

Group Board (General Purpose Joint Committee) meeting in Public

Wednesday 7 October 2026, 10:30 - 13:30

JPUH - Lecture Theatre, Burrage Centre, Lowestoft Road,
Gorleston NR31 6LA



Agenda

10:30 - 10:30

0 min

1. Agenda, welcome and apologies

Group Chair

0 - Group Board in public - Agenda - 07.10.26 iw.pdf (3 pages)

10:30 - 10:30

0 min

2. Declarations of interest

Information Group Chair

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

Patient Story

10:30 - 10:50

20 min

3. Reflections from Board walkrounds and Patient Story

Discussion Group Chief Nurse

Introductory items and reports

10:50 - 10:55

5 min

4. Minutes of the previous meeting

Decision Group Chair

To approve the Minutes of the meeting held on 5 August 2026

4 - Draft Group Board Minutes 05.08.26 iw.pdf (17 pages)

10:55 - 10:55

0 min

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

Discussion Group Director of Governance

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

10:55 - 11:05

10 min

6. Group Chief Executive's Report

Discussion Group Chief Executive

6.1 - Group Chief Executive's Board Report October 2026 iw.pdf (6 pages)

Group and Trust performance

11:05 - 11:25

20 min

7. Group performance overview

Walker Ian
05/10/2026 10:45:15

7.1. Integrated Performance Report (including One Recovery)

Discussion

Group Chief Delivery Officer

📄 7.1.1 - Group Board in public - Integrated Performance Report September 2026 iw.pdf (5 pages)

📄 7.1.2 - Group Board in public - Group Integrated Performance Report September (August data) VF.pdf (45 pages)

7.2. Group Finance Report

Discussion

Group Chief Finance Officer

📄 7.2.1 - Group Finance Report M5 cover sheet iw.pdf (1 pages)

📄 7.2.2 - Group Finance Report M05 2627 iw.pdf (13 pages)

11:25 - 11:40
15 min

8. Queen Elizabeth Hospital King's Lynn NHS FT

8.1. Executive Managing Director's report (including NOF)

Discussion

Executive Managing Director

📄 8 - QEH EMD Group Board Report October 2026 iw.pdf (7 pages)

8.2. Link Non-Executive Directors' update

Discussion

Link NEDs

11:40 - 11:55
15 min

9. Norfolk and Norwich University Hospitals NHS FT

9.1. Executive Managing Director's report (including NOF)

Discussion

Executive Managing Director's report

📄 9 - NNUH EMD Group Board Report October 2026 iw.pdf (8 pages)

9.2. Link Non-Executive Directors' update

Discussion

Link NEDs

11:55 - 12:10
15 min

10. James Paget University Hospitals NHS FT

10.1. Executive Managing Director's report (including NOF)

Discussion

Executive Managing Director

📄 10 - JPUH EMD Group Board Report October 2026 iw.pdf (7 pages)

10.2. Link Non-Executive Directors' update

Discussion

Link NEDs

Business items

12:10 - 12:20
10 min

11. Reports from the Chairs of Board Committees

11.1. Group Quality and Outcomes Committee

Information

Committee Chair

📄 11.1 - Group Quality and Outcomes Committee - Chair's report iw.pdf (3 pages)

Waterian
05/10/2026 10:15:14

11.2. Group Risk Assurance Committee

Information

Committee Chair

 11.2 - Group Risk Assurance Committee - Chair's report iw.pdf (3 pages)

11.3. Group Strategy, Technology, Investments and Partnerships Committee

Information

Committee Chair

 11.3 - Group STIP Committee - Chair's report iw.pdf (4 pages)

11.4. Group Audit Committees in Common

Information

Committee Chair

 11.4 - Group Audit Committees in Common - Chair's report iw.pdf (3 pages)

12:20 - 12:30

10 min

12. Thirlwall Inquiry

Discussion

Group Chief Nurse

 12.1 - Thirlwall Inquiry Group Board paper iw.pdf (6 pages)

12:30 - 12:40

10 min

13. Group Perinatal report

Decision

Group Chief Nurse

 13.1 - Group Perinatal Report iw.pdf (5 pages)

12:40 - 12:50

10 min

14. Freedom to Speak Up

Discussion

Group Chief People Officer

 14.1 - FTSU report for Group Board October 2026 iw.pdf (6 pages)

12:50 - 13:00

10 min

15. Provider Capability Assessments

Decision

Group Director of Governance

 15.1 - Provider Capability Assessments 2026 - Group Board paper iw.pdf (5 pages)

Governance, compliance and risk

13:00 - 13:05

5 min

16. Board Committee terms of reference

Decision

Group Director of Governance

 16.1 - Board committee terms of reference cover sheet iw.pdf (2 pages)

 16.2 - Group Quality and Outcomes Committee Draft ToRs August 2026 iw.pdf (5 pages)

 16.3 - Group Risk Assurance Committee terms of reference iw.pdf (5 pages)

13:05 - 13:05

0 min

17. Standing Financial Instructions amendments

Decision

Group Chief Finance Officer

Paper required

 17.1 - Standing Financial Instructions iw.pdf (4 pages)

 17.2 - SFIs - proposed amendments September 2026 iw.pdf (9 pages)

Walker Ian
05/10/2026 10:45:15

13:05 - 13:05
0 min

18. Standing Orders of the Council of Governors

Decision

Group Director of Governance

Paper required

 18.1 - Standing Orders of the Councils of Governors iw.pdf (2 pages)

 18.2 - Standing Orders - Councils of Governors September 2026 iw.pdf (7 pages)

13:05 - 13:05
0 min

19. Appointment of Group Deputy Chair

Decision

Group Director of Governance

 19 - Appointment of Group Deputy Chair iw.pdf (1 pages)

13:05 - 13:10
5 min

20. Group Board Assurance Framework

Decision

Group Director of Governance

 20.1 - Report to Group Board - BAF update September 2026 iw.pdf (5 pages)

 20.2 - NWUHG BAF - September 2026 Summary page iw.pdf (1 pages)

13:10 - 13:15
5 min

21. Compliance update

Information

Group Director of Governance

 21 - Compliance update iw.pdf (3 pages)

Other items

13:15 - 13:20
5 min

22. Any Other Business

Group Chair

13:20 - 13:30
10 min

23. Questions from Members of the Public

Discussion

Group Chair

To respond to pre-submitted questions

13:30 - 13:30
0 min

24. Date of the Next Meeting

Information

Wednesday 2 December 2026 at 10:30 in the Board Room, Queen Elizabeth Hospital, Gayton Road, King's Lynn, Norfolk PE30 4ET

13:30 - 13:30
0 min

25. Resolution

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)

13:30 - 13:30
0 min

26. Close of Meeting

Walker Ian
05/10/2026 10:45:15

Group Board (General Purpose Joint Committee)

Meeting in public on 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

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 5 August 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	Group Chief Executive
Group and Trust performance					
11.05	7.	Group performance overview			
Walker Ian 05/10/2026 10:45:15	7.1	Integrated Performance Report (including One Recovery)	For discussion	Yes	Group Chief Delivery Officer
	7.2	Group Finance Report	For discussion	Yes	Group Chief Finance Officer

11.25	8.	Queen Elizabeth Hospital King's Lynn NHS FT	For discussion	Yes No	Executive Managing Director and Link NEDs
	8.1	Executive Managing Director's report (including NOF)			
	8.2	Link Non-Executive Directors' update			
11.40	9.	Norfolk and Norwich University Hospitals NHS FT	For discussion	Yes No	Executive Managing Director and Link NEDs
	9.1	Executive Managing Director's report (including NOF)			
	9.2	Link Non-Executive Directors' update			
11.55	10.	James Paget University Hospitals NHS FT	For discussion	Yes No	Executive Managing Director and Link NEDs
	10.1	Executive Managing Director's report (including NOF)			
	10.2	Link Non-Executive Directors' update			
Business items					
12.10	11.	Reports from the Chairs of Board Committees	For information	Yes	Committee Chairs
	11.1	Group Quality and Outcomes Committee			
	11.2	Group Risk Assurance Committee			
	11.3	Group Strategy, Technology, Investments and Partnerships Committee			
	11.4	Group Audit Committees in Common			
12.20	12.	Thirlwall Inquiry	For discussion	Yes	Group Chief Nurse
12.30	13.	Group Perinatal report	For decision	Yes	Group Chief Nurse
12.40	14.	Freedom to Speak Up	For discussion	Yes	Group Chief People Officer
12.50	15.	Provider Capability Assessments	For decision	Yes	Group Director of Governance
Governance, compliance and risk					
13.00	16.	Board Committee terms of reference	For decision	Yes	Group Director of Governance

	17.	Standing Financial Instructions amendments	For decision	Yes	Group Chief Finance Officer
	18.	Standing Orders of the Councils of Governors	For decision	Yes	Group Director of Governance
	19.	Appointment of Group Deputy Chair	For decision	Yes	Group Director of Governance
13.05	20.	Group Board Assurance Framework	For decision	Yes	Group Director of Governance
13.10	21.	Compliance update	For information	Yes	Group Director of Governance
Other items					
13.15	22.	Any other business		No	Group Chair
13.20	23.	Questions from members of the public To respond to pre-submitted questions	For discussion	No	Group Chair
	24.	Date of the next meeting Wednesday 2 December 2026 at 10.30 in the Board Room, Queen Elizabeth Hospital, Gayton Road, King's Lynn, Norfolk PE30 4ET.	For information		
	25.	Resolution That representatives 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
13.30	26.	Close of meeting			

Group Board (General Purpose Joint Committee) meeting in public

Minutes of the meeting held on Wednesday 5 August 2026 at 10.30 in the John Innes Conference Centre, Norwich Research Park, Norwich NR4 7UG

Board members present	Position
David Roberts	Group Chair
Tanvir Alam	Group Non-Executive Director
Marcus Bailey *	Group Associate Non-Executive Director
Jack Bowman	Group Non-Executive Director
Jo Churchill	Group Non-Executive Director
Rachael Cocker	Group Chief Nurse
Sally Collier	Group Non-Executive Director and Senior Independent Director
Gee Cook *	Group Associate Non-Executive Director
Jonathan Gardner	Executive Managing Director, James Paget University Hospitals NHS Foundation Trust (JPUH)
Shane Gordon	Executive Managing Director, Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)
Nikki Gray	Group Non-Executive Director
Stephen Javes	Group Non-Executive Director
Andy McKechnie	Group Non-Executive Director
Susan Putters	Group Non-Executive Director
Joanne Segasby	Group Chief Delivery Officer and Acting Executive Managing Director, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH)
Robert Sherwin	Group Chief Medical Officer
Marcus Thorman	Group Chief Finance Officer (deputising for Group Chief Executive)
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

Philip Baker	Group Non-Executive Director
Lesley Dwyer	Group Chief Executive
Emma-Jayne Perez Chies*	Interim Group Chief People Officer
Edward Prosser-Snelling *	Group Director of Digital

In attendance

Deborah O'Hara	Director of People and Culture, JPUH (attending for Interim Group Chief People Officer)
Mike Shemko	Chief Data Officer (attending for Group Director of Digital)

1. Agenda, welcome and apologies

Purpose: For Information

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

He welcomed those Group Non-Executive Directors and Group Associate Non-Executive Directors who were attending their first Group Board meeting since their formal appointment,

Apologies were received from Lesley Dwyer, Philip Baker, Emma-Jane Perez Chies and Edward Prosser-Snelling.

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. Patient story

Purpose: For Discussion

Lucy Weavers, Chief Nurse for NNUH, introduced Sharon Wrath, the NNUH Frailty Lead, who presented a patient story illustrating the complexity of coordinating care for an older person with significant frailty and dependency. The account highlighted the importance of timely multi-disciplinary working, community support, appropriate care packages and clear communication across organisational boundaries.

Jo Churchill, Group Non-Executive Director, asked whether partnership working could be systematised to improve coordination with virtual wards, the Integrated Care Board (ICB) and community services. It was explained that the Group was seeking to encourage proactive care models and identify people at risk of deterioration earlier, including through a community geriatrician approach.

William Van't Hoff, Group Non-Executive Director, asked whether frailty scoring was applied consistently across hospital, primary care and community settings. It was explained that there were currently differences between scoring approaches but there was a move towards greater standardisation. Through further questions, it was noted that nurse-led and paramedic-led frailty scoring was increasingly important.

Resolution: The Group Board noted the patient story and the wider implications for integrated frailty pathways, consistent assessment and partnership working. Board members thanked Sharon Wrath and colleagues involved in the patient's care.

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 3 June 2026.

No amendments were proposed.

Resolution: The Group Board approved the minutes as a true and accurate record.

5. Action log and matters arising

Purpose: For Discussion

The Interim Group Director of Governance presented the action log. The charities options appraisal remained open and not yet due. Actions relating to the establishment of a Quality and Outcomes Committee and amendments to committee terms of reference would be progressed through papers on the agenda. The amendment to Council of Governors' Standing Orders would proceed through the three Councils of Governors and the next Group Board meeting.

William Van't Hoff sought assurance that representatives of all three charities would be involved in the charities options appraisal. It was confirmed that this would be the case.

Resolution: The Group Board noted the action log and agreed that actions 11 and 12 had been completed and should be closed.

6. Group Chief Executive's Report

Purpose: For Discussion

Marcus Thorman, Group Chief Finance Officer, presented the Group Chief Executive's report. He described progress on One Strategy, including workshops with senior clinicians across the three hospitals, and the establishment of the Transformation Design Authority to help align the New Hospital Programme, digital transformation, the Electronic Patient Record (EPR) and other major change programmes.

It was noted that a review of the One Recovery programme had taken place. The overall programme architecture remained appropriate but the review had identified a need to strengthen execution and delivery. Board members also noted the intensive work undertaken in response to NHS England concerns relating to QEH performance and the positive feedback received on the resulting action plan, while recognising that delivery against commitments remained essential.

Further updates covered engagement with Health Overview and Scrutiny Committees and Norwich City Council; Governor elections; the national maternity reviews and related NHS England response; preparations for the QEH Well-Led inspection; the substantive appointment of the Group Chief Nurse; and the position on potential industrial action by consultants.

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

7. Executive Managing Directors' Reports

Purpose: For Discussion

7.1. James Paget University Hospitals NHS Foundation Trust

Purpose: For Discussion

The Executive Managing Director for JPUH reported positive trends in patient experience, healthcare acquired infections, pressure ulcers and falls, sickness absence, mandatory training and appraisal. He also noted sustained reductions in the overall waiting list and 52-week waits, improvement in Referral to Treatment performance and elective activity delivery, and an improved financial position.

The Executive Managing Director for JPUH described positive neighbourhood working, including strengthened primary care leadership and a memorandum of understanding with the community provider.

The principal operational risks at JPUH related to diagnostic waits following increased MRI demand, cancer waiting time performance and a high number of 65 week waits in ear, nose and throat (ENT) services. A business case had been approved for outsourced MRI capacity, with a six-month lead time for mobilisation and a planned nine-month timetable to clear the backlog. Long waits in ENT reflected a longstanding capacity gap and work was being undertaken with NNUH to reduce the backlogs. It was expected to take around 12 weeks to reduce the adult backlog and around 29 weeks to reduce the backlog in paediatrics.

The Summary Hospital-level Mortality Indicator (SHMI) was higher than expected. This did not reflect an increase in the actual number of deaths but rather a reduction in the expected number of deaths due to reduced depth of coding. Work was underway to address this.

In summary, and while recognising ongoing areas of concern, the Executive Managing Director for JPUH felt that the organisation had turned a corner and had a strong grip on processes which should continue to drive improvement.

Stephen Javes, Associate Chair for JPUH, endorsed this assessment and reported increased confidence in the Trust's trajectory and governance arrangements. He explained that he was meeting regularly with the Executive Managing Director for JPUH and Link NEDs were planning regular visits and walkrounds. He also planned to meet the JPUH Lead Governor on a monthly basis.

Jon Churchill asked about the increase in mental-health related Emergency Department attendances, including waits over 12 hours. The Executive Managing Director for JPUH agreed that this was a significant area of concern and work was being undertaken with the mental health trust on provision on neighbourhood emergency mental health hubs.

In response to a question from Jo Churchill on the increase in urgent and emergency care walk-ins, the Executive Managing Director for JPUH confirmed that there had been a 17% increase. An additional registrar had been recruited to support the increase in activity and work was being undertaken to understand to what extent the increase reflected changes in GP pathways.

It was noted that discussions were taking place with social care in relation to continuing high levels of patients with no criteria to reside.

Jack Bowman, Group Non-Executive Director, asked for an update on the planned Urgent Treatment Centre at JPUH. It was confirmed that this was on track for delivery in spring 2027. External funding was in place following a previous capital bid.

In relation to hot-weather mitigation, it was confirmed that all three Trusts had purchased additional fans during the recent heatwaves and a number of air conditioning units were available to be deployed as appropriate, while recognising that these could not be used in all locations due to infection control requirements.

William Van't Hoff sought assurance that mortality metrics other than SHMI did not indicate any excess deaths. The Group Chief Medical Officer confirmed that other mortality indicators were stable and emphasised that a change in the depth of coding over the past 12 months appeared to have had a significant impact on SHMI.

Jack Bowman asked what work had been undertaken across the Group to standardise the approach to clinical coding and the role of digital within this. The Group Chief Medical Officer explained that coding was now a centralised function. Following a recent recruitment exercise, additional coders would be trained and allocated to JPUH to increase the depth of coding. In addition, consideration was being given to introducing digital tools, while recognising that this was a complex area which was reliant on information recorded by clinicians at the front end. The introduction of the EPR would also support the depth of coding.

Resolution: The Group Board noted the JPUH report, the improving trajectory and the identified risks requiring continued oversight.

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

Purpose: For Discussion

The Acting Executive Managing Director for QEH highlighted the recent ground-breaking ceremony for the multi-storey car park as part of the new hospital development, research achievements and preparation for the forthcoming CQC Well-Led inspection.

As part of a neighbourhood hub approach, the Trust was also working with partners outside the Norfolk and Suffolk system. This included exploring the scope to provide additional services at the North Cambridgeshire Hospital in Wisbech.

On General Surgery, positive progress was being made. Consultant workforce resilience was increasing through joint appointments with NNUH. There had been improvements in ward processes and MDTs were now being reviewed. Patient experience continued to be monitored. Overall, this was a positive piece of work providing evidence of effective Group working.

However, it was disappointing to report that the University of East Anglia and the University of Cambridge had suspended undergraduate medical student placements at QEH for the 2026/27 academic year. Work was being undertaken with the universities and NHS England to deliver improvements in education governance arrangements.

In relation to performance, improvements had been seen in Referral to Treatment waiting times in June and July 2026 and the Trust was on track to achieve the trajectory set out in the response to NHS England. Cancer performance remained challenging. There had been some improvement in the Faster Diagnosis Standard but significant work was required in endoscopy and gynaecology.

In relation to urgent and emergency care, there was a focus on flow through the hospital. There had been an improvement in ambulance handover times and 12-hour waits but 4-hour performance had deteriorated due to an increase in walk-in patients. Refurbishment works and preparation for the Urgent Treatment Centre was also adversely impacting on performance. Work was planned during August on re-booking patients who attended late in the evening for the next day.

The Group Chief Finance Officer highlighted the Cost improvement Programme (CIP) risk at QEH which had been discussed by GRAC. The required scale of CIP delivery for 2026/27 was significant, particularly in the context of the performance challenges at QEH.

The Acting Executive Managing Director for QEH reported that, in response to the significant challenges facing the organisation, a draft two-phase recovery plan had been developed and discussed at the Group Risk Assurance Committee (GRAC). This would be further developed during August.

The Group Chair welcomed the structure and focus which the Acting Executive Managing Director had brought to the QEH recovery plan and noted that the Group Board had a good understanding of the key issues facing the organisation.

Tanvir Alam, Associate Chair for QEH, noted that he and the other QEH Link Non-Executive Directors were planning to undertake visits at QEH on a regular basis. He had also recently chaired the QEH Council of Governors' meeting.

William Van't Hoff welcomed the increased focus on risk management at QEH which had been discussed at GRAC, and the support for QEH from the rest of the Group. In addition to planned visits, he had spoken with the QEH Freedom to Speak Up Guardian and he reported that the QEH Youth Council was currently recruiting new members and had been invited by the Mayor to present at the Town Hall.

Nikki Gray, Group Non-Executive Director, reflected on the GRAC discussion of the QEH recovery plan and the need for clarity on key priorities and dependencies in what was an extensive plan. It would be important to focus on actions which would drive performance improvement.

Gee Cook, Group Associate Non-Executive Director, asked about the likely timeframe for lifting the suspension of medical student placements. The Acting Executive Managing Director for QEH explained that an education improvement plan was being developed and would be informed by an education summit which was planned for later in the week. Significant work would be required to address the issues which had been identified and the action plan would be reviewed by the Group Research, Innovation and Education Committee. It was important to note that this did not impact on non-medical trainees in the organisation.

Jo Churchill congratulated Tonicha Patterson on being named Student Nurse of the Year: Children in the recent Student Nursing Times Awards. It was agreed that the Group Chair would write to congratulate her on behalf of the Group Board.

The Group Chair emphasised the scale of the challenge at QEH but welcomed the increased grip and control which could be observed and the focus of both the Trust and the Group in coming together to monitor performance.

Resolution: The Group Board noted the QEH report, the recovery arrangements and the key quality, operational, workforce, regulatory and financial risks.

Action: Group Chair to write to Tonicha Patterson on behalf of the Group Board.

7.3. Norfolk and Norwich University Hospitals NHS Foundation Trust

Purpose: For Discussion

The Executive Managing Director of NNUH noted that urgent and emergency care performance was slightly behind plan in June 2026 on 4 and 12 hour waits and ambulance handovers. An action plan had been developed and performance had shown an improvement in July 2026, with the 4-hour standard achieved. This was in the context of seeing around 1,000 more patients per month compared to a year ago.

At 62.6% in June 2026, 18 Week Referral to Treatment performance was 1 percentage point below plan while time to first appointment was ahead of plan. However, the total elective waiting list had increased since the end of 2025/26 given a 7% increase in referral volumes since the end of last year. The Trust was working with the ICB to understand the reasons for this. A potential data quality issue in relation to recording was also being investigated. Long wait performance was behind plan but was expected to recover in August 2026.

The Trust continued to exceed the cancer Faster Diagnosis Standard but remained below plan on the 31 and 62 day waiting time standards. However, performance continued to improve and was expected to achieve the plan by August 2026.

The Trust was slightly ahead of its financial plan in the year to date, including on CIP, and capital expenditure was anticipated to catch up to its planned level.

In terms of quality, there had been a slight increase in the SHMI. As with the other Trusts, there was a focus on capturing the complexity and depth of coding. There had been three falls causing moderate harm. Midwifery fill rates were a concern and an action plan had been developed with the Perinatal team. The Executive Managing Director was chairing a new Perinatal Resilience Forum and working closely with the Group Chief Nurse to improve the position. Mandatory training, turnover and sickness absence were all positive but there had been a seasonal dip in non-medical appraisal rates.

In relation to Group working, NNUH continued to support general surgery at QEH and good progress was being made. NNUH was also supporting audiology, with a single paediatric audiology service now having been established with QEH.

In terms of the National Oversight Framework (NOF), NNUH had remained in Segment 3 and improved from 91st to 76th in 2025/26 Q4. With changes to NOF metrics for 2026/27, some quarterly volatility was expected.

The very hot weather was having a significant impact. This was frustrating given the relatively modern nature of much of NNUH's estate but a lack of air conditioning. The Trust's heatwave plan had been refreshed to include additional mitigations but patient experience remained unsatisfactory. A longer-term plan had been developed but was dependent on having sufficient electrical capacity on site. The Trust had reported a heat-related critical incident in June 2026 affecting MRI scanners. This had been resolved within 48 hours and all affected patients had now received their scans.

NIS enforcement notices in relation to Multi Factor Authentication for NNUH and QEH were being addressed at Group level. Additional cyber security investment was being deployed at NNUH.

Susan Putters, Associate Chair for NNUH, noted that regular meetings had been established with the Link Non-Executive Directors, the Executive Managing Director and the Lead Governor. The Link Non-Executive Directors would be planning visits to various areas of the hospital. She was also meeting regularly with the Charity Director.

A particular concern identified was the level of violence perpetrated against staff.

Sally Collier asked whether the increase in the number of patients attending the Emergency Department and the increase in the referral rate was likely to represent a 'new normal'. It was noted that JPUH had seen similar increases but this was not being replicated at QEH. It was therefore important to undertake work as a Group with the ICB to better understand the reasons for the increases and the differences in the West of the county.

The Group Chair asked about the recorded increase in pressure ulcers. The Group Chief Nurse explained that this related to a data capture issue and the number of pressure ulcers would reduce when this was resolved.

Resolution: The Group Board noted the NNUH report.

8. Group Integrated Performance Report

Purpose: For Discussion

The Group Chief Delivery Officer introduced the Integrated Performance Report for June 2026. The paper noted that NHS England required Winter Plan assurance submissions to be approved by Boards and submitted to NHS England by 30 September 2026. Given that the next Group Board meeting was not until 7 October 2026, it was proposed that the Winter Plan board assurance statements should be reviewed by GRAC at its meeting on 30 September 2026 and approved on behalf of the Group Board.

The Group Chief Nurse highlighted that, following a data cleanse, a standard approach was now being followed to setting infection control targets. A common risk assessment tool for pressure ulcers had been introduced across the Group. Work was also being undertaken to ensure a standard approach to reporting on nursing and midwifery fill rates across the three Trusts.

William Van't Hoff questioned whether the Group model provided an opportunity to work with partners on a system approach to antibiotic prescribing. The Group Chief Nurse and Group Chief Medical Officer agreed that this was an area for future focus.

The Director of People and Culture for JPUH explained that a single People function for the Group was being established, with a common approach to areas including sickness absence management and employee relations.

The Group Chief Delivery Officer noted that operational performance had been covered through the Trust reports. The One Recovery programme was focused on supporting operational recovery.

The Group Chair observed that GRAC was seeking assurance on operational and financial performance on behalf of the Group Board, with support from the Link Non-Executive Directors.

Resolution: The Group Board noted the Integrated Performance Report and delegated approval of the Winter Plan board assurance statements for the three Trusts to the Group Risk Assurance Committee.

9. Group Finance Report

Purpose: For Discussion

The Group Chief Finance Officer reported that the financial position had received detailed scrutiny at GRAC. Further work was required on site-level CIP delivery, bank expenditure and aged debt. The QEH cash position, which had been supported by NNUH, remained a significant concern. The importance of the delivery of income and expenditure plans and CIPs to secure quarterly Deficit Support Funding for QEH and JPUH was emphasised. In relation to capital, the funding

for mechanical thrombectomy had now been resolved and discussions continued with NHS England on EPR funding.

Susan Putters asked about the projected year-end position. The Group Chief Finance Officer confirmed that NNUH and JPUH were expected to deliver breakeven positions for 2026/27. The position for QEH was more challenging given the scale of CIP savings required and extensive work continued to address the position.

In response to a question from Susan Putters, the Group Chief Financial Officer explained that current international instability was having an impact on the supply chain but this was generally being managed by swapping products in and out. This had been discussed at GRAC earlier in the year.

Sally Collier asked about the £4½m overspend on drugs and clinical supplies in Q1 and whether this could be recovered. The Group Chief Finance Officer explained that some of this related to higher-than-expected inflation but the majority was offset by other income.

Andy McKechnie, Group Non-Executive Director, noted that 100% of the CIP programme had been identified at JPUH and asked when NNUH and QEH would achieve this level. He also asked when financial planning for 2027/28 would commence. The Group Chief Finance Officer explained that progress continued to be made on identifying CIPs but this remained a high risk at QEH. Planning for 2027/28 would commence in the autumn.

Resolution: The Group Board noted the forecast break-even position, the work still required to achieve it, and that no change was proposed to the finance principal risk.

10. Reports from the Chairs of Board Committees

Purpose: For Information

10.1. Group Risk Assurance Committee

Purpose: For Information

Nikki Gray reported that the Committee continued to evolve positively. Establishment of the Strategy, Technology, Investments and Partnerships Committee and the Quality and Outcomes Committees had created space for deeper consideration of operational and financial performance, while the balance between performance and detailed risk scrutiny would continue to be refined. She highlighted effective cross-committee escalation of the issue relating to QEH medical students.

Resolution: The Group Board noted the Group Risk Assurance Committee report.

05/10/2026 10:45:15
Eliker, Ian

10.2. Group Audit Committees in Common

Purpose: For Information

Stephen Javes noted the discussion of reports on financial governance at QEH and JPUH, counter-fraud awareness, stronger tracking of Internal Audit recommendations and a planned lessons-learned review of the year-end process.

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

10.3. Group Research, Innovation and Education Committee

Purpose: For Information

William Van't Hoff reported that the 'Collectively Curious' review had identified the need to strengthen research strategy and delivery. The work represented both an opportunity and a performance requirement because future research investment depended on compliance with increasingly stringent expectations.

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

10.4. Group Strategy, Technology, Investments and Partnerships Committee

Purpose: For Information

Andy McKechnie reported mobilisation of workstreams, including on neighbourhoods, the clinical strategy, New Hospital Programme business-case modelling and benefits realisation.

Resolution: The Group Board noted the Group Strategy, Technology, Investments and Partnerships Committee report.

10.5. Charitable Funds Committees

Purpose: For Information

Resolution: The Group Board noted the reports of the Charitable Funds Committees.

11. Perinatal services

Purpose: For Discussion

Maternity triage specification

The Group Chief Nurse presented the national maternity triage specification which was part of the national Ten Point Plan in response to the recent Ockenden and Amos reports. Each Trust was undertaking a gap analysis of its maternity triage service. The specification required a 24-hour, seven-day service and would require particular attention to issues relating to estates, information

technology, internal telephone arrangements, training and pathways from Emergency Departments. The initial submissions were due in October 2026 with full compliance required by July 2027.

Nikki Gray asked whether it was the expectation that maternity triage sat as part of the Emergency Department or Perinatal services. The Group Chief Nurse confirmed that it was the latter. Consideration would be given to developing a Group solution to a triage phone service and ensuring appropriate training for Emergency Department staff.

Maternity Incentive Scheme (MIS)

The Group Chief Nurse reported that all three Trusts were declaring at Q1 that they were on track to achieve the MIS six core safety standards for 2026/27. Given the scale of the perinatal safety agenda, it was important to put in place a robust governance structure. The establishment of the Group Quality and Outcomes Committee would allow some of the MIS evidence to be considered there rather than by the Group Board.

In response to a question from Andy McKechnie, the Group Chief Nurse explained that the evolution of a single Perinatal leadership team, the implementation of the EPR and oversight from the Group Non-Executive Director Perinatal Safety Champion and the Group Quality and Outcomes Committee were key to being able to provide effective assurance to the Group Board.

The Acting Executive Managing Director for QEH noted that, while NNUH and JPUH had completed the desktop Maternity Outcomes Signal System (MOSS) skill drill, it had not yet been undertaken at QEH. This was scheduled for November 2026.

Jo Churchill asked about the scope to standardise reporting across the three maternity units. The Group Chief Nurse agreed on the need to comply with regional and national reporting requirements and noted that a single reporting template was being developed.

William Van't Hoff expressed the view that Perinatal services should be a priority area for work on culture given the strong link to quality of care and outcomes.

Group Perinatal report

The Group Chief Nurse introduced the Group Perinatal report and explained the intention to increase the standardisation of reporting in future, including the incorporation of the Ten Point Plan and metrics relating to service user voice.

NNUH was reporting an outlier position for postpartum haemorrhage (PPH) following a caesarean section. This was being investigated further and a multi-disciplinary improvement group was in place.

On smoking in pregnancy, considerable progress had been made over the past 12 months with the introduction of site-based smoking cessation services. For May 2026, all sites were reporting rates lower than the national average of 6% compared to baseline rates of over 10% for JPUH

and QEH. Jo Churchill commended this work and particularly the progress made at JPUH where smoking at time of booking was around 20%, the highest rate in the country.

QEH was 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 had improved in May 2026.

All three Trusts would be joining the national Perinatal Equity and Anti-Discrimination Programme when it was launched across the East of England in January 2027.

All three Trusts were in various stages of an external Birthrate Plus midwifery staffing review. Given national recommendations, the regional maternity team had completed a review of midwifery headroom. A paper had been formulated for the Group to consider the regional report's methodology and recommendations.

The outstanding CQC Section 31 improvement notice relating to training compliance at QEH had now been formally closed.

Jack Bowman asked about progress on standardising data systems across the Trusts. The Group Chief Nurse explained that it was much easier to get data from the maternity system used by QEH than it was from that used by NNUH and JPUH. While consideration had been given to addressing this within the current system, it had been agreed to focus resources on the deployment of the forthcoming EPR solution across all three Trusts.

Jo Churchill noted that the hot weather had posed significant challenges for all three perinatal services and she thanked members of staff for all they had done to minimise the impact on mothers and babies. She also expressed concerns relating to mandatory training and staffing levels at QEH and asked whether more could be done to stop smoking anywhere on the hospital sites. The Group Chief Nurse noted that such issues would be picked up through the Perinatal Quality Standards Group.

Resolution: The Group Board noted the maternity triage specification report and the national implementation timescales and quarterly reporting requirements.

Resolution: The Group Board noted the Maternity Incentive Scheme Board Declaration Process and the deadline for submission of 2 March 2027, noted the current position against the six core safety actions and supported monthly reporting to the Perinatal Quality Standards Group.

Resolution: The Group Board noted the Group Perinatal report and noted the planned further standardisation of the report across the three Trusts and the inclusion of greater triangulation and analysis.

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05/10/2026 10:45:15

12. Equality, Diversity and Inclusion Workforce Plan

Purpose: For Decision

The Director of People and Culture for JPUH introduced the paper.

On 4 June 2026 Lord Mann had published his independent review into tackling racism and antisemitism within the NHS. NHS England had accepted the recommendations in full and set 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 had considered and approved the Group's first EDI Workforce Strategy 2026/27 and the Anti-Racism, Dignity and Respect Policy on 29 July 2026. The strategy set out 36 actions across six phases. It was built against the national framework, with every action mapping 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 or the immediate NHS England actions.

The strategy responded to a baseline that varied across the Group. The EDI desktop review had found the most developed approach at JPUH and identified scope to strengthen strategic coordination, governance and reporting at NNUH and QEH. No Trust in the Group currently produced a comprehensive annual EDI report. At QEH, concerns about the experience of resident doctors had been raised with the Trust and an organisational development diagnostic had been commissioned and mobilised.

The Anti-Racism, Dignity and Respect Policy adopted both national definitions, published application guidance for managers and investigators, created a rebuttable presumption in favour of formal investigation for racism cases, set specialist investigator standards and addressed racism originating from patients and visitors. The Group had taken independent legal advice on the adoption of the definitions.

The Group Chief Delivery Officer asked about whether this was supported by a communications and engagement plan. The Group Director of Communications and Engagement noted that EDI would be incorporated within the wider Group Communications and Engagement Strategy which would be brought to the Group Board in the autumn.

Andy McKechnie sought clarity on the policy approval process. The Interim Group Director of Governance explained that it was standard practice for NHS Boards to reserve the approval of a relatively small subset of policies to the Board of Directors and to delegate approval of the much larger balance of policies and procedures to the Executive. It was proposed to develop a set of core policies, the approval of which was reserved to Group Board, with others delegated to the Group Executive. This proposal would be brought to the Group Board in the autumn.

Resolution: The Group Board:

- Approved the public commitment statement on tackling racism for publication on the three Trusts' websites, subject to final review with Communications.
- Agreed that all Group Board members would complete the national anti-racism training within six months of its release, with completion reported annually to the Board.
- Endorsed the Group EDI Workforce Strategy 2026/27 action plan as set out at Appendix A of the paper, following approval by the Group Executive on 29 July 2026.
- Ratified the Anti-Racism, Dignity and Respect Policy, which was approved by the Group Executive on 29 July 2026, subject to the conclusion of Staffside consultation.
- Endorsed the adoption of the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism and the Government definition of anti-Muslim hostility, as agreed by the Group Executive on 29 July 2026.
- Noted the Group's sign up to the Race and Health Observatory's Seven Principles of anti-racism.
- Noted the intention to report quarterly to the Executive Risk Assurance Group with an annual report to the Group Board.
- Agreed that a Group Board EDI development session should be arranged for the autumn.

Action: Group Communications and Engagement Strategy to be brought to the Group Board in the autumn.

Action: Arrange a Group Board development session on EDI.

Action: Develop a proposal for the Group Board on a set of core policies to be reserved for Board approval.

13. Group Board Assurance Framework

Purpose: For Discussion

The Interim Group Director of Governance presented the latest Group Board Assurance Framework. Group Board members noted that the framework remained a work in progress following the recent risk workshop.

Resolution: The Group Board noted the Group Board Assurance Framework.

14. Group Board committees and membership

Purpose: For Decision

The Interim Group Director of Governance presented the paper.

Resolution: The Group Board approved the establishment of the Quality and Outcomes Committee, revised Board committee membership and the amendments to the Group Strategy, Technology, Investments and Partnerships Committee terms of reference.

15. Group Audit Committees in Common terms of reference

Purpose: For Decision

The Interim Group Director of Governance presented the paper.

Resolution: The Group Board approved the amendments to 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.

Resolution: The Group Board approved the amendments to 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.

Resolution: The Group Board approved the amendments to 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.

16. Any Other Business

Purpose: For Information

No other business was raised.

17. Questions from Members of the Public

Purpose: For Discussion

The Group Chair confirmed that no questions had been received from members of the public.

18. Meeting review and reflections

Purpose: For Discussion

Members reflected positively on the level of questioning and challenge, the developing contribution of committee chairs and Link Non-Executive Directors, and the revised structure of the agenda. They also cautioned against duplication between Executive Managing Director reports, the Integrated Performance Report and committee reports.

The Board discussed the need for clearer governance over which policies required Board approval or endorsement and which fell within Executive authority.

Members also noted the importance of allowing adequate time to consider significant papers and questions arising from them.

19. Date of the Next Meeting

Purpose: For Information

The next meeting of the Group Board in public would be held on Wednesday 7 October 2026 at 10.30 at James Paget University Hospital.

20. Resolution

Purpose: For Decision

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

21. Close of meeting

Purpose: For Information

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

Walker, Ian
05/10/2026 10:45:15

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 December 2026.	Open – not yet due
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 Group Board meeting on 7 October 2026 and then at Councils of Governors' meetings during October 2026.	Open
14	05.08.26	QEH EMD report	Group Chair to write to Tonicha Patterson, Student Nurse of the Year: Children on behalf of the Group Board.	Group Director of Governance	Completed.	To close
15	05.08.26	EDI Workforce Plan	Group Communications and Engagement Strategy to be brought to the Group Board in the autumn.	Group Director of Communications and Engagement	Scheduled for December 2026 Group Board meeting.	Open – not yet due

Walker, Ian
05/10/2026 10:45:15

16	05.08.26	EDI Workforce Plan	Arrange a Group Board development session on EDI.	Group Director of Governance	Scheduled and in diaries for November 2026.	To close
17	05.08.26	EDI Workforce Plan	Develop a proposal for the Group Board on a set of core policies to be reserved for Board approval.	Group Director of Governance	Scheduled for December 2026 Group Board meeting.	Open – not yet due

Walker, Ian
05/10/2026 10:45:15

Report to the Board of Directors in public: 7 October 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

Clinical Strategy

- Clinically-led work on the Case for Change is nearing completion, supported by strong public engagement through Healthwatch Norfolk; the emerging direction is for more neighbourhood and digitally-enabled care, with any significant service changes subject to appropriate assurance, engagement and formal consultation.

General Surgery

- The shared QEH and NNUH service has stabilised delivery and reduced immediate workforce risks; a strengthened interim model has been approved while a fully integrated network service is developed.

Thirlwall Inquiry

- The Group is reviewing the findings and required actions, with oversight through the Quality Standards Group and the Group Quality and Outcomes Committee. A report is included at agenda item 12.

NHS Oversight Framework

- Quarter 1 ratings remain unchanged: JPUH and QEH are in segment 4 and NNUH is in segment 3. The position and implications are considered further under agenda items 8 to 10.

NHS England Mid-Year Review

- NHS England recognised progress in elective recovery, cancer and diagnostics, while highlighting continuing risks in urgent and emergency care, discharge, workforce resilience, winter capacity and financial recovery, particularly at QEH.

Recommendations

The Group Board is asked to note the report.

Alignment to Board Assurance Framework risk(s)	All
Previously considered by	n/a
Any background papers in Admin Control Reading Room	No

Walker, Ian
05/10/2026 10:45:15

Norfolk and Waveney University Hospitals Group

Group Board in public: 7 October 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 8 – 10).

Group and Trust Developments

2. One Strategy – Clinical Strategy Case for Change

Over the summer, we have undertaken a clinically-led programme of work to build the evidence for change and explore the strategic choices that will need to be considered as we develop our future model of care. We are concluding this phase over the coming weeks and expect to present our Case for Change to the Group Board in late October and to the Norfolk Health Overview and Scrutiny Committee in November. This will provide an important opportunity to discuss the evidence, the case for further work and the approach we will take with our partners to develop and assure proposals for the future model of care over the next 10 to 20 years. Any proposals for significant service change would be subject to the appropriate assurance, engagement and formal consultation processes before decisions are made.

As part of this early work, we have partnered with Healthwatch Norfolk to understand what matters most to our patients and communities. We have received an excellent response, with over 2,000 responses at the time of writing, and I would like to thank everyone who has taken the time to share their experiences and views with us. Listening, engagement and co-development will remain central as this work progresses.

Over the coming months, we will continue to work with patients, communities, colleagues and system partners to develop and test how care could be delivered differently. Our emerging direction remains to provide more care through neighbourhood and digitally-enabled models wherever this is safe and appropriate, while ensuring that patients can access the complex, specialist and acute care that requires the facilities and expertise of our hospitals.

3. CQC Well-led inspection

The Care Quality Commission (CQC) undertook their Well-led inspection at QEH on 22-24 September. I would like to thank the inspection team for the professionalism with which they conducted the inspection and all those across the Trust and the Group who contributed. We look forward to receiving the CQC's findings.

Walker Ian
05/10/2026 10:45:15

4. General Surgery

The three-month review of the shared general surgery service between The Queen Elizabeth Hospital King's Lynn (QEH) and Norfolk and Norwich University Hospitals (NNUH) confirmed that the first phase has stabilised delivery, strengthened clinical, operational and nursing leadership, improved governance and reduced immediate workforce risks, with seven consultants appointed. Elective activity has been broadly maintained across both sites; however, further work is required to address cross-site communication, multidisciplinary team and theatre capacity, lower gastrointestinal cancer pathways, education and cultural issues, and differences in employment, performance and financial accountability.

The General Surgery Oversight Group, chaired by the Group Chief Executive, has approved a strengthened interim shared-service model while a fully integrated network service is developed, with flexibility to move to full integration earlier if required. Following an audit, the mandatory second-opinion process for emergency laparotomy has been removed, with structured mentorship and case review retained for newly-appointed consultants.

As the service moves into its next phase, the monthly oversight meetings have been stood down. Significant changes and outstanding risks will instead be reported through established hospital management and quality governance arrangements to the Group Quality and Outcomes Committee, with regional partners updated through scheduled oversight meetings.

5. Culture and Equality, Diversity and Inclusion (EDI)

Following the reports considered by the Group Board in August, work continues across the Group to strengthen our approach to organisational culture, equality, diversity and inclusion. Targeted action at QEH, in response to the Royal College of Surgeons' report, includes the Awareness to Accountability programme for medical staff. An independent culture diagnostic is nearing completion and will inform delivery of the Group EDI Workforce Strategy and Anti-Racism, Dignity and Respect Policy, supported by the 18,000 Voices programme, of which Vanderbilt is a workstream.

A Group Board workshop on culture change and EDI has been scheduled for 18 November 2026.

6. Vanderbilt Programme

The Vanderbilt Professional Accountability Programme is an evidence-based approach to strengthening organisational culture by promoting professional behaviours and enabling staff to raise concerns fairly, consistently, and proportionately.

