Group Board (General Purpose Joint Committee) meeting in Public

Wednesday 5 August 2026, 10:30 - 13:00

McClintock Seminar Rm, John Innes Conference Ctre, Norwich Research Park NR47UH

Norfolk and Waveney University Hospitals Group

Agenda

10:30 - 10:30
0 min

1. Agenda, welcome and apologies

For information *Group Chair*

0 - Group Board in public - Agenda - 05.08.26 iw.pdf (3 pages)

10:30 - 10:30
0 min

2. Declarations of interest

For information *Group Chair*

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

10:30 - 10:50
20 min

3. Reflections from Board walkrounds and Patient Story

For discussion *Group Chief Nurse*

10:50 - 10:55
5 min

4. Minutes of the previous meeting

For decision *Group Chair*

To approve the Minutes of the meeting held on 3 June 2026

Paper required

4 - Group Board Minutes 03.06.26 iw.pdf (15 pages)

10:55 - 10:55
0 min

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

For discussion *Group Director of Governance*

Paper required

5 - Group Board in Public Action Log iw.pdf (2 pages)

10:55 - 11:05
10 min

6. Group Chief Executive's Report

For discussion *Acting Group Chief Executive*

Paper required

6 - Group Chief Executive's Report August 2026 iw.pdf (8 pages)

11:05 - 11:20
15 min

7. James Paget University Hospitals NHS FT

7.1. Executive Managing Director's report

For discussion *Executive Managing Director*

Paper required

7.1 - JPUH EMD report August 2026 iw.pdf (6 pages)

7.2. Link Non-Executive Directors update

For discussion *Link NEDs*

11:20 - 11:35
15 min

8. Queen Elizabeth Hospital King's Lynn NHS FT

8.1. Executive Managing Director's report

For discussion *Executive Managing Director*

Paper required

8.1 - QEH EMD report August 2026 iw.pdf (8 pages)

8.2. Link Non-Executive Directors' update

For discussion *Link NEDs*

11:35 - 11:50
15 min

9. Norfolk and Norwich University Hospitals NHS FT

9.1. Executive Managing Director's report

For discussion *Executive Managing Director*

Paper required

9.1 - NNUH EMD report August 2026 iw.pdf (9 pages)

9.2. Link Non-Executive Directors' update

For discussion *Link NEDs*

11:50 - 12:05
15 min

10. Group performance overview

10.1. Integrated Performance Report

For information *Group Chief Delivery Officer*

Paper required

10.1.1 - Group Board in public - Integrated Performance Report cover paper iw.pdf (5 pages)
10.1.2 - Group Board in public - Integrated Performance Report Summary domains iw.pdf (47 pages)

10.2. Group Finance Report

For information *Group Chief Finance Officer*

Paper required

10.2.1 - Group Finance Report M3 cover sheet iw.pdf (1 pages)
10.2.2 - Group Board Finance Report M3 iw.pdf (13 pages)

12:05 - 12:15
10 min

11. Reports from the Chairs of Board Committees

11.1. Group Risk Assurance Committee

For information *Committee Chair*

Paper required

11.1 - Group Risk Assurance Committee - Chair's report iw.pdf (2 pages)

11.2. Group Audit Committees in Common

For information *Committee Chair*

Paper required

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

11.3. Group Research, Innovation and Education Committee

For information *Committee Chair*

Paper required

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

11.4. Group Strategy, Technology, Investments and Partnerships Committee

For information *Committee Chair*

Paper required

11.4 - Group Strategy, Technology, Investments and Partnerships Committee - Chair's report iw.pdf (2 pages)

11.5. Trust Charitable Funds Committee

For information *Committee Chair*

Paper required

11.5 - Charitable Funds Committees - Chair's reports iw.pdf (5 pages)

12:15 - 12:25
10 min

12. Perinatal services report

For discussion *Group Chief Nurse*

Paper required

12.1. National maternity triage specification

Information *Group Chief Nurse*

12.1 - National maternity triage specification iw.pdf (5 pages)

12.2. Maternity Incentive Scheme update

Information *Group Chief Nurse*

12.2 - Maternity Incentive Scheme Quarter 1 report July 2026 iw.pdf (14 pages)

12.3. Group Perinatal report

Discussion *Group Chief Nurse*

12.3.1 - Group Perinatal Report cover sheet iw.pdf (3 pages)
12.3.2 - Group Perinatal Report July 2026 iw.pdf (72 pages)

12:25 - 12:40
15 min

13. Equality, Diversity and Inclusion Workforce Plan

For decision *Group Chief People Officer*

Paper required

13.1 - NWUHG EDI Workforce Plan iw.pdf (26 pages)

12:40 - 12:45
5 min

14. Group Board Assurance Framework

For discussion *Group Director of Governance*

Paper required

- 14.1 - Report to Group Board - BAF update July 2026 iw.pdf (4 pages)
- 14.2 - NWUHG BAF - July 2026 Summary Page iw.pdf (1 pages)

12:45 - 12:50
5 min

15. Group Board committees and membership

For decision *Group Director of Governance*

Paper required

- 15 - Group Board committees and membership iw.pdf (6 pages)

12:50 - 12:50
0 min

16. Group Audit Committees in Common terms of reference

For decision *Group Director of Governance*

Paper required

- 16.1 - Group Audit Committees in Common terms of reference cover sheet iw.pdf (2 pages)
- 16.2 - Group Audit Committees in Common terms of reference iw.pdf (7 pages)

12:50 - 12:55
5 min

17. Any Other Business

Group Chair

12:55 - 13:00
5 min

18. Questions from Members of the Public

For discussion *Group Chair*

To respond to pre-submitted questions

13:00 - 13:00
0 min

19. Meeting review and reflections

For discussion *Group Chair*

13:00 - 13:00
0 min

20. Date of the Next Meeting

For information

Wednesday 7 October 2026 at 10:30 in the Lecture Theatre, Burrage Centre, James Paget University Hospital, Lowestoft Road, Gorleston, Great Yarmouth, Norfolk NR31 6LA

13:00 - 13:00
0 min

21. Resolution

For decision *Group Chair*

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

13:00 - 13:00
0 min

22. Close of Meeting

Norfolk and Waveney
University Hospitals Group

Group Board (General Purpose Joint Committee)

Meeting in public on Wednesday 5 August 2026 at 10.30
in the McClintock Seminar Room, John Innes Conference Centre,
Norwich Research Park, Norwich NR4 7UH

AGENDA					
Time	**No.**	**Item**	**Purpose**	**Paper attached**	**Lead**
10.30	**1.**	**Welcome and apologies**			Group Chair
	2.	**Declarations of interest** Those present to declare any actual, potential or perceived interests relating to items on the agenda	For information	No	Group Chair
Patient story					
10.30	**3.**	**Reflections from Board walkrounds and Patient Story**	For discussion	No	Group Chief Nurse
Introductory items and reports					
10.50	**4.**	**Minutes of the previous meeting** To approve the Minutes of the meeting held on 3 June 2026	For decision	Yes	Group Chair
	5.	**Action log and matters arising not covered by other agenda items**	For discussion	Yes	Group Director of Governance
10.55	**6.**	**Group Chief Executive's report**	For discussion	Yes	Acting Group Chief Executive
Trust performance **(*the Group Integrated Performance Report and the Group Finance report support this section of the agenda*)**					
11.05	**7.** 7.1 7.2	**James Paget University Hospitals NHS FT** Executive Managing Director's report Link Non-Executive Directors' update	For discussion	 Yes No	Executive Managing Director and Link NEDs

11.20	**8.** 8.1 8.2	**Queen Elizabeth Hospital King's Lynn NHS FT** Executive Managing Director's report Link Non-Executive Directors' update	For discussion	 Yes No	Executive Managing Director and Link NEDs
11.35	**9.** 9.1 9.2	**Norfolk and Norwich University Hospitals NHS FT** Executive Managing Director's report Link Non-Executive Directors' update	For discussion	 Yes No	Executive Managing Director and Link NEDs
11.50	**10.** 10.1 10.2	**Group performance overview** Integrated Performance Report Group Finance Report	 For decision For information	 Yes Yes	 Group Chief Delivery Officer Group Chief Finance Officer
Business items					
12.05	**11.** 11.1 11.2 11.3 11.4 11.5	**Reports from the Chairs of Board Committees** Group Risk Assurance Committee Group Audit Committees in Common Group Research, Innovation and Education Committee Group Strategy, Technology, Investments and Partnerships Committee Trust Charitable Funds Committees	For information	Yes	Committee Chairs
12.15	**12.** 12.1 12.2 12.3	**Perinatal services** Maternity triage specification Maternity Incentive Scheme update Group Perinatal report	For discussion	Yes	Group Chief Nurse
12.25	**13.**	**Equality, Diversity and Inclusion Workforce Plan**	For decision	Yes	Group Chief People Officer
12.40	**14.**	**Group Board Assurance Framework**	For discussion	Yes	Group Director of Governance
Approvals					
12.45	**15.**	**Group Board committees and membership**	For decision	Yes	Group Director of Governance

	16.	**Group Audit Committees in Common terms of reference**	For decision	Yes	Group Director of Governance
Other items					
12.50	**17.**	**Any other business**		No	Group Chair
12.55	**18.**	**Questions from members of the public** To respond to pre-submitted questions	For discussion	No	Group Chair
	19.	**Meeting review and reflections**	For discussion	No	Group Chair
	20.	**Date of the next meeting** Wednesday 7 October 2026 at 10.30 in the Lecture Theatre, Burrage Centre, James Paget University Hospital, Lowestoft Road, Gorleston, Great Yarmouth, Norfolk NR31 6LA.	For information		
	21.	**Resolution** That representative of the press and other members of the public be excluded for from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (NHS Act 2006 as amended by the Health and Social Care Act 2012)	For decision		Group Chair
13.00	**22.**	**Close of meeting**			

NHS
Norfolk and Waveney
University Hospitals Group

Group Board (General Purpose Joint Committee) meeting in public

Minutes of the meeting held on Wednesday 3 June 2026 at 10.30 in the Board Room, Queen Elizabeth Hospital, Gayton Road, King's Lynn, Norfolk PE30 4ET

Board members present	Position
David Roberts	Group Chair
Lesley Dwyer	Group Chief Executive
Michelle Arrowsmith	Executive Managing Director, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH)
Philip Baker	Group Non-Executive Director
Jack Bowman	Group Non-Executive Director
Jo Churchill	Group Non-Executive Director
Chris Cobb	Acting Executive Managing Director, Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)
Rachael Cocker	Interim Group Chief Nurse
Sally Collier	Group Non-Executive Director and Senior Independent Director
Jonathan Gardner	Executive Managing Director, James Paget University Hospitals NHS Foundation Trust (JPUH)
Nikki Gray	Group Non-Executive Director
Stephen Javes	Group Non-Executive Director
Emma-Jayne Perez Chies *	Interim Group Chief People Officer
Edward Prosser-Snelling *	Group Director of Digital
Joanne Segasby	Group Chief Delivery Officer
Robert Sherwin	Group Chief Medical Officer
Marcus Thorman	Group Chief Finance Officer
William Van't Hoff	Group Non-Executive Director
Ian Walker *	Interim Group Director of Governance
Ben White *	Group Director of Communications and Engagement
** Non-voting member*	
Apologies	
Shane Gordon	Executive Managing Director, NNUH
In attendance	
Tanvir Alam	Group Non-Executive Director (Designate)
Charlie Helps	Group Secretary
Andy McKechnie	Group Non-Executive Director (Designate)
Susan Putters	Group Non-Executive Director (Designate)
Alison Stace	Deputy Executive Managing Director, NNUH

1. Agenda, welcome and apologies

Purpose: For Information

The Group Chair opened the Group Board meeting in public and welcomed Governors, members of the public and staff attending in person and online.

The Group Chair reported that Group Board members had undertaken a number of walk rounds within Maternity Services at Queen Elizabeth Hospital King's Lynn (QEH) before the meeting and he thanked staff for their time and feedback.

He welcomed Emma-Jayne Perez Chies, Interim Group Chief People Officer, and Ben White, Group Director of Communications and Engagement, to their first Group Board meetings. He also welcomed Tanvir Alam, Andy McKechnie and Susan Putters as Group Non-Executive Directors (Designate) pending their formal appointments. Marcus Bailey and Gee Cook, who were unable to be present, would shortly be formally appointed as Group Associate Non-Executive Directors. Alison Stace, who had recently taken up post as Deputy Executive Managing Director at NNUH was welcomed as an observer.

The Group Chair thanked Charlie Helps, Group Secretary, and Jo Hannam, Communications Adviser, for their valuable work in supporting the establishment of the Group, noting that for both this was their final Group Board meeting.

Apologies were received from Shane Gordon, Executive Managing Director for NNUH. Chris Cobb, Acting Executive Managing Director for NNUH, was attending in his place.

2. Declarations of interest

Purpose: For Information

The Group Chair invited declarations of interest relating to the business on the agenda.

No additional actual, potential or perceived interests were declared. It was noted that the current declarations of interest of Group Board members were published on the Group website.

3. Reflections from Group Board walk rounds and patient story

Purpose: For Discussion

Esther Dorken, Head of Midwifery at QEH, introduced the patient story. She explained that the mother, supported by the Maternity team, had provided written feedback following the birth of her daughter at QEH in May 2026. Both mother and daughter were present for the agenda item and the story was read by the Risk and Compliance Manager for Women's and Children's Services at QEH.

The account described a traumatic birth complicated by haemorrhage and emergency response. It also described clear communication, compassion, clinical professionalism and practical support from named midwifery, anaesthetic, medical and post-natal staff.

The mother stated that staff had explained what was happening, involved her husband and helped him to understand the emergency response, and provided reassurance after the event. She said that clear information and staff remaining calm had made the greatest difference because she and her husband understood that she was being looked after and that the situation was under control.

The Group Chief Executive linked the story to the Group Board walk rounds undertaken earlier in the day and stated that Group Board members had observed a high degree of staff compassion and support in Maternity services. William Van't Hoff, Group Non-Executive Director, reflected that the story evidenced ordered multi-disciplinary working between doctors and midwives during an emergency and that this was relevant to feedback received during the walk rounds. The Group Chair stated that the Board needed to hear positive and negative patient feedback and that the account provided direct evidence of compassionate care within QEH Maternity services.

It was noted that, while the patient story provided direct service user evidence of effective communication, compassion and multi-disciplinary working within the Maternity service, there was a wider perspective that needed to be considered through later performance and risk reporting.

Resolution: The Group Board noted the reflections from the Board walk rounds and the patient story. Board members thanked the mother for telling her story and attending with her daughter to respond to questions. Thanks were also extended to all members of staff in Maternity services who had supported the walk rounds.

4. Minutes of the previous meeting

Purpose: For Decision

The Group Chair invited comments on the accuracy of the minutes of the Group Board meeting held in public on 1 April 2026.

No amendments were proposed.

Resolution: The Group Board approved the minutes of the meeting held in public on 1 April 2026 as a true and accurate record.

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

Purpose: For Discussion

The Interim Group Director of Governance presented the action log. He reported that actions 3, 4, 5, 6, 7, 8 and 10 had been addressed and were proposed for closure. He reported that action 9, concerning the charities options appraisal, remained open because the update was scheduled on the Group Board planner within the agreed six-month timeframe.

Resolution: The Group Board noted the action log, agreed to close actions 3, 4, 5, 6, 7, 8 and 10, and agreed that action 9 should remain open until the charities options appraisal update returned to the Group Board.

6. Group Chief Executive's Report

Purpose: For Discussion

The Group Chief Executive presented her report. She stated that the Group Board would consider One Strategy later in the day and that the Group needed to align its major programmes, including the New Hospitals programme, the Electronic Patient Record (EPR), digital and neighbourhood work, into a single future operating model. She referred to a proposed Transformation Design Authority and supporting Board governance arrangements as the means by which the Group would maintain line of sight across these programmes.

The Group Chief Executive reported that updated Provider Capability Assessments would return to the Group Board for sign-off in due course under the NHS Oversight Framework (NOF). She reported that Phase 1 of the Corporate Services Transformation programme had completed and that Phase 2 would proceed through a design-led approach, supported by a rapid independent Gateway review to assess benefits from Phase 1 and learning for Phase 2.

The Group Chief Executive reported that the final 'Collectively Curious' review had been received and would return through the Group Research, Innovation and Education Committee. She also reported further resident doctors' industrial action scheduled for June 2026 and stated that the Executive would seek to reduce avoidable cancellations. She further reported that QEH was preparing an action plan to bring together Care Quality Commission (CQC), general surgery, and wider recovery work into a two-year programme.

The Chair challenged whether the pace of corporate services transformation was sufficient to address the requirements of the Cost Improvement Programme (CIP) reported in the finance paper. The Group Chief Executive stated that corporate services realignment had a target efficiency contribution and that the Group needed to assess whether corporate services were doing enough before clinical services were asked to absorb any further savings. The Group Chief Finance Officer explained that the first-quarter CIP variance was not related to the corporate services programme because the majority of those savings were scheduled for later in the year.

Jo Churchill, Group Non-Executive Director, asked whether QEH had the level of Group support required to respond to its financial, operational and regulatory challenges. The Group Chief Executive stated that the level of Group support remained under regular review, including through the One Recovery programme.

Resolution: The Group Board noted the Group Chief Executive's Report.

7. Executive Managing Directors' Reports

Purpose: For Discussion

7.1. Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Purpose: For Discussion

The Executive Managing Director (EMD) for QEH presented the report. She highlighted the appointment of Amanda Ramsay-Dunn as Director of Improvement and Recovery and stated that the QEH recovery plan would need to bring together CQC, CIP and service improvement work rather than manage those matters separately. She said that QEH needed to strengthen basic controls across quality and safety and operational and financial management.

QEH had been subject to a further unannounced CQC inspection covering urgent and emergency care (UEC) and medicine and had received further Section 29A enforcement notices. NHS England had convened a Rapid Quality Review in May 2026 focused on general surgery, including the Royal College of Surgeons and CQC findings, and regulators had assessed the grip and control in place. Work was under way to implement the action plan in response to the Information Commissioner's Office enforcement notice in relation to Freedom of Information Act compliance.

The EMD for QEH reported that QEH's regulatory, CIP and cash positions remained of material concern and needed to be triangulated so that actions addressed quality, finance, and operational controls together.

It was reported that performance across UEC, Referral to Treatment (RTT), Cancer and Diagnostics remained below national standards, although operational stability had improved in several areas during April 2026. Cancer performance remained below trajectory, particularly against the 62-day standard due to backlog, diagnostic constraints and pathway delays. Diagnostics performance also remained below standard, with Audiology and Echocardiography continuing to present the most significant pressures.

William Van't Hoff welcomed the reported response to the Rapid Quality Review. He asked whether pharmacy and audiology required Group-level attention because of service fragility, recruitment and equipment issues. The EMD for QEH stated that within pharmacy there was a focus on aseptic services, pharmacy processes and cost improvement opportunities. Audiology was being supported by NNUH colleagues, the Group Chief Medical Officer, and regional and national teams.

The Group Chair stated that Board members had heard open challenge from staff during the Board walk rounds and that staff should continue to be encouraged to speak up about any concerns through internal Trust channels as well as through external regulatory routes.

Resolution: The Group Board noted the report from the EMD for QEH.

7.2. James Paget University Hospitals NHS Foundation Trust

Purpose: For Discussion

The EMD for JPUH presented the report. He reported that the complaints backlog was improving and was expected to be cleared by the end of June 2026. He reported increased Executive visibility through quality visits, continued development of the top leaders' programme and an in-month sickness rate of just under 5 per cent, the lowest for 18 months.

The EMD for JPUH reported positively on the Trust's Freedom to Speak Up model and noted that the external provider had identified JPUH as an exemplar in terms of the responsiveness of managers to issues raised. He also reported that JPUH was piloting a staff general practitioner service to support early access to appointments.

Updates were also provided on the creation of the East Place Health Alliance with community and primary care partners; the 'test, learn and grow' anticipatory care pilot for frailty; work to move lower-complexity gynaecology procedures into community settings; and engagement with the police on violence and aggression in hospital.

The Group Chief Finance Officer welcomed the sickness absence improvement and noted that Internal Audit had been asked to revisit sickness action plans across all three Trusts in the next six months. Sally Collier, Group Non-Executive Director, asked for further details on the 'test, learn and grow' pilot. The EMD for JPUH explained that, while being locally-focused, it was taking account of national learning.

The Group Chief Executive stated that the Group should consider whether the JPUH Freedom to Speak Up approach provided a model for the other Trusts in the Group. The Interim Group Chief People Officer reported that initial conversations had started with the Lead Freedom to Speak Up Guardians on developing a Group proposal.

Nikki Gray, Group Non-Executive Director, questioned whether mental health services were sufficiently included within neighbourhood discussions. The EMD for JPUH noted that discussions had begun with Norfolk and Suffolk NHS Foundation Trust but that integration was at an early stage. The Group Chief Delivery Officer reported that estates discussions with Norfolk and Suffolk NHS Foundation Trust included mental health emergency department provision and mental health hubs, which needed to be considered alongside the neighbourhood approach.

Nikki Gray also suggested that the Group should distinguish between small voluntary organisations and larger charities providing commissioned NHS services. The Group Chief Executive agreed that voluntary, community and social enterprise partners would need to be included in the development of the Group's strategy.

Jo Churchill asked whether the staff general practitioner pilot would be evaluated and whether it might be extended to the other two Trusts. The EMD for JPUH confirmed that the pilot would be evaluated in order to inform any decision on whether to extend it in future.

Resolution: The Group Board noted the report from the EMD for JPUH.

7.3. Norfolk and Norwich University Hospitals NHS Foundation Trust

Purpose: For Discussion

Chris Cobb, Acting EMD for NNUH, presented the report. He reported on recent leadership changes including the appointments of David Partridge as Interim Director of People and Culture and Alison Stace as Deputy Executive Managing Director. He stated that the NNUH leadership team had undertaken facilitated development work and was considering how to extend high-functioning team practice more widely.

The Acting EMD for NNUH reported that urgent and emergency care (UEC) performance had exceeded the national standard in some areas during industrial action, supported by senior decision-makers. Ambulance handover and corridor care remained the key UEC risks. Elective performance remained close to plan despite lost weekend activity associated with industrial action and the bank holiday. Performance against the Cancer 31-day standard had remained strong, while performance against the 28-day faster diagnosis standard was expected to have recovered in May 2026. Month one financial performance was on-track and further work was required to convert CIP proposals into approved schemes before the planned increase in monthly CIP trajectory.

The Acting EMD reported that a 'Financial Improvement Plan Friday' event had generated further opportunities and that the Trust had reduced the residual gap against its £52 million CIP requirement. He also highlighted research and education activity, the importance of the relationship with the University of East Anglia, the accreditation of the Norwich and Norfolk Orthopaedic Centre, and staff recognition activity.

The Interim Group Chief Nurse asked whether ideas generated through the 'Financial Improvement Plan Friday' could be shared across the Group. The Acting EMD agreed to share these with colleagues at QEH and JPUH. Stephen Javes, Group Non-Executive Director, asked about the potential impact of CIP delivery on Trust performance given the scale of savings required. The Acting EMD explained that all CIP schemes were quality impact assessed and opportunities such as virtual hospital activity could improve care while releasing capacity and cost.

The Group Chair stated that he would like to see future EMD reports covering a common set of key performance metrics to support the Board in assessing performance against agreed commitments. The Group Chief Executive agreed that this should be the direction of travel, supported by an enhanced business intelligence function.

Resolution: The Group Board noted the report from the Acting EMD for NNUH and noted the Chair's request that future reporting be developed to focus on a common set of Trust-level performance metrics.

8. Reports from the Chairs of Board Committees

Purpose: For Information

8.1. Group Risk Assurance Committee

Purpose: For Information

Nikki Gray, Committee Chair, presented the Group Risk Assurance Committee (GRAC) Chair's report. She stated that there were currently more than 60 risks scoring 12 or above across the Group Board Assurance Framework (BAF), the three Trusts and major programmes. The July 2026 risk appetite workshop would be important in helping the Board to determine how those risks should be filtered, tolerated or escalated. She reported that GRAC had started to move towards undertaking deeper reviews of a smaller number of risks, with a focus on the effectiveness of controls.

The Committee Chair stated that the Group Board still needed to determine whether quality and safety risks should be considered by a separate Board sub-committee or through a different approach within GRAC.

Sally Collier felt that, while at an early stage, the revised GRAC approach was proving effective. The Group Chair stated that the Group did not appear inherently more risky than other NHS provider organisations but that the Group Board needed to keep under review how risks were held and escalated across a multi-Trust structure.

Resolution: The Group Board noted the GRAC Chair's report.

Action: A decision on the potential establishment of a Quality and Outcomes sub-committee should be brought to the next Group Board meeting on 5 August 2026.

8.2. Group Audit Committees in Common

Purpose: For Information

Stephen Javes, Committee Chair, presented the Group Audit Committees in Common Chair's report. He reported that Internal Audit work on sickness absence had provided partial assurance and that a report on harmonisation and performance improvement in relation to sickness absence management would be brought to the Committees in Common in the autumn. He also reported that the QEH and JPUH Internal Audit positions had potential implications for the 2025/26 External Audit outcomes and that the final position would be clearer later in June 2026.

The Committee Chair reported that consideration of Clinical Audit had been deferred to the next meeting and that the 2026/27 Internal Audit plan had been finalised.

The Group Chief Finance Officer confirmed that the Group Audit Committees in Common was scheduled to meet on 22 June 2026 to consider the Annual Reports and Accounts of all three Trusts.

Resolution: The Group Board noted the Group Audit Committees in Common Chair's report.

8.3. Group Research, Innovation and Education Committee
Purpose: For Information

Philip Baker, Committee Chair, presented the Group Research, Innovation and Education Committee Chair's report. He stated that the Committee had met twice since the previous Group Board meeting and continued to explore the issues facing research, innovation and education across the Group. He noted examples of good practice and also marked disparities and challenges across both the three Trusts and the three components of the Committee's remit.

The Committee Chair reported that the Committee had started to examine the metrics and data required to assess assurance. He stated that the independent review by Dr Liz Sutton, referred to earlier by the Group Chief Executive, would support the Committee's work and that the Committee would consider the recommendations and required actions at its next meeting.

Resolution: The Group Board noted the Group Research, Innovation and Education Committee Chair's report.

8.4. Group Nomination and Remuneration Committees in Common
Purpose: For Information

Sally Collier, Committee Chair, presented the Group Nomination and Remuneration Committees in Common Chair's report. She stated that the first meeting had established baselines, noted progress in populating Group roles, and discussed the Group's approach to Very Senior Manager (VSM) pay and objective-setting. She reported that the Committees had reviewed Group roles and VSM roles within the Trusts.

Resolution: The Group Board noted the Group Nomination and Remuneration Committees in Common Chair's report.

The Group Chair noted that the Group Board committee structure was now substantially in place, with the Group Strategy, Technology, Investments and Partnerships Committee due to hold its first full meeting during June 2026.

9. Performance reports
Purpose: For Discussion

9.1. Group Integrated Performance Report (including One Recovery)
Purpose: For Discussion

The Group Chief Delivery Officer introduced the Group Integrated Performance Report (IPR). She reported early signs of improvement in some metrics and material areas of risk across the four domains of performance, particularly at QEH. She drew attention to the Medium-Term Plan close-out letters in the Board library and stated that common themes included the need to implement the performance commitments in the plans, ambulance handover improvement across all three organisations and productivity improvement.

The Group Chief Medical Officer outlined key mortality indicators, explaining that the Summary Hospital-level Mortality Indicator (SHMI) compared actual deaths with expected deaths calculated from the recorded acuity and complexity of patients. With reference to the high SHMI for QEH, he noted that QEH had experienced material coding challenges after losing half of its coding team around a year ago, creating a backlog of approximately 8,000 case notes, mainly for inpatients. He stated that the QEH SHMI position was now moving down as the coding backlog was addressed.

Philip Baker challenged the SHMI position and stated that, while he accepted the coding explanation and the direction of travel, the SHMI for all three Trusts was above 1.0 and the Group Board should therefore not be complacent. The Group Chief Medical Officer agreed that documentation, clinical language and coding work needed to be improved and shared across the three Trusts. The EMD for JPUH noted that JPUH was examining the underlying data to identify outlier areas and determine whether they reflected coding or clinical quality issues. The Group Chief Executive stated that mortality indicators went to the core of patient safety and outcomes and that coding improvements, documentation and digital tools needed to be addressed together. William Van't Hoff stated that clinicians and coders used different language and that structured work between coders and clinicians could reduce that barrier. The Group Director of Digital reported that NNUH had an on-premises large language model that converted clinical language into coding language and that the Group was considering its wider use across the three Trusts.

The Group Chair concluded that the Board needed to understand when coding work would be sufficiently improved to distinguish data issues from any underlying quality concerns. He noted that the Board had heard warning signals, that further administrative and coding work was required, and that the timing of the improvement work needed to be clarified.

The Interim Group Chief Nurse reported that all three Trusts were working to ensure that staff fill rates did not compromise patient care. She reported on Group work on pressure ulcers prevention following a deep dive exercise, including movement towards a standardised pressure-area assessment tool and training across all three Trusts.

The Interim Group Chief People Officer reported on a Group approach to sickness absence management, harmonisation of employment policies, occupational health support for musculoskeletal and mental health pathways, and a coordinated response to bullying, harassment, and discrimination.

Philip Baker challenged on mandatory training and non-medical appraisal rates, particularly at QEH. The Interim Group Chief People Officer stated that she would be review the data quality and agreeing targeted improvement plans with Medical Directors and other colleagues.

Jo Churchill welcomed the planned work on culture and bullying and asked whether sickness support for nursing and midwifery staff would consider wider social and caring factors. The Interim Group Chief People Officer stated that the approach would be based on listening events and benchmarking rather than adding initiatives without understanding staff need. The Interim Group Chief Nurse added that self-rostering and sharing good practice across the three Trusts was part of the work.

Sally Collier asked whether the Group was ready for the new national staff standards which would require quarterly publication of staff experience data and asked about a reported misalignment between staff costs and whole-time equivalent data in the Medium-Term Plan close-out letters. The Interim Group Chief People Officer stated that the reporting requirements were being reviewed with Trust colleagues. The Group Chief Finance Officer stated that the staff cost and whole-time equivalent reference was likely to reflect a triangulation issue between the finance and workforce returns.

The Group Chair noted the statement in the covering report that improvement would require tighter grip, clearer accountability, and faster execution, and asked who was responsible for this. The Group Chief Delivery Officer stated that tighter grip and faster execution sat with her while clearer accountability sat with the EMDs because they were responsible for Trust performance. The Group Chief Executive stated that the Executive needed a clearer reporting route for One Recovery, and that the first six months of the One Recovery programme were focused on improving the National Oversight Framework (NOF) positions of the Trusts by concentrating on the cross-Group programmes that mattered most.

Resolution: The Group Board noted the Group Integrated Performance Report.

9.2. Group Finance Report

Purpose: For Discussion

The Group Chief Finance Officer presented the Group Finance Report. He noted that the Group had a planned deficit at Month One. While NNUH and JPUH were on plan, QEH was adverse to plan, mainly due to bank and agency expenditure. Productivity remained the key driver of the financial risk – the Group needed either to conduct the same level of activity at lower cost or more activity at the same cost.

Industrial action by Resident Doctors in April 2026 had adversely affected activity and national discussions on funding of lost income due to industrial action were continuing. While the Group's cash position appeared healthy in aggregate, QEH's cash position was precarious. A fortnightly Cash Committee had been established at QEH and the NHS England regional team had asked to see papers from the next meeting of the Cash Committee for assurance.

The Group Chief Finance Officer reported that the main financial risk remained CIP delivery. JPUH had made the most progress in identifying schemes, while NNUH and QEH still had further work to complete. Control of sickness absence would reduce bank and agency reliance and support savings. The EMD for JPUH stated that JPUH was on plan in months 1 and 2 but noted that the CIP requirement increased from July 2026. The Group Chief Finance Officer stated that this profile applied to all three organisations.

The Group Chair asked the Group Chief Finance Officer to clarify the position on the Group being able to move funds between the three Trusts to balance individual Trust positions. The Group Chief Finance Officer explained that the three Trusts, as statutory organisations, each needed to maintain materially correct income and expenditure positions. He stated that the Group could provide some support, for example in relation to lending of cash between Trusts, but the External Auditors would assess each statutory organisation individually.

Resolution: The Group Board noted the forecast break-even position for 2026/27, the level of CIP required to achieve that position, and that no change was proposed to the overall principal finance risk.

10. Group Board Assurance Framework

Purpose: For Discussion

The Interim Group Director of Governance presented the Group Board Assurance Framework (BAF). He stated that the BAF was reviewed monthly with Executive risk leads and received by the Executive Risk Assurance Group (ERAG) and GRAC. He reported that GRAC had moved towards deep dives into a smaller number of BAF risks at each meeting, with recent focus on Principal Risk (PR) 1 (quality standards variation), PR3 (access, flow and productivity) and PR8 (cyber security). He also noted that GRAC had undertaken a deep dive in April 2026 on CIP risks linked to PR4 (financial sustainability).

The Interim Group Director of Governance reported that the Group BAF currently contained 14 Principal Risks, of which 10 were rated at 12 or above. He reported that the risk score for PR5 (workforce engagement and morale) had recently increased from 10 to 12. He noted the forthcoming Group Board workshop on 22 July 2026 which would focus on risk appetite and consider whether the strategic risks remained appropriately specified in light of the revised Group strategy. He also stated that further work was required on how Group-wide operational risks should be represented in the risk system.

The Group Chair stated that the Group BAF was evolving in a positive way and that Board members would have further opportunity to contribute to this at the forthcoming workshop.

Resolution: The Group Board noted the report on the Group BAF.

11. Group Governance Framework

Purpose: For Decision

The Interim Group Director of Governance presented the report on the Group Governance Framework, stating that this confirmed the implementation of the Framework as set out in the October 2025 Provider Collaboration Agreement.

The Group Board had approved a number of statutory governance documents in April 2026 and the Group Board was now being asked to approve the aligned Standing Orders of the Councils of Governors, which had already been approved by the three Councils of Governors; updated terms of reference for the Group Audit Committees in Common, which had been reviewed by that Committee; and terms of reference and membership for the Group Strategy, Technology, Investments and Partnerships Committee (STIP).

Sally Collier proposed two additions to the terms of reference of the Group Audit Committees in Common to include explicit reference to responsibility for procurement and waivers, and to make clearer reference to the oversight of implementation of audit recommendations. It was agreed

that wording for these amendments would be considered by the Group Audit Committees in Common before being brought back to the Group Board for approval.

Stephen Javes proposed that the Standing Orders of the Councils of Governors should refer to the Group Chair or Associate Chairs chairing Council of Governors meetings. The Group Chair agreed that the Standing Orders should be amended to reflect the new Associate Chair role.

Jack Bowman, Group Non-Executive Director, asked whether a separate Technology Committee should be considered, given the importance of digital technology and the Electronic Patient Record (EPR) programme. The Group Chief Executive said that the Group needed to balance the number of committees with the need for adequate scrutiny and that STIP should be able to consider technology within strategy, investment and transformation decisions. The Group Director of Digital stated that technology should not be isolated from clinical strategy, investment and transformation because digital and artificial intelligence would affect clinical, workforce and future care models. The Group Chair concluded that STIP should begin its work and in doing so consider how best to address digital and technology matters.

The Group Director of Delivery asked whether STIP should have delegated authority for certain financial decisions, given the scale and pace of the New Hospital Programme and some other business cases. The Group Chair stated that sub-committees supported the Group Board by scrutinising business so that the Board could take decisions more efficiently based on considered recommendations, but that the Group Board remained the decision-making body unless this was delegated by the Board on a case-by-case basis.

In response to a question about the Chief Transformation Officer role described in the terms of reference, the Group Chief Executive confirmed that the Head of the Transformation Design Authority would assume this role on an interim basis.

Resolution: The Group Board, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust, approved the terms of reference of the Group Audit Committees in Common and the Standing Orders of the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust, noting the further proposed amendments agreed in the meeting.

Resolution: The Group Board, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, approved the terms of reference of the Group Audit Committees in Common and the Standing Orders of the Council of Governors of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, noting the further proposed amendments agreed in the meeting.

Resolution: The Group Board, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust, approved the terms of reference of the Group Audit Committees in Common and the Standing Orders of the Council of Governors of James Paget University Hospitals NHS Foundation Trust, noting the further proposed amendments agreed in the meeting.

Resolution: The Group Board approved the terms of reference and membership of the Group Strategy, Technology, Investments and Partnerships Committee as a sub-committee of the Group Board.

Actions:
Further review the terms of reference of the Group Audit Committees in Common to include explicit reference to responsibility for procurement and waivers, and to make clearer reference to the oversight of implementation of audit recommendations. Wording for these amendments to be considered by the Group Audit Committees in Common before being brought back to the Group Board for approval.

The Standing Orders of the Councils of Governors to be amended to refer to the Group Chair or Associate Chairs chairing Council of Governors meetings. Wording for this amendment to be brought back to the Councils of Governors and the Group Board for approval.

12. Consent items
No consent items were raised for discussion.

13. Any Other Business
No other business was raised.

14. Questions from Members of the Public
Purpose: For Discussion

The Group Chair confirmed that no public questions had been received for response at the meeting.

15. Meeting review and reflections
Purpose: For Discussion

The Group Chair invited reflections on the conduct of the meeting and stated that Board members could provide comments to the Interim Group Director of Governance after the meeting.

16. Date of the Next Meeting
Purpose: For Information

The next meeting of the Group Board in public would be held on Wednesday 5 August 2026 at the John Innes Conference Centre, Norwich Research Park.

17. Resolution

Purpose: For Decision

The Group Chair moved the meeting towards private business and asked members of the public to leave the meeting.

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

18. Close of Meeting

The Group Chair thanked those present for attending and closed the meeting in public.

Norfolk and Waveney University Hospitals Group

GROUP BOARD MEETING IN PUBLIC: ACTION LOG

Ref.	Meeting date	Agenda item	Action	Lead	Update	Status
9	01.04.26	Charities	Amend proposed timeframe for producing an outline options appraisal on the future of the three charities from 12 months to 6 months.	Group Director of Governance and Group Chief Finance Officer	Update to the Group Board to be scheduled for October/December 2026.	Open – not yet due
11	03.06.26	Report from Group Risk Assurance Committee	A decision on the potential establishment of a Quality and Outcomes sub-committee should be brought to the next Group Board meeting on 5 August 2026.	Group Director of Governance	Proposal to establish a Quality and Outcomes Committee is included on the agenda for the Group Board meting on 5 August 2026.	Propose to close
12	03.06.26	Group Governance Framework	Further review the terms of reference of the Group Audit Committees in Common to include explicit reference to responsibility for procurement and waivers, and to make clearer reference to the oversight of implementation of audit recommendations. Wording for these amendments to be considered by the Group Audit Committees in Common before	Group Director of Governance	Revised wording agreed by Group Audit Committees in Common and recommended for approval at group Board meeting on 5 August 2026.	Propose to close

			being brought back to the Group Board for approval.			
13	03.06.26	Group Governance Framework	The Standing Orders of the Councils of Governors to be amended to refer to the Group Chair or Associate Chairs chairing Council of Governors meetings. Wording for this amendment to be brought back to the Councils of Governors and the Group Board for approval.	Group Director of Governance	Revised wording to be agreed at next Councils of Governors' meetings and then brought to the Group Board for approval.	Open

Norfolk and Waveney
University Hospitals Group

Report to the Board of Directors in public: 5 August 2026

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

Executive summary

Strategic Progress

- Work is underway to develop the Group's shared clinical strategy and future operating model, aligning major programmes around neighbourhood, digitally enabled and sustainable acute care, with future options to be evidence-led, clinically informed and subject to appropriate engagement, assurance and consultation.
- The Transformation Design Authority has been established, supported by a Clinical Advisory Group, to align major programmes including the New Hospital Programme, neighbourhood development, digital roadmap and Electronic Patient Record with the Group's single strategic direction and future operating model.

One Recovery

- The programme remains the Group's principal two-year delivery plan for improving NHS Oversight Framework performance, with a reset underway to sharpen prioritisation, sequencing and resourcing of the highest-impact programmes, supported by strengthened oversight of delivery, risks and benefits.

Health Overview Scrutiny Committee (HOSC)

- Early engagement has taken place with Norfolk HOSC following the May elections, including a briefing on the Group, its challenges and emerging clinical strategy, with further engagement planned ahead of the November case for change discussion; the Group has also been invited to attend a Suffolk HOSC provider workshop in autumn.

National Maternity and Neonatal Investigation

- The Group recognises the findings of the national investigation and the local Queen Elizabeth Hospital (QEH) report, including the experiences described by families and staff, and will continue to strengthen maternity and neonatal safety through ongoing local improvement work aligned with the national Taskforce and NHS England's 10 Point Plan.

Care Quality Commission (CQC)

- The QEH surgical services inspection identified areas for improvement in safety, governance and the care environment, with immediate actions and wider

improvement work underway, supported by strengthened Group oversight and preparation for Well-led inspection in September.

Industrial Action

- Consultants have voted in favour of potential industrial action, while SAS doctors did not meet the legal turnout threshold; no strike action has been announced and the position will continue to be monitored.

Recommendations

The Group Board is asked to note the report.

Alignment to Board Assurance Framework risk(s)	All
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	None

Norfolk and Waveney University Hospitals Group

Board of Directors in public: 5 August 2026
Group Chief Executive's Report

1. Introduction and background

This report updates the Group Board (the General Purpose Joint Committee) on recent Group developments and should be read alongside the separate reports from the Executive Managing Directors of the three Trusts (agenda items 7-9).

Group and Trust Developments

2. One Strategy

We have begun work to define what our shared strategic direction for the Norfolk and Waveney University Hospitals Group means for the care we offer as we align our hospitals, services and major programmes around a future model of neighbourhood health and more sustainable acute care. As NHS pressures continue to grow, doing nothing is not an option. The emerging direction is clear: more care to be delivered through neighbourhood and digitally enabled models, with hospitals increasingly focused on complex, specialist and acute care that require hospital facilities and expertise. This will require closer partnership working across providers and a more integrated Group approach to clinical services, workforce, digital and infrastructure planning.

To make the greatest difference for patients, we must consider not only the investment required in our hospitals, but also how services are organised, how we work together as a Group, and how patients are able to access the best expertise available across Norfolk and Waveney. No decisions have yet been taken about future service configuration. As the work develops, we will involve colleagues, patients, communities and system partners in shaping the options, testing the evidence and understanding the implications for access, quality and experience. Any proposals for significant service change would be subject to the appropriate assurance, engagement and formal consultation processes before decisions are made.

A significant milestone has recently been reached, with senior clinicians from across our three hospitals coming together to begin shaping a shared clinical strategy for the Group. Importantly, this work has not started with organisational structures or assumptions about how services should be configured, but with a fundamental question: what is the right model of care for our population over the next 10 to 20 years. This will require careful consideration of how services should be provided across our hospitals, where specialist care is best delivered, and how we ensure patients receive care in the most appropriate setting, whether at home, in the community or in hospital.

Over the coming months, this work will develop One Strategy and our future operating model, ensuring that decisions are evidence-led, clinically informed and focused on improving quality, access, and sustainability for the communities we serve. Work to deliver against One Strategy is already underway. We have established the Transformation Design Authority to ensure that the Group's major programmes, including the New Hospital Programme, neighbourhood development, digital roadmap and Electronic Patient Record, are aligned with our single strategic direction and support our future operating model.

3. One Recovery

One Recovery remains the Group's principal two-year delivery plan to improve NHS Oversight Framework performance and support sustainable recovery across our three hospitals.

The programme has established clear strategic priorities, strengthened collaboration across the Trusts, and moved a number of programmes from mobilisation into delivery, including outpatient reform, elective recovery and redesign, cancer, urgent and emergency care, World Class Basics, cost improvement and 18,000 Voices.

A recent State of Delivery Review confirms that the strategic intent remains right and that there is broad organisational support; however, it also identifies that delivery has not progressed at the pace originally intended, largely because leadership, transformation, clinical, operational, business intelligence and communications capacity have been spread too thinly across a wide portfolio. The Group is therefore resetting One Recovery to strengthen execution, with clearer prioritisation, sequencing, and resourcing of the highest-impact programmes, particularly outpatient reform and elective recovery and redesign, while maintaining focus on urgent and emergency care, cancer pathways, operational standards, culture, and financial sustainability.

Progress, risks, and benefits will continue to be overseen through the One Recovery Oversight Group, with a sharper focus on delivery, measurable improvement, and the contribution of each programme to NHS Oversight Framework performance.

In late June, NHS England raised concerns that a number of operational performance metrics at Queen Elizabeth Hospital King's Lynn (relating to elective recovery, cancer standards and planned diagnostic waits) were materially off-plan. NHS England required the Board and the ICB to undertake a joint self-assessment of planning, oversight and assurance arrangements and to submit a jointly-owned recovery plan. This work was undertaken and submitted in mid-July. NHS England has subsequently confirmed that it is satisfied that the Board has a clear and shared understanding of the drivers of the current position; that appropriate governance, oversight and assurance arrangements are in place; and that there is a credible, jointly-owned recovery plan, with clear ownership and timescales agreed between the Trust and the

ICB. The Group Risk Assurance Committee will seek assurance on behalf of the Group Board on performance against the Medium-term Plan trajectories.

4. Health Overview Scrutiny Committee (HOSC)

Norfolk Health Overview and Scrutiny Committee

I attended the first Norfolk Health Overview and Scrutiny Committee meeting following the May elections on 16 July, alongside Rob Sherwin, Group Chief Medical Officer, and Ben White, Group Director of Communications and Engagement.

Councillor Lucy Shires was elected as Chair and Councillor Justin Cork as Vice-Chair.
Rob and I subsequently provided a private briefing to committee members to introduce the Norfolk and Waveney health context, the Group and our hospitals, the challenges we face, and the opportunity to transform services through the development of our clinical strategy. This was particularly important given that most county councillors are new to the committee.

The discussion was positive and constructive, with members engaging on issues including partnership working across health and social care, recruitment and retention, opportunities for Group efficiencies, digital developments, and the implications of future service models for transport and access. This early engagement represents a positive start, and further work will continue with the Committee ahead of the planned discussion on the case for change in November.

Suffolk Health Overview and Scrutiny Committee

We have recently been contacted by the Suffolk Health Scrutiny Committee, which includes five County Councillors and one councillor representative from each of Suffolk's five district and borough councils. Similar to Norfolk, the Committee has seen significant changes in membership following the May elections and is currently undertaking an induction process to brief new members and refresh the knowledge of existing members. As part of this process, we have been invited to attend a provider workshop session planned for late September or October. This will provide an opportunity to introduce the Group to the Committee, alongside the ambulance service and other Suffolk and cross-boundary providers, and to support members' understanding of the wider health and care context.

5. Norwich City Council Visits

A delegation from Norwich City Council visited Norwich Research Park on 27 July 2026, with Marcus Thorman, Group Chief Finance Officer and Deputy Chief Executive, representing the Group. The visit included the Quadram Institute and Norfolk and Norwich University Hospitals (NNUH)-led facilities, providing an important opportunity to showcase the Group's contribution to research, innovation, prevention and population health. It highlighted NNUH's role as a founding partner of the Quadram Institute, the strength of its clinical

research portfolio, and the wider contribution of Norwich Research Park to skills, employment, sustainability and economic growth. This engagement was particularly timely given the anticipated changes to council boundaries in 2028, reinforcing the importance of strong and proactive relationships with civic partners as local government structures evolve. The visit supported shared ambitions to strengthen collaboration, promote Norwich as a leading science and health innovation hub, and ensure that research continues to deliver benefits for patients, communities and the wider local population.

6. Governor elections

As noted in the last report, Governor elections launched on 8 June across all three foundation trusts within the Group to fill a large number of current and forthcoming vacancies among both public and staff governors. I am pleased to say that the elections have generated strong interest, with 82 nominations received for 41 public and staff governor vacancies across the three Trusts. Most constituencies are being contested and voting commenced on 20 July 2026. The results are anticipated in mid-August and we look forward to welcoming and inducting new Governors to the Councils.

7. Link Non-Executive Directors

As part of spending time at each of our Trusts, I met with the relevant Trust lead, the link Non-Executive Directors and Associate Chair for each organisation. These meetings were informative and constructive, providing greater clarity on how the roles will support oversight, strengthen Group working and help ensure the distinct identity and priorities of each Trust continue to be recognised.

For James Paget University Hospitals NHS Foundation Trust, the link NEDs are Stephen Javes, Associate Chair, Gee Cook and Sally Collier; for Norfolk and Norwich University Hospitals NHS Foundation Trust, Susan Putters, Associate Chair, supported by Nikki Gray and Marcus Bailey; and for The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, Tanvir Alam, Associate Chair, supported by Andy McKechnie and William Van't Hoff.

Jo Churchill, Non-Executive Director, is our Maternity Champion and provides senior independent oversight and support for this important area of work across the Group.

Under the Group operating model, link NEDs and Associate Chairs will support Trust-specific oversight and assurance, develop effective relationships with Governors, contribute to patient, community and staff engagement, support Board-to-Ward visibility through visits to services and clinical areas, and provide insight back to the wider Group Board on Trust-specific issues and risks. These roles do not delegate authority from the Group Chair or Group Board, nor do they replace operational management arrangements, but they provide an important additional route for understanding local priorities and strengthening assurance.

I would also like to thank the staff in the clinical areas I was able to visit during my time at each hospital. Their commitment, professionalism and focus on patient care were clearly evident, and I look forward to spending time at each of our sites every month to continue listening, learning and supporting colleagues across the Group.

8. National Maternity and Neonatal Investigation

The final report of the National Maternity and Neonatal Investigation, led by Baroness Amos, was published at the end of June and included a local report on maternity and neonatal services at The Queen Elizabeth Hospital King's Lynn (QEH). The report draws on the experiences of families and staff and reflects themes seen nationally, including the importance of listening to women and families, communicating clearly, taking concerns seriously and providing consistent support following complex or traumatic experiences. We are sorry for the distress described by families and recognise the lasting impact these experiences can have.

At QEH, important improvements have been made in recent years, including strengthened triage, investment in staffing, enhanced governance arrangements and improved facilities; however, this report, alongside the Ockenden review into maternity services at Nottingham University Hospitals NHS Trust, makes clear that there is more to do. Our local improvement work will align with the National Maternity and Neonatal Taskforce and NHS England's 10 Point Plan, which set the national direction for strengthening safety, oversight, responsiveness, equity and learning. Our ongoing focus is on listening to families, supporting staff and ensuring concerns are escalated and acted on promptly. More detailed updates are included in the perinatal reports elsewhere on this agenda.

9. Care Quality Commission (CQC)

The CQC published its report on the March 2026 inspection of surgical services at The Queen Elizabeth Hospital King's Lynn (QEH) in July. The report identifies concerns relating to patient safety, governance, staff training, documentation and aspects of the care environment, including two breaches of regulations relating to safe care and treatment and premises and equipment. Many of the issues identified were addressed immediately following the inspection, with further work continuing to strengthen patient safety, governance, risk management, training compliance and oversight across surgical services. While the report identifies areas requiring improvement, it also recognises positive patient feedback, improved responsiveness and the commitment of staff. This work forms part of wider improvement activity already underway, including actions following the Royal College of Surgeons invited review of general surgery, strengthened Group oversight, support from clinical leaders at Norfolk and Norwich University Hospitals and ongoing recruitment and service improvement work. The report of the subsequent CQC inspection of urgent and emergency care and medicine is awaited, and further detail on the forthcoming Well-led inspection is included in the QEH Executive Managing Director report.

10. Group Structure

Since the previous Group Board meeting, Michelle Arrowsmith left her role as Executive Managing Director of Queen Elizabeth Hospital (QEH) during June 2026. Jo Segasby, Group Chief Delivery Officer, has taken on the role of Acting Executive Managing Director of QEH. Simon Nearney has been appointed as substantive Group Chief People Officer and will take up post in September, following a handover with Emma-Jayne Perez Chies. Rachael Cocker has also been substantively appointed as Group Chief Nurse, following support from the Group Nomination and Remuneration Committees in Common. Recruitment is underway to appoint substantively to the Group Director of Governance role through a formal competitive process.

National and Regional Context

11. Change in Government

The recent change in Government and appointment of Andy Burnham as Prime Minister signal a renewed focus on public service reform, prevention, population health and health and care integration. These priorities align closely with the Group's strategic direction, including our focus on neighbourhood health, sustainable acute care, workforce transformation and stronger system partnership.

Yvette Cooper has been appointed Secretary of State for Health and Social Care, with early priorities expected to include maternity services, social care and support for NHS staff. The Group will continue to monitor policy developments, particularly where they affect acute services, social care capacity, workforce planning and wider system transformation.

12. Industrial action

Following resolution of the Resident Doctors' dispute, 76% of consultants have voted in favour of potential industrial action, meeting the legal turnout threshold and giving the BMA a mandate for action over the next 12 months. SAS doctors also voted in favour, but turnout did not meet the legal threshold, so there is currently no mandate for SAS doctor strike action. No strike action has been announced, and the position will continue to be monitored for potential impacts on service continuity, workforce planning and patient access.

13. Recommendations

The Group Board is asked to note the report.

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	7.1		
Title	Executive Managing Director's report: James Paget University Hospitals NHS Foundation Trust		
Author(s)	Jonathan Gardner, Executive Managing Director		
Executive sponsor	Jonathan Gardner, Executive Managing Director		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

Programmes to strengthen **fundamentals of care** are delivering improvements in pressure ulcer prevention, falls reduction, nutrition and hydration, infection control and patient supervision. **Length of stay** initiatives continue to support patient flow, with sustained reductions in both elective and non-elective length of stay and improved discharge performance. **Complaints** backlog has reduced significantly from over 150 cases in January to just eight by June.

Workforce indicators Sickness absence is above target but still lowest for 18 months. Leadership development, staff engagement initiatives and measures to reduce violence and aggression continue to aim to strengthen organisational culture.

Partnership working continues to develop through neighbourhood health programmes, place-based collaboration and integrated care initiatives. The appointment of an Associate Medical Director for Community, progress with Integrated Neighbourhood Teams, the East Place Health Alliance support the Trust's ambition to strengthen population health and service integration.

Elective recovery performance remains ahead of plan. Although cancer performance and ENT-related 65-week waits remain challenging. Emergency care performance continues to improve compared with last year despite sustained demand pressures, increasing walk-in activity and discharge challenges.

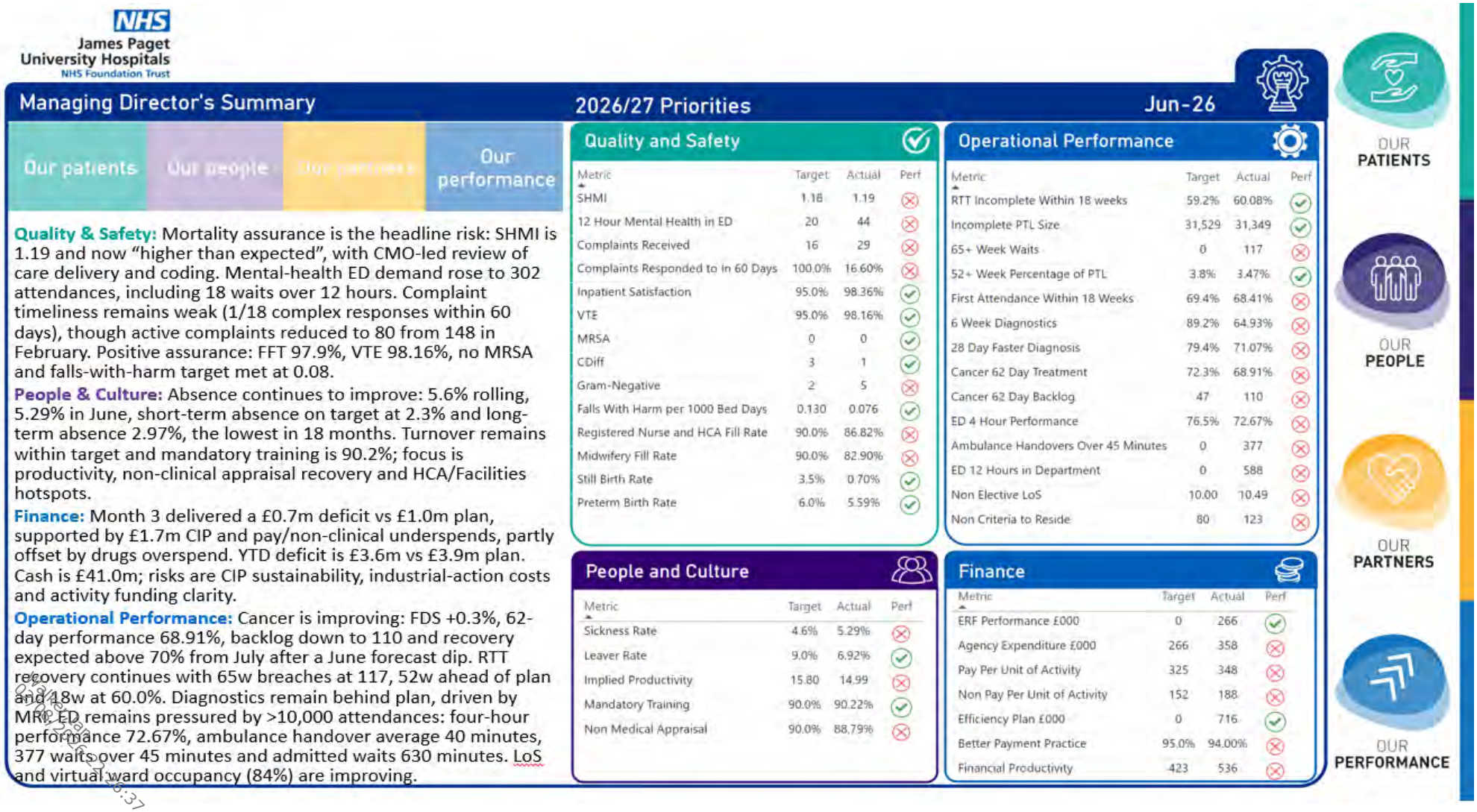
Financial performance remains strong. The Trust exceeded its Q1 financial plan, delivered £3.4m of efficiencies against a £2.4m target and continues to mature its cost improvement programme. While risks remain to full-year delivery, focused oversight and recovery programmes are in place to mitigate gaps and support achievement of the £22.5m savings target.

Recommendations

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

Alignment to BAF risk(s)	Various Principal Risks
Previously considered by	n/a
Any background papers in Admin Control Reading Room	No

Performance one-page summary



Norfolk and Waveney University Hospitals Group

Group Board in public: 5 August 2026
Executive Managing Director's report: James Paget University Hospitals NHS Foundation Trust

1. Patients - Quality and Safety

1.1 **Fundamentals of care**: There is a monthly rolling programme to audit each of the fundamentals of care 2 times a year.

1.2 Pressure ulcers: we are preparing for a move to the NNUH system called Purpose T. Our QSAFE system now has pictures to help with classification.

1.3 Nutrition/Hydration: we have reinstated milkshake rounds with a picture above the bed to prompt.

1.4 Healthcare acquired infections: constant reminders of best practice along with quick isolation, the Chief Nurse is introducing a culture of challenging unacceptable practice.

1.5 Falls: each ward have been given their target to contribute to reductions, we have introduced red lanyards for to provide a quick visual prompt that nursing staff are proving and enhanced supervision and should not leave their patient, and BIDE system which lights up when a patient moves..

1.6 **Improve discharge processes**: programmes of work focused on criteria led discharge, therapy intervention and the Long Length of Stay programme. We have expanded our weekly Time to Care forum and launched a Project Dashboard – particularly of note is the reduction in 14- and 21-day LLOS patients and the over 10% improvement in patients discharge on CLD pathway. Non elective LoS has reduced to 10.5 days for the end of Q1 showing a 9 month sustained reduction, and elective LoS has reduced to 1.97 days9 month sustained reduction in LOS,

1.7 **One year of robotic surgery**: The Trust hosted a one-year anniversary reflection evening on 15th July to commemorate a year of activity of the Howes Robot surgical system at our hospital. It has been used for more than 225 general surgery operations, as well as over 110 gynaecological cases. Many patients are able to go home either on the day, for others the average length of time in hospital has been reduced.

1.8 **Urgent Treatment Centre**: The Trust has submitted plans for a new Urgent Treatment Centre (UTC). The new unit, due to go live in Spring next year, will give the hospital additional urgent and emergency care capacity.

1.9 **UNICEF Recognition - Neonatal Team**: The Neonatal Team has been recognised by UNICEF for the quality of support they offer to families and their babies, meeting all the standards to achieve stage 2 accreditation in UNICEF's Baby Friendly Initiative.

1.10 **Colocap research 250th participant**: Our Colocap research team have been recognised for recruiting the 250th participant into the Colocap study, a national clinical diagnostic study aiming to improve the clinical pathway for the diagnosis of bowel cancer.

1.11 **Complaints**: We have now reduced the backlog from over 150 in January to 8 in June.

1.12 **Heat response**: During the heat wave we have responded swiftly and proactively for staff and patients, however, it has still been very challenging with the lack of air conditioning through the hospital.

2. People

2.1 **Hello, My Name Is…:** James Paget Hospital has launched its introduction of the yellow 'Hello, My Name Is' badges across the hospital to help improve identification and patient experience across the hospital, and to increase safety by breaking down hierarchies and supporting staff to speak out.

2.2 **Supporting Staff Absence Reduction**: Sickness rate has slightly increase to 5.29% but still remains at the lowest rate for over a year. We have completed over 1270 returns to work in the last 3 months increasing completion rates by 36%

2.3 **Rosters**: all rosters are now approved at 8 weeks highest approval rate in 20 months

2.4 **Staff engagement**: Last month we had a top leaders programme session on the staff survey as part of our programme to improve take up and engagement. In your shoes, quality visits and team brief and a new "message of the week" continue.

2.5 **National Trainee Survey**: Some excellent NTS survey responses – Anaesthetics, Obs and Gynae, Palliative care, ED, however, acute medicine and surgery are challenging mainly as a result of a difficult implementation of our SDEC.

