Norfolk and Waveney
University Hospitals Group

NORFOLK AND WAVENEY
UNIVERSITY HOSPITALS GROUP

GROUP BOARD MEETING IN PUBLIC:
5 AUGUST 2026

SUPPLEMENTARY PAPERS

This pack contains additional material referenced within individual Group Board papers for the meeting on 5 August 2026

Norfolk and Waveney
University Hospitals Group

NORFOLK AND WAVENEY
UNIVERSITY HOSPITALS GROUP

GROUP BOARD MEETING IN PUBLIC:
5 AUGUST 2026

SUPPLEMENTARY PAPERS
FOR AGENDA ITEM 10.1

NHS
Norfolk and Waveney
University Hospitals Group

Group Integrated Performance Report

Jun-26

NHS
James Paget University Hospitals NHS Foundation Trust

NHS
Norfolk and Norwich University Hospitals NHS Foundation Trust

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

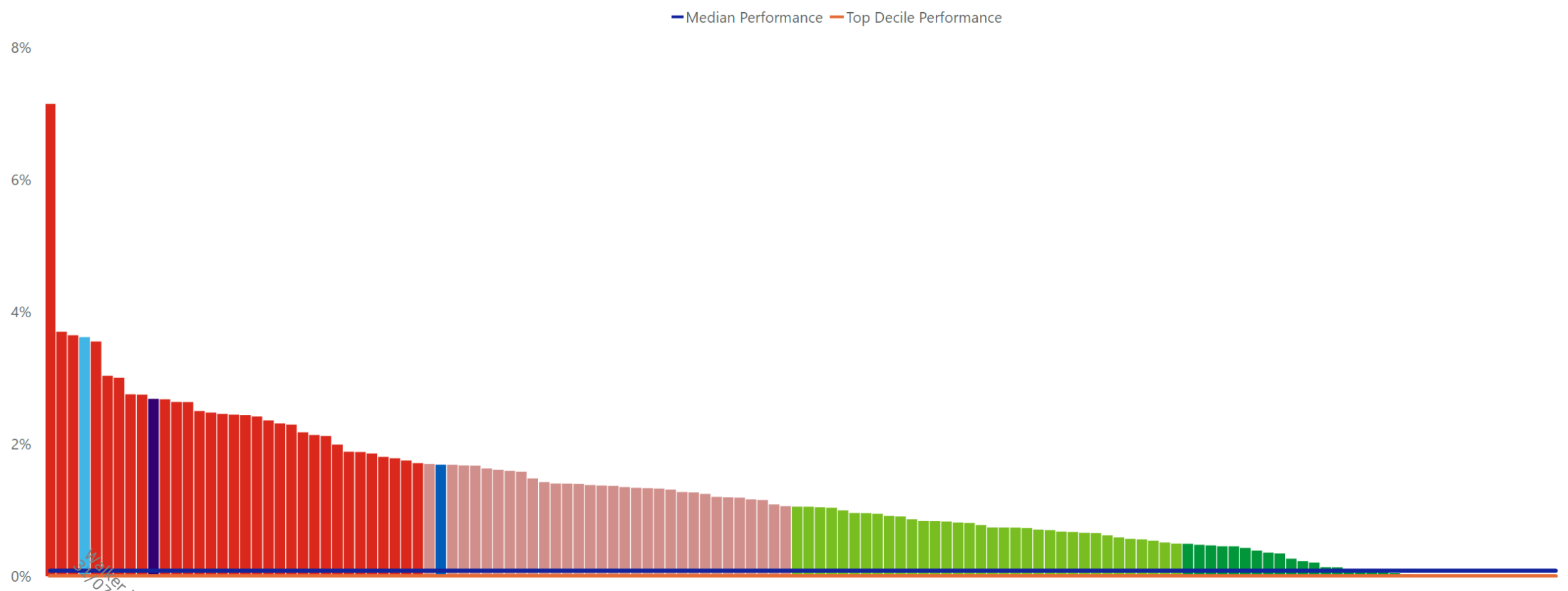
Norfolk and Waveney University Hospitals Group

Benchmarking data is sourced from nationally published NHS England/NHS Digital datasets. Due to differences in publication and validation timetables, benchmark data may relate to an earlier reporting period than the current IPR. The reporting period applicable to each benchmark is shown on the relevant chart.

Benchmarking

May-26

RTT 52+ Weeks



Current Performance

JPUH	3.62%
NNUH	2.68%
QEH	1.69%
0.03% Top Decile	
1.06% Median	

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

Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

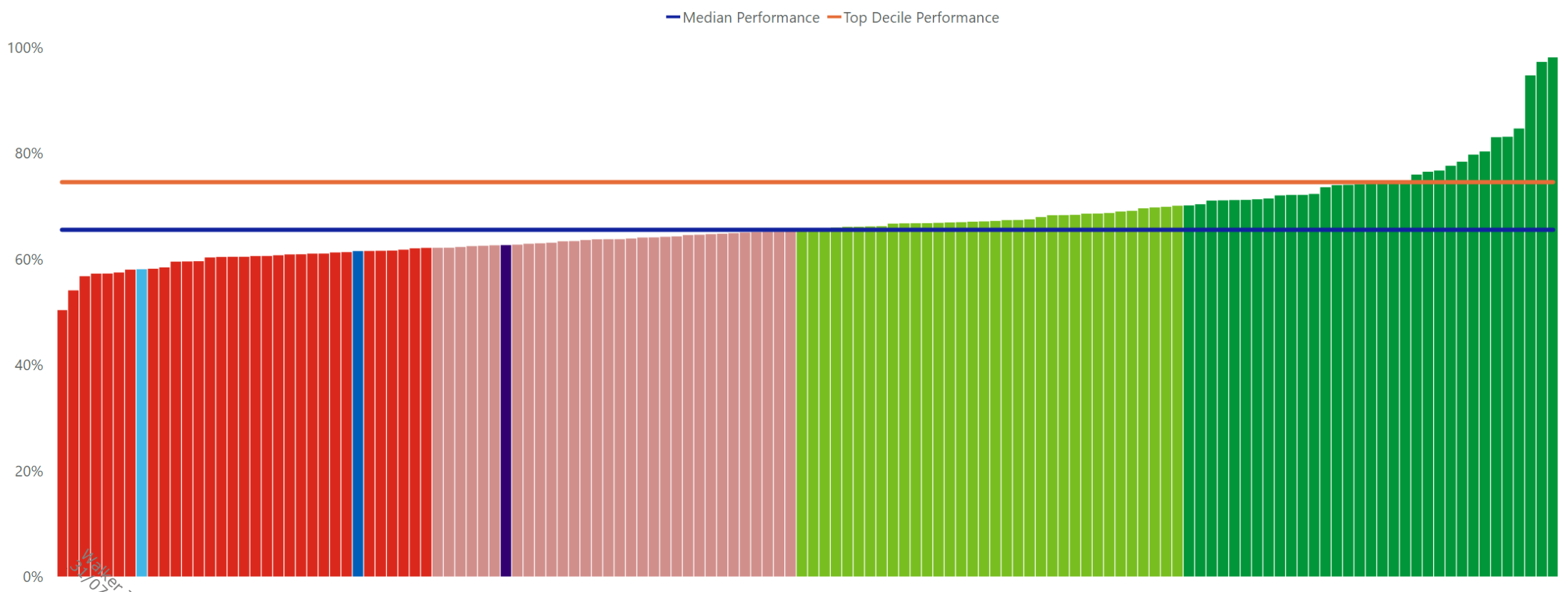
Norfolk and Waveney University Hospitals Group

Benchmarking data is sourced from nationally published NHS England/NHS Digital datasets. Due to differences in publication and validation timetables, benchmark data may relate to an earlier reporting period than the current IPR. The reporting period applicable to each benchmark is shown on the relevant chart.

Benchmarking

May-26

RTT Within 18 Weeks



Current Performance

JPUH	58.06%
NNUH	62.62%
QEH	61.49%
74.51% Top Decile	
65.50% Median	

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

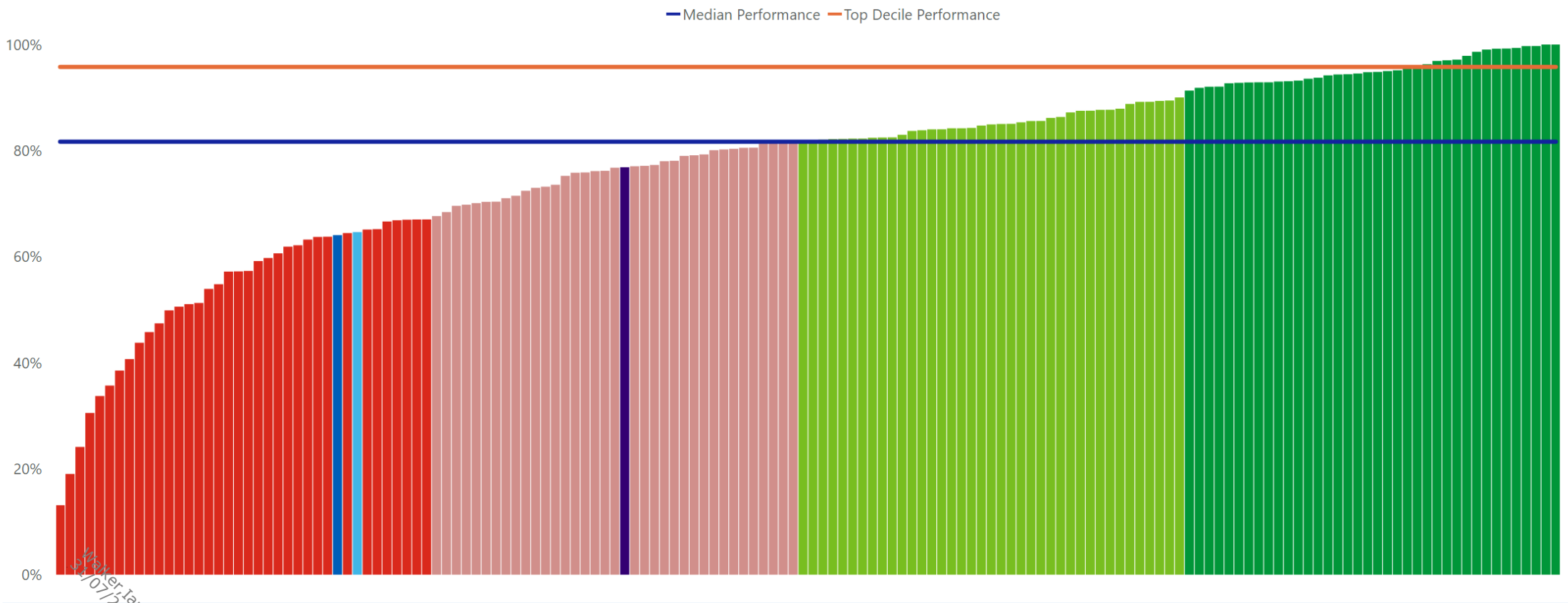
Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

Norfolk and Waveney University Hospitals Group

Benchmarking

Apr-26

6 Week Diagnostics



Current Performance

JPUH 64.62%

NNUH 76.85%

QEH 64.05%

95.76% Top Decile

81.65% Median

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

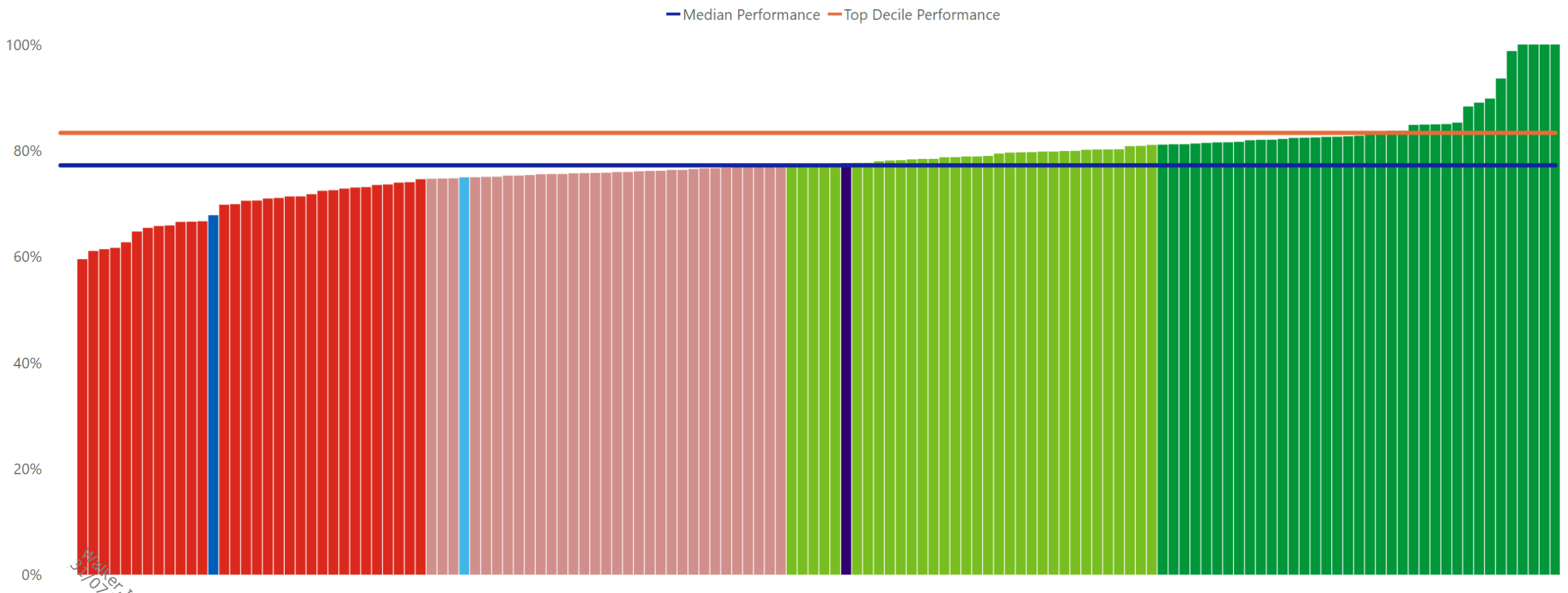
Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

Norfolk and Waveney University Hospitals Group

Benchmarking

Apr-26

Cancer 28 Day FDS - Rolling 12 Months



Current Performance

JPUH	74.95%
NNUH	77.60%
QEH	67.81%
83.33% Top Decile	
77.21% Median	

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

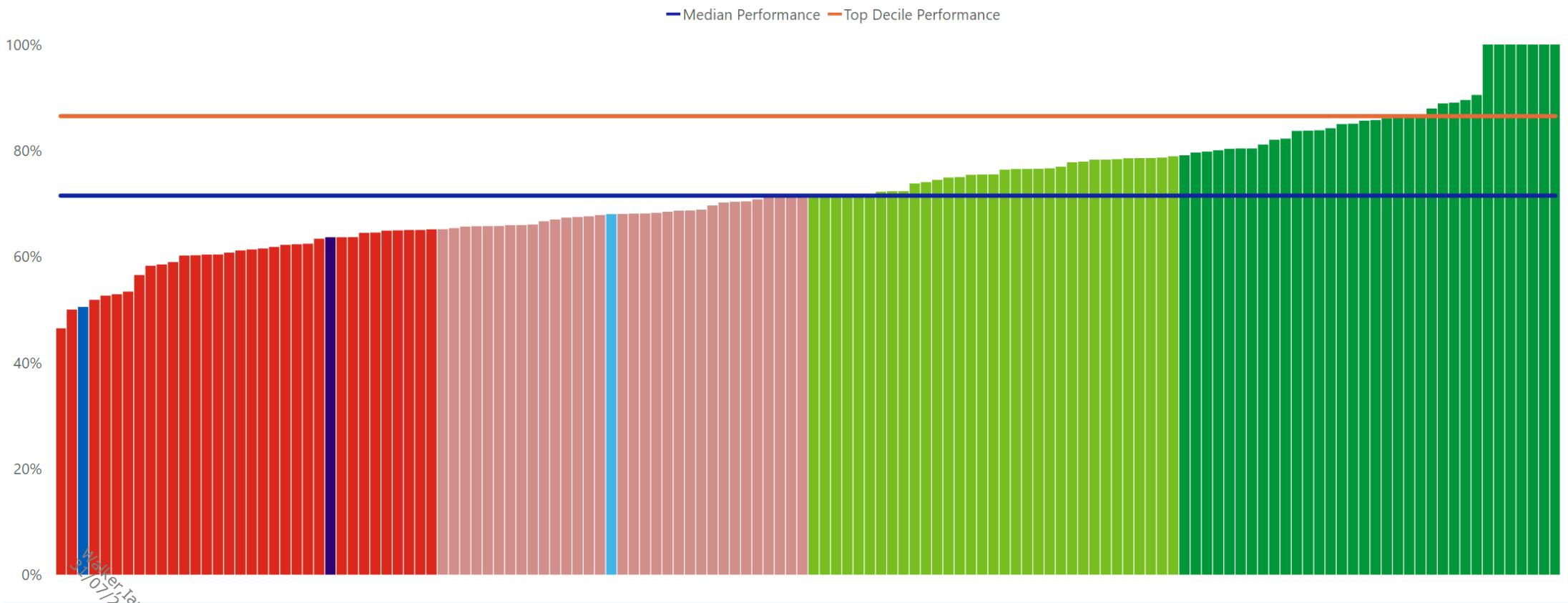
Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

Norfolk and Waveney University Hospitals Group

Benchmarking

Apr-26

Cancer 62 Day Treatment - Current



Current Performance

JPUH 68.02%

NNUH 63.65%

QEH 50.51%

86.50% Top Decile

71.49% Median

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

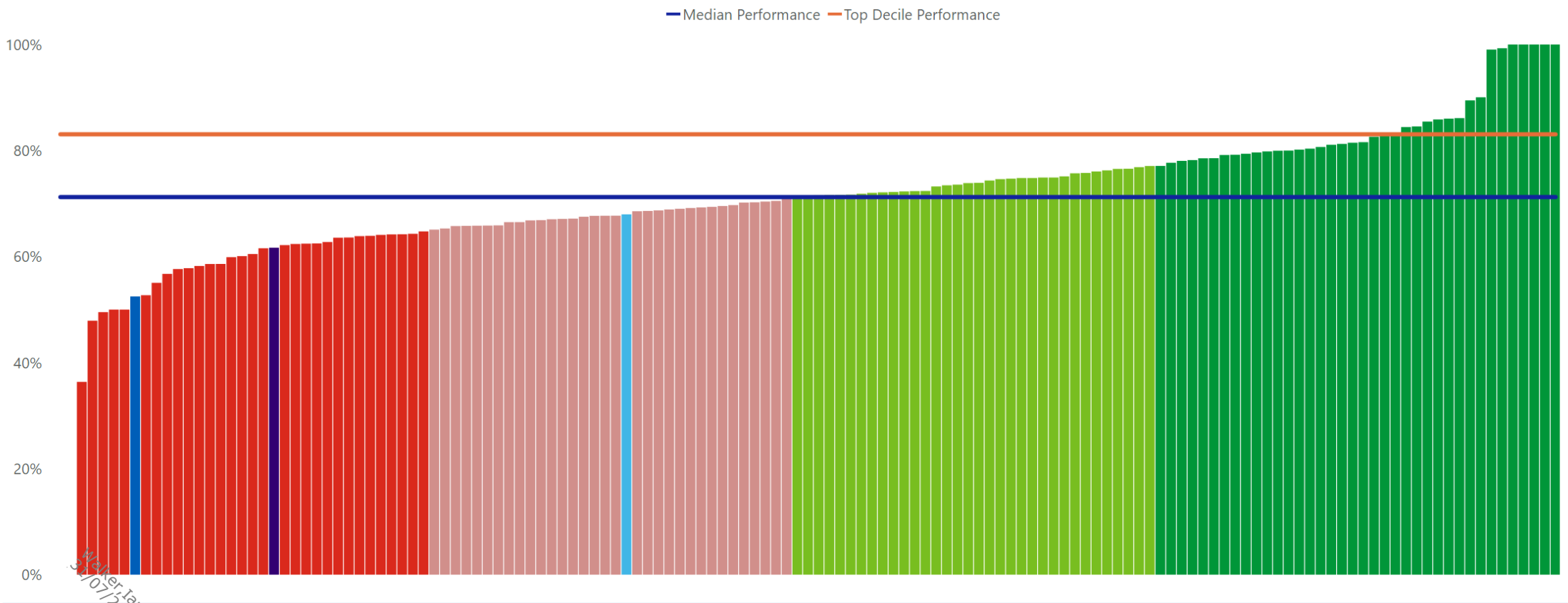
Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

