Group Board (General Purpose Joint Committee) Meeting in Public

Wed 03 June 2026, 10:30 - 12:45

Board Room, Queen Elizabeth Hospital, Gayton Road, King's Lynn, Norfolk PE30 4ET

Agenda

10:30 - 10:35
5 min

1. Agenda, welcome and apologies

For information *Group Chair*

0 - Group Board in public - Agenda - 03.06.26 iw.pdf (3 pages)

10:35 - 10:35
0 min

2. Declarations of interest

For information *Group Chair*

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

10:35 - 10:55
20 min

3. Reflections from Board walkrounds and Patient Story

For discussion *Group Chief Nurse*

10:55 - 11:00
5 min

4. Minutes of the previous meeting

For decision *Group Chair*

To approve the Minutes of the meeting held on 1 April 2026

Paper required

4 - Minutes of the Group Board meeting in public 01.04.26.pdf (11 pages)

11:00 - 11:00
0 min

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

For discussion *Group Director of Governance*

Paper required

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

11:00 - 11:15
15 min

6. Group Chief Executive's Report

For discussion *Group Chief Executive*

Paper required

6 - Group CEO Board Report iw.pdf (8 pages)

11:15 - 11:45
30 min

7. Executive Managing Directors' Reports

Walker,Ian
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7.1. Queen Elizabeth Hospital King's Lynn NHS FT

For discussion *Executive Managing Director*

Paper required

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

7.2. James Paget University Hospitals NHS FT

For discussion *Executive Managing Director*

Paper required

7.2 - JPUH EMD Group Board Report iw.pdf (7 pages)

7.3. Norfolk and Norwich University Hospitals NHS FT

For discussion *Executive Managing Director*

Paper required

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

11:45 - 11:55
10 min

8. Reports from the Chairs of Board Committees

8.1. Group Risk Assurance Committee

For information *Committee Chair*

Paper required

8.2. Group Audit Committees in Common

For information *Committee Chair*

Paper required

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

8.3. Group Research, Innovation and Education Committee

For information *Committee Chair*

Paper required

8.3 - Group Research, Innovation and Education Committee - Chair's report iw.pdf (3 pages)

8.4. Group Nomination and Remuneration Committees in Common

For information *Committee Chair*

8.4 - Group Nomination and Remuneration Committees in Common - Chair's report iw.pdf (2 pages)

11:55 - 12:15
20 min

9. Performance reports

9.1. Group Integrated Performance Report (including One Recovery)

For discussion *Group Chief Delivery Officer*

Paper required

9.1.1 - Group IPR cover sheet iw.pdf (7 pages)
9.1.2 - Group IPR - Apr 26 Group Board 280526 iw.pdf (60 pages)

9.2. Group Finance Report

For discussion *Group Chief Finance Officer*

Paper required

Walker,Ian
29/05/2026 11:13:09

9.2.1 - Group Finance Report cover sheet iw.pdf (1 pages)
9.2.2 - Group Finance Report M1 2627 iw.pdf (11 pages)

12:15 - 12:25

10. Group Board Assurance Framework

10 min

For discussion *Group Director of Governance*

- 10.1 - Report to Group Board - BAF update May 2026 iw.pdf (3 pages)
- 10.2 - NWUHG BAF - May 2026 iw.pdf (39 pages)

12:25 - 12:35
10 min

11. Group Governance Framework

For decision *Group Director of Governance*

- 11.1 - Group Governance Framework iw.pdf (7 pages)
- 11.2 - Appendix 1 Standing Orders of the Councils of Governors iw.pdf (7 pages)
- 11.3 - Appendix 2 Group Audit Committees in Common terms of reference iw.pdf (7 pages)
- 11.4 - Appendix 3 Strategy, Technology, Investments and Partnerships Committee - draft ToRs iw.pdf (5 pages)

12:35 - 12:35
0 min

12. Consent items

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

Paper required

12:35 - 12:40
5 min

13. Any Other Business

Group Chair

12:40 - 12:40
0 min

14. Questions from Members of the Public

For discussion *Group Chair*

To respond to pre-submitted questions

12:40 - 12:45
5 min

15. Meeting review and reflections

For discussion *Group Chair*

12:45 - 12:45
0 min

16. Date of the Next Meeting

For information

Wednesday 5 August 2026 at the Norfolk and Norwich University Hospital

12:45 - 12:45
0 min

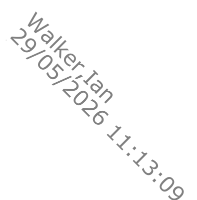
17. Resolution

For decision *Group Chair*

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

12:45 - 12:45
0 min

18. Close of Meeting


Walker,Ian
29/05/2026 11:13:09

Group Board (General Purpose Joint Committee)

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

AGENDA					
Time	**No.**	**Item**	**Purpose**	**Paper attached**	**Lead**
10.30	**1.**	**Welcome and apologies**			Group Chair
	2.	**Declarations of interest** Those present to declare any actual, potential or perceived interests relating to items on the agenda	For information	No	Group Chair
Patient story					
10.35	**3.**	**Reflections from Board walkrounds and Patient Story**	For discussion	No	Group Chief Nurse
Introductory items and reports					
10.55	**4.**	**Minutes of the previous meeting** To approve the Minutes of the meeting held on 1 April 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
11.00	**6.**	**Group Chief Executive's report**	For discussion	Yes	Group Chief Executive
11.15	**7.** 7.1 7.2 7.3	**Executive Managing Directors' reports** Queen Elizabeth Hospital King's Lynn NHS FT James Paget University Hospitals NHS FT Norfolk and Norwich University Hospitals NHS FT	For discussion	Yes	Executive Managing Directors

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11.45	**8.** 8.1 8.2 8.3 8.4	**Reports from the Chairs of Board Committees** Group Risk Assurance Committee Group Audit Committees in Common Group Research, Innovation and Education Committee Group Nomination and Remuneration Committees in Common	For information	Yes	Committee Chairs
Performance items					
11.55	**9.** 9.1 9.2	**Performance reports** Group Integrated Performance Report (including One Recovery) Group Finance Report	For discussion	 Yes Yes	 Group Chief Delivery Officer Group Chief Finance Officer
Governance items					
12.15	**10.**	**Group Board Assurance Framework**	For discussion	Yes	Group Director of Governance
12.25	**11.**	**Group Governance Framework**	For decision	Yes	Group Director of Governance
Consent items (*not for discussion unless notified to the Group Chair in advance*)					
	12.				

Other items					
12.35	**13.**	**Any other business**		No	Group Chair
12.40	**14.**	**Questions from members of the public** To respond to pre-submitted questions	For discussion	No	Group Chair
	15.	**Meeting review and reflections**	For discussion	No	Group Chair
	16.	**Date of the next meeting** Wednesday 5 August 2026 at the Norfolk and Norwich University Hospital.	For information		
	17.	**Resolution** That representative of the press and other members of the public be excluded for from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (NHS Act 2006 as amended by the Health and Social Care Act 2012)	For decision		Group Chair
12.45	**18.**	**Close of meeting**			

Group Board (General Purpose Joint Committee) Meeting in Public

Wednesday 1 April 2026, 10:30 - 12:45

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

Attendees

Board members

Lesley Dwyer (Group Chief Executive), David Roberts (Group Chair), Joanne Segasby (Group Chief Delivery Officer), Marcus Thorman (Group Chief Finance Officer), Rachael Cocker (Group Chief Nurse), Robert Sherwin (Group Chief Medical Officer), Michelle Arrowsmith (Executive Managing Director QEHKL), Jonathan Gardner (Executive Managing Director JPUH), Shane Gordon (Executive Managing Director NNUH), Edward Prosser-Snelling (Group Director of Digital), Jack Bowman (Group Non-Executive Director), Jo Churchill (Group Non-Executive Director), Sally Collier (Group Non-Executive Director), Nikki Gray (Group Non-Executive Director), William Van't Hoff (Group Non-Executive Director), Stephen Javes (Group Non-Executive Director), Ian Walker (Group Director of Governance)

Apologies

Philip Baker (Group Non-Executive Director)

Attendees

Charlie Helps FRSA (Secretary)

Meeting minutes

1. Welcome and Apologies

For Information

Group Chair

David Roberts, Group Chair, welcomed members of the public and Governors and extended a particular welcome to April Brown and Shruthi Belavadi from the National Provider Improvement Programme at NHS England.

Apologies were received from Philip Baker, Group Non-Executive Director. It was noted that Jo Churchill, Group Non-Executive Director, would be joining the meeting shortly.

The Chair declared that the meeting was quorate.

The Board **NOTED** the apologies and the formal opening of the meeting.

2. Declarations of Interest

For Information

Group Chair

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

No actual, potential or perceived interests were declared in addition to those already recorded.

3. Reflections from Board Walk-rounds and Patient Story

For Discussion

Group Chief Nurse

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Rachael Cocker, Group Chief Nurse, provided feedback from the walkrounds undertaken by Board members earlier in the day across four locations within the urgent and emergency care footprint at James Paget University Hospital (JPUH). It was noted that staff had engaged positively with changes already implemented, that quality improvement methods were becoming more visible in practice and that further work was required to strengthen links with primary care and community services in relation to discharge arrangements and neighbourhood working. Board members observed that the walkrounds had provided direct evidence from staff of operational pressures and improvement opportunities.

Dr Robert Major, Medical Director at JPUH, presented a patient story about a patient with a penetrating abdominal injury and traumatic cardiac arrest who was resuscitated and treated successfully through coordinated emergency, surgical and intensive care intervention. He explained that the case illustrated the value of multidisciplinary working, trauma network links and rapid clinical decision-making.
The Board noted the reflections from the Board walkrounds and the patient story.

4. Minutes of the Previous Meeting

For Decision

Group Chair

The Chair invited comments on the minutes of the previous Group Board meeting held on 17 December 2025.

Resolution: The Board resolved to approve the minutes of the meeting held on 17 December 2025 as a true and accurate record, subject to correction of the identified typographical errors.

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

For Discussion

Group Director of Governance

Ian Walker, Group Director of Governance, presented the action log and reported that the action concerning the composite list of legacy actions from the constituent Boards had been completed through a process of monthly tracking at the Executive Risk Assurance Group and quarterly reporting to the Group Risk Assurance Committee. He reported that the action concerning a financial briefing for Group Non-Executive Directors had also been completed, the briefing having taken place on 28 January 2026. He advised that the action concerning Emergency Preparedness, Resilience and Response and cyber assurance within the 2026/27 internal audit programme remained open because the Internal Audit Plan had not yet been finalised and would be considered by the Group Audit Committees in Common in April 2026.

Action: It was requested that the Group Chief Executive undertake a further Executive review of the 2026/27 Internal Audit Plan ahead of the April 2026 meeting of the Group Audit Committees in Common.

The Group Board noted the update on the action log.

6. Group Chief Executive's Report

For Discussion

Group Chief Executive

Professor Lesley Dwyer, Group Chief Executive, presented her report and explained that it should be read alongside the Executive Managing Directors' reports at agenda item 7. She updated the Board on work discussed at the recent Board away day to analyse population needs and consider the Group's response to the NHS 10-Year Plan, noting the restrictions arising from being in a local government pre-election period.

She reported that the Quarter 3 National Oversight Framework (NOF) rankings showed a positive movement across the Group, including an improvement for Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) from segment 4 to segment 3 and smaller improvements within segment 4 for JPUH and Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH), while making clear that the position at QEH remained fragile and required sustained attention.

Walker, Ian
29/05/2026 11:15:09

The Group Chief Executive reported that QEH had been included within the National Provider Improvement Programme (NPIIP) and that the Trust and the Group would continue to work with the programme to strengthen governance, clinical care, safety and staff engagement. She also reported on the implementation of the Group corporate services transformation, including transfer arrangements for some staff and the creation of Group-wide functions across a range of corporate services. She advised that the national staff survey results across all three Trusts were disappointing, particularly in relation to

engagement, morale and advocacy, and that immediate Group action would include the 18,000 Voices programme, leadership development, regular “Gemba” activity by Group leaders, and continued implementation of the Vanderbilt cultural improvement programme. She further reported on preparedness for resident doctor industrial action over the Easter period, the maintenance of safe services and safe staffing, progress on the Electronic Patient Record implementation timetable, and discussions with NHS England on Group formation, the future operating model and recovery arrangements.

Stephen Javes, Group Non-Executive Director, asked how the 18,000 Voices programme would demonstrate to staff that feedback had led to visible action. The Group Chief Executive stated that the programme would include visible action and feedback loops, that Trust-level work already in hand would continue, and that Group leaders would spend regular time in operational areas to hear concerns directly and act on them.

The Group Chair asked Executive Managing Directors (EMDs) to confirm readiness for the forthcoming resident doctor industrial action, particularly at QEH. The Group Chief Executive and Michelle Arrowsmith, Executive Managing Director for QEH, noted that a Group on-call rota had been established to coordinate resources and support across the sites and that local plans were in place.

The Group Chair also asked whether the transfer of corporate services staff had caused any unintended workforce consequences. The Group Chief Executive stated that she had not identified a material increase in staff turnover arising from those changes but this would be monitored closely.

Board members noted that material workforce, quality and operational risks remained and that assurance on several aspects of the report would arise through later agenda items, including the EMDs’ reports, performance reports, the Board Assurance Framework and governance papers.
Resolution: The Board noted the report from the Group Chief Executive.

7. Foundation Trust Update Reports

7.1. Queen Elizabeth Hospital King's Lynn NHS FT

For Discussion

Executive Managing Director

The EMD for QEH presented the report. She welcomed Dawn Collins as the new Interim Chief Nurse and reported positively on the staff response to the appointment. She also reported on QEH’s achievement of the Defence Employer Recognition Scheme Gold Award.

She updated the Board on work with the NPIP and on an unannounced Care Quality Commission (CQC) inspection of surgery on 17 and 18 March 2026. She stated that staff had engaged openly with the inspection and that two enforcement notices had subsequently been issued, one concerning nutrition risk assessments and one concerning ward security. She reported that immediate actions were underway, including temporary ward security measures pending permanent swipe access arrangements.

She further reported that the QEH Medical Director was leading the response to the Royal College of Surgeons review of general surgery. Daily ward and management huddles were in place to monitor quality risk and patient flow, some elective cases had been moved to NNUH to relieve pressure, and a more stable general surgery configuration was being developed.

Walker, Ian
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William Van’t Hoff, Group Non-Executive Director, challenged whether the controls in place for general surgery were sufficient to protect patients while the service remained under pressure. Michelle Arrowsmith stated that the daily huddles monitored compliance with the immediate control actions, supported escalation of concerns and enabled executive and clinical oversight. The Chair asked that the learning arising from the Care Quality Commission feedback at Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust be considered explicitly by the other two Trusts. The Board was partially assured that

immediate controls were in place for the current general surgery risk position at Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. The Board noted that the residual risks to patient safety, surgical capacity, ward security, and regulatory compliance remained material until the longer-term general surgery plan and the Care Quality Commission response had been completed.
Resolution: The Group Board noted the report from the QEH EMD.

Action: The Board requested that the EMDs for NNUH and JPUH confirm that the issues highlighted in the CQC feedback from the recent QEH inspection had been considered by the other two Trusts.

7.2. James Paget University Hospitals NHS FT

For Discussion

Executive Managing Director

Jonathan Gardner, EMD for JPUH, presented the report. He explained that the Trust remained under pressure but that there had been visible improvement in staff engagement, performance and access. He highlighted work with community geriatricians and a community cardiac nurse, progress in neighbourhood working and the benefits of senior leaders spending more time in operational areas. He reported that low registered nurse fill rates remained one of the Trust's most material risks, driven by sickness, winter escalation capacity and the continued opening of additional beds, but stated that a recruitment plan was in place and that closing the remaining escalation beds on the Acute Medical Unit would improve the position materially.

The Group Chair challenged the low nursing fill rate and asked what specific actions were in place and to what timescale the position would improve. The JPUH EMD stated that care hours per patient day had not reduced but skill mix had shifted and required correction. He advised that the closure of escalation beds and implementation of the recruitment plan formed the first steps in the corrective action.

Jo Churchill, Group Non-Executive Director, welcomed the visibility of senior leadership in the organisation and asked how JPUH was evaluating the impact of community geriatric and cardiac roles in reducing admissions and shifting care closer to home. The JPUH EMD stated that formal evaluation was at an early stage, that existing models used elsewhere would inform future business cases, and that the roles were intended to reduce Emergency Department demand and improve prevention.

The Board was partially assured that management action was in place to address nursing fill rates and to support neighbourhood-based models of care. The Board noted that workforce capacity, skill mix and the sustainability of operational improvement remained material risks.

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

Action: The Board requested that the Group Chief Executive and the Executive Managing Director for JPUH provide an update ahead of the next meeting on the actions being taken to improve low nursing fill rates at JPUH.

7.3. Norfolk and Norwich University Hospitals NHS FT

For Discussion

Executive Managing Director

Shane Gordon, EMD for NNUH, presented the report. He reported improvement in core operational measures, including ambulance handovers, cancer performance and the financial position. He stated that collaborative work with community partners and the development of integrated neighbourhood models formed part of the Trust's longer-term approach to hospital flow and service redesign. He also reported that the Trust was preparing for future hospital development planning and continued to support Group-level work on strategy, digital and new hospital arrangements.

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The Board was partially assured that operational improvement work was under way at NNUH, but noted that flow, demand, and system dependencies remained material risks.

Resolution: The Group Board noted the report from the NNUH EMD.

8. Reports from the Chairs of Board Committees

8.1. Group Risk Assurance Committee

For Information

Committee Chair

Nikki Gray, Committee Chair, reported that GRAC had evolved since its establishment and was beginning to function more effectively as the principal committee for Group risk oversight. She stated that the Committee had recently considered the registered nurse fill rate risk at JPUH but that, in a number of areas, clearer measurable actions were still required so that Group Non-Executive Directors could evaluate progress and hold the Executive to account. She also reported that the Committee had started to create more time for a deeper focus on clinical quality and safety risks, with William Van't Hoff supporting that part of the agenda.

She further reported concern that the Integrated Performance Report did not yet surface wider cultural and workforce issues sufficiently, and that more Committee time was required for scrutiny of Group finances, including the cost improvement programmes.

William Van't Hoff reported on the Committee's increasing focus on quality and outcomes. The Group Chief Nurse and Dr Robert Sherwin, Group Chief Medical Officer, confirmed that the quality risks identified by the Committee were either already subject to deep dives or were being addressed through the One Recovery programme.

Resolution: The Group Board noted the report and the progress on increasing GRAC's focus on clinical quality and safety.

8.2. Group Audit Committees in Common

For Information

Committee Chair

Stephen Javes, Committee Chair, reported that work continued to align audit and financial control arrangements across the Group. He advised that internal audit year-end assurance at QEH was likely to be limited because a number of internal audit actions had not been completed within the required timescale, and that this could affect the Annual Governance Statement and value for money reporting. He stated that future internal audit plans were being set earlier so that actions could be completed before year end. He also reported that an issue relating to medical equipment controls at JPUH had been addressed. He advised that the 2026/27 Internal Audit Plan would be considered by the Committee on 28 April 2026. He also reported that the Committee had challenged the use of external auditors for consultancy work and that a revised policy would return to the Committee.

The Group Chair emphasised the importance of internal audit resource being directed towards clinical and other high-risk areas. It was noted that audit planning took account of the Group Board Assurance Framework and principal risks.

Resolution: The Group Board noted the report.

8.3. Group Research, Innovation and Education Committee

For Information

Committee Chair

Walker, Ian
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In the absence of Philip Baker, Committee Chair, the Chair invited the Board to take the report as read. The Board noted that the inaugural meeting of the Committee had focused on establishing research, innovation and education as core Group priorities linked to the Group's ambition to operate as a university hospital system.

Resolution: The Group Board noted the report.

9. Performance Reports

9.1. Group Integrated Performance Report

For Discussion

Group Chief Delivery Officer

Joanne Segasby, Group Chief Delivery Officer, introduced the summary Group IPR and confirmed that the fuller report, including site narrative, had been considered by GRAC on 26 March 2026. She explained that the report brought together quality, workforce, operational and finance indicators and was intended to support cross-site scrutiny of common themes, actions and learning.

Board members discussed workforce sickness, infection prevention and control, complaints handling, maternity oversight, elective waits above 65 weeks, diagnostics, cancer waiting time deterioration over Christmas and New Year, ambulance handover performance, and the continuing outlier position at JPUH on elective access. The Board noted the positive performance of NNUH in faster diagnosis and cancer pathways and an improvement in some urgent and emergency care metrics. It was felt that workforce and cultural risks were not sufficiently visible within the current reporting format.

The Group Board noted that the report provided a consolidated view of Group performance and that management action was in place to address a number of the principal operational risks. The Board noted that workforce capacity, infection prevention and control, long elective waits, cancer performance, ambulance handovers, and data quality remained material risks linked to principal risks within the Board Assurance Framework.

Resolution: The Group Board noted the report.

9.2. Group Finance Report

For Discussion

Group Chief Finance Officer

Marcus Thorman, Group Chief Finance Officer, presented the Month 11 Group Finance Report. He reported that the Group was close to a breakeven position at Month 11 and that, following additional support announced by NHS England in the preceding 24 hours, QEH and JPUH would end the year with a £1.6 million surplus and NNUH would end the year with a £4.9 million surplus. He stated that this would improve cash support entering 2026/27. He reported continuing pay pressures at QEH because reductions in substantive workforce had not been achieved in line with plan and as a result of additional investment in some clinical service areas, including the Emergency Department. However, each Trust would achieve its forecast outturn for 2025/26 and the risk of not doing so had been reduced accordingly. He further reported that, while the cost improvement programme had slightly underperformed on identification, it had overperformed on implementation. Some schemes had been rejected through the quality impact assessment process, capital slippage had been transferred into the new financial year, and a cash committee had been established to manage cash timing issues at QEH.

The Group Chair recognised the strength of the closing 2025/26 position. In response to a question about whether the QEH workforce reduction programme would continue in 2027/27, the Group Chief Finance Officer stated that the focus was on whole-time equivalent analysis and non-clinical workforce growth was being examined as part of the 2026/27 cost improvement programme.

The Group Board noted that the principal financial risk now related to the delivery of the 2026/27 financial plan, including implementation of the cost improvement programme, pay pressures at QEH and delivery of the capital programme.

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Resolution: The Group Board noted the reduction in the risk score for delivery of the 2025/26 financial plan and the cost improvement programme risks associated with the 2026/27 financial plan.

9.3. One Recovery Programme

For Discussion

Group Chief Delivery Officer and Executive Managing Directors

The Group Chief Executive and the Group Chief Delivery Officer presented the One Recovery Programme as the principal vehicle through which the Group intended to improve operational performance, workforce culture and the financial position. The Group Chief Executive stated that the programme comprised seven core workstreams, with an additional enabling function to accelerate Trust-level implementation, and that it should not be viewed separately from the Medium-term Plan or the cost improvement programme. She advised that the Group Board would subsequently receive a view of how the programme would mature beyond the immediate six-month intensive phase. The Group Chief Delivery Officer reported that the programme charters had been approved with the exception of 18,000 Voices, which was slightly later because of the timing of the national staff survey results. She explained that projected NOF ratings were underpinned by analytical work but external overrides could affect formal segmentation.

The JPUH EMD cautioned the Board against expecting an immediate change in NOF ratings at the next publication point because recent performance improvements would take time to feed through to the published rankings. The focus should be on sustained improvement. It was noted that the Board required measurable and time-bound actions and a clearer link between One Recovery, the IPR and Group risk assurance. The Group Chief Delivery Officer stated that the analysis had been built from the submitted Medium-term Plans, that the programme teams were developing detailed key performance indicators, and that fuller assurance should be possible once the required reporting had matured. The Group Chief Executive agreed that more explicit reporting to GRAC was required, including clearer articulation of implementation risks.

Action: The Group Board requested that the Group Chief Delivery Officer report on the One Recovery programme and the programme charters to the Group Risk Assurance Committee in April 2026.

Resolution: The Group Board noted the report.

10. Board Assurance Framework Report

For Discussion

Group Director of Governance

Ian Walker, Group Director of Governance, presented the Group Board Assurance Framework (BAF) Report and explained that it had been developed over four months since the first Group Board meeting. He stated that it remained work in progress, particularly in relation to risk appetite and medium-term risk movement, and that it had been reviewed monthly with executive leads through the Executive Risk Assurance Group (ERAG) and monthly by GRAC. He advised that the BAF contained 14 Principal Risks, of which nine were rated as 'Significant'.

The Group Chair felt that the BAF report reflected reality, enabled risk movement to be seen over time, and showed gaps in controls clearly enough for Board challenge. He also observed that there remained material gaps between current risk, target risk and the level of assurance, and that further work on risk appetite would be essential. He asked that the Executive consider whether supply chain and pharmaceutical availability risks arising from geopolitical instability should be brought forward through ERAG and GRAC. The Group Chief Executive agreed that a more detailed review was warranted. During discussion, the Group Chair also asked whether the BAF should in future sit more explicitly with the Group Risk Assurance Committee as the Board's main route for assimilation of Group risks.

The Group Board noted that the BAF Report identified the Group's Principal Risks and that the current format supported tracking and challenge. However, further work was required in relation to risk appetite and medium-term risk trajectories.

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

Walker,Ian 29/05/2026 10:13:09

Action: The Group Board requested that the Group Chief Finance Officer report an update on supply chain risks to the Group Risk Assurance Committee in April 2026.

11. Trust Charities

For Decision

Group Chief Executive

The Group Chief Executive, introduced the report and explained that the purpose was to restore appropriate governance committee arrangements to the hospital charities, reduce avoidable overheads and examine options for future alignment. She explained that the three Charitable Funds Committees had not met since the Group's formal establishment and therefore needed to be re-established with standardised terms of reference and core membership, as proposed in the paper. This proposed delegated expenditure limits of £250,000 for the NNUH Charity and £125,000 for the charities associated with QEH and JPUH, with higher value approvals being sought from the Group Board acting as the relevant Trust's Board of Directors.

In discussion, clarification was sought as to the rationale for different delegated approval limits between the three Trust charities. It was explained that this reflected prior arrangements and the scale and nature of expenditure historically approved by the respective charities. The Group Board agreed that the differential approval limits should be retained for the time being but be kept under review in relation to actual transactions.

Board members discussed the proposed 12-month timescale for the options appraisal on the future of the three charities and the scope to shorten this. It was agreed to amend the proposed timeframe for producing an outline options appraisal on the future of the three charities from 12 months to six months.

Action: The Group Board requested that the Group Director of Governance and the Group Chief Finance Officer bring back in six months an outline options appraisal on the future of the three charities, including options for combining or rationalising support functions and any wider structural options.

Resolutions:

- The Group Board approved the establishment of a Charitable Funds Committee (CFC) for the Norfolk and Norwich University Hospitals NHS Foundation Trust, delegated authority for the CFC to approve expenditure up to £250,000 and the core terms of reference attached at Appendix 1 of the paper, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust (as the Corporate Trustee).
- The Group Board approved the establishment of a Charitable Funds Committee (CFC) for the James Paget University Hospitals NHS Foundation Trust, delegated authority for the CFC to approve expenditure up to £125,000 and the core terms of reference attached at Appendix 1 of the paper, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust (as the Corporate Trustee).
- The Group Board approved the establishment of a Charitable Funds Committee (CFC) for the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, delegated authority for the CFC to approve expenditure up to £125,000 and the core terms of reference attached at Appendix 1 of the paper, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (as the Corporate Trustee).

12. Group Governance Framework — Decision

Group Secretary

The Group Director of Governance presented the remaining statutory governance instruments and explained that these completed the standardised statutory governance set for the three Trusts. He stated that the papers brought together updated and aligned Constitutions, Standing Orders, Standing Financial Instructions and a minor variation to the GPJC terms of reference so that the documents operated coherently. He advised that the Constitutions followed the NHS Model Core Constitution for NHS foundation trusts, that governors had been engaged in development of the documents, and that the Constitutions would also require approval by the respective Councils of Governors. He explained that the documents had been developed with legal support and that the intention was to ensure lawful delegation to the GPJC within clear limits.

Walker, Ian
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In discussion, it was noted that Sally Collier had questioned the clarity of the drafting of paragraph 8.4.5 of the Standing Financial Instructions in relation to business case approval and contract award approval as legally distinct elements. It was agreed that the Group Chief Finance Officer would propose amended wording, agree this with Sally Collier and circulate the revised version to Group Board members via email.

The Group Board was assured that the statutory governance instruments had been prepared with external legal support, were standardised across the three Trusts and coherent with one another and were capable of external scrutiny. The Board noted one residual drafting issue within the Standing Financial Instructions which required amendment before final issue.
Resolutions:

- The Group Board approved the Constitution, Standing Orders and Standing Financial Instructions (subject to the agreed amendment) of Norfolk and Norwich University Hospitals NHS Foundation Trust and the Variation to the Provider Collaboration Agreement in relation to the terms of reference for the GPJC, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust.
- The Group Board approved the Constitution, Standing Orders and Standing Financial Instructions (subject to the agreed amendment) of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and the Variation to the Provider Collaboration Agreement in relation to the terms of reference for the GPJC, acting for this reserved function as the Board of Directors of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.
- The Group Board approved the Constitution, Standing Orders and Standing Financial Instructions (subject to the agreed amendment) of James Paget University Hospitals NHS Foundation Trust and the Variation to the Provider Collaboration Agreement in relation to the terms of reference for the GPJC, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust.
- The Group Board noted that the statutory governance set defines authority, and that risk management, internal control, and assurance arrangements operate as operational control systems to support its discharge.

The Group Board noted the Group Scheme of Reservation and Delegation, approved in October 2025, which illustrate the governance instrument cascade.

Action: The Group Chief Finance Officer would propose amended wording for paragraph 8.4.5 of the Standing Financial Instructions, agree this with Sally Collier and circulate the revised version to Group Board members via email.

13. Group Committee Terms of Reference

13.1. Nomination and Remuneration Committees in Common

The Group Director of Governance presented revised terms of reference for the Group Nomination and Remuneration Committees in Common. He explained that, following further consideration since December 2025, it was considered clearer and more transparent to separate arrangements for Executive appointments and remuneration from those relating to the Chair and Non-Executive Directors, the latter being matters for Governors. He stated that the revised terms of reference had been reviewed with Sally Collier as the Chair of the Committees in Common and that the first meeting was scheduled for the end of April 2026.

