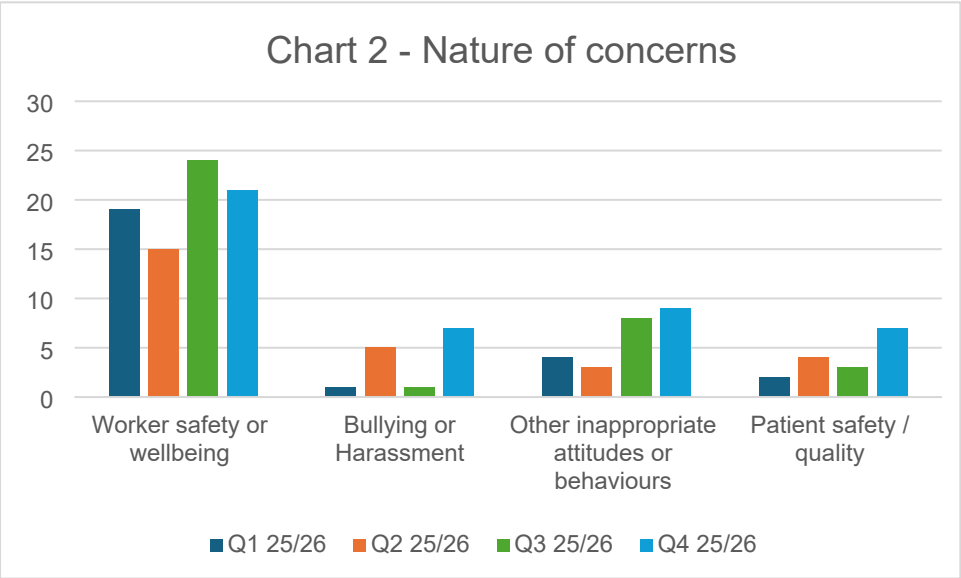
The majority of individuals contacting FTSU had already engaged with line management, senior managers, HR or formal processes before approaching the service. This pattern was consistent across all four quarters and reinforces FTSU’s role as a complementary support function, particularly where processes feel prolonged or difficult to navigate.

Nature of Concerns

Concerns are categorised according to guidance from the National Guardian’s Office. The four headings are: working safety and wellbeing; bullying or harassment; other inappropriate attitudes or behaviours; patient safety/quality. Each case is allocated a category by ‘best fit’ principles; it is acknowledged that there are limitations to this approach.

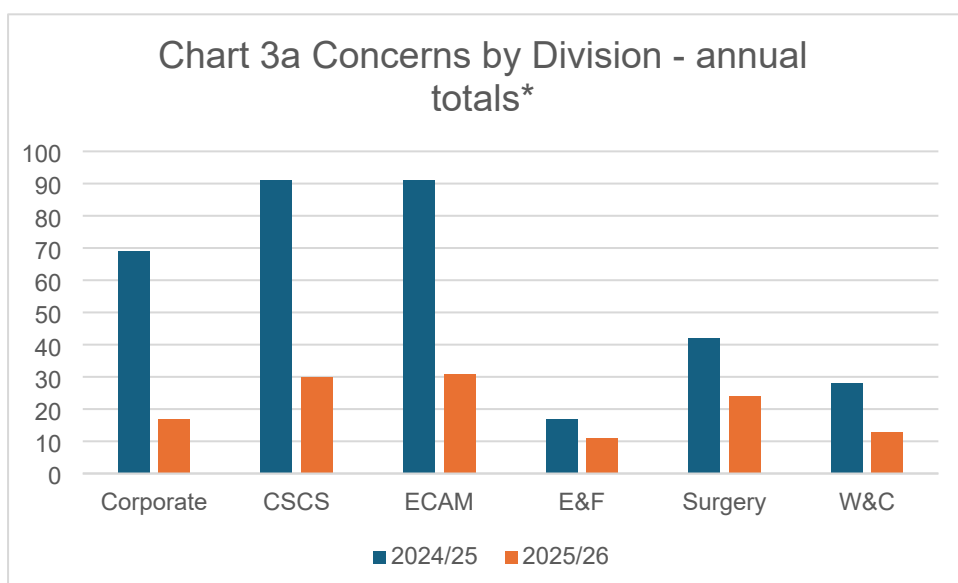
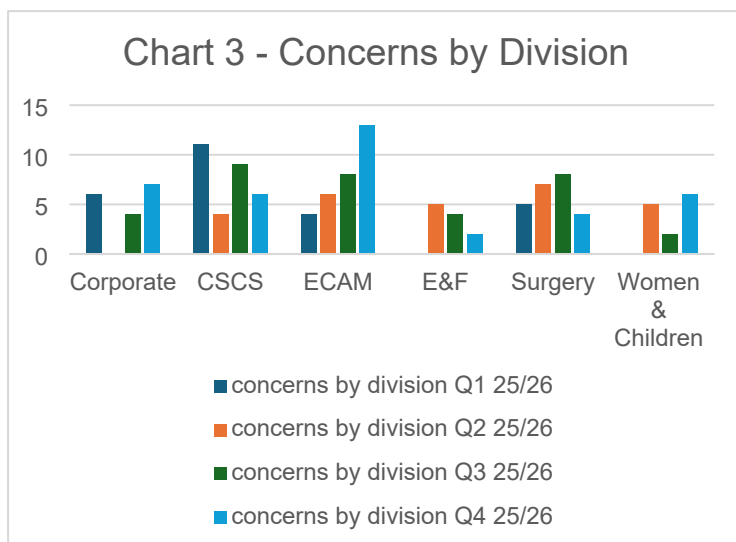
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Worker safety and wellbeing was the predominant category in every quarter, accounting for 79 of the 134 cases recorded across the year. Bullying and harassment increased notably in the second half, with Q4 seeing the most significant rise, including three anonymous cases raising concerns about racial discrimination within a single division, consistent with themes first identified in Q2. Patient safety concerns also increased in Q4, with seven cases relating to staffing levels, clinical decision-making and delays in investigation outcomes, all of which were escalated appropriately.



Divisional Picture

Cases were recorded across all divisions throughout the year. ECAM recorded the highest annual volume at 31 cases, closely followed by Clinical Support and Cancer Services at 30. Women and Children saw a marked increase in Q4 compared to earlier in the year. The spread across all divisions continues to suggest that the themes emerging from 2025–26 are organisation-wide rather than concentrated in any single area.



*Data for 2023/24 not included in Chart 3a due to rearrangement of Divisions

Key Themes

Impact of HR and management processes

The most persistent theme across all four quarters has been the experience of being in an HR or management process. Staff are not predominantly saying that processes have been handled wrongly. What they describe is the experience of the process itself, the silence, the uncertainty, the wait, as deeply distressing in its own right. FTSU involvement has consistently focused on supporting individuals to navigate processes, understand their options and ensure their concerns are heard. The Guardian has met regularly with the HR Director, the Culture and Engagement Business Partner and the Psychological Safety team to share insights and identify opportunities for improvement.

Wellbeing and psychological safety

Across all quarters, individuals described a significant impact on their personal wellbeing, including stress, anxiety and reduced confidence. FTSU has provided a neutral, supportive

space throughout, helping staff to feel heard while formal processes continue. The service has worked in collaboration with the Psychological Team and Culture and Engagement colleagues to strengthen the conditions for psychological safety across the organisation.

Communication and clarity

A recurring driver of distress across the year has been poor communication and unclear timelines within formal processes. Where realistic expectations are not set and updates are not provided, uncertainty escalates.

Dignity at work and speaking up culture

The rise in bullying, harassment and discrimination concerns in the second half of the year reflects something that case numbers alone do not fully capture. Individuals raising these concerns frequently felt uncertain about whether speaking up would improve their situation or make it worse. Building genuine confidence that concerns will be taken seriously, and that there will be no detriment for raising them, remains one of the most important foundations for a healthy speaking up culture.

Conclusion

The FTSU service remained accessible and responsive throughout 2025–26 despite operating at significantly reduced capacity for the majority of the year. Rising case volumes across the four quarters reflect growing trust in the service as much as growing concern and that is a positive development. Seven cases remain open at the close of Q4 and will carry forward into Q1 2026–27.

The themes emerging from this year, HR process transparency, psychological safety, communication and dignity at work are consistent, cross-divisional and warrant ongoing attention. The service alone cannot resolve them, but it has an important role in surfacing them and in supporting the organisation to respond.

Reasonable assurance: the service is functioning and demand is being met, but reduced capacity, rising case volumes and unresolved themes around culture and HR process mean full assurance cannot be provided at this time.

Recommendations

The People & Culture Management Group is asked to:

- Reflect on the four themes identified (HR process experience, wellbeing and psychological safety, communication, and dignity at work) and consider whether any further organisational action or focus is warranted.

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**NORFOLK AND WAVENEY
UNIVERSITY HOSPITALS GROUP**

**GROUP BOARD MEETING IN PUBLIC:
7 OCTOBER 2026**

**SUPPLEMENTARY PAPERS
FOR AGENDA ITEM 15**

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Provider capability self-assessment template 2026: Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to their regional oversight lead by **5pm Friday October 2**.

I. Strategy, leadership and planning

Capability statements	Proposed domain rating
	Amber-Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	The Trust has a five-year strategy in place – Caring with Pride. The strategy, published in 2022 sets out five strategic commitments and priorities, underpinned by the Trust's PRIDE values. The Norfolk and Waveney University Hospitals Group (NWUHG) is currently developing a clinical strategy, working with teams across all Trusts and health system partners. This will be in place when the Caring with Pride strategy concludes in 2027. The priorities included in the Trust's strategy are reflected in the Medium-term Plan which has been developed in alignment with system priorities and is supported by the Norfolk and Suffolk Integrated Care Board (ICB) and accepted by NHS England (NHSE). This includes alignment of financial and capital planning. Further to the Medium-term Plan, the NWUHG is overseeing the One Recovery Transformation Programme which is aligned with the Medium-term Plan and reflects the ICB investment priorities. The Trust's plans reflect its current role and strengths within the local healthcare economy, while recognising that these will continue to evolve through the development of the NWUHG clinical strategy. Transformation priorities are increasingly being aligned across the Group and with wider system objectives, including improvements in urgent and emergency care, flow, admission avoidance and the shift of care closer to home.

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2. If in breach of licence: The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	The Trust holds a valid NHS provider licence and there is no current enforcement action or discretionary requirements listed against the Trust
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	All Board positions are filled substantively through the Group Board structure with the exception of the Group Chair which is currently appointed to on an interim basis. A recruitment exercise to appoint a substantive Group Chair is underway and due to complete in December 2026. Three additional Group Non-Executive Directors (NED) and two Group Associate NEDs were recruited in summer 2026 to increase NED capacity and skills. Link NEDs have been assigned to each Trust. NNUH has site level management, assurance and escalation arrangements within the Group structure, and the Group Board receives NNUH specific information to exercise oversight of NNUH as a statutory organisation. Clear accountabilities and responsibilities are in place for the key areas of Trust operations, including quality, access and delivery, operational planning and finance. Each domain is overseen through defined monthly management groups operating to agreed terms of reference, with formal routes for assurance and escalation through to the Group Board. There is a formal performance and accountability framework that sets out escalation and 'Group step in arrangements' in the event of underperformance.
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and	The former Norfolk Acute Provider Collaborative has developed into the Norfolk and Waveney University Hospitals Group (NWUHG), bringing NNUH, The James Paget University Hospital (JPUH) and The Queen Elizabeth Hospital King's Lynn (QEHKL) together to address common challenges, reduce unwarranted variation and make more effective use of workforce, digital infrastructure and other resources. Collaborative work includes the development of a Group clinical strategy, transformation of corporate services, implementation of a shared Electronic Patient Record (EPR), development of two new acute hospitals (under

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population served	the national New Hospital Programme) and development of integrated clinical services. The Trust also works actively with wider system partners through the ICB, urgent care arrangements, Place and Health and Wellbeing partnerships. Examples of collaborative delivery include integrated clinical services between NWUHG Trusts (Audiology, Ear Nose and Throat (ENT), General Surgery, Gynaecology, Oncology and Urology), and collaborations with community partners including virtual wards, domiciliary support following discharge, GP streaming and community palliative care. System working has also supported admission avoidance, Discharge to Assess and integrated intermediate care, including streamlined referral processes and Trusted Assessment arrangements designed to reduce duplication and improve discharge pathways. The Trust is re-establishing a Central Place Board which will operate in shadow form from October 2026. The Trust has participated in a system programme of engagement which has facilitated the development of a neighbourhood health model for Norfolk and Waveney. NWUHG is positioning itself to fully embrace a “Neighbourhood Max” approach, making neighbourhood health the organising principle for future service transformation, clinical strategy, estate planning, digital development and system partnership. The approach aligns with national policy, ICB priorities and the wider shift towards prevention, proactive care and care delivered closer to home.
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	The NWUHG Digital Strategy has been developed as a single strategy across the Group and is aligned with both local and national digital priorities. A single Digital Team is being put in place across the Group. The Digital Strategy includes alignment with the What Good Looks Like framework, the Data Security and Protection Toolkit (DSPT), national data and digital strategies and the requirements of the New Hospital Programme. The strategy supports coordinated digital transformation across NNUH, JPUH and QEH, including digital maturity assessment and major shared digital enablers such as the EPR and Federated Data Platform.