Norfolk and Waveney University Hospitals Group

Benchmarking

Apr-26

Cancer 62 Day Treatment - Rolling 12 Months



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

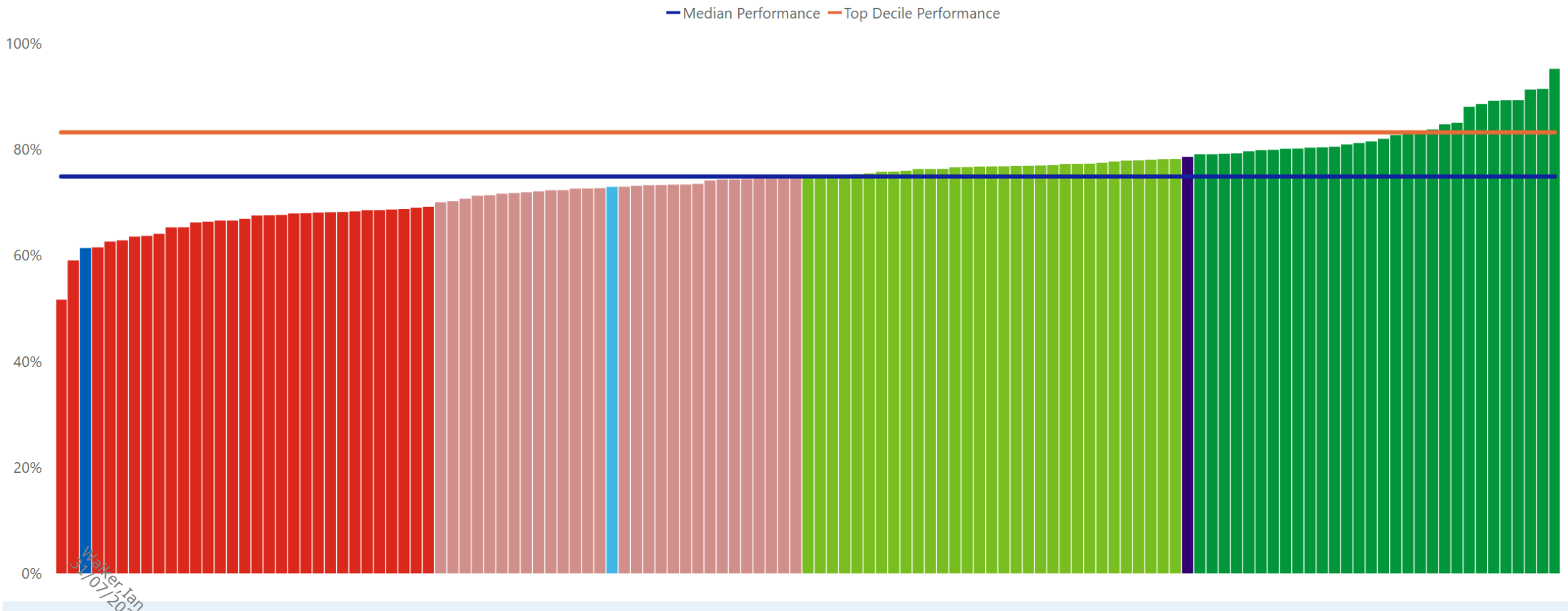
Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

Norfolk and Waveney University Hospitals Group

Benchmarking

Jun-26

ED 4 Hours - Current



Current Performance

JPUH 72.89%

NNUH 78.55%

QEH 61.35%

83.18% Top Decile

74.85% Median

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

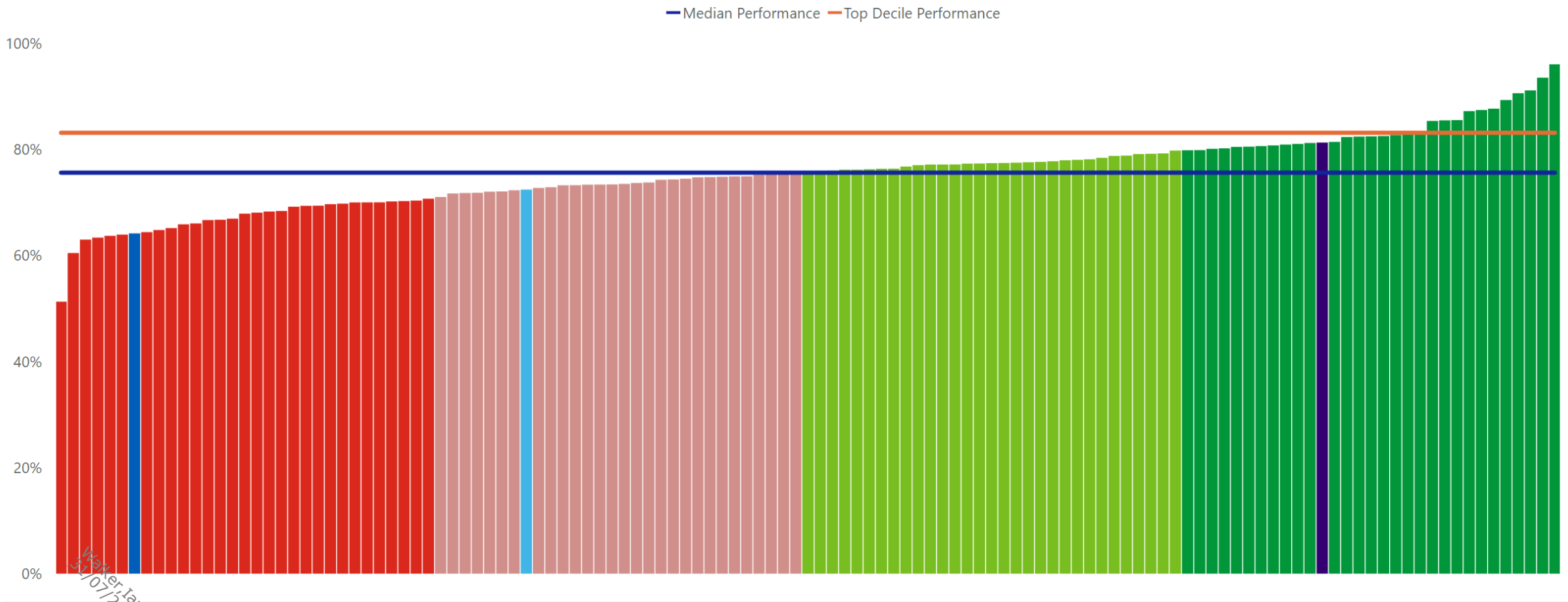
Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

Norfolk and Waveney University Hospitals Group

Benchmarking

Jun-26

ED 4 Hours - Rolling 3 Months



Current Performance

JPUH 72.39%

NNUH 81.26%

QEH 64.14%

83.11% Top Decile

75.58% Median

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

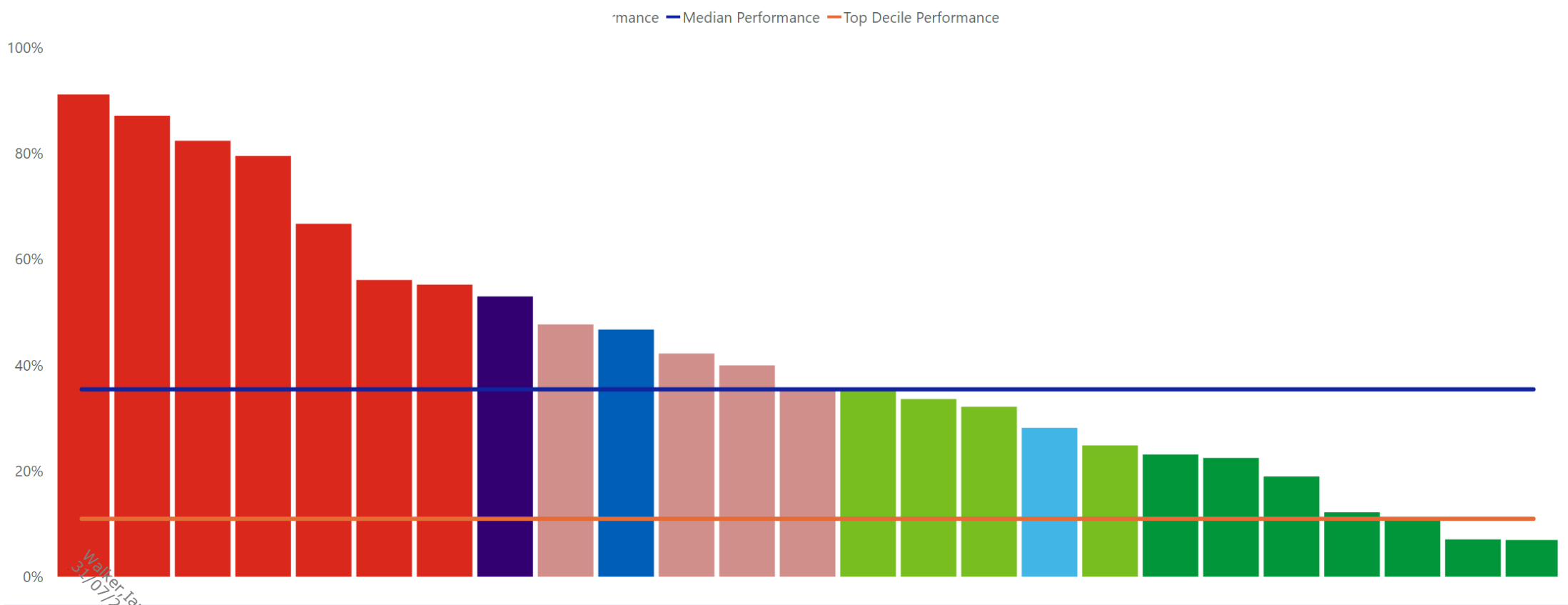
Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

Norfolk and Waveney University Hospitals Group

Benchmarking

Jun-26

Ambulance Handovers - 30 Minutes Current



Current Performance

JPUH 28.13%

NNUH 52.94%

QEH 46.68%

10.93% Top Decile

35.38% Median

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

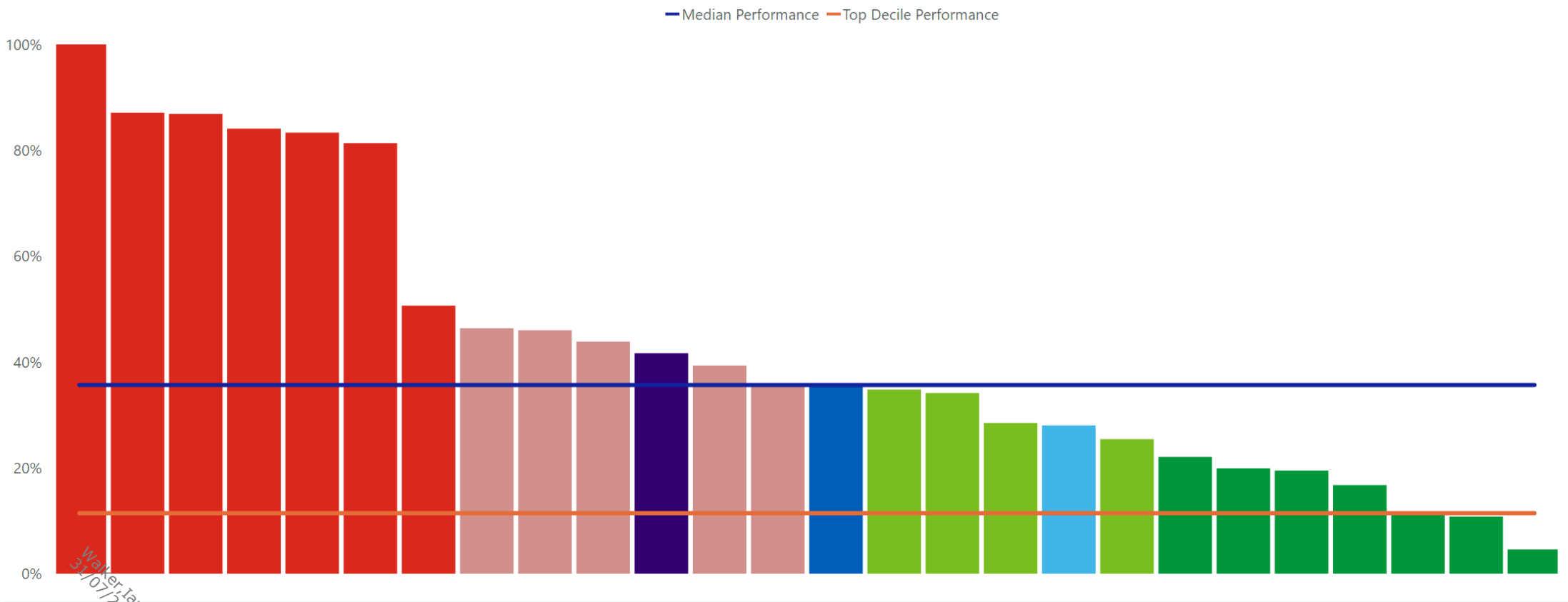
Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

Norfolk and Waveney University Hospitals Group

Benchmarking

Jun-26

Ambulance Handovers - 30 Minutes Rolling 3 Months



Current Performance

JPUH 28.02%

NNUH 41.66%

QEH 35.55%

11.44% Top Decile

35.66% Median

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

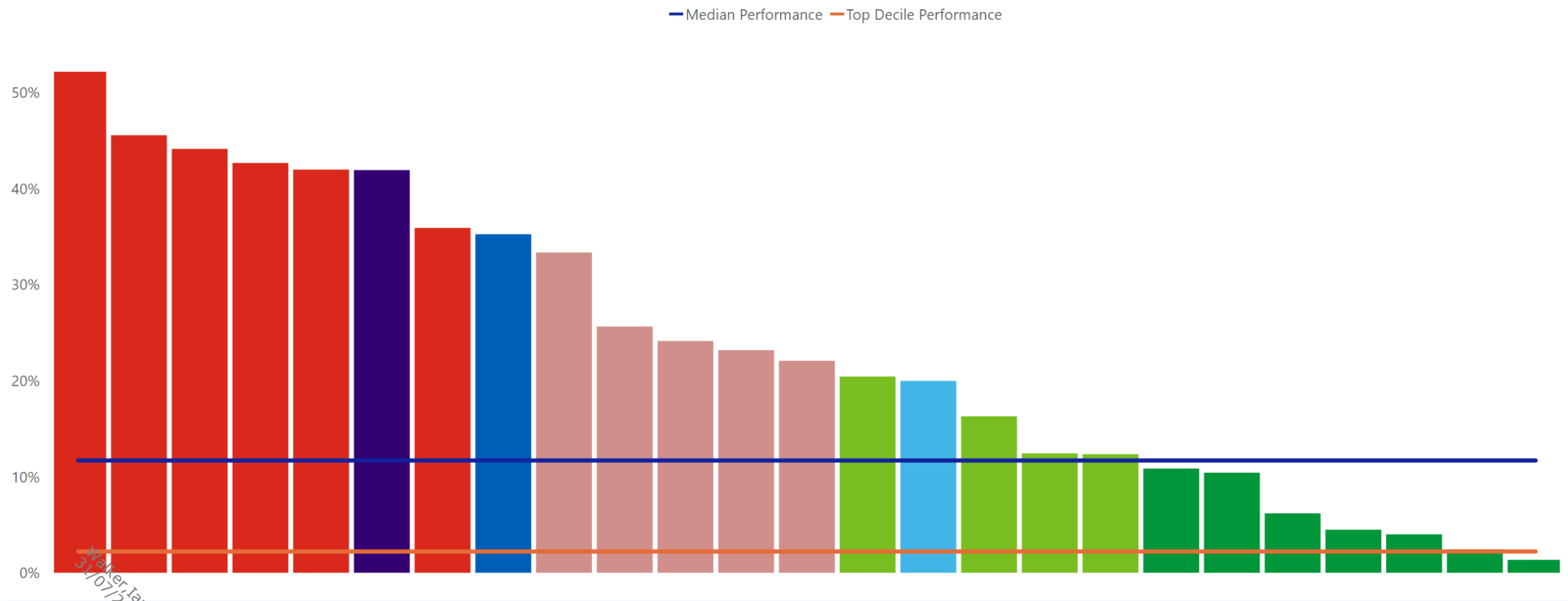
Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

Norfolk and Waveney University Hospitals Group

Benchmarking

Jun-26

Ambulance Handovers - 45 Minutes Current



Current Performance

JPUH 19.97%

NNUH 41.92%

QEH 35.24%

4.00% Top Decile

21.24% Median

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

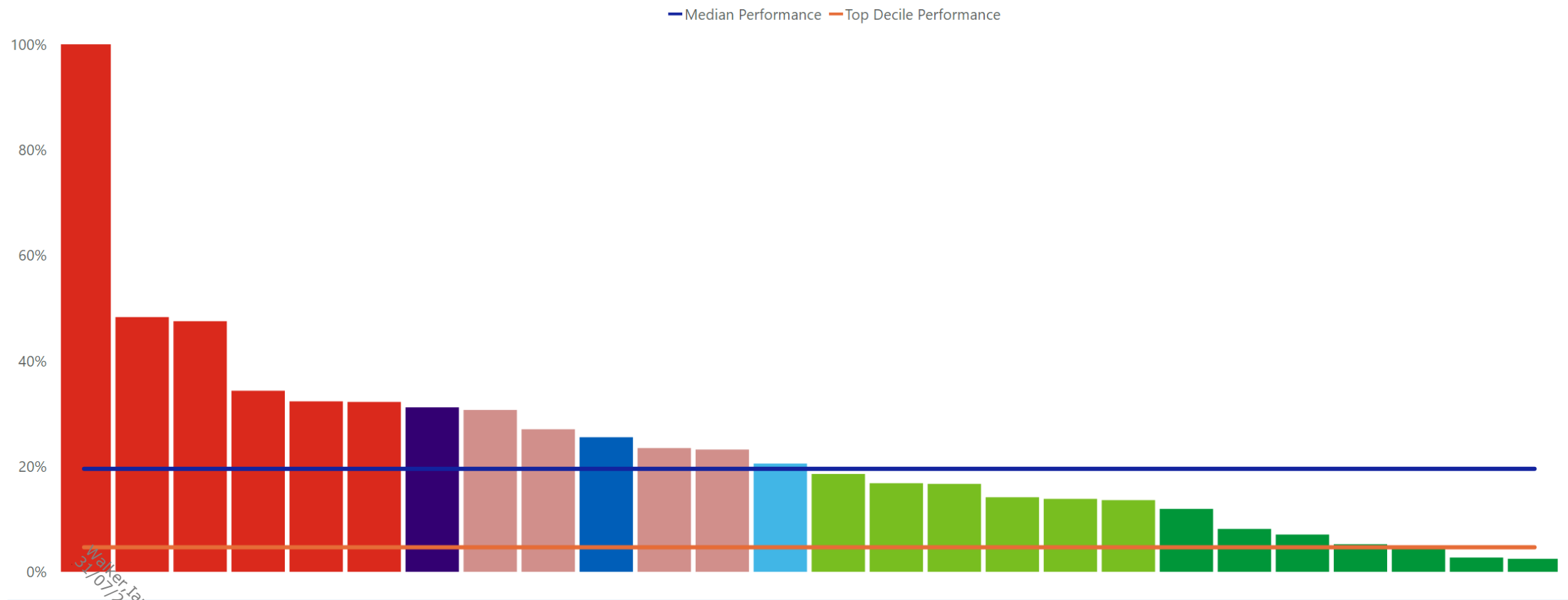
Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

Norfolk and Waveney University Hospitals Group

Benchmarking

Jun-26

Ambulance Handovers - 45 Minutes Rolling 3 Months



Current Performance

JPUH 20.52%

NNUH 31.18%

QEH 25.51%

4.64% Top Decile

19.53% Median

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

Data note: National benchmarking information is sourced from NHS England/NHS Digital published datasets. These publications are released on a delayed schedule and do not align with the Group's internal reporting cycle. As a result, the most recent nationally validated benchmark data available at the time of report production may be several months behind the reporting period being presented.