2.6 **Reduction in Violence and Aggression faced by our staff**; Over 370 staff have been trained. New Police liaison has begun with regular beat manager walk abouts and a new poster going up in ED about prosecutions.

3. Partners

3.1 **Associate Medical Director for Community**: we appointed a GP to lead our integration work and neighbourhood work with Primary Care and Community colleagues.

3.2 **JPUH health research and circus skills project**: The Circus Project, run by the Research team is in the running for two Nursing Times Awards. It aims to better understand the healthcare and research priorities of our communities, and was organised by JPUH in collaboration with the Oak Circus Centre in Norwich.

3.3 **Place board collaboration** Monthly Board meetings in place and GY&W Place Partners part of the national Community of Practice on neighbourhood Health Development.

3.4 **Design leadership**: we have supported ICB appointed PA Consulting and working with PPL to define the role of Place in delivering neighbourhood from a system and Group perspective.

3.5 **Community Collaborative**: Frailty Test, Learn & Grow Frailty MDT Project on track;

3.6 **Integrated Neighbourhood team being established**. INT lead and case manager roles to be out to advert in July 2026.

3.7 **East Place Health Alliance**: MoU signed by ECCH, NPC & JPUH in June 2026. Priority areas are Parkinson's, Respiratory, Heart Failure and Diabetes

3.8 **UEA**: Chief Nurse Jacky Copping and Deputy Chief Nurse Kirsty attended healthcare science graduations at the University of East Anglia on the 13th and 15th of July. Well done and congratulations to all our members of staff who have recently graduated.

4. Performance (see also appended performance summary)

4.1 **Elective care recovery**

4.2 June activity is above plan by £450k. And the RTT performance is also above plan and has moved us from 129 on the rankings to around 100. Cancer metrics have fluctuated over the last couple of months as per the performance report and have been below plan and target unfortunately.

4.3 52 weeks continues to be above plan and in July we have gone below 1000 patients for the first time in 4 years

4.4 65 week waits continue to be a challenge with ENT being the vast majority of the issues.

4.5 **Improve outpatient bookings processes** (One Recovery): Progress has been focused on bidding for digital systems to enable robotic process automation. We are now progressing towards Single Point of Access.

4.6 **Improve preoperative assessment** to reduce cancellations (One Recovery): Over the past eight months, JPUH has utilised insourcing support to sustain preoperative assessment activity. Following internal transformation work, JPUH has served notice on external support arrangements 3 months early (30 Jun'26).

4.7 **Urgent and emergency care (UEC) recovery** The length of stay work has been reported under "Patients" above, however, the impact has been that our ED 4hr target has continued to be around 73% which is below plan but still several percentage points above last year. We are seeing 17% increase in walk-ins and very high levels of Criteria to reside not met patients hampering our ability to maintain flow.

5. Finance

5.1 We over delivered against our financial plan by £0.3m and activity by £0.5m.

5.2 CIP: £3.4m has been delivered against a £2.4m plan, resulting in £1.0m overachievement for Q1. The plan has been phased, with an increase in planned efficiencies in Q2, where average monthly targets increase from £0.8m to £2.1m.

5.3 Financial Intervention Programme Management (FIPM) meetings continue to hold scheme SROs to account for delivery. Internal forecasts suggest some schemes may not deliver as planned, leaving a gap to achieve the full £22.5m. The One Recovery Programme is aiming to close this gap, alongside additional internal schemes.

5.4 However, we have also improved the maturity of some schemes and red rated high risk schemes have reduced from £8m to £4.5m

6. Governance

6.1 We have written a quarterly report on achievement against objectives and reported that to HMG and to GRAC

7. Recommendation

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

JPUH performance at a glance

James Paget University Hospitals NHS Foundation Trust

Overall readout: JPUH demonstrated strength in infection control, patient experience and CIP delivery; however pressures remain within access, long waits and workforce fill rates.

SAFE & EFFECTIVE CARE

0 MRSA cases — Target 0	**1** C. difficile cases — Target ≤4	**2** E. coli cases — Target 0
67 Falls with harm — Target 67	**97.91%** FFT score — Target 95%	**86.82%** Registered nurse fill — Target 90%
82.90% Midwifery fill — Target 90%	**1.19** SHMI — Target ≤1	**14** Pressure ulcers — Target 0

PEOPLE & CULTURE

5.29% Sickness rate — Target 4.6%	**6.92%** Turnover rate — Target 10%
90.22% Mandatory training — Target 90%	**88.79%** Non-medical appraisal — Target 85%

ACCESS & FLOW

Urgent & emergency care

June 2026

- **72.67%** ED within 4 hours — Target 76.5%
- **7.31%** 12-hour performance — Target 7.4%
- **377** Ambulance handovers >45m — Target 0
- **10.49** Non-elective LOS — Target 10

Elective care

June 2026

- **60.08%** RTT within 18 weeks — Target 59.2%
- **31,349** Waiting list size — Target 31,529
- **3.47%** 52+ week waits — Target 3.8%
- **117** 65+ week waits — Target 0

Cancer

Latest validated: May 2026

- **71.07%** 28-day faster diagnosis — Target 79.4%
- **68.91%** 62-day treatment — Target 72.3%

PRODUCTIVITY & EFFICIENCY

£0.70m deficit In-month position — June 2026	**£3.61m deficit** YTD position — June 2026
£1.66m CIP delivered in month — Plan £0.94m	**£3.41m** CIP delivered YTD — Plan £2.42m
-3.28% Agency variance to cap — Below cap	**+2.86%** Bank variance to cap — Above cap
£41,090 Cash position	

Definition key: Green Achieving Target — meets/exceeds target · Amber Close / Improving — within 5% or improving · Red Off Target — >5% from target or deteriorating

Source: NWUHG Group Integrated Performance Report | Reporting month: June 2026. Cancer metrics use the latest validated month where reported.

Norfolk and Waveney
University Hospitals Group

Report to the Board of Directors in public: 5 August 2026

Agenda item number	8.1		
Title	Executive Managing Director's Report: The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust		
Author(s)	Jo Segasby, Acting EMD for QEH, Group Chief Delivery Officer and Group Deputy Chief Executive		
Executive sponsor	As above		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

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

Recommendations

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

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

Norfolk and Waveney University Hospitals Group

Board of Directors in public: 5 August 2026
Executive Managing Director's report: The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Celebrating QEH

On Tuesday 21 July we hosted an official ground-breaking ceremony for our new multi-storey car park, marking a significant milestone in the journey towards our new hospital. The ceremony celebrated the official start of the project, which will enable the New QEH to be built on the site of the current main car park. The £39 million multi-storey car park is one of the first major enabling projects for the New QEH and represents a visible step forward in a once-in-a-generation opportunity to transform healthcare for communities across West Norfolk.

A QEH-led research project exploring a new treatment for a rare but debilitating bladder condition has received national recognition, with plans now underway to expand the study following the success of an initial pilot. The project, led by our Urology team in partnership with Norfolk and Norwich University Hospital (NNUH), investigated the use of a synthetic gel called PuraStat (RADA16) to treat severe radiation cystitis – a condition that can develop years after pelvic radiotherapy and can cause pain, bleeding, incontinence and repeated hospital admissions.

Tonicha Patterson, known as Tee, an undergraduate at Anglia Ruskin University's (ARU) campus in Peterborough, was named Student Nurse of the Year at the Student Nursing Times Awards. Inspired by her own childhood experience as a patient at The QEH, Tee had dreamed of becoming a children's nurse since the age of five and describes the role as a privilege and a rewarding career. During her community placement at the Trust, Tee said she had the opportunity to work alongside one of the nurses who cared for her as a child, making her connection to the QEH team even more meaningful.

Colleagues across The QEH said a fond farewell to Site Matron Chrissie Johnston, who retired after an incredible 45 years of dedicated NHS service.

Regulatory

Care Quality Commission (CQC)

The Group was notified on 26 June of a planned Well-Led inspection scheduled for 22-24 September 2026. Preparations are underway, with key actions focused on:

- Responding to the CQC data request, supported by an assurance process for document collation and review. The submission deadline is 28 August.
- Coordinating staff attendance for CQC interviews and focus groups during 22-24 September, including briefing and preparation sessions.
- Delivering a communications and engagement plan, including staff roadshows.
- Planning briefing sessions for Board members and senior leaders.
- Completing an executive-led self-assessment against the eight Well-Led themes.

A key aspect of engagement with the CQC will be ensuring a clear understanding of the Group model, including its governance, operating arrangements, and interdependencies across the organisation.

In parallel, a draft response is being prepared to update the CQC on progress against the recommendations set out in the warning notices issued in May. Significant work has been undertaken to implement the required improvements. The draft response was reviewed by the QEH Senior Leadership Team on 30 July ahead of submission to the CQC by the 10 August 2026 deadline.

North Cambridgeshire Hospital

The Trust continues to engage with Central East ICB and other providers of services at the North Cambridgeshire Hospital at Wisbech.

An internal cross-divisional working group has been established to identify a clear strategy for NCH by September 2026, augmented by partnership discussions with Wisbech Primary Care Network and other providers. Key to the approach is a commitment to deliver appropriate services for local people based on population need

Resolution of issues with currently provided services including Endoscopy and Radiology continues. Staff consultation with the Endoscopy Unit team is nearing completion. Subject to the outcome of the consultation, it is proposed that there is a temporary closure (6 months) of the service while the Trust reviews the future provision of endoscopy services at Wisbech. This decision follows independent advice which highlighted the increasing challenges around compliance, workforce sustainability and the investment needed to maintain a small standalone unit. A cross partner working group has been established for Radiology to seek to develop a sustainable delivery model which will be key to expansion of future service delivery from the site.

General Surgery RCS

Progress continues across the General Surgery Single Service programme, with consultant recruitment on track and governance and pathway standardisation work progressing as planned. Consultant workforce resilience is improving, with all approved posts expected to be filled by January 2027.

Actions to improve ward management, patient oversight and operational efficiency have been implemented, with positive early feedback. Work to streamline cancer pathways and strengthen MDT arrangements is ongoing, supported by patient experience feedback and capacity reviews. Shared governance arrangements across both organisations continue to develop as planned.

Priorities for the next period include finalising governance and staffing arrangements, progressing pathway improvements, launching the patient survey, and completing the three-month programme review

Freedom of Information

Work is ongoing to implement the actions agreed in response to the Information Commissioner notice. Two key actions, which addressed a number of areas in the action plan were;

- Appointment of the vacant FOI Officer. This was recruited to in May and the

postholder commenced on 29 July. Their immediate priority will be to continue to clear any backlog by end September.

- The consideration of new software system to manage requests and FOI and Subject Access responses. This is being progressed and a business case will be presented to the three sites for a common system during August and then the respective approvals processes.

Since 1 January 2026 we have received 533 FOI requests, of which 399 (75%) have been responded to. Of the previous (2025) backlog 105 have been reviewed a second time and the requestors contacted again to determine if they still would like a response. If there is no response these will be closed. The backlog will be eliminated by 23 Sept in line with the action plan agreed with the ICO. On an ongoing basis the target compliance rate is 80% within statutory response times for Q2 26/27.

Baroness Amos independent review

The Queen Elizabeth Hospital (QEH) was one of 12 NHS trusts involved in Baroness Amos' independent review of maternity and neonatal services in England. The Trust fully supported the review, hosting the investigation team for a three-day visit to King's Lynn. During the visit, the team met with women and families through evidence panels and individual discussions, and heard from executive, clinical and operational leaders, as well as staff across all grades through dedicated listening events.

Before publication, the Trust reviewed the draft report, challenged factual inaccuracies and submitted a formal response, resulting in several amendments to the final version. It is important to note that some feedback reflects historical experiences, particularly relating to workforce challenges, and may not represent the current service. The report also spans multiple time periods rather than focusing on a specific timeframe. The review did not identify any immediate actions specific to QEH, nor were any Trust-specific recommendations issued following the visit.

Medical Students

The University of Cambridge School of Clinical Medicine and Norwich Medical School at the University of East Anglia have notified the Trust that they have suspended undergraduate medical student placements at QEH for the 2026/27 academic year. The decision relates solely to undergraduate medical placements and follows concerns about aspects of the educational environment, governance arrangements, and the ability to provide assurance that students consistently receive the standards expected within a modern NHS organisation.

The Trust is working closely with NHS England and its university partners to identify and deliver the improvements required to restore confidence in the learning environment.

Performance

Following release of month one data, the Trust has undertaken a deep dive to understand the performance drivers for distance from plan for elective, diagnostics and cancer headline performance metrics. A revised trajectory to return performance to the Medium-term Plan has been reviewed by the Board of Directors and is being delivery is being tracked through internal meetings and the Group Risk Assurance Committee. A summary of Trust performance is appended to this report.

RTT
Waiting times continued to improve during June. With incomplete performance increasing to 62.8%, from 61.5% in May, although remained approximately 1.0 percentage point below the June Medium-term Plan trajectory of 63.8%.

Activity increased, with 1,075 admitted pathways completed (+158) and 2,239 non-admitted pathways completed (+100).

The total incomplete waiting list reduced by 514 patients to 25,086, despite new clock starts increasing by 665 to 6,033. This represents positive month-on-month progress, although the list remained 1,587 patients above the June plan of 23,499. The number of patients waiting more than 18 weeks reduced by 532 to 9,326.

Long-wait performance also improved. Patients waiting more than 52 weeks reduced by 60 to 373, although this remains above the original June trajectory. There were two patients waiting more than 65 weeks and no patients waiting more than 78 or 104 weeks.

Recovery remains focused on additional first outpatient activity, targeted booking of patients already waiting over 18 weeks, weekly executive review of all long-wait patients, dedicated validation support and additional WLI, insourcing and independent-sector capacity. The revised recovery plan targets 65.4% RTT performance, a total waiting list of 22,224 and no more than 93 patients waiting over 52 weeks by the end of September.

Cancer
Cancer remains a significant performance challenge and is therefore a major focus of the Trust's recovery work. Provisional June performance was 68.5% for the 28-day Faster Diagnosis Standard, 56.9% for the 62-day standard and 96.5% for the 31-day standard.

Weekly executive oversight is in place, supported by focused specialty recovery plans and clear delivery milestones. There are encouraging signs of progress within some pathways, including reductions in the number of patients waiting in gynaecology and skin although sustained improvement is still required.

Current priorities include protecting endoscopy capacity, improving lower gastrointestinal pathways and multidisciplinary working, further expanding gynaecology diagnostic capacity, improving radiology and histology turnaround, moving prostate biopsy into the outpatient setting and maintaining additional dermatology capacity. The trust is receiving support from the Cancer Alliance with implementing pathway changes.

UEC work
Urgent and Emergency Care performance remained below the level we want to achieve in June. Validated four-hour performance was 61.35%; 13.99% of attendances spent more than 12 hours in the department, and 659 ambulance handovers exceeded 45 minutes. Reducing prolonged waits, particularly ambulance offload delays and 12-hour stays, remains a key operational priority.

The focus through July has been on improving flow across the hospital, protecting

SDEC capacity and making best use of the more flexible discharge lounge space, now available following completion of the RAAC works. Work is also progressing to develop timelier, booked pathways for suitable minor illness and injury patients ahead of the introduction of the Urgent Treatment Centre.

Finance
Month 3 deficit of £1.3m (surplus to plan of £0.1m), year to date deficit of £7m (£1.1m deficit to plan). In month improvement attributable to over delivery of efficiencies, with 40% achieved through non recurrent, noncash releasing means. At the end of Q1 CIP delivery is £70k below plan but M4 planned efficiency is £1.2m, double the requirement in M3 and continues to pose a significant risk to the plan delivery.

Q2 deficit support funding has been confirmed, providing some stability to the cash position.

Forecast gap includes £10m unidentified CIP, Development of a financial recovery plan is in train, led at a divisional level.

Place, Neighbourhood and partnership working

The Trust is progressing opportunities aligned to the Group's Neighbourhood Max approach and emerging ICB investment plans. Of 54 identified left shift opportunities, 27 are underway or prioritised. Key developments include the transfer of Dermatology services to the Kings Lynn Health Hub and approved plans to transfer three community services to EECHC, with the ICB leading discussions.

Work continues with Norfolk Primary Care and local PCNs to strengthen collaboration, particularly in planned care, supported by new engagement arrangements from September 2026. Place-based work is advancing around proactive care, attendance and admission avoidance, and risk-stratified outpatient models, with QEH proposed as a pilot site.

Development of Integrated Neighbourhood Teams and wider system partnership working continues across West Norfolk. A mapping exercise identified 25 major initiatives and opportunities for greater alignment around neighbourhood health, regeneration, employment, community engagement and reducing inequalities. Work is also progressing to establish a Group-wide approach to health equity.

QEH Recovery plan

An Extraordinary Board meeting on 15 May considered the findings from the first 100 days of the Executive Managing Director and agreed the need for a focused recovery plan for The Queen Elizabeth Hospital.

The plan has been developed in response to enhanced regulatory oversight, including CQC inspections, Section 29A notices, NPIP mobilisation and draft NHSE legal undertakings, and is designed to complement the Group's One Recovery approach rather than replace it.

The recovery plan has been drafted and is currently under review from Group Executives and the QEH leadership teams. It sets out a two-year improvement trajectory. Year One focuses on laying the foundations and getting the basics right across timely access to care, effective use of resources, delivery of fundamental

standards, and staff support through visible and effective leadership. Year Two builds on this by strengthening quality, culture, digital innovation and partnership working to support sustainable clinical services and improved patient outcomes.

Key delivery risks include the breadth and pace of change required, organisational capacity and capability, the need for reliable data to demonstrate progress, and the importance of securing sustained organisational engagement. Mitigations include a tactical year-one delivery focus, clear phasing over two years, targeted Group and external support, development of measurable KPIs and a local business intelligence (BI) dashboard, and a layered communications and engagement approach.

Governance will be strengthened through a detailed action plan with nominated leads, coordinated Programme management, and establishment of a QEH Recovery Oversight Group chaired by the Group Deputy Chief Executive. Progress will be reported through QEH Hospital Management Group and onward to the Executive Risk Assurance Group and Group Risk Assurance Committee on a monthly basis.

Recommendation

The Board is asked to note the report and progress with developing an overarching QEH recovery plan.

Jo Segasby
Acting Executive Managing Director for QEH
Group Chief Delivery Officer and Group Deputy Chief Executive

QEH performance at a glance

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

Overall readout: QEH demonstrated improvement in elective and cancer performance; however pressures remain within urgent care, workforce compliance and financial delivery.

SAFE & EFFECTIVE CARE

0 MRSA cases — Target 0	**7** C. difficile cases — Target ≤4	**8** E. coli cases — Target 0
81 Falls — Target 54	**92.49%** FFT score — Target 95%	**90.37%** Registered nurse fill — Target 90%
80.88% Midwifery fill — Target 90%	**1.15** SHMI — Target ≤1	**2** Pressure ulcers — Target 0

PEOPLE & CULTURE

4.23% Sickness rate — Target 4.6%	**9.90%** Turnover rate — Target 10%
80.71% Mandatory training — Target 90%	**77.98%** Non-medical appraisal — Target 85%

ACCESS & FLOW

Urgent & emergency care

June 2026

- **61.35%** ED within 4 hours — Target 78%
- **13.99%** 12-hour performance — Target ≤12.1%
- **659** Ambulance handovers >45m — Target 0
- **11.26** Non-elective LOS — Target 10

Elective care

June 2026

- **62.82%** RTT within 18 weeks — Target 92%
- **25,086** Waiting list size — Target 244,963
- **1.68%** 52+ week waits — Target 1.5%
- **2** 65+ week waits — Target 0

Cancer

Latest validated: May 2026

- **68.56%** 28-day faster diagnosis — Target 75%
- **53.68%** 62-day treatment — Target 85%

PRODUCTIVITY & EFFICIENCY

£1.27m deficit In-month position — £0.12m favourable	**£6.98m deficit** YTD position — £1.11m adverse
£1.09m CIP delivered in month — £0.41m ahead	**£1.82m** CIP delivered YTD — £0.07m behind
+54.44% Agency variance to cap — Above cap	**+25.91%** Bank variance to cap — Above cap
£13,100 Cash position	

Definition key: Green Achieving Target — meets/exceeds target · Amber Close / Improving — within 5% or improving · Red Off Target — >5% from target or deteriorating

Source: NWUHG Group Integrated Performance Report | Reporting month: June 2026. Cancer metrics use the latest validated month where reported.

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	9.1		
Title	Executive Managing Director's report: Norfolk and Norwich University Hospitals NHS Foundation Trust		
Author(s)	Dr. Shane Gordon, Executive Managing Director		
Executive sponsor	Dr. Shane Gordon, Executive Managing Director		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

This report provides an update on key developments across the Trust in relation to financial performance, activity, regulatory compliance and research. The Group Board is asked to note the contents of the report.

Recommendations

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

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

Norfolk and Waveney University Hospitals Group

Board of Directors in public: 5 August 2026
Executive Managing Directors Report Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)

1. Changes within Hospital Leadership Team

Thanks are given to Chris Cobb, NNUH Chief Operating Officer for acting into the role of Executive Managing Director for the duration of Shane Gordon's planned absence.

Edward Smith, who has been appointed as the substantive Director of Finance joins the Trust on 15 September. Clare Hinton, Deputy Director of Finance continues to act up into the role of interim Director of Finance. Thanks to Clare for her ongoing leadership.

2. Performance

A summary of Trust performance is appended to this report.

Activity

Combined four-hour performance was below plan at 78.55%. However, July performance is forecast to exceed plan. The IPR demonstrates twelve-hour performance at 5.05%. The validated figure for June is 5.3% which remains behind plan. Although performance has improved during July, it is forecast to remain behind plan at month-end. The number of patients spending more than twelve hours from arrival to departure reduced in June compared to May but remained above plan. A further reduction is expected in July, although performance is still forecast to be above plan due to a more ambitious target than in previous months. NNUH remains in the best performing quartile nationally for 12-hour DTA performance.

Ambulance handover performance also remained behind plan in June. The average handover time increased to 58 minutes (36 minutes above plan), while the proportion of handovers exceeding 45 minutes rose to 41.8% (31.5% behind plan). This represents a deterioration compared with April and May. Daily ambulance handover incident management meetings are being held throughout July to review performance, escalate issues, agree actions, and monitor compliance. July performance is on track to improve across all urgent and emergency care metrics and is 2nd best performing in the East of England currently.

18-week elective care performance is reported on the IPR to be 59.22%. Further validation, after the date of data extraction for the IPR, has improved the percentage to 62.6%, which remains just below plan. The time to first appointment exceeded plan for the sixth consecutive month.

The IPR reported an overall waiting list of 69,109, however, further validation since the IPR was produced demonstrates an increased waiting list, currently standing at 70,523. This is 9.3% above plan, driven by a 7% increase in referral volumes compared with the previous four-month average. In addition, a potential pathway-reporting issue has subsequently been identified within the June waiting-list position. BI, Data Quality and operational teams are urgently reviewing the data and reconciling it against the source systems to ensure appropriate actions are put in place to manage this impact.

The 52-week position is reported in the IPR as being 3.35%, however, further validation has brought this percentage down to 2.6% which is consistent with May. This is behind plan and targeted interventions during July and August are expected to improve both the 52-week position and the overall waiting list.

Validated Cancer performance for May exceeded plan for both the 31-day standard (90.3%) and the 28-day Faster Diagnosis Standard 79.37% (81.2% after further validation). However, 62-day performance remained 5.6% below plan, despite improving compared with April. Forecast performance for June and July indicates that the 31-day standard and Faster Diagnosis Standard will continue to exceed plan, while 62-day performance is expected to improve further but remain below plan, with recovery to plan anticipated in August.

Overall, performance remained mixed in May and June. Urgent and emergency care metrics were below plan, although improvement during July is expected to deliver stronger month-end performance. Elective care also remained below plan, with targeted recovery actions in place to improve waiting list performance and reduce long waits. Cancer performance continued to exceed plan for the 31-day and Faster Diagnosis Standards, while 62-day performance improved but remained below target, with recovery to plan expected in August.

Finance

The Trust's financial position is slightly ahead of plan YTD but the forecast outturn position remains challenging in 2026/27. The year-to-date position is reported as a deficit of £6.0m against the planned £6.1m. There has been an increase in supplies costs and an adverse variance in net drugs expenditure. These pressures have been partially offset by favourable pay performance within care group pay expenditure which is currently underspent by £1.3m.

Cash reserves remain strong and above plan following funding received in March, although balances are expected to reduce over the remainder of the financial year in line with forecast expenditure.

Delivery of the Cost Improvement Programme (CIP) has been positive in the early part of the year, with £6.5m achieved against a planned target of £6.07m. YTD CIP performance has been supported by non-recurrent savings brought forward, and more challenging CIP delivery requirements remain in the coming months. Further intensive work is ongoing with Care Groups to identify the remaining CIP for this year.

Capital expenditure is currently below plan. This is largely due to delays associated with the NaNOC2 project. Work is ongoing to present a balanced capital forecast.

After accounting for known investments and mitigating actions, the current forecast outturn projects a £14.1m deficit against the Trust's break-even plan. The principal driver of the adverse forecast remains the anticipated shortfall in CIP delivery, with a significant increase in savings requirements profiled during the remainder of the year. Comprehensive financial recovery plan and initial actions have already been considered through the Hospital Leadership Team. Continued organisational focus and collective action will be required over the coming months to close the forecast gap and support delivery of the Trust's financial objectives for 2026/27.

Safe and Effective Care

In relation to mortality, our Summary Hospital-level Mortality Indicator (SHMI) for the period March 2025 to February 2026 is reported at 1.18. This has increased from 1.17 for the February 2025 to January 2026. These figures demonstrate a 'higher than expected' rate, and an updated action plan is in development. The next SHMI publication is due on 13th August.

In June, 1 hospital onset MRSA bacteraemia was record against a threshold of 0. There were also 6 Clostridioides Difficile (C. Diff) infections recorded against an annual threshold of 81 (total cases 27 year to date, of which 15 were hospital acquired). 9 Escherichia coli (E.coli) cases were reported against an annual threshold of 94 (32 year to date with 22 of these being hospital acquired).

Friends and Family Test (FFT) scores remain below the 95% target with a combined score of 89.6%. The emergency department achieving 81.05%, and Maternity 83.87%. Day case FFT achieved 97.52%, with inpatient and outpatient areas achieving 93.01% and 93.52% respectively.

There were 147 falls with harm in June, with three of these resulting in moderate harm or greater. This remains under the average number of moderate harm or above falls which stands at five and work is ongoing to reduce rates of falls in the hospital.

Midwifery fill rates were 83.01% in June which is 17% below target. 1:1 care in labour is reported at 98.9% against a 100% target. Actions are underway to strengthen workforce resilience in perinatal care, and this is being overseen by the monthly Perinatal Resilience Forum, chaired by the Executive Managing Director.

Workforce

The Trust continues to exceed the 90% target on mandatory training, with the overall compliance rate for June being 93.1%, representing the highest compliance achieved. Compliance has been maintained since December 2022. Overall compliance including Bank staff is 92.1%. Specifically for Medical staff, the compliance rate for permanent staff was 92.4%.

In terms of Turnover, the monthly rate for June 2026 is 0.53%. The 12-month average turnover rate is currently 6.6% which is below the Trust target of 10% (national average 9.7% in April).

Of the 41.7 (FTE) leavers that left in the month of June (compared to 40.4 in May 2026); 31.7 were from three main staff groups: additional clinical services (e.g. Healthcare Assistants and other support workers); administration and clerical; and registered nursing and midwifery. The main reasons for leaving in June were 'Other' (25.8%), and 'Relocation' (21.0%).

Sickness absence remains marginally above target at 4.21% compared to 4.29% the previous month and against a target of 4.2%. This has seen a sustained improvement from December 2025 where the rate was 5.4%. The improvement trajectory is likely to continue the current level for next two months due to a higher rate of annual leave over summer. From November there is a risk of increased sickness absence, noting seasonal trends, which will be mitigated by managers utilising the new absence policy to manage absence and wellbeing with reactive as well as preventative measures.

Non-medical appraisal compliance is below target at 84.48% compared to 87.42% in May and against a target of 85%. Historical trends over the last three years have seen the lowest point of compliance in June/July each year, before improving back to the target. This coincides with the appraisal refresh window. It is therefore expected that this rate will improve as per trends over the last three years. To prevent future seasonal dips in performance, Care Group triumvirates will be tasked with scheduling appraisals prior to expiry.

3. Group working

NNUH is supporting the QEH General Surgery recovery and is now the temporary provider of the clinical delivery at both sites. The collaboration has been implemented with minimal levels of bureaucracy, and the Group model has allowed a positive and swift intervention that may not have been possible as standalone organisations.

We have also created a single Audiology team to help recover Paediatric Audiology performance at QEH. Again, a single clinical and operational leadership team are working together across both sites to resolve a waiting list issue that may have been difficult to replicate in the absence of the Group model.

4. National Oversight Framework

The most recent quarterly publication of the National Oversight Framework (NOF) showed that The Trust had moved up in the national rankings from 91st to 76th (out of 134 acute trusts). This improvement reflects the progress made, including improved cancer performance, waiting list reductions, and delivering to our financial plan in 2025/26.

While we welcome the improvement in our position, work continues to embed the improvements and achieve a NOF ranking that aligns to the excellent services we provide and that we can be truly proud of.

5. Responding to Extremes in weather conditions and Climate Change

The increasing frequency of extreme weather events highlights the importance of ensuring the Trust remains resilient to the impacts of climate change. During recent periods of exceptionally hot weather, the Trust implemented its Heatwave Response Plan to support the safety and wellbeing of patients and staff, including additional cooling measures, water distribution and enhanced business continuity arrangements. The Trust continues to assess longer-term resilience measures, including how its estate and infrastructure can adapt to future climate-related challenges.

6. MRI Major Incident

A critical incident was declared on 24 June after the cooling systems supporting our MRI scanners within the hospital building and our Community Diagnostic Centre failed in the hot and humid weather. Teams worked tirelessly to bring the scanners back on online and we de-escalated to a business continuity incident on 26th June. This was stood down after assurance was received that all patients' appointments that needed to be cancelled had been rebooked.

We have taken steps to modify the cooling systems within the MRI scanner environments and have introduced new procedures that will help ensure that there is no repetition of this type of incident on this scale during future periods of extreme temperature and humidity.

7. Regulation

The Department of Health and Social Care (DHSC), acting as the Competent Authority under the Security of Network and Information Systems (NIS) Regulations 2018, has issued Enforcement Notices to both NNUH and QEH requiring full compliance with the NHS Multi-Factor Authentication (MFA) Policy by 18 December 2026.

The notices formalise existing regulatory requirements and introduce enhanced statutory oversight, including monthly progress reporting to DHSC. Work continues to deliver the remaining MFA implementation programme, with established governance, executive oversight and dedicated workstreams in place. NNUH has supported improvement in cybersecurity through significant investment in this year and subsequent years. Failure to achieve compliance could result in further regulatory action, including financial penalties. The Group Board is receiving regular assurance on progress towards compliance.

8. Capital Investments

During 2025/26, the Trust invested more than £14 million in new and replacement clinical equipment, ensuring patients and staff have access to modern, reliable technology that supports safe, effective and high-quality care. The programme delivered significant upgrades across diagnostic services, theatres, pharmacy, endoscopy and patient monitoring, alongside investment in training equipment and patient flow resources. This investment strengthens the Trust's ability to meet current demand while supporting improvements in patient experience, productivity and clinical outcomes.

9. Research

One of the UK's first tonsil biorepositories has been established through a partnership between NNUH and Quadram Institute Bioscience, creating a new oral biobank to support research into oral health conditions. Supported by funding from the Quadram Institute Clinical Seedcorn Fund and N&N Hospitals Charity, the project will securely store tissue samples from tonsillectomy procedures that would otherwise be discarded. The biobank will support research into conditions including tonsillitis and oral cancers, with plans to collect around 300 samples following regulatory approval.

The initiative highlights the strength of collaboration across NNUH, the Quadram Institute and Norwich Research Park, and is one of seven projects to receive charitable seedcorn funding to advance research and improve patient care.

Research is key to unlocking better treatments, earlier diagnoses and improved care for our patients and is committed to enhancing research activities in collaboration with our partners.

10. Governance

The 2026 governor elections are now underway, with staff nominations received and voting open until 10 August. The process supports continued staff representation on the Council of Governors and provides colleagues with an opportunity to elect representatives who will represent the views of staff, patients and the wider community.

11. Conclusion

The Trust continues to make progress, with positive developments in research, and aspects of operational performance and service improvement. Whilst financial, activity and regulatory challenges remain, focused programmes of work are in place to address these.

The Trust remains committed to delivering high-quality patient care, improving performance and achieving long-term financial sustainability, while continuing to strengthen partnerships and support innovation for the benefit of patients, staff and the wider community. The Board is asked to note the contents of this report.

12. Recommendations

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

Shane Gordon
Executive Managing Director for NNUH

NNUH performance at a glance

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

Overall readout: NNUH demonstrated strength in emergency care, nurse fill and cancer diagnosis; however pressures remain within long waits, patient experience and infections.

SAFE & EFFECTIVE CARE

1 MRSA cases — Target 0	**6** C. difficile cases — Target ≤4	**9** E. coli cases — Target 0
147 Falls with harm — Target 187	**89.60%** FFT score — Target 95%	**95.35%** Registered nurse fill — Target 90%
83.01% Midwifery fill — Target 90%	**1.18** SHMI — Target ≤1	**23** Pressure ulcers — Target 0

PEOPLE & CULTURE

4.21% Sickness rate — Target 4.2%	**6.65%** Turnover rate — Target 10%
93.14% Mandatory training — Target 90%	**84.48%** Non-medical appraisal — Target 85%

ACCESS & FLOW

Urgent & emergency care

June 2026

- **78.55%** ED within 4 hours — Target 78%
- **5.05%** 12-hour performance — Target 4%
- **1,374** Ambulance handovers >45m — Target 0
- **Data not reported** Non-elective LOS — Target not reported

Elective care

June 2026

- **59.22%** RTT within 18 weeks — National 92%
- **69,109** Waiting list size — Target 81,265
- **3.35%** 52+ week waits — Target 2.2%
- **317** 65+ week waits — Target 0

Cancer

Latest validated: June 2026

- **79.37%** 28-day faster diagnosis — Target 75%
- **57.08%** 62-day treatment — Target 85%

Note: Cancer 62-day performance is subject to significant month-end validation and pathway reconciliation activity. As a result, the June position reported within the CPR reflects an early in-month view and is expected to improve materially ahead of national submission in August.

PRODUCTIVITY & EFFICIENCY

£0.91m deficit In-month position — June 2026	**£6.01m deficit** YTD position — June 2026
£3.53m CIP delivered in month — Plan £2.06m	**£6.50m** CIP delivered YTD — Plan £6.07m
-23.02% Agency variance to cap — Below cap	**+4.70%** Bank variance to cap — Above cap
£83,999 Cash position	

Definition key: Green Achieving Target — meets/exceeds target · Amber Close / Improving — within 5% or improving · Red Off Target — >5% from target or deteriorating

Source: NWUHG Group Integrated Performance Report | Reporting month: June 2026. Cancer metrics use the latest validated month where reported.

Norfolk and Waveney
University Hospitals Group

Report to the Board of Directors in public: 5 August 2026

Agenda item number	10.1		
Title	Group Integrated Performance Report		
Author(s)	Jo Segasby, Group Chief Delivery Officer		
Executive sponsor	Jo Segasby, Group Chief Delivery Officer		
Purpose of report	**For decision** ☒	**For discussion** ☐	**For information** ☐

Executive summary

The Group Integrated Performance Report provides a consolidated assessment of performance across Safe and Effective Care, People and Culture, Access and Flow, and Productivity and Efficiency. The report enables comparison across Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), James Paget University Hospitals NHS Foundation Trust (JPUH) and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) and supports identification of common themes, risks, recovery actions, and opportunities to share best practice. All metrics within this report relate to 1-30 June 2026 performance unless otherwise specified. Cancer performance is reported using the most recent available position, noting that NNUH cancer data for June remains unvalidated and may change following completion of local validation processes and national submission.

Recommendations

The Group Board is asked to:

- Receive and discuss the Group Integrated Performance Report for June 2026.
- In light of the NHS England requirement to submit the Winter Planning Board Assurance Framework (BAF) by 30 September 2026 and recognising that this falls outside the Board meeting cycle, the Board is requested to delegate authority to the Group Risk Assurance Committee (GRAC) to review and approve the Winter Planning BAF on its behalf. Any material issues identified through this process will be reported back to the Group Board for assurance and oversight.

Alignment to Board Assurance Framework risk(s)	Principal Risks 1, 2, 3, 4, 5
Previously considered by	Group Risk Assurance Committee, 30 July 2026
Any background papers in Admin Control Reading Room	Yes – operational performance benchmarking data.

Board of Directors in public: 5 August 2026
Integrated Performance Report

1. Overall performance

Overall performance remains mixed. There are encouraging signs of improvement in selected areas, including JPUH urgent and emergency care performance, elements of elective recovery, cancer pathway management, improving sickness absence at NNUH and JPUH, and favourable in-month financial positions across all three Trusts. However, performance remains fragile, with sustained risks across quality, workforce, access, flow, and financial delivery.

2. Safe and Effective Care

2.1 Quality and Safety

Positives: Group-wide quality improvement arrangements continue to mature, with strategic programmes now established for mortality improvement, pressure ulcer prevention, and safer staffing. Early progress has been reported through reduced variation in reporting and a reduction in Category 2 pressure ulcers.

Key Risks and Challenges: Escherichia coli (E. coli) performance remains above target across all three Trusts. However, the absolute number of cases remains small and should therefore be interpreted with caution; the appropriateness of the current target is also being reviewed. Summary Hospital-level Mortality Indicator (SHMI) remains above the expected threshold at NNUH and JPUH, and readmission rates remain above target at both organisations. Friends and Family Test (FFT) performance remains below target at NNUH and QEH, complaints activity remains elevated across the Group, and pressure ulcers continue to be reported above tolerance levels**.**

Recovery actions: Recovery actions continue through the Group SHMI Improvement Programme, Medical Examiner Review, infection prevention and control initiatives, and the Group Pressure Ulcer Prevention Improvement Programme. In addition, the Group Safe Staffing Assurance Group is providing strengthened oversight and coordinated improvement through the development of a Group-wide safer staffing assurance framework.

2.2 Maternity

Positives: JPUH reported an improvement in unplanned neonatal intensive care unit (NICU) admissions compared to the previous month, maternity complaints reduced at QEH, and NNUH continues to report strong performance for 1:1 care in labour.

Key risks and challenges: Midwifery fill rates remain below target, reflecting ongoing recruitment pressures, sickness absence, maternity leave, and wider workforce resilience issues, but active recruitment and retention plans are progressing.

Unplanned NICU admissions remain above expected levels at both JPUH and NNUH, whilst QEH continues to report variation in stillbirth and pre-term birth indicators. Complaints remain elevated at NNUH and JPUH, although levels at QEH continue to improve.

Recovery actions: The Safer Staffing and Escalation programme, alongside Trust-led actions, is providing a strengthened Group approach to nursing and midwifery staffing assurance, supporting consistent oversight, timely escalation, and shared learning across all three Trusts.

3. People and Culture

Positives: The sickness trajectory is now a sustained Group-wide trend. QEH's reduction from 5.72% in April to 4.23% in June is the standout movement nearly 1.5 percentage points in two months and demonstrates that the refreshed improvement programme and new approaches to OH referrals and early supportive engagement are delivering. NNUH has effectively reached target, having reduced from 5.4% to 4.21% over six months following implementation of the revised Absence Management Policy. JPUH has brought its annualised rate down from 5.68% in April to 5.29%, with a comprehensive attendance management and wellbeing programme now embedded. All three Trusts demonstrate that structured programmes with management accountability produce results. RSM audit actions remain due to the Audit Committee in Autumn 2026 but the trajectory is wholly improved.

Key risks and challenges: Whilst sickness is improving, the compliance position has worsened since May 2026. NNUH appraisal is now below target for the first time attributed to a recognised seasonal dip and expected to recover from July, but requiring monitoring. QEH is deteriorating on both appraisal and mandatory training, with appraisal falling a further three percentage points after the withdrawal of enhanced support. QEH mandatory training at 80.71% is materially below target and requires a substantial recovery trajectory; role-specific alignment work concluding in August is expected to support improvement from September.

Recovery actions: Each HRD is leading a strengthened approach to case management within their Trust, with Group-level oversight to ensure consistency of practice, pace of intervention and assurance reporting across all three sites. QEH appraisal compliance will now be monitored through core divisional IPR reviews and Performance Review Meetings. QEH mandatory training improvement is expected from September following conclusion of the role-specific alignment work in August. The three strategic programmes case management strategy, policy harmonisation, and EDI response continue on track. Recovery plans for mandatory training and appraisal compliance continue, with progress monitored through Trust performance review meetings and reported against national workforce standards.

4. Access and Flow

4.1 Elective

Positives: All three Trusts reported progress against recovery trajectories, with improvements seen in Referral to Treatment (RTT) performance, waiting list size and

long-wait reduction activity. NNUH and JPUH continue to report that they remain on track to achieve key year-end elective objectives.

Key risks and challenges: Performance remained below plan across a number of measures during June. Long waits, particularly 65-week waits, alongside diagnostic capacity and workforce constraints, continue to limit the pace of recovery and remain the principal risks to sustained delivery of elective standards.

Recovery actions: Recovery activity remains focused on reducing long waits, expanding elective and diagnostic capacity, strengthening validation processes, and maintaining executive oversight of challenged specialties. Delivery of trajectories remains dependent on additional capacity, workforce resilience and sustained operational grip.

4.2 Cancer

Positives: Cancer performance improved across the Group during June, with improvement in Faster Diagnosis Standard and 62-day performance reported across the three Trusts.

Key risks and challenges: However, performance remained below trajectory overall and the principal challenge remains converting improvements in diagnostic performance and pathway management into sustained improvements in treatment performance.

Recovery actions: Recovery actions continue to focus on pathway redesign, increased diagnostic, and clinic capacity, teledematology, insourcing, workforce recruitment, additional clinical sessions and strengthened pathway oversight.

4.3 Urgent and Emergency Care

Positives: There were encouraging signs of improvement in urgent and emergency care during June, with NNUH maintaining delivery of the 4-hour standard despite exceptionally high levels of demand and flow pressures, and JPUH reporting improvements in Emergency Department performance, ambulance handovers and non-elective length of stay.

Key risks and challenges: Performance however remains challenged across the Group, with ongoing variation in emergency access standards, ambulance handovers, and patient flow measures. Whilst some improvement was reported during June, overall performance remains below target across a number of key measures and continues to be affected by demand, flow constraints, and delayed patient progression through the system.

Recovery actions: Group recovery activity remains centred on delivery of One Recovery actions, improving patient flow, reducing ambulance handover delays, strengthening same day emergency care, increasing discharge performance, and maintaining oversight of bed occupancy and escalation capacity. Whilst improvement is expected over coming months, performance remains fragile and dependent on sustained delivery of recovery plans across all three organisations.

5. Productivity and efficiency

Positives: The Group reported a combined Month 3 deficit of approximately £2.9m, around £0.5m favourable to plan. Cost Improvement Programme (CIP) delivery also remained ahead of, or broadly in line with, expected levels.

Key risks and challenges: Despite the positive in-month position, year-to-date performance remains challenged, particularly at QEH, reflecting continuing operational pressures, activity gaps, and temporary staffing costs. Significant risks remain around delivery of recurrent efficiencies, productivity improvement, and full-year financial plans.

Recovery actions: Recovery efforts remain focused on strengthening CIP delivery, improving activity performance, maintaining robust financial controls, and reducing reliance on temporary staffing to support longer-term financial sustainability across the Group. The June position provides some assurance that these actions are beginning to have an impact, but sustained delivery will be required to secure the full-year position.

6. Recommendations

The Group Board is asked to:

- Receive and discuss the Group Integrated Performance Report for June 2026.
- In light of the NHS England requirement to submit the Winter Planning Board Assurance Framework (BAF) by 30 September 2026 and recognising that this falls outside the Board meeting cycle, the Board is requested to delegate authority to the Group Risk Assurance Committee (GRAC) to review and approve the Winter Planning BAF on its behalf. Any material issues identified through this process will be reported back to the Group Board for assurance and oversight.

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

Introduction

Jun-26

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

- **Safe and Effective Care**
- **People and Culture**
- **Access and Flow**
- **Productivity and Efficiency**

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

Over the coming months, the report will continue to be refined ensuring it and supports informed decision-making across the Group.

NHS
James Paget University Hospitals
NHS Foundation Trust

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

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Compliance

- Target being met
- Target not met
- N/A — No target

Variation

- Common cause
- H / L — Special cause of concerning nature
- H / L — Special cause of improving nature

Assurance

- Inconsistent achievement of target
- P — Consistent achievement of target
- F — Consistent failure of target

Escalation Status

- **Assure** — Performing as expected
- **Advise** — Ongoing monitoring/ negative assurance
- **Alert** — Attention required/ not performing as expected

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

Group Summary

Jun-26

NHS James Paget University Hospitals NHS Foundation Trust

	P	?	F
H/L		7	5
?	4	23	7
H/L	1	2	

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

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

	P	?	F
H/L	2	5	2
?	2	25	6
H/L		3	1

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

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

	P	?	F
H/L		6	
?	4	28	3
H/L		1	1

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

NHS
Norfolk and Waveney
University Hospitals Group

Annual Metrics

CQC Safe Domain Rating

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

Inpatient Satisfaction

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

Staff Survey - We are Safe and Healthy

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

National - 6.07

Staff Survey - Engagement Score

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

National - 6.74

Staff Survey - Advocacy Score

NHS James Paget University Hospitals NHS Foundation Trust	6.37
NHS Norfolk and Norwich University Hospitals NHS Foundation Trust	5.70
NHS The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	5.27

National - 6.64

Staff Survey - Raising Concerns

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

National - 6.30

Annual Metrics

Maternity Survey 2025

NHS James Paget University Hospitals NHS Foundation Trust

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

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

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

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

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

Walker Ian
02/08/2026 22:26:37

National Cost Collection - Productivity Relative Cost Difference (24/25)

NHS James Paget University Hospitals NHS Foundation Trust	104
NHS Norfolk and Norwich University Hospitals NHS Foundation Trust	98
NHS The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	108

2025 | National Education and Training Survey — Overall Experience

NHS James Paget University Hospitals NHS Foundation Trust	65.9%
NHS Norfolk and Norwich University Hospitals NHS Foundation Trust	73.2%
NHS The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	74.0%

Norfolk and Waveney
University Hospitals Group

Safe and Effective Care Domain Metrics

NHS
Norfolk and Waveney
University Hospitals Group

Metric Summary Matrix - Safe and Effective Care

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

Safe and Effective Care Assurance

NHS James Paget University Hospitals NHS Foundation Trust

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

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

Safe and Effective Care Assurance

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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

Safe and Effective Care Assurance

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

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

NHS
Norfolk and Waveney
University Hospitals Group

Safe and Effective Care Domain Summary

Jun-26

Metric
SHMI
MRSA
CDiff
Ecoli
Average number of days between planned and actual discharge date
Readmission Rate

James Paget

Date	Target	Actual	Compliance	Variation	Assurance
Jan-26	1.18	1.19	✗	H	?
Jun-26	0	0	✓	~	P
Jun-26	3	1	✓	~	?
Jun-26	0	2	✗	~	?
Jun-26	2	7	✗	~	F
May-26	10.0%	11.83%	✗	~	?

Norfolk and Norwich

Date	Target	Actual	Compliance	Variation	Assurance
Jan-26	1.17	1.18	✗	~	?
Jun-26	0	1	✗	~	?
Jun-26	8	6	✓	~	?
Jun-26	0	9	✗	~	?
Jun-26	2	6	✗	H	F
May-26	10.0%	13.03%	✗	~	F

Queen Elizabeth

Date	Target	Actual	Compliance	Variation	Assurance
Jan-26	1.18	1.15	✓	~	?
Jun-26	0	0	✓	~	P
Jun-26	4	7	✗	~	?
Jun-26	0	8	✗	~	?

Group Summary

Performance remained mixed across the Group during June, **E. coli performance was reported above target at all three trusts,** with Trusts continuing to implement infection prevention and control measures and review associated learning. **SHMI (Feb data) remained above the expected threshold at NNUH and JPUH.** The Group Summary Hospital-level Mortality Indicator (SHMI) Improvement Programme and Medical Examiner Review are now positioned as strategic Group-wide quality and safety priorities, moving from recognition of variation in mortality indicators into a coordinated programme to strengthen mortality assurance, improve clinical documentation and coding quality, and standardise learning from deaths processes across NNUH, JPUH and QEH. Current reporting demonstrates variation in SHMI performance and there remains a need to reduce unwarranted variation and improve diagnostic-level oversight. The programme therefore remains appropriately rated as **Limited Assurance** while Group-wide governance, KPI reporting and implementation infrastructure are established. The immediate focus is delivery of the SMART action plan, including programme governance, diagnostic deep dives, clinical coding and documentation improvement, alignment with Learning from Deaths and SJR processes, completion of the Medical Examiner Review, shared best practice, dashboard development and quarterly assurance reporting through Group governance routes.

30 Day Readmission rates also remained above target at NNUH and JPUH, with limited movement in the reported position during the month. The Group is continuing to work with the QEH who are not yet reporting metrics on the average number of days between planned and actual discharge date, while re-admission rate reporting is also being reviewed by Q2 26/27. As this work continues it will provide greater consistency in performance reporting, enable robust Group-wide oversight of improvement actions, and support sustained improvements in discharge processes and patient outcomes. It is anticipated that the QEH will be able to report these metrics by September 2026.Trusts continue to progress a range of improvement actions in response to the reported variation.

NHS
Norfolk and Waveney
University Hospitals Group

Safe and Effective Care Domain Summary

Jun-26

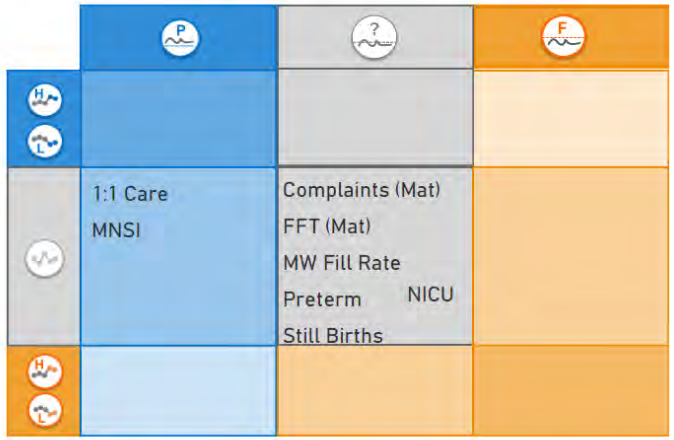
Metric	James Paget					Norfolk and Norwich					Queen Elizabeth				
	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance
FFT Score	Jun-26	95.0%	97.91%	✓	~	P	Jun-26	95.0%	89.60%	✗	L	?	Jun-26	95.0%	92.49%	✗	~	?
Complaints Received	Jun-26	0	29	✗	~	F	Jun-26	0	107	✗	~	F	Jun-26	0	58	✗	H	F
Pressure Ulcers	Jun-26	0	14.00	✗	~	F	Jun-26	0	23.00	✗	~	F	Jun-26	0	2.00	✗	~	?
Registered Nurse Fill Rate	Jun-26	90.0%	86.82%	✗	~	?	Jun-26	90.0%	95.35%	✓	H	P	Jun-26	90.0%	90.37%	✓	~	?
Care Hour Per Patient Day (CHPPD)	Jun-26	8.00	8.56	✓	~	?	Jun-26	8.00	7.51	✗	~	?	Jun-26	8.00	7.58	✗	H	?
Falls	Jun-26	67	67	✓	~	?	Jun-26	187	147	✓	~	?	Jun-26	54	81	✗	~	?
PSII Number	Jun-26	0	1	✗	~	?	Jun-26	0	1	✗	L	F	Jun-26	0	0	✓	~	P

Group Summary

In June, **FFT scores remained below target at NNUH and QEH, whilst complaint activity remained elevated across all three trusts,** with an increase of complaints due to a combination of higher reported volumes, backlog processing and increased triage reporting contributing to the current position. Initial analysis suggests no dominant theme or recurring issue driving the increase. **In addition, pressure ulcers continued to be reported above the zero-tolerance target,** please note the Group is reporting Category 1 – 4 rather than 3 - 4 as per the NOF Guidance.The Group Pressure Ulcer Prevention Improvement Programme is now a strategic Group-wide quality and safety priority, moving from deep-dive findings into a coordinated programme to reduce avoidable harm, improve data quality and standardise prevention across NNUH, JPUH and QEH. Early progress is evident through a 36% reduction in Category 2 pressure ulcers and reduced data variation; however, the programme remains rated as **Limited Assurance** while Group-wide oversight infrastructure develops. The immediate focus is standardised Purpose-T, aligned care planning and audit, stronger training and competency assurance, digital documentation, resilience in high-risk areas and the shared Keep Moving campaign, supported through Group governance and One Recovery routes. **Registered Nurse Fill Rate performance remained variable across the Group,** with NNUH exceeding target, QEH maintaining performance around the target threshold and JPUH remaining below target. The safer staffing programme has been established to provide assurance that nurse fill rate and Care Hours Per Patient Day (CHPPD) will form part of a consistent, Group-wide safer staffing assurance framework across NNUH, JPUH and QEHKL. These metrics will be used alongside nationally recognised tools, including Safer Nursing Care Tool (SNCT), Emergency Department (ED)-SNCT, and triangulated with acuity and dependency data, professional judgement, nurse-sensitive indicators, red flags, quality outcomes and workforce intelligence. This approach supports a more rounded assessment of whether registered staffing and care hours are aligned to patient need, while enabling comparison, benchmarking and escalation across the Group.

Norfolk and Waveney University Hospitals Group

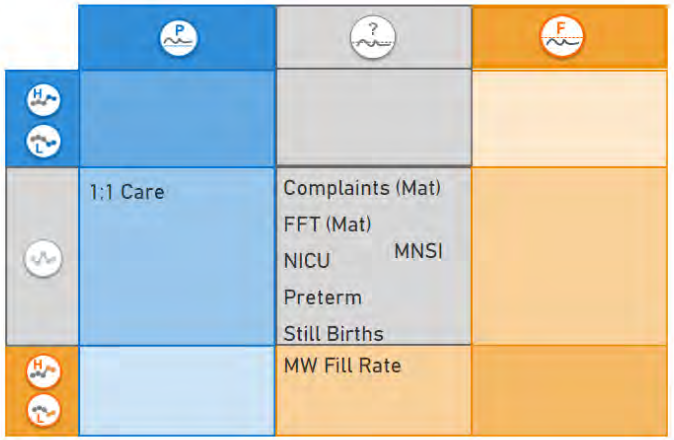
Metric Summary Matrix - Safe and Effective Care - Maternity



Safe and Effective Care Assurance

James Paget University Hospitals NHS Foundation Trust

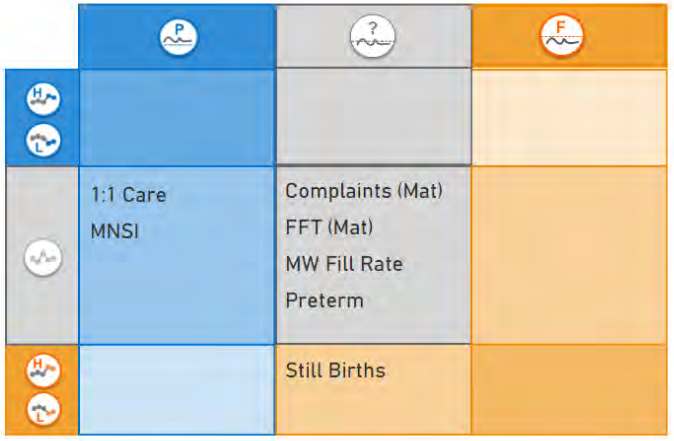
- Still Birth Rate
- Midwifery Fill Rate
- Preterm Birth Rate
- Maternity FFT
- Complaints Received - Maternity
- MNSI
- 1:1 Care
- Unplanned Admissions to NICU



Safe and Effective Care Assurance

Norfolk and Norwich University Hospitals NHS Foundation Trust

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



Safe and Effective Care Assurance

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

- Still Birth Rate
- Midwifery Fill Rate
- Preterm Birth Rate
- Maternity FFT
- Complaints Received - Maternity
- MNSI
- 1:1 Care

NHS
Norfolk and Waveney
University Hospitals Group

Safe and Effective Care Domain Summary - Maternity

Jun-26

Metric	James Paget					Norfolk and Norwich					Queen Elizabeth				
	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance
Still Birth Rate	Jun-26	3.5%	0.70%	✓	~	?	Jun-26	3.5%	0.00%	✓	~	?	May-26	3.5%	3.55%	✗	H	?
Midwifery Fill Rate	Jun-26	90.0%	82.90%	✗	~	?	Jun-26	90.0%	83.01%	✗	L	?	Jun-26	90.0%	80.88%	✗	~	?
Preterm Birth Rate	Jun-26	6.0%	5.59%	✓	~	?	Jun-26	6.0%	6.09%	✗	~	?	May-26	6.0%	6.67%	✗	~	?
Maternity FFT	Jun-26	95.0%	94.74%	✗	~	?	Jun-26	95.0%	83.87%	✗	~	?	Jun-26	95.0%	97.67%	✓	~	?
Complaints Received - Maternity	Jun-26	0	5	✗	~	?	Jun-26	0	5	✗	~	?	Jun-26	0	2	✗	~	?
MNSI	Jun-26	0	0	✓	~	P	Jun-26	0	2	✗	~	?	May-26	0	0	✓	~	P
1:1 Care	Jun-26	97.0%	100.00%	✓	~	P	Jun-26	97.0%	98.93%	✓	~	P	May-26	97.0%	100.00%	✓	~	P
Unplanned Admissions to NICU	Jun-26	0	7	✗	~	?	May-26	0	8	✗	~	?						

Group Summary

Midwifery **fill rates remained below target at all three trusts,** reflecting ongoing workforce capacity challenges and recruitment pressures. The Safer Staffing and Escalation Task and Finish Group will provide assurance that a consistent Group-wide operational framework for Nursing and Midwifery safer staffing is implemented across NNUH, JPUH and QEHKL. Strategically, the programme supports strengthened ward-to-board assurance, reduced unwarranted variation and alignment with nationally recognised methodologies, including SNCT, ED-SNCT, Care Hours Patient Day (CHPPD) and Birthrate Plus, where applicable. While each Trust has existing arrangements in place, the current position identifies variation in funded uplift (including short notice leave, sickness and training mandatory demands), establishment review and workforce assurance, with regional maternity findings highlighting the need for a more consistent approach to planned and unplanned absence. Next steps include completing the Group baseline assessment and gap analysis, aligning Safe Care and e-rostering, synchronising acuity census windows, progressing maternity workforce and financial modelling and delivering the first Group Nursing establishment review to Trust Boards by March 2027 (subject to Group Board approval). This will maintain local Board accountability while strengthening Group-level oversight, benchmarking, escalation and assurance of safer staffing risks and outcomes. **Unplanned NICU admissions** continued above expected levels at NNUH and JPUH, indicating persistent variation in neonatal activity despite improvement initiatives being reported. QEH reported continued variation in stillbirth and preterm birth rates. Patient experience and complaint metrics were also variable, with **complaints remaining elevated at NNUH and JPUH but with improvement at QEH.** The Group is continuing to work with the QEH who are not yet reporting metrics on unplanned admissions to the NICU. As this work continues it will provide greater consistency in performance reporting, enable robust Group-wide oversight of improvement actions, and support sustained improvements in discharge processes and patient outcomes. It is anticipated that the QEH will be able to report these metrics by August 2026.

Norfolk and Waveney
University Hospitals Group

People and Culture Domain Metrics

Norfolk and Waveney
University Hospitals Group

Metric Summary Matrix - People and Culture

Jun-26

James Paget University Hospitals NHS Foundation Trust

	P	?	F
H / L (improvement)		Appraisal	
Common cause			Sickness
H / L (concern)	Training	Turnover	

Norfolk and Norwich University Hospitals NHS Foundation Trust

	P	?	F
H / L (improvement)	Training	Turnover	
Common cause		Appraisal Sickness	
H / L (concern)			

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

	P	?	F
H / L (improvement)		Sickness Training	
Common cause		Appraisal Turnover	
H / L (concern)			

People and Culture (James Paget) – !

Metric	Status
Sickness Rate	!
Turnover Rate	Watch
Mandatory Training	Watch
Non Medical Appraisal	Watch

People and Culture (Norfolk and Norwich) – Watch

Metric	Status
Sickness Rate	Watch
Turnover Rate	Watch
Mandatory Training	✓
Non Medical Appraisal	Watch

People and Culture (Queen Elizabeth) – Watch

Metric	Status
Sickness Rate	Watch
Turnover Rate	Watch
Mandatory Training	Watch
Non Medical Appraisal	Watch

NHS
Norfolk and Waveney
University Hospitals Group

People and Culture Domain Summary

Jun-26

Metric
Sickness Rate
Turnover Rate
Mandatory Training
Non Medical Appraisal

James Paget

Date	Target	Actual	Compliance	Variation	Assurance
Jun-26	4.6%	5.29%	✗		F
Jun-26	10.0%	6.92%	✓	H	
Jun-26	90.0%	90.22%	✓	L	P
Jun-26	85.0%	88.79%	✓	H	

Norfolk and Norwich

Date	Target	Actual	Compliance	Variation	Assurance
Jun-26	4.2%	4.21%	✗		
Jun-26	10.0%	6.65%	✓	L	
Jun-26	90.0%	93.14%	✓	H	P
Jun-26	85.0%	84.48%	✗		

Queen Elizabeth

Date	Target	Actual	Compliance	Variation	Assurance
Jun-26	4.5%	4.23%	✓	L	
Jun-26	10.0%	9.90%	✓		
Jun-26	90.0%	80.71%	✗	H	
Jun-26	85.0%	77.98%	✗		

Group Summary

Sickness absence, mandatory training and non-medical appraisal compliance are ongoing workforce assurance risks, with the pattern of risk differing by site.