Resolutions:

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

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13.2. Research, Innovation, and Education Committee

The Group Director of Governance presented the terms of reference for the Group Research, Innovation and Education Committee and advised that these reflected discussion at the inaugural Committee meeting held on 24 February 2026. He explained that, unlike item 13.1, this was a Group Board committee rather than a reserved function of each Trust Board.

Resolution: The Group Board approved the terms of reference of the Group Research, Innovation and Education Committee.

14. Committee Membership and NED Roles — For Information

Group Director of Governance

The Group Director of Governance presented the paper confirming Committee chairing arrangements, Committee membership and specific roles for Non-Executive Directors. In discussion, the Group Chair requested that a note be issued to the three Councils of Governors setting out Non-Executive Directors' committee and other roles so that Governors had a clear summary of their responsibilities.

Resolution: The Group Board:

- Noted the appointment of Sally Collier as Senior Independent Director.
- Noted the appointments to Board committees as set out in the paper.
- Note the appointment of Group NEDs to designated roles for Perinatal Safety (Jo Churchill), Maintaining High Professional Standards (Sally Collier) and Freedom to Speak Up (William Van't Hoff).

15. Any Other Business

Group Chair

No additional items of business were raised.

16. Questions from Members of the Public — For Discussion

Group Chair

The Chair invited the Group Director of Governance to present the pre-submitted public questions.

The first question, submitted by Robin De Bray on behalf of the Waveney Trades Union Council, concerned the use of Palantir within the NHS Federated Data Platform, and sought assurance on data governance, control of patient information and public confidence. In response, Edward Prosser-Snelling, Group Director of Digital, advised that each Trust remained the data controller for its own local Federated Data Platform instance, that the Group's current use related to the Optica discharge planning product, that local risk assessments had been completed, that risk registers were maintained, and that the supplier's contractual role was limited to providing the platform under NHS instruction. The Board was advised that Palantir could not commercialise or market NHS data and that patients should remain confident that control of the data remained with the NHS.

The second question, submitted by Jayne Murray, supported use of the former Lowestoft Hospital site as a community medical hub. The JPUH EMD responded that neighbourhood working in Lowestoft remained important, that all options for future sites and models of working were under consideration, and that no specific proposal could yet be confirmed. In response to supplementary clarification, he confirmed that the former Lowestoft Hospital site remained one of the options under consideration and stated that he would meet the questioner outside the meeting to discuss the proposal further.

Resolution: The Board noted the public questions and responses.

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17. Meeting Review and Reflections — For Discussion

Group Chair

The group chair briefly invited reflections on the conduct and focus of the meeting. No specific comments or suggestions for change were recorded.

18. Date of the Next Meeting

For Information

The Group Board noted that the next meeting would be held on Wednesday 3 June 2026 at the Queen Elizabeth Hospital King's Lynn.

19. Resolution

For Decision

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

20. Close of Meeting

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

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GROUP BOARD MEETING IN PUBLIC: ACTION LOG

Ref.	Meeting date	Agenda item	Action	Lead	Update	Status
3	17.12.25	Emergency Preparedness, Resilience and Response (EPRR) Core Standards	Include EPRR and cyber assurance in discussions on the Internal Audit programme.	Group Chief Finance Officer	Considered as part of further discussions on the 2026/27 Internal Audit Plan which was approved at the April 2026 meeting of the Group Audit Committees in Common. Cyber Assessment Framework included in Audit Plan. EPRR/business continuity considered for potential inclusion next year.	Propose to close
4	01.04.26	Action log	Undertake a further Executive review of the 2026/27 Internal Audit Plan ahead of the April 2026 meeting of the Group Audit Committees in Common.	Group Chief Executive	Further review undertaken with a final proposal presented to and approved by the Committee on 28 April 2026.	Propose to close
5	01.04.26	JPUH EMD report	Low nursing fill rates – provide update on actions being taken	Group CEO; EMD, JPUH	Included in JPUH EMD report to Group Risk	Propose to close

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			through either Group CEO report or JPUH EMD report.		Assurance Committee in April 2026.	
6	01.04.26	QEH EMD report	NNUH and JPUH to confirm that issues highlighted in the CQC feedback from the recent QEH inspection have been considered by the other two trusts.	EMDs for NNUH and JPUH.	EMDs have confirmed that they continue to review CQC feedback from QEH inspections.	Propose to close
7	01.04.26	One Recovery	Report to Group Risk Assurance Committee (GRAC) on One Recovery programme and charters.	Group Chief Delivery Officer	One Recovery included on GRAC agendas for April and May 2026.	Propose to close
8	01.04.26	Board Assurance Framework	Update on supply chain risks to be reported to GRAC.	Group Chief Finance Officer	Included on April 2026 GRAC agenda.	Propose to close
9	01.04.26	Charities	Amend proposed timeframe for producing an outline options appraisal on the future of the three charities from 12 months to 6 months.	Group Director of Governance and Group Chief Finance Officer	Update to the Group Board to be scheduled for October/December 2026.	Open – not yet due
10	01.04.26	Standing Financial Instructions (SFIs)	Amend wording of SFIs paragraph 8.4.5 re: business case and contract award approvals.	Group Chief Finance Officer	Wording amended and circulated to Group Board members.	Propose to close

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Report to the Group Board in public: 3 June 2026

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

Executive summary

Strategic Progress

- The Board will be asked to consider progress to date and the next steps in developing the Group's One Strategy in Part B of the meeting. This will include establishing the Transformation Design Authority (TDA), which will act as the custodian of the vision for change, responsible for maintaining alignment and coherence across programmes.

One Recovery

- One Recovery governance is established, with six programmes mobilised; delivery risks reflect early-stage capacity and Cost Improvement Programme (CIP) constraints, with mitigations and performance monitoring now in development.
- The updated NHS Oversight Framework for 2026/27 is due to be published shortly. It includes changes to the quality domains, continued financial override arrangements, and a stronger emphasis on data quality measures.

Council of Governors

- Governor elections will launch on 8 June across all three Trusts to fill public and staff vacancies, supporting strong community representation and accountability through the Councils of Governors.

Corporate Services Transformation

- Phase 1 of Corporate Services Transformation was completed on 1 April 2026. Phase 2 will now take a design-led approach, supported by an independent Gateway review to assess confidence in delivery and to draw on learning from other systems that have successfully integrated corporate services.

'Collectively Curious' – Developing our Research, Innovation and Education Strategy

- An independent review has identified priorities to support the Group's ambition for a University Hospital System, with work now underway to strengthen partnership working, leadership, governance and delivery across research, innovation and education.

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National and Regional Context

- Further resident doctors' industrial action has been announced for 15 - 19 June 2026.
- The Norfolk and Suffolk system has responded to the Chief Executive of NHS England's letter of 1 April 2026, supporting a stronger strategic commissioning model and calling for national enablers, including financial and capital reform, to support neighbourhood care and acute transformation.
- Integrated Care Board discussions reinforced the importance of neighbourhood working, transformation and financial recovery for the Group's One Strategy and future acute operating model.

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	Letter from the Chief Executive of NHS England and system response, and letter from the Secretary of State for Health and Social Care, available for Board Members via Admin Control Reading Room.

Norfolk and Waveney University Hospitals Group

Group Board in public: 3 June 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 item 7).

Group and Trust Developments

2. One Strategy

One Strategy has established a shared strategic direction for the Norfolk and Waveney University Hospitals Group, aligning our hospitals, services and major programmes around a future model of neighbourhood health and more sustainable acute care. The work completed to date demonstrates the scale of the challenge facing our hospitals over the coming decade and the extent to which current models of care, estate and service configuration will not remain sustainable without significant change.

The emerging direction is clear: more care will need to be delivered through neighbourhood and digitally-enabled models, with our hospitals increasingly focused on the complex, specialist and acute care that can only be delivered within hospital settings. Delivering this will require closer partnership working across providers and a more integrated Group approach to clinical services, workforce, digital and infrastructure planning.

To support this transition, work is now underway to ensure that the Group's major programmes, including the New Hospital Programme, neighbourhood development, digital roadmap and Electronic Patient Record, are aligned to a single strategic direction and future operating model. A new Design Authority and supporting Board governance arrangements are being established to provide oversight of these programmes, strengthen strategic coordination and support decision-making across the Group.

Over the coming months, work will focus on agreeing a phased implementation roadmap with partners, identifying the changes required to improve quality, access and sustainability of care, and ensuring the Group is positioned to realise the opportunities afforded through working together at scale.

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3. One Recovery

The Oversight Group is now in place and meeting regularly, and programme plans continue to develop.

Six of the seven programmes are now established, with key enablers in place, including programme roles, Key Performance Indicators (KPIs), digital requirements and initial milestones.

However, six programmes are currently rated as at risk, primarily reflecting the early stage of mobilisation rather than a fundamental failure of delivery. The principal concerns are limited Business Intelligence (BI) and transformation capacity across several programmes, digital resource constraints, and the pace at which CIP plans are maturing.

These delivery risks are being addressed through active recruitment and longer-term plans to strengthen Digital and BI capability through One Digital and external support.

Monitoring of performance against plan, and of the impact on NHS Oversight Framework (NOF) metrics, is being developed.

NHS Oversight Framework 2026/27

A national webinar on the NHS Oversight Framework for 2026/27 was attended in April by the Group Chief Delivery Officer. The revised framework has been approved by the NHS England Board and is expected to be published shortly.

The revised approach separates quality into three domains: effectiveness, experience and safety, with contextual metrics no longer scored.

The current financial override will remain for 2026/27, although this is expected to be retired in future, and a separate quality override will not be introduced.

The webinar also confirmed that segmentation will continue to draw on nationally published datasets, with data quality measures strengthened through inclusion of Data Quality Maturity Index (DQMI) indicators.

The provider capability assessment will be undertaken by the Group in May and June 2026 and used alongside performance metrics to reflect wider improvement activity and Care Quality Commission (CQC) insight. The Board will recall the requirement to sign off these self-assessments, which will be presented at a future meeting.

Quarter 4 2025/26 ratings are expected in early June, with Quarter 1 2026/27 ratings due in August alongside technical guidance on metric methodology and thresholds.

4. Governor elections

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Governor elections will launch on 8 June across all three foundation trusts within the Group to fill a large number of current and forthcoming vacancies among both public and staff governors.

Governors play a key role in holding the Board to account through the Non-Executive Directors, helping to shape future strategy and providing an important link between our hospitals and the communities they serve.

On behalf of the Group Board, I would like to thank all our governors for the significant time and effort they give to our hospitals, and I encourage patients, local residents and staff to consider standing for election to our Councils of Governors.

5. Corporate Services Transformation

Phase 1 of the Corporate Services Transformation Programme completed on 1 April 2026, with Digital, Finance and Communications services transferred into a single employing entity. This provides a stronger foundation for reducing duplication, simplifying management arrangements and improving efficiency across the Group.

Following learning from Phase 1, Phase 2 will take a design-led approach, with services redesigned first to support safe and effective transfer at the right point rather than moving existing arrangements unchanged. This phase will cover Transformation and Emergency Preparedness, Resilience and Response (EPRR), Clinical Digital Leadership, Estates and Facilities, Corporate Governance and Human Resources.

I have asked that a rapid independent Gateway review be undertaken to assess the impact of Phase 1 and inform delivery of Phase 2 to ensure that lessons have been learned and that we consider the progress of other systems.

Phase 2 is planned to conclude by 31 October 2026. Key risks relating to timetable, staff engagement and final confirmation of roles continue to be mitigated.

6. 'Collectively Curious' – Developing our Research, Innovation and Education Strategy

Our ambition is to establish a University Hospital System for Norfolk and Waveney, embedding research, innovation and education as core components of how we deliver care, develop our staff and improve outcomes for our population. To support this, I commissioned an independent review ("Collectively Curious") to assess our current position and identify the steps required to deliver against this ambition.

The review identified three major areas of focus. First, the need to define clearer strategic strengths and areas of differentiation for the Group, particularly around gut health, nutrition, microbiome science, genomics and translational research linked to the unique capabilities of the Norwich Research Park. Second, the need to strengthen partnership working across the Group, particularly with UEA and our research park partners, to better translate research and innovation into improvements in patient care. Third, the need for a more coordinated Group-wide operating model for research, innovation and education, with clearer leadership, governance and delivery arrangements.

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Following a presentation by Dr Liz Sutton to the Research, Innovation and Education Committee, work closely aligned to the One Strategy is now underway to implement these recommendations and strengthen research capacity, capability and infrastructure across the Group. This includes establishing clearer Group-wide leadership and delivery arrangements, embedding research and innovation more consistently within clinical care, and supporting the development of a more curious, innovative and research-active organisational culture in which learning, improvement and collaboration are central to how we work.

7. Group Structure

Since the previous Group Board meeting, Emma-Jayne Perez Chies has been appointed as interim Group Chief People Officer and started in mid-April 2026. Recruitment to the substantive post is underway through a formal competitive process, with interviews scheduled for 8 June 2026. Ben White, Group Director of Communications and Engagement, commenced on 11 May 2026.

National and Regional Developments

8. Secretary of State for Health and Social Care

Following his appointment, the new Secretary of State for Health and Social Care wrote to NHS and Social Care staff thanking them for their contribution, recognising progress in reducing waiting lists and improving earlier cancer diagnosis. He set out his priorities, including further reducing waiting times, accelerating innovation and delivering the 10-Year Health Plan, with technology, digitisation and Artificial Intelligence (AI) identified as key enablers of service improvement and productivity. The letter is available in the Reading Centre on Admin Control.

9. Resident Doctors' Industrial Action

At the time of writing, the British Medical Association (BMA) has announced a further four days of industrial action by Resident Doctors in England, from 7am on 15 June to 6.59am on 19 June 2026.

As previously reported, each Trust has well-rehearsed plans for managing industrial action, and this will be the 16th period of action involving resident medical staff. A ballot on possible industrial action by consultants is also underway until July and may result in further action by medical staff. A verbal update on preparedness will be provided at the meeting.

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10. Chief Executive of NHS England's letter and system response

On 1 April 2026, the Chief Executive of NHS England wrote to systems setting out the next steps on planning and priorities for 2026/27. The letter acknowledged progress during 2025/26 and asked each Integrated Care Board, working with local partners, to submit a single system-wide response

covering four areas: development of strategic commissioning over the next three years, neighbourhood care, changes to financial flows or payment systems, and further national action to accelerate local change.

In response, Norfolk and Suffolk Integrated Care Board, with system partners including the Norfolk and Waveney University Hospitals Group, submitted a joint letter on 15 May 2026. It sets out an ambition for a more strategic, neighbourhood-focused model of commissioning and care, supported by population health management, prevention, outcomes-based commissioning and closer partnership working. Of particular relevance to providers, it calls for financial and capital reforms to better support "left shift" investment, neighbourhood models of care and local flexibility, while recognising the role of acute transformation, including the Group's One Strategy, in enabling this shift. These letters are available to Board Members in the Resource Centre on Admin Control.

11. University Hospitals Association

The Group is a member of the University Hospitals Association (UHA). The Chief Executive of NHS England attended the recent executive meeting and discussed the role of university hospitals in supporting improvement, innovation and workforce reform, with particular emphasis on enabling progress while avoiding unnecessary central processes and inflexible national targets.

Discussion also highlighted the contribution of university hospital partnerships and wider system organisations to research, innovation, workforce development and service improvement.

Following the meeting, the UHA Secretariat was asked to prepare a short letter to the Chief Executive of NHS England summarising the discussion. The Group has been invited to contribute to this correspondence, which is being facilitated through the Group's Research, Innovation and Education Committee. The letter will draw on our emerging Research, Innovation and Education Strategy and set out the key shifts we intend to make to establish a culture of curiosity.

The Board should note that our application for all three Trusts to be included within the University Hospital designation for the Group remains pending, as we need to update the submission against the new criteria recently published by the Association.

12. NHS Norfolk and Suffolk Integrated Care Board (ICB)

I represent the Group as a partner member of the ICB Board and attended the most recent meeting in May 2026. The Board received a detailed update on neighbourhood working across Norfolk and Waveney, confirming this as a core strategic direction for the system to shift care closer to home, strengthen prevention and reduce fragmentation across services. This has direct relevance for the Group's One Strategy and future acute operating model, given the link between neighbourhood development, reduced acute demand, redesigned pathways and the long-term sustainability of hospital services.

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The ICB's integrated performance report identified continued improvement in elective recovery, cancer faster diagnosis and some outpatient measures, although diagnostic capacity, urgent and emergency care pressures, ambulance handover delays and variation across pathways remain significant challenges.

The ICB's 2026/27 budget was approved on a breakeven basis, with a requirement to deliver over £100 million of efficiencies. The Board recognised the continued importance of aligning financial recovery with service transformation and system performance improvement.

Other issues of note included the system commitment to end adult inappropriate out-of-area mental health placements by March 2028, ongoing oversight of patients placed at St Andrew's Healthcare, and interim arrangements for the new ICB's Board Assurance Framework and committee structures.

The Board also received the Norfolk and Waveney Research and Innovation annual report, which highlighted nationally recognised work to strengthen research participation, primary care research capability and innovation adoption across the system, with relevance to future service development and academic partnership opportunities for the Group.

13. Recommendations

The Group Board is asked to note the report.

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Report to the Group Board in public: 3 June 2026

Agenda item number	7.1		
Title	Executive Managing Director's Report – Queen Elizabeth Hospital Kings Lynn NHS FT		
Author(s)	Michelle Arrowsmith, Executive Managing Director		
Executive sponsor	Michelle Arrowsmith, Executive Managing Director		
Purpose of report	For decision ☐	For discussion ☒	For information ☐

Executive summary
This report is presented to the Group Board to provide an overview of key priorities and actions which are the current focus for the QEH.

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

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Norfolk and Waveney University Hospitals Group

Group Board in public: 3 June 2026
Executive Managing Director's Report: Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Site Leadership Team

Amanda Ramsay-Dunn has started with the Trust as our Director of Improvement and Recovery. Amanda will lead the work across the Trust to support our improvement and recovery programme with a clear focus on helping the QEH to achieve a breakeven financial position in the context of quality and safety improvement.

National recognition for QEH Student Midwife

A student midwife currently on placement here at the QEH has become the first ever recipient of a new national accolade. Nancy Williams-Eley received the Student Excellence Award presented by the Chief Midwifery Officer and Chief Nursing Officer for England on 13 May 2026. The award recognises Nancy for identifying a gap in the birth environment and successfully securing funding to introduce specialised lighting to better support physiological birth. The improvement has enhanced the experience for women and families, while also supporting staff working across the service.

The QEH ranked in the top 10 NHS trust in England for Clinical Research Delivery

The QEH has been ranked within the top 10 NHS trusts in England for study setup and clinical research delivery in 2025/26, reflecting the commitment and collaboration of teams across the Trust. The achievement follows a significant transformation in how research is delivered at the QEH over the past three years, and highlights the role colleagues across clinical services, pharmacy, governance and support teams have played in strengthening research for our patients.

Over the coming year, the QEH plan to expand research into respiratory and critical care, supported by further strategic funding and investment in dedicated research space. As research activity continues to grow, staff across the Trust will continue to play a key role in ensuring local patients benefit from nationally leading NHS research.

Regulatory

National Provider Improvement Programme (NPIP)

Following the Trust formally entering NPIP, we have received the initial mobilisation report for factual accuracy checking followed by the final draft report. Discussions continue with the Regional NHS England team around the future format and structure of the NPIP support offer in light of the national announcement on a change in approach.

Care Quality Commission (CQC)

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Medicine / Urgent and Emergency Care (UEC)

The Trust was subject to an unannounced CQC on-site inspection in relation to the Emergency Department (ED) and Medical wards on 28/29 April. The inspection lasted for two days and was followed up with informal on-site feedback which was subsequently confirmed by letter.

Immediate requests for data were responded to alongside the formal information request (for 230 items of information) which was completed within the required timescales by 14 May 2026.

Formal correspondence has confirmed the implementation of further Section 29A enforcement notices.

Surgery
The Trust was subject to an unannounced CQC on-site inspection in relation to Surgery on 17 March. The inspection lasted for two days and was followed up with informal on-site feedback which was subsequently confirmed by letter. Formal correspondence confirmed the implementation of two Section 29A enforcement notices.

Pharmacy
A CQC enquiry relating to Pharmacy was received via e-mail on 22 April requesting clarification and assurance on a number of areas which were both broad and deep on pharmacy clinical operational matters.

Detailed evidence and a formal response were submitted within the agreed timeline of 30 April 2026.

North Cambridgeshire Hospital
A formal enquiry from CQC was received on the 5 May 2026 with regard to the continuation of service delivery from the Endoscopy Unit at North Cambridgeshire Hospital.

This was responded to within the agreed timeframe of 12 May 2026 with an update and assurance in relation to the work which is in train to complete a clinically led review of Endoscopy service provision at the site, due end of May/beginning of June.

The formal reports for both Surgery and ED / Medicine are awaited. In light of the breadth of the actions which are required to be completed, the Trust is currently using a bronze, silver and gold command style approach to immediate actions and improvement, with audit and evidence logging, and an ongoing monitoring process. This is being led by the Trust's CNO. We are also developing an Integrated Improvement Plan. This plan will incorporate all elements of improvement work which are required and will enable robust oversight, monitoring and assurance. Detailed action plans will underpin delivery with Director led oversight.

General Surgery Royal College of Surgeons Report
We have now received a response from our report response update sent to RCS in April 2026. The review team reflected on the Trust producing a meaningful and constructive plan to address some very difficult and deep-seated problems. They were appreciative of the detailed update provided.

The review team requested that one further update is provided in four months, 14th September 2026. There was also concern that the internal dysfunction within the department had not yet been resolved. Within the further requested update, the review team would be keen to know what the Trust's plans were to monitor this, and the further steps they planned to put in place.

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Freedom of Information
The Trust received an Information Commissioners Enforcement Notice on 23 March 2026. The Enforcement Notice relates to the Trust's backlog of responses to Freedom Information requests and ability to respond within the required statutory timeframes. The Trust has taken immediate actions including a short-term increase in capacity alongside longer-term substantive recruitment to the team. An action plan and lessons learnt report has been developed and was shared with the Information Commissioner by the deadline of 26 April 2026. This is now being monitored through the hospital management set of meetings.

Rapid Quality Review
An NHS East of England rapid quality review took place on 21 May chaired by the Regional Medical Director with a focus on general surgery, including medical education, and recent CQC inspection of surgery. A further update meeting will take place in autumn 2026.

Baroness AMOS Maternity Review
We are advised that both the national report and trust level report are due in June 2026.

Performance

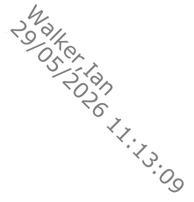
Operational performance

Audiology
The Trust continues to manage backlog and quality pressures within Audiology services, particularly within Paediatric Audiology, where ongoing NHS England oversight remains in place regarding historical Auditory Brain Response (ABR) testing, backlog recovery and harm review processes.

NHS England specialist reviewers are supporting the review process, with current planning assumptions aiming to complete the subject matter expert review phase by September 2026. Progress has been impacted by historic data quality issues, IT access challenges and limited availability of suitably qualified paediatric audiology specialists.

Ophthalmology
The Trust continues to manage operational pressures within Ophthalmology services, reflecting both local workforce constraints and the wider national challenge relating to ophthalmology follow-up demand and capacity.

Validation, harm review and clinical prioritisation processes continue, alongside targeted waiting list initiative activity focused on the highest risk cohorts. A workforce and service plan is scheduled for completion by the end of May 2026, alongside development of a formal options paper for consideration.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Improvement and Delivery

QEH specific improvement plan

QEH are continuing their work on the improvement turnaround plan for the next two years. With a current focus on Q1 and therefore the CQC actions and the Cost Improvement Programme (CIP). Work to finalise a full first draft plan is expected to be complete by the end of June.

CIP

The CIP is a high-risk matter for the Trust. CIP was under delivered by £350k against a plan of £580k at M1. The 2026/27 plan includes £2.7m of unidentified schemes and circa £13m of identified opportunity but without detailed schemes behind it. The delivery of CIP is directly linked to the release of Deficit Support Funding (DSF) by NHS England in Q2 and failure to improve our CIP delivery in the next two months could result in NHS England withholding DSF. The quantum of DSF in Q2 is circa £4m. The Trust has appointed a Director of Improvement and Recovery (turnaround) who will be driving the identification and delivery of the CIP at pace, aligned to the regulatory and quality and safety and performance elements of our work. It is imperative given the level of CIP required this year that we ensure that we do not worsen any areas of safety risk.

Cash

Cash remains a significant risk to the Trust. The most recent cash forecast shows that the Trust will incur a cash deficit by August, if cash releasing CIP is not achieved and our activity levels do not deliver 90% of plan. The cash committee is monitoring this position on a bi-weekly basis and looking at differing assumption models. Forecasts include the assumption that DSF will be received in year.

One Recovery

The Trust continues to work within the One Recovery programme to coordinate operational recovery and improvement activity across UEC, Elective, Diagnostics and Outpatients. During April, focus remained on improving operational consistency, strengthening specialty accountability and ensuring recovery plans align to agreed organisational and regional trajectories. Work continued across ED and Acute Medicine to embed revised operational models and strengthen specialty responsiveness and discharge processes.

Elective and outpatient work focused on validation, productivity, clinic template optimisation, PIFU expansion and reduction of long waiting cohorts. Increased oversight has been established through Finance and Performance Management Group with requirement for clearer trajectory-led improvement plans and delivery milestones.

A revised Cancer Improvement Plan focused on Lower GI, Skin and Urology pathways has also been developed and is progressing through Finance and Performance Management Group sign-off and oversight arrangements.

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Performance and activity

Performance across UEC, Referral to Treatment (RTT), Cancer and Diagnostics remains below national standards, although operational stability improved in several areas during April.

UEC performance remained broadly stable at 66.6%, with continued improvement in

ambulance handover performance and reductions in delays greater than 45 minutes. RTT performance improved to 58.97% (unvalidated April position), with additional activity and validation continuing across challenged specialties.

Cancer performance remains below trajectory, particularly against the 62-day standard where March performance was 56.5%. Diagnostics performance also remains below standard, with Audiology and Echocardiography continuing to present the most significant pressures.

Overall activity delivery during April was close to plan, although performance was impacted by Easter timing, industrial action and ongoing specialty-level challenges across a number of elective and diagnostic pathways. Industrial action impacts were largely mitigated through rescheduling and operational recovery arrangements.

Delivery continues to be supported through strengthened weekly oversight, specialty-level review and targeted recovery activity aligned to agreed trajectories.

Place, Neighbourhood and partnership working

Work is in train at Place, Group and ICB level to further develop the approach to Place and Neighbourhood Health.

Within the Trust there is a clear focus to ensure robust triangulation in relation to delivery at Place and Improvement Plan impact, notably within UEC, Elective and Outpatients and with the emerging ICB led 'left shift' investments.

There is an emphasis on the 'left shift' financial recovery workstream aligned to Clinical Strategy and New QEH ambitions.

Triangulation of Group led strategic work is required to ensure that work which has already been done at Place in relation to New QEH mitigators, 'left shift' and future delivery models is built upon.

Strategic discussions are taking place with Cambridgeshire and Peterborough ICB in relation to the Trust's utilisation of the North Cambridgeshire Hospital site in Wisbech. An evidence-based approach to future service delivery from the site is essential.

Health Inequalities delivery requirements have been confirmed contractually by the ICB necessitating a step change in delivery approach including clear focus on data utilisation to inform proactive pathway changes and decision-making supported by staff training.

Conclusion

The Trust remains focused on performance and productivity improvement and ensuring that services remain safe. There is much work to do and the two-year improvement plan is pivotal to ensuring conditions for success to deliver the improvement required.

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Recommendation and Decision

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

Report to the Group Board in public: 3 June 2026

Agenda item number	7.2		
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

The Trust continues to demonstrate strong progress across quality, workforce, system integration, operational performance and financial control, with clear evidence of improved leadership grip and delivery.

In **quality and safety**, the maternity service Care Quality Commission (CQC) rating improved from *Inadequate* to *Requires Improvement*, contributing to an overall Trust rating of *Good*. This reflects sustained focus on governance and care standards. Supporting actions include enhanced staff training, strengthened CQC readiness arrangements, improved complaints handling (on track to clear backlog) and increased policy compliance. Ongoing quality visits and staff recognition further reinforce a positive safety culture.

Within **people and leadership**, the Top Leaders Programme and increased executive visibility are strengthening engagement and responsiveness. Workforce metrics are improving significantly, with sickness absence reduced to 4.95% (lowest in 18 months), delivering both wellbeing benefits and an estimated £1.5m saving. Speaking Up processes demonstrate high resolution and growing staff confidence, with the Trust recognised as an exemplar. Targeted initiatives such as the staff GP pilot and strengthened recruitment pipelines support workforce sustainability.

Partnership and neighbourhood working is advancing through the East Place Health Alliance and local pilots shifting care closer to home. Initiatives such as the gynaecology activity shift and frailty-focused neighbourhood models are improving pathway efficiency, reducing hospital demand and strengthening system collaboration.

Operational performance shows continued recovery. Elective activity remains strong, with plans to recover Referral to Treatment (RTT) targets. Urgent care performance has improved, including removal from national tiering and progress in Emergency Department (ED) flow. Length of stay and stranded patient metrics are at historic lows, supported by effective discharge processes now recognised as exemplar practice.

Financially, the Trust remains stable, delivering break-even at year-end and achieving plan in April 2026, including cost improvement targets.

Overall, the Trust is delivering measurable improvement with strong foundations for sustained performance and system leadership.

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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
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Norfolk and Waveney University Hospitals Group

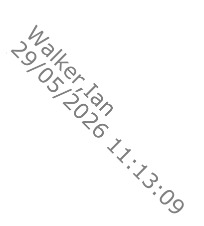
Group Board in public: 3 June 2026
Executive Managing Director's report: James Paget University Hospitals NHS Foundation Trust

1. Patients - Quality and Safety

1.1 We received the final CQC report from their visit to Maternity services in September 2025. It improved our rating from 'Inadequate' to 'Requires Improvement'. This in turn (due to the way the metrics are calculated) increased the rating of the Well Led domain for the Trust to 'Good' and the overall rating of the Trust also to 'Good'. This is a great story of huge improvement by the maternity teams.