Norfolk and Waveney
University Hospitals Group

NORFOLK AND WAVENEY
UNIVERSITY HOSPITALS GROUP

GROUP BOARD MEETING IN PUBLIC:
5 AUGUST 2026

SUPPLEMENTARY PAPERS
FOR AGENDA ITEM 13

Norfolk and Waveney
University Hospitals Group

Norfolk and Waveney University Hospitals Group
Anti-Racism, Dignity and Respect Policy

Version 0.4 — July 2026

Approved by the Group Executive Group, 29 July 2026. Presented to the Group Board for ratification, 5 August 2026.

Incorporating the Group's response to Lord Mann's Review, NHS England PRN02538, the IHRA Working Definition of Antisemitism, the Government Definition of Anti-Muslim Hostility, and the NHS Race and Health Observatory Seven Principles of Anti-Racism.

Document Control

For Use In	Norfolk and Waveney University Hospitals Group (NNUH, JPUH, QEH King's Lynn)
Search Keywords	Anti-racism, antisemitism, Islamophobia, anti-Muslim hostility, dignity, respect, harassment, bullying, IHRA, Mann Review, PRN02538, RHO, VPR, discrimination
Document Author	Group Chief People Officer
Document Owner	Group Chief Executive Officer
Approved By	Group Executive Group — 29 July 2026. Staff-side consultation (JNCC/JSCC at each constituent Trust and the staff networks) closed 30 July 2026; should consultation have proposed any significant changes, the policy returns to the Group Executive Group for further approval. The adoption of the IHRA and anti-Muslim hostility definitions and the confirmation to NHS England are unaffected by any such changes.
Ratified By	Group Board — 5 August 2026
Approval Date	29 July 2026
Date to be reviewed by	July 2028, or sooner if required, including on publication of the national uniform guidance or the national anti-racism training
Implementation Date	On ratification by the Group Board
Reference Number	To be assigned by TrustDocs

Version History

Version	Date	Author	Reason / Change
V0.1	June 2026	Group Chief People Officer	Initial draft incorporating the Lord Mann Review, PRN02538, the IHRA and anti-Muslim hostility definitions and the RHO Seven Principles of Anti-Racism.
V0.2	July 2026	Group Chief People Officer	Definitions text restructured into shorter paragraphs; new provision on applying the definitions in practice; freedom of expression safeguards expanded; triage and escalation of concerns added at Section 4.1; safeguarding principles added at Section 4.2; interim measures at Section 4.5 revised to preserve discretion.
V0.3	July 2026	Group Chief People Officer	Status of the IHRA illustrative examples and the operative test set out; prohibition on reliance on stereotypes as a basis for decisions; symbol and political identifier provisions confined to patient-facing settings; recognition that certain political beliefs are capable of protection under the Equality Act 2010; worked examples added at Appendix D.

Version	Date	Author	Reason / Change
V0.4	July 2026	Group Chief People Officer	Section 3.7 revised and retitled; Section 10 cross-reference table reinstated; section numbering and internal cross-references corrected; editorial amendments throughout.

Previous Titles for this Document

This is a new Group policy — the first Group-wide policy of the policy standardisation project. It will be cross-referenced from the Group Misconduct Policy, Group Dignity at Work Policy and Group Grievance Policy as Trust-level policies are harmonised into Group-wide versions.

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from each Trust's intranet or document management system.

Consultation

The following were consulted during the development of this document:

- Group Chief People Officer and Trust HR leads
- Trade Union Partnership Forum / JNCC / JSCC at each Trust (consultation closed 30 July 2026; see Approved By above)
- Staff-side representatives
- Jewish, Muslim and BME staff network representatives
- Group Chief Nurse (Violence Prevention and Reduction Standard alignment)
- Group Director of Governance (Freedom to Speak Up cross-reference)
- Group Director of Communications (engagement provisions)
- Executive Managing Directors, NNUH, JPUH and QEH
- Freedom to Speak Up Guardians

Change Control

No individual Trust is permitted to make changes to this document without prior collaboration with the other two Trusts. It is the responsibility of the owner to instruct the author to conduct a review. Joint agreement must be obtained prior to amending this document.

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this procedural document. This review is continuous; as a minimum it will be achieved at the point the document requires review, for example on changes in legislation, findings from incidents, or document expiry.

Relationship to other procedural documents

This document is a policy applicable to the Norfolk and Waveney University Hospitals Group (NNUH, JPUH and QEH King's Lynn) and is the first Group-wide policy of the policy standardisation project; no other Group-wide policies are yet in place. As the standardisation project harmonises existing Trust-level conduct, dignity at work, grievance and capability policies into Group-wide versions, those Group policies will cross-reference this document for anti-racism standards, definitions and the reporting and response framework. See the cross-reference table at Section 10.

1. Introduction

1.1 Rationale

On 4 June 2026, Lord Mann published his independent review into tackling racism and antisemitism within the NHS. NHS England accepted his recommendations in full. Sir Jim Mackey, Chief Executive of NHS England, and Danny Mortimer, Director General for People, issued PRN02538 the same day, setting out immediate actions for every NHS organisation, with a hard deadline of Friday 31 July 2026 for confirming adoption of the IHRA working definition of antisemitism and the Government definition of anti-Muslim hostility.

Antisemitism and all forms of racism have no place in the NHS. Patients should never feel anxious when receiving care and no member of staff should ever feel isolated, intimidated or unwelcome in their workplace. This policy sets out how the Norfolk and Waveney University Hospitals Group will meet its obligations under the Mann Review, PRN02538, the Equality Act 2010, the NHS Constitution and the NHS Long Term Workforce Strategy.

A co-signed all-staff communication from the Group Chief Executive Officer and Group Chief People Officer was issued in June 2026 setting out the Group's five commitments: standards; adoption of the definitions and the RHO principles; a single Group approach to dignity at work; training, including Board-level anti-racism training; and support and safety, with protection from retaliation. This policy gives effect to those commitments. It is presented alongside, and forms Phase 2 of, the Group's first EDI Workforce Strategy 2026/27, approved by the Group Executive Group on 29 July 2026.

This policy is the first Group-wide policy of the Group's policy standardisation project. As existing Trust-level conduct, dignity at work, grievance and capability policies are harmonised into single Group-wide versions, those policies will cross-reference this document as the authoritative source for anti-racism definitions, standards and the reporting and response framework for racism cases.

1.2 Objective

The objective of this policy is to:

- Formally adopt the IHRA working definition of antisemitism and the Government definition of anti-Muslim hostility across the Group, with practical guidance on their application.
- Commit the Group to the NHS Race and Health Observatory Seven Principles of Anti-Racism.
- Establish a clear, consistent reporting and response framework for racism, antisemitism, anti-Muslim hostility and all forms of race-related harassment and discrimination across NNUH, JPUH and QEH.
- Create a rebuttable presumption in favour of formal investigation where racism, antisemitism or anti-Muslim hostility is the subject matter, so that cases are not "resolved away" informally without proper findings.
- Set specialist investigator standards for cases involving racism, antisemitism and anti-Muslim hostility.
- Establish provisions addressing racist behaviour by patients, visitors and members of the public towards staff, aligned with the Violence Prevention and Reduction Standard.
- Define mandatory training requirements, including Board-level anti-racism training accountability.
- Set governance and accountability requirements for Board-level scrutiny of staff survey data on racism, disproportionality monitoring, and alignment with the NHS Staff Standards.
- Ensure clear routing for racism-related concerns through Freedom to Speak Up.

- Provide the audit trail required by NHS England PRN02538, with a cross-reference matrix showing how each Mann Review and PRN02538 requirement is met (Appendix A).

1.3 Scope

This policy applies to:

- All colleagues employed by NNUH, JPUH or QEH, including those on honorary contracts, secondment, bank, agency and locum arrangements.
- All volunteers working within any Group site.
- All students on placement within any Group site.
- Board members, Non-Executive Directors, governors and committee members of each Trust and of the Group.
- In respect of Section 5 (Patient, Visitor and Public-Originating Racism), all patients, visitors and members of the public while on Group premises or engaging with Group services, including community and home-based services.

For medical staff, this policy is subject to the requirements set out in Maintaining High Professional Standards (MHPS) in the NHS and the GMC Order 2026 (as amended). Where MHPS provisions conflict with this policy, MHPS takes precedence on procedural matters; the substantive anti-racism standards in this policy apply to all staff groups without exception.

1.4 Glossary

Term	Definition
BAME / BME	Black, Asian and minority ethnic (noting current debate on terminology; used here for consistency with WRES reporting)
EDHR	Equality, Diversity and Human Rights
EMD	Executive Managing Director
ERAG	Executive Risk and Assurance Group
FTSU	Freedom to Speak Up
GCPO	Group Chief People Officer
GMC	General Medical Council
IHRA	International Holocaust Remembrance Alliance
JNCC / JSCC	Joint Negotiating and Consultative Committee / Joint Staff Consultative Committee
JPUH	James Paget University Hospitals NHS Foundation Trust
MHPS	Maintaining High Professional Standards
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
NWUHG	Norfolk and Waveney University Hospitals Group
PCMG	People and Culture Management Group
PALS	Patient Advice and Liaison Service
PRN02538	NHS England publication reference for the 4 June 2026 letter to NHS leaders
QEH	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
RHO	NHS Race and Health Observatory
VPR	Violence Prevention and Reduction
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

2. Responsibilities

Group Board / Group Chair. Accountable for setting the tone on anti-racism across the Group and for ensuring each constituent Trust Board adopts this policy and monitors progress against it.

Group Chief Executive Officer. Senior accountable officer for this policy and for the Group EDI Workforce Strategy 2026/27. Responsible for the public Group commitment statement naming antisemitism, anti-Muslim hostility, anti-Black racism, anti-Asian racism and all forms of racism, for publication on all three Trust websites following ratification. Accountable for the response to problem areas identified at any constituent Trust.

Group Chief People Officer (GCPO). Document author, and responsible for the delivery of this policy and of the Group EDI Workforce Strategy 2026/27, reporting to the Group Chief Executive Officer as senior accountable officer. Responsible for the development, review and operational implementation of this policy. Responsible for completing the NHS England PRN02538 confirmation survey, one return per constituent Trust. Leads quarterly reporting to the Executive Risk and Assurance Group on anti-racism metrics including detriment and disproportionality data, with an annual deep-dive to the Group Board. Named officer for escalated race discrimination and Freedom to Speak Up concerns.

Executive Managing Directors (EMDs) — NNUH, JPUH and QEH. Responsible for the implementation of this policy and delivery of the Group strategy at site level, and for ensuring Board and committee scrutiny of staff survey data on racism experience at their Trust. Accountable to the Group Chief Executive Officer for doing so.

Trust HR leads. Responsible for operational delivery of the reporting and response framework in Section 4, including ensuring investigating officers meet the specialist standards in Section 4.3. Responsible for maintaining disproportionality data and producing quarterly reports.

All line managers. Responsible for creating an environment free from racism, harassment and discrimination. Responsible for following the reporting and response framework in Section 4 when concerns are raised, including the default-to-formal requirement in Section 4.2. Responsible for recording incidents via Datix.

All colleagues. Every member of staff has a responsibility to treat colleagues, patients and visitors with dignity and respect, a right to work in an environment free from racism, harassment and discrimination, and is encouraged to report racist behaviour, whether experienced or witnessed, through the routes set out in Section 4.1.

Freedom to Speak Up Guardians. Responsible for ensuring racism-related concerns raised through FTSU are routed in accordance with Section 9 and Appendix B.

Group Chief Nurse. Co-owner, with the GCPO, of Section 5 (patient, visitor and public-originating racism) and of Violence Prevention and Reduction Standard alignment. Responsible for ensuring PALS and complaints handlers receive bespoke training (Section 7.4).

Group Director of Governance. Responsible for ensuring Datix reporting categories are configured to capture racism-related incidents in a way that supports disaggregated analysis by protected characteristic, and for maintaining the detriment and disproportionality assessment (Appendix C).

Staff network chairs (Jewish, Muslim, BME and other faith and ethnic networks). Provide lived-experience insight to inform the development, review and application of this policy, and will be engaged as part of any review or revision of the definitions' application guidance.

3. Strategic Framework and Definitions

3.1 The Group's Anti-Racism Commitment

The Norfolk and Waveney University Hospitals Group is committed to being an actively anti-racist organisation. We name racism, including antisemitism, anti-Muslim hostility, anti-Black racism, anti-Asian racism and racism against any ethnic or religious group, as unacceptable in any form, in any setting, from any source. This includes racism between colleagues, racism by colleagues towards patients, racism by patients or visitors towards colleagues, and structural or systemic racism in our policies, practices and decision-making.

We recognise that the NHS is not immune to the persistent and systemic challenges of racism, discrimination and inequality that exist in wider society. We commit to being honest about the challenges we face and taking strong action to address them.

3.2 IHRA Working Definition of Antisemitism

The Group formally adopts the International Holocaust Remembrance Alliance (IHRA) non-legally binding working definition of antisemitism, adopted by the IHRA Plenary in Bucharest on 26 May 2016 and by the UK Government on 12 December 2016. The full text of the IHRA working definition is as follows:

> *"Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities."*

To guide the Group in its work, the definition is accompanied by the IHRA's illustrative guidance and contemporary examples. Manifestations might include the targeting of the State of Israel, conceived as a Jewish collectivity; however, criticism of Israel similar to that levelled against any other country cannot be regarded as antisemitic.

The full set of the IHRA's contemporary illustrative examples is adopted with the definition, covering, among others: calling for or justifying harm to Jews; mendacious, dehumanising or stereotypical allegations about Jews or Jewish collective power; collective responsibility; Holocaust denial or distortion; accusations of dual loyalty; denial of the Jewish people's right to self-determination; double standards; classic antisemitic symbols and imagery; Nazi comparisons; and holding Jews collectively responsible for the actions of the State of Israel.

Antisemitic acts are criminal when they are so defined by law. Criminal acts are antisemitic when the targets are selected because they are, or are perceived to be, Jewish or linked to Jews. Antisemitic discrimination is the denial to Jews of opportunities or services available to others.

The definition and its illustrative examples are a tool to help identify antisemitism; they are not a mechanism to suppress legitimate debate. Sections 3.4 and 3.5 set out the approach to application and how this balance is managed in practice.

3.3 Government Definition of Anti-Muslim Hostility

The Group formally adopts the UK Government's non-statutory definition of anti-Muslim hostility, published on 9 March 2026 as part of the Social Cohesion Action Plan ("Protecting What Matters"), developed by the independent Working Group chaired by Dominic Grieve KC. The full text of the Government's definition is as follows:

> *"Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts — including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated — that are directed at Muslims because*

of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

It is engaging in unlawful discrimination where the relevant conduct — including the creation or use of practices and biases within institutions — is intended to disadvantage Muslims in public and economic life."

This definition must be read alongside its accompanying text, which makes clear that open debate in the public interest is important and must be fully safeguarded. Protected expression includes: criticism of a religion or belief, including Islam, or of its practices, or critical analyses of its historical development; ridiculing or insulting a religion or belief, or portraying it in a manner some adherents might find disrespectful; criticism of the belief systems or practices of individual adherents; raising concerns in the public interest; and contributing to debates in the public interest, including academic and political debate.

The terminology "anti-Muslim hostility" reflects the wider prejudice and discrimination Muslims face and focuses squarely on Muslims as individuals rather than Islam as a religion; "hostility" focuses on actions and conduct rather than the holding of beliefs. The definition is non-statutory, does not change or override the law, does not affect sentencing or create new crimes, does not prevent raising concerns in the public interest, and is not about protecting a religion from criticism — only protecting people from targeted hostility. Context must always be taken into account when interpreting and applying the definition.

3.4 Applying the Definitions in Practice

This section is the application guidance referred to at Section 1.2. It is binding on every manager, investigator and decision-maker across the Group. Worked examples are at Appendix D.

Status of the definitions and the illustrative examples. The definitions are an aid to identification and understanding. They are not determinative of whether misconduct, harassment or discrimination has occurred. The IHRA's illustrative examples are illustrative, not determinative: whether any example is engaged is a matter to be assessed in the light of the overall context, as the IHRA text itself and the Mann Review both make clear. No conduct is antisemitic, or amounts to anti-Muslim hostility, merely because it can be placed alongside one of the examples.

The operative test. In assessing whether conduct is antisemitic, the question is whether it evidences hatred or hostility towards Jewish people as Jewish people. In assessing whether conduct amounts to anti-Muslim hostility, the question is whether it evidences hostility towards Muslims, or those perceived to be Muslim, as Muslims. Criticism of the policies or actions of the State of Israel, or of Zionism as a political position, is not to be treated as antisemitic in the absence of cogent evidence of such hostility. Criticism of Islamic theology or practice is not to be treated as anti-Muslim hostility in the absence of cogent evidence of hostility towards Muslims as people.

Matters to be assessed. Managers, investigators and decision-makers should consider the wording used, the context in which it was used, the audience, any pattern of conduct, the purpose and effect of the conduct, the impact on those affected, and whether any illustrative example is engaged.