Sickness absence is improving at both NNUH and JPUH but remains above target at each. NNUH is marginally above target at 4.21% (target 4.2%), sustaining improvement from 5.4% in December 2025 following implementation of the revised Absence Management Policy. JPUH remains 0.69 percentage points above target at 5.29% (target 4.6%), with long-term absence at its lowest rate in eighteen months, over 900 cases actively managed and a comprehensive attendance management and wellbeing programme in delivery.

Mandatory training compliance at QEH remains materially below target at 80.71% (target 90.0%). A substantial recovery trajectory is now required. Conclusion of the role specific training alignment work in August is expected to support improvement from September 2026 onwards.

Non-medical appraisal compliance is below target at NNUH (84.48%, target 85%) and QEH (77.98%, target 85%). The NNUH position reflects a recognised seasonal dip and is expected to recover from July. The QEH deterioration follows the withdrawal of enhanced support measures; compliance will now be monitored through core divisional IPR reviews and Performance Review Meetings to ensure the position improves. .

Norfolk and Waveney
University Hospitals Group

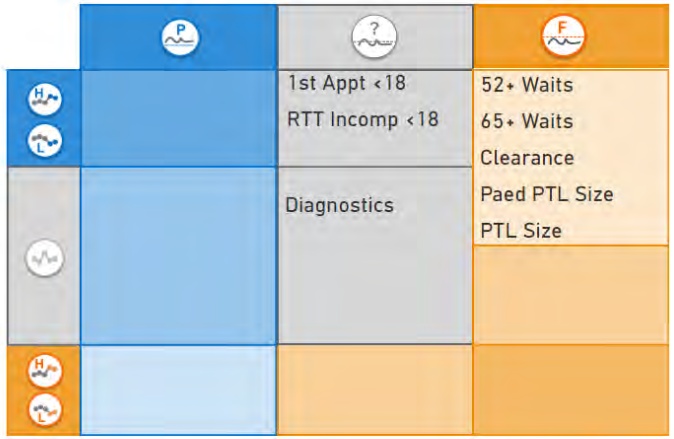
Access and Flow Domain Metrics

Norfolk and Waveney University Hospitals Group

Metric Summary Matrix - Access and Flow - Elective Care

Jun-26

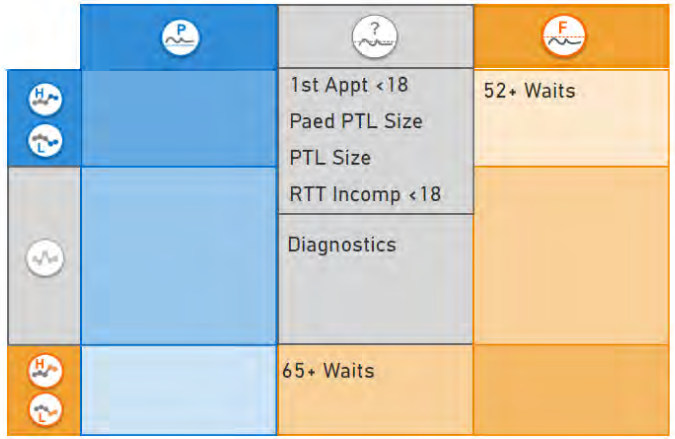
James Paget University Hospitals NHS Foundation Trust



Access and Flow

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

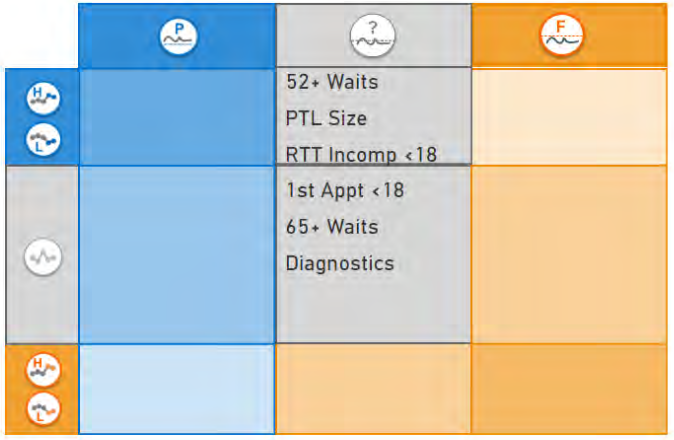
Norfolk and Norwich University Hospitals NHS Foundation Trust



Access and Flow

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

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust



Access and Flow

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

NHS Norfolk and Waveney University Hospitals Group

Access and Flow Domain Summary - Elective Care

Jun-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Total PTL Size	Jun-26	31,529	31,349	✓	L	F
RTT Incomplete Within 18 weeks	Jun-26	59.2%	60.08%	✓	H	?
65+ Week Waits	Jun-26	0	117	✗	L	F
52+ Week Performance	Jun-26	3.8%	3.47%	✓	L	F
First Attendance Within 18 Weeks	Jun-26	64.0%	68.41%	✓	H	?
6 Week Diagnostics	Jun-26	89.2%	64.93%	✗	—	?
Under 18s elective waiting list size	Jun-26	2,615	2,856	✗	L	F
Estimated clearance times	Jun-26	18	24	✗	L	F

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Total PTL Size	Jun-26	81,265	69,109	✓	L	?
RTT Incomplete Within 18 weeks	Jun-26	92.0%	59.22%	✗	H	?
65+ Week Waits	Jun-26	0	317	✗	H	?
52+ Week Performance	Jun-26	2.2%	3.35%	✗	L	F
First Attendance Within 18 Weeks	Jun-26	64.0%	71.40%	✓	H	?
6 Week Diagnostics	Jun-26	95.0%	75.81%	✗	—	?
Under 18s elective waiting list size	Jun-26	8,368	7,330	✓	L	?

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Total PTL Size	Jun-26	24,963	25,086	✗	L	?
RTT Incomplete Within 18 weeks	Jun-26	92.0%	62.82%	✗	H	?
65+ Week Waits	Jun-26	0	2	✗	—	?
52+ Week Performance	Jun-26	1.5%	1.68%	✗	L	?
First Attendance Within 18 Weeks	Jun-26	64.0%	64.10%	✓	—	?
6 Week Diagnostics	Jun-26	95.0%	62.71%	✗	—	?

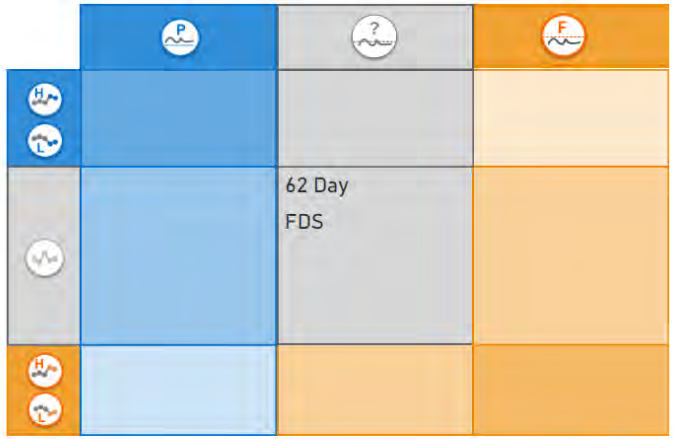
Group Summary

Elective performance remained mixed across the Group during June, with **continued progress in some waiting time metrics offset by ongoing challenges in long waits, diagnostics and overall RTT delivery.** QEH reported improvements in RTT performance, total waiting list size and 52-week waits, whilst NNUH forecast delivery of its RTT trajectory and improvement in 52-week performance. However**, 65-week waits increased significantly at NNUH** and remained above zero at all three trusts, whilst **diagnostic performance remained substantially below target at both NNUH and JPUH due to capacity constraints, workforce pressures and demand exceeding available capacity.** Across the Group, performance continues to be affected by a combination of complex high-acuity patient cohorts, constrained diagnostic capacity, recruitment challenges and delays in mobilising additional capacity. **Trusts have established a range of recovery actions** including daily long-wait validation, targeted patient-level reviews, insourcing and outsourcing arrangements, expansion of theatre and diagnostic capacity, recruitment initiatives and strengthened executive oversight. **Recovery trajectories indicate planned improvement across RTT, 65-week waits, diagnostics and histology performance;** however, successful delivery remains dependent upon additional capacity coming online, workforce resilience and continued focus on the longest-waiting cohorts.

Metric Summary Matrix - Access and Flow - Cancer

Jun-26

James Paget University Hospitals NHS Foundation Trust

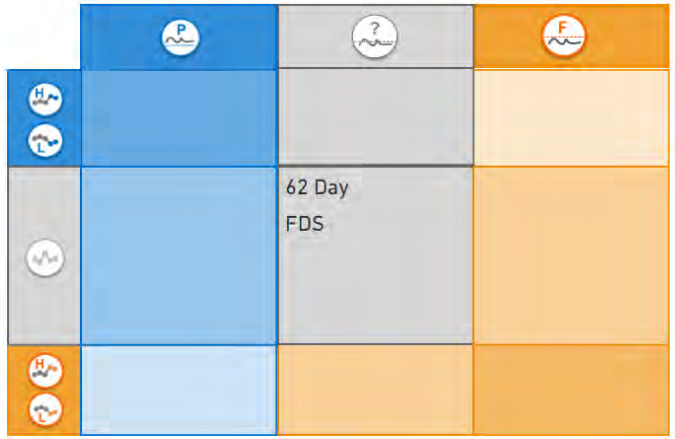


Access and Flow

28 Day Faster Diagnosis

Cancer 62 Day Treatment

Norfolk and Norwich University Hospitals NHS Foundation Trust

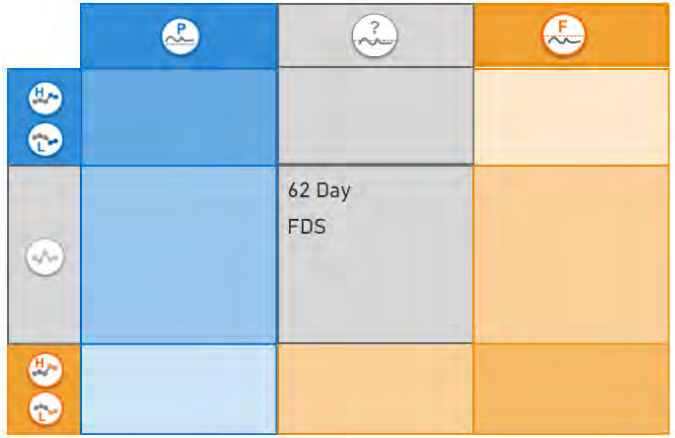


Access and Flow

28 Day Faster Diagnosis

Cancer 62 Day Treatment

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust



Access and Flow

28 Day Faster Diagnosis

Cancer 62 Day Treatment

NHS
Norfolk and Waveney
University Hospitals Group

Access and Flow Domain Summary - Cancer

Jun-26

Metric	James Paget Date	Target	Actual	Compliance	Variation	Assurance	Norfolk and Norwich Date	Target	Actual	Compliance	Variation	Assurance	Queen Elizabeth Date	Target	Actual	Compliance	Variation	Assurance
28 Day Faster Diagnosis	May-26	79.4%	71.07%	✗			Jun-26	75.0%	79.37%	✓			May-26	75.0%	68.56%	✗		
Cancer 62 Day Treatment	May-26	72.3%	68.91%	✗			Jun-26	85.0%	57.08%	✗			May-26	85.0%	53.68%	✗		

Note: Cancer 62-day performance is subject to significant month-end validation and pathway reconciliation activity. As a result, the June position reported within this IPR reflects an early in-month view and is expected to improve materially ahead of national submission in August.

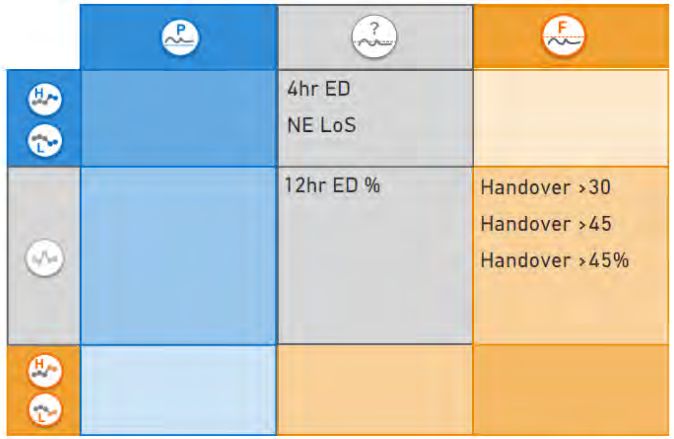
Group Summary

The **28-day Faster Diagnosis Standard improved at JPUH and QEH, with NNUH achieving the target,** while **62-day performance improved at all three trusts** but remained below trajectory. The principal **challenge remains converting improvements in diagnosis and pathway management into sustained improvements in 62-day treatment performance.**Across the Group there are diagnostic pathway constraints, including endoscopy, MRI, histology, hysteroscopy, breast one-stop capacity and specialty-specific pressures within Urology, Gynaecology, Lower GI and Colorectal pathways. In response, trusts are implementing targeted recovery actions including pathway redesign, increased diagnostic and clinic capacity, teledematology, insourcing, workforce recruitment, additional clinical sessions and strengthened pathway oversight. Recovery trajectories across all three trusts indicate planned improvement in Faster Diagnosis and 62-day performance, although delivery remains dependent on sustained pathway grip, timely diagnostic turnaround and successful implementation of additional capacity initiatives.

Metric Summary Matrix - Access and Flow - UEC

Jun-26

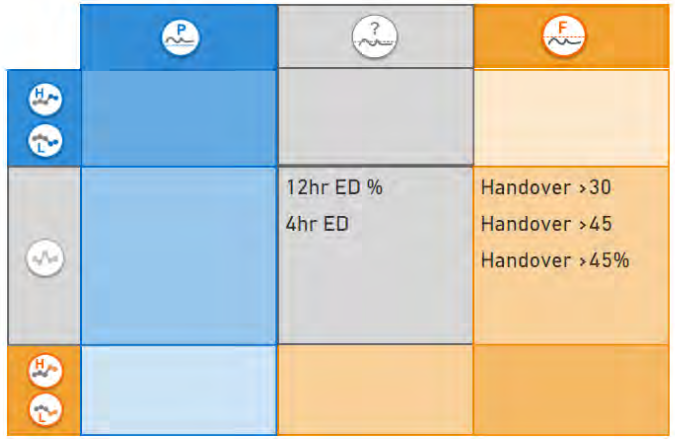
James Paget University Hospitals NHS Foundation Trust



Access and Flow

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

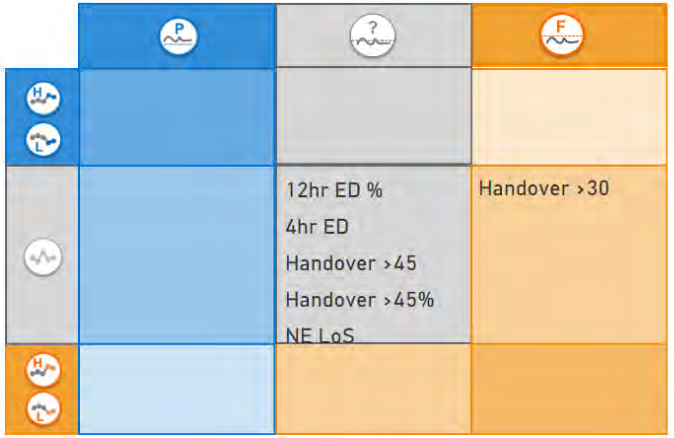
Norfolk and Norwich University Hospitals NHS Foundation Trust



Access and Flow

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

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust



Access and Flow

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

NHS
Norfolk and Waveney
University Hospitals Group

Access and Flow Domain Summary - UEC

Jun-26

Metric	James Paget					Norfolk and Norwich					Queen Elizabeth				
	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance
ED 4 Hour Performance	Jun-26	76.5%	72.67%	⊗	H	?	Jun-26	78.0%	78.55%	✓	~	?	Jun-26	78.0%	61.35%	⊗	~	?
ED 12 Hours in Department %	Jun-26	7.4%	7.31%	✓	~	?	Jun-26	4.0%	5.05%	⊗	~	?	Jun-26	12.1%	13.99%	⊗	~	?
Ambulance Handovers Over 30 Minutes	Jun-26	0	531	⊗	~	F	Jun-26	0	1,863	⊗	~	F	Jun-26	0	873	⊗	~	F
Ambulance Handovers Over 45 Minutes	Jun-26	0	377	⊗	~	F	Jun-26	0	1,374	⊗	~	F	Jun-26	0	659	⊗	~	?
Ambulance Handovers Over 45 Minutes %	Jun-26	0.0%	19.97%	⊗	~	F	Jun-26	0.0%	43.41%	⊗	~	F	Jun-26	0.0%	34.90%	⊗	~	?
Non Elective LoS	Jun-26	10	10.49	⊗	T	?							Jun-26	10	11.26	⊗	~	?

Group Summary

Performance remained challenged across the Group during June, with **continued variation in ED access standards, ambulance handovers and flow measures.** NNUH maintained delivery of the 4-hour standard but reported deterioration in 12-hour performance and ongoing ambulance handover delays, whilst QEH remained below both 4-hour and 12-hour standards despite maintaining performance at an improved level compared to previous performance. JPUH reported continued improvement in the 4-hour standard, alongside reductions in ambulance handover delays and improved non-elective length of stay; however, performance remained below target for ED access, ambulance handovers and length of stay measures

At JPUH, performance remains influenced by ongoing ambulance handover delays, emergency department crowding and flow constraints, with non-elective length of stay remaining above target despite sustained month-on-month improvement. At NNUH, performance continues to be affected by exceptionally high emergency demand, delays transferring patients from ED to inpatient beds, ambulance handover delays, discharge activity failing to keep pace with demand and constraints associated with side room availability. QEH reports a predominantly flow-driven position, reflecting admitted pathway delays, reduced patient progression, variable specialty responsiveness, lower GP Front Door capacity and sustained periods of ED congestion. Recovery activity across the Group is focused on the One Recovery Plan, protecting SDEC capacity, strengthening weekend preparation, improving ambulance handover processes, increasing early-day discharge delivery and maintaining active oversight of bed occupancy, escalation capacity and empty G&A beds. Performance is therefore expected to improve during July and August.

Norfolk and Waveney
University Hospitals Group

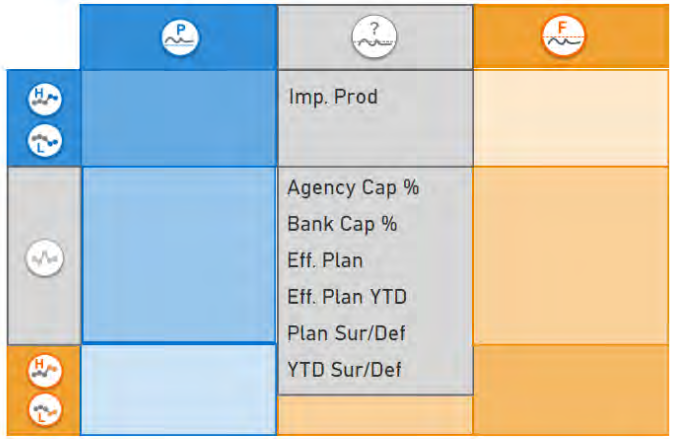
Productivity and Efficiency Domain Metrics

NHS
Norfolk and Waveney
University Hospitals Group

JPUH Metric Summary Matrix - Productivity and Efficiency

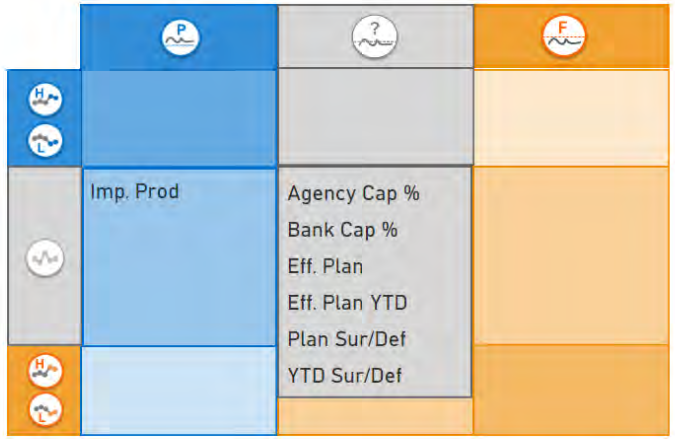
Jun-26

NHS James Paget University Hospitals NHS Foundation Trust



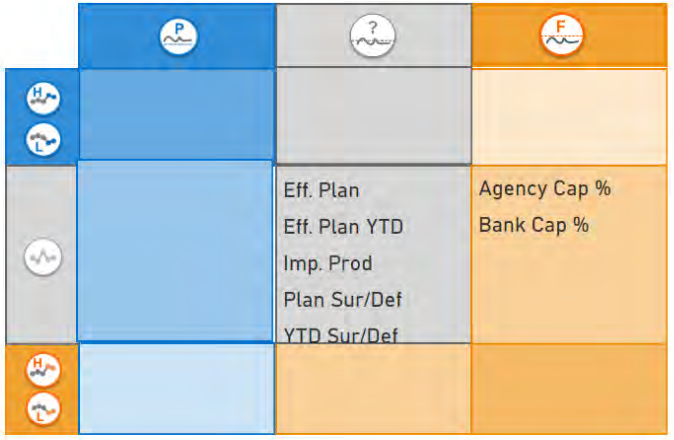
Productivity and Efficiency	
Implied Productivity	
Planned surplus/deficit	
YTD Surplus/deficit	
Variance to Agency Spend Cap %	
Variance to Bank Spend Cap %	
Efficiency Plan £000	
Efficiency Plan YTD £000	

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust



Productivity and Efficiency	
Implied Productivity	✓
Planned surplus/deficit	
YTD Surplus/deficit	
Variance to Agency Spend Cap %	
Variance to Bank Spend Cap %	
Efficiency Plan £000	
Efficiency Plan YTD £000	

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



Productivity and Efficiency	!
Implied Productivity	
Planned surplus/deficit	
YTD Surplus/deficit	
Variance to Agency Spend Cap %	!
Variance to Bank Spend Cap %	!
Efficiency Plan £000	
Efficiency Plan YTD £000	

NHS
Norfolk and Waveney
University Hospitals Group

Productivity and Efficiency Domain Summary

Jun-26

Metric	James Paget					Norfolk and Norwich					Queen Elizabeth				
	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance
Implied Productivity	Feb-26	3	3.00	✓	H	?	Feb-26	3	3.90	✓		P	Feb-26	3	-2.20	✗		?
Planned surplus/deficit	Jun-26	-1,003	-695	✓		?	Jun-26	-979	-912	✓		?	Jun-26	-1,396	-1,273	✓		?
YTD Surplus/deficit	Jun-26	-3,932	-3,614	✓		?	Jun-26	-5,133	-6,005	✗		?	Jun-26	-5,865	-6,975	✗		?
Variance to Agency Spend Cap %	Jun-26	0.0%	-3.28%	✓		?	Jun-26	0.0%	-23.02%	✓		?	Jun-26	0.0%	54.44%	✗		F
Variance to Bank Spend Cap %	Jun-26	0.0%	2.86%	✗		?	Jun-26	0.0%	4.70%	✗		?	Jun-26	0.0%	25.91%	✗		F
Efficiency Plan £000	Jun-26	942	1,658	✓		?	Jun-26	2,063	3,534	✓		?	Jun-26	679	1,090	✓		?
Efficiency Plan YTD £000	Jun-26	2,422	3,406	✓		?	Jun-26	6,071	6,502	✓		?	Jun-26	1,896	1,822	✗		?

Group Summary

All three trusts **delivered in-month financial positions that were in line with or better than plan,** supported by strong CIP delivery at NNUH and JPUH and broadly on-plan delivery at QEH. However, **year-to-date performance remains challenged, particularly at QEH,** reflecting continued operational pressures, activity gaps and temporary staffing costs. Whilst **CIP delivery remains ahead of or broadly in line with plan across the Group, risks remain where schemes have yet to be fully identified,** particularly at QEH, while high emergency demand, patient acuity and temporary staffing expenditure continue to drive workforce pressures.

Recovery actions are focused on the development of CIP schemes, increased grip and control measures on pay and non-pay, and a continued drive on activity performance to meet plan. Trusts continue to focus on the identification of efficiency schemes, including recurrent, cash-releasing efficiencies. Whilst June performance was broadly favourable, risks remain in relation to CIP identification and delivery, activity performance and temporary staffing expenditure, with continued focus on improving productivity and reducing activity gaps to plan.

Norfolk and Waveney
University Hospitals Group

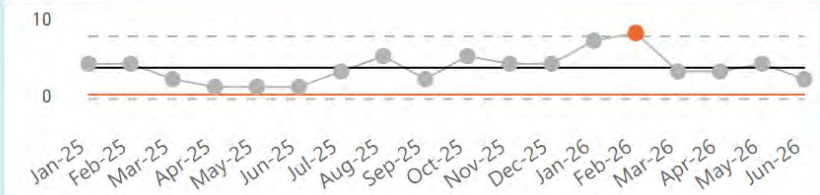
Appendices

Norfolk and Waveney University Hospitals Group

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

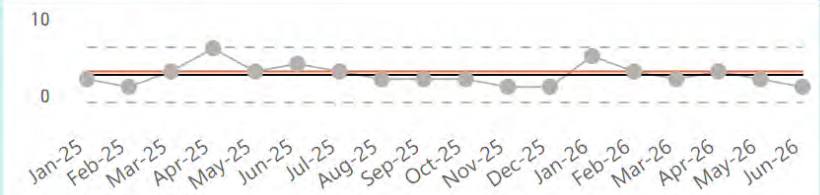
Jun-26

JPUH - Ecoli 2

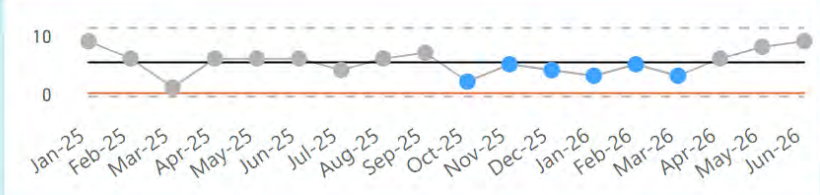


JPUH - MRSA 0

JPUH - CDiff 1

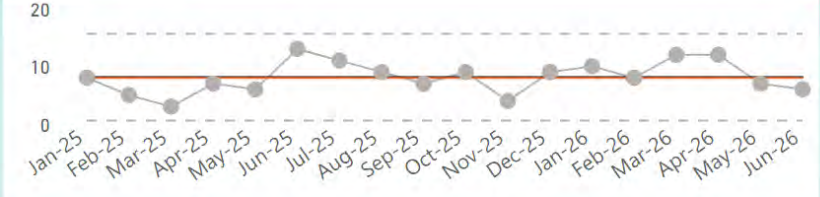


NNUH - Ecoli 9



NNUH - MRSA 1

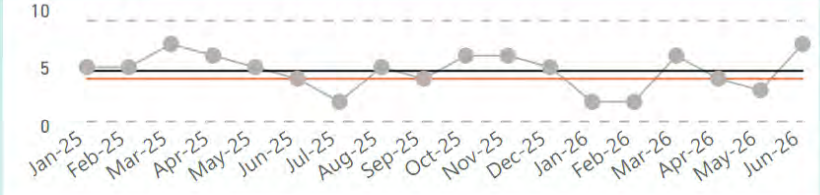
NNUH - CDiff 6



QEH - Ecoli 8

QEH - MRSA 0

QEH - CDiff 7



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	2				
NNUH	0	9				
QEH	0	8				

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

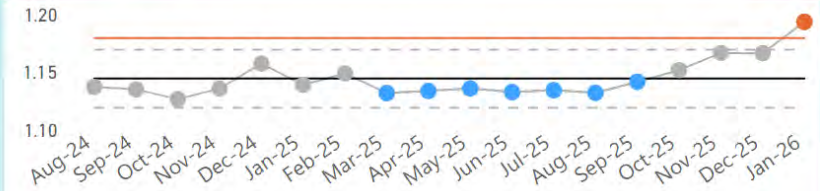
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3	1				
NNUH	8	6				
QEH	4	7				

Norfolk and Waveney University Hospitals Group

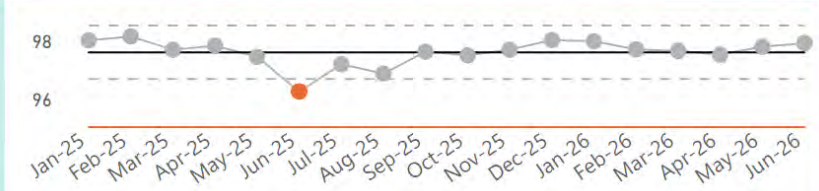
Safe and Effective Care Domain Appendix - SHMI, FFT, Complaints Received

Jun-26

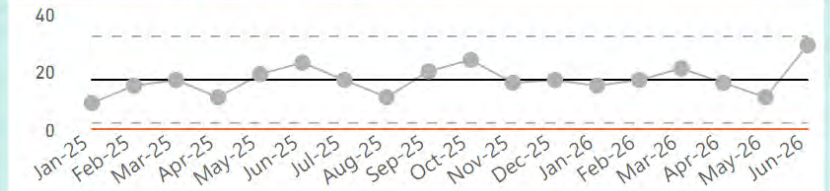
JPUH - SHMI 1.19



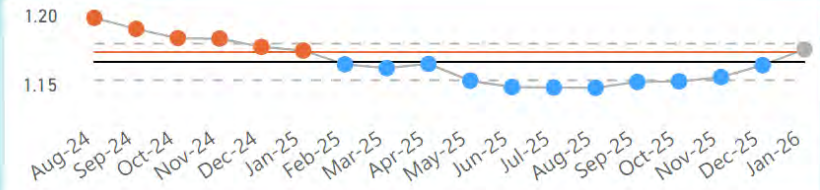
JPUH - FFT Score 97.91%



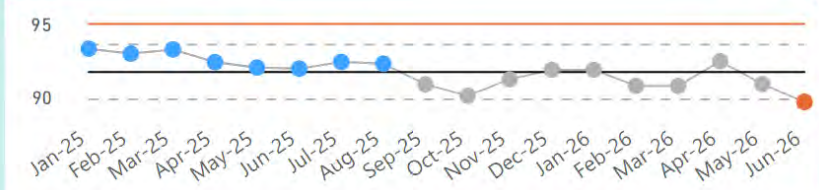
JPUH - Complaints Received 29



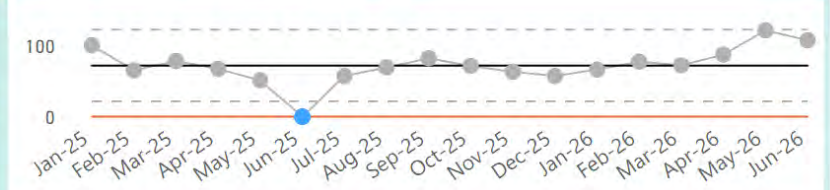
NNUH - SHMI 1.18



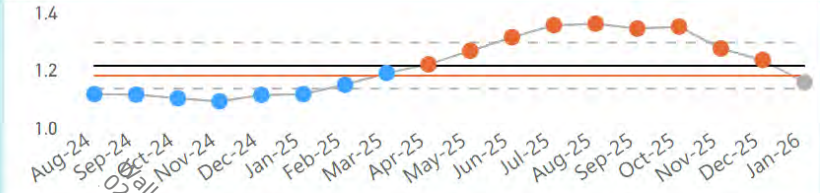
NNUH - FFT Score 89.60%



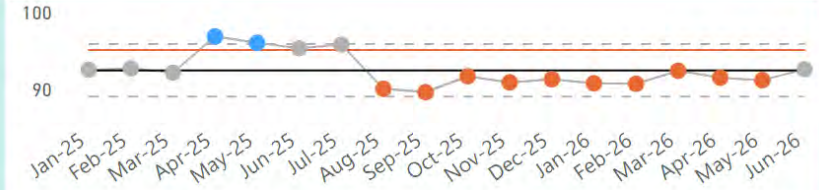
NNUH - Complaints Received 107



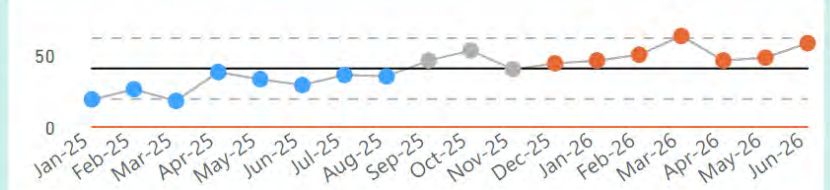
QEH - SHMI 1.15



QEH - FFT Score 92.49%



QEH - Complaints Received 58



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	1.18	1.19	⊗	H	?	
NNUH	1.17	1.18	⊗		?	
QEH	1.18	1.15	✓		?	

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	95.0%	97.91%	✓		P	✓
NNUH	95.0%	89.60%	⊗	L	?	
QEH	95.0%	92.49%	⊗		?	

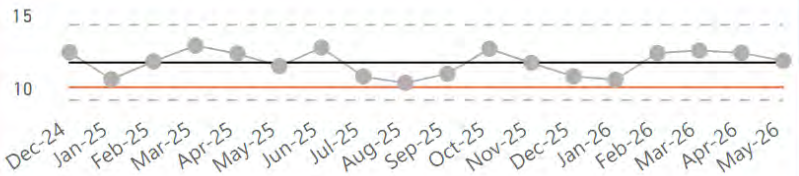
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	29	⊗		F	!
NNUH	0	107	⊗		F	!
QEH	0	58	⊗	H	F	!

Norfolk and Waveney University Hospitals Group

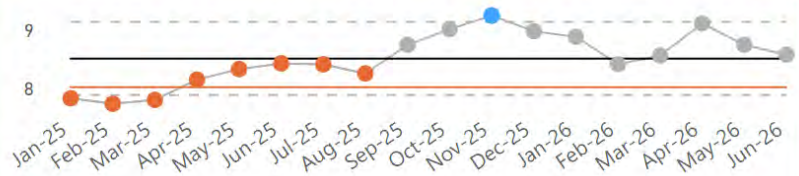
Safe and Effective Care Domain Appendix - Readmission Rate, CHPPD & Discharge Delay

Jun-26

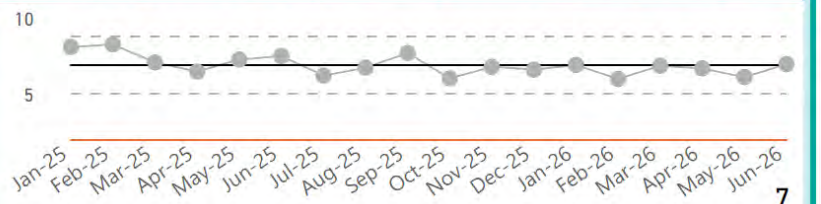
JPUH - Readmission Rate 11.83%



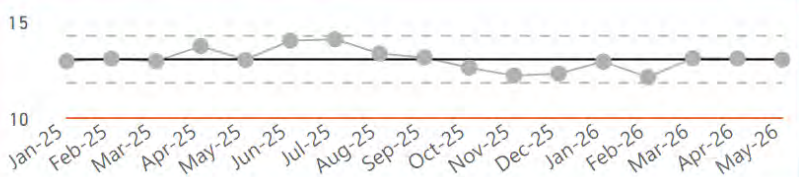
JPUH - Care Hour Per Patient Day (CHPPD) 8.56



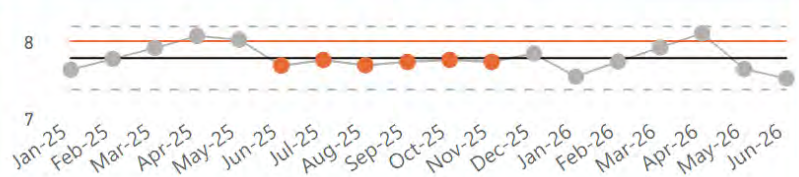
JPUH - Average number of days between planned and actual discharge date



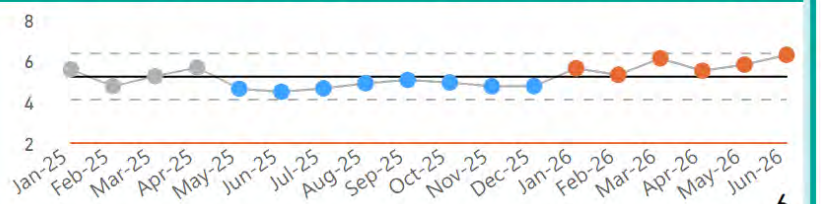
NNUH - Readmission Rate 13.03%



NNUH - Care Hour Per Patient Day (CHPPD) 7.51

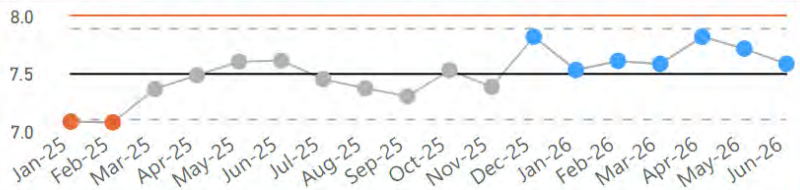


NNUH - Average number of days between planned and actual discharge date



-

QEH - Care Hour Per Patient Day (CHPPD) 7.58



-

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	10.0%	11.83%	⊗	~	?	◉
NNUH	10.0%	13.03%	⊗	~	F	!

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	8.00	8.56	✓	~	?	◉
NNUH	8.00	7.51	⊗	~	?	◉
QEH	8.00	7.58	⊗	H	?	◉

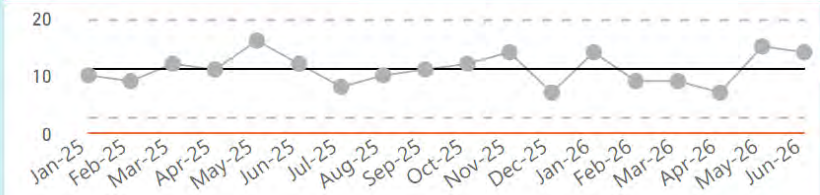
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	2	7	⊗	~	F	!
NNUH	2	6	⊗	H	F	!

Norfolk and Waveney University Hospitals Group

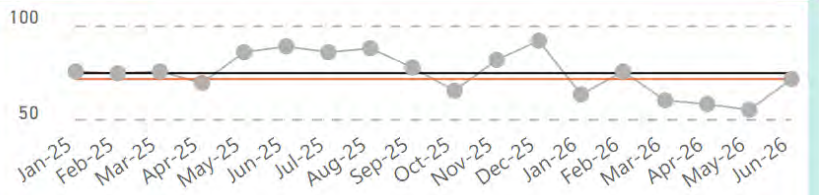
Safe and Effective Care Domain Appendix - Pressure Ulcers, Falls and RN Fill

Jun-26

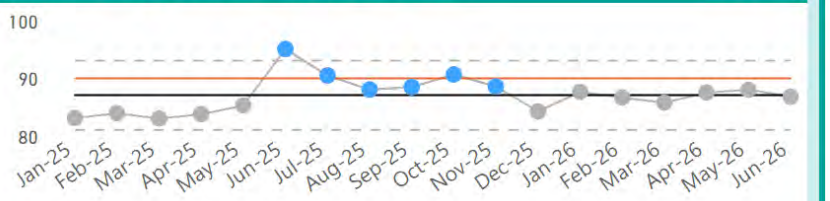
JPUH - Pressure Ulcers 14.00



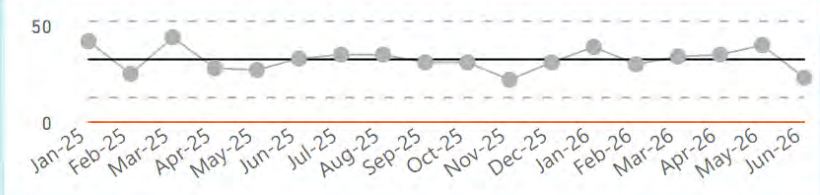
JPUH - Falls 67



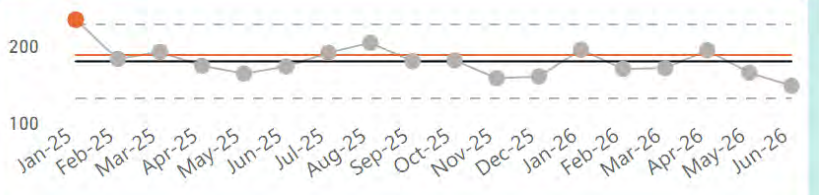
JPUH - Registered Nurse Fill Rate 86.82%



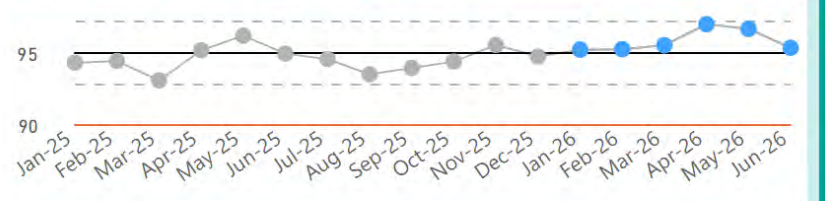
NNUH - Pressure Ulcers 23.00



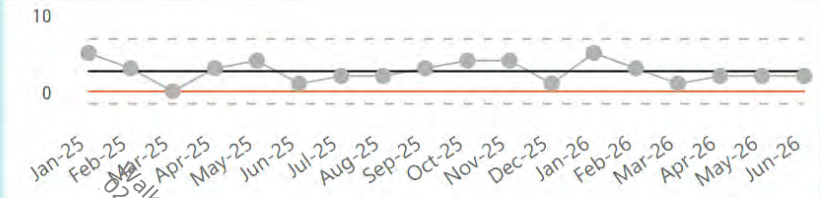
NNUH - Falls 147



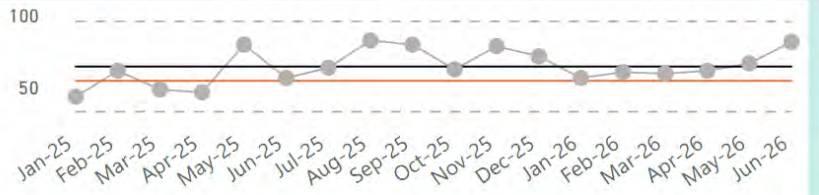
NNUH - Registered Nurse Fill Rate 95.35%



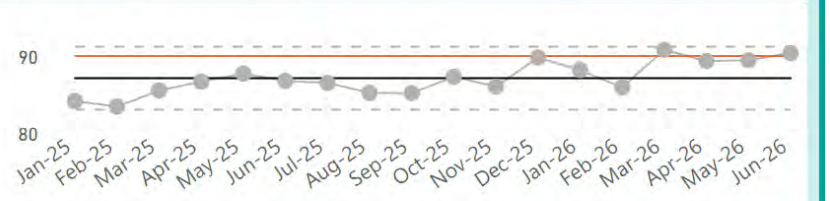
QEH - Pressure Ulcers 2.00



QEH - Falls 81



QEH - Registered Nurse Fill Rate 90.37%



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	14.00				
NNUH	0	23.00				
QEH	0	2.00				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	67	67				
NNUH	187	147				
QEH	54	81				

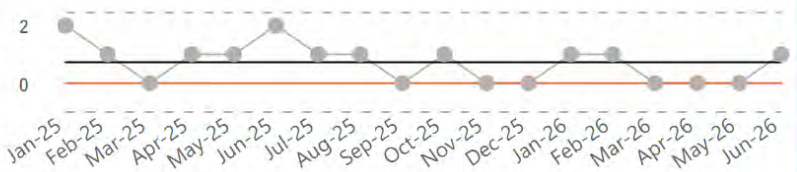
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	86.82%				
NNUH	90.0%	95.35%				
QEH	90.0%	90.37%				

Norfolk and Waveney University Hospitals Group

Safe and Effective Care Domain Appendix - PSII

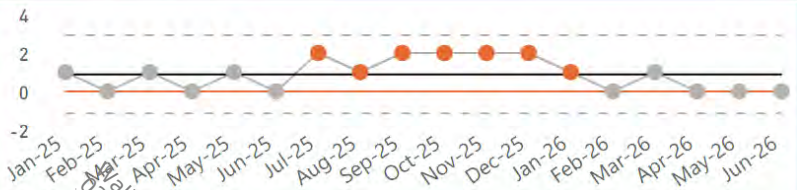
Jun-26

JPUH - PSII Number 1



NNUH – PSII Number 1

QEH - PSII Number 0



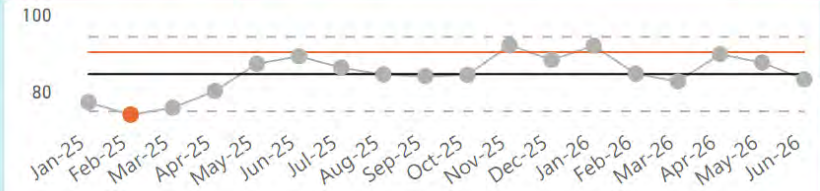
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	1	⊗	~	?	👁
NNUH	0	1	⊗	~	F	👁
QEH	0	0	✓	~	P	✓

Norfolk and Waveney University Hospitals Group

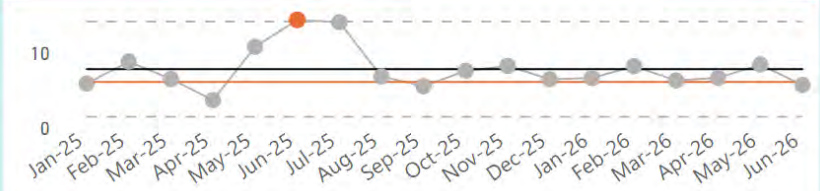
Safe and Effective Care Domain Appendix - Midwifery Fill Rate, Stillbirth Rate, Preterm Birth Rate

Jun-26

JPUH - Midwifery Fill Rate 82.90%

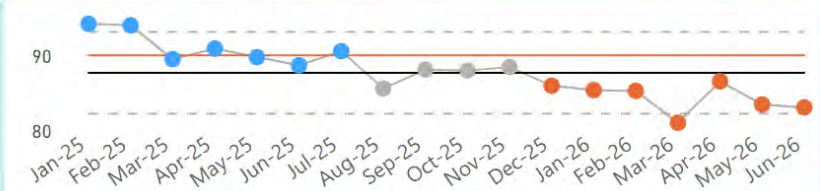


JPUH - Preterm Birth Rate 5.59%

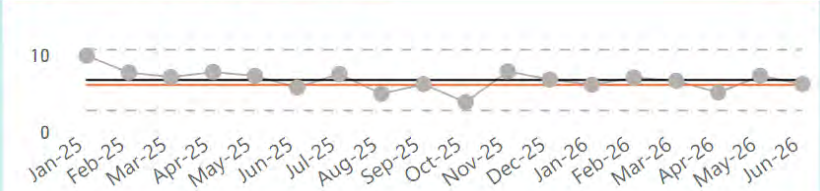


JPUH - Still Birth Rate 0.70%

NNUH - Midwifery Fill Rate 83.01%

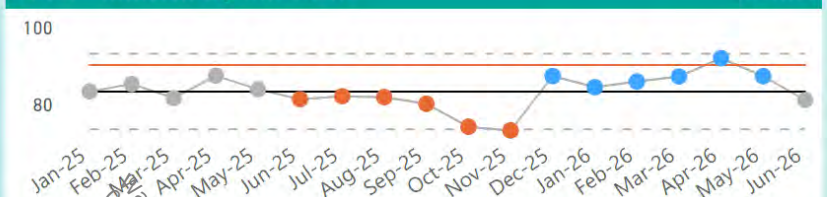


NNUH - Preterm Birth Rate 6.09%

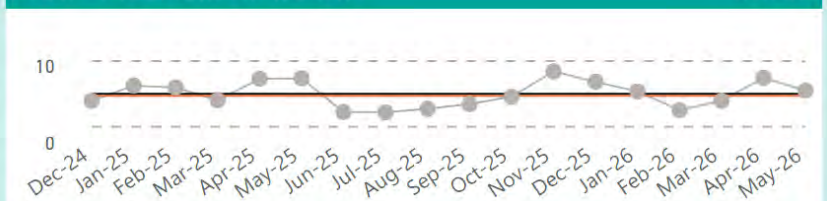


NNUH - Still Birth Rate 0.00%

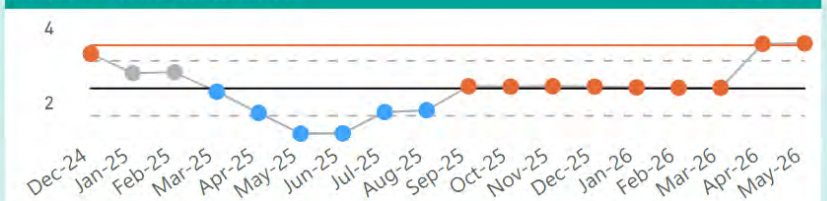
QEH - Midwifery Fill Rate 80.88%



QEH - Preterm Birth Rate 6.67%



QEH - Still Birth Rate 3.55%



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	82.90%				
NNUH	90.0%	83.01%				
QEH	90.0%	80.88%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	6.0%	5.59%				
NNUH	6.0%	6.09%				
QEH	6.0%	6.67%				

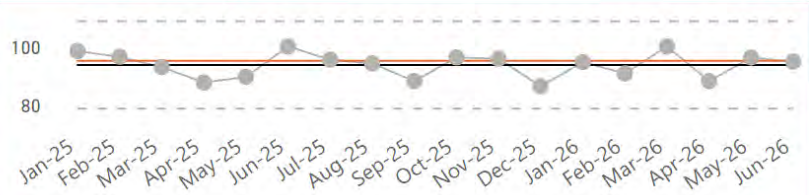
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3.5%	0.70%				
NNUH	3.5%	0.00%				
QEH	3.5%	3.55%				

Norfolk and Waveney University Hospitals Group

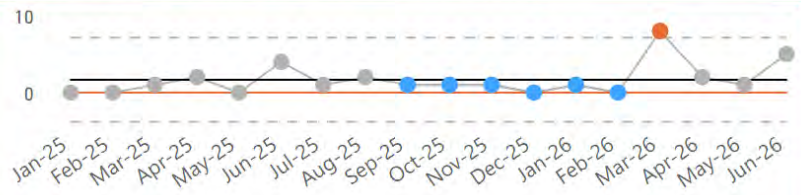
Safe and Effective Care Domain Appendix - FFT (Maternity) and Complaints (Maternity)

Jun-26

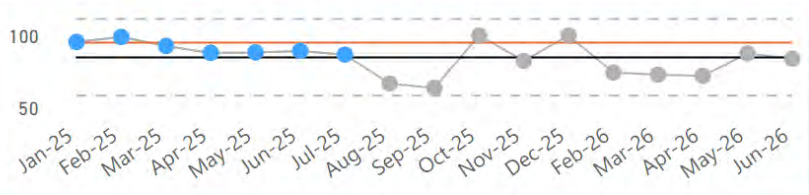
JPUH - Maternity FFT 94.74%



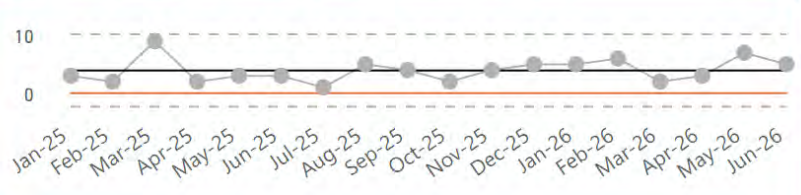
JPUH - Complaints Received - Maternity 5



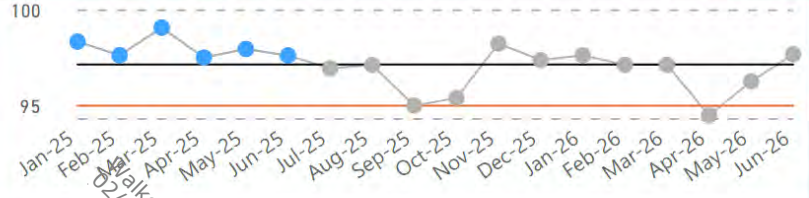
NNUH - Maternity FFT 83.87%



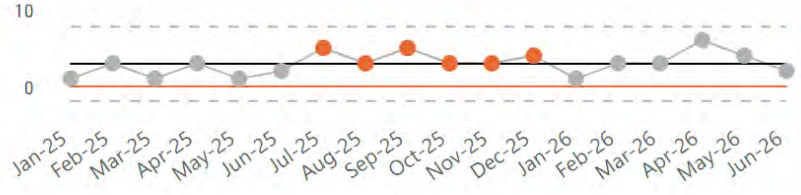
NNUH - Complaints Received - Maternity 5



QEH - Maternity FFT 97.67%



QEH - Complaints Received - Maternity 2



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	95.0%	94.74%	⊗	~	?	
NNUH	95.0%	83.87%	⊗	~	?	
QEH	95.0%	97.67%	✓	~	?	

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	5	⊗	~	?	
NNUH	0	5	⊗	~	?	
QEH	0	2	⊗	~	?	

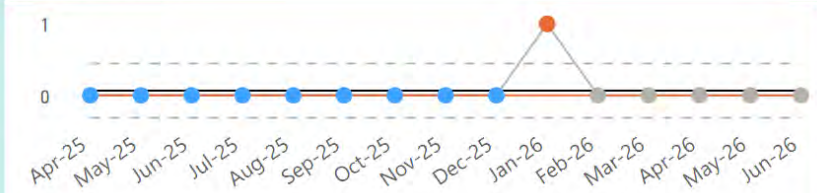
Norfolk and Waveney University Hospitals Group

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

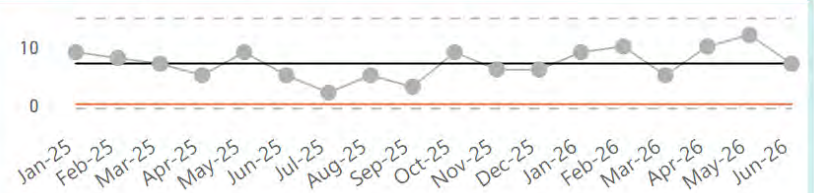
Jun-26

JPUH - 1:1 Care 100.00%

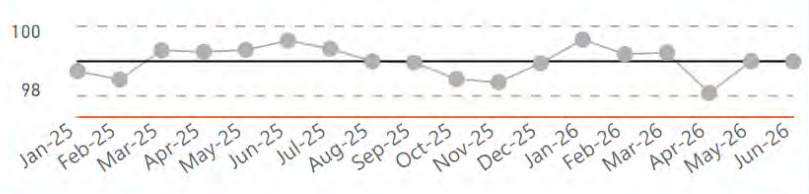
JPUH - MNSI 0



JPUH - Unplanned Admissions to NICU 7

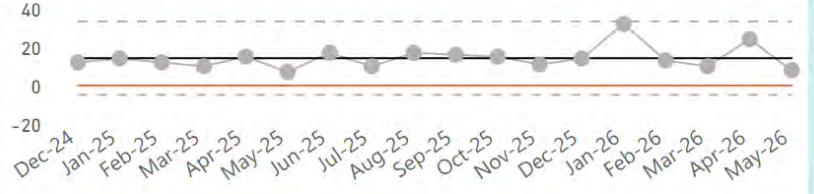


NNUH - 1:1 Care 98.93%

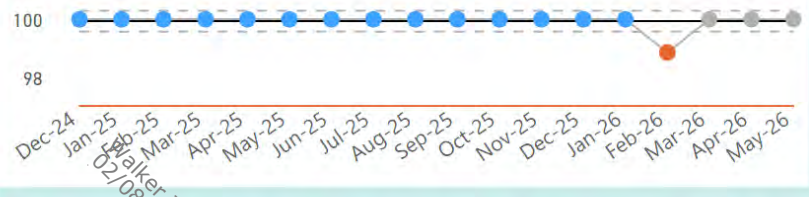


NNUH - MNSI 2

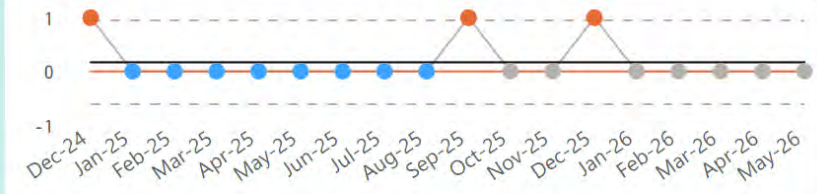
NNUH - Unplanned Admissions to NICU 8



QEH - 1:1 Care 100.00%



QEH - MNSI 0



-

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	97.0%	100.00%	✓	~	P	✓
NNUH	97.0%	98.93%	✓	~	P	✓
QEH	97.0%	100.00%	✓	~	P	✓

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	0	✓	~	P	✓
NNUH	0	2	✗	~	?	!
QEH	0	0	✓	~	P	✓

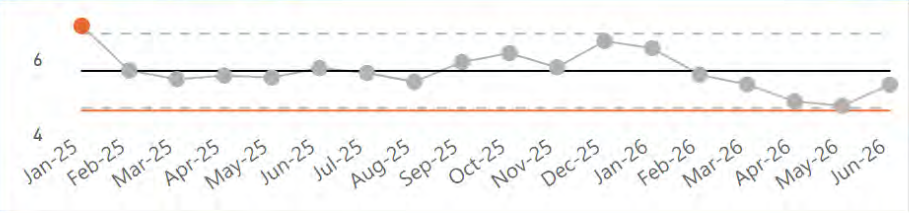
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	7	✗	~	?	!
NNUH	0	8	✗	~	?	!