Across the Norfolk and Waveney University Hospitals Group, the programme will operate through a primarily non-punitive, peer-led model. Concerns will be submitted through the 'InPhase' reporting system and reviewed confidentially by a multidisciplinary triage team. Where appropriate, and in the majority of cases, they will be addressed through a supportive conversation led by a

trained peer messenger, with formal processes available for matters requiring escalation.

Supported by the Vanderbilt team, preparatory work has included readiness workshops, local adaptation and testing, the development of reporting and triage arrangements, and the training of approximately 200 peer messengers across the three Trusts.

The programme launched across the Group on 5 October 2026. An early review will assess implementation and refine the process, alongside ongoing evaluation in partnership with the University of East Anglia.

The programme is expected to improve staff experience and morale, support better outcomes for patients and reduce the number of serious and complex employee relations cases requiring formal resolution.

7. Group Appointments

Since the previous Group Board meeting, Simon Nearney commenced as Group Chief People Officer on 14 September, following a formal handover from Emma-Jayne Perez Chies, who concluded her interim role on 30 September. Following a formal competitive process, Ian Walker has been appointed substantively as Group Director of Governance and Group Secretary and commenced in post on 1 October. Carin Charlton took up post as Group Director of Estates and Facilities on 14 September.

8. Governor elections

The Governor elections were completed at all three Trusts in mid-August and I would like to congratulate both newly-elected and re-elected public and staff governors on their appointments. I would also like to thank all those who stood for election and thanks those governors who have recently stood down from our Councils of Governors for their service.

A Group-wide induction for new Governors was held on 1 September and local Trust induction programmes are underway. On 2 September, I and a number of other members of the Group Board attended a joint meeting of the three Councils of Governors which provided an update on the clinical strategy case for change and discussed how the three Councils can work together more closely in the future.

National and Regional Context

9. Thirlwall Inquiry

The final report of the Thirlwall Inquiry, which examined events at the Countess of Chester Hospital and their implications following the trial and subsequent convictions of former neonatal nurse Lucy Letby, highlights serious failures in patient safety, safeguarding, leadership, governance and organisational culture, and reinforces the need for professional curiosity and for staff to feel confident to speak up and escalate concerns.

Walker Ian
05/10/2026 10:45:13

NHS England has asked every Trust and Integrated Care Board to consider the findings at its next public Board meeting and seek assurance that babies and children are protected in all care settings. Immediate priorities include applying the Sudden and Unexpected Death in Children protocol, strengthening bereavement support, ensuring safe access to and storage of insulin in neonatal units, maintaining compliance with safeguarding training and confirming clear escalation routes for staff. The Group is reviewing the recommendations and its current arrangements, including support for families and staff. Delivery of the resulting actions and risks will be overseen through the Quality Standards Group and reported to the Group Quality and Outcomes Committee as part of the established Board assurance arrangements.

This is covered further under agenda item 12.

10. NHS Oversight Framework (NOF) Ratings

NHS England has confirmed the first Quarter 1 segmentation and rankings under the revised 2026/27 NHS Oversight Framework, which uses updated metrics and a threshold-based methodology. JPUH and QEH remain in segment 4, ranked 125th and 132nd respectively out of 134 acute trusts, while NNUH remains in segment 3, ranked 85th. The next refresh, using Quarter 2 data, is expected at the end of November. The position and implications will be considered in more detail under agenda items 8 to 10.

11. Mid-Year Review

NHS England's mid-year review (see the supplementary documents pack in the Admin Control Reading Room) recognised progress across the Group in elective recovery, cancer pathways and diagnostic performance, with all three Trusts reporting confidence in delivering planned waiting-list and 18-week trajectories. Significant challenges remain in urgent and emergency care, ambulance handovers, discharge pathways, workforce resilience and financial recovery, particularly at QEH. Winter plans have been developed, although constrained bed and community capacity, rising numbers of patients with no criteria to reside and the impact of the Reinforced Autoclaved Aerated Concrete (RAAC) programme continue to present risks across all three Trusts.

Agreed next steps include targeted system work on ambulance handovers and discharge, further assurance on elective and diagnostic recovery, development of the QEH acute medicine operating model and submission of an updated financial recovery plan.

12. Recommendations

The Group Board is asked to note the report.

Walker Ian
05/10/2026 10:45:15

Report to the Group Board in public: 7 October 2026

Agenda item number	7.1		
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 the following National Health Service (NHS) foundation trusts: 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 1-31 August 2026 performance unless otherwise specified. Due to differences in reporting schedules and national publication dates the position presented within the Integrated Performance Report (IPR) may differ from nationally published data and from the current operational position where more recent, unvalidated data is available locally.

A verbal update on the One Recovery programme reset will be provided at the Group Board meeting.

Recommendations

The Group Board is asked to receive and discuss the Group Integrated Performance Report for August 2026; note the Month 5 performance position and the principal risks to delivery; and seek assurance that recovery actions are being delivered and are having the required impact.

Alignment to Board Assurance Framework risk(s)	Principal Risks 1, 2, 3, 4, 5
Previously considered by	Group Risk Assurance Committee, September 2026
Any background papers in Admin Control Reading Room	-

Group Board in public: 7 October 2026

Integrated Performance Report

1. Overall performance

Overall performance across the Group remains mixed. Improvements have been demonstrated in selected areas, including cancer performance at JPUH and QEH, strong four-hour performance at NNUH, sickness absence and appraisal performance at NNUH, and favourable financial positions at NNUH and JPUH. However, material risks remain across healthcare-associated infections, workforce performance, elective and diagnostic recovery, cancer pathways, urgent and emergency care flow, and financial delivery. Whilst recovery actions are in place, performance remains fragile, with sustained risks across quality, workforce, access, flow, and financial delivery.

National Oversight Framework (NOF) performance is also included within this paper, with NNUH reporting a strengthened position driven by a Segment 1 Finance domain, JPUH maintaining a largely stable position with improvements in RTT and UEC performance offset by cancer and methodology changes, and QEH benefiting from strong improvements in elective and UEC (Urgent and Emergency Care) performance, although this is partially offset by deterioration in variance to plan and the associated Finance domain impact.

2. National Oversight Framework (Quarter 1)

The Board should interpret quarter one (Q1) assessments primarily as a change in methodology rather than a like-for-like comparison with quarter four (Q4). NOF scoring is positional, so performance can improve while the score deteriorates if thresholds or peer rankings change. Key changes include the new Effectiveness of care and population health domain; annual survey measures that now account for 50% of both the People and Experience of care domains; tighter thresholds for 52-week Referral to Treatment (RTT) and 62-day cancer; and the restriction of 12-hour UEC reporting to Type 1 and 2 activity.

JPUH: Four of the six domains are in Segment 3, with Access and People in Segment 4. Improvement was delivered in 18-week RTT, from 55.5% to 60.1%, and 12-hour UEC waits, from 8.7% to 6.8%. This was offset by 62-day cancer falling from 69.6% to 66.9%, compounded by the threshold increasing to 80%. The Access deterioration is fully attributable to changes in the mental health and community metrics. People was the only domain where segment position worsened despite an improved score, falling to Segment 4 following the introduction of new annual survey measures. However, JPUH remains close to improvement thresholds, with Finance 0.04 points from the threshold for Segment 2, People 0.05 points from the threshold from Segment 3 and Patient Safety 0.20 points from the threshold of Segment 2, although in-year movement across People, Experience of Care and Patient Safety is largely constrained by annual survey metrics. Highest-impact opportunities for NOF improvement are relative cost difference, six-week diagnostics and 28-day faster diagnosis.

NNUH: Finance, Productivity and Innovation is the strongest domain at 1.93 and Segment 1, supported by the trust moving out of deficit and maintaining a positive variance to plan. Access moved from Segment 2 to Segment 3, driven largely by narrowly missing the 80% faster diagnosis standard by 0.17 percentage points and the 82% four-hour UEC standard by 0.7 percentage points. Performance also reduced on 18-week RTT from 63.7% to 62.4%. Experience of Care deteriorated from Segment 2 to Segment 4 following the introduction of the staff survey advocacy metric, while Patient Safety improved by 0.42 but remains 0.10 short of the threshold for Segment 3 and People is 0.14 points away from the threshold for Segment 2; however, progress across all three domains is constrained by annual survey measures that cannot be influenced in-year. The immediate opportunities for NOF improvement are therefore crossing the faster diagnosis and four-hour thresholds, alongside improving clinical trial set-up from 44.4% to 80%.

QEH: There was no change to the domain segments in Q1. The new Effectiveness of care and population health domain is the strongest position at 1.72 and Segment 1. Access to services remained largely stable (+0.08). The 52-week RTT methodology change was largely offset by strong 18-week RTT and 12-hour UEC improvement, and validated July cancer positions point to a further estimated gain of around 0.50 on faster diagnosis. Patient Safety remained at segment 3 but improved most and is 0.06 points from the threshold for Segment 2. Experience of Care and Finance, (both segment 4) deteriorated. The Finance position could improve if a positive variance to plan is restored and sustained. People is 0.32 points away from the threshold for Segment 3 and, as detailed above, is capped by annual survey metrics. Highest-impact opportunities are clinical trial set-up, six-week diagnostics and sickness absence, with recovery of variance to plan remaining an important finance lever.

3. Safe and Effective Care

3.1 Quality and Safety

Positives: Improvement has been demonstrated in selected quality and safety measures across the Group, with progress in parts of infection prevention and control, patient safety and safer staffing recovery programmes.

Key risks and challenges: Performance remains variable across the Group, with continuing challenges in healthcare-associated infections, patient experience, safer staffing, discharge processes and readmissions.

Recovery actions: Recovery actions are focused on strengthening infection prevention and control, improving safer staffing oversight, reducing discharge delays and readmissions, implementing patient safety improvement programmes, and enhancing quality governance and assurance arrangements.

3.2 Maternity

Positives: Positive performance continues to be demonstrated in selected maternity measures, including stillbirth rates, one-to-one care and Maternity and Newborn Safety Investigations (MNSI) compliance across the majority of Trusts. NNUH has also

reported improvement in midwifery fill rates and a reduction in unplanned Neonatal Intensive Care Unit (NICU) admissions.

Key risks and challenges: Midwifery fill rates remain below target across all three Trusts, reflecting ongoing workforce and establishment pressures. Workforce capacity continues to be affected by recruitment challenges, sickness absence, planned leave and onboarding delays for newly qualified midwives. Unplanned NICU admissions and variation in maternity outcomes remain areas requiring continued oversight, alongside pressures relating to patient experience and communication.

Recovery actions: Recovery actions are focused on workforce stabilisation through recruitment, retention, temporary staffing and safe staffing controls, alongside strengthening quality improvement programmes, governance and outcome monitoring across maternity services.

4. People and Culture

Positives: Workforce performance remains broadly stable across the Group, with improvements in sickness absence and appraisal performance at NNUH, while staff turnover remains within target across all three Trusts.

Key risks and challenges: Workforce pressures remain evident across the Group, with sickness absence above target at all three Trusts and continuing challenges in mandatory training compliance and appraisal completion. QEH remains the principal area of concern, with sickness absence, mandatory training compliance and appraisal performance all materially below target.

Recovery actions: Recovery actions are focused on improving staff wellbeing, reducing sickness absence, increasing mandatory training compliance, improving appraisal completion rates and strengthening workforce management arrangements. Enhanced oversight and targeted improvement plans remain in place across the Group.

5. Access and Flow

5.1 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. JPUH total Patient Tracking List (PTL) remains close to plan and QEH expects elective recovery actions to return performance to plan in September. NNUH validated 18-week performance was above its improvement plan.

5.2 Cancer

Positives: Cancer performance has improved across the Group, with progress in both Faster Diagnosis Standard (FDS) and 62-day performance, particularly at JPUH and QEH. Improvement is being supported by backlog reduction, pathway management and recovery activity.

Key risks and challenges: Despite recent improvement, performance remains below trajectory in several areas and recovery is not yet being delivered at the pace required

to achieve planned standards. There is an ongoing risk that improvements in diagnostic performance do not fully translate into improvements in 62-day treatment performance. Capacity constraints and diagnostic turnaround times continue to present risks to sustained recovery.

Recovery actions: Recovery actions continue to focus on backlog reduction, pathway oversight, tumour-site escalation and maintaining sufficient diagnostic capacity to support sustained improvement.

5.3 Urgent and Emergency Care (UEC)

Positives: NNUH has maintained strong four-hour performance and some improvement has been seen in selected UEC measures across the Group.

Key risks and challenges: JPUH and QEH continue to report material variance from plan across key UEC measures. High demand, discharge delays, inpatient capacity constraints and whole-hospital flow challenges continue to impact performance.

Recovery actions: Recovery actions are focused on improving patient flow through the hospital, reducing discharge delays, strengthening front-door assessment and delivering Trust-specific recovery plans supported by enhanced operational oversight and escalation processes.

6. Productivity and efficiency

Positives: Productivity and efficiency performance remains mixed with NNUH and JPUH continue to report favourable positions against plan and continued delivery of efficiency programmes.

Key risks and challenges: QEH remains the principal area of concern, with deterioration in the financial position driven by under-delivery of efficiencies and continued pressures from temporary staffing expenditure. Delivery of recurrent efficiency savings, achievement of activity-related income and reduction in bank and agency expenditure remain key risks across the Group.

Recovery actions: Recovery actions are focused on strengthening financial controls, accelerating delivery of efficiency programmes, improving productivity and activity performance, reducing reliance on temporary staffing, and implementing targeted financial recovery arrangements where required.

7. Recommendations

The Group Board is asked to receive and discuss the Group Integrated Performance Report for August 2026; note the Month 5 performance position and the principal risks to delivery; and seek assurance that recovery actions are being delivered and are having the required impact.

Walker Ian
05/10/2026 10:45:15

Group Integrated Performance Report

Aug-26

Walker, Ian
05/10/2026 10:45:15



James Paget
University Hospitals
NHS Foundation Trust



Norfolk and Norwich
University Hospitals
NHS Foundation Trust



The Queen Elizabeth
Hospital King's Lynn
NHS Foundation Trust



James Paget
University Hospitals
NHS Foundation Trust

	P	?	F
H L	2	3	5
	2	27	6
H L	1	2	



Norfolk and Norwich
University Hospitals
NHS Foundation Trust

	P	?	F
H L	1	4	3
	3	23	6
H L	1	3	2



The Queen Elizabeth
Hospital King's Lynn
NHS Foundation Trust

	P	?	F
H L	1	5	2
	2	27	5
H L		2	1

Walker Ian
05/10/2026 10:45:15



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



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 - 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		

Inpatient Satisfaction 2025

NHS James Paget University Hospitals NHS Foundation Trust	Overall experience	Patient Response ⓘ 8.3 / 10	Compared with other trusts ⓘ About the same
NHS Norfolk and Norwich University Hospitals NHS Foundation Trust	Overall experience	Patient Response ⓘ 8.2 / 10	Compared with other trusts ⓘ About the same
NHS The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	Overall experience	Patient Response ⓘ 7.8 / 10	Compared with other trusts ⓘ About the same



Annual Metrics

Maternity Survey 2025

James Paget
University Hospitals
NHS Foundation Trust

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

Norfolk and Norwich
University Hospitals
NHS Foundation Trust

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

The Queen Elizabeth
Hospital King's Lynn
NHS Foundation Trust

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

Walker Ian
05/10/2026 10:45:15

2025 | National Education and Training Survey Overall Experience

James Paget
University Hospitals
NHS Foundation Trust

65.9%

Norfolk and Norwich
University Hospitals
NHS Foundation Trust

73.2%

The Queen Elizabeth
Hospital King's Lynn
NHS Foundation Trust

74.0%

Safe and Effective Care Domain Metrics

Walker, J
05/10/2026 10:45:15



Metric Summary Matrix - Safe and Effective Care

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

Safe and Effective Care Assurance

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

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

Safe and Effective Care Assurance

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

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

Safe and Effective Care Assurance

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

Safe and Effective Care Domain Summary (Clinical Outcomes)

Aug-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
SHMI	Mar-26	1.18	1.21				Mar-26	1.17	1.19				Mar-26	1.18	1.10			
MRSA	Aug-26	0	0				Aug-26	0	0				Aug-26	0	1			
CDiff	Aug-26	3	2				Aug-26	8	8				Aug-26	4	7			
Ecoli	Aug-26	0	7				Aug-26	0	5				Aug-26	0	6			
Average number of days between planned and actual discharge date	Aug-26	2	8				Aug-26	2	6				Jul-26	2	1			
Readmission Rate	Jul-26	10.0%	13.59%				Jul-26	10.0%	12.05%									

Group Summary

- Current Performance:** Group performance remains mixed, with continuing challenges in healthcare-associated infections, discharge processes and readmission, No MRSA cases were reported at JPU or NNUH, whilst QEH reported one case during the month. The number of C. difficile infections reported in the month has remained the same for JPUH and NNUH as last month, with QEH seeing an increase of one case. The number of E. coli cases reported in the month has also decreased compared to last month. Average delays between planned and actual discharge dates remain elevated at JPUH and NNUH, reflecting ongoing system flow pressures, and readmission rates remain above target at both organisations. SHMI remains below the expected range at QEH, and marginally above target at JPUH and NNUH.
- Reasons for underperformance:** Sustained infection, flow and readmission pressures continue to affect delivery. Target setting is an additional barrier, and further investigation is required to establish whether current target trajectories appropriately reflect national mandates and local variation.
- Progress against recovery actions:** Recovery actions continue across infection prevention, discharge flow and readmissions. The SHMI response includes a diagnostic deep dive to identify underlying drivers, including septicaemia and pneumonia, alongside the use of the mortality learning framework to translate case-review findings into measurable improvement. Targeted action is also required to bring invalid primary diagnosis coding in line with national expectations, with all three trusts currently substantially below the national average: JPUH and NNUH each report 0.1%, while QEH reports 0.3%. Target trajectories will be investigated, with the findings informing any proposal for revised targets for agreement by the Trust Chief Medical Officers and Chief Nurses by November 2026.
- Key risks:** include persistent operational pressures, or delays in completing the trajectory review and agreeing any required revisions, could further constrain delivery. It is important to note that national SHMI reporting is refreshed retrospectively and will therefore remain several months behind the IPR reporting period.



Safe and Effective Care Domain Summary (Quality and Safety)

Aug-26

	James Paget						Norfolk and Norwich						Queen Elizabeth					
Metric	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance
FFT Score	Aug-26	95.0%	98.04%				Aug-26	95.0%	89.01%				Aug-26	95.0%	91.12%			
Complaints Received	Aug-26	0	12				Aug-26	0	237				Aug-26	0	46			
Pressure Ulcers	Aug-26	0	15.00				Aug-26	0	15.00				Aug-26	0	3.00			
Registered Nurse Fill Rate	Aug-26	90.0%	79.66%				Aug-26	90.0%	92.94%				Aug-26	90.0%	86.39%			
Care Hour Per Patient Day (CHPPD)	Aug-26	8.00	8.08				Aug-26	8.00	7.55				Aug-26	8.00	7.29			
Falls	Aug-26	67	75				Aug-26	187	182				Aug-26	54	71			
PSII Number	Aug-26	0	1				Aug-26	0	1				Aug-26	0	1			

Data note: NNUH reports CHPPD excluding specialist areas, while JPUH and QEH include specialist areas.

Group Summary

- **Current Performance:** Group performance remains variable across patient experience, staffing and patient safety. FFT remains above target at JPUH but below target at NNUH and QEH. Registered nurse fill rates are below target at JPUH and QEH, due to maternity leaves and sickness workforce gaps. While CHPPD is below expected levels at NNUH as it excludes specialist areas within this actual performance figure. Pressure ulcers reduced by 16% across the Group compared with the previous month. Falls increased at JPUH and QEH but improved marginally at NNUH, while NNUH recorded 130 more complaints than in the previous month, due to backlog operational pressures.
- **Reasons for underperformance:** Targets may not fully account for national guidance, local service profiles, establishment, activity or patient acuity; uniform CHPPD and complaints thresholds may therefore misrepresent performance. Communication is the principal complaint theme emerging across all three trusts.
- **Progress against recovery actions:** Recovery work is underway to validate establishment assessments and establish a baseline across the three trusts, while standardising nursing fill-rate measures and aligning SafeCare with the Safer Staffing profile. Target trajectories will be developed through Chief Nurse governance and phased according to evidence, capacity and dependencies. Group-wide alignment to T-Purpose for pressure ulcer prevention was completed in August. Plans have been implemented across all three trusts to review complaint backlogs, with improvement evident at two of the three trusts. Further work to establish a systematic review process is being explored, including digital solutions and links to the World Class Basics programme.
- **Key Risks:** Unsuitable targets distorting assurance, delays in implementing a digital solution for recording pressure ulcers, financial constraints, and incomplete safer staffing baselines (including inconsistent systems and SafeCare licensing constraints), which may delay systematic change.

Safe and Effective Care Domain Summary - Maternity

Aug-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	Aug-26	3.5%	0.00%	✓	⚡	?	Aug-26	3.5%	0.72%	✓	⚡	?	Jul-26	3.5%	0.48%	✓	⚡	?
Midwifery Fill Rate	Aug-26	90.0%	86.12%	✗	⚡	?	Aug-26	90.0%	87.03%	✗	⚡	?	Aug-26	90.0%	76.24%	✗	⚡	?
Preterm Birth Rate	Aug-26	6.0%	7.09%	✗	⚡	?	Aug-26	6.0%	7.23%	✗	⚡	?	Jul-26	6.0%	5.44%	✓	⚡	?
Maternity FFT	Aug-26	95.0%	100.00%	✓	⚡	?	Aug-26	95.0%	79.31%	✗	⚡	?	Aug-26	95.0%	98.17%	✓	⚡	?
Complaints Received - Maternity	Aug-26	0	1	✗	⚡	?	Aug-26	0	5	✗	⚡	?	Aug-26	0	2	✗	⚡	?
MNSI	Aug-26	0	0	✓	⚡	P	Aug-26	0	1	✗	⚡	?	Jul-26	0	0	✓	⚡	P
1:1 Care	Aug-26	97.0%	100.00%	✓	⚡	P	Aug-26	97.0%	99.67%	✓	⚡	P	Jul-26	97.0%	100.00%	✓	⚡	P
Unplanned Admissions to NICU	Aug-26	0	10	✗	⚡	?	Aug-26	0	18	✗	⚡	?	Jul-26	0	5	✗	⚡	F

Group Summary

- **Current Performance:** Group performance remains variable across maternity workforce, outcomes and quality measures. Midwifery fill rates remain below target across all three organisations, while pre-term birth rates remain above target at JPUH and NNUH. Unplanned NICU admissions continue to reflect ongoing service pressures. Positive performance is noted in stillbirth rates, one-to-one care and MNSI compliance across the majority of trusts.
- **Reasons for underperformance:** Establishment gaps, transitional workforce pressures, sickness and planned leave, mandatory training and delays in NQM onboarding. Existing measures may not fully reflect maternity activity, acuity and local variation, with incomplete assessments and inconsistent roster data limiting comparability. Complaints received relate primarily to ultrasound scans, induction of labour and communication.
- **Progress against recovery actions:** Recovery work is progressing across all three sites, with recruitment underway across substantive, fixed-term and NQM appointments, alongside temporary staffing, Bank and redeployment measures to maintain safe cover. Work is also progressing to establish a consistent maternity-specific measurement framework, including Birth Rate Plus, fill rates, OPAL, delayed activity, outcomes and experience. Developing Workforce Safeguards is being implemented to inform future targets, alongside a phased nursing and midwifery workforce plan. Recovery priorities remain focused on workforce stabilisation, maintaining safe staffing levels, reducing unwarranted variation in outcomes and strengthening quality improvement programmes across maternity services.
- **Key risks:** Uniform targets not fully reflecting maternity safety, incomplete evidence, duplication of tools, inconsistent data and licensing requirements, with limited capacity potentially delaying implementation beyond March 2027.

People and Culture Domain Metrics



Walker, J
05/10/2026 10:45:15

Metric Summary Matrix - People and Culture

Aug-26



NHS
James Paget
University Hospitals
NHS Foundation Trust

	P	?	F
H		Appraisal	Sickness
L			
		Turnover	
H	Training		
L			

NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

	P	?	F
H	Training	Turnover	
L			
		Appraisal Sickness	
H			
L			

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

	P	?	F
H		Turnover	
L			
		Appraisal Training	Sickness
H			
L			

People and Culture

Sickness Rate
Turnover Rate
Mandatory Training
Non Medical Appraisal



People and Culture

Sickness Rate
Turnover Rate
Mandatory Training
Non Medical Appraisal



People and Culture

Sickness Rate
Turnover Rate
Mandatory Training
Non Medical Appraisal



People and Culture Domain Summary

Aug-26



Metric
Sickness Rate
Turnover Rate
Mandatory Training
Non Medical Appraisal

James Paget					
Date	Target	Actual	Compliance	Variation	Assurance
Aug-26	4.6%	5.08%	✗		
Aug-26	10.0%	6.39%	✓		
Aug-26	90.0%	88.88%	✗		
Aug-26	85.0%	88.08%	✓		

Norfolk and Norwich					
Date	Target	Actual	Compliance	Variation	Assurance
Aug-26	4.2%	4.30%	✗		
Aug-26	10.0%	6.46%	✓		
Aug-26	90.0%	93.05%	✓		
Aug-26	85.0%	84.68%	✗		

Queen Elizabeth					
Date	Target	Actual	Compliance	Variation	Assurance
Aug-26	4.5%	5.92%	✗		
Aug-26	10.0%	9.45%	✓		
Aug-26	90.0%	78.22%	✗		
Aug-26	85.0%	76.44%	✗		

Group Summary

Workforce performance remains broadly stable across the Group, with staff turnover remaining within target across all three Trusts. NNUH has demonstrated improvement in sickness absence and appraisal performance, while mandatory training compliance remains above target. Despite these improvements, sickness absence remains above target across all organisations and performance against mandatory training and appraisal standards remains variable. Workforce pressures continue to impact performance, including sustained sickness absence, workforce vacancies and operational demands across services. Mandatory training compliance remains below target at JPUH and QEH, whilst appraisal performance remains below the required standard at NNUH and QEH. Ongoing workforce supply challenges, capacity constraints and pressures associated with service recovery continue to affect workforce resilience.

Recovery actions continue to focus on reducing sickness absence through enhanced attendance management, wellbeing support and return-to-work processes. Targeted programmes are in place to improve mandatory training compliance and appraisal completion, alongside recruitment, retention, leadership development and workforce digital transformation initiatives to strengthen workforce capacity, productivity and engagement.

Access and Flow Domain Metrics



Walker, JH
05/10/2026 10:45:15

Metric Summary Matrix - Access and Flow - Elective Care

Aug-26



NHS
James Paget
University Hospitals
NHS Foundation Trust

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

Access and Flow

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



NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

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

Access and Flow

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



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

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

Access and Flow

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



Access and Flow Domain Summary - Elective Care

Aug-26



	James Paget						Norfolk and Norwich						Queen Elizabeth					
Metric	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance
Total PTL Size	Aug-26	31,080	31,210	✗			Aug-26	62,810	65,987	✗			Jul-26	23,074	24,150	✗		
RTT Incomplete Within 18 weeks	Aug-26	61.3%	61.46%	✓			Aug-26	63.7%	63.4%	✗			Jul-26	64.3%	64.30%	✗		
65+ Week Waits	Aug-26	0	137	✗			Aug-26	0	180	✗			Jul-26	0	0	✓		
52+ Week Performance	Aug-26	3.6%	2.57%	✓			Aug-26	1.9%	2.60%	✗			Jul-26	0.6%	1.15%	✗		
First Attendance Within 18 Weeks	Aug-26	64.0%	67.74%	✓			Aug-26	64.0%	71.11%	✓			Aug-26	64.0%	66.15%	✓		
6 Week Diagnostics	Aug-26	91.7%	66.01%	✗			Aug-26	82.0%	70.51%	✗			Jul-26	73.9%	57.99%	✗		
Under 18s elective waiting list size	Aug-26	2,615	2,812	✗			Aug-26	8,368	7,705	✓								

Group Summary

Elective performance remains challenged across the Group. RTT waiting-list size, 18-week performance, long waits and diagnostic performance remain the principal areas of variance from plan. JPUH is close to plan for overall PTL size, although its 65-week ENT cohort has increased and the under-18 waiting list remains above target. NNUH's waiting list is above trajectory, with continuing pressure across 52-week and 65-week waits. QEH's waiting list has increased and 18-week performance remains below trajectory. DM01 remains substantially below trajectory at all three Trusts, driven principally by MRI and NOUS at JPUH, Echocardiography and NOUS at NNUH, and Audiology at QEH. The Group position reflects referral and demand growth exceeding available capacity, delayed mobilisation of independent-sector activity, workforce and sickness constraints, and specialty-specific case-mix pressures. Recovery actions continue to be delivered across all three Trusts, focused on increasing elective and diagnostic capacity, reducing long-wait cohorts, strengthening pathway management and improving diagnostic performance. Additional activity, independent-sector support, validation programmes, diagnostic recovery initiatives and specialty-level recovery plans are in place across the Group, with evidence of improving performance in several areas. However, some diagnostic recovery programmes remain behind plan, particularly where workforce and capacity constraints continue to affect delivery. The Group's recovery remains dependent on sustaining additional capacity, managing continued demand growth and delivering planned reductions in waiting lists and diagnostic backlogs. Ongoing capacity constraints, workforce challenges and diagnostic underperformance continue to present risks to delivery of elective recovery trajectories and may also impact wider cancer and access performance.



NHS
James Paget
University Hospitals
NHS Foundation Trust

	P	?	F
H L			
		62 Day FDS	
H L			

Access and Flow

28 Day Faster Diagnosis



Cancer 62 Day Treatment



NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

	P	?	F
H L		62 Day	
		FDS	
H L			

Access and Flow

28 Day Faster Diagnosis



Cancer 62 Day Treatment



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

	P	?	F
H L			
		62 Day FDS	
H L			

Access and Flow

28 Day Faster Diagnosis



Cancer 62 Day Treatment





Access and Flow Domain Summary - Cancer

Jul-26

Metric
28 Day Faster Diagnosis
Cancer 62 Day Treatment

James Paget						
Date	Target	Actual	Compliance	Variation	Assurance	
Jul-26	82.0%	78.57%	⊗	📉	?	
Jul-26	72.3%	65.25%	⊗	📉	?	

Norfolk and Norwich						
Date	Target	Actual	Compliance	Variation	Assurance	
Jul-26	80.0%	80.4%	⊗	📉	?	
Jul-26	74.6%	70.8%	⊗	📉	?	

Queen Elizabeth						
Date	Target	Actual	Compliance	Variation	Assurance	
Jul-26	74.8%	73.28%	⊗	📉	?	
Jul-26	76.6%	57.45%	⊗	📉	?	

Group Summary

Cancer performance remains below trajectory across the Group, although improvement is evident at JPUH and QEH. JPUH FDS has improved to 78.57%, above its revised trajectory, while 62-day performance has increased to 65.25% but remains below trajectory. NNUH’s July performance was above the national FDS standard for a third consecutive month, and 62-day performance improved to 70.8%, but remained below trajectory; however, both measures are expected to be below plan in September. QEH has improved FDS to 73.28% and 62-day performance to 57.45%, but both remain below trajectory. Cancer performance continues to be impacted by a combination of demand and capacity pressures across the Group, including diagnostic and pathway constraints.

Recovery actions continue to be implemented across all three Trusts, with a focus on strengthening pathway management, increasing capacity, reducing diagnostic and treatment delays, and improving performance within the highest-risk tumour sites. While there are signs of improvement in several key measures, recovery remains at an early stage and sustained delivery of agreed plans will be required to achieve planned trajectories.

Metric Summary Matrix - Access and Flow - UEC

Aug-26



NHS
James Paget
University Hospitals
NHS Foundation Trust

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

Access and Flow

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

NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

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

Access and Flow

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

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

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

Access and Flow

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

Access and Flow Domain Summary - UEC

Aug-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	Aug-26	77.5%	68.63%	✗	📉	?	Aug-26	82.1%	82.10%	✓	📉	?	Aug-26	73.5%	63.23%	✗	📉	?
ED 12 Hours in Department %	Aug-26	7.2%	8.13%	✗	📉	?	Aug-26	2.9%	3.11%	✗	📉	?	Aug-26	10.7%	13.48%	✗	📈	?
Ambulance Handovers Over 30 Minutes	Aug-26	0	852	✗	📉	F	Aug-26	0	1,189	✗	📉	F	Aug-26	0	750	✗	📉	F
Ambulance Handovers Over 45 Minutes	Aug-26	0	670	✗	📉	F	Aug-26	0	783	✗	📉	F	Aug-26	0	502	✗	📉	?
Ambulance Handovers Over 45 Minutes %	Aug-26	0.0%	34.82%	✗	📉	F	Aug-26	0.0%	23.08%	✗	📉	F	Aug-26	0.0%	28.46%	✗	📉	?
Non Elective LoS	Aug-26	10	10.48	✗	📉	?							Aug-26	10	10.29	✗	📉	?

Group Summary

UEC performance remains mixed across the Group. NNUH continues to perform strongly against the four-hour trajectory at 82.1%, although 12-hour waits and ambulance handovers remain challenged. JPUH's four-hour performance has deteriorated to approximately 68.3%, 12-hour performance remains above trajectory and ambulance handover delays remain significant. QEH has improved across several measures, including reductions in handovers exceeding 30 and 45 minutes, but four-hour performance and the wider UEC position remain below plan. The principal Group-wide driver is growth in demand and acuity exceeding available emergency and inpatient capacity. JPUH reports record non-admitted attendances, with walk-ins 23% higher year on year and ambulance attendances 7% higher. NNUH's Emergency Department attendances have averaged 5% above plan during 2026/27, with August recording the highest number of admissions in the calendar year. At QEH, performance continues to be impacted by wider operational pressures, including workforce challenges and reduced capacity associated with ongoing Emergency Department and Urgent Treatment Centre refurbishment works. Recovery actions are in place across the Group and continue to focus on improving patient flow, reducing delays, strengthening operational grip and maximising available capacity. Whilst there is evidence of improvement in several urgent and emergency care measures, sustained demand pressures, flow constraints and capacity challenges could limit the pace of recovery.

Productivity and Efficiency Domain Metrics



Walker, J
05/10/2026 10:45:15

JPUH Metric Summary Matrix - Productivity and Efficiency

Aug-26



NHS
James Paget
University Hospitals
NHS Foundation Trust

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



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

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



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

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



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



Productivity and Efficiency Domain Summary

Aug-26



	James Paget						Norfolk and Norwich						Queen Elizabeth					
Metric	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance	Date	Target	Actual	Compliance	Variation	Assurance
Implied Productivity	Mar-26	3	1.30	✗	📉	?	Mar-26	3	2.60	✓	📉	⚠️	Mar-26	3	-3.20	✗	📉	?
Planned surplus/deficit	Aug-26	-248	-159	✓	📉	?	Aug-26	-690	-790	✗	📉	?	Aug-26	-330	-1,364	✗	📉	?
YTD Surplus/deficit	Aug-26	-4,174	-3,441	✓	📉	?	Aug-26	-6,078	-6,051	✓	📉	?	Aug-26	-5,801	-9,737	✗	📉	?
Variance to Agency Spend Cap %	Aug-26	0.0%	6.84%	✗	📉	?	Aug-26	0.0%	-17.40%	✓	📉	?	Aug-26	0.0%	48.38%	✗	📉	⚠️
Variance to Bank Spend Cap %	Aug-26	0.0%	4.75%	✗	📉	?	Aug-26	0.0%	10.56%	✗	📉	⚠️	Aug-26	0.0%	60.14%	✗	📉	⚠️
Efficiency Plan £000	Aug-26	2,024	2,190	✓	📉	?	Aug-26	5,288	4,142	✗	📉	?	Aug-26	1,829	858	✗	📉	?
Efficiency Plan YTD £000	Aug-26	6,470	7,547	✓	📉	?	Aug-26	14,705	15,143	✓	📉	?	Aug-26	4,980	3,645	✗	📉	?

Group Summary

Productivity and efficiency performance remains mixed across the Group, with QEH the principal area of concern. NNUH continues to deliver its financial and efficiency plans, with a favourable year-to-date variance against programme targets, although bank spend remains materially above the NHSE cap. JPUH is reporting a favourable financial position against plan and continues to over-deliver against efficiency targets, albeit with some benefits reflecting timing differences. Performance is being affected by sustained operational demand, workforce pressures and continued reliance on bank and agency staffing to maintain service delivery and support escalation capacity. Higher urgent and emergency care demand, elevated numbers of patients with no criteria to reside, substantive workforce vacancies and delays in workforce transformation programmes continue to drive temporary staffing expenditure above plan. At QEH, efficiency delivery remains behind trajectory, and financial performance continues to be impacted by increased staffing costs and delivery shortfalls within the CIP programme.

Recovery actions continue across the Group, with a focus on strengthening financial control, improving productivity, reducing reliance on temporary staffing and delivering planned efficiency programmes. Trusts have enhanced oversight arrangements and are implementing recovery plans to improve workforce utilisation, support delivery of efficiency targets and strengthen financial sustainability. Whilst progress is being made in several areas, recovery remains dependent on sustained delivery of planned improvements and effective management of operational demand pressures which is a principal risk to delivery.

Appendices



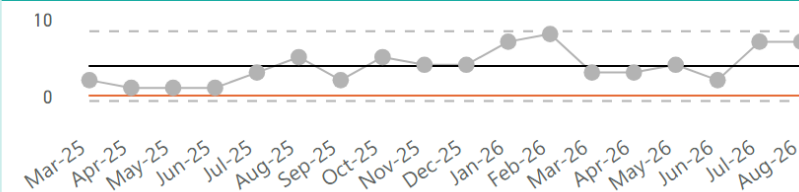
Walker JH
05/10/2026 10:45:15

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

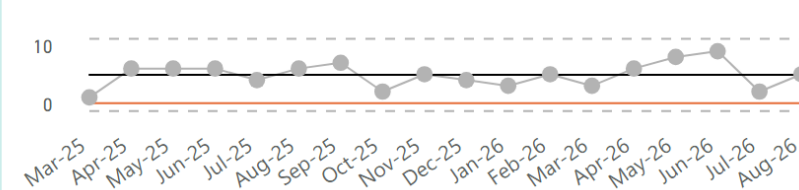
Aug-26



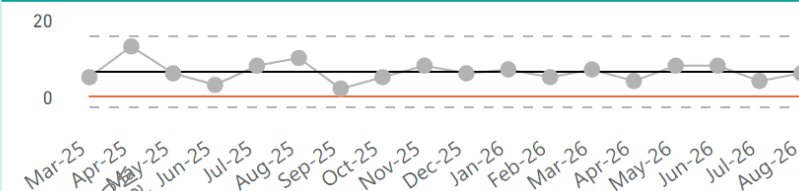
JPUH - Ecoli 7



NNUH - Ecoli 5

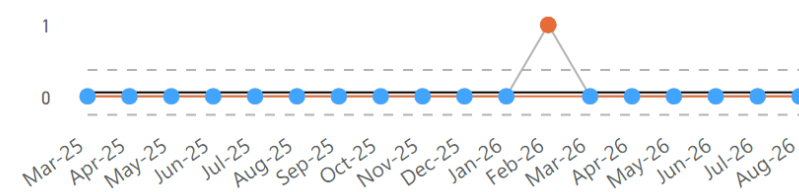


QEH - Ecoli 6

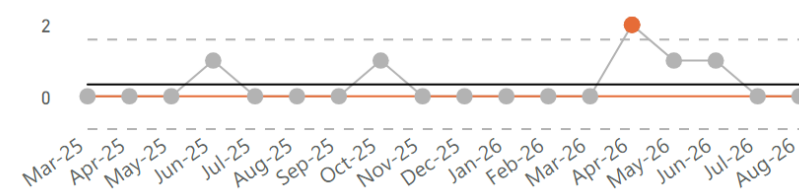


Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0	7	✗	⚠	?
NNUH	0	5	✗	⚠	?
QEH	0	6	✗	⚠	?

JPUH - MRSA 0



NNUH - MRSA 0

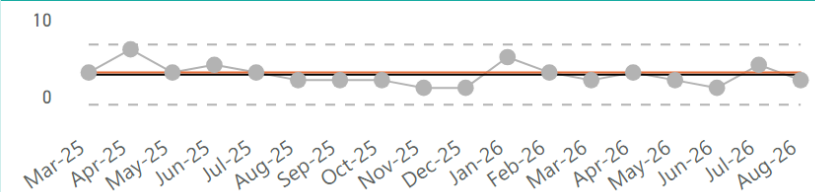


QEH - MRSA 1

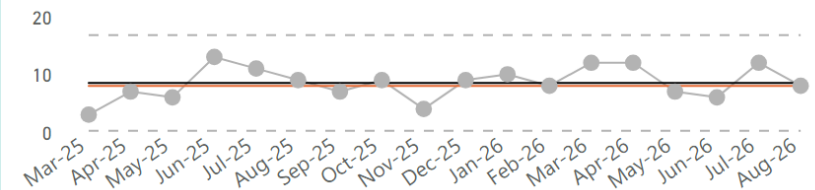


Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0	0	✓	⚠	P
NNUH	0	0	✓	⚠	P
QEH	0	1	✗	⚠	?

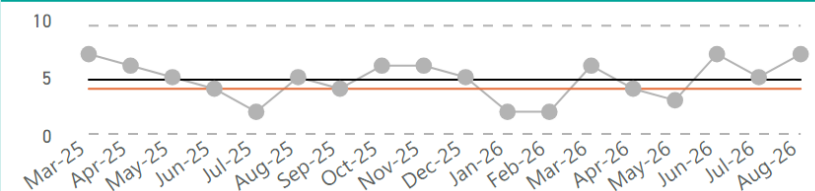
JPUH - CDiff 2



NNUH - CDiff 8



QEH - CDiff 7



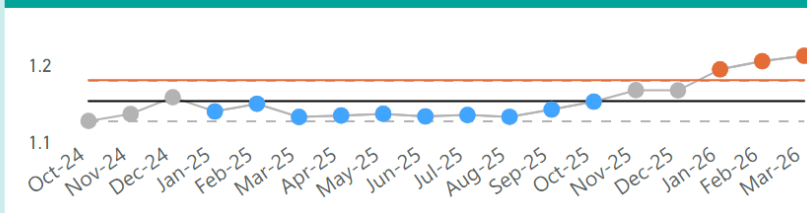
Site	Target	Actual	Compliance	Variation	Assurance
JPUH	3	2	✓	⚠	?
NNUH	8	8	✓	⚠	?
QEH	4	7	✗	⚠	?