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	The Group has a cyber security strategy, and assurance is sought through the Group Board's Strategy, Technology, Investments and Partnerships (STIP) Committee. There is a specific cyber security risk on the Group Board Assurance Framework (BAF). The cyber security strategy identifies the scale of investment needed to remediate the cyber security position. A cyber task force is in place to oversee delivery by December 2026 of a remediation plan to address the UK Network and Information Systems (NIS) Improvement Notice issued to NNUH.
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II. Quality of care

Capability statements	Proposed domain rating
	Amber-Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	The Trust has implemented the NHSE Patient Safety Incident Response Framework (PSIRF), with a strong focus on proportionate learning responses and meaningful patient and family engagement. Patient safety incidents are recorded on InPhase and reviewed within Care Groups, with significant or complex events escalated for multidisciplinary review. The Trust's Patient Safety Incident Response Plan sets out the Trust's approach in responding to, reviewing and learning from patient safety events. The Trust also considers learning and guidance arising externally from relevant regulatory bodies including the Care Quality Commission (CQC). National patient safety alerts and learning from other sources such as the Health Services Safety Investigations Body (HSSIB) are reviewed and disseminated, and services have been reviewed against learning arising from significant national investigations and inquiries, including the Ockenden and Fuller inquiries. This is managed through established governance processes with any areas for improvement embedded in practice. Complaints, clinical audit, mortality and other quality intelligence are similarly incorporated within the Trust's assurance arrangements. These data points are triangulated through our Management Meetings. An internal audit of complaints completed in August 2025 provided a Reasonable Assurance opinion.
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of	Quality and safety performance is reported through the Trust Integrated Performance Report (IPR), incorporating measures including falls, hospital-acquired pressure ulcers, safer staffing, infection prevention and control, cleanliness, complaints, compliments and patient experience. The quality and safety elements of the IPR is reviewed in the Quality, Safety and Patient Experience (QSEMG) Management Group in detail, and with the full IPR at the Hospital Management Group (HMG). HMG reports to the Group Executive and Group Board committees. This includes the Trust IPR which is reported to the Group Board as part of the Group IPR, combined

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healthcare provided to its patients	with the IPR data from QEH and JPUH. The Group Board is a committee-in-common which functions as the Trust Board for all three hospitals in the Group. The Group Board has established a Quality and Outcomes Committee which meets monthly to provide NED-led challenge and seek assurance in respect of the quality of care provided across the Trusts within the Group. At a more granular level in NNUH, quality and safety information is reviewed through monthly Care Group performance arrangements, with Care Groups receiving an assurance assessment and will develop improvement plans where required. The Trust has 10 Care Groups providing leadership, oversight and accountability for all clinical and clinical support services. The Care Groups are led by multi-disciplinary leadership teams, comprising medical, nursing (or midwifery or AHP) and operational roles. For perinatal services, there is an Obstetric lead and a Paediatric lead. As part of the Trust's governance framework, the Trust has a dedicated Evidence Group focused on regulatory compliance and delivery of our quality priorities. Outcomes and escalations are reported through the Quality, Safety & Effectiveness Management Group, with exceptions escalated to the Hospital Management Group and to the Group Risk Assurance Committee. Reports from the Quality, Safety and Effectiveness Management Group are also received by the Group Board's Quality and Outcomes Committee. Specialist teams including Tissue Viability, Falls, VTE and Patient Safety contribute directly to this assurance framework. Patient safety incidents recorded in InPhase are reviewed daily within Care Groups to determine the appropriate learning response, with cases requiring broader oversight referred to the weekly Complex Case Review Group. The forum considers the required learning response, immediate actions and support required for patients, families and staff. Continuous improvement is supported through the Quality, Service Improvement and Redesign (QSIR) methodology and associated training. Improvement projects are increasingly being captured through
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	InPhase, with further development of oversight and dashboard functionality planned. The Trust sets an annual clinical audit programme, and delivery of this is overseen by the Quality & Safety Effectiveness Management Group. The Trust has also introduced a new risk management model, including a 5+5+5 methodology which provides greater emphasis on the effectiveness of controls when assessing and managing risk.
8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	The Trust triangulates quantitative and qualitative patient experience information to provide oversight of emerging themes and concerns. Monthly reporting to the Patient Experience and Engagement Group includes PALS activity, complaints, Friends and Family Test response rates and scores, compliments and narrative on the principal issues being raised by patients. This is supplemented by patient stories, national patient surveys including inpatient, maternity, cancer and children and young people surveys, PLACE results and other patient experience intelligence. The Patient Experience and Engagement Group reports to the Quality, Safety and Effectiveness Management Group. Service users are directly involved in quality assessment and improvement through the established Patient Panel, whose members participate in Care Assurance visits, PLACE assessments, service improvement work and key governance forums. Further involvement is provided through groups representing maternity service users, carers, veterans and children and young people, alongside Governors and external partners including Healthwatch Norfolk. Processes are in place for the management of complaints and escalation of serious or recurring concerns through the Trust's governance arrangements. Patient experience themes and resulting improvement actions, including "you said, we did" actions, are reported through quality governance. The Trust regularly reviews these processes and is actively strengthening them. In addition to the Quality and Outcomes Committee referenced above, Link NEDs meet regularly with the Trust's Executive Managing Director and Lead Governor and undertake visits to wards, services and departments

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	to support the triangulation of information on quality and safety. Patient stories are presented at the Group Board.
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III. People and culture

Capability statements	Proposed domain rating
	Amber-Green
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	The Trust uses a range of mechanisms to understand staff experience and identify opportunities for improvement, including the national NHS Staff Survey, local Pulse surveys, Freedom to Speak Up (FTSU) information and workforce equality information including Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reporting. This information is considered through the Trust's People and Culture Management Group (PCMG) and is supplemented by direct engagement with staff. PCMG reports to the Hospital Management Group (HMG), which triangulates information from quality and safety, and finance and performance. HMG reports to the Group Executive and Group Board Committees. The IPR includes a dedicated section on staff information and metrics. This is received by the Group Board at each meeting as part of a combined Group IPR with the other two Trusts. The Group Board's Group Risk Assurance Committee oversees workforce risks escalated through the Group's risk-based assurance model. The Board receives updates on the staff survey results and programmes to improve workforce engagement, including '18,000 Voices' as part of the One Recovery Programme. Staff are able to contribute through a range of established forums including the Resident Doctors Forum, Consultant Staff Committee, Staff Council, Joint Staff Consultative Committee, staff networks, Shared Council and staff Governor engagement. There is evidence that staff feedback has resulted in organisational change, including review and amendment of the Health and Wellbeing Policy and Civility and Respect Policy and action taken in

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	response to Resident Doctor feedback. These arrangements provide mechanisms for staff feedback to influence both staff experience and wider organisational improvement.
10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	The Trust maintains arrangements for mandatory training, Personal Development Reviews and wider continuing professional development (CPD) and professional training. Compliance with mandatory training and associated workforce measures is monitored through the Integrated Performance Report and the People and Culture Management Group (described above), enabling areas of concern or non-compliance to be identified and addressed. The Trust sets and regularly reviews staffing establishments for its services. Corrective actions are taken as required to ensure capacity is available for staff. These arrangements are supported by the wider range of training, CPD opportunities including Group wide initiatives such as the newly implemented Vanderbilt Professionalism and Accountability framework and the Proud to be Ops programme. The site leadership team have an externally facilitated development programme which encompasses the wider hospital leadership and care group teams.
11. Staff can express concerns in an open and constructive environment	The Trust encourages staff to raise concerns directly with their line manager where they are comfortable to do so, and the leadership team hold regular 'Connected' briefings that allow staff to raise concerns in an open, all Trust forum which are responded to by the leadership team. Dedicated Q&A Connected sessions have been scheduled to allow more time for this. The Trust has also implemented 'Coffee & Conversation' events where members of staff can meet with the senior leadership team to discuss concerns. The Trust also has established FTSU arrangements through which staff can raise concerns, including routes that enable concerns to be raised anonymously. Information on the available routes is accessible to staff through the intranet, and Resident Doctors also have a dedicated mechanism for raising concerns through the postgraduate medical education arrangements. FTSU intelligence is reported through People and Culture governance and to the Board and is considered

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	alongside information from the Staff Survey, Pulse surveys and other staff feedback. The FTSU Guardian has regular meetings with the Executive Managing Director to discuss anonymised case data and any emerging themes or urgent concerns. The Trust has strengthened the feedback loop following concerns being raised, particularly by ensuring that actions agreed through FTSU reporting are routinely updated and reported back through the People and Culture Management Group. Work in this area is intended to provide clearer assurance both to individuals who speak up and to the wider workforce that concerns lead to visible action and learning. There is a Group NED champion for Freedom to Speak Up who meets regularly with the Freedom to Speak Up Guardian and workforce leads.
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IV. Access and delivery of services

Capability statements	Proposed domain rating
	Amber-Green
12. Plans are in place to improve performance against the relevant access and waiting times standards	Performance against national access standards is subject to established operational and Board oversight. Care Groups present performance through monthly Delivery Oversight arrangements, supported by the Trust-wide Delivery Dashboard. Where areas are off trajectory, oversight is increased and specialty-level Performance Check and Challenge meetings are used to understand the causes of variance and agree improvement action. Performance and recovery plans are reported through the Finance and Performance Management Group (FPMG) to the Hospital Management Group (HMG) which triangulates this with quality and safety, and people and culture information. HMG reports to the Group Risk Assurance Committee and the Group Board, including through the IPR and the Group's One Recovery programme. Additional oversight and support are provided by the NHSE tiering programme for Elective and Diagnostics.

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	The Trust has a range of programmes in place to support recovery. The multiyear One Recovery programme supports delivery of the Medium-term Plan, which aims progressively to return performance metrics towards national standards. Improvement plans are tracked through Trust-wide and Care Group delivery dashboards, supported by programmes including the Patient Value work in outpatients and theatres, national Further Faster workstreams and the NNUH GIRFT Board. The Trust also participates in system and national improvement activity, including elective improvement and urgent and emergency care programmes.
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	The Trust is developing its ability to identify and respond to inequalities in access and outcomes. Waiting-list outcomes, including waiting-list harm, are monitored in relation to any variations in care related to deprivation, and Core20PLUS5 champions have been identified with individual work programmes. The Trust is also strengthening its data capability to support more detailed analysis of inequalities, including enhanced capture and use of Index of Multiple Deprivation information, with further opportunities expected through implementation of the EPR. This remains an area in development, with further work required to demonstrate consistently how identified variation is translated into measurable improvement.
14. Appropriate population health targets have been agreed with the ICB	There are established links between population-health priorities and a number of Trust services. Examples include the Older People's Emergency Department/Frailty Hub and associated frailty services, development of maternity services in response to population need, and specialty involvement in community-focused COPD/respiratory, heart failure and frailty pathways. Work is also underway to enhance end-of-life pathways. The Trust has recognised the need to broaden understanding and engagement with population-health objectives across the organisation. Engagement with primary care has commenced to support closer alignment of acute services with wider system population-health priorities and the development of more integrated pathways.

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V. Productivity and value for money

Capability statements	Proposed domain rating
	Green
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	The Board has not regularly received and reviewed benchmarking data. The Trust uses Model Health System information and other benchmarking to compare key productivity measures with peers and to understand changes in relative performance over time. Benchmarking packs are also provided to specialties to support local analysis and identify areas of significant variation and opportunity. There is regular programme oversight of productivity and cost improvement through a bi-weekly Finance Improvement and Productivity Meeting (FIPM) chaired by the Executive Managing Director. Productivity is reported through the Finance and Performance Management Group to the Hospital Management Group (HMG). Where unwarranted variation is identified, this is used to inform transformation and pathway improvement. Examples include the Theatre Productivity Board and associated improvement plans aimed at upper-quartile performance and the NNUH GIRFT Board, which identifies and oversees work to address areas of variation. The Trust has evidence of productivity improvement against baseline through NHS Oversight Framework outputs. Productivity improvement is also incorporated into operational planning, including schemes to increase outpatient clinic productivity, theatre utilisation and improve day-case rates.