1.2 Some developments include:

- All security teams have been trained as per new Prevention and Management of Behaviours of Concern training (3 days). This will help us deal more compassionately and effectively with challenging patients.
- Enhanced Therapeutic Observation and Care (Enhanced Supervision) work is well under way which will be supplemented with a week-long training plan in August to help improve awareness, understanding and application of the Mental Capacity Act.
- A significant number of CQC readiness assessments are taking place, with the introduction of an Evidence Group in progress to support this. The key focus is on fundamental care delivery.
- The 2025/26 JPUH Annual Quality Account includes an update on the Year 2 (of 3) end position for the Quality Priorities which highlights the continued need to focus on improvements in fundamental care delivery. Key areas of achievement include continued successful embedding of the Patient Safety Incident Response Framework (PSIRF), progress in enhancing our Older People's Medicine service and strengthened patient and public involvement.
- The complaints trajectory in on track to eliminate the response backlog by early June
- The out-of-date procedural documents trajectory was met for May and is on track to achieve 95% of in-date policies by the end of August.
- Quality Visits – 12 visits undertaken across clinical and non-clinical areas, with good engagement and response from staff. Discussion points have included: staffing and workforce pressures, environment space and facilities, patient safety, experience and pathways, leadership visibility and engagement, training, appraisals and development, systems, processes and access to IT. Overall emerging strengths: committed staff, strong teamwork and positive patient focus; risks: workforce pressure, environment constraints and inconsistency on acting on staff feedback; opportunities to deliver improvement and increase staff confidence: targeted actions on staffing, estates and pathways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- Two nursing publication proposals have been submitted this month. First, to the Journal of Research Nursing, ‘The Self-Assessment of Organisational Research Readiness Tool (SORT)’ has been reviewed to demonstrate how SORT can be operationalised within complex healthcare organisations as a foundation to embedding research within nursing midwifery and allied health professional (NMAHP) practice. The second publication is to The Nursing Times and reports on an evaluation of a long-established preceptorship programme at JPUH. Using survey data, semi-structured interviews and portfolio review, the evaluation explored the experiences and perceptions of preceptees, preceptors, ward managers and clinical educators. Findings highlight strong support for supernumerary periods and early allocation of preceptors, persistent challenges related to protected time, staffing pressures and inconsistent engagement with reflective meetings and portfolios.

2. People

Top Leaders Programme

2.1 The Top Leaders Programme is progressing well and receiving positive feedback. Every month we bring in an external speaker or spend time listening and co-designing solutions to issues that staff have. I have also introduced a mandated Team Brief which is moving into month 2. We have also increased visible leadership through ‘in your shoes’ and an Executive visit tracker.

Sickness reduction

2.2 The organisation continues to deliver strong improvement in sickness absence, with the in-month rate reducing to 4.95% (the lowest for 18 months) and the rolling annual rate improving to 5.68%. Short-term absence is now below target at 2.2%, with long-term absence also reducing to 2.68%. This sustained focus has been driven by robust management processes, improved return-to-work compliance, and targeted support in high-risk areas. This progress is translating into tangible benefits, with an estimated £1.5 million saving if current levels are sustained, demonstrating both improved staff wellbeing and stronger operational grip.

Guardian of Safe Working / Freedom to Speak Up

2.3 There has been exceptional progress in strengthening the speaking up culture, with 112 cases managed over the past year and only two currently open, demonstrating effective resolution and responsiveness. Feedback from the People and Culture group confirms growing staff confidence in the process, with concerns being addressed earlier and more pragmatically. This reflects a mature culture of openness and psychological safety, where staff are increasingly assured that raising concerns leads to meaningful action and visible outcomes. The trust has been asked to be on an exemplar programme.

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Staff GP Pilot Initiative

2.4 A new staff GP pilot has been approved, with strong demand evidenced by 81% of staff reporting difficulty accessing GP appointments and 91% indicating they

would use an internal service. The pilot will provide two same-day appointments per day plus a weekly clinic (~20+ slots), designed to support timely intervention and reduce avoidable sickness absence. This targeted investment aligns directly with workforce need and is expected to support earlier treatment, improved staff experience and reduced absence duration.

Recruitment

- 27 out of the 28 newly-qualified nurses have been allocated roles in the Trust. We are awaiting confirmation of the final allocation.
- We have succeeded in getting £125,000 per year of grant funding for the next two years for pharmacists and radiographers in the National Institute for Health and Care Research (NIHR) Health and Care Professional Internship Programme.
- We have employed five clinical teaching fellows to support our resident doctors, and are getting two extra tariff-funded IMT (Internal Medicine Training) doctor posts from August. We are reviewing our safer staffing templates and rotas to ensure we have the right clinicians in the right places.

3. Partners - Neighbourhoods

East Place Health Alliance: Partners are formalising an equal, place-based alliance across acute, community and primary care to improve outcomes, flow and patient experience. It provides a structured but non-legally binding framework to redesign pathways and shift care closer to home. Executive governance will enable collective decision-making, shared accountability and transparent resource use. Initial focus is on high-impact pathways including Parkinsons, respiratory, heart failure and diabetes. The ambition is to reduce admissions, improve flow and move to aligned financial risk/gain sharing over time.

Gynaecology Activity Shift Pilot: A pilot to shift low-complexity gynaecology procedures from acute settings into primary care with consultant oversight is being developed. This will reduce avoidable referrals and free up outpatient and day case capacity for more complex patients. Expected benefits include shorter waiting times, improved RTT performance and reduced workforce pressures. It builds sustainable capability within primary care while improving use of the acute estate. Crucially, it establishes a scalable model for outpatient transformation and integrated women's health care.

Great Yarmouth & Waveney Community Collaborative: System partners are delivering a neighbourhood model aligning services around people, communities and four local geographies. It combines strategic partnerships with Integrated Neighbourhood Teams (INTs) to manage frailty and wider population need. Using population health management and shared data, the model supports proactive identification and earlier intervention. There is a strong focus on tackling inequalities, co-production with communities and digital enablement. The ambition is to shift from reactive hospital care to preventative, coordinated support at neighbourhood level.

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Test, Learn & Grow Pilot (GYW): A data-driven multi-disciplinary team (MDT) model is targeting two frailty cohorts: high-complexity patients and those with reversible risk. It enables coordinated multi-agency support to stabilise demand and prevent deterioration. Use of tools such as Eclipse and "what matters to me" conversations strengthen personalised care planning. Early results show better identification of unmet need, improved coordination and earlier intervention. The pilot is building evidence for a scalable neighbourhood model that reduces crisis demand and improves outcomes.

Other partners:
I have also been out with colleagues meeting and negotiating with our key other partners, including

- Primary Care Network Clinical Director discussing incentivising preventative GP behaviours.
- Great Yarmouth Police, discussing better support for our staff and more proactive preventative support in the Emergency Department.
- The Chief Executive and Leader of Great Yarmouth Council discussing neighbourhood working and sites for community hubs.
- Representatives of Lowestoft Hospital Group discussing the site and potential for health hubs.

4. Performance

Elective care recovery

4.1 Since the last Board meeting, the elective care programme has been dominated by finishing the sprint work during Q4 and we have managed to keep that activity going into this financial year, hitting our Indicative Activity Plan (IAP) for April. Although we did not hit the RTT plan target, we expect to recover that in May. Cancer metrics have fluctuated over the last couple of months as per the performance report.

Urgent and emergency care (UEC) recovery

4.2 We have received agreement for the funding to build and deliver a JPUH Urgent Treatment Centre (UTC) and we are no longer in tiering across the UEC domain which is a huge credit to the work of all the teams across the hospital. We are better than the mean for our 30-minute ambulance offload delays and the ED continues to improve its 4-hour metric. We have expanded our ED consultant workforce with two new consultants to support further improvement.

4.3 The stranded patient metrics have reduced to an all-time low, exceeding the 14-day and 21-day targets set for this year. Current performance is 116 for 14 days and 77 for 21 days. Work continues at pace with both internal clinical teams and system partners where we have agreed to reduce our target to 70 for 21 days and over to match pre-Covid levels. Criteria Led Discharge continues to show month-on-month improvements, contributing to bringing length of stay down significantly and we are a seven-month positive outlier in reducing our length of stay (LOS). We brought in Getting It Right First Time (GIRFT)/NHS England to run a "time to care" week in April which helped escalate difficult discharge issues. But the even greater success has been in

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how we have embedded that process into our weekly ward meeting cadence, to the extent that GIRFT are now using us as an exemplar. The new Direction of Choice Policy gets rolled out in June and OPTICA is now the agreed and well-used platform for all discharge communication. We are linking all of this work into the One Recovery programme.

Finance

4.4 We ended the year on plan delivering break-even. April is also on plan with a £1.4m planned deficit and we hit our CIP and income targets.

Governance

4.5 We have refreshed our yearly strategic objectives aligning them with the One Recovery programme as per the following slide:

Strategic Ambition	2026-27 Objectives	Key Projects to deliver this
OUR PATIENTS	1. Deliver Our Quality Priorities 2. Improve the way patients contact & interact with us 3. Reduce the time patients spend in our hospital	• Improve the fundamentals of care (e.g. falls, pressure ulcers) • Introduce a new telephone calling system for patients • Improve perinatal care • Improve discharge processes • Redesign UEC pathways (One Recovery)
OUR PEOPLE	1. Improve Staff Engagement and Morale 2. Reduce the level of sickness absence 3. Reduce the occurrence and impact of violence and aggression faced by our staff	• Listen better to staff – team brief cascade (18k voices) • Support managers to support you better (Top leaders programme) • Support people to come back to work after sickness • Introduce “My name is” badges and use of first names • Tackle violence, aggression and unacceptable behaviour
OUR PARTNERS	1. Deliver effective ‘Neighbourhood Health’ through partnership working 2. Improve patient pathways across the Group and system partners 3. Redesign support services to meet the needs of the Group	• Build a stronger alliance with ECCH and Norfolk Primary Care • Create neighbourhood teams that can prevent admissions • Move frailty resources to support primary care in the community • Consider new group approach to ENT and urology pathways • Centralise support functions in the group
OUR PERFORMANCE	1. Reduce waiting times 2. Reduce the wait for cancer treatment 3. Deliver the Cost Improvement Programme	• Improve outpatient bookings processes (One Recovery) • Improve preoperative assessment to reduce cancellations (One Recovery) • Introduce new cancer system and better resources for tracking (One Recovery) • Create training programme and standard ward processes (World Class Basics) • Take out costs where there is waste (CIP)

5. Recommendation

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

Report to the Group Board in public: 3 June 2026

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

Executive summary

This report highlights continued progress at NNUH in operational performance, research and innovation, and external recognition. April performance showed broadly stable performance, and a positive 2025/26 financial outturn, while significant challenges remain in delivering the 2026/27 financial improvement requirement.

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

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Norfolk and Waveney University Hospitals Group

Group Board in public: 3 June 2026
Executive Managing Director's report: Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)

1. Changes within Hospital Leadership Team

Chris Cobb, Chief Operating Officer at NNUH is acting Executive Managing Director for the duration of Shane Gordon's planned absence.

Following Lorraine Hooper's departure at the end of February, Clare Hinton, Deputy Director of Finance has acted up into the role of interim Director of Finance.

Louise Ludgrove, Interim Director of People and Culture, left the Trust at the end of March. Kathryn Jones, Head of HR Business Partnering and Medical Workforce, acted up into the role until a longer-term appointment could be made. David Partridge joined the Trust in mid-May as Interim Director of People and Culture. We welcome David to the team and thank Kathryn for her support and leadership during her period of acting up.

Finally, Alison Stace joined the Trust as Deputy Executive Managing Director on 1 June from the James Paget University Hospital where she has held the position of Chief Delivery Officer since October 2025, and before that, was Director of Operations at East Suffolk and North Essex NHS Foundation Trust. Alison's initial focus as deputy EMD will be supporting the neighbourhood health agenda and work to reduce length of stay, which are key areas to help improve services for our patients and staff experience. We welcome Alison to the team.

2. Performance

Activity

April's performance shows combined four-hour performance at 83.8%, which is above plan, above the national standard, and improved on the same period last year. Twelve-hour performance also improved to 3.2%, representing the best position since July 2025 and performance ahead of plan. Ambulance handover metrics remain off track, but average handover time improved to its best performance since July 2024, and the proportion of handovers over 45 minutes improved to its best performance since July 2025, indicating some positive movement in patient flow despite continued operational pressure.

18-week performance was in line with plan for April, while time to first appointment was above plan and at its second highest level in the last two years. The overall waiting list reduced by 1,375 compared with March, although it remains above plan, and the 52-week position also remains slightly behind plan, impacted by industrial action.

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Cancer performance was mixed with 31-day performance above plan and at its highest level since July 2025, while provisional April performance for the 28-day

Faster Diagnosis Standard and 62-day standard was below plan, notwithstanding strong confirmed March performance in both measures. Performance is expected to improve in May.

Overall, April performance showed continued improvement across urgent and emergency care, with four-hour and twelve-hour metrics ahead of plan and improving month on month, while ambulance handover delays also continued to improve, despite remaining behind plan. Elective care performance remained broadly stable, with the cumulative impact of Easter and Industrial Action constraining further progress. Cancer performance was mixed, with strong 31-day performance, yet provisional underperformance against the 28-day and 62-day standards, although improvement is expected in May.

Finance

The 2025/26 financial year ended positively from a financial perspective, achieving our goal of breaking even and ended the year with a £4.9m surplus following receipt of redistributed Deficit Support Funding from NHS England in March. For 2026/27 we have a breakeven plan which requires us to identify £52.2m of efficiency improvements, c.5.0% of the cost base.

As of 21 May 2026 we have signed off detailed delivery plans, including Clinical Quality Impact Assessments for £24.4m (47% of target), with schemes for the remaining balance in development. There are a number of intensive Hospital Leadership Team (HLT) led actions ongoing which are expected to significantly reduce the planning gap by the end of quarter one.

A successful first "FIP (Financial Improvement Plan) Friday" took place on the 15 May, bringing together colleagues from clinical and corporate teams which generated a number of new ideas, focused work on a revised bed model - realising benefits from a number of interventions across length of stay reduction and clinical pathway redesign, and Hospital Leadership Team review of various medical workforce improvements which are being led by the senior medical leadership team.

3. National Oversight Framework (NOF)

The most recent quarterly publication of the National Oversight Framework (NOF) showed that The Trust had moved up in the national rankings from 108th to 91st (out of 134 acute trusts). This improvement reflects the progress made in 2025/26 including improved cancer performance, waiting list reductions, and delivering to our financial plan. While we welcome the improvement in our position, we are still not where we aspire to be. Work continues to embed the improvements and achieve a NOF ranking that aligns to the excellent services we provide and that we can be truly proud of.

Changes to the metrics used to rank trusts are expected to be included in the next publication of the NOF later in June.

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4. Research and Innovation

Research and innovation remain central to our ambition to deliver excellence and to strengthen the Trust's role within the wider Norwich Research Park. A recent example is the work on Primary Sclerosing Cholangitis (PSC), a rare and life-threatening liver disease for which treatment options remain extremely limited. Working across NNUH, the Earlham Institute and the Quadram Institute, this programme is helping to generate new insight into how the disease develops and progresses, with the potential to identify future therapeutic targets and improve outcomes for patients.

This work also demonstrates the value of close collaboration between clinical services and research partners across the Norwich Research Park. With support from NNUH teams including gastroenterology, endoscopy, radiology and histopathology, alongside academic and biorepository colleagues, the project has enabled advanced analysis of tissue from patients at very early stages of disease using innovative techniques such as single-cell RNA sequencing and spatial transcriptomics. In addition to its potential direct benefit for patients with PSC, the programme strengthens the infrastructure for research in Norwich and reinforces the Trust's wider commitment to research, innovation and partnership as key drivers of future service improvement.

Professor Jeremy Turner has been appointed Director of the NIHR Norfolk Clinical Research Facility, joining Dr Jenny Longmore as Co-Director since 24 March. His appointment brings considerable expertise in research leadership and clinical trial delivery and will help strengthen the strategic direction of the Facility, supporting growth in early phase studies, translational research, and partnership working across the Norwich Research Park. We congratulate Jeremy on his new role.

5. Education and Workforce Partnership with University of East Anglia

The Talking Heads project is a joint initiative between NNUH, the University of East Anglia (UEA) and other partners to create a series of short videos showcasing the experiences, motivations and values of staff who support learners across health and care settings. The aim is to provide a more authentic and human perspective on working within the NHS, while also promoting the quality of the learning environment and strengthening the attractiveness of both the UEA and NNUH to current and prospective learners. This reflects the shared commitment between NNUH and UEA to education, workforce development and increasing the visibility of NHS careers and learning opportunities.

More broadly, the project highlights the strategic value of the relationship between NNUH and UEA in supporting recruitment, retention and local identity across the health and care system. The outputs will be used across UEA communication channels, including its website, YouTube and social media platforms, helping to promote both course opportunities and the strength of local clinical learning partnerships.

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6. Norfolk and Norwich Orthopaedic Centre Accreditation

The Norfolk and Norwich Orthopaedic Centre (NaNOC) has received national accreditation as an orthopaedic hub, recognising the high standards of its clinical and operational practice. The accreditation, awarded through NHS England's Getting It Right First Time programme in collaboration with the Royal College of Surgeons of England and supported by the Royal College of Anaesthetists, provides external assurance of the quality of care delivered and the effectiveness of the centre as part of the national approach to increasing elective capacity.

NaNOC is one of 69 accredited hubs nationally and has been recognised for its strong performance, patient outcomes and commitment to continuous improvement. The accreditation reflects the significant work undertaken by the multidisciplinary team in developing the centre and evidencing its impact, including improvements in length of stay, patient experience and operational delivery. As a dedicated elective facility, separate from the main hospital and emergency services, NaNOC continues to play an important role in supporting elective recovery, reducing waiting times and improving the experience of patients requiring orthopaedic surgery.

7. Recognition Days

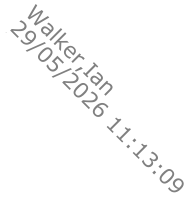
During April and May we celebrated colleagues from across the organisation as part of a number of national and international recognition days. These included colleagues from a variety of backgrounds including nursing, midwifery, operating department practitioners, facilities management colleagues, and those working in administrative professions. We want to say a big thank you and recognise the work of our clinical, clerical colleagues across our hospitals for their continued dedication and commitment to each other, and the community we serve.

8. Conclusion

Overall, the period has seen encouraging progress across a number of areas, and external recognition of service quality. At the same time, significant challenges remain in sustaining ambulance handover improvement and delivery of the 2026/27 financial plan. Our focus in the coming months will be on maintaining operational improvement, strengthening financial grip, and continuing to deliver against our ambition for excellence.

9. Recommendations

The Group Board is asked to receive and note the report.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Report to the Group Board in public: 3 June 2026

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

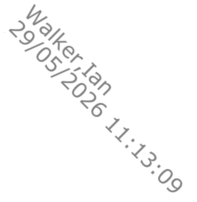
Executive summary
The Group governance structure includes a Group Audit Committees in Common which meets four times per year (with an additional meeting on the Annual Report and Accounts).

The attached report summarises the key areas of discussion at the Committee's latest meeting which was held on 28 April 2026.

Recommendations

The Group Board is asked to note the report of the Group Audit Committees in Common meeting held on 28 April 2026.

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



Chair's Report from the Group Audit Committees in Common: 28 April 2026

The Committee received reports covering:

1. External Audit: there was reasonable assurance that all three audits were on plan.
2. Internal Audit: partial assurance and see alerts below.
3. Counter Fraud: reasonable assurance and an alert.
4. Declarations of Interest processes: partial assurance with plan to be fully assured in place.
5. Quarterly waivers: partial assurance with assurance that revised processes and an improved report will be in place for the June 2026 meeting.
6. Annual accounts and Annual Governance Statement: reasonable assurance.
7. Terms of Reference: reasonable assurance.

Alerts:

1. All three Trusts received partial assurance regarding sickness management. It was therefore agreed that the three Human Resources Directors, together with the newly-appointed Interim Group Chief People Officer, should review best practice across the Trusts in order to harmonise processes and seek improvement in performance and that they should attend the autumn meeting to outline the work undertaken and progress.

2. There are concerns that the final internal audit report for the Queen Elizabeth Hospital will only provide partial assurance and this may therefore impact on the Annual Governance Statement and Value for Money report.

3. There are some concerns that the last three internal audit reports at the James Paget were partial assurance. However, it was noted that two of these were requested by the hospital due to internal concerns and as such this should be seen as a positive.

Advice

1. There was concern that one fraud investigation at Queen Elizabeth Hospital was still ongoing after a year. It was agreed that the Group Chief Executive would review the case and ensure all appropriate actions are being and will be taken.

Stephen Javes
Committee Chair

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Report to the Group Board in public: 3 June 2026

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

Executive summary

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

The attached report summarises the key areas of discussion at the Committee's meetings held on 28 April and 22 May 2026.

Recommendations

The Group Board is asked to note the report of the Group Research, Innovation and Education Committee meetings held on 28 April and 22 May 2026.

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

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Chair's Report from the Group Research, Innovation and Education Committee: 28 April and 22 May 2026

The Group Research, Innovation and Education (RIE) Committee has met twice since the last Group Board meeting on 1 April 2026 (28 April and 22 May 2026). This more frequent cadence was put in place to maintain momentum in developing and establishing reporting structures and supporting the development of the recommendations report developed by Dr Liz Sutton concerning a Group-wide model for RIE across the Group.

These meetings focused principally on:

- Establishment of the first integrated Group-level research and education dashboards and reporting arrangements.
- Receipt and discussion of the emerging "Collectively Curious" report and recommendations regarding the future RIE Target Operating Model.
- Consideration of the Group's external strategic positioning and future development trajectory.

Across the two meetings, the Committee recognised progress in moving from three largely sovereign approaches to research and education towards a more integrated Group model, while also identifying substantial variation in organisational maturity, reporting, infrastructure, workforce arrangements and strategic alignment across the three Trusts.

The focus on establishing a shared "dashboard" style reporting channels into the Committee was in response to the need to establish clearer Group-wide reporting channels, baseline metrics and oversight arrangements for research and education, which did not previously exist in any mature format. The Committee's focus has been on developing consistent reporting methodologies, benchmarking and organisational health metrics capable of supporting strategic decision-making and future performance management at Group level to support it in discharging its duties.

Across the meetings, the Committee also received, provided feedback on and discussed the emerging "Collectively Curious" report, which set out recommendations regarding how the Group should structure itself to support its longer-term ambitions for RIE. The report sets out the need to move from fragmented local arrangements towards a clearer Group-wide vision, strategy and operating model, with stronger Group-level leadership for strategy, partnerships, infrastructure and external positioning, whilst retaining site-level operational delivery and local strengths. The full, final report reflecting this feedback will be received by the Group Chief Executive and inform the future development plan for RIE.

Through the Committee's meetings, particular emphasis has been placed on the need to fully integrate RIE within future care models and clinical operations, rather than continuing to treat these as adjunct activities. The Committee also identified research nursing and wider research delivery infrastructure as key enabling functions requiring more coordinated Group-wide leadership and workforce planning. Alignment and integration with the One Strategy will be key to realising this.

Walker, Jan
29/05/2026 11:43:09

The Committee will next meet on 18 June 2026 and then on 19 August 2026 from which point it will move to a bi-monthly cadence to year end. The June meeting will be a development session in response to the “Collectively Curious” report with a sub-section of the Committee. This meeting will focus on development of a single shared RIE strategy and implementation roadmap, and proposals regarding future leadership, governance and delivery structures aligned to the Group’s wider One Strategy programme and ambition to establish a University Hospital System.

Philip Baker
Committee Chair

Walker,Ian
29/05/2026 11:13:09

Report to the Group Board in public: 3 June 2026

Agenda item number	8.4		
Title	Group Nomination and Remuneration Committees in Common – Chair's report		
Author(s)	Sally Collier, 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 Nomination and Remuneration Committees in Common which meets twice per year (with additional meetings as required).

The attached report summarises the key areas of discussion at the Committee's meeting which was held on 29 April 2026.

Recommendations

The Group Board is asked to note the report of the Group Nomination and Remuneration Committees in Common meeting held on 29 April 2026.

Alignment to Board Assurance Framework risk(s)	BAF Principal Risk 14 (corporate governance)
Previously considered by	Not applicable
Any background papers in Admin Control Reading Room	No

Walker,Ian
29/05/2026 11:13:09

Chair's Report from the Group Nomination and Remuneration Committees in Common: 29 April 2026

At its meeting on 29 April 2026, the Committee discussed the following matters:

- Group approach to Very Senior Manager (VSM) pay: the Committee endorsed a consistent, compliant approach to VSM pay across all three Trusts, with VSM salaries set in accordance with the NHS England VSM Pay Framework.

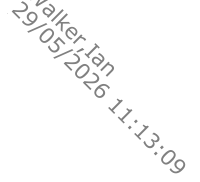
- Group Executive and other VSM roles: the Committee reviewed and discussed the current position in relation to the remuneration and terms and conditions of Group Executives and other VSM roles at Group/Trust level.

- Termination and/or settlement payments: in accordance with its terms of reference, the Committee received details of any termination and/or settlement payments made by the Trusts.

- Group Executive objective setting: the Committee received a report from the Group Chief Executive on the process for setting objectives and reviewing the performance of Group Executives.

- In addition, the Committee discussed specific issues relating to individuals within its remit.

Sally Collier
Committee Chair



Report to the Group Board in public: 3 June 2026

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

Executive summary

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

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

This report provides a summary of key performance issues for April 2026 including assessment of the Medium-term Plans submitted.

Recommendations

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

Alignment to Board Assurance Framework risk(s)	Principal Risks 1, 2, 3, 4, 5
Previously considered by	Group Risk Assurance Committee, 28 May 2026
Any background papers in Admin Control Reading Room	Close down letters available in the reading room for Board members

Walker,Ian
29/05/2026 11:13:09

Norfolk and Waveney University Hospitals Group

Group Board in public: 3 June 2026

Group Integrated Performance Report (IPR)

Overall Performance

The IPR provides a consolidated view of quality, workforce, operational performance and finance across the three Trust sites (NNUH, JPUH and QEH).

There are early signs of improvement across flow and some performance metrics, but delivery remains fragile and uneven, with key risks in quality, workforce, access standards, and financial delivery.

Patient experience metrics perform strongly, and core quality metrics are stable.

The full-year financial plan remains breakeven, but delivery is highly dependent on CIP and productivity improvements.

Risks remain with workforce capacity and sickness, diagnostic constraints, CIP delivery with particular risks for quality, workforce and finance evident at QEH.

Sustained delivery of One Recovery and associated local recovery programmes across all Trusts are required to achieve the improvements needed.

1. Safe and Effective Care

1.1 Quality and Safety

The Group position shows stable mortality (except QEH coding-driven variance), and strong patient experience; however, infection control pressures, and complaints timeliness remain key risks.

A key focus is on coding quality and strengthened Group-wide quality programmes.

Workforce continues to be a key pressure in maternity services with midwifery fill rates below target. This is driven by high sickness (notably at NNUH) and training requirements.

Position

Walker,Ian
29/05/2026 11:13:49

- Mortality broadly stable, with QEH higher than expected (coding/data quality issues) and NNUH/JPUH within expected range.
- Patient experience strong overall (high Friends and Family Test (FFT)), but variation exists across services.
- Maternity outcomes stable, including low stillbirth rates, though workforce pressures persist.

Key Risks/Challenges

- Infection control pressures (notably NNUH).
- Complaints timeliness and backlog.
- Workforce gaps impacting safe staffing (particularly JPUH and maternity).
- Data quality/coding affecting assurance (QEH).

Priorities

- Strengthen coding quality and clinical assurance.
- Deliver Group-wide quality improvement programmes (e.g., pressure ulcers, falls).
- Improve complaints handling and learning systems.

1.2 Maternity

Maternity performance is broadly stable with low stillbirth rates and an improving workforce trajectory at JPUH; however, staffing capacity, sickness absence and experience remain key risks.

Focus is on workforce stabilisation, targeted QI (post partum haemorrhage (PPH), NICU admissions), and strengthening Group-wide alignment and data-driven improvement.

Positives

- Stillbirth rates low across all sites.
- Positive trajectory in workforce improvements (JPUH).
- Strong 1:1 care in labour (NNUH).
- Increasing use of QI and data-driven approaches.

Key Risks / Challenges

- Workforce capacity and experience mix remains the primary risk.
- Sickness absence impacting staffing resilience.
- Variation in:
    - FFT engagement and feedback quality
    - Neonatal admissions and PPH rates

Priorities

- Strengthen midwifery recruitment, retention, and support.
- Improve consistency of care quality and outcomes across sites.
- Enhance data, reporting, and feedback utilisation.
- Continue group-wide alignment of maternity services.

Walker,Ian
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2. People and Culture

Group position

Sickness absence is the primary Group-wide challenge with all three Trusts above target: JPUH 5.68% (target 4.6%), NNUH 4.30% (target 4.2%), QEH 5.72% (target 4.5%); JPUH and QEH are also above the c.5.1% national average. JPUH and NNUH meet target on turnover, mandatory training and non-medical appraisal. QEH is non-compliant across all four domains.

Why this matters now

From April 2026, new national Staff Standards require quarterly publication of staff-experience data, with poor outcomes acting as a CQC early-warning signal. These four domains are now a regulatory matter, set against a national direction of sickness reduction toward 4.1%, stronger management accountability, reformed mandatory training, and tighter agency/bank controls. Internal audit reports across all three Trusts have confirmed control weaknesses in attendance management; the Group Audit Committees in Common has requested demonstrable improvement by autumn 2026.

Key risks:

- High long-term sickness and workforce capacity constraints across all sites.
- QEH systemic non-compliance concentrating regulatory exposure.
- Bullying, harassment and discrimination of BAME staff raised at JPUH, visible Group-wide, carrying statutory risk under the Equality Act, Public Sector Equality Duty and Workforce Race Equality Scheme (WRES).
- Temporary staffing spend running ahead of mandated national reductions.