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

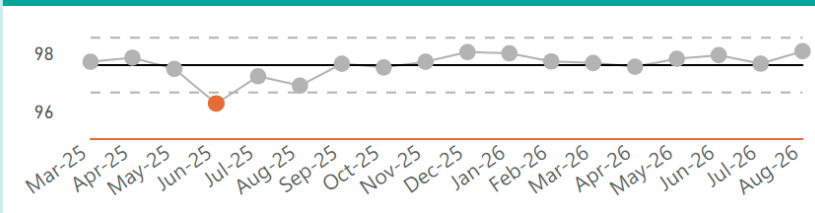
Aug-26



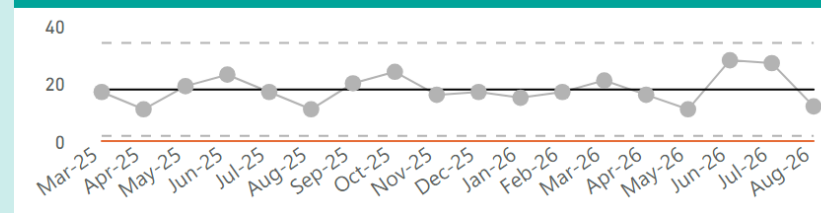
JPUH - SHMI 1.21



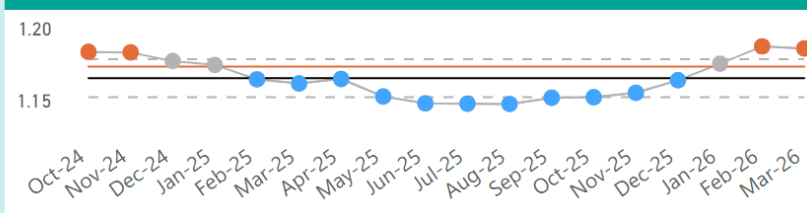
JPUH - FFT Score 98.04%



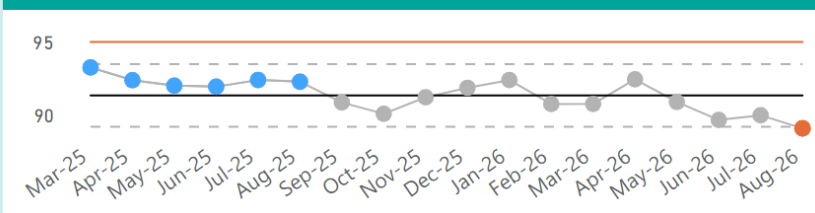
JPUH - Complaints Received 12



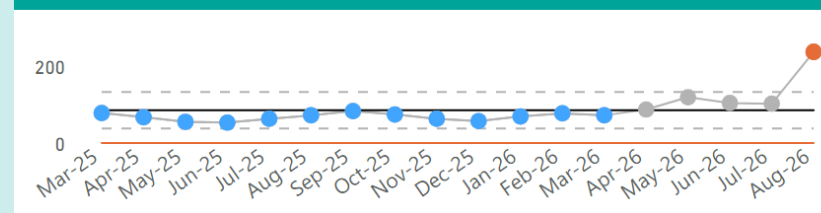
NNUH - SHMI 1.19



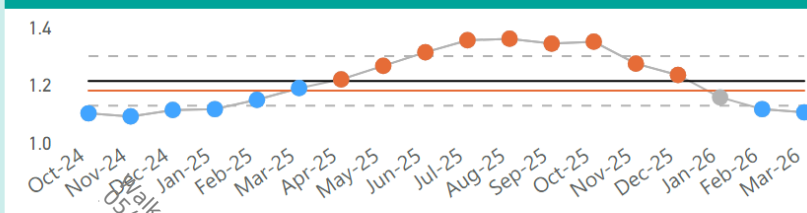
NNUH - FFT Score 89.01%



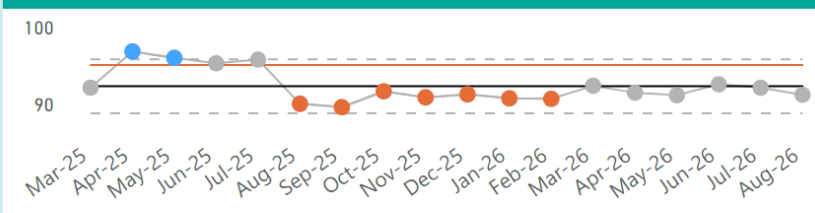
NNUH - Complaints Received 237



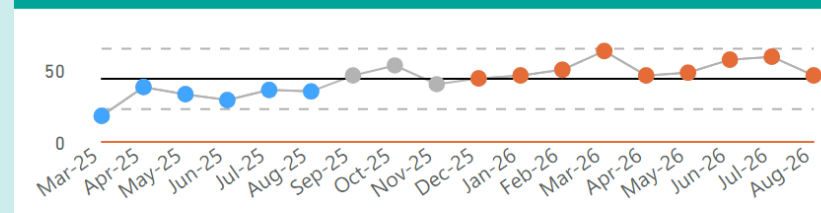
QEH - SHMI 1.10



QEH - FFT Score 91.12%



QEH - Complaints Received 46



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	1.18	1.21	⊗	H	?
NNUH	1.17	1.19	⊗	H	?
QEH	1.18	1.10	⊙	L	?

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	95.0%	98.04%	⊙	L	P
NNUH	95.0%	89.01%	⊗	H	?
QEH	95.0%	91.12%	⊗	H	?

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0	12	⊗	L	F
NNUH	0	237	⊗	H	F
QEH	0	46	⊗	H	F

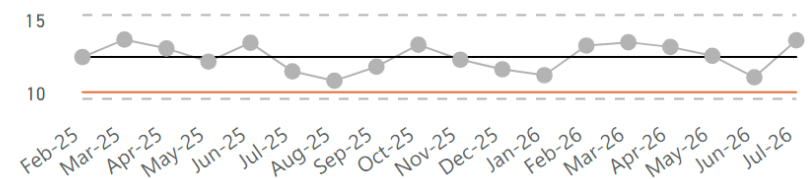
Safe and Effective Care Domain Appendix - Readmission Rate, CHPPD & Discharge Delay

Aug-26



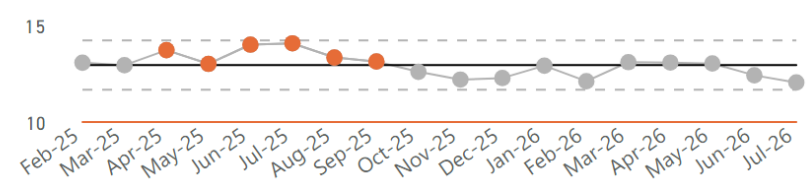
JPUH - Readmission Rate

13.59%



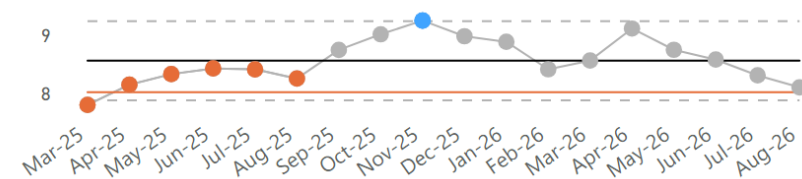
NNUH - Readmission Rate

12.05%



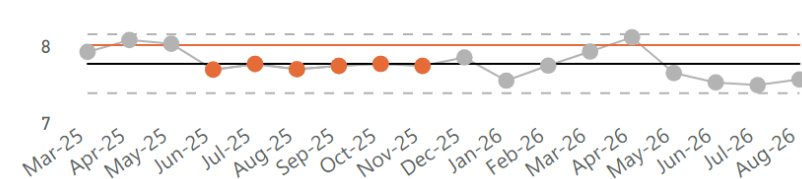
JPUH - Care Hour Per Patient Day (CHPPD)

8.08



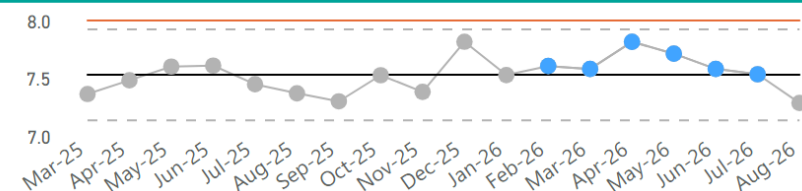
NNUH - Care Hour Per Patient Day (CHPPD)

7.55

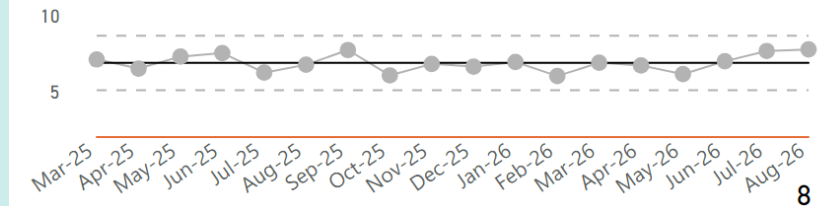


QEH - Care Hour Per Patient Day (CHPPD)

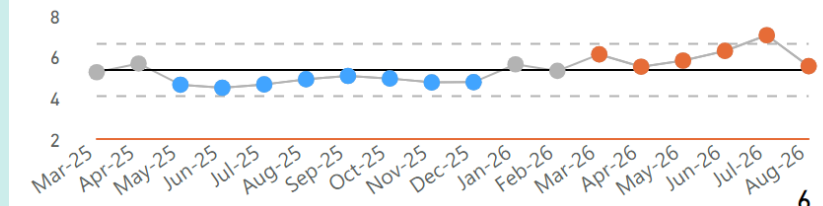
7.29



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



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



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	10.0%	13.59%	✗	⚡	?
NNUH	10.0%	12.05%	✗	⚡	F

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	8.00	8.08	✓	⚡	?
NNUH	8.00	7.55	✗	⚡	?
QEH	8.00	7.29	✗	⚡	?

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	2	8	✗	⚡	F
NNUH	2	6	✗	H	F
QEH	2	1	✓	⚡	?

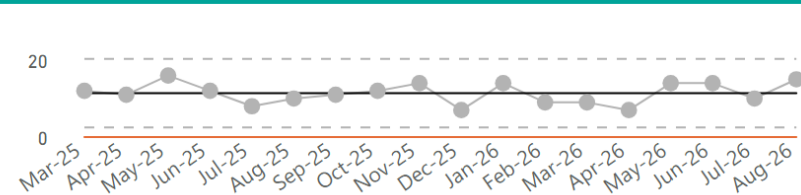
Safe and Effective Care Domain Appendix - Pressure Ulcers, Falls and RN Fill

Aug-26



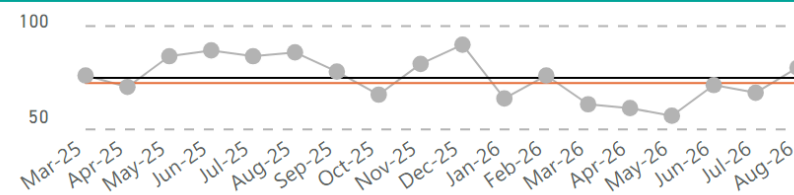
JPUH - Pressure Ulcers

15.00



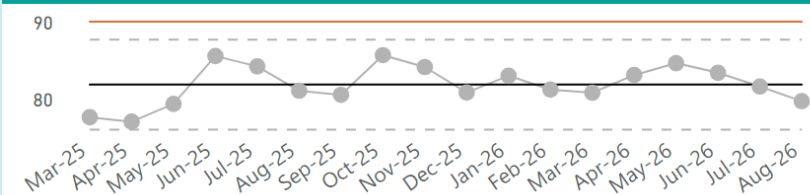
JPUH - Falls

75



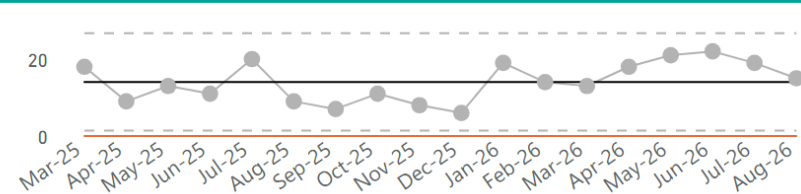
JPUH - Registered Nurse Fill Rate

79.66%



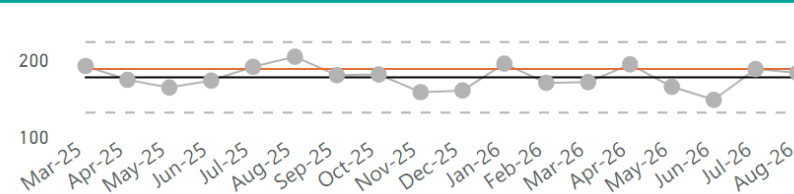
NNUH - Pressure Ulcers

15.00



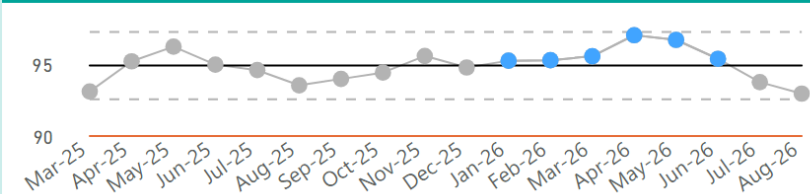
NNUH - Falls

182



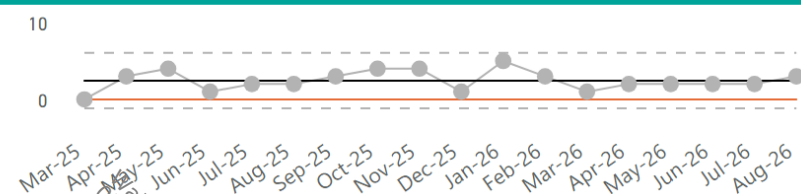
NNUH - Registered Nurse Fill Rate

92.94%



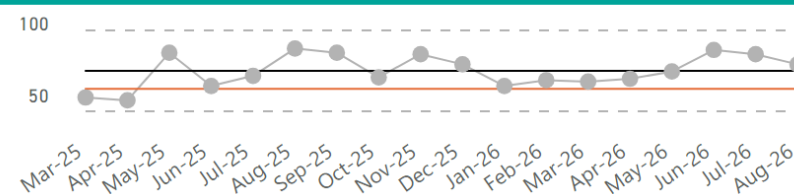
QEH - Pressure Ulcers

3.00



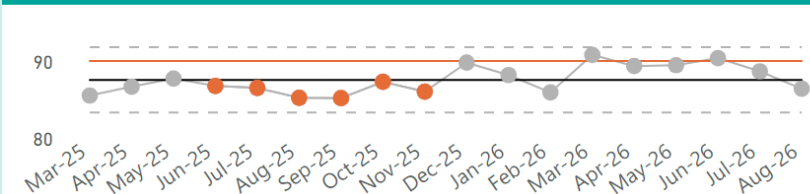
QEH - Falls

71



QEH - Registered Nurse Fill Rate

86.39%



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0	15.00	⊗	⚡	⚡
NNUH	15.00	15.00	⊗	⚡	⚡
QEH	0	3.00	⊗	⚡	⚡

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	67	75	⊗	⚡	⚡
NNUH	187	182	⊙	⚡	⚡
QEH	54	71	⊗	⚡	⚡

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	90.0%	79.66%	⊗	⚡	⚡
NNUH	90.0%	92.94%	⊙	⚡	⚡
QEH	90.0%	86.39%	⊗	⚡	⚡

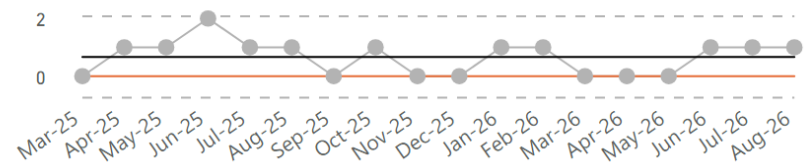
Safe and Effective Care Domain Appendix - PSII

Aug-26



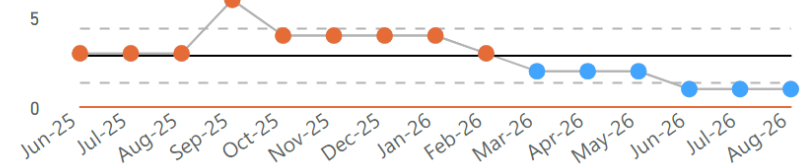
JPUH - PSII Number

1



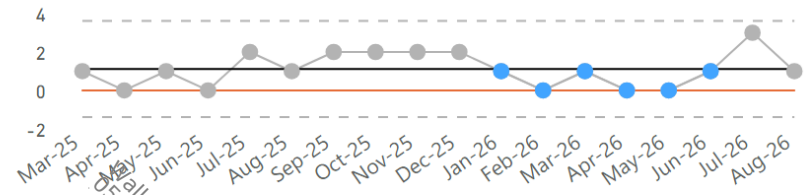
NNUH - PSII Number

1



QEH - PSII Number

1



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0	1	⊗	⚡	?
NNUH	1	1	⊗	⚡	F
QEH	0	1	⊗	⚡	?

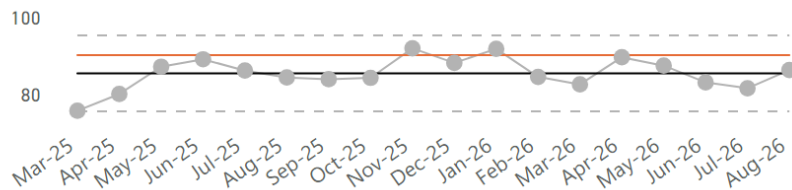
Safe and Effective Care Domain Appendix - Midwifery Fill Rate, Stillbirth Rate, Preterm Birth Rate

Aug-26



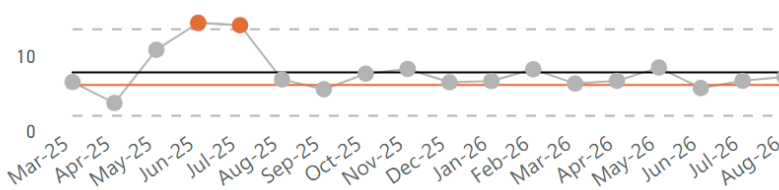
JPUH - Midwifery Fill Rate

86.12%



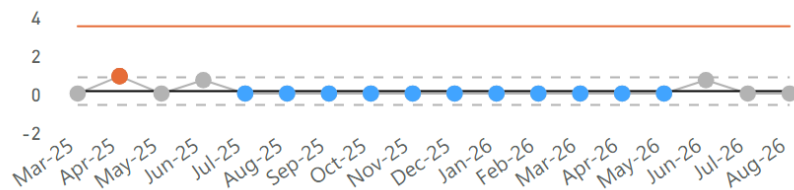
JPUH - Preterm Birth Rate

7.09%



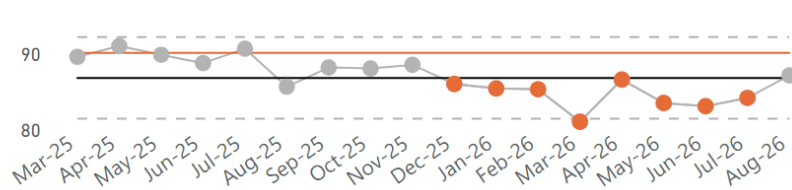
JPUH - Still Birth Rate

0.00%



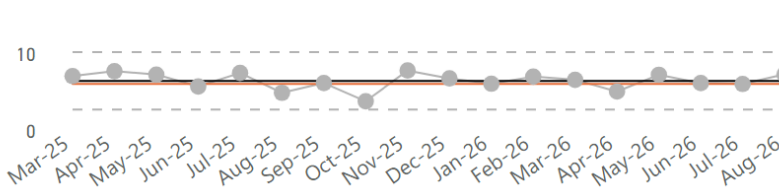
NNUH - Midwifery Fill Rate

87.03%



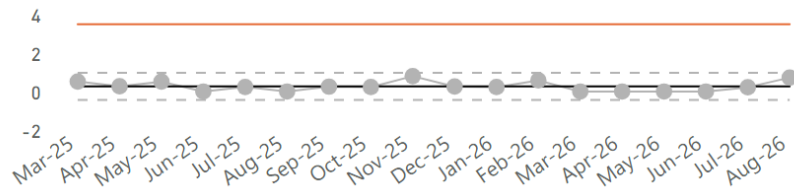
NNUH - Preterm Birth Rate

7.23%



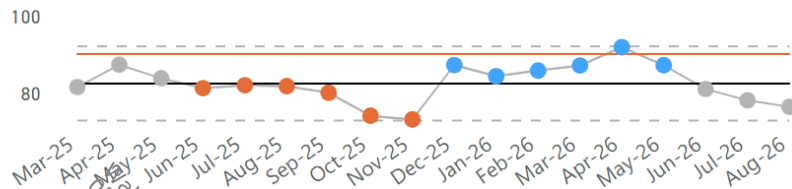
NNUH - Still Birth Rate

0.72%



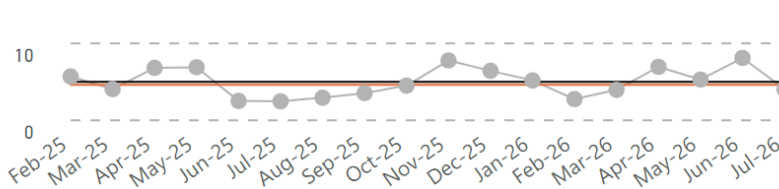
QEH - Midwifery Fill Rate

76.24%



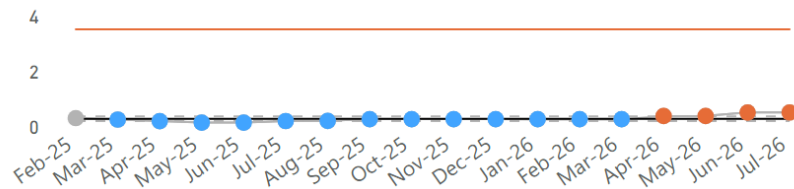
QEH - Preterm Birth Rate

5.44%



QEH - Still Birth Rate

0.48%



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	90.0%	86.12%	⊗	📉	?
NNUH	90.0%	87.03%	⊗	📉	?
QEH	90.0%	76.24%	⊗	📉	?

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	6.0%	7.09%	⊗	📉	?
NNUH	6.0%	7.23%	⊗	📉	?
QEH	6.0%	5.44%	⊙	📉	?

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	3.5%	0.00%	⊙	📉	?
NNUH	3.5%	0.72%	⊙	📉	?
QEH	3.5%	0.48%	⊙	📉	?

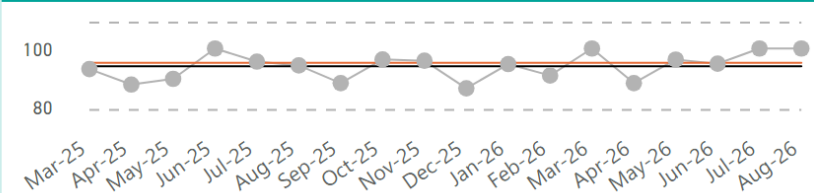
Safe and Effective Care Domain Appendix - FFT (Maternity) and Complaints (Maternity)

Aug-26



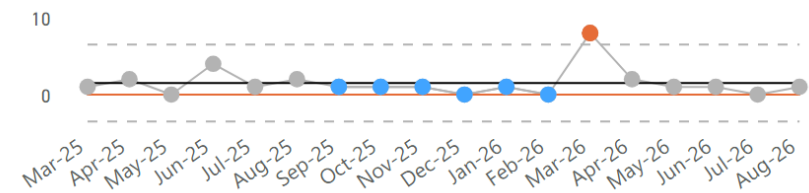
JPUH - Maternity FFT

100.00%



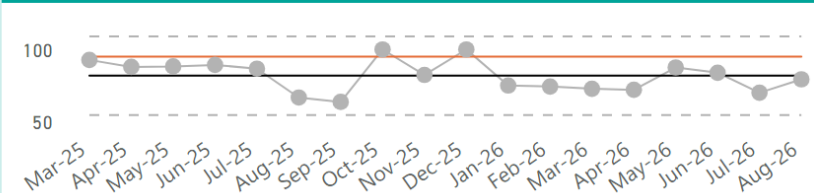
JPUH - Complaints Received - Maternity

1



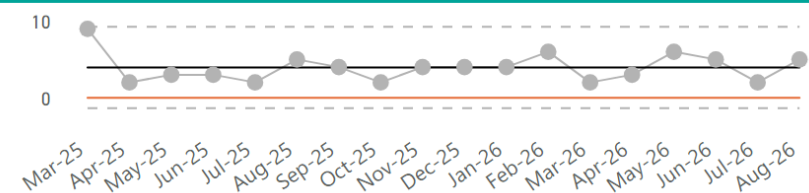
NNUH - Maternity FFT

79.31%



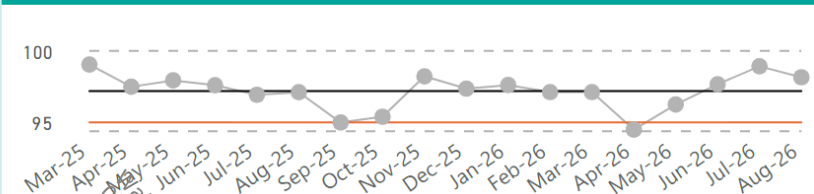
NNUH - Complaints Received - Maternity

5



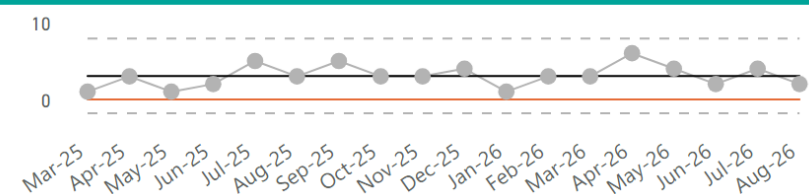
QEH - Maternity FFT

98.17%



QEH - Complaints Received - Maternity

2



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	95.0%	100.00%	✓	⚡	?
NNUH	95.0%	79.31%	✗	⚡	?
QEH	95.0%	98.17%	✓	⚡	?

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0	1	✗	⚡	?
NNUH	0	5	✗	⚡	?
QEH	0	2	✗	⚡	?

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

Aug-26



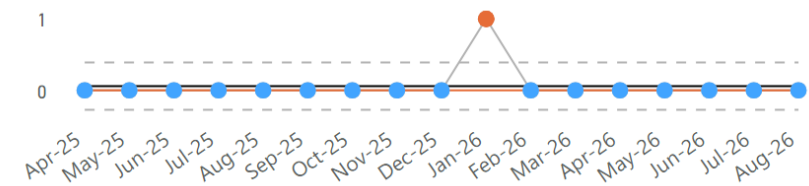
JPUH - 1:1 Care

100.00%



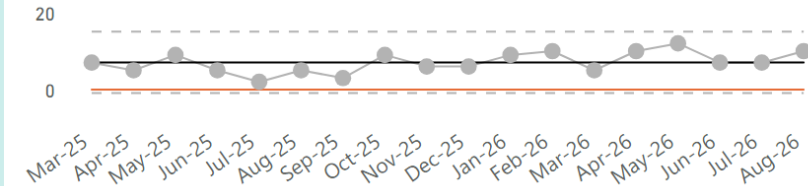
JPUH - MNSI

0



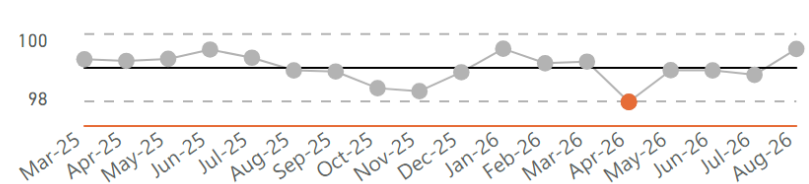
JPUH - Unplanned Admissions to NICU

10



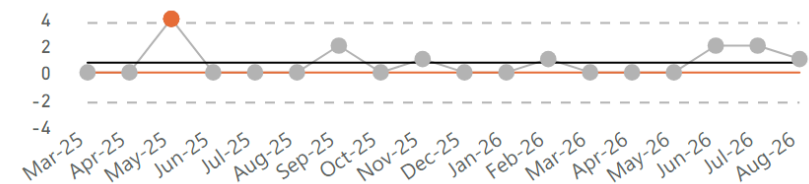
NNUH - 1:1 Care

99.67%



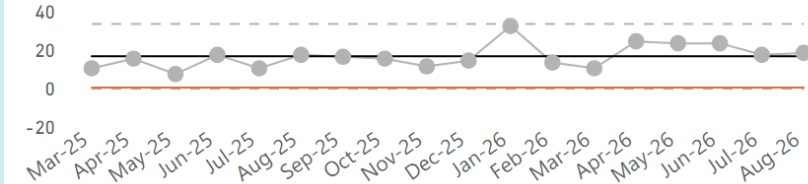
NNUH - MNSI

1



NNUH - Unplanned Admissions to NICU

18



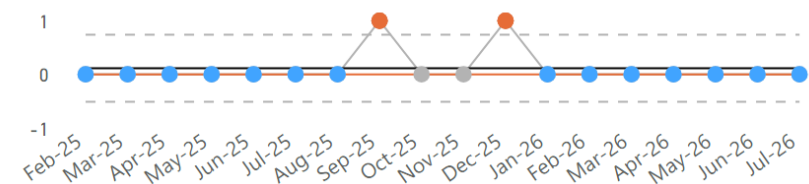
QEH - 1:1 Care

100.00%



QEH - MNSI

0



-

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	97.0%	100.00%	✓	⚡	Ⓟ
NNUH	97.0%	99.67%	✓	⚡	Ⓟ
QEH	97.0%	100.00%	✓	⚡	Ⓟ

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0	0	✓	⚡	Ⓟ
NNUH	0	1	✗	⚡	Ⓟ
QEH	0	0	✓	⚡	Ⓟ

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0	10	✗	⚡	Ⓟ
NNUH	0	18	✗	⚡	Ⓟ
QEH	0	5	✗	⚡	Ⓟ

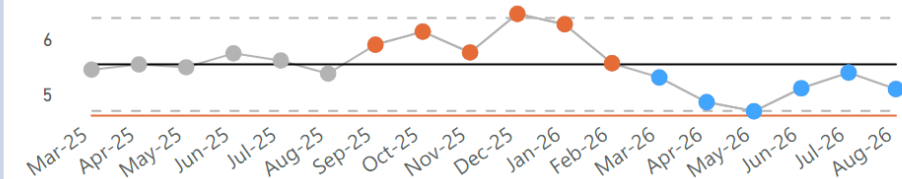
People and Culture Domain Appendix - Sickness and Turnover

Aug-26



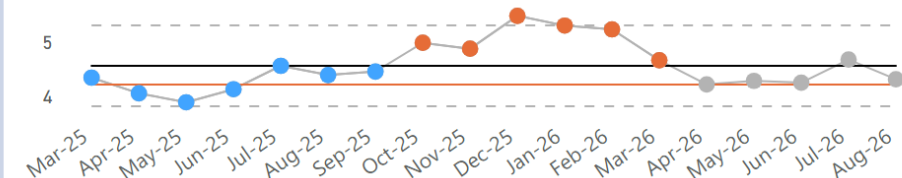
JPUH - Sickness Rate

5.08%



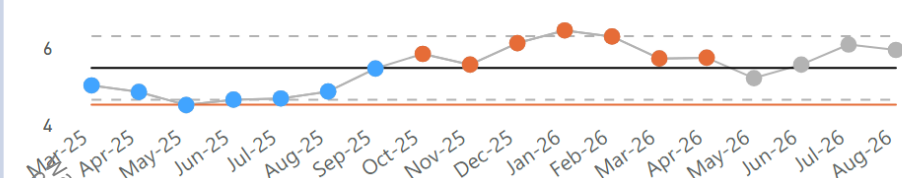
NNUH - Sickness Rate

4.30%



QEH - Sickness Rate

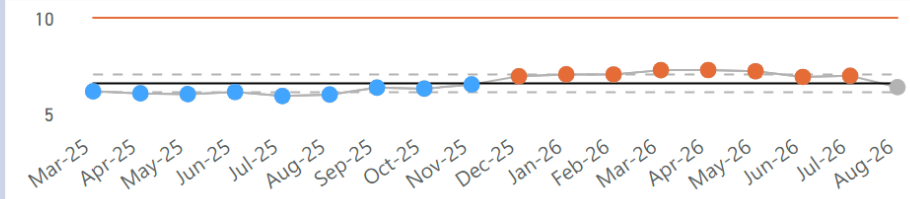
5.92%



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	4.6%	5.08%	✗	📈	🔴
NNUH	4.2%	4.30%	✗	📈	🔴
QEH	4.5%	5.92%	✗	📈	🔴

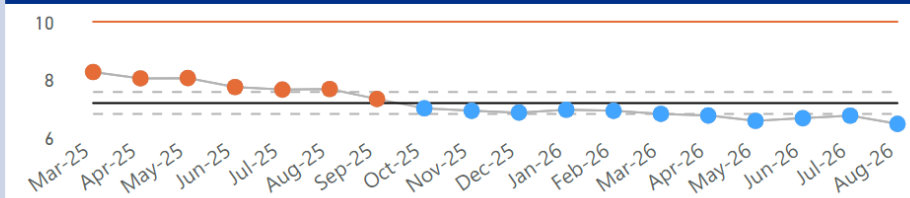
JPUH - Turnover Rate

6.39%



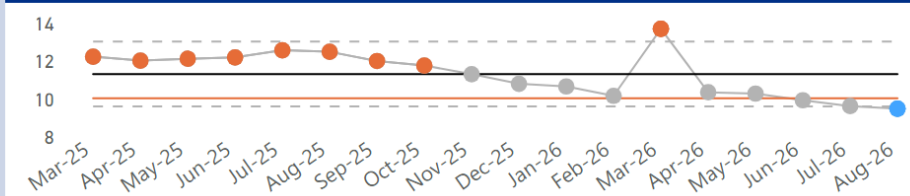
NNUH - Turnover Rate

6.46%



QEH - Turnover Rate

9.45%



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	10.0%	6.39%	✓	📈	🔴
NNUH	10.0%	6.46%	✓	📈	🔴
QEH	10.0%	9.45%	✓	📈	🔴

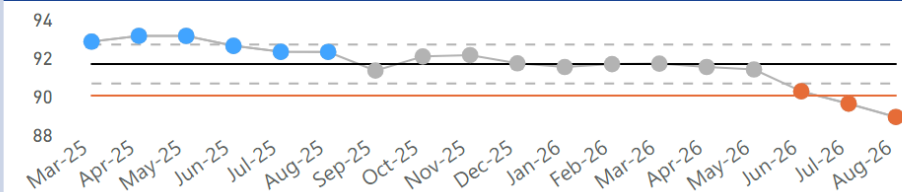
People and Culture Domain Appendix - Mandatory Training and Appraisals

Aug-26



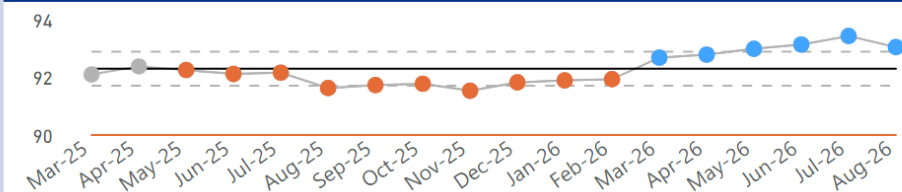
JPUH - Mandatory Training

88.88%



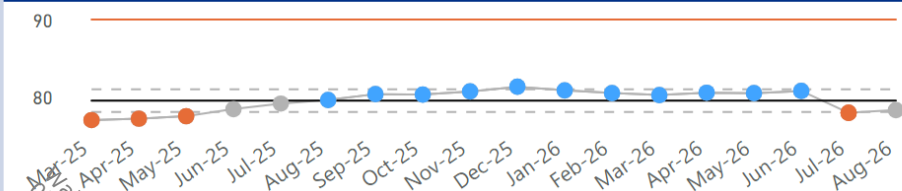
NNUH - Mandatory Training

93.05%



QEH - Mandatory Training

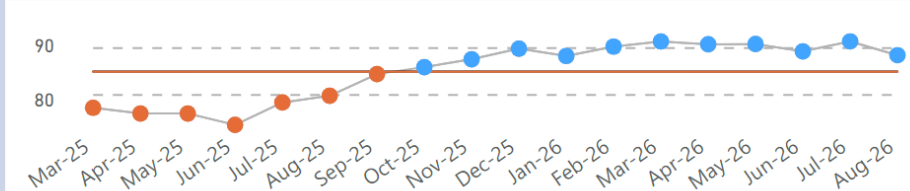
78.22%



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	90.0%	88.88%	✗	📉	🔍
NNUH	90.0%	93.05%	✓	📈	🔍
QEH	90.0%	78.22%	✗	📉	🔍

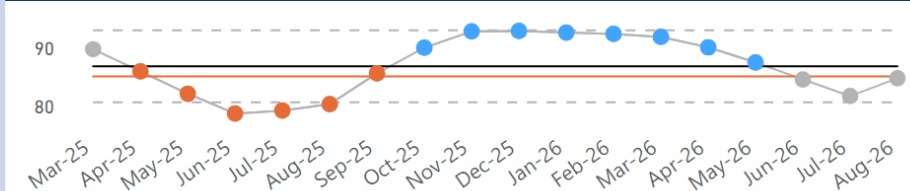
JPUH - Non Medical Appraisal

88.08%



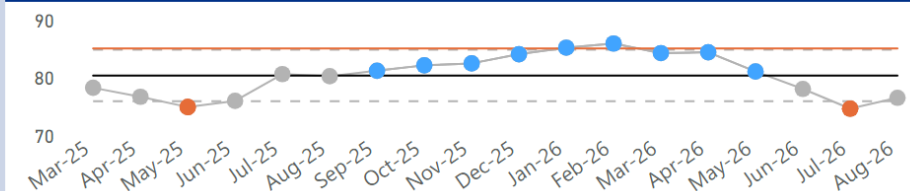
NNUH - Non Medical Appraisal

84.68%



QEH - Non Medical Appraisal

76.44%



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	85.0%	88.08%	✓	📈	🔍
NNUH	85.0%	84.68%	✗	📉	🔍
QEH	85.0%	76.44%	✗	📉	🔍

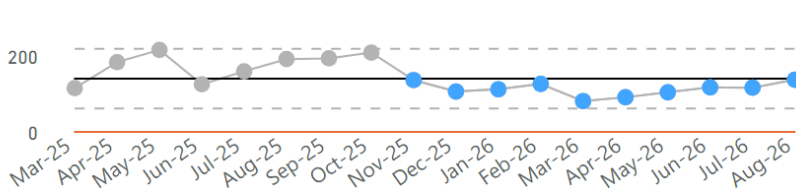
Access and Flow Domain Appendix - RTT

Aug-26



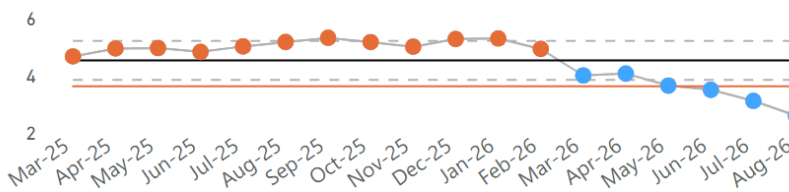
JPUH - 65+ Week Waits

137



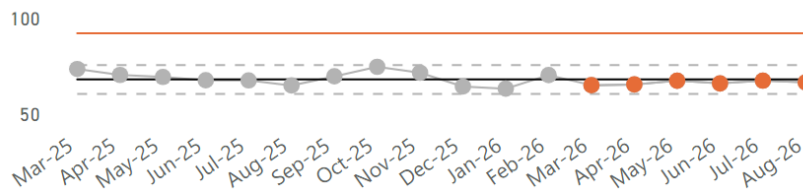
JPUH - 52+ Week Performance

2.57%



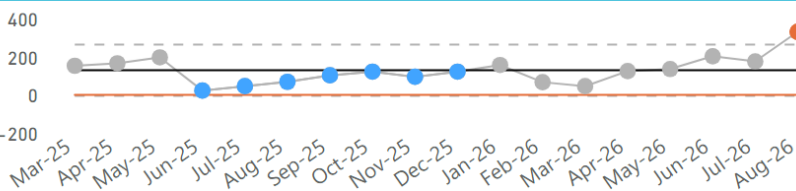
JPUH - 6 Week Diagnostics

66.01%



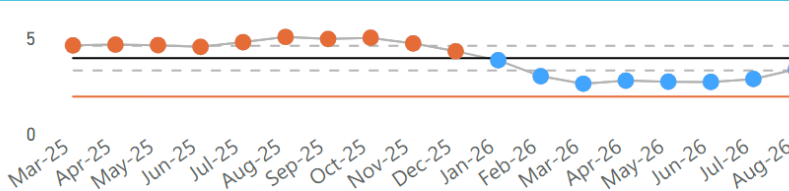
NNUH - 65+ Week Waits

330



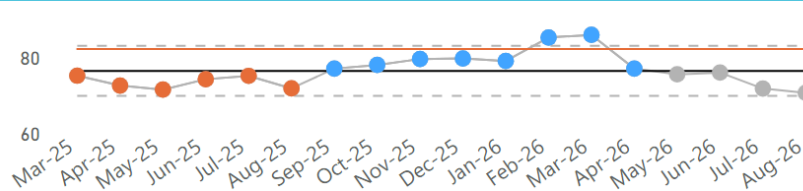
NNUH - 52+ Week Performance

3.34%



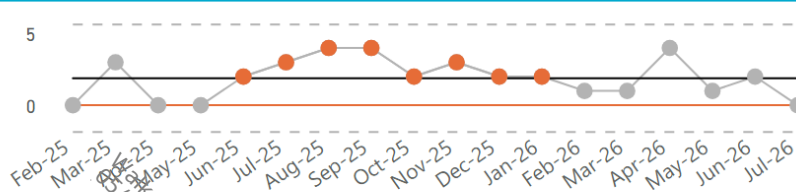
NNUH - 6 Week Diagnostics

70.51%



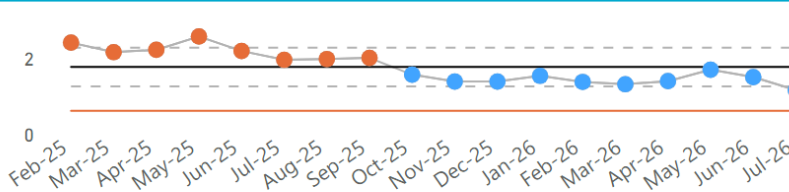
QEH - 65+ Week Waits

0



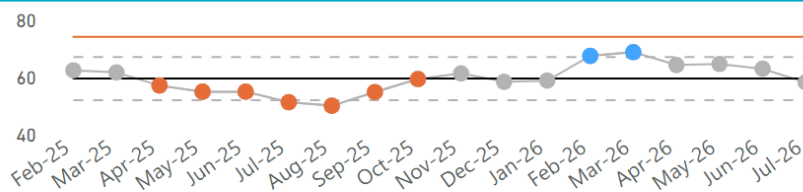
QEH - 52+ Week Performance

1.15%



QEH - 6 Week Diagnostics

57.99%



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0	137	⊗	⚡	⚠
NNUH	0	330	⊗	⚡	?
QEH	0	0	✅	⚡	⚡

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	3.6%	2.57%	✅	⚡	⚠
NNUH	1.9%	3.34%	⊗	⚡	⚠
QEH	0.6%	1.15%	⊗	⚡	⚠

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	91.7%	66.01%	⊗	⚡	?
NNUH	82.0%	70.51%	⊗	⚡	?
QEH	73.9%	57.99%	⊗	⚡	?