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VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Amber-Green
16. The trust has a robust financial governance framework and appropriate contract management arrangements	The Trust has an established financial governance framework including annual budgeting, utilising a Care Group management structure with regular monthly performance reviews against an Accountability Framework (AF). The AF is applied, using a standardised scoring methodology, to evaluate the performance of Care Groups against quality and safety, performance, finance and workforce KPIs. Persistent or significant under-performance attracts an escalating level of senior support or intervention until this is rectified. Care Group budget performance is subject to this stepped intervention with additional support and oversight being introduced to correct performance where required. This includes dedicated interventions with the Care Group leadership teams. Care Group financial governance is reported through the Finance and Performance Management Group (FPMG) to the Hospital Management Group, which triangulates this with quality and safety, and people and culture information. HMG reports to the Group Executive and Group Board committees. The Trust has a clear Scheme of Delegation and authorisation processes in place to support value for money and good financial governance. The Trust has an internal audit programme covering financial systems and controls, with the 2026/27 plan reviewed through the Group Audit Committees in Common. The programme includes key financial controls and provides coverage across financial systems and processes over a rolling cycle. Contract issues are subject to established governance and procurement support. The Trust has an agreed contract management policy with contract managers being assigned to key contracts across the Trust and escalation routes available as required.

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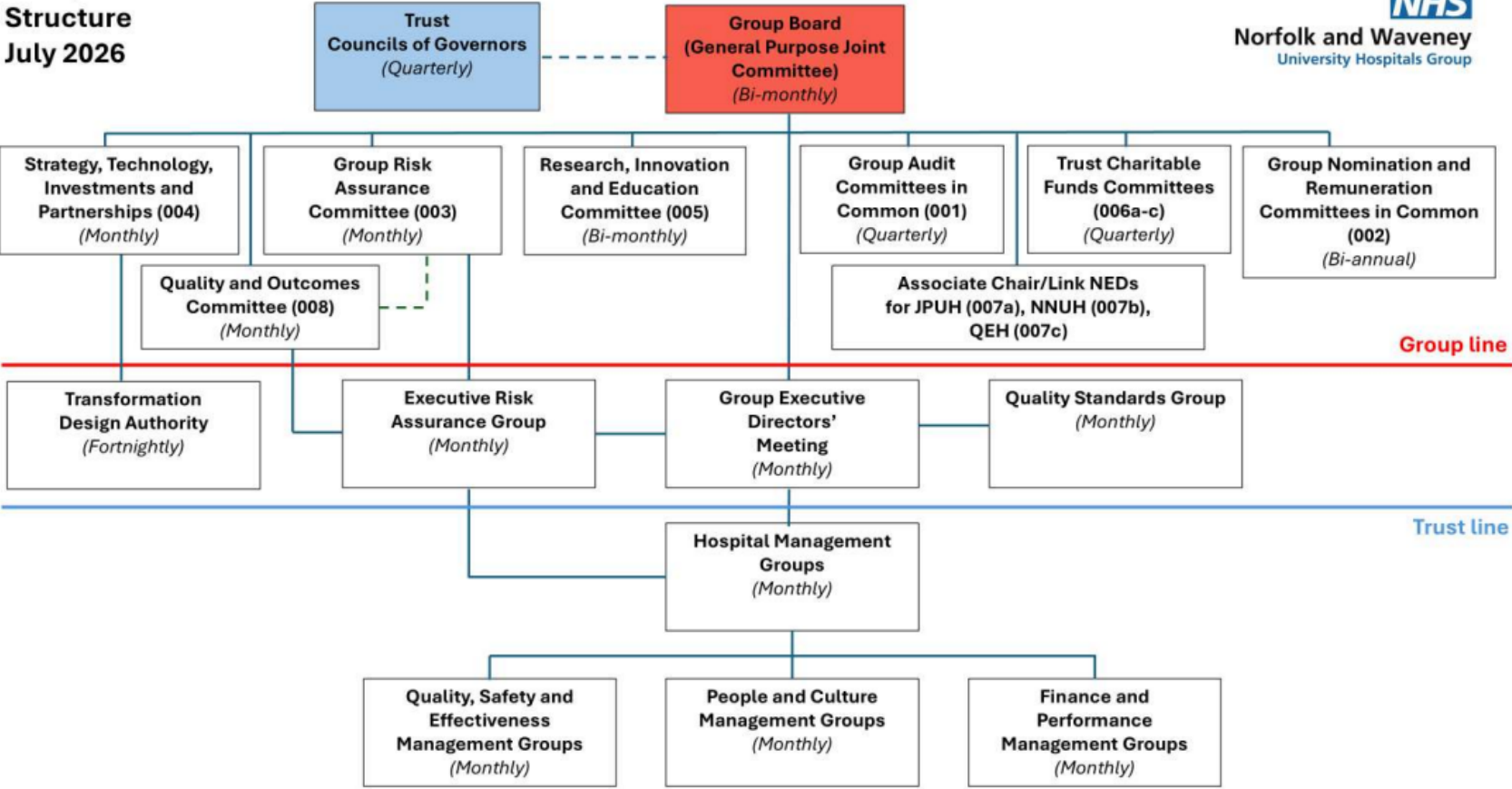
	Workforce and financial information is routinely reviewed through the above structure, with additional reporting introduced to identify staffing hotspots across medical and nursing workforces. NHSE bank and agency reduction targets have been achieved year to date. Rostering and financial establishments are aligned, although the underlying systems are not automatically integrated and continue to require manual intervention. This remains an area where further development of formal workforce, activity and financial triangulation would strengthen assurance.
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	Financial efficiency plans are subject to formal clinical quality impact assessment (CQIA) before implementation. Individual schemes require assessment of their potential impact on quality and approval by the Chief Nurse and Medical Director, or their nominated deputies, before proceeding. Efficiency plans are initially considered through site leadership and Board planning arrangements, with the CQIA process providing additional clinical and professional assurance over individual schemes. Financial performance and risk are monitored monthly through Finance and Performance Management Group and Hospital Management Group, including performance against the planned financial position and delivery of efficiency plans. Reports identify the underlying drivers of variance and are scrutinised through Hospital Management and Care Group performance arrangements. This provides a mechanism to consider financial delivery and value for money, alongside operational performance and quality rather than in isolation. In addition, the Trust has a monthly Financial Improvement and Productivity Meeting to oversee the delivery of the productivity and cost improvement programme (CIP). HMG reports to the Group Board's Group Risk Assurance Committee, which monitors financial performance and risks on a monthly basis, including delivery of finance and CIP, and provides reports to the Group Board.
18. The trust engages with	Group and Trust directors engage with system partners on investment decisions and opportunities to

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its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	make more effective use of resources, including both acute pathways and opportunities to shift care closer to home. The development of the NWUHG provides a further mechanism for the acute trusts to address financial challenges and investment opportunities collaboratively. The Trust's financial plan is aligned with those of system partners and commissioners, with assumptions developed to avoid gaps between organisational plans. The Trust continues to engage with community partners on the wider system ambition to provide more care closer to home and recognises that sustainable solutions to current operational and financial challenges require collaborative system working. The Trust has identified an opportunity to strengthen engagement by involving system partners at an earlier stage when investment and resource-allocation opportunities are being developed. Continued development of the Group model and neighbourhood working provides a route to strengthen this further.
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**Group Governance
Structure
July 2026**



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Signed on behalf of the Board of Directors

Chair: _____

Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: _____

Signature: _____ Date: _____

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Provider capability self-assessment template 2026: James Paget University Hospitals NHS Foundation Trust (JPUH)

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to their regional oversight lead by **5pm Friday October 2**.

I. Strategy, leadership and planning

Capability statements	Proposed domain rating
	Amber-Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	The Trust has a five-year strategy for 2023-2028 in place – Building a Healthier Future Together. The strategy sets out the Trust's priorities and ambitions and is underpinned by the Trust's CARES values. The Norfolk and Waveney University Hospitals Group (NWUHG) is currently developing a clinical strategy, working with teams across all Trusts and health system partners. The Trust's Medium-term Plan has been developed in alignment with system priorities and is supported by the Norfolk and Suffolk ICB, including alignment of financial and capital planning. Further to the Medium-term Plan, the NWUHG is overseeing the One Recovery Transformation Programme which is aligned with the Medium-term Plan and reflects the ICB investment priorities. The Trust's plans reflect its current role and strengths within the local healthcare economy, while recognising that these will continue to evolve through the development of the NWUHG clinical strategy. Transformation priorities are increasingly being aligned across the Group and with wider system objectives, including improvements in urgent and emergency care, flow, admission avoidance and the shift of care closer to home.
2. If in breach of licence: The trust is meeting and will continue to meet any requirements placed on it by ongoing	The Trust holds a valid NHS provider licence and there is no current enforcement action or discretionary requirements listed against the Trust.

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enforcement action from NHSE	
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	All Board positions are filled substantively through the Group Board structure with the exception of the Group Chair which is currently appointed to on an interim basis. A recruitment exercise to appoint a substantive Group Chair is underway and due to complete in December 2026. Three additional Group NEDs and two Group Associate NEDs were recruited in summer 2026 to increase NED bandwidth and skills. Link NEDs have been assigned to each Trust. JPUH has site-level management, (with all posts appointed to permanently), assurance and escalation arrangements within the Group structure, and the Group Board receives JPUH-specific information to exercise oversight of JPUH as a statutory organisation. Clear accountabilities and responsibilities are in place for the key areas of Trust operations, including quality, access and delivery, workforce and culture, and operational planning and finance. Each domain is overseen through defined monthly management groups operating to agreed terms of reference, up to a main Hospital Management Group, with formal routes for assurance and escalation through to the Group Board. There is a formal performance and accountability framework that sets out escalation and 'Group step in arrangements' in the event of underperformance.
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	The former Norfolk acute provider collaborative has developed into the Norfolk and Waveney University Hospitals Group, bringing NNUH, JPUH and QEH together to address common challenges, reduce unwarranted variation and make more effective use of workforce, digital infrastructure and other resources. Collaborative work includes the development of the Group clinical strategy, transformation of corporate services, implementation of a shared Electronic Patient Record, development of two new acute hospitals (under the national New Hospital Programme) and development of integrated clinical services. Examples of collaborative delivery include integrated clinical services between our three Trusts (urology, ENT, gynaecology, general surgery, audiology and oncology). Strong relationships have been formed with key stakeholders at Place and ICB, with strategic programmes adopted and delivered at both a local and system level. Mature relationships are in place including with primary care; evidenced through the monthly meetings between the Trust and the Clinical Directors of the PCNs.

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	A comprehensive approach is being taken, based on evidence, to develop services with partners to tackle the needs of the local population - including operationalising projects that underpin the neighbourhood health focus. This includes the recent establishment of the East Place Health Alliance which brings Norfolk Primary Care (the GP Federation), East Coast Community Healthcare (ECCH – the community provider) and the JPUH. Four programmes of work have been agreed, diabetes, respiratory (asthma), Parkinson’s and heart failure. Bringing together clinical and operational leads from across the health providers allows pathway redesign and ‘left shift’ opportunities. In addition to the four areas agreed other ‘deliver at pace’ opportunities are being explored such as the provision of iron infusion in the community and not on the acute footprint. This work has been greatly enabled through the introduction of a new post of Assistant Medical Director (Community) that has seen a community GP, and PCN Clinical Director, appointed to the Paget to work with acute clinicians to support pathway redesign. The Trust has also been part of the national Community of Practice Programme that has brought health and social care providers together to inform the development of Integrated Neighbourhood Teams (supporting the wider systems approach to Neighbourhood Health). A ‘test, learn and grow’ pilot working with a cohort of frailty patients has seen the significant opportunities of working with those with reversible risk in the community to coordinate preventative care. The success of this work is likely to see a significant investment in Gt Yarmouth & Waveney by the ICB to lead the approach to Neighbourhood Health.
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	The NWUHG Digital Strategy has been developed as a single strategy across the Group and is aligned with both local and national digital priorities. A single Digital Team is being put in place across the Group. The Digital Strategy s includes alignment with the What Good Looks Like framework, the Data Security and Protection Toolkit (DSPT), national data and digital strategies and the requirements of the New Hospital Programme. The strategy supports coordinated digital transformation across NNUH, JPUH and QEH, including digital maturity assessment and major shared digital enablers such as the Electronic Patient Record and Federated Data Platform. The Group has a Cyber Security Strategy and assurance is sought through the Group Board’s Strategy, Technology, Investments and Partnerships (STIP) Committee. There is a specific cyber security risk on the Group Board Assurance Framework. The cyber strategy identifies the scale of investment needed to remediate the cyber security position.