Planned response

Three programmes of work will now be developed:

1. A Group Sickness Absence Management Strategy aligned to the 10 Year Health Plan 4.1% target, consolidating three Trust attendance policies into a single Group Attendance and Wellbeing Policy, retiring the Bradford Score, investing in manager capability, commissioning targeted musculoskeletal and mental-health pathways, and introducing a Group sickness dashboard into the IPR.

2. A six-policy harmonisation programme (including attendance and wellbeing) led by the Group Chief People Officer and Human Resources Directors to eliminate site-to-site variation in workforce management practice.

3. A coordinated Equality, Diversity and Inclusion response - consistent WRES/WDES (Workforce Disability Equality Scheme) action plans, Freedom to Speak Up alignment, implementation of the Sexual Safety in Healthcare Charter, and a civility and respect programme addressing cultural root causes.

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3. Access and Flow

3.1 Elective

Elective recovery is progressing across all Trusts, but remains constrained by diagnostics capacity, long waits (particularly >65 weeks), and productivity gaps. Focus is on accelerating long-wait reduction, expanding capacity (insourcing and diagnostics), and strengthening pathway and booking control through One Recovery.

Positives

- Clear recovery plans in place across all Trusts.
- Increasing use of insourcing and targeted capacity expansion.
- Strengthening governance and specialty-level oversight.

Key Risks/Challenges

- Long waits (>52 and >65 weeks) remain a major system risk.
- Diagnostics capacity constraints limiting recovery pace.
- Productivity gaps across theatres, outpatients, and pathways.
- External pressures (industrial action, demand surges).

Priorities

- Accelerate long-wait clearance (52+ and 65+ weeks).
- Expand diagnostics and elective capacity sustainably.
- Improve productivity (theatres, clinics, pathway control).
- Strengthen validation and demand management processes.

3.2 Cancer

Cancer performance remains challenged, with 62-day standards below target across all Trusts due to backlog, diagnostic constraints, and pathway delays. Recovery is focused on digital transformation, pathway redesign, and targeted capacity expansion, with reducing backlog and improving Faster Diagnosis Standard (FDS) performance as key priorities.

Positives

- Structured recovery programmes in place across all Trusts.
- Increased use of digital tools and pathway redesign.
- Stronger areas of performance (e.g., NNUH FDS, QEH 31-day standard).

Key Risks/Challenges

Walker,Ian 29/05/2026 11:13:40

- 62-day backlog remains the most significant system risk.
- Diagnostics (particularly histology) continue to constrain performance.
- Workforce capacity and pathway inefficiencies slowing recovery.
- External pressures (industrial action) impacting delivery.

Priorities

- Reduce 62-day backlog at pace.
- Expand and stabilise diagnostic capacity (especially histology).
- Accelerate digital transformation (Cancer 360, Teledermatology).
- Embed standardised, best practice pathways across the Group.

3.3 UEC

UEC performance is improving, particularly in ambulance handovers and 12-hour waits, but remains constrained by rising demand, discharge delays, and reduced escalation capacity.

Focus is on embedding sustainable flow, strengthening front door models, and reducing length of stay to maintain improvements

Positives

- Clear improvement trajectory in flow and handovers across all sites.
- Stronger front door decision-making and coordination.
- Evidence that targeted operational interventions are effective.

Key Risks/Challenges

- Rising Emergency Department (ED) attendances increasing demand pressure.
- Length of stay and discharge delays remain core constraints.
- Reduced reliance on escalation capacity increases system fragility.

Priorities

- Sustain and embed flow improvements without escalation capacity.
- Accelerate discharge and length of stay reduction.
- Continue improving ambulance handover performance.
- Strengthen front door models and senior decision-making.

4. Performance and Efficiency

The Group reports a £6.8m April deficit driven by QEH underperformance, primarily due to CIP shortfall and higher temporary staffing costs, though the full-year breakeven position is maintained.

The key risk remains delivery of efficiencies (CIP), alongside reliance on agency spend and productivity gaps, with a strong focus on financial recovery and control measures.

- April deficit: £6.8m, £0.6m adverse to plan, driven entirely by QEH variance.
- Key driver: under-delivery of efficiencies (CIP) and increased bank/agency spend (~£0.5m vs prior year).
- Despite Month 1 variance, full-year forecast remains breakeven.

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Positives

- Full-year breakeven position maintained despite Month 1 pressure.
- Strong governance and financial grip across all Trusts.
- Early progress in CIP delivery (JPUH).

Key Risks/Challenges

- CIP delivery gap is the primary system risk, particularly at QEH and NNUH.
- Bank and agency cost pressures across the Group.
- Productivity and activity delivery shortfalls impacting income recovery.
- QEH-specific risks:
    - Financial recovery trajectory
    - Cash sustainability

Priorities

- Accelerate CIP identification and delivery.
- Strengthen controls on temporary staffing spend.
- Improve productivity and activity performance.
- Maintain tight financial governance and oversight across the Group.

5. Close Down Letters

Following submission of the Medium-term Plans in March 2026, all the three Trusts have received confirmation that plans are partially compliant: with conditions to achieve full compliance set out for each Trust.

Detail of the assessment has been reviewed by the Group Executive and reporting and oversight of delivery against the conditions will be included in Site Performance meetings.

6. Conclusion

In conclusion, while there are encouraging signs of improvement in operational flow and core quality measures, overall Group performance remains fragile and requires immediate, sustained action. The priority now must be to accelerate delivery in the areas of greatest risk: workforce resilience, elective and cancer recovery, urgent and emergency care flow, and financial recovery, with particular focus on the scale of challenge at QEH. This will require tighter grip, clearer accountability, and faster execution of One Recovery and local improvement plans, supported by rigorous oversight of risk, performance and delivery, to secure tangible improvement and maintain confidence in achievement of the Group's 2026/27 objectives.

Walker,Ian
29/05/2026 11:13:09

Group Integrated Performance Report

Apr-26

Walker,Ian
29/05/2026 11:13:09

Introduction

Apr-26

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

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

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

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

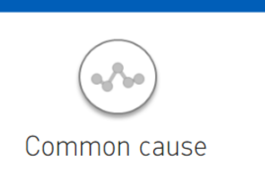
Compliance

Target being met

Target not met

No target

Variation


Common cause

Special cause of concerning nature

Special cause of improving nature

Assurance

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Inconsistent achievement of target

Consistent achievement of target

Consistent failure of target

Escalation Status

Assure
Performing as expected

Advise
Ongoing monitoring/ negative assurance

Alert
Attention required/ not performing as expected

NHS
James Paget University Hospitals
NHS Foundation Trust

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Group Summary

Apr-26

NHS James Paget University Hospitals NHS Foundation Trust

	P	?	F
H / L		8	4
	11	17	6
H / L	1	2	

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

	P	?	F
H / L	2	9	1
	9	15	7
H / L		2	

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

	P	?	F
H / L		7	1
	10	18	2
H / L		4	1

Annual Metrics

CQC Safe Domain Rating

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

Inpatient Satisfaction

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

Staff Survey - We are Safe and Healthy

National - 6.07

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

Staff Survey - Engagement Score

National - 6.74

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

Staff Survey - Raising Concerns

National - 6.30

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

Annual Metrics

Maternity Survey 2025

James Paget University Hospitals NHS Foundation Trust

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

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

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

Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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2024 | National Education and Training Survey — Overall Experience

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

Safe and Effective Care Domain Metrics

Walker,Ian
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Metric Summary Matrix - Safe and Effective Care

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

Safe and Effective Care Assurance

NHS James Paget University Hospitals NHS Foundation Trust

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

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

Safe and Effective Care Assurance

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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

Safe and Effective Care Assurance

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

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

Safe and Effective Care Domain Summary

Apr-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
SHMI	Dec-25	1.17	1.17			
MRSA	Apr-26	0	0			
CDiff	Apr-26	3	3			
Ecoli	Apr-26	0	3			
Average number of days between planned and actual discharge date	Apr-26	2	7			
Readmission Rate	Mar-26	10.0%	12.54%			

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
SHMI	Dec-25	1.17	1.16			
MRSA	Apr-26	0	2			
CDiff	Apr-26	8	12			
Ecoli	Apr-26	0	6			
Average number of days between planned and actual discharge date	Apr-26	2	6			
Readmission Rate	Mar-26	10.0%	13.11%			

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
SHMI	Dec-25	1.17	1.23			
MRSA	Apr-26	0	0			
CDiff	Apr-26	4	4			
Ecoli	Apr-26	0	4			

Group Summary

QEH - Mortality data remains higher than expected with reduction in SHMI for last 3 months, rolling 12-month data as impact of addressing coding backlog beginning to impact on data.

NNUH – SHMI data for reporting period December 2024 - November 2025 is reported at 1.1548, rounded to 1.16. This demonstrates an increase from previous reporting months but remains within 'as expected' range/classification by NHSE. Actions remain ongoing including the development of a ‘Frailty Drivers Coding Checklist’ pilot document which is due for completion on the ward by clinical teams clerking to capture co-morbidities contributing to frailty clearly in the anticipation that this will support enhanced depth of coding and ultimately support SHMI improvements. Long term, it is anticipated the implementation of EPR will have a significant positive impact on clinical data quality and depth of coding.

JPUH – Mortality data remains as expected.

Safe and Effective Care Domain Summary

Apr-26

Metric	James Paget Date	Target	Actual	Compliance	Variation	Assurance	Norfolk and Norwich Date	Target	Actual	Compliance	Variation	Assurance	Queen Elizabeth Date	Target	Actual	Compliance	Variation	Assurance
FFT Score	Apr-26	95.0%	97.51%	✓		P	Apr-26	95.0%	92.42%	✗		?	Apr-26	95.0%	91.39%	✗	L	?
Complaints Received	Apr-26	0	16	✗		F	Apr-26	0	96	✗		F	Apr-26	0	46	✗	H	F
Pressure Ulcers	Apr-26	0	4.00	✗		?	Apr-26	0	36.00	✗		F	Apr-26	0	2.00	✗	L	?
Registered Nurse Fill Rate	Apr-26	90.0%	87.53%	✗		?	Apr-26	90.0%	96.99%	✓	H	P	Mar-26	90.0%	90.79%	✓	H	?
Care Hour Per Patient Day (CHPPD)	Apr-26	8.00	8.66	✓		?	Apr-26	8.00	8.10	✓		?	Mar-26	8.00	7.58	✗		?
Falls	Apr-26	67	54	✓		?	Apr-26	187	193	✗		?	Apr-26	54	61	✗		?
PSII Number	Apr-26	0	0	✓		P							Apr-26	0	0	✓		P

Group Summary

Complaints backlog is being addressed, and current complaints are being responded to in a more timely manner.

Following the Group Chief Nurse deep dive and paper, the Group wide Pressure Ulcer Taskforce commences in June and will report through the Quality Standards Group.

Walker,Ian
29/05/2026 11:13:09

Metric Summary Matrix - Safe and Effective Care - Maternity

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

Safe and Effective Care Assurance

NHS James Paget University Hospitals NHS Foundation Trust

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

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

Safe and Effective Care Assurance

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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

Safe and Effective Care Assurance

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

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

Walker, Ian 29/05/2026 11:13:09

Safe and Effective Care Domain Summary - Maternity

Apr-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Still Birth Rate	Apr-26	3.5%	0.00%			
Midwifery Fill Rate	Apr-26	90.0%	89.45%			
Preterm Birth Rate	Apr-26	6.0%	6.56%			
Maternity FFT	Apr-26	95.0%	88.00%			
Complaints Received - Maternity	Apr-26	0	2			
MNSI	Apr-26	0	0			
1:1 Care	Apr-26	97.0%	100.00%			
Unplanned Admissions to NICU	Apr-26	0	10			

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Still Birth Rate	Apr-26	3.5%	0.00%			
Midwifery Fill Rate	Apr-26	90.0%	86.51%			
Preterm Birth Rate	Apr-26	6.0%	5.00%			
Maternity FFT	Apr-26	95.0%	72.00%			
Complaints Received - Maternity	Apr-26	0	4			
MNSI	Apr-26	0	0			
1:1 Care	Apr-26	97.0%	97.83%			
Unplanned Admissions to NICU	Apr-26	0	24			

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Still Birth Rate	Mar-26	3.5%	0.24%			
Midwifery Fill Rate	Mar-26	90.0%	86.99%			
Preterm Birth Rate	Mar-26	6.0%	5.34%			
Maternity FFT	Apr-26	95.0%	94.50%			
Complaints Received - Maternity	Apr-26	0	6			
MNSI	Apr-26	0	0			
1:1 Care	Mar-26	97.0%	100.00%			

Group Summary

Safer staffing rates for nursing and midwifery – maternity units are recruiting but often vacancies are filled by less experienced midwives and therefore additional support is required at the point of employment, within the preceptorship programme. Sickness in midwives is high at NNUH and in addition the professional training requirements impact on staffing rates.

Walker,Ian
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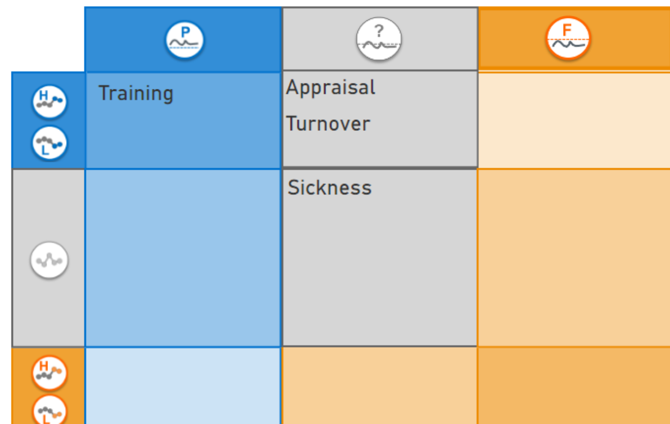
Metric Summary Matrix - People and Culture

Apr-26

James Paget University Hospitals NHS Foundation Trust

	P	?	F
H / L		Appraisal	Sickness
~			
H / L	Training	Turnover	

Norfolk and Norwich University Hospitals NHS Foundation Trust



The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

	P	?	F
H / L		Appraisal Training	
~		Turnover	Sickness
H / L			

People and Culture (James Paget)

- Sickness Rate
- Turnover Rate
- Mandatory Training
- Non Medical Appraisal

People and Culture (Norfolk and Norwich)

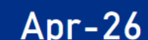
- Sickness Rate
- Turnover Rate
- Mandatory Training
- Non Medical Appraisal

People and Culture (Queen Elizabeth)

- Sickness Rate
- Turnover Rate
- Mandatory Training
- Non Medical Appraisal

Walker Ian 29/05/2026 11:13:09

People and Culture Domain Summary


Apr-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Sickness Rate	Apr-26	4.6%	5.68%	✗		
Turnover Rate	Apr-26	10.0%	7.28%	✓		
Mandatory Training	Apr-26	90.0%	91.49%	✓		
Non Medical Appraisal	Apr-26	85.0%	90.09%	✓		

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Sickness Rate	Apr-26	4.2%	4.30%	✗		
Turnover Rate	Apr-26	10.0%	6.73%	✓		
Mandatory Training	Apr-26	90.0%	92.79%	✓		
Non Medical Appraisal	Apr-26	85.0%	90.04%	✓		

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Sickness Rate	Apr-26	4.5%	5.72%	✗		
Turnover Rate	Apr-26	10.0%	10.32%	✗		
Mandatory Training	Apr-26	90.0%	80.48%	✗		
Non Medical Appraisal	Apr-26	85.0%	84.34%	✗		

Group Summary

Group position (Apr-26): Sickness is the shared challenge — all three Trusts above their individual target: JPUH 5.68% (target 4.6%), NNUH 4.30% (target 4.2%), QEH 5.72% (target 4.5%); JPUH and QEH also above the c.5.1% national average. JPUH and NNUH meet target on turnover (10.0%), mandatory training (90.0%) and non-medical appraisal (85.0%). QEH is non-compliant across all four domains.

Why this matters: From April 2026, new national Staff Standards require quarterly publication of staff-experience data, with poor outcomes acting as a CQC early-warning signal — so these four domains are now a regulatory matter, set against a national direction of lower sickness, stronger appraisal and accountability, and tighter agency/bank controls.

Group priorities:

•**Single reporting framework** across the four domains, aligned to the new Staff Standards, so the Group reports and assures consistently.

•**Sickness and attendance** — align trajectories and share what works (NNUH attendance/wellbeing; JPUH's recent improvement), focusing on long-term absence management reduction.

•**Workforce equality and staff experience** — consistent Group delivery of statutory duties (WRES/WDES, Equality Act/PSED) and Freedom to Speak Up, after the JPUH bullying/harassment signal.

Access and Flow Domain Metrics

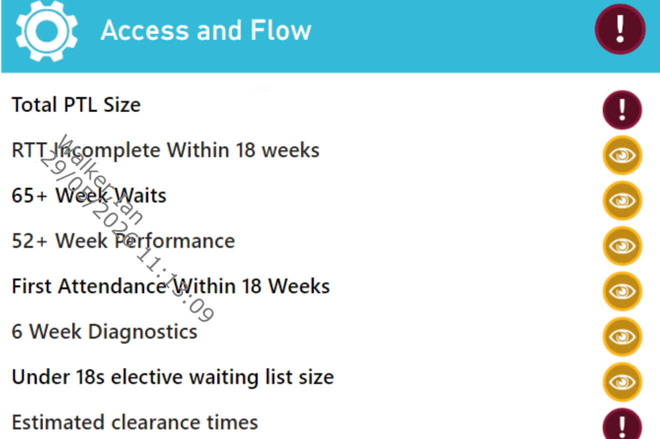
Walker,Ian
29/05/2026 11:13:09

Metric Summary Matrix - Access and Flow - Elective Care

Apr-26

James Paget University Hospitals NHS Foundation Trust

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



Access and Flow

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

Walker,Sian
29/07/2025 11:..:09

Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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

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

Access and Flow

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

Access and Flow Domain Summary - Elective Care

Apr-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Total PTL Size	Apr-26	32,074	32,920			
RTT Incomplete Within 18 weeks	Apr-26	57.1%	55.62%			
65+ Week Waits	Apr-26	0	105			
52+ Week Performance	Apr-26	5.6%	4.11%			
First Attendance Within 18 Weeks	Apr-26	64.0%	63.56%			
6 Week Diagnostics	Apr-26	75.9%	64.88%			
Under 18s elective waiting list size	Apr-26	2,615	2,891			
Estimated clearance times	Apr-26	18	26			

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Total PTL Size	Apr-26	81,265	67,558			
RTT Incomplete Within 18 weeks	Apr-26	92.0%	59.94%			
65+ Week Waits	Apr-26	0	198			
52+ Week Performance	Apr-26	2.2%	3.20%			
First Attendance Within 18 Weeks	Apr-26	64.0%	74.03%			
6 Week Diagnostics	Apr-26	95.0%	76.86%			
Under 18s elective waiting list size	Apr-26	8,368	6,963			

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Total PTL Size	Apr-26	24,963	25,151			
RTT Incomplete Within 18 weeks	Apr-26	92.0%	58.97%			
65+ Week Waits	Apr-26	0	4			
52+ Week Performance	Apr-26	1.5%	1.39%			
First Attendance Within 18 Weeks	Apr-26	64.0%	40.99%			
6 Week Diagnostics	Apr-26	95.0%	64.04%			

Group Summary

All three trusts show some degree of improvement, but each still carries material long-wait, waiting-list, or productivity risk.

Focus has shifted in 26/27 to reducing patients waiting over 52 weeks, with a significant risk at JPUH and NNUH both you have patients waiting over 65 weeks, ENT a is of significant concern with targeted short term actions being put in place to cover capacity gaps and longer term service redesign through One Recovery.

Diagnostics with MRI, NOUS, Echo, histology, and wider DM01 performance impacting on overall performance.

Recovery plans are operational with a focus on capacity including; insourcing, extra sessions, but also include targeted validation, productivity gains through theatres and outpatients , and booking/process control.

RTT 52+ Weeks

Median Performance — Top Decile Performance

8%
6%
4%
2%
0%

Current Performance

JPUH	3.98%
NNUH	2.58%
QEH	1.30%

0.09% Top Decile

0.94% Median

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

Waller,Ian 29/05/2026 11:13:05

Benchmarking

Mar-26

RTT Within 18 Weeks

Median Performance — Top Decile Performance

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

Current Performance

JPUH	55.49%
NNUH	63.68%
QEH	58.46%

76.06%
Top Decile

65.04%
Median

Walker,Ian
29/05/2026 11:13:00

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

Benchmarking

Mar-26

6 Week Diagnostics

Median Performance — Top Decile Performance

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

Current Performance	
JPUH	64.37%
NNUH	85.68%
QEH	68.52%

97.35%
Top Decile

84.86%
Median

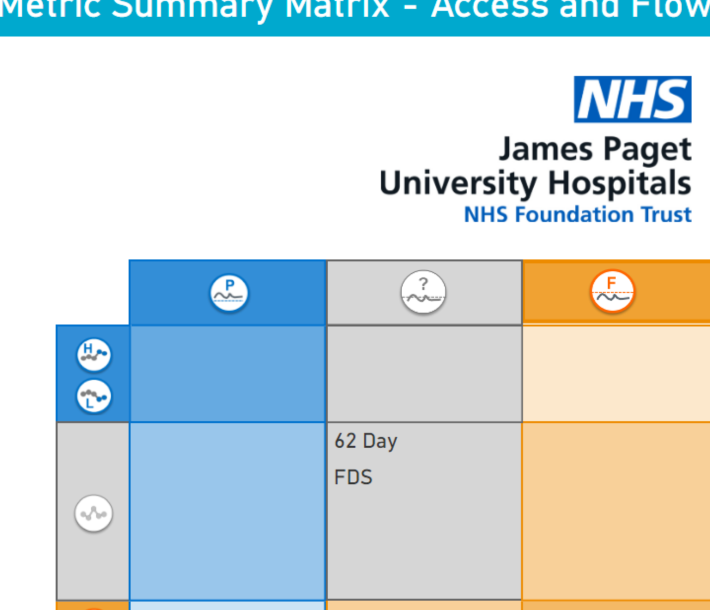
Metric Name	Percentage of patients waiting less than 6 weeks for a diagnostic test
Basis	End of period
Description	Of the total number of eligible diagnostic appointments undertaken in the month, the percentage of patients who were seen within 6 weeks.
Purpose	This metric ensures that patients are receiving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

Walker,Ian 29/05/2026 11:53:00

Metric Summary Matrix - Access and Flow - Cancer

Mar-26

James Paget University Hospitals NHS Foundation Trust



Access and Flow

28 Day Faster Diagnosis

Cancer 62 Day Treatment

Walker,Ian
29/05/2026 11:13:09

Norfolk and Norwich University Hospitals NHS Foundation Trust

62 Day

FDS

Access and Flow

28 Day Faster Diagnosis

Cancer 62 Day Treatment

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

62 Day

FDS

28 Day Faster Diagnosis

Cancer 62 Day Treatment

Access and Flow Domain Summary - Cancer

Mar-26

Metric	James Paget Date	James Paget Target	James Paget Actual	James Paget Compliance	James Paget Variation	James Paget Assurance	Norfolk and Norwich Date	Norfolk and Norwich Target	Norfolk and Norwich Actual	Norfolk and Norwich Compliance	Norfolk and Norwich Variation	Norfolk and Norwich Assurance	Queen Elizabeth Date	Queen Elizabeth Target	Queen Elizabeth Actual	Queen Elizabeth Compliance	Queen Elizabeth Variation	Queen Elizabeth Assurance
28 Day Faster Diagnosis	Mar-26	78.0%	75.71%				Mar-26	75.0%	80.54%				Mar-26	75.0%	69.92%			
Cancer 62 Day Treatment	Mar-26	78.0%	72.52%				Mar-26	85.0%	69.90%				Mar-26	85.0%	56.50%			

Group Summary

62 day performance remains significantly below the required target across all three trusts. With backlog of patients, diagnostic constraints and pathway delays a common theme. NNUH continues to perform strongly with 28 day FDS with JPUH and QEH focussing on specialty level plans to improve both 28 day and 62 day waiting times.

One stop models, triage redesign and digital tools feature strongly across all the three trusts and are included in the One Recovery – Cancer programme.

Benchmarking

Mar-26

Cancer 28 Day FDS - Current

Current Performance

JPUH	75.71%
NNUH	83.48%
QEH	69.92%

86.45% Top Decile

81.24% Median

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

Walker,Ian 29/05/2026 11:13:06

Benchmarking

Mar-26

Cancer 28 Day FDS - Rolling 12 Months

Median Performance — Top Decile Performance

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

Current Performance

JPUH	75.28%
NNUH	77.80%
QEH	68.04%

83.01% Top Decile
77.44% Median

Walker,Ian 29/05/2026 11:03:06

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

Cancer 62 Day Treatment - Current

Median Performance — Top Decile Performance

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

Current Performance

JPUH	72.52%
NNUH	68.74%
QEH	56.50%

86.36% Top Decile
74.29% Median

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

Walker,Ian
29/05/2026 11:13:06

Cancer 62 Day Treatment - Rolling 12 Months

Median Performance
Top Decile Performance

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

Current Performance

JPUH 68.28%

NNUH 61.10%

QEH 53.25%

83.17% Top Decile

71.32% Median

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

Walker, Ian 29/05/2026 11:03:06

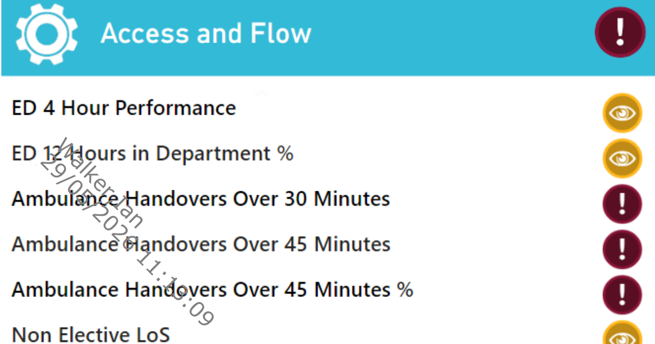
Metric Summary Matrix - Access and Flow - UEC

Apr-26

James Paget University Hospitals NHS Foundation Trust

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

Access and Flow



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

Norfolk and Norwich University Hospitals NHS Foundation Trust

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

Access and Flow

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

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

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

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

Apr-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
ED 4 Hour Performance	Apr-26	75.5%	72.98%			
ED 12 Hours in Department %	Apr-26	7.9%	6.44%			
Ambulance Handovers Over 30 Minutes	Apr-26	0	427			
Ambulance Handovers Over 45 Minutes	Apr-26	0	313			
Ambulance Handovers Over 45 Minutes %	Apr-26	0.0%	17.29%			
Non Elective LoS	Apr-26	10	11.19			

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
ED 4 Hour Performance	Apr-26	78.0%	83.82%			
ED 12 Hours in Department %	Apr-26	4.0%	3.59%			
Ambulance Handovers Over 30 Minutes	Apr-26	0	1,130			
Ambulance Handovers Over 45 Minutes	Apr-26	0	783			
Ambulance Handovers Over 45 Minutes %	Apr-26	0.0%	20.87%			

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
ED 4 Hour Performance	Apr-26	78.0%	66.58%			
ED 12 Hours in Department %	Apr-26	12.1%	12.13%			
Ambulance Handovers Over 30 Minutes	Apr-26	0	336			
Ambulance Handovers Over 45 Minutes	Apr-26	0	195			
Ambulance Handovers Over 45 Minutes %	Apr-26	0.0%	10.57%			
Non Elective LoS	Apr-26	10	10.53			

Group Summary

All three trusts are seeing an improving position with operational flow especially noticeable with ambulance handover and 12 hour waiting times even though performance remains under pressure.

Rising attendances and persistent admitted patient delays show that hospital capacity and discharge flow are still the limiting factors.

Senior decision making, revised off load pathways and tighter control of patient flow have delivered clear benefits.

Temporary Surge capacity and escalation spaces have been reduced which places an increased requirement on sustainable pathway changes.