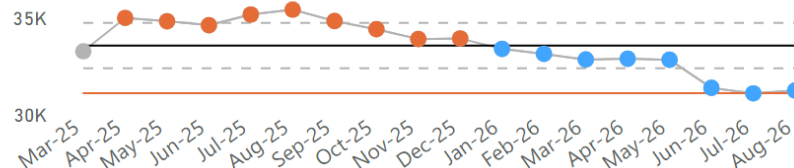
Access and Flow Domain Appendix - RTT

Aug-26



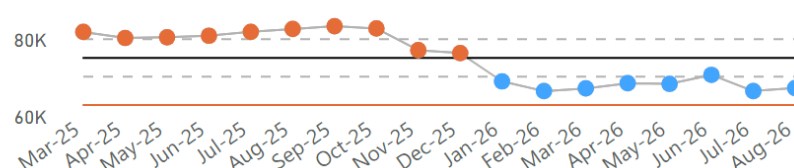
JPUH - Total PTL Size

31,210



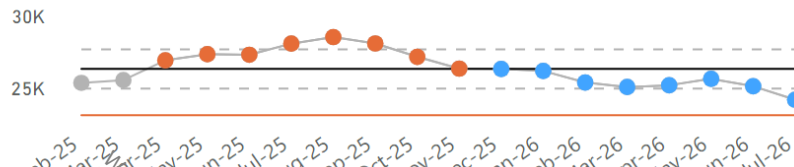
NNUH - Total PTL Size

67,221



QEH - Total PTL Size

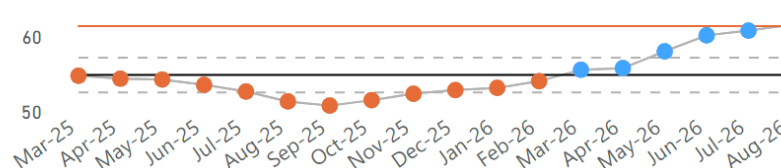
24,150



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	31,080	31,210	⊗	📉	🔴
NNUH	62,810	67,221	⊗	📉	🔴
QEH	23,074	24,150	⊗	📉	🔴

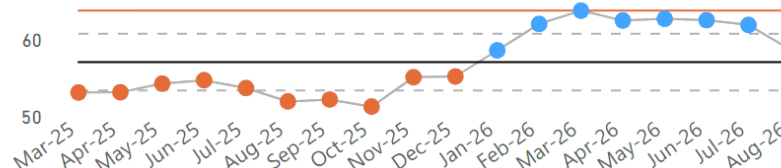
JPUH - RTT Incomplete Within 18 weeks

61.46%



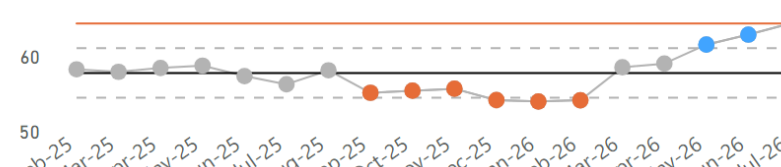
NNUH - RTT Incomplete Within 18 weeks

58.61%



QEH - RTT Incomplete Within 18 weeks

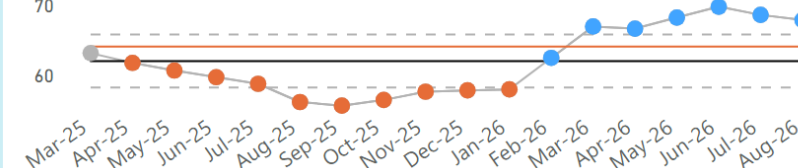
64.30%



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	61.3%	61.46%	✅	📈	🟡
NNUH	63.7%	58.61%	⊗	📉	🟡
QEH	64.3%	64.30%	⊗	📉	🟡

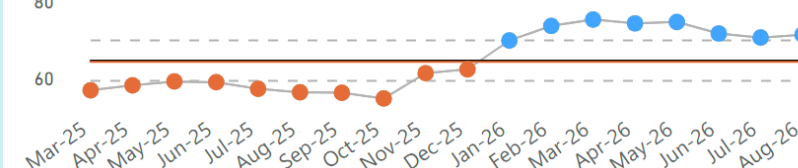
JPUH - First Attendance Within 18 Weeks

67.74%



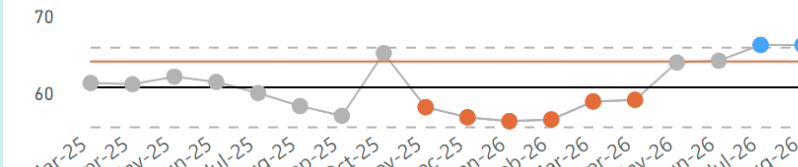
NNUH - First Attendance Within 18 Weeks

71.11%



QEH - First Attendance Within 18 Weeks

66.15%



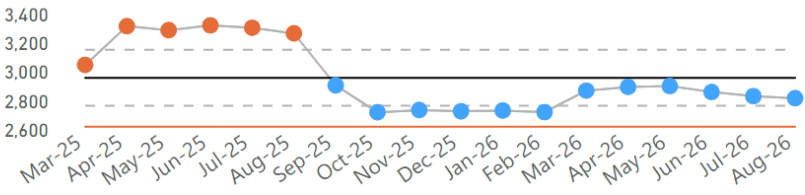
Site	Target	Actual	Compliance	Variation	Assurance
JPUH	64.0%	67.74%	✅	📈	🟡
NNUH	64.0%	71.11%	✅	📈	🟡
QEH	64.0%	66.15%	✅	📈	🟡



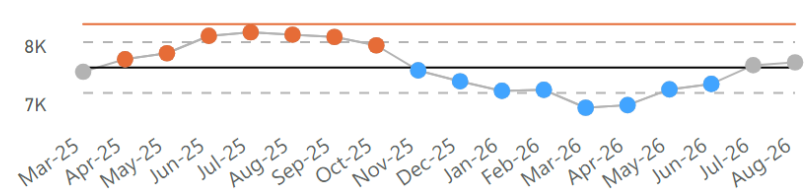
Access and Flow Domain Appendix - Clearance Times

Aug-26

JPUH - Under 18s elective waiting list size 2,812



NNUH - Under 18s elective waiting list size 7,705



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	2,615	2,812			
NNUH	8,368	7,705			

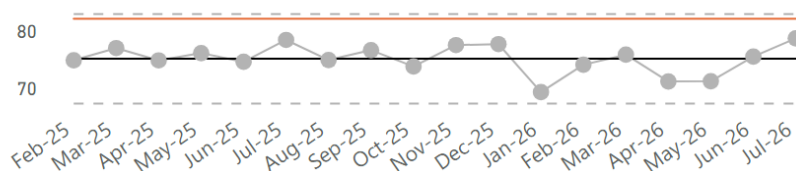
Walker, Ian
05/10/2026 10:43:15



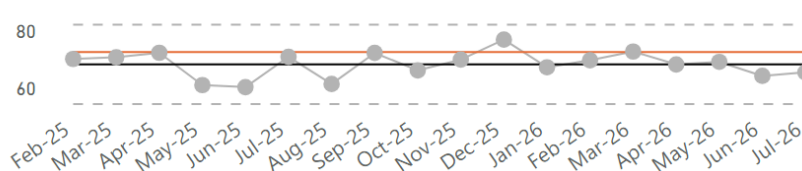
Access and Flow Domain Appendix - Cancer

Jul-26

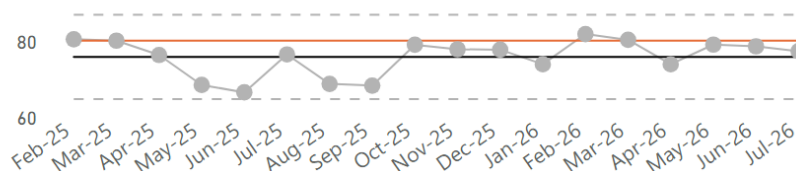
JPUH - 28 Day Faster Diagnosis 78.57%



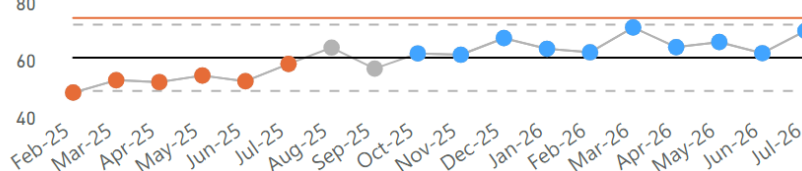
JPUH - Cancer 62 Day Treatment 65.25%



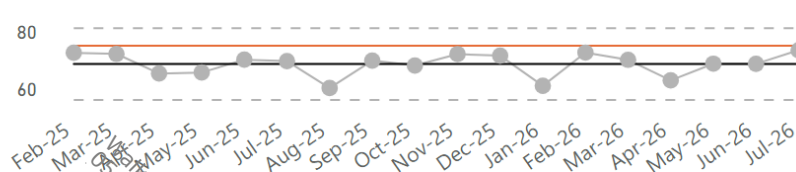
NNUH - 28 Day Faster Diagnosis 77.22%



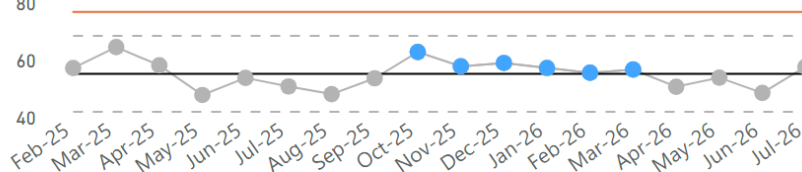
NNUH - Cancer 62 Day Treatment 70.05%



QEH - 28 Day Faster Diagnosis 73.28%



QEH - Cancer 62 Day Treatment 57.45%



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	82.0%	78.57%	⊗	📉	?
NNUH	80.0%	77.22%	⊗	📉	?
QEH	74.8%	73.28%	⊗	📉	?

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	72.3%	65.25%	⊗	📉	?
NNUH	74.6%	70.05%	⊗	📉	?
QEH	76.6%	57.45%	⊗	📉	?

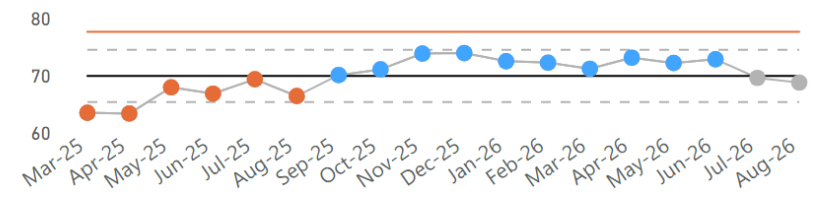
Access and Flow Domain Appendix - UEC

Aug-26



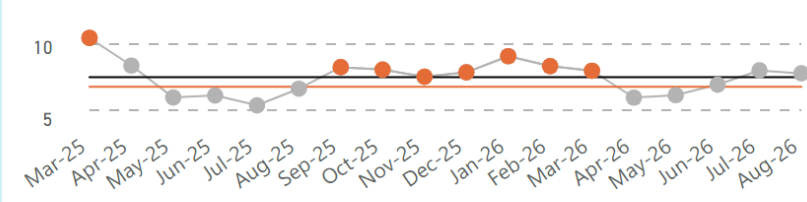
JPUH - ED 4 Hour Performance

68.63%



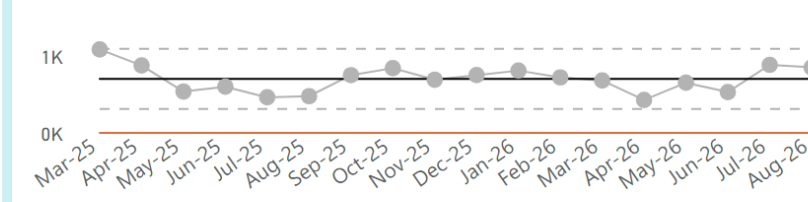
JPUH - ED 12 Hours in Department %

8.13%



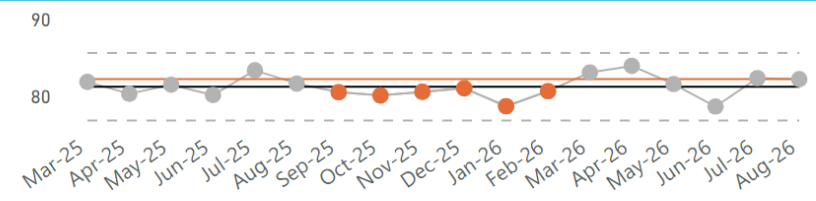
JPUH - Ambulance Handovers Over 30 Minutes

852



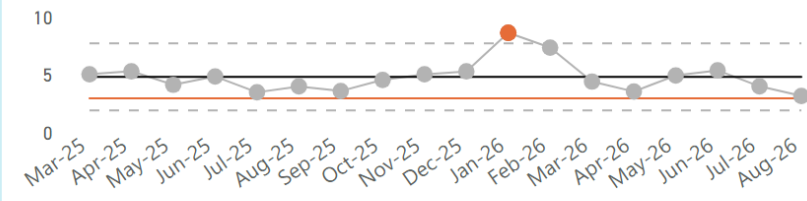
NNUH - ED 4 Hour Performance

82.10%



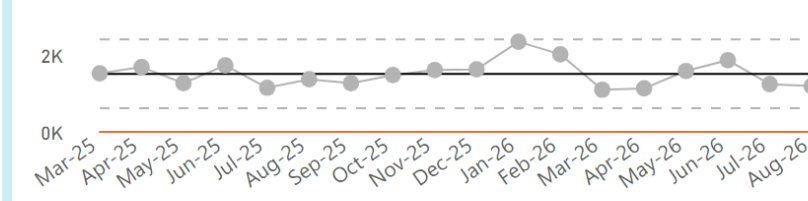
NNUH - ED 12 Hours in Department %

3.11%



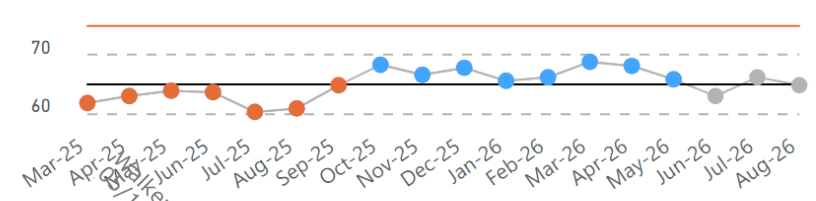
NNUH - Ambulance Handovers Over 30 Minutes

1,189



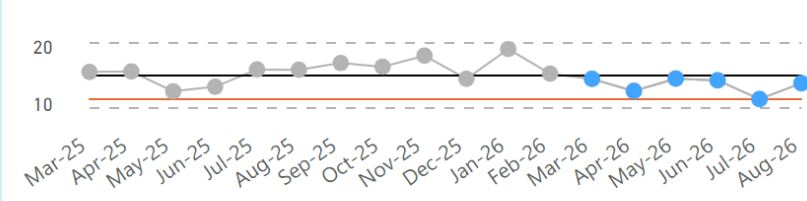
QEH - ED 4 Hour Performance

63.23%



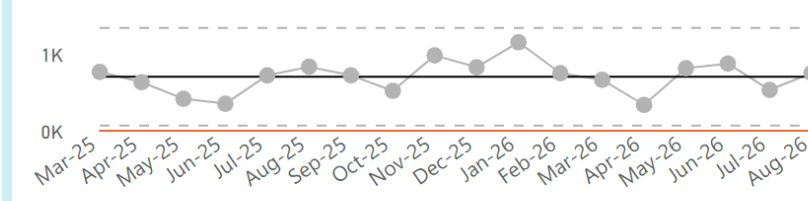
QEH - ED 12 Hours in Department %

13.48%



QEH - Ambulance Handovers Over 30 Minutes

750



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	75.5%	68.63%	⊗	⚡	?
NNUH	82.1%	82.10%	⊙	⚡	?
QEH	73.5%	63.23%	⊗	⚡	?

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	7.2%	8.13%	⊗	⚡	?
NNUH	2.9%	3.11%	⊗	⚡	?
QEH	10.7%	13.48%	⊗	⚡	?

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0	852	⊗	⚡	F
NNUH	0	1,189	⊗	⚡	F
QEH	0	750	⊗	⚡	F

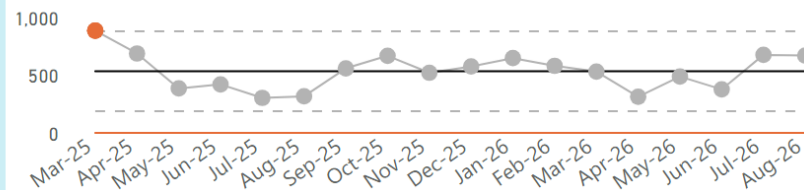
Access and Flow Domain Appendix - UEC

Aug-26



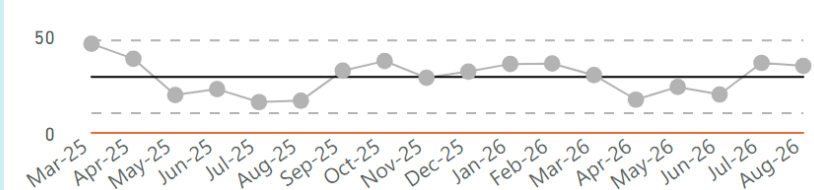
JPUH - Ambulance Handovers Over 45 Minutes

670



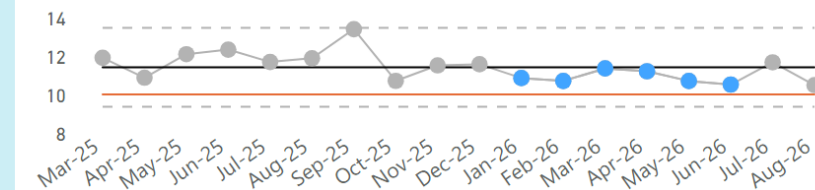
JPUH - Ambulance Handovers Over 45 Minutes %

34.82%



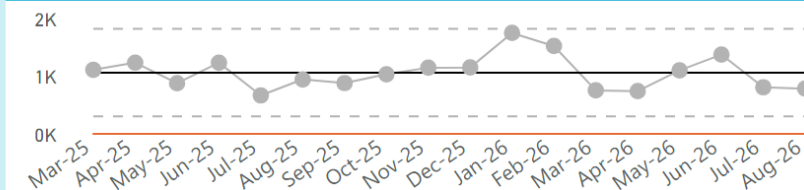
JPUH - Non Elective LoS

10.48



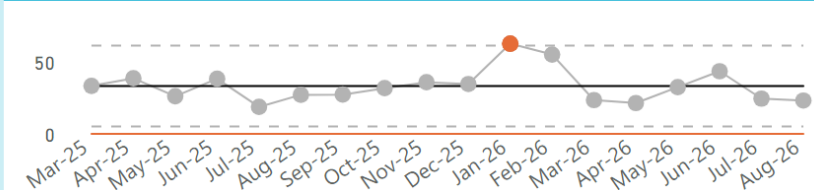
NNUH - Ambulance Handovers Over 45 Minutes

783



NNUH - Ambulance Handovers Over 45 Minutes %

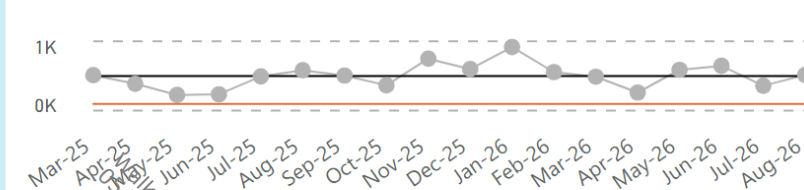
23.08%



-

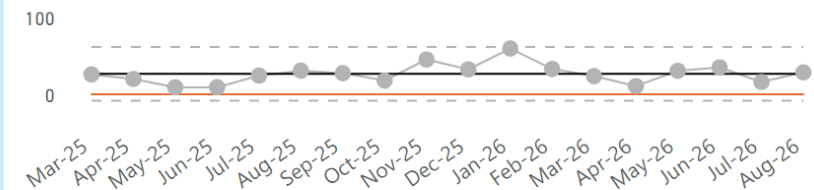
QEH - Ambulance Handovers Over 45 Minutes

502



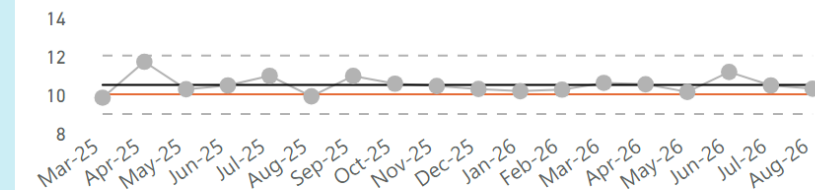
QEH - Ambulance Handovers Over 45 Minutes %

28.46%



QEH - Non Elective LoS

10.29



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0	670	⊗	⊗	⊗
NNUH	0	783	⊗	⊗	⊗
QEH	0	502	⊗	⊗	⊗

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0.0%	34.82%	⊗	⊗	⊗
NNUH	0.0%	23.08%	⊗	⊗	⊗
QEH	0.0%	28.46%	⊗	⊗	⊗

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	10	10.48	⊗	⊗	⊗
QEH	10	10.29	⊗	⊗	⊗

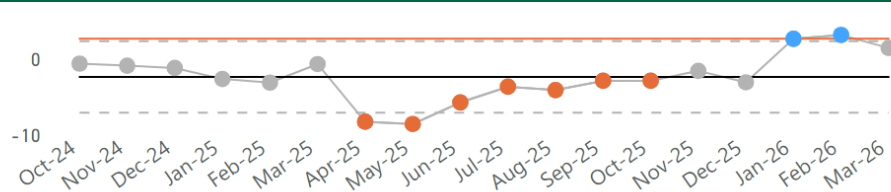
Productivity and Efficiency Domain Appendix

Mar-26



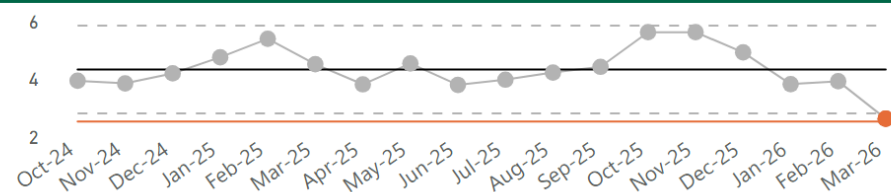
JPUH - Implied Productivity

1.30



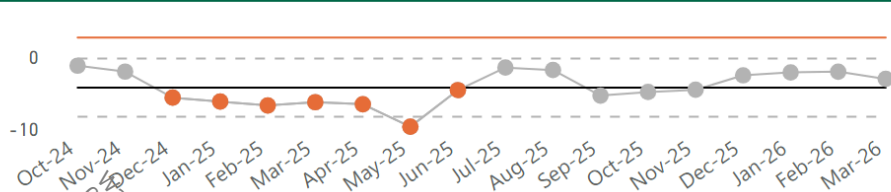
NNUH - Implied Productivity

2.60



QEH - Implied Productivity

-3.20



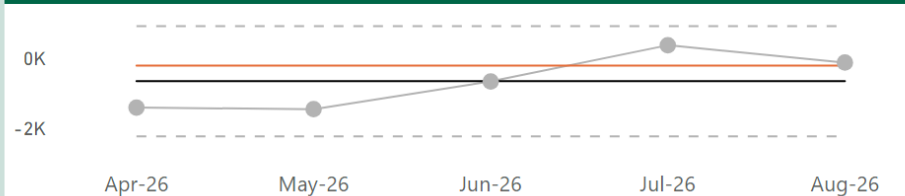
Site	Target	Actual	Compliance	Variation	Assurance
JPUH	3	1.30	⊗	📉	?
NNUH	3	2.60	✅	📈	🔍
QEH	3	-3.20	⊗	📉	?



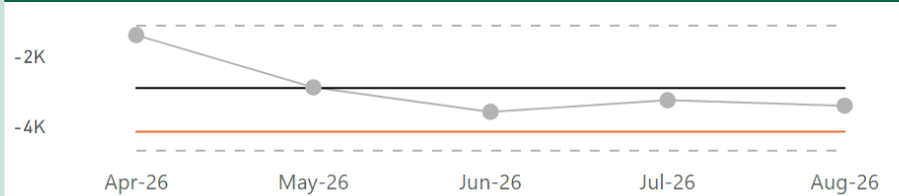
Productivity and Efficiency Domain Appendix

Aug-26

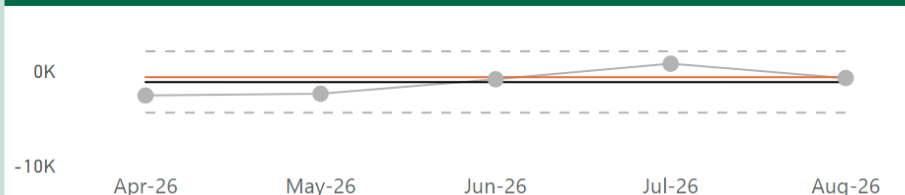
JPUH - Planned surplus/deficit -159



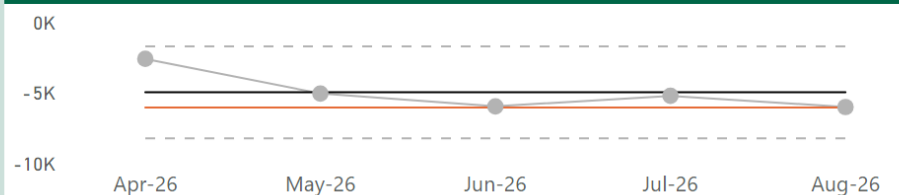
JPUH - YTD Surplus/deficit -3,441



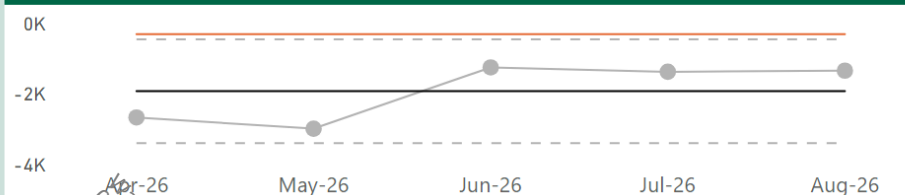
NNUH - Planned surplus/deficit -790



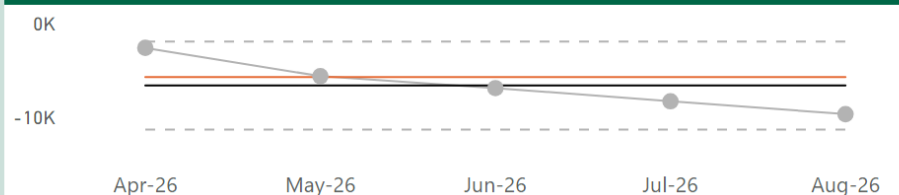
NNUH - YTD Surplus/deficit -6,051



QEH - Planned surplus/deficit -1,364



QEH - YTD Surplus/deficit -9,737



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	-248	-159	✓	📉	?
NNUH	-690	-790	✗	📉	?
QEH	-330	-1,364	✗	📉	?

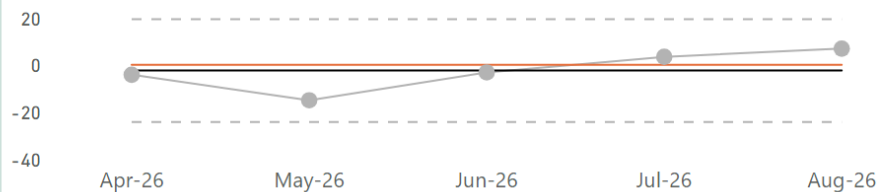
Site	Target	Actual	Compliance	Variation	Assurance
JPUH	-4,174	-3,441	✓	📉	?
NNUH	-6,078	-6,051	✓	📉	?
QEH	-5,801	-9,737	✗	📉	?

Productivity and Efficiency Domain Appendix

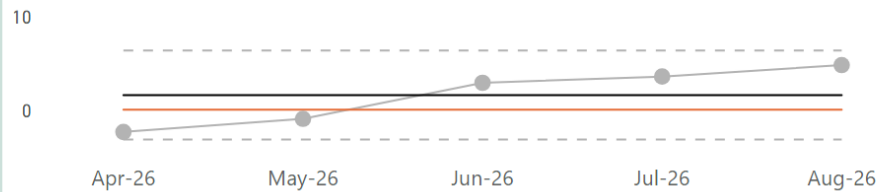
Aug-26



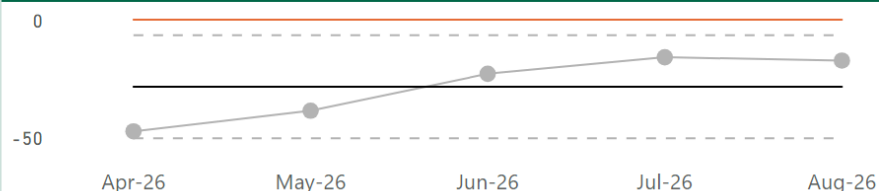
JPUH - Variance to Agency Spend Cap % 6.84%



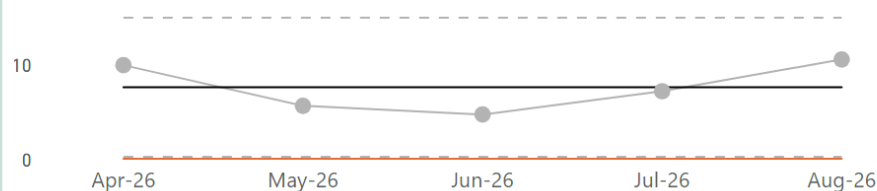
JPUH - Variance to Bank Spend Cap % 4.75%



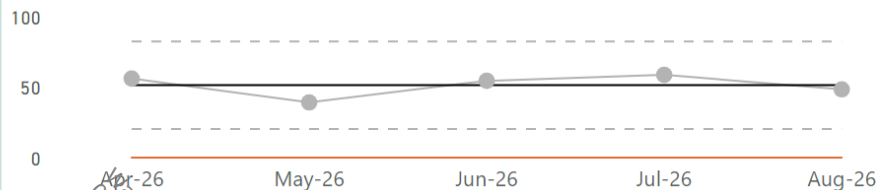
NNUH - Variance to Agency Spend Cap % -17.40%



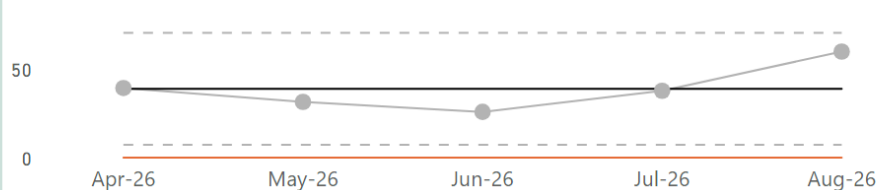
NNUH - Variance to Bank Spend Cap % 10.56%



QEH - Variance to Agency Spend Cap % 48.38%



QEH - Variance to Bank Spend Cap % 60.14%



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0.0%	6.84%	⊗	📉	?
NNUH	0.0%	-17.40%	⊙	📉	?
QEH	0.0%	48.38%	⊗	📉	⊗

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	0.0%	4.75%	⊗	📉	?
NNUH	0.0%	10.56%	⊗	📉	⊗
QEH	0.0%	60.14%	⊗	📉	⊗

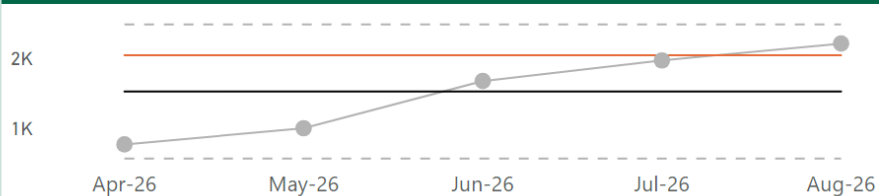


Productivity and Efficiency Domain Appendix

Aug-26

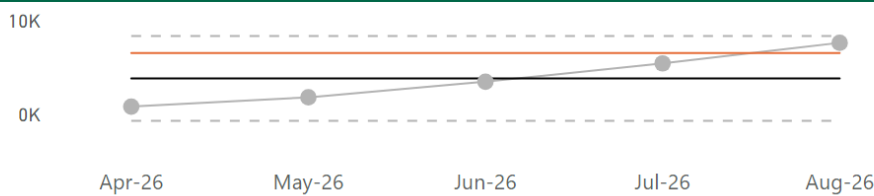
JPUH - Efficiency Plan £000

2,190



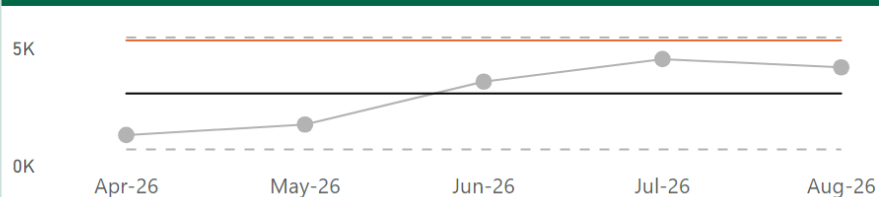
JPUH - Efficiency Plan YTD £000

7,547



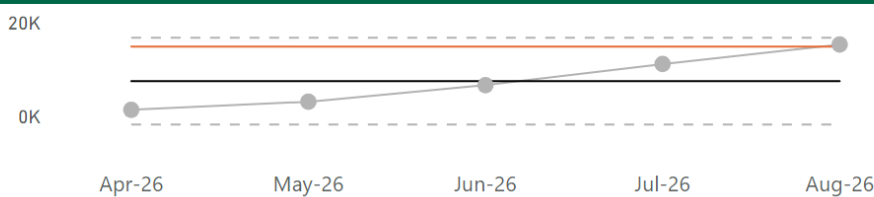
NNUH - Efficiency Plan £000

4,142



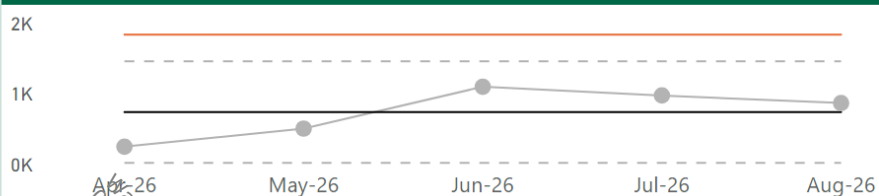
NNUH - Efficiency Plan YTD £000

15,143



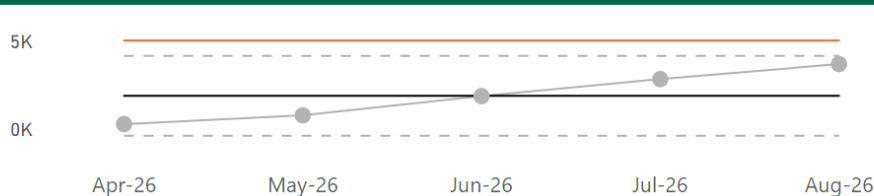
QEH - Efficiency Plan £000

858



QEH - Efficiency Plan YTD £000

3,645



Site	Target	Actual	Compliance	Variation	Assurance
JPUH	2,024	2,190	✓	📉	?
NNUH	5,288	4,142	✗	📉	?
QEH	1,829	858	✗	📉	?

Site	Target	Actual	Compliance	Variation	Assurance
JPUH	6,470	7,547	✓	📉	?
NNUH	14,705	15,143	✓	📉	?
QEH	4,980	3,645	✗	📉	?



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.

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Understanding the Matrix

Assurance				
Variation/Performance				
		Excellent - 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. Celebrate and Learn	Average - 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. Investigate and Understand	Concerning - 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. Celebrate but Take Action
		Excellent - 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. Celebrate and Learn	Average - 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. Investigate and Understand	Concerning - 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. Celebrate but Take Action
		Good - 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. Celebrate and Understand	Average - 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. Investigate and Understand	Concerning - 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. Investigate and Take Action
		Concerning - 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. Investigate and Understand	Concerning - 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. Investigate and Take Action	Very Concerning - 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 Investigate and Take Action
		Concerning - 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. Investigate and Understand	Concerning - 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. Investigate and Take Action	Very Concerning - 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 Investigate and Take Action

Report to the Group Board in public: 7 October 2026

Agenda item number	7.2		
Title	Group Finance Report Month 5		
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 continues to forecast breakeven for 2026/27, but delivery depends on a substantial recovery over the remainder of the year. The year-to-date deficit is £19.2m, £3.2m worse than plan, and achieving breakeven requires average monthly surpluses of approximately £2.8m.

QEH is driving the financial deterioration. Its £3.9m adverse variance reflects temporary staffing costs, under-delivery of efficiencies and lower activity income. NNUH is on plan and JPUH is £0.7m favourable, partially offsetting QEH's position.

The savings programme is the principal risk to breakeven. Year-to-date CIP delivery is broadly on plan, but only £79.9m of schemes are approved against the £102.1m annual requirement, leaving a £22.2m gap.

Capital underspending masks delivery and funding risks. Year-to-date expenditure is £70.2m behind plan. The forecast includes £39.0m of New Hospital Programme underspending from delays, alongside a £14.4m EPR overspend against plan whose additional funding remains unresolved, although a business case is in process for this and NHSE are expecting the case to be supported.

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.

Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 4 – Financial sustainability
Previously considered by	Group Risk Assurance Committee, 30 September 2026
Any background papers in Admin Control Reading Room	No

Norfolk and Waveney University Hospitals Group

Group Finance Report August 2026

7 October 2026

Marcus Thorman, Group Chief Finance Officer

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Contents

This report sets out the Group’s financial performance and forms part of the Group’s performance reporting suite.
The report has been structured to provide the reader with an overview of the Group’s financial performance using the following framework.

1.0	Executive Summary/Dashboard	Page 3-4
2.0	Operational Performance	Page 5-8
3.0	CIP	Page 9
4.0	Cash	Page 10
5.0	Statement of Financial Position	Page 11
6.0	Capital	Page 12
7.0	Risk	Page 13

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1.1 Executive Summary

Financial Performance

Year to date the Group has reported a £19.2m deficit, which is £3.2m adverse to the planned £16.0m deficit. QEH is £3.9m adverse to plan 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 has a favourable variance and NNUH are on plan.

Activity driven income performance is adverse by £4.5m year to date, driven primarily by activity shortfalls across the Group with NNUH: £2.4m adverse and QEH: £2.1m adverse. This reflects lower than planned activity levels, which is a key financial risk given the reliance on activity-based income delivery. August performance was £2.0m adverse with all three trusts having an adverse performance.

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 (excluding drugs) shows an adverse variance of £2.5m year to date, however this is largely driven by income backed Research and Development and Cancer Alliance expenditure.

Productivity and Efficiency

On the CIP year-to-date performance there was £26.2m delivered vs £26.0m plan; a £0.2m favourable variance.

The overall programme position is £79.9m of schemes approved (Gateway 2) meaning a £22.2m 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 for the EPR, which means the scheme is currently forecasting an overspend. A business case is in progress. The replacement NANOC scheme is now in the process of a business case which will be with STIP in October and then on to Board for approval.

For cash the closing position in month was £141.8m, £75.0m favourable to plan, cash balances have decreased since the start of the year by £32.2m driven by timings mainly of income received at NNUH, and 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.

A review of the deficit support funding for quarter 3 is ongoing and it has been clarified that the overall plan can be delivered at Group or within the ICB to secure the funding rather than at individual trust level.

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; QEH controls of variable pay indicates 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

1.2 Executive Dashboard

August is a £2.4m deficit on a control total basis, £1.1m adverse to the planned £1.3m deficit.

The adverse variance is driven by QEH and in the main is linked to overspends in pay particularly the use of temporary staff.

Year to date position is a £19.2m deficit on a control total basis, which is £3.2m adverse to the planned £16.0m 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 31st August was £141.8m, £75.0m favourable to the planned £66.8m.

Capital Expenditure: Year-to-date capital spend is £35.2m, £70.2m behind the planned spend of £105.4m.

CIP: Year-to-date CIP delivery is £26.2m against a budgeted plan of £26.0m, a favourable variance of £0.2m, comprised of a favourable planning variance of £3.0m and an adverse performance variance of £0.9m. As at 4th September 2026, the programme consists of £79.9m of Gateway 2 approved schemes. This is £22.2m adverse to the planned £102.1m full year CIP requirement. Of the £79.9m of schemes at Gateway 2, £31.5m relates to non-recurrent schemes. The Full Year Effect of Gateway 2 schemes is £67.4m, £28.2m adverse to the planned £95.6m.

Activity: Value-based activity performance for August was adverse by £2.0m, driven by adverse activity performance at JPUH (£0.6m) and NNUH (£0.6m) with QEH (£0.8m). Year to date value-based activity performance is adverse by £4.5m, driven by adverse variances at NNUH (£2.4m) and QEH (£2.1m).

	In Month			Year To Date		
	Plan	Actual	Variance	Plan	Actual	Variance
SOCi						
	£m	£m	£m	£m	£m	£m
Clinical Income	121.0	123.1	2.1	614.7	618.1	3.3
Other Income	18.6	17.4	(1.2)	89.9	88.9	(1.0)
TOTAL INCOME	139.6	140.4	0.9	704.7	707.0	2.3
Pay	(90.7)	(92.4)	(1.7)	(461.5)	(464.8)	(3.3)
Non Pay	(38.0)	(38.3)	(0.3)	(196.2)	(198.7)	(2.5)
Drugs (Net Expenditure)	(4.5)	(5.2)	(0.8)	(25.5)	(26.5)	(1.0)
TOTAL EXPENDITURE	(133.2)	(136.0)	(2.8)	(683.2)	(690.0)	(6.9)
Non Opex	(7.6)	(6.8)	0.9	(37.5)	(36.1)	1.3
Control Total Surplus / (Deficit)	(1.3)	(2.4)	(1.1)	(16.0)	(19.2)	(3.2)
Statutory Surplus / (Deficit)	(0.4)	(1.9)	(1.5)	(11.5)	(15.0)	(3.5)
Other Financial Metrics						
	£m	£m	£m	£m	£m	£m
Cash at Bank (before support funding)	66.8	141.8	75.0	66.8	141.8	75.0
Capital Programme Expenditure	23.1	9.4	(13.7)	105.4	35.2	(70.2)
CIP Delivery	9.1	7.2	(1.9)	26.0	26.2	0.2
Aligned Payment Incentive (API) contract performance	72.6	70.6	(2.0)	373.7	369.3	(4.5)

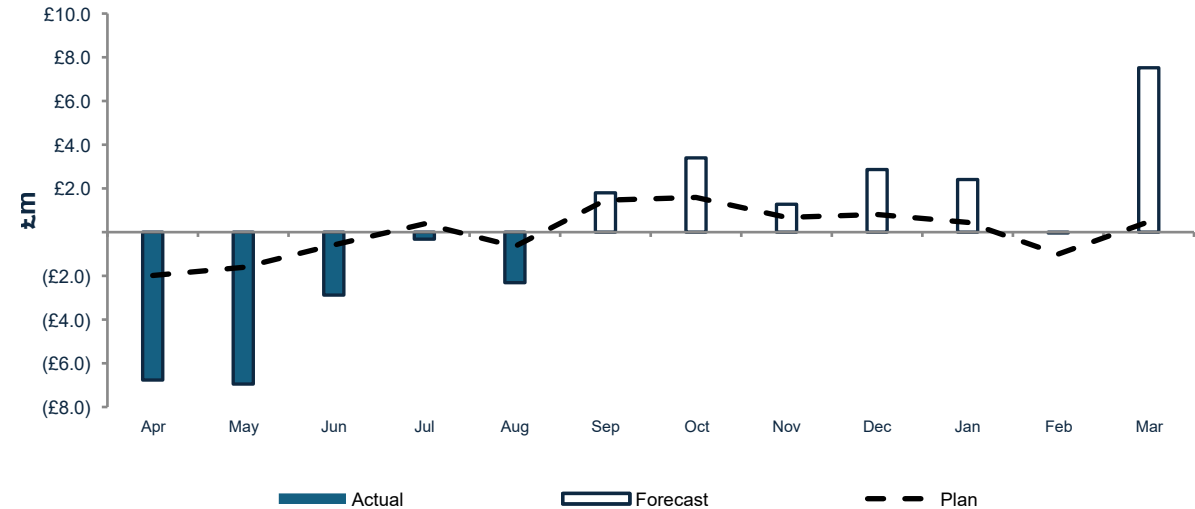
2.1 Financial Performance – Run Rate

August position is a £2.3m deficit on a control total basis, a £1.9m deterioration to the July deficit of £0.4m.