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II. Quality of care

Capability statements	Proposed domain rating
	Amber-Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	The Trust has implemented the NHSE Patient Safety Incident Response Framework (PSIRF), with a strong focus on proportionate learning responses and meaningful patient and family engagement. Established complaints, clinical audit and effectiveness, mortality review, etc. processes in place, these are governed by Trust assurance groups, which assess compliance to standards through agreed workplans and escalate accordingly to executive forums. The Trust also considers learning and guidance arising externally from relevant regulatory bodies including the Care Quality Commission (CQC). National patient safety alerts and learning from other sources such as the Health Services Safety Investigations Body (HSSIB) are reviewed and disseminated, and services have been reviewed against learning arising from significant national investigations and inquiries, including Ockenden, the Fuller mortuary inquiry and the Thirlwall inquiry. Complaints, clinical audit, mortality and other quality intelligence are similarly incorporated within the Trust's assurance arrangements.
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	Quality and safety performance is monitored through the Integrated Performance Report (IPR), incorporating measures including falls, hospital-acquired pressure ulcers, safer staffing, infection prevention and control, EMSA, cleanliness, complaints, compliments and patient experience. Information is reviewed through monthly performance arrangements. Outcomes and escalations are reported through the Quality, Safety & Effectiveness Management Group, with exceptions escalated to the Hospital Management Group (HMG). HMG reports to the Group Executive and Group Board committees. This includes the Trust IPR which is reported to the Group Board as part of the Group IPR, combined with the IPR data from QEH and NNUH. The Group Board is a committee-in-common which functions as the Trust Board for all three hospitals in the Group. The Group Board has established a Quality and Outcomes Committee which meets monthly to provide NED-led

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	challenge and seek assurance in respect of the quality of care provided across the Trusts within the Group. The Trust has also introduced a new risk management model, including a 5+5+5 methodology which provides greater emphasis on the effectiveness of controls when assessing and managing risk. The Trust has a learning from deaths lead and mature system, including structured judgment case reviews, partnering with the Medical Examiner's office, to identify themes and share learning from deaths widely throughout the trusts clinical teams.
8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	The Trust uses both quantitative and qualitative data, including Friends and Family Test (FFT), complaints, PALS, and incident reports. Performance against national indicators such as SHMI, PROMs, and responsiveness to personal needs is reported. The Trust engages with Healthwatch Norfolk and Healthwatch Suffolk and other stakeholders to ensure inclusive feedback and considers variation in patient experience. It also has a Maternity Voices Partnership. EDI networks in place and executive-led, overseeing and ensuring that national guidance and legislative requirements are adhered to, e.g. transgender mixed sex accommodation. EDI inclusion agenda includes several methods of collecting data to understand the impact on these patient groups – we are continually improving on what we now do with that information, such as exploring routes to reduce DNAs from our deprived populations. The Patient Advice and Liaison Service (PALS) also plays a key role in gathering and responding to patient feedback, ensuring that concerns are addressed and that learning is shared across the organisation. This approach supports a culture of continuous improvement and responsiveness to patient experience. In addition to the Quality and Outcomes Committee referenced above, Link NEDs meet regularly with the Trust's Executive Managing Director and Lead Governor and undertake visits to wards, services and departments to support the triangulation of information on quality and safety. Patient stories are presented at the Group Board.

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	The Trust leadership team also have a number of routes to ensure triangulation of data with real life experience. The site leadership team regularly walk around the trust and this is recorded on a board in the staff canteen, they aim to get to every area of the trust every couple of months. In addition there is a programme of “in your shoes” which are 2hr visits to areas to understand what it is like to work in that area, and finally there are “quality visits” or GEMBA walks which are 1hr long visits where specific questions are asked and learnings/ actions taken.
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III. People and culture

Capability statements	Proposed domain rating
	Amber-Green
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	The Trust uses a range of mechanisms to understand staff experience and identify opportunities for improvement, including the national NHS Staff Survey, local Pulse surveys, Freedom to Speak Up information and workforce equality information including WRES and WDES. This information is considered through the Trust’s People and Culture governance arrangements and is supplemented by direct engagement with staff. The Integrated Performance Report includes a dedicated section on staff information and metrics. This is received by the Group Board at each meeting. The Group Board’s Group Risk Assurance Committee oversees workforce risks escalated through the Group’s risk-based assurance model. The Board receives updates on the staff survey results and programmes to improve workforce engagement, including ‘18,000 Voices’ as part of the One Recovery Programme. Staff networks are in place and provide feedback via the People and Culture Management Group. Staff Experience Plan, with regular updates on progress with delivery. ‘You said, we did’ summary which is fed back to staff to show actions taken since last Staff Survey. The Trust leadership team also have a number of routes to ensure triangulation of data with real life experience. The site leadership team regularly walk around the Trust and this is recorded on a board in the staff canteen, they aim to get to every area of the trust every couple of months. In addition, there is a programme of “in your shoes” which are 2-hour visits to areas to understand what it is like to work in that area, and finally there are “quality visits” or GEMBA walks which are 1hr

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	long visits where specific questions are asked and learnings/ actions taken. In addition, the senior leadership team have “your voice” events to allow all staff to speak up, and where needed we add events for further engagement, such as a recent band 5-6 maternity listening event and a planned band 4 and below admin event. We have also introduced “team brief” which is a monthly opportunity for all staff to feedback to executives in person or online. Feedback from doctors of all levels is received through the GMC and National Training Survey and action plans are created to identify and mitigate any raised issues. There is a resident doctor lead who meets regularly with the chief Medical Officer to raise any issues from resident staff and to support the national 10-point plan for resident doctors. We have an independent FTSU organisation (The Guardian Office) that report monthly to the EMD and the feedback is that staff do speak up and that the management respond effectively to issues raised.
10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	The Trust maintains arrangements for mandatory training, Personal Development Reviews and wider continuing professional development and professional training. Compliance with mandatory training and associated workforce measures is monitored through the Integrated Performance Report and the People and Culture governance structure, enabling areas of concern or non-compliance to be identified and addressed. These arrangements are supported by the wider range of training and CPD opportunities available to staff and provide a framework through which the organisation can monitor and develop the skills required by its workforce. Quality Improvement training is also offered to all staff so that staff are given the skills to drive quality initiatives in their own service area. This has recently been expanded to give specific services the opportunity to have a larger supported QI programme. There is a Top Leaders Programme for the top 250 staff which is a monthly programme of development.
11. Staff can express concerns in an open and constructive environment	The Trust encourages staff to raise concerns directly with their line manager where they are comfortable to do so, and the leadership team hold regular staff briefings that allow staff to raise concerns in an open, all Trust forum which will be responded to by the leadership team.

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	The Trust also has established Freedom to Speak Up arrangements – delivered by the Independent Guardian Service - through which staff can raise concerns, including routes that enable concerns to be raised anonymously. FTSU intelligence is reported through People and Culture governance and to the Board and is considered alongside information from the Staff Survey, Pulse surveys and other staff feedback. The executive managing director has a monthly meeting with the FTSU guardian to ensure direct feedback is possible. There is a Group NED champion for Freedom to Speak Up who meets regularly with the Freedom to Speak Up Guardian and workforce leads. The answers to question 9 also apply to this question. As described there we have numerous informal and formal ways in which staff can see senior members of staff to speak up.
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IV. Access and delivery of services

Capability statements	Proposed domain rating
	Amber-Green
12.Plans are in place to improve performance against the relevant access and waiting times standards	JPUH is on an improvement journey that is beginning to show fruits. Waiting lists have reduced every month for the last 8 months consistently. RTT and 52 week targets are on plan. DM01 has had a demand and capacity issue which will be fixed by the end of the year with an external MRI having been secured. 64 weeks is a known issue with ENT which has now had further investment put in to begin to reduce the waits. Cancer has a recovery plan with FDS likely to be achieved from August and 62 day by the end of the year. UEC is the largest gap at the moment, after a good start to the year. This is mainly driven through lack of bed availability due to 100+ CRTNM patients for pathways 1-3. LOS is a day better than last year and criteria led discharge is now at 40% demonstrating reasonable grip on internal processes. At JPUH we have a performance / risk-based approach through sub committees and hospital management group (HMG). And in parallel we have an improvement programmatic approach with elective, cancer and UEC improvement boards reporting to HMG. These link through to the Group One Recovery programme.

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	Performance against national access standards is subject to established operational and Board oversight. Performance and recovery plans are reported to the Group Risk Assurance Committee and the Group Board, including through the Integrated Performance Report and the One Recovery programme. The Trust has a range of programmes in place to support recovery. The multi-year One Recovery programme supports delivery of the Medium -term Plan, which aims progressively to return performance metrics towards national standards. Improvement plans are tracked through Trust-wide and Care Group delivery dashboards, supported by programmes including the Patient Value work in outpatients and theatres, national Further Faster workstreams and the NNUH GIRFT Board. The Trust also participates in system and national improvement activity, including elective improvement and urgent and emergency care programmes.
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	The Trust is working in the Group context to develop a Health Equity Plan. This supports the work of the Trust in using data to identify the health inequalities of the local population and ensure services take these into account. Health Inequalities is an integral part of the Speciality Development plans. Health Inequalities is also a key component of the work programme of the Gt Yarmouth & Waveney Place Board. The Trust is also strengthening its data capability to support more detailed analysis of inequalities, including enhanced capture and use of Index of Multiple Deprivation information, with further opportunities expected through implementation of the Electronic Patient Record. This remains an area in development, with further work required to demonstrate consistently how identified variation is translated into measurable improvement. The data at the Paget shows a particularly deprived patient cohort with complex comorbidities. Within that cohort, we believe we have some of the most complex comorbidities during pregnancy in the country. Despite that the data shows that we are delivering outcomes far great than might be expected for those mothers. One example is that 20% of mothers smoke at time of booking, but this is reduced to 3% by the interventions of our teams.

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14. Appropriate population health targets have been agreed with the ICB	This work is underway with the Group and the ICB. The Group's Medical Director is the lead for this work and clear plans for areas of focus are in train.
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V. Productivity and value for money

Capability statements	Proposed domain rating
	Amber-Green
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	The Board has not regularly received and reviewed benchmarking data. Model Health is used as a benchmark across all available clinical and non-clinical areas, and reviews are built in during the planning cycle to support development of plans to improve performance against peers. Corporate benchmarking exercise takes place where leads are expected to justify and build any mitigations into annual plans for cost improvement and increased productivity. In order to keep track of all available benchmarking and unwarranted variation information (e.g. Model Health, GIRFT, etc) - an unwarranted variation terms of reference and supporting action log was created in 2021. This is managed at a Trust level to ensure services are accountable for delivering key actions to reduce unwarranted variation. The Paget now have a report for example of all the new to follow up ratios by specialty. Overall as a Trust we compare very favourably in the country, nevertheless we have plans in place to go further focusing on the outlying specialties. Our PIFU rate is increasing and our theatre utilisation rate is very strong. Our improvement programmes are focussing now on the number of cases per list. Our length of stay has improved by 1 day in the past year with more to go at.

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VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Green
16. The trust has a robust financial governance framework and appropriate contract management arrangements	The Trust has an established financial governance framework. The Trust has an internal audit programme covering financial systems and controls, with the 2026/27 plan reviewed through the Group Audit Committees in Common. The programme includes key financial controls and provides coverage across financial systems and processes over a rolling cycle. Contract issues are subject to established governance and procurement support. Despite considerable operational pressures in the first half of this year, we have held onto our financial plan including CIP targets.
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	A Quality Impact Assessment Panel has been set up to review all financial efficiency schemes prior to them moving to 'fully developed' and being included in the financial improvement plan. The panel consists of Executive Triumvirate (Ops, Clinical and Medical) and schemes are agreed by all three, which includes the review of a Quality Impact Assessment - covering patient safety, quality of care and well-being of staff. Financial performance and risk are monitored monthly through Finance and Performance Management Group and Hospital Management Group reporting, including performance against the planned financial position and delivery of efficiency plans. Reports identify the underlying drivers of variance and are also scrutinised through Hospital Management arrangements. This provides a mechanism to consider financial delivery alongside operational performance and quality rather than in isolation. The Group Board's Group Risk Assurance Committee monitors financial performance and risks on a monthly basis, including delivery of finance and CIP plans, and provides reports to the Group Board.