Norfolk and Waveney University Hospitals Group

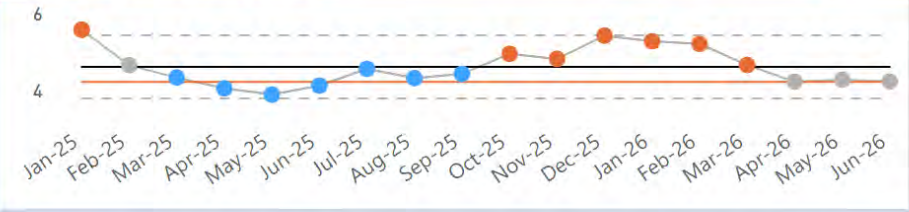
People and Culture Domain Appendix - Sickness and Turnover

Jun-26

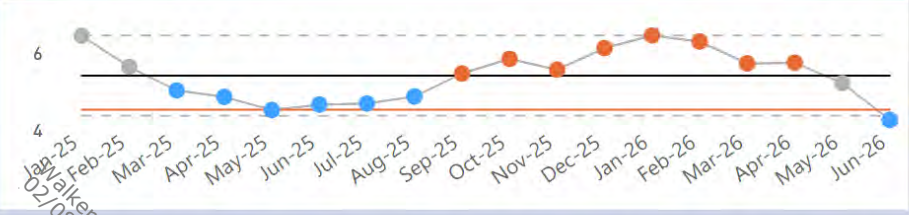
JPUH - Sickness Rate 5.29%



NNUH - Sickness Rate 4.21%

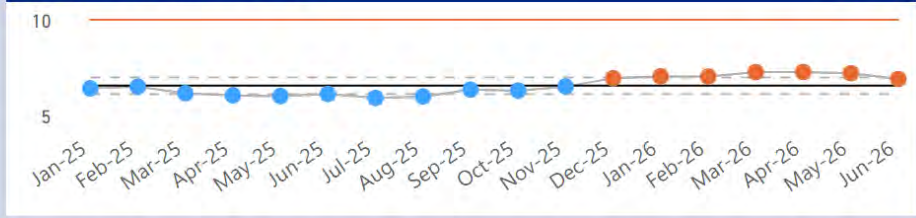


QEH - Sickness Rate 4.23%

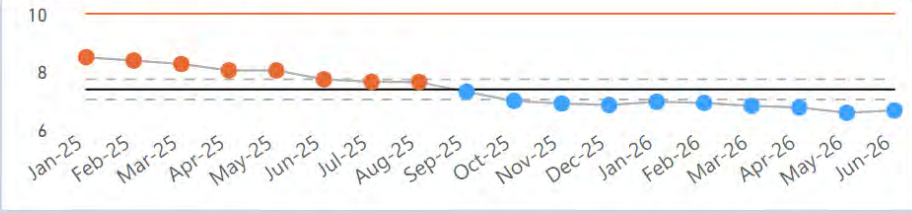


Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	4.6%	5.29%				
NNUH	4.2%	4.21%				
QEH	4.5%	4.23%				

JPUH - Turnover Rate 6.92%



NNUH - Turnover Rate 6.65%



QEH - Turnover Rate 9.90%

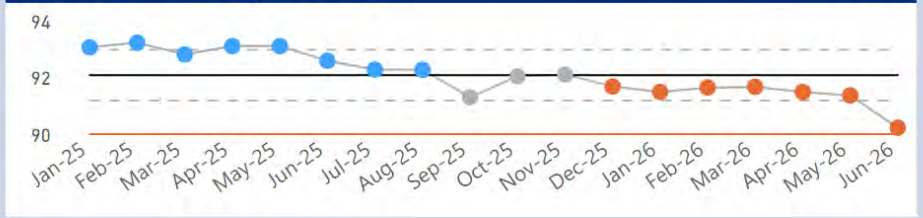
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	10.0%	6.92%				
NNUH	10.0%	6.65%				
QEH	10.0%	9.90%				

Norfolk and Waveney University Hospitals Group

People and Culture Domain Appendix - Mandatory Training and Appraisals

Jun-26

JPUH - Mandatory Training 90.22%

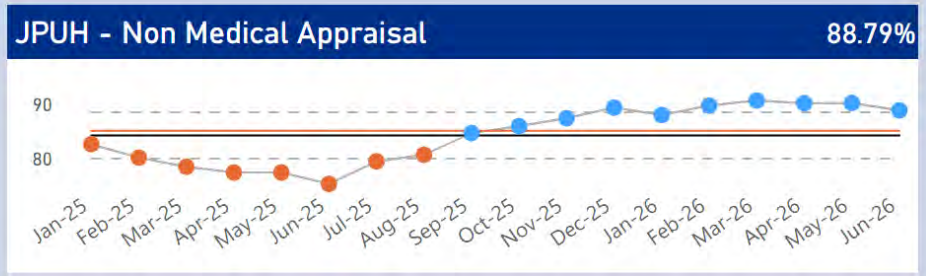


NNUH - Mandatory Training 93.14%

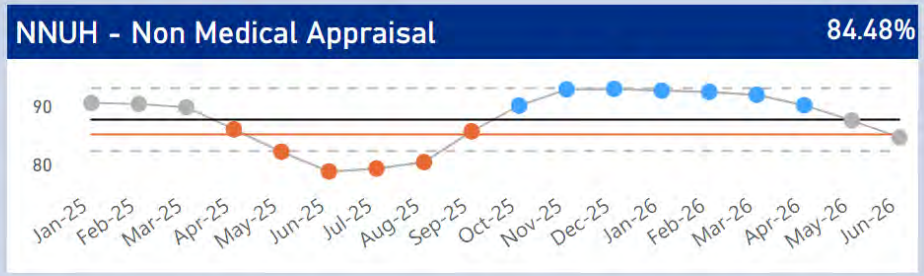
QEH - Mandatory Training 80.71%

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	90.22%	✓			
NNUH	90.0%	93.14%	✓			✓
QEH	90.0%	80.71%	✗			

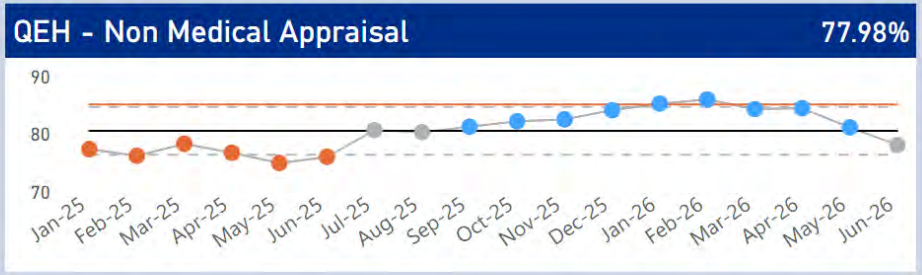
JPUH - Non Medical Appraisal 88.79%



NNUH - Non Medical Appraisal 84.48%



QEH - Non Medical Appraisal 77.98%



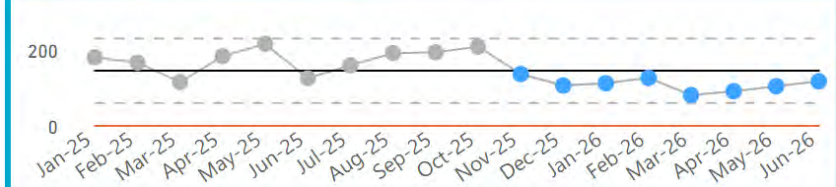
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	85.0%	88.79%	✓			
NNUH	85.0%	84.48%	✗			
QEH	85.0%	77.98%	✗			

Norfolk and Waveney University Hospitals Group

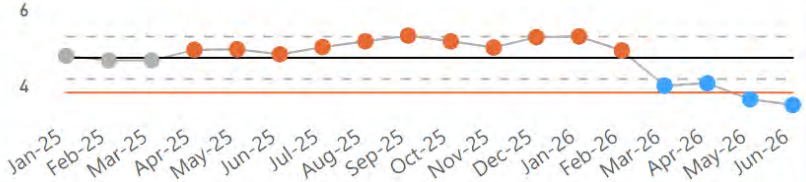
Access and Flow Domain Appendix - RTT

Jun-26

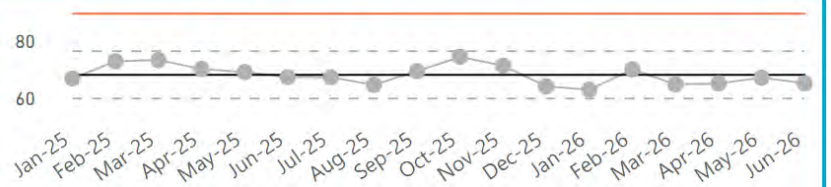
JPUH - 65+ Week Waits 117



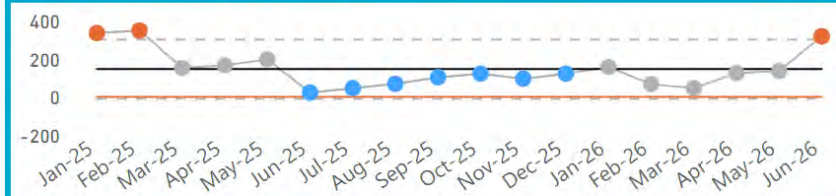
JPUH - 52+ Week Performance 3.47%



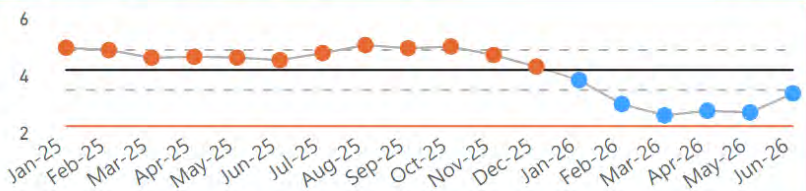
JPUH - 6 Week Diagnostics 64.93%



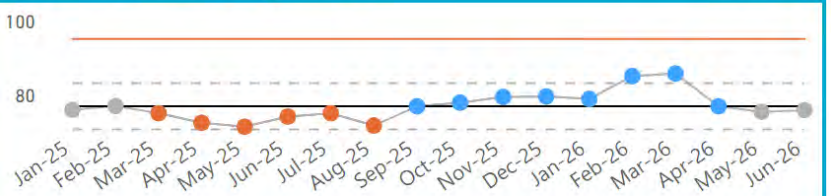
NNUH - 65+ Week Waits 317



NNUH - 52+ Week Performance 3.35%

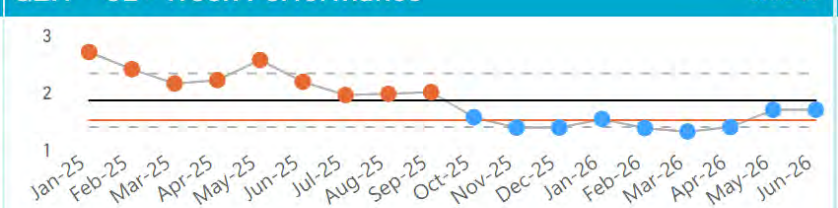


NNUH - 6 Week Diagnostics 75.81%

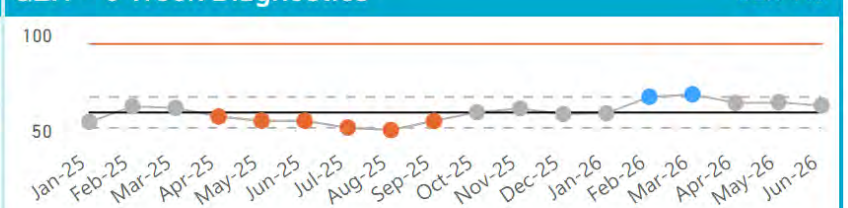


QEH - 65+ Week Waits 2

QEH - 52+ Week Performance 1.68%



QEH - 6 Week Diagnostics 62.71%



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	117				
NNUH	0	317				
QEH	0	2				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3.8%	3.47%				
NNUH	2.2%	3.35%				
QEH	1.5%	1.68%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	89.2%	64.93%				
NNUH	95.0%	75.81%				
QEH	95.0%	62.71%				

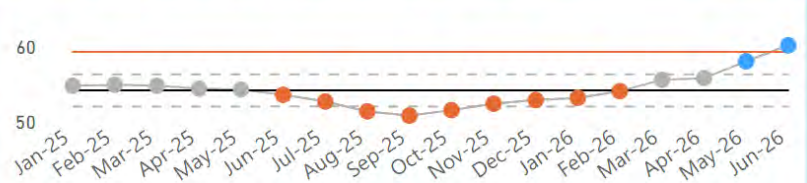
Norfolk and Waveney University Hospitals Group

Access and Flow Domain Appendix - RTT

Jun-26

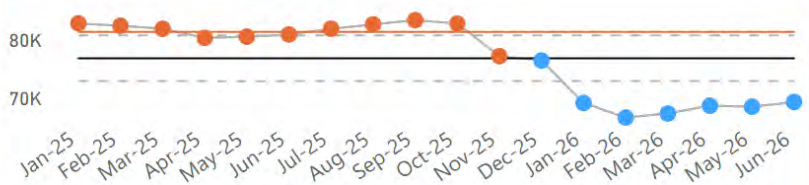
JPUH - Total PTL Size 31,349

JPUH - RTT Incomplete Within 18 weeks 60.08%



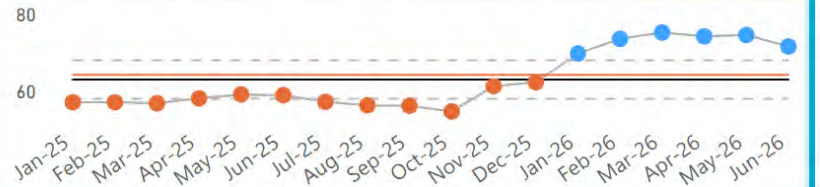
JPUH - First Attendance Within 18 Weeks 68.41%

NNUH - Total PTL Size 69,109

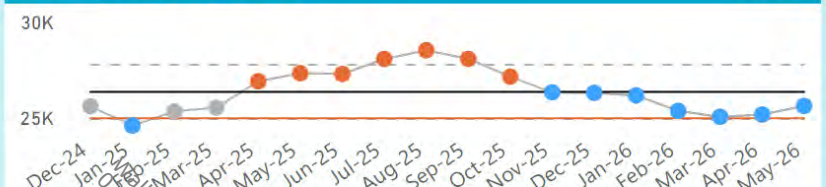


NNUH - RTT Incomplete Within 18 weeks 59.22%

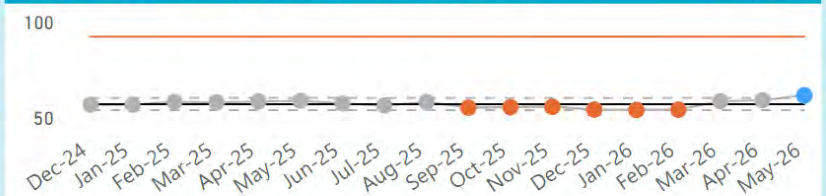
NNUH - First Attendance Within 18 Weeks 71.40%



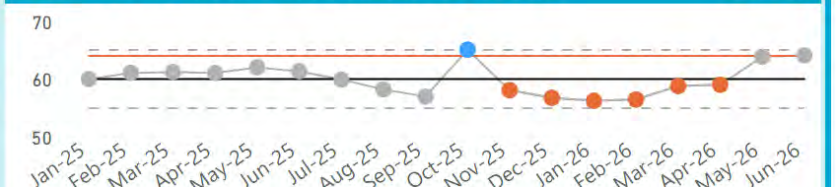
QEH - Total PTL Size 25,600



QEH - RTT Incomplete Within 18 weeks 61.49%



QEH - First Attendance Within 18 Weeks 64.10%



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	31,529	31,349	✓	L	F	
NNUH	81,265	69,109	✓	L	?	
QEH	24,963	25,600	✗	L	?	

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	59.2%	60.08%	✓	H	?	
NNUH	92.0%	59.22%	✗	H	?	
QEH	92.0%	61.49%	✗	H	?	

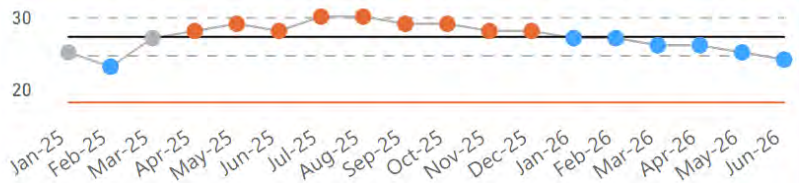
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	64.0%	68.41%	✓	H	?	
NNUH	64.0%	71.40%	✓	H	?	
QEH	64.0%	64.10%	✓	~	?	

Norfolk and Waveney University Hospitals Group

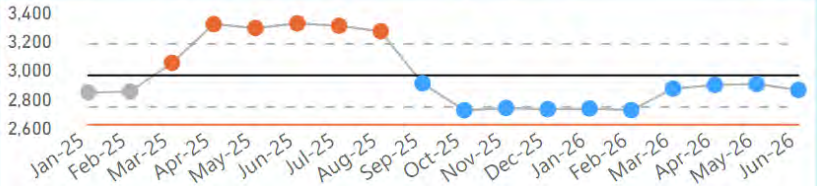
Access and Flow Domain Appendix - Clearance Times

Jun-26

JPUH - Estimated clearance times 24



JPUH - Under 18s elective waiting list size 2,856



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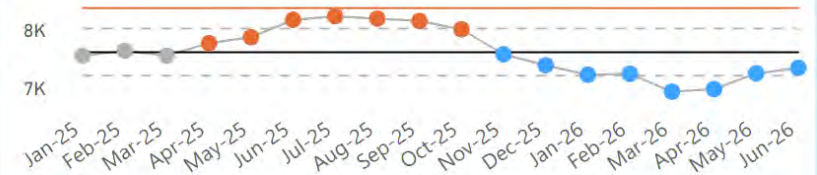
NNUH - Under 18s elective waiting list size 7,330



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Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	18	24				

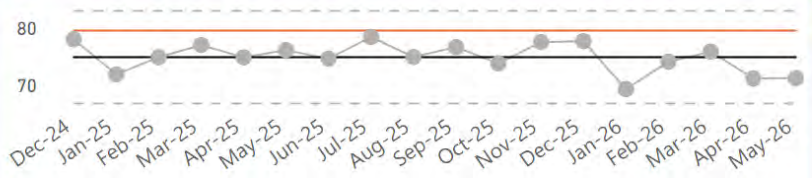
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	2,615	2,856				
NNUH	8,368	7,330				

Norfolk and Waveney University Hospitals Group

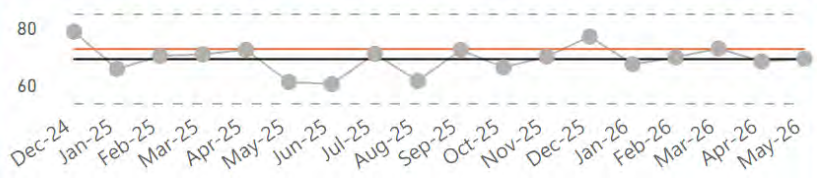
Access and Flow Domain Appendix - Cancer

Jun-26

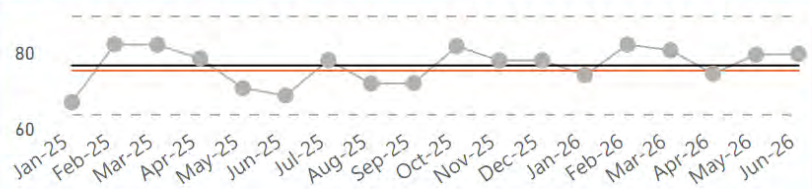
JPUH - 28 Day Faster Diagnosis 71.07%



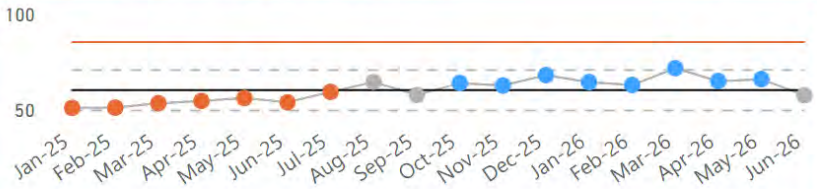
JPUH - Cancer 62 Day Treatment 68.91%



NNUH - 28 Day Faster Diagnosis 79.37%

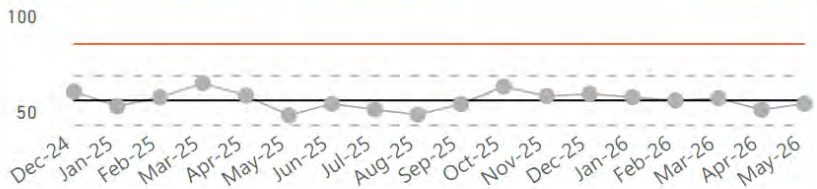


NNUH - Cancer 62 Day Treatment 57.08%



QEH - 28 Day Faster Diagnosis 68.56%

QEH - Cancer 62 Day Treatment 53.68%



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	79.4%	71.07%	⊗	~	?	
NNUH	75.0%	79.37%	✓	~	?	
QEH	75.0%	68.56%	⊗	~	?	

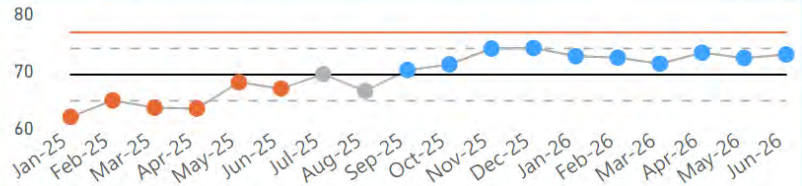
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	72.3%	68.91%	⊗	~	?	
NNUH	85.0%	57.08%	⊗	~	?	
QEH	85.0%	53.68%	⊗	~	?	

Norfolk and Waveney University Hospitals Group

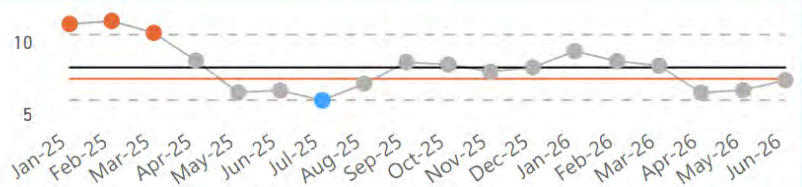
Access and Flow Domain Appendix - UEC

Jun-26

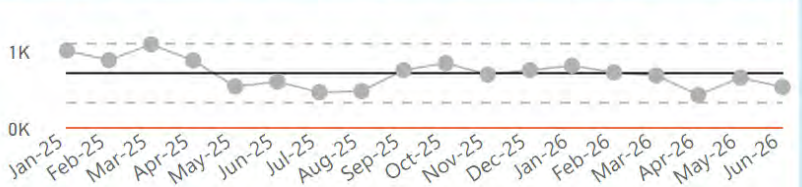
JPUH - ED 4 Hour Performance 72.67%



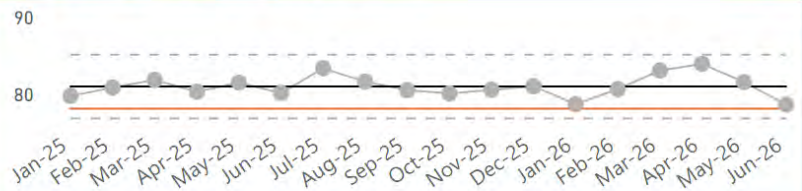
JPUH - ED 12 Hours in Department % 7.31%



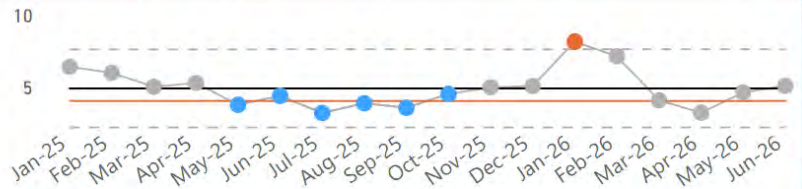
JPUH - Ambulance Handovers Over 30 Minutes 531



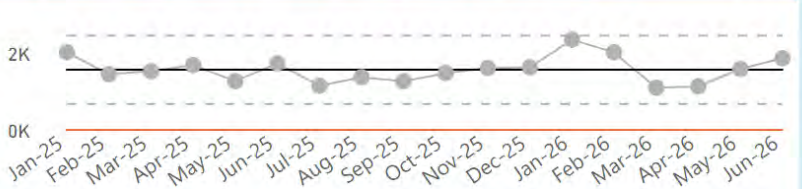
NNUH - ED 4 Hour Performance 78.55%



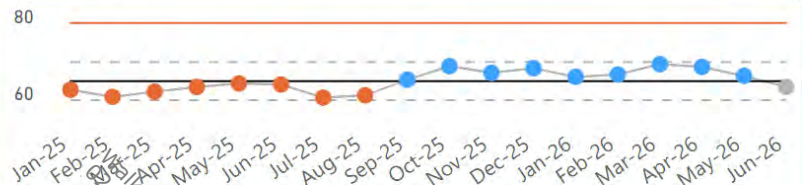
NNUH - ED 12 Hours in Department % 5.05%



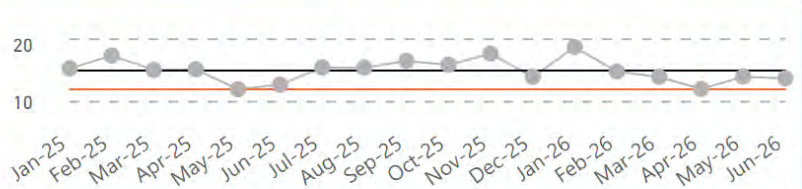
NNUH - Ambulance Handovers Over 30 Minutes 1,863



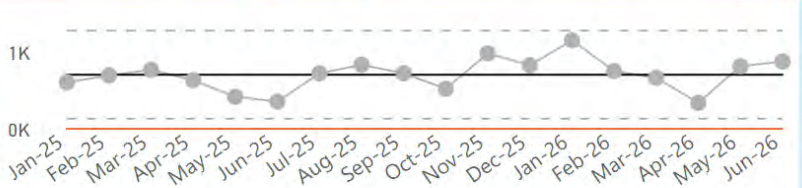
QEH - ED 4 Hour Performance 61.35%



QEH - ED 12 Hours in Department % 13.99%



QEH - Ambulance Handovers Over 30 Minutes 873



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	76.5%	72.67%	⊗	H	?	
NNUH	78.0%	78.55%	✓	~	?	
QEH	78.0%	61.35%	⊗	~	?	

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	7.4%	7.31%	✓	~	?	
NNUH	4.0%	5.05%	⊗	~	?	
QEH	12.1%	13.99%	⊗	~	?	

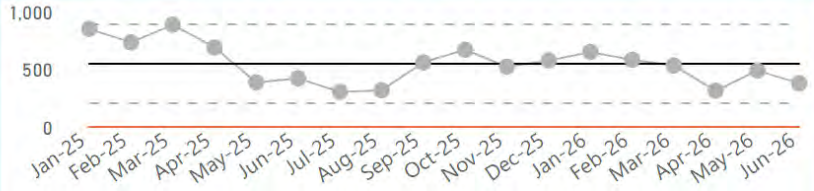
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	531	⊗	~	F	!
NNUH	0	1,863	⊗	~	F	!
QEH	0	873	⊗	~	F	!

Norfolk and Waveney University Hospitals Group

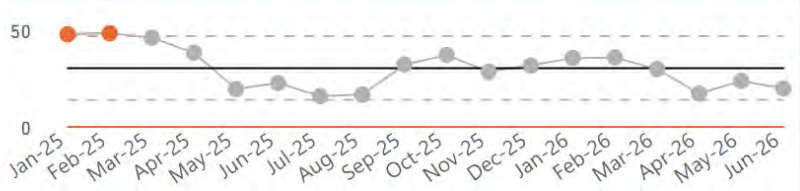
Access and Flow Domain Appendix - UEC

Jun-26

JPUH - Ambulance Handovers Over 45 Minutes 377

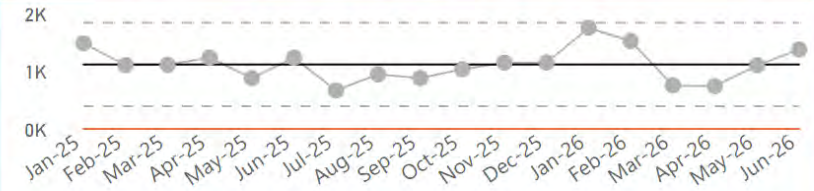


JPUH - Ambulance Handovers Over 45 Minutes % 19.97%

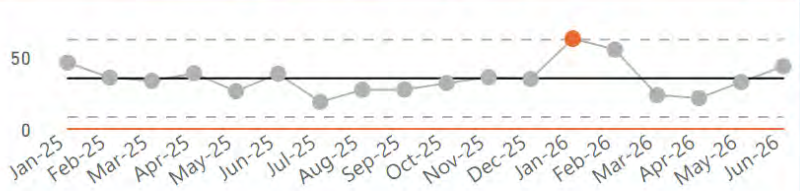


JPUH - Non Elective LoS 10.49

NNUH - Ambulance Handovers Over 45 Minutes 1,374



NNUH - Ambulance Handovers Over 45 Minutes % 43.41%



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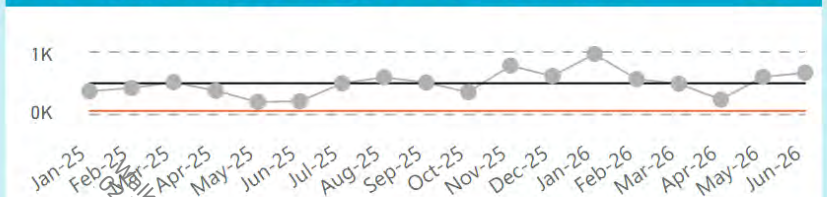
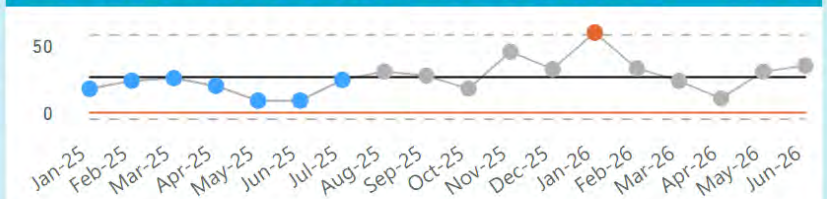
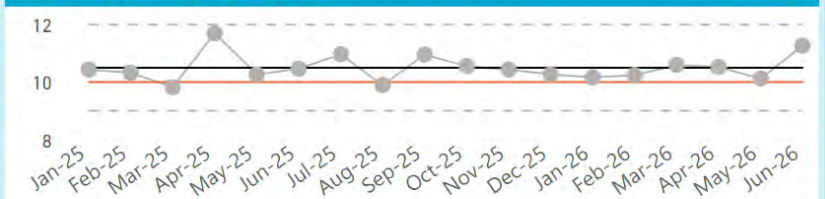
QEH - Ambulance Handovers Over 45 Minutes 659



QEH - Ambulance Handovers Over 45 Minutes % 34.90%



QEH - Non Elective LoS 11.26



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	377				
NNUH	0	1,374				
QEH	0	659				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0.0%	19.97%				
NNUH	0.0%	43.41%				
QEH	0.0%	34.90%				

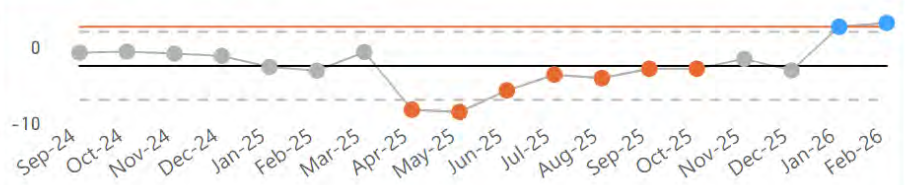
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	10	10.49				
QEH	10	11.26				

Norfolk and Waveney University Hospitals Group

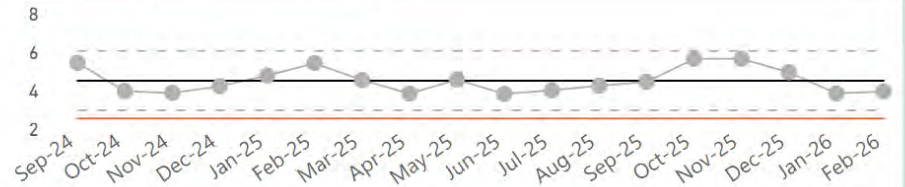
Productivity and Efficiency Domain Appendix

Feb-26

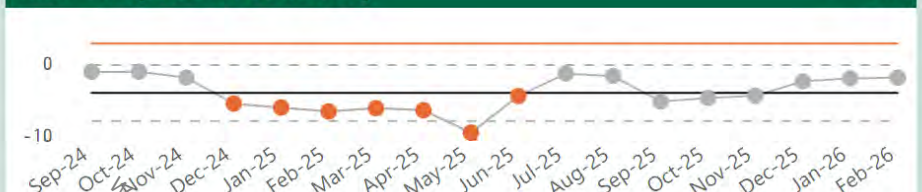
JPUH - Implied Productivity 3.00



NNUH - Implied Productivity 3.90



QEH - Implied Productivity -2.20



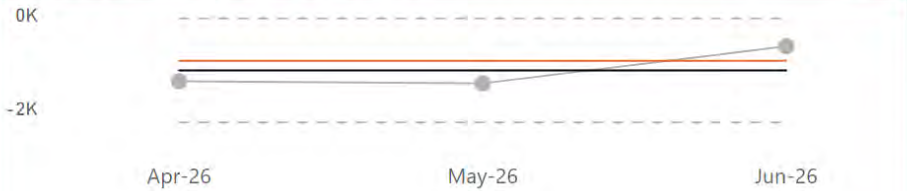
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3	3.00	✓	H	?	👁
NNUH	3	3.90	✓	~	P	✓
QEH	3	-2.20	✗	~	?	👁

Norfolk and Waveney University Hospitals Group

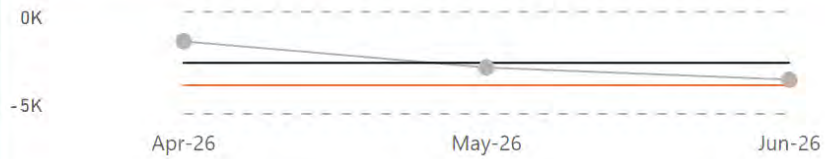
Productivity and Efficiency Domain Appendix

Jun-26

JPUH - Planned surplus/deficit -695

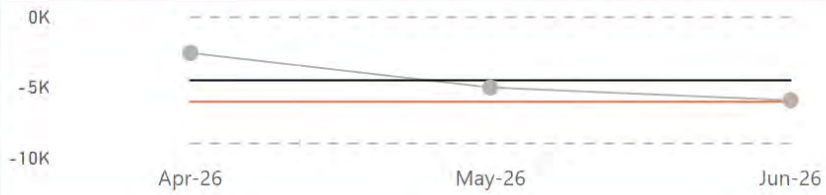


JPUH - YTD Surplus/deficit -3,614

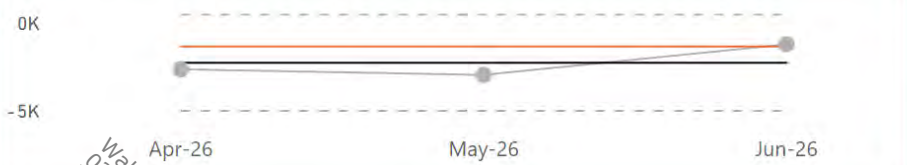


NNUH - Planned surplus/deficit -912

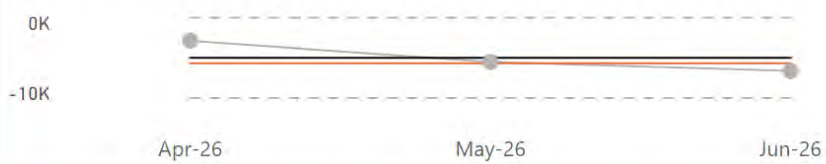
NNUH - YTD Surplus/deficit -6,005



QEH - Planned surplus/deficit -1,273



QEH - YTD Surplus/deficit -6,975



Walker Ian 02/08/2026 22:26:37

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	-1,003	-695				
NNUH	-979	-912				
QEH	-1,396	-1,273				

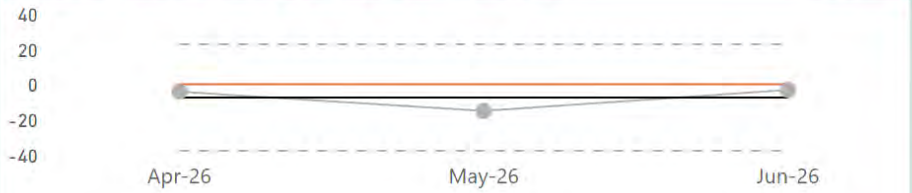
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	-3,932	-3,614				
NNUH	-6,112	-6,005				
QEH	-5,865	-6,975				

Norfolk and Waveney University Hospitals Group

Productivity and Efficiency Domain Appendix

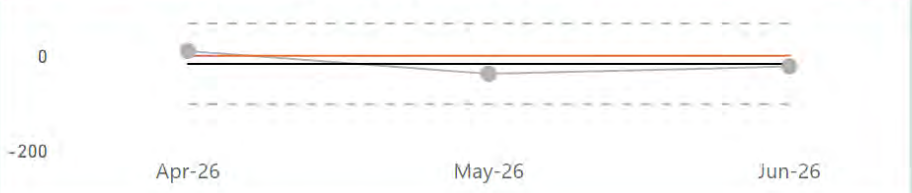
Jun-26

JPUH - Variance to Agency Spend Cap % -3.28%

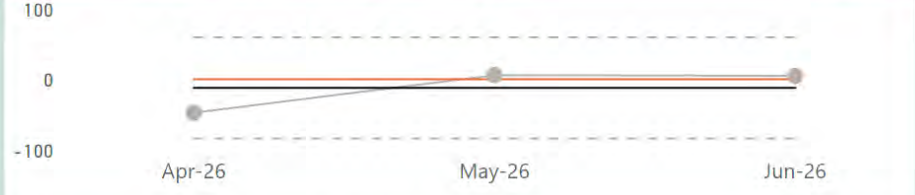


JPUH - Variance to Bank Spend Cap % 2.86%

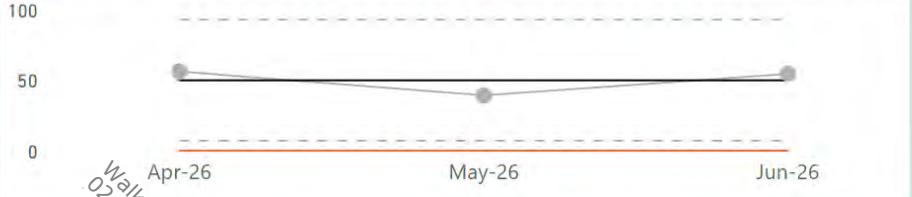
NNUH - Variance to Agency Spend Cap % -23.02%



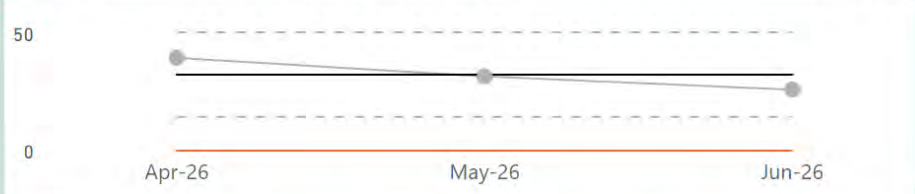
NNUH - Variance to Bank Spend Cap % 4.70%



QEH - Variance to Agency Spend Cap % 54.44%



QEH - Variance to Bank Spend Cap % 25.91%



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0.0%	-3.28%				
NNUH	0.0%	-23.02%				
QEH	0.0%	54.44%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0.0%	2.86%				
NNUH	0.0%	4.70%				
QEH	0.0%	25.91%				

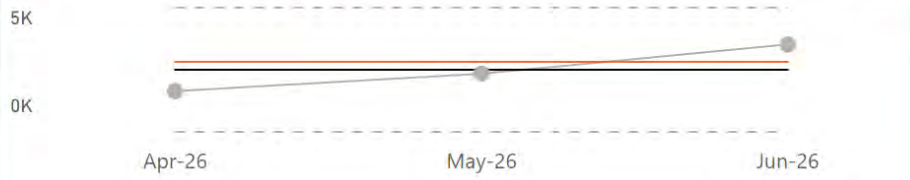
Norfolk and Waveney University Hospitals Group

Productivity and Efficiency Domain Appendix

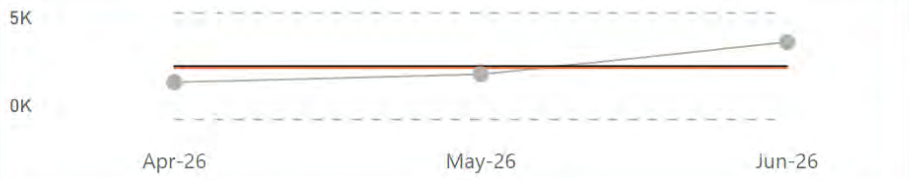
Jun-26

JPUH - Efficiency Plan £000 1,658

JPUH - Efficiency Plan YTD £000 3,406

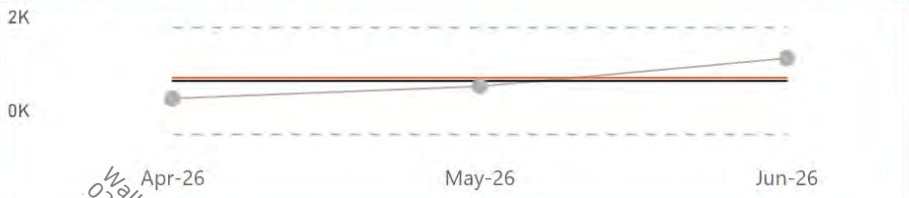


NNUH - Efficiency Plan £000 3,534



NNUH - Efficiency Plan YTD £000 6,502

QEH - Efficiency Plan £000 1,090



QEH - Efficiency Plan YTD £000 1,822

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	942	1,658				
NNUH	2,063	3,534				
QEH	679	1,090				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	2,422	3,406				
NNUH	6,071	6,502				
QEH	1,896	1,822				

Icon Descriptions

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

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

Understanding the Matrix

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

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	10.2		
Title	Group Finance Report Month 3		
Author(s)	Marcus Thorman, Group Chief Finance Officer		
Executive sponsor	Marcus Thorman, Group Chief Finance Officer		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

The Group reported a year-to-date deficit of £16.6m as at June 2026, which is £0.7m adverse to the planned £15.9m deficit. The net adverse variance all relates to QEH and is linked to the under-delivery of planned efficiencies and bank expenditure above the plan. There was an increase in variable pay expenditure (bank and agency) in the first two months compared to the previous financial year, however this has now reduced to the expected position.

The CIP programme has accelerated the value that has moved into delivery and there continues to be regular oversight of moving the programmes forward.

Some of the capital programmes are continuing at risk awaiting confirmation of funding from national programmes.

The full year forecast for 2026/27 remains breakeven, in line with the submitted financial plan.

Recommendations

The Group Board is asked to:

- Note the forecast breakeven position for the 2026/27 financial year and the level of Cost Improvement Programme (CIP) required to deliver this.
- Note that no change is proposed in the overall principal risk score.

Alignment to Board Assurance Framework risk(s)	Principal Risk 4 – Financial sustainability
Previously considered by	Group Risk Assurance Committee, 30 July 2026
Any background papers in Admin Control Reading Room	None

NHS
Norfolk and Waveney
University Hospitals Group

Norfolk and Waveney University Hospitals Group

Group Finance Report: June 2026

Group Board meeting: 5 August 2026

Marcus Thorman, Group Chief Finance Officer

Contents

Norfolk and Waveney University Hospitals Group

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

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

Norfolk and Waveney University Hospitals Group

1. Executive Summary

Financial Performance

Year to date the Group has reported a £16.6m deficit, which is £0.7m adverse to the planned £15.9m deficit. QEH is £1.1m adverse to plan and in the main is linked to the under-delivery of planned efficiencies and overspends in variable pay expenditure (bank and agency). An urgent action to review the controls in this area is in place to address the increase in expenditure. JPUH and NNUH are £0.3m & £0.1 favourable respectively.

Income performance is adverse by £1.0m year to date, driven primarily by activity shortfalls across the Group with NNUH: £0.8m adverse and QEH: £1.3m adverse. This reflects lower than planned activity levels, which is a key financial risk given the reliance on activity-based income delivery. June performance was £0.3m favourable with only QEH adverse (£0.4m)

Apart from the variable pay at QEH, financial performance pressures are linked to: industrial action (£0.4m impact) and ongoing workforce constraints, including reliance on bank and agency staff. These pressures align with wider risks on delivering workforce efficiency and agency reduction targets.

Non-pay performance shows an adverse variance of £2.0m however this is largely driven by income backed Research and Development and Cancer Alliance expenditure.

Despite the year to date variance, the full year forecast remains breakeven, in line with the submitted financial plan.

Productivity and Efficiency

On the CIP year-to-date performance there was £11.7m delivered vs £10.4m plan; a £1.3m favourable variance.

The overall programme position is £73.9m of schemes approved (Gateway 2) meaning a £28.2m shortfall against the £102.1m full-year CIP requirement. The key issues relate to insufficient recurrent schemes identified and mobilised, particularly at NNUH and QEH. JPUH has identified 100% of its CIP requirement.

CIP delivery represents the primary financial risk to achieving the breakeven plan. Early year to date underperformance and a significant pipeline gap indicate a requirement for urgent recovery actions.

Cash and Capital

There is still clarification required on the source of funds of some nationally funded capital schemes which means the schemes are currently forecasting an overspend. Clarification on these schemes are being worked through with the Regional team.

For cash the closing position in month was £138.2m, £68.9m favourable to plan, cash balances have decreased since the start of the year by £34.5m driven by timings mainly driven by timings of income received at NNUH and timings in cashflow seen at QEH relating to capital.. While liquidity is currently favourable, structural risks remain in-year if financial performance deteriorates, particularly at QEH based on the deficit support funding.

Risks

CIP Delivery Risk: high reliance on CIP to deliver financial balance; significant proportion of schemes remain high risk; shift from over £80m delivery in 2025/26 to identification challenge in 2026/27
Financial Performance Risk: plans assume delivery of breakeven position; underperformance in months 1 and 2 indicates early trajectory risk.
Workforce Risk (Bank/Agency): further reductions increasingly difficult; dependent on reducing sickness and escalation capacity
Cash Risk: ongoing cash fragility at QEH, requiring targeted management; risk to continued cash support if financial plan not delivered
Capital Risk: year to date delivery behind significantly behind plan, risk to in year delivery as programmes are further delayed

Norfolk and Waveney University Hospitals Group

1. Executive Dashboard

June position is a £3.0m deficit on a control total basis, £0.4m favourable to the planned £3.4m deficit.

The favourable variance is driven by JPUH and in the main is linked to the over-delivery of planned efficiencies.

Year to date position is a £16.6m deficit on a control total basis, which is £0.7m adverse to the planned £15.9m deficit.

The net adverse variance all relates to QEH and in the main is linked to the under-delivery of planned efficiencies and overspends in variable pay expenditure (bank and agency).

Forecast Outturn: Forecast outturn for the year remains breakeven, no change from the breakeven submitted plan.

Cash: Cash held on 30th June was £138.2m, £68.9m favourable to the planned £69.3m.

Capital Expenditure: Year-to-date capital spend is £19.7m, £28.9m behind the planned spend of £48.6m.

CIP: Year-to-date CIP delivery is £11.7m against a budgeted plan of £10.4m, a favourable variance of £1.3m, comprised of a favourable planning variance of £0.2m and a favourable performance variance of £1.1m. As at 3rd July 2026, the programme consists of £73.9m of Gateway 2 approved schemes. This is £28.2m adverse to the planned £102.1m full year CIP requirement.

Activity: Value-based activity performance for June was favourable by £0.3m, driven by favourable activity performance at JPUH (£0.7m) and NNUH (£0.1m) off set by an adverse variance at QEH of £0.4m. Year to date value-based activity performance is adverse by £1.0m, driven by favourable activity performance at JPUH (£1.0m) and NNUH (£0.8m) off set by an adverse variance at QEH of £1.3m.

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	In Month			Year To Date		
	Plan	Actual	Variance	Plan	Actual	Variance
SOCI	£m	£m	£m	£m	£m	£m
Clinical Income	124.9	124.2	(0.7)	365.5	366.5	1.0
Other Income	18.2	19.0	0.8	54.1	55.1	1.0
TOTAL INCOME	**143.0**	**143.1**	**0.1**	**419.6**	**421.6**	**2.0**
Pay	(94.7)	(94.2)	0.5	(280.4)	(279.9)	0.6
Non Pay	(40.2)	(39.7)	0.5	(118.8)	(120.9)	(2.0)
Drugs (Net Expenditure)	(4.5)	(4.8)	(0.3)	(13.7)	(15.3)	(1.6)
TOTAL EXPENDITURE	**(139.4)**	**(138.7)**	**0.7**	**(413.0)**	**(416.0)**	**(3.0)**
Non Opex	(7.0)	(7.4)	(0.4)	(22.5)	(22.2)	0.3
Control Total Surplus / (Deficit)	(3.4)	(3.0)	0.4	(15.9)	(16.6)	(0.7)
Statutory Surplus / (Deficit)	(2.4)	(1.9)	0.5	(13.1)	(13.7)	(0.6)

Other Financial Metrics						
	£m	£m	£m	£m	£m	£m
Cash at Bank (before support funding)	69.3	138.2	68.9	69.3	138.2	68.9
Capital Programme Expenditure	23.0	8.3	(14.7)	48.6	19.7	(28.9)
CIP Delivery	3.7	6.3	2.6	10.4	11.7	1.3
Aligned Payment Incentive (API) contract performance	75.1	75.4	0.3	221.5	220.5	(1.0)

Norfolk and Waveney University Hospitals Group

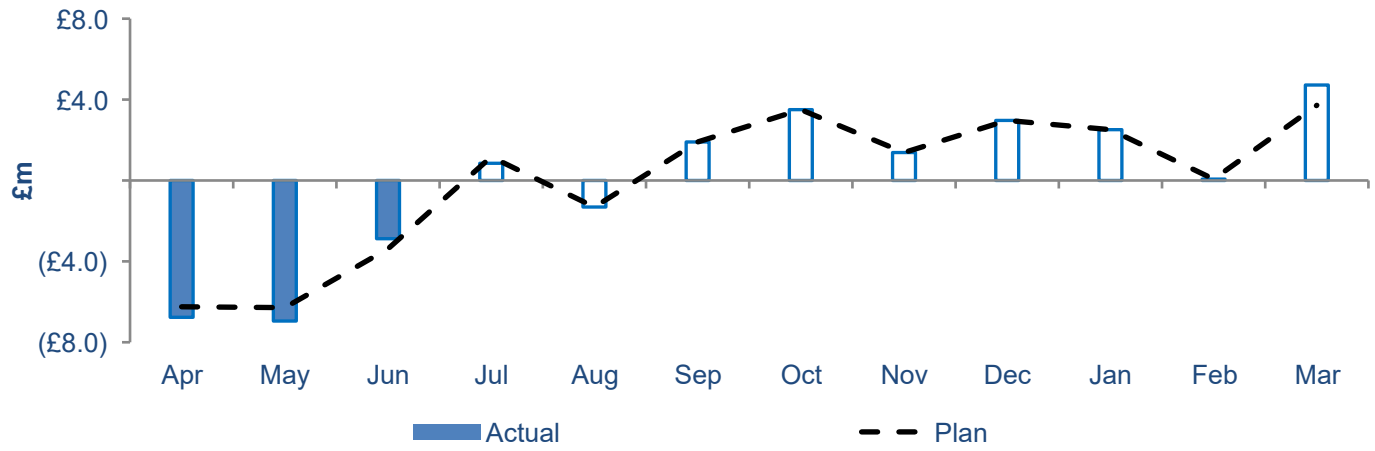
2.1 Financial Performance – Run Rate

June position is a £3.0m deficit on a control total basis, a £4.0m improvement to the May deficit of £7.0m.

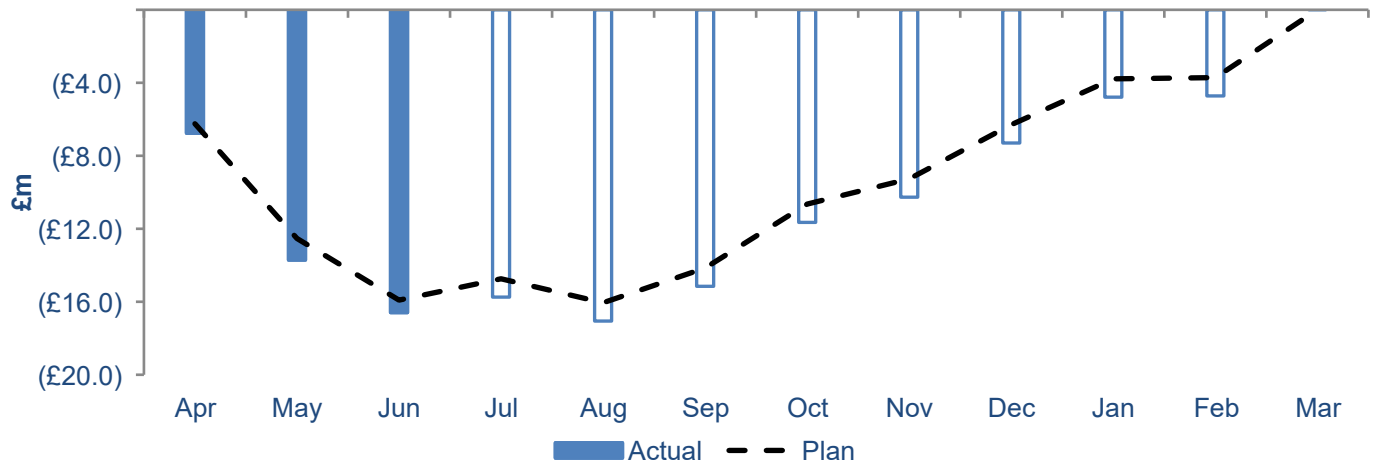
All three Trusts have seen significant run rate improvements in the month – JPUH by £0.8m, NNUH by £1.6m and QEH by £1.7m. The improvement is in the main driven by increased variable activity due to the higher number of working days (23 in June v May (19) & April (20)).

Forecast Outturn: Forecast outturn for the year remains breakeven, no change from the breakeven submitted plan. This requires an average monthly surplus of £1.8m per month, a favourable swing of £7.3m.

Monthly Actual/Forecast Surplus/(Deficit) v Plan



Cumulative Actual/Forecast Surplus/(Deficit) v Plan



Norfolk and Waveney University Hospitals Group

2.2 Financial Performance - SOCI

Year to date position is a £16.6m deficit on a control total basis, which is £0.7m adverse to the planned £15.9m deficit.

Jun-26	In Month			YTD			FOT		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical Income	124.9	124.2	(0.7)	365.5	366.5	1.0	1,476.2	1,479.0	2.8
NT Drugs Income	9.7	10.6	0.9	29.0	29.0	(0.0)	117.9	117.9	0.0
Total Clinical Income	**134.5**	**134.7**	**0.2**	**394.5**	**395.5**	**1.0**	**1,594.1**	**1,596.9**	**2.8**
Other Income Incl. Non NHS Clinical Income	18.2	19.0	0.8	54.1	55.1	1.0	216.3	216.3	(0.0)
Total Operating Income	**152.7**	**153.7**	**1.0**	**448.6**	**450.6**	**2.0**	**1,810.3**	**1,813.1**	**2.8**
Substantive	(79.5)	(74.9)	4.6	(232.1)	(221.1)	11.0	(1,041.4)	(1,043.0)	(1.6)
Bank	(7.1)	(11.0)	(3.9)	(21.2)	(32.5)	(11.3)	(31.1)	(30.9)	0.2
Agency	(4.3)	(4.3)	(0.0)	(13.1)	(12.2)	0.9	(9.1)	(9.1)	0.0
Other Employee Expenses	(3.8)	(4.0)	(0.1)	(14.0)	(14.1)	(0.0)	(5.8)	(5.8)	0.0
Total Employee Expenses	**(94.7)**	**(94.2)**	**0.5**	**(280.4)**	**(279.9)**	**0.6**	**(1,087.5)**	**(1,088.9)**	**(1.4)**
Drugs Costs	(14.2)	(15.4)	(1.2)	(42.7)	(44.2)	(1.6)	(171.0)	(171.0)	0.0
Clinical Supplies	(14.1)	(15.5)	(1.4)	(42.3)	(45.3)	(2.9)	(173.9)	(173.9)	0.0
Non Clinical Supplies	(23.7)	(21.8)	1.9	(67.7)	(66.8)	0.9	(246.7)	(249.5)	(2.8)
PFI	(2.4)	(2.4)	(0.0)	(8.8)	(8.8)	(0.0)	(37.3)	(37.3)	0.0
Total Expenditure Excl. Employee Expenses	**(54.3)**	**(55.1)**	**(0.7)**	**(161.5)**	**(165.1)**	**(3.6)**	**(628.9)**	**(631.7)**	**(2.8)**
Total Operating Expenditure	**(149.0)**	**(149.2)**	**(0.2)**	**(441.9)**	**(444.9)**	**(3.0)**	**(1,716.4)**	**(1,720.6)**	**(4.2)**
Total Operating Surplus/(Deficit)	**3.7**	**4.5**	**0.8**	**6.7**	**5.7**	**(1.0)**	**93.9**	**92.5**	**(1.4)**
Total Non Operating Expenditure	(5.9)	(6.2)	(0.4)	(19.1)	(18.7)	0.3	(79.3)	(79.3)	0.0
Adjust PFI revenue costs to UK GAAP basis	(1.2)	(1.2)	(0.0)	(3.5)	(3.5)	(0.1)	(14.4)	(14.4)	0.0
Control Total Surplus/(Deficit)	**(3.4)**	**(3.0)**	**0.4**	**(15.9)**	**(16.6)**	**(0.7)**	**0.2**	**(1.2)**	**(1.4)**
Control Total Adjustments									
Donated/Peppercorn lease Income & Equipment	0.0	0.1	0.1	(0.0)	0.2	0.3	(1.0)	(1.0)	0.0
Donated/ Peppercorn lease Assets Dep'n	(0.2)	(0.3)	(0.1)	(0.7)	(0.9)	(0.2)	0.2	0.2	(0.0)
Adjust PFI revenue costs to UK GAAP basis	1.2	1.2	0.0	3.5	3.5	0.1	14.4	14.4	0.0
Statutory Surplus / (Deficit)	**(2.4)**	**(2.0)**	**0.5**	**(13.1)**	**(13.7)**	**(0.6)**	**13.8**	**12.4**	**(1.4)**

Norfolk and Waveney University Hospitals Group

2.3 Financial Performance – Trust Performance

Year to Date	JPUH Plan £m	JPUH Actual £m	JPUH Variance £m	NNUH Plan £m	NNUH Actual £m	NNUH Variance £m	QEH Plan £m	QEH Actual £m	QEH Variance £m
Total Operating Income	89.7	90.8	1.1	275.8	276.3	0.4	83.0	83.5	0.5
Total Employee Expenses	(60.7)	(61.1)	(0.4)	(161.7)	(159.2)	2.6	(57.9)	(59.6)	(1.7)
Total Expenditure Excl. Employee Expenses	(32.4)	(32.8)	(0.3)	(99.0)	(102.0)	(3.1)	(30.1)	(30.3)	(0.2)
Total Operating Expenditure	(93.1)	(93.9)	(0.7)	(260.7)	(261.2)	(0.4)	(88.0)	(89.9)	(1.8)
Total Operating Surplus/(Deficit)	(3.4)	(3.1)	0.3	15.1	15.1	0.0	(5.0)	(6.3)	(1.3)
Total Non Operating Expenditure	(0.5)	(0.5)	(0.0)	(17.7)	(17.5)	0.1	(0.9)	(0.6)	0.2
Adjust PFI revenue costs to UK GAAP basis	0.0	0.0	0.0	(3.5)	(3.5)	(0.1)	0.0	0.0	0.0
Control Total Surplus/(Deficit)	(3.9)	(3.6)	0.3	(6.1)	(6.0)	0.1	(5.9)	(7.0)	(1.1)
Statutory Surplus / (Deficit)	(4.0)	(3.7)	0.3	(3.1)	(2.8)	(0.1)	(6.0)	(7.1)	(1.1)

	JPUH Plan £m	JPUH Actual £m	JPUH Variance £m	NNUH Plan £m	NNUH Actual £m	NNUH Variance £m	QEH Plan £m	QEH Actual £m	QEH Variance £m
Cash at Bank (before support funding)	6.8	41.1	34.3	51.9	84.0	32.1	10.6	13.1	2.5
Capital Programme Expenditure	13.4	6.4	(7.0)	13.1	5.4	(7.7)	22.1	7.9	(14.2)
CIP Delivery	2.4	3.4	1.0	6.1	6.5	0.4	1.9	1.8	(0.1)
Aligned Payment Incentive (API) contract performance	53.8	54.8	1.0	125.1	124.4	(0.8)	42.6	41.3	(1.3)

The year-to-date position is a deficit of £3.6m, this is £0.3m favourable to the planned deficit of £3.9m. This is mainly driven by a favourable CIP delivery of £1.0m offset by £0.3m of expenditure associated with the Industrial Action in April and a £0.4m overspend on pay across substantive and bank staff.

The year-to-date position is a £6.0m deficit on a control total basis, £0.1m favourable to the planned £6.1m deficit. Underperformance of variable activity of £0.8m, net drugs expenditure of £0.6m adverse, and clinical supplies of £1.3m adverse are offset by circa £1.5m relating to the delayed utilisation of service development and investment funding. Care Group pay is £1.3m underspent (including the costs associated with Industrial Action). The impact of the industrial action is estimated to be c. £0.8m, of which £0.5m relates to activity and £0.3m relates to pay expenditure.

The year-to-date position is a deficit of £7.0m, this is £1.1m adverse to a planned deficit of £5.9m. This is mainly due to overspends on the use of temporary staff, under-delivery of efficiencies, and under-delivery of activity leading to lower than planned clinical income. FOT remains on plan.

Norfolk and Waveney University Hospitals Group

2.3 Financial Performance – Variable Activity

Year to date value based activity is £1.0m adverse to plan, the in month position was £0.3m favourable.

Performance v value based activity plan	JPUH YTD Plan £m	JPUH YTD Actual £m	JPUH Variance to Plan £m	NNUH YTD Plan £m	NNUH YTD Actual £m	NNUH Variance to Plan £m	QEH YTD Plan £m	QEH YTD Actual £m	QEH Variance to Plan £m	N&W GROUP YTD Plan £m	N&W GROUP YTD Actual £m	N&W GROUP Variance to Plan £m	N&W GROUP Performance v Plan %
Day Case	9.0	8.7	(0.3)	19.1	19.0	(0.1)	6.3	6.5	0.2	34.4	34.2	(0.2)	99%
Elective Inpatient	5.6	5.7	0.1	14.3	14.8	0.5	3.1	2.4	(0.7)	23.0	22.9	(0.1)	100%
Outpatients - New	4.2	4.5	0.3	8.6	8.0	(0.6)	3.5	3.6	0.1	16.3	16.1	(0.2)	99%
Outpatients - Procedures	3.0	3.2	0.2	8.6	8.1	(0.5)	2.3	1.9	(0.4)	13.9	13.3	(0.7)	95%
Total Elective Value	**21.8**	**22.1**	**0.3**	**50.6**	**50.0**	**(0.6)**	**15.2**	**14.4**	**(0.8)**	**87.5**	**86.4**	**(1.1)**	**99%**
Urgent and Emergency Care (UEC)*	**28.4**	**29.1**	**0.7**	**66.7**	**67.0**	**0.3**	**25.4**	**25.0**	**(0.4)**	**120.5**	**121.1**	**0.6**	**100%**
Diagnostic Imaging	1.6	1.9	0.3	2.7	2.6	(0.1)	0.9	0.9	0.0	5.2	5.4	0.2	104%
Chemotherapy Delivery	0.0	0.0	0.0	2.2	2.1	(0.1)	0.5	0.5	0.0	2.7	2.6	(0.1)	97%
Community Diagnostic Centre	2.1	1.8	(0.3)	3.0	2.7	(0.3)	0.6	0.5	(0.1)	5.6	5.0	(0.6)	89%
Total Other Chargeable API	**3.6**	**3.7**	**0.0**	**7.8**	**7.4**	**(0.5)**	**2.0**	**1.9**	**(0.1)**	**13.5**	**13.0**	**(0.5)**	**96%**
Total with adjustment	**53.8**	**54.8**	**1.0**	**125.1**	**124.4**	**(0.8)**	**42.6**	**41.3**	**(1.3)**	**221.5**	**220.5**	**(1.0)**	**100%**

*Variance to plan recognised at 20% of actual value

Performance v value based activity plan	JPUH June Plan £m	JPUH June Actual £m	JPUH Variance to Plan £m	NNUH June Plan £m	NNUH June Actual £m	NNUH Variance to Plan £m	QEH June Plan £m	QEH June Actual £m	QEH Variance to Plan £m	N&W GROUP June Plan £m	N&W GROUP June Actual £m	N&W GROUP Variance to Plan £m	N&W GROUP Performance v Plan %
Day Case	3.2	3.2	(0.0)	6.9	6.9	(0.0)	2.3	2.4	0.1	12.4	12.4	0.1	100%
Elective Inpatient	1.9	2.0	0.2	4.9	5.4	0.5	1.1	0.9	(0.2)	7.9	8.3	0.5	106%
Outpatients - New	1.5	1.6	0.1	3.0	3.0	(0.1)	1.2	1.4	0.2	5.7	6.0	0.3	105%
Outpatients - Procedures	1.1	1.1	0.1	3.0	2.8	(0.2)	0.8	0.4	(0.4)	4.9	4.3	(0.5)	89%
Total Elective Value	**7.6**	**8.0**	**0.4**	**17.8**	**18.0**	**0.2**	**5.4**	**5.1**	**(0.3)**	**30.8**	**31.1**	**0.3**	**101%**
Urgent and Emergency Care (UEC)*	**9.1**	**9.4**	**0.3**	**21.9**	**22.1**	**0.2**	**8.4**	**8.3**	**(0.1)**	**39.4**	**39.8**	**0.4**	**101%**
Diagnostic Imaging	0.5	0.6	0.1	1.0	0.9	(0.1)	0.3	0.3	0.0	1.8	1.8	0.0	101%
Chemotherapy Delivery	0.0	0.0	0.0	0.8	0.7	(0.1)	0.2	0.2	0.0	1.0	0.9	(0.1)	91%
Community Diagnostic Centre	0.7	0.6	(0.1)	0.9	0.8	(0.1)	0.3	0.3	0.0	2.0	1.7	(0.2)	88%
Total Other Chargeable API	**1.3**	**1.2**	**(0.0)**	**2.7**	**2.4**	**(0.3)**	**0.8**	**0.8**	**0.0**	**4.8**	**4.4**	**(0.3)**	**93%**
Total	**18.0**	**18.6**	**0.7**	**42.5**	**42.5**	**0.1**	**14.6**	**14.2**	**(0.4)**	**75.1**	**75.4**	**0.3**	**100%**

*Variance to plan recognised at 20% of actual value

Norfolk and Waveney University Hospitals Group

3. CIP

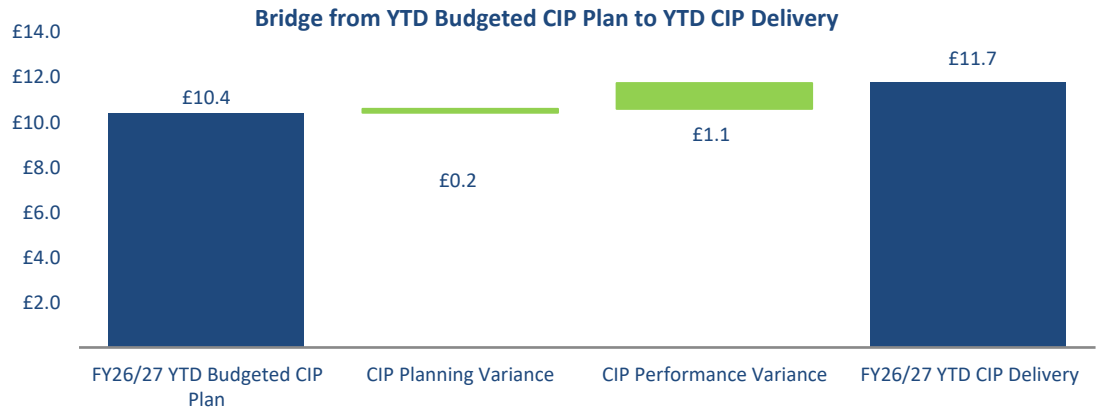
Year-to-date CIP delivery is £11.7m against a budgeted plan of £10.4m, a favourable variance of £1.3m, comprised of a favourable planning variance of £0.2m and a favourable performance variance of £1.1m. As at 3rd July 2026, the programme consists of £73.9m of Gateway 2 approved schemes. This is £28.2m adverse to the planned £102.1m full year CIP requirement.