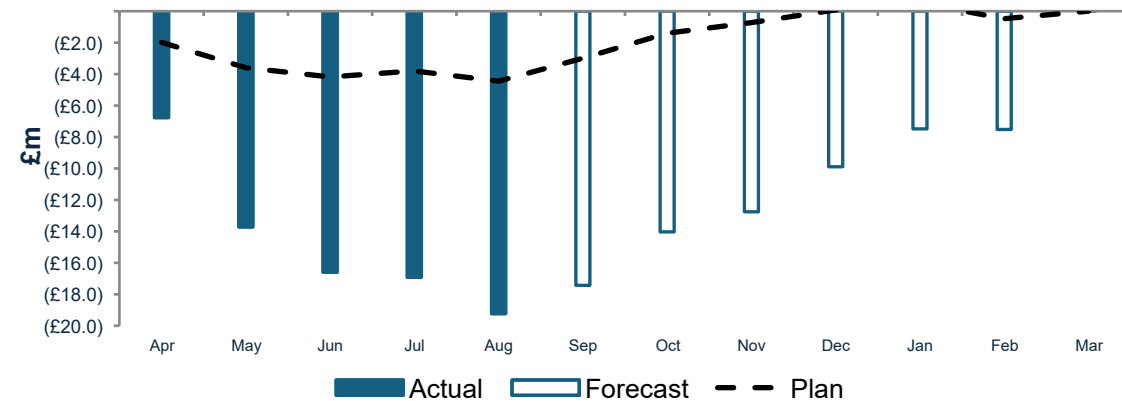
Two of the Trusts have seen run rate deteriorations in the month – JPUH by £0.5m, NNUH by £1.5m, with QEH improving by £0.1m. The deterioration is in the main driven by reduced variable activity, as a result of fewer working days in August.

Forecast Outturn: Forecast outturn for the year remains breakeven, no change from the breakeven submitted plan. This requires an average monthly surplus of £2.8m per month.

Monthly Actual/Forecast Surplus/(Deficit) v Plan



Cumulative Actual/Forecast Surplus/(Deficit) v Plan



Walker Ian
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2.2 Financial Performance - SOCI

Year to date position is a £19.2m deficit on a control total basis, which is £3.2m adverse to the planned £16.0m deficit.

Aug-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	121.0	123.1	2.1	614.7	618.1	3.3	1,477.9	1,482.8	4.9
NT Drugs Income	9.7	8.8	(0.9)	45.8	47.9	2.1	115.7	115.7	0.0
Total Clinical Income	130.7	131.9	1.3	660.6	666.0	5.4	1,593.6	1,598.5	4.9
Other Income Incl. Non NHS Clinical Income	18.6	17.4	(1.2)	89.9	88.9	(1.0)	218.7	217.2	(1.5)
Total Operating Income	149.3	149.3	0.0	750.5	754.9	4.4	1,812.3	1,815.7	3.4
Substantive	(87.0)	(84.5)	2.4	(440.6)	(423.9)	16.8	(1,043.2)	(1,045.7)	(2.5)
Bank	(2.4)	(7.3)	(4.8)	(14.0)	(34.4)	(20.4)	(30.7)	(30.6)	0.1
Agency	(0.7)	(1.0)	(0.3)	(4.0)	(5.4)	(1.4)	(9.1)	(9.1)	(0.0)
Other Employee Expenses	(0.6)	0.4	1.0	(2.9)	(1.2)	1.7	(6.1)	(6.1)	0.0
Total Employee Expenses	(90.7)	(92.4)	(1.7)	(461.5)	(464.8)	(3.3)	(1,089.1)	(1,091.5)	(2.4)
Drugs Costs	(14.2)	(14.1)	0.1	(71.3)	(74.5)	(3.1)	(170.4)	(170.4)	0.0
Clinical Supplies	(14.3)	(15.4)	(1.1)	(71.2)	(76.6)	(5.4)	(167.8)	(173.4)	(5.6)
Non Clinical Supplies	(20.6)	(19.8)	0.8	(109.9)	(107.0)	2.9	(255.1)	(250.5)	4.5
PFI	(3.2)	(3.1)	0.0	(15.1)	(15.1)	0.0	(37.3)	(37.3)	0.0
Total Expenditure Excl. Employee Expenses	(52.2)	(52.4)	(0.2)	(267.5)	(273.2)	(5.6)	(630.6)	(631.6)	(1.0)
Total Operating Expenditure	(142.9)	(144.8)	(1.9)	(729.0)	(738.0)	(9.0)	(1,719.7)	(1,723.1)	(3.4)
Total Operating Surplus/(Deficit)	6.4	4.5	(1.9)	21.4	16.9	(4.5)	92.6	92.6	(0.0)
Total Non Operating Expenditure	(6.5)	(5.6)	0.9	(31.7)	(30.3)	1.5	(78.1)	(78.1)	0.0
Adjust PFI revenue costs to UK GAAP basis	(1.2)	(1.2)	(0.0)	(5.8)	(5.9)	(0.1)	(14.4)	(14.4)	0.0
Control Total Surplus/(Deficit)	(1.3)	(2.3)	(1.0)	(16.0)	(19.2)	(3.2)	0.0	0.0	(0.0)
Control Total Adjustments									
Donated/Pepper from lease Income & Equipment	(0.0)	(0.5)	(0.5)	(0.1)	(0.3)	(0.2)	(1.0)	(1.0)	0.0
Donated/ Pepper from lease Assets Dep'n	(0.2)	(0.3)	(0.0)	(1.1)	(1.4)	(0.3)	0.2	0.2	(0.0)
Adjust PFI revenue costs to UK GAAP basis	1.2	1.2	0.0	5.8	5.9	0.1	14.4	14.4	0.0
Statutory Surplus / (Deficit)	(0.4)	(1.9)	(1.5)	(11.5)	(15.0)	(3.5)	13.7	13.7	0.0
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m
Cash at Bank (before support funding)	66.8	141.8	75.1	66.8	141.8	75.0	79.6	59.6	(20.0)
Capital Programme Expenditure	23.1	9.4	(13.7)	105.4	35.2	(70.2)	248.5	239.3	(9.2)
CIP Delivery	9.1	7.2	(1.9)	26.1	26.3	0.2	93.6	93.6	0.0
Aligned Payment Incentive (API) contract performance	72.6	70.6	(2.0)	373.7	369.3	(4.5)	402.0	402.0	0.0

2.3 Financial Performance – Trust Performance

Year to Date	JPUH			NNUH			QEH		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Total Operating Income	149.6	153.5	4.0	461.0	460.3	(0.7)	139.9	141.0	1.1
Total Employee Expenses	(98.8)	(101.6)	(2.9)	(268.6)	(264.1)	4.6	(94.0)	(99.1)	(5.1)
Total Expenditure Excl. Employee Expenses	(54.0)	(55.2)	(1.2)	(163.3)	(167.5)	(4.2)	(50.2)	(50.5)	(0.3)
Total Operating Expenditure	(152.8)	(156.8)	(4.0)	(432.0)	(431.6)	0.4	(144.2)	(149.6)	(5.4)
Total Operating Surplus/(Deficit)	(3.2)	(3.3)	(0.0)	29.1	28.7	(0.3)	(4.3)	(8.6)	(4.2)
Total Non Operating Expenditure	(0.9)	(0.2)	0.8	(29.3)	(28.9)	0.4	(1.5)	(1.2)	0.3
Adjust PFI revenue costs to UK GAAP basis	0.0	0.0	0.0	(5.8)	(5.9)	(0.1)	0.0	0.0	0.0
Control Total Surplus/(Deficit)	(4.2)	(3.4)	0.7	(6.1)	(6.1)	0.0	(5.8)	(9.7)	(3.9)
Statutory Surplus / (Deficit)	(4.3)	(3.6)	0.7	(1.2)	(1.3)	0.2	(6.0)	(10.0)	(4.0)
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Cash at Bank (before support funding)	6.5	37.5	31.0	56.1	90.9	34.8	4.2	13.5	9.3
Capital Programme Expenditure	25.7	11.3	(14.5)	25.3	7.4	(17.9)	54.3	16.5	(37.8)
CIP Delivery	6.4	7.5	1.2	14.7	15.1	0.4	5.0	3.6	(1.4)
Aligned Payment Incentive (API) contract performance	92.6	92.6	0.0	209.1	206.7	(2.4)	72.0	69.9	(2.1)

The year-to-date position is a deficit of £3.4m, this is £0.7m favourable to the planned deficit of £4.2m. This is mainly driven by a favourable CIP delivery of £0.9m offset by £0.3m of expenditure associated with the Industrial Action in April.

The year-to-date position is a £6.1m deficit on a control total basis, on plan to the planned £6.1m deficit. Under performance of variable activity of £2.4m, and clinical supplies of £2.3m adverse are offset by c.£2.8m relating to the delayed utilisation of service development and investment funding, and Care Group pay is £2.5m 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 impact of Group costs at NNUH is an adverse variance of £0.6m.

The year-to-date position is a deficit of £9.7m, this is £3.9m adverse to a planned deficit of £5.8m. This is mainly due to overspends on the use of temporary staff, under-delivery of efficiencies, under-delivery of activity leading to lower than planned clinical income offset by low value CV's and higher than planned non clinical income.

Walker Ian
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2.4 Financial Performance – Variable Activity

Year to date value based activity is £4.6m adverse to plan, the in month position was £2.0m adverse.

	JPUH			NNUH			QEH			N&W GROUP			
Performance v value based activity plan	YTD Plan £m	YTD Actual £m	Variance to Plan £m	YTD Plan £m	YTD Actual £m	Variance to Plan £m	YTD Plan £m	YTD Actual £m	Variance to Plan £m	YTD Plan £m	YTD Actual £m	Variance to Plan £m	Performance v Plan %
Day Case	15.5	15.2	(0.2)	31.8	31.5	(0.3)	10.7	11.4	0.7	58.0	58.1	0.1	100%
Elective Inpatient	9.6	9.5	(0.1)	24.2	24.4	0.2	5.3	4.3	(1.0)	39.1	38.2	(0.9)	98%
Outpatients - New	7.1	7.9	0.9	14.1	13.5	(0.7)	5.9	6.1	0.2	27.1	27.5	0.4	101%
Outpatients - Procedures	5.2	5.3	0.0	14.5	13.8	(0.7)	4.0	3.8	(0.2)	23.7	22.8	(0.9)	96%
Total Elective Value	37.4	37.9	0.5	84.7	83.1	(1.5)	25.9	25.6	(0.3)	147.9	146.6	(1.3)	99%
Urgent and Emergency Care (UEC)*	48.5	48.6	0.1	111.1	111.1	0.0	42.7	40.9	(1.8)	202.3	200.5	(1.7)	99%
Diagnostic Imaging	2.8	3.1	0.3	4.6	4.5	(0.1)	1.6	1.6	0.0	9.1	9.2	0.1	101%
Chemotherapy Delivery	0.0	0.0	0.0	3.8	3.6	(0.2)	0.9	0.9	0.0	4.7	4.5	(0.2)	96%
Community Diagnostic Centre	3.9	3.1	(0.8)	4.9	4.4	(0.5)	0.9	0.9	0.0	9.8	8.4	(1.3)	86%
Total Other Chargeable API	6.8	6.2	(0.5)	13.4	12.5	(0.9)	3.4	3.4	0.0	23.5	22.1	(1.4)	94%
Total with adjustment	92.6	92.6	0.0	209.1	206.7	(2.4)	72.0	69.9	(2.1)	373.7	369.3	(4.5)	99%
*Variance to plan recognised at 20% of actual value													

	Aug Plan £m	Aug Actual £m	Variance to Plan £m	Aug Plan £m	Aug Actual £m	Variance to Plan £m	Aug Plan £m	Aug Actual £m	Variance to Plan £m	Aug Plan £m	Aug Actual £m	Variance to Plan £m	Performance v Plan %
Day Case	3.1	2.8	(0.3)	6.1	6.0	(0.1)	2.1	2.3	0.2	11.2	11.1	(0.2)	99%
Elective Inpatient	1.9	1.7	(0.2)	5.0	4.9	(0.1)	1.0	1.2	0.2	7.9	7.8	(0.1)	99%
Outpatients - New	1.3	1.5	0.1	2.5	2.6	0.1	1.1	1.1	0.0	5.0	5.2	0.2	104%
Outpatients - Procedures	1.0	0.9	(0.1)	2.7	2.3	(0.4)	0.8	0.8	0.0	4.6	4.0	(0.5)	89%
Total Elective Value	7.3	6.9	(0.5)	16.3	15.8	(0.5)	5.0	5.4	0.4	28.6	28.1	(0.6)	98%
Urgent and Emergency Care (UEC)*	9.4	9.4	(0.0)	21.5	21.6	0.1	8.6	7.2	(1.4)	39.5	38.2	(1.3)	97%
Diagnostic Imaging	0.6	0.6	0.1	0.9	0.9	(0.0)	0.3	0.3	0.0	1.8	1.8	0.0	103%
Chemotherapy Delivery	0.0	0.0	0.0	0.8	0.7	(0.1)	0.1	0.2	0.1	0.9	0.9	0.0	104%
Community Diagnostic Centre	0.8	0.6	(0.2)	1.0	0.9	(0.1)	0.1	0.2	0.1	1.8	1.7	(0.2)	90%
Total Other Chargeable API	1.3	1.2	(0.1)	2.6	2.4	(0.2)	0.5	0.7	0.2	4.5	4.4	(0.1)	98%
Total	18.1	17.5	(0.6)	40.4	39.8	(0.6)	14.1	13.3	(0.8)	72.6	70.6	(2.0)	97%
*Variance to plan recognised at 20% of actual value													

3. CIP

Year-to-date CIP delivery is £26.3m against a budgeted plan of £26.1m, a favourable variance of £0.2m, comprised of a favourable planning variance of £3.0m and an adverse performance variance of £0.9m. As at 4th September 2026, the programme consists of £79.9m of Gateway 2 approved schemes. This is £22.2m adverse to the planned £102.1m full year CIP requirement.

FY26/27 CIP Programme Delivery

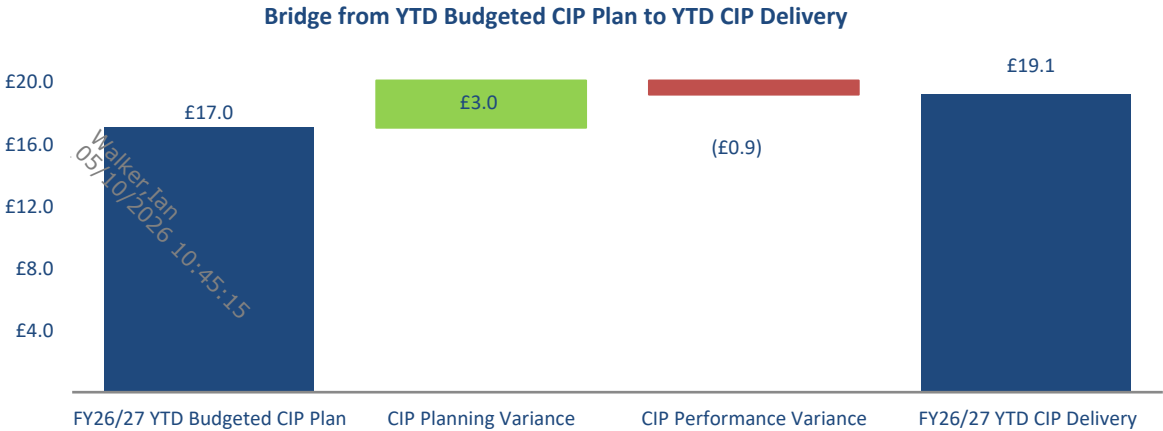
Year to date the Group has delivered £26.3m of CIPs against a budgeted plan of £26.2m, a favourable variance of £0.2m, comprised of (see bridge):

- A favourable planning variance of £3.0m; and
- An adverse performance variance of £0.9m.

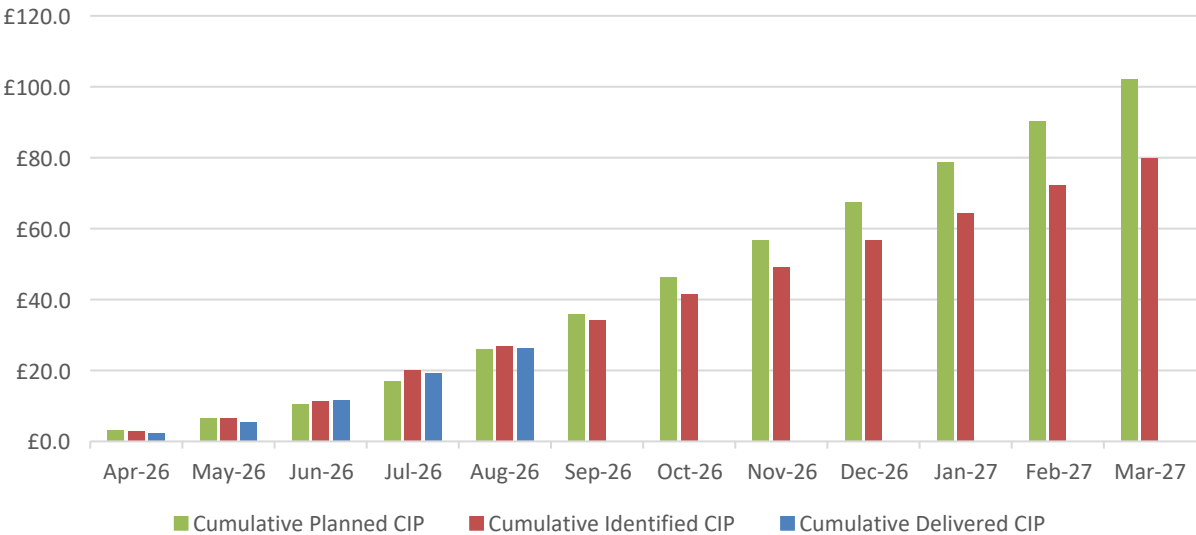
As at 4th September, the programme consists of £79.9m of Gateway 2 approved schemes. This is £22.2m adverse to the planned £102.1m full year CIP requirement. This has arisen as a result of insufficient recurrent schemes being identified and progressed through Gateways for implementation and delivery at NNUH & QEH. JPUH have identified 100% of planned CIP for 2026/27. The Full Year Effect of Gateway 2 schemes is £67.4m, £28.2m adverse to the planned £95.6m.

- Of the £79.9m Gateway 2 approved schemes £31.5m is non-recurrent; JPUH £7.0m, QEH £3.2m, and NNUH £21.3m.
- Of the identified CIP £7.3m is classed as high risk, of which: JPUH £4.5m, QEH £0.5m, and NNUH £2.3m.

	Year to Date			Current Year		Full Year	
	Planned £m	Identified £m	Delivered £m	Planned £m	Identified £m	Planned £m	Identified £m
JPUH	6.5	6.5	7.5	22.5	22.5	22.5	22.5
NNUH	14.7	15.2	15.1	52.2	44.1	40.8	30.3
QEH	5.0	5.1	3.6	27.4	13.3	32.3	14.5
Total	26.2	26.8	26.3	102.1	79.9	95.6	67.4

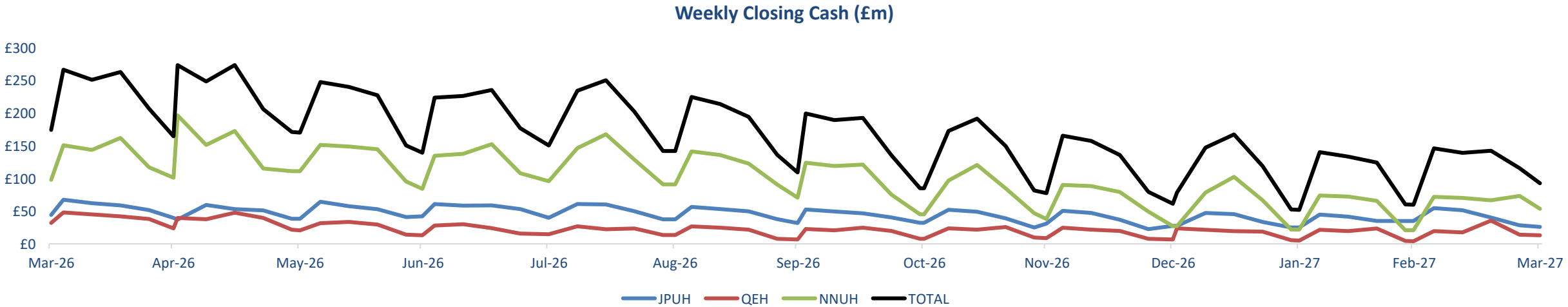


FY 26/27 Planned Delivery Profile



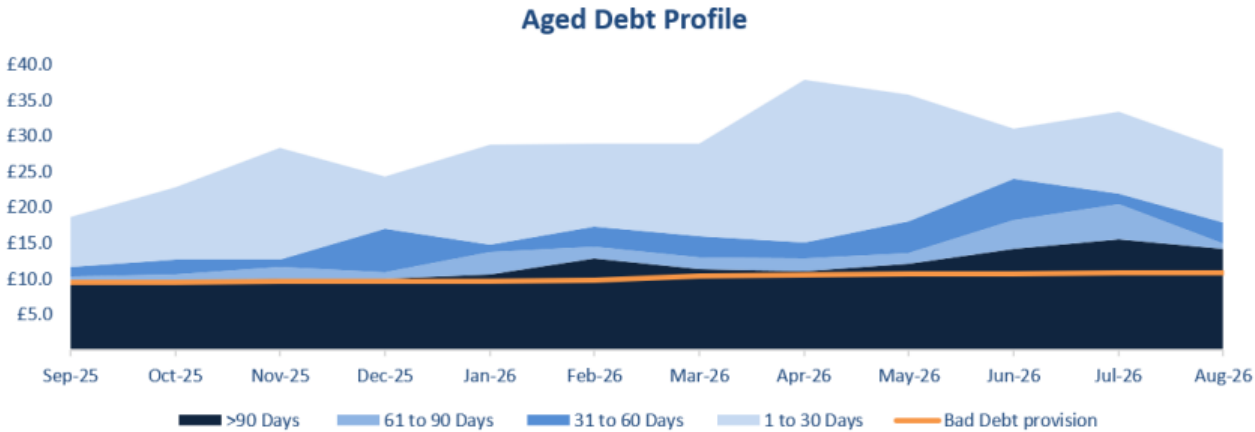
4. Cash

Cash held on 31st August was £141.8m, £75.0m favourable to the planned £66.8m. Cash balances have decreased since the start of the year by £32.2m mainly driven by timings of income received at NNUH, and timings in cashflow seen at QEH relating to capital.



Aged Debtors: Debtors on 31st August were £26.4m, £3.3m lower than July 2026 driven by timing of invoice payments at NNUH. £11.8m is over 90 days. Of the Non-NHS debt greater than 90 days £1.2m relates to an ongoing legal dispute. The Trusts continue to focus on resolving these debts and a suitable bad debt provision is being held.

Debtors by Type	Total Debt			Debt > 90 days		
	Jun-26 £m	Jul-26 £m	Aug-26 £m	Jun-26 £m	Jul-26 £m	Aug-26 £m
NHS	26.0	20.6	18.6	9.7	10.4	7.6
Non NHS	7.7	9.0	7.8	5.1	5.2	4.2
Total	33.7	29.7	26.4	14.9	15.6	11.8
NNUH/QEH	9.4	8.1	8.1	5.5	5.9	5.0
Total Excl. NNUH/QEH	24.3	21.6	18.3	9.4	9.7	6.8



5. Statement of Financial Position

The Statement of Financial Position at the end of August has increased by £2.7m compared to the opening balance.

	JPUH			NNUH			QEHL			N&W GROUP		
	Mar-26 £m	Jul-26 £m	YTD Movement £m	Mar-26 £m	Jul-26 £m	YTD Movement £m	Mar-26 £m	Jul-26 £m	YTD Movement £m	Mar-26 £m	Jul-26 £m	YTD Movement £m
Property, plant and equipment	169.5	175.4	5.9	444.7	441.4	(3.3)	176.8	186.2	9.4	791.0	803.0	12.0
Right of use assets - leased assets	2.1	1.8	(0.3)	44.5	40.7	(3.8)	4.1	3.9	(0.2)	50.7	46.4	(4.3)
Receivables: due from DHSC group bodies	0.0	0.0	0.0	3.1	2.8	(0.3)	0.5	0.5	0.0	3.6	3.3	(0.3)
Receivables: due from non-DHSC bodies	0.5	0.5	0.0	53.0	55.5	2.5	0.0	0.0	0.0	53.5	56.0	2.5
Total non-current assets	172.1	177.7	5.6	545.3	540.4	(4.9)	181.4	190.6	9.2	898.8	908.7	9.9
Inventories	3.6	2.9	(0.7)	20.2	21.8	1.6	3.3	3.1	(0.2)	27.1	27.8	0.7
Receivables: due from DHSC group bodies	8.6	9.4	0.8	28.3	22.9	(5.4)	2.8	4.6	1.8	39.7	36.9	(2.8)
Receivables: due from non-DHSC group bodies	7.8	7.2	(0.6)	32.5	31.8	(0.7)	6.1	4.5	(1.6)	46.4	43.5	(2.9)
Assets held for sale	0.7	0.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.7	0.0
Cash and cash equivalents	44.3	37.1	(7.3)	96.4	88.1	(8.3)	32.0	13.5	(18.5)	172.7	138.7	(34.1)
Total current assets	64.9	57.2	(7.7)	177.4	164.6	(12.8)	44.2	25.7	(18.5)	286.5	247.5	(39.0)
Trade and other payables: capital	(15.2)	(5.2)	10.0	(23.0)	(14.6)	8.4	(7.6)	(3.6)	4.0	(45.8)	(23.4)	22.4
Trade and other payables: non-capital	(33.3)	(32.7)	0.6	(125.2)	(119.7)	5.5	(49.1)	(45.3)	3.8	(207.6)	(197.7)	9.9
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)	(0.5)	0.2	(8.4)	(7.9)	0.5	(0.2)	(0.4)	(0.2)	(9.4)	(8.8)	0.5
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)	(10.9)	(2.4)	(28.3)	(32.1)	(3.8)	(1.5)	(3.9)	(2.4)	(38.2)	(46.9)	(8.6)
Total current liabilities	(58.0)	(49.6)	8.4	(209.3)	(198.7)	10.6	(58.6)	(53.4)	5.2	(325.9)	(301.7)	24.2
Total assets less current liabilities	179.0	185.3	6.2	513.4	506.3	(7.1)	167.0	162.9	(4.1)	859.4	854.5	(5.0)
Borrowings - PFI	0.0	0.0	0.0	(346.6)	(342.3)	4.3	0.0	0.0	0.0	(346.6)	(342.3)	4.3
Borrowings: leases non-current	(1.0)	(0.7)	0.3	(28.1)	(25.4)	2.7	(3.9)	(3.8)	0.1	(33.0)	(29.9)	3.1
Provisions	(0.7)	(0.6)	0.0	(3.4)	(3.3)	0.1	(1.4)	(1.3)	0.1	(5.5)	(5.2)	0.2
Deferred Income	0.0	0.0	0.0	(1.0)	(1.0)	0.0	0.0	0.0	0.0	(1.0)	(1.0)	0.0
Total non-current liabilities	(1.7)	(1.3)	0.4	(379.1)	(372.0)	7.1	(5.3)	(5.1)	0.2	(386.1)	(378.4)	7.7
Total assets employed	177.4	183.9	6.5	134.3	134.3	(0.0)	161.7	157.8	(3.9)	473.4	476.0	2.6
Financed by												
Public dividend capital	256.0	266.3	10.2	412.1	412.1	0.0	440.8	446.9	6.1	1,108.9	1,125.3	16.3
Retained Earnings (Accumulated Losses)	(80.9)	(84.5)	(3.6)	(312.6)	(311.3)	1.3	(284.5)	(294.5)	(10.0)	(678.0)	(690.3)	(12.3)
Revaluation reserve	2.2	2.2	(0.0)	34.8	33.5	(1.3)	5.4	5.4	0.0	42.4	41.1	(1.3)
Total Taxpayers' and others' equity	177.4	183.9	6.6	134.3	134.3	0.0	161.7	157.8	(3.9)	473.4	476.0	2.7

6. Capital

Month 5 forecast outturn for total CDEL is a £17.4m favourable compared to the plan. The key drivers of the variance being EPR (adverse by £14.4m), JPUH CDEL uplift (adverse by £2.0m), JPUH estates safety funds (£2.0m adverse) offset set by £39.0m favourable variance on NHP in QEH & JPUH. These variances need to be agreed with NHSE as assumptions have changed since plan submission. Once agreed these need to be reflected in the revised plan.

System CDEL (excluding donations) forecasted to be £1.76m adverse compared to the plan. This is mainly driven by JPUH being awarded a £2.0m CDEL uplift in recognition of UEC performance.

Nationally funded programmes £19.2m forecast underspend: On EPR programme JPUH, NNUH and QEH are forecasting to spend £4.4m, £7.6m and £2.4m 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 £39.0m forecasted underspent on NHP - £22.0m relates to JPUH driven by delays in recommending OBC and UKPN due to an updated programme from the supplier following detailed designs, £17.0m relates to QEH driven by delays in OBC. 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 05 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	15.6	(0.0)	0.0	0.0	(0.0)
	Other Adjustments:grants/donations/peppercorn leases	0.2	5.6	0.5	6.2	0.2	6.0	0.5	6.7	0.0	(0.4)	0.0	(0.4)
	Disposals	0.7	0.0	0.0	0.7	0.0	(0.1)	0.0	(0.1)	0.7	0.1	0.0	0.7
Total System CDEL		11.7	32.5	13.3	57.5	13.0	32.9	13.3	59.3	(1.3)	(0.4)	0.0	(1.8)
Nationally Funded Schemes	Front Line Digitisation	0.0	2.5	2.1	4.6	4.4	10.0	4.5	18.9	(4.4)	(7.5)	(2.4)	(14.4)
	NHP	37.1	0.0	62.3	99.4	15.0	0.0	45.2	60.2	22.1	0.0	17.1	39.3
	RAAC Plank	17.5	0.0	25.1	42.5	17.5	0.0	25.1	42.5	0.0	0.0	0.0	0.0
	UEC	10.0	7.4	3.9	21.3	10.0	7.9	3.9	21.8	0.0	(0.5)	0.0	(0.5)
	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	9.2	0.1	9.3	0.0	(2.6)	0.0	(2.6)
	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	0.5	0.0	0.5	0.0	(0.5)	0.0	(0.5)
Total Nationally Funded		64.6	45.1	96.1	205.8	49.0	56.2	81.4	186.6	15.6	(11.1)	14.8	19.2
Total CDEL		76.3	77.6	109.4	263.3	62.1	89.2	94.6	245.9	14.2	(11.6)	14.8	17.4

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.

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	4	13
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	4	12
4	Risks of failing to deliver a CDEL compliant capital programme	5	3	3	11

Commentary:

The key financial risks are delivery of CIP and control of variable pay. The risks of delivering the plan, and bank and agency controls have increased their overall scores in month reflecting the current performance at QEH and the respective controls.

- 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. This is particularly an issue at QEH
- 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: EPR Programme review in progress with potentially significant implications for FLD and self-funded capital programmes in 2026/27 and 2027/28. As it stands the EPR programme is forecasted to be £14.4m 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. An updated business case is being completed and will be submitted to NHSE for review.

Actions:

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

Report to the Group Board in public: 7 October 2026

Agenda item number	8		
Title	Executive Managing Director's Report: Queen Elizabeth Hospital King's Lynn NHS Foundation Trust		
Author(s)	Jo Segasby, Chief Delivery Officer and Deputy Chief Executive		
Executive sponsor	Jo Segasby, Chief Delivery Officer and Deputy Chief Executive		
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 highlights, priorities and actions which are in train within the Queen Elizabeth Hospital (QEH).

The Care Quality Commission's (CQC) Well-Led inspection took place during September 2026 with inspectors and subject matter experts on site for three days visiting clinical and corporate teams.

Programme governance for the QEH Priorities has been established, with early reporting arrangements in place that will mature over the coming months. Key areas of concern are financial recovery, workforce productivity, urgent and emergency care access standards, and medical education. These areas are receiving increased focus, supported by the Group and external partners where required.

Key performance metrics are reflected at Appendix 1, with National Oversight Framework (NOF) 2026/27 Q1 ratings summarised at Appendix 2.

Recommendations

The Group Board is asked to note the report and progress with developing an overarching QEH recovery plan through the priorities and related projects.

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

Walker Ian
05/10/2026 10:45:15

Norfolk and Waveney University Hospitals Group

Board of Directors in public: 7 October 2026

Executive Managing Director's Report: Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Celebrating QEH

We welcomed colleagues, governors, members of the public, partners and stakeholders to the QEH Annual Members' Meeting in September. This provided an opportunity to reflect on our progress over the past year and look ahead to the future. The meeting highlighted the improvements being made across our organisation, recognised the dedication of colleagues across Team QEH and explored how we will continue improving care for patients and communities across West Norfolk. Teams from Research and Maternity showcased their work and attendees heard from hospital and Group leaders about our achievements, the challenges we continue to face and our ambitions for the years ahead.

The QEH was pleased to welcome the Care Quality Commission (CQC) on site from 22 to 24 September as part of their Well-Led inspection, meeting with staff, visiting clinical and corporate teams, and gaining a first-hand understanding of the experience of working at QEH and being part of the Norfolk and Waveney University Hospitals Group. The Trust remains transparent about the challenges it faces and recognises that there are areas where further improvement is required; however, this is balanced by the significant commitment, dedication and improvement activity being delivered every day, which continues to support the delivery of safe, high-quality care for patients.

The launch of the first cohort of 11 onsite Anglia Ruskin University (ARU) BSc Nursing students at QEH marks an important step in developing a sustainable local nursing workforce. The programme provides a local route into nursing education, supports future recruitment and retention, and builds on the successful partnership with ARU, with potential to expand to 30 students per cohort and further strengthen workforce sustainability across the Trust and wider health and care system.

A huge congratulations to our September 2024 Trainee Nursing Associate (TNA) Cohort, who officially completed their programme in August. The cohort marked their final day of learning with a visit from lecturers from Anglia Ruskin University (ARU), who came onsite to congratulate the group on successfully completing their training and celebrate everything they have achieved over the past two years. The TNA programme combines academic learning with hands-on clinical experience, supporting colleagues to develop the knowledge and skills needed to become registered Nursing Associates.

Our research, elderly medicine, trauma and orthopaedic teams are celebrating after QEH became the top recruiting hospital in the country for a major hip fracture treatment study. The team was the first hospital to recruit 200 participants to the POP-I (Perioperative Iron and EPO Intervention) clinical trial and is on track to recruit 10% of the trial's overall 2,400-participant target. Even more impressively, QEH joined the study later than many other centres but has consistently recruited more participants than the 40 other hospitals taking part. The POP-I trial, coordinated by the University of Nottingham and funded by the National Institute for Health and Care Research (NIHR), is investigating whether intravenous iron infusion or an erythropoiesis stimulating agent (ESA) injection can improve outcomes for older people with hip fractures and anaemia, compared with normal care.

Waikiki
05/10/2026 10:45:15

QEH Priorities

The QEH Priorities provide the framework through which the Trust is delivering improvement in quality, safety, operational performance, financial sustainability and staff experience, aligned to the wider Group One Strategy and One Recovery ambitions.

The priorities are:

- **Right care at the right time:** helping patients get to the right service first time and reducing delays.
- **Providing safe and effective care:** delivering safe, compassionate and effective care every time.
- **Managing our workforce, resources and money well:** supporting colleagues to be their best, avoiding waste and duplication, and making the most of our money.
- **Supporting our staff through effective leadership:** creating an environment where colleagues feel valued, supported and empowered.

Phase 1 comprises 47 projects with identified executive and operational leadership, clear objectives and defined outcome measures.

Early implementation has established governance arrangements, accountability and programme oversight across all priority areas. Whilst many projects are progressing as planned, a number are experiencing challenges which require focused management attention, particularly within financial recovery, workforce productivity and medical education. Recovery actions are in place for all projects rated red or amber.

Overall, the programme is currently rated Red, reflecting the Trust's assessment of the scale of improvement required and the need to accelerate delivery in several areas.

Red rated projects

Overall, four projects are currently rated red and one is rated amber/red. The red ratings relate to financial recovery, workforce deployment (x 2) and medical education. The amber/red rating relates to CIP delivery. Detailed recovery plans are established for each area, with executive oversight and defined milestones in place.

Key risks remain associated with delivery of the financial plan, including the remaining Cost Improvement Programme gap and continued reliance on temporary staffing expenditure. Workforce-related improvement programmes are also being progressed to strengthen rostering, safer staffing arrangements and agency reduction. In addition, an Educational Improvement Plan has been developed in response to medical training concerns and will continue to be a key area of organisational focus.

Despite these challenges, the majority of projects are progressing in line with planned trajectories, with thirty projects rated green and further amber-rated projects expected to improve as recovery actions become embedded over the coming months.

Right Care at the Right Time

This priority is currently rated Red. While no individual projects are rated red, seven of the twelve projects are rated amber, reflecting the scale of the operational challenges facing the Trust and the pace of improvement required to achieve sustainable performance.

There has been noticeable improvement in elective and cancer access standards but the Trust continues to experience significant pressure across urgent and emergency care pathways. Delays in patient flow, extended Emergency Department waiting times and ambulance handover delays remain key areas of concern. Whilst improvement actions have been agreed

and are being implemented as part of wider urgent and emergency care and winter planning arrangements, the benefits of these interventions have yet to be fully realised.

Progress is being made to improve, discharge processes and the development of services closer to home. However, delivery timelines for some programmes have been impacted by workforce capacity, interdependencies with partner organisations and digital system requirements.

The Trust remains committed to improving patient flow and ensuring that patients receive care in the most appropriate setting, at the right time and with the right support. This will continue to require close collaboration with health and care partners across the system, alongside sustained organisational focus on operational improvement and discharge performance.

Providing Safe and Effective Care

This priority is currently rated Green, with all nine projects reporting delivery broadly in line with plan. The programme continues to support the Trust's commitment to delivering safe, effective and compassionate care for patients.

Progress has been made across a number of quality, safety and governance initiatives, including delivery of improvement plans relating to clinical governance, risk management, patient safety and regulatory compliance. These programmes are helping to strengthen quality oversight and support continuous improvement across services.

Whilst performance within this priority is positive overall, work continues to ensure that improvements are embedded and sustainable, with deployment of a ward accreditation programme a key enabler.

The Information Commissioner's Office action plan remains subject to ongoing work, primarily due to external dependencies relating to procurement of a digital solution, although progress has been made and performance in responding to Freedom of Information requests has improved significantly.

Managing Our Workforce, Resources and Money Well

This priority is currently rated Amber. Progress is being made across the majority of projects; however, significant challenges remain in relation to financial recovery and delivery of the Trust's financial plan.

The Trust continues to face a challenging financial position, driven by a combination of cost improvement programme under-delivery and continued expenditure on temporary staffing. Whilst a range of recovery actions are being developed and implemented, delivery of the full financial plan remains a significant risk and further efficiency opportunities are required.

Workforce productivity, theatre utilisation and outpatient transformation programmes continue to progress, although some projects are experiencing delays linked to digital dependencies, capacity constraints and the complexity of delivering change alongside day-to-day operational pressures.

Progress has been made in strengthening financial governance, workforce planning and productivity improvement arrangements. However, the Trust recognises that restoring financial sustainability will require sustained focus and continued delivery over the remainder of the year and beyond.

Supporting Our Staff Through Effective Leadership

This priority is currently rated Red, reflecting challenges across workforce deployment, temporary staffing and medical education. Three projects are rated red and three amber.

The Trust continues to recognise that colleague experience, leadership capability and workforce sustainability are fundamental to achieving improvements in quality, operational performance and financial recovery. Whilst progress has been made in some areas, significant challenges remain.

Particular concerns relate to reliance on temporary staffing, the maturity of rostering and safer staffing arrangements and the delivery of actions within the Educational Improvement Plan ahead of external review. Whilst improvement plans are in place and executive oversight has been strengthened, these programmes require accelerated delivery to achieve the intended benefits.

Performance in several workforce measures is improving, including appraisal compliance, although progress remains behind trajectory and further improvement is required. The Trust continues to invest in leadership development, workforce planning and staff engagement initiatives to support a positive organisational culture and improve staff experience.

The Trust recognises that delivering sustainable cultural and workforce improvement will take time and will require consistent leadership, engagement with colleagues and continued organisational focus.

General Surgery RCS

The three-month review of Phase One of the single General Surgery service across NNUH and QEH shows good progress in stabilising the service, with strengthened clinical leadership, governance arrangements and cross-site working, alongside significant improvements in medical workforce resilience through the successful recruitment of seven consultants. Collaborative working between clinical, nursing and operational teams has improved, and no new quality concerns have been identified, although patient and staff feedback highlights ongoing challenges relating to patient transfers, communication and travel between sites. A Phase Two workplan through Q3 2026/27 is under development. This will further embed service stability, workforce integration, financial sustainability, performance improvement and pathway standardisation.

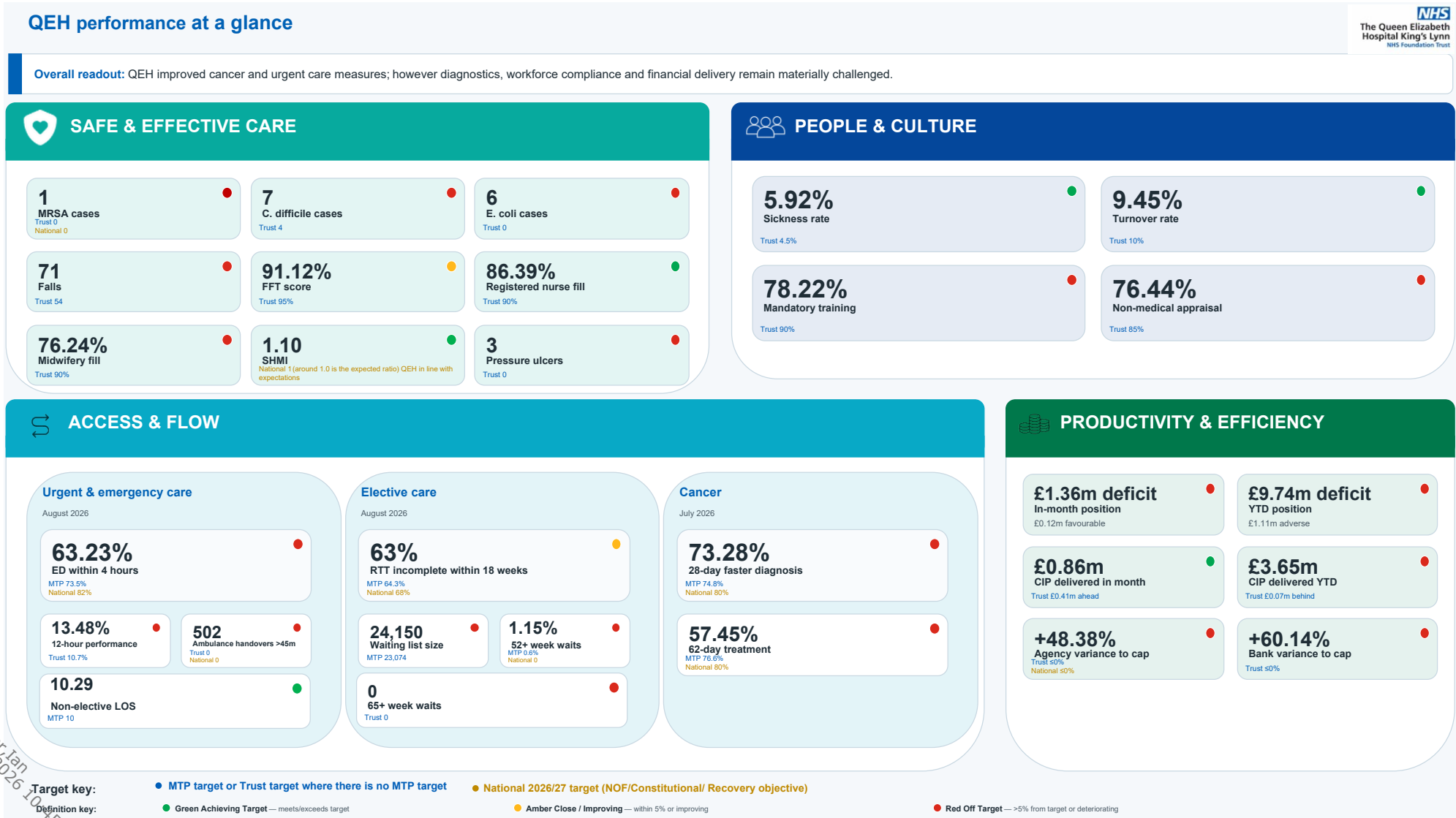
Recommendation

The Group Board is asked to note the report and progress with developing an overarching QEH recovery plan through the priorities and related projects.