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18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	Group and Trust directors engage with system partners on investment decisions and opportunities to make more effective use of resources, including both acute pathways and opportunities to shift care closer to home. The development of NWUHG provides a further mechanism for the acute Trusts to address financial challenges and investment opportunities collaboratively. The Trust's financial plan is aligned with those of system partners and commissioners, with assumptions developed to avoid gaps between organisational plans. The Trust continues to engage with community partners on the wider system ambition to provide more care closer to home and recognises that sustainable solutions to current operational and financial challenges require collaborative system working. The previous assessment identified an opportunity to strengthen engagement by involving the Trust and system partners jointly at an earlier stage when investment and resource-allocation opportunities are being developed. Continued development of the Group model and neighbourhood working provides a route to strengthen this further. As answered above, the Trust is working effectively in Neighbourhoods working with NPC and ECCH to improve care and move to prevention.
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Signed on behalf of the Board of Directors

Chair: _____

Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: _____

Signature: _____ Date: _____

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Provider capability self-assessment template 2026: Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH)

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to their regional oversight lead by **5pm Friday October 2**.

I. Strategy, leadership and planning

Capability statements	Proposed domain rating
	Amber-Red
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	The Trust has a six-year strategy for 2024-2030 in place – Our Strategy. The strategy sets out the Trust's vision, mission and delivery ambitions and is underpinned by the Trust's Kindness, Wellness and Fairness values. It was collaboratively developed with broad organisational engagement. The Norfolk and Waveney University Hospitals Group (NWUHG) is currently developing a clinical strategy, working with teams across all Trusts and health system partners. The Trust's Medium-term Plan has been developed in alignment with system priorities and is supported by the Norfolk and Suffolk ICB, including alignment of financial and capital planning. Further to the Medium-term Plan, the NWUHG is overseeing the One Recovery Transformation Programme which is aligned with the Medium-term Plan and reflects the ICB investment priorities. The Trust's plans reflect its current role and strengths within the local healthcare economy, while recognising that these will continue to evolve through the development of the NWUHG clinical strategy. Transformation priorities are increasingly being aligned across the Group and with wider system objectives, including improvements in urgent and emergency care, flow, admission avoidance and the shift of care closer to home. It is recognised that QEH continues to face significant performance and regulatory challenges. In light of the Trust's need to focus on recovery and delivery in line with the current NOF ranking and regulatory position, the Trust has developed a clear set of two-phase 'QEH Priorities', with Phase 1 focused on Laying the Foundations and Phase 2 focused on Safer Better Together. Phase One – Laying the foundations

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	- Providing timely appropriate access to care and treatment - Efficiently managing our resources - Delivering care in accordance with fundamental standards - Supporting our staff through effective leadership Phase Two – Safer, Better, Together - Providing high quality sustainable and responsive care to our patients - Consistently living our values through our staff - Driving technology and innovation through digital technology - Maximising our partnerships to deliver our clinical strategy Behind the Phase One objectives, there are clear and measurable actions and KPIs. The monitoring approach to this is in development and will use existing data such as the Integrated Performance Report alongside qualitative information. Delivery progress will be routinely measured by the QEH Recovery Group with a clear process for actions to improve any areas of performance which are not meeting the required trajectories.
2. If in breach of licence: The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	The Trust holds a valid NHS provider licence. The Trust is currently working with NHS England to agree a set of Enforcement Undertakings. The Trust also faces a number of other regulatory actions: CQC Warning Notices from recent urgent and emergency care and medical care inspections; and ICO enforcement action in relation to Freedom of Information Act response compliance.
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	All Board positions are filled substantively through the Group Board structure with the exception of the Group Chair which is currently appointed to on an interim basis. A recruitment exercise to appoint a substantive Group Chair is underway and due to complete in December 2026. Three additional Group NEDs and two Group Associate NEDs were recruited in summer 2026 to increase NED bandwidth and skills. Link NEDs have been assigned to each Trust. The Group Chief Delivery Officer is currently also the Acting Executive Managing Director for the QEH. QEH has site-level management, assurance and escalation arrangements within the Group structure, and the Group Board receives QEH-specific information to exercise oversight of QEH as a statutory organisation. Clear accountabilities and responsibilities are in place for the key areas of Trust operations, including quality, access and delivery, operational planning and finance. Each domain is overseen through

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	defined monthly management groups operating to agreed terms of reference, with formal routes for risk-based assurance and escalation through to the Group Risk Assurance Committee and the Group Board. There is a formal performance and accountability framework that sets out escalation and 'Group step in arrangements' in the event of underperformance.
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	The former Norfolk acute provider collaborative has developed into the Norfolk and Waveney University Hospitals Group, bringing NNUH, JPUH and QEH together to address common challenges, reduce unwarranted variation and make more effective use of workforce, digital infrastructure and other resources. Collaborative work includes the development of the Group clinical strategy, transformation of corporate services, implementation of a shared Electronic Patient Record, development of two new acute hospitals (under the national New Hospital Programme) and development of integrated clinical services. Examples of collaborative delivery include integrated clinical services between our three Trusts (urology, ENT, gynaecology, general surgery, audiology and oncology). The Trust is actively engaged in the West Place Board, the West Norfolk Health and Wellbeing Partnership, the Vision Kings Lynn Group and Neighbourhood Board. The Director of Strategy and Integration chairs the Place Board and is the Trust's representative on the Neighbourhood Board. Senior members of the Trust attend the Partnership and Operational Vision Kings Lynn Group. Discussions are in train to develop a (matrix working) West Norfolk PMO which will enable the collaborative delivery of key projects in the Place and Neighbourhood space. This PMO will include QEH, EECHC, KL&WN Borough Council, NCC, Norfolk and Suffolk ICB and Public Health. Within the forums within West Norfolk, key priority areas are focused upon, including the Pride in Place programme, health and the wider determinants of health, such as housing, education, and employment. This includes the Marmot Place Programme, a pioneering initiative launched in partnership with the Borough Council, Norfolk County Council Public Health. It applies eight evidence-based principles to reduce health inequalities, particularly in rural communities where access to services is more limited. The programme aims to close the 11.5-year life expectancy gap between the most and least deprived areas by addressing social and economic conditions that influence health.

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	The Trust has an Anchor Programme in place with a current emphasis on the two pillars of 'employment and sustainability' within which significant activity is in train.
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	The NWUHG Digital Strategy has been developed as a single strategy across the Group and is aligned with both local and national digital priorities. A single Digital Team is being put in place across the Group. The Digital Strategy includes alignment with the What Good Looks Like framework, the Data Security and Protection Toolkit (DSPT), national data and digital strategies and the requirements of the New Hospital Programme. The strategy supports coordinated digital transformation across NNUH, JPUH and QEH, including digital maturity assessment and major shared digital enablers such as the Electronic Patient Record and Federated Data Platform. The Group has a Cyber Security Strategy, and assurance is sought through the Group Board's Strategy, Technology, Investments and Partnerships (STIP) Committee. There is a specific cyber security risk on the Group Board Assurance Framework. The cyber strategy identifies the scale of investment needed to remediate the cyber security position. A Cyber Task Force is in place to oversee delivery by December 2026 of a remediation plan to address the NIS Improvement Notice issued to QEH.

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II Quality of care

Capability statements	Proposed domain rating
	Amber-Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	The Trust has implemented the NHSE Patient Safety Incident Response Framework (PSIRF), with a strong focus on patient and family engagement. Established complaints, clinical audit and effectiveness, mortality review etc processes in place, these are governed by Trust assurance groups, which assess compliance to standards through agreed workplans and escalate accordingly to executive forums. The Trust also considers learning and guidance arising externally from relevant regulatory bodies including the Care Quality Commission. National patient safety alerts and learning from other sources such as HSSIB are reviewed and disseminated, and services have been reviewed against learning arising from significant national investigations and inquiries, including Ockenden, the Fuller mortuary inquiry and the Thirlwall inquiry. Complaints, clinical audit, mortality and other quality intelligence are similarly incorporated within the Trust's assurance arrangements.
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	Providing safe and effective care is a key element of Phase 1 of the QEH priorities recovery plan. Quality and safety performance is monitored through the Integrated Performance Report (IPR), incorporating measures including falls, hospital-acquired pressure ulcers, safer staffing, infection prevention and control, EMSA, cleanliness, complaints, compliments and patient experience. Information is reviewed through monthly performance arrangements. Outcomes and escalations are reported through the Quality, Safety & Effectiveness Management Group, with exceptions escalated to the Hospital Management Group (HMG). HMG reports to the Group Executive and Group Board committees. This includes the Trust IPR which is reported to the Group Board as part of the Group IPR, combined with the IPR data from JPUH and NNUH. The Group Board is a committee-in-common which functions as the Trust Board for all three hospitals in the Group. The Group Board has established a Quality and Outcomes Committee which meets monthly to provide NED-led

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	challenge and seek assurance in respect of the quality of care provided across the Trusts within the Group. The Chief Nurse's office co-ordinates the Trust-wide Quality Assurance Visits (QAV) which offer a mixed peer review with clinical and non-clinical reviewers bringing a "fresh eyes" approach following an informal but structured review process. The QAV report into the Quality, Safety and Effectiveness Management Group and then into the Hospital Management Group. Additionally, the QAV findings are reported in varied formats to the ward/department visited via Divisional and Trust-wide via newsletters. The Trust has also introduced a new risk management model, including a 5+5+5 methodology which provides greater emphasis on the effectiveness of controls when assessing and managing risk. Recognising a number of areas of concern relating to clinical quality and outcomes, including in General Surgery, an external review of the Trust's clinical governance arrangements is currently being undertaken.
8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	The Trust uses both quantitative and qualitative data, including Friends and Family Test (FFT), complaints, PALS, and incident reports. Performance against national indicators such as SHMI, PROMs, and responsiveness to personal needs is reported. The Trust engages with Healthwatch Norfolk and Cambridgeshire and other stakeholders to ensure inclusive feedback and considers variation in patient experience. EDI networks are in place and executive-led, overseeing and ensuring that national guidance and legislative requirements are adhered to. An EDI inclusion agenda is in place with several methods of collecting data to understand the impact on these patient groups. Engagement with harder to reach communities and cultures is an ongoing piece of work with examples of individualised care but this is not a formalised process currently. The Trust has a Patient Panel, Readers Panel and Youth Council in place. Governors, ICB colleagues and Patient panel members support the QAV. The workstreams each have patient panel members within their meeting membership. In line with PSIRF and NHS

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	Impact, members of the patient panel and our Patient Safety Partner have received bespoke QSIR Fundamentals training and have supported Patient Safety and QI with a number of observational reviews as part of the Trust's patient safety priority programme. In addition to the Quality and Outcomes Committee referenced above, Link NEDs meet regularly with the Trust's Executive Managing Director and Lead Governor and undertake visits to wards, services and departments to support the triangulation of information on quality and safety. Patient stories are presented at the Group Board.
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III. People and culture

Capability statements	Proposed domain rating
	Amber-Red
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	The Trust uses a range of mechanisms to understand staff experience and identify opportunities for improvement, including the national NHS Staff Survey, National Education Training Survey (NETS) , Freedom to Speak Up reports and workforce equality information including WRES and WDES and Gender Pay reporting. This information is considered through the Trust's People and Culture management group which provides a Chair's Assurance report to Hospital Management Group (HMG) and is supplemented by engagement with trade unions through the monthly Joint Staff Consultative Committee (JSCC) and Local Negotiating Committee (LNC). This is supplemented with staff networks, with site leadership sponsors and direct engagement with staff, especially through the HMSC (Consultants), Resident Doctors forum and individual meetings with the Chief Nurse and site leads In addition the Trust has a Exec MD webinar monthly which regularly has more than 100 attendees. The Integrated Performance Report includes a dedicated section on staff information and metrics and a site level version is seen at HMG monthly. A Group level version is received by the Group Board at each meeting. The Group Board's Group Risk Assurance Committee oversees workforce risks escalated through the Group's risk-based assurance model. The Board receives updates on the staff survey results and programmes to improve workforce engagement, including ' 18,000 Voices' as part of the One Recovery Programme. Staff networks are in place and are being relaunched with an site level Sponsor. They provide feedback via the People and Culture Management Group. National Staff Survey and WRES and WDES actions plans are in place and are monitored through PMG. The National Staff Survey action plan was co-produced with a cross section of staff and trade union colleagues and feedback from GMC and NETS surveys contributed to several of the key actions. The senior leadership team also undertake routine visits and hold scheduled drop in sessions with the COO and Chief Nurse and walkabouts to have the opportunity to understand the details facing specific areas in the Trust and to hear from front line staff first hand of the challenges and opportunities faced which are then addressed / supported.