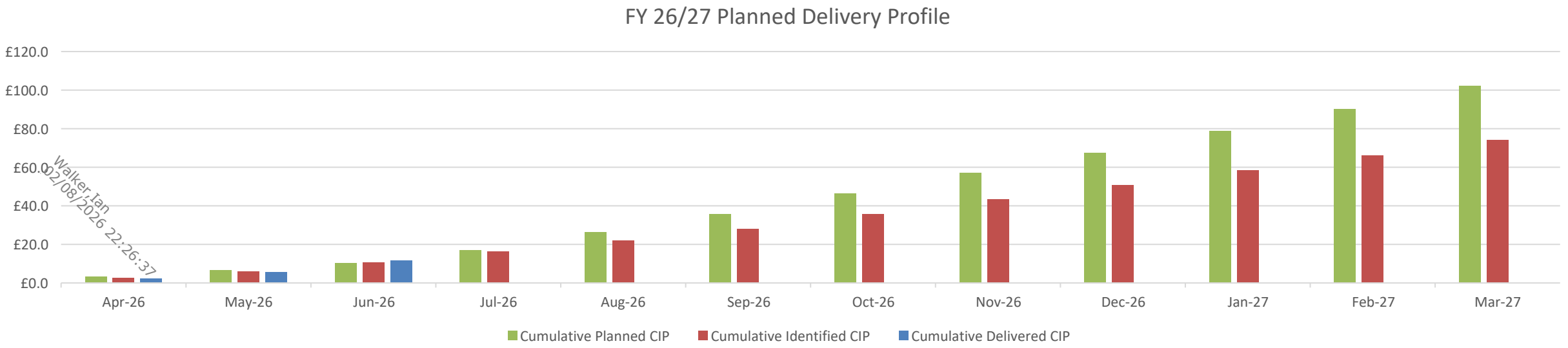
FY26/27 CIP Programme Delivery

Year to date the Group has delivered £11.7m of CIPs against a budgeted plan of £10.4m, a favourable variance of £1.3m, comprised of (see bridge):

- A favourable planning variance of £0.2m; and
- A favourable performance variance of £1.1m.

As at 3rd July 2026, the programme consists of £73.9m of Gateway 2 approved schemes. This is £28.2m adverse to the planned £102.1m full year CIP requirement. This has arisen as a result of insufficient recurrent schemes being identified and progressed through Gateways for implementation and delivery at NNUH & QEH. JPUH have identified 100% of planned CIP for 2026/27.



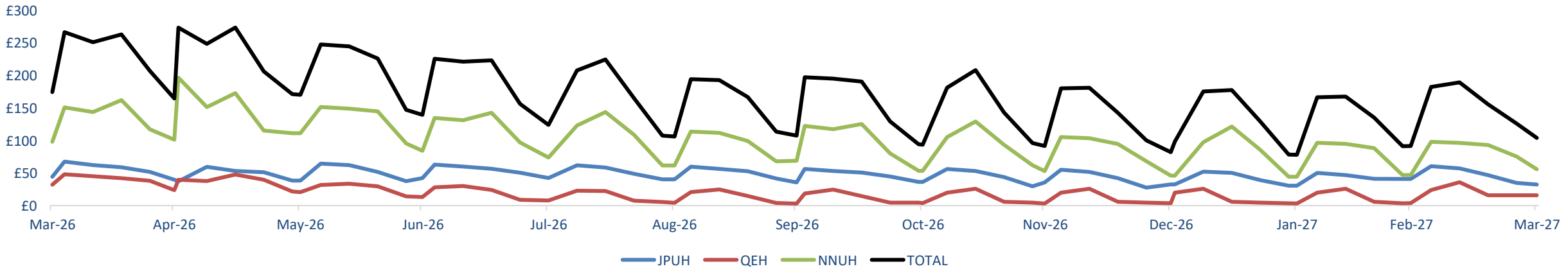


Norfolk and Waveney University Hospitals Group

4. Cash

Cash held on 30th June was £138.2m, £68.9m favourable to the planned £69.3m. Cash balances have decreased since the start of the year by £34.5m mainly driven by timings of income received at NNUH and timings in cashflow seen at QEH relating to capital.

Weekly Closing Cash (£m)



Aged Debtors: Debtors on 30th June were £33.7m, £1.4m higher than May 2026 driven by timing of invoice payments at NNUH. £14.9m is over 90 days. Of the Non-NHS debt greater than 90 days £2.5m relates to an ongoing legal dispute. The Trusts continue to focus on resolving these debts and a bad debt provision of £11.0m is being held.

Debtors £m	Total Debt			Debt > 90 days		
	Apr-26 £m	May-26 £m	Jun-26 £m	Apr-26 £m	May-26 £m	Jun-26 £m
NHS	33.9	22.9	26.0	6.8	8.1	9.7
Non NHS	9.6	9.4	7.7	6.7	6.5	5.1
Total	43.5	32.3	33.7	13.6	14.7	14.9

Aged Debt Profile

Norfolk and Waveney University Hospitals Group

5. Statement of Financial Position

The Statement of Financial Position at the end of June has decreased by £5.2m compared to the opening balance.

	JPUH			NNUH			QEH			N&W GROUP		
	Mar-26 £m	Jun-26 £m	YTD Movement £m	Mar-26 £m	Jun-26 £m	YTD Movement £m	Mar-26 £m	Jun-26 £m	YTD Movement £m	Mar-26 £m	Jun-26 £m	YTD Movement £m
Property, plant and equipment	169.5	172.8	3.3	444.7	443.7	(1.0)	176.8	182.1	5.3	791.0	798.6	7.6
Right of use assets - leased assets	2.1	1.9	(0.2)	44.5	42.3	(2.2)	4.1	3.8	(0.3)	50.7	48.0	(2.7)
Receivables: due from DHSC group bodies	0.0	0.0	0.0	3.1	2.9	(0.2)	0.0	0.0	0.0	3.1	2.9	(0.2)
Receivables: due from non-DHSC bodies	0.5	0.5	0.1	53.0	54.5	1.5	0.5	0.3	(0.2)	54.0	55.3	1.4
Total non-current assets	**172.1**	**175.2**	**3.1**	**545.3**	**543.4**	**(1.9)**	**181.4**	**186.2**	**4.8**	**898.8**	**904.8**	**6.0**
Inventories	3.6	3.3	(0.2)	20.2	21.2	1.0	3.3	3.1	(0.2)	27.1	27.6	0.6
Receivables: due from DHSC group bodies	8.6	8.4	(0.2)	28.3	30.4	2.1	2.8	4.7	1.9	39.7	43.5	3.8
Receivables: due from non-DHSC group bodies	7.8	9.0	1.2	32.5	31.8	(0.7)	6.1	5.5	(0.6)	46.4	46.3	(0.1)
Assets held for sale	0.7	0.7	0.0	0.0	0.0	0.0						
Cash and cash equivalents	44.3	41.1	(3.2)	96.4	80.5	(15.9)	32.0	13.1	(18.9)	172.7	134.7	(38.0)
Total current assets	**64.9**	**62.5**	**(2.4)**	**177.4**	**163.9**	**(13.5)**	**44.2**	**26.4**	**(17.8)**	**286.5**	**252.8**	**(33.7)**
Trade and other payables: capital	(15.2)	(9.6)	5.6	(23.0)	(16.8)	6.2	(7.6)	(2.2)	5.4	(45.8)	(28.6)	17.2
Trade and other payables: non-capital	(33.3)	(36.7)	(3.4)	(125.2)	(124.2)	1.0	(49.1)	(46.0)	3.1	(207.6)	(206.9)	0.7
Borrowings - PFI	0.0	0.0	0.0	(20.5)	(20.5)	0.0	0.0	0.0	0.0	(20.5)	(20.5)	0.0
Borrowings: leases current	(0.8)	(0.6)	0.1	(8.4)	(8.1)	0.3	(0.2)	(0.4)	(0.2)	(9.4)	(9.1)	0.2
Current provisions	(0.3)	(0.3)	0.0	(3.9)	(3.9)	0.0	(0.2)	(0.2)	0.0	(4.4)	(4.4)	0.0
Deferred Income	(8.4)	(9.1)	(0.7)	(28.3)	(27.5)	0.8	(1.5)	(1.8)	(0.3)	(38.2)	(38.4)	(0.2)
Total current liabilities	**(58.0)**	**(56.5)**	**1.5**	**(209.3)**	**(201.0)**	**8.3**	**(58.6)**	**(50.6)**	**8.0**	**(325.9)**	**(308.1)**	**17.8**
Total assets less current liabilities	**179.0**	**181.2**	**2.2**	**513.4**	**506.3**	**(7.1)**	**167.0**	**162.0**	**(5.0)**	**859.4**	**849.5**	**(9.9)**
Borrowings: PFI	0.0	0.0	0.0	(346.6)	(344.0)	2.6	0.0	0.0	0.0	(346.6)	(344.0)	2.6
Borrowings: leases non-current	(1.0)	(0.7)	0.3	(28.1)	(26.5)	1.6	(3.9)	(3.8)	0.1	(33.0)	(31.0)	2.0
Provisions	(0.7)	(0.7)	(0.0)	(3.4)	(3.4)	0.0	(1.4)	(1.4)	0.0	(5.5)	(5.5)	(0.0)
Deferred Income	0.0	0.0	0.0	(1.0)	(0.9)	0.1	0.0	0.0	0.0	(1.0)	(0.9)	0.1
Total non-current liabilities	**(1.7)**	**(1.3)**	**0.3**	**(379.1)**	**(374.8)**	**4.3**	**(5.3)**	**(5.2)**	**0.1**	**(386.1)**	**(381.3)**	**4.7**
Total assets employed	**177.4**	**179.9**	**2.5**	**134.3**	**131.5**	**(2.8)**	**161.7**	**156.8**	**(4.9)**	**473.4**	**468.2**	**(5.2)**
Financed by												
Public dividend capital	256.0	262.3	6.3	412.1	412.1	0.0	440.8	443.1	2.3	1,108.9	1,117.5	8.6
Retained Earnings (Accumulated Losses)	(80.9)	(84.6)	(3.7)	(312.6)	(314.6)	(2.0)	(284.5)	(291.7)	(7.2)	(678.0)	(690.9)	(12.9)
Revaluation reserve	2.2	2.2	(0.0)	34.8	34.0	(0.8)	5.4	5.4	0.0	42.4	41.6	(0.8)
Total Taxpayers' and others' equity	**177.4**	**179.9**	**2.5**	**134.3**	**131.5**	**(2.8)**	**161.7**	**156.8**	**(4.9)**	**473.4**	**468.2**	**(5.2)**

Norfolk and Waveney University Hospitals Group

6. Capital

Month 3 forecast outturn for total CDEL is a £0.7m adverse compared to the plan. The key drivers of the variance being EPR (adverse by £11.4m),JPUH CDEL uplift (adverse by £2.0m), JPUH estates safety funds (£2m adverse) offset set £15.8m on NHP in QEH. These variances needs to be agreed with NHSE as assumptions have changed since plan submission. Once agreed these needs to be reflected in the revised plan.

System CDEL (excluding donations) forecasted to be £2m adverse compared to the plan. This is mainly driven by JPUH being awarded a £2m CDEL uplift in recognition of our UEC performance.

Nationally funded programmes £1.6m underspend: On EPR programme NNUH and JPUH are forecasting to spend £10.2m and £1.2m more than original plan, respectively. The remaining forecasted overspends are driven by centrally funded schemes that were approved following on from the final plan submission. It includes £1.2m for Bowel cancer screening (NNUH),£0.3m for Hologic Panther (NNUH) and £2.1m for BLM – Estates Safety Fund (JPUH). These are offset by £15.8m forecast underspend on NHP as a result of the ACS programme (£6.0m) and the NHP UKPN enabling works plan which has been revised following detailed designs (£10.1m). Further work is required to align in-year plan changes to provide assurance that FOT aligns to NHSE expectations.

		Revised Plan				FOT				FOT Variance			
Month 03 FOT		JPUH	NNUH	QEH	N&WUHG	JPUH	NNUH	QEH	N&WUHG	JPUH	NNUH	QEH	N&WUHG
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£M
Internally Funded	Owned	10.8	11.5	12.7	35.0	12.8	11.6	12.7	37.0	(2.0)	(0.1)	0.0	(2.0)
	Right to use Asset	0.0	15.4	0.1	15.6	0.1	15.4	0.1	15.7	(0.0)	(0.0)	0.0	(0.0)
	Other Adjustments:grants/donations/peppercorn leases	0.2	5.3	0.5	5.9	0.2	5.6	0.5	6.3	0.0	(0.4)	0.0	(0.4)
	Disposals	0.7	0.0	0.0	0.7	0.7	(0.1)	0.0	0.6	0.0	0.1	0.0	0.1
Total System CDEL		11.7	32.2	13.3	57.2	13.7	32.6	13.3	59.6	(2.0)	(0.4)	0.0	(2.4)
Nationally Funded Schemes	Front Line Digitisation	0.0	2.5	2.1	4.6	1.2	12.7	2.1	16.0	(1.2)	(10.2)	0.0	(11.4)
	NHP	37.1	0.0	61.1	98.3	37.1	0.0	45.3	82.5	0.0	0.0	15.8	15.8
	RAAC Plank	17.5	0.0	25.2	42.6	17.5	0.0	25.2	42.6	0.0	0.0	0.0	0.0
	UEC	10.0	7.4	3.9	21.3	10.0	7.4	3.9	21.3	0.0	0.0	0.0	0.0
	Elective Recovery	0.0	27.8	0.0	27.8	0.0	27.8	0.0	27.8	0.0	0.0	0.0	0.0
	Diagnostics	0.0	6.6	0.1	6.7	0.0	7.3	0.1	7.4	0.0	(0.6)	0.0	(0.6)
	Estates Safety	0.0	0.9	2.6	3.5	2.1	0.9	2.6	5.6	(2.1)	0.0	0.0	(2.1)
	Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Nationally Funded		64.6	45.1	95.1	204.7	67.9	55.9	79.2	203.1	(3.3)	(10.9)	15.8	1.6
Total CDEL		76.3	77.3	108.3	261.9	81.6	88.5	92.5	262.7	(5.3)	(11.2)	15.8	(0.7)

Plan values reflect revised plan including in-year funding changes notified by NHSE where apparent from Trust reporting. In-year plan changes are not consistently reported and there may be variation to internal Board reported plan values until this is standardised across the Group. Variances will not therefore reconcile to NHSE reporting.

Norfolk and Waveney University Hospitals Group

7. Risk

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

Risks to in-year delivery

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

Commentary:

The key risk is relating to delivery of CIP in 2026/27. Having delivered over £80m in 2025/26 the focus has changed to identification and delivery of the CIP in year.

- Financial Performance: the plans for 2026/27 were approved by NHSE in March with "close down" letters sent out by Region. The Trusts have set ambitious breakeven plans to deliver the reduction in deficit support monies. The CIP plans are the driver for delivery of the overall financial performance and there is still a large proportion in the high-risk category and will require constant monitoring to deliver the overall plan in year. This is a key part of the One Recovery programme for the Trusts in 2026/27.
- Bank/Agency rate reduction: The reductions become much harder in 2026/27 for agency as there are only a small number of hard to recruit roles that are now using agency. Bank reductions are reliant on reducing sickness levels across all Trusts as well as reducing the need for escalation space.
- Cash: this continues to be an issue with QEH due to the precarious cash position and a cash committee has been set up chaired by the EMD to support the ongoing management of the position. Despite the reduction in deficit support money in 2026/27 there is still a significant amount of cash support for QEH and JPUH, which if the financial plan is not delivered then the quarterly cash is at risk.
- Capital: NNUH Stroke Thrombectomy Programme slippage of £1.1m forecasted into 27/28 and confirmation of funding sources is still ongoing. This is mainly driven by additional time required for PFI legal process to complete and increase in build costs.
- Capital: EPR Programme review in progress with potentially significant implications for FLD and self-funded capital programmes in 26/27 and 27/28. Update expected in Q2. As it stands the EPR programme is forecasted to be £11.4m adverse compared to the plan. Inability to secure additional funding may lead to potential cash pressures, , CDEL breach or even failure to complete the programme.

Actions:

- Continued focus on identifying recurrent and non recurrent CIPs to deliver the 2026/27 financial plans.
- Continuation of the controls on the use of temporary staffing, with a focus on medical staffing.
- Ongoing discussions with NHSE on the revenue position to ensure the cash position does not deteriorate.
- Ongoing discussions with NHSE/system partners on how Stroke Thrombectomy capital slippage can be managed

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	11.1		
Title	Group Risk Assurance Committee – Chair's report		
Author(s)	Nikki Gray, Committee Chair and Group Non-Executive Director		
Executive sponsor	Not applicable		
Purpose of report	**For decision** ☐	**For discussion** ☐	**For information** ☒

Executive summary

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

The attached report summarises the key areas of discussion at the Committee's latest meeting which was held on 30 July 2026.

Recommendations

The Group Board is asked to note the report of the Group Risk Assurance Committee meeting held on 30 July 2026.

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

Chair's Report from the Group Risk Assurance Committee (GRAC): 30 July 2026

Matters for Board consideration

1. The Committee noted 50 Principal and Significant risks which have been risk scored as >=12 (48 on the risk summary and a further 2 within the Finance pack).

2. With the Group Strategy, Technology, Investments and Partnerships (STIP) Committee now established, the GRAC agenda was re-shaped to afford deeper conversations and scrutiny regarding operational and financial performance. The challenge now is to ensure the right balance at GRAC between performance and risk which may require a review of the terms of reference in conjunction with other refinements following the risk workshop held on 22 July 2026.

3. The Committee received very positive updates on the progress made with the 'Group Clinical Harom Review Process' and the 'Pressure Ulcer Prevention Improvement Programme' – both topics which will be considered by the new Group Quality and Outcomes Committee going forward with escalation to GRAC only if risk sits at a score of >=12.

4. In all three of the Trust reports, it was acknowledged that risk culture within each Trust is developing, albeit at different levels of maturity. Of particular note was the reflection of the NNUH Executive Managing Director that the NNUH team are improving their recognition of limited assurance but now need to focus on identifying and delivering the requisite actions to move towards better assurance levels.

5. Cost Improvement Plan (CIP) risk was discussed, acknowledging the Q1 delivery of a £1.3m favourable variance to plan. However, it was noted that the Q2 plan is more stretching and that there is still a shortfall in identified and validated CIP schemes. Given the CIP risk, the Committee has asked the Group Chief Finance Officer to include more detail in future finance reports (noting that this need may be obviated once the One Recovery reporting is up and running).

6. While discussing the removal of medical students from QEH, the Committee reflected that student-related issues across all three Trusts had been flagged to the Special Purpose Joint Committees (SPJC) in September 2025, although no formal actions had been captured, rather a series of principles and next steps. This matter and consideration of learnings in terms of Board governance have been escalated to the Group Research, Innovation and Education Committee.

Walker Ian 02/08/2026 12:16:37

Nikki Gray
Committee Chair

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	11.2		
Title	Group Audit Committees in Common – Chair's report		
Author(s)	Stephen Javes, Committee Chair and Group Non-Executive Director		
Executive sponsor	Not applicable		
Purpose of report	**For decision** ☐	**For discussion** ☐	**For information** ☒

Executive summary

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

The attached report summarises the key areas of discussion at the Committee's latest meeting which was held on 22 June 2026.

Recommendations

The Group Board is asked to note the report of the Group Audit Committees in Common meeting held on 22 June 2026.

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

Chair's Report from the Group Audit Committees in Common: 22 June 2026

This meeting was primarily to cover the end of year results and associated reports for each of the three Trusts.

For each Trust, reports were received for 2025/26 as follows:

- Head of Internal Audit opinion
- Draft annual accounts
- Draft Annual Report (including Annual Governance Statement)
- Auditors' annual report
- Letter of representation

The annual accounts were all "clean" (with unqualified opinions) and showed a surplus for the year. There was only one issue across all whereby the auditors did not agree with the way in which accruals for payments associated with the Band 5/6 nurse pay awards had been handled. That said the matter was not material to the approval.

Also, while approving the draft Head of Internal Audit opinions, there were two outstanding internal reports:

- Norfolk and Norwich University Hospitals (NNUH): Consultant Job Planning
- Queen Elizabeth Hospital King's Lynn (QEH): Temporary staffing

The Group Audit Committees in Common recommended the Annual Reports and Annual Accounts for approval to the Group Board.

It was agreed that a review would take place of the processes involved to understand where improvements could be made for next year and for this to be considered by the Committees at the next meeting.

In addition to the above, attention was given to:

- A follow up review of financial governance at both QEH and James Paget University Hospitals (JPUH). A number of improvements had been completed, with the Group Chief Finance Officer seeking to close all of the items by the next meeting.
- A clinical audit update. This was positive with the Group Chief Medical Officer seeking to align best practice across all three Trusts.
- Single tender waivers. The Finance team has put new procedures in place to tighten the process and will produce the updated report for the next meeting.
- It was agreed that External Auditors would only used in a consultancy role under exceptional circumstances.
- Minor amendments to the terms of reference were agreed and recommended for Group Board approval (as included on the Group Board agenda).

Stephen Javes
Committee Chair

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	11.3		
Title	Group Research, Innovation and Education Committee – Chair's report		
Author(s)	Prof. Philip Baker, Committee Chair and Group Non-Executive Director		
Executive sponsor	Not applicable		
Purpose of report	**For decision** ☐	**For discussion** ☐	**For information** ☒

Executive summary

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

The attached report summarises the key areas of discussion at the Committee's meetings held on 18 June 2026.

Recommendations

The Group Board is asked to note the report of the Group Research, Innovation and Education Committee meetings held on 18 June 2026.

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

Chair's Report from the Group Research, Innovation and Education Committee: 18 June 2026

The Group Research, Innovation and Education Committee met on 18 June 2026.

The Committee considered the *Collectively Curious* review and supported its overall direction. Members advised that its recommendations should be prioritised and translated into a phased implementation programme.

Key recommendations are stronger Group leadership and operating arrangements for research, innovation and education. There is also a need for early action on infrastructure utilisation, study set-up times, research delivery accountability and a smaller set of meaningful Group performance measures.

Members emphasised the importance of retaining clear professional leadership for the research delivery workforce, strengthening education quality and assurance, and involving patients and the public in shaping the Group's ambitions.

This advice has informed the Research, Innovation and Education Strategic Delivery Framework which has been endorsed by the Committee and which will be presented separately to the Group Board. The framework proposes seven strategic focus areas, dedicated Group leadership for research and innovation, and a phased implementation plan.

The Committee also supported progression of the University Hospitals Association application, presenting University Hospital status as a platform for improvement rather than evidence that the Group's development is complete. The revised application has been submitted and we await a response from the UHA.

The meeting scheduled for 19 August 2026 has been deferred because of member availability. The Committee will next meet on 22 October 2026.

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	11.4		
Title	Group Strategy, Technology, Investments and Partnerships Committee – Chair's report		
Author(s)	David Roberts, Group Chair and Committee Chair Andy McKechnie, Group Non-Executive Director (Committee Chair from August 2026)		
Executive sponsor	Not applicable		
Purpose of report	**For decision** ☐	**For discussion** ☐	**For information** ☒

Executive summary

The Group governance structure includes a Group Strategy, Technology, Investments and Partnerships Committee which will meet monthly from August 2026.

The attached report summarises the key areas of discussion at the Committee's inaugural meeting which was held on 22 June 2026.

Recommendations

The Group Board is asked to note the report of the Group Strategy, Technology, Investments and Partnerships Committee meeting held on 22 June 2026.

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

Walker Ian
02/08/2026 22:26:37

Chair's Report from the Group Strategy, Technology, Investments and Partnerships Committee: 22 June 2026

The Committee held its inaugural meeting and reviewed the Group's major transformation programmes, with members recognising the scale of change required over the next 12–18 months. The Chair emphasised that the Committee's role was to provide strategic oversight of transformation, technology, investment and partnership activity, while helping the Group Board gain assurance on major programmes and their interdependencies.

Transformation Design Authority (TDA)
The Committee received the TDA baseline assessment, which confirmed significant interdependencies across major programmes and identified potential conflicts between the New Hospital Programme, Clinical Strategy, the Electronic Patient Record programme and Group ways of working initiatives. Members agreed that the TDA will be central to coordinating delivery, managing programme dependencies and providing a portfolio view of transformation activity.

Clinical Strategy and Case for Change
The Committee considered proposals for a Case for Change to support future service configuration and the New Hospital Programme. The work will assess clinical sustainability, neighbourhood transformation, fragile services and future hospital requirements. Members acknowledged the challenging timescales and the need to balance clinical, financial and political considerations while ensuring future services remain sustainable.

New Hospital Programme
An update was received on the proposed Alliance Agreement and Stage Zero Call-Off Contract. Discussion focused on maintaining momentum while the wider clinical strategy develops, minimising duplication of design work and ensuring appropriate control of costs and risks. The Committee recommended Group Board approval of the Alliance Agreement and the Stage Zero Call-Off Contract.

Electronic Patient Record Programme
The Committee reviewed the findings from the discovery review, which concluded that delivery remains achievable but requires stronger governance, programme controls and standardisation across the Group. Particular risks were highlighted around pathology, laboratory services, oncology and data migration. Members also requested greater clarity around procurement governance and future approval arrangements.

Future Committee focus
Members agreed future meetings should become increasingly data-driven, with a strong focus on:

- Programme milestones and critical paths.
- Portfolio risks and dependencies.
- Programme assurance and performance metrics.
- Change control and governance.
- Patient outcomes, patient experience and health inequalities.

David Roberts
Committee Chair

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	11.5		
Title	Charitable Funds Committees – Chair's reports		
Author(s)	Nikki Gray, Committee Chair (NNUH) William Van't Hoff, Committee Chair (QEH) Sally Collier, Committee Chair (JPUH)		
Executive sponsor	Not applicable		
Purpose of report	**For decision** ☐	**For discussion** ☐	**For information** ☒

Executive summary

The Group governance structure includes a Charitable Funds Committee for each Trust which meets four times per year. Each Charitable Funds Committee is chaired by a Group Non-Executive Director representing the Board of Directors of the respective Trust (as corporate trustee).

The attached report summarises the key areas of discussion at the Committees' most recent meetings.

Recommendations

The Group Board is asked to note the reports of the Charitable Funds Committees.

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

Chair's Report from the Norfolk and Norwich University Hospitals (NNUH) Charitable Funds Committee: 4 June 2026

1. The Committee received grant applications for 2 items related to leadership development across the 3 Trusts:
   a) Proud2Be – amounting to £131,452 (46% share of total cost), and
   b) Vanderbilt Professional Accountability Programme Evaluation – amounting to £125k

   While the Committee expressed categoric support for activity relating to leadership development, it was concerned that this was not an appropriate use of charitable funds, with monies incorrectly being seen as a 'top-up' for operational expenditure within the hospitals.

   The Proud2Be grant application was declined, with an action to consider approval of a smaller amount, were patient benefit to be more clearly attributed.

   The Vanderbilt grant application was also declined, with an action to understand better the references to 'supporting research' to establish whether there may be some funds available. (Note: since the Committee met, a request for an additional £1,000 for 'celebrations' has also been received and declined.)

2. The Committee considered and agreed revisions to the Charity's grant approval limits, recognising the need for pragmatism in light of infrequent Committees and the need for grant applications and associated activity to move forward in the intervening periods.

3. The Committee discussed the need to establish the pros and cons of the three hospital charities working more closely together, sharing back-office support initially and/or moving to a full merger. It was noted that QEH no longer has dedicated charity leadership or finance support and therefore whether there would be some immediate benefit of bringing NNUH and QEH charities more closely together. It was further noted that the NNUH Charity Director does not have the formal mandate from the Group to explore fully the options (e.g. access to budgets and expenditure at the other two hospitals) and that without this mandate, it is extremely hard to develop the thinking ahead of presentation to the Group Board later in the year. I have raised this matter with the Group Director of Governance and await clarification.

Nikki Gray
Committee Chair, NNUH Charity

Chair's Report from the Queen Elizabeth Hospital King's Lynn (QEH)
Charitable Funds Committee: 4 June 2026

Alert: (serious risks, areas of limited assurance, urgent issues needing intervention)

- Underutilisation of charitable funds, with reserves at £2.7m and a need to increase spending to maximise impact.
- Restricted fund constraints, particularly the Way Trust fund, requiring Charity Commission engagement for repurposing.
- Risk to long-term sustainability of income, with current funding streams requiring diversification.
- Limited engagement from some fund managers, potentially impacting oversight and governance effectiveness.

Assure: (positive findings, high performing areas, evidence controls working)

- Strong financial performance: income £1.3m, expenditure £0.81m, surplus ~£0.5m.
- Healthy reserves position (£2.7m) with appropriate financial oversight.
- Robust governance with active Non-Executive Director involvement and appropriate scrutiny.
- Effective and well-governed funding approvals aligned to patient care, staff wellbeing, and quality improvement priorities.

Advise: (general updates, progress on action plans, for Group to note)

- Financial statements for year ending 31 March 2026 reviewed and supported by the Committee.
- Terms of Reference and governance arrangements under review to reflect changes in membership and structure.
- Progress on management of restricted funds, including COVID fund follow-up and Way Trust proposals.
- Development of a sustainable income strategy, including consideration of a staff lottery and benchmarking with other NHS charities.
- Approval of a Band 5 Events and Engagement Officer to strengthen charity delivery capacity.

Actions: (key actions being taken/planned to be taken, with dates and leads)

- Confirm outstanding COVID fund invoice status.
- Develop and submit proposal to repurpose Way Trust fund.
- Review and update trustee listings in financial statements.
- Develop comprehensive sustainable income strategy.
- Improve fund manager engagement and review signatory rights.

Identified Themes: (themes highlighted from data discussed at meeting)

- Need to increase focus on charitable impact and spending rather than fund accumulation.
- Importance of income diversification and long-term sustainability.
- Strengthening of governance and accountability arrangements.
- Continued emphasis on staff wellbeing and patient benefit.

Identified Learning: (learning – what are we doing different)

- Greater emphasis on evaluation and sustainability of funded projects.
- More strategic approach to allocation of charitable funds.
- Increased use of benchmarking and stakeholder engagement in decision-making.
- Proactive management of restricted funds and compliance requirements.

William Van't Hoff
Committee Chair, QEH Charity

Walker Ian
02/08/2026 22:26:37

Chair's Report from the James Paget University Hospitals (JPUH) Charitable Funds Committee: 24 June 2026

The first meeting of the newly structured JPUH Charitable Funds Committee focused on charity governance, assurance, risk management and future development.

Members agreed that the Director of Charity should not be a voting member and discussed widening participation through clinical and patient representation while maintaining the committee's governance focus.

The committee reviewed the charity assurance framework and risk register, noting that the main ongoing concern is holding reserves above the desired level and ensuring charitable funds are spent in line with their intended purpose. The committee also reviewed charity governance training, fund balances, and a proposal to increase the Charity Director's hours on a six-month trial basis, supporting the proposal subject to measurable KPIs and a report demonstrating impact.

The committee approved, or agreed in principle to support, several funding proposals and development initiatives.

Members welcomed the success of the robotic surgery programme and requested a future report comparing actual outcomes against the original business case.

Funding requests considered included the Brayden CPR training kiosk, the "Proud to be Ops" leadership development programme, and activity coordinator roles to enhance patient experience, all of which received broad support subject to governance, procurement and assurance requirements being clarified where necessary.

Significant discussion focused on ensuring robust governance processes, particularly where projects originate through wider group structures rather than directly through charity processes.

The meeting concluded with agreement to strengthen assurance information accompanying future proposals, review committee timings due to the volume of business, and continue developing a more proactive long-term strategy for the charity that balances spending existing reserves with future fundraising ambitions.

Sally Collier
Committee Chair, JPUH Charity

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	12.1		
Title	National Maternity Triage Specification		
Author(s)	Penny Snowden, Group Director of Midwifery		
Executive sponsor	Rachael Cocker, Group Chief Nurse Rob Sherwin, Group Chief Medical Officer		
Purpose of report	**For decision** ☐	**For discussion** ☐	**For information** ☒

Executive summary

Triage has been included in NHS England's 10 Point Plan for maternity and neonatal services (2026). The urgent action required from providers is a commitment to providing safe and effective maternity triage.

NHS Providers are expected to complete an audit of current Triage services and a baseline gap analysis against the national specification within three months (mid-October 2026). This informs the implementation plan that will support full implementation of the specification within a 12-month period. Maternity Services are required to report progress against the implementation plan at Board meetings in public and to NHS England regional teams on a quarterly basis.

The report outlines the 10 principles of the specification and the wider implications of implementation particularly on estates, telephony and the Electronic Patient Record (EPR). Proposed reporting processes and metrics are also outlined in the report.

Recommendations

The Group Board is asked to:

- Note the contents of the report and the national timescales regarding implementation (deadline: July 2027 for full implementation).
- Note the national timescales for completing the baseline gap analysis (mid-October 2026) and quarterly reporting requirements.
- Note the proposed performance metrics which are outlined on the NHS Futures Platform.
- Note and consider the wider implications on the Trusts' services.

Alignment to Board Assurance Framework risk(s)	Principal Risk 2, Maternity Services Improvement
Previously considered by	Quality Standards Group
Any background papers in Admin Control Reading Room	No

Norfolk and Waveney University Hospitals Group

Group Board in public: 5 August 2026

1. Introduction and background

In 2024, the Care Quality Commission (CQC) published National review of maternity services found systemic failures in how NHS trusts operate telephone and in-person Triage. With no standard national targets, unsafe triage practices formed the basis of 81% of CQC enforcement actions during their inspection period. The recent review into Nottingham Maternity Services (Ockenden, 2026) also reported concerns regarding Triage services including failing to listen to women's concerns through telephone triage and being denied timely reassessment despite deteriorating symptoms.

Triage has been included in the NHS England's 10 Point Plan for maternity and neonatal services (2026). The urgent action required from providers is a commitment to providing safe and effective maternity triage. More specifically, each NHS Provider should complete a board-level audit to identify any gaps and ensure services are consistently safe, responsive and appropriately resourced within three months. To support that action, Providers should refer to the newly published national Maternity Triage Specification.

The requirement to take immediate action on maternity triage is also outlined in the Medium-Term Planning Framework and this document sets a clear vision for best practice that services should work towards.

2. The Maternity Triage Specification[1]

The purpose of the Specification is to outline what good maternity triage services should look like, recognising maternity triage as a safety-critical clinical environment, as the emergency front door for urgent and unscheduled maternity care.

It establishes consistent national principles to strengthen, protect and sustain this core part of maternity services, closing gaps in current provision and supporting seamless pathways from early pregnancy services into maternity triage, so that women and families receive safe, timely urgent care when they need it.

The specification outlines ten principles which are summarised in the table below.

[1] prn02402-national-maternity-triage-specification-july-2026.pdf

No	Principle	Key Message
1	Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.
2	Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such
3	Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care
4	Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried
5	Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.
6	Service user voice and experience	Women's feedback must shape service design, improvement and experience.
7	Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.
8	Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is Principle Key message needed
9	Equity and equality	Services must use data and targeted action to identify and reduce inequalities
10	Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.

3. Implementation

NHS Providers are expected to complete an audit of current Triage services and a baseline gap analysis against the national specification within three months. This informs the implementation plan that will support full implementation of the specification within a twelve-month period. Maternity Services are required to report progress against the implementation plan at public Trust Board meetings and to NHS England regional teams.

Assurance reporting through the governance processes to Trust Board should include routine monitoring of key performance data, including time to initial assessment, waiting times, review times, frequency of staff redeployment from triage, outcomes for women who experience delays, and evidence that actions to improve the service are implemented where issues are identified. These metrics should be included in routine reporting and form part of ongoing Board oversight of maternity services.

To support reporting, it is proposed that each services uses the national model template which is outlined below.

Triage

Safety	Quality and learning	Workforce	Risks and mitigations

Metric	Month 1	Month 2	Month 3
1. Proportion of women for whom expected timeframes are met for initial assessment and for clinical review, based on their category of urgency.	%		
2. a) Proportion of women who experience a delay in assessment, review or onward care b) proportion of these where there is an outcome recorded.	% % of a)		
3. Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback	Number		
4. Frequency of staff being redeployed to other maternity care areas within the unit from maternity triage: % of shifts affected by re-deployment	%		

Improvement actions	Progress	Impact	Responsible

NHS England Jun 2026 15

The specification contains many more measurable metrics, and it is proposed that these form part of a quarterly audit which then feed back into the implementation plan and form part of the quarterly progress reports.

4. Wider Considerations and Implications

The specification contains the following areas- all of which require implementation within 12 months. Currently no national funding has been announced to support implementation. Each Service will need to develop a business case based on the initial gap analysis given the staffing requirements and wider implications as summarised below.

4.1 Estates:

- Clear signposting to Maternity Triage needs to be present across sites.
- The location of telephone triage needs to be reviewed and may require works to be undertaken so that telephone triage is operated from a protected, quiet, confidential space, away from the main clinical area and clinical office space.
- Triages require to be co-located or positioned as close as possible to delivery suite.
- There should be a suitably sized waiting area that is visible to staff.
- There should be a reception area to report on arrival and assist if need is more urgent.
- Office facility should be provided.

4.2 EPR:

- Ensure maternity triage services are supported by modern, interoperable digital solutions, including real-time documentation, escalation and timely information sharing across maternity and neonatal services.

4.3 Telephony:

The following areas will require involvement, design and possible procurement:

- Clear telephone access with call waiting. Calls required audio taping and drop off calls need to be monitored. Call waiting times also required monitoring.

5. Governance and Oversight

It is proposed to commence monthly reporting on the above metrics from September 2026 at site level. Those metrics are then upwardly reported to the proposed Group Perinatal Quality Standards Meeting on a monthly basis.

A quarterly update commencing October 2026 which will include the gap analysis and implementation plan. Subsequent quarterly reports will include update on the implementation plan and audit data.

A Group quarterly report will then be submitted to the Group Board in public.

6. Recommendations

The Group Board is asked to:

1. Note the contents of the report and the national timescales regarding implementation (deadline: July 2027 for full implementation).
2. Note the national timescales for completing the baseline gap analysis (mid-October 2026) and quarterly reporting requirements.
3. Note the proposed performance metrics which are outlined on the NHS Futures Platform.
4. Note and consider the wider implications on the Trusts' services.

7. Conclusion

The national Maternity Triage Specification is one of the urgent actions outlined in the 10-Point Plan and needs to be implemented with 12 months. An initial audit of current Triage services and a baseline gap analysis is required to be completed by the end of September 2026. Reporting of progress against the implementation should include Trust Board and Regional oversight.

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	12.2		
Title	NHS Resolution Maternity Incentive Scheme Year Eight – Quarter One Report		
Author(s)	Penny Snowden, Group Director of Midwifery		
Executive sponsor	Rachael Cocker, Group Chief Nurse Rob Sherwin, Group Chief Medical Officer		
Purpose of report	**For decision** ☐	**For discussion** ☐	**For information** ☒

Executive summary

The Maternity (Perinatal) Incentive Scheme has been refreshed and streamlined for Year 8 to reflect feedback from system and providers as well as recognising significant pressures on services. The new approach enables providers to focus effort on local priorities which are likely to make the biggest impact on quality improvement. The new standards also reflect the evolving national policy and priorities.

The previous ten safety actions have been into six core safety actions, and these are:

1. Workforce and Capacity
2. Training
3. Learning from reviews and investigations
4. Service User Voice and Equity
5. Care Bundles
6. Board Oversight, Governance, Culture and Leadership

In recognition of the new regional and ICB Model blueprint, declaration of compliance is made by the Provider Trust Board. The Board needs to be satisfied that the evidence provided to them demonstrates achievement of both the six core perinatal safety actions and meets the required safety actions' sub-requirements as set out in the national guidance document. All other requirements relating to declaration must also be satisfied. The Perinatal Leadership team and Maternity Neonatal Voice Partnership Lead will present to the Board progress and compliance. Where actions are not met, an action plan will be in place. The deadline for the Board Declaration is 2 March 2027.

The report outlines the progress made by each of the three sites against the six core safety actions

Recommendations

The Group Board is asked to:

- Note the Board Declaration Process and the deadline for submission of 2 March 2027.
- Note the current position against the six core safety actions.
- Support monthly reporting to the Perinatal Quality Standards Group against year 8 given the size of the national agenda for maternity to reduce the likelihood of missing key requirements.

Alignment to Board Assurance Framework risk(s)	PR2 Maternity Services Improvement
Previously considered by	Quality Standards Group
Any background papers in Admin Control Reading Room	No

Group Board in public: 5 August 2026

1. Introduction and background

The Maternity (Perinatal) Incentive Scheme has been refreshed and streamlined for Year 8 to reflect feedback from system and providers as well as recognising significant pressures on services. The new approach enables providers to focus effort on local priorities which are likely to make the biggest impact on quality improvement. The new standards also reflect the evolving national policy and priorities.

The previous ten safety actions have been into six core safety actions, and these are:

1. Workforce and Capacity
2. Training
3. Learning from reviews and investigations
4. Service User Voice and Equity
5. Care Bundles
6. Board Oversight, Governance, Culture and Leadership

The aim of the safety actions are to be more outcome focused than previous years. Supplementary guidance has been provided to outline what good looks like.

Successful achievement of Year 8 will result in each of the three organisations receiving a rebate on their 10% CNST Premium. If a service does not meet the six core safety actions, an improvement plan using the national template is submitted alongside the declaration. Discretionary funding to support the improvement maybe received by the organisation from NHS Resolution.

Additional assurances regarding accuracy of compliance will be undertaken including continued sense checking with the CQC and regional Chief Midwifery oversight through regional perinatal meetings. In addition, NHS Resolution will publish a mid-year spot check which for Year 8 is for advisory and supportive to organisations.

2. Board Declaration Process

In recognition of the new regional and ICB Model blueprint, declaration of compliance is now only made by the Provider Trust Board. This is in recognition that the Trust Board is wholly accountable and ultimately responsible for ensuring the safety and quality of all care provided in the organisation. It is therefore important there is robust assurance processes regarding the Maternity Incentive Schem compliance requirements.

The Trust Board need to be satisfied that the evidence provided to them demonstrates achievement of both the six core perinatal safety actions and meets the required safety actions' sub-requirements as set out in the national guidance document.

All other requirements relating to declaration must also be satisfied including that there are no reports covering either year 2025/26 or 2026/27 that relate to the provision of maternity and / or neonatal services that may subsequently provide conflicting information to the

Year 8 declaration from the same time-period (e.g. CQC inspection report, Health Services Safety Investigations Body (HSSIB) or MNSI investigation reports etc.).

Once satisfied, The Trust Board need to formally provide agreement and consent for the Chief Executive Officer (CEO) to undertake the organisation's final MIS sign-off.

The deadline for the Board Declaration is **12 noon on 2 March 2027**.

3. Quarter One Overall Summary

The report outlines the progress made by each of the three sites against the six core safety actions. The table below provides an overall summary of how each site has rated their progress.

Core Safety Action	JPUH	NNUH	QEHKL
Workforce and capacity	On Track	On Track	On Track
Training	On Track	On Track	On Track
Learning from reviews and investigations	On Track	On Track	On Track
Service-user voice and equity	On Track	On Track	On Track
Care bundles	On Track	On Track	On Track
Board oversight, governance, culture and leadership	On Track	On Track	On Track

There are however risks to this given the size of the national priorities for maternity services, the restructure of the ICB in particular the loss of the Local Maternity Neonatal Service and the evolving group governance arrangements.

a. Core Safety Action A: Workforce and capacity

Clinical Staffing is presented in the monthly perinatal report at site and group level. Progress is also reported to the regional on a quarterly basis. The full detail of the current position is outlined in Appendix 1.

The main issue to note is that QEHKL does not meet the British Association of Perinatal Medicine standards regarding neonatal nursing. Providers need to ensure at least 70% of nurses are qualified in speciality. The current position is 47%. There is a plan in place which a trajectory of meeting 66% in September and over 70% in January 2027 as a result of people completing training courses.

In terms of midwifery staffing, JPUH have commissioned an external Birthrate Plus report and are in receipt of the draft report. QEHKL have also commissioned an external Birthrate Plus review which is due to commence in September 2026. NNUH are in early discussions with Birthrate Plus to commission a review. Midwifery staffing is presented monthly and also monitored on a daily basis through the manager of the day. Escalation processes are in place in each organisation and daily OPEL reporting is fully embedded. A paper has also been developed that requests the Group Board to consider local headroom as recommended by Ockenden 2022 Shrewsbury and Telford and reinforced in Ockenden 2026.

In terms of capacity, delays in induction of labour are reported monthly through the perinatal report and through the daily OPEL reporting. Delays in activity and suspension of services are also recorded. JPUH have reported three obstetric closures in May 2026 (due to the Special Care Baby Unit closing for Infection prevention reasons) and three occasions in June 2026 as result of increased activity/acuity. The regional Chief Midwife has been informed together with the reasons for each closure.

Induction of labour delays are more prevalent on NNUH site, and this has been escalated through site governance. An improvement plan is in place and is overseen at the perinatal resilience forum and through the Divisional Operational Performance meetings.

Further work is required to review caesarean section capacity, and this will be reported in future reports.

b. Core Safety Action B: Training

All training programmes across the three sites include all areas specified in Year eight which are obstetric emergency training, neonatal resuscitation and fetal wellbeing training. To meet this action, compliance is required

Training	JPUH	NNUH	QEHKL
Obstetric Emergency	89.1%	All staff groups above 90% except anaesthetic trainees (88%)	97%
Neonatal Resuscitation	89.1%	All staff groups above 90%	97%
Fetal Wellbeing	89.1%	All staff Groups above 90%	91% Obs (76%)

Each service is required to have two review points through the Year 8 reporting period; one of which is November. NNUH's review point was 2nd July and were compliant with 90% across all elements of training for all staff groups. QEHKL have set their first review point for September 2026 and JPUH have their review date set for the 31 July 2026.

Two Emergency simulations are also required. All sites have their simulations set and learning will be included in future progress reports.

Training compliance was reported to Trust Board in April 2026 with an update included int the table above which is line with the requirements outlined in this safety action regarding Board oversight. Further work is required to present the data to provide trend analysis.

c. Core Safety Action C: Learning from reviews and investigations

The monthly perinatal report includes narrative regarding learning from reviews and investigations. Data referring to MNSI referrals are also captured as well as the number of incidents. Quarterly reporting for Perinatal Mortality Review Tool continues with quarterly reports discussed at the Perinatal Safety Champion meetings. The reports also include MOSS (Maternity Outcome Safety Signal) alerts. Learning is also reported on a quarterly basis to the Regional Perinatal Oversight Meeting.

To date, no MOSS alerts have been received by the maternity services.

Work is also underway to share learning more widely across the Norfolk and Suffolk maternity services with the three Director of Midwifery leading the establishment of a shared learning forum which is being implemented by each governance team across the five services. The first forum is due to held in September 2026.

Compliance with specific metrics is summarised in the table below

Metric	JPUH	NNUH	QEHKL
Notify all qualifying events	100%	100%	100%
Seek parents' views of care (100%)	100%	100%	100%
External multi-disciplinary reviewers (60%)	100%	100%	100%
Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews	100%	100%	100%
Duty of Candour compliance	100%	100%	100%
Offer parents a meeting with relevant specialists	100%	100%	100%

While the monthly perinatal report includes learning, a quarterly thematic learning report will be developed with the first quarter being presented through site and group governance in August/ September 2026.

d. Core Safety Action D: Service-user voice and equity

The perinatal reports do include some element of service user feedback and will be strengthened in line with the national ten-point plan. The Maternity Neonatal Voice Partnership Lead also attends the Group Perinatal Safety Champions to provide feedback and ensure the service user voice is heard.

Each Service together with their Maternity Neonatal Voice Partnership Lead has a coproduced CQC service user survey improvement plan which is being progressed.

Progress on this action has been impacted by the ICB restructure which has seen the current MNVP leads being given notice. A new model which will be one MNVP lead for Norfolk has been implemented. The post has been recruited to and one the postholder has commenced, work can gain pace. This risk is on each service's risk register.

e. Core Safety Action E: Care bundles

This safety action relates to two bundles. One is Saving Babies Lives Care Bundle v3.2 and the second is the Maternity Care Bundle.

3.5.1 Maternity Care Bundle

Each service has completed the baseline assessment against the new Maternity Care Bundle which has previously being reported to Quality Standards Group. The following tables capture the progress against the five elements

Maternity Care Bundle Progress – JPUH

Element	Current Position
1.Venous Thromboembolism	Scoping completed and medical and midwifery leaders identified . To be part of Group work. Current VTE assessments of 100% (AN, IP & PN) demonstrated within the IPR.
2.Pre-hospital and acute care	Scoping completed and medical and midwifery leaders identified. Early booking QI has shown marked improvements towards the KPI of 90% thus increasing early contact and risk assessment. MEWS implemented trust wide – audits ongoing.
3.Epilepsy in pregnancy	Scoping completed and medical and midwifery leaders identified. Epilepsy team in place.
4.Maternal Mental Health	Scoping completed and medical and midwifery leaders identified Lotus team in place. Eden team offer continuity of care for ante and postnatal care for this cohort. Awaiting decision on EPDS tool being mandatory from national team.
5.Obstetric Haemorrhage	Scoping completed and medical and midwifery leaders identified. PPH Deep Dive has been completed and QI work has made a visible difference to the rates and outcomes. Scales being used in Community for blood loss.

Maternity Care Bundle Progress – NNUH

Element	Current Position
1.Venous Thromboembolism	Scoping work completed. Midwifery and Medical leaders identified. Significant work already implemented including the National new VTE self-assessment tool (including translatable options) and Early pregnancy VTE risk assessment pathway in place including access to LMWH prescribing. Patient information also being supported in accessible formats through JON information development and incorporates National SA tool for VTE. Early collaborations already started with other clinical points of access including ICB/primary care and EPAU/ED. ToR for reporting and governance underway.
2.Pre-hospital and acute care	Scoping work completed. Midwifery and Medical Leaders identified. Recent update of ED pathways and guidance undertaken for > 18 weeks of pregnancy , further guideline development and intradepartmental collaboration planned to support early pregnancy and Urgent care pathways and use of MMC/MMN referral pathways across all areas and gestations. MNVP engagement already planned to 'walk the patch' and review signage and escalation of any requirements of this in collaboration with maternity services and plans to review also with EoE ambulance services. ToR for reporting and governance underway.
3.Epilepsy in pregnancy	Scoping completed. Midwifery and medical leaders identified. Local epilepsy team in place already including Monthly MDT and regional support through MMC. Current guideline under review to support new MCB recommendations and Clinical redesign of services to support local and regional care. Early pregnancy pathway process already actioned to ensure timely review from point of pregnancy test and first point of contact into maternity services. ToR for reporting and governance underway.
4.Maternal Mental Health	Scoping completed. Medical and midwifery leaders identified. NNUH Perinatal specialist midwifery team Skylark, Lotus and collaborative services already in place. Self- assessment embedding of the MH assessment questions to be mapped out and how this is achievable with current digital system
5.Obstetric Haemorrhage	Scoping completed. Medical and Midwifery leaders identified. PPH deep dive project and QI work already underway and already has implemented many of MCB recommendations. Drapes only outstanding but on order.

Maternity Care Bundle Progress – QEHKL

Element	Current Position
1.Venous Thromboembolism	VTE questions are now part of the booking form, alongside questions around epilepsy and diabetes. All booking forms are being sent through to DAU where they are now screened. Any women requiring LMWH immediately will be contacted and a prescription arranged. We need to look at amending the guideline to encompass this and also the junior doctors having an awareness of this potential ask. Any women that are epileptic or diabetic are being sent through to Maternal Medicine so that the diabetes team have oversight for early appointments and if higher dose folic acid is needed.
2.Pre-hospital and acute care	Varied workstreams have completed most of this especially EEAST we will need to actively seek engagement for ED and UTC and start to audit MEWS compliance in all areas
3.Epilepsy in pregnancy	Guideline with the NNUH is reviewed and updated. A collegiate approach with the NNUH MMN to supporting this for QEH is underway
4.Maternal Mental Health	We are just discussing adding the Whooley questions to the booking form to tick the box for self-administering these questions pre-booking. We don't have a plan for repeating them 25-28 and 31-34 weeks but discussions are continuing between community, digital and PNMH.
5.Obstetric Haemorrhage	Fully compliant in most areas apart from the coagulation screening protocol. Successful in gaining a bid for a POC testing machine for the delivery suite. Will need to write or acquire and share a fibrinogen policy

Each service is required to have an implementation plan signed off by Trust Board that demonstrates full implementation by March 2027. Currently, two out of the three sites have completed their implementation plan so all plans will be submitted to Trust Board in October 2026 to enable time to report through site and group governance ahead of Board Reporting.

The risk to full implementation by March 2027 is the role and responsibilities of primary care and other agencies in issues such as risk assessment of VTE and the early prescription of therapeutic treatment. This has been raised with the ICB on 17th July 2026 with recognition of the challenge. The requirement for year 8 CNST is that progress is being made towards full implementation.

3.5.2 Saving Babies Lives Care Bundle

Saving Babies Lives Care Bundle is a continuation of previous years. Quarterly reports are included in the site perinatal reports, and the last group report was presented to Trust Board in April 2026.

It is also a requirement of Year 8 to review fetal growth surveillance pathways and processes in light of recent NHS England guidance regarding Intergrow (a non-customised growth chart). Currently, all services use a customised grow chart and processes (population based and individualised) known as Grow. JPUH and QEHKL use GROW 2.0 and NNUH use GROW 1.5. NNUH are planning to change to a non-customised growth chart and processes using the Hadlock model. Nationally there is a difference in professional opinion into whether customised or non-customised growth charts are more effective. One of the recommendations from Ockenden's review of Nottingham Maternity Services 2026 is that there needs to be a national steer and recommendation to fetal growth surveillance systems and processes. In the meantime, services are reporting quarterly on all metrics outlined in the Saving Babies Lives Care Bundle.

Each Site is currently reporting differently against the bundle, and this will be standardised over the next month to focus on clinical outcomes with the aim of reporting through site and group governance over August/September 2026.

The third bundle is Neonatal Pulse Oximetry, and this will be presented in next month's progress report.

f. Core Safety Action F: Board oversight, governance, culture and leadership

3.6.1 Board Oversight of Maternity and Neonatal Quality and Safety

The group model was established in 2025, and governance structures are evolving. This poses a risk to compliance against this safety action given that the Trust Board meeting is bimonthly and there is currently no sub board quality meeting that is attended by the Non-Executive Directors. Cycle of business has been discussed with the interim director of governance.

Currently monthly perinatal services are presented to the site quality, safety and effectiveness meeting and upwardly reported to Quality Standards. A specific perinatal quality standard group will commence 21 August and will be attended by the Non-Executive Safety Champion, and this will improve the ward to board reporting. A sub board Quality Outcomes Meeting is planned, and it proposed that maternity report monthly to ensure that all reporting requirements are met.

The current perinatal reports include all elements of the national Perinatal Quality Oversight Model so complying with the technical guidance of safety action 6.

Regional oversight is in place through the quarterly perinatal oversight meeting which upwardly reports to the regional maternity board.

3.6.2 Maternity Outcomes Signal System

MOSS reporting is completed monthly in line with the recommendations. To date, none of the sites have achieved an alert. In accordance with Year 8 guidance a desk top MOSS skill drill needs to be completed. This has been completed by NNUH and JPUH with plans to gain Board safety champion approval at the next group safety champion meeting.
NNUH have submitted their test drill to the regional team in line with Year 8 requirements.

3.6.3. Maternity and Neonatal Board Safety Champions

Group Board perinatal safety champions are in place and undertaken monthly visits to each site. A monthly focus theme has identified areas of improvement and also sharing good practice across the sites. Feedback from the safety champions is included in the perinatal report and also in the quarterly upward report to the region. From August 12, staff engagement sessions with the non-executive safety champion will commence.

In addition to the walk rounds, a group perinatal safety champion meeting is held which is accordance with Year 8 guidance.

3.6.4 Perinatal Culture Improvement Plan

Each site reports on progress against their cultural improvement plan. The full plan has been discussed at the group perinatal safety champion meeting in line with national guidance.

Conclusion

Each service has rated themselves as being on track to delivering year 8 maternity incentive scheme. However, there are some risks to full compliance including evolving

board and group governance arrangements enabling maternity to comply with reporting requirements, the size of the national priority agenda for perinatal services all of which has be delivered by March 2027, the loss of the LMNS through the ICB restructure and the change in MNVP model impacting of the robustness of service user engagement and coproduction.

Recommendations

The Group Board is asked to:

- Note the Board Declaration Process and the deadline for submission of 2 March 2027.
- Note the current position against the six core safety actions.
- Support monthly reporting to the Perinatal Quality Standards Group against year 8 given the size of the national agenda for maternity to reduce the likelihood of missing key requirements.

Appendix 1: Workforce and Capacity

	JPUH	NNUH	QEHKL
Total number of consultants (WTE) **(number obs, number gynae, number combined O&G)**	Total of 14 wte Consultants who undertake combined O&G caseload. Medical staffing specifically supporting Obstetrics is 56.89 PA's including 15% SPA.	12 Obstetric Only	13.66 (combined rota)
Total number vacancy (WTE) **(number obs, number gynae, number combined O&G)**	There is 1 Consultant position due to be vacant soon – recruitment underway.	0	2 WTE interviews for substantive posts May 2026 due to start August/ September 2026
Is cover achieved as per RCOG standards for number of births (yes/no 100%)	Yes	Yes	Yes
On call frequency	Weekdays 1:12 Weekends 1:12	1:12	1:10
Consultant sickness (%) (Target 2.25%): **Other medical grades sickness (%) (Target 2.25%):**	April 2026 - 0.49% April 2026 - 0.99%	TBC	TBC

Consultant obstetrician lead roles and PA allocation for these (as per NHSE roles and responsibilities)	All Lead roles are in place and Job Planned for Obstetrics and Gynaecology – plan for R&G and Fetal Monitoring lead required.	TBC	TBC
Is consultant attendance achieved as per RCOG guidance (minimum standard 80%)	Yes. 'RCOG Must Attend Audit' for 2025 completed as part of CNST.	Yes	Yes
Are you working towards implementation of the RCOG guidance on compensatory rest or have you achieved this?	In place and the RCOG requirements are stipulated in trust policy.	Working towards	Yes
Total Number of *residents & non training grade doctors* (WTE) - on each tier (1st/2nd/3rd on call)	Middle Grades = 11 (including 1 x Gynae Oncology Senior Clinical Fellow - fixed term contract expires November 2026). Junior Doctors (SHO) = 10 currently on 1:10 rota.	Tier 1=10 Tier 2=10 Tier 3= 13	18.7 wte (8 Tier 1and 2, 10.7 Tier 3 up)
Total number *residents & non training grade doctors'* vacancy (WTE) - on each tier (1st/2nd/3rd on call)	Middle Grades = 11 (2 locum middle grades due to 2 WTE establishment vacancies). 3 trainees on August rotation (2.2 WTE out of 3.0). Junior Doctors (SHO) = 10+1 (additional Deanery Trainee).	0	-0.5 Tier 1 and 2 +0.2 Tier 3 and up

Cover achieved as per RCOG triage standards for medical reviews within a timely manner?	Yes	No	Yes
On call frequency for *residents & non training grade doctors*	1.10	Tier 1 – 1:13 Tier 2= 1:10 Tier 3 + 1:9	1:10
Sickness rates for *residents & non training grade doctors* (%)	0.99%	TBC	TBC
Is there a *duty anaesthetist* immediately available for the obstetric unit 24 hours a day with direct communication to the consultant anaesthetist?	Yes	Yes	Yes
Does the neonatal unit meet the relevant BAPM national standards of *medical staffing*?	Yes	Yes	Yes

Does the neonatal unit meet the relevant BAPM national standards of *medical staffing*?	Yes	Yes	No QIS at 47% trajectory to 69% by December 2026 mitigation in place to ensure safe care

Norfolk and Waveney University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	12.3		
Title	Group Perinatal Report		
Author(s)	Penny Snowden, Group Director of Midwifery Esther Dorken, Head of Midwifery and Nursing, QEHKL Nicola Lovett, Head of Midwifery, JPUH Lisa Mastrullo, Head of Midwifery, NNUH		
Executive sponsor	Rachael Cocker, Group Chief Nurse Rob Sherwin, Group Chief Medical Officer		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

The lack of Trust Board oversight has been a theme highlighted in recent national maternity reviews and to address this national Policy including the Perinatal Quality Oversight Model and NHS Resolution Maternity Incentive Scheme (CNST) require maternity services to report a range of metrics through service governance up to Trust Boards. The perinatal report includes these metrics and has been updated to reflect key emerging areas from the recently published reviews such as service user feedback. Further standardisation of the perinatal report at site level is in progress. Additionally, there will be greater triangulation and analysis of the data to identify areas that are progressing well and where further improvement is required.