Norfolk and Waveney University Hospitals Group

Benchmarking

Apr-26

ED 4 Hours - Current

Median Performance — Top Decile Performance

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

Current Performance

JPUH 72.81%

NNUH 83.82%

QEH 66.58%

83.82% Top Decile

76.97% Median

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

Walker, Ian 29/05/2026 11:13:09

Benchmarking

Apr-26

ED 4 Hours - Rolling 3 Months

Median Performance — Top Decile Performance

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

Current Performance

JPUH
72.01%

NNUH
82.52%

QEH
66.18%

82.70%
Top Decile

75.80%
Median

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

Walker,Ian 29/05/2026 11:03:06

Apr-26

Ambulance Handovers - 30 Minutes Current

ʳmance — Median Performance — Top Decile Performance

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

Current Performance

JPUH
23.59%

NNUH
30.13%

QEH
18.20%

13.95%
Top Decile

30.86%
Median

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

Walker,Ian
29/05/2026 11:13:02

Benchmarking

Apr-26

Ambulance Handovers - 30 Minutes Rolling 3 Months

Current Performance

JPUH	35.21%
NNUH	40.73%
QEH	31.69%

14.23% Top Decile

38.91% Median

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

Walker,Ian 29/05/2026 11:13:00

Ambulance Handovers - 45 Minutes Current

Median Performance — Top Decile Performance

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

Current Performance

JPUH 17.29%

NNUH 20.87%

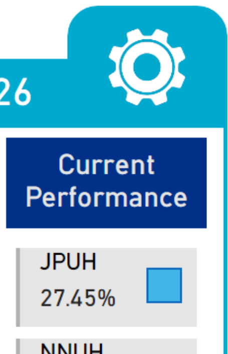
QEH 10.56%

1.98% Top Decile

15.28% Median

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

Walker,Ian 29/05/2026 11:13:09

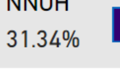


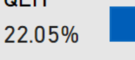
Ambulance Handovers - 45 Minutes Rolling 3 Months

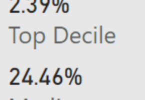
Median Performance | Top Decile Performance

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

Current Performance

JPUH 27.45%


NNUH 31.34%


QEH 22.05%


2.39% Top Decile
24.46% Median

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

Walker,Ian 29/05/2026 11:13:08

Productivity and Efficiency Domain Metrics

Walker,Ian
29/05/2026 11:13:09

JPUH Metric Summary Matrix - Productivity and Efficiency

Apr-26

James Paget University Hospitals NHS Foundation Trust

Matrix: Agency Cap %, Bank Cap %, Eff. Plan, Eff. Plan YTD, Plan Sur/Def, YTD Sur/Def; Imp. Prod

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

Walker, Ian 29/07/2026 11:15:09

Norfolk and Norwich University Hospitals NHS Foundation Trust

Matrix: Agency Cap %, Bank Cap %, Eff. Plan, Eff. Plan YTD, Imp. Prod, Plan Sur/Def, 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

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Matrix: Agency Cap %, Bank Cap %, Eff. Plan, Eff. Plan YTD, Plan Sur/Def, YTD Sur/Def; Imp. Prod

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

Apr-26

James Paget

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Implied Productivity	Dec-25	3	-3.20	✗		
Planned surplus/deficit	Apr-26	-1,450	-1,437	✓		
YTD Surplus/deficit	Apr-26	-1,450	-1,437	✓		
Variance to Agency Spend Cap %	Apr-26	0.0%	-4.27%	✓		
Variance to Bank Spend Cap %	Apr-26	0.0%	-2.36%	✓		
Efficiency Plan £000	Apr-26	659	759	✓		
Efficiency Plan YTD £000	Apr-26	659	759	✓		

Norfolk and Norwich

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Implied Productivity	Dec-25	3	4.90	✓		
Planned surplus/deficit	Apr-26	-2,664	-2,641	✓		
YTD Surplus/deficit	Apr-26	-2,664	-2,641	✓		
Variance to Agency Spend Cap %	Apr-26	0.0%	9.95%	✗		
Variance to Bank Spend Cap %	Apr-26	0.0%	-47.56%	✓		
Efficiency Plan £000	Apr-26	2,004	1,260	✗		
Efficiency Plan YTD £000	Apr-26	2,004	1,260	✗		

Queen Elizabeth

Metric	Date	Target	Actual	Compliance	Variation	Assurance
Implied Productivity	Dec-25	3	-2.70	✗		
Planned surplus/deficit	Apr-26	-2,131	-2,692	✗		
YTD Surplus/deficit	Apr-26	-2,131	-2,692	✗		
Variance to Agency Spend Cap %	Apr-26	0.0%	56.06%	✗		
Variance to Bank Spend Cap %	Apr-26	0.0%	39.44%	✗		
Efficiency Plan £000	Apr-26	581	236	✗		
Efficiency Plan YTD £000	Apr-26	581	236	✗		

Group Summary

The Group reported a £6.8m deficit in April, which is £0.6m adverse to the planned £6.2m deficit. The net adverse variance all relates to QEH and in the main is linked to the under-delivery of planned efficiencies, however there was an increase in variable pay expenditure (bank and agency) of c£0.5m compared to the previous financial year. An urgent action to review the controls in this area is in place to address the increase in expenditure.

Despite the Month 1 variance, the full year forecast remains breakeven, in line with the submitted financial plan.

Walker, Ian
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Appendices

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

Apr-26

JPUH - Ecoli 3

JPUH - MRSA 0

JPUH - CDiff 3

NNUH - Ecoli 6

NNUH - MRSA 2

NNUH - CDiff 12

QEH - Ecoli 4

QEH - MRSA 0

QEH - CDiff 4

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Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	3				
NNUH	0	6				
QEH	0	4				

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

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3	3				
NNUH	8	12				
QEH	4	4				

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

Apr-26

JPUH - SHMI 1.17

JPUH - FFT Score 97.51%

JPUH - Complaints Received 16

NNUH - SHMI 1.16

NNUH - FFT Score 92.42%

NNUH - Complaints Received 96

QEH - SHMI 1.23

QEH - FFT Score 91.39%

QEH - Complaints Received 46

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	1.17	1.17				
NNUH	1.17	1.16				
QEH	1.17	1.23				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	95.0%	97.51%				
NNUH	95.0%	92.42%				
QEH	95.0%	91.39%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	16				
NNUH	0	96				
QEH	0	46				

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

Apr-26

JPUH - Readmission Rate 12.54%

JPUH - Care Hour Per Patient Day (CHPPD) 8.66

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

7

NNUH - Readmission Rate 13.11%

NNUH - Care Hour Per Patient Day (CHPPD) 8.10

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

6

-

QEH - Care Hour Per Patient Day (CHPPD) 7.58

-

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	10.0%	12.54%				
NNUH	10.0%	13.11%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	8.00	8.66				
NNUH	8.00	8.10				
QEH	8.00	7.58				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	2	7				
NNUH	2	6				

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

Apr-26

JPUH - Pressure Ulcers 4.00

JPUH - Falls 54

JPUH - Registered Nurse Fill Rate 87.53%

NNUH - Pressure Ulcers 36.00

NNUH - Falls 193

NNUH - Registered Nurse Fill Rate 96.99%

QEH - Pressure Ulcers 2.00

QEH - Falls 61

QEH - Registered Nurse Fill Rate 90.79%

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	4.00				
NNUH	0	36.00				
QEH	0	2.00				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	67	54				
NNUH	187	193				
QEH	54	61				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	87.53%				
NNUH	90.0%	96.99%				
QEH	90.0%	90.79%				

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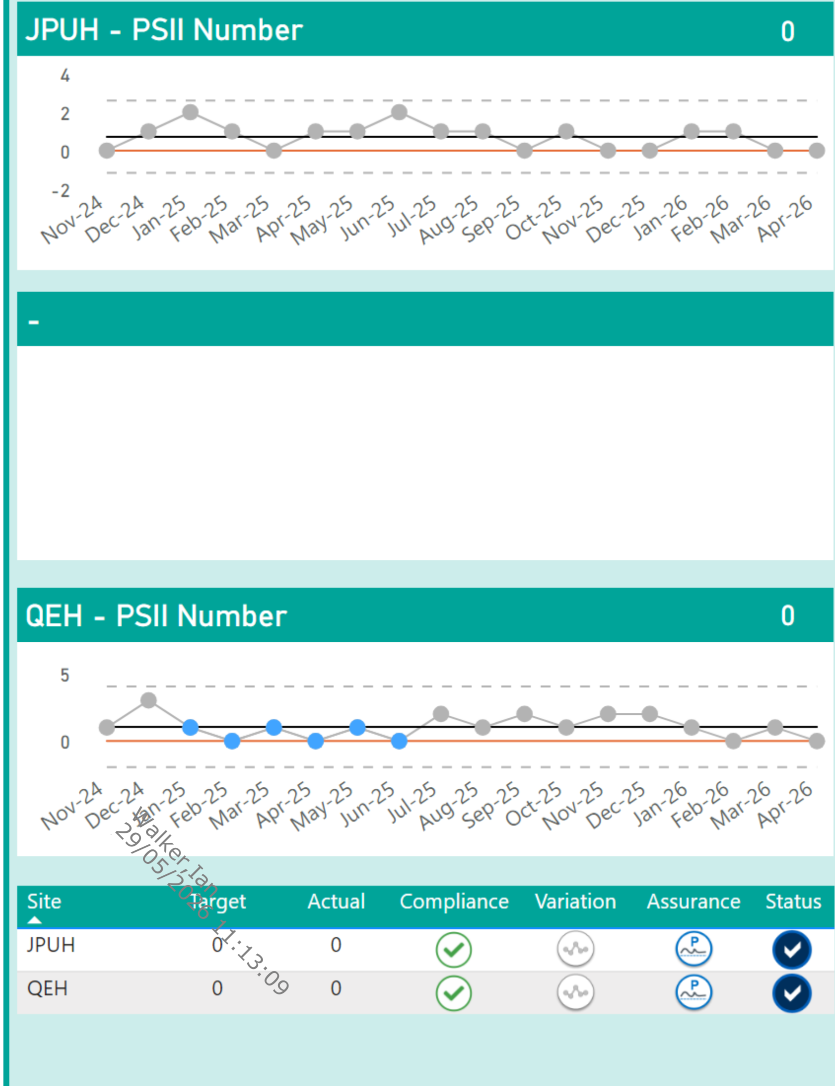
Safe and Effective Care Domain Appendix - PSII

Apr-26



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

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

Apr-26

JPUH - Midwifery Fill Rate 89.45%

JPUH - Preterm Birth Rate 6.56%

JPUH - Still Birth Rate 0.00%

NNUH - Midwifery Fill Rate 86.51%

NNUH - Preterm Birth Rate 5.00%

NNUH - Still Birth Rate 0.00%

QEH - Midwifery Fill Rate 86.99%

QEH - Preterm Birth Rate 5.34%

QEH - Still Birth Rate 0.24%

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Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	89.45%				
NNUH	90.0%	86.51%				
QEH	90.0%	86.99%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	6.0%	6.56%				
NNUH	6.0%	5.00%				
QEH	6.0%	5.34%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3.5%	0.00%				
NNUH	3.5%	0.00%				
QEH	3.5%	0.24%				

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

Apr-26

JPUH - Maternity FFT 88.00%

JPUH - Complaints Received - Maternity 2

NNUH - Maternity FFT 72.00%

NNUH - Complaints Received - Maternity 4

QEH - Maternity FFT 94.50%

QEH - Complaints Received - Maternity 6

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	95.0%	88.00%				
NNUH	95.0%	72.00%				
QEH	95.0%	94.50%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	2				
NNUH	0	4				
QEH	0	6				

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

Apr-26

JPUH - 1:1 Care 100.00%

100
98
Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26

JPUH - MNSI 0

1
0
Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26

JPUH - Unplanned Admissions to NICU 10

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

NNUH - 1:1 Care 97.83%

100
98
Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26

NNUH - MNSI 0

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

NNUH - Unplanned Admissions to NICU 24

40
20
0
-20
Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26

QEH - 1:1 Care 100.00%

100
98
Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26

QEH - MNSI 0

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

-

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	97.0%	100.00%				
NNUH	97.0%	97.83%				
QEH	97.0%	100.00%				

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

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	10				
NNUH	0	24				

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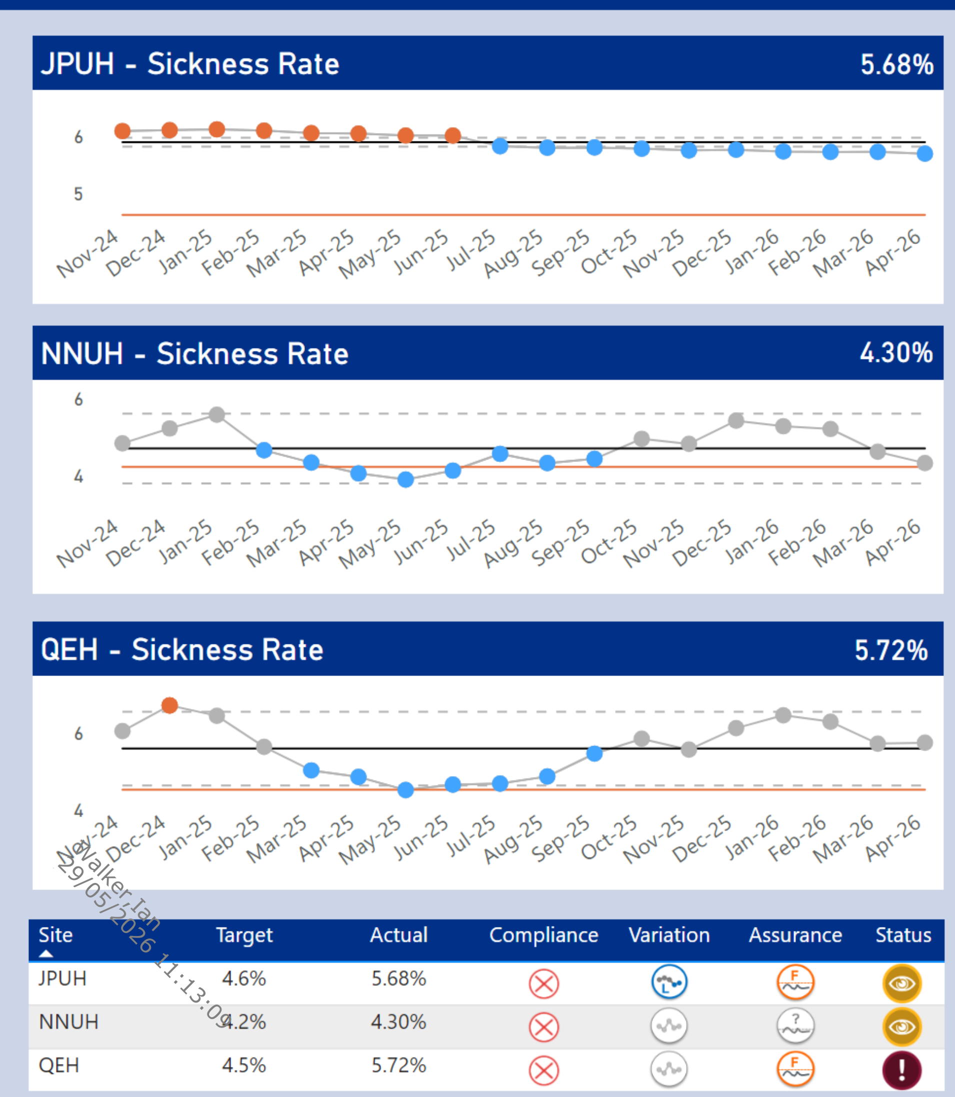
People and Culture Domain Appendix - Sickness and Turnover

Apr-26



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	4.6%	5.68%				
NNUH	4.2%	4.30%				
QEH	4.5%	5.72%				

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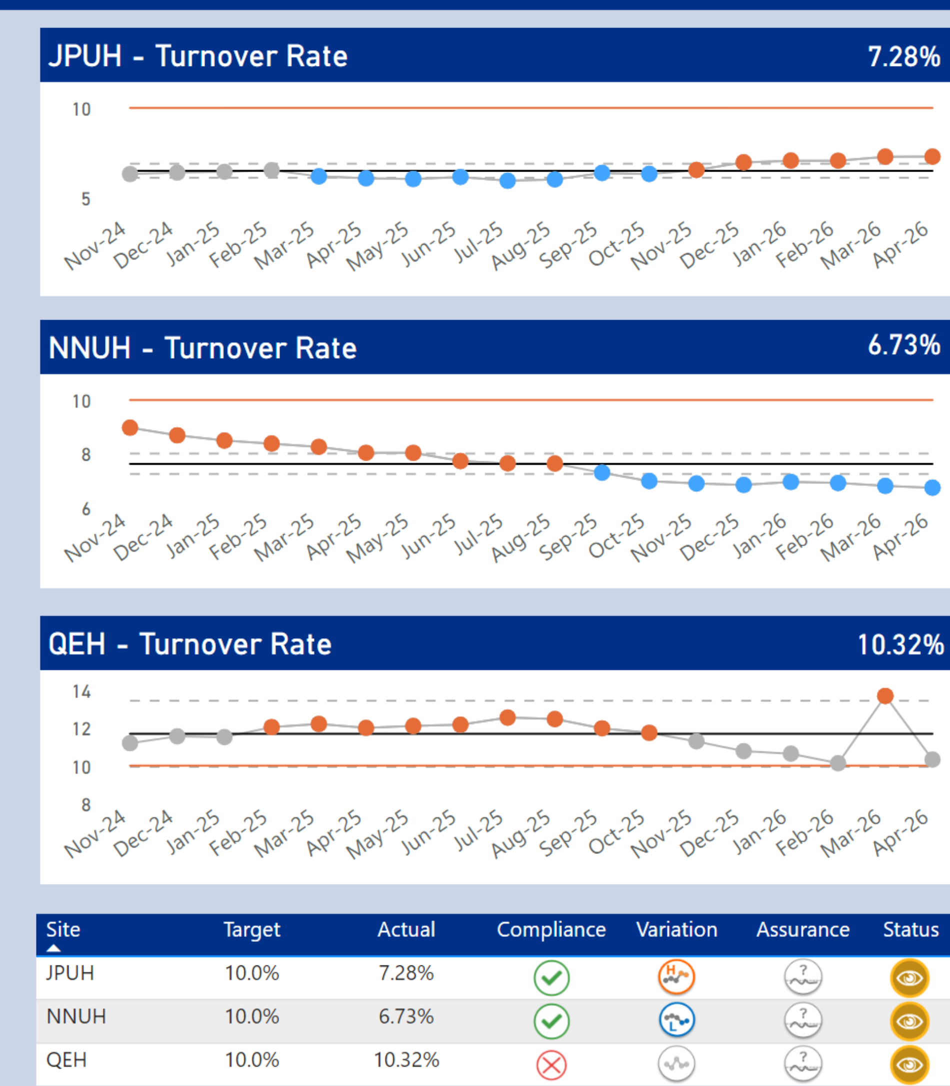
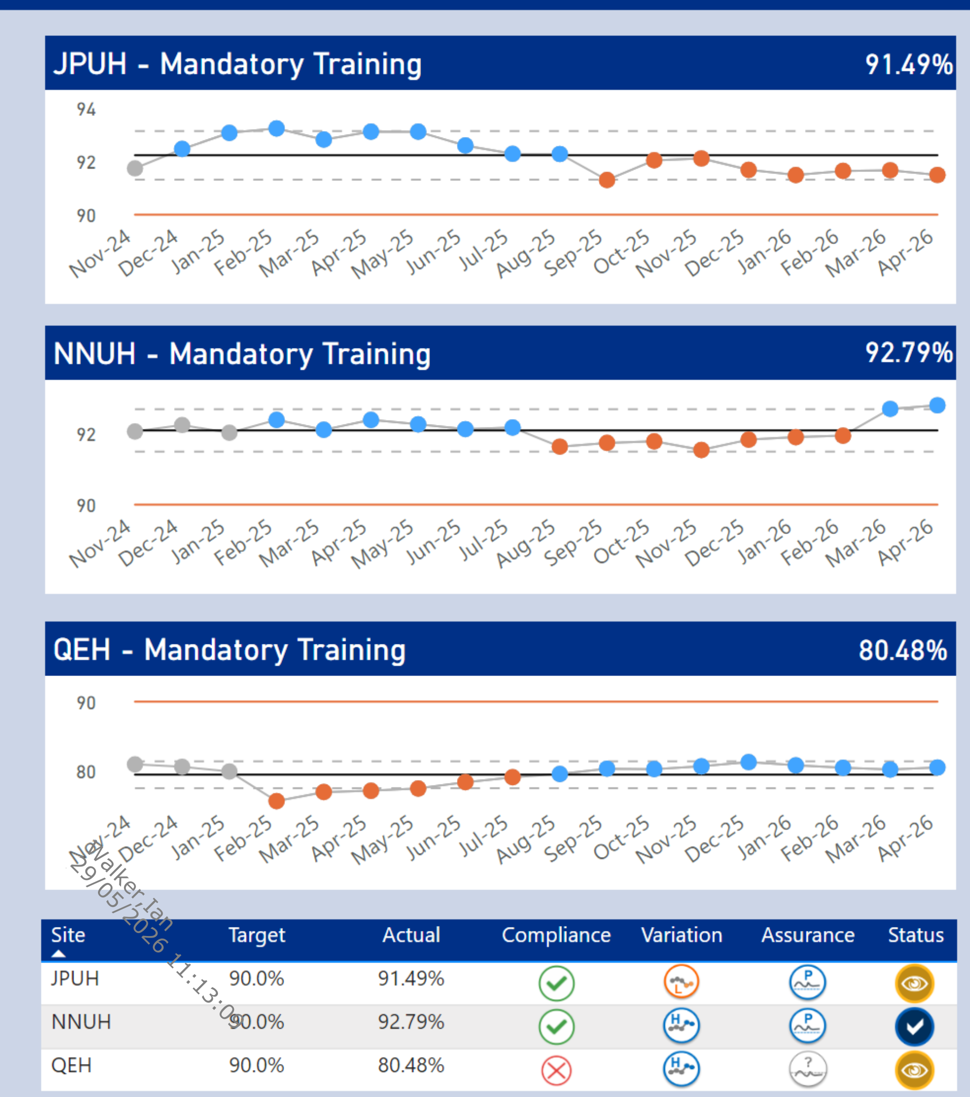


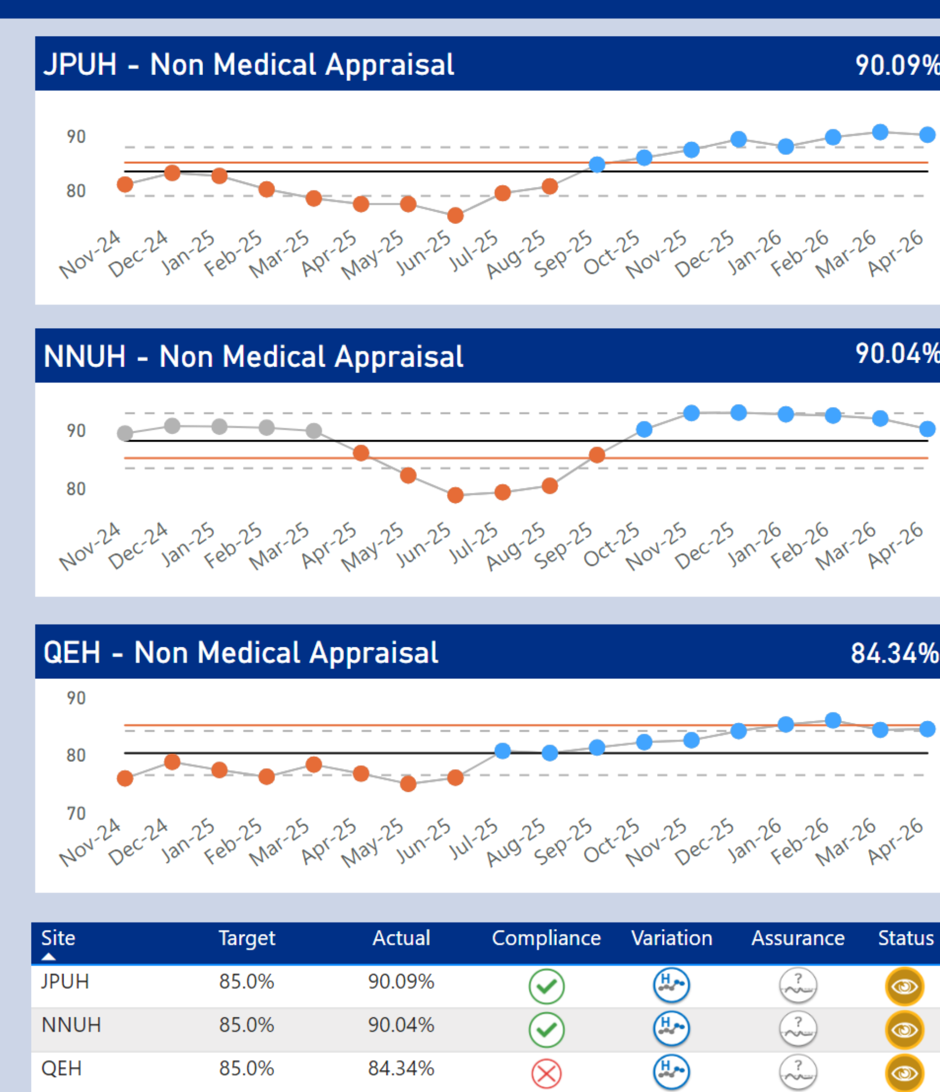
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	10.0%	7.28%				
NNUH	10.0%	6.73%				
QEH	10.0%	10.32%				

People and Culture Domain Appendix - Mandatory Training and Appraisals

Apr-26



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	91.49%				
NNUH	90.0%	92.79%				
QEH	90.0%	80.48%				



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	85.0%	90.09%				
NNUH	85.0%	90.04%				
QEH	85.0%	84.34%				

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Access and Flow Domain Appendix - RTT

Apr-26

JPUH - 65+ Week Waits — 105

JPUH - 52+ Week Performance — 4.11%

JPUH - 6 Week Diagnostics — 64.88%

NNUH - 65+ Week Waits — 198

NNUH - 52+ Week Performance — 3.20%

NNUH - 6 Week Diagnostics — 76.86%

QEH - 65+ Week Waits — 4

QEH - 52+ Week Performance — 1.39%

QEH - 6 Week Diagnostics — 64.04%

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	105				
NNUH	0	198				
QEH	0	4				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	5.6%	4.11%				
NNUH	2.2%	3.20%				
QEH	1.5%	1.39%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	75.9%	64.88%				
NNUH	95.0%	76.86%				
QEH	95.0%	64.04%				

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Access and Flow Domain Appendix - RTT

Apr-26

JPUH - Total PTL Size 32,920

JPUH - RTT Incomplete Within 18 weeks 55.62%

JPUH - First Attendance Within 18 Weeks 63.56%

NNUH - Total PTL Size 67,558

NNUH - RTT Incomplete Within 18 weeks 59.94%

NNUH - First Attendance Within 18 Weeks 74.03%

QEH - Total PTL Size 25,151

QEH - RTT Incomplete Within 18 weeks 58.97%

QEH - First Attendance Within 18 Weeks 59.01%

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	32,074	32,920				
NNUH	81,265	67,558				
QEH	24,963	25,151				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	57.1%	55.62%				
NNUH	92.0%	59.94%				
QEH	92.0%	58.97%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	64.0%	63.56%				
NNUH	64.0%	74.03%				
QEH	64.0%	59.01%				

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Access and Flow Domain Appendix - Clearance Times

Apr-26

JPUH - Estimated clearance times 26

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

JPUH - Under 18s elective waiting list size 2,891

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

-

NNUH - Under 18s elective waiting list size 6,963

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

-

-

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Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	18	26				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	2,615	2,891				
NNUH	8,368	6,963				

Access and Flow Domain Appendix - Cancer

Mar-26

JPUH - 28 Day Faster Diagnosis 75.71%

JPUH - Cancer 62 Day Treatment 72.52%

NNUH - 28 Day Faster Diagnosis 80.54%

NNUH - Cancer 62 Day Treatment 69.90%

QEH - 28 Day Faster Diagnosis 69.92%

QEH - Cancer 62 Day Treatment 56.50%

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	78.0%	75.71%				
NNUH	75.0%	80.54%				
QEH	75.0%	69.92%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	78.0%	72.52%				
NNUH	85.0%	69.90%				
QEH	85.0%	56.50%				

Site	Target	Actual	Compliance	Variation	Assurance	Status

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Access and Flow Domain Appendix - UEC

Apr-26

JPUH - ED 4 Hour Performance 72.98%

JPUH - ED 12 Hours in Department % 6.44%

JPUH - Ambulance Handovers Over 30 Minutes 427

NNUH - ED 4 Hour Performance 83.82%

NNUH - ED 12 Hours in Department % 3.59%

NNUH - Ambulance Handovers Over 30 Minutes 1,130

QEH - ED 4 Hour Performance 66.58%

QEH - ED 12 Hours in Department % 12.13%

QEH - Ambulance Handovers Over 30 Minutes 336

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	75.5%	72.98%				
NNUH	78.0%	83.82%				
QEH	78.0%	66.58%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	7.9%	6.44%				
NNUH	4.0%	3.59%				
QEH	12.1%	12.13%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	427				
NNUH	0	1,130				
QEH	0	336				

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Access and Flow Domain Appendix - UEC

Apr-26

JPUH - Ambulance Handovers Over 45 Minutes 313

JPUH - Ambulance Handovers Over 45 Minutes % 17.29%

JPUH - Non Elective LoS 11.19

NNUH - Ambulance Handovers Over 45 Minutes 783

NNUH - Ambulance Handovers Over 45 Minutes % 20.87%

-

QEH - Ambulance Handovers Over 45 Minutes 195

QEH - Ambulance Handovers Over 45 Minutes % 10.57%

QEH - Non Elective LoS 10.53

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	313				
NNUH	0	783				
QEH	0	195				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0.0%	17.29%				
NNUH	0.0%	20.87%				
QEH	0.0%	10.57%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	10	11.19				
QEH	10	10.53				

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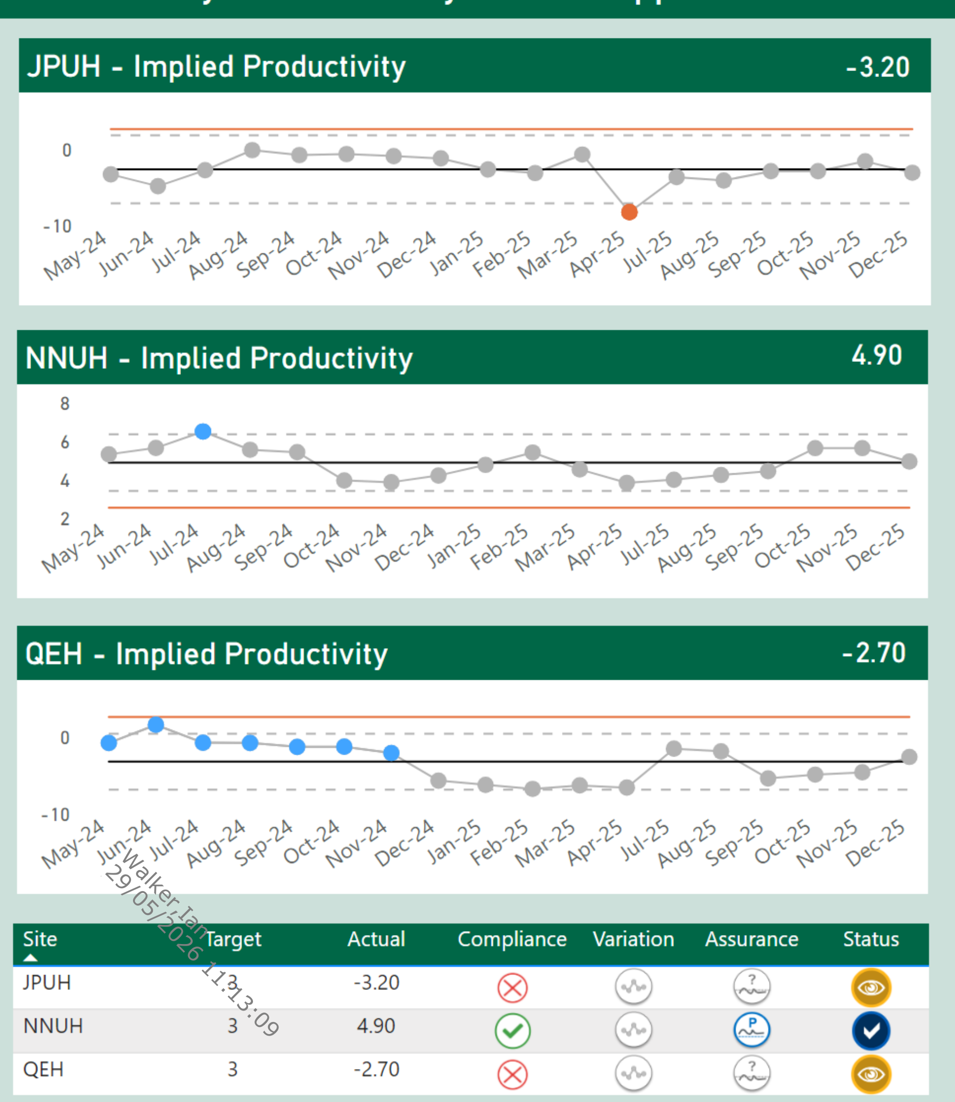
Productivity and Efficiency Domain Appendix