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10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	Substantively appointed staff go through a competitive selection process. The Trust maintains arrangements for mandatory training, Personal Development Reviews and wider continuing professional development and professional training. Compliance with mandatory training and associated workforce measures is monitored through the Integrated Performance Report, divisional performance review meetings and the People and Culture governance structure, enabling areas of concern or non-compliance to be identified and addressed. These arrangements are supported by the wider range of training and CPD opportunities available to staff and provide a framework through which the organisation can monitor and develop the skills required by its workforce. The Trust offers award winning THRIVE and GROW programmes for HCSW and new qualified nurses. Training of clinicians and senior leaders in the Vanderbilt (professional accountability programme) principles has commenced as part of a Group-wide programme. The Trust provides access to leadership and management development training. As part of the Group model a consistent and coherent leadership development offer is under development. The '18,000 Voices' programme is a Group-wide programme built around staff voice, front-line engagement, staff-led improvement and leadership development. Quality Improvement training is also offered to all staff so that staff are given the skills to drive quality initiatives in their own service area.
11. Staff can express concerns in an open and constructive environment	QEHKL is committed to fostering a culture where colleagues feel safe to speak up, raise concerns and contribute ideas, confident that their voice will be heard and acted upon. Central to this commitment is the Trust's Freedom to Speak Up Guardian (FTSUG) service, which provides independent and confidential support to staff who wish to raise concerns, seek advice or discuss issues relating to patient safety, quality of care, workplace culture or their experience at work. The FTSUG service supports early identification of concerns and organisational learning, with quarterly reports presented to the People Management Group (PMG) and Joint Staff Consultative Committee (JSCC). Themes

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and risks are escalated through Trust governance structures, including the Hospital Management Group (HMG).

The Trust is candid that its Guardian service operated at significantly reduced capacity for most of 2025/26: the independent Guardian retired in October 2025, and the Lead Guardian sadly passed away in August 2026 after a long illness. An additional full-time Guardian was appointed in March 2026 and they are supported by a network of 14 Speak Up Champions. Cases fell from 328 in 2024/25 to 134 in 2025/26, and the Trust reads this as reduced access rather than fewer concerns. The service provided reasonable assurance only for the year, with quarterly reporting to the People Management Group and an annual overview presented in May 2026. The Group Non-Executive Director with Freedom to Speak Up oversight provides Board-level challenge.

The Trust has been open and transparent about these findings and has developed a comprehensive improvement programme to address the issues identified. The NHS Staff Survey Action Plan, which is aligned to the Trust Recovery Plan, was developed collaboratively with staff and trade union representatives and focuses on improving staff voice, involvement, engagement and organisational culture.

A number of targeted actions are underway to strengthen speaking up culture and psychological safety. These include an externally led culture diagnostic which commenced in August 2026, to identify the root causes of staff concerns and inform targeted improvement activity; the development of communication standards designed to promote respect, dignity and open dialogue; and the relaunch of staff networks with site leadership sponsorship, enabling underrepresented groups to influence decisions and provide direct feedback to leaders. The FTSUG team now attend Resident Doctor and Trust inductions and are a highly visible part of the Trust's actions to provide psychological safety and encourage speaking up.

Senior leaders will increase their visibility through site visits, shadowing shifts, leadership forums and informal staff discussions, helping to strengthen relationships, improve trust and ensure that concerns raised by staff receive visible responses. In addition, the Trust has commissioned expert delivered, targeted cultural interventions after receiving GMC survey feedback and linked to the wider education improvement work. This work includes co-producing with the resident doctor forum, improved ways to raise concerns and for those concerns, when addressed to be fed back to them.

The Trust is also promoting anti-racism initiatives, in part prompted by concerns raised by and through the FTSUG service,

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	strengthening support for staff experiencing discrimination and embedding EDI objectives within leadership appraisals to ensure leaders are accountable for creating inclusive environments where all staff feel able to speak up. Progress is monitored through PMG, HMG and wider governance arrangements to ensure that staff feedback leads to visible action, learning and sustainable cultural improvement. A single Group-wide Freedom to Speak Up model is in development to provide consistent and equitable access to the Guardian service for all staff across the three hospitals and to strengthen Board-level oversight of themes and outcomes.
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IV. Access and delivery of services

Capability statements	Proposed domain rating
	Amber-Red
12. Plans are in place to improve performance against the relevant access and waiting times standards	QEH's performance against access standards shows improvement in some areas, although significant gaps remain and recovery is not yet consistent across services. Referral to Treatment (RTT) performance has improved, alongside improvement in the cancer 28-day Faster Diagnosis Standard. These gains provide evidence of progress, but require further consolidation, with continued focus on long waits, diagnostic delays and delivery of the 62-day cancer treatment standard. Urgent and emergency care performance remains challenged and volatile. There have been periods of improved ambulance handover times and reduced waits exceeding 12 hours, but these gains have not been consistently sustained. Four-hour performance and prolonged emergency department waits remain key areas of concern. The overall position is therefore one of demonstrable but uneven improvement, with further work required to sustain recovery and translate progress into consistently timely access for patients. Performance against national access standards is subject to established operational and Board oversight. Performance and recovery plans are reported to the Group Risk Assurance Committee and the Group Board, including through the Integrated Performance Report and the One Recovery programme.

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	The Trust has a range of programmes in place to support recovery. The multi-year One Recovery programme supports delivery of the Medium-term Plan, which aims progressively to return performance metrics towards national standards. This is supplemented by the specific two-phase 'QEH Priorities' recovery plan. Earlier this year, QEH was identified by NHS England as a Trust where performance was off-trajectory at Month 1 / 2, with concerns raised as to whether the Board was sufficiently sighted on the reasons and the recovery trajectory. The Trust worked with the ICB to develop a Board-approved response and recovery trajectories which were agreed by NHS England. The Trust also participates in system and national improvement activity, including elective improvement and urgent and emergency care programmes.
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	The Trust is working in the Group context to develop a Health Equity Plan. This supports the work of the Trust in using data to identify the health inequalities of the local population and ensure services take these into account. Health Inequalities is an integral part of the work of the Divisional teams. Health Inequalities is also a key component of the work programme of the West Place Board. The Trust is also strengthening its data capability to support more detailed analysis of inequalities, including enhanced capture and use of Index of Multiple Deprivation information, with further opportunities expected through implementation of the Electronic Patient Record. This remains an area in development, with further work required to demonstrate consistently how identified variation is translated into measurable improvement. A refreshed Health Inequalities Self-Assessment and draft Trust action plan are in development. As part of the development of the Group's clinical strategy, detailed work on inequalities has been undertaken and reviewed by the Group Board.
14. Appropriate population health targets have been agreed with the ICB	This work is underway with the Group and the ICB. The Group's Medical Director is the lead for this work and clear plans for areas of focus are in train. West Norfolk became Norfolk's first Marmot Place in March 2025, providing a shared framework with system partners.

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	Governance structures are in place internally which support dissemination of work at Place / Health and Wellbeing Partnership aligned to health and wellbeing. All Divisions have specialties which have specific focuses on the wider determinants of health. The Trust also contributes as an anchor institution through local employment and sustainability programmes.
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V. Productivity and value for money

Capability statements	Proposed domain rating
	Red
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	The Board has not regularly received and reviewed benchmarking data. Reports on the national cost collection exercise have been presented to Finance & Performance Management Group and Hospital Management Group, which have highlighted variation to peers and unwarranted variation. However, subsequent actions to address these variations and opportunities haven't been identified, regularly monitored or shared with the Group Board. This is a significant area of weakness which needs to be addressed with immediate effect. The national cost collection data alongside Model Health, GIRFT and internal service line reporting is being widely reviewed across the Trust and is driving conversations about efficiency and productivity improvements. There are key clinical advocates for the service line reporting who are supporting peers to understand and use the data in a meaningful way. The data has been used this financial year to identify efficiencies included in the Cost Improvement Plan, but more can be done to use the data to drive the efficiency plan and identify recurrent and sustainable schemes. Oversight of the data and identified actions is required at Management Group level to provide assurance,

VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Red
16. The trust has a robust financial governance framework and appropriate contract management arrangements	The Trust has an established financial governance framework. The Trust has an internal audit programme covering financial systems and controls, with the 2026/27 plan reviewed through the Group Audit Committees in Common. The programme includes key financial controls and provides coverage across financial systems and processes over a rolling cycle. Contract issues are subject to established governance and procurement support.

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	There have not been any NHS Clinical services contract disputes in the past 12 months. Clinical activity contracts are managed by a dedicated team. However, non-clinical contracts are not routinely managed by a specific team, but are the responsibility of the end user. This is an area of weakness that was tested through the internal audit plan for 2025/26. A Procurement and Contract Management Policy has now been developed and put in place with contracts and the associated KPIs monitored through the Procurement and Contracting Group and reported up to Finance and Performance Management Group. Work is ongoing to embed this policy and ensure all contracts are appropriately recorded and monitored on a contracts database.
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	A Quality Impact Assessment Panel has been set up to review all financial efficiency schemes prior to them moving to 'fully developed' and being included in the financial improvement plan. The panel consists of Executive Triumvirate (Ops, Clinical and Medical) and schemes are agreed by all three, which includes the review of a Quality Impact Assessment - covering patient safety, quality of care and well-being of staff. Financial performance and risk are monitored monthly through Finance and Performance Management Group and Hospital Management Group reporting, including performance against the planned financial position and delivery of efficiency plans. Reports identify the underlying drivers of variance and are also scrutinised through Hospital Management arrangements. This provides a mechanism to consider financial delivery alongside operational performance and quality rather than in isolation. The Group Board's Group Risk Assurance Committee monitors financial performance and risks on a monthly basis, including delivery of finance and CIP plans, and provides reports to the Group Board. QEH continues to have a structural financial deficit with ongoing reliance on Deficit Support Funding. QEH is behind trajectory in delivery of its CIP plan for 2026/27. In addition, the Trust faces significant challenges in managing its cash position and a dedicated Cash Committee has been established to support this.

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18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	Group and Trust directors engage with system partners on investment decisions and opportunities to make more effective use of resources, including both acute pathways and opportunities to shift care closer to home. The development of NWUHG provides a further mechanism for the acute Trusts to address financial challenges and investment opportunities collaboratively. The Trust's financial plan is aligned with those of system partners and commissioners, with assumptions developed to avoid gaps between organisational plans. The Trust continues to engage with community partners on the wider system ambition to provide more care closer to home and recognises that sustainable solutions to current operational and financial challenges require collaborative system working. The previous assessment identified an opportunity to strengthen engagement by involving the Trust and system partners jointly at an earlier stage when investment and resource-allocation opportunities are being developed. Continued development of the Group model and neighbourhood working provides a route to strengthen this further.
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Signed on behalf of the Board of Directors

Chair: _____

Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: _____

Signature: _____ Date: _____

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**NORFOLK AND WAVENEY
UNIVERSITY HOSPITALS GROUP**

**GROUP BOARD MEETING IN PUBLIC:
7 OCTOBER 2026**

**SUPPLEMENTARY PAPERS
FOR AGENDA ITEM 20**

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

C Current risk score

T Target risk score

Risk appetite range (to follow)

PR = Principal Risk

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	September 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	3	2	9
Risk appetite				
Within appetite range?				

Related Group/Trust significant risks (12 and above)

NNUH: 734 (PALS response), 352 (Aseptic services), 708 (General surgery), 162 (extreme heat events); QEH: 3194 (Mental Health Act), 4088 (quality and safety failures), 4102 (absence of general surgeons); JPUH: 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	12	12	12	12	12	12	12	12	12	11	11	11	10	10	10	10	10	10	10	10	10	9	9	9	9
Actual	12	12	12	12	12	12	12	12	12																

Summary of monthly review/amendments

- Current risk score unchanged.
- Removal of Third line assurance AT4 to reflect revised position of National Provider Improvement Programme (NPIP).

Planned risk trajectory: reduction to 11 in October 2026 reflecting implementation of clinical governance review findings, with further reduction to 10 from January 2027 following further embedding and measurement of impact.