Jo Segasby
Chief Delivery Officer and Deputy Chief Executive

Walker Ian
05/10/2026 10:45:15

Appendix 1: Summary performance



Appendix 2: NOF summary 2026/27 Q1

NOF summary - QEH



Domain	Q1 domain score	Q1 segment	Q4 domain score	Q4 segment	Score change	Segment change
Access to services	3.60	4	3.52	4	+0.08	0
Effectiveness of care and population health	1.72	1	n/a	n/a	n/a	n/a
Experience of care	3.49	4	2.61	4	+0.88	0
Finance, productivity and innovation	3.19	4	2.89	4	+0.30	0
Patient safety	2.33	3	2.94	3	-0.61	0
People	3.09	4	3.19	4	-0.10	0

- Effectiveness of care and population health is the bright spot at 1.72 and Segment 1, on a perfect 30-day readmission score, a strong delayed inductions rate and SHMI returning to within the expected range.
- No domain changed segment this quarter. Patient safety improved most (-0.61) and sits 0.06 off Segment 2. Experience of care (+0.88) and Finance, productivity and innovation (+0.30) both fell.
- The finance drop is recoverable. Negative year-to-date variance to plan took combined finance from 2.00 to 4.00. Holding positive variance would have given 2.69 and Segment 3. Clinical trial set-up at 66.7% is the other lever, moving to 3.00 at 80%.
- Access to services barely moved (+0.08). The 52-week RTT methodology change was largely offset by strong 18-week RTT and 12-hour UEC improvement, and validated July cancer positions point to a further gain of around 0.50 on faster diagnosis. People is 0.32 off Segment 3 and capped by annual survey metrics.

Walker Jan
05/10/2026 10:45:15

Report to the Group Board in public: 7 October 2026

Agenda item number	9		
Title	Executive Managing Director’s report: Norfolk and Norwich University Hospitals NHS Foundation Trust		
Author(s)	Shane Gordon, Executive Managing Director		
Executive sponsor	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 performance, our National Oversight Framework standing and research.

Recommendations

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

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

Walker Ian
 05/10/2026 10:45:15

Norfolk and Waveney University Hospitals Group

Group Board in public: 7 October 2026

Executive Managing Director's Report: Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)

1. Changes within Hospital Leadership Team

- 1.1 Ed Smith has joined the Hospital Leadership Team as substantive Director of Finance and Deputy Group Chief Finance Officer. We welcome him to the team and thank Clare Hinton for her contribution in the interim as she returns to her substantive role as Deputy Director of Finance.

2. Performance - see *Summary performance, Appendix 1*

Activity

- 2.1 Urgent and emergency care (UEC) performance remained broadly stable in August, despite sustained high demand and increased acuity, with admissions reaching their highest level so far this calendar year. Four-hour performance was 82.1%, on plan and 0.1 percentage points above the national target. Encouragingly, 12-hour performance improved to 3.1%, the best position since August 2024, while the number of patients spending more than 12 hours from arrival to departure reduced to its lowest level since April. Ambulance handover performance also improved, with average handover time reducing to 35 minutes and the proportion of handovers exceeding 45 minutes falling to 22.5%; both were the best positions since April 2026. September performance is forecast to come under further pressure across all UEC metrics as demand and capacity pressures continue; this remains a key area of focus, with recovery actions in place to support flow and mitigate the impact of these pressures.
- 2.2 Elective care continued to make strong progress in August, with 18-week performance increasing to 63.4%, above the recovery plan and the highest position year to date. Time to first appointment performance remained above plan for the eighth consecutive month at 71.1%. The overall waiting list reduced to 65,987, its lowest level since April 2021, although remaining 5.1% above plan. Both 18-week performance and the overall waiting list are expected to return to plan in September. The 52-week position also improved to 2.6% in August and, while 0.7 percentage points behind plan, further improvement is forecast in September, providing continued assurance on the elective recovery trajectory.
- 2.3 Validated cancer performance for July exceeded plan against both the 28-day Faster Diagnosis Standard, at 80.4%, and the 31-day standard, at 92.2%. While 62-day performance remained 3.8 percentage points below plan, July represented the highest performance since August 2019, providing positive assurance on the direction of travel. Forecast performance indicates that the 31-day standard will remain above plan in August, while 62-day performance is expected to improve in August, although remains below plan. Faster Diagnosis performance is forecast to fall below plan in August and September, with improvement expected from October.

Walker Ian
05/10/2026 14:45

- 2.4 Overall, performance in August continued to show positive progress across several key measures, despite ongoing operational pressures. UEC performance remained below plan, but improvements were achieved across most measures compared with July, including the strongest 12-hour and ambulance handover positions for several months. Elective care continued to improve, with the lowest waiting list for over five years and further improvements forecast in September. Cancer performance remained strong against the 31-day and Faster Diagnosis Standards, while 62-day performance continued to improve, albeit remaining below plan. September is expected to bring further pressure in UEC and some variation in cancer performance, but established recovery actions remain in place, with continued focus on patient flow, reducing waiting times and sustaining improvements.

Finance

- 2.5 Financial performance in August remained broadly in line with plan, with a £0.8 million deficit reported for the month, £0.1 million adverse to plan, and a year-to-date deficit of £6.1 million, in line with plan. However, the risk-assessed forecast outturn indicates a £12.1 million deficit against the breakeven plan, and the Financial Delivery Reset has identified £14.1 million of run-rate improvements required to support delivery of breakeven.
- 2.6 Cost Improvement Programme delivery stood at £15.1 million against a plan of £14.7 million, although the risk-adjusted full-year forecast of £43.9 million represents an £8.3 million shortfall. Pay expenditure was £1.1 million favourable in August and £4.6 million favourable year to date, while non-pay expenditure of £31.0 million was £0.5 million adverse to the monthly plan and £3.8 million adverse year to date. Cash holdings remained strong at £90.9 million at 31 August, £34.8 million above plan. Capital expenditure was £7.4 million, £17.9 million below plan, primarily reflecting programme timing and delays associated with Norfolk and Norwich Orthopaedic Centre Two (NaNOC2); the forecast also includes £7.5 million of Electronic Patient Record (EPR) costs for which funding has not yet been confirmed.

Safe and Effective Care

- 2.7 The Summary Hospital-level Mortality Indicator (SHMI) remained above the expected range at 1.1855, rounded to 1.19 in the IPR below, for the reporting period April 2025 to March 2026. A clinical validation and improvement programme is under way, including reviews of coding, clinical documentation and mortality processes.
- 2.8 The overall Friends and Family Test score for August was 89.01%, below the 95% target. Improvement work includes strengthening response capture and targeted action in lower-scoring services.
- 2.9 There were 182 falls that resulted in harm in August. Five of these resulted in moderate harm or greater. This is the average number of moderate harm or above falls for a single month at the NNUH.

Wendy Ian
09/10/2026 10:45:15

- 2.10 Staffing fill rates remained below the 90% standard and reflected continuing workforce pressures across nursing and maternity services. Daily staffing oversight, recruitment, retention and enhanced-care reviews remain in place.
- 2.11 Midwifery fill rate has improved from 84.10% to 87.03%, moving closer to but remaining below the 90% standard. Recruitment is ongoing to bolster the midwifery workforce and interim safety mitigations remain in place. One to one care in labour for August is reported at 99.7%. The team can escalate when required, and any gaps can be highlighted and mitigated at the safer staffing meeting which take place twice daily.
- 2.12 237 complaints were recorded in August, compared with 107 in the previous month. This is an anticipated increase following the review and work to clear the backlog of PALs enquiries. The trajectory to clear the PALS backlog is improving with regular senior oversight in place.

Workforce

- 2.13 Workforce performance remained broadly stable, with mandatory training compliance continuing above the Trust's 90% target, although a small number of individual subjects require focused action. Non-medical appraisal compliance was approximately 84.7%, marginally below the 85% target, with Care Groups completing the appraisal refresh with weekly oversight.
- 2.14 The sickness absence rate was 4.3%, above the 4.2% target, with musculoskeletal conditions and anxiety, stress and depression remaining the principal causes. Monthly turnover was approximately 0.5%, while the 12-month average of 6.46% remained below the 10% threshold. Against an establishment of 9,673 whole-time equivalent staff, the Trust had 8,615 substantive and 737 temporary whole-time equivalent staff, resulting in a net vacancy of 321 whole-time equivalents.

3. National Oversight Framework (NOF) – see *Appendix 2*

- 3.1 NNUH's NOF ranking moved from 76th in Q4 2025/26 to 85th of 134 acute providers in Q1 2026/27, with its average metric score increasing from 2.37 to 2.55, while remaining in Segment 3. The published domain scores indicate that access to services was the principal area of adverse movement, alongside weaknesses in staff experience (which are only measured annually in the NHS Staff Survey) and selected patient safety indicators. These pressures were partly offset by comparatively strong emergency care performance and improved aggregate scores for people and patient safety. However, changes to the metrics and segmentation methodology for 2026/27 mean that the results are not directly comparable.; the ranking movement should therefore be interpreted cautiously and does not, in isolation, demonstrate an equivalent deterioration in overall Trust performance.

Vanderbilt

- 4.1 The Vanderbilt Professionalism and Accountability Programme launched across the Norfolk and Waveney University Hospitals Group at the beginning of October, providing a consistent approach for raising, reviewing and responding to concerns about professional behaviours. The launch follows two days of Peer Messenger

training in September, attended by 100 colleagues from NNUH. A dedicated InPhase reporting process has been developed by the team at NNUH to support confidential submission, triage, allocation and escalation where required. This is an exciting initiative which is part of the wider NWUHG One Recovery and 18,000 voices programme and we look forward to rolling out further Peer Messenger training in the coming months.

5. Governance

Annual Members' Meeting

- 5.1 The Trust's Annual Members Meeting took place on 15 September and included a look back at the Trust's performance over the past year and a presentation of the hospital's accounts.
- 5.2 Attendees heard from the Spinal Assessment Service team, who shared the incredible work they have done to reduce spinal waiting lists and waiting times, helping patients receive faster, more appropriate care. The video recording is now live for all to watch on our website.
- 5.3 I was pleased to be able to provide an update (albeit in pre-recorded form) on the exciting opportunity we have at the NNUH to become a centre of excellence for robotic surgery.

Governors

- 5.4 The 2026 Governor elections have concluded, and the successful candidates completed their NWUHG and local inductions on 29 September. We warmly welcome our new Governors and thank those who continue in their roles for their ongoing support and commitment.

6. Robotics

- 6.1 During the second week of August, three patients underwent major robotic colorectal cancer surgery on a single surgical list. This was the first time three major robotic colorectal cancer resections had been performed by the same team in one day at NNUH. The Trust was also the first hospital in East Anglia, and one of only a small number of hospitals across the UK, to achieve this milestone.
- 6.2 The Broads Institute of Robotic Surgery officially opened on 12 September, marking a significant milestone in the Trust's ten year robotic surgery programme. Supported by the Norfolk & Norwich Hospitals Charity, a £2.8 million investment in two additional da Vinci surgical systems has doubled the Trust's complement to four robots, expanding access to minimally invasive surgery and supporting reduced pain and faster recovery for patients.
- 6.3 The Institute brings together clinical innovation and surgical education, with a multi-specialty training programme being developed in partnership with the University of East Anglia. The opening also celebrated community involvement through a schools' competition to name the new robots (Renew and Curiosity), demonstrating the contribution of charitable support and local partnerships to improving patient care.

7. Staff Engagement

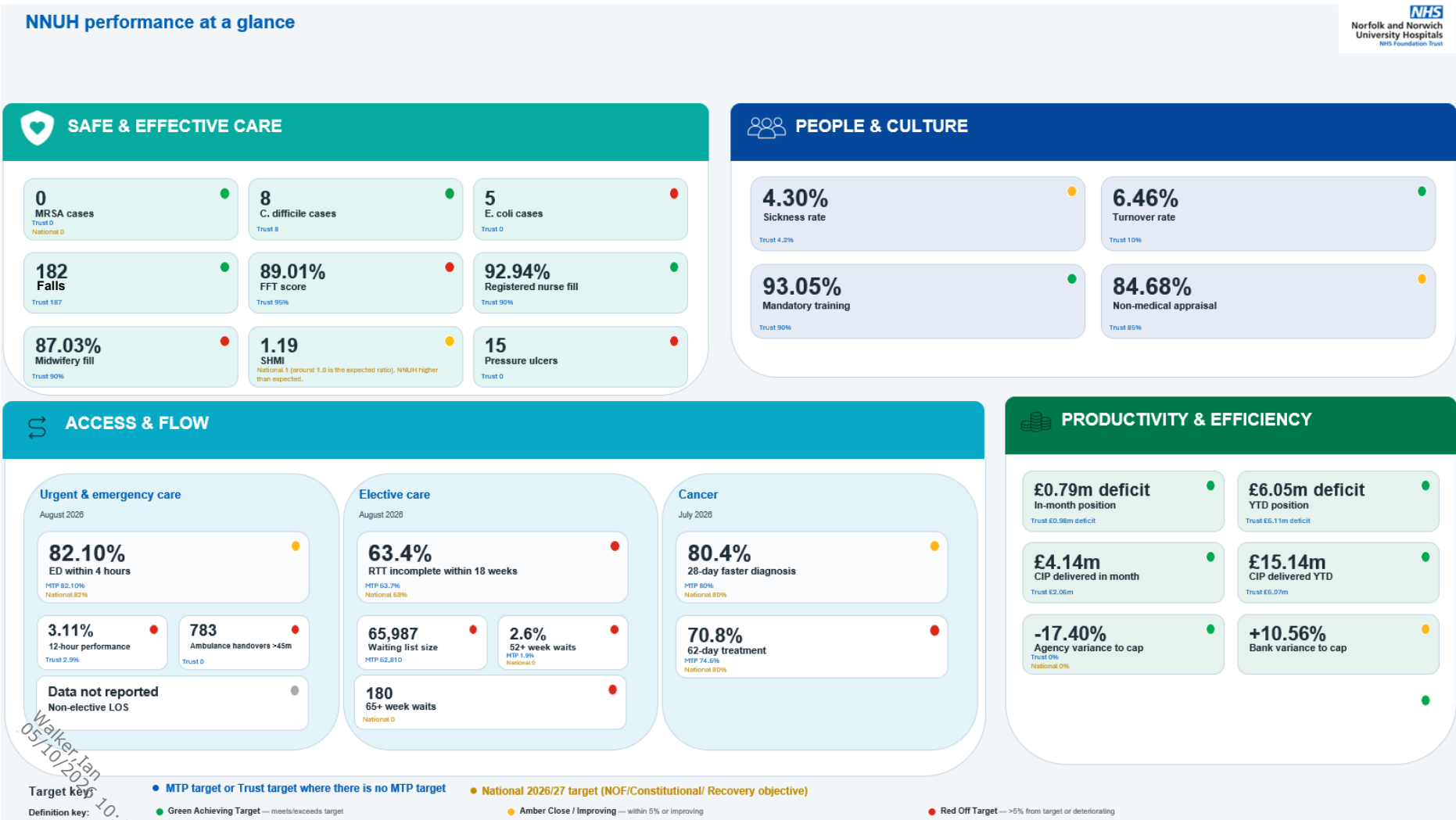
- 7.1 Weekly “Coffee and Conversation” sessions have been arranged, with two members of the Hospital Leadership Team attending each week. These sessions are designed to be informal, giving staff an opportunity to share their experiences and ideas, and raise what matters to them. They also help leaders hear directly from teams and strengthen connections across the hospital. Two sessions have taken place and have been well received and attended.
- 7.2 I also undertook my first Gemba walks (Gemba being a Japanese word meaning “the real place”). These visits allow me to spend time with a team to understand their work, recognise what is going well and explore challenges and potential improvements.
- 7.3 During my first visit, I spent two hours on Dunston and Elsing wards, speaking with colleagues across specialisms and to patients. I was impressed by the strong team spirit. Colleagues were supportive, compassionate and full of praise for one another. Both wards were calm and well managed despite the pressures they faced, including caring for patients in temporary care spaces.
- 7.4 Leadership was visible and engaged, with colleagues asking questions, exploring concerns and identifying actions. Discussions focused on understanding root causes and testing improvements, including social worker involvement in red-to-green meetings to support discharge. I saw a clear commitment to team development and quality improvement, with colleagues able to describe their priorities.
- 7.5 Actions arising during the visit were captured and assigned, including a concern about exit doors on the refurbished ward, which I am taking forward with Estates and Facilities. The team’s feedback was that they felt valued and listened to, and could see the practical benefit of sharing concerns with senior leaders. Thank you and well done to everyone working on both wards. I will visit one team each month and have encouraged other Hospital Leadership Team members to do the same.

8. Recommendation

- 8.1 The Group Board is asked to receive and note the report

Walker Ian
05/10/2026 10:45:15

Appendix 1: Summary performance



Walker Jan
05/10/2025 10:45:15

Appendix 2: NOF summary 2026/27 Q1



NOF summary - NNUH

Domain	Q1 domain score	Q1 segment	Q4 domain score	Q4 segment	Score change	Segment change
Access to services	2.77	3	2.13	2	+0.64	+1
Effectiveness of care and population health	2.43	3	n/a	n/a	n/a	n/a
Experience of care	2.95	4	2.15	2	+0.80	+2
Finance, productivity and innovation	1.93	1	1.82	2	+0.11	-1
Patient safety	2.81	4	3.23	4	-0.42	0
People	2.53	3	2.79	3	-0.26	0

- Q1 is a methodology reset rather than a like-for-like comparison. New, removed and re-thresholded metrics drive much of the movement, and Effectiveness of care and population health has no Q4 baseline at all.
- Finance, productivity and innovation is the standout at 1.93 and Segment 1, driven by coming out of deficit and holding positive variance to plan. That also lifts the financial override on NNUH moving into Segment 2 overall. Clinical trial set-up (4.00) is the sole weakness in the domain.
- Access to services fell 0.64 to Segment 3, mostly from narrowly missing two thresholds previously held: faster diagnosis by 0.17% and the four-hour UEC target by 0.7%. A removed metric scored at 1.00 was also replaced by a new one scoring at 3.05.
- Experience of care fell two segments on the new staff survey advocacy sub-score (3.91). Patient safety improved 0.42 but stays in Segment 4, 0.10 off Segment 3, and People is 0.14 off Segment 2. Annual survey metrics cap in-year movement in all three.

Walker Jan
05/10/2026 10:45:15

Report to the Group Board in public: 7 October 2026

Agenda item number	10		
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** continue to progress, however, over the summer, falls and e. coli infections have risen slightly. **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, nevertheless patients waiting for packages of care have dramatically increased resulting in considerable delays at the front door. **Complaints** backlog has now been cleared.

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 starting of our 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.

Financial performance remains strong. The Trust exceeded its year to date financial plan and has 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)	Principal Risks 1, 2, 3, 4, 5
Previously considered by	n/a
Any background papers in Admin Control Reading Room	No

Norfolk and Waveney University Hospitals Group

Group Board in public: 7 October 2026

Executive Managing Director's report: James Paget University Hospitals NHS Foundation Trust (JPUH)

1. Patients - Quality and Safety

- 1.1 **A&E, ambulance handover and flow:** This is our biggest concern for quality of care and performance at the moment, because over the summer we have seen a deterioration of A&E 4hr performance. Unfortunately this has led to long ambulance delays also. A full presentation was given to GRAC but in short:

Reasons for deterioration:

- 23% increase in walk-in activity for the last 3 months now regularly over 10,000 a month
- 7% Increase in ambulance activity for the last 2 months
- On average 22 more patients per day NCTR on P1 and P3 in last two months
- Inability to open more escalation beds because of RAAC work

Key actions taken and impact:

- LOS 1 day less than last year, criteria led discharge at an all-time high
- Reduction in pathway 0 delays (those in our gift)
- All escalation beds open when ever needed leading to £1.7m staffing overspend YTD
- Full capacity protocol and critical incident including cancelling all SPA time to get more discharges

Key new actions in place:

- ICB approving more GP capacity at the front door to manage walk-in uplift
- Bridging service extended through the winter
- Extra consultant approved for outlier work, working to set up the West Herts EMAC model
- Daily escalation to Norfolk Council re P1 capacity

- 1.2 **Fundamentals of care:** There is a monthly rolling programme to audit each of the fundamentals of care 2 times a year.
- 1.3 **SHMI:** SHMI remains above target and will do so for a number more months due to coding issues previously reported, an 8 point action plan is in place to improve this.
- 1.4 **Pressure ulcers:** we have now moved to the NNUH system called Purpose T which has included training for many of our nurses. We have also introduced a validation process and governance to ensure data accuracy. Our tissue viability team is now fully recruited to.
- 1.5 **Healthcare acquired infections:** Over the summer we saw an uplift in e coli infections from the community. This appeared to be related to dehydration and urinary tract infections as a result. To help combat this public comms were sent out. We are also working through the world class basics to embed best ward practices.
- 1.6 **Falls:** each ward have been given their target to contribute to reductions, in addition to the lanyards, we are now introducing socks and blankets as a visual prompt and prevention. If a patient falls we are introducing SWARMS to quickly bring the team together to learn.
- 1.7 **WHO Patient safety day event** on 17th September. We had a timetable where all the matrons with quality topics went to the wards to promote patient safety linked to their topic. This was supported by the education team and included a skills trolley. There was excellent engagement throughout the day, and we received a great deal of positive feedback from staff.

Many commented on how beneficial the micro-teaching sessions were, and some were especially pleased to receive a few goodies as well, which added to the positive experience.

- 1.8 **Urgent Treatment Centre:** The Trust has now signed the building contract for the 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 **Complaints:** We have now reduced the backlog from over 150 in January to 0 in September.
- 1.10 **Research:** As regional hosts for the NIHR Internship Programme, 23 interns have completed cohort 1 and 33 places are being awarded for cohort 2 — reinforcing JPUH's growing national research leadership. JPUH is now the UK's highest recruiting NHS Trust for a major paediatric insomnia trial, expanding its commercial research portfolio with six new studies across multiple specialties.
- 1.11 **Stroll Augmented Reality** – our physiotherapy team are now supporting patients using VR headsets to aid mobility
- 1.12 **Ward 12 Shop** – Ward 12 has created a 'tuck shop' to engage with patients with cognitive impairments, which has received lots of praise across our local media

2. People – engagement and culture

- 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. More than half the staff now have these badges.
- 2.2 **Workforce Wellbeing** Monthly sickness absence has reduced to 5.1%, remaining below the same period last year, with long-term absence now at its lowest level in 18 months. This reflects the continued impact of targeted wellbeing support and a sustained focus on supporting colleagues to remain healthy and at work.
- 2.3 Alongside this, the GP trail initiative has been positively received, providing an additional opportunity for engagement, collaboration and shared learning between primary and secondary care colleagues.
- 2.4 **Wellbeing on Wheels** – the Wellbeing Champions are visiting wards and departments across the Trust, offering staff a drink, a chat, and wellbeing resources
- 2.5 **Staff Engagement and Leadership:** Leadership visibility and staff engagement continue to strengthen through Team Briefs, Your Voice sessions and leadership walkabouts. We recently held NHS Staff Survey sessions within the Top Leaders Presentation the staff survey sessions programme reinforced the importance of staff experience, equipping leaders to better understand colleague feedback and translate it into meaningful local improvements.
- 2.6 **Learning and Development:** Unfortunately, mandatory training and appraisals have fallen slightly below target this month due to annual leave and flow pressures. The Trust continues to receive positive feedback in a number of specialties through national trainee feedback

mechanisms, reflecting the commitment of teams to creating supportive learning environments and developing the future workforce.

2.7 **Safe and Supportive Workplace** Progress continues in creating a safer working environment, with over 394 colleagues trained in violence and aggression prevention, supported by strengthened partnership working with local policing teams and enhanced awareness initiatives across the organisation.

2.8 **Awards:** Rene Gray, Professional Lead for Therapies and Embedded Researcher: NIHR 20 award. (£10,000 personal award for development); Mehar Shiju RN, Research and Evaluation Associate: NIHR Developing Research Leaders (NIHR DRL) Fellowship: 3 year fellowship (circa £180k) to build capacity and capability of healthcare workforce.

3. Partners – collaboration and neighbourhoods

3.1 **Our Associate Medical Director for Community Rupert Talboys, started this month** to lead our integration work and neighbourhood work with Primary Care and Community colleagues.

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

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

3.4 **Integrated Neighbourhood team being established.** INT lead and case manager roles are being interviewed now.

3.5 **East Place Health Alliance:** Priority areas Parkinson's, Respiratory, Heart Failure and Diabetes are progressing.

3.6 The Great Yarmouth and Waveney system, with James Paget as a key partner, is presenting its **Test, Learn and Grow frailty pilot** to the national Integrated Neighbourhood Teams Community of Practice in London on Tuesday 29 September 2026. The pilot has brought partners together through integrated neighbourhood working to test a proactive, multidisciplinary approach for people living with frailty. The learning from this initial phase will help inform the wider rollout of the model across Great Yarmouth and Waveney. This is a good example of the James Paget contributing to system leadership, developing new models of care and sharing local learning nationally.

4. Performance

4.1 **Activity:** Due to summer holidays and extra flow pressures August showed an £0.6m negative variance to plan on activity. YTD, variable income is now broadly in line with Plan due to earlier over performances.

4.2 **RTT performance** in August is better than plan at 61.8% and maintains us in the 90s on the NHSE rankings.

4.3 **DM01 performance** behind plan. RAP for NOUS ahead of plan. MRI main driver of overall performance and a new MRI started on site 2 weeks ago.

- 4.4 **Cancer metrics** have fluctuated over the last couple of months as per the performance report and have been below plan and target unfortunately.
- 4.5 **52 weeks** continues to be above plan and in August we have gone below 800 patients.
- 4.6 **65 week** waits continue to be a challenge with ENT being the vast majority of the issues. We have just started the extra activity for ENT which will see this number come down.
- 4.7 **Improve outpatient bookings processes** (One Recovery): Our Single Point of Access is now ready for almost all specialties, and we are now targeting new to follow-up ratios where we are worse than benchmark.
- 4.8 **National Oversight Framework (NOF)**: We have move up 6 places from Q4 last year to Q1 this year. Unfortunately, due to changes in the metrics used, some of our gains in RTT and 52 weeks have not come through as much in the final scores. The main reason for this is the addition of community children's services waits, where we have some of the worst waits in the country. Investment has been put in this year with more investment likely to be agreed shortly by the ICB. See Appendix 2 for a summary of the 2026/27 NOF ratings.

5. Finance

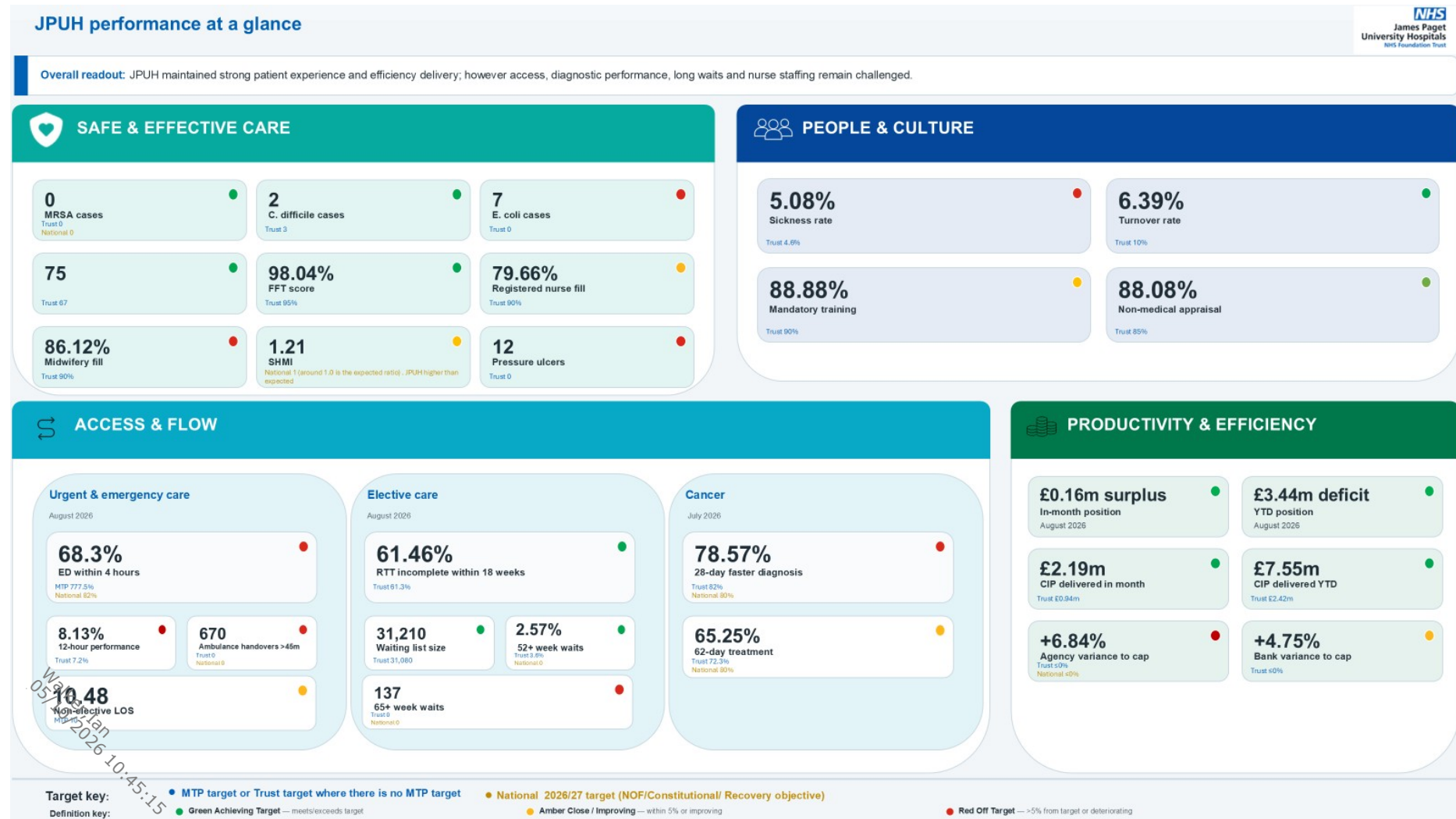
- 5 **August** position is a £0.1m deficit against the planned £0.2m deficit, meaning an in-month £0.1m positive variance to plan
- 5.1 **Year to date**: at month 5, the Trust is reporting a £3.5m deficit against a planned £4.2m deficit, meaning a £0.7m positive variance to plan. Overachievement on income compared to plan is partially offset with negative variances on expenditure. YTD CIP is £1.1m above plan at month 5.
- 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. Recommendation

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

Walker Ian
05/10/2026 10:45:15

Appendix 1: Summary performance



Appendix 2: NOF summary 2026/27 Q1

NOF summary - JPUH

Domain	Q1 domain score	Q1 segment	Q4 domain score	Q4 segment	Score change	Segment change
Access to services	3.51	4	3.35	4	+0.16	0
Effectiveness of care and population health	2.46	3	n/a	n/a	n/a	n/a
Experience of care	2.52	3	2.65	4	-0.13	-1
Finance, productivity and innovation	2.41	3	2.62	3	-0.21	0
Patient safety	2.47	3	3.04	4	-0.57	-1
People	2.82	4	2.97	3	-0.15	+1

- Q1 is a methodology reset rather than a like-for-like comparison. New, removed and re-thresholded metrics drive most of the movement, and Effectiveness of care and population health has no Q4 baseline at all.
- Four of six domains sit in Segment 3. Patient safety (-0.57), Finance, productivity and innovation (-0.21) and Experience of care (-0.13) all improved. Access to services is the only domain to deteriorate (+0.16), which the MH/Community metric swap accounts for in full.
- People is the exception on segment. The score improved to 2.82 but the domain fell to Segment 4 on the addition of two annual survey metrics. Excluding those metrics for all trusts, JPUH would sit in Segment 2 at 2.26.
- Margins are thin and largely survey-bound. Finance is 0.04 from Segment 2, People 0.05 from Segment 3 and Patient safety 0.20 from Segment 2, but annual survey metrics cap in-year movement in People, Experience of care and Patient safety.

Walker Jan
05/10/2026 10:45:15

Report to the Group Board in public: 7 October 2026

Agenda item number	11.1		
Title	Group Quality and Outcomes Committee – Chair’s report		
Author(s)	William Van’t Hoff, 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 Quality and Outcomes Committee which meets monthly. The attached report summarises the key areas of discussion at the Committee’s latest meeting which was held on 29 September 2026.

The Quality and Outcomes Committee reviewed the Group’s principal risks relating to safe, effective and high-quality care, drawing on Trust-level quality, standards and experience reports.

Key items:

- Principal risk 1: a reduction in score is anticipated once the findings of clinical governance reviews at the Trusts are completed and reviewed at Group level.
- Principle risk 2: score is unchanged in the context of addressing several national recommendations and requirements.
- Perinatal services: the Committee received and approved reports regarding compliance to Baroness Amos 10 Point Plan, the National Triage Service Specification and received the update on the CNST position for all three sites. Compliance is Partial although progressing. Implementation of key recommendations following the Thirlwall Inquiry is required, dependent in part on forthcoming national policies. The potential for financial impact was discussed. A high-level Perinatal Report was approved.

Recommendations

The Group Board is asked to note the report of the Group Quality and Outcomes Committee meeting held on 29 September 2026.

Alignment to Board Assurance Framework risk(s)	BAF Principal Risks PR1 (quality standards variation) and PR2 (maternity services)
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

Norfolk and Waveney University Hospitals Group
Report to the Group Board: 7 October 2026
Quality and Outcomes Committee – Chair’s Report

1. Introduction and background

The Group Quality and Outcomes Committee (QOC) met on 29 September 2026 and reviewed Principal Risks (PR1, PR2). QOC received and discussed Trust reports from their respective Quality, Standards and Effectiveness Groups.

PR1 Quality Standards Variation: Risk score remains 12: Limited Assurance

- SHMI remains above the expected thresholds and further clinical engagement is needed to support improved coding and address Structured Judgement Reviews (review of patient notes after a death in hospital).
- Higher than threshold rates of infections (E.coli, Klebsiella, Clostridium) at all sites. Infection Protection and Control (IPC) processes are well-established, yet a focus on the impacts of extreme heat on IPC is recommended.
- Pressure ulcers remain above the zero-tolerance threshold. The PurposeT tool monitoring has been implemented across sites and should support improvement.
- There is a need to provide assurance on workforce experience and culture, patient experience and medicines management.
- Whilst Martha’s rule has been implemented, the outputs indicate it is frequently used when communication is felt inadequate (rather than to highlight concern or deterioration). There is a lack of evidence that it is fulfilling its key purpose and that patients and families are assured by the process.

Reduction in risk score anticipated with strengthening of controls

PR2 Maternity Services Improvement: Risk score: 11 Limited Assurance

- Midwifery staffing remains below 90% target across all sites.
- While there are areas of strong compliance to the NHS Resolution Maternity Incentive Scheme (e.g. training), the Group perinatal report cites Trust ratings as amber in 5 of 7 domains (QEH) and 7 of 7 (NNUH).
- Significant improvements and efficiencies could be expected from the forthcoming establishment of a Group Perinatal Service.

2. Key matters highlighted from QOC to GRAC

2.1. Medium-term Plan: all sites show a deterioration in performance in August (Month 5) and assurance of its delivery is limited. Key challenges in Diagnostics (DM01) and Cancer 62day treatment target (all sites), RTT list size and ED performance. High volumes of activity for ED and Diagnostics are key issues. While cancer diagnosis is improving there is a lack of assurance on achieving required improvements in timeliness of cancer treatment

2.2. Maternity:

2.2.1. Midwifery staffing rates remain below recommended levels at all three sites.

2.2.2. Trusts have completed baseline assessments for national and regional standards. Compliance to Baroness Amos 10 Point Plan, National Triage

Service Specification is Partial although progressing. Implementation of key recommendations from Thirlwall is required, dependent in part on forthcoming national policies.

2.2.3. An update on the CNST position for all three sites and a high-level Perinatal Report was approved.

2.2.4. Compliance with national recommendations/requirements will very likely have a financial impact and will have implications for the estate and digital services.

2.2.5. The establishment of the Group Perinatal Service will significantly facilitate compliance, monitoring and improvement of our services.

2.3. Workforce issues: Trust reports indicate reduced Registered Nurse rates (JPUH), Healthcare Support Worker shortages (NNUH) and critical shortages in Audiology, Breast services and Neurophysiology (QEH). Challenges in recruitment have also been highlighted as impacting safe and effective care, not only for clinical roles but for non-clinical posts supporting clinical activity.

2.4. Workforce experience and culture: the clinical staff must feel empowered and engaged to deliver best care. There is currently a lack of evidence and incomplete governance to assess this. Lack of clinical engagement is cited across two Trusts and has been clearly identified at QEH in two external reviews (RCS, CQC).

2.5. Increases in pressure ulcers, falls and in infectious diseases noted through summer months and it is recommended to consider the impacts of extreme heat on these and other quality markers.

2.6. Violence and Aggression against staff: the Trusts have been providing their assessments and plans against the 7 domains and 43 indicators in the NHS England Violence Prevention and Reduction Standard, Version 2 (2024). JPUH reports 4 of 7 domains as Green, rest as Amber. NNUH and QEH (work in progress) report 7 of 7 as Amber. While the Group will consolidate progress against all three Trust action plans through an appropriate governance route, assurance at this time is Limited.

Walker Ian
05/10/2026 10:45:15

Report to the Group Board in public: 7 October 2026

Agenda item number	11.2		
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 September 2026.

Recommendations

The Group Board is asked to note the report of the Group Risk Assurance Committee meeting held on 30 September 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
 05/10/2026 10:45:15

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

Matters for Board consideration

1. The Committee noted 57 Principal and Significant risks which have been risk scored as ≥ 12 , including 2 scored at 15. It was acknowledged that all Trusts continue to develop their understanding, identification and mitigation of risks.
2. The One Recovery initiatives have now been risk scored with 6 scored at 12 and 1 at 15, a score which is expected to reduce rapidly as recently recruited staff commence roles.
3. The other risk scored at 15 relates to the Laboratory Information System (LIMS) integration with the Electronic Patient Record (EPR), a risk which is scrutinised at the Strategy, Investment and Partnership (STIP) Committee.
4. The Committee discussed and noted risks which it felt had not been fully reflected in either Trust risk registers or within Principal Risks (PR); these include:
 - a. Limited support from system partners – particularly in relation to winter planning.
 - b. Cultural risks, which were discussed in the context of QEH and JPUH generally and histopathology specifically.
 - c. Workforce risks: NNUH, maternity and perinatal services, fragile services at QEH.
 - d. Risks arising from recent media attention.
5. The Committee noted that PR5 (Workforce engagement and morale) and PR15 (Public and stakeholder confidence) will be reviewed ahead of the next GRAC. These reviews will consider risks b), c) and d) as noted in Item 4 above.
6. The Committee discussed recent high-profile instances of patient data being inappropriately accessed at other Trusts and letters received from NHS England. Further discussion was had regarding legitimate access to patient records for the purposes of establishing research cohorts. The Committee was **REASSURED** that process and communication exists to minimise the risk of such data breaches occurring within the Group.
7. The Committee received three operational performance reports: the Integrated Performance Report (IPR) which continues to evolve and improve; the QEH recovery plan report; and the National Oversight Framework (NOF) summary. The QEH recovery report provided **ASSURANCE** that operational performance targets committed to in our response to NHS England will be mostly met. The NOF report provided a very useful summary of NOF methodology and will be evolved next month to include a forecast of our Q2 NOF scores using September data.

Walker Ian
05/10/2026 10:45:15

8. The Committee noted and discussed financial performance at QEH, particularly the risk associated with CIP delivery and the overspend in bank and agency costs. This is an area of increasing concern for GRAC, where **LIMITED ASSURANCE** was taken regarding the effectiveness of the grip and controls in place and the ability to return to a breakeven position by the year end. A deep-dive on QEH financials has been commissioned by GRAC, to be received at the October meeting.
9. The Committee noted the ongoing risk to receipt of Q3 Deficit Support Funding at QEH but took some **REASSURANCE** from ongoing discussions that the Group Chief Finance Officer is having with NHS England at both a regional and national level.

Approvals and recommendations

10. **Revised Terms of Reference (ToR) for GRAC:** The Committee noted updates to the ToR, reflecting the work of the STIP and Quality and Outcomes Committees and increased emphasis on scrutiny of financial and operational performance. The Committee **RECOMMENDS** that the Group Board approves the updated ToR. (see Group Board agenda item 16)
11. **Winter Planning:** the Committee was assured that full risk assessments had been undertaken and that these were accurately reflected in the Board Assurance Statements for each of the three Trusts. 'No Assurance/Red' matters were discussed and acknowledged as requiring further work. Subject to final review to ensure consistency of answers relating to Board scrutiny and acting within the authority delegated by the Board, the Committee **APPROVED** submission of the Winter Plan assurance statements under the delegated authority of the Group Board (provided at the Group Board meeting on 5 August 2026). Copies of the submissions are available to Board members via the Admin Control Reading Room.
12. **62 day Cancer Trajectories at JPUH:** The Committee noted and **AGREED** the proposal to revise these trajectories, noting that this has already been discussed with NHS England Region.

Nikki Gray
Committee Chair

Walker Ian
05/10/2026 10:45:15

Report to the Group Board in public: 7 October 2026

Agenda item number	11.3		
Title	Group Strategy, Technology, Investments and Partnerships Committee – Chair's report		
Author(s)	Andy McKechnie, 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 Strategy, Technology, Investments and Partnerships Committee which meets monthly.

The attached report summarises the key areas of discussion at the Committee's latest meetings which were held on 17 August and 21 September 2026.

Recommendations

The Group Board is asked to note the report of the Group Strategy, Technology, Investments and Partnerships Committee meeting held on 17 August and 21 September 2026.

Alignment to Board Assurance Framework risk(s)	BAF Principal Risks PR6 (digital capability), PR7 (Electronic Patient Record), PR8 (cyber security), PR9 (estate and infrastructure), PR11 (transformation capacity), PR13 (New Hospital Programme)
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

Walker Ian
05/10/2026 10:45:15

Chair's Report from the Group Strategy, Technology, Investments and Partnerships Committee: 17 August and 21 September 2026

17 August 2026

Business cases and contracts

The Committee approved the NNUH Endoscopy Managed Service contract under the delegated authority of the Group Board, subject to final contract due diligence. It was agreed that procurement advice would be obtained on potential future inclusion of JPUH and QEH in such contracts.

The Committee also approved under the delegated authority of the Group Board the NNUH Green Energy Infrastructure project to reduce directly controlled carbon emissions by 70%. It was agreed to bring a milestone report to the Committee in January 2027.

Transformation and One Recovery

The Transformation Design Authority (TDA) was being developed as an assurance function across major programmes, focusing on dependencies, potential delivery collisions and risks rather than owning individual programmes. The Committee requested consistent transformation risk reporting and a defined package of organisational development, cultural, communications and stakeholder support. The One Recovery review confirmed continued focus on urgent and emergency care, planned care, cancer, outpatients and cost improvement, with stronger prioritisation, phased mobilisation and clearer leadership ownership. Workforce culture remained a material issue, particularly at QEH, and was being addressed in part through the 18,000 Voices programme.

Clinical strategy case for change

The Committee received an update on the work to develop the clinical strategy case for change and the key milestones in the period ahead.

New Hospital Programme

The Committee received an update on the New Hospital Programme.

Electronic Patient Record

The Committee reviewed the EPR programme and discussed training backfill, LIMS complexity, funding and delivery risk. It noted the NHS Digital 25-domain assurance scorecard which would support oversight of the programme and the requirement for external gateway reviews at key readiness points.