Dec-25



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3	-3.20				
NNUH	3	4.90				
QEH	3	-2.70				

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Productivity and Efficiency Domain Appendix

Apr-26

JPUH - Planned surplus/deficit -1,437

-1,440
-1,450
Apr-26

JPUH - YTD Surplus/deficit -1,437

-1,440
-1,450
Apr-26

NNUH - Planned surplus/deficit -2,641

-2,640
-2,660
Apr-26

NNUH - YTD Surplus/deficit -2,641

-2,640
-2,660
Apr-26

QEH - Planned surplus/deficit -2,692

-2,000
-2,500
Apr-26

QEH - YTD Surplus/deficit -2,692

-2,000
-2,500
Apr-26

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	-1,450	-1,437				
NNUH	-2,664	-2,641				
QEH	-2,131	-2,692				

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Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	-1,450	-1,437				
NNUH	-2,664	-2,641				
QEH	-2,131	-2,692				

Productivity and Efficiency Domain Appendix

Apr-26

JPUH - Variance to Agency Spend Cap % -4.27%

Y-axis: 0, -5. X-axis: Apr-26

JPUH - Variance to Bank Spend Cap % -2.36%

Y-axis: 0, -2. X-axis: Apr-26

NNUH - Variance to Agency Spend Cap % 9.95%

Y-axis: 10, 5, 0. X-axis: Apr-26

NNUH - Variance to Bank Spend Cap % -47.56%

Y-axis: 0, -50. X-axis: Apr-26

QEH - Variance to Agency Spend Cap % 56.06%

Y-axis: 50, 0. X-axis: Apr-26

QEH - Variance to Bank Spend Cap % 39.44%

Y-axis: 40, 20, 0. X-axis: Apr-26

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0.0%	-4.27%	✓			✓
NNUH	0.0%	9.95%	✗			✓
QEH	0.0%	56.06%	✗			✓

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0.0%	-2.36%	✓			✓
NNUH	0.0%	-47.56%	✓			✓
QEH	0.0%	39.44%	✗			✓

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Productivity and Efficiency Domain Appendix

Apr-26

JPUH - Efficiency Plan £000 — 759

800
700
Apr-26

JPUH - Efficiency Plan YTD £000 — 759

800
700
Apr-26

NNUH - Efficiency Plan £000 — 1,260

2K
1K
Apr-26

NNUH - Efficiency Plan YTD £000 — 1,260

2K
1K
Apr-26

QEH - Efficiency Plan £000 — 236

600
400
200
Apr-26

QEH - Efficiency Plan YTD £000 — 236

600
400
200
Apr-26

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	659	759				
NNUH	2,004	1,260				
QEH	581	236				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	659	759				
NNUH	2,004	1,260				
QEH	581	236				

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Icon Descriptions

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	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

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

Walker,Tan 29/05/2026 11:13:09

Report to the Group Board in public: 3 June 2026

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

Executive summary

The Group reported a £6.8m deficit in April 2026, which is £0.6m adverse to the planned £6.2m deficit. The net adverse variance all relates to QEH and in the main is linked to the under-delivery of planned efficiencies. However, there was an increase in variable pay expenditure (bank and agency) of circa £0.5m compared to the previous financial year. An urgent action to review the controls in this area is in place to address the increase in expenditure.

Despite the Month 1 variance, the full year forecast for 2026/27 remains breakeven, in line with the submitted financial plan.

Recommendations

The Group Board is asked to:

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

Alignment to Board Assurance Framework risk(s)	Principal Risk 4 – Financial sustainability
Previously considered by	Group Risk Assurance Committee, 28 May 2026
Any background papers in Admin Control Reading Room	None

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Norfolk and Waveney University Hospitals Group

Group Finance Report
April 2026

3 June 2026

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Marcus Thorman, Group Chief Finance Officer

Contents

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

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

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

1. Executive Summary

Month 1 Financial Performance

The Group reported a £6.8m deficit in April, which is £0.6m adverse to the planned £6.2m deficit. The net adverse variance all relates to QEH and in the main is linked to the under-delivery of planned efficiencies, however there was an increase in variable pay expenditure (bank and agency) of c£0.5m compared to the previous financial year. An urgent action to review the controls in this area is in place to address the increase in expenditure.

Income performance in April was adverse by £1.8m, driven primarily by activity shortfalls across the Group with NNUH: £1.1m adverse and QEH: £0.7m adverse. This reflects lower than planned activity levels, which is a key financial risk given the reliance on activity-based income delivery.

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

Non-pay performance shows a favourable timing position of c. £0.8m, due to delayed utilisation of service development and investment funding. This represents a non-recurrent benefit, with underlying expenditure pressures remaining.

Despite the Month 1 variance, the full year forecast remains breakeven, in line with the submitted financial plan.

Productivity and Efficiency

On the CIP year-to-date performance there was £2.3m delivered vs £3.3m plan; £1.0m adverse variance.

The overall programme position is £57.8m of schemes approved (Gateway 2) meaning a £44.3m 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 underperformance in Month 1 and a significant pipeline gap indicate a requirement for urgent recovery actions.

Cash and Capital

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

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For cash the closing position in month was £162.7m, £70.8m favourable to plan, however, cash has reduced by £11.3m during April, driven by timing differences, particularly at QEH. While liquidity is currently favourable, structural risks remain in-year if financial performance deteriorates, particularly at QEH based on the deficit support funding.

Risks

CIP Delivery Risk: high reliance on CIP to deliver financial balance; significant proportion of schemes remain high risk; shift from over £80m delivery in 2025/26 to identification challenge in 2026/27
Financial Performance Risk: plans assume delivery of breakeven position; underperformance in month 1 indicates early trajectory risk.
Workforce Risk (Bank/Agency): further reductions increasingly difficult; dependent on reducing sickness and escalation capacity
Cash Risk: ongoing cash fragility at QEH, requiring targeted management; risk to continued cash support if financial plan not delivered
Capital Risk: forecast £14.6m overspend, driven by nationally funded schemes; requires alignment with NHSE and plan revision.

NHS Norfolk and Waveney University Hospitals Group

1. Executive Dashboard

April position is a £6.8m deficit on a control total basis, £0.6m adverse to the planned £6.2m deficit.

The main driver of the adverse variance is due to the £1.0m under delivery of the planned efficiency and £0.4m net impact of Industrial Action. This is offset by c. £0.8m relating to the delayed utilisation of service development and investment funding.

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

Cash: Cash held on 30th April was £162.7m, £70.8m favourable to the planned £91.9m.

Capital Expenditure: Full Year capital spend is £12.1m, £7.2m behind the planned spend of £4.9m.

CIP: Full Year CIP delivery is £2.3m against a budgeted plan of £3.3m, an adverse variance of £1.0m, comprised of an adverse planning variance of £0.5m and an adverse performance variance of £0.5m. As at 6th May 2026, the programme consists of £57.8m of Gateway 2 approved schemes. This is £44.3m adverse to the planned £102.1m full year CIP requirement.

Activity: Value-based activity performance for April was adverse by £1.8m, driven by adverse activity performance at NNUH (£1.1m) and QEH (£0.7m)

	In Month			Year To Date		
	Plan	Actual	Variance	Plan	Actual	Variance
SOCI	£m	£m	£m	£m	£m	£m
Clinical Income	120.1	120.3	0.2	120.1	120.3	0.2
Other Income	17.2	17.1	(0.1)	17.2	17.1	(0.1)
TOTAL INCOME	**137.3**	**137.4**	**0.1**	**137.3**	**137.4**	**0.1**
Pay	(94.1)	(93.0)	1.1	(94.1)	(93.0)	1.1
Non Pay	(37.2)	(39.0)	(1.8)	(37.2)	(39.0)	(1.8)
Drugs (Net Expenditure)	(4.4)	(4.8)	(0.3)	(4.4)	(4.8)	(0.3)
TOTAL EXPENDITURE	**(135.7)**	**(136.8)**	**(1.1)**	**(135.7)**	**(136.8)**	**(1.1)**
Non Opex	(7.8)	(7.4)	0.4	(7.8)	(7.4)	0.4
Control Total Surplus / (Deficit)	(6.2)	(6.8)	(0.6)	(6.2)	(6.8)	(0.6)
Statutory Surplus / (Deficit)	(5.4)	(5.8)	(0.4)	(5.4)	(5.8)	(0.4)
Other Financial Metrics	£m	£m	£m	£m	£m	£m
Cash at Bank (before support funding)	91.9	162.7	70.8	91.9	162.7	70.8
Capital Programme Expenditure	12.1	4.9	(7.2)	12.1	4.9	(7.2)
CIP Delivery	3.3	2.3	(1.0)	3.3	2.3	(1.0)
Aligned Payment Incentive (API) contract performance	65.0	63.2	(1.8)	65.0	63.2	(1.8)

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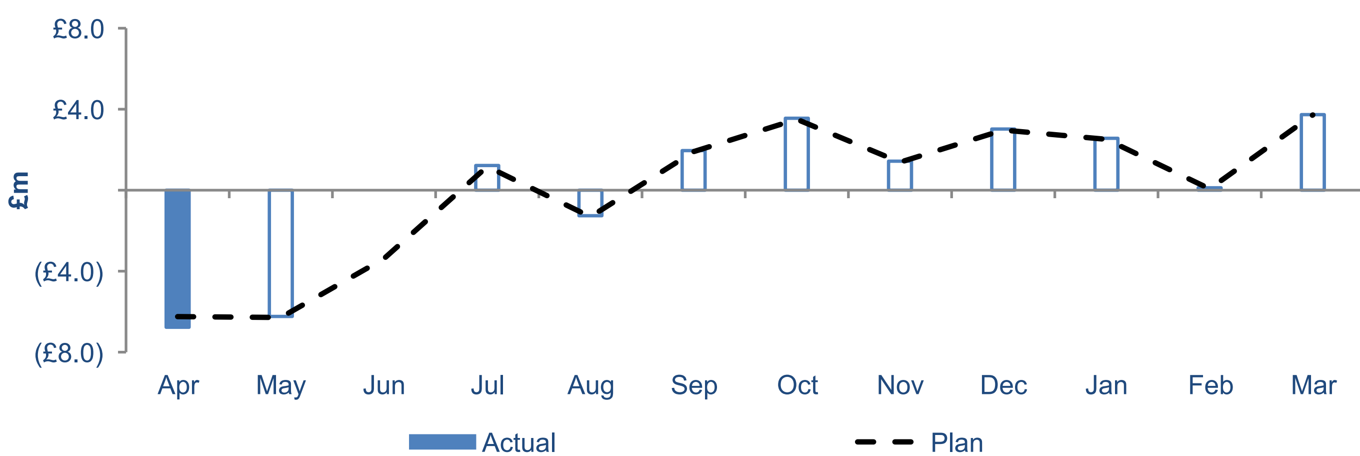
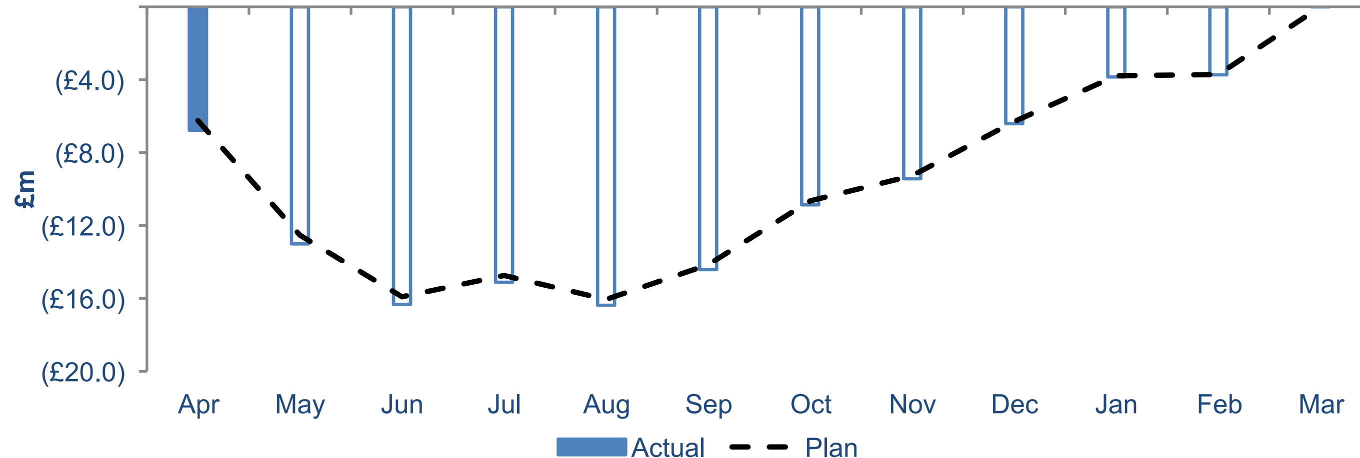
Norfolk and Waveney University Hospitals Group

2.1 Financial Performance

April position is a £6.8m deficit on a control total basis, £0.6m adverse to the planned £6.2m deficit.

The main driver of the adverse variance is due to the £1.0m under delivery of the planned efficiency and £0.4m net impact of Industrial Action. This is offset by c. £0.8m relating to the delayed utilisation of service development and investment funding.





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NHS
Norfolk and Waveney
University Hospitals Group

2.1 Financial Performance

April position is a £6.8m deficit on a control total basis, £0.6m adverse to the planned £6.2m deficit. Forecast outturn for the year remains breakeven, no change from the breakeven submitted plan.

Apr-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	120.1	120.3	0.2	120.1	120.3	0.2	1,463.3	1,169.9	(293.4)
NT Drugs Income	9.7	10.3	0.6	9.7	10.3	0.6	115.9	96.7	(19.2)
Total Clinical Income	**129.8**	**130.6**	**0.8**	**129.8**	**130.6**	**0.8**	**1,579.2**	**1,266.6**	**(312.6)**
Other Income Incl. Non NHS Clinical Income	17.2	17.1	(0.1)	17.2	17.1	(0.1)	209.3	186.2	(23.1)
Total Operating Income	**147.1**	**147.7**	**0.7**	**147.1**	**147.7**	**0.7**	**1,788.5**	**1,452.8**	**(335.7)**
Substantive	(89.2)	(84.1)	5.1	(89.2)	(84.1)	5.1	(1,043.7)	(834.7)	209.0
Bank	(3.0)	(7.1)	(4.1)	(3.0)	(7.1)	(4.1)	(30.2)	(19.1)	11.1
Agency	(0.9)	(1.0)	(0.2)	(0.9)	(1.0)	(0.2)	(9.2)	(5.7)	3.5
Other Employee Expenses	(1.0)	(0.7)	0.3	(1.0)	(0.7)	0.3	(12.1)	(12.1)	0.0
Total Employee Expenses	**(94.1)**	**(93.0)**	**1.1**	**(94.1)**	**(93.0)**	**1.1**	**(1,095.2)**	**(871.6)**	**223.6**
Drugs Costs	(14.2)	(15.1)	(0.9)	(14.2)	(15.1)	(0.9)	(169.1)	(143.4)	25.7
Clinical Supplies	(13.6)	(14.6)	(1.0)	(13.6)	(14.6)	(1.0)	(174.4)	(135.8)	38.6
Non Clinical Supplies	(20.4)	(21.2)	(0.8)	(20.4)	(21.2)	(0.8)	(216.7)	(172.4)	44.3
PFI	(3.2)	(3.2)	0.0	(3.2)	(3.2)	0.0	(37.3)	(37.3)	0.0
Total Expenditure Excl. Employee Expenses	**(51.4)**	**(54.1)**	**(2.7)**	**(51.4)**	**(54.1)**	**(2.7)**	**(597.6)**	**(489.0)**	**108.6**
Total Operating Expenditure	**(145.5)**	**(147.1)**	**(1.6)**	**(145.5)**	**(147.1)**	**(1.6)**	**(1,692.8)**	**(1,360.6)**	**332.2**
Total Operating Surplus/(Deficit)	**1.6**	**0.6**	**(0.9)**	**1.6**	**0.6**	**(0.9)**	**95.7**	**92.2**	**(3.5)**
Total Non Operating Expenditure	(6.7)	(6.3)	0.4	(6.7)	(6.3)	0.4	(81.2)	(77.7)	3.5
Adjust PFI revenue costs to UK GAAP basis	(1.2)	(1.2)	(0.0)	(1.2)	(1.2)	(0.0)	(14.4)	(14.4)	0.0
Control Total Surplus/(Deficit)	**(6.2)**	**(6.8)**	**(0.5)**	**(6.2)**	**(6.8)**	**(0.5)**	**0.0**	**0.0**	**0.0**
Control Total Adjustments									
Donated/Peppercorn lease Income & Equipment	(0.0)	0.1	0.1	(0.0)	0.1	0.1	(1.0)	(1.0)	0.0
Donated/ Peppercorn lease Assets Dep'n	(0.2)	(0.3)	(0.1)	(0.2)	(0.3)	(0.1)	0.2	0.6	0.4
Adjust PFI revenue costs to UK GAAP basis	1.2	1.2	0.0	1.2	1.2	0.0	14.4	14.4	0.0
Statutory Surplus / (Deficit)	**(5.3)**	**(5.8)**	**(0.4)**	**(5.3)**	**(5.8)**	**(0.4)**	**13.6**	**14.0**	**0.4**

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3. CIP

Full year CIP delivery is £2.3m against a budgeted plan of £3.3m, an adverse variance of £1.0m, comprised of an adverse planning variance of £0.5m and an adverse performance variance of £0.5m. As at 6th May 2026, the programme consists of £57.8m of Gateway 2 approved schemes. This is £44.3m adverse to the planned £102.1m full year CIP requirement.

FY26/27 CIP Programme Delivery

Year to date the Group has delivered £2.3m of CIPs against a budgeted plan of £3.39m, an adevsre variance of £1.0m, comprised of (see bridge):

- An adverse planning variance of £0.5m; and
- An adverse performance variance of £0.5m.

As at 6th May 2026, the programme consists of £57.8m of Gateway 2 approved schemes. This is £44.3m 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 26/27.

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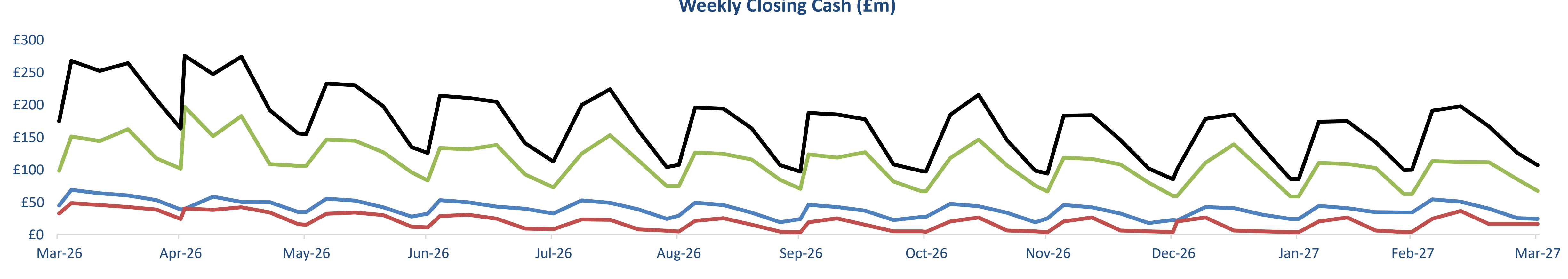
4. Cash

Cash held on 30th April was £162.7m, £70.8m favourable to the planned £91.9m. Cash balances have decreased since the start of the year by £11.3m driven by timings in cashflow seen at QEH relating to capital.



Aged Debtors: Debtors on 30th April were £43.8m, £3.6m higher than March 2026. £13.6m is over 90 days. Of the Non-NHS debt greater than 90 days £2.5m relates to an ongoing legal dispute. The Trusts continue to focus on resolving these debts and a bad debt provision of £10.0m is being held.

Debtors by Type	Total Debt			Debt > 90 days		
	Feb-26 £m	Mar-26 £m	Apr-26 £m	Feb-26 £m	Mar-26 £m	Apr-26 £m
NHS	21.6	29.9	31.4	5.9	5.6	6.9
Non NHS	10.4	10.3	12.4	7.3	6.6	6.7
Total	32.0	40.2	43.8	13.1	12.2	13.6

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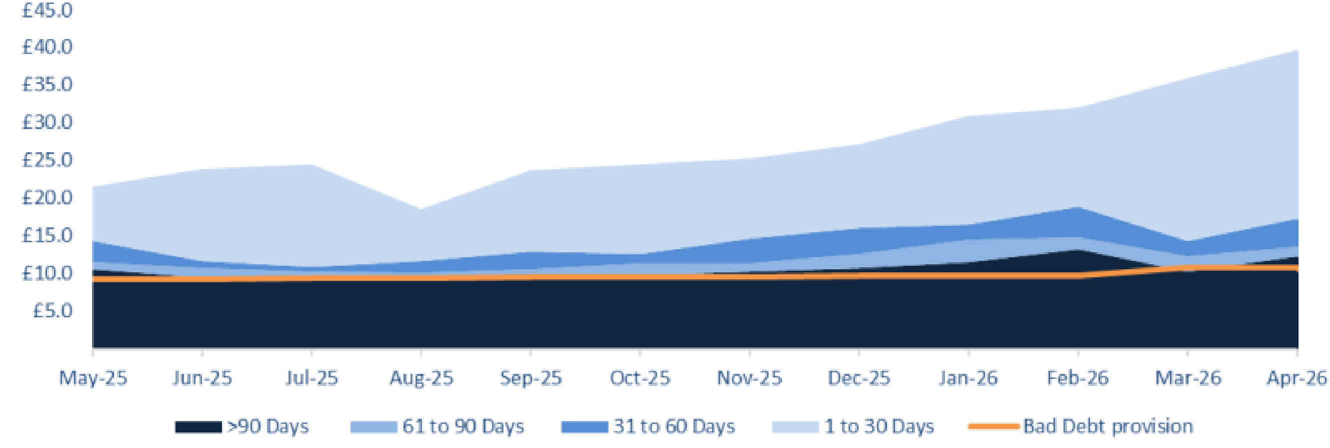

Norfolk and Waveney University Hospitals Group

5. Statement of Financial Position

The Statement of Financial Position at the end of April has decreased by £5.8m compared to the opening balance.

	JPUH			NNUH			QEH			N&W GROUP		
	Mar-26 £m	Apr-26 £m	YTD Movement £m	Mar-26 £m	Apr-26 £m	YTD Movement £m	Mar-26 £m	Apr-26 £m	YTD Movement £m	Mar-26 £m	Apr-26 £m	YTD Movement £m
Property, plant and equipment	169.5	170.2	0.7	444.7	444.0	(0.7)	176.8	177.7	0.9	791.0	791.9	0.9
Right of use assets - leased assets	2.1	2.1	(0.1)	44.5	43.7	(0.8)	4.1	4.0	(0.1)	50.7	49.8	(1.0)
Receivables: due from DHSC group bodies	0.0	0.0	0.0	3.1	3.0	(0.1)	0.0	0.0	0.0	3.1	3.0	(0.1)
Receivables: due from non-DHSC bodies	0.5	0.4	(0.0)	53.0	53.5	0.5	0.5	0.5	0.0	54.0	54.4	0.5
Total non-current assets	**172.1**	**172.7**	**0.6**	**545.3**	**544.2**	**(1.1)**	**181.4**	**182.2**	**0.8**	**898.8**	**899.1**	**0.3**
Inventories	3.6	3.3	(0.2)	20.2	20.5	0.3	3.3	3.3	0.0	27.1	27.1	0.1
Receivables: due from DHSC group bodies	8.6	10.0	1.4	28.3	30.5	2.2	4.6	4.6	0.0	41.5	45.1	3.6
Receivables: due from non-DHSC group bodies	7.8	6.2	(1.6)	32.5	30.3	(2.2)	4.1	6.0	1.9	44.4	42.5	(1.9)
Assets held for sale	0.7	0.7	0.0	0.0	0.0	0.0						
Cash and cash equivalents	44.3	38.2	(6.2)	96.4	100.9	4.5	32.0	23.6	(8.4)	172.7	162.7	(10.1)
Total current assets	**64.9**	**58.4**	**(6.6)**	**177.4**	**182.2**	**4.8**	**44.0**	**37.5**	**(6.5)**	**286.3**	**278.1**	**(8.3)**
Trade and other payables: capital	(15.2)	(10.7)	4.4	(23.0)	(19.2)	3.8	(7.7)	(3.9)	3.8	(45.9)	(33.8)	12.0
Trade and other payables: non-capital	(33.3)	(31.6)	1.7	(125.2)	(130.3)	(5.1)	(49.7)	(49.2)	0.5	(208.2)	(211.1)	(2.9)
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)	(0.6)	0.1	(8.4)	(8.3)	0.1	(0.2)	(0.2)	0.0	(9.4)	(9.1)	0.2
Current provisions	(0.3)	(0.3)	0.0	(3.9)	(3.8)	0.1	(0.2)	(0.2)	0.0	(4.4)	(4.3)	0.1
Deferred Income	(8.4)	(10.5)	(2.1)	(28.3)	(33.9)	(5.6)	(1.5)	(3.0)	(1.5)	(38.2)	(47.4)	(9.2)
Total current liabilities	**(58.0)**	**(53.8)**	**4.2**	**(209.3)**	**(216.0)**	**(6.7)**	**(59.3)**	**(56.5)**	**2.8**	**(326.6)**	**(326.3)**	**0.3**
Total assets less current liabilities	**179.0**	**177.3**	**(1.7)**	**513.4**	**510.4**	**(3.0)**	**166.1**	**163.2**	**(2.9)**	**858.5**	**850.9**	**(7.6)**
Borrowings: PFI	0.0	0.0	0.0	(346.6)	(345.8)	0.8	0.0	0.0	0.0	(346.6)	(345.8)	0.8
Borrowings: leases non-current	(1.0)	(0.8)	0.3	(28.1)	(27.5)	0.6	(4.0)	(3.9)	0.1	(33.1)	(32.2)	1.0
Provisions	(0.7)	(0.7)	(0.0)	(3.4)	(3.4)	0.0	(0.4)	(0.4)	0.0	(4.5)	(4.5)	(0.0)
Deferred Income	0.0	0.0	0.0	(1.0)	(0.9)	0.1	0.0	0.0	0.0	(1.0)	(0.9)	0.1
Total non-current liabilities	**(1.7)**	**(1.4)**	**0.3**	**(379.1)**	**(377.6)**	**1.5**	**(4.4)**	**(4.3)**	**0.1**	**(385.2)**	**(383.3)**	**1.9**
Total assets employed	**177.4**	**175.9**	**(1.5)**	**134.3**	**132.8**	**(1.5)**	**161.7**	**158.9**	**(2.8)**	**473.4**	**467.6**	**(5.8)**
Financed by												
Public dividend capital	256.0	256.0	0.0	412.1	412.1	0.0	440.8	440.8	0.0	1,108.9	1,108.9	0.0
Retained Earnings (Accumulated Losses)	(80.9)	(82.4)	(1.5)	(312.6)	(313.9)	(1.3)	(282.2)	(285.0)	(2.8)	(675.7)	(681.3)	(5.6)
Revaluation reserve	2.2	2.2	(0.0)	34.8	34.6	(0.2)	3.1	3.1	0.0	40.1	39.9	(0.2)
Total Taxpayers' and others' equity	**177.4**	**175.9**	**(1.5)**	**134.3**	**132.8**	**(1.5)**	**161.7**	**158.9**	**(2.8)**	**473.4**	**467.6**	**(5.8)**

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6. Capital

Month 1 forecast outturn for total CDEL is a £14.6m overspend compared to the plan, all of which relates to nationally funded programmes. These variances needs to be agreed with NHSE as assumptions have changed since plan submission. Once agreed these needs to be reflected in the revised plan.

System CDEL forecasted to be in line with the plan across all 3 sites.