For an overall summary, each site has self-assessed their progress and performance with NNUH rating amber for six domains (service user feedback, staff experience, safety, quality and learning, governance and oversight and workforce – equity not rated this month). Key issues include delayed Induction of Labour which are featuring in service user feedback, clinical incidents and with staffing levels impacting on performance. The lack of digital EPR maturity impacts on the service to have robust oversight of performance. Assistance is being provided to the service to develop an alterative electronic data capture system as an interim measure until the introduction of MEDITECH. Other mitigating action taken includes the introduction of the manager of the day who leads the daily escalation in accordance with the policy. This is issue is Risk #242 on the service risk register. An improvement plan has been developed with oversight of progress at the Perinatal Resilience Forum which is chaired by the Executive Managing Director/ Site Leadership team.

The second issue is telephony which is also featuring in service user feedback and clinical issues This relates to the difficulty in accessing telephone advice and support. Significant improvement and possibly investment will be required for the service to be

compliant with the newly published national Triage Specification which links to completion of the 10-point plan. The issue has been escalated to the Site Leadership team with solutions being explored.
The safety exception reports for NNUH highlight an outlier position for Stillbirths (3 cases) and Neonatal deaths (2 cases) for babies born from a Black and Brown Heritage on a 12-month rolling period. There has been no stillbirths or neonatal deaths for four months. Each case has been reviewed by the multiprofessional team in line with national guidance. No recurrent themes were identified. No language issues were noted. The mortality review processes have been revised in response to the cessation of the ICB Local Maternity Neonatal Voice Partnership with external representation strengthened at the review meetings.

NNUH safety reports also highlight an outlier position for postpartum haemorrhage (PPH) following a caesarean section. It is worth noting that NNUH are a regional site for Abnormal Invasive Placenta (AIP) (where the placenta grows too deeply into the womb lining. Whilst rare, it does have a higher haemorrhage risk). Currently, it is not known the impact of AIP on the overall PPH following caesarean section rate. However, NNUH are reporting higher rates than Cambridge which is the other regional unit in East of England. A multiprofessional group are leading improvement including the introduction of Carbetocin (drug that helps to contract the uterus and control bleeding) which is known to be effective in managing blood loss post caesarean section. Additionally, element five of the national maternity care bundle focuses on Obstetric Haemorrhage and to assist with further compliance, the team are progressing the introduction of measuring drapes to assist with accurate assessment of blood loss. Carbetocin is already in place at JPUH and QEHKL.

Smoking in pregnancy has been a challenge for all Norfolk sites and considerable progress has been made over the past 12 months with the introduction and evolvement of site based smoking cessation services. Performance metrics are outlined in the national Saving Babies Lives Care Bundle and all sites are compliant with CO monitoring in pregnancy. For May 2026, all sites are reporting rates lower than the national average of 6% which is a significant improvement as baseline rates were over 10% for JPUH and QEHKL which is reflective of the local demographics.

QEHKL are currently undertaking a deep dive into term baby admissions to the neonatal unit following a meeting in July 2026 with the regional neonatal and maternity team. The meeting was held in response to reporting rates higher than the national 6% target for several quarters. This position has improved in May 2026.

Equity in Pregnancy is critical to the safety of maternity services, and a section has been included in the report. Main points include JPUH's learning from incidents that has led to improvements in translation provision including greater use of video linked translation being used. All three sites will be joining the national Perinatal Equity and Anti-Discrimination Programme when it is launched across the East of England in January 2027. The programme will consist of 5 stages and will include ensuring clinical guidelines are inclusive, leaders are equipped to address discrimination and inequalities as well as the implementation of the national anti-discrimination framework.

From a regulatory perspective, the outstanding CQC 31 improvement notice relating to training compliance at QEHKL has now been formally closed.

From a workforce perspective there are several issues to note. Firstly, the lack of compliance with national British Association of Perinatal Medicine standards regarding neonatal nursing qualified in speciality standards at QEHKL The standard is 70% and the current position is 47% with a trajectory to reach 69% in December 2026 and over 70% in early 2027.

All three sites are in various stages of an external Birthrate Plus midwifery staffing review. Given the recommendations made following both Shrewsbury and Nottingham investigations, the regional maternity team have completed a review of midwifery headroom. This is particularly relevant given the nationally required training that needs to be completed on an annual basis. This equates to 75hours per midwife. Additionally maternity leave and sickness rates tend to be higher across the midwifery staff group than other groups. Currently this is not funded across the three sites and can places operational pressures on the units to safely staff activity and acuity potentially leading to delays in treatment. All services have to achieve training compliance as part of the national NHS Resolution Maternity Incentive Scheme (CNST). A paper has been formulated for the group to consider the need to accept the regional report's methodology and recommendations.

The executive summary highlights the key issues in the perinatal report with further detail in the slide deck report. It is recognised that the perinatal report is extensive. This is as a result of each service being a separate service and the need to independently report against the metrics. A group single service operating model would assist with streamlining the report. Redaction of the report has not been undertaken as this would comprise the evidence required by each site to demonstrate robust ward to board reporting as outlined in the NHS Resolution Maternity Incentive Scheme (CNST).

Recommendations

The Group Board is asked to:

- Note the contents of the report.
- Note the further standardisation of the report across the three services and the inclusion of greater triangulation and analysis.

Alignment to Board Assurance Framework risk(s)	PR2 Maternity Services Improvement
Previously considered by	Quality Standards Group
Any background papers in Admin Control Reading Room	No

NHS
Norfolk and Waveney
University Hospitals Group

NWUHG Perinatal Report Template

Month: July 2026

uthor: Penny Snowden, Group Director of Midwifery and

Site Perinatal Leadership Teams

Purpose of the Report

- In line with the National Perinatal Quality Oversight Model, the report's purpose is to inform the Group and Group Board of the quality and safety of maternity and neonatal services.
- The report provides both a group and site perspective in acknowledgement of the different size of service, service model and local community.
- In line with national guidance and NHS Resolution Maternity Incentive Scheme, the reports strengthens the ward to board reporting of perinatal oversight.
- The metrics included in the report are aligned to those specified in the Maternity Incentive Scheme, national Maternity Dashboard, the regional Perinatal Quality Oversight Model and those proposed in the National Oversight Framework.
- In line with NHS England's Blueprint model, the report forms part of the upward reporting to the regional Maternity Oversight Meeting
- The length of the report reflects that three separate services are being reported on and the number of metrics/areas that are required to be reported.

Contents

Executive summary – JPUH (Self Assessment)

Domain	RAG	Key Message
Service User Feedback		FFT recommend rate is good. All complaints responded to promptly with all families meeting with the perinatal leadership to ensure their voice has been heard properly
Staff Experience		Staff survey shows positive results and improved culture and leadership
Safety		Clinical and safety parameters remain within target
Quality and Learning		All incidents and events translate into learning and embedded into monthly R&G and Education feedback and mandatory education. QI Projects commissioned in direct repose to incidents.
Governance & oversight		Governance teams depleted due to vacancy and maternity leave. Escalation to Trust HR re recruitment which is now urgent . All aspects of governance up to date with all incidents being closed within 30 days
Workforce		Birthrate review completed and going to EMAG this month for approval. Vacancies recruited to.

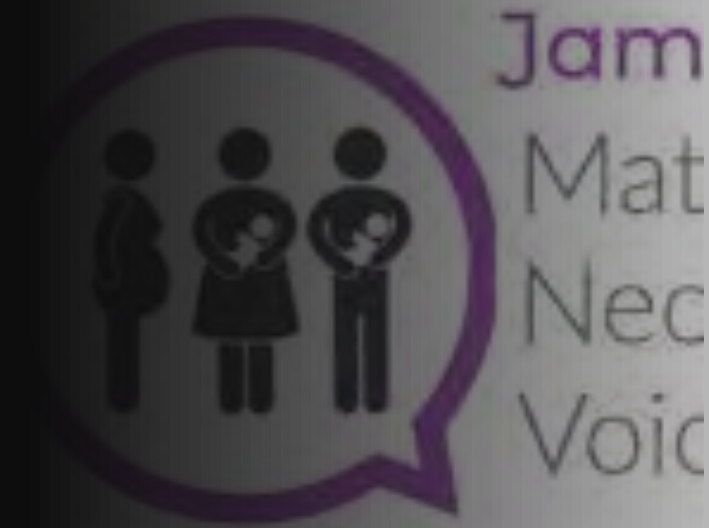
Executive summary – NNUH (Self Assessment)

Domain	RAG	Key Message
Service User Feedback		In liaison with ICB re MNVP. FFT /complaints /incidents data triangulation for presentation at Perinatal Resilience Forum (PRF)
Staff Experience		Wellbeing support in place via CG & OC Health Targeted sickness reduction work in place in collaboration with HRBP Leadership development ongoing with mentoring of CG Leads, Matrons & B7
Safety		Moss drill completed and identified themes and learning Pt safety coordinator in recruitment HLT /CG action plan shared at huddles HLT led Perinatal resilience forum established HLT /CG walk rounds
Quality and Learning		Moss Drill completed learning identified and shared at QSEG/HLT/Board . 60 steps feedback mirrored PRF/QSEG – shared with Board IOL plan /telephone triage monitored via PRF & QSEG
Governance & oversight		RR review & updated /PRF established DTI – x2 B7 roles to enhance RM governance resource
Workforce		B5/B6 interviews set for W/C 27/7, rapid onboarding in place B7 patient safety coordinator out to advert Workforce trajectory monitored via DOM/PRF Birthrate Plus review in process of commissioning

Executive summary – QEHKL (Self Assessment)

Domain	RAG	Key Message
Service User Feedback		Consistently good FFT communication and poor behaviours being seen as themes within complaints
Staff Experience		Teamwork feedback as a positive consistently some areas of concerns with the medical team
Safety		Positive assurance in most areas as evidenced, with good understanding of areas that need closer monitoring
Quality and Learning		Quality reporting is positive, learning is seen through the progression in the perinatal focus and data outcome improvements
Governance & oversight		Good governance and oversight within division through to the local Trust HMG by exception
Workforce		Some challenges with staffing despite having minimal vacancy. Headroom not adequate for the service

Service User Voice



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Summary of Service User Feedback - JPUH

Area of Feedback	Themes	Action Taken	Next Steps required
Maternity Neonatal Voice Partnership (MNVP)	Neurodivergent needs whilst an impatient-	• All staff have received additional training regarding neurodiversity. • Neurodivergent packs including "worry worm", ear plugs and eye masks to assist with de-sensitisation of the clinical environment • Reasonable adjustments in place too for patients and visitors	
Friends and Family Test	94.7% of people responded that positively. Lower satisfaction for birth experience and postnatal care reported Higher response rates reported for Maternity Triage and Maternity Assessment Unit	• Feedback related to unit diverts – all families have met with the team and received an apology letter.	BR+ staffing report commissioned and will work through the recommendations. Interpretation of the East of England Neonatal ODN demand and Capacity review. Improving cross group working through more transparent OPEL levels
Complaints	3 PALS and 2 formal complaints reported. Main complaint themes relates to communication and clinical care	1. Learning feedback to staff through Maternity Daily safety brief 2. Individual reflection where appropriate	• To improve communication to patients during periods of high activity and acuity • Improving the Induction of Labour leaflet to raise possibility of delays and manage expectations
Surveys	Poor environment – noise and cramped	• Estates revamped and services moved back to new modernised ward and Triage. • Recliner chairs in place for partners	• Ongoing work on Delivery suite • Bereavement Suite being upgraded. Service User involvement and QEHKL has been visited to learn from best practice.

Service User Co-production - JPUH

Current Projects	Improvements due to current projects
Birth Choices clinic	Part of Planned Caesarean QI work and in response to feedback on improving informed choice. Ensures consistency and thoroughness in counselling around birth choices.
IOL video	Improve the quality, consistency and accessibility of information on induction of labour, to support informed choice and manage expectations.
PN discharge video	Improve information-sharing on the postnatal discharge process to allow realistic expectations and therefore improve experiences.

CQC service user survey areas of focus	Areas of Focus
Labour & Birth	MDT communication, responsiveness to concerns. Co-produced action plan with MNVP now in place. PROMPT/skills scenarios reflective of service user voice.
Postnatal Care	Staffing, discharge process, analgesia, responsiveness. Ward 11 working group underway to prioritise improvements responsively to feedback.

Summary of Service User Feedback - NNUH

Area of Feedback	Themes	Action Taken	Next Steps required
Maternity Neonatal Voice Partnership (MNVP)	Booking by 9+6 weeks	Co-production of booking online self referral form Communications to women regarding booking early	To transfer to new MNVP model following the ICB restructure
Friends and Family Test	78.26% rated maternity experience as very good Themes included telephones, continuity, staffing and communication	Issue regarding telephones explored and reported through governance and site leadership team assisting with resolution	EPR build will standardise processes and improve continuity of carer
Complaints	Top three themes include: 1. Induction of Labour Delays 2. Communication and telephone issues 3. Labour and Postnatal Experience	1. Action taken above re telephones 2. Induction of labour delay improvement plan in place 3. Paper to Board regarding midwifery headroom funding in line with national average which will improve resilience. Recruitment to vacancies also in progress. Graduate funding announced	To implement the national Triage specification regarding a telephone helpline over the next 12 months
NICU Patient Experience Survey	92% rated overall experience as very good 100% rated communication with the clinical team as very good 91% felt equal partners in their baby's care 91% felt the amount of information provided as "just right"		• To target feedback from seldom heard families • To link in with wider work to capturing family's experiences.

Service User Co-production - NNUH

Current Projects	Improvements due to current projects
Social media programme for pregnancy and postnatal journey	Rolling programme to ensure key messages and information are received
Continued work with CQC survey action plan	Consent information and BRAIN to be translated and posted on social media.
'Book before 10'	Coproduction working group to increase bookings before 10 weeks. Improvement of self referral form and information provision.

CQC Maternity Service Users survey	
Where service user experience is best	**Where service user experience could improve and actions taken**
Being treated with respect and dignity (C17, B14)	Discharge Delays and asking questions about you're the labour and birth (C19 D2). Social media information shared including a video of what to expect for discharge
Did a midwife ask about your mental health? (G10)	Were you given appropriate information and advice on the risks associated with IOL? (C4). Continuous work ongoing re IOL – action plan in place with Trust. Social media information about IOL on rolling programme
Involving partner in care during labour and birth (C9)	Thinking about your antenatal care, were you given information about any warning signs to look out for during your pregnancy? (B16). Social media rolling content to share information regularly which would be translatable

Summary of Service User Feedback - QEHKL

Area of Feedback	Themes	Action Taken	Next Steps required
Maternity Neonatal Voice Partnership (MNVP)	No active MNVP for over 6 months	Awaiting substantive appointment of the joint MNVP lead for the three N&W Trusts	
Friends and Family Test	87.6-100% very good or good consistent responses across the division	Shared with staff on an individual basis and across governance	Continue to drive the ask for FFT at all stages of pregnancy and beyond birth
Complaints	Communication, behaviours of staff	1. Individual feedback given to those mentioned 2. 'My Story Matters' shared through governance	Continued triangulation of the themes and learning on an individual basis as well as the team
Surveys	None completed recently however good overall CQC service user feedback in the last year with positive improvements in all areas.		

Service User Co-production QEHKL

Current Projects	Improvements due to current projects
Infant Feeding plans	Full teaching plan now a year on to upskill staff in all areas of feeding this continues some challenges with the feeding team and the MNVP lack of resource due to current maternity leave
User face to face survey around neurodiversity	Now handed to staff to move forward due to the lack of MNVP

CQC Maternity Service Users survey	
Where service user experience is best	**Where service user experience could improve and actions taken**
Partners being able to stay	Culture between doctors and midwives as described above
Raising concerns and being listened too	Discharge planning; further focused work on improving timeliness and understanding through communication to women and families of potential reasons for delays that are not within our control
Pain relief in labour	*Gap in MNVP representation due to maternity leave and changes in ICB restructure*
Information around feeding your baby	*Gap in MNVP representation due to maternity leave and changes in ICB restructure*
Being able to ask questions about the birth	*Gap in MNVP representation due to maternity leave and changes in ICB restructure*

Staff Experience and culture

Staff Experience - JPUH

Area	Themes/ position	Action Taken	Next Steps
Proportion of midwives responding 'agree' or 'strongly agree' to whether they would recommend their trust as a place to work or receive treatment(PQOM Metric)	Awaiting 2025 data to be reported		
Proportion of specialty trainees in obstetrics and gynaecology rating the quality of clinical supervision out of hours as 'excellent' or 'good' (PQOM Metric)	The Trust score is 55.6 compared to a national score of 79	Overall, high satisfaction amongst trainees leading to the Deanery increasing trainee numbers	
Escalated Concerns	Staffing numbers on each shift given the opening of a separate Triage	• Considered as part of the external BR+ staffing review • Triage task and finish group established to ensure robust staff engagement.	• Implement national Triage Specification
Sickness/ absence Trends	Stress and Mental health related to staffing levels	• Time to talk with staff sessions facilitated • Rosters reviewed • On-call arrangements reviewed	• Explore further wellbeing initiatives
Staff Survey	Improved from last year particularly in relation to culture, leadership and morale	• Celebrated successes • Responsive to Community midwives to work 12 hours. • Continued improvement through staff engagement sessions	• Exploring implementing greater rotation amongst midwives

Culture Improvement Update- JPUH

Themes	Actions	How will you know when improvement is achieved?
Culture between Midwives and Obstetricians from CQC	• Joint GMC and NMC workshops • Weekly walk rounds • HOM attends Consultant's meetings and education sessions • HR action taken • New team now in place • Escalation Survey –are people happy to escalate?	GMC trainee Results Staff Survey Workforce KPI's
CQC Survey highlighted poorer feedback around perceived obstetric/midwifery relationships in Central Delivery Suite (this has not been a theme present in complaints or other feedback)	• Team of the Shift now utilised as tool for knowing who is on team and who to escalate to • 'Advise/Inform/Do' and 'Teach or Treat' launched as Safety Escalation Toolkit; promotes opportunities for learning within escalation and professional challenge • Labour Ward Coordinator Away Day with focus on wellbeing and listening to concerns	Escalation survey results Monitoring of ongoing feedback from Labour Ward Forum Monitoring for theme in complaints/MNVP feedback – reviewed at Quarterly Feedback Meeting

Staff experience- NNUH

Area	Themes/ position	Action Taken	Next Steps
Proportion of midwives responding 'agree' or 'strongly agree' to whether they would recommend their trust as a place to work or receive treatment(PQOM Metric)	Awaiting 2025 data to be reported		
Proportion of specialty trainees in obstetrics and gynaecology rating the quality of clinical supervision out of hours as 'excellent' or 'good' (PQOM Metric)	Higher than the national average for quality of clinical supervision (85.7) and handovers to trainees (		Improvement required for support working environment where the Trust reported a score of 57.1 against a national average of 72.2
Escalated Concerns	Lack of equipment	Equipment inventory created. Equipment ordered	To ensure robust processes to ensure adequate equipment in the clinical area.
Sickness/ absence Trends	Sickness rate at 6% with the most common reason for absence stress, anxiety and depression	• Stress action plans being undertaken • Wellbeing on Wheels will be visiting the service • Review of rosters	To develop a plan to achieve national ratio of Professional Midwifery Advocates per midwife to ensure adequate restorative supervision support.
Staff Survey	Deterioration in all scores for the maternity service. Lowest scores were morale, flexible working, always learning, respected and rewarded and safe/healthy	• Cultural improvement plan in place. • External Birthrate Plus staffing review due to be commissioned • Active Bystander training to be delivered to 280 staff.	

Culture Improvement Update- NNUH

Themes	Actions	How will you know when improvement is achieved?
High sickness rate for midwives and MCA's. Particularly stress and anxiety	Continued work with HRBP and team to reduce sickness. This includes planned whole unit stress risk assessment with PMA's. Wellbeing conversations with staff when sick and offered generally. Plan to fill shifts with overtime and agency, ongoing workforce plan for vacancy.	Sickness rates improve
Culture between teams	Work being undertaken to address culture issues between teams with PMA. Including meetings for representatives for each area	Less incident reports and reports of concerns
Culture improvement plan	This is ongoing and will be fluid with new additions including the above 8 actions currently – 2 closed. 2 to be added. Template to be improved to share at next quarterly meeting	Staff survey results improvement Safety champion walkabout suggest our culture is improving

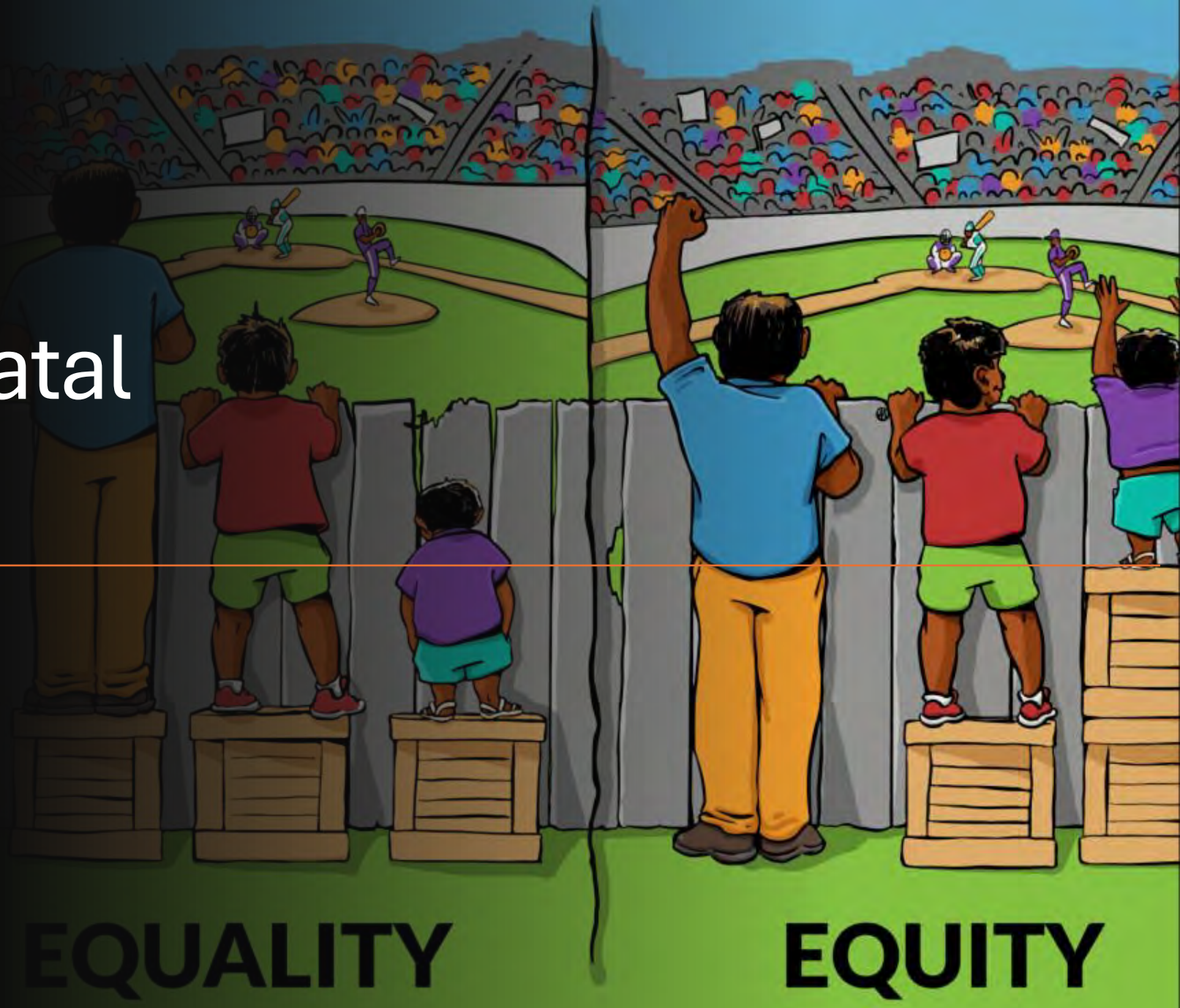
Staff experience -QEHKL

Area	Themes/ position	Action Taken	Next Steps
Proportion of midwives responding 'agree' or 'strongly agree' to whether they would recommend their trust as a place to work or receive treatment(PQOM Metric)	Organisation 36.5% Nursing and Midwifery Registered 37.9% Division of W&C 52.3%	Sharing themes of the Staff survey	Part of the N&W One Recovery Continue with our own W&C staff Survey and show results through a dashboard every 6 months
Proportion of specialty trainees in obstetrics and gynaecology rating the quality of clinical supervision out of hours as 'excellent' or 'good' (PQOM Metric)	The Trust score is 57 compared to a national score of 79	Shared with the consultant team being managed by the medical director	Potential Student engagement sessions being held Trustwide consideration of a divisional feedback opportunity
Escalated Concerns	• Some concerns raised with staff from the ward unhappy with the perceived non reciprocated support from the Delivery Suite at times of high acuity. • Poor behaviours of some consultants	SMOC contact shared more widely any staff can escalate a concern at any time. Staff reviews each 4 hours at times of high acuity Visibility of the SLT in all areas Escalation to the DLT and to the Medical director	Monitor staff through our W&C staff survey to gauge any change Ask for feedback from the medical director the 'so what' Vanderbilt will help once launched
Sickness/ absence Trends		All staff have supportive return to work conversations/flexible working conversations/ Staff vacancies reviewed and recruited to /Bank cover if needed	Continue to monitor
Staff Survey	Please see next slide for detail	Survey has only just been shared with the DLT Engagement sessions have started to share with the staff with emails of the results being sent out to all staff	Vanderbilt as a part of the N&W One Recovery programme

Culture Improvement Update- QEHKL

Themes	Actions	How will you know when improvement is achieved?
Communication Behaviours Attitudes	Monthly Culture improvement meeting with actions progressing. Further survey within division being undertaken for June to inform the dashboard Engagements sessions with staff although not well attended	Positive up turn in the culture dashboard results
Felt that the midwives and / or doctors looking after them worked well together during labour and birth was less favourable than last years results in the CQC survey	Triangulation of the data has helped focus on culture between midwives and doctors and ideas to improve communication are actioned through the culture improvement plan.	Positive improvement in the culture dashboard Improved staff satisfaction scores Improved CQC survey in that area of focus
The 2025 Staff Survey shows a broad decline in staff experience compared to 2024 across both the organisation and the W&C division. While core elements of team culture, purpose, and line management remain strengths, this is being offset by significant pressures relating to staffing, workload, and organisational responsiveness. W&C results broadly mirror organisational trends but are consistently lower in key areas, particularly those linked to capacity, recognition, and confidence in the organisation.	Strategic Priorities for Action • Address workforce pressure • Safe staffing, rota stability, and workload management • Strengthen organisational listening and response • Demonstrable action on concerns raised (“you said, we did”) • Improve recognition and visibility • Strengthen organisational-level appreciation and feedback • Enhance manager capability • Focus on feedback, involvement, and supportive conversations • Reinvigorate career development • Clear pathways, meaningful appraisals, and development outcomes	Positive staff survey reports Better staff engagement with the senior team

Equity in Perinatal Care



Equality, Diversity and Inclusion improvement - JPUH

Equality, Diversity and Inclusion	Inequalities identified	QI projects aligned to EDI themes	How will you know when improvement is achieved?
Workforce	Staff unable to articulate the importance of EDI .	Data now included in all projects, and EDI is a regular conversation. The Perinatal IPR includes EDI status against clinical outcomes and support staff in recognition of needs. Midwives' Mandatory Training includes session on Marginalised Voices in Maternity Care. Use of Inclusive language Neurodiversity work with the MNVP. Personalised care plans. Social media and documentation reflects inclusion. Neurodiversity video created and reasonable adjustments in place. Subject included in mandatory training. Eden Team supports teenage parents and birthing people from the travelling community.	EDI consideration becomes BAU
Service user	High % incidence of neonatal readmission from families who do not have English as first language Translation services	Eden Team now identify these families and caseload their care. This increases continuity of care (not intrapartum) to 90-100% and will ensure that health and social needs are recognised early and correct signposting is initiated to support a multi-disciplinary approach to care. Upcoming 'Topic of the Month' planned to focus on translation services.	Reduction in readmission rates.

Equality, Diversity and Inclusion Improvement - NNUH

Equality, Diversity and Inclusion	Inequalities identified	QI projects aligned to EDI themes	How will you know when improvement is achieved?
Workforce	EDI training for staff	MNVP coproduction will cease in July but work will continue with PMA's support	Awareness of EDI is evident in interviews
Service user	Booking before 10 weeks below target - specifically for women from black and Asian minority ethnic groups	Working group have established specific social media and hard copy information in the top 3 languages for the NNUH. Awaiting final sign off for release.	Bookings before 10 weeks for black and Asian minority ethnic groups is improved

Equality, Diversity and Inclusion Improvement- QEHKL

Equality, Diversity and Inclusion	Inequalities identified	QI projects aligned to EDI themes	How will you know when improvement is achieved?
Workforce	None identified	Workforce equality programmes in Trust: Monitoring WDES and WRES data and sharing at board level Staff networks in place: LGBTQ+, disability and service personnel Disability mandated training for staff Policies in place to support management of bullying, harassment and discrimination Staff signed up to a reverse mentoring programme	N/A
Service user	None identified	Provide translation services Use accessible information i.e. braille Consistently support making individual plans using reasonable adjustments Respectful of cultural and religious needs Understanding our demographic and the need for targeted support for some Work with our MNVP on service design and change	N/A

Safety Performance JPUH

Maternity Safety Performance Summary – JPUH May 2026

Measure	JPUH May Data	Rolling Yearly Rate	Target	Regional Average Performance
Number of Births	143	1567	n/a	n/a
Number of Births (Black, Asian, and Mixed Black and Mixed Asian Women and Birthing People)		80	n/a	n/a
Stillbirth Rate, per 1000	0.7	0.6	<2.6	2.6
Stillbirth Rate (Black, Asian, and Mixed Black and Mixed Asian Babies), per 1000	0.0	0.0	<2.6	3.4
Neonatal Death Rate, per 1000	0.0	1.3	<3.5	1.52
Neonatal Death Rate (Black, Asian, and Mixed Black and Mixed Asian Babies), per 1000	0.0	0.0	<3.5	1.87
Numbers of Babies Born with HIE 2&3	0	0		
Maternal Deaths	0	0		
Term Admissions (%)		5.0	6.0%	
Bookings by 10 Weeks – All, (%)	88.6%	88%	90%	
Bookings by 10 Weeks (Black, Asian, Mixed Black & Mixed Asian), (%)	78%	72.6%	90%	

Maternity Safety Performance Summary – JPUH May 2026

Measure	JPUH May Data	Rolling Yearly Rate	Target	Regional Average Performance
PPH ≥ 1500mls (%) SVD	1.4%	3.0	3.2%	3.1%
PPH ≥ 1500mls (%) CS	2.2%	3.5	3.5%	3.5%
Admission to ITU	0		N/A	
Third- and fourth-degree tears, SVD(%)	0%	1.5	2.5%	2.4%
Third- and fourth-degree tears, Instrumental (%)	0%	3.8	4.5%	5.6%
Triage – initial assessment with a midwife within 15 minutes (%)	89%	89.3	>85%	84.8%
Triage – medical assessment for orange rated within 15 mins of midwifery initial assessment (%) (new KPI to report to region)	New metric	New metric	TBC	
Delay in Induction of Labour of over 24 hours	2		0	
Smoking at time of delivery, (%)	3.4%		<6%	

Neonatal Safety Summary JPUH – May 2026

Measure	JPUH May Data	Rolling Yearly Rate	Target	Regional Average Performance
Preterm Birth Rate	5.6	8.3%	<6%	7.0%
Place of Birth – Number of Births < 27 weeks gestation, multiples < 28 weeks gestation, or any gestation with fetal weight < 800g	1	2	N/A	
% babies born < 30 weeks of gestation who received In utero magnesium sulphate within the 24 hours prior to birth	0% (1 baby)	50%	85%	82.3%
% babies who were eligible for antenatal steroids that received it	0% (1 Baby)	51.5%	85%	48.9%
% babies born < 34 weeks of gestation who received IV intrapartum antibiotic prophylaxis	60% % (1 baby)	75%	95%	69.6%
% babies born < 34 weeks of gestation who had their umbilical cord clamped at or after one minute after birth	100%	81.8%	85%	73.2%
% babies born <34 weeks of gestation who receive their own mother's milk within 24 hrs	49%	45.5%	100%	57.4%
% babies born <34 weeks of gestation who have temperature taken within one hour of birth AND which is between 36.5– 37.5°C	100%	90.9%	80%	85.9%

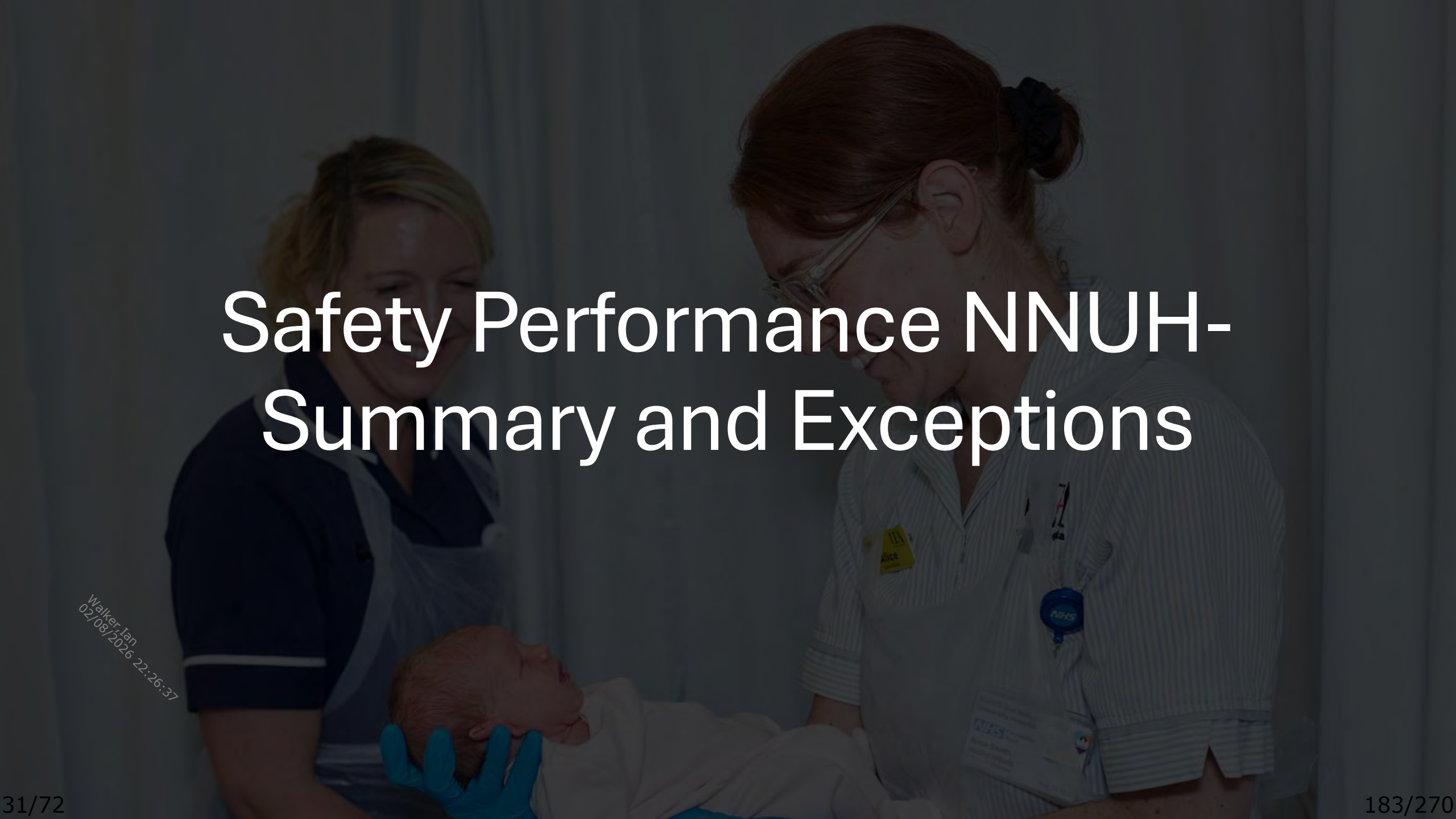
Safety Champions meetings and walk rounds- JPUH

Feedback raised by staff, last three months	Response
Leadership, visibility and recruitment processes.	Monthly Workforce meeting introduced. Management and Specialists supporting with clinical cover during periods of high acuity and increased sickness absence/establishment vacancies. Additional on call cover provided when out of guidance homebirth is due. Time to Talk sessions available.
Preceptorship support.	One to one meetings held with Preceptorship Midwives and very positive feedback received about support. No concerns raised. Increase of contractual hours supported and actioned for part-time staff. A preceptorship training package for planned caesareans is now in development.
Feedback raised by service users, last three months	**Response**
Delays and process around Induction of Labour.	IOL information animation video (adapted from QEH) has been produced, will help to manage expectations on length of process and make IOL information more accessible and support informed decision making. IOL patient leaflet updated to reflect option of misoprostol. Reporting criteria under review by Inpatient Matron to ensure local incident reporting system, SitRep and Red Flag reporting aligns where possible. New risk assessment tool developed to aid robust risk assessment in practice and clear documentation
Informed Consent: challenges to achieving information sharing to allow informed consent during emergencies.	Informed consent has now been embedded into PROMPT training; one of the scenarios includes evolving risks and levels of urgency to allow staff to practice pressured informed consent conversations in a safe environment.
Additional safety champions intelligence, last three months	**Response**
Bereavement	Bereavement room requires upgrade. Plans for re-decoration once RAAC works completed on CDS.
Early pregnancy loss	Early pregnancy loss – escalated to the division. Co-ordinated MDT response to Fuller report and action plan in place.

National Data Monitoring Tools- JPUH

Number of MOSS signals in last three months	Was review completed and approved by trust board executive within 8 working days?	If not, why?
0	N/A	

Closures reported in daily Sit Rep last three months (frequency and by area MLU, Obs, Homebirth)	Themes identified by MDT review of closures	QI
April 0 **May** 3 **June** 3 Walker Ian 02/08/2026 22:26:37	X2 occasions divert was implemented due to Maternity operational pressures X4 occasions divert was implemented due to Neonatal capacity: Escalated to Divisional Governance – consideration for risk regarding neonatal capacity to be added to Trust Risk Register	



Safety Performance NNUH- Summary and Exceptions

Maternity Safety Performance Summary – NNUH May 2026

Measure	May Data	Rolling Yearly Rate	Target	Regional Average Performance
Number of Births	395	4720	n/a	n/a
Number of Births (Black, Asian, and Mixed Black and Mixed Asian Women and Birthing People)	59	553	n/a	n/a
Stillbirth Rate, per 1000	0	2.8	<2.6	2.6
Stillbirth Rate (Black, Asian, and Mixed Black and Mixed Asian Babies), per 1000	0	5.4 (3 cases)	<2.6	3.4
Neonatal Death Rate, per 1000	2.5	3.6	<3.5	1.52
Neonatal Death Rate (Black, Asian, and Mixed Black and Mixed Asian Babies), per 1000	0	6.1 (2 Cases)	<3.5	1.87
Numbers of Babies Born with HIE 2&3	0	0.9		
Maternal Deaths	0	2		
Term Admissions (%)	7.6%	5.7%	6.0%	
Bookings by 10 Weeks – All, (%)	75.6%	73.6%	90%	
Bookings by 10 Weeks (Black, Asian, Mixed Black & Mixed Asian), (%)	73.3%	63.1%	90%	

Maternity Safety Performance Summary - NNUH: May 2026

Measure	NNUH May Data	Rolling Yearly Rate	Target	Regional Average Performance
PPH ≥ 1500mls (%) SVD	1.9%	2.4%	3.2%	3.1%
PPH ≥ 1500mls (%) CS	8.6%	4.3%	3.5%	3.5%
Admission to ITU	1		N/A	
Third- and fourth-degree tears, SVD(%)	2.5%	2.4%	2.5%	2.4%
Third- and fourth-degree tears, Instrumental (%)	6%	5%	4.5%	5.6%
Triage – initial assessment with a midwife within 15 minutes (%)	88%	85%	>85%	84.8%
Triage – medical assessment for orange rated within 15 mins of midwifery initial assessment (%) (new KPI to report to region)	66%	TBC	TBC	
Delay in Induction of Labour of over 24 hours	See exception report		0	
Smoking at time of delivery, (%)	2%	4.8%	<6%	

Neonatal Safety Performance NNUH: May 2026

Measure	NNUH May Data	Rolling Yearly Rate	Target	Regional Average Performance
Preterm Birth Rate	8.7%	7.0%	<6%	7.0%
Place of Birth – Number of Births < 27 weeks gestation, multiples < 28 weeks gestation, or any gestation with fetal weight < 800g	2	20	N/A	
% babies born < 30 weeks of gestation who received In utero magnesium sulphate within the 24 hours prior to birth	100%	92.9%	85%	82.3%
% babies who were eligible for antenatal steroids that received it	33%	49.5%	85%	48.9%
% babies born < 34 weeks of gestation who received IV intrapartum antibiotic prophylaxis	100%	78.2%	95%	69.6%
% babies born < 34 weeks of gestation who had their umbilical cord clamped at or after one minute after birth	66.7%	72.5%	85%	73.2%
% babies born <34 weeks of gestation who receive their own mother's milk within 24 hrs	77.8%	69.7%	100%	57.4%
% babies born <34 weeks of gestation who have temperature taken within one hour of birth AND which is between 36.5– 37.5°C	89%	93.6%%	80%	85.9%

Safety Champions meetings and walk rounds themes NNUH

Feedback raised by staff, last three months	Response
Equipment concern raised by staff	Equipment ordered and process in place to ensure equipment always available
Staffing	Adverts out for Band 6 and Band 5 to fill vacancy
Feedback raised by service users, last three months	**Response**
Issues with telephony service and getting through to correct area	SLT and digital team have action plan to resolve.
MNVP and feedback provision	ICB to recruit lead for NWUHG
Additional safety champions intelligence, last three months	**Response**
No fast- track route for women who have had an amniocentesis or CVS post procedure at NNUH	Fast track process agreed with gynaecology and fetal medicine team. Pathway in place and implemented
Use of a candle being on Delivery Suite at QEHKL to signify to staff that the bereavement suite was being used	Adapted and implemented at NNUH

National Data Monitoring Tools

Number of MOSS signals in last three months	Was review completed and approved by trust board executive within 8 working days?	Learning – themes from Critical Safety Review
0	N/A	

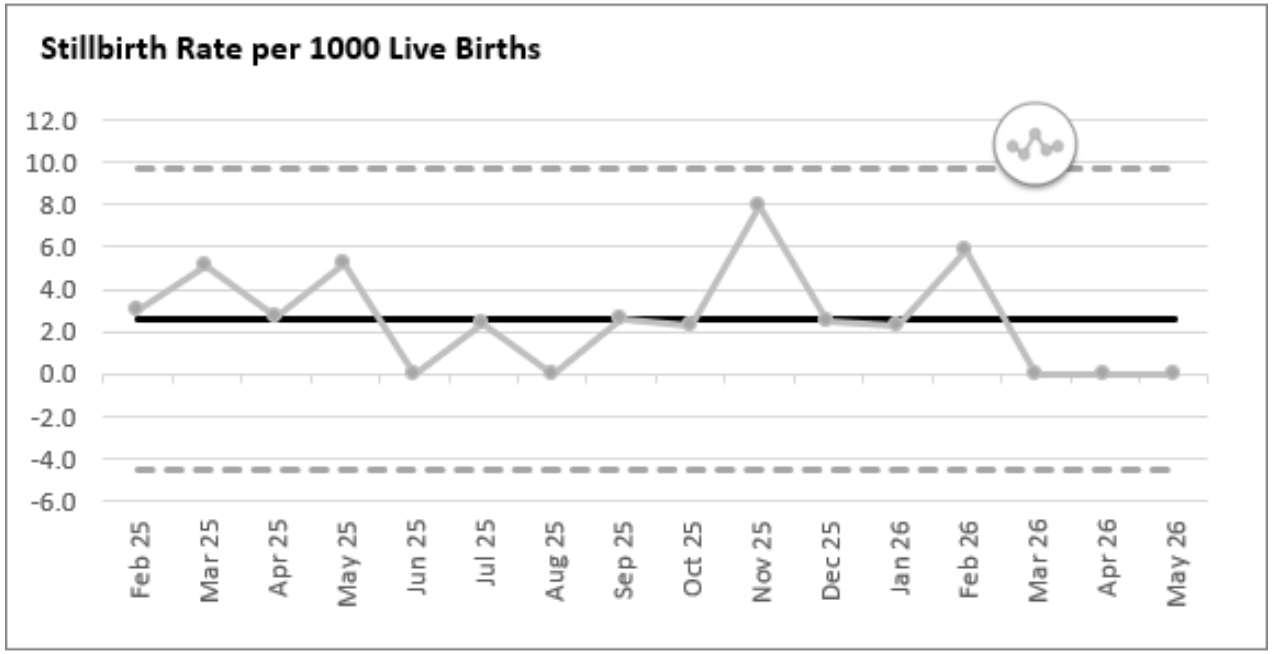
Closures reported in daily Sit Rep last three months (frequency and by area MLU, Obs, Homebirth)	Themes identified by MDT review of closures	QI
NNUH – 2 MLBU - 5	Staffing and acuity/NICU closure	Utilisation of SitRep for assistance

Stillbirth Rate per 1000 Live Births

RAG	MBRRACE

May - 26	Rolling YTD	Standard
0.0	2.8	<2.6

Compliance	Variance	Assurance	Actions
			



Site Performance

- In May there were no stillbirths reported
- Rolling YTD is 2.8 Stillbirths per 1000 births, 0.2 over target.

Summary of Progress

- Each case is reviewed via internal governance processes and PMRT
- Uterine Artery Doppler pathway being progressed.

Action to be taken

- Review of Mortality process completed
- Improved quarterly reporting to identify themes
- External representation at review meetings strengthened

Risks and Issues

- 1 quarter behind with reporting
- Delay in identifying themes and implementing actions

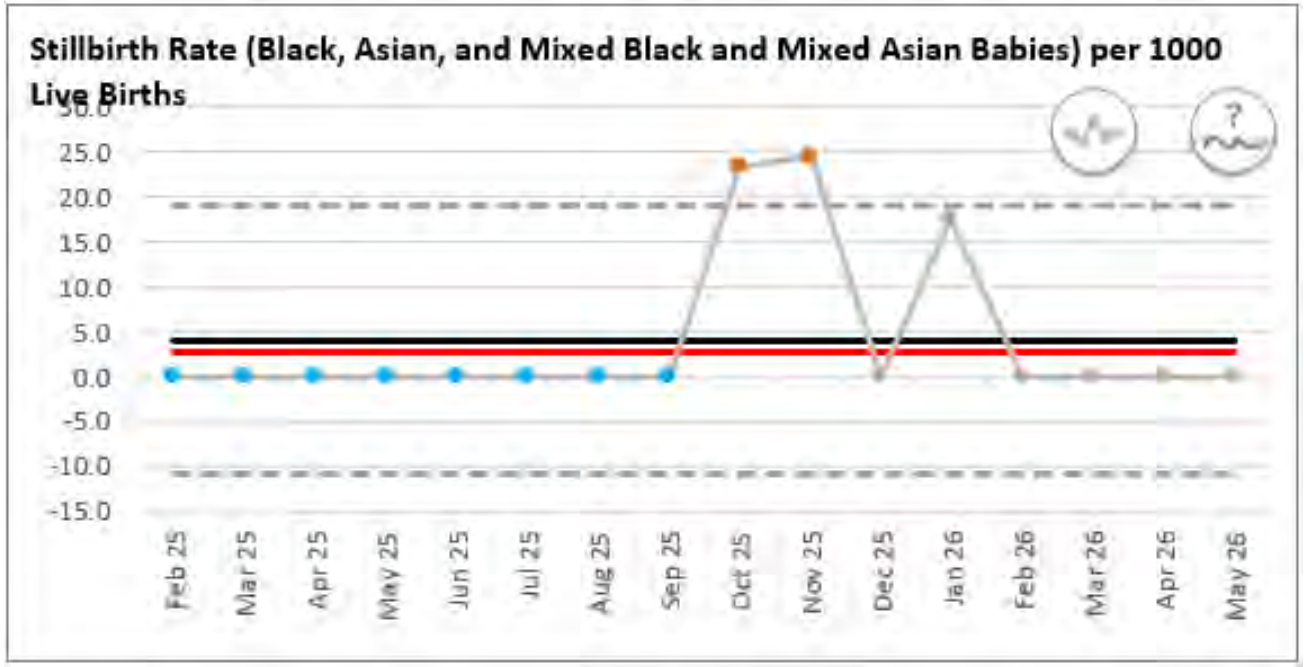
being addressed through discussions regarding governance team resource

Stillbirth Rate (Black, Asian, and Mixed Black and Mixed Asian Babies) per 1000 Live Births

RAG	MBRRACE

May - 26	Rolling YTD	Standard
0.0	5.4	<2.6

Compliance	Variance	Assurance	Actions
			



Site Performance

- In May there were no stillbirths reported- this the fourth month of no cases.
- Rolling YTD is 5.4 Stillbirths per 1000 births, 2.8 above target.

Summary of Progress

- Each case is reviewed via internal governance processes and PMRT
- Work with MNVP to increase booking by 10 weeks

Action to be taken

- Review of Mortality process Completed
- National Perinatal Equity and Anti-discrimination programme to be launched later in 2026 across East of England

Risks and Issues

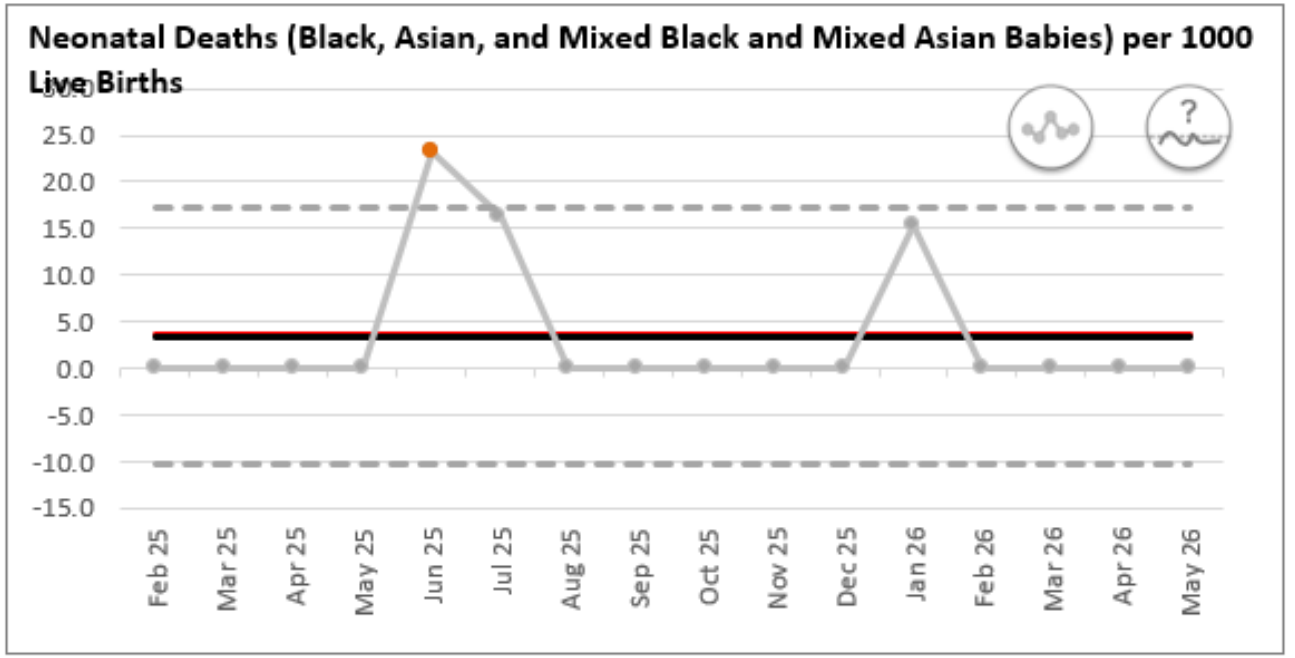
- 1 quarter behind with reporting
- Delay in identifying themes and implementing actions
- Loss of MNVP to support QI work and feedback

Neonatal Deaths (Black, Asian, and Mixed Black and Mixed Asian Babies) per 1000 Live Births

RAG	MBRRACE

May - 26	Rolling YTD	Standard
0.0	6.1	<3.5

Compliance	Variance	Assurance	Actions
			



Site Performance

- In May there were no neonatal deaths reported
- Rolling YTD is 6.1 Stillbirths per 1000 births.

Summary of Progress

- Each case is reviewed via internal governance processes and PMRT

Action to be taken

- Mortality review with Neonatal and Maternity Mortality teams to improve processes, learning and escalation

Risks and Issues

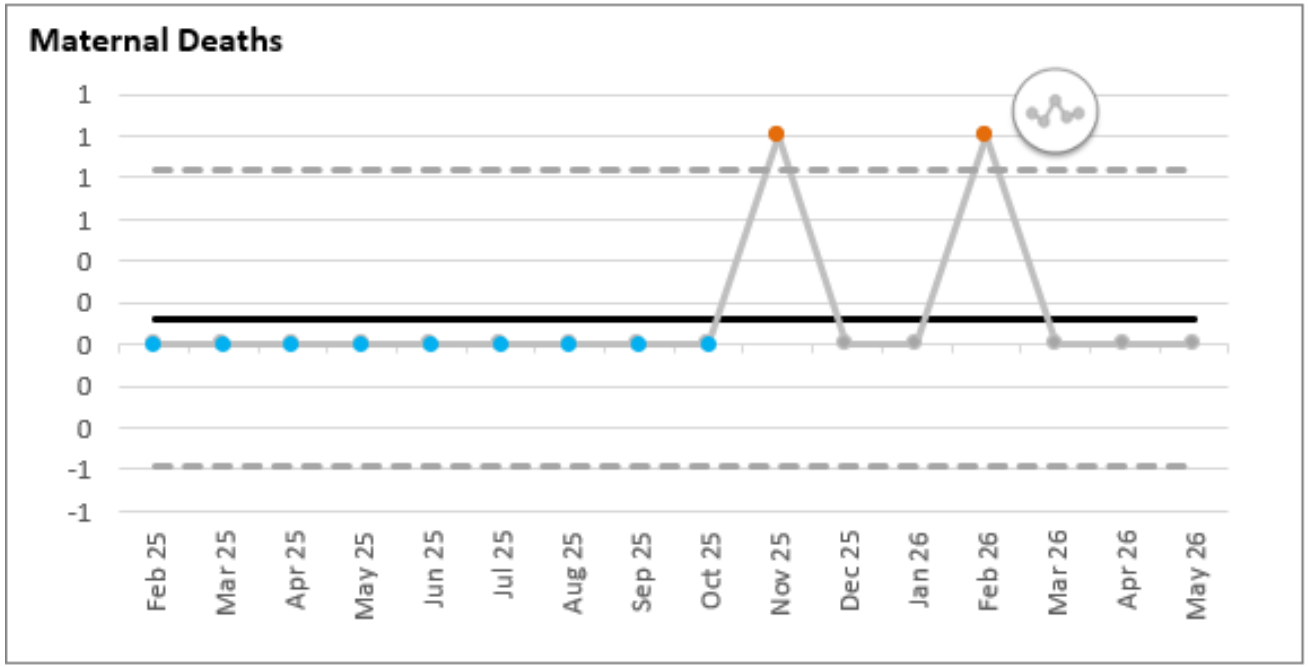
- Lack of QI support to improve status being discussed with Site leadership team
- Loss of MNVP to support QI work and support feedback (on risk register) and discussions with ICB in progress

Maternal Deaths

RAG	MBRRACE

May - 26	Rolling YTD	Standard
0	2	NA

Compliance	Variance	Assurance	Actions
			



Site Performance

- Sadly, there have been two maternal deaths this year at the NNUH by suicide
- 1st death late maternal death, known mental ill health
- One death was following miscarriage at 6 weeks. Not booked

Summary of Progress

- All deaths reviewed by team and no care concerns from NNUH
- Process in place for mortuary to inform Bereavement team
- Changes in early pregnancy referral to mental health team

Action to be taken

- Cross agency working for report with NSFT

Risks and Issues

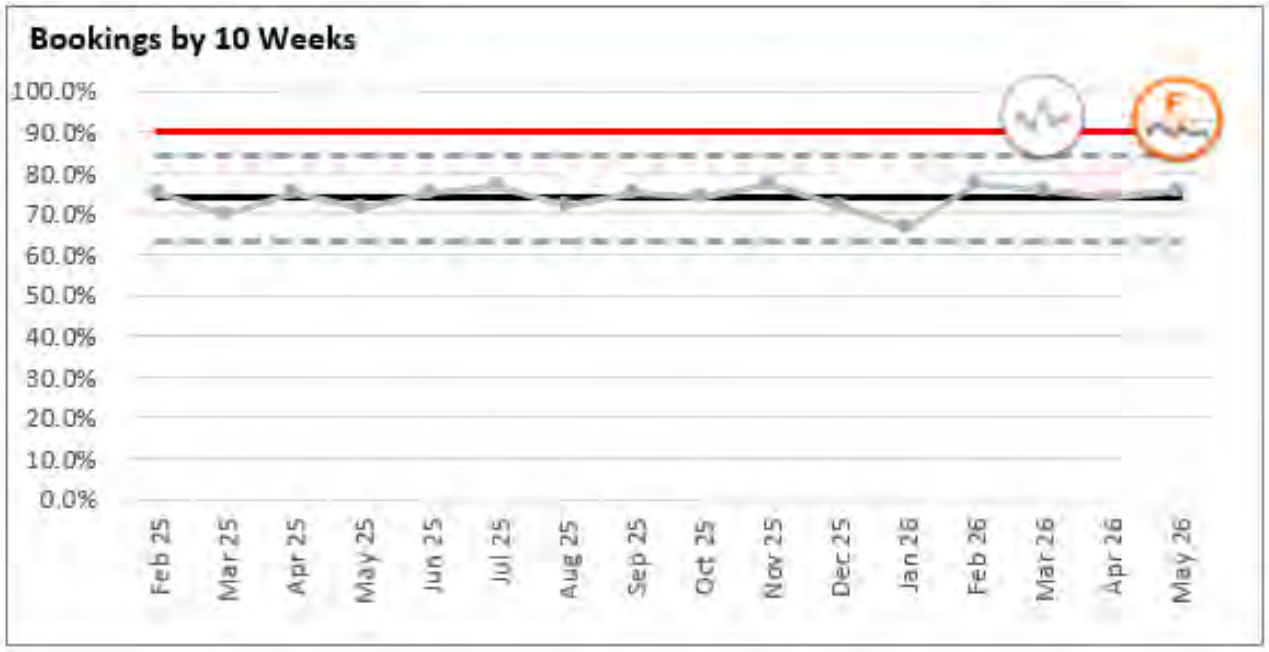
- Concern for vulnerable women and processes in place

Bookings by 10 Weeks

RAG	Local/Regional/ National

May - 26	Rolling YTD	Standard
75.6%	73.6%	90%

Compliance	Variance	Assurance	Actions
			



Site Performance

- Below target of 90% bookings before 10 weeks

Summary of Progress

- Working group in place to reduce variance
- Updated referral form linked to spreadsheet to give priority to those nearing 10 weeks

Action to be taken

- Social media programme for 'Book before 10' ready for release
- Information on how to book and when

Risks and Issues

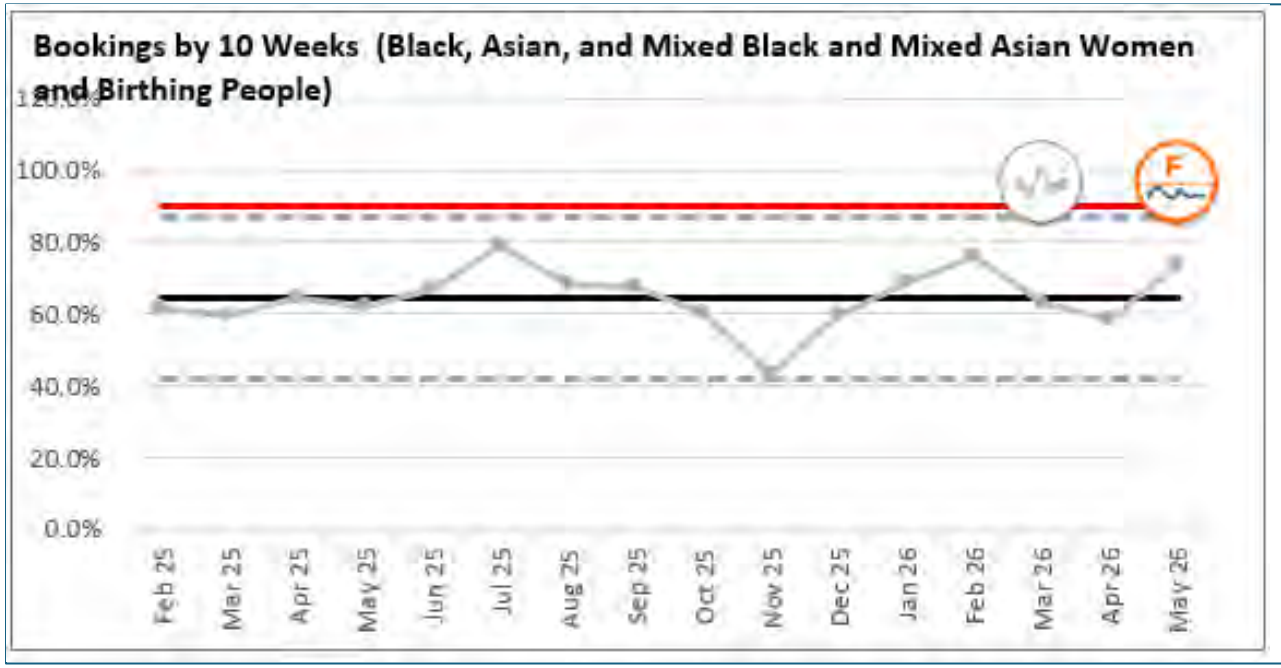
- Bookings require a call to CMC for appointment
- Issues with phonelines ongoing but plan in place for resolution
- Email address issued to arrange call backs
- Loss of MNVP to support feedback and QI

Bookings by 10 Weeks (Black, Asian, and Mixed Black and Mixed Asian Women and Birthing People)

RAG	Local/Regional/National

May - 26	Rolling YTD	Standard
73.3%	63.1%	90%

Compliance	Variance	Assurance	Actions
			



Site Performance

- Below target of 90% bookings before 10 weeks
- This is lower for Black, Asian and Mixed Asian women and vulnerable groups

Summary of Progress

- Working group in place to reduce variance
- Updated referral form linked to spreadsheet to give priority to Black, Asian and Mixed Asian women and vulnerable groups

Action to be taken

- Translated social media programme and posters created in top 3 languages
- Rolling content
- Posters to be used in GP surgeries, contact centres, library's etc.