Evidential threshold. A finding that conduct is antisemitic or amounts to anti-Muslim hostility requires cogent evidence. It must not be inferred from a person's ethnicity, nationality, faith, or from the political views they are known or assumed to hold.

Prohibition on reliance on stereotypes. No decision under this policy may rely on any of the following assumptions, each of which is prohibited as a basis for any finding, sanction or interim measure:

- that Palestinian, Arab or Muslim colleagues are, by reason of their ethnicity, nationality or faith, more likely to be antisemitic;
- that Jewish colleagues necessarily identify with, support or are answerable for the State of Israel or its policies — an assumption which may itself be antisemitic;
- that colleagues holding pro-Palestinian or anti-Zionist views are for that reason antisemitic;
- that colleagues expressing concern about anti-Muslim hostility are for that reason hostile to Jewish colleagues.

Recording. Where either definition is relied on in reaching a decision, the decision-maker must record in writing which definition was applied, the evidence relied on, and the reasoning. This record forms part of the case file and is subject to the disproportionality analysis at Section 8.2.

Consequences. Conduct assessed as antisemitic or as amounting to anti-Muslim hostility will be addressed under the Group's conduct, dignity at work or grievance arrangements as applicable, proportionately to its seriousness. The definitions do not create a separate sanction and do not displace the ordinary requirements of fairness or the ACAS Code of Practice.

3.5 Balancing the Definitions with Freedom of Expression

Both definitions exist in a legal landscape that includes Articles 9 and 10 of the European Convention on Human Rights (freedom of thought, conscience and religion, and freedom of expression) and the protections of the Equality Act 2010. The Group recognises that:

- The right to freedom of expression is a qualified right and must be balanced against the rights of others to dignity, safety and protection from discrimination.
- The definitions are tools for identification and education, not instruments of censorship. They do not override any individual's legal right to hold or express a belief, provided that expression does not amount to harassment, discrimination, victimisation, or instructing, causing or inducing any of those.
- Criticism of the policies or actions of the State of Israel, expressions of support for a Palestinian state, advocacy of Palestinian rights and discussion of Middle East politics, where not expressed in a way that is antisemitic, are legitimate political discourse and are not captured by the IHRA definition.
- Criticism of Islamic theology or practice, where not directed at individuals or expressed in a way that harasses or discriminates, is legitimate and is not captured by the Government definition.
- Harassment under section 26 of the Equality Act 2010 may be established by the effect of conduct as well as its purpose. A person may not intend to harass, but if the conduct has that effect, having regard to the perception of the person affected, the other circumstances and whether it is reasonable for the conduct to have that effect, the definition may be met.
- In applying these definitions, decision-makers must consider context, content, purpose, effect and overall circumstances. A single comment may not constitute harassment; a pattern of behaviour may do so.
- Any action taken on the basis of either definition must be proportionate and compliant with the Equality Act 2010, the Human Rights Act 1998 and relevant

employment law. The Group will not use either definition to pursue vexatious or disproportionate action.

The Group notes that the adoption of the IHRA definition is the subject of contention within some professional bodies, including a British Medical Association motion calling for its revocation pending free-speech safeguards. The safeguards in this section and at Section 3.4 — together with the even-handed, cross-characteristic scope of this policy, which names and addresses all forms of racism equally — are the Group's answer to those concerns and will be kept under review through staff-side partnership arrangements.

3.6 NHS Race and Health Observatory Seven Principles of Anti-Racism

The Group signs up to the NHS Race and Health Observatory (RHO) Seven Principles of Anti-Racism, in line with NHS England PRN02538. As published by the RHO, the principles are:

- Name Racism — demonstrate leadership by naming racism.
- Understand and Acknowledge — understand and acknowledge racism and its impacts.
- Meaningfully Involve Communities — co-produce solutions with staff and communities.
- Collect and Publish Data — collect, analyse, act on and publish race and ethnicity data.
- Identify Racial Bias — identify and address racial bias in systems and processes.
- Apply a Race-critical Lens — apply a race-critical lens to policy and practice.
- Evaluate and Reflect — evaluate impact and reflect to continuously improve.

These principles inform the design and review of all Group people policies, including those being harmonised through the policy standardisation project. The GCPO will report annually to the Group Board on progress against each principle.

3.7 The Group's Position

3.7.1 Adoption is a decision, not a requirement. NHS England has adopted the IHRA working definition and PRN02538 strongly encourages NHS organisations to do the same, but no direction has been made requiring NHS providers to adopt it. The Group has adopted both definitions as a matter of decision, approved by the Group Executive Group on 29 July 2026 and ratified by the Group Board on 5 August 2026, having considered the legal implications of doing so.

3.7.2 Adoption with published application guidance. The Group's position is that a definition adopted without guidance on how it will be applied gives managers no defensible basis for the decisions it asks them to make. The Group has therefore adopted both definitions together with the operative test, the evidential threshold, the status of the illustrative examples, the prohibition on reliance on stereotypes and the recording requirement at Section 3.4; the freedom of expression safeguards at Section 3.5; the provisions on symbols and political identifiers at Section 6; and the worked examples at Appendix D. The Group has considered a counsel's opinion of 15 July 2026 on the legal implications of the adoption of the IHRA definition within the NHS, commissioned by a third party and circulated to NHS organisations, and the matters that opinion identifies as necessary where a definition is adopted are addressed in those provisions.

3.7.3 Protected beliefs. The Group recognises that beliefs concerning Israel, Zionism and Palestinian rights may constitute philosophical beliefs capable of protection under section 10 of the Equality Act 2010, and that an Employment Tribunal has so held in respect of anti-Zionist beliefs. Holding such a belief is not, and must never be treated as, evidence of antisemitism. The manifestation of any belief remains subject to the same standards of

conduct as apply to everyone under this policy. The Group will keep this section under review as case law develops.

3.7.4 Independent advice. Where appropriate, and in any genuinely contested case, the Group will take independent legal advice before reaching a decision. Human Resources must be involved in any case in which either definition is relied on.

3.8 Definitions: Racism, Harassment, Bullying and Discrimination

Term	Definition
Racism	Prejudice, discrimination, hostility or abuse directed at someone because of their race, ethnicity, colour, nationality, national origin, or perceived racial or ethnic background. Racism can be direct or indirect, individual or structural. It includes but is not limited to antisemitism, anti-Muslim hostility, anti-Black racism, anti-Asian racism, racism against Gypsy, Roma and Traveller communities, and racism against any other ethnic group.
Antisemitism	As defined in Section 3.2 (IHRA working definition), applied in accordance with Section 3.4.
Anti-Muslim hostility / Islamophobia	As defined in Section 3.3 (Government definition), applied in accordance with Section 3.4.
Racial harassment	Unwanted conduct related to race that has the purpose or effect of violating a person's dignity, or creating an intimidating, hostile, degrading, humiliating or offensive environment for that person (Equality Act 2010, s.26). A single incident of unwanted conduct can amount to harassment.
Racial discrimination	Treating a person less favourably because of their race (direct discrimination) or applying a provision, criterion or practice that is not a proportionate means of achieving a legitimate aim and which puts persons of a particular race at a particular disadvantage (indirect discrimination) (Equality Act 2010, ss.13 and 19).
Victimisation	Treating a person less favourably because they have made or supported a complaint of racial discrimination or harassment, or because they are suspected of having done or intending to do so (Equality Act 2010, s.27).
Microaggression	Brief, commonplace exchanges that send denigrating messages to individuals based on their group membership. While individual microaggressions may appear minor, their cumulative effect can be significant and damaging.

4. Reporting and Response Framework

This section establishes the Group's framework for reporting, investigating and resolving cases of racism, antisemitism, anti-Muslim hostility and race-related harassment and discrimination. It applies to all concerns involving staff-to-staff, staff-to-patient, or patient and visitor-to-staff racism. As the policy standardisation project harmonises the existing Trust-level conduct and grievance policies into Group-wide versions, those Group policies will reference this framework as the required process for racism cases.

4.1 Reporting Routes

Any colleague who experiences or witnesses racist behaviour may report it through any of the following routes:

- Directly to their line manager or a more senior manager.
- To their Trust's HR team.
- To their trade union representative.
- Through the Freedom to Speak Up Guardian (see Section 9).
- Via Datix incident reporting, using the racism and hate-incident category.
- To the Employee Assistance Programme for confidential support (this route does not initiate an investigation but ensures wellbeing support).

- To the GCPO or EMD directly, where the colleague does not feel safe using other routes.

Anonymous reporting is possible via Datix or FTSU. The Group encourages named reporting where the individual feels able to do so, as this allows a more thorough investigation and better support for the individual.

Reports of racism will be recognised and named as such, and appropriately triaged, categorised, risk assessed and escalated on receipt. They must not be recorded under a generic heading that obscures the racial or religious element.

No concern will be closed without a recorded decision and rationale. The Group will not administratively close racism-related cases. Every case must have a recorded finding (substantiated, not substantiated, or partially substantiated) and a named decision-maker.

4.2 Default to Formal Investigation for Racism Cases

Provision introduced in response to the Lord Mann Review and PRN02538.

Where a complaint or concern raises an allegation of racism, antisemitism, anti-Muslim hostility, or race-related harassment or discrimination, there is a rebuttable presumption in favour of formal investigation. This means:

- The default position is that the case will proceed to a formal investigation under the Group's conduct, misconduct or grievance policy as harmonised through the policy standardisation project.
- Informal resolution, including mediation, may only be used if **all** of the following conditions are met: (a) the complainant expressly requests informal resolution after having been informed of the formal route and their right to use it; (b) the HR lead for the case and a senior manager at Band 8b or above agree that informal resolution is appropriate given the nature and severity of the allegation; and (c) the decision to proceed informally, and the reasons for it, are recorded in writing.
- Where informal resolution is used, the case must still be recorded on Datix and flagged for inclusion in the quarterly disproportionality data report (Section 8.2).
- If the complainant initially agrees to informal resolution but later wishes to escalate to formal investigation, this must be facilitated without delay and without any adverse inference being drawn from the initial choice of route.

All racism investigations shall be conducted in accordance with safeguarding principles, including safety, dignity, confidentiality, protection from retaliation and wellbeing support.

Rationale. Lord Mann's review found large volumes of antisemitism-related complaints closed without meaningful resolution. The resolution-default culture in many Trusts, while well-intentioned as a general approach to workplace conflict, can have the unintended effect of sweeping racist conduct under the carpet. This provision ensures that racism cases receive the investigative scrutiny they require, while preserving the complainant's agency to choose informal resolution if they genuinely wish to. Lord Mann also recommends that trusts consider routes for early intervention and resolution and take account of the ACAS Code of Practice; the presumption is therefore rebuttable rather than absolute, and is designed to make decision-makers stop, consider each case on its facts and document the rationale, so that complaints are not lost and the reasoning can be scrutinised at Group level and tested for trends. The existing Trust-level policies — the NNUH Misconduct Policy (Ref 15355), the JPUH Just and Learning Workplace Policy, and the QEH Grievance Policy (V5) — all currently front-load informal resolution; this provision overrides that default for racism cases as those policies are harmonised into Group-wide versions.

4.3 Specialist Investigator Standards

Where a formal investigation involves allegations of racism, antisemitism, anti-Muslim hostility or race-related harassment, the investigating officer must meet the following standards:

- They must have completed the Group's specialist anti-racism investigator training. Approximately 150 investigating officers and senior line managers will be trained from September 2026, drawing on external subject-matter expertise from organisations such as the Community Security Trust for antisemitism and Tell MAMA for anti-Muslim hatred, or equivalent bodies.
- They must have no conflict of interest and no prior involvement in the case.
- They must demonstrate understanding of the IHRA working definition of antisemitism and the Government definition of anti-Muslim hostility, and be able to apply them in an investigative context in accordance with Section 3.4, including the evidential threshold and the prohibition on reliance on stereotypes.
- Where internal investigating officers with the required competence are not available, the Trust HR lead may commission an external specialist investigator. The cost of external investigators will be approved by the relevant EMD.
- Where internal investigators encounter particularly complex allegations, external expert advice may be sought.
- The terms of reference for the investigation must explicitly address the racism, antisemitism or anti-Muslim hostility element and not subsume it into generic bullying and harassment terms.

4.4 Timescales

Racism-related investigations should be completed within 12 weeks of the formal complaint being raised. Where this is not achievable, for example due to complexity, witness availability, or parallel regulatory processes, the investigating officer must notify the commissioning manager and the GCPO in writing, setting out the reason for the delay and the revised target date. The complainant must be kept informed throughout.

4.5 Victim Support Framework

The Group will provide the following support to any colleague who reports racist behaviour:

- A named point of contact, who will not be the investigating officer or the accused person's line manager, providing pastoral support throughout the process.
- Access to the Employee Assistance Programme for confidential counselling.
- Occupational Health referral where the colleague's health or wellbeing is affected.
- Signposting to relevant professional regulator advocacy services where applicable.
- Regular updates on the progress of any investigation, at least fortnightly or more frequently if the colleague requests.
- As a general principle, where the colleague and the accused person work in the same team or area, consideration will first be given to the temporary redeployment or restriction of the accused person. Any interim measures will be determined on a case-by-case basis, taking account of the circumstances, the wellbeing of those involved and operational requirements. Interim measures are neutral acts and are not a sanction or a finding.

4.6 Protection from Retaliation

Any colleague who reports racist behaviour in good faith is protected from retaliation. Retaliation against a person who has made a complaint of racism, or who has supported or witnessed such a complaint, will be treated as a serious disciplinary matter and may itself constitute gross misconduct. This protection extends to colleagues who report via any route,

including FTSU, Datix, line management, HR or trade union, and to colleagues who give evidence as witnesses in an investigation. Where a colleague believes they have suffered retaliation, they may raise this as a separate complaint under this policy or via FTSU.

5. Patient, Visitor and Public-Originating Racism

5.1 Violence Prevention and Reduction Standard Alignment

The Group is committed to implementing the NHS Violence Prevention and Reduction (VPR) Standard. This includes data capture on violence, aggression and abuse directed at staff by patients, visitors and members of the public, disaggregated by the protected characteristics of the staff member affected. This data will be monitored via the NHS Oversight Framework.

5.2 Expectations of Patient and Visitor Behaviour

Patients, visitors and members of the public are expected to treat all NHS staff with dignity and respect. Racist, antisemitic, anti-Muslim or otherwise discriminatory behaviour towards staff is not acceptable and will not be tolerated. Signage and patient information at all Group sites will make clear that racist and discriminatory behaviour is unacceptable and may result in action including the withdrawal of non-essential services, restriction of visiting rights, or, in serious cases, reporting to the police.

5.3 Response to Patient or Visitor Racism

Where a patient, visitor or member of the public directs racist behaviour towards a member of staff:

- The staff member may withdraw from the interaction where it is clinically safe to do so, or request a colleague to take over their care duties.
- The line manager, or the most senior clinician present, should intervene immediately to address the behaviour with the patient or visitor, making clear that it is unacceptable.
- The incident must be reported via Datix using the racism and hate-incident category.
- The line manager must ensure the affected staff member receives immediate pastoral support, including the offer of a break, access to the Employee Assistance Programme, and a debrief.
- Where the behaviour is criminal, for example racially aggravated assault or a public order offence, the Trust's security team and, where appropriate, the police should be contacted.
- A pattern of racist behaviour by the same patient or visitor should be escalated to the relevant clinical director and the Trust's safeguarding lead, and may result in a restriction of access to services for non-emergency care or the imposition of a behavioural agreement.
- Clinical care must never be withdrawn from a patient on the basis of their behaviour alone where there is an immediate clinical need. Clinical and ethical judgements about the provision of care must be made by the responsible clinician.

5.4 Data Capture and Monitoring

All racism-related incidents involving patients, visitors or members of the public must be recorded on Datix. Data must be captured in a way that enables analysis by the ethnicity and faith of the staff member affected, the nature of the incident, the clinical setting, and the action taken. This data will form part of the quarterly VPR report to each Trust Board, the People and Culture Management Group and ERAG, and will be available for the NHS Oversight Framework.

6. Political Identifiers, Symbols and Uniform Guidance

NHS England has indicated that national uniform guidance addressing the display of politicised badges and symbols will be published in short order. The Group will adopt the national guidance when it is issued and will update the Group Uniform and Workwear Policy accordingly. In the interim, the following principles apply.

Patient-facing settings. In patient-facing settings, staff should not display badges, symbols, flags or insignia that are primarily political, as distinct from professional, religious or trade union-related, in nature. This restriction exists to protect the confidence of patients in the impartiality of their care.

Even-handed application. Any restriction under this section must be applied consistently to all causes and all political positions. A restriction that is applied to one cause and not to others, or which is enforced selectively, is not permitted under this policy.

Non-patient-facing settings. Restrictions do not extend to staff-only areas such as offices, rest areas and staff rooms, or to personal social media, except where the conduct in question amounts to harassment, discrimination or victimisation, or breaches the Group's social media or conduct standards.

National and cultural identity. Blanket restrictions on the expression of national, ethnic or cultural identity are prohibited. Items expressing national or cultural heritage are not to be treated as political identifiers by reason of that heritage alone. Where such an item is worn in a patient-facing setting in a manner intended as political expression, the patient-facing principle above applies, on the same basis as it would to any other cause.

Religious expression. Religious expression through dress, for example hijab, turban, kippah or cross, is permitted and protected under the Equality Act 2010. The Group's uniform policy will be updated in line with Manchester University NHS Foundation Trust and University College London Hospitals practice, as cited in PRN0222 and the Mann Review, to balance religious expression with patient safety requirements.

Permitted items. NHS Rainbow and other NHS-issued inclusion badges are permitted. Trade union badges are permitted.

Disputes. Any dispute about whether a specific item constitutes a political identifier should be escalated to the Trust HR lead for a case-by-case determination, recorded in writing. Worked examples are at Appendix D.

7. Training and Development

7.1 Mandatory EDI Training

All staff across the Group must complete the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes strengthened content on antisemitism and anti-Muslim hostility. The Group target is 95 per cent compliance within six months of the module's national release. When the new bitesize module co-created with faith leaders in the NHS becomes available, all staff must complete it, with the exception of those who have completed the EDHR mandatory training within the previous six months.

7.2 Board-Level Anti-Racism Training

All Board members and Non-Executive Directors across the Group must complete anti-racism training when it becomes available nationally. The Group Executive Group agreed on 29 July 2026 that all Board members will undertake this training, endorsed by the Group Board on 5 August 2026; the Mann Review expects provider Board completion within six months of the training's national release. Board-level training is not a one-off requirement: the Group will incorporate regular anti-racism development into the annual Board

development programme, including engagement with staff networks and lived-experience testimony.

7.3 Investigator and Manager Capability

Approximately 150 investigating officers and senior line managers across the Group will receive targeted training from September 2026 to January 2027 on contemporary manifestations of antisemitism, anti-Muslim hostility and racism, and on how to apply the definitions in an investigative context. The training will cover, as a minimum: the operative test and the status of the illustrative examples; the evidential threshold; the prohibition on reliance on stereotypes and the risk of stereotyping in both directions; obligations under Articles 9 and 10 of the European Convention on Human Rights and the Equality Act 2010; and the recording requirements at Section 3.4. It will draw on external specialist input from organisations such as the Community Security Trust and Tell MAMA, or equivalent bodies.