Nationally funded programmes £14.6m overspend: On EPR programme NNUH and JPUH are forecasting to spend £9.8m and £1.2m more than original plan, respectively. The remaining forecasted overspends are driven by centrally funded schemes that were approved following on from the final plan submission. It includes £1.2m for bowel cancer screening (NNUH), £0.3m for Hologic Panther (NNUH) and £2.1m for BLM – Estates Safety Fund (JPUH). 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 01 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	10,802	11,529	10,695	33,026	10,761	11,529	10,695	32,985	41	0	0	41
	Right to use Asset	44	15,425	140	15,609	85	15,425	140	15,650	(41)	(0)	0	(41)
	Other Adjustments:grants/donations/peppercorn leases	200	5,277	460	5,937	200	5,277	460	5,937	0	0	0	0
	Disposals	651	0	0	651	651	0	0	651	0	0	0	0
Total System CDEL		**11,697**	**32,231**	**11,295**	**55,223**	**11,697**	**32,231**	**11,295**	**55,223**	**0**	**(0)**	**0**	**0**
Nationally Funded Scheme	Front Line Digitisation	0	2,460	2,535	4,995	1,212	12,272	2,535	16,019	(1,212)	(9,812)	0	(11,024)
	NHP	37,122	0	61,293	98,415	37,122	0	61,293	98,415	0	0	0	0
	RAAC Plank	17,467	0	25,400	42,867	17,467	0	25,400	42,867	0	0	0	0
	UEC	10,000	7,366	3,892	21,258	10,000	7,366	3,892	21,258	0	0	0	0
	Elective Recovery	0	27,750	0	27,750	0	27,750	0	27,750	0	0	0	0
	Diagnostics	0	6,610	2,114	8,724	0	8,036	2,114	10,150	0	(1,426)	0	(1,426)
	Estates Safety	0	886	113	999	2,111	886	113	3,110	(2,111)	0	0	(2,111)
	Other	0	0	0	0	0	0	0	0	0	0	0	0
Total Nationally Funded		**64,589**	**45,072**	**95,347**	**205,008**	**67,912**	**56,309**	**95,347**	**219,568**	**(3,323)**	**(11,237)**	**0**	**(14,560)**
Total CDEL		**76,286**	**77,303**	**106,642**	**260,231**	**79,609**	**88,541**	**106,642**	**274,791**	**(3,323)**	**(11,237)**	**0**	**(14,560)**

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.

Walker, Ian
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Norfolk and Waveney University Hospitals Group

7. Risk

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

Risks to in-year delivery

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

Commentary:

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

- Financial Performance: the plans for 2026/27 were approved by NHSE in March with “close down” letters sent out by Region. The Trusts have set ambitious breakeven plans to deliver the reduction in deficit support monies. The CIP plans are the driver for delivery of the overall financial performance and there is still a large proportion in the high-risk category and will require constant monitoring to deliver the overall plan in year. This is a key part of the One Recovery programme for the Trusts in 2026/27.
- Bank/Agency rate reduction: The reductions become much harder in 2026/27 for agency as there are only a small number of hard to recruit roles that are now using agency. Bank reductions are reliant on reducing sickness levels across all Trusts as well as reducing the need for escalation space.
- Cash: this continues to be an issue with QEH due to the precarious cash position and a cash committee has been set up chaired by the EMD to support the ongoing management of the position. Despite the reduction in deficit support money in 2026/27 there is still a significant amount of cash support for QEH and JPUH, which if the financial plan is not delivered then the quarterly cash is at risk.

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.

Walker,Ian 28/05/2026 11:43:09

Report to the Group Board in public: 3 June 2026

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

Executive summary
The Board Assurance Framework (BAF) is a strategic tool used by Boards to identify, assess and monitor the key (Principal) risks to achieving an organisation's strategic objectives. The Group BAF has been developed and populated over the past six months, based on an initial set of strategic objectives agreed by the Special Purpose Joint Committee in autumn 2025. It has been updated with the Executive lead for each risk and reviewed by the Executive Risk Assurance Group (ERAG) and the Group Risk Assurance Committee (GRAC). The paper documents the current risk profile and key risk movements since the last group Board meeting in April 2026. 10 of the 14 risks are currently rated as 'Significant' (12 and above) – up from 9 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, including the work to develop the Group's risk appetite statement and apply it to the BAF. A Board risk workshop is scheduled for 22 July 2026.

Recommendations
The Group Board is asked to:
- Note and comment on the appended Group BAF.
- Note the further work planned to populate and develop the BAF in the period ahead.

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

Walker,Ian
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Group Board in public: 3 June 2026

Group Board Assurance Framework (BAF)

1. Introduction and background

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

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

1.3 This paper presents the current version of the Group BAF. Each risk has been reviewed with the Executive risk lead as part of the monthly review cycle, ahead of monthly discussion at the Executive Risk Assurance Group (ERAG) and the Board's Group Risk Assurance Committee (GRAC).

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

2. Principal Risks

2.1 Of the 14 Principal Risks 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)

2.2 Over the past two months since the previous meeting of the Group Board, no risks have been de-escalated from the BAF.

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

- PR3 (access, flow and productivity): decrease from 13 to 12 in May 2026 based on an improvement in the control effectiveness score through the measures in the Medium-term Plan.

- PR5 (workforce engagement and morale: increase from 10 to 12 in April 2026, following a review and reworking of the risk to focus on staff engagement and morale. This includes a revised risk description, updated controls, and a set of gaps in control and associated actions specifically focused on the 18,000 Voices Programme and its key sub-programmes.

- PR11 (transformation capacity and programme discipline): decrease from 13 to 12 in May 2026 based on a reduction in the likelihood score from 5 to 4 based on implementation of additional controls through the One Recovery programme.

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

3. Further work

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

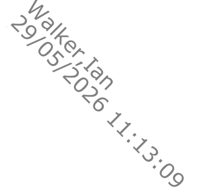
- Work is planned with the Group Board through a risk workshop on 22 July 2026 to review the Principal Risks, following approval of a revised Group Strategy, and define the Group's risk appetite. This will enable the risk appetite element of the BAF to be populated, providing visibility on the extent to which Principal Risks are currently outside the agreed risk appetite range and planned to return to within range, supporting challenge as to whether additional actions are required. Once the risk appetite has been defined, this should be a key trigger for focusing discussions on BAF risks which sit outside the Group's risk appetite range.

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

4. Recommendations

4.1 The Group Board is asked to:

- Note and comment on the appended Group BAF.
- Note the further work planned to populate and develop the BAF in the period ahead.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Group Board Assurance Framework: May 2026

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

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

Group Board Assurance Framework: May 2026

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

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

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

Risk rating	**Consequence**	**Likelihood**	**Control Effectiveness**	**Risk score (C+L+CE)**
Current	4	4	4	**12**
Target	4	3	2	9

Risk appetite	
Within appetite range?	

Related Group/Trust significant risks (12 and above)
NNUH: 80 (mortality outliers); QEH: 3762 (Histopathology), 3194 (Mental Health Act), 3723 (general surgery); 3014 (Clinical Safety Officer role); JPUH: 587 (Complaints), 223 (Histopathology)

	Risk score trajectory																									
	Jan 26	**Feb 26**	**Mar 26**	**Apr 26**	**May 26**	**Jun 26**	**Jul 26**	**Aug 26**	**Sep 26**	**Oct 26**	**Nov 26**	**Dec 26**	**Jan 27**	**Feb 27**	**Mar 27**	**Apr 27**	**May 27**	**Jun 27**	**Jul 27**	**Aug 27**	**Sep 27**	**Oct 27**	**Nov 27**	**Dec 27**		**Target**
Planned	12	12	12	12	12	12	12	12	12	11	11	11	10	10	10	10	10	10	10	10	10	9	9	9		9
Actual	12	12	12	12	12																					

Summary of monthly review/amendments

- Current risk score unchanged. Target score amended from 7 to 9 to reflect assessment of realistic target over the next 18 months.
- Risk trajectory added – risk reduction to 11 (C4+L4+CE3) from October 2026 and 10 (C4+L3+CE3) from January 2027 based on implementation of actions to address gaps in control GC1-GC3. Reduction to 9 (C4+L3+CE2) following EPR implementation.
- Update to second line assurances on control effectiveness to reflect Group Executive attendance at HMG meetings for each Trust in place of Executive Performance Review meetings.
- Gap in assurance GA1 closed – Quality Standards Group established in April 2026. Moved to second line controls.
- Update to gap in control GA1 to reflect planned discussion at Executive Directors' Group on patient and public involvement.
- Update to gap in control GA2 to reflect ongoing discussions of quality assurance at GRAC.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Patient safety framework and individual Trust policies on implementation of national quality standards and guidance. C2. Clinical governance framework in place in individual trusts. C3. Monitoring of key quality metrics in the Integrated Performance Report. C4. Monitoring of patient feedback through surveys, complaints, etc. C5. Agreed quality improvement methodology and training programme. C6. Specialist clinical networks sharing best practice and providing peer challenge. C7. Clinical audit programmes in each Trust.	AF1. Trust-level Quality Management Groups reporting to Hospital Management Groups.	AS1. AS1. Group Executive attendance at HMG meetings for each Trust. AS2. Executive-level Quality Standards Group meeting since April 2026. Reporting to Executive Risk Assurance Group. AS3. Reporting to Group Risk Assurance Committee and Group Board.	AT1. NHS England regional oversight meetings. AT2. CQC inspections. AT3. Regulatory accreditation visits. AT4. Inclusion of QEH in National Provider Improvement Programme (status tbc).

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

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	improvement methodology to be approved through One Recovery Programme Board.	
GC3. Monitoring quality data in real time on a consistent basis.	Development of Integrated Performance Report and supporting insight following market engagement exercise.	tbc
GA1. Development of Group-wide approach to patient and service user feedback and co-production.	Design, develop and implement a Group-wide patient and public involvement strategy. To be informed by Internal Audit planned as part of 2026/27 Internal Audit Plan. To be discussed at Executive Directors' meeting informed by Healthwatch report.	December 2026
GA2. Enhanced Board committee oversight of quality and outcomes to be put in place.	Specific section on Quality and Outcomes added to Group Risk Assurance Committee agenda in April and May 2026 ahead of potential move to a separate Quality and Outcomes Committee.	June 2026

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

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

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

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

Risk appetite	
Within appetite range?	

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

	Risk score trajectory																									
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		Target
Planned	11	11	11	11	11	11	11	10	10	10	10	10	10	10	9	9	9	9	9	8	8	8	8	8		8
Actual	11	11	11	11	11																					

Summary of monthly review/amendments

- Current risk score unchanged.
- Second line assurances updated to reflect reporting to Quality Standards Group.
- Third line assurances updated to reflect regional quality visit undertaken at JPUH in May 2026.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Site specific maternity improvement actions plans, including CNST Maternity Incentive Scheme (MIS) compliance. C2. Group-wide perinatal governance framework developed. C3. Monthly perinatal reporting in place. C4. National maternity outcomes signal system implemented. C5. Daily national OPEL reporting. C6. Future roadmap in place for perinatal services across the Group (Perinatal Clinical Strategic Network).	AF1. Reporting through Trust perinatal governance framework to Trust Quality Management Groups and Hospital Management Groups. AF2. Review of CNST MIS compliance through Trust Maternity Evidence Groups. AF3. Perinatal strategic network meetings.	AS1. Reporting to Executive Quality Standards Group. AS2. Reporting to Executive Risk Assurance Group. AS3. Reporting to Group Risk Assurance Committee and Group Board. AS4. NED and Executive Perinatal Safety Champions in place. AS5. Group Perinatal Safety Champions meetings and monthly walkrounds. AS6. Group Board review and approval in February 2026 of MIS Year 7 full compliance. AS7. Reporting to Group Executive and Group Board.	AT1. Regional Maternity Oversight Group. AT2. Local Maternity and Neonatal System (LMNS) Programme Board. AT3. CQC user survey results (positive assurance for QEH and JPUH). AT4. National maternity support programme for JPUH. AT5. Regional Quality Visit at JPUH (May 2026)

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Lack of end-to-end perinatal electronic patient record across Group.	Decision to proceed with Meditech solution as part of EPR programme.	August 2027
GC2. Group perinatal governance framework implementation.	Implementation plan to be developed and rolled out, including revised Group reporting.	March 2027
GA1. Regulatory notice in place for maternity services at QEH.	Evidence on training compliance provided to CQC and awaiting outcome and lifting of Section 31.	Awaiting CQC feedback.

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

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Group Board Assurance Framework: May 2026

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

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

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

Risk rating	Consequence	Likelihood	Control Effectiveness	Risk score (C+L+CE)
Current	4	5	3	12 ↓
Target (by Dec 26)	4	3	2	9

Risk appetite	
Within appetite range?	

Related Group/Trust significant risks (12 and above)
NNUH: 216 (UEC/ambulance offloads), 70 (Cellular pathology reporting delays); QEH: 2244 (mental health community beds), 2794 (Outpatients access), 2799 (CT/MRI reporting delays); JPUH: 157 (RTT/^% week waits), 152 (ED waist/ambulance handovers)

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

Summary of monthly review/amendments

- Proposed reduction in current risk score from 12 to 11 based on improvement in control effectiveness through 2026/27 plans.
- Update to second line assurances on control effectiveness to reflect Group Executive attendance at HMG meetings for each Trust in place of Executive Performance Review meetings.
- Due date for action to address gap in assurance GA1 amended from April to May 2026, pending Business Intelligence support.
- Gap in control GA2 updated to reflect confirmed inclusion of One Recovery programme in Internal Audit Plan for 2026/27, with audit planned for final quarter of the year.

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Key controls	Assurances on effectiveness of controls		
	First line	**Second line**	**Third line**
C1. Access and flow policies and processes at Trust level for elective and non-elective care, including escalation arrangements. C2. Trust recovery and delivery plans with agreed trajectories against targets. C3. Work of Trust operational and clinical teams with regular rhythm of daily/weekly meetings to manage access and flow. C4. Board-approved Medium-term Plans for 2026/27 and beyond. C5. Group One Recovery Plan in place.	AF1. Oversight at Hospital Management Groups and relevant sub-groups, with review of site Integrated Performance Reviews (IPRs) and trajectories.	AS1. Group Executive attendance at HMG meetings for each Trust. AS2. Risk-based oversight and assurance at Executive Risk Assurance Group (ERAG), Group Risk Assurance Committee (GRAC) and Group Board, with review of Group IPR. AS3. One Recovery Oversight Group meeting twice monthly.	AT1. NHS England (NHSE) Regional and National tiering calls. AT2. Monthly Regional Oversight and Scrutiny meeting with NHSE.

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Implementation of Group Recovery Plan.	In-year delivery of One Recovery Plan and trajectories, monitored via One Recovery Oversight Group and Group Board.	March 2027
GC2. Performance and accountability framework due for review.	Review, refresh and embed Performance and Accountability Framework.	End June 2026
GA1. Monitoring approach to One Recovery and Medium-term Plans to be developed.	Working with analytical support to develop monitoring approach.	End May 2026 (amended from end April 2026)
GA2. Limited sources of external assurance in place.	Inclusion of One Recovery Plan within 2026/27 Internal Audit plan – audit scheduled for Q4.	March 2027

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

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

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

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

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

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

Summary of monthly review/amendments
• Current risk score unchanged. • Update to second line assurances on control effectiveness to reflect Group Executive attendance at HMG meetings for each Trust in place of Executive Performance Review meetings. • Key controls added relating to monthly tracking against Trusts' activity plans (C2) and Vacancy Panels for pay control (C4). • Gap in control GC1 updated for CIP gateway and quality impact assessment process; due for completion by end of May 2026. • Gap in assurance GA1 closed and additional second line assurance (AS5) added following CIP deep dive at GRAC in April 2026.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Planning environment – Board-approved Medium-term Plan for 2026/27 and beyond. C2. Monthly tracking against Trust's activity plans. C3. CIP plans for 2026/27 finalised and 2027/28 in development. One Recovery CIP Charter signed off in March 2026. C4. Pay controls – Vacancy Panels in place in all three Trusts. C5. Bank and agency controls in line with NHSE reductions. C6. Capital plan for 2026/27.	AF1. Trust Finance and Performance meetings reporting to Hospital Management Groups.	AS1. Group Executive attendance at HMG meetings for each Trust. AS2. One Recovery Programme meetings twice monthly. AS3. Reporting to Executive Risk Assurance Group, Group Risk Assurance Committee and Group Board. AS4. Review of controls in place through Annual Governance Statement. AS5. CIP deep dive undertaken at GRAC in April 2026.	AT1. Monthly financial reporting to NHSE. AT2. Monthly NHSE Oversight meetings. AT3. Head of Internal Audit Opinion annually. AT4. Value for Money review/ conclusion from External Audit.

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Finalise CIP programmes for 2026/27.	All three Trusts have identified CIP schemes. Gateway and Clinical Quality Impact Assessments in progress.	End May 2026
GC2. Implementation of 2026/27 CIP programmes.	Agree resources, programme management arrangements for delivery of each scheme and oversight of CIP programmes in each Trust.	Ongoing to end of March 2027
GC3. Need to develop Trust-level control totals on Whole Time Equivalents (WTEs).	Plans in development with Trust Directors of Finance.	May 2026

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Principal Risk 5: Workforce engagement and morale
If appropriate plans and actions are not developed and implemented effectively to address reductions in staff engagement, morale and confidence as evidenced through the NHS Staff Survey, then continuing low staff engagement and morale may have an adverse impact on recruitment and retention, staff wellbeing and the quality and safety of care provided to patients.

Risk lead	Interim Group CPO
Last update	May 2026
Group Aim and Enabling Objectives	A3: People and culture EO 13, 14, 15, 16

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

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

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

Risk score trajectory

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

Summary of monthly review/amendments

- Current risk score unchanged.
- Risk trajectory amended to reduce planned score from 12 to 10 (L4+C3+CE3) in December 2026 and from 10 to 8 (L4+C2+CE2) in August 2027. Reduction to 10 by December 2026 reflects implementation of HR Shared Service and more effective staff management (sickness, case management, workforce planning, staff engagement). Further reduction from summer 2027 following embedding of work on leadership development, job planning and 18,000 Voices programme.
- New gaps in control GC1 on standardised case management approach and process; and GC3 on job planning (One Recovery).

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Trust staff engagement plans and activities. C2. Trust training and development programmes. C3. Trust processes for Freedom to Speak Up and raising concerns. C4. Trust arrangements for staff wellbeing support. C5. Trust-specific NHS Staff Survey response plans. C6. Cross-cutting "18,000 Voices" programme as part of One Recovery.	AF1. Trust oversight at People and Culture Management Groups reporting to HMGs.	AS1. One Recovery Programme oversight meetings twice monthly. AS2. Risk-based oversight and assurance at Executive Risk Assurance Group (ERAG) and Group Risk Assurance Committee (GRAC). AS3. Reporting to Group Board via Group CEO's and Executive Managing Directors' reports.	AT1. NHS England monthly oversight meetings. AT2. NHS Staff Survey results. AT3. National benchmarking data on Freedom to Speak Up.

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Standardised approach and process for case management across the three Trusts.	Implementation of HR shared service and standardised policies and processes. Contribution from wider corporate services transformation.	October 2026
GC2. Need to develop an intentional culture of improvement and engagement across the Group.	Development of "18,000 Voices" programme as part of One Recovery, comprising four key elements (see below) with agreed programme mandates.	May 2026
GC2a: Vanderbilt	Phased implementation of **Vanderbilt** professional advocacy programme with a focus on a culture of safety and respect, to be delivered over a four-year period.	Medical staff/senior leadership roll out from April 2026 Other staff groups roll out summer 2026 to spring 2027.
GC2b: Gemba	Implementation of **Gemba** programme, with leaders spending time in front-line areas, across Group Executive and Trust leadership teams.	Monthly programme in place from June 2026

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GC2c: Leaders Within	Develop "**Leaders Within**" network to develop future leadership capability across the Group and bring together staff networks.	tbc
GC2d: Single improvement methodology	Agree and implement single improvement methodology to be introduced through One Recovery programme.	tbc
GC3: Improve job planning	Progress through World Class Basics programme as part of One Recovery.	tbc

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

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

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

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

Risk appetite	
Within appetite range?	

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

	Risk score trajectory																									
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27		Target
Planned	13	13	13	13	13	13	12	12	12	12	12	12	12	12	12	10	10	10	10	10	10	10	10	10		8
Actual	13	13	13	13	13																					

Summary of monthly review/amendments
• Current risk score unchanged. • No amendments – Digital Roadmap complete and going through governance processes.

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

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

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

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

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

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

Related Group/Trust significant risks (12 and above)
NNUH: 81 (EPR disruption during/after go-live); EPR programme: 6216 (financial consequences of delay), 6217 (impact on operational performance), 2118 (EPR programme delivery), 5202 (multi-Trust convergence complexity)

	Risk score trajectory																									
	Jan 26	**Feb 26**	**Mar 26**	**Apr 26**	**May 26**	**Jun 26**	**Jul 26**	**Aug 26**	**Sep 26**	**Oct 26**	**Nov 26**	**Dec 26**	**Jan 27**	**Feb 27**	**Mar 27**	**Apr 27**	**May 27**	**Jun 27**	**Jul 27**	**Aug 27**	**Sep 27**	**Oct 27**	**Nov 27**	**Dec 27**		**Target**
Planned	13	13	13	13	13	13	12	12	12	12	12	12	11	11	11	9	9	9	9	9	8	8	8	8		8
Actual	13	13	13	13	13																					

Summary of monthly review/amendments

- Current risk score unchanged.
- No amendments.

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

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

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

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

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

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

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

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

Summary of monthly review/amendments
• Current risk score unchanged. • Risk trajectory amended based on initial implementation phase of Cyber Strategy – revised from 13 to 12 (C5+L4+CE3) in February 2027. • Gaps in control updated to reflect work on business cases to implement Cyber Security Strategy. Previous gaps CC2 and GC4 incorporated as part of GC1.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Data Protection and Security Toolkit (DPST) Improvement Plan.	AF1-3. Digital Group.	AS1-3. Executive Risk Assurance Committee, Group Risk Assurance Committee and Group Board.	AT1. Annual audit of DPST.
C2. Cyber security strategy.			
C3. Cyber Security Action Plan overseen by Cyber Security Task Force.			AT2. Internal Audit programme on cyber security.
C4. Layered technical controls, user education and supplier contractual clauses for cyber risk management.			AT3 Annual DSPT/Cyber Assessment Framework (CAF) audit; ISO27001 and CE (JPUH only); IT Health Checks/PEN tests.

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Business cases to implement Cyber Security strategy.	Business cases to be developed to define and right size investment and sourcing of cyber security service. Infrastructure refresh programme - strategic approach to asset management and refresh to be established across the Group and move to a sustainable footing, aligned to maximise support for DPST/CAF compliance.	Costed and prioritised plan in place for NNUH. May 2026 for JPUH and QEH business cases.
GC2. Information Governance and Cyber Security governance and policy alignment.	Alignment of policy and decision making for Information Governance across the Group. Approach agreed at Executive Directors' meeting in February 2026 to be implemented on an interim basis from March 2026 and on a substantive basis from July 2026 following creation of a Single Digital Team.	June 2026
GC3. Response to specific Artificial Intelligence (AI) threats including Mythos.	Evaluating impact of potential threats in liaison with NHS colleagues.	Timeline tbc

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

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

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

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

Risk appetite	
Within appetite range?	

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

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

Summary of monthly review/amendments
• Risk score unchanged. • No amendments – risk under review, including case for separation of risks between PFI and non-PFI assets.

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Group Board Assurance Framework: May 2026

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

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

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

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

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

Risk rating	Consequence	Likelihood	Control Effectiveness	Risk score (C+L+CE)
Current	4	4	4	12 ↓
Target	4	3	2	9

Risk appetite	
Within appetite range?	

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

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

Summary of monthly review/amendments

- Proposed reduction in current risk from 12 to 11 based on reduction in likelihood from 5 to 4 through implementation of additional controls.
- Reordering of key controls to emphasise One Recovery programme.
- Addition of third line assurance on control effectiveness to reflect planned Internal Audit of One Recovery programme in 2026/27Q4.
- Gap in assurance GA1 closed – One Recovery programme reporting developed and in place.

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

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Group Transformation resourcing and team structure.	Transformation function and operating model to be included in Phase 2 of Corporate Services restructuring.	July 2026
GC2. Improvement methodology not yet formalised and rolled out.	Work with Transformation Team to agree formal methodology and implementation plan.	May 2026
GC3. Training programme on improvement programme required.	Develop and roll out training programme for Transformation Team and across the three Trusts.	March 2027

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

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

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

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

Risk appetite	
Within appetite range?	

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

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

Summary of monthly review/amendments
• Current risk score unchanged. • Gap in assurance GA1 closed as complete and moves to third line assurances on control effectiveness – NHP audit included in 2026/27 Internal Audit Plan approved by the Group Audit Committees in Common in April 2026.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Strategic Outline Cases (SOCs) approved for both schemes.		AS1-6. Monthly New Hospitals Programme Board meetings. Reporting to Executive Risk Assurance Group, Group Risk Assurance Committee and Group Board. Group Board approval of business cases.	AT1. National approval process for SOC and Outline/Full Business Cases, including independent Gateway Reviews. AT2. NHS England and national NHP attendance at monthly programme board. Gateway Review assurance embedded within Integrated Assurance and Approvals Plan (IAAP). AT3. Internal Audit Plan for 2026/27 includes audit of NHP programme.
C2. SOCs include detailed design and clinical services configuration, backed by demand and capacity modelling.			
C3. NHP programme infrastructure and funding in place.			
C4. Anchor and strategic milestones agreed with NHP, supported by programme plans and milestones.	AF4-6. Programme Delivery group chaired by Strategic Programme Director.		
C5. Risk registers and benefits realisation plans in place.			
C6. Stakeholder engagement programmes in place for both schemes.			

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Clinical strategy for Group.	Ongoing work to review and develop Group clinical strategy to inform further work on specification of schemes.	July 2026 - tbc
GC2. No public engagement plan.	Develop and implement engagement plan on Clinical Strategy and impact on services and hospital design.	End of May 2026

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Principal Risk 14: Corporate governance
If a robust corporate governance and risk management framework is not developed, implemented and embedded across the Group, then decisions may be ultra vires, regulatory action may follow and public trust may be impaired.

Risk lead	Group DG
Last update	May 2026
Group Aim and Enabling Objectives	A7: Governance EO 30-33

Assurance strength rating (1-5)
2. Reasonable assurance

Risk rating	Consequence	Likelihood	Control Effectiveness	Risk score (C+L+CE)
Current	4	4	3	**11**
Target	4	2	1	7

Risk appetite	
Within appetite range?	

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

	Risk score trajectory																								
	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27	Target
Planned	11	11	11	11	11	11	9	9	9	9	9	9	7	7	7	7	7	7	7	7	7	7	7	7	7
Actual	11	11	11	11	11																				

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

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Group Model Mobilisation Plan.	AF1. Tracking of progress through Executive Directors' Group.	AF2. Progress reporting to Group Board.	AT1. NHS England review of Group Model Mobilisation Plan – report received in January 2026.
C2. Governance framework at Group and Trust levels (including Provider Collaboration Agreement; FT Constitutions; Standing Orders; Schemes of Reservation and Delegation; committee structure with agreed terms of reference).	AF2. Corporate Governance function supports Group Board and committees, Executive Directors' Group and Hospital Management Groups to operate within Governance Framework and terms of reference.	AS2. Audit Committees in Common seek assurance on governance, risk and internal control effectiveness (*ongoing*). Annual Governance Statements agreed by Group Board (*due May 2026*).	AT2. NHS England review of Group Model Mobilisation Plan (December 2025). CQC Well-Led reviews (*not yet undertaken*). Annual Head of Internal Audit Opinion (*due in May 2026*).
C3. Annual review of Board and committee effectiveness.	AF3. Groups and committees to complete effectiveness reviews annually.	Group Board receives annual review of Board and committee effectiveness (*not yet undertaken*).	
C4. Risk management framework and policy, Board Assurance Framework (BAF) and Trust risk registers.	AF4. Ongoing review by Executive Risk Assurance Group.	AS4. Audit Committees in Common seek assurance on governance, risk and internal control effectiveness (*ongoing*). Annual Governance Statements agreed by Group Board (*due May 2026*).	AT4. Annual Internal Audit review of effectiveness of risk management system (*due May 2026*). CQC Well-Led review (*not yet undertaken*).

Gap in control/assurance	Action to address gap in control/assurance	Due date
G1. Group governance structure not fully implemented.	A1. Remaining Board committees to be established; Constitutions, SOs and SFIs to be finalised. Arrangements then to be embedded.	June 2026 (December 2026 for embedding)
G2. Risk management framework remains in development.	A2. BAF to be fully populated; principal risks to be reviewed by Group Board as Group Strategy finalised; Group Board to review and agree risk appetite statement. Then to be embedded.	June 2026 (December 2026 for embedding)
G3. NED vacancy and three Associate NED vacancies.	A3. Competitive recruitment process being undertaken. Appointment and induction to roles.	June 2026

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Principal Risk 15: Public and stakeholder confidence
If external scrutiny, performance challenges, infrastructure concerns (including Reinforced Autoclaved Aerated Concrete), or service disruption undermine public, patient, and stakeholder confidence in the Group's hospitals then recruitment and retention may suffer, patient choice may shift to alternative providers, partnership relationships may weaken, staff morale may decline, and regulatory intervention may intensify.

Risk lead	Group CEO
Last update	May 2026
Group Aim and Enabling Objectives	A6: Partnerships EO 27-29

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

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

Risk appetite	
Within appetite range?	

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

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

Summary of monthly review/amendments
• Risk scores unchanged. • Gap in control GC1 closed following new Group Director of Communications and Engagement taking up post in May 2026. • Risk to be reviewed by new Group Director.

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Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Appointment of Group Director of Communications and Engagement.	AF1. Reporting to Group Chief Executive.	AS1.	AT1.
C2. Strategic Communications Oversight of key reputational issues.	AF2. Reporting to Group Chief Executive and Executive Directors' Group.	AS2. Reporting to Group Board.	AT2.
C3. Trust and Group level communications work plans – narrative and key messages, tactical communications plan, project-specific plans, stakeholder management grids, etc.	AF3. Oversight at each Trust's Hospital Management Group.	AS3. Oversight at Executive Director's Group.	AT3.
C4. Regular briefing of key stakeholders.	AF4. Oversight at each Trust's Hospital Management Group.	AS4. Oversight at Executive Director's Group.	AT4. Stakeholder feedback.
C5. Targeted communications activities on reputational issues.	AF5. Oversight at each Trust's Hospital Management Group.	AS5. Oversight at Executive Director's Group.	AT5. Stakeholder feedback.
C6. Strategic review of communications and engagement services.	AF6. Reporting to Group Chief Executive.	AS6. Corporate Services Programme Board.	