Risks and Issues

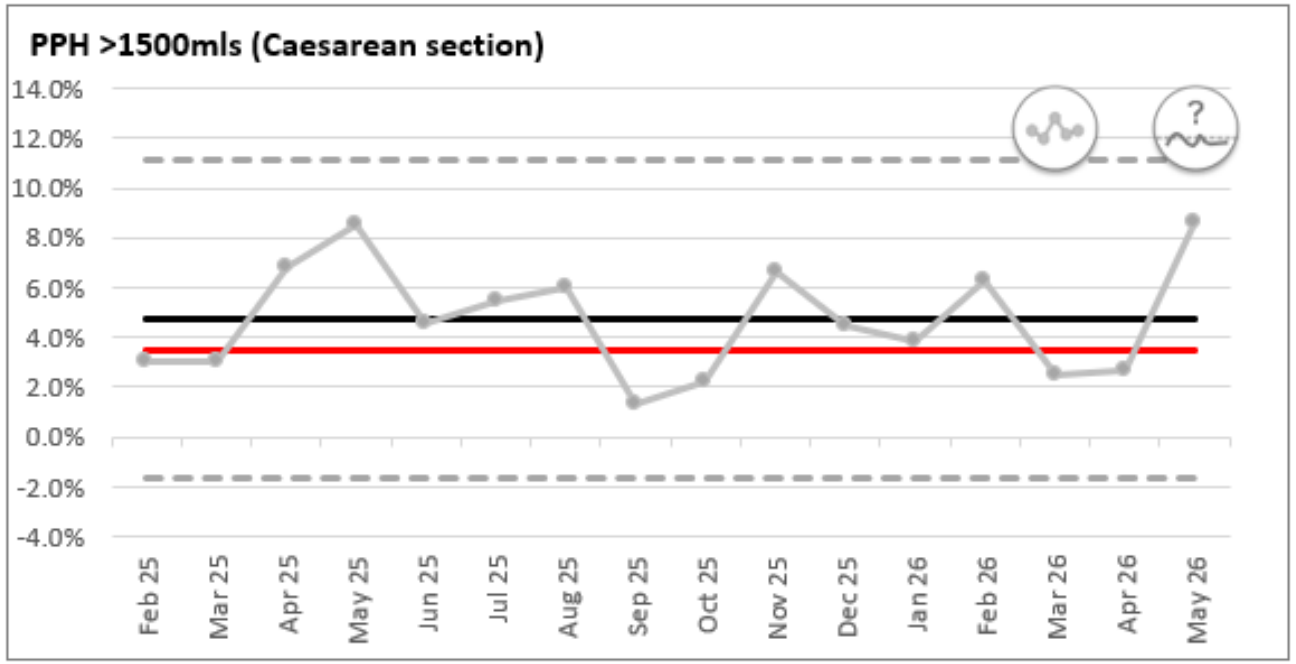
- Bookings require a call to CMC for appointment
- Issues with phonelines ongoing but plan in place for resolution
- Email address issued to arrange call backs
- Loss of MNVP affecting QI and feedback

PPH >1500mls (Caesarean section)

Alert	Local/Regional/National

May - 26	Rolling YTD	Standard
8.6%	4.3%	3.5%

Compliance	Variance	Assurance	Actions
			



Site Performance

- Higher than average for PPH rates for Caesarean Section
- Not above upper limits but improvement work is needed.

Summary of Progress

- Back to basics learning
- Topic of the Month
- Carbetocin to be used in Caesarean section deliveries to reduce PPH
- Updated 3rd stage guidance

Action to be taken

- Continued review of rates
- Implementation of Maternal Care Bundle
- Revival of Group PPH improvement team

Risks and Issues

Actions to be implemented at pace.

Delay in Induction of Labour

RAG	NOF

May - 26	Rolling YTD	Standard
TBC	TBC	0

Compliance	Variance	Assurance	Actions
			

We do not have accurate data for this metric. E3 data for women receiving prostaglandin medication suggest 82.4% commence IOL within 6 hours from admission. Therefore, we cannot say what the delay is for the remaining group who have induction without prostaglandin medication (mechanical IOL or amniotomy).

Our red flag data for the same time period reports at least 2.3% of IOLs are delayed more than 6 hours at the point of admission.

We have limited assurance that operational plans will improve performance in achieving commencement of IOLs within 6 hours of admission. There is a lack of operational oversight of this metric due to digital immaturity and process gaps. Midwifery staffing, antenatal/intrapartum/postnatal bedspace availability and neonatal capacity are all contributing factors to delays.

Site Performance

- Action plan oversight at Directorate Oversight Meeting and Q&S
- Due back for review July 2026
- Trust Risk ID #242

Summary of Progress

- Process for electronic recording for IOL being agreed via ICE clinical form and ? ORSOS for home waits.
- Daily escalation processes in place.
- All incidents reported via InPhase.

Action to be taken

- Implement electronic recording process. (expected by 31.08.2026).

Risks and Issues

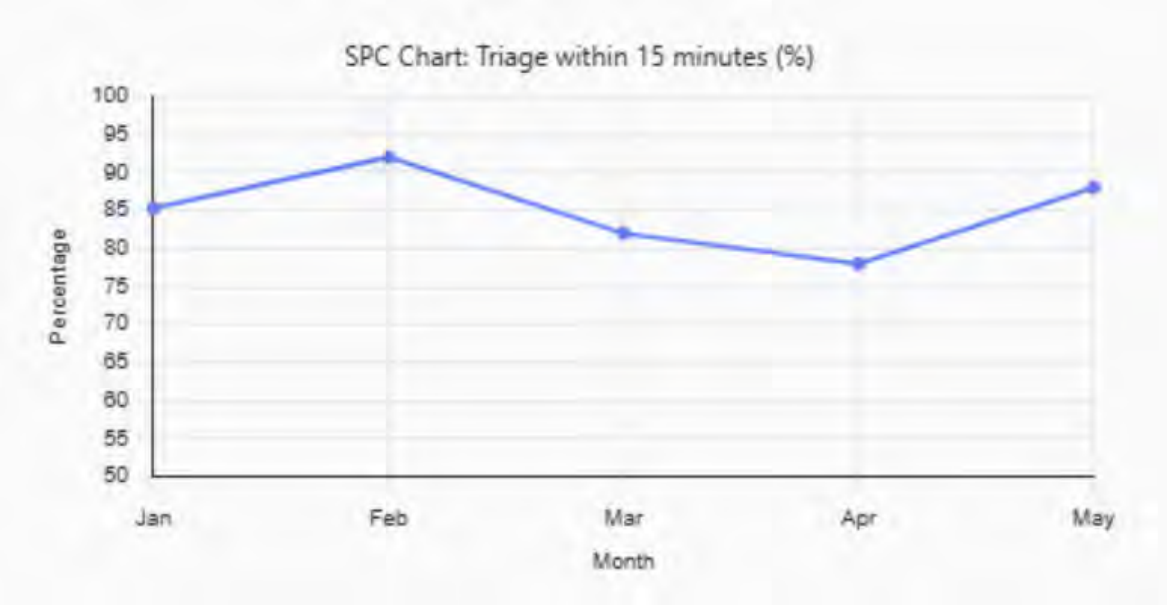
- Ability to obtain accurate data – previous system not effective and time consuming
- Staffing shortages impacting ability to provide 1:1 care

Maternity Triage

RAG	Local/Regional/Amos/ Ockenden

May - 26	Rolling YTD	Standard
88%	85%	>85%

Compliance	Variance	Assurance	Actions
			



Site Performance

- Delays in data for local and regional dashboards
- Below target for some months

Summary of Progress

- EOI for more triage midwives
- Training sessions for staff to increase compliance and improve standards
- Triage lead given more time for data

Action to be taken

- Further improvement needed on time for Dr review
- Consider substantive post for Triage lead
- Change in data collection and system
- Increase in hours for telephone shift

Risks and Issues

- Triage data is manual as current system does not collate the information
- This is time-consuming
- No dedicated Dr for Triage which impacts reviews
- Workforce and vacancies having an impact on rapid assessment.

Safety Performance Summary- QEHKL

Maternity Safety Performance QEHKL- May 2026

Measure	Current month rate	Target	Rolling Year rate	Regional Average Performance
Number of births	141		1685	n/a
Number of births, Black, Asian and mixed Black and mixed Asian women and birthing people	10			n/a
Stillbirth rate, per 1000	0	>=3.73	3.55%	2.6
Stillbirth rate Black, Asian and mixed Black and mixed Asian babies, per 1000	0	0	0	3.4
Neonatal death rate, per 1000	0	0	0	1.52
Neonatal death rate Black, Asian and mixed Black and mixed Asian babies, per 1000	0	0	0	1.87
Number of Babies born with HIE 2&3	0	0	0	
Maternal Deaths	0	0	0	
Term admissions, (%)	4.35%	>=6%	5.9%	
Bookings by 10 weeks – All, (%)	77.12%	85%	79.7%	
Bookings by 10 weeks - Black, Asian, Mixed Black & Mixed Asian, (%)	92.9%	85%	71.8%	

Maternity Safety Performance QEHKL May 2026

Measure	Current month rate	Target	Rolling Year Rate	Regional Average Performance
PPH ≥ 1500mls, (%)	2.90%	>=4%	3.05%	3.1%
Admissions to ITU	0		1	3.5%
Third and fourth degree tears, (%)	1.5%	>=3.1%	3.0%	
Triage – initial assessment with a midwife within 15 minutes (%)	95.24%	>=85%	94.9%	2.4%
Triage – medical assessment for orange rated within 15 mins of midwifery initial assessment (%)	85% (Q4)	85%		5.6%
Delay in Induction of Labour of over 24 hours	0		0	84.8%
Smoking at time of delivery, (%)	5.93%	>=6%	10.36%	
Enhanced Midwifery Continuity of Antenatal and Postnatal Carer in place	1		1	
Full Enhanced Midwifery Continuity of Carer, number of teams in place	1		1	

Neonatal Safety Performance QEHKL- May 2026

Measure	Current month rate	Rolling 12 months	Regional Average Performance
Preterm Birth Rate	8.7	6.9%	7.0%
Place of birth - NUMBER of Births less than 27 weeks gestation, multiples less than 28 weeks gestation, or any gestation with fetal weight of less than 800g	0	3	
% babies born < 30 weeks of gestation who received In utero magnesium sulphate within the 24 hours prior to birth	0	66.7%	82.3%
% babies who were eligible for antenatal steroids that received it	3 (100%)	37.9%	48.9%
% babies born < 34 weeks of gestation who received IV intrapartum antibiotic prophylaxis	3 (100%)	82.4%	69.6%
% babies born < 34 weeks of gestation who had their umbilical cord clamped at or after one minute after birth.	3 (100)%	72.4%	73.2%
% babies born <34 weeks of gestation who receive their own mother's milk within 24 hours of birth.	3 (100%)	41.4%	57.4%
% babies born <34 weeks of gestation who have temperature taken within one hour AND which is between 36.5– 37.5°C	3 (100%)	79.3%	85.9%

Safety Champions meetings and walk rounds – theme: NICU Outreach service QEHKL

Feedback raised by staff	Response
Accompanied by the Outreach lead nurse who has been in post for a short time. Outreach team currently have one vacancy which is in the process of being recruited too. The current team both undertake shifts in NICU which has a great deal of benefit for the outreach service and understanding how the unit runs and to meet families prior to utilising the outreach service. Visited NICU and the outreach office which is some distance from NICU but is a shared space with the community paediatric nurses which has benefits. Discussed the use of badger net to ensure single point of documentation. Discussed the need for consultant cover for the outreach service and a regular "ward round " for these families	Continue with the recruitment process to ensure the team are fully established. Continue conversation re a dedicated outreach consultant and a regular ward round Link with outreach teams across the group to consider how consultant cover has been managed. Understand the quality improvement opportunities and start to develop an action plan for improvement across the service
Feedback raised by service users	
The team told us that the service (NICU Outreach) is valued by the families but currently there is no formal written response or collection of patient experience	Lead nurse for service to discuss how this can be implemented and captured.
Additional safety champions intelligence,	**Response**
Some concerns from staff on Brancaster raised in inequity of supporting CDS and this not being reciprocated at times	Discussion with the Matrons and ward managers around this, possibly an individual's perception as there are times where staff are sent to Brancaster to support. Need for a record of movement of staff as a 'you said we did' piece of work may support the understanding including escalation open to all staff to the SMoC if concerns arise

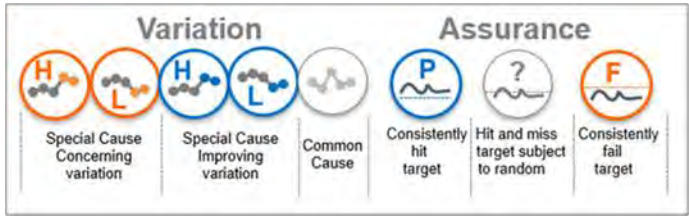
National Data Monitoring Tools - QEHKL

Number of MOSS signals in last three months	Was review completed and approved by trust board executive within 8 working days?	Learning – themes from Critical Safety Review
0	N/A	N/A

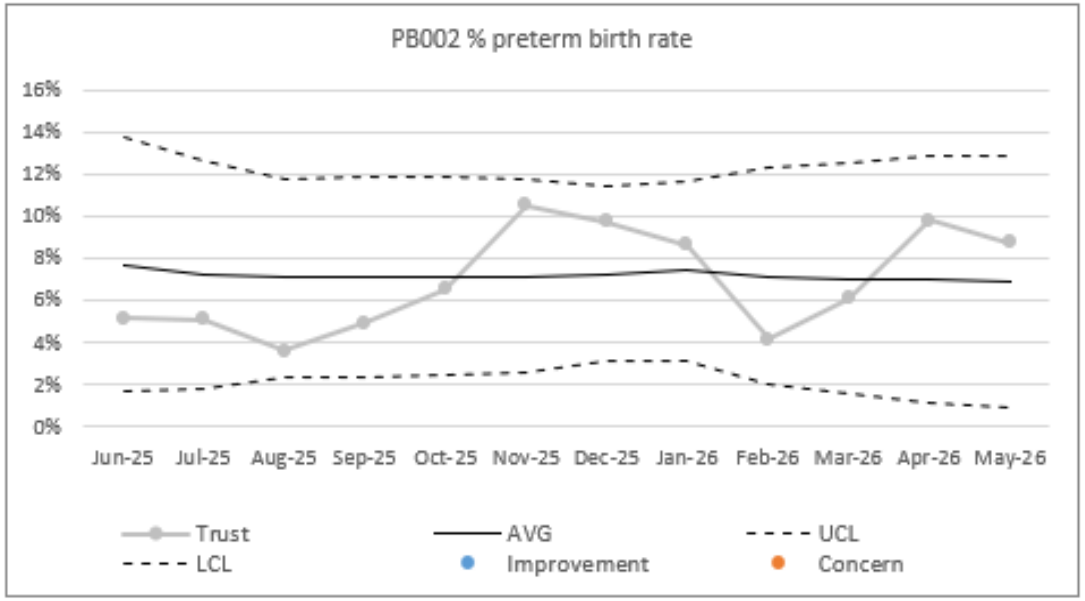
Closures reported in daily Sit Rep last three months (frequency and by area MLU, Obs, Homebirth)	Themes identified by MDT review of closures	QI
0	0	

Walker Ian
02/08/2026 22:26:37

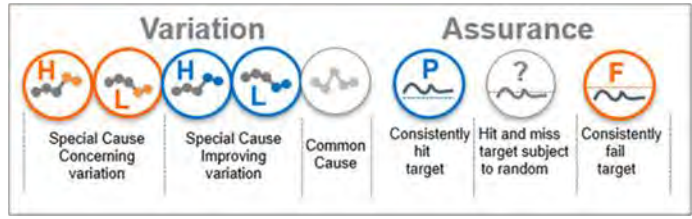
Exception Reporting: Preterm Births



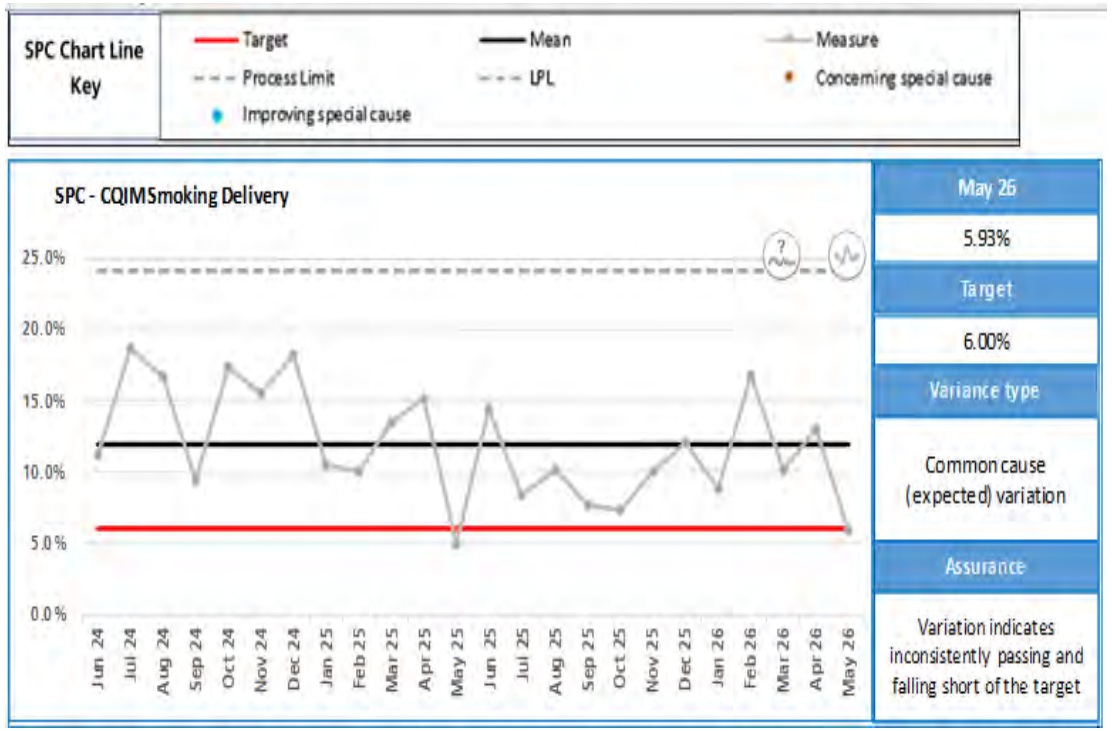
What is the data telling us	• Consistently reporting above the national benchmark
What action has been completed to improve the position	• Audit of cases to ensure accuracy of data and highlight any themes • Note that the QEH have had 10 inutero transfers over the last year in support of EoE NICU services which could be impacting the overall number of pre term babies being born here
What further action is required to improve the position and by when	• Once audit results available actions as needed to be put in place for improvement pathways due to be reported through local governance in August 2026
Is there anything to escalate to assist improvement?	



Exception Reporting: Smoking



What is the data telling us	• Significant improvement seen this month with the percentage smoking at delivery reducing to below the national benchmark
What action has been completed to improve the position	• All women have co monitoring with good compliance as per the SBLCB data • Data review ongoing • Staff training: Women who vape are not classed as smokers
What further action is required to improve the position and by when	• Discussion with Smoking cessation team to see if we need to do targeted intervention for some women
Is there anything to escalate to assist improvement?	• Continued scrutiny and monitoring of this issue is needed with ICB support to get it right for women and families. • Consideration of the Trust stance and addressing smokers that continue to use hospital grounds



Quality and Learning

Incident Reporting in last 3 months - JPUH

Total incidents reported	Total number of moderate and severe	Total incidents that are open more than 30 working days	Date of the oldest incident open	How many action plans remain incomplete
April 95 **May** 120 **June** 126 **TOTAL: 341**		At end of: **April** 62 **May** 42 **June** 42	As of 14.07.26: **24.10.24** – *linked to Coroner's Inquest scheduled August 2026*	All action plans overseen by R&G team – all on track.

April	0	0
May	0	0
June	0	0

Number Duty of Candour	Of these, number where DOC timeline was achieved in line with Regulation 20
April 0 **May** 0 **June** 0	N/A

Learning from Incidents: Insights from the last three months (JPUH) (MNSI, PMRT, PSii, complaints, ombudsman, ATAIN, service user feedback, PFDs)

Top 3 themes	Changes implemented
1. Consistent use of translation services and resource barriers	• Enhanced team education regarding Trust Translation Services Policy and approved resources via email communication, posters displayed in clinical areas, content with monthly Risk Round Up newsletter, PDM Topic of the Month scheduled, consideration to include Just One Norfolk resources within Trust Translation Services Policy • Risk added to Trust Risk Register • Introduction of monthly audit of practice as per Trust Translation Services Policy • PROMPT scenarios to include non-English speaking patients • Eden Team Midwifery Mandatory Day presentation to include implications of non-adherence to policy and importance of reporting when resources fail/not fit for purpose • COWS added to in-patient area desktops • Apps downloaded to all mobile phones including community team • All non-English speaking patients living in an area of deprivation to be assessed by Eden Team to ensure suitable case-loading
2. Documentation standards	• Regular documentation audits continue – staff encouraged to conduct as additional auditors via QR code • Documentation standards reminders sent to all, signed declaration of having been read & understood • Documentation standards posters in clinical areas • Documentation audits standard part of Safety Champions walk arounds • Documentation issues captured at incident review meetings and individuals/line managers informed of expectations
3. Staffing	• As of mid-July recent recruitment successes uplifted establishment by 156hrs / 4.16 wte • Manager on call policy under review with HR with a view to establishing a two-tier escalation/manager on call system • Bank midwives pool increased • Interviews scheduled for experienced band 6 midwives

Incident Reporting in last 3 months - NNUH (April – June)

Total incidents reported	Total number of moderate and severe	Total incidents that are open more than 30 working days	Date of the oldest incident open	How many action plans remain incomplete
568 Incidents Reported 512 Maternity 56 Neonatal	13 Moderate or severe	101	3rd February 2026	8 Open Action Plans 5 With overdue actions

Number Duty of Candour	Of these, number where DOC timeline was not achieved in line with Regulation 20
14 Incidents met DoC	100% achieved on time

Number of PSii in progress	Of these, number over 6-month timeline
No PSii in progress 1 MNSI ongoing 2 MNSI awaiting confirmation	0

Learning from Incidents: Insights from the last three months (NNUH) (MNSI, PMRT, PSii, complaints, ombudsman, ATAIN, service user feedback, PFDs)

Top 3 themes		Changes implemented
1. PPH	Back to basics training. Timely administration of oxytocic drugs. Better documentation	Improved care and reduction in PPH, hospital stay and better experience
2. Elective Caesarean section care	More timely auscultation of fetal heart following spinal. All the team consulted before sending for next lady. New caesarean section proforma created to minimise unnecessary documentation	Ensures that the midwife is present to undertake key actions prior to following the caesarean section. Improved timely care and improved experience.
3. Bilious vomiting and escalation awareness	Safer practice notice released to all staff. Always a red flag and should be escalated immediately to the neonatologist	Timely review to assess for obstructed bowel and whether surgery required.

Incident Reporting in last 3 months (QEHKL) (March/April/May)

Total incidents reported	Total number of moderate and severe	Total incidents that are open more than 30 working days	Date of the oldest incident open	How many action plans remain incomplete
378	7	52		1 MNSI

Number Duty of Candour	Of these, number where DOC timeline was not achieved in line with Regulation 20
10	N/A

Number of PSii in progress	Of these, number over 6-month timeline
0	

Learning from Incidents: Insights from the last three months (QEHKL) (MNSI, PMRT, PSii, complaints, ombudsman, ATAIN, service user feedback, PFDs)

Top 3 themes	Changes implemented
PMRT cases	All care delivery concerns have been identified in the MNSI safety recommendations/safety prompts and actions have been assigned to address these concerns. 2 hrly professional conversations are now occurring with all women on the MLBU irrespective of labour progress
Significant rise noted in OASI rate with primip assisted births, currently sitting at 12%.	Liaising with education lead regarding training sessions for those who undertake instrumental delivery relating to the adapted care bundle to ensure practices meet expected standards. Involvement from the Urogynaecologist to support training
PPH MDT • Placental separation and completeness- In one case review there was a placenta that was documented as complete and the mother later required a return to theatre for EUA where a large piece of placenta was removed. • Documentation- There was some difficulty obtaining clear clinical narrative for some PPH case reviews, especially when they have been in theatre. This has limited the ability to undertake a robust case review. • Fluid balance- Fluid balance charts were not completed in the majority of PPH case reviews. This reduces the ability to assess haemodynamic management. • PPH management in theatre- In multiple PPH case reviews in theatre, neither the emergency bell nor a 2222 call was activated. Escalation- In some PPH case reviews the CDS Coordinator was not aware until the blood loss has settled.	Documentation should capture whether there were any signs of placental separation prior to removal of the placenta, and that the technique used for the delivery of the placenta is clearly identified. Bitesize learning sessions will be implemented to address this. Each case reviewed and any specific learning identified Fluid Balance charts are included within the bitesize training sessions. The theatre whiteboards have now been updated to ensure these actions have been considered/taken and an action has been added to the QI action plan to address the PPH management in theatre. CDS Coordinator must be bleeped when blood loss has reached 1L.


Governance and Oversight
Walker Ian
02/08/2026 22:26:37

CQC Ratings JPUH

Date of last inspection: **March**

Site	Safe	Effective	Caring	Responsive	Well Led	Overall
JPUH	Requires improvement	Good	Good	Outstanding	Requires improvement	Requires improvement

Regulatory Enforcement (if applicable)

Enforcement Notice	Outcome	Progress
Not applicable		

Maternity and Neonatal Improvement Support Team

Level of Support Targeted/Intense	Date onboarded	Progress
Regional oversight	23/02/2026	CQC report received on 01/04/2026.

CQC Ratings NNUH

Date of last inspection:

Site	Safe	Effective	Caring	Responsive	Well Led	Overall
NNUH						

Regulatory Enforcement (if applicable)

Enforcement Notice	Outcome	Progress
None		

Maternity and Neonatal Improvement Support Team or enhanced Regional support

Level of Support Targeted/Intense/ enhanced	Date onboarded	Progress
N/A		

CQC Ratings - QEHKL

Date of last inspection: October 2023

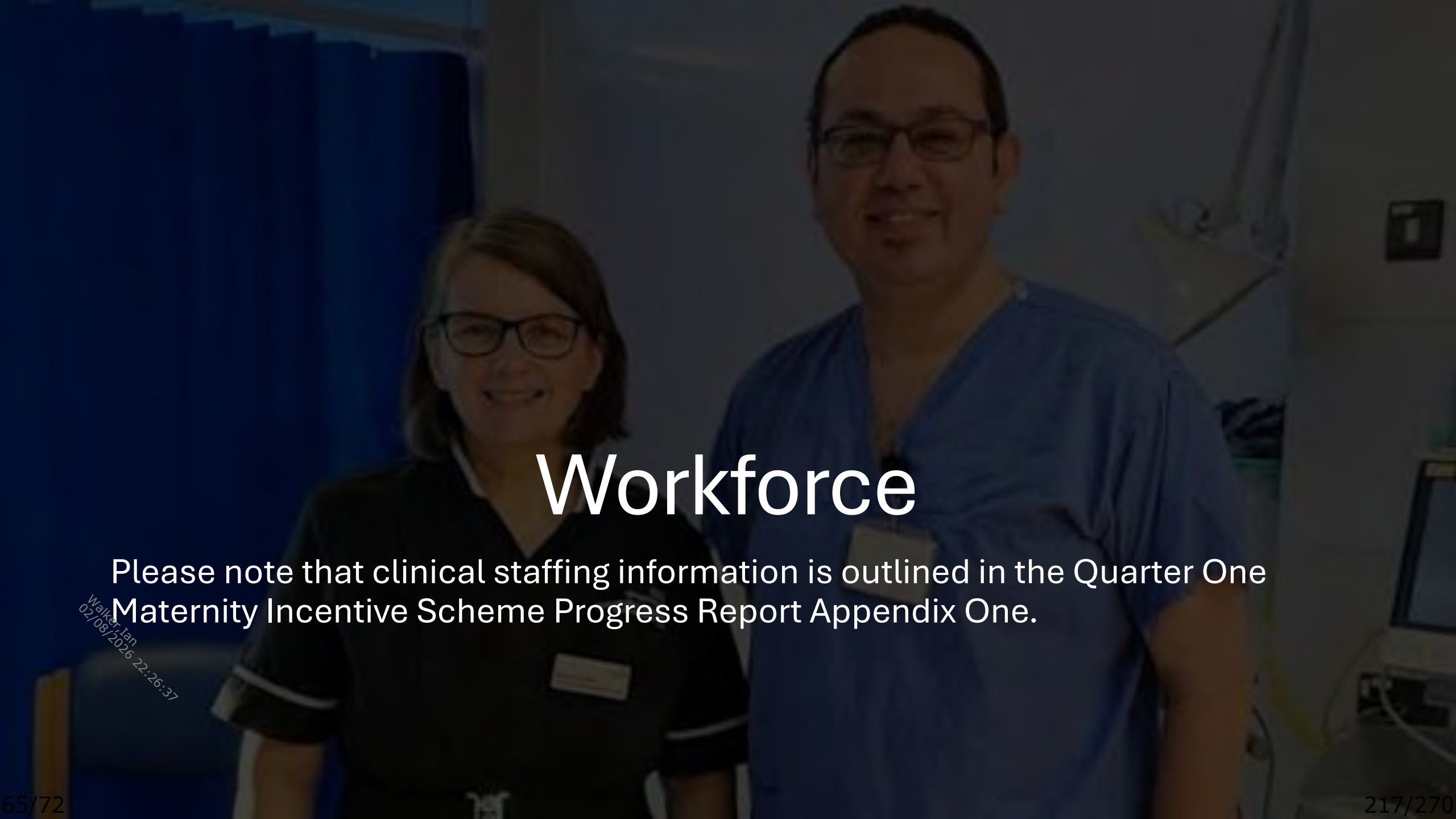
Site	Safe	Effective	Caring	Responsive	Well Led	Overall
QEH	Requires Improvement	Good	Good	Good	Good	Good

Regulatory Enforcement (if applicable)

Enforcement Notice	Outcome	Progress
None	Section 31 letter of closure received June 2026	

Maternity and Neonatal Improvement Support Team or enhanced Regional support

Level of Support Targeted/Intense/ enhanced	Date onboarded	Progress
N/A		



Workforce

Please note that clinical staffing information is outlined in the Quarter One Maternity Incentive Scheme Progress Report Appendix One.

Safe Maternity staffing- JPUH (as of 30th June 2026)

Midwifery

Midwifery staffing	WTE
BR+ recommended establishment (2023, inc 20% CoC)	103.26
Current funded establishment	112.22
Staff in post (not including those in pipeline)	107.42
Current vacancy against funded establishment	7.06

Vacancy by staff group	%
Maternity Support workers	3.11%

Midwifery uplift	%
Funded recruitable uplift	22%
Midwifery sickness rate	7.81 %
Midwifery maternity leave rate	4.6%
Required training hours per head	50
Midwifery headcount (n)	134

- Recruitment in place for vacant posts and graduate pipeline plan drafted
- 50 hours training currently funded against a requirement of 75hrs
- Midwifery sickness above national average for midwives (6%)

Safe Maternity staffing – NNUH May data

Midwifery

Midwifery staffing	WTE
BR+ recommended establishment	217.26
Current funded establishment	221.59
Staff in post (not including those in pipeline)	208.57
Current vacancy against funded establishment	13.02

Vacancy by staff group	%
Maternity Support workers	9.4

Midwifery uplift	%
Funded recruitable uplift	23%
Midwifery sickness rate	6% avg
Midwifery maternity leave rate	6%
Required training hours per head	27.5
Midwifery headcount (n)	256

- Recruitment in place for vacant posts and graduate pipeline plan drafted
- 27.5 hours training currently funded against a requirement of 75hrs

Safe Midwifery Staffing QEHKL(May 2026)

Midwifery staffing	WTE
BR+ recommended establishment	1:24
Current funded establishment	121.24
Staff in post (not including those in pipeline)	114
Current vacancy against funded establishment	7
Number of Third Year Students	15

Vacancy by staff group	%
Maternity Support workers	5.66%
Midwifery	5.87%
Admin	

Red Flags	Value
Number of red flags reported	0
Themes of red flags	0

Midwifery uplift	%
Funded recruitable uplift	22%
Midwifery sickness rate	5.52%
Midwifery maternity leave rate	8.76 WTE
Required training hours per head	36 minimum
Midwifery headcount (n)	129*
One to One Care in Labour	100%
Supernumerary Status of the Labour Ward Co-ordinator	100%
BR+ completion rate	84.95%

- Graduate pipeline plan drafted
- 36 hours training currently funded against a requirement of 75hrs


Perinatal Transformation
Walker Ian
02/08/2026 22:26:37

NHS Resolution Maternity Incentive Scheme Year 8

** please see separate report on Quarter One Progress*

	JPUH	NNUH	QEHKL
1 – Workforce and Capacity Ensuring appropriate staffing levels and skill mix.	On track	On track	On track
2 - Training Focussed multi-professional training to improve safety.	On track	On track	On track
3 - Learning from Reviews & Investigations Incorporating learning from incidents and neonatal reviews.	On track	On track	On track
4 - Service-User Voice and Equity Strengthening engagement with families and reducing healthcare inequalities.	On track	On track	On track
5 - Care Bundles Implementing clinical care bundles to standardise care.	On track	On track	On track
6 - Board Oversight, Governance, Culture, and Leadership Maintaining board-level accountability and fostering a positive safety culture.	On track	On track	On track

Group Clinical Guideline Reconciliation Project

Action to date

- Draft SOP in place outlining methodology for reconciling each maternity site guideline into a group guideline. There are currently over 100 clinical policies in place across each maternity site.
- The project is interfacing with the EPR build to support the development of consistent clinical pathways and processes.
- Members from each site are coming together to inform guideline development. Members are choosing depending on role and expertise.
- The following policies: Home Birth, Care of women with additional social needs have been reconciled and approved by each governance meeting
- The following documents are in different stages of development: reduced fetal movements, antenatal booking, routine antenatal care, antenatal and newborn screening and preterm birth
- Work reconciliation on fetal growth surveillance has paused to enable further discussion between sites and to await national guidance
- LMNS system wide polices received as part of the handover

Action Planned for Quarter 2

- LMNS policies to be reviewed as there has been site version updates
- To complete all policies
- Perinatal Bereavement working group to be established
- To review all policies that involve an antenatal risk assessment to support the EPR build.
- To commence on high- risk pregnancy pathway policies such as diabetes.

Risks and Issues

- Each service is a sovereign organisation and that is impacting on the degree of engagement amongst some members
- The three separate services mean that each policy requires ratification and approval through those services' governance processes which is adding duplication
- There is a risk given that it is one not one single perinatal service that further local variation to policies is undertaken though involvement of each governance team will hopefully mitigate this.

Group Perinatal EPR Project

Action to date

- Reset completed with lessons learnt. Engagement event with perinatal leadership team held to strengthen support for the project and assist with communication at site.
- Digital Midwifery Matron recruited to focus specifically on the MEDITECH build to achieve pace in development
- Lead EPR person focusing on build working closely with the matron
- Regular monthly progress meetings in place to solve escalations with the group Director of Midwifery and EPR team
- Monthly engagement events with the perinatal leadership commencing in July 2026
- Antenatal booking rebuilt based on Director and Heads of Midwifery feedback with sensing checking with community midwives completed.
- Appointment scheduling completed which is based on regional community improvement outputs
- Antenatal risk assessments first version built
- Antenatal schedule of appointments built
- Digital champions across obstetrics, maternity and neonates recruited to by the EPR team and moving forward will be involved in the monthly engagement sessions

Action planned for Quarter 2

- To demonstrate the antenatal build to the perinatal leadership team and digital champions – July 2026
- To explore the patient portal functionality to support self referral
- To confirm risk assessments are aligned to the Maternity Care Bundle and all national recommendations
- To confirm the lead professional ordering process and subsequent communication with community midwives
- To develop order bundles to reduce repetition
- To commence linking policies to the EPR system
- To commence the higher risk pregnancy schedule and intrapartum model
- Agree interfaces

Risks and Issues

1. Significant amount of work to complete to meet the build deadline of Oct/Nov 2026
2. National recommendations from the maternity taskforce may impact on the EPR build.
3. Publication of the national Triage Specification has EPR implications
4. Continued communication to ensure engagement particularly in view of the anxiety at the sites regarding the new EPR.;

Report to the Group Board in public: 5 August 2026

Agenda item number	13		
Title	Group Equality, Diversity and Inclusion (EDI) Workforce Strategy 2026/27 and Anti-Racism, Dignity and Respect Policy		
Author(s)	Emma-Jayne Pérez Chies, Group Chief People Officer		
Executive sponsor	Emma-Jayne Pérez Chies, Group Chief People Officer		
Purpose of report	**For decision** ☒	**For discussion** ☐	**For information** ☐

Executive summary

On 4 June 2026 Lord Mann published his independent review into tackling racism and antisemitism within the NHS. NHS England accepted the recommendations in full and issued PRN02538 the same day, setting immediate actions for every NHS organisation and a deadline of 31 July 2026 for confirming adoption of the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism and the Government definition of anti-Muslim hostility.

The Group Executive Group considered and approved the Group's first EDI Workforce Strategy 2026/27 and the Anti-Racism, Dignity and Respect Policy on 29 July 2026. This paper brings both to the Group Board for endorsement, and the policy for ratification.

The strategy sets out 36 actions across six phases, each with a named owner, a milestone, a baseline, a measure of success and a red/amber/green (RAG) status as at July 2026. It is built against the national framework rather than alongside it: every action maps to the NHS Race and Health Observatory (RHO) Seven Principles of Anti-Racism, the six high impact actions of the NHS England EDI Improvement Plan, the NHS Staff Standards published on 6 July 2026, or the immediate actions in PRN02538. The mapping is at Appendix D.

The strategy responds to a baseline that varies across the Group. The EDI desktop review found the most developed approach at James Paget University Hospitals (JPUH), and identified scope to strengthen strategic coordination, governance and reporting at Norfolk and Norwich University Hospitals (NNUH) and The Queen Elizabeth Hospital King's Lynn (QEH). No Trust in the Group currently produces a comprehensive annual EDI report. At QEH, concerns about the experience of resident doctors have been raised with the Trust, and an organisational development diagnostic has been commissioned and mobilised, reporting at the end of August 2026.

The Anti-Racism, Dignity and Respect Policy is the Group's first Group-wide policy. It adopts both national definitions, publishes application guidance for managers and investigators, creates a rebuttable presumption in favour of formal investigation for racism cases, sets specialist investigator standards, and addresses racism originating from patients and visitors. It does not supersede any existing instrument; its standards feed into the Group-wide policies being developed through the policy standardisation project. The Group has taken independent legal advice on the adoption of the definitions and on the terms of the policy; Sections 6 and 9 record the position.

Delivery is substantially through existing internal resource, including the four EDI roles (3.5 whole time equivalent) added through the People Directorate redesign. The only committed external cost is the QEH diagnostic which sits within existing budget parameters. No additional funding is sought.

Recommendations

The Group Board is asked to:

1. **Approve** the public commitment statement at Enclosure 7 for publication on the NNUH, JPUH and QEH websites following ratification, subject to final review with communications.

2. **Agree** that all Group Board and constituent Trust Board members will complete the national anti-racism training within six months of its release, with completion reported annually to the Board.

3. **Endorse** the Group EDI Workforce Strategy 2026/27 at Appendix A, as approved by the Group Executive Group on 29 July 2026.

4. **Ratify** the Anti-Racism, Dignity and Respect Policy V0.4 (Enclosure 1) as the first Group-wide policy of the policy standardisation project.

5. **Endorse** the Group's adoption of the IHRA working definition of antisemitism and the Government definition of anti-Muslim hostility across NNUH, JPUH and QEH.

6. **Note** that the NHS England confirmation return was completed for each constituent Trust ahead of the 31 July 2026 deadline set by PRN02538.

7. **Note** the Group's sign-up to the RHO Seven Principles of Anti-Racism and approve the issue of the notification letter at Enclosure 8 to the Chief Executive of the RHO on ratification.

8. **Note** the assurance route: quarterly reporting to the Executive Risk Assurance Group, with an annual deep-dive report to the Group Board.

Alignment to Board Assurance Framework risk(s)	BAF Risk P05 — workforce and culture. The plan also evidences compliance with the Public Sector Equality Duty under section 149 of the Equality Act 2010.
Previously considered by	Group Executive Group, 29 July 2026 — approved.
Any background papers in Admin Control Reading Room	See list of enclosures on page 26.

Norfolk and Waveney University Hospitals Group
Board of Directors in public: 5 August 2026

Group Equality, Diversity and Inclusion (EDI) Workforce Strategy 2026/27 and Anti-Racism, Dignity and Respect Policy

Contents

1. Introduction and background

1.1 This paper presents the Group's first Equality, Diversity and Inclusion (EDI) Workforce Strategy for 2026/27, together with the Anti-Racism, Dignity and Respect Policy, which is the first Group-wide policy to be produced through the policy standardisation project. Both were approved by the Group Executive Group on 29 July 2026 and are brought to the Group Board for endorsement, and in the case of the policy for ratification. The strategy delivery will form part of the Group Employee Engagement Strategy and is the workforce equality component of it; it is not a free-standing initiative and should be read alongside the wider engagement, retention and culture work already under way.

1.2 The immediate driver is national. Lord Mann's independent review into tackling racism and antisemitism within the NHS was published on 4 June 2026. NHS England accepted the recommendations in full and issued PRN02538 the same day, requiring every NHS organisation to take a set of immediate actions and to confirm adoption of the IHRA working definition of antisemitism and the Government definition of anti-Muslim hostility by 31 July 2026.

1.3 The Group was formed in May 2025 and is still harmonising the policies, governance and reporting of three constituent Trusts with different starting points. The requirements arising from the Mann review have been used as the organising spine for a single Group strategy covering the wider EDI workforce agenda, so that the Group meets the national deadline and closes the structural gaps identified in its own baseline review at the same time.

1.4 The Strategic Response to Lord Mann's Rapid Review, considered by the Group Chief Executive Officer in May and June 2026, has been absorbed into it in full and is not circulated separately. Activity already resourced and delivered through constituent Trust plans — the NNUH Diversity, Inclusion and Belonging work, the JPUH Better Together work, the Women and Children's Culture Improvement Plan and the QEH improvement work — is assured at Group level rather than duplicated, and is marked in the strategy as "site plan". The naming convention follows from this: there is one overarching EDI workforce strategy, held at Group level, which sets direction; delivery at each Trust is through the EDI leads. Where existing site documents are currently titled strategies they will be restated as plans as they are refreshed.

1.5 The paper is structured to answer four questions in order: what the national framework requires (Section 2); how the strategy is built against that framework and against comparator practice (Section 3); what the Group's baseline actually is (Section 4); and what the Group will do about it, at what cost and under what assurance (Sections 5 to 10).

2. National context and requirements

2.1 Five national requirements shape this strategy.

2.1.1 The Lord Mann review and PRN02538

The review found large volumes of antisemitism-related complaints closed without meaningful resolution, and set expectations on naming racism, triage and escalation of concerns, investigation rooted in safeguarding principles, victim support, and Board-level ownership. PRN02538 converts these into immediate actions: sign-up to the RHO Seven Principles of Anti-Racism; adoption of the two national definitions and confirmation to NHS England by 31 July 2026; implementation of the Violence Prevention and Reduction (VPR) Standard with disaggregated data capture; completion of the refreshed NHS Core Skills Framework module on Equality, Diversity and Human Rights and the new bitesize module co-created with faith leaders; Board-level anti-racism training; bespoke training for Patient Advice and Liaison Service (PALS) and

complaints handlers; communication to colleagues, representatives, patients and communities; and Board and committee scrutiny of staff survey data on racism. Appendix A of the policy maps each immediate action to the provision that delivers it.

2.1.2 NHS Staff Standards

The NHS Staff Standards were published on 6 July 2026 and apply to secondary care trusts from July 2026, assessed through a headline metric in the NHS Oversight Framework. They cover tackling racism, violence prevention and reduction, sexual safety, flexible working, line management, and health and wellbeing support. A separate paper on the Staff Standards is being prepared for the Group Executive Group with a view to coming to board in October 2026; this plan cross-references the Standards where its actions deliver them rather than duplicating that work.

2.1.3 Workforce equality standards and the Public Sector Equality Duty

The WRES, the WDES, the Medical Workforce Race Equality Standard (MWRES), the Equality Delivery System 2022 (EDS22), gender pay gap reporting and the Public Sector Equality Duty under section 149 of the Equality Act 2010 are all continuing statutory or mandated obligations. The desktop review found compliance to be uneven across the three Trusts; Phase 3 of the strategy addresses this directly.

2.1.4 Regulatory change

The draft General Medical Council (GMC) Order 2026 implements the first tranche of the Mann recommendations, including faster removal powers for racist conduct. Referral thresholds and investigator practice need to be recalibrated accordingly; this is addressed at action 2.3.

2.1.5 The disproportionality constraint

The national framework asks NHS organisations to be more rigorous on racist conduct and, at the same time, fairer on disciplinary disproportionality. The 2024 national WRES data showed that in 51 per cent of NHS trusts, staff from Black, Asian and minority ethnic backgrounds were more than 1.25 times as likely to enter formal disciplinary processes as white staff. A poorly designed zero-tolerance stance can entrench that disparity. The policy resolves this at the threshold of investigation, through recorded rationale, specialist investigators and quarterly disproportionality monitoring; Appendix C of the policy sets out the detriment assessment in full. We will ensure there is practical guidance for managers developed as we roll out any training.

3. Alignment to national standards, guidance and best practice

3.1 The strategy has been built against the national framework rather than written first and mapped afterwards. Each of the 36 actions carries a national alignment reference in the strategy itself, and Appendix D sets out the full mapping. This section records the standards used and how the Group meets them.

3.2 NHS Race and Health Observatory: Seven Principles of Anti-Racism

3.2.1 PRN02538 asks NHS organisations to sign up to the RHO Seven Principles of Anti-Racism. The Group has done so, and the commitment is recorded in the policy at Section 3.6. The Chief Executive of the RHO will be notified on 5 August 2026.

The seven principles, and where the plan delivers each, are:

RHO principle	How the Group delivers it	Strategy actions
1. Name Racism	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; all-staff communication issued; racism named explicitly in the Group policy rather than folded into generic dignity at work language.	1.3, 4.1, 2.2
2. Understand and Acknowledge	EDI desktop review of all three Trusts; QEH organisational development diagnostic mobilised; scope decision on extending the diagnostic to NNUH and JPUH; internal audit of racism-related cases closed in the last 36 months.	2.5, 4.4, 4.5
3. Meaningfully Involve Communities	Staff-side consultation on the policy through the Joint Negotiating and Consultative Committee and Joint Staff Consultative Committee at each Trust; establishment of Group-level Jewish and Muslim staff networks and refresh of the network terms of reference with protected time and executive sponsorship; patient and community engagement through EDS22.	4.2, 4.3, 3.5
4. Collect and Publish Data	Quarterly disproportionality reporting disaggregated by ethnicity and religion; WRES, WDES and MWRES completion across all three Trusts; a comprehensive annual EDI report for each Trust, which the desktop review found none currently produces; VPR data capture disaggregated by the characteristics of the staff member affected.	3.1, 3.2, 3.3, 3.4
5. Identify Racial Bias	Specialist investigator standards and bias-aware investigator training; recorded rationale at the threshold of formal investigation; hotspot identification triangulating WRES, MWRES, WDES, staff survey, Freedom to Speak Up (FTSU) and incident data.	2.3, 3.4, 6.5
6. Apply a Race-critical Lens	Equality impact assessment requirements carried into every policy harmonised through the standardisation project; inclusive recruitment and talent management standards; ethnicity pay gap reporting.	2.4, 5.1, 5.2, 5.3
7. Evaluate and Reflect	Annual independent assurance review against the strategy and the WRES and WDES indicators, reported to the Group Board and shared with the integrated care board (ICB) and NHS England East of England; annual Board self-assessment against the six high impact actions.	1.5, 1.7, 5.5

3.2.2 The Group also notes the shared principles for advancing workforce race equity published by the RHO in May 2026 and adopted by nine health and social care regulators, including the Care Quality Commission (CQC), the GMC and the Nursing and Midwifery Council. They build on the seven principles and signal the standard against which the Group is likely to be regulated. No separate action is required; the plan already delivers against them.

3.3 NHS England EDI Improvement Plan: six high impact actions

3.3.1 The six high impact actions remain the national framework for NHS workforce EDI. The desktop review found delivery against them to be partial and inconsistent across the Group. Phase 5 of the strategy is directed at the actions where the Group is weakest — inclusive recruitment, talent management and pay gap reporting.

High impact action	Group position at July 2026	Strategy actions
1. Measurable EDI objectives for chief executives, chairs and board members, individually and collectively accountable	Not yet in place consistently. Objectives to be embedded in executive appraisal and referenced in pay decisions where relevant; this mirrors the approach approved by the NHS Norfolk and Suffolk ICB Remuneration Committee and Board on 15 July 2026.	5.5, 1.5
2. Fair and inclusive recruitment and talent	Practice is partial and differs by Trust. A single Group standard for inclusive recruitment, diverse panels and	5.1, 5.2

High impact action	Group position at July 2026	Strategy actions
management targeting under-representation	structured inclusion questions is to be set, with a talent management approach for senior and executive roles.	
3. Improvement plan to eliminate pay gaps	Gender pay gap reporting is in place at NNUH and JPUH. Ethnicity and disability pay gap reporting has not started at any Trust.	5.3
4. Improvement plan to address health inequalities within the workforce	Occupational health and wellbeing provision exists at each Trust; workforce health inequalities are not analysed by ethnicity or disability.	5.4
5. Comprehensive induction, onboarding and development for internationally recruited staff	The Group has a high reliance on internationally educated staff, who nationally experience disproportionate disciplinary action and harassment. Provision varies by Trust and is to be brought to a single Group standard.	5.1, 6.4
6. An environment that eliminates the conditions in which bullying, discrimination, harassment and violence occur	The principal focus of the Anti-Racism, Dignity and Respect Policy, the VPR Standard work and the QEH and wider diagnostics.	2.2, 3.3, 4.4, 4.6

3.4 NHS Employers guidance

3.4.1 The Group is a signatory to the NHS Employers statement of commitment to addressing antisemitism, anti-Muslim hostility and all forms of racism. The strategy follows NHS Employers guidance in four specific respects: unambiguous leadership that names each form of racism explicitly rather than in aggregate; prompt processes with bias-aware investigators; consistent accountability including regulatory referral where the threshold is met; and visible victim support with published reporting routes. The anti-racism hub resources and case studies have been used in designing the investigator training specification at action 2.3.

3.5 Comparator benchmarking

3.5.1 Seven comparator Trusts and Groups were reviewed: Manchester University NHS Foundation Trust and University College London Hospitals (both cited in national guidance on uniform and workwear); Mersey and West Lancashire Teaching Hospitals, Mid and South Essex and the Northern Care Alliance (structurally comparable group or merged models); Sherwood Forest Hospitals (cross-characteristic campaign practice); and Royal Free London (complaint-handling experience at scale). Appendix C sets out the comparison and what the Group has taken from each.

3.5.2 Four findings shaped the strategy. Group-level harmonisation of conduct and dignity policies is the dominant model among comparable groups, which is why the anti-racism policy has been written as a Group policy from the outset. Civility and respect framing is now standard but must be calibrated so that racist conduct is not resolved away informally, which is what the rebuttable presumption in favour of formal investigation addresses. Cross-characteristic campaigns are more durable than single-issue ones, which is why the policy names all forms of racism evenly. And specialist subject-matter expertise for investigations is increasingly bought in or pooled regionally as we build in-house capability, which is the approach taken at action 2.3.

4. Where the Group is now — the 2026/27 baseline

4.1 The EDI desktop review commissioned from Pamela Permalloo-Bass, EDI Consultant, assessed governance, workforce equality reporting, strategic planning and compliance with the Public Sector Equality Duty across the three Trusts. It is a desktop analysis of published and internal documentation; findings may differ following site visits and staff engagement, and the review does not represent a regulatory assessment. Its summary position is:

Trust	Position at July 2026	Key observation
James Paget University Hospitals NHS Foundation Trust	Most developed in the Group	The most developed EDI approach in the Group and its current exemplar. Clear Better Together strategy; strong alignment between workforce equality reporting and strategic priorities. WRES reporting nonetheless identifies bullying, harassment and discrimination rates above national averages, which the Trust is acting on.
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	Further development needed	EDI activity is evident but dispersed across multiple documents and reporting routes. The Trust would benefit from a single overarching strategy, a consolidated annual report and clearer governance structures, which would also make strategic priorities and progress easier to evidence publicly.
Norfolk and Norwich University Hospitals NHS Foundation Trust	Further development needed	A range of positive operational interventions is in place, including the Civility and Respect Policy, Call It Out training, the No Excuse for Abuse campaign and WRES and WDES action plans. Strategic coordination, leadership accountability and programme management are the areas to strengthen. EDS22 records 21.9 per cent of staff reporting harassment, bullying or abuse from colleagues, statistically unchanged from 2023.

4.2 Four findings apply across all three Trusts: no comprehensive annual EDI report is produced anywhere in the Group; EDI reporting and governance arrangements are inconsistent; concerns about bullying, harassment, discrimination and racism experienced by staff persist; and accountability, leadership ownership and programme coordination need to be strengthened. The review also identified that confidence in reporting racism, particularly where it arises in interactions between patients and staff, needs to be rebuilt through consistent and timely handling of concerns. The reporting and response framework in the policy is directed at exactly this.

4.3 QEH is the Group's immediate priority. Concerns about the experience of resident doctors, including incidents involving racism arising both between colleagues and in interactions with patients, have been raised with the Trust and are being addressed with the East of England Deanery. An organisational development diagnostic has been commissioned from Aqua in partnership with The King's Fund and mobilised in July 2026, with Phase 1 findings and interim recommendations due at the end of August 2026. ERAG will receive the interim recommendations and the resulting improvement plan.

4.4 The Group's starting position is not uniformly weak. The United Against Racism and All Forms of Abusive Behaviour campaign launched at NNUH in February 2026, the NNUH WRES action plan running to 2028, the JPUH Better Together plan and the Women and Children's Culture Improvement Plan all pre-date this strategy and continue. The Group structure itself, formed in May 2025, creates single lines of accountability that did not exist 18 months ago, and the policy standardisation project is a one-off opportunity to set common standards as policies are harmonised rather than retrofitting them later.

5. The Group EDI Workforce Strategy 2026/27

5.1 The strategy at Appendix A contains 36 actions in six phases. Every action carries a named owner, a milestone, a baseline, a measure of success, a national alignment reference and a RAG status as at July 2026. Named ownership is a deliberate response to the CQC finding that a previous NNUH action plan lacked a named accountable person for the outcome.

Phase	Focus	Actions	Green	Amber	Red
1	Governance, accountability and Board oversight	7	1	4	2
2	Policy, definitions, process and case handling	6	1	4	1
3	Workforce equality data, standards and monitoring	6	0	3	3
4	Communication, staff voice, support and diagnostics	7	1	3	3
5	Representation, progression, pay and appraisal	5	0	3	2
6	Training, capability and inclusive leadership	5	0	4	1
	Total	**36**	**3**	**21**	**12**

5.2 The RAG profile is honest as we have just commenced the strategy delivery. Three actions are green, and all three are commitments the Group has already delivered or mobilised. Twelve are red. Seven of those are red because they are scheduled to start in the second half of the year; five are red because they are gaps the desktop review exposed which the Group has not previously resourced — ethnicity and disability pay gap reporting, workforce health inequalities analysis, Group-level Jewish and Muslim staff networks, EDS22 completion and talent management. The Board should expect the red count to fall through Quarter 3 rather than immediately.

5.3 Ownership has been reviewed since the executive meeting. The Group Chief Executive Officer is the senior accountable officer for the strategy. The Group Chief People Officer is responsible for its delivery and leads 13 of the 36 actions. The remainder are led by the Group Chief Executive Officer, the Group Chair, the Executive Managing Directors, Trust HR leads, the Group Chief Nurse, the Group Chief Medical Officer, the Group Head of EDI, the Group Director of Communications, the Group Organisational Development Lead and the Group Remuneration Committee. Distributing delivery while holding single-point accountability is the intended design, not a dilution of it.

5.4 The strategy runs to March 2027. Actions falling beyond that horizon, principally the second annual assurance cycle and the extension of the cultural diagnostic across all sites — are identified as 2027/28 commitments so that the Board can see the full arc rather than a single year in isolation.

6. The Anti-Racism, Dignity and Respect Policy

6.1 The policy is at Enclosure 1 and summarised at Appendix B. It is the Group's first Group-wide policy. It does not supersede any existing Trust instrument. Its standards, definitions and reporting framework will be carried into the Group Misconduct Policy, the Group Dignity at Work Policy and the Group Grievance Policy as those are harmonised through the policy standardisation project, and the cross-reference table at Section 10 of the policy records how.

6.2 The policy does seven things. It adopts the IHRA working definition of antisemitism and the Government definition of anti-Muslim hostility, and publishes guidance on how they are to be applied in practice. It commits the Group to the RHO Seven Principles of Anti-Racism. It 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. It sets specialist investigator standards. It establishes a victim support framework and protection from retaliation. It addresses racism directed at staff by patients, visitors and members of the public, aligned to the VPR Standard. And it sets the governance requirements for Board scrutiny of staff survey data and quarterly disproportionality monitoring.

6.3 Adoption of the IHRA definition is voluntary rather than mandatory: PRN02538 strongly encourages it and NHS England has adopted it, but no direction has been made

requiring NHS providers to do so. The Group's decision is therefore a Board decision on its merits. Section 9 sets out those considerations.

6.4 The Group has taken independent legal advice on the adoption of the definitions and on the terms of this policy, and the policy is presented to the Board having had the benefit of that advice. The advice is legally privileged. It is not reproduced in this paper or in the policy, and nothing in this paper is intended to waive privilege; the Board may consider it in private if it wishes. The policy remains subject to final review by staff side and the Group Chief People Officer will report any resulting amendments to the Board.

6.5 The policy has been strengthened in four respects since the version first drafted in June, in each case to make application safer for decision-makers rather than to change the Group's position:

- **Status of the illustrative examples.** The policy states that the definitions are an aid to identification and are not determinative of whether misconduct, harassment or discrimination has occurred, and that the operative question is whether conduct evidences hostility towards Jewish people as Jewish people. Context, audience, pattern and impact must be assessed in every case. This reflects how the Mann review itself describes the examples.
- **Prohibition on stereotyping.** Decision-makers may not rely on assumptions that Palestinian, Arab or Muslim colleagues are inherently antisemitic, or that Jewish colleagues necessarily identify with the State of Israel. Both are expressly prohibited as a basis for any decision.
- **Symbols and political identifiers.** Restrictions are confined to patient-facing settings, applied evenly to all causes, and blanket restrictions on the expression of national or cultural identity are prohibited. Religious dress remains protected.
- **Protected beliefs.** The policy records that an Employment Tribunal has held anti-Zionist beliefs capable of protection under the Equality Act 2010, and that the Group will keep the position under review as case law develops.

6.6 Worked examples for managers and investigators are published at Appendix D of the policy, covering social media, staff events, expression in front of patients, and symbols and badges. These exist because a policy that adopts a definition without saying how it will be applied gives managers no defensible basis for the decisions it asks them to make.

6.7 Staff-side consultation through the Joint Negotiating and Consultative Committee and Joint Staff Consultative Committee at each Trust and the Group staff networks closed on 30 July 2026. Should the consultation have proposed significant changes, the policy returns to the Group Executive Group before implementation; the adoption of the two definitions and the confirmation to NHS England are unaffected either way. The Group Chief People Officer will report the consultation outcome verbally at the meeting if available.

7. Resources and costs

7.1 The strategy is designed to be delivered from within the existing combined People Services budget envelope. The great majority of the 36 actions are policy, governance, data, training and communications work carried out by existing teams, and no additional funding is sought in this paper.

7.2 Capacity for the specialist element is already approved. Four EDI roles totalling 3.5 whole time equivalent will support delivery as we implement the Group People Services redesign, with the Group Head of EDI expected in post from November 2026. There was agreement to advertise this vacancy. The desktop review identified insufficient dedicated EDI capacity as a constraint across all three Trusts; these posts are the response to that finding and are the reason the strategy does not carry a larger external spend.

7.3 External expenditure is confined to work that requires independence or specialist subject-matter expertise the Group does not hold. There is one committed external cost: the QEH organisational development diagnostic, commissioned from Aqua in partnership with The King's Fund and mobilised in July 2026, covering mobilisation, the Phase 1 to 4 diagnostic and programme co-ordination. Phase 1 diagnostic findings and interim recommendations are due in August 2026. Any subsequent intervention phase will be costed on the basis of those findings, and from within existing budget.

Item	Basis	Cost	Status
QEH organisational development diagnostic — Aqua and The King's Fund	Mobilisation, Phase 1–4 diagnostic, programme co-ordination, travel and accommodation	£19,735 excluding VAT	Committed; mobilised July 2026, Phase 1 reports August 2026
Internal audit of closed racism-related cases	Commissioned to RSM within the agreed internal audit plan	No additional cost	Commissioned; terms of reference awaited
Specialist investigator and manager training — external input	Subject-matter expertise on contemporary antisemitism and anti-Muslim hostility, for approximately 150 investigators and senior managers	To be scoped (sourced from existing budgets)	In scoping; regional pooling through the ICB to be tested before procurement
Extension of the cultural diagnostic to NNUH and JPUH	Scope and phasing to be decided on the QEH Phase 1 findings	Similar costings to QEH (sourced from existing budgets)	Scope decision October 2026; ICB and NHS England East of England funding to be explored first
National training — Core Skills Framework module, bitesize faith module, Board anti-racism training, PALS eLearning	Provided nationally	No cost to the Group	Awaiting national release
All other actions	Delivered by existing teams and the four approved EDI roles (3.5 whole time equivalent)	Within existing budget	In delivery

NB: Any additional costs arising from the scoping exercises requiring approval will be tabled at the nearest Board discussion.

7.4 Two items are not yet costed and are flagged for transparency rather than hidden in the strategy: the external input to investigator training, and any extension of the cultural diagnostic beyond QEH. Both will be brought back with firm figures once scoped if they cannot be supported through existing budgets.

8. Risks

8.1 The strategy is aligned to BAF Risk P05, workforce and culture. The specific risks arising are:

Risk	Mitigation
Adoption of the IHRA definition is contested, including within professional bodies, and mechanical application could engage rights under Articles 9 and 10 of the European Convention on Human Rights or the Equality Act 2010.	The policy publishes an operative test and application guidance rather than adopting the definition bare; illustrative examples are expressly not determinative; freedom of expression safeguards are set out at Section 3.5; stereotyping is prohibited as a basis for decisions; worked examples are published at Appendix D; investigator training covers the evidential threshold and human rights obligations as well as recognition.
The rebuttable presumption in favour of formal investigation increases formal case volume and could entrench disciplinary disproportionality.	The presumption is rebuttable and applies to complaints by any person against any person; informal resolution remains available with recorded rationale; quarterly monitoring tracks the ethnicity profile of complainants and respondents separately; an annual independent

Risk	Mitigation
	review tests for disproportionate impact; the target ratio range is 0.80 to 1.25 at each Trust.
Concerns about the experience of resident doctors at QEH are not resolved ahead of the diagnostic reporting.	Diagnostic mobilised July 2026 with interim recommendations at the end of August; Group Chief Executive Officer accountability, with Executive Managing Director delivery at site level; continued engagement with the East of England Deanery led by the Group Chief Medical Officer; improvement plan to the Board on receipt of the interim recommendations.
Delivery outstrips capacity, particularly before the new EDI posts are filled.	Accountability held by the Group Chief Executive Officer with delivery distributed across ten named executive and senior leaders; site plan activity assured rather than duplicated; phasing weighted to the second half of the year for actions dependent on the new posts; RAG reported quarterly so slippage is visible early.
Staff cynicism about successive culture initiatives reduces reporting and engagement.	Cross-characteristic framing naming all forms of racism evenly; visible victim support and protection from retaliation; staff network establishment with protected time and executive sponsorship; outcomes reported publicly through the annual EDI report.
National training and uniform guidance are delayed, holding up dependent actions.	Dependencies identified explicitly in the strategy; interim uniform and political identifier guidance already in force at Section 6 of the policy; Group training specification developed in parallel so rollout can follow release quickly.

9. Equality and legal considerations

9.1 The policy carries a completed equality impact assessment. It records the potential for the rebuttable presumption in favour of formal investigation to increase formal case numbers, and the mitigations that accompany it. The assessment concludes that no full impact assessment is required at this stage, with the disproportionality monitoring framework providing continuing assurance and a commitment to review the policy if unintended consequences emerge.

9.2 The Public Sector Equality Duty at section 149 of the Equality Act 2010 requires the Board to have due regard, in taking this decision, to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity and to foster good relations between people who share a protected characteristic and those who do not. Race and religion or belief are both engaged, and are engaged in more than one direction: the decision affects Jewish colleagues, Muslim colleagues, colleagues of other faiths and none, and colleagues holding political beliefs about the Middle East, whose beliefs may themselves be capable of protection. The policy has been written to hold all of these together rather than to prioritise one.

9.3 Adoption of the IHRA working definition is voluntary. In reaching its decision the Group Executive has considered the legal implications of adoption, and we have done so having taken independent legal advice on the adoption of the definitions and on the terms of the policy. The Group has separately considered a counsel's opinion of 15 July 2026 on the legal implications of adopting the IHRA definition within the NHS, which was commissioned by a third party and circulated to NHS organisations. The substance of the advice the Group has received is legally privileged. It is not reproduced in this paper or in the policy, and nothing in this paper is intended to waive privilege; the Board may consider the advice in private if it wishes. That record is the evidence of due regard if the decision is ever challenged, from either direction.

9.4 Religion and belief features in the strategy alongside race, and not only as a subset of it. Quarterly disproportionality monitoring is disaggregated by religion as well as ethnicity, VPR data capture records the faith of the staff member affected, and the definitions application guidance addresses both antisemitism and anti-Muslim hostility on the same terms. Developing case law on beliefs concerning Israel and Zionism is

subject to a watching brief by the Group Chief People Officer, and the policy will be reviewed if the position changes materially.

9.5 Detriment is addressed explicitly and in both directions. No colleague who raises a concern about racism in good faith, or who supports or witnesses such a concern, may suffer detriment for having done so; retaliation is capable of amounting to gross misconduct under Section 4.6 of the policy, and the same protection applies to concerns raised through Freedom to Speak Up. Separately, the Group has assessed whether the policy itself could cause detriment. The rebuttable presumption in favour of formal investigation raises the number of cases entering formal processes, and national WRES data shows ethnic minority staff already entering those processes at a disproportionate rate. The detriment and disproportionality assessment at Appendix C of the policy records that risk, the mitigations, and the monitoring that will detect it: quarterly reporting of entry rates, outcomes and suspension use disaggregated by ethnicity and religion, tracked separately for complainants and respondents, against a target ratio range of 0.80 to 1.25 at each Trust, with an annual internal review testing for disproportionate impact. The Group Director of Governance is responsible for the Datix configuration that makes this analysis possible, and the changes are required by the end of October 2026.

10. Governance, assurance and reporting

10.1 There is no Group People Committee. Assurance against the strategy therefore runs through the Executive Risk Assurance Group (ERAG), with the Group Board receiving an annual deep-dive. The site interface is the People and Culture Management Group at each constituent Trust, which receives and acts on the Trust-level position and escalates to ERAG. The Group Executive Group remains the approval route for the strategy and the policy, and is not a duplicate assurance layer:

Forum	What it receives	Frequency
Group Board	Annual deep-dive on disproportionality data, case outcomes and progress against the strategy; annual independent assurance review; annual report on Board-level anti-racism training completion; policy review every two years or sooner if required.	Annual
Executive Risk and Assurance Group (ERAG)	Anti-racism metrics including detriment and disproportionality data; RAG-rated progress against all 36 actions; case audit of the proportion of racism cases proceeding to formal investigation; specialist investigator deployment; escalations from the People and Culture Management Groups.	Quarterly
Trust HMG and People and Culture Management Group (NNUH, JPUH, QEH)	The site interface with ERAG. WRES indicators 5 to 8 disaggregated by Trust and, where sample size permits, by department; VPR data including patient and visitor-originating racism; mandatory training compliance; local action plans for identified problem areas, escalated to ERAG where unresolved.	Quarterly, with training compliance monthly during rollout
Group Audit Committee	Outcome of the internal audit of racism-related cases closed in the last 36 months, undertaken by RSM as the Group's internal auditors.	On completion

10.2 The Group Chief Executive Officer is the senior accountable officer for the strategy. The Group Chief People Officer is responsible for its delivery and is the named officer for escalated race discrimination concerns and Freedom to Speak Up issues, as the desktop review recommended.

10.3 Executive Managing Directors are responsible for delivering the resulting action plans through their People and Culture Management Group, reported back within one quarter. The first quarterly report to ERAG is due in September 2026 and the first detriment and disproportionality report in December 2026.

11. Recommendations

11.1 The Group Board is asked to:

11.1.1 **Endorse** the Group EDI Workforce Strategy 2026/27 at Appendix A, as approved by the Group Executive Group on 29 July 2026.

11.1.2 **Ratify** the Anti-Racism, Dignity and Respect Policy V0.4 (Enclosure 1) as the first Group-wide policy of the policy standardisation project.

11.1.3 **Endorse** the Group's adoption of the IHRA working definition of antisemitism and the Government definition of anti-Muslim hostility across NNUH, JPUH and QEH, and record that it has considered the legal implications of adoption in doing so.

11.1.4 **Note** that the NHS England confirmation return was completed for each constituent Trust ahead of the 31 July 2026 deadline set by PRN02538.

11.1.5 **Note** the Group's sign-up to the RHO Seven Principles of Anti-Racism and approve the issue of the notification letter at Enclosure 8 to the Chief Executive of the RHO on ratification.

11.1.6 **Approve** the public commitment statement at Enclosure 7 for publication on the NNUH, JPUH and QEH websites following ratification, subject to final review with communications.

11.1.7 **Agree** that all Group Board and constituent Trust Board members will complete the national anti-racism training within six months of its release, with completion reported annually to the Board.

11.1.8 **Note** the assurance route: quarterly reporting to the Executive Risk Assurance Group, with an annual deep-dive report to the Group Board.

Appendix A — Group EDI Workforce Strategy 2026/27: action plan

Thirty-six actions in six phases. Every action carries a named owner, in line with the Care Quality Commission finding that a previous action plan lacked a named accountable person for the outcome. RAG status reflects the position as at July 2026, carried forward from the version considered by the Group Executive Group on 29 July 2026 and updated for the decisions taken at that meeting. Actions marked "site plan" are delivered and resourced through the referenced constituent Trust plan and are assured, not duplicated, at Group level. RHO numbers denote the NHS Race and Health Observatory Seven Principles of Anti-Racism; HIA numbers denote the NHS England EDI Improvement Plan high impact actions. Abbreviations are set out at Appendix E.

Phase 1 — Governance, accountability and Board oversight

Establishing a single Group assurance route, named accountability and the public commitments required by PRN02538.

Ref	Action	Owner	Milestone	Baseline at July 2026	Measure of success	National alignment	RAG status (July 2026)
1.1	Single Group EDI assurance and reporting route	GCPO	First quarterly report Sept 2026	No single Group reporting route; no Group People Committee exists	Four quarterly reports to the Executive Risk and Assurance Group and one annual Board deep-dive delivered in year	PRN02538; RHO 7; HIA 1	AMBER – route established through this paper; first report September 2026
1.2	Consistent EDI governance framework across the three Trusts	Group Head of EDI / Trust HR leads	Design Sept 2026; in place Dec 2026	Desktop review found inconsistent EDI reporting and governance arrangements across the Group	Common terms of reference, reporting cycle and escalation route operating at NNUH, JPUH and QEH	RHO 7; HIA 1	AMBER – design phase
1.3	Group public commitment statement naming all forms of racism	Group Chair / Group CEO / Group Director of Communications	Published by 31 Jul 2026	NNUH campaign only; no Group-level public statement	Statement co-signed by the Group Chair, Group CEO and three EMDs and published on all three Trust websites in the same week	PRN02538; Mann; RHO 1	AMBER – approved 29 July 2026; in final review with communications, for publication on ratification
1.4	Sign-up to the RHO Seven Principles of Anti-Racism	GCPO	July 2026	Not signed at Group or constituent Trust level	Commitment recorded at Section 3.6 of the Group policy; RHO notified on ratification; annual report to the Group Board on progress against each principle	PRN02538; RHO 1–7	GREEN – approved 29 July 2026; notification letter to iRHO, 5 August 2026
1.5	Comprehensive annual EDI report for each constituent Trust	Group Head of EDI / Trust HR leads	First reports June 2027	No comprehensive annual EDI report produced at any of the three Trusts	Published annual EDI report at NNUH, JPUH and QEH evidencing PSED compliance, workforce equality standards and progress against objectives	PSED; RHO 4, 7; HIA 1	RED – not started
1.6	Baseline self-assessment against the NHS Staff Standards	GCPO / Group Chief Nurse	Baseline Sept 2026; ongoing NOF monitoring	Standards published 6 July 2026 and applying to secondary care trusts from July 2026	Self-assessment complete at each Trust and a Group readiness position reported ahead of Oversight Framework assessment	NHS Staff Standards; NOF	AMBER – baseline assessment under way
1.7	Independent external assurance review of the strategy	Group Chief Executive Officer / NED sponsor	First review April 2027	No external assurance of EDI delivery at Group level	Assurance review of progress against the strategy and WRES and WDES indicators reported to the Group Board and shared with the ICB and NHS England East of England	RHO 7	RED – not started; planned for 2027/28

Phase 2 — Policy, definitions, process and case handling

Meeting the national deadline, and putting a single defensible process behind it.

Ref	Action	Owner	Milestone	Baseline at July 2026	Measure of success	National alignment	RAG status (July 2026)
2.1	Adopt the IHRA and anti-Muslim hostility definitions and confirm to NHS England	GCPO	Adopt July 2026; confirm by 31 Jul 2026	Neither definition adopted at Group or constituent Trust level	Both definitions adopted across the Group and the NHS England confirmation return completed for each constituent Trust by the national deadline	PRN02538; Mann; RHO 1	GREEN – adopted 29 July 2026; NHS England return completed for each Trust 29 July 2026
2.2	Ratify and implement the Group Anti-Racism, Dignity and Respect Policy	GCPO / Group Board	Ratify 5 Aug 2026; implement from ratification	No Group-wide policy; three different Trust conduct, dignity and grievance policies	Policy ratified, reference number assigned and published on all three intranets; definitions application guidance and worked examples available to managers and investigators	PRN02538; Mann; RHO 1, 5	AMBER – V0.4 presented for ratification; staff-side consultation closed 30 July 2026
2.3	Specialist investigator standards, triage and recorded threshold decisions	Trust HR leads / GCPO	Standards live on ratification; first case audit Dec 2026	No specialist standard; racism concerns subsumed into generic bullying and harassment terms of reference; referral thresholds not recalibrated for the draft GMC Order 2026	Every racism case assigned to a trained investigator with the racism element explicit in the terms of reference; recorded rationale and named decision-maker at every threshold decision; zero administratively closed cases	Mann; RHO 5; NHS Employers	AMBER – in scoping
2.4	Carry the anti-racism standards into the harmonised Group policies	GCPO / Trade Union Partnership Forum	Group Misconduct, Dignity at Work and Grievance policies by Mar 2027	Standardisation project in negotiation; no Group-wide policies yet in place	Each harmonised Group policy cross-references the anti-racism framework and carries an equality impact assessment acknowledging WRES disproportionality	RHO 6; HIA 6	AMBER – in negotiation through the standardisation project
2.5	Internal audit of closed racism-related cases	GCPO / Head of Internal Audit	Report to Group Audit Committee Dec 2026	Volume and outcome of cases closed without findings unknown across the Group	All conduct, dignity at work and grievance cases closed in the last 36 months with a racial or religious dimension reviewed; findings, themes and remedial actions reported	Mann; RHO 2, 4	AMBER – commissioned to RSM, the Group's internal auditors; terms of reference awaited
2.6	Group uniform and workwear policy including political identifiers	Group Chief Nurse / GCPO	Within 3 months of national guidance	Different uniform policies at each Trust; interim guidance in force at Section 6 of the Group policy	Single Group policy adopting the national guidance, drawing on MFT and UCLH practice, engaged with staff networks, protecting religious dress and applied evenly to all causes	PRN02538; Mann	RED – not started; dependent on national guidance

Phase 3 — Workforce equality data, standards and monitoring

Closing the statutory and mandated reporting gaps the desktop review identified, and putting disproportionality under regular scrutiny.

Ref	Action	Owner	Milestone	Baseline at July 2026	Measure of success	National alignment	RAG status (July 2026)
3.1	WRES, WDES and MWRES completion and aligned action planning	Trust HR leads / Group Head of EDI	WRES and WDES plans aligned Nov 2026; MWRES complete Mar 2027	WRES and WDES reported at all three Trusts; MWRES incomplete; QEH papers considered by People and Culture Management Group 17 July 2026	Single Group-level WRES, WDES and MWRES position with aligned action plans and named owners at each Trust	HIA 1–6; RHO 4	AMBER – updated WRES and WDES considered by QEH People and Culture Management Group 17 July 2026; gaps remain
3.2	Quarterly detriment and disproportionality reporting by ethnicity and religion	GCPO / Trust HR leads	First report Dec 2026	Disciplinary, grievance and dignity at work case data not reported disaggregated	Entry rates, outcomes, suspension use, closure timeliness and formal-to-informal ratio reported quarterly; disproportionality ratio within 0.80–1.25 at each Trust	Mann; HIA 6; RHO 4, 5	RED – not started; first report December 2026
3.3	VPR Standard implementation with disaggregated data capture	Group Chief Nurse	Datix categories configured Oct 2026	VPR Standard in place; racism and hate-incident category and disaggregation not configured	All patient and visitor-originating racism recorded on Datix and analysable by ethnicity and faith of the staff member affected, clinical setting and action taken	PRN02538; NHS Staff Standards; NOF	AMBER – VPR in place; disaggregation to be added
3.4	Hotspot identification and targeted improvement plans	Group Head of EDI / Trust HR leads	First hotspot analysis Jan 2027	No triangulated analysis; recommended by the EDI desktop review	WRES, MWRES, WDES, gender pay gap, staff survey, FTSU and incident data triangulated; targeted improvement plans owned by named senior leaders for each identified area	RHO 4, 5; HIA 6	RED – not started
3.5	NHS Staff Survey 2025 action plans at all three Trusts	Trust HR leads / EMDs	Aligned Group position Nov 2026	Complete at JPUH; partial at NNUH; outstanding at QEH	Action plan in place at each Trust with named owners, reported quarterly to Trust Boards and consolidated at Group level	HIA 6; RHO 4	AMBER – complete at JPUH; NNUH partial; QEH outstanding
3.6	EDS22 completion and patient equality reporting	Group Chief Nurse / Group Head of EDI	Complete Mar 2027	Full EDS22 at JPUH; at NNUH embedded within the patient engagement domain only; not evidenced at QEH	EDS22 completed, graded and published at all three Trusts	PSED; RHO 4, 6	RED – not started

Phase 4 — Communication, staff voice, support and diagnostics

Making the commitment visible, hearing from staff directly, and supporting those affected.

Ref	Action	Owner	Milestone	Baseline at July 2026	Measure of success	National alignment	RAG status (July 2026)
4.1	Communication to colleagues, representatives, patients and communities	Group Director of Communications / GCPO	Rolling plan from Aug 2026	All-staff communication issued June 2026	Public statement published following ratification; rolling internal communications plan in place; patient	PRN02538; RHO 1, 3	GREEN – all-staff communication issued; public statement in final

Ref	Action	Owner	Milestone	Baseline at July 2026	Measure of success	National alignment	RAG status (July 2026)
					and visitor behaviour expectations displayed at all sites		review with communications
4.2	Staff-side and staff network consultation on the Group policy	GCPO / Trade Union Partnership Forum	Consultation closed 30 Jul 2026	Three separate staff-side arrangements; no Group consultation precedent	Consultation concluded through JNCC/JSCC at each Trust and the staff networks; feedback recorded and responded to; policy returns to the Group Executive Group if significant changes are proposed	RHO 3	AMBER – consultation closed 30 July 2026; outcome reported to the Board
4.3	Group-level Jewish and Muslim staff networks; BME network refresh	Group Head of EDI / EMDs	Networks established Dec 2026	Networks fragmented across the Group; no Group Jewish or Muslim network	Networks established with terms of reference, protected paid time and EMD-level sponsorship; engaged in any review of the definitions application guidance	Mann; RHO 3	RED – networks fragmented; no Group Jewish or Muslim network
4.4	QEH organisational development diagnostic	QEH EMD / GCPO	Phase 1 reports Aug 2026	Concerns raised about the experience of resident doctors, including incidents involving racism between colleagues and in interactions with patients	Diagnostic delivered; interim recommendations received and converted into an owned improvement plan with Board-level oversight	RHO 2; HIA 6	GREEN – commissioned; mobilised July 2026
4.5	Scope decision on extending the cultural diagnostic to NNUH and JPUH	GCPO / NNUH and JPUH EMDs	Scope decision Oct 2026; delivery to Mar 2027	No Group-wide diagnostic; QEH only	Scope, phasing and funding route agreed on the basis of QEH Phase 1 findings; ICB and NHS England East of England funding tested before external procurement	RHO 2, 3	RED – not started; dependent on QEH Phase 1
4.6	Single Group victim support framework and FTSU racism routing	GCPO / FTSU Guardians	Live Dec 2026	Support routes exist at each Trust but differ; no single framework or racism routing addendum	Named point of contact, occupational health pathway, regulator advocacy signposting and protection from retaliation available across all three Trusts; FTSU racism flag in use and feeding quarterly thematic reporting	Mann; RHO 3	AMBER – routes exist; single framework in design
4.7	Reward and recognition: EDI and culture award	Group Head of EDI / Group Director of Communications	First award 2027	No EDI-specific recognition at Group level; recommended by the EDI desktop review	Award established within the Group recognition scheme and awarded in year	RHO 7	RED – not started

Phase 5 — Representation, progression, pay and appraisal

The high impact actions where the Group is furthest behind.

Ref	Action	Owner	Milestone	Baseline at July 2026	Measure of success	National alignment	RAG status (July 2026)
5.1	Single Group inclusive recruitment standard	Group Head of EDI / Trust HR leads	Standard live Jan 2027	Practice partial and different at each Trust; high reliance on internationally educated staff with variable induction and onboarding	Diverse panels, structured inclusion questions and bias-aware shortlisting applied to all Band 8a and above appointments; WRES indicator 2 improving at each Trust	HIA 2, 5; RHO 5, 6	AMBER – practice partial; Group standard to be set

Ref	Action	Owner	Milestone	Baseline at July 2026	Measure of success	National alignment	RAG status (July 2026)
5.2	Talent management and progression for ethnic minority and disabled staff	Group OD Lead / GCPO	Plan by Feb 2027	No Group talent management plan; WRES indicator 3 disparities persist	Talent management plan in place targeting under-representation in senior and executive roles, with measurable progression outcomes	HIA 2; RHO 6	RED – not started
5.3	Ethnicity and disability pay gap reporting	Trust HR leads / Group Head of EDI	First reports Mar 2027	Gender pay gap reported at NNUH and JPUH; ethnicity and disability pay gap reporting not started at any Trust	Ethnicity and disability pay gaps calculated and published at all three Trusts with improvement plans	HIA 3; RHO 4	AMBER – gender pay gap at NNUH and JPUH; ethnicity and disability not started
5.4	Workforce health inequalities analysis	Group Chief Nurse / GCPO	Analysis Feb 2027	Workforce health inequalities not analysed by ethnicity or disability at any Trust	Workforce health inequalities identified and reflected in health and wellbeing provision and in the NHS Staff Standards self-assessment	HIA 4; NHS Staff Standards	RED – not started
5.5	EDI objectives in executive appraisal and pay	Group CEO / Group Remuneration Committee	From the 2026/27 appraisal cycle	EDI objectives not consistently measurable or referenced in pay decisions	Measurable EDI objectives in every executive and Board-level appraisal, with WRES and WDES performance referenced in pay decisions where relevant; this mirrors the approach approved by the NHS Norfolk and Suffolk ICB Remuneration Committee and Board on 15 July 2026	PRN02538; HIA 1; RHO 1, 7	AMBER – design phase

Phase 6 — Training, capability and inclusive leadership

Building the capability to apply the policy correctly, in both directions.

Ref	Action	Owner	Milestone	Baseline at July 2026	Measure of success	National alignment	RAG status (July 2026)
6.1	Board-level anti-racism training	GCPO	Within 6 months of national release	Not undertaken by the Group Board or any constituent Trust Board	All Group Board and constituent Trust Board members complete the national training; attendance reported annually; anti-racism development built into the annual Board development programme	PRN02538; Mann; HIA 1	AMBER – Board agreement sought at this meeting; pending national release

Ref	Action	Owner	Milestone	Baseline at July 2026	Measure of success	National alignment	RAG status (July 2026)
6.2	Mandatory EDHR module and bitesize faith module	Group OD Lead	ESR verification Aug 2026; rollout within 6 months of release	Existing EDHR compliance to be verified via ESR across all three Trusts	95% compliance across the Group within six months of national release, monitored monthly during rollout	PRN02538	AMBER – pending national release
6.3	PALS and complaints handler training	Group Chief Nurse	Within 3 months of national release	Bespoke national eLearning not yet released	All PALS and complaints staff across the Group complete the training	PRN02538	AMBER – pending national release
6.4	Inclusive leadership programme	Group OD Lead / Group Head of EDI	Design Oct 2026; delivery from Jan 2027	No accountable inclusive leadership programme; recommended by the EDI desktop review	Senior leaders complete the programme, built on the RHO workforce race equality resources and the Board leadership competency framework; aligned to the JPUH Better Together milestone (site plan)	RHO 1, 2, 6; HIA 1	RED – not started
6.5	Investigator and manager capability	GCPO / Trust HR leads	Sept 2026 – Jan 2027	No specialist training in place; approximately 150 investigators and senior line managers in scope	All in-scope investigators and senior managers trained on contemporary antisemitism and anti-Muslim hostility, the evidential threshold, stereotyping risk in both directions and Article 9 and 10 obligations, with external specialist input	Mann; RHO 5; NHS Employers	AMBER – in scoping

Appendix B — Anti-Racism, Dignity and Respect Policy V0.4: summary

The full policy is circulated as Enclosure 1. This page is a reference summary; it is not a substitute for the policy text.

Field	Detail
Status	V0.4, July 2026. Approved by the Group Executive Group on 29 July 2026; presented to the Group Board for ratification on 5 August 2026.
Standing	The first Group-wide policy of the policy standardisation project. It supersedes no existing instrument. Its standards feed into the Group Misconduct, Dignity at Work and Grievance policies as those are harmonised.
Legal review	Independent legal advice has been taken on the adoption of the definitions and on the terms of the policy. The advice is privileged and is not reproduced. A counsel's opinion of 15 July 2026, commissioned by a third party and circulated to NHS organisations, has also been considered. See Section 9.
Scope	All colleagues at NNUH, JPUH and QEH including honorary, secondment, bank, agency and locum arrangements; volunteers; students on placement; Board members, Non-Executive Directors, governors and committee members. Section 5 applies to patients, visitors and members of the public.
Definitions adopted	The IHRA working definition of antisemitism and the Government definition of anti-Muslim hostility, each with published guidance on application (Section 3.4) and freedom of expression safeguards (Section 3.5).
Operative test	The definitions are an aid to identification and are not determinative of whether misconduct, harassment or discrimination has occurred. Decision-makers assess wording, context, audience, pattern of conduct and impact, and whether conduct evidences hostility towards Jewish people as Jewish people, or towards Muslims as Muslims.
Process	Rebuttable presumption in favour of formal investigation for racism cases (Section 4.2). Informal resolution available only where the complainant requests it having been informed of the formal route, the HR lead and a Band 8b or above manager agree, and the rationale is recorded. No case closed without a recorded finding and a named decision-maker. Investigations conducted in accordance with safeguarding principles. Twelve-week completion target.
Investigators	Specialist standards at Section 4.3: completed Group anti-racism investigator training, no conflict of interest, demonstrable understanding of both definitions, and terms of reference that name the racism element explicitly.
Support and protection	Named point of contact, Employee Assistance Programme, occupational health, regulator advocacy signposting, fortnightly updates, and interim measures determined case by case (Section 4.5). Retaliation may constitute gross misconduct (Section 4.6).
Patients and visitors	Section 5: expectations of behaviour, response protocol, VPR Standard alignment and disaggregated Datix capture. Clinical care is never withdrawn where there is immediate clinical need.
Symbols and identifiers	Section 6: restrictions confined to patient-facing settings and applied evenly to all causes. Religious dress protected. Blanket restrictions on the expression of national or cultural identity prohibited.
Governance	Section 8: quarterly disproportionality monitoring with a target ratio range of 0.80–1.25 at each Trust; quarterly reporting to the Executive Risk and Assurance Group; annual deep-dive to the Group Board; review every two years or sooner.
Appendices	A — PRN02538 immediate action cross-reference matrix. B — FTSU racism routing addendum. C — detriment and disproportionality assessment note. D — worked examples for managers and investigators. Equality impact assessment.
Changes at V0.4	Status of the illustrative examples and the operative test (3.4); prohibition on stereotyping as a basis for decisions (3.4); expanded freedom of expression safeguards (3.5); recognition that anti-Zionist beliefs have been held capable of protection under the Equality Act 2010 (3.7); symbol provisions confined to patient-facing settings (6); worked examples added (Appendix D); triage and escalation on receipt (4.1); safeguarding principles in investigation (4.2); interim measures determined case by case (4.5); Section 3.7 revised and retitled; Section 10 cross-reference table reinstated.

Appendix C — Benchmarking against comparator Trusts and Groups

Seven comparators were selected on the basis of a similar group or merged structure, explicit citation in national guidance, published anti-racism practice, or relevant complaint-handling experience. The full analysis is held in the Admin Control Reading Room.

Trust or Group	Model	Practice reviewed	What the Group has taken from it
Manchester University NHS Foundation Trust	Large acute group, multi-hospital	Cited in national guidance as good practice on uniform and workwear guidance balancing religious expression and patient safety; established anti-racism strategy.	Template for the Group uniform and workwear refresh at action 2.6; the group-level policy approach matches the Group structure.
University College London Hospitals NHS Foundation Trust	Single-site teaching trust, London	Also cited in national guidance on uniform policy. Active EDI board and sustained Jewish and Muslim staff network engagement.	Staff network design at action 4.3, and the implementation experience curve on applying the IHRA definition in practice.
Mersey and West Lancashire Teaching Hospitals NHS Trust	Acute group formed 2023, multi-site	Mature civility and respect programme; hosts a video learning library used nationally.	The closest structural peer. Their route to harmonising three cultures informed the sequencing of the policy standardisation project at action 2.4.
Mid and South Essex NHS Foundation Trust	Merged acute trust, formed 2020	Lived experience of merging three acute trusts' EDI and conduct policies; published cultural integration learning.	The most comparable lived experience. Confirmed the decision to write the anti-racism policy as a Group policy from the outset rather than harmonising three existing ones.
Northern Care Alliance NHS Foundation Trust	Group model, North West	Group People function with consistent disciplinary and dignity at work processes across constituent care organisations.	Reference model for the People function design and for the single Group assurance route at action 1.1.
Sherwood Forest Hospitals NHS Foundation Trust	Single mid-sized acute trust	Cross-characteristic approach to abuse and discrimination, with reported reduction in colleague incidents.	The even-handed, all-characteristics campaign tone adopted in the Group public statement and policy, which names each form of racism explicitly rather than in aggregate.
Royal Free London NHS Foundation Trust	Group model, London	Long-established group People function; experience of handling antisemitism complaints at scale.	Complaint review methodology, which informed the scope of the independent audit of closed cases at action 2.5.

Headline findings

- Group-level harmonisation of conduct, dignity and respect policies is the dominant model among comparable groups. The Group should reach the same end state, and the anti-racism policy is the first step.
- Civility and respect, rather than bullying and harassment, is now the dominant policy framing. Post-Mann it must be calibrated so that racist conduct is not resolved away informally.
- Cross-characteristic campaigns are gaining ground over single-issue ones. They avoid a hierarchy of victimhood and are more durable.
- Specialist subject-matter expertise for antisemitism and anti-Muslim hostility investigations is bought in by larger Trusts and pooled regionally through integrated care boards by smaller ones. The Group will test the regional route before procuring externally.

Appendix D — Alignment to national standards: mapping matrix

Each national requirement, and the strategy actions and policy provisions that deliver it.

Source	Requirement	Strategy actions	Policy
NHS England PRN02538	Sign up to the RHO Seven Principles of Anti-Racism	1.4	Section 3.6
NHS England PRN02538	Confirm adoption of the IHRA definition and the Government definition of anti-Muslim hostility by 31 July 2026	2.1	Sections 3.2, 3.3
NHS England PRN02538	Implement the VPR Standard including disaggregated data capture and use it to target improvement with affected groups	3.3	Sections 5.1, 5.4
NHS England PRN02538	Prepare to implement the NHS Staff Standards	1.6	Section 8.3
NHS England PRN02538	All staff complete the Core Skills Framework EDHR module and the bitesize faith module	6.2	Section 7.1
NHS England PRN02538	Board agreement to the new anti-racism training	6.1	Section 7.2
NHS England PRN02538	Bespoke training for PALS and complaints handlers	6.3	Section 7.4
NHS England PRN02538	Communicate actions to colleagues, representatives, patients and communities	1.3, 4.1	Sections 2, 5.2
NHS England PRN02538	Boards and committees fully understand staff survey data on racism and act on key problem areas	1.1, 3.5	Section 8.1
NHS England PRN02538	Strengthened accountability for racial inclusion through executive appraisals	5.5	Section 8.1
Lord Mann review	Concerns recognised, named, triaged and escalated; no case closed without resolution	2.3, 2.5	Sections 4.1, 4.2
Lord Mann review	Investigation rooted in safeguarding principles; specialist investigator capability	6.5	Sections 4.2, 4.3
Lord Mann review	Visible victim support and protection from retaliation	4.6	Sections 4.5, 4.6
Lord Mann review	National guidance on political identifiers and uniform	2.6	Section 6
RHO Seven Principles	All seven principles — see Section 3.1 of this paper	All phases	Section 3.6
NHS EDI Improvement Plan	HIA 1 — measurable EDI objectives for board members	1.5, 5.5	Section 8.1
NHS EDI Improvement Plan	HIA 2 — fair and inclusive recruitment and talent management	5.1, 5.2	—
NHS EDI Improvement Plan	HIA 3 — improvement plan to eliminate pay gaps	5.3	—
NHS EDI Improvement Plan	HIA 4 — workforce health inequalities	5.4	—
NHS EDI Improvement Plan	HIA 5 — induction and development for internationally recruited staff	5.1	—
NHS EDI Improvement Plan	HIA 6 — eliminate the conditions in which bullying, discrimination, harassment and violence occur	2.2, 3.3, 4.4, 4.6	Sections 4, 5
NHS Staff Standards (6 July 2026)	Six standards assessed through the NHS Oversight Framework; separate Group Executive paper in preparation	1.6, 3.3, 5.4	Section 8.3
Equality Act 2010 and PSED	Due regard; WRES, WDES, MWRES, EDS22 and pay gap reporting	1.5, 3.1, 3.6, 5.3	Equality impact assessment

Source	Requirement	Strategy actions	Policy
NHS Employers	Statement of commitment; anti-racism hub guidance on bias-aware investigation and victim support	2.3, 6.5	Sections 4.3, 4.5

Appendix E — Glossary

Term	Meaning
Aqua	Advancing Quality Alliance
BAF	Board Assurance Framework
BME / BAME	Black, Asian and minority ethnic; used for consistency with WRES reporting
CQC	Care Quality Commission
EDHR	Equality, Diversity and Human Rights (NHS Core Skills Framework module)
EDI	Equality, diversity and inclusion
EDS22	Equality Delivery System 2022
EIA	Equality impact assessment
EMD	Executive Managing Director
ERAG	Executive Risk and Assurance Group
ESR	Electronic Staff Record
FTSU	Freedom to Speak Up
GCPO	Group Chief People Officer
GMC	General Medical Council
HIA	High impact action (NHS England EDI Improvement Plan)
ICB	Integrated care board
IHRA	International Holocaust Remembrance Alliance
JNCC / JSCC	Joint Negotiating and Consultative Committee / Joint Staff Consultative Committee
JPUH	James Paget University Hospitals NHS Foundation Trust
MFT	Manchester University NHS Foundation Trust
MHPS	Maintaining High Professional Standards in the NHS
MWRES	Medical Workforce Race Equality Standard
NED	Non-Executive Director
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
NOF	NHS Oversight Framework
NWUHG	Norfolk and Waveney University Hospitals Group
OD	Organisational development
PCMG	People and Culture Management Group
PALS	Patient Advice and Liaison Service
PRN02538	NHS England publication reference for the letter to NHS leaders of 4 June 2026
PSED	Public Sector Equality Duty (section 149, Equality Act 2010)
QEH	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
RAG	Red, amber, green status rating
RHO	NHS Race and Health Observatory
UCLH	University College London Hospitals NHS Foundation Trust
VAT	Value added tax
VPR	Violence Prevention and Reduction Standard
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole time equivalent

Appendix F — Enclosures

Enclosures are circulated with this paper and numbered to match this list. The Strategic Response to Lord Mann's Rapid Review is not enclosed separately; it has been absorbed into the Group EDI Workforce Strategy 2026/27 at Appendix A.

No.	Enclosure	Status
1	NWUHG Anti-Racism, Dignity and Respect Policy V0.4 (July 2026)	For ratification — Recommendation 2
2	All-staff communication on the Lord Mann Review, as issued June 2026	For information — already issued
3	EDI Desktop Review — summary of findings, Pamela Permalloo-Bass, EDI Consultant	For information — report to the Group Chief People Officer
4	The Queen Elizabeth Hospital King's Lynn organisational development proposal and timeline — Aqua and The King's Fund, 15 July 2026	For information — commissioned and mobilised
5	NHS England PRN02538 — letter to NHS leaders following publication of the Lord Mann Review, 4 June 2026	For information — national letter
6	Staff-side consultation communication — Anti-Racism, Dignity and Respect Policy	For information — consultation closed 30 July 2026
7	Public website statement for NNUH, JPUH and QEH	For approval — Recommendation 6; for publication following ratification, subject to final review with communications
8	Notification letter to Professor Habib Naqvi MBE, Chief Executive, NHS Race and Health Observatory	For approval — Recommendation 5; for issue on ratification

External references

- NHS Race and Health Observatory — Seven Anti-Racism Principles and briefings — https://nhsrho.org/resources/seven-anti-racism-principles/
- NHS England — NHS equality, diversity and inclusion improvement plan — https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/
- NHS Employers — statement of commitment to addressing antisemitism, anti-Muslim hostility and all forms of racism — https://www.nhsemployers.org/articles/statement-commitment-addressing-antisemitism-anti-muslim-hostility-and-all-forms-racism
- NHS Employers — anti-racism in the NHS hub — https://www.nhsemployers.org/news/new-anti-racism-nhs-hub
- NHS England — Workforce Race Equality Standard 2025 data analysis report — https://www.england.nhs.uk/publication/workforce-race-equality-standard-2025-data-analysis-report-for-nhs-trusts/
- International Holocaust Remembrance Alliance — working definition of antisemitism — https://holocaustremembrance.com/resources/working-definition-antisemitism
- NHS England — Civility and Respect programme — https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/civility-and-respect/

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	14		
Title	Group Board Assurance Framework (BAF)		
Author(s)	Ian Walker, Interim Group Director of Governance		
Executive sponsor	Ian Walker, Interim Group Director of Governance		
Purpose of report	**For decision** ☐	**For discussion** ☒	**For information** ☐

Executive summary

The Board Assurance Framework (BAF) is a strategic tool used by Boards to identify, assess and monitor the key (Principal) risks to achieving an organisation's strategic objectives. The Group BAF has been developed and populated based on an initial set of strategic objectives agreed by the Special Purpose Joint Committee in autumn 2025. It has been updated with the Executive lead for each risk and reviewed by the Executive Risk Assurance Group (ERAG) and the Group Risk Assurance Committee (GRAC). The paper documents the current risk profile and key risk movements since the last group Board meeting in June 2026. 10 of the 14 risks are currently rated as 'Significant' (12 and above) – the same as two months ago. A summary of the overall risk profile is provided on the first page of the attached full Group BAF document.

The paper also describes further work planned to develop the BAF and the wider risk management framework, following a Group Board risk workshop which took place on 22 July 2026.

Recommendations

The Group Board is asked to:

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

Alignment to Board Assurance Framework risk(s)	All BAF risks
Previously considered by	Group Risk Assurance Committee, 30 July 2026
Any background papers in Admin Control Reading Room	Full Group BAF document

Norfolk and Waveney University Hospitals Group

Group Board in public: 5 August 2026

Group Board Assurance Framework (BAF)

1. Introduction and background

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

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

1.3 This paper presents the current version of the Group BAF. Each risk has been reviewed with the Executive risk lead as part of the monthly review cycle, ahead of monthly discussion at the Executive Risk Assurance Group (ERAG) and the Board's Group Risk Assurance Committee (GRAC).

1.4 A summary of the Principal Risks, their current and target risk scores, and the overall assurance strength rating is attached. The full Group BAF is included in the pack of supplementary papers.

2. Principal Risks

2.1 Of the 14 Principal Risks currently on the Group BAF:

- 10 are rated as Significant (with scores of 12 or 13)
- 4 are rated as Serious (with scores of 10 or 11)
- There have been no changes to current risk scores in the past two months (since the previous Group Board report)

2.2 Over the past two months, no risks have been de-escalated from the BAF.

2.3 The following key changes have been agreed over the past two months:

- PR2 (maternity services improvement): reflection of the publication of the NHS England 10-Point Plan following publication of the Baroness Amos and Ockenden (Nottingham) investigation reports.

- PR3 (access, flow and productivity): the risk trajectory included a reduction in the risk score to 11 in June 2026 (from the current level of 12). However, a reduction in the current risk score was not proposed. While performance metrics across the three Trusts are broadly tracking to the Medium-term Plan trajectories, some gaps remain. In particular, a number of metrics at QEH are below trajectory and cancer waiting time performance for all three Trusts remains a concern. Therefore the 'Likelihood' score is assessed as remaining at 5 rather than reducing to

4 as per the planned risk trajectory. A new gap in control has been added in relation to cancer waiting time performance. In addition, in July, the risk was updated to reflect development of the QEH Recovery Plan and plans to strengthen Board-level oversight of operational performance via monthly GRAC meetings.

- PR4 (financial sustainability): updated to reflect plans to strengthen Board-level oversight of financial performance via monthly GRAC meetings.

- PR5 (workforce engagement and morale): the risk description has been updated to explicitly reference the impact of bullying, harassment and racism and key controls have been updated to include the Trusts' Equality, Diversity and Inclusion (EDI) action plans and the Group's response to Lord Mann's recommendations on racism and antisemitism in the NHS. Three new gaps in control have also been added relating to the implementation of Lord Mann's recommendations.

- PR8 (cyber security and information governance): the risk has been reviewed and the controls and gaps in control have both been updated to align with the Group's Cyber Security strategy which was received at the Group Risk Assurance Committee in May 2026 and which will be discussed at a forthcoming meeting of the Group Strategy, Technology, Investments and Partnerships Committee. A new gap in control has been added in relation to NIS enforcement notices at NNUH and QEH on Multi-Factor Authentication (MFA).

2.4 Since the end of May, GRAC has undertaken 'deep dives' on the following Principal Risks: PR1, PR3, PR5 and PR8.

3. Further work

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

- The outcome of the Group Board's Risk Appetite workshop on 22 July 2026 will be incorporated over the next quarter. This will include a review of the strategic risks included in the BAF; a review of the visual presentation of the BAF risks; and the population of the risk appetite element of the BAF.

- The latter will provide visibility on the extent to which Principal Risks are currently outside the agreed risk appetite range and planned to return to within the risk appetite range, supporting challenge as to whether additional actions are required. Once the risk appetite has been defined, this should be a key trigger for focusing discussions on BAF risks which sit outside the Group's risk appetite range.

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

4. Recommendations

4.1 The Group Board is asked to:

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

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

Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	15		
Title	Group Board committees and membership		
Author(s)	Ian Walker, Group Director of Governance		
Executive sponsor	Ian Walker, Group Director of Governance		
Purpose of report	**For decision** ☒	**For discussion** ☐	**For information** ☐

Executive summary

This paper proposes the establishment of an additional committee of the Group Board focused on Quality and Outcomes and sets out proposed Board committee membership following the appointment of additional Group Non-Executive Directors and Group Associate Non-Executive Directors.

Recommendations

The Group Board is asked to:

- Approve the establishment of a Quality and Outcomes Committee of the Group Board.
- Approve the membership of Board committees as set out in the paper.
- Approve a revision to the terms of reference of the Group Strategy, Technology, Investments and Partnerships Committee to revise the NED membership to be three Group Non-Executive Directors (previously the Group Chair and five Group Non-Executive Directors).

Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 14 (corporate governance)
Previously considered by	Not applicable – this is a matter for the Group Board
Any background papers in Admin Control Reading Room	No

Norfolk and Waveney University Hospitals Group

Group Board in public: 5 August 2026

Group Board committees and membership

1. Introduction and background

1.1 This paper proposes the establishment of an additional committee of the Group Board focused on Quality and Outcomes and sets out proposed committee membership following the appointment of additional Group Non-Executive Directors (NEDs) and Group Associate Non-Executive Directors.

2. Board committees

2.1 The following Board committees have been established to date in accordance with the Group Governance Framework set out in the Provider Collaboration Agreement of October 2025:

- Group Audit Committees in Common
- Group Nomination and Remuneration Committees in Common
- Group Risk Assurance Committee
- Group Research, Innovation and Education Committee
- Group Strategy, Technology, Investments and Partnerships Committee
- Charitable Funds Committees for each Trust

Link NEDs

2.2 In addition, as reported at the June 2026 Group Board meeting, an 'Associate Chair' and two other Groups NEDs/Associate NEDs have been aligned to each Trust to facilitate closer links between NEDs and the Trusts. In each case, these three NEDs (see table below) are supported by the Group NED Perinatal Safety Champion (Jo Churchill) whose role extends across all three Trusts.

2.3 The purpose of these roles is not to delegate authority from the Group Chair and the Group Board. All Group NEDs remain jointly and equally accountable for three Trusts within the Group. The Associate Chair will represent the Group Chair and NED Group in relation to a number of Trust-related roles and activities. And, together, the three NEDs linked to each Trust will be able to gain a more in-depth understanding of Trust-specific issues and risks and report back on these to the other Group NEDs and the Group Board. These roles are therefore equivalent to the assurance roles of NED chairs and members of Group Board committees – but with a Trust focus rather than a subject matter focus.

2.4 The roles and responsibilities of the Associate Chair, supported by the other two link NEDs, for each Trust are as follows:

- Work with and support Governors in patient, community and staff engagement activities.
- Develop an effective relationship with Governors, including the Lead Governor.
- Deputise for the Group Chair in chairing the Council of Governors and attend Council of Governors' meetings.
- Contribute to Group Board oversight and assurance on the Trust's operational performance, finance and clinical quality.
- Chair the Charitable Funds Committee.
- Ensure that there is a programme of NED visits to services/wards/departments/etc. (as part of ensuring effective Board to Ward governance).
- Represent NEDs at Trust/site events (e.g. staff awards).

Quality and Outcomes Committee

2.5 It is proposed to establish an additional Board committee with specific responsibility for reviewing risks and seeking assurance in relation to patient quality and outcomes. This committee will have a reporting line to the Group Board but have a strong link to the Group Risk Assurance Committee (GRAC) which currently covers quality and safety and which will continue to take a Group-wide view of risk. At least one NED member of the Quality and Outcomes Committee will also be a member of GRAC.

2.6 The role and responsibilities of this committee will be set out in terms of reference which will be brought to the next meeting of the Group Board for approval.

2.7 The updated Group Governance Structure is set out at Appendix 1.

3. Committee membership

3.1 The membership of these committees with effect from 5 August 2026 is proposed to be as set out in the table below. Changes from the previous membership are highlighted in bold and strikethrough:

Board committee	Membership
Group Audit Committees in Common	Stephen Javes (Chair) ~~Jo Churchill~~ Nikki Gray **Jack Bowman**
Group Nomination and Remuneration Committees in Common	~~Sally Collier (Chair)~~ **Susan Putters (Chair)** Philip Baker Nikki Gray

Group Risk Assurance Committee	Nikki Gray (Chair) Sally Collier William Van't Hoff
Group Research, Innovation and Education Committee	Philip Baker (Chair) Jack Bowman William Van't Hoff **Gee Cook** Group Chief Nurse Group Chief Medical Officer Executive Managing Director (x1)
Group Strategy, Technology, Investments and Partnerships Committee	~~David Roberts (Chair)~~ Andy McKechnie (Chair) Jack Bowman Sally Collier ~~Tanvir Alam~~ ~~Marcus Bailey~~ Group Chief Executive Group Chief Finance Officer Group Chief Medical Officer
Group Quality and Outcomes Committee	**William Van't Hoff (Chair)** **Jo Churchill** **Philip Baker** **Marcus Bailey**
James Paget University Hospitals NHS Foundation Trust link NEDs	Stephen Javes (Associate Chair) Gee Cook Sally Collier
Norfolk and Norwich University Hospitals NHS Foundation Trust link NEDs	Susan Putters (Associate Chair) Nikki Gray Marcus Bailey
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust link NEDs	Tanvir Alam (Associate Chair) Andy McKechnie William Van't Hoff

4. Recommendations

4.1 The Group Board is asked to:

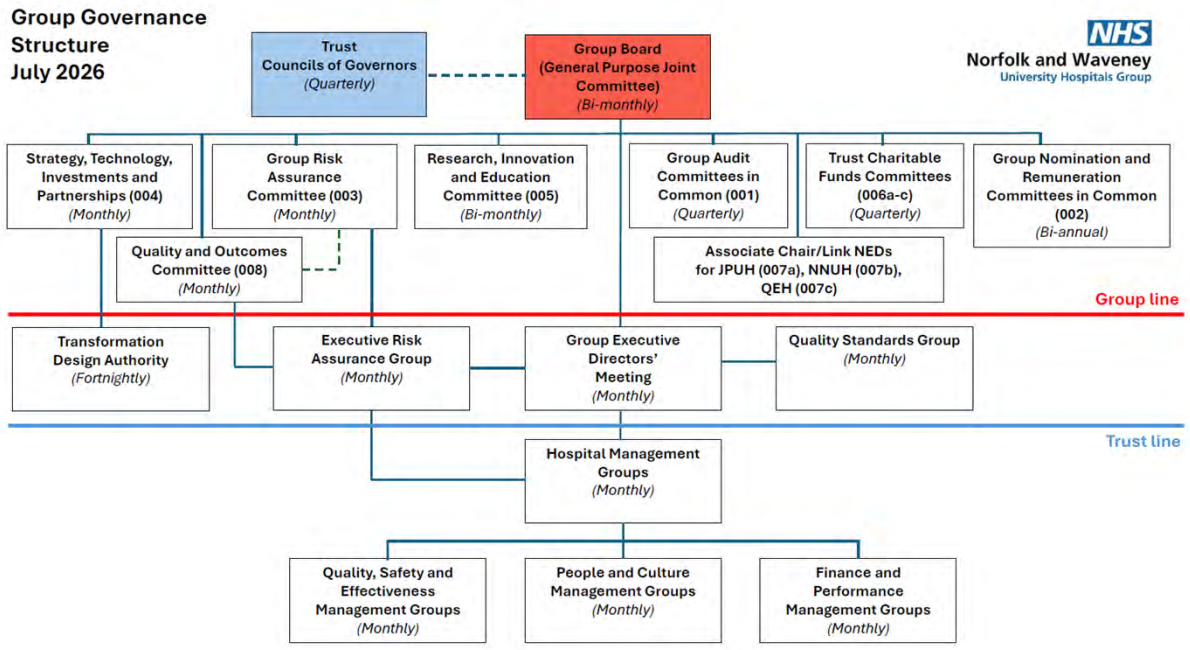
- Approve the establishment of a Quality and Outcomes Committee of the Group Board.
- Approve the membership of Board committees as set out in the paper.
- Approve a revision to the terms of reference of the Group Strategy, Technology, Investments and Partnerships Committee to revise the

NED membership to be three Group Non-Executive Directors (previously the Group Chair and five Group Non-Executive Directors).

Appendices

Appendix 1: Group Governance Structure

Appendix 1: Group Governance Structure



Norfolk and Waveney
University Hospitals Group

Report to the Group Board in public: 5 August 2026

Agenda item number	16		
Title	Group Audit Committees in Common terms of reference		
Author(s)	Ian Walker, Group Director of Governance		
Executive sponsor	Ian Walker, Group Director of Governance		
Purpose of report	**For decision** ☒	**For discussion** ☐	**For information** ☐

Executive summary

The Group Board received the updated terms of reference for the Group Audit Committees in Common at its meeting on 3 June 2026. These were approved by the Group Board (acting in its capacity as the Boards of each of the three Trusts) subject to two amendments:

- Inclusion of specific reference to the Committees' oversight of outstanding audit recommendations.
- Explicit reference to the Committees' role in relation to procurement and waivers of competition.

The attached version of the terms of reference incorporates the proposed additional wording in red text. This wording was agreed by the Group Audit Committees in Common at its meeting on 22 June 2026 and recommended for approval by the Group Board.

Recommendations

The Group Board is asked to:

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

Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 14
Previously considered by	Group Audit Committees in Common, 22 June 2026
Any background papers in Admin Control Reading Room	No

Norfolk and Waveney
University Hospitals Group

GROUP AUDIT COMMITTEES IN COMMON

TERMS OF REFERENCE

1. Introduction

1.1 The Norfolk and Waveney University Hospitals Group (NWUHG) Audit Committees in Common is established under the Provider Collaboration Agreement (PCA)[1].

2. Accountability and authority

2.1 The Boards of each of the three Trusts[2] have agreed and arranged for their Audit Committees to operate together as Committees in Common.

2.2 In operating as Committees in Common, each Trust's Audit Committee shall continue at all times to be directly accountable to its respective Board of Directors but shall routinely report its activities, findings, conclusions and recommendations to the Group Board (the General Purpose Joint Committee).

2.3 Decisions of the Group Audit Committees in Common regarding delegated joint functions are binding on each of the Trusts. Resolutions legally reflect the simultaneous decision of the Audit Committees of all three Trusts.

2.4 The Committees in Common is authorised by the Group Board to act within these terms of reference. It has no executive powers other than those specifically delegated in these terms of reference.

2.5 All members of staff of the three Trusts are directed to cooperate with any request made by the Committees in Common.

2.6 The Committees in Common are authorised by the Group Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

3. Purpose

3.1 The purpose of the Group Audit Committees in Common is to provide independent and objective scrutiny of the adequacy and effectiveness of governance, risk management and internal control across the three Trusts operating within the Group model.

[1] Provider Collaboration Agreement for the purpose of establishing Norfolk and Waveney University Hospitals Group joint working arrangements and appointment of a General Purpose Joint Committee to exercise joint functions, 23 October 2025.
[2] Norfolk and Norwich University Hospitals NHS Foundation Trust, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and James Paget University Hospitals NHS Foundation Trust.

4. Membership and attendance

4.1 The members of the Group Audit Committees in Common will be appointed by the Boards of Directors of the three Trusts and comprise three Group Non-Executive Directors. The Group Chair shall not be a member.

4.2 One Group Non-Executive Director will be appointed as the Chair of the Group Audit Committees in Common by the Boards of Directors of the three Trusts.

4.3 At least one member of the Group Audit Committees in Common must have recent and relevant financial experience.

4.4 The Group Chief Executive will identify a link Executive Director for the Group Audit Committees in Common.

4.5 A quorum shall be two Group Non-Executive Directors.

4.6 The Group Chief Finance Officer will attend all meetings. In exceptional circumstances, an appropriate nominated deputy may attend in their place. The Group Chief Executive will be invited to attend all meetings and should discuss at least annually with the Group Audit Committees in Common the process for assurance that supports the Annual Governance Statements.

4.7 The Head of Internal Audit, a representative of External Audit and the Local Counter Fraud Specialist will be standing attendees.

4.8 Other Group and Trust staff will be invited to attend for specific agenda items with the agreement of the Chair of the Group Audit Committees in Common.

5. Secretariat

5.1 The Group Director of Governance will provide a Secretary to the Group Audit Committees in Common to provide administrative support to the Chair and members. This will include agreement of the agenda with the Chair and Executive lead, collation and circulation of papers, producing the minutes of the meetings, recording agreed actions and follow up, and advising the Chair and members as appropriate.

6. Frequency of meetings

6.1 Meetings will be held four times a year, with an additional meeting to review the Annual Reports and Accounts.

6.2 The Chair may convene additional meetings if necessary to consider business requiring urgent attention.

6.3 At least once a year, members of the Group Audit Committees in Common will meet with the Internal Auditors, External Auditors and the Local Counter Fraud Specialist without any others present.

6.4 To assist in the management of business over the year, an annual workplan will be maintained detailing the main items of business to be considered at each scheduled meeting.

7. Reporting

7.1 A report will be presented to the next meeting of the Group Board following each meeting of the Group Audit Committees in Common to draw attention to any matters that require disclosure or escalation to the Group Board.

7.2 The Trusts' Annual Reports will include a section describing the work of the Group Audit Committees in Common in discharging its responsibilities.

8. Duties and responsibilities

Governance, risk management and internal control

8.1 The Group Audit Committees in Common will review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisations' activities (clinical and non-clinical), that supports the achievement of the organisations' objectives.

8.2 In particular, the Group Audit Committees in Common will review the adequacy and effectiveness of:

- The Group's Risk Management Strategy and Policy and other systems of control.
- All risk and control related disclosure statements (in particular the Annual Governance Statements), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Group Board.
- The underlying assurance processes that indicate the degree of achievement of the organisations' objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider Licence.
- The policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

8.3 In carrying out this work, the Group Audit Committees in Common will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

8.4 This will be evidenced through the Group Audit Committee in Common's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

8.5 As part of its integrated approach, the Group Audit Committees in Common will have effective relationships with other key committees, including the Group Risk Assurance Committee, so that it understands processes and linkages.

Internal Audit

8.6 The Group Audit Committees in Common will ensure that there is an effective internal audit function that meets the Global internal audit standards, 2017 and provides appropriate independent assurance to the Group Audit Committees in Common, the Group Chief Executive as Accounting Officer and the Group Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisations as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response) and ensuring coordination between the internal and external auditors to optimise the use of audit resources.
- Monitoring management's progress on implementing audit recommendations.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisations.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit

8.7 The Group Audit Committees in Common will review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Group Audit Committees in Common will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Make recommendations to the Council of Governors of the three Trusts regarding the appointment, reappointment, termination of appointment and fees of the External Auditor.
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the

appropriateness of management responses and the implementation of audit recommendations.

- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other assurance functions

8.8 The Group Audit Committees in Common will review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisations.

8.9 These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

8.10 In addition, the Group Audit Committees in Common will review the work of other committees within the organisations, whose work can provide relevant assurance to the Group Audit Committees in Common's own areas of responsibility. In particular this will include any committees covering safety/quality, for which assurance from clinical audit can be assessed, and risk management.

Counter Fraud

8.11 The Group Audit Committees in Common shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

8.12 With regards to the local counter fraud specialist, it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Management

8.13 The Group Audit Committees in Common will request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

8.14 The Group Audit Committees in Common may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

Financial reporting

8.15 The Group Audit Committees in Common will monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

8.16 The Group Audit Committees in Common should ensure that the systems for financial reporting to the Group Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

8.17 The Group Audit Committees in Common will review the annual reports and financial statements before submission to the Boards of Directors of the three Trusts, focusing particularly on:

- The wording in the Annual Governance Statements and other disclosures relevant to these terms of reference.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Explanations for significant variances.

8.18 Review the Annual Reports and Accounts of the three Trusts' Charitable Funds, and the associated reports to management and letters of representation, ahead of submission to the Boards of Directors of the three Trusts (acting as corporate trustee).

Systems for raising concerns

8.19 The Group Audit Committees in Common will review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisations (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

Governance and regulatory compliance

8.20 The Group Audit Committees in Common shall review the operation of, and proposed changes to, the Standing Orders, Standing Financial Instructions ~~(including single tender waivers)~~ and Schemes of Reservation and Delegation.

8.21 The Group Audit Committees in Common shall review compliance with the Trusts' procurement policies including the use of single tender waivers.

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8.22 The Group Audit Committees in Common shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and Codes of Conduct.

8.23 The Group Audit Committees in Common will satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

9. Review of effectiveness

9.1 The Group Audit Committees in Common will undertake an annual review of its effectiveness which will inform the review of the terms of reference and the work programme of the Group Audit Committees in Common.

10. Review of terms of reference

10.1 The terms of reference will be reviewed by the Group Audit Committees in Common and approved by the Boards of Directors of the three Trusts annually.

Date approved by the Boards of Directors: [5 August 2026]

Next review date: July 2027