7.4 PALS and Complaints Handler Training

NHS England is developing bespoke eLearning for NHS PALS and complaints handlers. All PALS and complaints staff across the Group must complete this training when it becomes available. The Group Chief Nurse is the named owner for ensuring compliance.

8. Governance and Accountability

8.1 Oversight and Staff Survey Scrutiny

Each Trust and its relevant committees must fully understand the staff survey data on the experience of racism in their organisation. This is not an ad-hoc agenda item. Assurance against this policy and the Group EDI Workforce Strategy 2026/27 runs through the Executive Risk and Assurance Group (ERAG), with the People and Culture Management Group at each Trust as the site interface, and an annual deep-dive to the Group Board. The Group will build racism experience data scrutiny into the standing reporting cycle as follows:

- Quarterly reporting to each Trust's People and Culture Management Group on WRES indicators 5 to 8, disaggregated by Trust and, where sample size permits, by department, with escalation to ERAG where concerns are unresolved.
- Quarterly reporting to the Executive Risk and Assurance Group on anti-racism metrics, including disproportionality data — the single Group-level quarterly assurance route, avoiding duplicate reporting layers.
- Annual deep-dive report to the Group Board presenting disproportionality data, case outcomes, and progress against the Group EDI Workforce Strategy 2026/27.
- Group Chief Executive Officer accountability for the response to identified problem areas at each Trust, with Executive Managing Directors responsible for delivering the resulting action plans, reported back to the Board within one quarter.
- Strengthened accountability for racial inclusion through executive appraisals, in line with PRN02538. This mirrors the approach approved by the NHS Norfolk and Suffolk ICB Remuneration Committee and Board on 15 July 2026.

8.2 Detriment and Disproportionality Monitoring

The Group will monitor detriment and disproportionality across disciplinary, grievance and dignity at work case data, disaggregated by ethnicity and religion, on a quarterly basis. This monitoring will track: entry rates into formal processes by ethnicity (the WRES disproportionality indicator); outcomes of formal processes by ethnicity, substantiated against not substantiated and sanction level; use of suspension by ethnicity; complainant satisfaction and case closure timeliness; the ratio of formal to informal resolution for racism-related cases against all other cases; and any reported detriment to colleagues who have raised or supported a concern.

The target range for the disciplinary disproportionality ratio, comparing BME and white staff entry into formal processes, is 0.80 to 1.25 at each Trust. Where a Trust falls outside this range, the Group Chief Executive Officer must commission an independent case review and report to the Group Board. An annual independent review of disproportionality findings will be commissioned and presented to the Group Board. See Appendix C for the full detriment and disproportionality assessment framework.

8.3 NHS Staff Standards and Oversight Framework

The NHS Staff Standards relating to the experience of racism were published on 6 July 2026, apply to secondary care trusts from July 2026, and are assessed through a headline metric in the NHS Oversight Framework. The Group will implement these Standards, incorporating them into the Group policy review cycle and the organisational development planning cycle for 2026/27 onwards; a separate paper on the Staff Standards is being prepared for the Group Executive Group. The VPR Standard and racism-related data capture will be monitored via the NHS Oversight Framework. The GCPO and Group Chief Nurse are jointly responsible for ensuring Group compliance.

9. Freedom to Speak Up: Racism Routing

See Appendix B for the full routing procedure. Colleagues may raise racism-related concerns through Freedom to Speak Up. The Group's FTSU Guardians will apply the following principles:

- Racism-related concerns raised through FTSU will be treated with the same seriousness and urgency as patient safety concerns.
- The FTSU Guardian will, with the colleague's consent, refer the concern to the Trust HR lead or GCPO for action under this policy. Where the colleague does not consent to referral, the Guardian will explain the limitations this places on the Group's ability to investigate, while respecting the colleague's autonomy.
- The no-detriment commitment in Section 4.6 applies equally to concerns raised via FTSU.
- FTSU Guardians will record racism-related concerns in a way that enables them to be included in the quarterly disproportionality data, anonymised where the individual has not consented to named referral.
- Where a pattern of concerns emerges from a particular department, site or staff group, the FTSU Guardian will alert the GCPO and the relevant EMD, even where individual concerns remain anonymous.

10. Cross-Reference to Group Policies (Policy Standardisation Project)

This policy supersedes no existing instrument. The following table maps it to the Trust-level policies being harmonised into Group-wide versions through the policy standardisation project. As each Group policy is published, this table will be updated.

Current Trust-level policy	Group policy (in development)	Relationship to this policy
NNUH Misconduct Policy (Ref 15355)	Group Misconduct Policy	Racism and harassment already classified as gross misconduct. The default-to-formal provision at Section 4.2 will be written into the Group version as the required process for racism cases, together with the specialist investigator standard at Section 4.3.
NNUH Performance Improvement Policy (Ref 23918)	Group Performance Improvement Policy	No direct conflict. Cross-reference to this policy for any performance concern with a racial dimension.

Current Trust-level policy	Group policy (in development)	Relationship to this policy
JPUH Just and Learning Workplace Policy (POL/TWD/JT1507/02)	To be disaggregated into separate Group Misconduct, Group Dignity at Work and Group Grievance policies	The combined policy's dignity at work and grievance sections will be replaced by the Group equivalents. Its equality impact assessment already acknowledges WRES disproportionality; that acknowledgement will be carried into all Group policies.
QEH Grievance Policy (V5)	Group Grievance Policy	The default-to-formal provision at Section 4.2 takes precedence for racism-related grievances.
QEH Dignity at Work / Respectful Resolution Pathway	Group Dignity at Work Policy	This policy supplements it with specific anti-racism standards, definitions, application guidance and the specialist investigator requirement.
QEH Attendance Policy (V3); NNUH Attendance and Wellbeing Policy (Ref 12666)	Group Attendance and Wellbeing Policy (already in train)	No direct conflict.
QEH Capability Policy (V6); NNUH Performance Improvement Policy	Group Capability / Performance Improvement Policy	No direct conflict.
Uniform and workwear policies (various)	Group Uniform and Workwear Policy (pending national guidance)	Section 6 of this policy provides the interim guidance.
FTSU policies (each Trust)	Group FTSU Policy	Section 9 and Appendix B provide the racism-specific routing addendum.

11. Related Documents

- Lord Mann, review into tackling racism and antisemitism within the NHS, and the Government response (4 June 2026)
- NHS England PRN02538: letter to NHS leaders following publication of the Lord Mann Review (4 June 2026)
- NHS England PRN0222: request for action on racism including antisemitism (17 October 2025)
- IHRA Working Definition of Antisemitism (adopted 26 May 2016)
- UK Government Definition of Anti-Muslim Hostility (published 9 March 2026)
- NHS Race and Health Observatory Seven Principles of Anti-Racism
- NHS Staff Standards (published 6 July 2026)
- NHS Core Skills Framework: EDHR module
- NHS Violence Prevention and Reduction Standard
- NHS Equality, Diversity and Inclusion Improvement Plan
- Equality Act 2010; Human Rights Act 1998
- GMC Order 2026 (as amended)
- NWUHG Group EDI Workforce Strategy 2026/27 (Group Executive Group, 29 July 2026; Group Board, 5 August 2026)
- NWUHG all-staff communication on the Mann Review (issued June 2026)
- WRES 2025 national data analysis report for NHS trusts
- ACAS Code of Practice on disciplinary and grievance procedures

12. Monitoring Compliance

Key element	Process for monitoring	By whom	Responsible forum	Frequency
Adoption of the IHRA and anti-Muslim hostility definitions	Short NHS England confirmation survey completed, one return per constituent Trust	GCPO	Group Executive Group / Group Board	One-off, by 31 July 2026

Key element	Process for monitoring	By whom	Responsible forum	Frequency
confirmed to NHS England				
Default-to-formal compliance for racism cases	Case audit: proportion of racism cases proceeding to formal investigation, and recorded rationale where they do not	Trust HR leads	Executive Risk and Assurance Group (ERAG)	Quarterly
Application of the definitions	Audit of recorded decisions under Section 3.4 for evidential threshold and absence of stereotype reliance	Trust HR leads	Executive Risk and Assurance Group (ERAG)	Quarterly
Specialist investigator deployment	Audit of investigator training records and case assignment	Trust HR leads	Executive Risk and Assurance Group (ERAG)	Quarterly
Mandatory EDHR training compliance	ESR training compliance reports	Group OD Lead	People and Culture Management Group and Trust Board	Monthly during rollout, then quarterly
Board-level anti-racism training	Training attendance records	GCPO	Group Board	Annual
Disproportionality ratio within the 0.80–1.25 range	WRES data and internal disciplinary data	GCPO / Trust HR leads	ERAG quarterly; Group Board annual deep-dive	Quarterly
VPR data capture on racism against staff	Datix reporting analysis	Group Chief Nurse / GCPO	People and Culture Management Group and Trust Board	Quarterly
Staff survey racism indicators improving	WRES indicators 5 to 8	GCPO	Group Board	Annual, staff survey cycle
Policy review	Full policy review	GCPO	Group Board	Every 2 years, or sooner if required

Appendix A — PRN02538 Immediate Action Cross-Reference Matrix

For audit trail purposes, each immediate action from NHS England PRN02538 (4 June 2026) is mapped to the relevant provision in this policy and to the Group EDI Workforce Strategy 2026/27.

PRN02538 immediate action	Policy section	Strategy ref	Status
Sign up to the RHO Seven Principles of Anti-Racism	Section 3.6	1.4	Approved by the Group Executive Group 29 July 2026; RHO to be notified on ratification
Confirm adoption of the IHRA definition and the anti-Muslim hostility definition to NHS England by 31 July 2026	Sections 3.2, 3.3, 3.7	2.1	Approved 29 July 2026; GCPO completed the NHS England confirmation survey, one return per constituent Trust, ahead of the deadline
Implement the Violence Prevention and Reduction Standard, including data capture and use of the data to target improvement with affected groups	Sections 5.1, 5.4	3.3	Covered in this policy; operational implementation owned by the Group Chief Nurse; Datix categories configured October 2026
Prepare to implement the NHS Staff Standards	Section 8.3	1.6	Standards published 6 July 2026 and applying from July 2026; baseline self-assessment September 2026
Adopt the new Government definition of anti-Muslim hostility	Section 3.3	2.1	Approved 29 July 2026
Ensure all staff complete the NHS Core Skills Framework EDHR module	Section 7.1	6.2	Compliance being verified via ESR, August 2026
Ensure all staff complete the new bitesize faith-leader module when available; Board agreement to the new anti-racism training	Sections 7.1, 7.2	6.1, 6.2	Executive agreement recorded 29 July 2026 and endorsed by the Group Board 5 August 2026; Mann Review expects Board completion within six months of national release
Bespoke training for PALS and complaints handlers	Section 7.4	6.3	Awaiting national release
Communicate actions to colleagues, staff representatives, patients and communities through internal and external channels	Sections 2, 5.2, 10	1.3, 4.1	All-staff communication issued June 2026; public Group commitment statement for publication on all three Trust websites following ratification; ongoing staff communications plan from August 2026
Ensure Boards and committees fully understand staff survey data on racism and act on key problem areas	Section 8.1	1.1, 3.5	Built into the standing reporting cycle; first disproportionality report December 2026
Strengthened accountability for racial inclusion through executive appraisals	Section 8.1	5.5	Design phase; from the 2026/27 appraisal cycle

Appendix B — FTSU Racism Routing Addendum

This addendum should be read alongside each Trust's Freedom to Speak Up policy and, once published, the Group FTSU Policy. It establishes the specific routing for racism-related concerns raised through FTSU.

1. Routing procedure. When a colleague raises a concern with a FTSU Guardian that involves or may involve racism, antisemitism, anti-Muslim hostility or race-related harassment or discrimination, the Guardian should:

- Listen without judgement and record the concern using the FTSU case management system.
- Categorise the concern using the FTSU national taxonomy and add a racism and discrimination flag.
- Explain to the colleague the options available, including referral to the Trust HR lead for formal investigation under this policy, direct complaint via HR, or continuation through FTSU with anonymised alerting.
- With the colleague's consent, refer the concern to the Trust HR lead, or to the GCPO if the concern relates to a senior manager, for action under this policy, including the default-to-formal mechanism at Section 4.2.
- Where the colleague does not consent to named referral, record the concern anonymously and include it in the quarterly thematic report to the GCPO and the relevant EMD.

2. The no-detriment commitment. The Group explicitly commits that no colleague will suffer detriment as a result of raising a racism-related concern through FTSU. This commitment is consistent with the Employment Rights Act 1996 as amended, the NHS Constitution, and National Guardian's Office guidance. Detriment includes but is not limited to dismissal, disciplinary action, failure to promote, exclusion from training or development opportunities, ostracism, or any other adverse treatment.

3. Escalation triggers. The FTSU Guardian must escalate to the GCPO immediately, regardless of anonymity, where: the concern suggests a patient safety risk arising from racist behaviour; the concern suggests a pattern of racist behaviour in a particular department or site; the concern involves an allegation against a senior leader at Band 8c or above; or the colleague reports that they have suffered retaliation for a previous complaint of racism.

Appendix C — Detriment and Disproportionality Assessment Note

Purpose. This appendix sets out how the Group captures and monitors racism and disproportionality in its people processes, and confirms the assessment framework in light of the Lord Mann Review and the default-to-formal investigation provision at Section 4.2.

1. The disproportionality paradox. The Mann Review and PRN02538 require Trusts to be more rigorous on racist conduct while also being fairer on disciplinary disproportionality. The 2024 national WRES data showed that in 51 per cent of NHS trusts, BME staff were over 1.25 times more likely to enter formal disciplinary processes than white staff. Without careful design, a zero-tolerance stance on racism could entrench existing disproportionality.

2. How this policy manages the paradox.

- The default-to-formal provision at Section 4.2 applies to complaints of racism by any person against any other person, regardless of ethnicity. It is not a provision that targets any ethnic group.
- The application guidance at Section 3.4, in particular the evidential threshold and the prohibition on reliance on stereotypes, is designed to prevent findings being reached on the basis of a person's ethnicity, faith or political views.
- The specialist investigator standards at Section 4.3 ensure that investigations are conducted by people who understand the nuances of racism, antisemitism and anti-Muslim hostility, reducing the risk of both under-recognition and over-prosecution.
- The disproportionality monitoring at Section 8.2 provides a real-time check on whether the policy is being applied equitably. If BME staff are disproportionately entering formal processes as respondents, this will be flagged and investigated.
- The victim support framework at Section 4.5 ensures that complainants are supported, not deterred. The retaliation protection at Section 4.6 ensures that the act of complaining does not itself become a source of disproportionate treatment.
- Decisions at the threshold of investigation must be recorded in writing with a clear rationale, creating an auditable trail that enables disproportionality analysis.

3. Equality impact assessment requirement. As each Trust-level policy is harmonised into a Group-wide version through the policy standardisation project, its equality impact assessment must acknowledge the WRES disproportionality data and set out the mitigations in place.

4. Does the detriment assessment need updating? Yes. The introduction of the default-to-formal investigation provision at Section 4.2 changes the threshold at which cases enter formal processes. This must be reflected in the Group's detriment and disproportionality monitoring framework. Specifically: Datix reporting categories must be updated to enable disaggregation of racism-related formal cases from all other formal cases; quarterly disproportionality reports must separately track the ethnicity profile of complainants and respondents in racism-related formal cases; an annual independent review must assess whether the default-to-formal provision is having any disproportionate impact on any ethnic group as respondents; and the Group Director of Governance must ensure these changes are in place within three months of ratification, that is by the end of October 2026.

Appendix D — Worked Examples for Managers and Investigators

These examples are illustrative. They do not replace the requirement to assess each case on its own facts in accordance with Section 3.4, and they do not displace HR advice. Where a case does not resemble any example below, the operative test at Section 3.4 applies.

Scenario	Approach
A colleague posts on personal social media criticising the actions of the Israeli government and calling for a ceasefire.	Not antisemitic. This is political expression of a kind protected by Article 10 and expressly outside the IHRA definition. No action. It would only become a conduct matter if the post targeted Jewish colleagues, invoked antisemitic tropes such as conspiracy or collective responsibility, or was directed at an individual in a way amounting to harassment.
A colleague posts on social media that Jewish colleagues at the Trust should be “asked where their loyalties lie”.	Capable of being antisemitic. This engages the dual-loyalty example and, more importantly, evidences hostility towards Jewish people as Jewish people. It is also capable of amounting to harassment under section 26 of the Equality Act 2010. Formal investigation under Section 4.2.
A staff network organises an educational panel discussion on the humanitarian situation in Gaza, held in a staff-only area outside working hours.	Permitted. Discussion of Middle East politics is legitimate discourse. The Group should assure itself that the event is open, that speakers are briefed on the conduct standards in this policy, and that any colleague who reports feeling targeted is supported under Section 4.5. The event is not to be cancelled on the basis of its subject matter alone. The same approach applies to an event on antisemitism or on anti-Muslim hostility.
A colleague repeatedly raises the Israel-Palestine conflict with a Jewish colleague who has asked them to stop, on the assumption that the Jewish colleague speaks for Israel.	Capable of amounting to harassment, and the underlying assumption is one this policy expressly prohibits at Section 3.4. The relevant question is the effect of the conduct on the colleague affected, not whether the person intended to cause offence. Formal investigation.
A doctor wears a keffiyeh in a staff-only office area.	No action. Section 6 restrictions apply to patient-facing settings. A keffiyeh is also an item of cultural dress; blanket restrictions on the expression of national or cultural identity are prohibited.
A nurse wears a flag badge of any nation on their uniform while delivering care on a ward.	Addressed under the patient-facing principle at Section 6, applied identically whichever nation the badge represents. A conversation and a request to remove it while in the patient-facing setting is proportionate. A restriction applied to one flag but not others would not be lawful under this policy.
A manager wishes to exclude a Muslim colleague from an investigation panel concerning an antisemitism allegation, on the basis of their faith.	Not permitted. This is reliance on a prohibited stereotype under Section 3.4 and is capable of amounting to direct discrimination. Panel composition is determined by conflict of interest, training and competence under Section 4.3, not by faith or ethnicity.
A colleague states in a team meeting that they believe the State of Israel should not exist as a Jewish state.	Requires careful assessment. This engages one of the IHRA illustrative examples, but the examples are not determinative and the belief may itself be capable of protection under section 10 of the Equality Act 2010 (Section 3.7.3). The operative question is whether the conduct evidences hostility towards Jewish people as Jewish people, assessed on context, audience, manner and effect. The setting matters: a political view expressed in a workplace team meeting may be inappropriate as to time and place without being antisemitic. HR advice must be taken and the reasoning recorded.
A patient refuses treatment from a Black doctor and uses racist language.	Section 5.3 applies. Immediate intervention by the senior clinician present, Datix report under the racism and hate-incident category, immediate pastoral support and debrief for the doctor, and escalation where there is a pattern. Clinical care is not withdrawn where there is immediate clinical need.

Equality Impact Assessment

Type of function or policy	New
Division / department	Corporate — People Services
Name of person completing form	Emma-Jayne Pérez Chies, Group Chief People Officer
Date	July 2026

Equality area	Potential negative impact	Positive impact	Groups affected	Full EIA required
Race	See note below	Yes — the policy is specifically designed to improve outcomes for staff affected by racism	All staff; particular benefit to ethnic minority, Jewish and Muslim staff	No — designed to mitigate identified detriment
Religion and belief	See note below	Yes — formally adopts definitions protective of Jewish and Muslim staff, addresses faith-based harassment, and recognises that political and philosophical beliefs may be capable of protection	Jewish and Muslim staff in particular; all staff of faith and none; staff holding protected beliefs	No — designed to mitigate identified detriment
Pregnancy and maternity / disability / sex / gender reassignment / sexual orientation / age / marriage and civil partnership	None	None	Not applicable	No

EDS22 — impact on the equality and diversity strategic plan. This policy directly supports the Group's commitments under the WRES, the NHS EDI Improvement Plan and the RHO Seven Principles of Anti-Racism, and forms part of the Group's first EDI Workforce Strategy 2026/27. It addresses identified gaps in the Group's current policy suite for the protection of staff from racism, antisemitism and anti-Muslim hostility.

Note on race and religion or belief. National WRES data shows that BME staff are disproportionately more likely to enter formal disciplinary processes. This policy introduces a default-to-formal investigation for racism cases at Section 4.2, which could in theory increase the number of formal cases. That provision applies equally to all staff regardless of ethnicity and is accompanied by the application guidance and evidential threshold at Section 3.4, the disproportionality monitoring safeguards at Section 8.2 and annual independent review under Appendix C. The policy also engages religion and belief in more than one direction: it protects Jewish and Muslim colleagues from hostility, and it protects colleagues holding beliefs about Israel, Zionism and Palestinian rights from adverse treatment on the basis of those beliefs alone. The overall intent and design of the policy is to reduce detriment. No full impact assessment is required at this stage, but the monitoring framework will provide ongoing assurance and the policy will be reviewed if unintended consequences emerge. A full assessment will be required if the impact is potentially discriminatory under the general equality duty, if any group could be potentially disadvantaged by the policy, or if the policy is assessed to be of high significance.

Author: Emma-Jayne Pérez Chies, Group Chief People Officer
Approval date: 29 July 2026 Ratification: 5 August 2026 Next review: July 2028

Dear colleagues,

Last week, on 4 June, Lord John Mann published his independent review into racism and antisemitism in the NHS. The Government and NHS England have accepted his recommendations in full. [^c0][^c1]We want to write to you directly about what this means for us as Norfolk and Waveney University Hospitals Group, what you can expect from us in the coming months, and what we need from each other.

Lord Mann's review is honest about something that we need to be honest about too. The NHS — like wider society — is not immune to racism, antisemitism, anti-Muslim hostility or other forms of discrimination. Our own NHS Staff Survey results, and the experiences many of you have shared with us, tell us that this is true at NNUH, JPUH and QEH as well. We have great practice in many places, but we know we are not yet consistent, and we know there are colleagues among us — and patients in our care — who have experienced things that are wholly contrary to the values of our organisations and of the NHS.

We are sorry that this is the case, and we are determined to change it[^c2].

WHAT WE ARE COMMITTING TO

First, we are clear about the standard. There is no place in our hospitals for racism, antisemitism, anti-Muslim hostility, or any other form of discrimination, harassment or bullying. That applies on every site, every shift, in every clinical area and every back-office team, and it applies equally to staff, patients, families and visitors.

Second, we will adopt at Group Board level the IHRA[^c3] Working Definition of Antisemitism and the Government Definition of Anti-Muslim Hostility[^c4] — by the end of July, in line with NHS England's requirement. We will also sign the Group up to the NHS Race and Health Observatory's Seven Anti-Racism Principles.[^c5] These are not statements alone; they will sit at the heart of how we work.

Third, we will develop a single Group approach to dignity at work — one consistent set of standards, reporting routes and protections across all three Trusts. Our Joint Negotiation and Consultative Committees and our staff networks will be central to shaping this. [^c6]You will hear more about this as we finalise this work.

Fourth, training: NHS England has updated the mandatory Equality, Diversity and Human Rights module and is releasing a new short module co-created with faith leaders. We will roll these out across the Group as soon as they are available, and all members of our Group Board and Trust Boards will undertake new anti-racism training as part of our own development. We will hold ourselves to the same standard we ask of you.

Fifth, support and safety. If you experience or witness racism, antisemitism, anti-Muslim hostility or any form of discrimination, you can raise it through your line manager, your Freedom to Speak Up Guardian, your HR Business Partner, a staff network sponsor or our confidential reporting channel. You will be taken seriously, supported and protected from retaliation. If you would prefer a route outside the Group, your trade union and (where relevant) your professional regulator are also there for you.[^c8]

WHAT WE NEED FROM EACH OTHER

This is not work that any one team or any one role can do alone. We need every colleague to treat every other colleague, every patient and every family with dignity and respect. We need everyone who sees something to feel able to say something. We need our line managers to set the standard within their teams and to act when concerns are raised. And we need to be willing to have honest conversations — sometimes uncomfortable ones — about what is happening within our own teams and what needs to change.

WE WILL COME BACK TO YOU

We will keep you updated as this work progresses, including through team meetings, the intranet, and your staff networks. If you want to read Lord Mann's review or NHS England's response in full, both are available via the staff intranet.

Thank you for the care and commitment you give to our patients, your colleagues and our communities every day. We are proud of this Group and the people in it, and we are determined to make NWUHG a place where every colleague, every patient and every visitor knows they are safe, respected and welcome.

With thanks,

Prof Lesley Dwyer

Group Chief Executive Officer

Emma-Jayne Perez Chies

Group Chief People Officer

Comments

[^c0] White, Ben (NNUHFT): What are the implications of this for us? Do the 5 commitments below = adopting Mann's recommendations in full? [^c1] White, Ben (NNUHFT): I've now scanned the Mann report. I can see 36 recommendations. My Q above stands - what do we need to do as the Govt has accepted these in full? [^c2] White, Ben (NNUHFT): Think the intro needs to remind readers about the universality of the NHS. Something like: As Lord Mann reminds us: "The NHS was built on the principle that everyone should be treated equally and with respect. Discrimination undermines everything the NHS stands for and its ability to provide safe, world class care. The NHS should be for everyone and there is an urgent need to look closely at how to protect patients and staff and hold perpetrators to account." [^c3] White, Ben (NNUHFT): Need to spell out - International Holocaust Remembrance Alliance [^c4] White, Ben (NNUHFT): These should both be linked. [^c5] White, Ben (NNUHFT): Also need to be linked. [^c6] White, Ben (NNUHFT): Can we involve other staff who aren't on the JNCC or in one of the networks? [^c8] White, Ben (NNUHFT): I'd be tempted to bump this up to second in the list. It's about our colleagues very directly and will probably resonate more than the three points above (about definitions, a policy and training).

Enclosure 3

Equality, Diversity and Inclusion Desktop Review — summary of findings

Item	Detail
Author	Pamela Permalloo-Bass, EDI Consultant
Prepared for	Emma-Jayne Perez Chies, Group Chief People Officer
Date	July 2026
Status	Summary of findings. This is a report to the Group Chief People Officer and is not a decision paper. It informs the Group EDI Workforce Plan 2026/27.
Scope	Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH); James Paget University Hospitals NHS Foundation Trust (JPUH); The Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust (QEH)
Method	Desktop analysis of published and internal documentation. No site visits, staff engagement or deeper organisational assessment were undertaken.

1. Introduction and approach

1.1 A desktop review of Equality, Diversity and Inclusion (EDI) arrangements across the three constituent Trusts of Norfolk and Waveney University Hospitals Group was undertaken to assess alignment with statutory duties, NHS workforce equality standards and Care Quality Commission (CQC) Well-Led expectations.

1.2 The review analysed publicly available and internal documentation relating to governance, workforce equality, strategic planning, reporting and compliance with the Public Sector Equality Duty (PSED).

1.3 An important caveat applies throughout. This review was undertaken solely through desktop analysis. Findings may differ following site visits, staff engagement activity or deeper organisational assessment. The findings should therefore be read as an assessment of the documented position rather than of lived experience.

1.4 Documents reviewed

- Organisational annual reports and quality reports for all three Trusts.
- Workforce Race Equality Standard (WRES) returns for all three Trusts.
- Workforce Disability Equality Standard (WDES) returns for all three Trusts.
- Gender pay gap reporting for NNUH and JPUH.
- EDI strategies for NNUH and JPUH.
- CQC Well-Led inspection reports for all three Trusts.
- Equality Delivery System 2022 (EDS22) submissions — the full and complete version at JPUH; at NNUH, EDS22 content embedded within the patient engagement domain.

2. Headline findings

2.1 Overall findings indicate varying levels of maturity across the three Trusts. Examples of positive practice were identified throughout the Group, but there remains a need for a more consistent and coordinated approach to EDI governance, accountability, reporting and delivery. The review identified:

- The strongest evidence of EDI maturity within James Paget University Hospitals NHS Foundation Trust.
- Inconsistent EDI reporting and governance arrangements across the Group.
- The absence of a comprehensive annual EDI report within all three organisations.
- Continued concerns relating to bullying, harassment, discrimination and racism experienced by staff.
- A need for stronger accountability, leadership ownership and programme coordination.
- An opportunity to develop a Group-wide strategic approach to EDI improvement.

3. Overall assessment

Trust	Overall EDI maturity	Key observation
James Paget University Hospitals NHS FT	Good	Most mature EDI approach within the Group. Strong evidence of compliance and strategic intent.
The Queen Elizabeth Hospital King's Lynn NHS FT	Requires improvement	EDI activity evident but fragmented across multiple documents and reporting routes.
Norfolk and Norwich University Hospitals NHS FT	Requires improvement	Positive operational interventions identified; however, strategic coordination and governance require strengthening.

4. James Paget University Hospitals NHS Foundation Trust

4.1 James Paget demonstrates the strongest evidence of EDI maturity and is currently the EDI exemplar organisation within the Group. The Trust appears compliant with Public Sector Equality Duty requirements, Equality Act 2010 obligations, and CQC Well-Led expectations relating to inclusion and workforce equality.

Areas of strength

- A clear EDI strategy, "Better Together".
- Strong alignment between workforce equality reporting and strategic priorities.
- Evidence of leadership commitment to EDI.
- Workforce equality data used to identify priority areas.
- A full and complete EDS22 submission — the only one of the three Trusts to have completed EDS22 in full.

Areas for improvement

- The Trust website does not currently contain a comprehensive annual EDI report. A single annual report would provide assurance against Public Sector Equality Duty requirements, workforce equality standards, EDI governance arrangements, and progress against objectives and action plans.
- While "Better Together" contains clear ambitions and priorities, it would benefit from SMART objectives, named executive accountability, delivery milestones and performance measures.
- WRES reporting identifies ongoing disparities between White British and Black, Asian and minority ethnic staff groups. Particular concern relates to bullying, harassment and discrimination between staff and managers. Rates remain significantly above national averages and require targeted intervention with executive oversight and formal monitoring of improvement actions.

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

5.1 The Trust demonstrates evidence of EDI activity and reporting; however, information is dispersed across multiple documents and lacks strategic coherence.

Areas of strength

- Inclusion of EDI information within the annual report.
- Evidence of compliance activity.
- Workforce equality data available.

Areas for improvement

- A single overarching EDI strategy.
- A consolidated annual EDI report.
- Clear governance structures.
- Public-facing reporting demonstrating progress and accountability.

5.2 The desktop review found it difficult to assess strategic EDI priorities, progress against objectives, governance oversight and organisational accountability at this Trust. QEH therefore has the least visible documented baseline of the three Trusts.

6. Norfolk and Norwich University Hospitals NHS Foundation Trust

6.1 The Trust demonstrates a number of positive operational initiatives to address bullying, harassment, violence and discrimination. However, the evidence suggests a need for greater strategic coordination, leadership accountability and programme management.

EDS22 findings

Indicator	Position
Physical violence from patients, service users or the public in the previous 12 months	12.4% of staff — a 2.4 percentage point improvement on 2023
Disproportionate experience of physical violence among Black, Asian and minority ethnic staff	Reduced by 6.2 percentage points during the reporting period
Physical violence from managers	99.6% of staff reported never experiencing this
Harassment, bullying or abuse from colleagues	21.9% of staff — statistically unchanged from 2023
Disproportionately poorer experience	Reported by disabled, LGBT+, religious minority and non-binary staff

Positive interventions identified

- Civility and Respect Policy implementation.
- “Call It Out” training programme.
- WRES and WDES action plans.
- “No Excuse for Abuse” campaign.
- Withdrawal of care protocol, used as a last resort.
- Zero-tolerance messaging regarding unacceptable behaviour.

7. Feedback from People Directors

7.1 Feedback was gathered from People Directors across the Group. Four themes emerged, recorded here in their own words.

> *“Underlying the more specific EDI challenges is a lack of understanding of and consistency in applying a professionalism and accountability framework. We have some teams whose conception of what is or is not a professional and appropriate behaviour need re-setting and managers, leaders and HR teams who are confident and consistent in supporting corrective action when this is needed.”*
>
> *“We also have a history of not addressing patient/staff interactions where there is an element of racism promptly and effectively which has affected willingness to report and confidence in reporting.”*
>
> *“A worry is the racist comments and violence and aggression numbers from patients as a result of political noises.”*
>
> *“The element which is missing is an overarching, cohesive strategy and resource to manage and coordinate this programme of work.”*

7.2 The single most consistent theme is the absence of an overarching, cohesive strategy and the resource to coordinate the programme of work.

8. Recommendations

8.1 The following eleven recommendations are proposed. Each is taken forward through the Group EDI Workforce Plan 2026/27; the delivering action is shown against each.

Recommendation	Detail	Taken forward by
1. Executive accountability	An accountable Chief People Officer to oversee and respond to escalated race discrimination concerns and Freedom to Speak Up issues. Actions to be formally recorded, monitored and reviewed regularly with notes on actions achieved.	Plan Section 9; actions 1.3 and 4.6

Recommendation	Detail	Taken forward by
2. Hotspot identification	Use workforce data to identify areas demonstrating disproportionate experiences of discrimination. Develop targeted EDI improvement plans and monitor outcomes through People and Culture governance reporting.	Action 3.6
3. Medical workforce inclusion	Develop a specific EDI improvement plan to address concerns emerging from postgraduate medical and dental trainee feedback, led by an accountable officer and reported through governance to the Chief People Officer and Chief Medical Officer.	Actions 3.4 and 4.4
4. Increase EDI capacity	Strengthen dedicated EDI resource across all Trusts, including expertise covering workforce EDI, patient equality and engagement, and community inclusion, with divisional heads accountable for EDI actions.	Plan Section 10 — four EDI roles (3.5 FTE) through the People Directorate redesign
5. Governance framework	Implement a consistent governance structure so that EDI performance is reported through Trust committees and to the Group, with Group-level assurance reports carrying SMART objectives and named accountability.	Action 1.1; Plan Section 9
6. Inclusive leadership accountability	Develop an accountable inclusive leadership programme for senior leaders, using the RHO Workforce Race Equality tool, the leadership competency framework for board members, and the Seven Principles of Anti-Racism.	Action 6.4
7. MWRES	Complete Medical Workforce Race Equality Standard implementation across all Trusts.	Action 3.4
8. Targeted improvement interventions	Triangulate WRES, MWRES, WDES, staff survey and Freedom to Speak Up data to identify hotspots and develop bespoke interventions supported by accountable senior leaders.	Action 3.6
9. NHS England EDI High Impact Actions	Self-assessment against the six High Impact Actions for each Trust Board and the Group.	Plan Section 5.3; action 1.2
10. Standing Together Against Racism standard	Use the standard to prepare and plan for Lord Mann's recommendations.	Plan Section 5.6.2
11. Reward and recognition	Include a specific EDI and culture award.	Action 4.7

9. The Seven Principles of Anti-Racism

9.1 Recommendation 6 refers to the NHS Race and Health Observatory's Seven Principles of Anti-Racism. They are reproduced here in full for reference, as they form the organising logic recommended for the Group plan.

Principle	What it asks of an organisation
1. Name racism	Use specific language. Name antisemitism, anti-Muslim hostility, anti-Black racism, anti-Asian racism and racism directed at internationally educated staff rather than relying on generalised terms that allow specific harm to go unaddressed.
2. Understand and acknowledge	Establish an honest baseline of where racism occurs in the organisation, including where past practice has fallen short, rather than assuming a position.
3. Meaningfully involve communities	Involve staff and communities affected by racism in designing the response, not only in being consulted on it afterwards.
4. Collect and publish data	Collect disaggregated data, publish it, and report on it openly including where it is unfavourable.
5. Identify racial bias	Look for bias at the point of decision — in recruitment, disciplinary, grievance and progression processes — rather than only in outcomes at aggregate level.

Principle	What it asks of an organisation
6. Apply a race-critical lens	Apply a race-conscious assessment to all policy, strategy and improvement work rather than treating race equality as a separate workstream.
7. Evaluate and reflect	Evaluate whether interventions have worked, publish the result, and change course where they have not.

10. Conclusion

10.1 The Norfolk and Waveney Group has established a range of EDI initiatives; however, maturity levels vary significantly across the three organisations.

10.2 A consistent Group-wide approach to governance, accountability, reporting and leadership is required to strengthen compliance with the Public Sector Equality Duty, NHS workforce equality standards and CQC Well-Led expectations.

10.3 The development of annual EDI reports, strengthened leadership accountability and enhanced EDI capacity should be prioritised to support sustained improvement and provide assurance to Boards, regulators and staff.

Pamela Permalloo-Bass
EDI Consultant
July 2026

Advancing Quality Alliance (Aqua)
3rd Floor, Crossgate House,
Cross Street,
Sale,
M33 7FT

15th July 2026

Dear Emma-Jayne,

Re: Queen Elizabeth – Kings Lynn organisational development work

Following our further discussions about your requirements, I am now writing to provide a refined proposal of the initial diagnostic work to understand the interventions required.

Thank you for the opportunity to learn about your organisation and provide the outline of the input that we can provide. We would value the opportunity to work with you and can mobilise rapidly to enable the work to begin shortly.

Kind regards

Dr Sonya Wallbank
People Director, Aqua

1. Your requirements

This organisational development intervention has been commissioned to support the Queen Elizabeth Hospital (QE) in King's Lynn with how it works to support its racially diverse staff group. The work is designed to rapidly diagnose and intervene following notification from the East of England Deanery that they are considering removing Resident Doctors from the Hospital. This is following a series of internal (staff-led) incidents where racism has been a dominant factor in events as well as external (patient-led) incidents where racism has been evident in the refusal or challenge of treatment decisions/interventions.

It is important to note that the QE, alongside many other organisations in the United Kingdom, finds itself in a challenging political environment locally with the County Council consisting of solely Reform Councillors. This has brought inevitable tensions within and around local organisations including our healthcare providers.

This phase of a wider programme of work across the hospital group needs to focus on understanding, addressing and ultimately eliminating racial tension and discrimination within the hospital. Recent concerns have highlighted the need for a structured and evidence-based review to identify where issues are occurring, the nature and impact of those issues, and the organisational, cultural and systemic factors that may be contributing to them.

Effective leadership is critical in shaping inclusive organisational cultures and addressing behaviours that undermine the values of the NHS. Through engagement with staff, leaders and key stakeholders, the work will seek to establish a clear picture of current experiences across different professional groups, starting with the medical teams who are under clear and significant pressures in this area. It will then move on to other services and teams, recognising that racial tension can manifest in both overt and subtle ways and may be experienced differently depending on role, background and context. The intervention will also explore the contribution of patient, visitor and staff behaviours, acknowledging that creating a safe, respectful and inclusive environment is a shared responsibility that requires collective ownership and leadership at every level.

At a time of outlined heightened national debate and political discourse on issues of race, identity and social cohesion, healthcare organisations face increasing challenges in maintaining psychologically safe workplaces where all individuals are treated with dignity and respect. Without timely intervention, there is a risk that existing tensions become normalised, staff trust and engagement deteriorate, and inequalities become further embedded within organisational systems and culture. By acting now, the organisation has an opportunity not only to understand and address current concerns, but also to strengthen leadership capability, reinforce accountability, and prevent similar issues from emerging or escalating elsewhere across the Trust. The outcome of this work will provide a robust foundation for targeted action, sustainable cultural change and the creation of a more equitable experience for both staff and patients.

2. About AQUA and The King's Fund

AQUA (Advancing Quality Alliance) is an NHS-based improvement organisation working with health and care systems to improve quality, safety, leadership and organisational effectiveness. Through strategic partnerships with NHS trusts, integrated care systems, local authorities and wider health and care organisations, AQUA supports the delivery of sustainable improvement that enhances outcomes for patients, staff and communities. Its vision is to inspire the best quality health and care for everyone.

For more than 15 years, AQUA has supported leaders, teams and organisations across the health and care system to build the capability, culture and confidence needed to deliver lasting improvement. Its expertise spans leadership and organisational development, quality improvement, patient safety, governance and regulatory support, helping organisations strengthen performance while embedding a culture of continuous learning and improvement. AQUA is also the national home of the Quality, Service Improvement and Redesign (QSIR) programme, supporting improvement capability across the NHS.

The King's Fund is an independent charity working to improve health and care in England. We help shape policy and practice through research and analysis; development of individuals, teams and organisations; promotion of understanding of the health and social care system; and bringing people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all. The King's Fund has been involved in leadership development in the Health and Care system for more than 65 years. We work with individuals, teams and organisations from across the health and care system to improve performance and support the delivery of high-quality care. We also carry out research and analysis to shape the way that people think about leadership and culture in the NHS.

We combine internationally renowned knowledge and expertise in health and social care with access to some of the best and most progressive thought leaders in the field. We bring a strong understanding of the challenges faced by charities, social enterprises, and health and care providers, including regulatory expectations, stakeholder complexity, and system partnership working. Our in-house team, and wider pool of associates, bring deep expertise in Board-level development work, including experience of designing and delivering programmes that strengthen culture, collective accountability, and effectiveness.

We have a range of specialists across our organisations who will provide direct support into the programme of work. These include analytical and data analysis support as well as an experienced and expert group to advise and guide the work as faculty members. For example, this could include colleagues such as Mark Patterson, Senior Consultant in Leadership & Organisational Development, Sharon Nash, Senior Consultant, and Kathryn Perera, Senior Consultant, who bring extensive experience in leadership development, organisational change, culture transformation and system-wide improvement.

We will tailor the individuals who support the programme of work as we work through the diagnostic phase together.

Together, The King's Fund and AQUA bring a powerful combination of thought leadership, organisational development expertise and practical improvement capability, enabling health and care organisations to deliver meaningful, sustainable change.

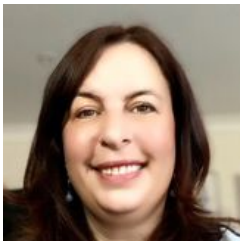
About the Leadership and Organisational Development team

The **Advancing Quality Alliance** (Aqua) is an NHS-based improvement organisation with over a decade of experience supporting health and care systems to strengthen leadership, culture, and team effectiveness. We work as a trusted development partner, combining coaching, organisational development, and improvement expertise to deliver sustainable changes in complex environments. We have extensive experience coaching senior interdisciplinary teams, including medical, nursing and operational leaders, helping them to strengthen team effectiveness, build psychological safety and lead collectively under pressure. Our work focuses on translating compassionate leadership into everyday behaviours and ways of working.

The King's Fund Leadership and Organisational Development team are compassionate, inclusive, and collaborative leaders whose role is to deliver the highest quality development for our health and care system. The King's Fund has a history of providing leadership and organisational development expertise to support people, leaders and teams in the health and care system. Our work is underpinned by thought leadership, research, extensive practice work, a commitment to anti-racist principles and practice and our learning partnership with brap. Our team of senior organisational development practitioners work with people to build confidence, competence and energy to create meaningful change across organisations and systems.

We are experts in the development of personal, team, organisational and system leadership development. The King's Fund can offer a programme of learning steeped in real time and relevant policy learning about the provision of high-quality healthcare services.

3. Our people



Dr Sonya Wallbank is a consultant clinical psychologist and specialises in workforce resilience and restorative approaches to wellbeing. She has worked in the NHS as a director of service delivery and workforce, leading complex change and improvement programmes for NHS England and NHS Improvement, including the delivery of the health and wellbeing response for NHS staff during the Covid-19 pandemic.

She has also led HR services and operating model change for the Department of Health and Social Care and worked directly with organisations, teams and individuals wanting to change how they work in the UK, Australia and the US. She has authored materials to enable organisations to embed their own approach to restorative supervision. Sonya lectures on how focusing supervision and support on the needs of the individual, not just the work they deliver reduces stress, burnout and improves the pleasure people derive from their work.

4. Diagnosing racial and behavioural tensions in a Specialist Hospital

The initial diagnostics are designed to understand current concerns relating to racial tension and other behaviours which are resulting in a break down within staff groups. Challenges are occurring:

- Between staff groups
- Between patients
- Between staff and patients from challenging the difficult behaviour of patients
- Within teams and professional groups
- Potentially embedded within organisational systems, policies and culture

The approach combines organisational diagnostics, lived-experience research, conflict analysis and change design. It deliberately goes beyond a standard EDI review and treats racial tensions as patient safety, workforce wellbeing, culture and operational effectiveness issue.

Objectives

The initial review will:

1. Establish the nature, scale and drivers of racial tensions.
2. Identify hotspots and high-risk areas.
3. Understand the experiences of different ethnic groups.
4. Assess the impact on patient care, staff wellbeing and retention.
5. Identify structural, cultural and behavioural issues.
6. Produce a practical improvement plan with clear ownership and measures and support to deliver the plan.

Diagnostics example

We have prepared an example of the work we can deliver below and the costings associated. We would want to ensure that we worked with you to co-design the diagnostic phase and the interventions as outlined. All our sessions will need support and input from a senior member of your team to enable the work to be sustained within the organisation post this period.

Phase 1: Mobilisation and Contracting

Leadership Alignment Session

Meet appropriate Executive and Board members to understand the concerns, clarify scope and agree confidentiality arrangements. Engage with Freedom to Speak Up Guardian, Trade Union representatives and Staff Network Chairs. Agree confidentiality arrangements. We will work with the Chief People Officer (CPO) to establish the sponsor group and draw on data from your existing grievances, ongoing investigations, patient safety and tribunal/reputational risks review to support an active risk assessment of the current situation.

Communications Plan

We will work with the communications team and sponsor to develop hospital-wide communications explaining:

- Purpose of the review
- Independence of the commissioning team
- Confidentiality
- Timescales

We would ask your Chief Executive and senior team to sponsor the work and consider the relationship with the local authority so seek their support with the patient's element of the work.

Phase 2: Organisational Diagnostic

We will conduct a working review with you of the available data to understand what is already known and action plans in place to enable change, this will include your **Workforce Data including**

Workforce Race Equality Standard (WRES). This will review recruitment outcomes; relative likelihood of disciplinary action; promotion rates; experiences of discrimination and harassment and bullying indicators. The **NHS Staff Survey** reviewing inclusion scores; psychological safety; speak up culture; teamworking and harassment indicators. We will use HR metrics and incident data to analyse the full range of performance data when it comes to signs of difficulties both within staff and their leaders. Also reviewing incident data to determine trends.

Phase 3: Deep Staff and Patients Listening Programme

Confidential Interviews
We will conduct interviews with **participant groups** including consultants; doctors in training; nurses; AHPs; Administrative staff; Porters; Domestic staff; Senior leaders and Staff network representatives. We will be exploring;

- Experiences of race; workplace relationships
- Inclusion/exclusion; microaggressions
- Bias, Power dynamics
- Team culture and progression opportunities

Psychological Safety Focus Groups
We will then conduct a series of focus groups with separate groups of staff with protected racial characteristics. This will help us to surface issues safely without dominant voices influencing findings.

Patient and Family Voice
Our final group is the voice of the patient and carers. We will conduct a **Patient Experience Review** including complaints; PALS contacts; Survey data; compliments; Escalations to specifically identify race-related themes.

We will review the team and patient dynamics to understand through direct observation what behaviours exist currently compared to what we have found and where is the impetus for

change. We will want to assess Team Dynamics, Patient Interactions and Cultural Norms. This will include observations of clinical handovers; MDT meetings; ward rounds; team meetings; staff rooms; public areas etc.

Phase 4: Findings and Root Cause Analysis

Using all data gathered, we will develop a racial climate assessment with a cultural heat map which can be used to drive and assess the impact of further development work.

Cultural Heat Map

Identifying:

- High-risk departments
- Hotspots
- Positive deviant teams
- Root Cause Themes including structural, cultural, behavioural and patient-driven

Following the diagnostic work, we will conclude this phase with a report which recommends next steps and a plan for co-designing future work.

Timeline

Month	Activities
Jul'26	Mobilisation and Phase 1-4 preparation meetings
Aug'26	Phase 1 diagnostic and interim recommendations completed

NHS England

To:
- NHS chief executives

cc.
- Chief people officers
- Chief nursing officers
- Medical directors
- Communications directors
- NHS England regional directors

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

4 June 2026

Dear colleagues,

Lord Mann Review

Today Lord Mann has published his review into tackling racism and antisemitism within the NHS with recommendations to support our shared goal of making our services safe for all patients, communities and colleagues.

Some of the events we see at home and abroad – not least of all the distressing events surrounding the death of Henry Nowak – can polarise opinions and harden division, going against the values that make the NHS what it is.

As the NHS, we can – and often do – create an environment where every person, patient or colleague feels treated with dignity, compassion and respect.

Today's review demonstrates that we are not achieving that consistently and as effectively as we should be. Just like wider society, the NHS is not immune to the persistent and systemic challenges of all forms of racism (including antisemitism and Islamophobia), discrimination and inequality, and we all have much more to do.

These recommendations will help us strengthen the way we drive change, and our focus should be ensuring that we are a place of compassion, care and unity – not conflict or discrimination, every day, on every site, in every home we visit, in every shift. Achieving this requires us all to be honest about the challenges we face and take strong action to address them.

Publication reference: PRN02538

Lord Mann's review set out a range of recommendations for NHS England, NHS organisations and leaders, the Department of Health and Social Care, as well as arm's-length-bodies (ALBs) and regulators. Collectively, these measures aim to:

- strengthen leadership and accountability,
- improve understanding and capability through training and development,
- set clear expectations regarding political identifiers and inclusive practice,
- improve and standardise support and protection for staff who experience racism,
- improve the consistency, quality and application of data relating to racism.

As NHS England, we welcome the recommendations and we accept the recommendations for us in full. As an immediate set of actions, we will:

- sign up to the NHS Race and Health Observatory Seven Anti-Racism Principles
- set clear Staff Standards relating to experience of racism
- support NHS improvement and assurance through the NHS Oversight Framework
- strengthen accountability for racial inclusion through our appraisals
- consult on adding Jewish and Sikh to NHS protected characteristic datasets
- develop bespoke eLearning for NHS PALS and complaints handlers
- ensure all NHS boards and system leaders complete regular anti-racism training

We also know the display of politicised badges and symbols has been a matter of debate and concern for staff and patients. We will complete engagement and publish the long-awaited national uniform guidance in short order.

Tackling all forms of racism within the NHS will require a joined-up, concerted effort at every level – we should all be acutely aware of the racial abuse and harassment our colleagues and patients are subject to. Our own staff surveys give clear voice to some of the unacceptable discrimination and abuse faced within our organisations. In addition, it is just as concerning when we see evidence of discrimination in our services or hear testimony from patients who have experienced unequal treatment or antisemitic or racial abuse when interacting with the NHS. We also know that we must better support staff when they experience racism in their interactions with the public.

We have set out a series of immediate actions we are asking you to take within your own organisations:

- To join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles.

- Ensure implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups, this will be monitored via the NHS Oversight Framework.
- Prepare to implement the forthcoming NHS Staff Standards.
- Adopt the new government definition of anti-Muslim hostility.
- Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia.
- Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months).
    - Ensure Board agreement to undertake new anti-racism training when it becomes available.
- Ensure colleagues, staff representatives, patients and communities are aware of your actions through your internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally.
- Ensure your Board and its relevant committees fully understand your staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress.

In addition, following on from our communications in October 2025, please can you confirm whether your organisation has adopted the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility. Please respond to this request, once for each organisation, by Friday 31 July 2026.

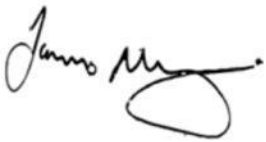
We know many organisations are already taking clear action, working in partnership with patients, community, trade unions and colleagues with lived experience – acknowledging and seeking to understand that experience is crucial to making the improvements we all want to see.

There are some fantastic examples of the work you are doing to tackle issues of racism and unequal access to services, and we'll work with you to share these widely across the system whilst encouraging you to use and support the delivery of the NHS equality, diversity and inclusion improvement plan.

Antisemitism and all forms of racism have no place in the NHS. Patients should never feel anxious when receiving care and no member of staff should ever feel isolated, intimidated or unwelcome in their workplace. The Lord Mann review gives us the opportunity to raise our standards and expectations about what we will accept and put our professional values –

care, compassion and clinical excellence first. It is part of every leader's role to actively begin to dismantle the structural discrimination which exists. We are grateful for your support in delivering the actions set out.

Yours sincerely,



Sir Jim Mackey
Chief Executive
NHS England

Danny Mortimer
Director General for People
NHS England

Norfolk and Waveney University Hospitals Group

Staff-side consultation — Anti-Racism, Dignity and Respect Policy

To: Staff-side chairs and representatives, Joint Negotiating and Consultative Committee and Joint Staff Consultative Committee at NNUH, JPUH and QEH; chairs of the Group and Trust staff networks

From: Emma-Jayne Pérez Chies, Group Chief People Officer

Date: July 2026

Feedback requested by: Thursday 30 July 2026

What we are consulting on

I am writing to invite your views on the draft Anti-Racism, Dignity and Respect Policy, which is circulated with this note. This is the first Group-wide policy for Norfolk and Waveney University Hospitals Group. It does not supersede any existing Trust policy. Its standards, definitions and reporting framework will be carried into the Group Misconduct, Dignity at Work and Grievance policies as those are harmonised through the policy standardisation project, which remains subject to the usual negotiation with staff side.

The policy responds to Lord Mann's independent review into tackling racism and antisemitism within the NHS, published on 4 June 2026, and to NHS England's letter PRN02538 issued the same day.

What the policy does

- Adopts the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism and the Government definition of anti-Muslim hostility, and publishes guidance on how they are to be applied, including the evidential threshold and an express prohibition on relying on stereotypes about any colleague.
- Commits the Group to the NHS Race and Health Observatory Seven Principles of Anti-Racism.
- Creates a rebuttable presumption in favour of formal investigation for racism cases, so that concerns are not closed without a recorded finding and a named decision-maker. Informal resolution remains available where the colleague raising the concern asks for it and the rationale is recorded.
- Sets specialist standards for anyone investigating a racism case.
- Sets out support for colleagues who report racism, and protection from retaliation.
- Addresses racism directed at staff by patients, visitors and members of the public.
- Sets out how the Group will monitor detriment and disproportionality in disciplinary and grievance processes, disaggregated by ethnicity and religion.

The points we would particularly welcome views on

- Whether the reporting routes at Section 4.1 are ones colleagues would actually use, and whether anything is missing.
- The balance struck at Section 4.2 between formal investigation and early resolution, and whether the safeguards around informal resolution are the right ones.
- The freedom of expression provisions at Section 3.5 and the guidance on symbols and political identifiers at Section 6.
- The victim support framework at Section 4.5, including the approach to interim measures.
- Anything in the policy that would be difficult to apply in practice on a ward or in a department.

Timetable and what happens next

The policy is being considered by the Group Executive Group on 29 July 2026, alongside the Group EDI Workforce Strategy 2026/27, and is scheduled for ratification by the Group Board on 5 August 2026. Consultation feedback is requested by Thursday 30 July 2026 so that it can be reflected before ratification. Where consultation proposes significant changes, the policy will return to the Group Executive Group for further approval before implementation.

One point of sequencing to be clear about. NHS England has set a deadline of 31 July 2026 for every NHS organisation to confirm adoption of the two national definitions. That confirmation is a separate requirement and is not contingent on this consultation. Consultation is on the policy — how the Group will apply the definitions, investigate concerns and support colleagues — and those provisions remain open to change.

Please send comments to me directly, or raise them through your Joint Negotiating and Consultative Committee or Joint Staff Consultative Committee. I am happy to attend any meeting to discuss the draft.

Emma-Jayne Pérez Chies
Group Chief People Officer

Our commitment: tackling racism in our hospitals

A statement from Norfolk and Waveney University Hospitals Group — draft for publication following Group Board ratification, 5 August 2026, subject to final review with communications

Racism has no place in our hospitals. That includes antisemitism, anti-Muslim hostility, anti-Black racism, anti-Asian racism and racism directed at any ethnic, national or religious group. It applies wherever it occurs and whoever it comes from — between colleagues, from colleagues towards patients, from patients or visitors towards our staff, and in the way our own policies and decisions work.

In June 2026 Lord Mann published his independent review into tackling racism and antisemitism within the NHS. We have used it, and the requirements NHS England set out alongside it, to look honestly at ourselves.

What we have done

- We have adopted the International Holocaust Remembrance Alliance working definition of antisemitism and the Government definition of anti-Muslim hostility across all three of our hospitals, and confirmed this to NHS England.
- We have signed up to the NHS Race and Health Observatory's Seven Principles of Anti-Racism.
- We have introduced an Anti-Racism, Dignity and Respect Policy — the first Group-wide policy across our three Trusts. It sets out how concerns are reported, how they are investigated, and the support available to anyone affected.
- We have committed that no concern about racism will be closed without a recorded decision and a named decision-maker, and that anyone raising a concern in good faith is protected from any form of retaliation.
- We have commissioned an internal audit of racism-related cases closed over the last three years, carried out by our internal auditors, to satisfy ourselves that concerns were properly handled.
- Our Board members and senior leaders will complete anti-racism training, and around 150 managers and investigators will receive specialist training on recognising and investigating racism, antisemitism and anti-Muslim hostility.

What we are honest about

We are not starting from a position of strength everywhere. Our own review of how we work found that equality, diversity and inclusion is more developed at some of our hospitals than others, that our reporting and governance are inconsistent, and that colleagues continue to tell us they experience bullying, harassment and discrimination. We know that confidence in reporting racism needs to be rebuilt, particularly where it arises in interactions between patients and staff. Saying so publicly is part of the commitment.

What we expect

Our staff have the right to come to work without being abused for who they are. We ask everyone using our services to treat our staff with dignity and respect. Racist or discriminatory behaviour towards our staff is not acceptable and may result in action, including restrictions on visiting, withdrawal of non-essential services or, in serious cases, involvement of the police. We will never withhold urgent clinical care from anyone who needs it.

Holding ourselves to account

Progress against our Equality, Diversity and Inclusion Workforce Strategy is reported to our Group Board, which will also receive an annual report on the experience of our staff, the outcomes of cases, and whether our processes are being applied fairly to everyone. Each of our hospitals will publish an annual equality report.

If you experience or witness racism in any of our hospitals, please tell us. Staff can raise concerns with their manager, their HR team, their trade union representative or a Freedom to Speak Up Guardian. Patients, visitors and members of the public can contact the Patient Advice and Liaison Service at any of our three hospitals.

David [surname]
Group Chair

Professor Lesley Dwyer
Group Chief Executive Officer

Jo Segasby
Chief Delivery Officer and Deputy CEO /Acting Executive Managing Director, The Queen Elizabeth Hospital King's Lynn

Shane Gordon
Executive Managing Director, Norfolk and Norwich University Hospitals

Jonathan Gardener
Executive Managing Director, James Paget University Hospitals

NHS
Norfolk and Waveney
University Hospitals Group

Norfolk and Waveney University Hospitals Group
Group Executive Office
Centrum, Level 1, Office 5
Norwich Research Park
NR4 7UG

30 July 2026

Professor Habib Naqvi MBE
Chief Executive
NHS Race and Health Observatory

Dear Professor Naqvi

Norfolk and Waveney University Hospitals Group — adoption of the Seven Principles of Anti-Racism

I am writing to notify the Observatory that Norfolk and Waveney University Hospitals Group — comprising Norfolk and Norwich University Hospitals NHS Foundation Trust, James Paget University Hospitals NHS Foundation Trust and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust — has formally signed up to the NHS Race and Health Observatory's Seven Principles of Anti-Racism.

The commitment was approved by the Group Executive Group on 29 July 2026 and is recorded at Section 3.6 of our Anti-Racism, Dignity and Respect Policy, which is presented to the Group Board for ratification on 5 August 2026. It sits alongside our adoption of the International Holocaust Remembrance Alliance working definition of antisemitism and the Government definition of anti-Muslim hostility, confirmed to NHS England for each of our three constituent Trusts ahead of the deadline set in PRN02538.

The seven principles are not a statement of intent for us. They are the framework against which our first Group Equality, Diversity and Inclusion Workforce Strategy for 2026/27 has been built, and every one of its 36 actions carries an alignment reference to them. In summary:

- **Name Racism** — a public Group commitment naming antisemitism, anti-Muslim hostility, anti-Black racism, anti-Asian racism and all forms of racism, published across our three hospitals.
- **Understand and Acknowledge** — an independent review of our equality arrangements, an organisational development diagnostic under way at one of our Trusts, and an internal audit of racism-related cases closed over the last three years.
- **Meaningfully Involve Communities** — staff-side and staff network consultation on the policy, and the establishment of Group-level Jewish and Muslim staff networks with protected time and executive sponsorship.
- **Collect and Publish Data** — quarterly detriment and disproportionality reporting disaggregated by ethnicity and religion, completion of the Workforce Race Equality Standard, Workforce Disability Equality Standard and Medical Workforce Race Equality Standard across all three Trusts, and a comprehensive annual equality report at each.

- **Identify Racial Bias** — specialist investigator standards, recorded rationale at the threshold of formal investigation, and triangulated analysis to identify areas of disproportionate experience.
- **Apply a Race-critical Lens** — equality impact assessment requirements carried into every policy harmonised through our standardisation project, and a single Group inclusive recruitment standard.
- **Evaluate and Reflect** — annual independent assurance against the plan, reported to our Group Board and shared with our integrated care board and NHS England East of England.

I will report annually to our Group Board on progress against each principle, and would be glad to share that reporting with the Observatory. If it would be helpful to colleagues elsewhere, we would also be willing to share our experience of adopting the two national definitions with published application guidance, which we took the view was necessary if the definitions were to be applied consistently and fairly by managers and investigators.

I would welcome the opportunity to draw on the Observatory's workforce race equality resources as we develop our inclusive leadership programme, and to discuss any aspect of this with you or your team.

Yours sincerely

Emma-Jayne Pérez Chies
Group Chief People Officer
Norfolk and Waveney University Hospitals Group

Norfolk and Waveney
University Hospitals Group

NORFOLK AND WAVENEY
UNIVERSITY HOSPITALS GROUP

GROUP BOARD MEETING IN PUBLIC:
5 AUGUST 2026

SUPPLEMENTARY PAPERS
FOR AGENDA ITEM 14

Group Board Assurance Framework: July 2026

Norfolk and Waveney University Hospitals Group

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

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

NHS
Norfolk and Waveney
University Hospitals Group

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	July 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: 80 (mortality outliers); QEH: 3762 (Histopathology), 3194 (Mental Health Act), 3723 (general surgery); 3014 (Clinical Safety Officer role); JPUH: 587 (Complaints), 223 (Histopathology)

	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	11	11	11	10	10	10	10	10	10	10	10	10	9	9	9		9
Actual	12	12	12	12	12	12	12																			

Summary of monthly review/amendments

- Current risk score unchanged.
- Due date for action to address gap in assurance GA2 amended from June to September 2026 to reflect ongoing discussions on establishment of a Quality and Outcomes Committee.

Walker Ian
31/07/2026 00:08:16

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. Reporting to Executive Risk Assurance Group. AS3. Reporting to 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. AT4. Inclusion of QEH in National Provider Improvement Programme (status tbc).
C2. Clinical governance framework in place in individual trusts.			
C3. Monitoring of key quality metrics in the Integrated Performance Report.			
C4. Monitoring of patient feedback through surveys, complaints, etc.			
C5. Agreed quality improvement methodology and training programme.			
C6. Specialist clinical networks sharing best practice and providing peer challenge.			
C7. Clinical audit programmes in each Trust.			

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Group-wide clinical governance framework focusing on reducing quality variation and improving quality of care.	Clinical governance review at QEH in response to General Surgery issues and to be extended to NNUH and JPUH to inform a Group-wide clinical governance framework, with standardised policy, process and reporting.	August 2026 – NNUH and JPUH governance reviews underway; progression of QEH review to be finalised following May 2026 Rapid Quality Review.
GC2. Group-wide quality improvement function and programme.	Programme and function to be developed and implemented. Creation of Quality Faculty and confirmation of quality	July 2026

	improvement methodology to be approved through One Recovery Programme Board.	
GC3. Monitoring quality data in real time on a consistent basis.	Development of Integrated Performance Report and supporting insight following market engagement exercise.	tbc
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. To be discussed at Executive Directors' meeting informed by Healthwatch report.	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 potential move to a separate Quality and Outcomes Committee.	~~June 2026~~ September 2026

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

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

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

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

Risk appetite	
Within appetite range?	

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

	Risk score trajectory																								
	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	9	8	8	8	8	8		8
Actual	11	11	11	11	11	11	11																			

Summary of monthly review/amendments

- Current risk score unchanged.
- Key controls updated to include establishment of Perinatal Resilience Forum at NNUH in July 2026.
- Gap in assurance GA2 updated to reflect publication of NHS England 10-Point Plan for maternity and neonatal services following Baroness Amos and Ockenden reports.
- Risk trajectory being reviewed for August 2026 following feedback in June.

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 Executive 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)
C2. Group-wide perinatal governance framework developed.			
C3. Monthly perinatal reporting in place.			
C4. National maternity outcomes signal system implemented.			
C5. Daily national OPEL reporting.			
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
GC2. Group perinatal governance framework implementation.	Implementation plan to be developed and rolled out, including revised Group reporting.	March 2027
GA1. Regulatory notice in place for maternity services at QEH.	Evidence on training compliance provided to CQC and awaiting outcome and lifting of Section 31.	Awaiting CQC feedback.

GA2. 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.	Development of Trust responses to 10-Point Pan including baseline gap analysis.	Reporting requirements awaited from NHS England.
GA3. Maternity and Neonatal Voices Partnership (MNVP) not meeting current national standards for funded time allowance.	Awaiting resolution from Integrated Care Board (ICB).	tbc

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

Risk lead	Group CDO
Last update	July 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: 216 (UEC/ambulance offloads), 70 (Cellular pathology reporting delays); QEH: 2244 (mental health community beds), 2794 (Outpatients access), 2799 (CT/MRI reporting delays); JPUH: 157 (RTT/18 week waits), 152 (ED waits/ambulance handovers)

	Risk score trajectory																								
	Jan 26	**Feb 26**	**Mar 26**	**Apr 26**	**May 26**	**Jun 26**	**Jul 26**	**Aug 26**	**Sep 26**	**Oct 26**	**Nov 26**	**Dec 26**	**Jan 27**	**Feb 27**	**Mar 27**	**Apr 27**	**May 27**	**Jun 27**	**Jul 27**	**Aug 27**	**Sep 27**	**Oct 27**	**Nov 27**	**Dec 27**		**Target**
Planned	13	13	13	13	13	11	11	11	11	11	11	9	9	9	9	9	9	9	9	9	9	9	9	9		9
Actual	13	13	13	13	12	12	12																			

Summary of monthly review/amendments

- Current risk score unchanged.
- Gap in control GC1 updated to reflect development of QEH Recovery Plan in July 2026 in response to NHS England letter.
- Gap in assurance GA2 closed following agreement of 2026/27 Internal Audit Plan – added to third line sources of assurance.
- New gap in assurance GA2 relating to strengthening of Board-level oversight and assurance on operational performance metrics.

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. 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.	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.

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
GC3. Cancer waiting time performance not improving at rate envisaged in Medium-term Plans.	Review individual Trusts' plans and refocus cancer One Recovery programme to return performance to trajectory.	Work by end of June 2026 to identify timeframe to return to trajectory – will then review risk trajectory.
GA1. Monitoring approach to One Recovery and Medium-term Plans to be developed.	Working with analytical support to develop monitoring approach.	End June 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.	End of July 2026 onwards.

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

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

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

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

Risk appetite	
Within appetite range?	

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

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

Summary of monthly review/amendments

- Current risk score unchanged.
- Due dates for actions to address gaps in control GC1 and GC3 amended from June 2026 to August 2026 pending confirmation of current position.
- New gap in assurance GA1 relating to strengthening of Board-level oversight and assurance on financial performance metrics.

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. AS2. One Recovery Programme meetings twice monthly. AS3. Reporting to Executive Risk Assurance Group, Group Risk Assurance Committee and Group Board. AS4. Review of controls in place through Annual Governance Statement. AS5. CIP deep dive undertaken at GRAC in April 2026.	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.			
C3. CIP plans for 2026/27 finalised and 2027/28 in development. One Recovery CIP Charter signed off in March 2026.			
C4. Pay controls – Vacancy Panels in place in all three Trusts.			
C5. Bank and agency controls in line with NHSE reductions.			
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. 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 for delivery of each scheme 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.	Dedicate time at monthly GRAC meetings to review of financial performance metrics against Medium-term Plan.	End of July 2026 onwards.

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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	July 2026
Group Aim and Enabling Objectives	A3: People and culture EO 13, 14, 15, 16

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?	

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

Related Group/Trust significant risks (12 and above)
NNUH: 523 (workforce team capacity), 82 (staff morale and engagement); QEH: 3848 (staff experience); JPUH: 614 (nursing fill rates), 758 (staff engagement/morale)

	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																		

Summary of monthly review/amendments
• Current risk score unchanged. • Second line assurance AS4 added in relation to GRAC deep dive on this risk in June 2026.

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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 – see gaps below.			

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.	
GC2a: Vanderbilt	Phased implementation of **Vanderbilt** professional advocacy programme with a focus on a culture of safety and respect, to	Medical staff/senior leadership roll out from April 2026

	be delivered over a four-year period. EDI markers being included in reporting system.	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 June 2026
GC2c: Leaders Within	Develop "**Leaders Within**" network to develop future leadership capability across the Group and bring together staff networks.	Commences in July 2026
GC2d: Single improvement methodology "Collectively Curious"	Agree and implement single improvement methodology to be introduced through One Recovery programme.	Commences in July 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.	By October 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.	November 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	July 2026
Group Aim and Enabling Objectives	A2: Access and flow EO 6, 7, 8, 9, 10, 11, 12

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

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

Risk appetite	
Within appetite range?	

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

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

Summary of monthly review/amendments
• Current risk score unchanged. • No amendments. • Risk trajectory to be reviewed in August 2026 to determine whether revision required (risk currently above trajectory from July 2026).

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.	AF5.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 Strategy, Technology, Investments and Partnerships Committee and then Group Board in August/ 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.	Stage 2 in progress – completion date tbc following Single Digital Team go-live.
GC5. Data analytics capability.	Develop and implement plans for a Group-wide Business Intelligence, Analytics and Data Quality function. Market testing exercise to consider outsourced/partially-outsourced data solutions.	July 2026 (with interim arrangements from April 2026).

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

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

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

Risk appetite	
Within appetite range?	

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

Related Group/Trust significant risks (12 and above)

NNUH: 81 (EPR disruption during/after go-live); EPR programme: 6216 (financial consequences of delay), 6217 (impact on operational performance), 2118 (EPR programme delivery), 5202 (multi-Trust convergence complexity)

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

Summary of monthly review/amendments

- Current risk score unchanged.
- Risk trajectory to be reviewed in August 2026 to determine whether revision required (risk currently above trajectory from July 2026).
- Gap in control GC1 updated to reflect update to Group Board scheduled for 22 July 2026.

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.	To be received 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.	Ongoing
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	July 2026
Group Aim and Enabling Objectives	A4: Financial sustainability EO 17-23

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

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

Risk appetite	
Within appetite range?	

Related Group/Trust significant risks (12 and above)
NNUH: 12 (data protection breaches), 7 (cyber security); QEH: 3449 (cyber security/MFA); JPUH: 76 (cyber security)

	Risk score trajectory																								
	Jan 26	**Feb 26**	**Mar 26**	**Apr 26**	**May 26**	**Jun 26**	**Jul 26**	**Aug 26**	**Sep 26**	**Oct 26**	**Nov 26**	**Dec 26**	**Jan 27**	**Feb 27**	**Mar 27**	**Apr 27**	**May 27**	**Jun 27**	**Jul 27**	**Aug 27**	**Sep 27**	**Oct 27**	**Nov 27**	**Dec 27**	**Target**
Planned	13	13	13	13	13	13	13	13	13	13	13	13	13	12	12	12	12	12	12	12	12	10	10	10	10
Actual	13	13	13	13	13	13	13																		

Summary of monthly review/amendments

- Current risk score unchanged.
- New gap in control GC4 added in relation to NIS enforcement notices on MFA compliance at NNUH and QEH.

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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 Risk Assurance 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).			

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 (VMDR)/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	July 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																		

Summary of monthly review/amendments

- Risk score unchanged.
- No material amendments – risk under review.

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

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	July 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	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																			

Summary of monthly review/amendments

- Current risk score unchanged.
- Due date for action to address gap in control GC1 amended from August to September 2026 to reflect corporate services Phase 2 consultation requirements.
- Previous gap in control GC2 closed – QI approach and methodology agreed at One Recovery Oversight Group in July 2026.
- Risk trajectory amended as above to reflect the fact that 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.

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 Group Executive 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~~ September 2026
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	July 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																								
	Jan 26	**Feb 26**	**Mar 26**	**Apr 26**	**May 26**	**Jun 26**	**Jul 26**	**Aug 26**	**Sep 26**	**Oct 26**	**Nov 26**	**Dec 26**	**Jan 27**	**Feb 27**	**Mar 27**	**Apr 27**	**May 27**	**Jun 27**	**Jul 27**	**Aug 27**	**Sep 27**	**Oct 27**	**Nov 27**	**Dec 27**	**Target**
Planned	12	12	12	12	12	12	12	12	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	8
Actual	12	12	12	12	12	12	12																		

Summary of monthly review/amendments

- Current risk score unchanged.
- No amendments.

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.	October 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	July 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																			

Summary of monthly review/amendments

- No amendment to current risk score pending actions below.
- Gap in control GC1 updated to reflect completion of all elements except establishment of proposed Quality and Outcomes Committee and agreement of risk appetite approach – revised date of September 2026.
- Gap in control GC3 closed following recruitment and appointment of an additional three Group NEDs and two Associate Group NEDs.
- Risk trajectory revised to reflect revised due date for actions to address gap in control GC1.

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 (*ongoing*). Annual Governance Statements agreed by Group Board.	AT2. NHS England review of Group Model Mobilisation Plan (December 2025). CQC Well-Led reviews (*not yet undertaken*). 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 (*not yet undertaken*).	
C4. Risk management framework and policy, Board Assurance Framework (BAF) and Trust risk registers.	AF4. Ongoing review by Executive Risk Assurance Group.	AS4. Audit Committees in Common seek assurance on governance, risk and internal control effectiveness (*ongoing*). Annual Governance Statements agreed by Group Board.	AT4. Annual Internal Audit review of effectiveness of risk management system. CQC Well-Led review (*not yet undertaken*).

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.	July 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	July 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																		

Summary of monthly review/amendments

- Risk scores unchanged.
- No amendments. Risk under review with new Group Director of Communications and Engagement.

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.	September 2026

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Principal Risk 16: Research, innovation and education
If we do not enhance our capability and capacity for research, innovation and education through the establishment of a university hospital system with our strategic partners, then our ability to improve the care we offer to patients will be constrained, our access to new knowledge, insight and resources to improve hospital performance will be limited, and the development of skills, expertise and experience across our workforce will be slowed.

Risk lead	Group CMO
Last update	July 2026
Group Aim and Enabling Objectives	A3: People and culture A5: Research and education EO 13-16, 24-26

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	3	4	3	**10**
Target	3	2	2	7

Risk appetite	
Within appetite range?	

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

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

	Risk score trajectory																								
	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													7
Actual	10	10	10	10	10	10	10																		

Summary of monthly review/amendments
• No amendments to risk scores. • No amendments in-month.

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.	August 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

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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

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).

Three lines of defence	The three lines of evidence the organisation gains on the effectiveness of the controls in place to mitigate a risk. *First line*: teams, managers and leaders in operational or service delivery functions and in support functions (*Trust level*) *Second line*: the oversight of management activity, separate from those responsible for delivery but not independent of the organisation's management chain (*Group level*) *Third line*: functions that provide independent and objective assurance regarding the integrity and effectiveness of risk management and related controls in the organisation (*External*)
Principal risks	Group-level strategic risks which would threaten the achievement of the Group's Aims.
Risk appetite	The amount and type of risk that an organisation is willing to pursue or retain.
Target risk score	The risk score (the summation of the Consequence, Likelihood and Control Effectiveness ratings) which the organisation aims to achieve once all identified and planned controls have been implemented.

Abbreviations	
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
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