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. Trust-level Quality Management Groups reporting to Hospital Management Groups.	AS1. Group Executive attendance at HMG meetings for each Trust. AS2. Executive-level Quality Standards Group meeting since April 2026 and Perinatal Standards Group meeting since August 2026. Reporting to Executive Risk Assurance Group. AS3. Reporting to Group Quality and Outcomes Committee (from August 2026), Group Risk Assurance Committee and Group Board. AS4. Reporting on Clinical Audit to Group Audit Committees in Common (June 2026).	AT1. NHS England regional oversight meetings. AT2. CQC inspections. AT3. Regulatory accreditation visits.
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 reviews at NNUH and JPUH with final diagnostic due at the end of August followed by implementation plan. QEH clinical governance review commencing in August 2026.	August 2026 October 2026 – revision reflects revised timing of QEH review
GC2. Group-wide quality improvement function and programme.	Programme and function developed. Creation of Quality Faculty and quality improvement methodology approved through One Recovery Programme Board.	July 2026 – achieved for development. April 2027 – for implementation

GC3. Monitoring quality data in real time on a consistent basis.	Development of Integrated Performance Report and supporting insight following market engagement exercise. Visibility and timeliness of information following EPR implementation will support addressing of quality issues.	October 2027
GA1. 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. To be informed by Internal Audit planned as part of 2026/27 Internal Audit Plan.	December 2026
GA2. Enhanced Board committee oversight of quality and outcomes to be put in place.	Specific section on Quality and Outcomes added to Group Risk Assurance Committee agenda in April and May 2026 ahead of move to a separate Quality and Outcomes Committee from August 2026.	June 2026 September 2026

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Principal Risk 2: Maternity services

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	September 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)

NNUH: 626 (midwifery workforce provision), 147 (community midwifery telephony service); QEH: n/a; JPUH: 812 (fragmented documentation for care across Ward 11)

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	11	10	10	10	10	10	10	10	9	9	9	9	8	8	8	8	8	8	8
Actual	11	11	11	11	11	11	11	11	11																

Summary of monthly review/amendments

- Proposed amendment to risk descriptor to focus on implementing the recommendations of national reviews and meeting national standards rather than increasing the pace of improvement across the Group. To be further considered in the next monthly review.
- Potential reduction in the current risk score from 11 to 10 (reduction in likelihood from 4 to 3) discussed by ERAG reflecting recent closure of CQC regulatory notices and publication of QEH Baroness Amos report, providing additional assurance on the effectiveness of current controls and hence the risk likelihood. Agreed to leave the risk score unchanged pending assessment of further recent national recommendations and requirements.
- Key control C3 updated to reflect approval of standardised perinatal reporting template including national KPIs.

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- Risk trajectory to be reviewed.

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. Perinatal Resilience Forum established at NNUH in July 2026.	AF1. Reporting through Trust perinatal governance framework to Trust Quality Management Groups and Hospital Management Groups. AF2. Review of CNST MIS compliance through Trust Maternity Evidence Groups. AF3. Perinatal strategic network meetings.	AS1. Reporting to Perinatal Quality Assurance Group and Quality Standards Group. AS2. Reporting to Executive Risk Assurance Group. AS3. Reporting to Group Risk Assurance Committee and Group Board. AS4. NED and Executive Perinatal Safety Champions in place. AS5. Group Perinatal Safety Champions meetings and monthly walkrounds. AS6. Group Board review and approval in February 2026 of MIS Year 7 full compliance. AS7. Reporting to Group Executive and Group Board.	AT1. Regional Maternity Oversight Group. AT2. Local Maternity and Neonatal System (LMNS) Programme Board. AT3. CQC user survey results (positive assurance for QEH and JPUH). AT4. National maternity support programme for JPUH. AT5. Regional Quality Visit at JPUH (May 2026) and NNUH and QEH (July/August 2026).
C2. Group-wide perinatal governance framework developed.			
C3. Monthly perinatal reporting in place with standardised template including national KPIs.			
C4. National maternity outcomes signal system implemented.			
C5. Daily national OPEL reporting.			
C6. Future roadmap in place for perinatal services across the Group (Perinatal Clinical Strategic Network).			

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.	August 2027

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GC2. Group perinatal governance framework implementation.	Implementation plan to be developed and rolled out, including revised Group reporting.	March 2027
GC3. Services do not meet all aspects of the new National Triage Service Specification.	Gap analysis for each Trust to be completed and signed off by the Group Board by October 2026 and full implementation due by July 2027.	July 2027
GA1. Response to NHS England 10-Point Plan on Maternity and Neonatal Services following outcomes of Baroness Amos Independent Maternity and Neonatal Investigation and Ockenden report on Nottingham, plus Thirlwall Inquiry recommendations.	Development of Trust responses to 10-Point Plan including baseline gap analysis. Group Board sign off required prior to submission deadlines of 25 September and 31 December 2026.	December 2026
GA2. Maternity and Neonatal Voices Partnership (MNVP) not meeting current national standards for funded time allowance.	MNVP Lead for Norfolk now recruited and commences post in September 2026.	October 2026
GA3. Schedule of quarterly Perinatal reporting to Group Board or delegated committee to be agreed to meet national standards.	Plan to meet Perinatal reporting requirements under development with proposals for reporting to Group Quality and Outcomes Committee and Group Board in public.	October 2026

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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	September 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	3	12
Target (by Dec 26)	4	3	2	9
Risk appetite				
Within appetite range?				

Related Group/Trust significant risks (12 and above)

NNUH: n/a; QEH: 2244 (mental health community beds); JPUH: 773 (non-RTT patient tracking list), 223 (histopathology delays)

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
Revised									12	12	12	12	11	11	11	11	11	11	11	9	9	9	9	9	9
Actual	13	13	13	13	12	12	12	12	12																

Summary of monthly review/amendments

- Current risk score unchanged.
- Trajectory reset to maintain risk at 12, reducing to 11 from January 2027 to reflect anticipated impact of additional elective funding, and reducing to 9 post-EPR rollout.
- Due date for action to address gap in control GC2 (review and update of Performance and Accountability Framework) amended from August to October 2026.
- Gap in assurance GA2 closed – strengthened oversight and assurance of operational performance implemented at GRAC and reflected in Second line assurances.

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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. Group Executive attendance at HMG meetings for each Trust. AS2. Risk-based oversight and assurance at Executive Risk Assurance Group (ERAG), Group Risk Assurance Committee (GRAC) and Group Board, with review of Group IPR. AS3. One Recovery Oversight Group meeting twice monthly.	AT1. NHS England (NHSE) Regional and National tiering calls. AT2. Monthly Regional Oversight and Scrutiny meeting with NHSE. AT3. One Recovery included in 2026/27 Internal Audit Plan.
C2. Trust recovery and delivery plans with agreed trajectories.			
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.			
C5. Group One Recovery Plan.			

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Implementation of Group Recovery Plan.	In-year delivery of One Recovery Plan and trajectories, monitored via Oversight Group and GRAC. QEH Recovery Plan developed in July 2026 in response to NHSE letter.	March 2027
GC2. Performance and accountability framework due for review.	Review, refresh and embed Performance and Accountability Framework.	End June 2026 End August 2026 End October 2026
GC3. Cancer waiting time performance not improving at rate envisaged in Medium-term Plans.	Review Trusts' plans and refocus cancer One Recovery programme to return performance to trajectory by Sep 2026.	September 2026
GA2. Strengthen Board-level oversight and assurance of operational performance.	Dedicate time at monthly GRAC meetings to review of operational performance metrics against Medium-term Plan.	Implement from July 2026 and embed during remainder of 2026 Implemented

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	September 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 (2026/27 breakeven financial plan), 500 (non-recurrent funding/CIPs); QEH: 3223 (cash availability), 4051 (CIP delivery in 2026/27); JPUH: 811 (redundancy costs), 791 (non-replacement of medical devices); Group: 1 (2026/27 plan delivery), 2 (2026/27 efficiency target delivery), 3 (2026/27 bank and agency control delivery)

	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	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	12	12	12	12	12	12																

Summary of monthly review/amendments

- Current risk score unchanged.

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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.	AF1. Trust Finance and Performance meetings reporting to Hospital Management Groups.	AS1. Group Executive attendance at HMG meetings for each Trust.	AT1. Monthly financial reporting to NHSE. AT2. Monthly NHSE Oversight meetings. AT3. Head of Internal Audit Opinion annually. AT4. Value for Money review/ conclusion from External Audit.
C2. Monthly tracking against Trust's activity plans.		AS2. One Recovery Programme meetings twice monthly.	
C3. CIP plans for 2026/27 finalised and 2027/28 in development. One Recovery CIP Charter signed off in March 2026.		AS3. Reporting to Executive Risk Assurance Group, Group Risk Assurance Committee and Group Board.	
C4. Pay controls – Vacancy Panels in place in all three Trusts.		AS4. Review of controls in place through Annual Governance Statement.	
C5. Bank and agency controls in line with NHSE reductions.		AS5. CIP deep dive undertaken at GRAC in April 2026.	
C6. Capital plan for 2026/27.			

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Finalise CIP programmes for 2026/27.	All three Trusts have identified CIP schemes but high-risk elements remain. Gateway and Clinical Quality Impact Assessments in progress.	End June 2026 August 2026
GC2. Implementation of 2026/27 CIP programmes.	Agree resources, programme management arrangements and oversight of CIP programmes in each Trust.	Ongoing to end of March 2027
GC3. Need to develop Trust-level control totals on Whole Time Equivalents (WTEs).	Plans in development with Trust Directors of Finance.	End June 2026 August 2026
GA1. Strengthen Board-level oversight and assurance of financial performance.	Monthly GRAC meetings to review financial performance metrics against Medium-term Plan.	Implement from July 2026 and embed during remainder of 2026
GA2. Detailed CIP monitoring.	Additional detail by Trust to be added to monthly GRAC report.	September 2026

Principal Risk 5: Workforce engagement and morale

If appropriate plans and actions are not developed and implemented effectively to address reductions in staff engagement and morale (including as a result of bullying, harassment and racism) as evidenced through the NHS Staff Survey, then continuing low staff engagement and morale may have an adverse impact on recruitment and retention, staff wellbeing and the quality and safety of care provided to patients.

Risk lead	Interim Group CPO
Last update	September 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	4	4	12
Target	4	2	2	8
Risk appetite				
Within appetite range?				

Related Group/Trust significant risks (12 and above)

NNUH: 82 (staff morale and engagement); QEH: 3848 (employee experience); JPUH: 774 (nursing staffing in surgery, 832 (staff morale), 468 (blood transfusion staffing)

	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	12	12	12	12	12	12	12	12	10	10	10	10	10	10	10	10	8	8	8	8	8		8
Actual	10	10	10	12	12	12	12	12	12																	

Summary of monthly review/amendments

- Current risk score unchanged.
- Key control G7 updated to reflect Group Board approval in August 2026 of EDI Policy and EDI Workforce Strategy and Plan.
- Actions to address gaps in control variously updated with additional detail on due dates.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Trust staff engagement plans and activities.	AF1. Trust oversight at People and Culture Management Groups reporting to HMGs.	AS1. One Recovery Programme oversight meetings twice monthly. AS2. Risk-based oversight and assurance at Executive Risk Assurance Group (ERAG) and Group Risk Assurance Committee (GRAC). AS3. Reporting to Group Board via Group CEO's and Executive Managing Directors' reports. AS4. GRAC deep-dive on PR5 risk in June 2026.	AT1. NHS England monthly oversight meetings. AT2. NHS Staff Survey results. AT3. National benchmarking data on Freedom to Speak Up.
C2. Trust training and development programmes.			
C3. Trust processes for Freedom to Speak Up and raising concerns.			
C4. Trust arrangements for staff wellbeing support.			
C5. Trust-specific NHS Staff Survey and Equality, Diversity and Inclusion (EDI) action plans (including WRES and WDES).			
C6. Cross-cutting "18,000 Voices" programme as part of One Recovery.			
C7. Adoption of Lord Mann's recommendations on racism and antisemitism in the NHS – Group EDI Policy and EDI Workforce and Plan approved by Board in August 2026.			

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Standardised approach and process for case management across the three Trusts.	Implementation of HR shared service and standardised policies and processes. Contribution from wider corporate services transformation.	October 2026
GC2. Need to develop an intentional culture of improvement and engagement across the Group.	Development of "18,000 Voices" programme as part of One Recovery, comprising four key elements (see below) with agreed programme mandates.	Charters approved in June 2026 and in delivery phase.

GC2a: Vanderbilt	Phased implementation of Vanderbilt professional advocacy programme with a focus on a culture of safety and respect, to be delivered over a four-year period. EDI markers being included in reporting system.	Medical staff/senior leadership roll out from April 2026 Other staff groups roll out summer 2026 to spring 2027.
GC2b: Gemba	Implementation of Gemba programme, with leaders spending time in front-line areas, across Group Executive and Trust leadership teams.	Monthly programme in place from September 2026 for Group Executive and Trust leadership roll out from 2026/27 Q4.
GC2c: Leaders Within	Develop “ Leaders Within ” network to develop future leadership capability across the Group and bring together staff networks.	Design commenced in July 2026 and recruitment from October 2026.
GC2d: Single improvement methodology “Collectively Curious”	Agree and implement single improvement methodology to be introduced through One Recovery programme.	Design commenced in July 2026 and Innovation Panel commences in October 2026.
GC3: Improve job planning	Progress through World Class Basics programme as part of One Recovery.	Ongoing during 2026/27
GC4. Adoption of Lord Mann’s recommendations on racism and antisemitism in the NHS	Paper to be presented to the Group Executive and the Group Board.	July and August 2026
GC5. Increase understanding of Lord Mann’s recommendations and implications for the Group.	Arrange a training and awareness session with the Group Board.	EDI Workforce Strategy and Plan approved by Board in August 2026 and Board workshop being scheduled for autumn 2026.
GC6. Implementation of Group-wide action plan in response to Lord Mann’s recommendations.	Appoint a subject matter expert, roll-out EDI training (including racism and antisemitism) and develop new anti-racism policy.	By December 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	September 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	4	4	12
Target	4	2	2	8
Risk appetite				
Within appetite range?				

Related Group/Trust corporate risks

NNUH: n/a; QEH: 3014 (digital clinical safety culture); JPUH: 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	12	12	12	12	12	12	12	12	12	10	10	10	10	10	10	10	10	10	8
Actual	13	13	13	13	13	13	13	12	12																

Summary of monthly review/amendments

- Current risk score unchanged.

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.	AF1-2. Shared Digital Committee reporting.	AS1-4. Group Executive Board and Group Board.	AT1-3. Annual NHS England Digital Maturity Assessment.

C2. Data Taskforce to deliver infrastructure improvements.			
C3. Single Digital Team to improve specialist capability.	AF3. Corporate Services Transformation Group.		
C4. Electronic Patient Record (EPR) preparatory work to improve data quality.	AF4. EPR Programme Board.		AT4. 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 to be discussed at Group STIP and then Group Board in September/October 2026.
GC2. Skills debt relating to digital immaturity.	Develop a plan to improve and strengthen digital literacy.	September 2027
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. Signed national tenant agreements following discovery work in August.	Single Digital Team Structure to be in place in November 2026 in line with other corporate services.
GC5. Data analytics capability.	Develop and implement plans for a Group-wide Business Intelligence, Analytics and Data Quality function. Market testing exercise to consider outsourced/partially-outsourced data solutions. Action completed.	Solution agreed by the executive in July 2026 and plan forming part of consultation with SDT to move forward.

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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	September 2026
Group Aim and Enabling Objectives	A4: Financial sustainability EO 17-23

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

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

Related Group/Trust significant risks (12 and above)

NNUH: n/a; QEH: n/a; JPUH: n/a; Group – EPR programme: 8008, 6217, 8028, 8029, 6215, 6231, 6255, 8024

	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	13	13	13	13	13	13	12	12	12	12	12	12	11	11	11	9	9	9	9	9	8	8	8	8	8
Actual	13	13	13	13	13	13	13	12	12																

Summary of monthly review/amendments

- Current risk score unchanged.

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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 undertaken with partners to reset programme and reprofile phasing of delivery. Delivery partner procured subject to Group Board approval. Update provided to Group Board and STIP sub-committee in June 2026.	Received and approved by Group Board on 22 July 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.	Training plans to be wrapped into annual activity plans for autumn 2026
GC3. Suppliers' ability to smoothly migrate data across multiple live environments.	Work on data migration and stabilisation with external and internal partners.	Ongoing

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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	September 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	5	3	2	10
Risk appetite				
Within appetite range?				

Related Group/Trust significant risks (12 and above)

NNUH: 7 (cyber security), 12 (data protection breaches); QEH: 3449 (cyber security and MFA); JPUH: 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	13	13	13	13	13	13	13	13	13	13	13	13	13	12	12	12	12	12	12	12	12	10	10	10	10
Actual	13	13	13	13	13	13	13	12	12																

Summary of monthly review/amendments

- Current risk score unchanged.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. CAF (Cyber Assessment Framework)-aligned Data Security and Protection Toolkit (DSPT) Improvement Plan and Board cyber risk appetite/dashboard.	AF1. Trust Digital/Cyber teams deliver local controls and evidence. AF2. Group Cyber Task Force tracks action plan, RAID and dashboard. AF3. Digital Group/Group Digital Transformation Forum oversight. AF4. Supplier, patch, restore and incident metrics reported monthly.	AS1. Executive Risk Assurance Group. AS2. Group Strategy, Technology, Investments and Partnerships Committee. AS3. Group Board oversight of PR8 trajectory. AS4. Senior Information Risk Owner (SIRO)/Caldicott review for data protection and clinical safety exceptions.	AT1. Annual DSPT/CAF audit. AT2. Internal Audit cyber programme. AT3. IT Health Checks/penetration tests; ISO27001 (JPUH). AT4. Cyber Essentials Plus readiness/certification pathway in FY2028/29.
C2. Cyber Security Strategy and Cyber Security Action Plan overseen by the Group Cyber Task Force.			
C3. Tier-1 controls: supplier Multi-Factor Authentication (MFA)/Privileged Access Management (PAM), Configuration management Database (CMDB)/asset inventory, vulnerability and patch automation, secure configuration, segmentation, immutable backups and tested recovery.			
C4. Security Information and Event Management (SIEM)/Security Operations Centre (SOC) monitoring, Security Orchestration, Automation and Response (SOAR)-enabled containment playbooks, user education, supplier assurance, document classification/labelling and data loss prevention (DLP).			

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Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Investment and tooling to implement Cyber Strategy and Tier-1 controls.	Finalise QEH/JPUH business cases and deliver Group tooling: MFA/PAM, CMDB, Vulnerability Management, Detection and Response (VMDBR)/patch automation, SIEM/SOC, SOAR, segmentation and backup/recovery; align legacy-estate remediation.	NNUH plan in place; QEH/JPUH cases May/July 2026; phased delivery 2026/27-2028/29.
GC2. IG/cyber governance, policy and document classification/labelling.	Align Group IG/cyber policies; define Microsoft sensitivity labels, retention/DLP and Copilot access controls for SharePoint/OneDrive migration.	Governance June/July 2026; design Q3 2026/27; rollout FY2027/28.
GC3. AI-assisted threat, accelerated patching and containment.	Establish AI-aware monitoring; reduce time-to-patch and time-to-contain for external critical/high exposure; develop SOAR playbooks with clinical safety gates.	Baseline Q3 2026/27; phased SOAR controls FY2027/28.
GC4. NIS regulatory enforcement action at NNUH and QEH in relation to completion of Multi-Factor Authentication (MFA) compliance work.	Funded plan in place and work in progress to complete MFA compliance work.	December 2026

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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	September 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	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		10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	8
Actual		10	10	10	10	10	10	10	10																

Summary of monthly review/amendments

- Risk score unchanged.
- Risk under review with Group Chief Finance Officer and new Group Director of Estates and Facilities.

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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.		
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.	AT5. NHS England regional monitoring. National Mott Macdonald report – December 2025.
C5. Reinforced Autoclaved Aerated Concrete (RAAC) mitigation plans for JPUH and QEH.	AF5. Tracking through respective Estates Groups.	AS5. Reporting to Hospital Management Groups.	

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.	July 2026
GC3. NNUH PFI – confirmation of lifecycle plan.	Working through timetable to programme works by areas/wards.	July 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	September 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	4	4	12
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
Revised							12	12	12	12	12	12	10	10	10	9	9	9	9	9	9	9	9	9	9
Actual	13	13	13	13	12	12	12	12	12																

Summary of monthly review/amendments

- Current risk score unchanged.
- Due date for action to address gap in control GC1 amended from September to October 2026 to reflect Trade Union feedback)

Risk trajectory: Senior Programme Directors have been recruited but will not be in post until October/November 2026, reducing the risk from 12 to 10 (4+3+3). Risk trajectory then reduces from 10 to 9 (4+3+2) following training roll out and implementation.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Work plan in place through One Recovery programme.	AF1. Overseen by Hospital Management Groups.	AS1. Reporting to Transformation Design Authority (TDA), Group Strategy, Technology, Investments and Partnerships (STIP) Committee and Group Board. AS2. Reporting to Group Executive and Group Board. AS3. One Recovery Oversight meetings twice monthly.	AT1. Planned Internal Audit of One Recovery programme in 2026/27 Q4.
C2. Transformation teams in three trusts working on site priorities.			
C3. Acute Clinical Strategy team supporting clinical strategy work.			
C4. Group operating model for transformation agreed by Group Executive in December 2025.			
C5. External consultancy support in place.			
C6. Group Transformation Director appointed.			

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Group Transformation resourcing and team structure.	Transformation function and operating model to be included in Phase 2 of Corporate Services restructuring.	August 2026 <u>September 2026</u> October 2026 (reflecting Trade Union feedback)
GC2. Training programme on improvement programme required.	Develop and roll out training programme for Transformation Team and across the three Trusts.	March 2027

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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	September 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	5	2	1	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	12	12	12	12	12	12	12	12	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	8
Revised									12	12	12	11	11	10	10	10	10	10	10	10	10	10	10	10	8
Actual	12	12	12	12	12	12	12	12																	

Summary of monthly review/amendments
Current risk score unchanged.

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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. AT2. NHS England and national NHP attendance at monthly programme board. Gateway Review assurance embedded within Integrated Assurance and Approvals Plan (IAAP). AT3. Internal Audit Plan for 2026/27 includes audit of NHP programme.
C2. SOCs include detailed design and clinical services configuration, backed by demand and capacity modelling.			
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. Agreement of strategic direction at June 2026 Group Board meeting and further work to be completed by October 2026 in advance of Health Overview and Scrutiny Committee (HOSC) engagement in November 2026.	October 2026 November 2026
GC2. No public engagement plan.	Develop and implement first phase of engagement plan on Clinical Strategy and impact on services and hospital design.	October 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	September 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
Revised							11	11	11	9	9	9	9	9	9	7	7	7	7	7	7	7	7	7	7
Actual	11	11	11	11	11	11	11	11	11																

Summary of monthly review/amendments

- No amendment to current risk score.

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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, including Link NED roles).	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 (<i>ongoing</i>). Annual Governance Statements agreed by Group Board.	AT2. NHS England review of Group Model Mobilisation Plan (December 2025). CQC Well-Led reviews (<i>not yet undertaken</i>). Annual Head of Internal Audit Opinion.
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 (<i>not yet undertaken</i>).	
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 (<i>ongoing</i>). Annual Governance Statements agreed by Group Board.	AT4. Annual Internal Audit review of effectiveness of risk management system. CQC Well-Led review (<i>not yet undertaken</i>).

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Group governance structure not fully implemented.	A1. Proposed Quality and Outcomes Committee to be established and risk appetite approach agreed.	June 2026 September 2026 (December 2026 for embedding)
GC2. 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.	October 2026 (December 2026 for embedding)

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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	September 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	12	12	12	12	12	12																

Summary of monthly review/amendments
• Risk scores unchanged. • No amendments. Risk under review with new Group Director of Communications and Engagement.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Appointment of Group Director of Communications and Engagement.	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. 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
GC2. Lack of Group Communications and Engagement Strategy.	Strategy to be developed following recruitment of new Group Director and implementation of new team.	December 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	September 2026
Group Aim and Enabling Objectives	A3: People and culture A5: Research and education EO 13-16, 24-26

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

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?				

Related Group/Trust significant risks (12 and above)

NNUH: n/a; QEH: 4011 (education governance in surgical specialties); JPUH: 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	10	10	10	10	10	10																

Summary of monthly review/amendments

- No amendments to risk scores.
- Risk requires refresh in October 2026 monthly review round.

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
GC1. Development of future Group operating model for Research, Innovation and Education.	Report commissioned to inform and support decision making on the future Group operating model for RIE. To be received by Group RIE Committee and Group Board.	Received by Group Board in August 2026. Operating model to be developed and update to Group RIE Committee in October 2026.

GA1. Developing Group-level framework defining objectives, risks, performance measures or escalation.	Group Research, Innovation and Education (RIE) Committee established from March 2026. RIE control and assurance framework, including University Hospitals Association (UHA) commitments as core assurance measures, to be developed.	August 2026
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.	August 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.	June 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

Appendix 2: Risk appetite [DRAFT – to be developed with Group Board in May 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

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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. <i>First line:</i> teams, managers and leaders in operational or service delivery functions and in support functions (<i>Trust level</i>) <i>Second line:</i> the oversight of management activity, separate from those responsible for delivery but not independent of the organisation's management chain (<i>Group level</i>) <i>Third line:</i> functions that provide independent and objective assurance regarding the integrity and effectiveness of risk management and related controls in the organisation (<i>External</i>)
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	
ACiC	Group Audit Committees in Common
CDO	Chief Delivery Officer
CEO	Chief Executive
CFO	Chief Financial Officer
CMO	Chief Medical Officer
CN	Chief Nurse
CPO	Chief People Officer
DD	Director of Digital
DG	Director of Governance
DoM	Director of Midwifery
EMD	Executive Managing Director
EO	Enabling Objective
GRAC	Group Risk Assurance Committee
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
QOC	Group Quality and Outcomes Committee
RIE	Group Research, Innovation and Education Committee
STIP	Group Strategy, Technology, Investments and Partnerships Committee

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