Cyber security

The Committee approved the Cyber Security Strategy and operational plan, including a single Group SIRO (Senior Information Risk Owner) with authority to disconnect systems presenting an immediate threat. JPUH has closed its regulatory notice, while

NNUH and QEH remain under enhanced monitoring. The Committee noted the need for wider Board awareness of cyber security and requested a further update on the proposed training approach.

Research, Innovation and Education Strategic Delivery Framework

The Committee noted that the Research, Innovation and Education Strategy now required a practical implementation plan setting out priorities, leadership and investment for the next 12 months. This would be overseen by the Research, Innovation and Education Committee.

Andy McKechnie
Committee Chair

Walker Ian
05/10/2026 10:45:15

21 September 2026

Business cases and contracts

The Committee approved the business case for the JPUH Urgent Treatment Centre under the delegated authority of the Group Board. Further assurance was requested on the operating model and digital infrastructure. A post-project evaluation will be reported to the Committee.

The Committee also supported continued development of the NNUH Ophthalmology Centre as a Group-wide networked ophthalmology model, subject to an Outline Business Case which would be brought back to the Committee ahead of seeking Group Board approval.

Transformation and One Recovery

The Committee received a report from the Transformation Design Authority on assurance on key programmes including the clinical strategy case for change and the Electronic Patient Record. The One Recovery programme remained work in progress following the mid-year review. Delivery trajectories were being re-set and Executive Managing Directors had assumed leadership of individual workstreams.

Electronic Patient Record

10 of 25 assurance domains had been assessed and further assurance was required on interoperability, technical architecture, identified gaps and contingency arrangements. An update was provided on the funding business case. Committee members sought clearer, consistent reporting and assurance before the next meeting on delivery, business-case readiness, funding and the timetable for closing gaps.

Cyber security

The Committee noted the appointment of an interim Chief Information Security Officer and delivery of regulatory actions on multi-factor authentication and third-party access. It supported further security assessment, subject to clarification of scope, alternative delivery options, contractual implications and procurement requirements.

Digital Strategy and Roadmap

It was agreed that the Digital Strategy and Roadmap would return to the next meeting following Committee members' comments.

Andy McKechnie
Committee Chair

Walker Ian
05/10/2026 10:45:15

Report to the Group Board in public: 7 October 2026

Agenda item number	11.4		
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 7 September 2026.

Recommendations

The Group Board is asked to note the report of the Group Audit Committees in Common meeting held on 7 September 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
 05/10/2026 10:45:15

Chair's Report from the Group Audit Committees in Common: 7 September 2026

The Committees covered the following items:

- External Audit update: this is progressing according to plan with a 2025/26 review to take place in September in order to assess improvements for 2026/27. There was also confirmation that audit opinions, annual auditors reports and audit certificates were issued and on time for 25/26.
- Internal Audit update. There were two outstanding internal audit reports from 2025/6. One was Risk Management Policy for QEH which provided reasonable assurance. The other was the Group cyber security self-assessment which was seen as High Risk and Low confidence. The Committees were not assured and it was agreed that committee chairs would look "offline" at ensuring progress and outcomes are monitored by Non-Executive Directors and properly captured. All other audits for 2026/27 are in train and will begin to be reported from the November meeting. All will be complete by the end of the financial year.
- An additional internal audit looking at Employment Case Management was agreed with budget provision in place.
- Local Counter Fraud reports. Reports were received from TIAA (JPUH) and RSM (NNUH and QEH). All were positive, giving the Committees substantial assurance. It was agreed that Finance Directors and TIAA/RSM representatives would discuss how to further improve staff awareness so that there is a better understanding of how referral's might be made.
- Quarterly Waivers report: this is for waivers over £50,000. It was a new format providing better information to the Committees. The Committees were reasonably assured. However, it was agreed that future reports would explore benchmarking data and a segmentation of waivers associated with the New Hospital Programme (NHP), Reinforced Autoclaved Aerated Concrete (RAAC) and the Electronic Patient Record (EPR).
- Standing Financial Instructions: these were standardised across all three Trusts in April 2-26. Some further amendments were proposed regarding Contract Change Notices and grant/donation funds. These were agreed with a recommendation for subsequent Group Board approval.

ALERTS

- To ensure Cyber security is captured by each committee and the Group Board where appropriate.
- A drive to improve Counter Fraud awareness.
- To note that there are internal audit actions for 2025/26 outstanding at all three Trusts with the majority (10) at QEH. It is, however, important to note that extensive efforts have and are being made to reduce this, giving reasonable assurance.

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ADVICE

- Financial waivers will be agreed under three circumstances: time, specialism or continuity.

Stephen Javes
Committee Chair

Walker, Ian
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Report to the Group Board in public: 7 October 2026

Agenda item number	12		
Title	Thirlwall Inquiry: Implications for NHS Providers		
Author(s)	Penny Snowden, Group Director of Midwifery		
Executive sponsor	Rachael Cocker, Group Chief Nurse Rob Sherwin, Group Medical Director		
Purpose of report	For decision ☐	For discussion ☒	For information ☐

Executive summary

The Thirlwall Inquiry report is the result of a public inquiry into the events that occurred at the Countess of Chester Hospital from 2015 to 2018. The report was published on 15 September 2026 and outlined individual and system failures to safeguard babies that were in the care of the neonatal unit.

The inquiry made 17 recommendations in total. The Government is currently considering the findings and full recommendations. However, the Secretary of State for Health and Social Care on 15 September 2026 confirmed a commitment to commence a series of actions outlined in this report.

On 22 September 2026, NHS England outlined five immediate actions which are set out in this report. One of these immediate actions involves every Trust to review the Thirlwall report and consider the findings at the next available public Board meeting. The report was discussed at the Group Quality and Outcomes Committee meeting on 29 September 2026.

Recommendations

The Group Board is asked to:

- Consider the Thirlwall Inquiry Report and agree how assurance can be gained that sufficient measures are in place to keep babies and children in our care safe.
- Note the actions supported by the Secretary of State for Health and Social Care.
- Note the immediate actions outlined to NHS Trusts in the recent NHS England letter dated 22 September 2026 and progress to date.

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Alignment to Board Assurance Framework risk(s)	BAF Principal Risk PR 2 (maternity services)
Previously considered by	Group Perinatal Quality Assurance meeting, 18 September 2026 Group Quality and Outcomes Committee, 29 September 2026
Any background papers in Admin Control Reading Room	Thirlwall Inquiry Report, 15 September 2026: https://thirlwall.public-inquiry.uk/ NHS England guidance, 22 September 2026: https://www.england.nhs.uk/long-read/thirlwall-inquiry-report-and-recommendations/

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Norfolk and Waveney University Hospitals Group

Group Board in public: 7 October 2026

Thirlwall Inquiry: Implications for NHS Providers

1. Introduction and background

- 1.1 The Thirlwall Inquiry is an independent public inquiry led by Lady Justice Thirlwall which was set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital between 2015 and 2018. The inquiry did not re-examine Letby’s guilt but reviewed hospital management and the wider issues across the NHS and Trust that could have led to faster action and therefore have saved lives.
- 1.2 The full report in two volumes was published on 15 September 2026 and made 17 recommendations. Key findings identified management failures including ignoring warnings, protecting organisational reputation, mistreating whistleblowers and delayed police contact. The inquiry cited “dysfunctional management and governance; a gulf between hospital leadership and clinicians; and failure to understand the fundamentals of safeguarding”.
- 1.3 Given that the report reveals systemic failures in NHS governance, patient safety protocols and leadership accountability that extend far beyond a single institution, NHS trusts now face fundamental questions about how patient safety is prioritised over reputation and how they respond to clinical warnings. In view of this, NHS England issued a letter on 22 September 2026 outlining five immediate actions (see below).

2. Thirlwall recommendations

2.1 The 17 recommendations outlined in the report are as follows:

No.	Recommendation	Summary of recommendation
1	CCTV and monitoring	All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video) by 31 March 2027
2	Insulin	All units meet the expected requirements for access control and storage of insulin set out in the NHS England Getting It Right First-Time guide, <i>GIRFT Neonatology: Guide to safe insulin use</i> by 31 March 2027 which includes the use of biometric data. The <i>GIRFT Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia</i> guidance for the testing and reporting of insulin and C-peptide results, issued in October 2025, must be made mandatory and of national application
3	Bereavement Care	The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027

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4	Safeguarding and contracts of employment	All Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members, including Non-Executive Directors. This training should include how to deal with concerns and suspicions about deliberate harm caused by staff. By March 2027, every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol
5	Operating systems (interoperability)	NHS England must provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS by December 2028
6	Monitoring deaths in hospitals	By 31 March 2027, all hospital Trusts must have in place effective mechanisms for Board-level monitoring of all deaths of children and babies. By 31 March 2027, all hospital Trusts must have in place a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.
7	Data reporting	All hospitals with a neonatal unit should name a 'lead reporter' with responsibility for inputting data regularly (at least weekly) and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system. The lead reporter should report to Trust Boards at least every six months and advise:
8	Sudden Unexpected Death in Infancy and Childhood (SUDIC)	NHSE to immediately inform all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital. NHSE to direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board
9	Suspicion of Deliberate Harm Protocol and guidance	By 31 March 2027, NHS England must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient
10	Panel of experts	Serious consideration should be given by DHSC to the setting up of a panel of independent experts from all specialties to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients
11	Medical examiners	The National Medical Examiner should, by 31 March 2027, prepare and distribute a one-page document setting out all the steps to be taken by a medical examiner when dealing with the death of a neonate.
12	Paediatric and perinatal pathologists	DHSC and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the workforce requirement set out by the Royal College of Pathologists in the November 2025 <i>Paediatric and Perinatal Pathology Workforce Report</i>
13	Accountability and regulation of managers	DHSC and NHS England must develop and put in place a barring system for all managers (clinical and non-clinical) by September 2027. It should be reviewed in 2030 with a view to moving to a full statutory regulation system by September 2032. NHS England must require any Trust seeking approval for the movement of a senior manager to another Trust to demonstrate that: a. The move is not proposed because of the manager's lack of capability or misconduct. b. The manager meets the fit and proper person test. NHS England must not grant approval, and Trusts must not seek approval, unless they are able to demonstrate the matters at a. and b. above.

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		In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers. The NHS Leadership and Management Framework Code, a code of conduct for NHS managers published in July 2026, must be amended urgently to set out, at the beginning, the uncontroversial duty of every manager to put patients first.
14	Care Quality Commission (CQC)	CQC should conduct without-notice inspections of hospital departments. Inspection teams should include at least two current practising experts in the relevant field
15	Assessment of the performance of CQC	There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Committee, initially once a year
16	Parliamentary and Health Service Ombudsman	The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England.
17	Implementation of recommendations	A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office.

- 2.2 The Secretary of State for Health and Social Care outlined the Government's commitment to several of the recommendations above including cot monitors, safe use and storage of insulin, a complete a review of "working together to safeguard children", regulation of managers and continuation of the rollout of the National Bereavement Care Pathway.

3. Implications for NHS Providers - immediate action required

- 3.1 On 22 September 2026, NHS England informed NHS Providers of five immediate actions. The full letter is available through the link in the front section of this report.

Trust Review of the Thirlwall Inquiry

- 3.2 The first action relates to every Board reviewing the report and ascertaining the level of assurance regarding whether such events could happen in their organisation. This report forms part of progressing this action.

Sudden and Unexpected Death in Children (SUDIC)

- 3.3 It can be confirmed that each neonatal unit on the three hospital sites have issued communications to all relevant staff regarding the SUDIC process and that a copy of the SUDIC policy has been provided to all staff. The SUDIC policy is a Group policy so consistent processes are used across all three sites. The deadline for this to be completed was 28 September 2026 and this was achieved. In addition, there have staff engagement events where the report and recommendations have been discussed. There have also been wider communications across the hospital sites.

National Bereavement Care Pathway for stillbirth and neonatal death

- 3.4 Implementation of the above care plan was integral to the Three-Year Delivery Plan for Maternity and Neonatal Services, which ends this year, and also the

Medium-Term Planning Guidance. Compliance against these standards have been completed by each of the perinatal services and reported through internal and external governance processes. The main area of non-compliance relates to estates at JPUH, and this is being addressed through the ongoing Reinforced Autoclaved Aerated Concrete (RAAC) improvement works.

Storage of Insulin

- 3.5 By 31 March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology guide to safe insulin use. Each site needs to ensure they receive progress reports against the GIRFT standards through the perinatal reporting process.

Safeguarding

- 3.6 Boards should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. This should be monitored through monthly reporting mechanisms to the site People and Culture meetings with upwardly reporting through the Integrated Performance Report (IPR) route.
- 3.7 Currently no national guidance has been received regarding oversight of completion of these actions. However, it is proposed that a report is brought to the Group Quality and Outcomes Committee by the Trust Chief Nurses to provide assurance that each of the actions has been completed.

4. Recommendations

- 4.1 The Group Board is asked to:
- Consider the Thirlwall Inquiry Report and agree how assurance can be gained that sufficient measures are in place to keep babies and children in our care safe.
 - Note the actions supported by the Secretary of State for Health and Social Care.
 - Note the immediate actions outlined to NHS Trusts in the recent NHS England letter dated 22 September 2026 and progress to date.

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Report to the Group Board in public: 7 October 2026

Agenda item number	13		
Title	Group Perinatal Report		
Author(s)	Penny Snowden, Group Director of Midwifery		
Executive sponsor	Rachael Cocker, Group Chief Nurse Rob Sherwin, Group Medical Director		
Purpose of report	For decision ☒	For discussion ☐	For information ☐

Executive summary

The report provides an update on progress made by each maternity service against the national agenda. The perinatal leadership teams are meeting the multiple demands made of maternity services and currently on track to deliver. However, it should be appreciated that there is still a substantial amount of work to complete to meet those national deadlines which the teams are committed to deliver.

Recommendations

The Group Board is asked to:

- Approve the Ten-Point Plan baseline assessment for all three maternity services.
- Approve the Maternity Triage Service Specification baseline assessment for all three maternity services.
- Approve the Maternal Care Bundle Implementation Plans (NNUH and JPUH only).
- Note the future direction of the Group perinatal report since the standardisation of the site reports.

Alignment to Board Assurance Framework risk(s)	BAF risk PR2 (maternity services)
Previously considered by	Group Perinatal Quality Assurance meeting, 18 September 2026 Group Quality and Outcomes Committee, 29 September 2026
Any background papers in Admin Control Reading Room	Trust Ten-Point Plan Baseline Assessments Trust Maternity Triage Service Specification Baseline Assessments Trust Maternal Care Bundle Implementation Plans (NNUH and JPUH only)

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Norfolk and Waveney University Hospitals Group

Group Board in public: 7 October 2026

Group Perinatal Report

1. Introduction and background

- 1.1 National Scrutiny on maternity services continues and ensuring there is robust Group Board oversight of the quality of maternity services is a consistent recommendation through the recent national published reviews and investigations.
- 1.2 This report consolidates papers that were presented at discussed at the meeting of the Group Quality and Outcomes Committee on 29 September 2026. Those papers were:
 - The national Maternity Ten-Point Plan baseline assessment
 - The national Triage Service Specification baseline assessment
 - Quarter two Maternity Incentive Scheme Year 8 progress report
 - Perinatal quality performance
- 1.3 Additionally, the Thirlwall Inquiry was discussed and is covered in a separate paper on the agenda given its wider implications.

2. National Maternity Ten-Point Plan

- 2.1 The Ten-Point Plan was published in response to both the Baroness Amos's investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at Nottingham University Hospitals NHS Trust.
- 2.2 Trusts were requested to complete a baseline assessment using a national standardised reporting template and submit this to the regional NHS England team by 25 September 2026. The tight deadline did not allow sufficient time for the completed baseline assessments to progress through site and Board governance in advance of the submission date.
- 2.3 Following correspondence with the regional NHS England team, submission ahead of Board sign off was permitted in recognition that each Trust had approved the baseline assessment. Each Trust has presented its baseline assessment to the Group Perinatal Assurance Meeting in August and September 2026. A more detailed paper outlining the current position of each maternity site was discussed at the Group Quality and Outcomes Committee on 29 September 2026 and the baseline assessments were agreed. The regional NHS England team will be notified following Group Board approval of the baseline assessments. A copy of each baseline assessment is included in the supplementary information pack in the Admin Control Reading Room.

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3. National Maternity Triage Service Specification

- 3.1 Given the reoccurring safety themes arising from maternity triage service, a national specification was developed. This forms part of the Ten-Point Plan which requires providers to commit to providing safe and effective maternity triage.
- 3.2 As outlined in the service specification, providers are required to complete a baseline assessment which is then presented to the Board. Full implementation is required to be achieved by July 2027, and this will impact on Estates and Staffing. Currently no additional national funding has been announced to support full implementation.
- 3.3 Each Trust has completed its baseline assessment and this has been signed off through Trust-level governance. Sign off has also been achieved through the Perinatal Quality Assurance meeting on 18 September and at the Group Quality and Outcomes Committee on 29 September 2026.
- 3.4 As the baseline assessment is part of the Ten-Point Plan, it has also been submitted with the latter baseline assessment (see Section 2) to the regional NHS England team. Approval of the baseline assessments are requested of the Group Board.
- 3.5 While the self-assessments vary across the Trusts, each service has implemented the recommended Birmingham Symptom Specific Triage System (BSOTS) and monthly monitoring of performance is in place. Regular updates will be provided to a Board-level meeting through the Group Perinatal report.

4. Quarter Two Maternity Incentive Scheme Progress

- 4.1 Quarter two progress against NHS Resolution Maternity Incentive Scheme was provided in detail to the Group Quality and Outcomes Committee on 29 September 2026. All Trusts are self-assessing themselves to be on track to deliver the Year 8 requirements, although greater progress has been made at NNUH and JPUH. It should be recognised that the work to be undertaken to achieve year 8 is significant; largely due to the maternal care bundle. This is in addition to the requirements of evidencing the Ten-Point Plan.
- 4.2 The Group Board is asked to approve the Maternal Care Bundle Implementation Plans for NNUH and JPUH as this approval is a requirement of core safety action 5. They have been previously considered through the Trust Quality, Safety and Effectiveness Meetings as well as the Group Perinatal Quality Assurance meeting.
- 4.3 Monthly updates regarding full implementation by March 2027 will be provided to Trust and Group through the Perinatal report by the Trust perinatal leadership teams. The Group Board needs to be aware that full implementation requires action to be undertaken by other providers such as primary care, ambulance trusts, fertility and termination services. For this reason, it has been escalated to regional to national NHS England teams regarding the requirement for maternity providers to be responsible for full implementation. It has also been raised with the Norfolk and Suffolk ICB to progress discussions with the providers outlined above.

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5. Perinatal performance

- 5.1 Site reporting has been standardised through a revised perinatal report. That report is aligned to the recommendations outlined in recent reviews; for example, an equity section has been added, new metrics include oversight or home births, monitoring of Martha's Rule and the report includes metrics outlined in the national Perinatal Quality Oversight Model.
- 5.2 The Trusts commenced reporting on the new template in September with the site perinatal leadership teams reporting to site Quality, Safety and Effectiveness Meeting and the Group Perinatal Assurance Meeting. The latter meeting is also attended by the Group Non-Executive Director Board-level Safety Champion. In October, the group Perinatal report will be developed so assist with Board Oversight given the many different metrics that perinatal services are required to report against. This will be presented monthly to the Group Quality and Outcomes Committee and four-monthly to the Group Board in line with national guidance.
- 5.3 Key issues so to highlight to the Group Board are as follows:
- While safety performance has been fairly stable at JPUH, a level one maternity outcome signal system (MOSS) alert was received on 18 September 2026. The alert was generated in response to two neonatal deaths. The critical safety checklist process has been completed and submitted to the regional NHS England within eight working days in accordance with the national process. No immediate safety concerns were identified during that process.
 - All sites have been operationally busy over the summer period with the impact being felt by the workforce. This has been exacerbated by the vacancy rates across each site and increased sickness in addition to a busy annual leave period. Recruitment of graduate midwives is in progress, and each site has been awarded national funding to support those staff. Each site has also commissioned an external staffing review through Birthrate Plus and are at different stages of that process. Fill rates are noted to be below 90%, and this is also due to rosters not reflecting internal redeployment of staff that occurs as part of managing activity and acuity across the maternity service. Maternity is part of a wider group improvement project regarding safer staffing oversight which has just commenced.
 - At QEH, there has been six stillbirths since April 2026, all occurring during the pregnancy and these have included risks such as extreme prematurity, concealed pregnancy and known congenital abnormalities. The service has completed a thematic review and key themes include reduced fetal movements and growth restriction which are elements included in the national Saving Babies Lives Care Bundle. Improvement work has commenced and focuses on documentation, detection of small babies and education regarding altered fetal movements. Oversight of improvement will continue through the QEH site quality, safety, and effectiveness meeting.
 - In July there were three stillbirths and two neonatal deaths at NNUH. All cases have been reviewed through the appropriate cross site multi-professional case review meetings. Issues such as extreme prematurity,

known congenital abnormality and known fetal growth issues were reported. Collaborative work with QEH regarding altered fetal movement recognition and detection is also proposed. Additionally, strengthened oversight of clinical outcome metrics within the Saving Babies Lives Care Bundle is being progressed.

- Last month, it was reported that NNUH is in an outlier position for postpartum haemorrhage (PPH) following a caesarean section. Carbetocin (a drug that helps to contract the uterus and control bleeding) was implemented in June and there has been slight improvement over the past two months. The team continue to focus on the timing of medication administration during PPH management, in education programmes and to ensure that blood loss is measured accurately, collection drapes have been ordered and are due to be implemented.

6. Recommendations

6.1 The Group Board is asked to:

- Approve the Ten-Point Plan baseline assessment for all three maternity services.
- Approve the Maternity Triage Service Specification baseline assessment for all three maternity services.
- Approve the Maternal Care Bundle Implementation Plans (NNUH and JPUH only).
- Note the future direction of the Group perinatal report since the standardisation of the site reports.

Walker Ian
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Report to the Group Board in public: 7 October 2026

Agenda item number	14		
Title	Freedom to Speak Up: Trust annual reports 2025/26 and development of a consolidated Group model		
Author(s)	Emma-Jayne Pérez Chies, Interim Group Chief People Officer		
Executive sponsor	Simon Nearney, Group Chief People Officer		
Purpose of report	For decision ☐	For discussion ☒	For information ☐

Executive summary

Each Trust in the Group maintains Freedom to Speak Up (FTSU) arrangements in line with the NHS Standard Contract and reports through its own governance. This paper brings the 2025/26 FTSU reports from NNUH, JPUH and QEH to the Group Board for information, and draws out for the first time the learning common to all three sites.

Colleagues raised 490 matters with Guardians across the Group in 2025/26. The themes are strikingly consistent: the experience of being in HR and management processes, poor communication during those processes, workload and staffing pressures, behaviour and relationships, and concerns with an element of discrimination, alongside evidence of reduced confidence that concerns raised will be acted upon. The three services differ markedly in delivery model, resilience and reporting, and there is no common dataset through which the Group Board can compare and seek assurance across its 18,000 staff.

The Group Executive has agreed interim measures to strengthen the service at QEH and has supported the principle of a consolidated Group service. A consolidated Group proposal, covering the service model, a single Group speak up policy, reporting and governance, is being designed and will be brought back to the Group Board for approval.

Recommendations

The Group Board is asked to:

- Note the 2025/26 FTSU reports from each Trust and the Group learning summarised in this paper.
- Note the interim measures agreed by the Group Executive to strengthen FTSU provision at QEH.
- Note that a consolidated Group FTSU proposal, covering service model and policy, is being designed and will be brought back to the Group Board for approval by April 2027.

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Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 5 (workforce engagement and morale)
Previously considered by	Hospital Management Groups
Any background papers in Admin Control Reading Room	Yes: NNUH Freedom to Speak Up Annual Report 25/26 JPUH Freedom to Speak Up Annual Report 25/26 QEH Freedom to Speak Up Annual Report 25/26

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Norfolk and Waveney University Hospitals Group

Group Board in public: 7 October 2026

Freedom to Speak Up: Trust annual reports 2025/26 and development of a consolidated Group model

1. Introduction and background

- 1.1 This paper brings the 2025/26 Freedom to Speak Up reports from NNUH, JPUH and QEH to the Group Board for information, summarises the learning common to the three hospitals, and sets out the work under way to design a consolidated Group service and policy for the Group Board's future approval. The Trust reports are available in the Admin Control Reading Room.
- 1.2 The Group Risk Assurance Committee has asked how FTSU should report to the Group Board, and Guardians and site people leads have sought clarity on the same point. This paper is the first step in answering that question and does not seek a decision on the future model.

2. National context and requirements

- 2.1 Each constituent Trust remains a distinct provider under the NHS Standard Contract and must appoint one or more Freedom to Speak Up Guardians operating in line with national guidance; this requirement continues in the 2026/27 Standard Contract. Guardians may be internal, external or shared across organisations, provided each Trust has ringfenced Guardian time, mandatory foundation training before Guardians start in role, secure recording and national data submission, a named executive and non-executive lead, and local policy aligned to the national speak up policy.
- 2.2 The National Guardian's Office closed on 30 June 2026, with national support and data collection functions transferring to NHS England. Greater responsibility for effective arrangements now sits with individual organisations, including a duty to provide psychological support for Guardians once nationally sourced support ends on 31 December 2026. Statutory whistleblowing protections under the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998, apply regardless of delivery model.
- 2.3 The national evidence base identifies what distinguishes exemplar organisations: a coherent strategy, visible leadership commitment, sufficient dedicated resource, collaboration between FTSU and HR and OD, and consistent feedback to those who speak up. Under-resourced Guardian arrangements and inconsistent processes are active barriers. A low volume of speaking up may indicate low confidence rather than an absence of concerns.

3. Trust reporting 2025/26

- 3.1 The table below summarises each Trust's position for 2025/26, drawn from the reports in the Admin Control Reading Room, with 2024/25 activity shown for

comparison. Each service categorises concerns differently, so the themes are not directly comparable.

	NNUH	JPUH	QEH
Delivery model	Internal service: Lead Guardian and five volunteer Guardians, supported by a Speak Up Champion network	External: The Guardian Service Ltd, commissioned May 2024, providing a dedicated Guardian and 24/7 access	Internal service in transition: independent Guardian retired October 2025; interim part-time secondment concluded April 2026; full-time assistant appointed March 2026; 14 Champions
Matters raised 2024/25	208	96 (from May 2024)	328
Matters raised 2025/26	244 (increase of 17%); anonymous concerns rose to 11%	112; 12 open at year end	134, rising from 26 in Q1 to 45 in Q4
Principal themes	Workload, wellbeing, discrimination, and development and training; increase in corporate activity linked to restructuring	Systems and processes (36), patient safety and quality (20), behaviour and relationships (18)	Worker safety and wellbeing (79 of 134); bullying, harassment and patient safety concerns rising in the second half of the year
Detriment	Detriment risk assessment tool implemented	Two colleagues reported experiencing detriment	Not separately reported
Reporting route	Annual report to Trust Board; quarterly report to People and Culture Management Group.	Annual report to Trust Board; monthly report to People and Culture Management Group.	Annual report to Trust Board; quarterly report to People and Culture Management Group.
Assurance position	Strong KPI compliance, but the 2025 NHS Staff Survey shows declining confidence that concerns raised will be addressed	Effective arrangements for responding to concerns; 40% of users had raised the matter before and felt unheard	Reasonable assurance only: service accessible and demand met, but operating at significantly reduced capacity for most of the year

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4. Group learning

What is common

- 4.1 The experience of being in an HR or management process is the most persistent theme at QEH and a leading theme at JPUH, where colleagues describe receiving little or no update during formal processes. Colleagues are not predominantly saying that processes were handled wrongly; they describe the silence, uncertainty and delay as distressing in themselves. At QEH, most colleagues had already engaged with their manager, HR or a formal process before contacting the service.
- 4.2 This suggests FTSU is absorbing the consequences of structural workforce pressures rather than solely fulfilling its intended role. Many of these matters can and should be resolved directly with a line manager or with HR. The transformation of people services across the group will enable line managers and HR to be more proactive and to find new ways of hearing and responding to concerns earlier, so that FTSU remains a safety valve rather than the default route.
- 4.3 All three hospitals report concerns with an element of discrimination, including concerns about racial discrimination at QEH, and workload or staffing pressures affecting wellbeing and patient care. Confidence is the common risk: the 2025 NHS Staff Survey shows declining confidence at NNUH that concerns raised will be addressed, and 40% of JPUH users in 2025/26 had raised their concern before and felt unheard. Manager capability is a shared lever; 293 managers at NNUH have completed the “Listen Up” training for managers.

What differs or is absent

- 4.4 The three services are not equally resilient. QEH's experience in 2025/26 shows how quickly an internal service dependent on one or two individuals can become fragile. There is no common dataset or set of categories, Board-level reporting is inconsistent across the three Trusts, and FTSU intelligence is not yet routed systematically into Group risk and assurance. Without these, the Group Board cannot compare, triangulate or seek assurance on speaking up across the Group.

Emerging interventions

- 4.5 The learning points to Group-wide and site-specific interventions, which will be developed within the consolidated proposal:
 - (a) **Group-wide:** a common dataset and indicators aligned to the NHS England national data collection; Group-wide use of the NNUH detriment risk assessment tool; speak up and listen up training for managers; triangulation with staff survey, workforce and patient safety intelligence as part of the 18,000 Voices culture programme; and routing of FTSU intelligence into the Group Risk Assurance Committee.
 - (b) **QEH:** restoring resilient Guardian capacity, addressed immediately through the interim measures in Section 5.

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- (c) **NNUH:** closing the loop with those who speak up, to rebuild confidence that concerns will be acted upon.
- (d) **JPUH:** continuity of the contracted service to its expiry in 2027, with transition planned as part of the Group model.

5. Interim measures at QEH

- 5.1 On 25 August 2026 the Group Executive Group agreed immediate interim measures to strengthen the Guardian service at QEH, drawing on capacity from the NNUH FTSU Guardian and, if required, short-term support from an external provider. This ensures QEH colleagues have a reliable route to speak up while the Group model is developed.

6. Developing the consolidated Group proposal

- 6.1 The Group Executive has supported the principle of a consolidated Group service, and further benchmarking is under way before a proposal is finalised. The proposal will cover:
 - (a) the Group delivery model, benchmarked on independence, resilience, out-of-hours access, cultural insight and cost, including a review of the independent external provision already in place at JPUH and the practice of peer NHS Groups.
 - (b) a single Group speak up policy aligned to the national speak up policy.
 - (c) clear roles and responsibilities at each site, with executive leadership for FTSU held at Group level by the Group Chief People Officer and the Group Non-Executive Director lead (William Van't Hoff), meeting each Trust's Standard Contract requirement for named leads.
 - (d) a Board reporting rhythm reflecting national practice: a consolidated annual report and six-monthly update presented by a Guardian; and the Group Chief People Officer.
 - (e) arrangements to meet the duty to provide psychological support for Guardians from 31 December 2026.
- 6.2 The proposal will be developed with Guardians, site people leads and staff side colleagues and brought back to the Group Board by April 2027.

7. Recommendations

- 7.1 The Group Board is asked to:
 - Note the 2025/26 FTSU reports from each Trust and the Group learning summarised in this paper.
 - Note the interim measures agreed by the Group Executive to strengthen FTSU provision at QEH.
 - Note that a consolidated Group FTSU proposal, covering service model and policy, is being designed and will be brought back to the Group Board for approval by April 2027.

Walker Ian
05/10/2026 10:45:15

Report to the Group Board in public: 7 October 2026

Agenda item number	15		
Title	Provider Capability Assessments (PCAs) 2026		
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 presents the proposed 2026 PCA self-assessments for NNUH, JPUH and QEH. Required under the NHS Oversight Framework, the annual Board-led assessment considers organisational capability across six domains: strategy, leadership and planning; quality of care; people and culture; access and service delivery; productivity and value for money; and financial performance and oversight. The proposed ratings reflect Trust-level evidence, leadership review and a Group-wide consistency check. They indicate comparatively stronger capability at NNUH and JPUH, while identifying more significant challenges at QEH, particularly in productivity, financial performance, operational recovery, regulatory compliance, leadership capacity and staff confidence. Across the Group, further improvement is required in access performance, health inequalities, workforce experience, cyber resilience, productivity and delivery of financial recovery. NHS England will triangulate the submissions with performance, regulatory and other intelligence before assigning final capability ratings.

Recommendations

The Group Board is asked to:

- Approve the proposed self-assessment ratings for the six capability domains for each Trust, subject to any amendments agreed at the meeting.
- Confirm that the supporting narrative is an accurate, balanced and evidence-based account of capability, including areas requiring improvement.
- Authorise the Group Chair and Group Chief Executive to sign the final returns and submit them to the NHS England regional oversight team immediately following the Group Board meeting.
- Note that action plans will be developed to address key areas of improvement identified through the self-assessments and that these will be overseen through Trust and Group governance arrangements, including through a mid-year report to the Group Board.

Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 14 (corporate governance)
Previously considered by	Group Executive, 1 October 2026
Any background papers in Admin Control Reading Room	Yes – Trust PCA self-assessment templates

Norfolk and Waveney University Hospitals Group

Group Board in public: 7 October 2026

Provider Capability Assessments 2026

1. Introduction and background

1.1 As part of the NHS Oversight Framework, NHS England assesses provider capability alongside performance segmentation to determine the nature and intensity of oversight, improvement support or intervention. For 2026, every NHS trust and foundation trust is required to complete an annual Board-led self-assessment against six domains derived from *The Insightful Provider Board*¹:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

1.2 NHS England's guidance is intended to focus Board attention on core organisational capabilities and support an open, 'no surprises' relationship between providers and oversight teams. The 2026 template is supported by 18 capability statements which describe the principal expectations within the six domains.

1.3 Boards should consider the extent to which each capability statement is met, the evidence underpinning that view, the effectiveness of governance and assurance, any concern or development need, and the corrective action in place. Evidence may include Board and committee assurance, performance and workforce information, quality and safety intelligence, financial and productivity data, internal and external audit, Care Quality Commission (CQC) information, staff and patient feedback, and delivery against agreed plans. Evidence is retained and made available to NHS England if requested rather than routinely appended in full.

1.4 For each domain, the self-assessment submission must assign a 4-stage RAG rating (Green, Amber-Green, Amber-Red, Red) together with a summary of the supporting evidence and any gaps or development needs.

1.5 Following submission, NHS England will triangulate each Trust's return with delivery history, regulatory information and other intelligence, undertake regional and national moderation, and assign an overall capability rating for each Trust. For 2025, NHS England assigned overall capability ratings as follows: NNUH: Amber-Green; JPUH: Amber-Red; QEH: Red. It should be noted that the self-assessment rating scale for the six domains has changed between 2025 and 2026.

¹ The Insightful Provider Board, NHS England, December 2024.

- 1.6 The national deadline for submission is 2 October 2026 but the Group has agreed with the NHS England regional team that the three Trusts can submit their returns on 7 October 2026 following the Group Board meeting.

2. Trust self-assessments

- 2.1 This paper sets out the proposed 2026 Provider Capability Assessment (PCA) self-assessment ratings for the three foundation trusts within the Norfolk and Waveney University Hospitals Group: Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) and James Paget University Hospitals NHS Foundation Trust (JPUH).

- 2.2 The proposed submission templates for the three Trusts are appended, including the proposed self-assessment ratings. These are summarised as follows:

Capability domain	NNUH	QEH	JPUH
1. Strategy, leadership and planning	Amber-Green	Amber-Red	Amber-Green
2. Quality of care	Amber-Green	Amber-Green	Amber-Green
3. People and culture	Amber-Green	Amber-Red	Amber-Green
4. Access and delivery of services	Amber-Green	Amber-Red	Amber-Green
5. Productivity and value for money	Green	Red	Amber-Green
6. Financial performance and oversight	Amber-Green	Red	Green

- 2.3 The NHS England guidance sets out indicative evidence or lines of enquiry for each capability statement and these have been used to inform the Trusts' self-assessments.

- 2.4 Common evidence and Group arrangements may support more than one submission, but they do not remove the need for an assessment of capability at individual Trust level, including the effectiveness of local governance and delivery grip. Trust leadership teams have therefore reviewed the capability statements, identified evidence and proposed ratings. A Group lens has also been applied to ensure consistency in relation to Group Board level governance, oversight and assurance.

- 2.5 In summary, the attached self-assessments identify the following particular areas where the Trusts are assessed as meeting the requirements and where improvements are required:

Walker Ian
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Provider Capability Self-Assessments 2026

	NNUH	JPUH	QEH
Key areas of achievement / strength	• Strategy, Medium-term Plan and One Recovery programme aligned with Group, ICB and national priorities. • Substantive leadership, strengthened NED capacity and clear assurance and escalation arrangements. • Effective system collaboration across integrated pathways, discharge and neighbourhood health. • Strong quality governance through PSIRF, integrated reporting, patient feedback and Board oversight. • Established productivity infrastructure, including benchmarking, GIRFT and theatre improvement.	• Clear five-year strategy and strong alignment with Group clinical and transformation priorities. • Substantive leadership, strengthened NED capacity and defined accountability arrangements. • Strong place-based collaboration through the East Place Health Alliance and neighbourhood initiatives. • Mature quality and patient-safety systems, including PSIRF, mortality review and leadership walk-rounds. • Strong staff voice, development and speaking-up arrangements, supported by an independent Guardian.	• Clear 2024–2030 strategy, recovery priorities and increasing alignment with Group and system plans. • Transparent recognition of regulatory, operational and financial challenges. • Strengthened Group Board capacity, Link NED arrangements and developing assurance structures. • Recovery plans, One Recovery support and system collaboration provide a credible improvement framework. • Staff Survey and speaking-up improvement programmes developed with staff and trade unions.
Key areas requiring improvement	• Complete and embed the Group clinical strategy. • Deliver the required cyber-security remediation investment. • Demonstrate that staff engagement consistently improves workforce experience. • Sustain elective, diagnostic and urgent-care recovery against national standards. • Strengthen analysis of access inequalities and evidence measurable impact.	• Address urgent and emergency care pressures, bed availability and delayed discharge. • Sustain recovery in ENT waits, diagnostics, cancer and other access standards. • Complete the Health Equity Plan and evidence measurable improvement. • Agree and implement population-health targets with the ICB. • Accelerate productivity and efficiency delivery and complete cyber remediation.	• Resolve regulatory concerns and sustain delivery against NHS England Enforcement Undertakings. • Strengthen substantive site-level leadership capacity and capability. • Recover RTT, cancer, diagnostic and urgent-care performance. • Rebuild Freedom to Speak Up capacity, psychological safety and staff confidence. • Address the structural deficit, cash pressures and high-risk CIP delivery while protecting quality.

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- 2.6 Where proposed ratings are below Green, action plans will be developed to address the key areas of improvement identified through the self-assessments and that these will be overseen through Trust and Group governance arrangements, including through a mid-year report to the Group Board.

3. Recommendations

3.1 The Group Board is asked to:

- Approve the proposed self-assessment ratings for the six capability domains for each Trust, subject to any amendments agreed at the meeting.
- Confirm that the supporting narrative is an accurate, balanced and evidence-based account of capability, including areas requiring improvement.
- Authorise the Group Chair and Group Chief Executive to sign the final returns and submit them to the NHS England regional oversight team immediately following the Group Board meeting.
- Note that action plans will be developed to address key areas of improvement identified through the self-assessments and that these will be overseen through Trust and Group governance arrangements, including through a mid-year report to the Group Board.

Walker Ian
05/10/2026 10:45:15

Report to the Group Board in public: 7 October 2026

Agenda item number	16		
Title	Board Committee terms of reference		
Author(s)	Ian Walker, Group Director of Governance		
Executive sponsor	Ian Walker, Group Director of Governance		
Purpose of report	For decision ☒	For discussion ☐	For information ☐

Executive summary

This report provides assurance that all Group Board committees have Board-approved terms of reference in place.

The terms of reference for Board committees were most recently approved by the Group Board at its meetings as follows:

- Group Nomination and Remuneration Committees in Common: 1 April 2026
- Group Research, Innovation and Education Committee: 1 April 2026
- Group Audit Committees in Common: 5 August 2026
- Group Strategy, Technology, Investments and Partnerships Committee: 3 June 2026

At its meeting on 5 August 2026, the Group Board agreed to establish a Group Quality and Outcomes Committee, with the terms of reference of the Committee to be approved at the next Group Board meeting. The terms of reference were reviewed by the Group Quality and Outcomes Committee (QOC) at its inaugural meeting in August 2026 and are now being brought to the Group Board for formal approval.

The establishment of the Group Quality and Outcomes Committee – and previously the Group Strategy, Technology, Investments and Partnerships Committee (STIP) – has implications for the Group Risk Assurance Committee (GRAC). The opportunity has therefore been taken to review and revise GRAC's existing terms of reference (approved by the Group Board in December 2025) and to adopt the same format as used for other committees of the Group Board. The revised terms of reference were reviewed and agreed by GRAC at its meeting in September 2026 and are now being brought to the Group Board for approval. In addition to a simplified format, the key amendments to the terms of reference are to (i) recognise the risk and assurance roles of QOC and STIP, and (ii) to more explicitly recognise the role of GRAC in oversight and assurance of operational and financial performance and risk.

Copies of the revised terms of reference are attached.

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Recommendations

The Group Board is asked to:

- Approve the terms of reference of the Group Quality and Outcomes Committee.
- Approve the revised terms of reference of the Group Risk Assurance Committee.
- Note that terms of reference for other Board committees have been reviewed and approved in the past six months.

Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 14 (corporate governance)
Previously considered by	Group Board: 1 April, 3 June, 5 August 2026 Group Quality and Outcomes Committee: 25 August 2026 Group Risk Assurance Committee: 30 September 2026
Any background papers in Admin Control Reading Room	No

Walker Ian
05/10/2026 10:45:15

GROUP QUALITY AND OUTCOMES COMMITTEE

TERMS OF REFERENCE

1. Introduction

- 1.1 The Norfolk and Waveney University Hospitals Group (NWUHG) Quality and Outcomes Committee is a formally constituted committee of the Group Board of Directors, established under the Provider Collaboration Agreement (PCA)¹ and the Constitutions of the three NHS Foundation Trusts².
- 1.2 It operates within the NWUHG Governance Framework and the risk-based Board oversight model which is brought together through the Group Risk Assurance Committee (GRAC). It is a governing assurance committee, not a management or operational forum.
- 1.3 The Committee has no powers other than those specifically stipulated in these Terms of Reference.

2. Purpose and function

- 2.1 For the purposes of this Committee, quality is defined as patient safety, clinical effectiveness and patient experience), focused on patient outcomes, including the timeliness, effectiveness and equality of care.
- 2.2 The purpose of the Group Quality and Outcomes Committee is to provide Non-Executive-Director led challenge and seek assurance in respect of the quality of care provided across the Trusts within NWUHG. It does not own, manage or direct quality activities, nor does it substitute for executive accountability. It will carry out its functions by:
 - Ensuring that the Trusts have appropriate quality governance structures, systems, processes and controls in place to achieve consistently high-quality care in line with the national NHS Quality Strategy³ and to meet the Trusts' legal and regulatory obligations.
 - Reviewing progress against the Trusts' quality priorities as set out in the Quality Accounts.
 - Seeking assurance that key risks relating to quality of care, as included on the Group Board Assurance Framework and the Trusts' Risk Registers, are being effectively managed and mitigated.
 - Identifying and reviewing themes and trends in key quality indicators and benchmarks, seeking assurance that appropriate action is being taken to respond to and learn from these.

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.

³ Quality Strategy for NHS-funded care in England, National Quality Board, NHS England, July 2026.

- Seeking assurance that appropriate progress is being made in implementing action plans put in place to address any shortcomings in quality of care.
- Promoting a mature quality assurance culture characterised by transparency, professional curiosity and explicit recognition of what is known, what is uncertain and what is not yet known.

2.3 While the Committee will report directly to the Group Board, it will work closely with the Group Risk Assurance Committee (via their respective Chairs) to avoid duplication and to ensure that the Group Risk Assurance Committee remains fully sighted on quality risk and assurance, given its remit across all aspects of enterprise risk.

3. Accountability and authority

3.1 The Committee is authorised by the Group Board to:

- Review, scrutinise and make recommendations on any activity relevant to its terms of reference.
- Seek any information it requires from any officer of the Group or the three Trusts that relates to the purpose of providing assurance to the Group Board on matters relevant to its terms of reference.
- Obtain independent professional advice as it deems necessary, should such advice not be available within the Group.
- Request the attendance of individuals from within or outside the Group and the Trusts where necessary.
- Establish sub-groups of the Committee to support the Committee in discharging its responsibilities.

3.2 The Committee is accountable to the Group Board.

4. Membership and attendance

4.1 The members of the Committee will be appointed by the Group Board and will comprise three Group Non-Executive Directors.

4.2 One of the Group Non-Executive Director members will be appointed as the Chair of the Committee. In their absence, another Group Non-Executive Director may chair the Committee.

4.3 At least one member of the Committee shall also be a member of the Group Risk Assurance Committee.

4.4 The Group Chief Executive will identify a link Executive Director or link Executive Directors for the Committee.

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- 4.5 The following will be invited to attend all meetings of the Committee but will not be members:
- One Group Associate Non-Executive Director
 - Group Chief Medical Officer
 - Group Chief Nurse
 - Trust Medical Directors
 - Trust Chief Nurses
 - Group Director of Midwifery
 - Group Director for Complex Health, Safeguarding and Professional Standards
- 4.6 The Chair of the Committee may invite other attendees as required for specific agenda items, including relevant Group Executive leads or other officers of the trusts.

5. Quorum

- 5.1 The quorum necessary for the transaction of business shall be two Group Non-Executive Director members.
- 5.2 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

6. Frequency of meetings

- 6.1 Meetings will be held monthly.
- 6.2 The Chair may convene additional meetings from time to time if business relating to the Committee requires urgent consideration.

7. Secretariat

- 7.1 The Group Director of Governance will ensure the provision of a Secretary to the Committee and appropriate administrative support to the Committee Chair and members in line with the Group standard. This will include:
- Agreement of the agenda with the Committee Chair and Executive lead(s)
 - Collation and circulation of papers
 - Producing minutes of the meetings
 - Keeping a record of agreed actions and follow up
 - Maintaining an annual workplan for the Committee
 - Advising the Committee Chair and members of the Committee as appropriate
- 7.2 Agendas will be circulated at least three clear working days in advance of each meeting, accompanied by supporting papers.

8. Meeting transparency and probity

- 8.1 The Committee Chair will ascertain, at the beginning of each meeting, the existence of any actual, potential or perceived conflicts of interest with matters on the agenda or related matters.

- 8.2 Such conflicts of interest will be managed by the Committee Chair and recorded in the minutes and, if appropriate, the Register of Declarations of Interest.

9. Duties and responsibilities

- 9.1 Receive a report at each meeting covering issues and risks escalated by the Group Chief Medical Officer and the Group Chief Nurse. This will draw on discussions at the Executive Quality Standards Group and the Trusts' Quality, Safety and Effectiveness Management Groups.
- 9.2 Scrutinise the effectiveness of the Trusts' quality governance arrangements, including the adequacy of controls, improvement actions, and learning and feedback mechanisms relied upon to maintain and improve the quality of patient care (in line with the national NHS Quality Strategy for NHS-funded care). This will encompass patient safety, clinical effectiveness and patient experience (including patient and community engagement and co-production).
- 9.3 Identify and review themes and trends in key quality indicators and benchmarks, including performance data, audit results and patient feedback, and seek assurance that appropriate action is being taken to respond to and learn from these.
- 9.4 Seek assurance that appropriate progress is being made in implementing action plans put in place to address any shortcomings in quality of care.
- 9.5 In conducting its business, have a clear focus on the equality of care and outcomes for patients, including with respect to protected characteristics.
- 9.6 Review quality-related risks on the Group Board Assurance Framework and significant risks relating to quality on the Trusts' risk registers, seeking assurance on the effectiveness of the controls in place to mitigate these risks and the actions to address identified gaps in controls and assurance, having regard to the Group Board's risk appetite.
- 9.7 Commission deep dives on specific quality issues or clinical services where performance and risk information indicates a potential lack of assurance on the quality of care being provided by the Trusts.
- 9.8 Celebrate and promote the sharing of examples of good practice, innovation and quality improvement across the Trusts.
- 9.9 Review on behalf of the Group Board quality-related reports and submissions requiring Board-level oversight and/or approval, including the annual Quality Accounts and Perinatal reports.
- 9.10 Seek assurance that appropriate arrangements are in place to achieve the Group's quality priorities as set out in the Quality Accounts.
- 9.11 Seek assurance that the Group is learning from the findings of external incidents and investigations which are relevant or potentially relevant to the quality of care provided by the Group.

- 9.12 Review any quality issues referred to the Committee by the Group Board or other Board Committees.
- 9.13 Develop an annual work programme agreed by the Committee to discharge the duties as set out above.

10. Reporting

- 10.1 The Committee Chair will provide a report to the Group Risk Assurance Committee and the Group Board after each meeting drawing attention to any matters that require disclosure or escalation. The report should highlight areas where the quality of care is or may be materially affected by issues outside of the Committee's direct assurance (e.g. financial, infrastructure, resource or cultural), to support appropriate triangulation of such matters.
- 10.2 The minutes of the Committee's meetings will be available for information to all members of the Group Board.
- 10.3 The Committee will produce an annual report to the Group Board detailing how it has discharged its responsibilities and met its terms of reference.

11. Review of terms of reference

- 11.1 The Terms of Reference will be reviewed by the Committee and approved by the Group Board at least once a year.

Date approved by the Boards of Directors:

Next review date:

Walker Ian
05/10/2026 10:45:15

GROUP RISK ASSURANCE COMMITTEE

TERMS OF REFERENCE

1. Introduction

- 1.1 The Norfolk and Waveney University Hospitals Group (NWUHG) Group Risk Assurance Committee is a formally constituted committee of the Group Board of Directors (the General Purpose Joint Committee), established under the Provider Collaboration Agreement¹ and the Constitutions of the three NHS Foundation Trusts².
- 1.2 The Committee has no powers other than those specifically stipulated in these Terms of Reference.

2. Purpose and function

- 2.1 The Committee provides non-executive oversight of the adequacy and effectiveness of the Group's risk management, control and assurance systems, with specific focus on the principal risks to the achievement of the Group's strategic aims and objectives.
- 2.2 The Committee shall seek assurance across the full range of clinical and non-clinical risks, recognising that the Group's strategic aims may be impacted by operational, financial, workforce, digital, estates, compliance and quality risks. In doing so, it will rely for some areas of risk on assurance sought by other Group Board committees including the Quality and Outcomes Committee, the Strategy, Technology, Investments and Partnerships Committee, the Research, Innovation and Education Committee and the three Link Non-Executive Director teams.
- 2.3 The Committee provides independent challenge and assurance. It does not own or manage risks, nor direct the manner of their treatment. The Committee's role is to provide assurance to the Group Board.

3. Accountability and authority

- 3.1 The Committee is authorised by the Group Board to:
 - Review, scrutinise and make recommendations on any activity relevant to its terms of reference.
 - Seek any information it requires from any officer of the Group or the three Trusts that relates to the purpose of providing assurance to the Group Board on matters relevant to its terms of reference.

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.

- Commission thematic deep dives or independent reviews into areas of significant risk or control weakness.
- Recommend escalation of risks to the Group Board where assurance is insufficient or residual risk exceeds risk appetite.
- Obtain independent professional advice as it deems necessary, should such advice not be available within the Group.
- Request the attendance of individuals from within or outside the Group and the Trusts where necessary.
- Refer matters to other Group Board committees for scrutiny and to seek assurance on behalf of the Group Risk Assurance Committee.
- Establish sub-groups of the Committee to support the Committee in discharging its responsibilities.

3.2 The Committee is accountable to the Group Board.

4. Membership and attendance

4.1 The members of the Committee will be appointed by the Group Board and will comprise three Group Non-Executive Directors. Wherever possible, each member of the Committee should also be a Link Non-Executive Director for each of the three Trusts.

4.2 One Group Non-Executive Director will be appointed as the Chair of the Committee by the Group Board.

4.3 The Group Chief Executive will identify a link Executive Director for the Committee.

4.4 The following will be invited to attend all meetings of the Committee but will not be members:

- Group Chief Executive
- Group Chief Delivery Officer
- Group Chief Finance Officer
- Group Chief Medical Officer
- Group Chief Nurse
- Group Chief People Officer
- Group Director of Digital
- Group Director of Governance
- Group Director of Communications and Engagement
- Executive Managing Directors of the three Trusts

4.5 The Chair of the Committee may invite other attendees as required for specific agenda items, including relevant Group Executive leads or other officers of the trusts; commercial, legal or financial advisers; and system or partner representatives.

5. Quorum

5.1 The quorum necessary for the transaction of business will be two members.

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- 5.2 A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee as a whole.

6. Frequency of meetings

- 6.1 Meetings will be held monthly.
- 6.2 The Chair may convene additional meetings from time to time if business relating to the Committee requires urgent consideration.

7. Secretariat

- 7.1 The Group Director of Governance will ensure the provision of a Secretary to the Committee and appropriate administrative support to the Committee Chair and members in line with the Group standard. This will include:
- Agreement of the agenda with the Committee Chair and Executive lead(s)
 - Collation and circulation of papers
 - Producing minutes of the meetings
 - Keeping a record of agreed actions and follow up
 - Maintaining an annual workplan for the Committee
 - Advising the Committee Chair and members of the Committee as appropriate

- 7.2 Agendas will be circulated at least three clear working days in advance of each meeting, accompanied by supporting papers.

8. Meeting transparency and probity

- 8.1 The Committee Chair will ascertain, at the beginning of each meeting, the existence of any actual, potential or perceived conflicts of interest with matters on the agenda or related matters.
- 8.2 Such conflicts of interest will be managed by the Committee Chair and recorded in the minutes and, if appropriate, the Register of Declarations of Interest.

9. Duties and responsibilities

- 9.1 Review the Group's Risk Management Strategy and Policy and risk appetite statement on an annual basis ahead of approval by the Group Board.
- 9.2 Review, challenge and seek assurance on the adequacy and effectiveness of risk treatment for principal risks set out in the Group Board Assurance Framework (BAF).
- 9.3 Review, challenge and seek assurance on the adequacy and effectiveness of risk treatment for Trust and Group operational and programme risks scoring 12 or above in line with the escalation threshold in the Group's Risk Management Policy.

- 9.4 Scrutinise applied controls and mitigation plans, ensuring they are evidence-based, proportionate, aligned with the Group Board's approved risk appetite and have clear ownership and delivery milestones.
- 9.5 Evaluate the strength, independence and triangulation of assurance sources.
- 9.6 Recommend escalation or de-escalation of risks to the Group Board Assurance Framework.
- 9.7 Commission thematic deep dives into risks where mitigation is weak or assurance is misaligned.
- 9.8 Specifically, scrutinise and seek assurance on operational and financial performance and risks across the three Trusts against national targets and Medium-term Plan trajectories.
- 9.9 Receive a report from the Chair of the Executive Risk Assurance Group highlighting any risks requiring escalation to the Group Risk Assurance Committee.
- 9.10 Receive an exception report at each meeting from the Quality and Outcomes Committee drawing the Group Risk Assurance Committee's attention to any significant areas of concern or risk identified by the Quality and Outcomes Committee.
- 9.11 Promote a risk-mature culture across the Group by supporting transparency, shared ownership, and the routine use of the Group BAF for informed Board decision-making.
- 9.12 Where risk treatments appear inadequate, excessive or misaligned, the Committee may recommend moderations or adjustments. Executive Directors in attendance will consider how best to action such moderations but remain accountable for ownership and management of risks.

10. Reporting

- 10.1 The Committee Chair will provide a report to the Group Board after each meeting drawing attention to any matters that require disclosure or escalation to the Group Board. The Committee Chair shall escalate significant risks or failures immediately to the Board.
- 10.2 The minutes of the Committee's meetings will be available for information to all members of the Group Board.
- 10.3 The Committee will produce an annual report to the Group Board detailing how it has discharged its responsibilities and met its terms of reference.

Walker Ian
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11. Review of terms of reference

- 11.1 The Terms of Reference will be reviewed by the Committee and approved by the Group Board at least once a year.

Date approved by the Boards of Directors:
Next review date:

Walker Ian
05/10/2026 10:45:15

Report to the Group Board: 7 October 2026

Agenda item number	17		
Title	Standing Financial Instructions amendments		
Author(s)	Deputy Director of Finance – Operations NNUH		
Executive sponsor	Marcus Thorman, Group Chief Finance Officer		
Purpose of report	For decision ☒	For discussion ☐	For information ☐

Executive summary

The Standing Financial Instructions (SFIs) were standardised across the three Trusts and approved by their Boards of Directors (as a matter reserved to each Board) on 1 April 2026. This paper sets out proposed amendments to the SFIs to reflect matters subsequently identified as requiring inclusion and clarification, relating to:

- The management and approval of Contract Change Notices (CCNs).
- Approval of expenditure or contractual commitments by Group Executive Directors.
- Explicit inclusion of provisions for grant and donation funding in relation to business cases and capital plans.

Details of the proposed amendments are set out in the paper and as tracked changes in the appended copy of Section 8 of the SFIs (no other sections are subject to changes). The proposed amendments were reviewed and agreed by the Group Audit Committees in Common at their meeting on 7 September 2026.

Recommendations

On the recommendation of the Group Audit Committees in Common, the Group Board is asked to:

- Approve the revisions to the Standing Financial Instructions of Norfolk and Norwich University Hospitals NHS Foundation Trust, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust.
- Approve the revisions to the Standing Financial Instructions of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.
- Approve the revisions to the Standing Financial Instructions of James Paget University Hospitals NHS Foundation Trust, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust.

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Alignment to Board Assurance Framework risk(s)	Principal Risk PR4 (financial sustainability), PR14 (corporate governance)
Previously considered by	Group Audit Committees in Common, 7 September 2026
Any background papers in Admin Control Reading Room	No

Walker Ian
05/10/2026 10:45:15

Norfolk and Waveney University Hospitals Group

Group Board in public: 7 October 2026 Standing Financial Instructions amendments

1. Introduction and background

- 1.1 The Standing Financial Instructions (SFIs) were standardised across the three Trusts and approved by their Boards of Directors (as a matter reserved to each Board) on 1 April 2026. This paper sets out some proposed amendments to the SFIs to reflect matters subsequently identified as requiring inclusion and clarification.
- 1.2 The proposed amendments were reviewed and agreed by the Group Audit Committees in Common at their meeting on 7 September 2026.
- 1.3 Details of the proposed amendments are set out in the paper and as tracked changes in the appended copy of Section 8 of the SFIs (no other sections are subject to changes).

2. Proposed amendments

Contract Change Notices

- 2.1 It was recently identified that Section 8.4 of the Standing Financial Instructions relating to expenditure and contractual commitments did not explicitly reference the position in relation to use of Contract Change Notices (CCNs). It was therefore agreed that the SFIs should be amended to include this.
- 2.2 It is therefore proposed that a new paragraph (8.4.8 in the appended version) is added to the SFIs to state that the approval of a change to an existing contract is based on the value of the increase (rather than the total value of the amended contract) with the exception of where the total value of the amended contract then exceeds the next approval threshold. An example is provided for clarity.

Approval of expenditure or contractual commitments by Group Executive Directors

- 2.3 It has been identified that the current version of the SFIs specifies within Section 8.4 financial approval limits for expenditure and contractual commitments for the Group Chief Executive, Group Chief Finance Officer, Group Chief Delivery Officer and Executive Managing Directors. However, it does not specify a financial approval limit for other Group Executive Directors.
- 2.4 It is therefore proposed to add a new paragraph 8.4.5 specifying that expenditure or contractual commitments up to £250,000 may be approved by the relevant Group Executive Director.

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Provisions for grant and donation funding in relation to business cases and capital plans

- 2.5 Paragraphs 8.2.5 and 8.3.4 of the appended SFIs relating to investment and capital plan approvals provide for higher approval limits in the case of investment/capital spend which is fully backed by additional NHS England income/Public Dividend Capital.
- 2.6 It is proposed to amend these paragraphs to make the “additional” nature explicit and also to extend these higher approval limits to grant and donation funding.

3. Recommendations

- 3.1 On the recommendation of the Group Audit Committees in Common, the Group Board is asked to:
- Approve the revisions to the Standing Financial Instructions of Norfolk and Norwich University Hospitals NHS Foundation Trust, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust.
 - Approve the revisions to the Standing Financial Instructions of Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust.
 - Approve the revisions to the Standing Financial Instructions of James Paget University Hospitals NHS Foundation Trust, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust.

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**Standing Financial Instructions of:
Norfolk and Norwich University Hospitals NHS Foundation
Trust
James Paget University Hospitals NHS Foundation Trust
The Queen Elizabeth Hospital King's Lynn NHS Foundation
Trust**

Adopted independently by each Trust's Board of Directors

Effective from 13 May 2026

These Standing Financial Instructions shall be read in conjunction with the Finance Operating Manual and the Scheme of Reservation and Delegation.

This document supersedes previous versions of the Standing Financial Instructions.

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Approved by the Boards of Directors on 12 May 2026

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8 FINANCIAL APPROVAL THRESHOLDS AND NON-PAY EXPENDITURE

8.1 STATUS OF FINANCIAL THRESHOLDS

- 8.1.1 The financial approval thresholds set out in this section define the maximum levels of financial authority delegated by each Trust Board through the Scheme of Reservation and Delegation.
- 8.1.2 No officer or committee may approve expenditure, capital investment, contractual commitment, write-off or other financial transaction above the limits specified in this section.
- 8.1.3 These thresholds may be amended only by formal approval of each Trust Board.

8.2 INVESTMENT

- 8.2.1 Outline Business Cases and Full Business Cases for investment above £5,000,000 shall require approval by the General Purpose Joint Committee acting as the Group Board, subject to NHS England approval where applicable.
- 8.2.2 Investment between £3,500,000 and £5,000,000 may be approved by the Chief Executive Officer, subject to NHS England approval where applicable.
- 8.2.3 Investment between £2,000,000 and £3,500,000 may be approved by the Chief Finance Officer or Chief Delivery Officer, subject to NHS England approval where applicable.
- 8.2.4 Investment up to £2,000,000 may be approved by the relevant Executive Managing Director.
- 8.2.5 Business cases for investment fully backed by **additional** NHS England income, **grants or donations** will be subject to the following higher approval limits:
 - a) Above £20,000,000 – approval by the General Purpose Joint Committee
 - b) Between £15,000,000 and £20,000,000 – approval by the Chief Executive Officer
 - c) Between £10,000,000 and £15,000,000 – approval by the Chief Finance Officer or Chief Delivery Officer
 - d) Up to £10,000,000 – approval by the relevant Executive Managing Director

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- 8.2.6 Where the approved value of a capital scheme is forecast to exceed the authorised amount, revised approval shall be obtained at the appropriate threshold.

8.3 CAPITAL PLAN

- 8.3.1 The General Purpose Joint Committee acting as the Group Board is responsible for approving the Capital Plan at the start of the financial year.
- 8.3.2 The Trust Hospital Management Group has delegated authority to reallocate spend across capital schemes within the Group Board approved total plan value.
- 8.3.3 For specific NHS England funded schemes identified and agreed by the Group Board at the start of the year, authority is delegated to the Chief Finance Officer or the Chief Delivery Officer to authorise commitments in excess of the Group Board approved plan insofar as those commitments are fully funded by NHS England.
- 8.3.4 For capital spend that is backed by **additional** in year NHS England Public Dividend Capital, **grant or donation** funding, authority to increase the capital plan is delegated as follows:
- (a) Between £15,000,000 and £20,000,000 – approval by the Chief Executive Officer
 - (b) Between £10,000,000 and £15,000,000 – approval by the Chief Finance Officer or Chief Delivery Officer
 - (c) Up to £10,000,000 – approval by the relevant Executive Managing Director

8.4 EXPENDITURE AND CONTRACTUAL COMMITMENTS

- 8.4.1 Expenditure or contractual commitments above £5,000,000 shall require approval by the General Purpose Joint Committee acting as the Group Board.
- 8.4.2 Expenditure or contractual commitments between £3,500,000 and £5,000,000 may be approved by the Chief Executive Officer.
- 8.4.3 Expenditure or contractual commitments between £2,000,000 and £3,500,000 may be approved by the Chief Finance Officer or Chief Delivery Officer.
- 8.4.4 Expenditure or contractual commitments up to £2,000,000 may be approved by the relevant Executive Managing Director.

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8.4.5 Expenditure or contractual commitments up to £250,000 may be approved by the relevant Group Executive Director.

8.4.6 Approval to enter into a contractual commitment must be sought either as part of a Full Business Case (see Section 8.2) or through a separate approval submission to the appropriate group or individual as detailed in Sections 8.4.1 to 8.4.5 above.

8.4.7 All commitments must be within approved budgets unless separately authorised by the appropriate approving body.

8.4.8 Approvals for contract changes are based on the value of the increase, rather than the total value of the amended contract, with the exception of when:

(a) The total value of the amended contract exceeds the next approval threshold, e.g. for an original contract for £4.0m approved by the Chief Executive, a subsequent contract change increase of £0.6m can be approved by the relevant Executive Managing Director, but a further contract change for £0.6m would then require approval from the Group Board because the total value of the contract then exceeds £5.0m

8.4.9 Approval for individual payments between members of the Norfolk and Waveney University Hospitals Group, where supported by a formal agreement or primary records (e.g. signed NHS contract, ICB income schedules, etc.) will be delegated as follows:

(a) Above £40,000,000 – Chief Executive Officer or Chief Finance Officer or Chief Delivery Officer

(b) Between £25,000,000 and £40,000,000 – relevant Director of Finance or relevant Executive Managing Director

(c) Up to £25,000,000 – relevant Director of Finance or formally named delegate

8.5 LOSSES AND SPECIAL PAYMENTS

8.5.1 Proposals for write-off of losses or making of special payments above the delegated limits to the Chief Executive Officer and Chief Finance Officer shall require approval by the General Purpose Joint Committee acting as the Group Board.

8.5.2 Delegated limits for losses and special payments shall comply with HM Treasury and NHS England requirements and shall be those approved by each Trust Board through the Scheme of Reservation and Delegation. The Finance Operating Manual may reproduce those limits for operational use, but shall not amend, override, or extend them.

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- 8.5.3 All losses and special payments shall be reported to the Audit Committees in Common in accordance with applicable guidance.

8.6 VIREMENTS AND BUDGET TRANSFERS

- 8.6.1 The Chief Finance Officer may approve budget virements within the overall revenue limit approved by the Group Board.
- 8.6.2 Detailed virement procedures and sub-delegated limits shall be set out in the Finance Operating Manual.
- 8.6.3 Virements that materially alter service delivery, strategic intent or risk exposure shall be reported to the Group Board.

8.7 TRANSPARENCY AND REPORTING OF SIGNIFICANT APPROVALS

- 8.7.1 All approvals of investment, expenditure or contractual commitments above £2,000,000 shall be reported to the next meeting of the General Purpose Joint Committee acting as the Group Board.
- 8.7.2 Such reporting shall be for transparency and oversight and shall not imply retrospective approval where authority has been exercised in accordance with these Standing Financial Instructions.

8.8 AGGREGATION AND ANTI-AVOIDANCE

- 8.8.1 Financial limits apply to the total value of a scheme, contract or transaction.
- 8.8.2 Artificial splitting, phased structuring, or other arrangements designed to avoid approval thresholds are prohibited.

8.9 FUNDS HELD ON TRUST

- 8.9.1 Approval of expenditure on Charitable Funds above £250,000 (for Norfolk and Norwich University Hospitals NHS Foundation Trust) and above £125,000 (for Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and James Paget University Hospitals NHS Foundation Trust) shall require approval by the respective Trust Board. Approval of expenditure below these levels will require the approval of the respective Charitable Funds Committee, unless otherwise delegated by the Committee.

8.10 RELATIONSHIP TO FINANCE OPERATING MANUAL

- 8.10.1 The Chief Finance Officer shall issue and maintain a Finance Operating Manual setting out detailed financial procedures, documentation standards, sub-delegated authority levels and operational controls.
- 8.10.2 The Finance Operating Manual:

- (a) must operate within the authority and limits established by these Standing Financial Instructions and the Scheme of Reservation and Delegation;
- (b) may be amended by the Chief Finance Officer with the approval of the Chief Executive Officer;
- (c) shall not amend, override or extend any financial threshold or reserved authority established by the Trust Boards.

8.10.3 Material amendments to the Finance Operating Manual shall be reported to the Audit Committees in Common for scrutiny.

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Report to the Group Board in public: 7 October 2026

Agenda item number	18		
Title	Standing Orders of the Councils of Governors		
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

At its meeting on 3 June 2026, the Group Board received updated Standing Orders of the Councils of Governors. These Standing Orders regulate the conduct of the business of the Councils of Governors, including meetings, quora and decision making. They have been simplified and aligned across all three Trusts. An amendment was requested to state that Council of Governors’ meetings will be chaired by either the Group Chair or the Associate Chair for the Trust (or another Group Non-Executive Director in their absence). This amendment has been incorporated in the appended version.

Once approved by the Boards of Directors, approval will also be sought from each Council of Governors.

Recommendations

The Group Board is asked to:

- Approve the Standing Orders of the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust.
- Approve the Standing Orders of the Council of Governors of Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust.
- Approve the Standing Orders of the Council of Governors of James Paget University Hospitals NHS Foundation Trust, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust.

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Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 14 (corporate governance)
Previously considered by	Group Board, 3 June 2026
Any background papers in Admin Control Reading Room	No

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Standing Orders for Practice and Procedure of the Council of Governors

1. Introduction

- 1.1 These Standing Orders set out the practice and procedure of the Council of Governors of each of Norfolk and Norwich University Hospitals NHS Foundation Trust, the James Paget University Hospitals NHS Foundation Trust, and Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (**the Trusts**). The Trusts are working together as the Norfolk and Waveney University Hospitals Group (**the Group**).

2. Interpretation

- 2.1 Save as permitted by law and subject to the Constitution of the relevant Trust, the Group Chair of the Trust shall be the final authority on the interpretation of these Standing Orders (on which they should be advised by the Group Secretary).
- 2.2 Unless contrary intention is evident or the context requires otherwise, words or expressions contained in these Standing Orders shall bear the same meaning as in the relevant Trust's Constitution.
- 2.3 These Standing Orders apply to each Council of Governors within the Group and references in these Standing Orders shall be interpreted accordingly to refer to the relevant Trust and its structures and policies, including its Constitution.
- 2.4 References to the 'Associate Chair of the Trust' relate to the Group Non-Executive Director appointed by the Group Board to that position as one of the Link Non-Executive Directors for the Trust.
- 2.5 References to the role of 'Group Chair' in this document shall be deemed to include the role of 'Associate Chair of the Trust'.

3. General

- 3.1 All business shall be conducted in the name of the Trust.

4. Meetings

- 4.1 Meetings of the Council of Governors must be open to the public, unless the Group Chair in their absolute discretion decides otherwise in accordance with paragraph 19.3 of the Constitution.
- 4.2 The Group Chair shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that business shall be conducted without interruption and disruption. The Chair of the meeting may exclude any member of the public or representative from the press

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from a meeting of the Council of Governors if they consider that that member of the public or representative from the press is interfering with or preventing the proper conduct of the meeting.

4.3 Any record of the proceedings taken by the public or representatives of the press shall only be in writing unless otherwise agreed by the Group Chair.

4.4 The Council of Governors is not obligated to permit recording or live reporting of the proceedings without the Group Chair's prior consent.

4.5 Calling Meetings

4.5.1 Meetings of the Council of Governors shall be held at such times, places and format (including in-person, electronic, or hybrid) as determined by the Group Chair. The Group Chair may also call additional meetings as needed.

4.5.2 Governors can request a meeting by notifying the Group Chair with a notice signed by at least one third of the governors.

4.5.3 If the Group Chair refuses to call a meeting after a requisition for that purpose has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them, such one-third or more of the members of the Council of Governors may forthwith call a meeting of the Council of Governors for the purposes of conducting that business.

4.6 Notice of Meetings

4.6.1 Before each meeting, a notice of the meeting, specifying the business proposed to be transacted, shall be delivered to every governor by email so as to be available to them at least seven clear days before the meeting. The Group Chair may waive the notice required in the case of emergencies or in the case of the need to conduct urgent business.

4.6.2 Failure to serve notice on any governor shall not affect the validity of a meeting.

4.6.3 A public notice of the date, time and place of each Council of Governors meeting will also be displayed on the Trust's website at least three clear days before the meeting, except in the case of emergency meetings.

4.7 Setting the Agenda

4.7.1 The agenda for all the meetings will be prepared by the Group Chair and the Group Secretary.

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- 4.7.2 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.
- 4.7.3 A governor desiring a matter to be included on an agenda, shall make their request in writing to the Group Chair at least 10 clear days before the meeting save in an emergency.
- 4.8 Chair of Meeting
- 4.8.1 At any meeting of the Council of Governors, the Group Chair or the Associate Chair for the Trust, if present, shall preside. If both are absent from the meeting, such Group Non-Executive Director as the Directors present shall choose shall preside.
- 4.8.2 If the Group Chair or the Associate Chair of the Trust is absent from a meeting temporarily on the grounds of a declared conflict of interest, or are disqualified from participating, such Group Non-Executive Director as the Directors present shall choose shall preside.
- 4.9 Quorum
- 4.9.1 No business shall be transacted at a meeting of the Council of Governors unless one third of the total number of governors in post is present with a majority of those present being Public Governors.
- 4.9.2 If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for seven days and upon reconvening, those present shall constitute a quorum.
- 4.9.3 If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.
- 4.10 Attendance at Meetings
- 4.10.1 The Group Chair may agree that members of the Council of Governors can participate in its meetings by telephone, video or computer link provided it remains live and uninterrupted. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.
- 4.10.2 Governors who are unable to attend a meeting should advise the Group Secretary in advance of the meeting so that their apologies may be submitted.

4.11 Chair's Ruling

- 4.11.1 Statements of governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.12 Voting

- 4.12.1 Subject to any legal requirements or any requirements of the Constitution, if in the opinion of the Chair of the meeting a vote should be required on a question at a meeting of the Council of Governors, it shall be determined by a majority of the votes of the governors present and voting on the question.
- 4.12.2 All questions put to a vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A secret paper ballot may also be used if a majority of the governors present so request or if the Chair of the meeting so directs.
- 4.12.3 In no circumstances may an absent governor vote by proxy. Absence is defined as being absent at the time of the vote.
- 4.12.4 The Group Chair, or a Group Non-Executive Director chairing the meeting on behalf of the Group Chair, is not a member of the Council of Governors and shall not be entitled to vote.

4.13 Minutes

- 4.13.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting, where they will be signed by the person presiding at it.
- 4.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair of the meeting considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.
- 4.13.3 The names of the governors present at the meeting shall be recorded in the minutes.
- 4.13.4 Minutes shall be circulated in accordance with the Council of Governors wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

5. Lead Governor and Deputy Lead Governor

- 5.1 In accordance with paragraph 16.1 of the Constitution, the governors will appoint one of the governors to be the Lead Governor. The role of the

Lead Governor is defined in NHS England's Code of Governance for NHS Provider Trusts.

- 5.2 The Council of Governors may choose to appoint a Deputy Lead Governor to deputise for and support the Lead Governor.
- 5.3 The Lead Governor and the Deputy Lead Governor must be public governors. If an individual in either of these roles ceases to be a public governor, their appointment as Lead Governor or Deputy Lead Governor will cease with immediate effect.
- 5.4 The Trust Secretary will administer the nominations process for the appointment of the Lead Governor. Nominations will be sought from among the public governors and, in the event of more than one nomination being received for the role, the Trust Secretary will administer a ballot of all governors, with each governor having one vote. The governor receiving most votes will be elected to the position of Lead Governor.
- 5.5 The optional appointment of a Deputy Lead Governor will be agreed by the Council of Governors on the basis of a recommendation from the Group Chair and the Lead Governor.
- 5.6 The appointments as Lead Governor and Deputy Lead Governor shall be for a period of three years or (if earlier) until the individual resigns the position by giving notice to the Group Chair in writing, or until the individual is removed from the position by a resolution passed by at least three quarters of the remaining governors at a general meeting of the Council of Governors.
- 5.7 An individual may serve for more than one term as Lead Governor or Deputy Lead Governor subject to a maximum tenure in each role of six years.

6. Arrangements for the Exercise of Functions

- 6.1 The Council of Governors may not delegate any of its functions or powers to an individual, committee, or sub-committee, but it may appoint groups consisting of its members, Directors and other persons to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the Group Secretary, request that advisers assist them or any working group they appoint in carrying out its duties.
- 6.2 To assist it in carrying out its functions, the Council of Governors may also agree to establish groups or committees in common with the Councils of Governors of the other Trusts working together as the Norfolk and Waveney University Hospitals Group. As set out in paragraph 6.1, no functions or powers may be delegated to such groups or committees.

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- 6.3 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All members of the Council of Governors have a duty to disclose any non-compliance with these Standing Orders to the Group Secretary as soon as possible.

7. Standards of Business Conduct and Interests

- 7.1 Each member of the Council of Governors shall comply with the Trust's Standard of Business Conduct, Conflicts of Interest and Anti-Fraud and Anti-Bribery Policies.
- 7.2 Governors are required to comply with the Trust's Standards of Business Conduct, to declare interests that are required to be declared by the Constitution and to declare any other interests that are material to the Council of Governors. All governors should declare such interests on appointment and on any subsequent occasion that a conflict arises.
- 7.3 If a conflict of interest is established during the course of a meeting of the Council of Governors, the governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt this includes voting on such an issue where a conflict is established.
- 7.4 If members of the Council of Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Group Chair or the Group Secretary.
- 7.5 Every Governor shall disclose to the Group Secretary any relationship between themselves and a candidate of whose candidature that a member of the Council of Governors is aware.
- 7.6 On election or appointment, Governors should disclose to the Group Secretary whether they are related to any other member of the Council of Governors or holder of any office in the Trust.
- 7.7 In accordance with the Constitution, the Group Secretary will ensure that a Register of Interests is established to record formal declarations of interests of governors.

8. Confidentiality

- 8.1 A governor shall not disclose a matter reported to the Council of Governors or otherwise dealt with by the Council of Governors, notwithstanding that the matter has been reported, or action has been concluded, if the Council of Governors shall resolve that it is confidential or they are otherwise notified that such matter is confidential by a Director of the Trust.

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- 8.2 A governor shall not reveal or disclose the contents of papers marked 'in confidence' or minutes headed 'Items taken in Private' outside of the Trust, without the express permission of the Group Chair. This prohibition shall apply equally to the content of any discussion during the meeting which may take place on such reports and papers.

9. Review, Suspension and Change of Standing Orders

- 9.1 The Standing Orders may not be suspended by the Council of Governors.
- 9.2 These Standing Orders may only be amended if agreed by the Board of Directors of the Trust.
- 9.3 These Standing Orders shall be reviewed at least every three years.

10. Adoption

- 10.1 These Standing Orders were approved by the Council of Governors on [DD MM YYYY] and take effect immediately.

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Report to the Group Board in public: 7 October 2026

Agenda item number	19		
Title	Appointment of Group Deputy Chair		
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

To support continuity over the course of the next year, the Group Chair has decided to appoint a Group Deputy Chair to support the functions and responsibilities of the Group Chair.

The Group Chair therefore invited expressions of interest from among the Group Non-Executive Directors (NEDs). Two Group NEDs expressed an interest in the position and produced supporting statements which the Group Chair discussed with the three Trusts' Lead Governors and with Sally Collier as Senior Independent Director.

After due consideration, the Group Chair proposes to appoint Andy McKechnie to the role of Group Deputy Chair for an initial period of one year. This will cover the period of transition to a new Group Chair.

In accordance with the Trust Constitution, a Deputy Chair is appointed by the Trusts' Boards of Directors.

Recommendations

The Group Board is asked to approve the appointment of Andy McKechnie to the role of Group Deputy Chair for an initial period of one year with immediate effect.

Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 14 (corporate governance)
Previously considered by	n/a
Any background papers in Admin Control Reading Room	No

Report to the Group Board in public: 7 October 2026

Agenda item number	20		
Title	Group Board Assurance Framework (BAF)		
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 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.

Group Board members are specifically invited to reflect on whether, in light of discussions at this Group Board meeting and at recent Group Board committees, there are any amendments required to existing BAF risks or additional strategic risks which should be considered for inclusion on the BAF.

Recommendations

The Group Board is asked to:

- Note and comment on the appended Group BAF, and specifically whether there are any further strategic risks identified by the Group Board which should be considered for inclusion.
- Agree that, going forward, proposed amendments to Group BAF current risk scores are reviewed and agreed by the Group Board committee with oversight of the relevant risk, based on a recommendation from GRAC.
- Note the further work planned to populate and develop the BAF in the period ahead.

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Alignment to Board Assurance Framework risk(s)	All BAF risks
Previously considered by	Group Risk Assurance Committee, 30 September 2026
Any background papers in Admin Control Reading Room	Full Group BAF document

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Norfolk and Waveney University Hospitals Group

Group Board in public: 7 October 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 three changes to current risk scores in the past two months (since the previous Group Board report), as detailed below
- 2.2 Over the past two months, no risks have been de-escalated from the BAF.
- 2.3 The following points are highlighted from the reviews over the past two months:
 - PR2 (maternity services): ERAG considered an amendment to the risk descriptor, a potential reduction in the current risk score from 11 to 10, and a revision to the risk trajectory. It was agreed to leave these unchanged at this stage, subject to further assessment over the next quarter taking account of recent new national recommendations and guidance (as covered elsewhere on the Group Board agenda).
 - PR3 (access, flow and productivity): an amended risk trajectory which maintains the risk at its current level of 12, with a later reduction to 11 from January 2027 to reflect the anticipated impact of additional elective funding, and with a further reduction to 9 from August 2027 following EPR roll-out. ERAG and GRAC supported this amendment but also

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noted current operational pressures, particularly in relation to urgent and emergency care, and hence the potential need to consider an increase in the risk in the next monthly review cycle.

- PR6 (digital capability and data readiness): a reduction in the current risk score from 13 to 12 in line with trajectory, on the basis that the Single Digital Team consultation has progressed, with the senior team now in place; the EPR delivery partner is in place and the diagnostic is complete; national tenant agreements have been signed following discovery work in August 2026; and the Business Intelligence model has been agreed by the Executive. On this basis, a Likelihood rating of 4 rather than 5 is judged appropriate.
- PR7 (EPR programme and dependent change): a reduction in the current risk score from 13 to 12 in line with trajectory, on the basis that the new EPR delivery partner is in place and under contract. Initial discovery work is complete, with the programme rated as Amber.
- PR8 (cyber security): a reduction in the current risk score from 13 to 12 - ahead of trajectory - through an improvement in control effectiveness from 4 to 3. SOC SIEM (Secure Boundary) and MFA Software Solutions (part of Control C3 and C4) are now fully in place and operational, and demonstrated to be working. All MFA systems used for Trusts' remote access are now enforced. Work is ongoing to enforce third party cloud-based MFA. The trusts are on track to close NIS regulatory notices by December 2026. This will be subject to further review by the Group Strategy, Technology, Investments and Partnerships Committee in October 2026.
- PR11 (transformation capacity): an amendment to the assurance strength rating from Very Limited assurance to Limited assurance in line with the Transformation Design Authority (TDA) assessment.
- PR13 (New Hospitals Programme): a revised trajectory to reflect the timetable for the clinical strategy and Case for Change and Health Overview and Scrutiny Committee (HOSC) engagement.
- PR9 (estates and infrastructure) and PR15 (public and stakeholder confidence) remain under review with their risk leads.
- More generally, in line with the development of risk summary reporting to GRAC, each BAF risk has been assigned a link Group Board committee which will have a specific role in reviewing the risk. At present, proposed changes in current risk scores are discussed at ERAG and presented to GRAC for agreement. The Chair of GRAC has proposed that, going forward, the relevant Group Board committee should review and agree any proposed changes in risk scores. ERAG and GRAC have discussed and supported this approach.

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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 visual presentation of the BAF risks; and the population of the risk appetite element of the BAF following the development of a draft risk appetite statement.
- 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, and specifically whether there are any further strategic risks identified by the Group Board which should be considered for inclusion.
- Agree that, going forward, proposed amendments to Group BAF current risk scores are reviewed and agreed by the Group Board committee with oversight of the relevant risk, based on a recommendation from GRAC.
- Note the further work planned to populate and develop the BAF in the period ahead.

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

C Current risk score

T Target risk score

Risk appetite range (to follow)

PR = Principal Risk

Report to the Group Board in public: 7 October 2026

Agenda item number	21		
Title	Compliance update		
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 report documents key publications in the period since the last Group Board meeting requiring Board action, oversight and/or assurance. It includes key regulatory guidance; national reports and inquiries, and responses to them; NHS England submission requirements; and national consultation exercises. The report documents how these are being progressed within the Trust and Group governance structure and forms the first stage of plans to develop a full ‘compliance map’ for the Group.

Recommendations

The Group Board is asked to note the compliance update.

Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 14 (corporate governance)
Previously considered by	n/a
Any background papers in Admin Control Reading Room	No

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Key compliance requirements

	Compliance issue	Publication date and organisation	Description	Trust/Group handling approach and status (as at 01.10.26)
1	Maternity and Neonatal Services Ten Point Plan and assurance process in response to Baroness Amos national investigation and Donna Ockenden review	NHS England 01.07.26 12.08.26	Requirement for Trusts to submit Board-approved baseline assessment by 25.09.26 and progress update by 31.12.26.	Baseline assessments submitted on 25.09.26, with approval at Group Quality and Outcomes Committee on 29.07.26 and paper to Group Board on 07.10.26.
2	National maternity triage specification	NHS England 07.07.26	Requirement to complete baseline assessments within three months and report to Boards in public; with full implementation of specification by July 2027.	Baseline assessments completed by all Trusts and reported to Group Quality and Outcomes Committee on 29.07.26, with paper to Group Board on 07.10.26.
3	Winter planning 2026/27	NHS England 17.07.26	Trust plans signed off by boards using Board Assurance Statements template and submitted by 30.09.26.	Trust BAS submissions reviewed by Group Risk Assurance Committee on 30.09.26 and approved under delegated authority of the Group Board.
4	Provider Capability Assessments 2026	NHS England 25.07.26	Requirement to submit PCA self-assessments for each Trust by 02.10.26 (07.10.26 agreed with NHSE).	Draft submissions being presented to Group Board on 07.10.26 for approval.
5	Townsend v Epsom and St Helier University Hospitals NHS Trust Supreme Court judgement re: patients who lack capacity – information request	NHS England 01.09.26	Requirement to submit information by 11.09.26.	Group response compiled and submitted by Group Safeguarding Lead. Update to be provided to Group Quality and Outcomes Committee in October 2026.

6	Thirlwall Inquiry report and recommendations – immediate actions	NHS England 21.09.26	Requirement to review Thirlwall report and findings at next available Board meeting. NHS England letter sets out five specific actions which Trusts are required to progress.	Paper received by Group Quality and Outcomes Committee on 29.07.26 and included on Group Board agenda for 07.10.26. Group Board paper of 07.10.26 covers these five actions. Future updates to be provided via the Group Quality and Outcomes Committee.
7	Unauthorised, inappropriate and unjustifiable access to confidential information by NHS employees	NHS England 25.09.26	Requirement to implement guidance with immediate effect.	Implementation being led by Group Chief People Officer and Group Director of Digital. Update noted at Group Risk Assurance Committee on 01.10.26.
8	Consultation on proposed NHS Education Funding Agreement for 2027-2030	NHS England 25.09.26	Consultation responses to be submitted to NHS England by 29.10.26.	Draft consultation response to be received by Group Research, Innovation and Education Committee on 22.10.26.

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