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Single Group Communications team.	Communications is part of Phase 1 of Corporate Services restructuring with service structure consultation due to commence in March 2026.	June 2026
GC2. Lack of Group Communications and Engagement Strategy.	Strategy to be developed following recruitment of new Group Director and implementation of new team.	September 2026

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

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

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

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

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

	Risk score trajectory																							
	Jan 26	**Feb 26**	**Mar 26**	**Apr 26**	**May 26**	**Jun 26**	**Jul 26**	**Aug 26**	**Sep 26**	**Oct 26**	**Nov 26**	**Dec 26**	**Jan 27**	**Feb 27**	**Mar 27**	**Apr 27**	**May 27**	**Jun 27**	**Jul 27**	**Aug 27**	**Sep 27**	**Oct 27**	**Nov 27**	**Dec 27**	**Target**
Planned	10	10	10	10	10	10	10	10	10	10	10	10													7
Actual	10	10	10	10	10																				

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Summary of monthly review/amendments
• No amendments to risk scores. • Gap in control GC1 added on report commissioned to inform and support decision making on the future Group operating model for Research, Innovation and Education. • Gaps in assurance updated.

Key controls	Assurances on effectiveness of controls		
	First line	Second line	Third line
C1. Existing Trust strategies.	AF1. Oversight and assurance of strategy position and delivery through existing Trust management mechanisms.	AS1. Escalation to Executive Risk Assurance Group and Group Risk Assurance Committee for strategic risks concerning Research, Innovation and Education.	AT1. Independent measures of success and compliance set by key partners, funders and the NHS, e.g. grant income, contractual compliance, ethics/protocol compliance.
C2. Research Operations Management – Delivery of Strategy.	AF2. Management and delivery oversight and assurance of strategy delivery through existing Trust management mechanisms.	AS2. Operational issues impacting delivery against existing strategy to be escalated through existing, pre-Group, management structures into Group Executive and Group Board structures.	AT2. External audit, funder reporting, shared management and governance structures with external partners e.g. supporting joint resource, e.g. Quadram Institute Clinical Research Facility.
C3. Education and Training Partnerships.	AF3. Existing Trust:Partner educational and training agreements and integration into Trust management structures.	AS3. Escalation of items representing a strategic risk to be escalated through existing, pre-Group, management structures into Group Executive and Group Board structures.	AT3. External audit, reporting, shared management and governance structures with external education partners.

Gap in control/assurance	Action to address gap in control/assurance	Due date
GC1. Development of future Group operating model for Research, Innovation and Education.	Report commissioned to inform and support decision making on the future Group operating model for RIE. To be received by Group RIE Committee and Group Board.	August 2026

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GA1. Developing Group-level framework defining objectives, risks, performance measures or escalation.	Group Research, Innovation and Education (RIE) Committee established from March 2026. RIE control and assurance framework, including University Hospitals Association (UHA) commitments as core assurance measures, to be developed.	August 2026
GA2. There is no routine, consolidated Group-level view of performance, delivery risks or compliance across Trusts; escalation is largely reactive.	Introduce interim Group-level RIE performance and risk reporting using a standardised dashboard, with clear escalation thresholds to the Group Executive.	August 2026
GA3. External assurance (funders, regulators, partners) is not consistently consolidated or reviewed at Group level, including arrangements with the University of East Anglia (UEA).	Approve the Group–UEA Memorandum of Understanding and implement a consolidated Group approach to monitoring external compliance, partnership delivery and assurance reporting through the RIE Committee.	June 2026

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Appendix 1: Risk and assurance scoring matrices

Risk score = Consequence (1-5) + Likelihood (1-5) + Control Effectiveness (1-5)
e.g. 5+5+5=15, using the descriptors below

	Consequence	Likelihood / Frequency	Control Effectiveness
1	Negligible	Remote / Not expected to occur for years	Fully Effective
2	Minor	Unlikely / Expected to occur at least annually	Largely Effective
3	Moderate	Possible / Expected to occur at least monthly	Partially Effective
4	Major	Likely / Expected to occur at least weekly	Planned but not in place
5	Catastrophic	Almost certain / Expected to occur at least daily	Absent

Risk score
Significant 12-15
Serious 10-11
Moderate 6-9
Low 3 - 5

Sources of assurances on the effectiveness of controls

1st line	Management assurance at site/Trust level
2nd line	Management and Board level assurance at Group level
3rd line	Independent assurance external to the Group/individual Trusts

Risks escalated to the Board Assurance Framework (BAF) also receive an assurance score (1-5)

1	2	3	4	5
Substantial Assurance	Reasonable Assurance	Limited Assurance	Very Limited/ Minimal Assurance	No Assurance

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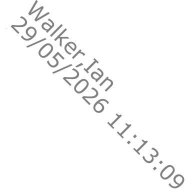
Appendix 2: Risk appetite [DRAFT – to be developed with Group Board in May 2025]

Risk appetite level	Likelihood / Frequency	Risk score range
Minimal	Very low tolerance. Risks must be rare and tightly controlled.	3-8
Moderate	Some risks accepted if aligned with strategic goals and managed effectively.	9-11
Open	Higher risk accepted in pursuit of innovation and transformation.	12-15



Appendix 3: Glossary and abbreviations

Glossary	
Aims	The Group Aims define what the Group Board intends to achieve to discharge its statutory purpose and fulfil its responsibilities to the population it services. These aims are supported by a set of Enabling Objectives.
Assurance	Assurance is the process for building confidence that services and systems are working as intended and that risks are being managed effectively provides certainty through triangulated evidence and brings confidence that systems are working effectively. a process for building confidence that services, systems, and standards are working as intended and that risks are being managed effectively
Board Assurance Framework (BAF)	A strategic tool used by Boards to identify, assess and monitor the key (principal) risks to achieving the organisation's strategic objectives.
Consequence	The outcome or impact of an event affecting objectives. (ISO 31000:2018).
Controls	A measure that modifies risk. (ISO 31000:2018) Controls are a dynamic and iterative framework of processes, policies, procedures, activities, devices, practices or other conditions and/or actions that maintain and/or modify risk.
Control effectiveness	An assessment of the effectiveness of the controls in place to manage a risk.
Current risk score	The risk score (the summation of the Consequence, Likelihood and Control Effectiveness ratings) based on the controls currently in place in the organisation.
Enabling objectives	These define what must be done to achieve the Group Aims. They set the boundaries for action, assign responsibility for creating the right conditions for success and establish progress expectations.
Likelihood	Refers to the chance of something happening - can be expressed qualitatively or quantitatively. (ISO 31000:2018).

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

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Abbreviations	
CDO	Chief Delivery Officer
CEO	Chief Executive
CFO	Chief Financial Officer
CMO	Chief Medical Officer
CN	Chief Nurse
CPO	Chief People Officer
DD	Director of Digital
DG	Director of Governance
DoM	Director of Midwifery
EMD	Executive Managing Director
EO	Enabling Objective
HRD	Human Resources Director
JPUH	James Paget University Hospital
NNUH	Norfolk and Norwich University Hospital
PR	Principal Risk
QEH	Queen Elizabeth Hospital, King's Lynn

Report to the Group Board in public: 3 June 2026

Agenda item number	11		
Title	Group Governance Framework		
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

A paper to the Group Board in April 2026 described in detail the Group Governance Framework and how it operates. This paper, which should be read alongside the previous one, seeks approval of the final elements of the Group Governance Framework and documents all the instruments now in place: the Trust Constitutions; Scheme of Reservation and Delegation; Standing Orders of the Boards of Directors and Councils of Governors; Standing Financial Instructions; and terms of reference of the Group Board.

With the establishment of the Strategy, Technology, Investments and Partnerships Committee (for which Group Board approval of the terms of reference are sought), this completes the Board committee structure as set out in the October 2025 Provider Collaboration Agreement.

The paper also notes the recent appointment of three additional Group NEDs and two Associate Group NEDs to increase Non-Executive bandwidth and facilitate closer links with the three Trusts. As detailed in the paper, this will be achieved by aligning an 'Associate Chair' to each Trust, supported by two Group NEDs/Associate NEDs.

Recommendations

The Group Board is asked to:

- Approve the terms of reference of the Group Audit Committees in Common and the Standing Orders of the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust.
- Approve the terms of reference of the Group Audit Committees in Common and the 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 terms of reference of the Group Audit Committees in Common and the Standing Orders of the Council of Governors of James Paget University Hospitals NHS Foundation Trust, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust.
- Approve the terms of reference and membership of the Group Strategy, Technology, Investments and Partnership Committee as a committee of the Group Board.

Alignment to Board Assurance Framework risk(s)	PR14 (corporate governance)
Previously considered by	Group Audit Committees in Common, 28 April 2026 (terms of reference)
Any background papers in Admin Control Reading Room	No

Norfolk and Waveney University Hospitals Group

Group Board in public: 3 June 2026

Group Governance Framework

1. Introduction and background

1.1 The Group Governance Framework forms the statutory basis for governance within the Group model, confirming that governance is exercised through the instruments defined in Schedule 7 of the NHS Act 2006, Foundation Trust Constitutions and Standing Orders.

1.2 The Provider Collaboration Agreement (PCA), approved by the three Trust Boards in October 2025, establishes the General Purpose Joint Committee (GPJC or Group Board) as the mechanism for the joint exercise of functions, while preserving the sovereignty of each of the three Trust Boards and the requirement that Reserved Functions remain with those Boards. The PCA also details the committees to be established to support the Group Board, and the three Trust Boards, in exercising their responsibilities.

1.3 A paper to the Group Board in April 2026 described in detail the Group Governance Framework and how it operates. This paper, which should be read alongside the previous one, seeks approval of the final elements of the Group Governance Framework and documents all the instruments now in place.

2. Statutory Governance Instruments

2.1 The following Statutory Governance Instruments are in place:

- **Foundation Trust Constitutions**, as approved by the Boards of the three Trusts in April 2026. The three Constitutions have been aligned around the NHS Model Core Constitution, with the only variation relating to the currently distinct composition of each Trust's membership constituencies and Council of Governors.
- **Scheme of Reservation and Delegation,** approved in October 2025. This defines those matters reserved to each Board of Directors and those delegated to the Group Board (General Purpose Joint Committee) and establishes the boundary for lawful delegation.
- **Standing Orders of the Boards of Directors**, as approved by the Boards of the three Trusts in April 2026. These have been aligned across the three Trusts and regulate the conduct of Board business, including meetings, quora, decision making and the exercise of Reserved Functions.
- **Standing Financial Instructions of the Boards of Directors**, as approved by the Boards of the three Trusts in April 2026. These have been aligned across the three Trusts, with any variations in financial

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delegations across the Trusts explicitly specified. They establish the framework for financial control, stewardship of public funds, regularity, propriety and value for money.

- **Group Board** (**GPJC) terms of reference**, amended and approved by the Boards of the three Trusts in April 2026.

2.2 The additional governance instrument for which approval is now sought is the **Standing Orders of the Councils of Governors** of the three Trusts (see Appendix 1). 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 and were approved by the three Councils of Governors during April 2026. Approval is now sought from the Boards of Directors of the three Trusts.

3. Board Committees

3.1 In accordance with a Provider Collaboration Agreement signed by the three Trusts in October 2025, the following Committees of the Group Board have been established:

- Group Audit Committees in Common
- Group Nomination and Remuneration Committees in Common
- Group Risk Assurance Committee
- Group Research, Innovation and Education Committee
- Trust Charitable Funds Committees

3.2 The membership of these Committees is recorded in a paper to the Group Board meeting of 1 April 2026. Terms of reference for each Committee have been approved at previous meetings of the Group Board/Boards of Directors.

Group Audit Committees in Common

3.3 The Group Audit Committees in Common reviewed its terms of reference at its meeting on 28 April 2026 and these are presented at Appendix 2 for approval. There are no material amendments to the version approved by the Boards of Directors of the three Trusts in December 2025. However, the terms of reference have been transferred to the new standard template which has been adopted for all Group committees. They have also been simplified and aligned with the model terms of reference published by the HFMA (Healthcare Financial Management Association).

Strategy, Technology, Investments and Partnerships Committee

3.4 The final Committee to be established, as set out in the Provider Collaboration Agreement, is the Strategy, Technology, Investments and Partnerships Committee (referred to as the Strategy and Partnerships Committee in the PCA). A meeting was held on 22 May 2026 with the Group Chair, Group Chief Executive and Jack Bowman (Group NED) to review the proposed terms of reference for this Committee and they are being brought to the Group Board for approval (see Appendix 3).

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3.5 The purpose of this Committee is to provide oversight, gain assurance and make recommendations to the Group Board (and the Boards of Directors of the three Trusts where applicable) on the implementation of the Group's vision for change and the organisational and clinical strategy, as approved by the Group Board; the development and delivery of the Group's supporting strategies, including in relation to digital and estates infrastructure; and all significant investments, joint ventures, partnerships and commercial arrangements entered into by the Group and/or Trusts, ensuring that they are aligned to the clinical strategy, deliver value for money and appropriately manage risk.

3.6 The Committee will be chaired by the Group Chair and its Non-Executive Director members will be Jack Bowman, Andrew McKechnie, Sally Collier, Marcus Bailey and Susan Putters.

Group Governance Structure

3.7 The diagram at Appendix 4 summarises the Group governance structure, including key committees at Group Board, Group Executive and Trust levels.

4. Additional NED/ANED appointments and links to Trusts

4.1 Following a competitive recruitment exercise, the Councils of Governors have recently approved the appointments of three additional Group Non-Executive Directors and two Associate Group Non-Executive Directors. The formal start date for these appointees will be confirmed shortly following the completion of the required pre-appointment checks. They are as follows:

- Tanvir Alam, Group NED (Designate)
- Andrew McKechnie, Group NED (Designate)
- Susan Putters, Group NED (Designate)
- Marcus Bailey, Associate Group NED (Designate)
- Gee Cook, Associate Group NED (Designate)

4.2 A key rationale for these appointments is to increase the Group's Non-Executive bandwidth and to facilitate closer links with the three Trusts (while recognising the accountability of all NEDs to each of the Trusts). This will be achieved by aligning an 'Associate Chair' to each Trust, supported by two Group NEDs/Associate NEDs as follows:

- JPUH: Stephen Javes (Associate Chair) supported by Sally Collier and Gee Cook
- QEH: Tanvir Alam (Associate Chair) supported by William Van't Hoff and Andrew McKechnie
- NNUH: Susan Putters (Associate Chair) supported by Nikki Gray and Marcus Bailey.

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4.3 It is proposed that the Associate Chair for each Trust, supported by the other two NEDs/Associate NEDs, will develop an effective relationship with Governors (including the Lead Governor); deputise for the Group Chair in chairing the Council of Governors; Chair the Trust's Charitable Funds Committee; ensure that there is a programme of NED visits; and represent NEDs at Trust/site events.

4.4 It is envisaged that the two NEDs/Associate NEDs supporting the Associate Chair will rotate between Trusts after 12 months.

5. Recommendations

5.1 The Group Board is asked to:

- Approve the terms of reference of the Group Audit Committees in Common and the Standing Orders of the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust, acting for this reserved function as the Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust.
- Approve the terms of reference of the Group Audit Committees in Common and the 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 terms of reference of the Group Audit Committees in Common and the Standing Orders of the Council of Governors of James Paget University Hospitals NHS Foundation Trust, acting for this reserved function as the Board of Directors of James Paget University Hospitals NHS Foundation Trust.
- Approve the terms of reference and membership of the Group Strategy, Technology, Investments and Partnerships Committee as a committee of the Group Board.

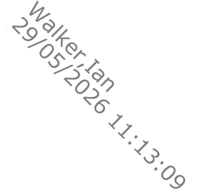
Appendices:

Appendix 1: Standing Orders of the Councils of Governors

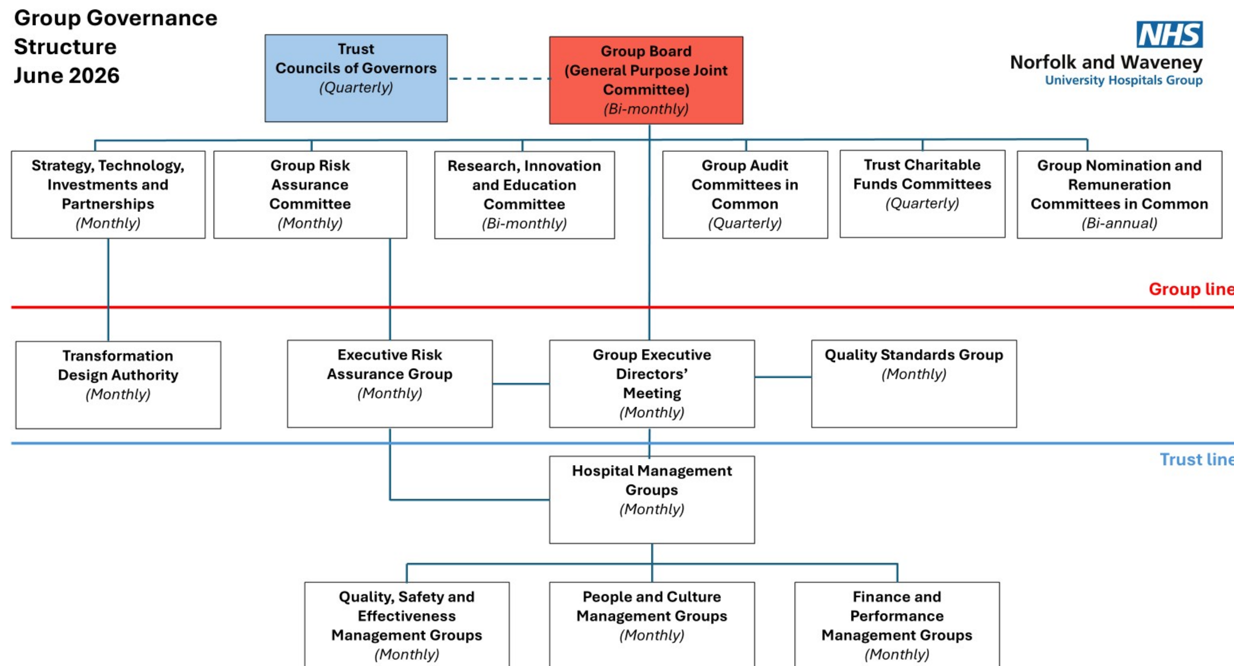
Appendix 2: Terms of reference of the Group Audit Committees in Common

Appendix 3: Terms of reference of the Strategy, Technology, Investments and Partnerships Committee

Appendix 4: Group Governance Structure



Appendix 4: Group Governance Structure



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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 Trust 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.

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 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.

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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 Trust Secretary.

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.

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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, if present, shall preside. If the Group Chair is absent from the meeting the Deputy Chair, if there is one and they are present, shall preside. If the Group Chair and Deputy Chair are absent, such Non-Executive Director as the Directors present shall choose shall preside.

4.8.2 If the Group Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if there is one and they are present, shall preside. If the Group Chair and Deputy Chair are absent, or are disqualified from participating, such 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 Trust 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

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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 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.

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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 Trust 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.

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 Trust Secretary as soon as possible.

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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 Trust Secretary.

7.5 Every Governor shall disclose to the Trust 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 Trust 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 Trust 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.

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.

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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 [insert date] and the Board of Directors on [insert date] and take effect immediately.

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GROUP AUDIT COMMITTEES IN COMMON

TERMS OF REFERENCE

1. Introduction

1.1 The Norfolk and Waveney University Hospitals Group (NWUHG) Audit Committees in Common is established under the Provider Collaboration Agreement (PCA)[1].

2. Accountability and authority

2.1 The Boards of each of the three Trusts[2] have agreed and arranged for their Audit Committees to operate together as Committees in Common.

2.2 In operating as Committees in Common, each Trust's Audit Committee shall continue at all times to be directly accountable to its respective Board of Directors but shall routinely report its activities, findings, conclusions and recommendations to the Group Board (the General Purpose Joint Committee).

2.3 Decisions of the Group Audit Committees in Common regarding delegated joint functions are binding on each of the Trusts. Resolutions legally reflect the simultaneous decision of the Audit Committees of all three Trusts.

2.4 The Committees in Common is authorised by the Group Board to act within these terms of reference. It has no executive powers other than those specifically delegated in these terms of reference.

2.5 All members of staff of the three Trusts are directed to cooperate with any request made by the Committees in Common.

2.6 The Committees in Common are authorised by the Group Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

3. Purpose

3.1 The purpose of the Group Audit Committees in Common is to provide independent and objective scrutiny of the adequacy and effectiveness of governance, risk management and internal control across the three Trusts operating within the Group model.

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[1] Provider Collaboration Agreement for the purpose of establishing Norfolk and Waveney University Hospitals Group joint working arrangements and appointment of a General Purpose Joint Committee to exercise joint functions, 23 October 2025.
[2] Norfolk and Norwich University Hospitals NHS Foundation Trust, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and James Paget University Hospitals NHS Foundation Trust.

4. Membership and attendance

4.1 The members of the Group Audit Committees in Common will be appointed by the Boards of Directors of the three Trusts and comprise three Group Non-Executive Directors. The Group Chair shall not be a member.

4.2 One Group Non-Executive Director will be appointed as the Chair of the Group Audit Committees in Common by the Boards of Directors of the three Trusts.

4.3 At least one member of the Group Audit Committees in Common must have recent and relevant financial experience.

4.4 The Group Chief Executive will identify a link Executive Director for the Group Audit Committees in Common.

4.5 A quorum shall be two Group Non-Executive Directors.

4.6 The Group Chief Finance Officer will attend all meetings. In exceptional circumstances, an appropriate nominated deputy may attend in their place. The Group Chief Executive will be invited to attend all meetings and should discuss at least annually with the Group Audit Committees in Common the process for assurance that supports the Annual Governance Statements.

4.7 The Head of Internal Audit, a representative of External Audit and the Local Counter Fraud Specialist will be standing attendees.

4.8 Other Group and Trust staff will be invited to attend for specific agenda items with the agreement of the Chair of the Group Audit Committees in Common.

5. Secretariat

5.1 The Group Director of Governance will provide a Secretary to the Group Audit Committees in Common to provide administrative support to the Chair and members. This will include agreement of the agenda with the Chair and Executive lead, collation and circulation of papers, producing the minutes of the meetings, recording agreed actions and follow up, and advising the Chair and members as appropriate.

6. Frequency of meetings

6.1 Meetings will be held four times a year, with an additional meeting to review the Annual Reports and Accounts.

6.2 The Chair may convene additional meetings if necessary to consider business requiring urgent attention.

6.3 At least once a year, members of the Group Audit Committees in Common will meet with the Internal Auditors, External Auditors and the Local Counter Fraud Specialist without any others present.

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6.4 To assist in the management of business over the year, an annual workplan will be maintained detailing the main items of business to be considered at each scheduled meeting.

7. Reporting

7.1 A report will be presented to the next meeting of the Group Board following each meeting of the Group Audit Committees in Common to draw attention to any matters that require disclosure or escalation to the Group Board.

7.2 The Trusts' Annual Reports will include a section describing the work of the Group Audit Committees in Common in discharging its responsibilities.

8. Duties and responsibilities

Governance, risk management and internal control

8.1 The Group Audit Committees in Common will review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisations' activities (clinical and non-clinical), that supports the achievement of the organisations' objectives.

8.2 In particular, the Group Audit Committees in Common will review the adequacy and effectiveness of:

- The Group's Risk Management Strategy and Policy and other systems of control.
- All risk and control related disclosure statements (in particular the Annual Governance Statements), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Group Board.
- The underlying assurance processes that indicate the degree of achievement of the organisations' objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider Licence.
- The policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

8.3 In carrying out this work, the Group Audit Committees in Common will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

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8.4 This will be evidenced through the Group Audit Committee in Common's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

8.5 As part of its integrated approach, the Group Audit Committees in Common will have effective relationships with other key committees, including the Group Risk Assurance Committee, so that it understands processes and linkages.

Internal Audit

8.6 The Group Audit Committees in Common will ensure that there is an effective internal audit function that meets the Global internal audit standards, 2017 and provides appropriate independent assurance to the Group Audit Committees in Common, the Group Chief Executive as Accounting Officer and the Group Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisations as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response) and ensuring coordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisations.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit

8.7 The Group Audit Committees in Common will review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Group Audit Committees in Common will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Make recommendations to the Council of Governors of the three Trusts regarding the appointment, reappointment, termination of appointment and fees of the External Auditor.
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

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- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other assurance functions

8.8 The Group Audit Committees in Common will review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisations.

8.9 These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

8.10 In addition, the Group Audit Committees in Common will review the work of other committees within the organisations, whose work can provide relevant assurance to the Group Audit Committees in Common's own areas of responsibility. In particular this will include any committees covering safety/quality, for which assurance from clinical audit can be assessed, and risk management.

Counter Fraud

8.11 The Group Audit Committees in Common shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

8.12 With regards to the local counter fraud specialist, it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Management

8.13 The Group Audit Committees in Common will request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

8.14 The Group Audit Committees in Common may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

Financial reporting

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8.15 The Group Audit Committees in Common will monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

8.16 The Group Audit Committees in Common should ensure that the systems for financial reporting to the Group Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

8.17 The Group Audit Committees in Common will review the annual reports and financial statements before submission to the Boards of Directors of the three Trusts, focusing particularly on:

- The wording in the Annual Governance Statements and other disclosures relevant to these terms of reference.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Explanations for significant variances.

8.18 Review the Annual Reports and Accounts of the three Trusts' Charitable Funds, and the associated reports to management and letters of representation, ahead of submission to the Boards of Directors of the three Trusts (acting as corporate trustee).

Systems for raising concerns

8.19 The Group Audit Committees in Common will review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisations (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

Governance regulatory compliance

8.20 The Group Audit Committees in Common shall review the operation of, and proposed changes to, the Standing Orders, Standing Financial Instructions (including single tender waivers) and Schemes of Reservation and Delegation.
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8.21 The Group Committee in Common shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and Codes of Conduct.

8.22 The Group Audit Committees in Common will satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

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9. Review of effectiveness

9.1 The Group Audit Committees in Common will undertake an annual review of its effectiveness which will inform the review of the terms of reference and the work programme of the Group Audit Committees in Common.

10. Review of terms of reference

10.1 The terms of reference will be reviewed by the Group Audit Committees in Common and approved by the Boards of Directors of the three Trusts annually.

Date approved by the Boards of Directors:

Next review date:

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GROUP STRATEGY, TECHNOLOGY, INVESTMENTS AND PARTNERSHIPS COMMITTEE

TERMS OF REFERENCE

1. Introduction

1.1 The Norfolk and Waveney University Hospitals Group (NWUHG) Strategy, Technology, Investments and Partnerships Committee is a formally constituted committee of the Group Board of Directors (the General Purpose Joint Committee), established under the Provider Collaboration Agreement[1] and the Constitutions of the three NHS Foundation Trusts[2].

1.2 The Committee has no powers other than those specifically stipulated in these Terms of Reference.

2. Purpose and function

2.1 A key role and responsibility of the Group Board is to formulate the vision, mission and purpose of the Group and its constituent Trusts and to agree the organisational and clinical strategy to deliver these.

2.2 The purpose of the Group Strategy, Technology, Investments and Partnerships Committee is to provide oversight, gain assurance and make recommendations to the Group Board (and the Boards of Directors of the three Trusts where applicable) on the implementation of the Group's vision for change and organisational and clinical strategy, as approved by the Group Board; the development and delivery of the Group's supporting strategies, including in relation to digital and estates infrastructure; and all significant investments, joint ventures, partnerships and commercial arrangements entered into by the Group and/or trusts, ensuring that they are aligned to the clinical strategy, deliver value for money and appropriately manage risk.

2.3 In undertaking this role, the Committee will receive reports from The Design Authority which is responsible for ensuring alignment and coherence across the key programmes of work intended to deliver the organisational and clinical strategy.

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.

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[1] Provider Collaboration Agreement for the purpose of establishing Norfolk and Waveney University Hospitals Group joint working arrangements and appointment of a General Purpose Joint Committee to exercise joint functions, 23 October 2025.
[2] Norfolk and Norwich University Hospitals NHS Foundation Trust, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and James Paget University Hospitals NHS Foundation Trust.

- 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:

- Group Chair
- Five Group Non-Executive Directors
- Group Chief Executive
- Group Chief Finance Officer
- Group Chief Medical Officer

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

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

4.4 The Group Chief Transformation Officer, the Group Director of Digital and the Group Director of Communications and Engagement will be invited to attend all meetings of the Committee but will not be members.

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 four members, comprising two Group Non-Executive Directors and two Group Executive Directors. In exceptional circumstances, an Executive Director member may send an appropriate nominated deputy in their place and this will count towards the quorum.

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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

The Design Authority

9.1 Receive reports from The Design Authority which is responsible for ensuring alignment and coherence across the key programmes of work designed to deliver the organisational and clinical strategy.

Business cases

9.2 Review business cases for investments above £5 million and make recommendations for approval (or otherwise) to the Group Board.

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9.3 Review expenditure or contractual commitments above £5 million and make recommendations for approval (or otherwise) to the Group Board.

9.4 Seek assurance on the realisation of benefits associated with previously-approved major business cases.

Joint ventures and partnership agreements

9.5 Scrutinise any proposals to establish or enter into Joint Venture or Subsidiary arrangements ahead of consideration by the Group Board.

9.6 Scrutinise any proposals to enter into significant Partnership Agreements ahead of consideration by the Group Board.

Estates infrastructure

9.7 Monitor and oversee the development and implementation of the Group's estates strategy.

9.8 Seek assurance on behalf of the Group Board on the effectiveness of the governance and risk management arrangements in place for the two new hospitals programmes as part of the national New Hospital Programme (NHP).

Digital infrastructure

9.9 Monitor and oversee the development and implementation of the Group's digital strategy.

9.10 Seek assurance on behalf of the Group Board on the effectiveness of the governance and risk management arrangements in place for the new Electronic Patient Record (EPR) programme across the three trusts.

9.11 Seek assurance on behalf of the Group Board on organisational cyber security compliance and resilience.

Other major strategic programmes

9.12 Seek assurance on behalf of the Group Board on the effectiveness of the governance and risk management arrangements in place for other major Group/Trust programmes identified by the Group Board which are aligned to the delivery of the organisational and clinical strategy.

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.

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.

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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: