Group Board (GPJC) Meeting in Public (Part A)

Wed 17 December 2025, 09:30 - 11:30

NNUH Boardroom located on Level 4 West Block, Colney Lane, Norwich NR4 7UY

The quorum for the General Purpose Joint Committee (GPJC), also referred to as the Group Board, is defined as follows:

1. **Minimum Attendance**: At least seven (7) voting members must be present for the meeting to be quorate.
2. **Composition**:
   - At least four (4) Non-Executive Directors must be in attendance.
   - At least three (3) Executive Directors must be present.
3. **Deputies**: Nominated deputies authorised by the Chair may count towards the quorum.

If the quorum is not met, the meeting may proceed if those attending agree, but no decisions can be made. This ensures that decisions are made with adequate representation from both Non-Executive and Executive Directors.

Agenda

09:30 - 09:33
3 min

1. Chair's Welcome

Formalities *Chair*

09:33 - 09:33
0 min

2. Apologies for Absence

09:33 - 09:33
0 min

3. Declarations of Interest

To declare any actual, potential, or perceived interest relating to items on the agenda. The Chair and Secretary will consider whether any of the declared interests require management of potential conflicts.

09:33 - 09:38
5 min

4. Minutes of Previous Meetings

Approval *Chair*

This is the inaugural meeting of the Group Board (General Purpose Joint Committee)

4.1. JPUH Board Minutes

Approval *Chair*

- 26 September 2025

4.1 JPUH Minutes_Board of Directors Meeting in Public (Part A)_26.09.2025.pdf (13 pages)

4.2. NNUH Board Minutes

Approval *Chair*

- 24 September 2025

4.2 Unconfirmed NNUHTB minutes in public 24.09.2025 V2.pdf (6 pages)

4.3.
QEHKL Board minutes

Approval *Chair*

- 25 September 2025

4.3 Draft Minutes - Board of Directors Public 25.09.25 (Final Board) rev by CB.pdf (13 pages)

09:38 - 09:46
8 min

5.
Chair's Report

Briefing *Chair*

09:46 - 09:54
8 min

6.
Chief Executive's Report

Briefing *Chief Executive*

6 Group Chief Executive Report to Board of Directors - PUBLIC_Draft_V2.pdf (7 pages)

09:54 - 10:06
12 min

7.
Board Committee Reports

7.1.
Group Audit Committees in Common

Assurance *Committee Chair*

27 November 2025

7.1 GACiC Chairs 3As Report Group Audit Committees in Common 19 November 2025.pdf (4 pages)

7.2.
Group Risk Assurance Committee

Information *Committee Chair*

19 November 2025

7.2 GRAC Chair’s 3As Report – Group Risk Assurance Committee 27 November 2025.pdf (4 pages)

7.3.
Group Executive Meeting

Assurance *Chief Executive*

7.3 Group Executive Meeting Chair's Report to Group Board_FINAL.pdf (2 pages)

10:06 - 10:06
0 min

8.
Performance Reports

8.1.
Group Integrated Performance Report

For Review *Group Chief Delivery Officer*

8.1 Group Board IPR - Oct 25 MASTER.pdf (46 pages)

8.2.
Group Finance Report

For Assurance *Group Chief Finance Officer*

8.2 Group Finance Report M7 - Board template.pdf (3 pages)
8.2. Group Finance Report M07.pdf (8 pages)

8.3.
Constituent Foundation Trust Update Reports

8.3.1.
James Paget University Hospitals NHS FT

For Review *Executive Managing Director JPUH NHS FT*

8.3.1 JPUH EMD Report to Group Board (GPJC) 2025-12-17.pdf (5 pages)

8.3.2.
Norfolk and Norwich University Hospitals NHS FT

For Review *Executive Managing Director NNUH NHS FT*

8.3.2 NNUH EMD Report to Group Board (GPJC).pdf (3 pages)

8.3.3.
Queen Elizabeth Hospital King's Lynn NHS FT

For Review *Executive Managing Director QEHKL NHS FT*

8.3.3 QEH EMD Report to Group Board (GPJC) December 2025.pdf (6 pages)

10:06 - 10:14
8 min

9.
Emergency Preparedness, Resilience, and Response Core Standards

For Assurance *Group Chief Delivery Officer*

To receive the report of the Group Chief Delivery Officer

9 Joint Emergency Preparedness Resilience and Response (EPRR) Report.pdf (6 pages)

10:14 - 10:29
15 min

10.
Board Governance Documentation

10.1.
NWUHG Directors' Code of Conduct

Adoption *Group Secretary*

To approve and adopt the Directors' Code of Conduct

10.1 NWUHG Directors' Code of Conduct Cover Sheet.pdf (3 pages)
10.1. NWUHG-GPJC-Code-001 - The Directors' Code of Conduct for the Norfolk and Waveney University Hospitals Group.pdf (5 pages)

10.2.
Board Committee Terms Reference

10.2.1.
Group Audit Committees in Common Terms of Reference

Approval *Group Secretary*

10.2.1 Group Audit CiC Terms of Reference Cover Sheet 2025-11-17.pdf (1 pages)
10.2.1 NWUHG Group Audit Committees in Common Terms of Reference.pdf (11 pages)

10.2.2.

Group Nomination and Remuneration Committees in Common Terms of Reference

Approval *Group Secretary*

- 10.2.2 Group N&R CiC Terms of Reference Cover Sheet 2025-11-17.pdf (1 pages)
- 10.2.2. DRAFT NWUHG Group Nomination and Reumneration Committees in Common Terms of Reference.pdf (6 pages)

10.2.3.
Group Risk Assurance Committee Terms of Reference

Aproval *Group Secretary*

- 10.2.3 Group Risk Assurance Committee Terms of Reference Cover Sheet 2025-11-17.pdf (1 pages)
- 10.2.3. GRAC - NWUHG Terms of Reference – Group Risk Assurance Committee (GRAC) 2025-09-06.pdf (8 pages)

10:29 - 10:29
0 min

11.
Group Board Calendar

To Note *Group Secretary*

Confirmation of Board meeting dates, times, and venues for the remainder of 2025-16 Financial year, and the full 2026-27 FY.

Date	Location/Trust	Room
04 February 2026	QEHKL	Board Room, QEHKL
01 April 2026	JPUH	Lecture Theatre, Burrage Centre, JPUH
03 June 2026	NNUH	Board Room, NNUH
05 August 2026	QEHKL	Board Room, QEHKL
07 October 2026	JPUH	Lecture Theatre, Burrage Centre, JPUH
02 December 2026	NNUH	Board Room, NNUH
03 February 2027	QEHKL	Board Room, QEHKL
07 April 2027	JPUH	Lecture Theatre, JPUH

10:29 - 10:34
5 min

12.
Any Other Business

Discussion *Chair*

10:34 - 10:37
3 min

13.
Meeting Review

Discussion *Chair*

10:37 - 10:37
0 min

14.
Date of Next Meeting

4 February 2026 - QEHKL Board Room

10:37 - 10:37
0 min

15.
Close of Meeting

Board of Directors Meeting in Public (Part A)

Friday 26 September 2025, 10:00 - 12:30

MS Teams

James Paget University Hospitals NHS Foundation Trust

Attendees

Board members

Mark Friend (Chair), Sally Collier (Senior Independent Director), Andrea Finegan (Non-executive Director), John Hennessey (Non-executive Director), Stephen Javes (Non-executive Director), Susanne Lindqvist (Non-executive Director), Charlie Helps (Head of Corporate Affairs), Jonathan Barber (Director of Strategy and Transformation), Vivek Chitre (Chief Medical Officer), Jacqueline Copping (Chief Nurse), Charlotte Dillaway (Chief Operating Officer), Lesley Dwyer (Group Chief Executive), Mark Flynn (Director of Strategic Projects), Sarah Goldie (Director of People and Culture), Shane Gordon (Executive Managing Director), Edmund Taylor (Chief Finance Officer), Jayne Geddes (Executive Assistant (Minutes))

Absent: Caitlin Notley (Non-executive Director), Jason Selvarajah (Non-executive Director), Sarah Whiteman (Non-executive Director)

Attendees

Lorraine Beattie (SERCO), Russell Edwards, Justine Goodwin (Head of Neonatal & CYP Services)

The quorum required for the Trust Board of Directors is one third of the whole number of the Directors appointed, including one Non-executive Director, and one Executive Director. An Officer in attendance for an Executive Director without formal acting up status shall not count towards the quorum.

Meeting minutes

1. Introduction

Meeting Formalities

1.1. Chair's Welcome and Apologies for Absence

To Note

The Chair opened the meeting by highlighting that this is the last James Paget board meeting in its current form and membership, due to the transition to a new group structure. He emphasised the importance of ensuring that outstanding items and actions are not lost during this transition, stating that these will be passed to the hospital leadership team, the group board, or relevant committees as appropriate. He assured attendees that he and Leslie Dwyer (LD) would take responsibility for making sure nothing is dropped, and that there will be a clear process for handing over ongoing actions and issues. He clarified that not every item would be itemised in this meeting, but the transition plan is in place to maintain oversight. The Chair checked for understanding and agreement from the board, confirming that everyone was clear on the process and next steps.

The apologies were noted.

The Chair welcomed Justine Goodwin, Head of Neonatal and CYP Services.

1.2. Declarations of Interest

To Note

There were no new declarations of interest or any interests in relation to matters on the agenda.

2. Staff and Patient Experience Programme

Stakeholder Engagement

2.1. Departmental Presentation - Paediatrics

Staff Engagement

Justine Goodwin, Head of Neonatal and Children and Young Peoples Services delivered a presentation to the board, "Walking Together" – which emphasised the importance of integrated care between hospital acute services and community services for children and young people.

Key Points:

- Described the two main services: hospital acute (urgent care, surgery, specialist) and community (long-term support at home).
- Highlighted the unique local integration at James Paget, enabling streamlined, continuous care for children, especially those with complex needs.
- Shared a case example of a young person discharged from an out-of-area hospital, illustrating the benefits of local, integrated paediatric specialties.
- Stressed the value of joint working (e.g., community nursing, physio, OTs, dietitians, paediatricians) to reduce care gaps, empower families, and prevent unnecessary hospital visits.
- Noted national direction for integration and how James Paget is already building bridges, not walls, between services.
- Closed with the message: integrated care is "simple, safe, human" and central to the hospital's vision for children's services.

The Chair asked about opportunities for improvement and what support paediatrics needs. Justine Goodwin noted that paediatrics often feels like the "poor relative" and is sometimes forgotten. Requested that board members always "think paediatrics" in all discussions, regardless of specialty, to ensure children's needs are not overlooked.

Jacky Copping (JC) asked about transition arrangements for children with complex needs moving to adult services. Justine Goodwin responded that transition is a major challenge. Some services (e.g., diabetes, gastro) have good transition processes, but many do not. Highlighted issues with neurodiverse children aging out of waiting lists and lacking adult services, and the need for better coordination with the ICB. Stephen Javes (SJ) noted the extensive discussions held in the Board to Ward meeting earlier and the need for executive action on transition, as current arrangements are "piecemeal."

Susanne Lindqvist (SL) asked why, despite longstanding awareness, integration between acute and community services is still not fully realised, and whether students on placement learn about integrated working. Justine Goodwin advised that JPUH unique structure (all under one umbrella) allows for better continuity, but national systems often force families to "start again" with each referral. For students, joint clinics and school-based care demonstrate the benefits of integrated, child-centered care.

JH praised the work and warned against losing focus on paediatrics in the new group structure, emphasising the value of early investment in children's services.

Vivek Chitre (VC) raised the issue of transition to adult services, referencing NICE guidance and a recent gap analysis showing significant work still needed, noting that HMG (Hospital Management Group) will need to continue holding the division accountable for progress on transition services.

JC asked about staff supervision and debriefing in paediatrics. Justine Goodwin advised immediate and formal debriefs are standard after any tragic event; peer support is strong, and the team finds paediatrics a fun and rewarding place to work.

The Chair reiterated the importance of not forgetting paediatrics and acknowledged the inspiration from the team's work.

3. Minutes and Matters Arising

For Approval

3.1. Minutes

For Approval

The Chair asked for comments on the previous minutes.

Sally Collier (SC) requested the following amendment:

- 5.1 Patient Safety and Quality Committee - press to be amended to pressure.

JC requested the following amendments:

- 5.3 penultimate bullet point "Revision" to be amended to Rebanding.
- 8.1 first paragraph last sentence to be amended "...agency fill has reduced..."
- 8.1 second paragraph, third sentence to be amended "...mainly for poor enhanced supervision capacity and RN gaps."

The Chair thanked everyone for their attention to detail and, subject to the above changes, asked for approval of the minutes. The board approved the minutes of 25 July 2025.

3.2. Action Log

For Review

The Chair noted the two Chief Nurse actions were closed.

Shane Gordon (ShG) updated on the BAF (Board Assurance Framework) action, stating that with the new group board, they would not revise BAF risks at this time but would ensure the action is addressed in the new process.

The board agreed to close the actions, with the understanding that the BAF action would be transferred to the new group structure.

4. Chair's, Chief Executive's, and Managing Director's Updates

To Note

4.1. Chair's Update - Verbal

Briefing

The Chair extended thanks to the board, reflecting on his involvement since October 2023 and highlighting the strong patient focus at James Paget. He emphasised the importance of balancing patient care and staff well-being during the ongoing organisational changes and transition to the group structure. He reiterated the need for the board to remain attentive to patient needs, staff welfare, and collaboration with other organisations as the group model is implemented. He stressed the importance of listening to staff and communities during this period of change.

4.2. Group Chief Executive's Update

Briefing

Lesley Dwyer (LD) reported that although James Paget and NNUH were not among the 14 trusts selected for the national maternity and neonatal review led by Baroness Amos, the group will closely monitor the review's findings at Queen Elizabeth Hospital (QEH) and apply relevant learning across all three trusts. She explained the selection criteria for the review and emphasised the importance of cross-trust support and shared learning, especially given QEH's recent challenges.

LD discussed the announcement of a new "model region" and the appointment of a regional chief executive, likening the structure to former strategic health authorities but with some differences. She noted the ICB's new executive team and anticipated renewed focus on key projects as the ICB moves past its internal restructuring.

LD referenced the letter from Jim Mackey outlining clear priorities for the rest of the year and described the upcoming mid-year review at group level, which will include representation from each trust. She highlighted the high level of scrutiny for trusts in receipt of deficit funding, with frequent finance meetings and close monitoring of end-year results.

LD stressed that recent ratings (e.g., NOF results) do not define the trusts, and that recovery will depend on improved staff engagement and a unified focus on improvement. She noted the importance of understanding staff sentiment through surveys and adapting support accordingly.

LD acknowledged the transition to the new group board, thanked non-executive directors and executive teams for their work, and highlighted the increasing alignment and sharing of best practices across the three boards. She specifically thanked Stephen Javes (SJ) for his support as Vice Chair and recognised Shane Gordon (ShG) for bringing a fresh perspective and addressing longstanding issues.

4.3. Executive Managing Director's Update

Briefing

ShG thanked board members and executive colleagues for their support and dedication, especially during the transition to the new group board. He acknowledged the long service of many and the contributions of non-executive directors who may be stepping down.

ShG highlighted ongoing innovation, including the Virtual Fracture Clinic and the opening of the Northgate Community Diagnostic Centre, which improves diagnosis speed, especially for cancer. He also mentioned the upcoming same day emergency care unit, expected to enhance patient safety and flow during winter.

ShG reported the organisation has reintroduced regular face-to-face staff briefings, with over 100 staff attending, and alternating with online briefings. Content is driven by staff questions, aiming for open dialogue and improved engagement.

ShG addressed the need to reduce non-clinical workforce growth through a voluntary redundancy scheme, acknowledging the stress and uncertainty this creates for affected staff and teams. He emphasised the importance of returning resources to an affordable level and becoming a leaner, more efficient organisation.

ShG noted high patient demand, increasing complexity, and the challenge of maintaining staff morale amid financial constraints and high workloads. He referenced ongoing staff well-being programs and anticipated that these efforts would be reflected in the upcoming staff survey, though he expected challenges across the NHS.

ShG flagged anticipated high levels of respiratory illness (influenza, RSV, COVID) based on Australian data, stressing the importance of staff vaccination to protect both staff and patients.

ShG described the benefits of the new group model, including opportunities for service improvement and innovation through collaboration. He cited the example of virtual wards for pregnant women with severe sickness, developed at NNUH and now being adopted at James Paget, as evidence of early group-level benefits.

The Chair commented on the importance of virtual wards and the need for specialist connection regardless of location, noting the frustration when such connections are lacking. ShG agreed, highlighting the power of bringing specialists to patients' homes and the need for improved connectivity.

5. Board Committee Chairs' Reports

For Assurance

To note the reports for assurance.

5.1. Patient Safety and Quality Committee

For Assurance

Vivek Chitre (VC) provided the following update of the meetings held on 19 August 2025 and 16 September 2025.

- **Assurance:** Sufficient assurance on safety and quality from the integrated performance report, except for stroke performance (due to missing data). End of life care and maternity showed improvement; partial assurance on risks due to transition to a new risk system.
- **Alerts:** Highlighted difficulties in the complaints team affecting timely complaint management; requested direction on delegated objectives for the new assurance group.
- **Advice:** Digital clinical safety strategy deferred for further information; recommended continuing the practice of hearing the patient voice at board meetings.

The Chair agreed to address complaints escalation during the IPR/BAF section.

5.2. Finance and Performance Committee

For Assurance

Susanne Lindqvist (SL) provided the following update of the meetings held 20 August 2025 and 17 September 2025.

- **Assurance:** Improvement in 4-hour ED performance (though September saw deterioration); virtual ward and non-criteria to reside performance positive; cancer and diagnostics partly assured; Cora Health introduction positive; 65/78-week waits and length of stay remain concerns.
- **Financials:** Agency spend and savings ahead of plan; capital programme behind plan; ERF income behind plan.
- **Alerts:** 65-week waits worsening; tier one status for elective/diagnostics; ERF behind plan; EPR go-live date and procurement compliance flagged as risks.
- **Advice:** Suggested external peer review for the Premises Assurance Model; encouraged empowering staff for discharge decisions; recommended a multi-year capital plan and radical options for financial recovery.

The Chair clarified EPR and procurement issues would be discussed in private; Sally contextualised the advice on empowering staff.

5.3. People and Culture Committee

For Assurance

Stephen Javes (SJ) provided the following update of the meetings held 21 August 2025 and 17 September 2025.

- **Assurance:** Substantive assurance on safe working and appraisal/revalidation; reasonable assurance on BAF, risk register, IPR, Freedom to Speak Up, nursing establishment, staff well-being, staff experience, and education plans.
- **Alerts:** Sickness trends above target (short-term sickness problematic); poor appraisal returns; negative pulse survey results (communication and management support); redundancy programme underway.
- **Closure Meeting:** Escalated BMA industrial action, need for group-wide Freedom to Speak Up approach, maternity shared learning, nursing profiles, group staff identity, staff engagement, and leadership capacity.

5.4. Audit Committee

For Assurance

John Hennessey (JH) provided the following update of the meeting held 18 September 2025.

- **Assurance:** BAF stabilised but in transition; risk register improved but needs timely updates and management training on new scoring; reasonable assurance on health and safety audit; audit actions nearly all complete.
- **Alerts:** Slight delay in audit report timetables; need to catch up by Q3; counter fraud cases need quicker closure and lesson learning.
- **Other:** Losses/compensation payments reviewed; noted reduction in write-offs but possible timing delay.

The Chair noted the upcoming group audit committee in common.

6. Risk and Board Assurance

6.1. Board Assurance Framework Report

For Review

ShG stated that no significant changes were made to the BAF structure or focus this month, as the transition to the group BAF is pending. He noted that a refresh of risk appetite and tolerance will occur at group level. No changes to risk ratings were reported.

The Chair asked about the absence of “efficiency” as a control or investigation line within the operational capacity section of the BAF, referencing anecdotal differences in efficiency pre- and post-COVID. ShG responded that efficiency is embedded within second-line controls such as improvement and remedial plans, which cover productivity, outsourcing, insourcing, and waiting list initiatives. He agreed it is not explicitly listed but is part of the approach.

7. Performance

7.1. Integrated Performance Report

Quality & Safety

JC reported:

- Highlighted eight missed quality and safety metrics.
- Noted continued absence of stroke SNAPS data, expected in October, and explained changes in national reporting and implications for interpreting future data.
- Reported an increase in 12-hour mental health waits in ED, with a record number of patients waiting for mental health beds, and ongoing work to address this.
- Addressed the significant complaints backlog, described the recovery plan (including mutual aid from the ICB and internal process changes), and provided updated figures showing improvement but warned of ongoing capacity challenges and the need for frequent review.
- Mentioned improvements in pressure ulcer and falls metrics due to renewed focus on harm prevention fundamentals.

VC reported:

- A slight drop in VTE (venous thromboembolism) compliance, attributing it to the transition from a paper-based to a digital process, and stated this would be monitored to ensure a return to compliance.
- Mortality rates, confirming the trust remains “as expected” but highlighted that other local trusts (Norfolk and Norwich, QEH) have moved to “more than expected” mortality. He emphasised ongoing focused work on secondary malignancies, sepsis, and acute respiratory infections, including audits and action plans.

LD asked about C. diff discrepancies between IPR and NOF scoring; JC suggested it may be due to trajectory definitions and will investigate further.

SJ welcomed the approach to complaints and asked about mental health support access for patients following a recent contact with a family; JC clarified that while anecdotal access issues are heard, these are primarily NSFT’s responsibility, and she would follow up with the mental health matron for more detail.

The Chair asked about the effectiveness of the relationship with NSFT (Norfolk and Suffolk Foundation Trust) regarding mental health support in ED, referencing a patient who waited overnight for mental health assessment. ShG stated that NSFT is generally collegiate and responsive, especially when issues are escalated, but acknowledged resource constraints and the challenges when mental health patients are in acute hospital care rather than dedicated mental health settings. Charlotte Dillaway (CD) explained that escalation processes with NSFT work effectively, but noted that NSFT manages many patients in the community and cannot always prioritise the small number in ED. She described regular meetings with NSFT’s interim COO and locality director to maintain integration and address bottlenecks.

Sally Collier (SC) strongly recommended tackling complaints at group level and exploring modern approaches; LD agreed and praised the progress on complaints backlog but stressed the importance of empowering staff to resolve issues in the moment.

Operational Performance

CD reported:

- **Cancer Performance:** Performance remained static, with FDS (Faster Diagnosis Standard) and 62-day treatment standards off trajectory. Main issues were in gynaecology (histology delays), urology (equipment failure, now resolved), and colorectal (clinical review delays, now improving). Joint work with the Cancer Alliance and NNUH for histology capacity is ongoing.
- **Emergency Department (ED):** Four-hour performance dropped in August but recovered in September. ECIST (national improvement support) is on site to help improve non-admitted performance and winter readiness. Ambulance handover times are broadly on plan, but reducing 30+ minute handovers remains a focus.
- **Elective Performance:** Challenges persist in eliminating 65-week waits, especially in gynaecology, urology, and ENT. Remedial action plans are in place, and additional capacity has been approved for some specialties.
- **Diagnostics:** Performance is below target and deteriorating, mainly due to non-obstetric ultrasound waits. Additional capacity has been brought online, but full recovery by year-end is not expected.

- **Patient Flow:** Correction noted in the report: non-elective length of stay is static; elective length of stay fell below three days.

The Chair asked about the underlying factors affecting operational plan delivery and what will make the difference in recovering performance, including whether issues are due to sickness, strike action, or other factors. CD explained that performance challenges are multifactorial, including limited resilience as a small DGH, the impact of turning off additional elective capacity due to funding changes, and the need to better understand and optimise core capacity and productivity. She noted that cultural and engagement issues vary by specialty. ShG emphasised that operational performance is under intensive internal and external scrutiny, with ongoing support and oversight from regional and national teams.

SC asked about the reliability of virtual ward occupancy figures and whether the right patient acuity is being managed. CD clarified that virtual ward occupancy can be maintained, but the focus should shift to ensuring the right acuity of patients are managed, not just occupancy numbers. Work is ongoing to align virtual ward criteria across the system.

LD stressed the importance of leveraging group working to improve operational performance, sharing best practices, and maximising mutual aid.

People & Culture

Sarah Goldie (SG) reported:

- **Turnover:** Remains low and compares favourably to national/regional benchmarks. However, organisational change may limit opportunities for staff movement and engagement.
- **Mandatory Training:** Above target overall; face-to-face training is improving, especially in one subject area, with successful actions being shared across other subjects.
- **Appraisals:** Non-medical appraisals are below target but improving, especially in corporate services. Confidence expressed in reaching target by year-end.
- **Sickness Absence:** Major concern, especially short-term sickness. Long-term sickness is improving, contributing to a reduction in monthly rates. New sickness absence policy and focused return-to-work discussions are being implemented.
- **Staff Well-being:** Relaunch of staff well-being champions and training in trauma risk incident management (TRIM) as part of the new well-being plan.

SC asked for clarification on sickness absence figures, noting a discrepancy between annualised and monthly rates, and questioned the significance of the monthly reduction. SG clarified the difference between annualized (5.9%) and monthly (5.3%) sickness rates, noting the monthly drop is driven by closing long-term cases, not short-term absence.

SC asked what specific actions leaders are being asked to take to reduce short-term sickness. SG outlined two key leadership actions: (1) day-to-day supportive management and understanding staff barriers, and (2) managing sickness with quality discussions, timely support, and consistent policy application.

Finance

Edmund Taylor (ET) report:

- **Financial Position:** At month 5, the Trust delivered a £0.5m surplus in August, resulting in a £0.3m favourable variance against plan. However, the year-to-date deficit is £2.2m, and the position is underpinned by £19m deficit support funding. The underlying deficit remains significant at £21.4m.
- **Efficiency Delivery:** £0.8m ahead of plan, reflecting strong cost control. Bank and agency reduction targets are being overachieved.
- **Financial Risks:** Main risks are delivery of the £25.9m efficiency plan and a £2.9m shortfall in Elective Recovery Fund (ERF) income, which is currently being offset by underspends elsewhere.
- **Recovery Plan:** A recovery plan for ERF income is in place and being tracked weekly, showing delivery on trajectory so far.

SC congratulated ET and the team for the current position against plan and asked about the steep reduction in deficit forecasted between months 7–9 and how ready the Trust is to achieve this. ET expressed confidence in the Trust's readiness to meet the challenging forecast, citing the financial recovery plan and manageable acceleration in efficiency delivery.

SJ asked about the future of deficit support funding post-2026/27 and its implications for the Trust. ET clarified that planning is underway for a future without deficit support funding, with a coordinated medium-term financial plan across the group. The underlying deficit for next year is £21.4m, inclusive of current support.

7.2. Seasonal Resilience Plan

Information

CD reported the plan responds to the winter letter and annual operational requirements, with board approval required for the assurance statement. Hospital Management Group requested further modeling on infection prevention and control (IPAC) and identification of areas for outbreak management. Ward 22 will be used as the escalation ward. The new Same Day Emergency Care facility is expected to open at the end of October, anticipated to improve patient flow, experience, outcomes, and reduce admissions/length of stay. The plan has been reviewed by the Group Chief Delivery Officer, with all comments incorporated.

JH praised the plan's early preparation and robustness compared to previous years.

The Chair asked about the absence of explicit performance trajectories (e.g., four-hour and 12-hour standards) in the papers, referencing another trust's approach. CD confirmed that ambulance handover and four-hour standard trajectories are included and acknowledged they are ambitious; ECIST is supporting improvement in these areas.

SL expressed excitement about the schemes and suggested a future review of preparedness and success post-winter.

SC questioned the reliability of the virtual ward occupancy statement, noting previous blips in maintaining the 95% target. CD stated confidence in maintaining virtual ward occupancy, but noted the need to focus on patient acuity rather than just numbers, and described ongoing work to align virtual ward criteria across the system.

LD asked if the national improvement body (ECIST) would review the plan to ensure recommendations are connected and actionable. CD agreed to have ECIST review the plan and ensure recommendations are integrated, not duplicative.

The Board approved the plan, subject to finalising performance trajectories for March (four-hour and ambulance handover standards).

7.3. Q1 Regional Assessment of Performance and Q2 Tiering Outcome Letter

Information

CD reported the Q1 regional assessment and Q2 tiering outcome letter were presented for noting, as this was the first board meeting after their release. There was a correction: the letter incorrectly stated the Trust was tiered for cancer performance, but the actual tiering was for elective and diagnostics (tier one), and for urgent and emergency care (UEC) for this quarter.

SC questioned the summary's statement that NHS England had concerns about several deteriorating metrics "without clear plans to improve the position," expressing surprise as the board had been reviewing plans. CD clarified that the statement was a direct quote from the NHS England letter and explained that while the Trust has plans, NHS England is not yet assured of their robustness. She noted ongoing regular conversations with the region to provide assurance on remedial actions.

The Board noted the paper and the correction to the letter.

8. Quality, People, and Finance

8.1. Chief Nurse Staffing Report

Assurance

JC reported registered nurse and midwife shift fill remains below 90%, actually under 84% for August, indicating ongoing staffing challenges. Temporary staffing (bank/agency) is above 90%, but there is a significant gap between overall shift fill and temporary staff coverage, with a plan vs. actual gap of nearly 13,500 nursing hours (over 1,100 shifts). Registered nurse vacancies are stable at 35, but maternity leave more than doubles the effective gap in capacity. All newly qualified nurses and midwives have been offered posts, with further cohorts expected in December, January, and February. Red flag reporting saw a change, with Red Flag 9 overtaking Red Flag 8 for the first time, possibly due to improved reporting. No pipeline exceptions, but a future gap is anticipated for nursing associates as the last cohort qualifies next year; a proposal will be brought to address band 4 workforce needs. The direct entry scholarship programme lost half its applicants, prompting a review to understand the reasons. Work experience applications are strong, with over 100 received. The annual safe staffing and nurse establishment review is underway, with data analysis and professional judgment meetings scheduled for October/November, aiming for submission in December/January.

SJ reminded the board of a potential crisis in 2027, when a gap between new starters and leavers could create significant staffing shortages.

8.2. Annual Review of Standing Financial Instructions and Scheme of Reservation and Delegation

Approval

ET reported the SFI document has been aligned across the ICS providers for several years; the current update is to reflect new group executive roles (e.g., group chief executive, group CFO) and ensure consistency across all three organisations. The SOD is now identical across the three trusts, with anything previously delegated to the chief executive now delegated to the Executive Managing Director, and CFO responsibilities to the site Director of Finance. A full legal review is planned for the following month. The SFI and SOD documents are available in the resource library.

SC asked if there were any changes to commercial and procurement limits in the SFI, specifically regarding contract sign-off thresholds (e.g., contracts over £1 million requiring trust board approval). ET confirmed there are no changes to commercial/procurement limits at this point; the SFI and SOD are now identical across the three organisations, with only minor adjustments (some small decreases in delegation).

The Chair sought clarification on whether the changes would increase the amounts individuals within the hospital can sign off, and if the £1 million threshold for the Executive Managing Director was a change from previous practice. ET confirmed the £1 million threshold for the Executive Managing Director is unchanged from previous practice.

SC further asked if contract sign-off remains with each individual trust board or is delegated to the group. ET clarified that the group board will act as the board for all three trusts, so escalation for contract sign-off will move to the group board, but the process remains essentially the same. LD clarified that while some delegations have increased to ensure consistency at the executive level, it is up to each site to determine further delegation below that level to maintain financial control. The SFI alignment does not automatically increase everyone's limits.

The Board approved the revisions to the Trust SFIs.

8.3. Medical Appraisal and Revalidation Annual Report and Statement of Compliance

Approval

VC reported the annual report and statement of compliance are statutory requirements for the designated body and must be submitted each year. The report had already been reviewed by the People and Culture Committee. Improvements highlighted include mandatory appraiser training via ESR for all new appraisers, introduction of an annual audit cycle for quality assurance, and a new process to address appraiser recruitment challenges. Despite filling four appraiser vacancies, four others retired or semi-retired, so recruitment remains an ongoing process.

SC questioned the reliance on the Freedom to Speak Up (FTSU) service for doctors, noting that doctors rarely use it, and asked if there were plans to address this.   The Chair suggested this issue (doctor voice and transparency) be considered more widely at both hospital and group level as governance evolves.

SC also raised a broader concern about transparency and board-level visibility regarding doctors' fitness to practice, suggesting this should be reviewed for future governance. VC explained that fitness to practice is managed through the Maintaining High Professional Standards (MHPS) process, overseen by the Responsible Officer Advisory Group (ROAG), which includes the Director of People and Culture and the Chief Medical Officer. This process is rigorous, confidential, and includes regular liaison with external advisory bodies (PPAS, GMC).   ShG reiterated that fitness to practice processes are robust, confidential, and externally regulated, and that he is kept apprised of any issues.

The Board approved the annual report and statement of compliance for submission.

8.4. Bi Annual Safe Staffing and Nurse Establishment Review

To Note

JC reported the biannual review was conducted using the Safer Nursing Care Tool and professional judgment, covering the period from February to June. No recommendations for changes to establishment were made in this report. Ward 4 was highlighted as a persistent area of concern regarding its ability to consistently meet patient needs; current risk assessment processes are in place, but escalation may be required in the next full report. Most areas are completing recruitment for uplifted posts from the previous November review, with only activity coordinators on Ward 12 still pending.

JH asked about the table referencing exceptions "awaiting uplift from November 24th review" and requested clarification. JC explained that the exceptions refer to areas where uplifted posts (mainly healthcare assistants) from the previous review are still in the recruitment process, and the timing of the report means some posts are not yet filled. JC confirmed that the only outstanding uplift is for activity coordinators on Ward 12, with recruitment in progress.

The Board noted the paper.

8.5. Patient Safety Incident Response Plan (PSIRP)

JC presented the PSIRP six-monthly review, authored by Barry Pinckney, focusing on how the plan was formulated and the thematic review of incidents from the previous 12 months. The plan outlines four levels of investigation, with Level 1 being the most complex and Level 4 being business as usual. The deteriorating patient theme was a major focus, with over 70 investigations (45 at Level 1) in the first year, leading to a multifactorial action plan. The scope for deteriorating patient investigations has been narrowed for year 2 to focus on three key areas.

The Chair asked about the visibility and emphasis of patient and family voice in the plan, noting it is highlighted in the review but less so in the forward plan, and stressed its importance for a learning organisation and non-defensive culture. JC assured that patient involvement is a key component of all major investigations, with personal contact made by patient safety investigators. She referenced a specific example (Rosie's story) to illustrate the impact of patient voice and described ongoing efforts to increase early, compassionate communication and resolution.

The Board approved the PSIRP.

8.6. Workforce Race and Disability Equality Standards Action Plan

Discussion

SG presented the action plan, which is required annually for board approval, following a detailed performance data review in May. The plan was developed with staff networks and focuses on five areas: improving senior-level diversity, fair recruitment and progression, addressing disciplinary disparities, developing staff networks, and eliminating bullying/harassment with an anti-racism focus. The plan includes specific targets and timelines, with some actions front-loaded for early traction.

SC questioned whether the management team had truly signed up to the ambitious targets, noted some actions were vague, and pointed out that actions were bunched into a short period rather than spread across the year. She asked for assurance that the actions and targets were achievable and supported by the executive. SG responded that the targets are intentionally ambitious but believed to be achievable, and that the actions are part of a wider EDI plan. She explained the rationale for front-loading actions. ShG confirmed the executive team's commitment to the plan, acknowledged the challenge of directly linking actions to outcomes, and emphasised the need for an aspirational approach to achieve equality and diversity improvements.

The Board approved the Workforce Race and Disability Equality Standards Action Plan.

9. Strategy and Business Planning

9.1. NHSE Provider Capability Self Assessment

Decision

Jonathan Barber (JB) introduced the NHSE requirement for all providers to complete a capability self-assessment covering six focus areas, with a submission deadline set by NHSE. The challenge of meeting the deadline was noted due to governance transitions as the organisation moves into a group structure. Group Delivery Officer Jo Segasby is in contact with NHSE to request a possible extension, as NHSE indicated some flexibility on a recent webinar.

JB clarified that each trust is conducting its own self-assessment and requested that the board delegate authority for final sign-off and submission to the Special Purpose Joint Committee (SPJC). The Board approved the delegated responsibility for signing off and submitting the NHSE provider capability self-assessment to the SPJC.

10. Corporate Governance

Nothing for consideration

11. Questions from the Public and Trust Governors

Stakeholder Engagement

Richard Chilvers, a member of the public, submitted a question in advance asked whether the JPUH has to pay for the use of the Carlton Court ward, which is owned by NSFT Trust, to process patient flow. ET thanked Richard Chilvers for submitting the question in advance of the meeting and confirmed that in the previous financial year, the Carlton Court facility cost about £4.5 million to run. He stated that this cost is now fully funded by the ICB for the current financial year. ET added that the payment to NSFT for use of the site is on a "peppercorn rent" basis, meaning the amount is negligible.

12. Meeting Review

12.1. Matters for Consideration by other Entities

For Decision

Nothing to report.

12.2. Reflection

For Discussion

The Chair expressed appreciation for the quality of the meeting and highlighting strong discussion around performance and related plans.

13. Next Meeting

For Information

Not applicable.

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NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 24 SEPTEMBER 2025

Present:	Mr T Spink	- interim Vice Chair
	Prof L Dwyer	- Group Chief Executive Officer
	Mrs T Bleakley	- interim Managing Director
	Dr B Brett	- Medical Director
	Mr C Cobb	- Chief Operating Officer
	Ms R Cocker	- Chief Nurse
	Mr M Shemko	- Head of Data Science
	Ms S Dinneen	- Non-Executive Director
	Prof P Baker	- Non-Executive Director
	Mr J Foster	- Non-Executive Director
	Mrs N Gray	- Non-Executive Director
	Mrs J Hannam	- Non-Executive Director
	Mr M Thorham	- Interim Chief Finance Officer
	Dr U Sarkar	- Non-Executive Director
In attendance:	Mrs E Batchelor	- Assistant to Board Secretary
	Ms A Berry	- Director of Transformation
	Mrs S Sewell	- * Deputy Director of Capital Projects Deputising for Mrs Martin
	Members of the public	

25/038 **APOLOGIES, DECLARATIONS OF INTEREST, AND REFLECTIONS ON VISITS**

Apologies were received from Mrs Gooch, Mrs Martin and Mr Friend No conflicts of Interest were declared in relation to matters for consideration by the Board.

Board members reflected on the recent clinical visit to the critical care area highlighting the exceptional dedication and teamwork demonstrated by the transplant service and supporting teams. Members noted the team's commitment to going above and beyond, the passion and care shown towards patients, families, and donors, and the collaborative effort involving over 20 teams to enable successful organ donations. The Board acknowledged the challenges faced due to operational and financial constraints, the importance of supporting innovation and development within the service, and the need to recognize and celebrate the achievements of all involved.

The Board will formally thank the teams and encourage wider communication of their outstanding work, while also promoting organ donor registration and family discussions.

25/039 **MINUTES OF PREVIOUS MEETING HELD ON 04 JUNE 2025**

The minutes of the meeting held on 04 June 2025 were agreed as a true record for signing by the Chair with minor changes.

25/040 **MATTERS ARISING AND UPDATE ON ACTIONS**

The Board reviewed the Action Points arising from previous meetings as follows:

25/007 – Freedom to Speak up - The Board discussed if freedom to speak up could communicate actions to complaints through-out the Trust and to consider implementing never events for the workforce. Although Mrs Bradfield and Mrs Dawson have been working together on communications the Board noted that the broader organisation may not be aware of change and therefore further efforts are needed to improve communication and ensure the impact of speaking up is widely recognised. The Board asked that Mrs Dawson provide and update at the June meeting.

Action: Closed

25/011 Patient Experience Story - The Board discussed ideas to develop the Youth Forum such as creating a Shadow Board and Youth Governor group and this will be discussed offline to assess viability.

Action: Closed

25/016 Green Plan update - The Board discussed the Green Plan and asked Mrs Goodwin links in with Professor Bakar and Mrs Cocker and the Nutrition and Hydration Steering Group.

Action: Carried Forward Mrs Bleakley

25/030 – Business cases for approval - The Board discussed the financial sustainability of the proposal, including the need to ensure future replacement costs are not solely reliant on charitable funding, and highlighted the importance of capturing both patient and operational benefits in the full business case. The Board also requested that an independent evaluation was added post implementation to track benefits.

Action: Closed

25/041 **GROUP CHAIR REPORT**

The Chair provided an update on the ongoing transition to the full Group model for the three acute hospitals, noting significant progress in governance arrangements and Committee structures. It was reported that, following extensive discussion, the decision was made to extend the transition period by four weeks to ensure all subcommittees are fully established and operational before going live. The tenure of Non-Executive Directors and Vice Chairs will be extended to the end of November to maintain continuity during this period. The Chair acknowledged the considerable work undertaken by all involved and highlighted the ongoing evolution of governance processes, with assurance that substantial progress has been made.

25/042 **CHIEF EXECUTIVE REPORT**

Professor Dwyer presented a comprehensive report covering national, regional, and local developments. The Board was updated on the recent publication of hospital rankings, noting disappointment with the results but confirming that improvement plans are in place for each hospital, with a focus on cancer backlog, elective waits, and urgent care performance. Professor Dwyer highlighted the Queen Elizabeth's inclusion in a national maternity and neonatal investigation, the rationale for its selection, and the importance of shared learning across the Group. The Board was informed of a recent unannounced CQC visit to James Paget, with no immediate remediation required, reflecting confidence in current support and governance. Anticipated changes in regional leadership and governance were outlined, including the appointment of a regional chief executive and establishment of regional boards.

Professor Dwyer acknowledged the impact of these developments on staff morale and emphasised the importance of ongoing engagement, communication, and recovery planning. Finally, Professor Dwyer recognised the Board's achievements and thanked the Chair and Non-Executive Directors for their support and leadership during the current Board's tenure in the final meeting of the Board in this capacity.

Mrs Hannam added the results of the recent NHS inpatient survey, highlighting that the hospital achieved ratings of over 9 out of 10 in four key areas: confidence in doctors, confidence in nurses, care and compassion, and treating patients with dignity and respect. Mrs Hannam emphasised that these outcomes, based on direct patient feedback, are notable achievements and should be celebrated, as they reflect the high level of confidence patients have in the care provided by the hospital

25/043 **INTERIM EXECUTIVE MANAGING DIREECTORS REPORT**

Mrs Bleakley provided an update as Interim Managing Director, focusing on the implementation of the new Laboratory Information Management System (LIMS), workforce reduction progress, staff survey engagement, and flu vaccination campaign. Mrs Bleakley outlined the challenges experienced with the LIMS upgrade, including issues with result delivery to GPs and system connectivity, and noted that most issues had been resolved by early September. Mrs Bleakley gave a formal thanks to the LIMS team for all their hard work. Mrs Bleakley highlighted lessons learned for future digital projects, particularly the need for improved system testing and communication with primary care. She reported on the ongoing workforce reduction programme, the launch of a visible staff survey campaign, and an ambitious flu vaccination target, with efforts to maximise uptake across all staff groups. In response to questions, Mrs Bleakley and colleagues discussed the importance of engaging diverse staff groups in the vaccination programme, the use of network leads and peer vaccinators, and the need for proactive outreach to address barriers to uptake. The Board also discussed the impact of LIMS issues on primary care and the importance of effective communication and shared learning for future implementations.

Mrs Bleakley further reported on the phased approach to workforce reduction, confirming that while the majority of voluntary redundancies would occur in October, the remaining gap would be addressed through ongoing service transformation and enhanced vacancy controls rather than additional large-scale redundancies. Mrs Bleakley assured the Board that operational impacts of staff exits were being managed in collaboration with care groups and teams. Mrs Bleakley also addressed the approach to the staff survey, emphasising increased executive visibility, the use of a central listening hub, and ongoing communication of actions taken in response to previous survey feedback. It was noted that the flu vaccination campaign was being promoted through a range of personal and organisational benefits, rather than a purely financial focus, and that the campaign would be supported by peer vaccinators and network leads to maximise uptake.

The Board asked the Executive Team to consider and explore the feasibility of offering opportunistic flu vaccinations to patients attending the hospital including the assessment of the vaccine allocation and operational requirements. This action will come to the first meeting of the HMG.

Action: Executive Team

Mrs Bleakley expressed thanks to Mr Spink on the ongoing support and provocation particularly in advancing palliative care initiative at both local and national levels.

25/044 **WINTER PLANNING UPDATE**

Mr Cobb provided a comprehensive update on winter planning, outlining the detailed assurance process undertaken, including participation in the national Exercise Aegis and the development of a robust escalation framework to address a range of winter scenarios. Mr Cobb highlighted ongoing collaboration with system partners to increase discharge volumes and the establishment of surge capacity, as well as the implementation of new pathways and rapid release protocols to manage operational pressures.

The Board reviewed the quality impact assessments and, following discussion, formally **approved** the Board Assurance Statement for submission to NHS England.

25/045 **NHS NNUH PROVIDER SELF ASSESSMENT**

Mr Cobb reported on the provider self-assessment process, noting that following collaborative review across the three trusts and guidance from a national seminar, a standardised approach was agreed for completion. Mr Cobb requested Board approval to delegate authority for finalizing and submitting the provider self-assessment to the Special Purpose Joint Committee, given the group board would not be in place until the end of November.

The Board **approved** to delegate authority for finalising and submitting the provider self-assessment to the Special Purpose Joint Committee.

25/046 **FINANCE YTD REPORT**

Mr Thorman presented the year-to-date finance report, highlighting an improved financial position with a small in-month surplus and a favourable variance to plan for August. The year-to-date deficit stands at £3.7 million, which is £2.5 million adverse to the planned position, primarily due to pay cost pressures. Mr Thorman noted that variable pay controls and workforce changes are expected to improve the run rate in future months. Income and non-pay variances were largely attributed to pass-through items such as drugs, devices, and R&D, with no significant concerns identified. Capital underspend was reported, mainly due to national programme timings, and cash balances remain favourable. The Board acknowledged the collective efforts leading to the improved position and noted ongoing scrutiny from NHS England.

25/047 **REPORTS FOR INFORMATION AND ASSURANCE**

(a) Quality and Safety Committee

Ms Fernandez provided a summary of the Quality and Safety Committee report, which covered four meetings, including an additional session to support the transition to group governance. The report highlighted positive patient feedback from inpatient and children's surveys, significant improvements in the spinal assessment pathway, and enhanced assurance regarding mortality statistics following a detailed review of coding and outlier diagnoses. The Committee discussed the need for strengthened clinical engagement in the EPR programme and ongoing development of the corporate risk register, recommending further oversight of mortality and EPR risks. Additional areas escalated included the impact of financial recovery pressures on quality and safety focus, and delays in information governance approvals affecting digital systems. MRs Cocker and Dr Brett contributed further assurance on these points.

(b) IPR – Quality, Safety and Patient Experience

The Board received the Integrated Performance Report (IPR), noting that data is now available in a more timely manner and is being used more effectively by care groups and through delivery oversight meetings. The report emphasised ongoing work to embed the use of the EPR, with a particular focus on maternity, and highlighted the importance of sharing learning across the three trusts, especially in maternity services. The Board acknowledged the progress made and the value of the IPR in supporting assurance on quality and safety.

(c) Finance, Investments and Performance Committee

The Board received the Finance, Investment and Performance Committee report, which confirmed closure or transfer of outstanding actions in preparation for the new governance structure. The Committee reviewed the Trust's improved financial position, including a reported surplus and progress on the CIP gap, and discussed ongoing challenges such as ambulance handover times and the importance of learning from recent digital implementations. The Committee also considered the cyber assurance framework, noting the need to accelerate investment to address identified risks and ensure the Trust meets required standards, with agreement to prioritize this within the new governance arrangements.

(d) IPR – Finance, Performance and Productivity

The Board reviewed the operational Integrated Performance Report (IPR), noting that activity levels in August were below target due to a combination of factors, including administrative delays and structural shifts related to pre-planned leave. It was reported that a validation exercise is underway to address these issues, with a commitment to NHS England that performance trajectories will be restored by the end of October. The Board acknowledged that while the current figures present a slightly negative view, corrective actions have already commenced and improvements are expected as data is updated.

(e) People and Culture Committee

The Board received the People and Culture Committee report, which highlighted the Committee's focus on the forthcoming staff survey and the importance of maximising staff engagement and response rates through enhanced communication and visible leadership. The Committee discussed the increasing number of Freedom to Speak Up contacts, including a rise in anonymous referrals, and emphasized the need for ongoing monitoring and support for the Freedom to Speak Up Guardian. The Committee also noted the importance of sustaining and developing a positive organisational culture during the transition to new governance arrangements, and recommended that cultural development and support for staff remain a priority for the Board.

(f) IPR – Workforce

The Board received the Workforce IPR. There was no comments on the workforce IPR.

On behalf of the Board, Mr Spink expressed his sincere thanks to all current and past committee chairs and co-chairs for their exceptional dedication and significant contributions to strengthening the organisation's assurance processes.

25/048 **REFLECTIONS FROM MEMBERS OF THE PUBLIC**

Mrs Bailey, on behalf of the governors, reflected positively on the meeting, welcoming the collaborative learning emerging across the three trusts and expressing appreciation for the Board's use of celebration to recognise achievements. Mrs Bailey emphasised the value of sharing successes more widely at a community level, noting that patient and governor feedback consistently highlights the high quality of care and compassion provided. Mrs Bailey also thanked the Board, executive team, and NEDs for their strong leadership, openness, and support, particularly acknowledging Mr Spink's role in advancing collaboration and strengthening the Council of Governors' contribution.

25/049 **ANY OTHER BUSINESS**

Upon closing the final meeting of the Board in its current format, Mr spink extended his gratitude to the executive team for their outstanding work in navigating significant challenges and achieving notable progress. Mr Spink also acknowledged the ongoing support and constructive challenge provided by the NEDs, as well as the valuable contributions of the governors in assuring the organisation's focus on staff and patient needs. Mr Spink reiterated the importance of celebrating collective achievements and thanked all involved for their commitment and dedication.

Signed by the Chair: …… Date: ……

Confirmed as a true record by the Special Purposes Joint Committee on 30 September 2025 [TBC]

Decisions Taken:

25/038 – Minutes of the Last Meeting	The minutes of the meeting held on 04 June 2025 were **agreed** as a true record for signing by the Chair subject to minor changes.
25/044 – Winter Planning Update	The Board reviewed the quality impact assessments and, following discussion, formally **approved** the Board Assurance Statement for submission to NHS England.
2/045 – NHS NNUH Provider Self Assessment	The Board **approved** to delegate authority for finalising and submitting the provider self-assessment to the Special Purpose Joint Committee

Action Points Arising:

Actions Carried Forward:	
25/016 Green Plan update -	The Board discussed the Green Plan and asked Mrs Goodwin links in with Professor Bakar and Mrs Cocker and the Nutrition and Hydration Steering Group. **Action: Carried Forward Mrs Bleakley**
New Actions Arising	
25/043 – Interim Executive Managing Directors Report	The Board asked the Executive Team to consider and explore the feasibility of offering opportunistic flu vaccinations to patients attending the hospital including the assessment of the vaccine allocation and operational requirements. This action will come to the first meeting of the HMG. **Action: Executive Team**

Board of Directors (held in Public)

Draft Minutes of the meeting of the **Board of Directors (held in Public)** held on **25 September 2025** in the Board Room, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, Gayton Road, King's Lynn, PE30 4ET, commencing at 10:00, and concluding at 12:22.

(note: these minutes include AI generated content)

Members present:
Chair: M Friend
Non-Executive Directors (NEDs): G Ward, S Ali, S Hayter, C Fernandez, W Van't Hoff, G Evbota, D Childerhouse
Group CEO: L Dwyer
Executive Directors: C Bown (Interim Executive Hospital Managing Director) R Martin (Medical Director), S Kelk (Interim Director of Finance), P Brooks (Director of Estates & Facilities), P Street (Chief Nurse), C West-Burnham (Director of Strategy & Integration), S Jones (Deputy Chief Operating Officer), J Syson (Director of People)

Others in attendance:
C Helps (Group Trust Secretary), E Dorken (Head of Midwifery), S Dean (Associate Director of Communications and Engagement), Peter Cox (NHP Programme Director), M Matore (Associate Director of Patient Experience), Jo Rowe (Volunteer Lead), C Thomas (Comms Team),
H Valentine (Senior Corporate Administrator – minutes

Observed by: Governors and Members of the public

Opening Business

1 Welcome and introductions

The Chair welcomed the public and Governors to the meeting. The Chair noted the importance of this meeting and advised that any unresolved items will be forwarded to the Hospital Leadership team.

2 Apologies for absence & Declarations of Interest

No apologies noted.
No declarations of interest were declared.

3 Minutes of the meeting held on 9 July 2025

The minutes of the meeting held on 9 July 2025 were approved.

4 Matters Arising / Action Log

The Board noted there were no outstanding actions.

Standing Agenda Items

5 Volunteer Story – Presented by P Street, Supported by M Matore & J Rowe

The Volunteer story presented to the Board was shared by Sakshi Thakur who had faced challenges whilst trying to secure a job in the NHS with several rejections, which had left her feeling isolated and disheartened. She wanted to gain experience in working in a hospital and she took the opportunity to volunteer. She felt that volunteering would offer her experience and the opportunity to build experience, develop confidence, and stay connected with the kind of environment she aspired to work in. But very quickly, she discovered that volunteering was so much more than that'. Within a few weeks, Sakshi describes beginning to understand the true value of giving time and energy selflessly. Whether it was meeting the pharmacy runner, greeting the front-desk volunteers, or simply being part of a community that showed up every day to help others, it all began to shape her perspective. Volunteering at QEH wasn't just about tasks, it was about compassion, presence, and genuine human connection.

Volunteering at QEH gave her more than just experience, it gave her confidence, purpose, and the opportunity to be part of something greater. It helped Sakshi to take the next step in her

career; her volunteering role has been instrumental in her gaining a substantive role as a Physiotherapy Assistant at Norfolk and Norwich University Hospital. Volunteering at QEH gave her a chance to grow, serve and to find joy in helping others

NED GW and other Board members reflected on the value and future expansion of the Volunteer Service.

NED WVH noted the volunteers have very strong patient interactions and queried whether any feedback is captured. NED WVH also queried how the training of volunteers can be reflected / used when training other members of staff.

MM advised that feedback is captured as part of surveys, and meeting with patients, and volunteers and feed back via the Patient Care Experience Forum and then that is then shared with all Forum members.

JR noted that training is bespoke and tailored for each volunteer. A One-to-One buddy is offered to those who are less confident during their first few days / weeks.

JS noted we also work closely with colleagues at the college of West Anglia and groups within deprived areas to support those who want to work within the NHS.

The Chair queried whether the QEH has the right number of volunteers and if the number needs to change asked MM for ideas. MM confirmed there is always more scope for more volunteers. JR confirmed the number of volunteers has already increased. Engagement with the job centre continues.

RESOLVED:
The Board noted the Volunteer Story noting the continued good work that is in progress and gave their full support in the development.

6 Group CEO Report – Presented by L Dwyer

The Board received the Group CEO Report. LD highlighted:

LD outlined the trust's position in the lowest quartile for performance, the impact of deficit funding, and the need to address performance issues, noting significant media interest and the importance of balancing negative and positive public feedback

The board discussed the transition to group governance, the need for formal recovery plans for all three trusts, and the establishment of a model region with new regional boards and a chief executive, aiming to streamline leadership and performance management. Plans were made to focus recovery efforts on key operational areas, re-engage staff, strengthen external partnerships, and finalise the clinical strategy by the end of the calendar year, aligning with the 10-year plan and shifting towards community and preventive care.

NED GW agreed all recognised there is still more work to do.

The Chair clarified that recovery plans and operational oversight would flow from the site leadership to the group board, with subcommittees ensuring continuity and clarity in governance as the board structure changes.

RESOLVED:
The Board noted the Group CEO report.

7 Executive Hospital Managing Directors (EHMD) Report – Presented by C Bown

The Board received the Executive Hospital Managing Directors Report. The report was taken as read. CB highlighted:

September saw the release of the National Oversight Framework (NOF) and the announcement that the QEHKL is one of the trusts selected as part of the National Neonatal and Maternity Investigation led by Baroness Amos

The site leadership team remain focused on improving performance in UEC, Cancer, Diagnostic access and finance. There is a particular drive to improve productivity across theatres and outpatients as this is central to improving sustainable elective waiting times, UEC performance and financial balance.

Whilst there is increased attention being directed towards performance improvement in these areas, the trust is mindful that it must remain fully sighted on service safety, quality and patient experience through the close monitoring of the relevant quality indicators.

CB advised he is leading the transition to the new group governance arrangements, and the team have reviewed all existing meetings and will be restructuring as required including the introduction of the new group risk management system.

An Interim Chief Operating Officer has been appointed. Richard Parker, commencing on the 6 October 25.

CB also highlight the important issues relating to our reporting around QEH mortality metrics and HSMR due to the significant backlog in clinical coding with approx. 1000 elective dating back to January 25 and therefore not understanding the mortality metrics which is flagging higher than expected. CB assured that we have not seen any increase in the number of deaths reported. A recovery plan is in place, however the trajectory to be up to date is not until December 2025.

CB noted he and NED SH attended a Patient Safety Day designated for children and babies. NED SH advised this was held as part of the of Patient Safety Event led by the Patient Safety team. Presentations on Martha's law, safeguarding from the Emergency Department onward were given. This demonstrated the enthusiasm and committee from individual staff as well as highlighting the good collaboration between all the divisions. The highlight was from a Patient NED and his mother who talked through their journey noting good support and communication received.

CB noted the improvements of the Place and neighbourhood developments continue. CWB advised that West Norfolk has been identified as a Marmot Place with an initial focus on children and early years. CWB noted it has been helpful to bring people together and has demonstrated we have the building blocks in place in terms of people's understanding and willingness to come and focus on this as a key area in West Norfolk. Therefore, work continues, with different phases noting the Trust are engaged within a broader partnership to drive this forward as well as be able to look at other local systems and how we can deliver care differently. Detailed work has started on the North Cambs Hospital and how best we can utilise with other partners to ensure that we are bringing care closer to people's homes.

NED WVH pleased to note the support being given to ED with the extra Consultants being bought in. SJ confirmed 2 Consultants have already started with a further 3 due to start.

The Chair congratulated the Executive colleagues and teams on their quick action taken towards recruitment.

The Chair queried the West UEC alliance and asked if we are clear sighted on what benefit that might bring and is there a target on what those might be. CWB advised there are 3 key workstreams sitting within the UEC alliance, one of which is focused firmly on in hospital improvement as well as building on the work that was carried out around discharge during 2024 and other support that can be given. The final element of improvement relates to the longer-

term strategic delivery aligned to winter planning and what the learning received can be used to do meetings differently which has good local support. CB advised the trial for the GP Front Door service is it's in early phase however advised that this has been successful so far.

RESOLVED:
The Board noted the EHMD report.

Board Assurance Framework

8 Board Assurance Framework and Corporate Risk Register – presented by the Executive Managing Director and Executive Directors

The updated Board Assurance Framework (BAF) and Corporate Risk Register was received and noted.

The Chair queried the current assurance rating and the risk score around build environment at 25 and asked if this was post the controls and mitigations or pre.

PB advised that the score is given in the moment however noted a reduction in the higher score should be seen following the review of all the risk scores under the new governance tool recently introduced. PB also advised that the Board Assurance Framework captures all the risks held and not those related to RAAC. It also captures infrastructure and will continue to do so until the new hospital is fully occupied. PB noted that all the clinical areas will be fail Safed by the end of 2025 at which time the score will be reviewed. The first £3m has been spent on the new infrastructure capital which has allowed the lifts to be replaced as well as the water tanks and chairs which have made a significant difference. Lots of larger items (lifts, water tanks). PB agreed the score is high noting it was fully debated before being increased with Board members but the assurance around what is being done to mitigate is very high.

CB advised the Risks aligned with the Chief Operating Officer will be reviewed after Richard Parker has started.

NED SA queried BAF 07, financial sustainability given the CIP and Cash position and asked if the BAF position should be escalated given the non-delivery of the combined back office.

CB agreed and advised that the Financial Plan already included the need for some in-sourcing and agreed that some of the challenges in our performance will indeed have an impact on our financial position. Month 5 results are included within agenda item no. 17.

The Chair agreed this was important to note.

RESOLVED:
The Board noted the Board Assurance Framework and Corporate Risk Register update

Quality

9 Integrated Performance Report

The Board received the Integrated Performance Report.

RESOLVED:
The Board noted the Integrated Performance Report and agreed to receive the updates from each area separately through agenda items 10, 13, 16, 18 and 20.

10 Quality Committee Chair's Assurance Report, July & September 2025 – Presented by S Hayter, P Street and R Martin

The committee reviewed assurance reports on learning from deaths, paediatric audiology, maternity, and improvement plans in ophthalmology, stroke, pharmacy, and radiology, identifying areas of limited assurance and recommending updates to business cases and pathways.

RM reported on the learning from deaths programme, highlighting improvements in multi-professional reviews, challenges with clinical coding backlogs affecting mortality data, and ongoing efforts to assure care quality through medical examiner reviews and patient safety meetings.

NED SH advised that a senior nurse has now been successfully recruited into the IPC team with just one further vacancy to fill. Close work continues with all the Clinicians within the hospital to reduce infection and manage any new infection.

RM advised the impact of the clinical coding backlog is not just within mortality, but also within our ability to participate in some of the national clinical audits that we are required to participate in.

The Chair and board discussed the transition of quality oversight to group-level committees, the establishment of a Quality Standards Group, and the importance of maintaining deep dives and shared learning across trusts to address areas of fragility and drive improvement.

NED SA advised that Pharmacy has been a concern across several Committees over a number of months.

New Action: Pharmacy Performance Improvement - to co-ordinate with Group to share learnings and support improvements in pharmacy performance, ensuring group-level opportunities are identified and acted upon.

RESOLVED:
The Board noted the Quality Committee Chair's Assurance updates

11 Maternity Services Quarter 1 Report – Presented by E Dorken

The Board noted the progress made with CNST and compliance with the three-year plan on track for completion March 2027. Recruitment of new midwives, ongoing quality improvement actions, and targeted efforts to address feedback from women with neurodiversity and disadvantaged backgrounds.

The team reported a number of incidents were awaiting investigation and closure. The committee were assured that all incidents are reviewed by MDT 3 times a week. The delay in investigation and closure is down to clinicians' capacity. The committee were updated that there is a pending MSNI following a stillbirth, but no concerns flagged externally at present around the wider service.

NED CF noted that the data in maternity is reviewed through the Maternity Safety Champion Forum and Quality Committee and noted the service is very responsive to areas for improvement. There is oversight of any quality improvement projects noting task and finish activities are in response to incidents seen.

RESOLVED:
The Board noted the Maternity Services Quarter 1 Report

12 Learning From Deaths – Quarter 1 Report – Presented by R Martin

RM reported on the learning from deaths programme, highlighting improvements in multi-professional reviews, challenges with clinical coding backlogs affecting mortality data, and ongoing efforts to assure care quality through medical examiner reviews and patient safety meetings.

While our standardised mortality metrics are reporting as higher than expected and have been subject to intense internal scrutiny through our established governance processes, the significant driver of our reported position is that we have only been coding elective care and the care of patients who have sadly died during their admission. This is causing us to have unreliable data. To mitigate this risk, we are using surrogate measures of quality alongside the scrutiny provided by the medical examiner's office whilst the actions to address the clinical coding are completed.

Our Learning from Deaths programme continues to run alongside our mortality metrics review and we have seen significant improvement in the number of SJRs undertaken. These reflect that although care is largely graded as good there are areas for improvement

NED WVH noted a good report but advised that reliable and sustainable data is imperative to enable the group to continue to be assured.

LD advised the Group have noted the issue relating to coding and agreed a permanent solution is needed but advised that when decisions are being made when responding to a concern, the consequence of that decision should also be thought about.

NED CF welcome the inclusion of the triangulation of data across the various committees and divisions however important that support is given on the SJR's.

New Action: Clinical Code Backlog:
Permanent solution to address the Clinical Coding backlog with consideration given to allocating physical coders and digital solutions across the group.

RESOLVED:
The Board noted Learning from Deaths Quarter 1 Report and assured by the content.

Strategy, Risk and Performance

13 Future Systems Committee Chair's Assurance Report, July & September 2025 – Presented by C Fernandez

C Fernandez provided an update on the Future Systems Committee's activities in July and September 25 and the following was discussed and highlighted:

- Health Equity – work is in train to develop clarity around the Group approach to Health Equity and is currently paused pending substantive appointment to the Group Chief Medical Officer in September. Work continues at a local, Place level with a focus on data and training.
- The EPR delivery scope has been reviewed and is being discussed by the EPR Programme Board. Final delivery plans are in development with a risk to changes in scope and go-live, this will affect benefit realisation, financial forecasting and may impact on service delivery. A deadline for the scope confirmation is required. The timescales and uncertainties around the EPR Programme present additional risks and financial implications for our digital maintenance and transformation programme which are being scoped to understand the operational and financial impact.
- ICB structural changes and nationally required head count reduction pose a risk to progress at place level. Areas expected to be impacted are current unknown.

- QEH is well-positioned in system partnerships leading on key areas of work at Place including in it's role as an Anchor Institution and collaboration with Anglia Ruskin and College of West Anglia.
- Local transformation work is progressing. Marmot, UEC, and Kings Lynn health screening, skills, support and employment programmes are active and there is focus on Children and Young People and health inequalities. Where there are screening programmes there is a need to ensure services are developed to meet the needs of the community.
- Engagement with Cambridgeshire is strong and there are opportunities to learn and leverage the C&P ICB Integrated Neighbourhoods North. This supports future integration across shared pathways.
- Work on the New Hospital Target Operating Model continues supported by a working group

RESOLVED:
The Committee noted the Future Systems Committee Chair's Assurance Report update.

14 Estates and RAAC Update incl. New Hospital – Presented by P Brooks

The Estates Report provided an update and assurance on key projects and initiatives at The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. The report highlights progress, risks, and planned activities for the RAAC Programme, Capital Programme, and New QEH Programme.

Year 5 RAAC Programme

The Year 5 program is now underway and is making good progress against the planned programme, with the Sterile Services building being the major scheme for this financial year

Following the completion of the failsafe in the Central Delivery Suite, the team, mothers and babies relocated from their decant area on Monday 16 June 2025. Wolferton has been prepared as the decant for Rudham Children's ward, leaving Rudham now empty for the contractors to commence the failsafe work.

Learning has been taken from these moves and shared at national level and a couple of other hospitals going through a similar process.

As part of the RAAC Programme strategy, the replacement of the roof covering is the final stage. This work has now commenced above the first floor areas that have been failsafed.

Following a successful bid for Critical Infrastructure Funding (£3m) the following projects have been agreed:

- Replacement of CT & Day Surgery Chillers
- Replacement of the main lifts
- Replacement of Medical Gas Air Plant
- Completion of Dry Riser work
- Replacement of 4 boilers
- Installation of new water tanks

The New QEH SOC was approved by the NHP Investment Committee, marking a major milestone, while internal planning for the Outline Business Case (OBC) has begun in earnest. Engagement remains strong across clinical, operational, and workforce areas, with targeted showcases and national collaboration helping to shape future models. Design and construction workstreams are navigating the transition to RIBA Stage 2, with dependencies on NHP design releases being actively managed. Sustainability, digital, and estates teams have delivered

tangible outputs, including carbon reduction initiatives and land acquisition progress, all contributing to the programme's readiness for the next phase.

NED WVH passed on his thanks for the work undertaken by the whole team and receiving approved of the outline business case and on-going work for RAAC.

RESOLVED:
The Committee noted the Estates and RAAC update inc. New Hospital

15 Winter Plan 25/26 & Board Assurance Statement – Presented by S Jones

The Board received the Winter Plan 25/26 and was taken as read.

The Board noted the lack of external winter funding, and outlined internal initiatives to manage winter pressures, including vaccination campaigns with a stretch target for staff flu vaccination and new strategies to increase uptake.

A new approach to staff flu vaccination was introduced, including training ward managers as peer vaccinators, launching a communications campaign, and setting a stretch target of 50% uptake, with ongoing efforts to share best practices across trusts.

The board discussed the importance of monitoring assumptions and risks in the winter plan, with key initiatives such as the realignment of the acute floor and development of intermediate care beds scheduled for completion by mid-October.

The winter plan focused on internal improvements, with contingency plans for extending frailty services and private ambulance transport, and the board agreed to approve the plan subject to revisions in trajectories and risk assessments.

New Action: To revise the Winter Plan to include credible trajectories and explicit risks, and submit the updated plan for approval prior to regional submission deadline.

RESOLVED:
The Committee noted and approved the plan subject to revisions in trajectories and risk assessments are updated prior to submission on the 30 September 25.

Finance and Performance

16 Finance and Performance Chair's Assurance Report, September 2025 – Presented by G Ward.

In acknowledgement of the formal closure of the Finance & Performance Committee, the group discussed the changes and learning required by the Management team to move to a new way of working under Group Governance and to continue to provide the challenge that has previously been provided by the Non-Executive Directors while holding ourselves to account.

Concerns were discussed over the static position of the workforce bridge and lack of movement in achieving the target. Concerns were raised as to how the Trust can achieve a positive move towards the target without affecting quality.

Pressures remain on Finance.

As a Trust we continue to be in receipt of £20 million deficit support funding. Our Cash position remains very precarious.

RESOLVED:
The Board noted the Finance and Performance Chairs Assurance Report.

17 Finance Report – Month 5 – Presented by S Kelk

The Trust is reporting a YTD deficit: £5.4m, which is £2.3m adverse to plan (£2.9m deficit).

The run rate has improved in M5 to £0.8m compared to £0.9m in M4 and is a continued improvement from 24/25
The trust was ahead of trajectory on its cost improvement programme, with 26 pipeline schemes under review for rapid implementation, and a focus on ensuring all savings are quality assessed before enactment.

The board highlighted the critical importance of maintaining deficit support funding, noting that failure to deliver the financial outturn could result in the loss of over £20 million, with mitigations and group-level discussions underway.

Efforts were made to engage clinical staff in understanding financial performance, with finance workshops, service line reporting, and streamlined administrative processes to support increased activity and productivity.

NED WVH highlighted that support for the clinical workforce should continue to encourage increased productivity but congratulated the finance team on their efforts to report earlier in the financial year the finance position. SK advised there has been increased appetite amongst all staff in wanting to know more about our financial position and to capitalise on that. A series of finance workshops have been established inviting all staff to come along to. Further requests have been received from divisions for further workshops.

The Chair noted this is the Boards whole responsibility, to support drive to change.

RESOLVED:
The Board noted the Finance Report for Month 5.

People

18 People & Culture Committee Chair's Assurance Report, July & September 2025 – Presented by D Childerhouse

The Chair's Assurance reports were taken as read. DC highlighted:

The People and Culture Committee noted sustained improvements in sickness absence rates, appraisal compliance, and job planning, with ongoing efforts to streamline role-specific training and support resident doctors.

Preparations for the National Staff Survey included targeted engagement with under-heard staff groups, proactive outreach, and a focus on achieving the highest response rate to date, with pulse survey results informing action plans.

The committee identified risks related to freedom to speak up capacity, reduced staff visibility during the move to group governance, and challenges in policy approvals, with mitigations discussed to maintain compliance and staff support.

Senior leadership increased engagement with staff through workshops, briefings, and peer-led initiatives, aiming to foster a culture of openness, efficiency, and collective responsibility for driving change.

RESOLVED:
The Board noted the People & Culture Committee Chairs Assurance report.

19 Pulse Survey – Presented by J Syson

The July 2025 survey had 619 participating compared to 661 in the April survey, around 15% of the workforce. The Trust did have resident doctor industrial action for a week of the survey period.

Team QEH performed above the national average in the following areas:
We Are Compassionate & Inclusive
We Have a Voice That Counts
We Are Recognised & Rewarded
We Work Flexibly
Results were below average in:
We Are Safe and Healthy
We Are Always Learning
We Are a Team

Where results were below the national average there was not a significant underperformance, with the exception of 'we are a team' which went from being one of the best to one of the worst performing areas for QEH. The small sample size may be a contributory factor in individual scores varying from survey to survey. Due to the small sample size it is difficult to draw conclusions but it is encouraging that the 'we are compassionate and inclusive' and 'we have a voice that counts' have improved between 2024 and 2025 as these were areas where interventions such as the management fundamentals and values sessions had targeted.

There is a disparity between the Trust's better than average people promise element performance and the below average responses to the following questions.

"I would recommend my organisation as a place to work" only 31.1% marked this positively.
If a friend or relative needed treatment, I would be happy with the standard of care" only 33.5% marked this positively

These two questions saw a decline with the 2024 national staff survey. The decline was also seen in drop between the July 2024 and January 2025 surveys. During this period the Trust entered financial special measures which necessitated significant additional grip and control measures on staffing and all elements of spend. This focus was needed to ensure that clinical services could be maintained and coincides with the decrease in recommend as a place to work and standard of care results.

Recent communications have highlighted how the Trust's moves towards financial stability have enabled improvements and investments in services and underlined the quality of care provided.

Delivery of the National Staff Survey action plan from the 2024 survey will also seek to address these concerns.

Next Steps
There is evidence to suggest that higher responses rates provide more accurate, and more positive results. Driving engagement in the NSS, taking responses above 50% is also likely to provide a more accurate, and positive reflection of the views of staff.

The 2025 NSS which commences on 25th September communications across the Trust will highlight some of the positive patient experiences, service developments and how the financial savings the Trust is making are contributing to providing patient care.

RESOLVED:
The Board noted the report.

Regulatory and Governance

20 Audit Committee Chair's Assurance Report, July & September 2025 – Presented by S Ali.

The Board received the Audit Committee Chair's Assurance Report. The paper was taken as read. SA highlighted:

The audit committee prioritised the development of a group-wide cyber assurance framework and the integration of internal audit plans across all three hospitals, ensuring site-level appropriateness and group synergies.

Pharmacy Performance Monitoring: Persistent issues with pharmacy performance were raised, with agreement to escalate the matter within the site leadership team and seek group-level support for improvement.

20a. Standard Financial Instructions Alignment - The board discussed interim approval of aligned standing financial instructions, pending the rollout of a single group-wide set and a standard scheme of reservation and delegation, with clear timelines for final approval.

It was noted the Standing Orders although have been agreed had not received by QEH.

New Action: Co-ordinate with MT to ensure a full set of standardised standing financial instructions and delegations is developed and presented for group level approval.

RESOLVED
The Board noted the update.

21 Provider Self-Assessment NHSE – Presented by CWB

The Board received the Provider Self-Assessment. CWB presented and highlighted:

As part of the NHS Oversight Framework (NOF), NHS England is assessing NHS trusts' capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards are asked to assess their organisation's capability against a range of expectations across 6 areas derived from 'The Insightful Provider Board', namely:

- strategy, leadership and planning
- quality of care
- people and culture
- access and delivery of services
- productivity and value for money
- financial performance and oversight

informed this report will be presented at all three Trust Boards highlighting that Trusts are required to undertake a self-assessment of capability as part of the NHS Oversight Framework. The deadline for submissions given by NHSE is 22nd October. On a national NHSE webinar on 18th September 2025, it was stated that flexibility over submission deadline could be agreed with NHSE. Due to reporting cycles with our Group, we are requesting a slight delay in the submission date for the three self-assessments to enable Group oversight through the Joint Purpose Special Committee.

These inform a self-assessment which is intended to strengthen board assurance and help oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. The purpose of this is to focus trust boards' attention on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams. NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability. This alongside the National Oversight Framework segmentation will be used to inform whether trusts are placed in the Provider Improvement Program (PIP).

This exercise will be repeated on an annual basis and should be considered as good preparation for well led inspections. Evidence to support the self-assessment should be gathered. With this in mind it requires a sufficient level of detail to inform the assessment which needs to be collated.

The submission deadline, with board-approved evidence, is 22 October 2025. A review period follows where NHSE regional teams have 4 weeks to triangulate data and assign capability ratings. The outcomes will be communicated in December 2025.

At an NHSE webinar on 18th September NHSE, it was stated there could be some flexibility in submission deadlines. Due to the complexities of individual trust board meeting dates, and the transition into a Group during this period, NHSE are being asked for delayed submission from the three hospitals.

It is proposed that individual trust boards give delegated responsibility to the Special Purpose Joint Committee, that meets in early November, to approve the self-assessments and submit to NHSE.

RESOLVED:
The Board noted and approved the report. The Board approved the Group CEO to sign the Statement of Compliance, and the Board approved the report for submission to NHSE.

22 Board Assurance Framework

Duplicate agenda item.

23 Use of the Trust Seal

The Board noted the use of the Trust Seal on the 26 August 2025.

Closing Business

24 Any Other Business

No AOB discussed

25 Questions from the Governors / Public

The Board noted that the Infection Control Team for QEH were listed as number 41 on their league table and passed on their congratulations and thanks.

The Chair thanked the Board for their leadership for their continued focus on patient care and quality. The Chair advised that any items / actions of significance will continue to be monitored via the Group Board.

Norfolk and Waveney
University Hospitals Group

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: Group Chief Executive's Report to the Group Board meeting held in public

Sponsor:	Group Chief Executive
Author:	Group Chief Executive
Previous scrutiny:	Direct
Purpose:	The paper is presented for **Briefing**

Executive Summary and Purpose

To update the Group Board on items for information which do not appear elsewhere on the agenda as well as to provide additional information on items listed for discussion at the meeting.

Key issues to draw to the Group Board's attention include:

- Flu rates which are significantly higher this year than in previous years.
- Further Industrial Action by Resident Doctors.
- Maternity and Neonatal Investigation – an on-site visit has taken place, led by Baroness Amos and the national investigation team, at the Queen Elizabeth Hospital King's Lynn (QEH).
- NHS England System Architecture Mid-Year review of establishment of the Group model - initial feedback determined that considerable progress has been made since the team previously visited in February 2025.
- Local Government reorganisation in Norfolk - official consultation has commenced on three proposals with responses required by 11 January 2026.

Board Action Required

Note: The Group Board is asked to note the contents of this report.

Introduction

Matters brought to the Group Board's attention and which will be discussed in the meeting.

National Oversight Framework (NOF) rankings

The latest NOF rankings were published in early December 2025. All three Trusts remain in segmentation four with both the Queen Elizabeth Hospital (QEH) and James Paget (JP) in the lowest 10 acute provider trusts in the country, and the Norfolk and Norwich (N&N) remaining in the lowest quartile. However, there have been some small shifts in areas of focus and an overall movement upwards for the N&N. We did not anticipate significant changes in the positions for the Group in these rankings but we would expect some improvement in the next quarter.

There are issues that require unified action and purpose to resolve, which is one of the key objectives of the Group.

Recovery and Transformation Programme

To support the improvement of the NOF scores across all segments, we have begun a recovery and transformation programme supported by an external partner, Q5. Although we are planning our recovery over a two-year period, there will be clear targets for quarterly improvement against the constitutional standards where we require rapid progress.

A workshop took place on 4 December 2025 with leaders from all three Trusts to identify priority areas across the Group for immediate mobilisation.

Strategic Ambition

The Group is also developing its strategic ambitions clinical blueprint, future models of care and longer-term priorities to support implementation of the NHS 10-Year Plan. This work is important to provide clarity of purpose and priorities for the Group as well as describing the changes to our services and Trusts that are required, particularly in informing the new hospital builds and the Electronic Patient Record (EPR) design.

Our external partners, Strasys, are facilitating a series of three workshops to support the development of our clinical strategy. Strasys uses data from a variety of sources to ensure that the needs of the local population are fully reflected in the design of the strategy. The second workshop took place at the end of November and the third workshop, with wider stakeholder attendance, takes place on 11 December 2025. I will be able to provide further information at the Group Board meeting.

90-Day Group Formation Plan

This Group Formation Plan has been renamed the Transition Plan and progress has previously been reported to the Special Purpose Joint Committee (SPJC). As many of the actions can now be evidenced as being closed or incorporated into business as usual, it is proposed that the Group Executive monitors delivery of the remaining actions, with the Group Board updated by exception only. We will ensure that the Board is informed via a corporate governance report when all the remaining actions have been completed and if further recommendations are made via the Mid-Year Review of the Group model recently undertaken by NHS England (see below).

Corporate Services transformation

We are working to transform our corporate services to foster a “one team” ethos in order to realise three main benefits: greater effectiveness by implementing unified standards and processes to improve usability and support; more opportunities for staff via enhanced training, development and career progression; and increased efficiency through streamlined operations and reduced duplication, leading to cost savings.

Our goal is to complete these transformations as quickly as possible, taking into account all necessary employment factors. We have adopted a phased approach to service areas and are using some specialist external resource to help us. Digital, Finance and Communications will be included in the first phase, with others to follow in the next few months. The programme is being taken forward by a Steering Group chaired by the Group Chief Financial Officer. We will keep the Board updated on progress.

NHS England System Architecture Mid-Year Review of establishment of Group Model

The NHS England Mid-Year Review commenced on 11 November 2025 with a meeting with myself and Mark Friend, the outgoing Interim Group Chair, and concluded on 28 November 2025 with verbal feedback being provided to myself and David Roberts, Interim Group Chair.

Richard Jeffery, Lead Reviewer for NHS England, provided initial feedback that a significant amount of progress has been made since their previous visit in February 2025, and that there is the confidence that the progress will continue. The review team were supportive of the way that the Group has developed, with arrangements to be finalised on monitoring and oversight with the regional team.

We expect to receive written confirmation of a small number of advisory recommendations which were discussed during the feedback session, including in relation to how Non-Executive Directors (NEDs) receive assurance from individual Trusts and how staff engage with Board members.

National Picture

Influenza (Flu)

Sir James Mackey, Chief Executive of NHS England, and Professor Susan Hopkins, Chief Medical Adviser at the UK Health Security Agency (UKHSA), held an urgent briefing on 1 December 2025 regarding the current national Influenza (flu) situation. Latest figures show an average of 1,717 patients were admitted to a hospital bed due to flu every day in the last week of November 2025 – a record high for this time of the year. Cases were 10 times higher than in the same week in 2023 and 50% higher than in the same week in 2024.

Annual flu vaccination programmes have been undertaken at all three Trusts and an update on current performance will be provided verbally at the Group Board meeting.

The Trusts’ Chief Nurses are reviewing the Universal Masking Tool and will implement guidance as advised.

Industrial Action by Resident Doctors

The next period of Industrial Action by Resident Doctors is scheduled to take place for five days from 7am on Wednesday 17 December 2025 until 7am on Monday 22 December 2025.

Hospitals have been asked to maintain 95% of elective activity recognising that winter is now upon us and, as stated in the previous section, flu levels are surging, with an expected rise in staff sickness which will increase pressure on services and staff who are not participating in industrial action.

The previous period of Industrial Action took place for five days between 14 and 19 November 2025 and was managed as previously through local and regional incident management teams. All three Trusts maintained patient safety, provided continuity of emergency services and delivered elective cases within the 95% target. More information is included in the Executive Managing Directors' reports.

The Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care, and Sir Jim Mackey, Chief Executive of NHS England, sent a letter (Appendix A) of appreciation to all colleagues in the NHS.

Maternity and Neonatal Investigation

The Queen Elizabeth Hospital King's Lynn (QEH) is one of 12 trusts being visited as part of the national Maternity and Neonatal Investigation. Baroness Amos led the on-site visit to QEH with the national investigation team on 25 November 2025. The team was on site for two days interviewing a number of staff, women and their families. There will be a further visit and follow up interviews taking place in late January 2026.

Baroness Amos has published a short report of her reflections of key themes from her work to date (see Appendix B), with the final investigation report expected to be released in spring 2026.

Advanced Foundation Trusts

Advanced Foundation Trusts will be the new marker of excellence for NHS provider organisations to drive the delivery of the three shifts set out in the NHS Plan, bring down waiting lists and work with partners to improve population health. Both existing NHS trusts and foundation trusts will be able to apply for Advanced Foundation Trust status, with those that pass a national NHS England assessment given greater autonomy and financial freedoms.

On 12 November 2025, the Secretary of State for Health and Social Care announced that eight trusts will be among those assessed next year as part of the first wave of the Advanced Foundation Trust Programme next year. Within the East of England, this includes Norfolk Community Health and Care NHS Trust and Cambridgeshire Community Services NHS Trust (these two trusts are proposing to merge on 1 April 2026).

We would not be considered eligible to apply for this status with the current NHS Oversight Framework segmentation and rankings for our three Trusts.

Budget 2025

The Chancellor of the Exchequer delivered the annual Budget on 27 November 2025. Key announcements for health and care included:

- £300m of funding for NHS technology to support staff in their work and boost productivity.
- Rollout of 250 new neighbourhood health centres co-locating GPs, nurses, dentists and pharmacists in community-based clinics, including new facilities funded as public-private partnerships.
- The soft drinks industry levy extended to cover more products including milk-based drinks from 1 January 2028.
- NHS prescription charges frozen at £9.90 for 2026/27.

Further detail is provided in the NHS Providers briefing (Appendix C).

Board Development Programme

NHS England have advised that, at this stage, the programme has been paused for the remainder of the financial year in line with the wider Department of Health and Social Care and NHS England moratorium on spend.

However, NHS Providers will continue to provide education for new and existing Non-Executive Directors as well as Executive Directors as part of their membership subscription.

NHS Providers Annual Conference

Chris Cobb, Chief Operating Officer at N&N, and Rees Millbourne, Chief of Staff for the Group, represented us at the NHS Providers Annual Conference in Manchester. Opportunities were taken to network and learn from other organisations, specifically in respect of ambient listening technology and the benefits for patients, staff, and productivity, which will be shared with colleagues.

The Secretary of State for Health and Social Care mentioned Chris Bown, Executive Managing Director of QEH in his address to the Conference, thanking Chris for his honesty and integrity when responding to the National Oversight Framework segmentation and performance rankings.

Local Picture

Local Government Reorganisation in Norfolk

A statutory consultation commenced on 19 November 2025 and will last for seven weeks until 11 January 2026. The purpose is to seek views following the Secretary of State's invitation to councils in Norfolk and Suffolk to submit proposals for unitary local government for their areas.

Five proposals in this consultation were made by councils in Norfolk and Suffolk, three of which relate to Norfolk:

- Norfolk County Council proposed one unitary council across the whole of the area of Norfolk.
- South Norfolk District Council proposed two unitary councils (East and West) across the whole of the area of Norfolk.

- Breckland District Council, Broadland District Council, Great Yarmouth Borough Council, King's Lynn and West Norfolk Borough Council, North Norfolk District Council, and Norwich City Council, proposed three unitary councils (West, Norwich and East) across the whole of the area of Norfolk. This includes a request to split existing district council areas between the proposed new councils.

The Special Purpose Joint Committee previously approved a letter (Appendix D) of support for the establishment of a single Unitary Council for Norfolk. The Group's position on this proposal has not changed and will inform our formal response to the consultation.

We have received notification this week that there is a likely delay to the inaugural Norfolk and Suffolk Mayoral elections which were due to take place in May 2026. This decision is not related to the above reorganisation.

Minister of State for Secondary Care

Ms Karin Smyth MP, Minister of State for Secondary Care, visited the University of East Anglia on 21 November 2025 to learn about the Norwich Research Park Health Strategy. During the visit, discussions with myself, Drs Jon Lartey, Emma Webb and Marco Gasparetto focused on research opportunities and challenges in nutrition, gut health and microbial science.

STEM sixth form college proposal

South Norfolk and Broadland Council have approached Norwich Research Park Institutes to support a proposed STEM sixth form college on the Park. A joint response is being coordinated, with particular focus on infrastructure and travel access issues affecting Norfolk and Norwich.

Group developments

As we begin to gain momentum as a Group, our priority is to ensure that we are making the best collective decisions for the future.

We are consolidating our New Hospitals Programmes at the Queen Elizabeth Hospital and at James Paget University Hospital and we are re-evaluating other strategic programmes, including the Electronic Patient Record. We are doing this within the context of ongoing work to define our Strategic Ambitions (as discussed above), which will provide us with the much-needed clarity to plan our services, work in partnership and deliver the care in the way we need to.

As we define and agree these Strategic Ambitions and the supporting objectives, the Group Board will also need to identify the Principal Risks to their achievement. This will form the basis of a new Group Board Assurance Framework and risk appetite statement which will drive our approach to risk-based assurance. Work on this is already underway through our Executive Risk Assurance Group and our Group Risk Assurance Committee and we will need to come back to this at the next Group Board meeting.

Group Executive appointments

Group Chief Medical Officer

Welcome to Dr Rob Sherwin, Group Chief Medical Officer. Rob officially started with us on Monday 1 December 2025.

Group Chief Nurse

I am pleased to announce that Rachael Cocker, Chief Nurse at the Norfolk and Norwich, will be seconded for 12 months as the interim Group Chief Nurse. This will ensure that we have the required statutory appointed roles to constitute the Group Board. Rachael will work closely with the Group Chief Medical Director to progress with the Quality Standards portfolio.

Executive Managing Directors

The following colleagues have been appointed for each of the three Trusts:

- Shane Gordon took up post as the Executive Managing Director of the Norfolk and Norwich University Hospitals NHS Foundation Trust on 8 December 2025. Thank you to Marcus Thorman, Group Chief Financial Officer, who was Interim Executive Managing Director ahead of Shane's appointment.
- Michelle Arrowsmith will commence in the role of Executive Managing Director of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust on 19 January 2026. Chris Bown will continue in the role of Interim Executive Managing Director until then.
- Jonathan Gardener joins us as Executive Managing Director of James Paget University Hospitals NHS Foundation Trust on 12 January 2026. Jonathan Barber is the Interim Executive Managing Director from 8 December 2025 until 12 January 2026, in succession to Shane Gordon.

Interim Group Director of Corporate Affairs

Welcome to Ian Walker who joined the Group on 10 November 2025 as Interim Group Director of Corporate Affairs to support the review and development of corporate governance across the Group.

I look forward to working with all these colleagues who will continue to help the Group to form and progress our challenging agenda.

Professor Lesley Dwyer
Group Chief Executive

List of Appendices
(Attachments in the Resource Library and available on request)

- Appendix A: Letter to NHS staff from the Secretary of State and NHS Chief Executive, 19 November 2025
- Appendix B: Baroness Amos Report, December 2025
- Appendix C: NHS Providers On the Day Briefing, Budget 2025
- Appendix D: 20250911 Letter of Support Unitary Authority Consultation

Norfolk and Waveney
University Hospitals Group

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: Committee Chair's Report – Group Audit Committees in Common 19 November 2025

Sponsor:	Julian Foster, Non-executive Director and Chair of the Group Audit Committees on Common
Author:	Group Secretary
Previous scrutiny:	This report summarises business scrutinised by the Group Audit Committees in Common their meeting on 19 November 2025.
Purpose:	The paper is presented for **Assurance**.

Executive Summary and Purpose

This report provides the Group Board with a summary of the Assurance, Alerts, and Advice arising from the inaugural meeting of Group Audit Committees in Common (ACiC) held on 19 November 2025.

The meeting confirmed the statutory independence of each Trust's audit committee while enabling aligned scrutiny under a Committees in Common arrangement. The Committee received reasonable assurance in relation to annual governance statements, internal audit progress, and counter fraud arrangements. Limited assurance was recorded in relation to cyber security, clinical audit arrangements, and aspects of procurement control.

The Committee highlighted progress in aligning assurance across the Group, as well as several material risks requiring Board attention.

Board Action Required

The Group Board is recommended to note the assurance provided, the matters escalated for attention, and the Committee's advice on areas requiring Board direction.

1. Introduction

Group Audit Committees in Common provide independent, objective assurance to the three Trust Boards on the system of governance, risk management, internal control, financial oversight, and audit arrangements.

- Establishment and operating protocols for Committees in Common
- Annual Governance Statement alignment
- Internal Audit progress, findings, and follow-up
- Clinical audit arrangements
- Cyber Security Internal Audit findings (JPUH)
- Single Tender Waiver (STW) reporting and procurement controls
- Counter Fraud updates
- Deloitte financial oversight follow-up
- External Audit planning and contract alignment

2. Analysis and Discussion

2.1 Assurance Received and Perceived (3A: Assurance)

The Committee received **partial to reasonable assurance** across the areas reviewed.

2.1.1 Annual Governance Statements

- Reasonable assurance was received that each Trust maintained functioning governance, internal control, and risk management arrangements during 2024/25.
- A harmonised AGS framework was supported to improve alignment while retaining trust-specific context.

2.1.2 Internal Audit Progress

- Reasonable assurance was received regarding delivery of internal audit plans.
- Legacy actions remain outstanding; the Committee stressed the need for timely closure and improved monitoring.
- Internal audit reporting formats and planning cycles will be standardised across Trusts.

2.1.3 Counter Fraud

- Reasonable assurance was received across fraud prevention, detection, and compliance activity.
- Staff engagement requires improvement to support early identification and referral.

2.1.4 Clinical Audit (NNUH)

- Limited assurance was recorded following a negative internal audit opinion on clinical audit arrangements.
- Issues included low engagement, weak follow-up, and limited demonstration of learning.
- A Group-wide review of clinical audit arrangements was advised.

2.1.5 Cyber Security (JPUH)

- Limited assurance was received following a negative Cyber Assessment Framework audit.
- Self-assessment ratings were overstated and remediation actions delayed.
- The Committee requested accelerated action and improved technical benchmarking across Trusts.

2.1.6 Single Tender Waivers (STWs)

- Limited assurance was received due to inconsistent waiver processes, variable documentation quality, and potential IR35 risks.
- A standard waiver template and early alignment of Standing Financial Instructions were supported to strengthen financial control.

2.1.7 External Audit Planning

- The Committee noted progress in preparing the external audit plans for 2025/26.
- Alignment of external audit contracts across the Trusts was supported.

2.2 Alerts (3A: Alerts)

2.2.1 Cyber Security

- Significant gaps exist in cyber resilience, with overstated compliance ratings and slow action delivery creating Group-wide risk.

2.2.2 Clinical Audit

- Weaknesses in clinical audit arrangements at NNUH indicate a risk that may be present across the Group.

2.2.3 Procurement Control and IR35

- Repeated contract rollover and limited IR35 evaluation create financial and compliance risk.

2.2.4 Standing Financial Instructions

- Misalignment of SFIs across Trusts presents audit and assurance risk and requires urgent resolution.

2.3 Advice (3A: Advice)

2.3.1 Annual Governance Statement Alignment

- The Board should endorse implementation of a harmonised AGS framework, promoting consistency and assurance.

2.3.2 Cyber Risk Oversight

- The Board should confirm the governance route for cyber risk across ACiC, GRAC, and DIG to ensure clear accountability.

2.3.3 Clinical Audit Arrangements

- The Board should commission a Group-wide review of clinical audit arrangements to ensure they support learning and assurance.

2.3.4 Procurement and IR35 Controls

- The Board should support improved oversight of waiver use and require routine reporting on IR35 compliance and contract rollover.

2.3.5 SFI Alignment

- The Board should expedite approval of aligned SFIs and procurement policies to strengthen financial control.

2.3.6 External Audit Contracts

- The Board should support alignment of external audit contracts following the recent procurement process.

3. Conclusion

This inaugural meeting marked a significant milestone in establishing aligned audit assurance across the Norfolk and Waveney Acute Hospital Group. While foundations are sound, material assurance gaps remain, particularly cyber resilience, clinical audit arrangements, and procurement control.

Continued Board direction is required to mature assurance across the Group and embed consistent standards across all Trusts.

4. Recommendation and Decision

The Board is recommended to note the assurance provided, consider the matters requiring attention, and accept the advice set out above, endorsing the follow-up actions identified.

Norfolk and Waveney
University Hospitals Group

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: Committee Chair's Report – Group Risk Assurance Committee 27 November 2025

Sponsor:	Nikki Gray, Non-Executive Director and Chair of the Group Risk Assurance Committee
Author:	Group Secretary
Previous scrutiny:	This report summarises business scrutinised by the Group Risk Assurance Committee at its meeting on 27 November 2025.
Purpose:	The paper is presented for **Assurance**.

Executive Summary and Purpose

This report provides the Group Board with a summary of the Assurance, Alerts, and Advice arising from the meeting of the Group Risk Assurance Committee (GRAC) held on 27 November 2025. The Committee reviewed executive risk reports, trust-level risks, major programme risks, and the emerging Group Board Assurance Framework (BAF) Report, and considered the maturity of the Group's integrated assurance arrangements.

The Committee agreed that overall assurance remains partial. The Committee welcomes the significant progress made in establishing the Group's principal risks, strengthening ERAG reporting, and improving triangulation, but emphasises areas requiring Board attention, particularly risk appetite, maternity and RCS reviews, cyber security assurance, and the EPR programme.

Board Action Required

The Group Board is recommended to note the assurance provided, the matters escalated for attention, and the Committee's advice on areas requiring Board direction.

1. Introduction

The Group Risk Assurance Committee provides independent, objective assurance to the Group Board on the robustness of risk management, the adequacy of internal control, and the effectiveness of triangulated evidence across the Norfolk and Waveney Acute Hospital Group.

At its meeting on 27 November 2025, the Committee considered:

- Executive Risk Assurance Group (ERAG) report
- Updated principal risks, aims and the early Group BAF Report draft
- Trust-level risk and assurance reports (JPUH, QEH, NNUH)
- Integrated Performance Report (IPR)
- Month 7 Group Finance Report
- Major programme risks, including the New Hospitals Programme (NHP) and Electronic Patient Record (EPR)

The Committee also reviewed the Action Log and reflected on the effectiveness of assurance flows and reporting maturity.

2. Analysis and Discussion

1. Assurance Received and Perceived (3A: Assurance)

The Committee received **partial assurance** across the areas reviewed.

1.1 Executive Risk Assurance Group (ERAG)

- ERAG is maturing; cadence and reporting have stabilised.
- Principal Risks now have named Executive Risk Owners, and controls and scoring are under active review.
- The Committee welcomed ERAG's challenge function but requires greater clarity on escalations, consistent assurance levels, and clearer depiction of trust-level thematic risks.
- A consolidated Group view of risks scoring ≥12 will be brought forward in December, with further refinement in January.

1.2 Principal Risks, Aims, and Draft BAF Report

- The Committee welcomed progress in defining 17 principal risks and developing the early draft BAF Report.
- GRAC emphasised the need for a formal Risk Appetite Framework, improved calibration of risk scores, clearer evaluation of controls, and time-bound mitigation actions.

1.3 Trust-Level Risk Reports

The Committee reviewed key risks across the Trusts, including:

- Elective and cancer performance
- Maternity staffing and maternity investigation at QEH
- Audiology, pharmacy, chronic pain, tissue viability, and seasonal preparedness
- Cyber incident risks and digital resilience

Further standardisation is required to improve comparability and triangulation.

1.4 Integrated Performance Report (IPR)

- Mortality (SHMI) remains elevated across all Trusts. Coding does not fully account for variance.
- GRAC commissioned a deep dive by ERAG into SHMI and coding.
- Elective performance remains a rising group risk, with worsening 65-week position and possible regulatory implications.

1.5 Finance Report

- The financial position is more controlled following ICB agreements.
- Redundancy costs at NNUH and capital underspend (notably for EPR) remain significant risks.
- Narrative and scoring will be strengthened in future reports.

1.6 Major Programmes

- NHP: Assured on direction, risks understood and managed.
- EPR: Assurance limited; material risks around delivery timeline, financial exposure, national compliance requirements, and options appraisal.

2. Alerts (3A: Alerts)

The Committee alerts the Board to the following:

2.1 Absence of a formal Group Risk Appetite Framework

Calibration of risk scoring is increasingly inconsistent and requires urgent Board direction.

2.2 Maternity Investigation and Royal College of Surgeons (RCS) Review

These matters were not brought to GRAC pending private Board discussion. The Board must confirm the future oversight route for these high-impact risks.

2.3 Cyber** Security **Assurance

Limited assurance reports and broader cyber vulnerabilities require a clear, consistent Group-level oversight route. Integration with ERAG/GRAC reporting is required.

2.4 Variation in** Assurance **Quality and Flow

The Committee identifies persistent variation in trust reporting quality and assurance triangulation. This continues to constrain assurance.

2.5 EPR** Programme **Risk

Significant risk remains across delivery timeline, financial exposure, and compliance. The Committee awaits the Board's decision on EPR direction and notes that this is a major systemic risk.

3. Advice (3A: Advice)

The Committee offers the following advice to the Board:

3.1** Adoption **of a formal Group Risk Appetite Framework

The Committee strongly advises the Board to set clear expectations and timeframes for establishing an agreed risk appetite.

3.2 Clarification** of **oversight for Maternity Services and RCS review

The Board needs to confirm whether GRAC or another Committee holds formal oversight.

*3.3 Strengthening **the Group BAF Report***

The Committee recommends that the Board support the development of a dynamic, responsive BAF Report, aligned to Group strategy, mapped to risk appetite, and showing evaluation of controls.

*3.4 Standardisation **of reporting across NHS FTs***

Board endorsement is sought for a single consistent template to improve comparability and triangulation.

*3.5 **EPR** Programme*

The Committee advises that:

- The Board ensure external assurance is in place before options are approved.
- The Board consider an extended or dedicated session to review options, risks, and financial implications.

*3.6 Strengthening **risk escalation pathways***

The Committee advises that the Board endorse the refinement of ERAG → GRAC pathways, with clear rationale when risks bypass the normal route.

3. Conclusion

The Committee acknowledges significant progress in maturing the Group's risk and assurance system. However, core elements: risk appetite, Group BAF Report maturity, cyber assurance, quality of trust reporting, and oversight of Maternity Services and EPR, require continued Board direction.

Residual risks requiring Board consideration include:

- EPR programme viability
- Maternity and RCS oversight route
- Risk appetite alignment and scoring calibration
- Group-wide consistency of risk and assurance reporting
- Persistent elective and mortality risks

4. Recommendation and Decision

The Board is recommended to note the assurance provided, the matters requiring attention, and the advice from the Group Risk Assurance Committee arising from its meeting on 27 November 2025.

Norfolk and Waveney
University Hospitals Group

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: Group Executive Meeting – Chair's Report

Sponsor: Group Chair

Author: Group Chief Executive

Previous scrutiny: Direct

Purpose: The paper is presented for **Assurance**.

Introduction

The Group Executive Meeting took place as on 28 November 2025.

Information is provided in the 3As format of matters to report for Committee assurance, alerts, and advisory, where applicable.

Assurance

1. **Corporate Services Review**

   The Group Executive reviewed and discussed the paper focusing on discussions around the workforce model. The Group Executive noted the services included in the programme and the agreed design principles. The Group Executive approved the proposed functional map subject to final clarification on points made, workforce approach and timeline. A further update is included in the Group Chief Executive's report to the Group Board.

Alerts

1. **Strategic Ambition and Group Recovery Plan**

   The Group Executive discussed these papers, the work to date and the detailed plans for both workshops in December. It was agreed that further work was required to ensure that these pieces of work are aligned with each other.

Advisory

1. **Full Business Case – Robotic Surgery Centre**

   The Group Executives discussed and gave challenge to some points raised from the Robotic Surgery Centre Full Business Case presented by Mr James Hernon, Consultant and Toby Lewis, Senior Business Manger both from the NNUH. Following clarification and justification on the points raised, with some additional detail to be included in the business case. The Group Executive endorsed approval for the Full Business Case to progress to Group Board for approval.

2. **Group Transition Plan**

   The Group Executives reviewed the updated transition plan; a detailed discussion took place that agreed and approved formal closure of the transition plan. Items were evidenced as completed or transitioned to business as usual or require monitoring through the meetings/committees within

the governance meeting framework. It was agreed that monitoring the remaining transition actions be monitored by the Executive Group rather than directly to Group Board unless Board approval is required.

3. **Additional items**

   The Group Executives discussed two items that will be reported at the Private Group Board in December.

Conclusion

All items highlighted are under active executive oversight, with remedial actions monitored through the Group Executive Meeting.

Group Board is not asked to endorse or approve any matter within this report but to receive assurance that the Executive continues to manage strategic and operational performance matters effectively and that items when required are reported for information or approval at future Group Board meetings.

NHS
Norfolk and Waveney
University Hospitals Group

Group Integrated Performance Report

Oct-25

NHS
James Paget University Hospitals NHS Foundation Trust

NHS
Norfolk and Norwich University Hospitals NHS Foundation Trust

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

NHS
Norfolk and Waveney
University Hospitals Group

Introduction

Oct-25

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.

NHS
James Paget University Hospitals
NHS Foundation Trust

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

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Compliance

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

Variation

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

Assurance

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

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Escalation Status

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

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

NHS
Norfolk and Waveney
University Hospitals Group

Group Summary

Oct-25

NHS James Paget University Hospitals NHS Foundation Trust

	P	?	F
H / L	1	5	3
	1	12	8
H / L		3	

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

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

	P	?	F
H / L		3	5
	3	11	6
H / L		3	

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

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

	P	?	F
H / L	1	2	1
		14	6
H / L		3	2

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

NHS
Norfolk and Waveney
University Hospitals Group

Annual Metrics

CQC Safe Domain Rating

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

Inpatient Satisfaction

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

Staff Survey - We are Safe and Healthy

National - 6.14

NHS James Paget University Hospitals NHS Foundation Trust	5.80
NHS Norfolk and Norwich University Hospitals NHS Foundation Trust	5.80
NHS The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	5.79

Staff Survey - Engagement Score

National - 6.85

NHS James Paget University Hospitals NHS Foundation Trust	6.68
NHS Norfolk and Norwich University Hospitals NHS Foundation Trust	6.39
NHS The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	6.40

Staff Survey - Raising Concerns

National - 6.45

NHS James Paget University Hospitals NHS Foundation Trust	6.19
NHS Norfolk and Norwich University Hospitals NHS Foundation Trust	5.95
NHS The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	5.60

Annual Metrics

Maternity Survey 2024

James Paget University Hospitals NHS Foundation Trust

	Patient Response	Compared with other trusts
Labour and birth	8.4 / 10	About the same
Staff caring for you	8.3 / 10	About the same
Care in hospital after the birth	6.9 / 10	About the same

Norfolk and Norwich University Hospitals NHS Foundation Trust

	Patient Response	Compared with other trusts
Labour and birth	8.7 / 10	Better than expected
Staff caring for you	8.7 / 10	About the same
Care in hospital after the birth	7.6 / 10	About the same

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

	Patient Response	Compared with other trusts
Labour and birth	Not available	
Staff caring for you	8.2 / 10	About the same
Care in hospital after the birth	7.2 / 10	About the same

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2024 | National Education and Training Survey 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%

Norfolk and Waveney
University Hospitals Group

Safe and Effective Care Domain Metrics

NHS
Norfolk and Waveney
University Hospitals Group

Metric Summary Matrix - Safe and Effective Care

	MRSA	CHPPD MW Fill Rate	
		Ecoli Cdiff Preterm Still Births	Av Disch Delay Complaints Falls Pr. Ulcers RN Fill Rate
		SHMI	

Safe and Effective Care Assurance

NHS James Paget University Hospitals NHS Foundation Trust

SHMI	
MRSA	✓
CDiff	
Ecoli	
Average number of days between planned and actual discharge date	!
Still Birth Rate	
Midwifery Fill Rate	
Complaints Received	!
Pressure Ulcers	!
Preterm Birth Rate	
Registered Nurse Fill Rate	
Care Hour Per Patient Day (CHPPD)	
Falls	!

			SHMI
	Readm Rate	Cdiff Still Births CHPPD Ecoli MRSA Preterm	Av Disch Delay Falls Pr. Ulcers RN Fill Rate Complaints
		MW Fill Rate	

Safe and Effective Care Assurance

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

SHMI	
MRSA	
CDiff	
Ecoli	
Average number of days between planned and actual discharge date	!
Readmission Rate	✓
Still Birth Rate	
Midwifery Fill Rate	
Complaints Received	!
Pressure Ulcers	!
Preterm Birth Rate	
Registered Nurse Fill Rate	✓
Care Hour Per Patient Day (CHPPD)	

	MRSA	Still Births	
		Cdiff CHPPD Ecoli Preterm	Av Disch Delay Falls Pr. Ulcers RN Fill Rate
		MW Fill Rate SHMI	

Safe and Effective Care Assurance

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

SHMI	
MRSA	✓
CDiff	
Ecoli	
Still Birth Rate	
Midwifery Fill Rate	
Complaints Received	!
Pressure Ulcers	
Preterm Birth Rate	
Registered Nurse Fill Rate	
Care Hour Per Patient Day (CHPPD)	
Falls	!

Norfolk and Waveney University Hospitals Group

Safe and Effective Care Domain Summary

Oct-25

Metric	Period	James Paget Target	James Paget Actual	James Paget Compliance	James Paget Variation	James Paget Assurance	Norfolk and Norwich Target	Norfolk and Norwich Actual	Norfolk and Norwich Compliance	Norfolk and Norwich Variation	Norfolk and Norwich Assurance	Queen Elizabeth Target	Queen Elizabeth Actual	Queen Elizabeth Compliance	Queen Elizabeth Variation	Queen Elizabeth Assurance
SHMI	Jun-25	1.16	1.13	✓	H	?	1.16	1.15	✓	L	F	1.16	1.31	✗	H	?
MRSA	Oct-25	0	0	✓	L	P	0	1	✗	~	?	0	0	✓	L	P
CDiff	Oct-25	3	2	✓	~	?	8	9	✗	~	?	4	6	✗	~	?
Ecoli	Oct-25	0	5	✗	~	?	0	2	✗	~	?	0	5	✗	~	?
Average number of days between planned and actual discharge date	Oct-25	2	6	✗	~	F	2	5	✗	~	F					
Readmission Rate	Sep-25						10.0%	13.14%	✓	~	P					

Group Summary

SHMI- processes in place to scrutinise, investigate and learn from themes and trends in place at all three trusts. Improvement plans for data quality and coding are monitored locally, QEH is a significant outlier with coding backlogs with focused plan in place to address this, this is likely to impact on SHMI reporting in 2026.

Infection Prevention and Control monitoring against agreed trajectories in place, culture of continuous learning from incidents and ongoing staff education, all areas reporting as expected.

Discharge delays and readmission rates are inconsistently being reported and actions in place to improve data completeness.

NHS
Norfolk and Waveney
University Hospitals Group

Safe and Effective Care Domain Summary

Oct-25

Metric	Period	James Paget Target	James Paget Actual	James Paget Compliance	James Paget Variation	James Paget Assurance	Norfolk and Norwich Target	Norfolk and Norwich Actual	Norfolk and Norwich Compliance	Norfolk and Norwich Variation	Norfolk and Norwich Assurance	Queen Elizabeth Target	Queen Elizabeth Actual	Queen Elizabeth Compliance	Queen Elizabeth Variation	Queen Elizabeth Assurance
Still Birth Rate	Oct-25	3.5%	0.00%	✓	~	?	3.5%	0.23%	✓	~	?	3.7%	2.40%	✓	~	?
Midwifery Fill Rate	Oct-25	90.0%	84.09%	✗	H	?	90.0%	87.96%	✗	~	?	90.0%	73.91%	✗	~	?
Complaints Received	Oct-25	0	24	✗	~	F	0	68	✗	~	F	0	53	✗	H	F
Pressure Ulcers	Oct-25	0	8.00	✗	~	F	0	31.00	✗	~	F	0	4.00	✗	~	?
Preterm Birth Rate	Oct-25	6.0%	7.50%	✓	~	?	6.0%	3.73%	✓	~	?	6.0%	4.92%	✓	~	?
Registered Nurse Fill Rate	Oct-25	90.0%	90.66%	✓	~	?	90.0%	94.40%	✓	~	P	90.0%	87.29%	✗	~	?
Care Hour Per Patient Day (CHPPD)	Oct-25	8.00	8.49	✓	H	?	8.00	7.76	✗	~	?	8.00	7.53	✗	~	?
Falls	Oct-25	0	4.41	✗	~	F						0	62.00	✗	~	F

Group Summary

The correlation between staffing levels and quality standards continues to receive scrutiny across all three trusts. Rigorous processes are in place to monitor and flex staffing resources across all areas on a daily basis. 6 monthly nursing staffing reviews have been completed and any changes to resource requirements will be included in planning for 2026/27. Midwifery fill rates across all three trusts are of concern and in particularly at QEH. Use of SafeCare and daily huddles manage this on a daily basis, with actions in place to address staff sickness rates and recruitment.

Data flows for patient experience remain outstanding with the aim to include Friends and Family Test as a more accurate picture of patient experience. The current complaint metric does demonstrate good practice in place at QEH which is being shared with JPUH and NNUH were complaint response rates are poor and improvement plans are in place.

Norfolk and Waveney
University Hospitals Group

People and Culture Domain Metrics

NHS
Norfolk and Waveney
University Hospitals Group

Metric Summary Matrix - People and Culture

Oct-25

NHS James Paget University Hospitals NHS Foundation Trust

		Appraisal	Sickness
	Training	Turnover	

People and Culture

Sickness Rate	
Turnover Rate	
Mandatory Training	
Non Medical Appraisal	

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

		Turnover	
	Training	Appraisal Sickness	

People and Culture

Sickness Rate	
Turnover Rate	
Mandatory Training	
Non Medical Appraisal	

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

		Appraisal Training	Sickness Turnover

People and Culture

Sickness Rate	!
Turnover Rate	!
Mandatory Training	
Non Medical Appraisal	

Norfolk and Waveney University Hospitals Group

People and Culture Domain Summary

Oct-25

Metric	Period	James Paget Target	James Paget Actual	James Paget Compliance	James Paget Variation	James Paget Assurance	Norfolk and Norwich Target	Norfolk and Norwich Actual	Norfolk and Norwich Compliance	Norfolk and Norwich Variation	Norfolk and Norwich Assurance	Queen Elizabeth Target	Queen Elizabeth Actual	Queen Elizabeth Compliance	Queen Elizabeth Variation	Queen Elizabeth Assurance
Sickness Rate	Oct-25	4.6%	5.77%	⊗	L	F	4.6%	4.88%	⊗		?	4.5%	5.82%	⊗		F
Turnover Rate	Oct-25	10.0%	6.31%	✓		?	10.0%	6.94%	✓	L	?	10.0%	11.74%	⊗		F
Mandatory Training	Oct-25	90.0%	92.03%	✓		P	90.0%	91.78%	✓		P	90.0%	80.24%	⊗		?
Non Medical Appraisal	Oct-25	90.0%	85.87%	⊗	H	?	90.0%	89.96%	⊗		?	90.0%	82.07%	⊗		?

Group Summary

- Sickness continues to be a challenge within two of the Trusts (JPUH and QEH) despite improvement plans, with all Trusts impacted by seasonal illness. Reducing sickness remains an area of focus for all Trusts.
- Turnover is better than target within two Trusts but a concern at QEH, although it has declined slightly for the fourth consecutive month.
- Mandatory training is above target at all but QEH but implementation of increased Safeguarding training capacity is expected to positively impact.
- Appraisal rates are below target at all Trusts, although only marginally for NNUH. All Trusts have plans to improve rates, which are having impact. NNUH and JPUH anticipate meeting the target by the end of December 2025.

Norfolk and Waveney
University Hospitals Group

Access and Flow Domain Metrics

Metric Summary Matrix - Access and Flow

Oct-25

James Paget University Hospitals NHS Foundation Trust

			52+ Waits 65+ Waits
		Diagnostics Paed PTL Size RTT Incomp <18	
		1st Appt <18 PTL Size	Clearance

Access and Flow !

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

Norfolk and Norwich University Hospitals NHS Foundation Trust

		Diagnostics	52+ Waits 65+ Waits PTL Size
			Paed PTL Size
		1st Appt <18 RTT Incomp <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
- Under 18s elective waiting list size !

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

		65+ Waits	52+ Waits
		1st Appt <18 Diagnostics RTT Incomp <18	
			PTL Size

Access and Flow !

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

NHS
Norfolk and Waveney
University Hospitals Group

Access and Flow Domain Summary - Elective Care

Oct-25

Metric	Period	James Paget Target	James Paget Actual	James Paget Compliance	James Paget Variation	James Paget Assurance	Norfolk and Norwich Target	Norfolk and Norwich Actual	Norfolk and Norwich Compliance	Norfolk and Norwich Variation	Norfolk and Norwich Assurance	Queen Elizabeth Target	Queen Elizabeth Actual	Queen Elizabeth Compliance	Queen Elizabeth Variation	Queen Elizabeth Assurance
Total PTL Size	Oct-25	34,402	34,399	✓	H	?	81,265	82,420	✗	L	F	24,963	27,123	✗	H	F
RTT Incomplete Within 18 weeks	Oct-25	53.0%	51.43%	✗	–	?	54.6%	50.18%	✗	L	?	60.0%	55.34%	✗	–	?
65+ Week Waits	Oct-25	0	208	✗	L	F	0	135	✗	L	F	0	2	✗	L	?
52+ Week Performance	Oct-25	4.7%	5.14%	✗	L	F	4.0%	5.08%	✗	L	F	1.5%	1.55%	✗	L	F
First Attendance Within 18 Weeks	Oct-25	64.9%	56.43%	✗	L	?	58.7%	54.49%	✗	L	?	63.9%	65.09%	✓	–	?
6 Week Diagnostics	Oct-25	90.5%	74.16%	✗	–	?	90.5%	77.81%	✗	H	?	90.5%	59.14%	✗	–	?
Under 18s elective waiting list size	Oct-25	2,615	2,715	✗	–	?	6,182	8,145	✗	–	F					
Estimated clearance times	Oct-25	18	29	✗	H	F										

Group Summary

Elective position across all three trusts remains relatively static. Although improvements in overall waiting list size are evident from the data, QEH are also seeing an improved position of patients waiting over 52 weeks. Despite this all three trusts remain in the lowest quartile for RTT performance with both NNUH and JPUH continuing to have patients waiting over 65 weeks. Trajectories are in place to deliver elective recovery for QEH and NNUH, recovery in JPUH is unlikely before March 2026. ENT, Urology and Gynaecology are the biggest contributors . Insourcing, outsourcing and data validation programmes are in place with mutual aid support across the group were possible. Targeted programmes to address these specific specialties will be included with the Group Recovery programme, utilising capacity and demand modelling, whole pathway changes and reduction in variation to improve productivity and reduce waiting times.

NHS
Norfolk and Waveney
University Hospitals Group

Metric Summary Matrix - Access and Flow

Oct-25

James Paget University Hospitals NHS Foundation Trust

H		4hr ED Paed PTL Size	
		62 Day FDS	Handover >30 Handover >45 Handover >45% NE LoS
L			

Access and Flow

28 Day Faster Diagnosis	
Cancer 62 Day Treatment	
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

H		FDS	
		4hr ED 62 Day Paed PTL Size	Handover >30 Handover >45 Handover >45%
L			

Access and Flow

28 Day Faster Diagnosis	
Cancer 62 Day Treatment	
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

H			
		4hr ED 62 Day Paed PTL Size	Handover >30 Handover >45 Handover >45%
L		FDS	

Access and Flow

28 Day Faster Diagnosis	
Cancer 62 Day Treatment	
ED 4 Hour Performance	
ED 12 Hours in Department %	
Ambulance Handovers Over 30 Minutes	!
Ambulance Handovers Over 45 Minutes	!
Ambulance Handovers Over 45 Minutes %	!

NHS
Norfolk and Waveney
University Hospitals Group

Access and Flow Domain Summary - UEC and Cancer

Oct-25

Metric	Period	James Paget Target	James Paget Actual	James Paget Compliance	James Paget Variation	James Paget Assurance	Norfolk and Norwich Target	Norfolk and Norwich Actual	Norfolk and Norwich Compliance	Norfolk and Norwich Variation	Norfolk and Norwich Assurance	Queen Elizabeth Target	Queen Elizabeth Actual	Queen Elizabeth Compliance	Queen Elizabeth Variation	Queen Elizabeth Assurance
28 Day Faster Diagnosis	Sep-25	81.0%	76.50%	⊗	?	?	71.6%	71.77%	✓	H	?	73.2%	69.68%	⊗	L	?
Cancer 62 Day Treatment	Sep-25	76.1%	72.01%	⊗	?	?	61.3%	56.94%	⊗	?	?	67.7%	52.13%	⊗	?	?
ED 4 Hour Performance	Oct-25	66.6%	70.93%	✓	H	?	81.5%	79.98%	⊗	?	?	62.3%	66.78%	✓	?	?
ED 12 Hours in Department %	Oct-25	8.0%	8.37%	⊗	L	?	3.0%	4.99%	⊗	?	?	12.1%	16.35%	⊗	?	?
Ambulance Handovers Over 30 Minutes	Oct-25	0	839	⊗	?	F	0	1,476	⊗	?	F	0	519	⊗	?	F
Ambulance Handovers Over 45 Minutes	Oct-25	0	667	⊗	?	F	0	1,033	⊗	?	F	0	324	⊗	?	F
Ambulance Handovers Over 45 Minutes %	Oct-25	0.0%	37.36%	⊗	?	F	0.0%	31.66%	⊗	?	F	0.0%	18.00%	⊗	?	F
Non Elective LoS	Oct-25	8	10.90	⊗	?	F										

Group Summary

Cancer performance remain static with significant improvement required at both NNUH and QEH. The Histopathology recovery plan is progressing and turnaround times are improving for urgent requests. This continues to be monitored closely by the Group Executive.

Significant change in pathways for UEC patients at JPUH are now in place with the opening of the SDEC unit, there has also been a steady improvement in 4 hour performance over recent months. QEH have also seen an improvement in 4 hour performance following the onboarding of additional senior decision makers in ED. All three trusts continue with poor ambulance handovers and this remains a static picture.
Seasonal resilience plans are in place and will be monitored through the winter with additional local actions if required to manage surges in demand

Norfolk and Waveney
University Hospitals Group

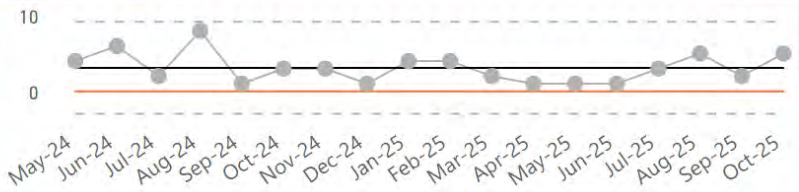
Appendices

Norfolk and Waveney University Hospitals Group

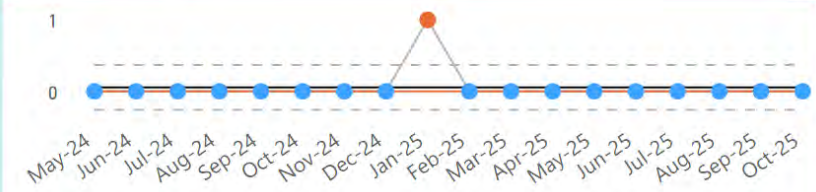
Safe and Effective Care Domain Appendix - E-Coli, MRSA, CDiff

Oct-25

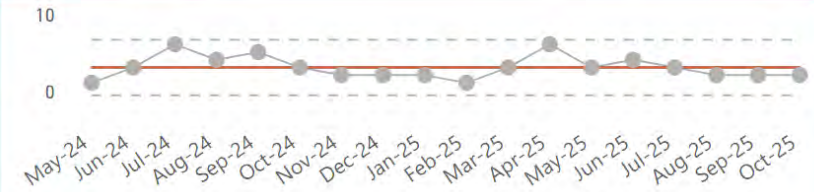
JPUH - Ecoli 5



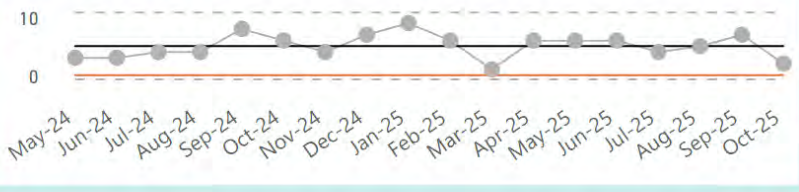
JPUH - MRSA 0



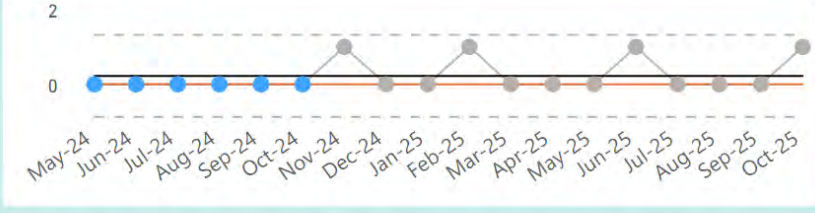
JPUH - CDiff 2



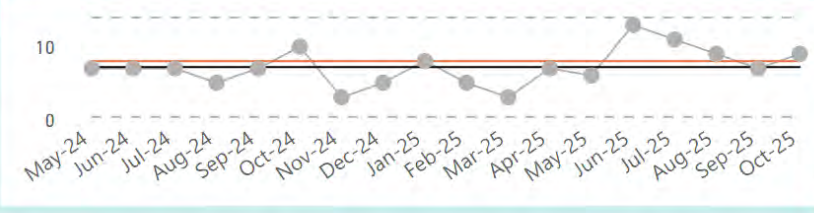
NNUH - Ecoli 2



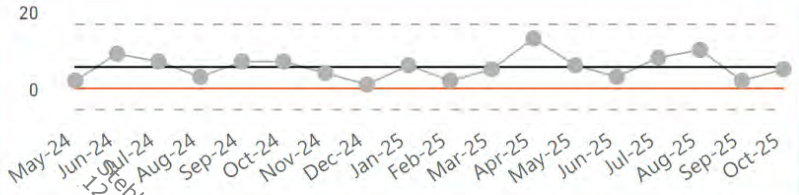
NNUH - MRSA 1



NNUH - CDiff 9

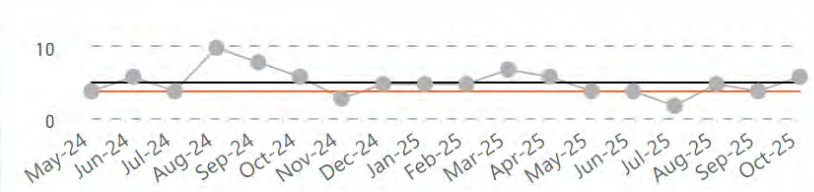


QEH - Ecoli 5



QEH - MRSA 0

QEH - CDiff 6



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

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

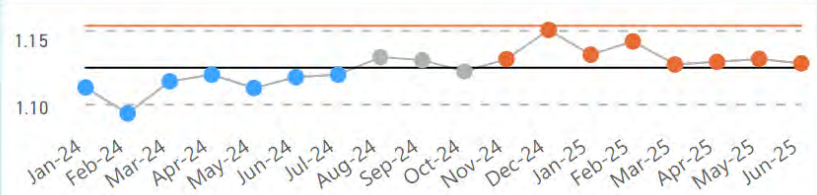
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3	2				
NNUH	8	9				
QEH	4	6				

Norfolk and Waveney University Hospitals Group

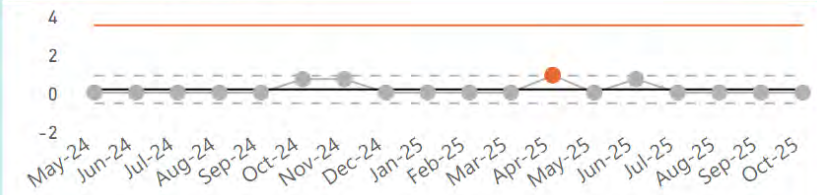
Safe and Effective Care Domain Appendix - SHMI, Still Birth Rate, Complaints Received

Oct-25

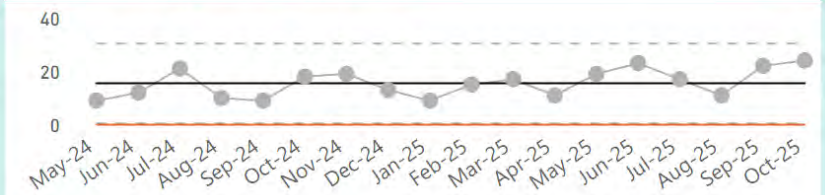
JPUH - SHMI 1.13



JPUH - Still Birth Rate 0.00%

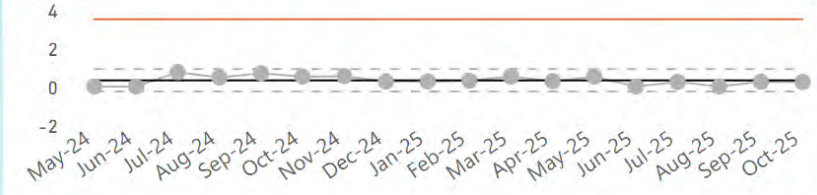


JPUH - Complaints Received 24

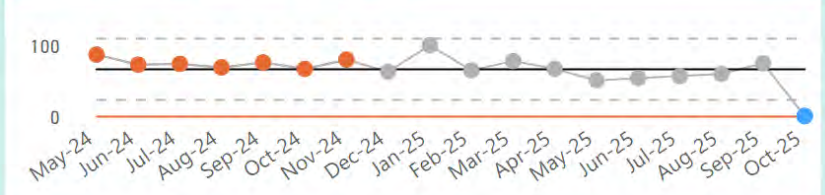


NNUH - SHMI 1.15

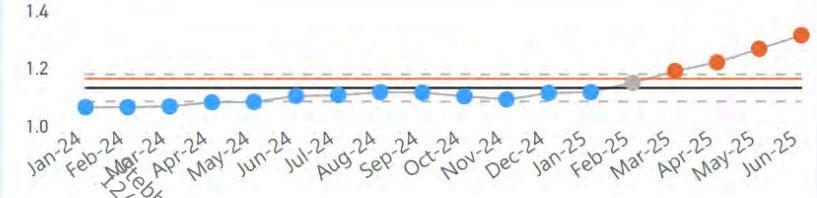
NNUH - Still Birth Rate 0.23%



NNUH - Complaints Received 1

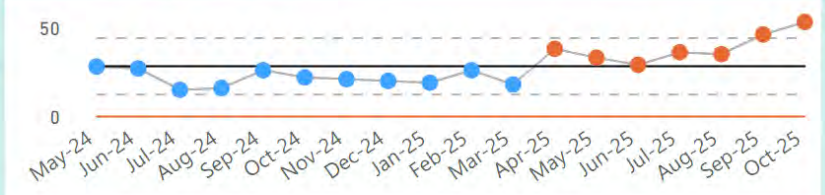


QEH - SHMI 1.31



QEH - Still Birth Rate 2.40%

QEH - Complaints Received 53



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	1.16	1.13	✓	H	?	
NNUH	1.16	1.15	✓	L	F	
QEH	1.16	1.31	✗	H	?	

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	3.5%	0.00%	✓		?	
NNUH	3.5%	0.23%	✓		?	
QEH	3.7%	2.40%	✓	L	?	

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	24	✗		F	!
NNUH	0	1	✗	L	F	
QEH	0	53	✗	H	F	!

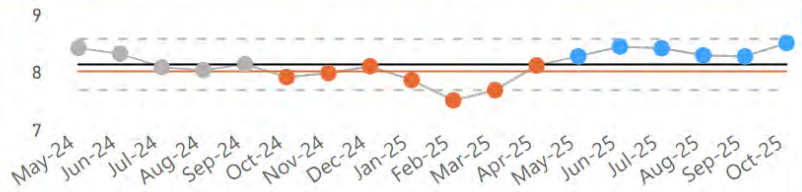
Norfolk and Waveney University Hospitals Group

Safe and Effective Care Domain Appendix - Pre-term Births, CHPPD & Discharge Delay

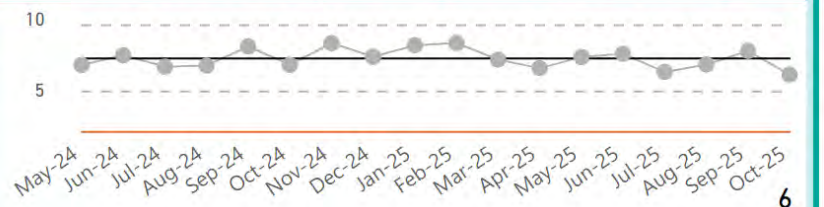
Oct-25

JPUH - Preterm Birth Rate 7.50%

JPUH - Care Hour Per Patient Day (CHPPD) 8.49

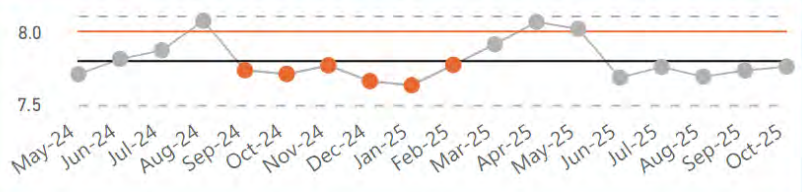


JPUH - Average number of days between planned and actual discharge date

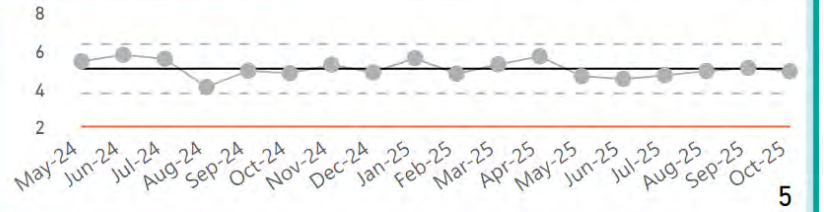


NNUH - Preterm Birth Rate 3.73%

NNUH - Care Hour Per Patient Day (CHPPD) 7.76

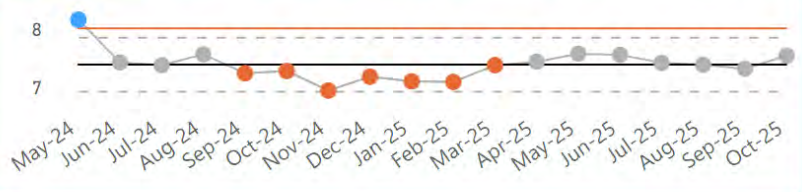


NNUH - Average number of days between planned and actual discharge date



QEH - Preterm Birth Rate 4.92%

QEH - Care Hour Per Patient Day (CHPPD) 7.53



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	5400.0%	7.50%	✓	~	?	◉
NNUH	5400.0%	3.73%	✓	~	?	◉
QEH	5400.0%	4.92%	✓	~	?	◉

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	8.00	8.49	✓	H	?	◉
NNUH	8.00	7.76	✗	~	?	◉
QEH	8.00	7.53	✗	~	?	◉

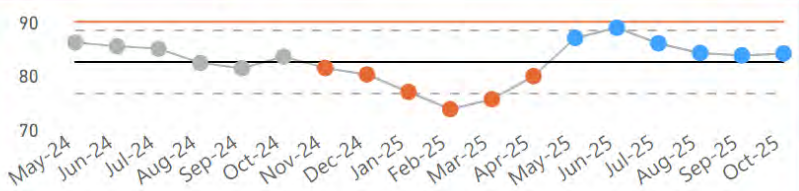
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	2	6	✗	~	F	!
NNUH	2	5	✗	~	F	!

Norfolk and Waveney University Hospitals Group

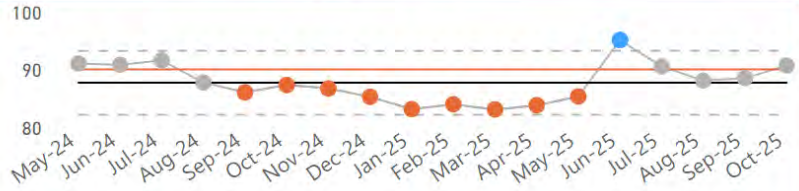
Safe and Effective Care Domain Appendix - Midwifery and Nursing Fill Rate, Readmission Rate

Oct-25

JPUH - Midwifery Fill Rate 84.09%



JPUH - Registered Nurse Fill Rate 90.66%



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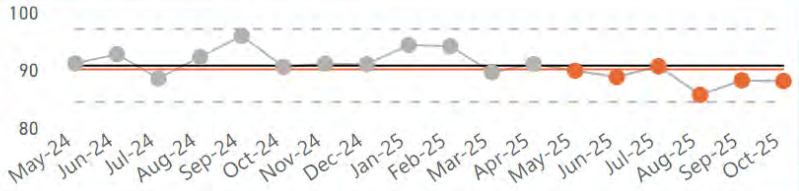
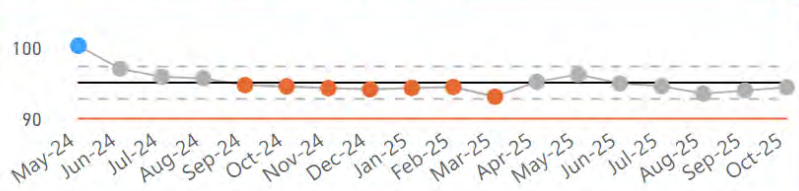
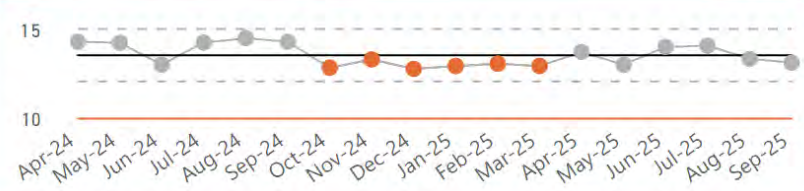
NNUH - Midwifery Fill Rate 87.96%



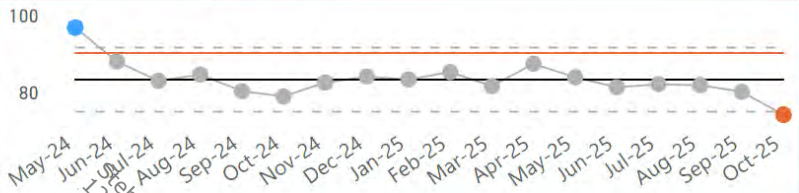
NNUH - Registered Nurse Fill Rate 94.40%



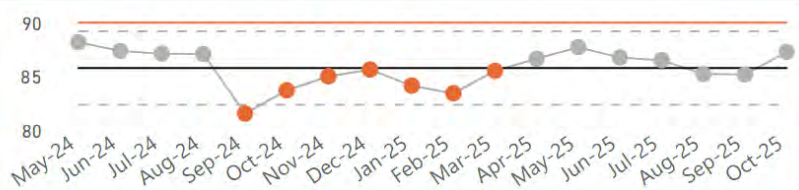
NNUH - Readmission Rate 13.14%



QEH - Midwifery Fill Rate 73.91%



QEH - Registered Nurse Fill Rate 87.29%



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Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	84.09%				
NNUH	90.0%	87.96%				
QEH	90.0%	73.91%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	90.66%				
NNUH	90.0%	94.40%				
QEH	90.0%	87.29%				

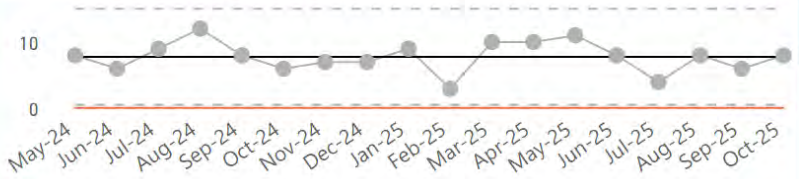
Site	Target	Actual	Compliance	Variation	Assurance	Status
NNUH	10.0%	13.14%				

Norfolk and Waveney University Hospitals Group

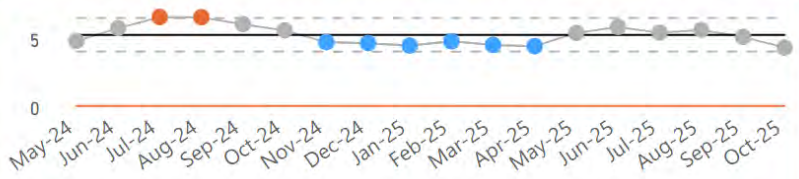
Safe and Effective Care Domain Appendix - Pressure Ulcers and Falls

Oct-25

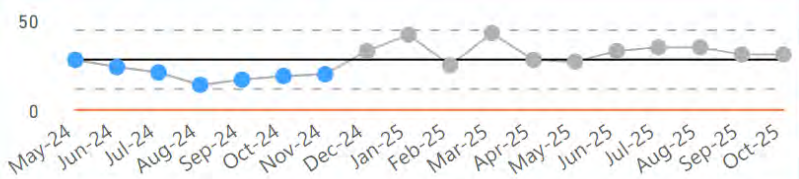
JPUH - Pressure Ulcers 8.00



JPUH - Falls



NNUH - Pressure Ulcers 31.00



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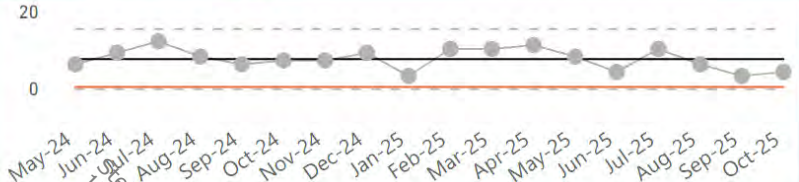
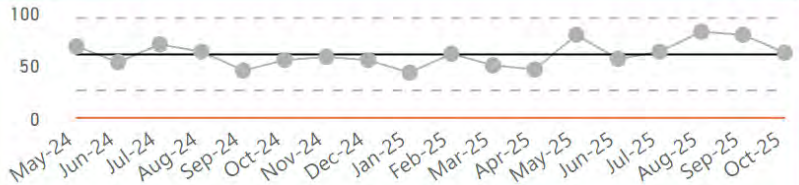
QEH - Pressure Ulcers 4.00



QEH - Falls 62.00



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	8.00				
NNUH	0	31.00				
QEH	0	4.00				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	4.41				
QEH	0	62.00				

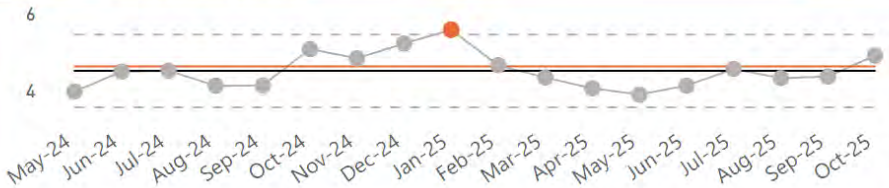
Norfolk and Waveney University Hospitals Group

People and Culture Domain Appendix - Sickness and Turnover

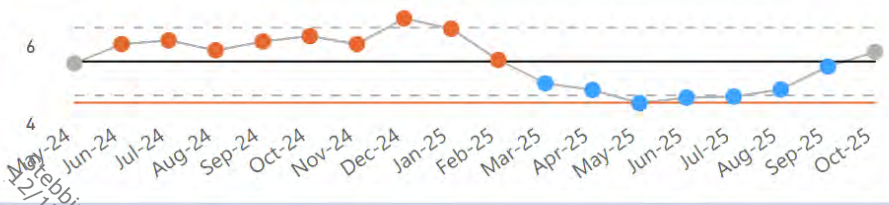
Oct-25

JPUH - Sickness Rate 5.77%

NNUH - Sickness Rate 4.88%



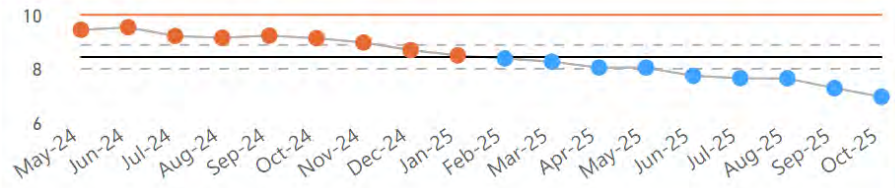
QEH - Sickness Rate 5.82%



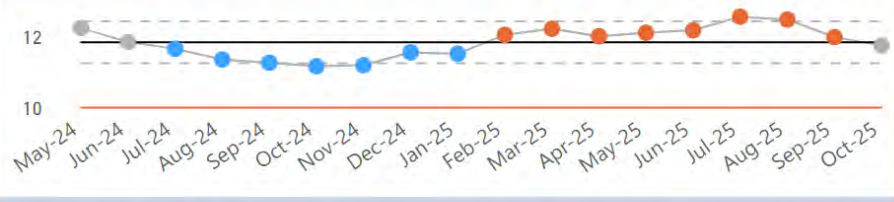
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	4.6%	5.77%	⊗	L	F	👁
NNUH	4.6%	4.88%	⊗	~	?	👁
QEH	4.5%	5.82%	⊗	~	F	!

JPUH - Turnover Rate 6.31%

NNUH - Turnover Rate 6.94%



QEH - Turnover Rate 11.74%



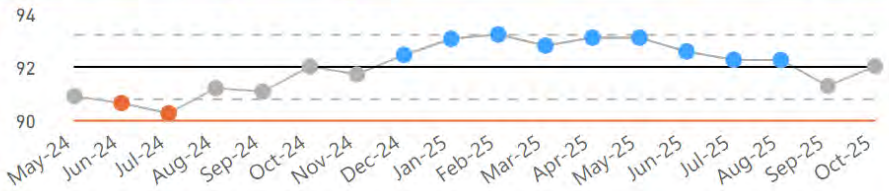
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	10.0%	6.31%	✓	~	?	👁
NNUH	10.0%	6.94%	✓	L	?	👁
QEH	10.0%	11.74%	⊗	~	F	!

Norfolk and Waveney University Hospitals Group

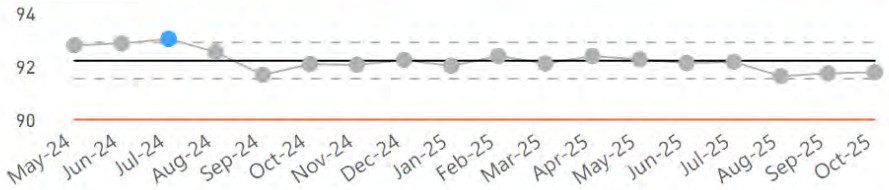
People and Culture Domain Appendix - Mandatory Training and Appraisals

Oct-25

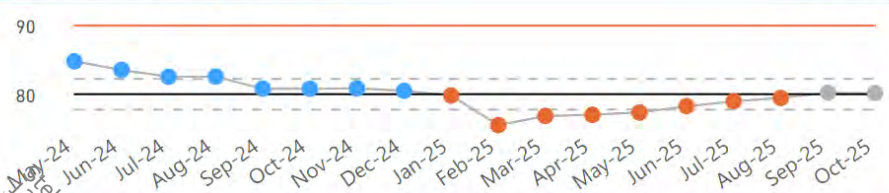
JPUH - Mandatory Training 92.03%



NNUH - Mandatory Training 91.78%

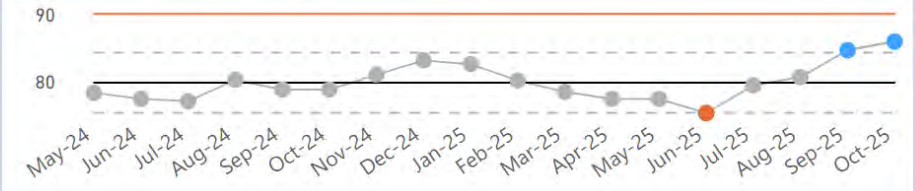


QEH - Mandatory Training 80.24%

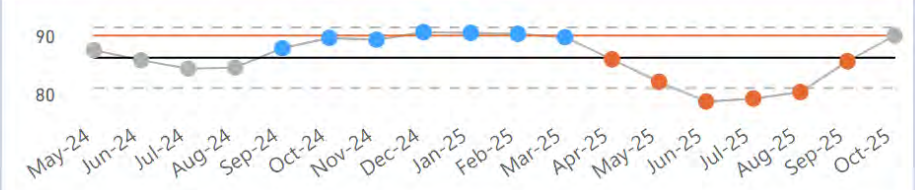


Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	92.03%	✓	~	P	✓
NNUH	90.0%	91.78%	✓	~	P	✓
QEH	90.0%	80.24%	✗	~	?	👁

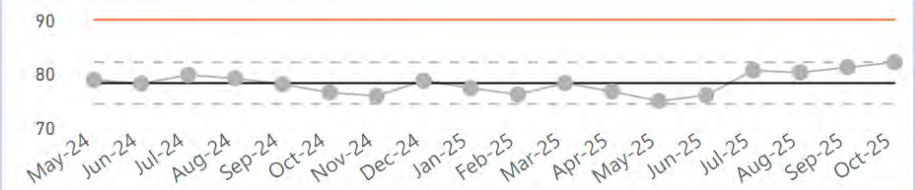
JPUH - Non Medical Appraisal 85.87%



NNUH - Non Medical Appraisal 89.96%



QEH - Non Medical Appraisal 82.07%



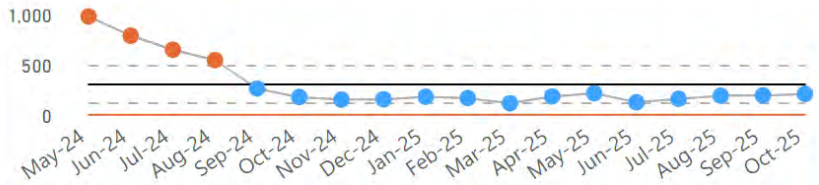
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.0%	85.87%	✗	H	?	👁
NNUH	90.0%	89.96%	✗	~	?	👁
QEH	90.0%	82.07%	✗	~	?	👁

Norfolk and Waveney University Hospitals Group

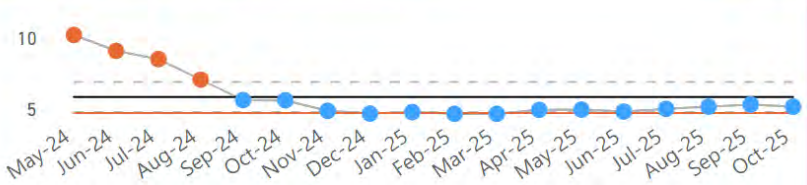
Access and Flow Domain Appendix - RTT

Oct-25

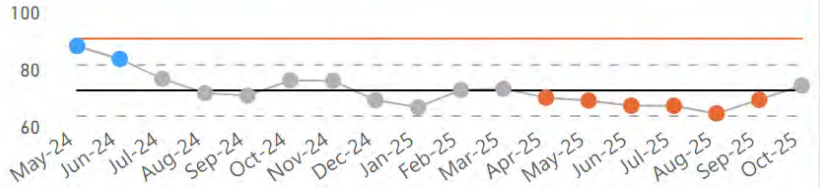
JPUH - 65+ Week Waits 208



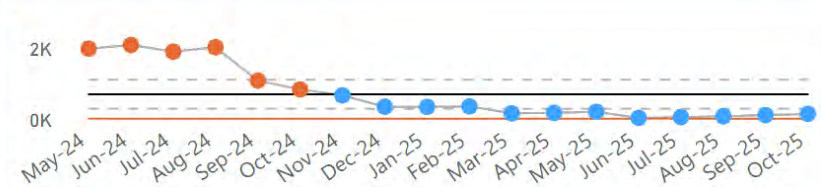
JPUH - 52+ Week Performance 5.14%



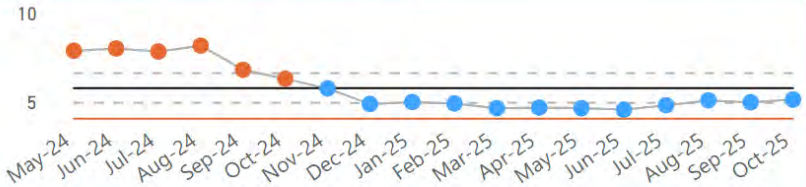
JPUH - 6 Week Diagnostics 74.16%



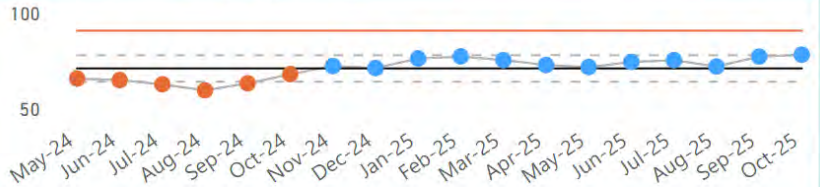
NNUH - 65+ Week Waits 135



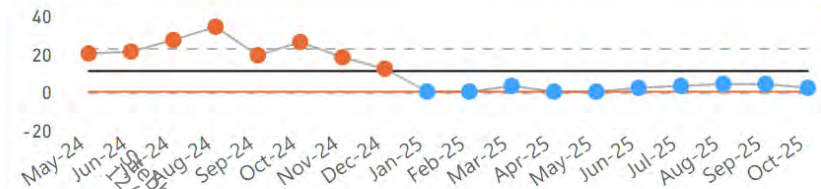
NNUH - 52+ Week Performance 5.08%



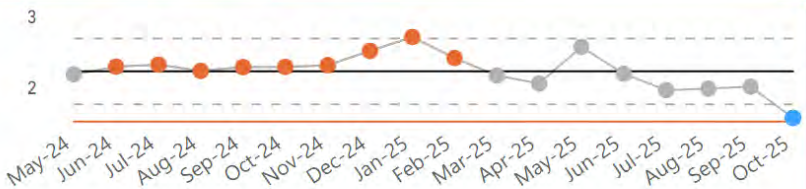
NNUH - 6 Week Diagnostics 77.81%



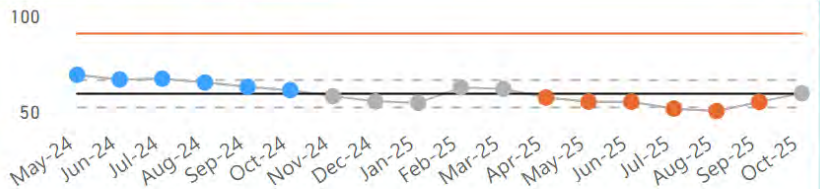
QEH - 65+ Week Waits 2



QEH - 52+ Week Performance 1.55%



QEH - 6 Week Diagnostics 59.14%



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	208	⊗	L	F	
NNUH	0	135	⊗	L	F	
QEH	0	2	⊗	L	?	

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	4.7%	5.14%	⊗	L	F	
NNUH	4.0%	5.08%	⊗	L	F	
QEH	1.5%	1.55%	⊗	L	F	

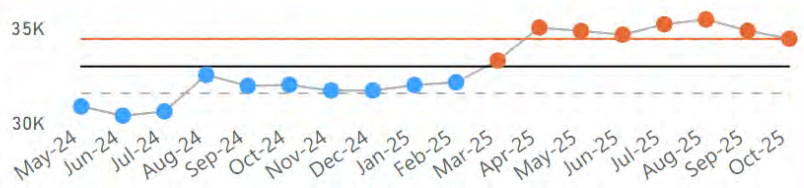
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	90.5%	74.16%	⊗	~	?	
NNUH	90.5%	77.81%	⊗	H	?	
QEH	90.5%	59.14%	⊗	~	?	

Norfolk and Waveney University Hospitals Group

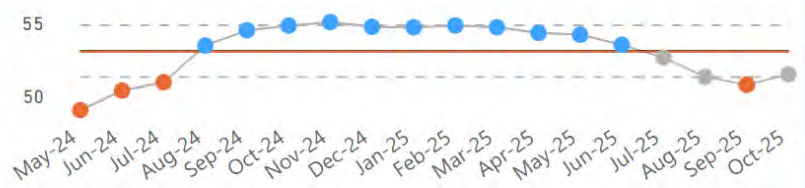
Access and Flow Domain Appendix - RTT

Oct-25

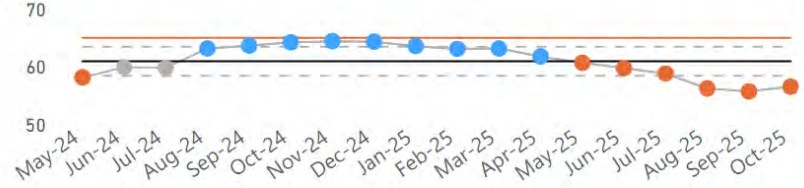
JPUH - Total PTL Size 34,399



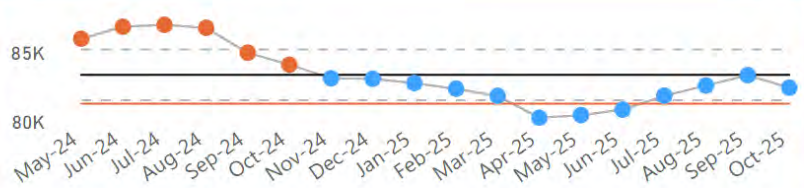
JPUH - RTT Incomplete Within 18 weeks 51.43%



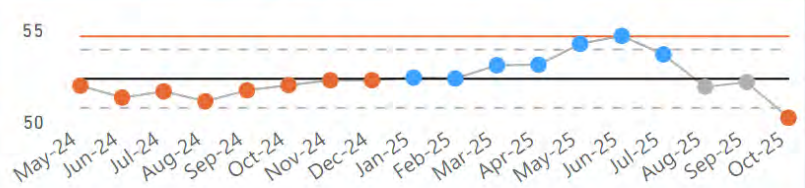
JPUH - First Attendance Within 18 Weeks 56.43%



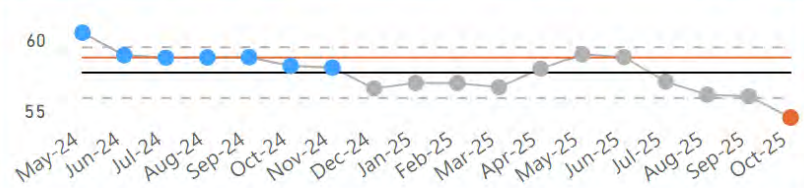
NNUH - Total PTL Size 82,420



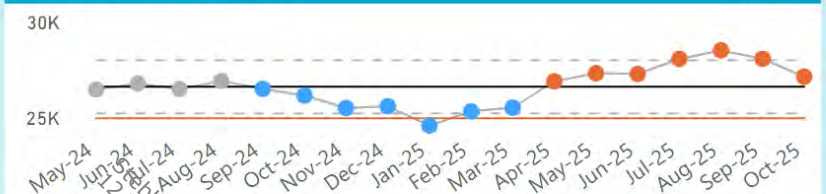
NNUH - RTT Incomplete Within 18 weeks 50.18%



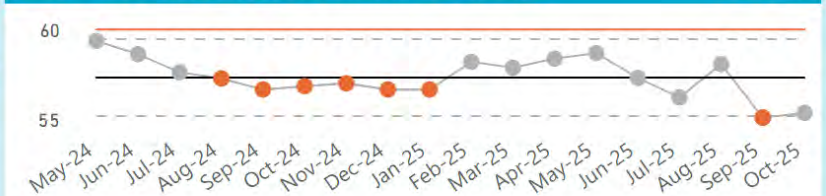
NNUH - First Attendance Within 18 Weeks 54.49%



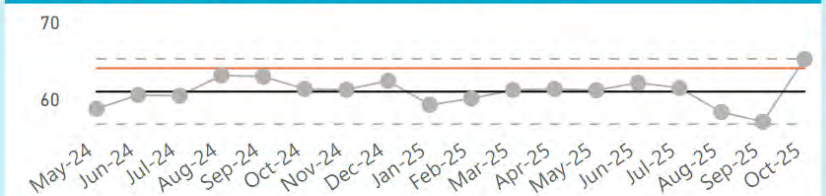
QEH - Total PTL Size 27,123



QEH - RTT Incomplete Within 18 weeks 55.34%



QEH - First Attendance Within 18 Weeks 65.09%



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	34,402	34,399	✓	H	?	
NNUH	81,265	82,420	✗	L	F	
QEH	24,963	27,123	✗	H	F	!

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	53.0%	51.43%	✗		?	
NNUH	54.6%	50.18%	✗	L		
QEH	60.0%	55.34%	✗		?	

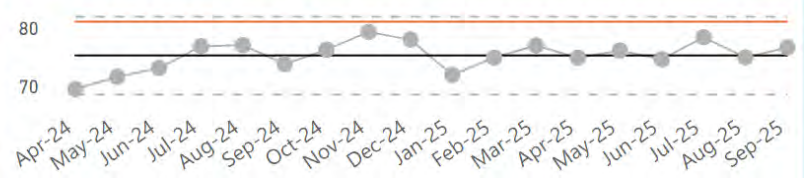
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	64.9%	56.43%	✗	L	?	
NNUH	58.7%	54.49%	✗	L	?	
QEH	63.9%	65.09%	✓		?	

Norfolk and Waveney University Hospitals Group

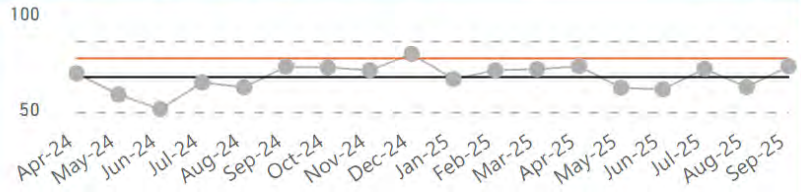
Access and Flow Domain Appendix - Cancer

Oct-25

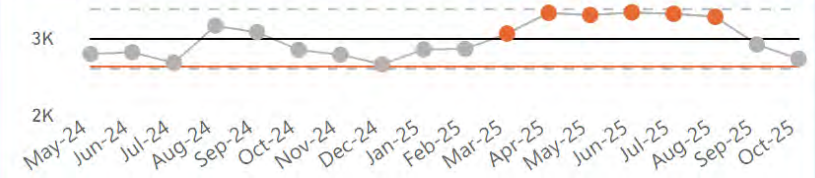
JPUH - 28 Day Faster Diagnosis 76.50%



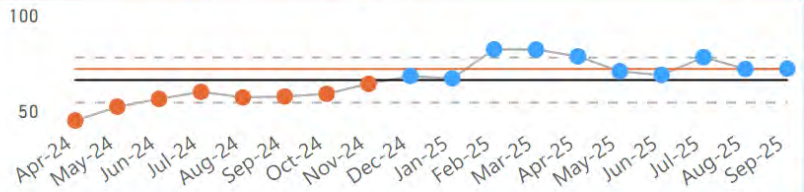
JPUH - Cancer 62 Day Treatment 72.01%



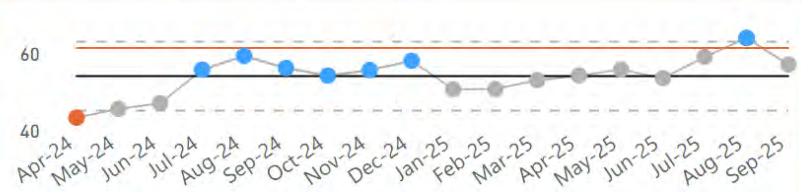
JPUH - Under 18s elective waiting list size 2,715



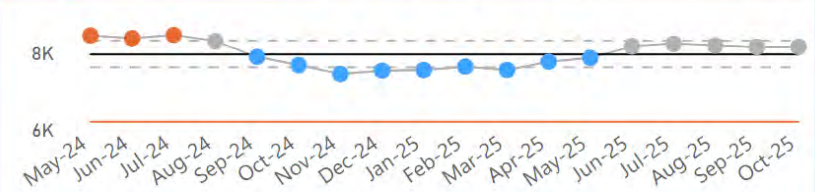
NNUH - 28 Day Faster Diagnosis 71.77%



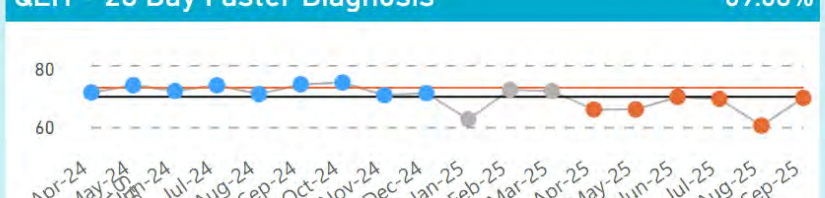
NNUH - Cancer 62 Day Treatment 56.94%



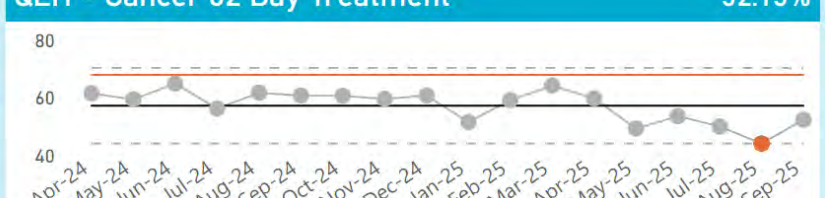
NNUH - Under 18s elective waiting list size 8,145



QEH - 28 Day Faster Diagnosis 69.68%



QEH - Cancer 62 Day Treatment 52.13%



-

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	81.0%	76.50%				
NNUH	71.6%	71.77%				
QEH	73.2%	69.68%				

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	76.1%	72.01%				
NNUH	61.3%	56.94%				
QEH	67.7%	52.13%				

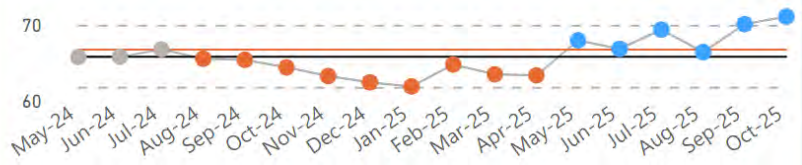
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	2,615	2,715				
NNUH	6,182	8,145				

Norfolk and Waveney University Hospitals Group

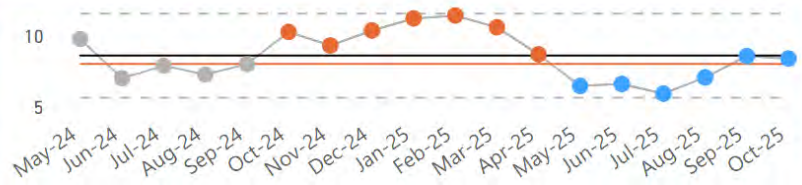
Access and Flow Domain Appendix - UEC

Oct-25

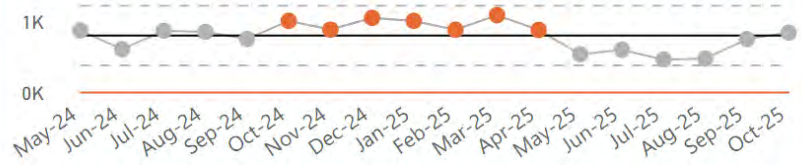
JPUH - ED 4 Hour Performance 70.93%



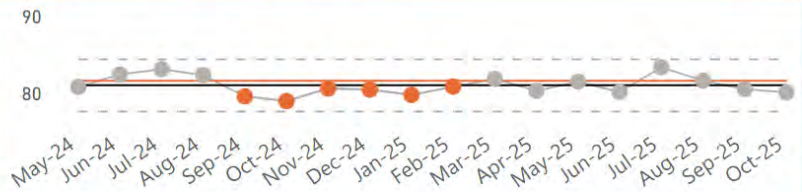
JPUH - ED 12 Hours in Department % 8.37%



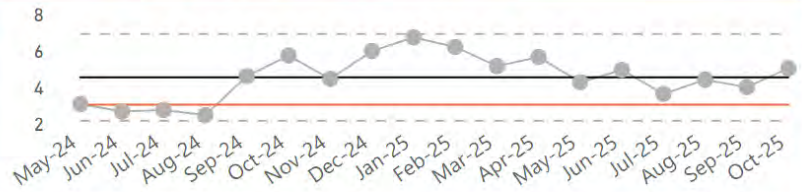
JPUH - Ambulance Handovers Over 30 Minutes 839



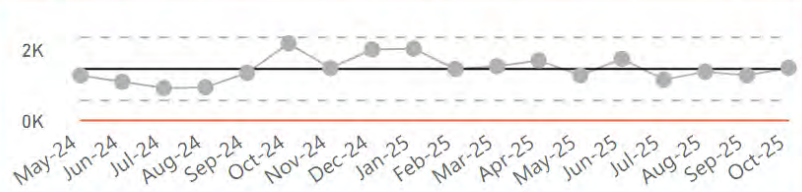
NNUH - ED 4 Hour Performance 79.98%



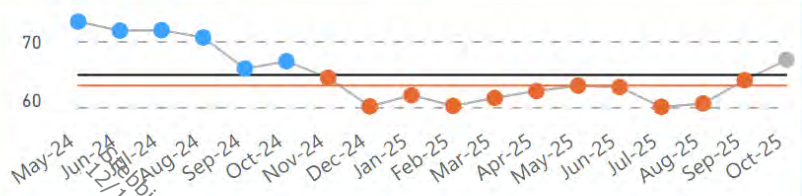
NNUH - ED 12 Hours in Department % 4.99%



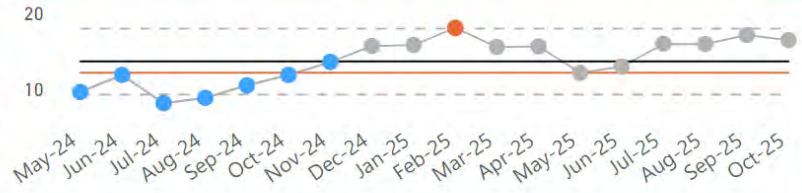
NNUH - Ambulance Handovers Over 30 Minutes 1,476



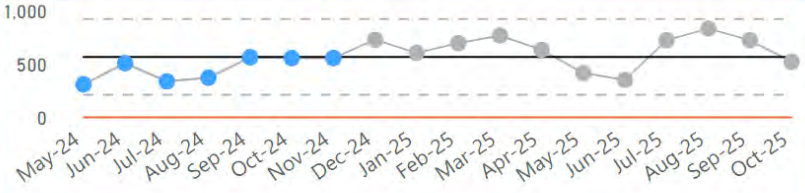
QEH - ED 4 Hour Performance 66.78%



QEH - ED 12 Hours in Department % 16.35%



QEH - Ambulance Handovers Over 30 Minutes 519



Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	66.6%	70.93%	✓	H	?	
NNUH	81.5%	79.98%	✗		?	
QEH	62.3%	66.78%	✓		?	

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	8.0%	8.37%	✗	L	?	
NNUH	3.0%	4.99%	✗		?	
QEH	12.1%	16.35%	✗		?	

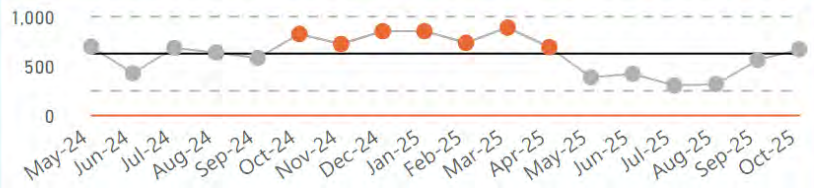
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	839	✗		F	!
NNUH	0	1,476	✗		F	!
QEH	0	519	✗		F	!

Norfolk and Waveney University Hospitals Group

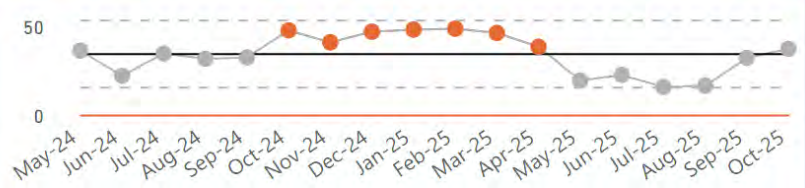
Access and Flow Domain Appendix - UEC

Oct-25

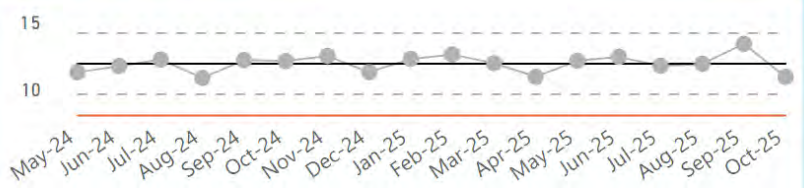
JPUH - Ambulance Handovers Over 45 Minutes 667



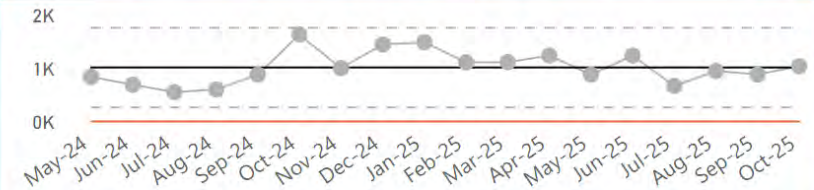
JPUH - Ambulance Handovers Over 45 Minutes % 37.36%



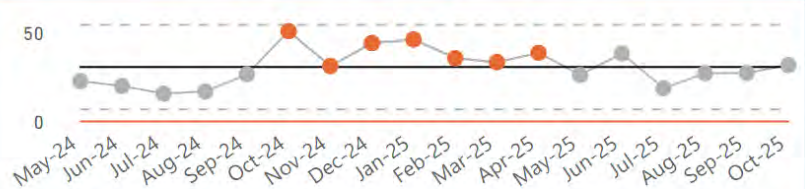
JPUH - Non Elective LoS 10.90



NNUH - Ambulance Handovers Over 45 Minutes 1,033



NNUH - Ambulance Handovers Over 45 Minutes % 31.66%



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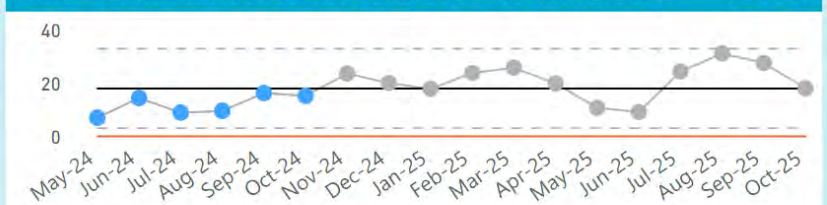
QEH - Ambulance Handovers Over 45 Minutes 324

QEH - Ambulance Handovers Over 45 Minutes % 18.00%



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Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0	667	⊗	~	F	!
NNUH	0	1,033	⊗	~	F	!
QEH	0	324	⊗	~	F	!

Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	0.0%	37.36%	⊗	~	F	!
NNUH	0.0%	31.66%	⊗	~	F	!
QEH	0.0%	18.00%	⊗	~	F	!

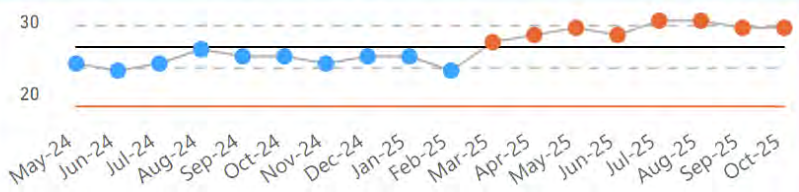
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	8	10.90	⊗	~	F	!

Norfolk and Waveney University Hospitals Group

Access and Flow Domain Appendix - Clearance Times

Oct-25

JPUH - Estimated clearance times 29



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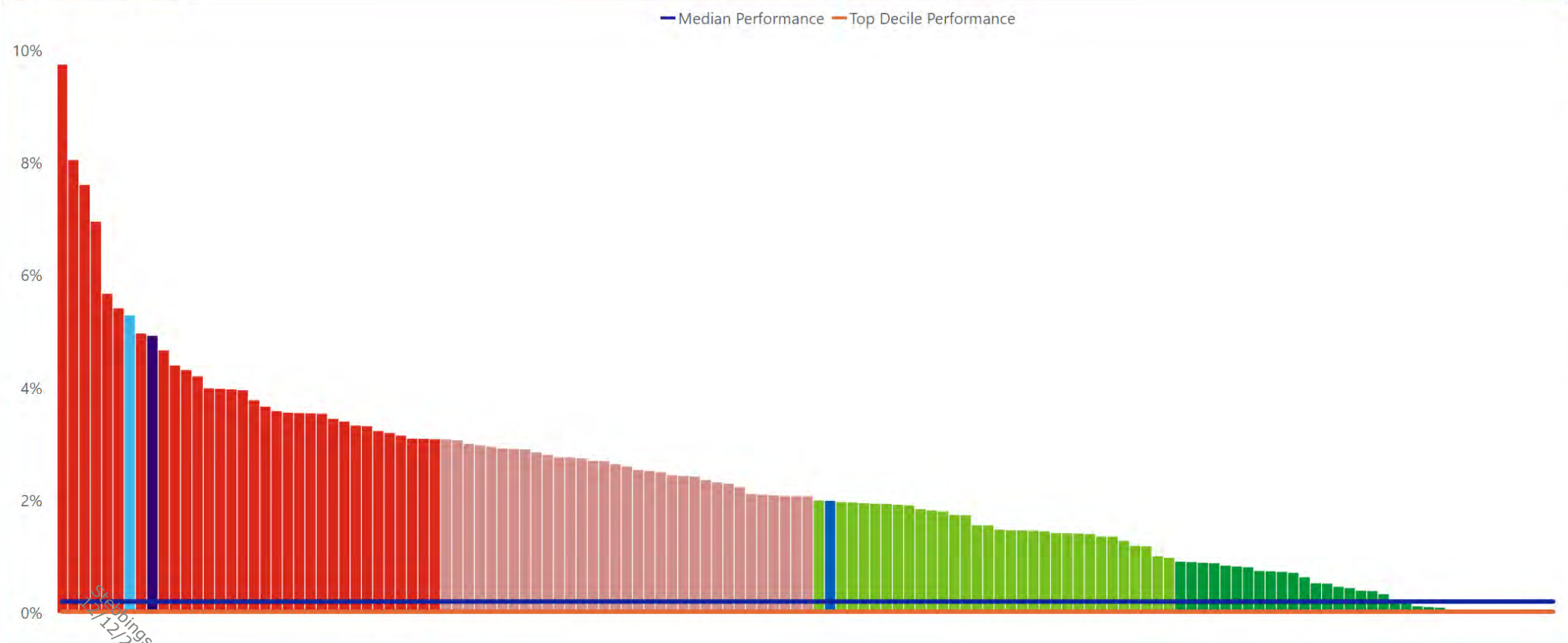
Site	Target	Actual	Compliance	Variation	Assurance	Status
JPUH	18	29	⊗	H	F	!

NHS
Norfolk and Waveney
University Hospitals Group

Benchmarking

Sep-25

RTT 52+ Weeks



Current Performance

JPUH	5.29%
NNUH	4.92%
QEH	1.99%
0.22% Top Decile	
2.04% Median	

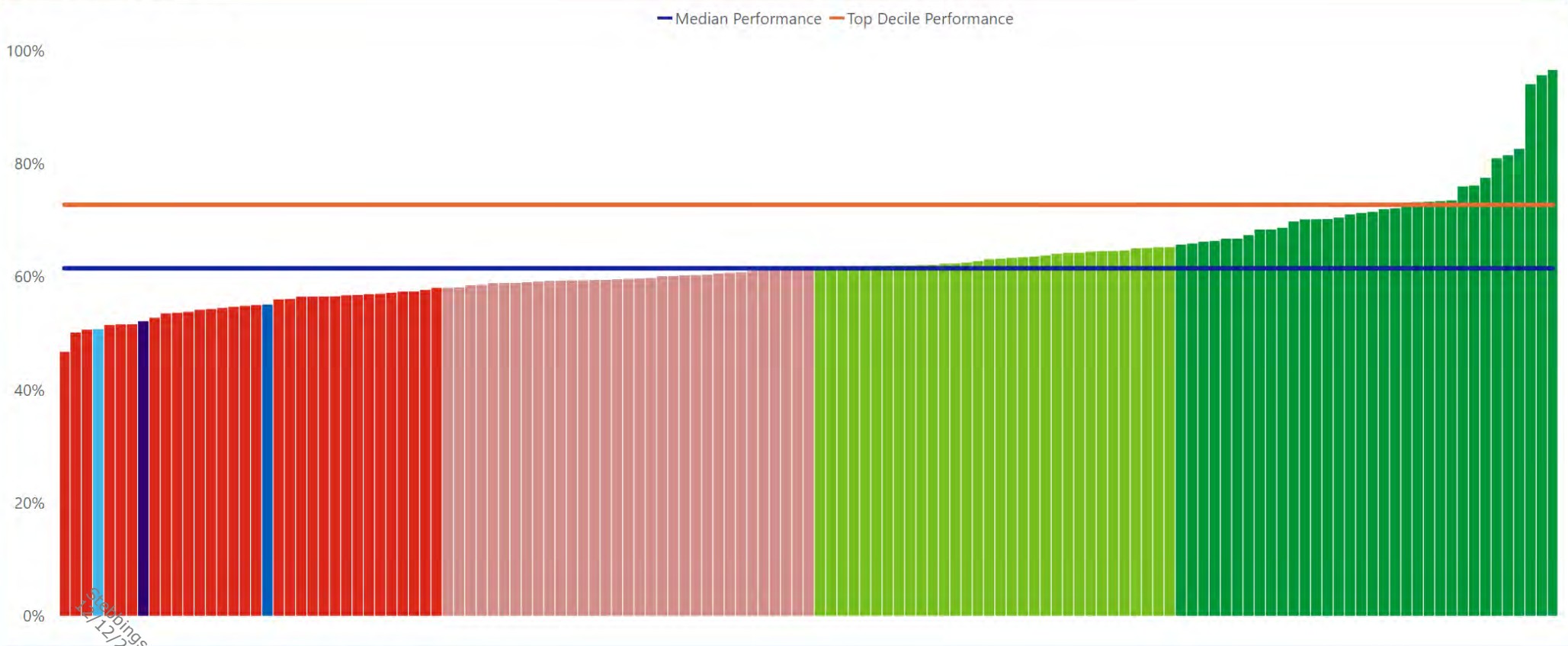
Metric Name	Percentage of patients waiting over 52 weeks
Basis	End of period
Description	Of the total elective (RTT) waiting list, the percentage of patients who have been waiting more than 52 weeks.
Purpose	This metric allows us to track delivery of the 2025/26 priority to reduce 52 week waits to below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

NHS
Norfolk and Waveney
University Hospitals Group

Benchmarking

Sep-25

RTT Within 18 Weeks



Current Performance

JPUH 50.71%

NNUH 52.11%

QEH 55.06%

72.72% Top Decile

61.46% Median

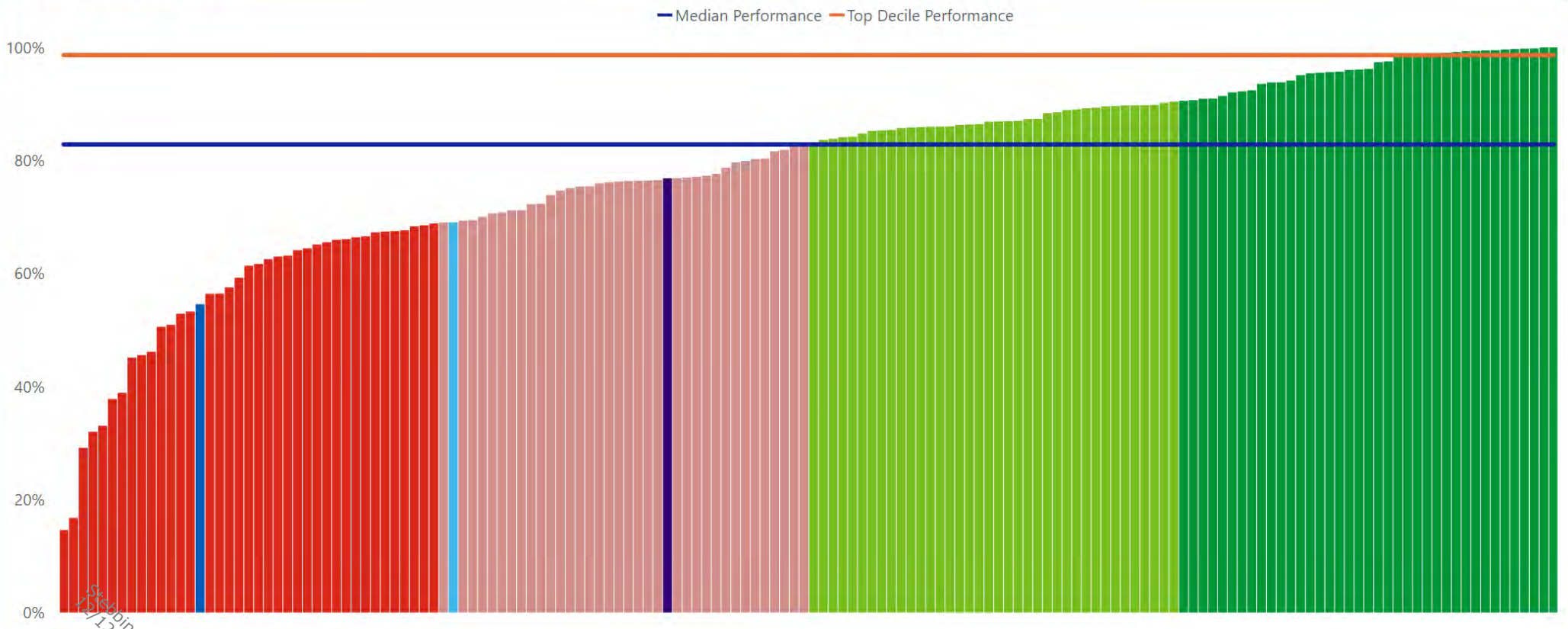
Metric Name	Percentage of patients waiting less than 18 weeks
Basis	End of period
Description	Of the total elective (RTT) waiting list, the number of patients who have been waiting less than 18 weeks.
Purpose	This allows absolute 18 week performance to be tracked to allow for direct performance comparisons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

NHS
Norfolk and Waveney
University Hospitals Group

Benchmarking

Sep-25

6 Week Diagnostics



Current Performance

JPUH	69.05%
NNUH	76.85%
QEH	54.56%
98.63% Top Decile	
82.82% 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.

NHS
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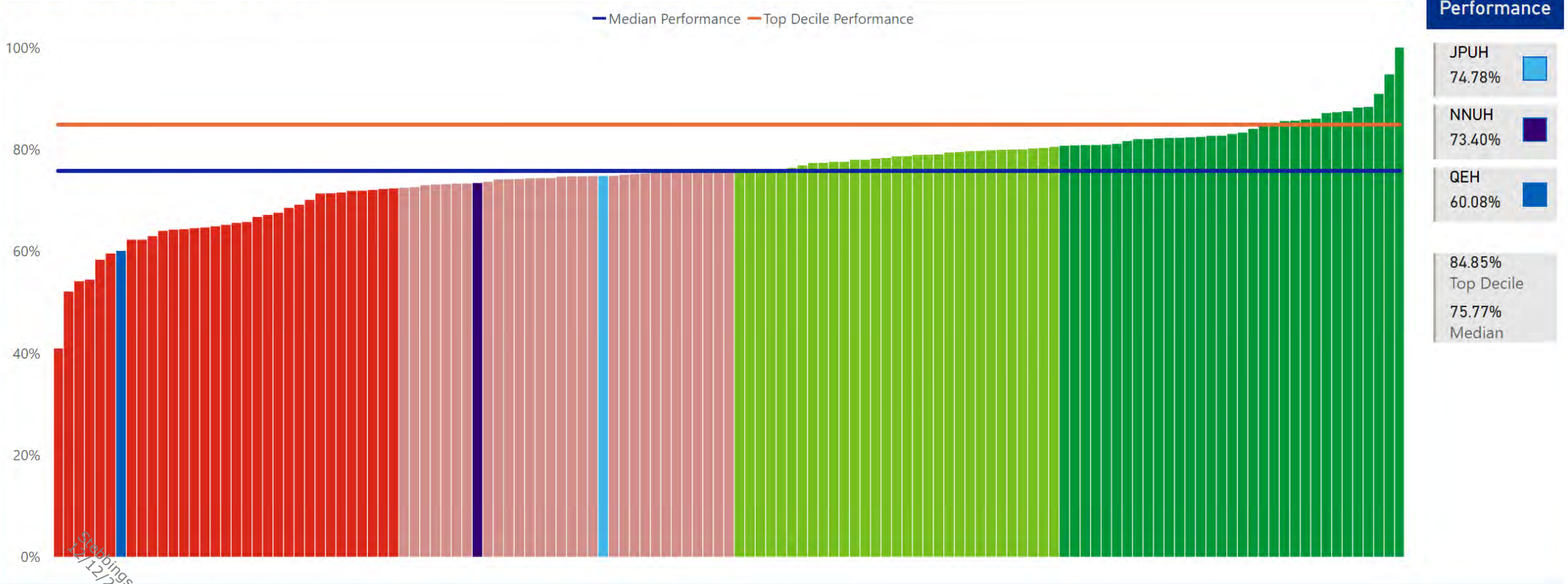
University Hospitals Group

Benchmarking

Aug-25

Cancer 28 Day FDS - Current



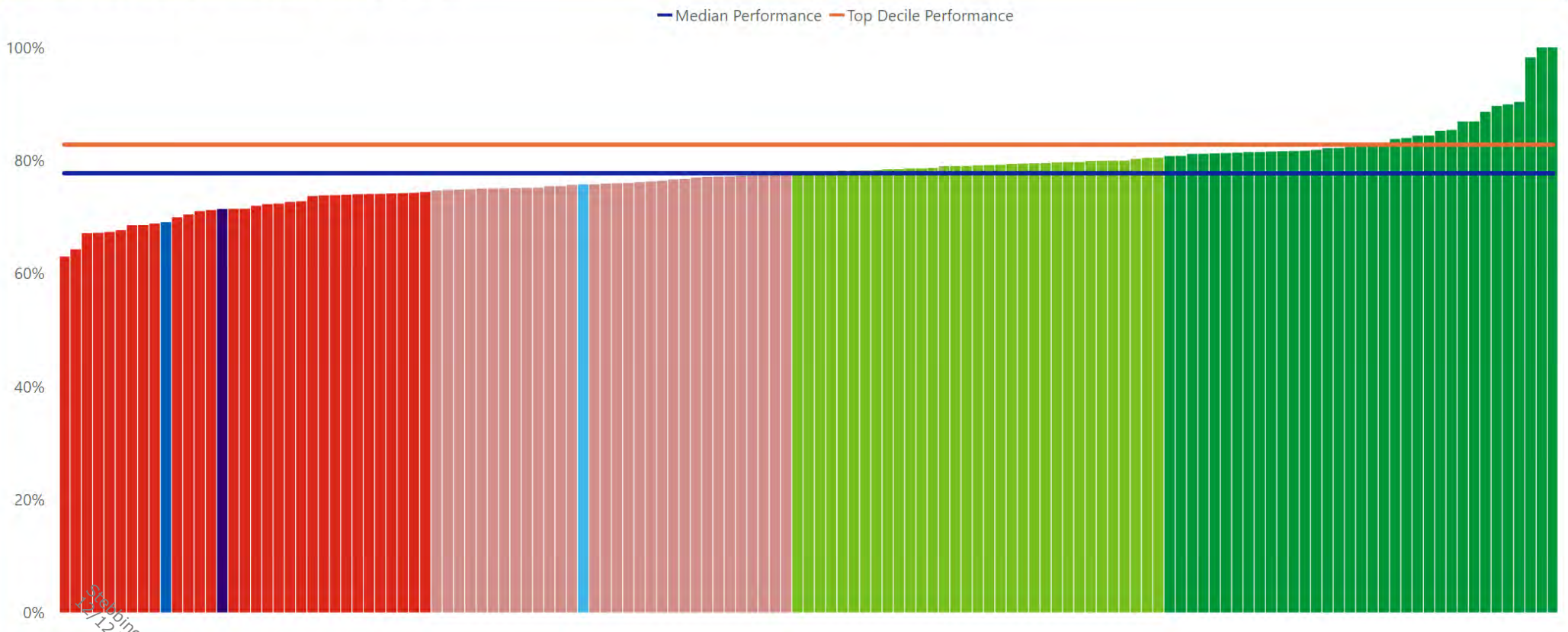
Metric Name	Percentage of urgent cancer referrals to receive a definitive diagnosis within four weeks.
Basis	End of Period
Description	Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat (FDS clock stops) within 28 days following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

NHS
Norfolk and Waveney
University Hospitals Group

Benchmarking

Aug-25

Cancer 28 Day FDS - Rolling 12 Months



Current Performance

JPUH 75.76%

NNUH 71.42%

QEH 69.09%

82.81% Top Decile

77.73% Median

Stebbings,Susan 12/12/2025 13:30:55

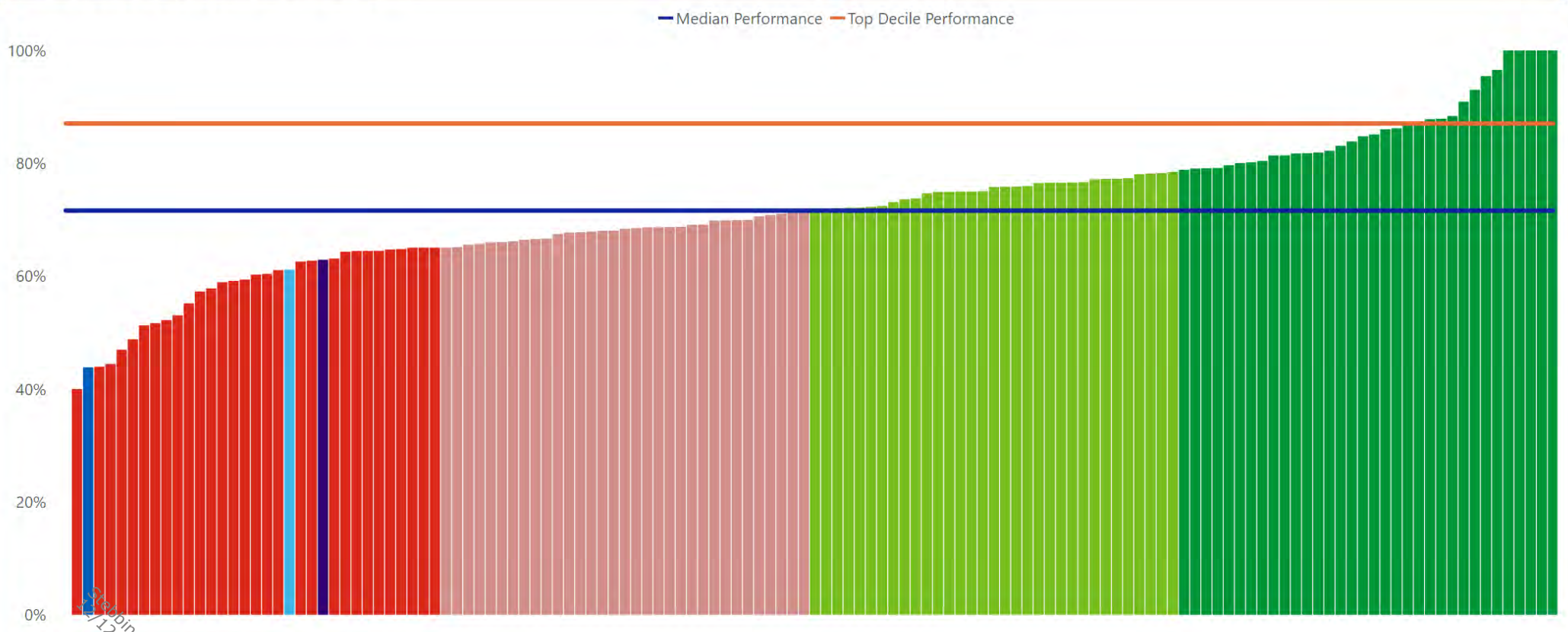
Metric Name	Percentage of urgent cancer referrals to receive a definitive diagnosis within four weeks.
Basis	Rolling 12-month
Description	Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat (FDS clock stops) within 28 days following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

NHS
Norfolk and Waveney
University Hospitals Group

Benchmarking

Aug-25

Cancer 62 Day Treatment - Current



Current Performance

JPUH 61.17%

NNUH 62.92%

QEH 43.84%

87.06% Top Decile

71.62% Median

Stebbings,Susan 12/12/2025 13:30:55

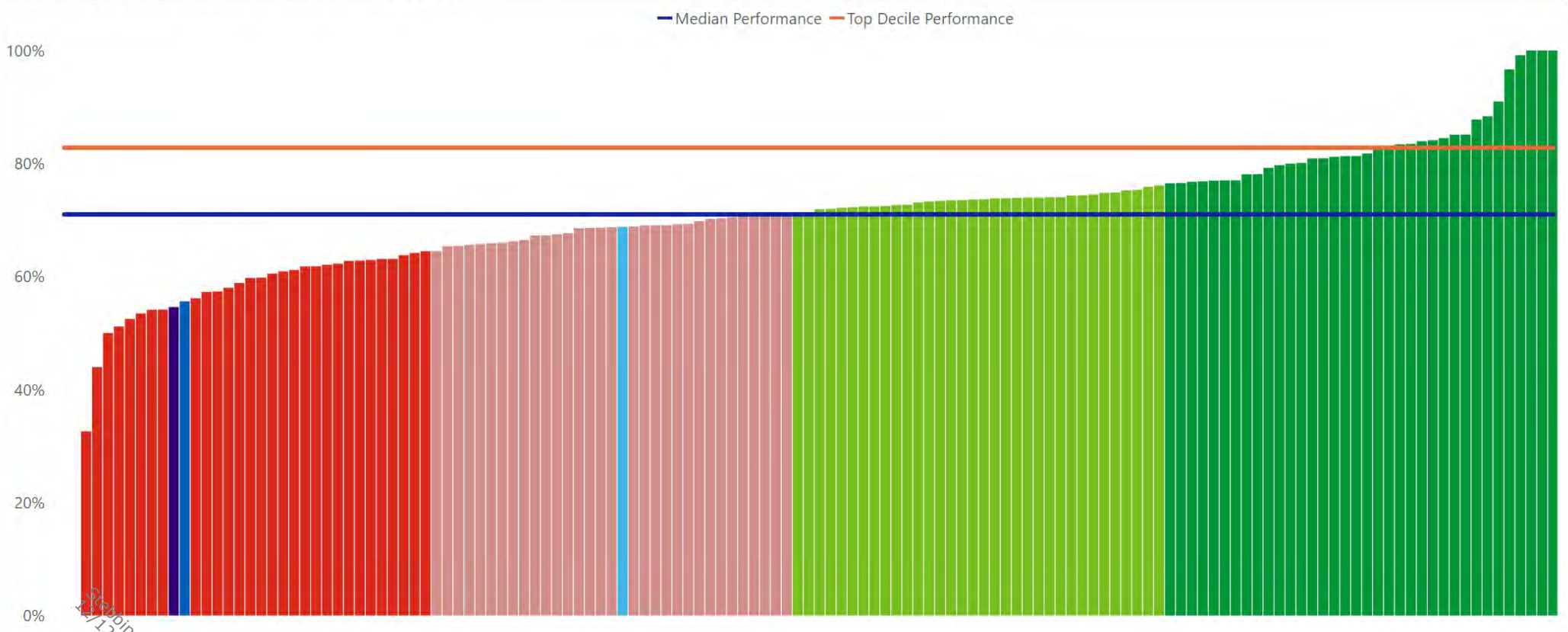
Metric Name	Percentage of patients treated for cancer within 62 days of referral
Basis	End of period.
Description	Percentage of patients receiving a first treatment for cancer within 62 days following an urgent referral.
Purpose	This measures the percentage of patients beginning treatment in a timely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

NHS
Norfolk and Waveney
University Hospitals Group

Benchmarking

Aug-25

Cancer 62 Day Treatment - Rolling 12 Months



Current Performance

JPUH 68.77%

NNUH 54.59%

QEH 55.60%

82.81% Top Decile

70.97% Median

Stebbings,Susan 12/12/2025 13:30:15

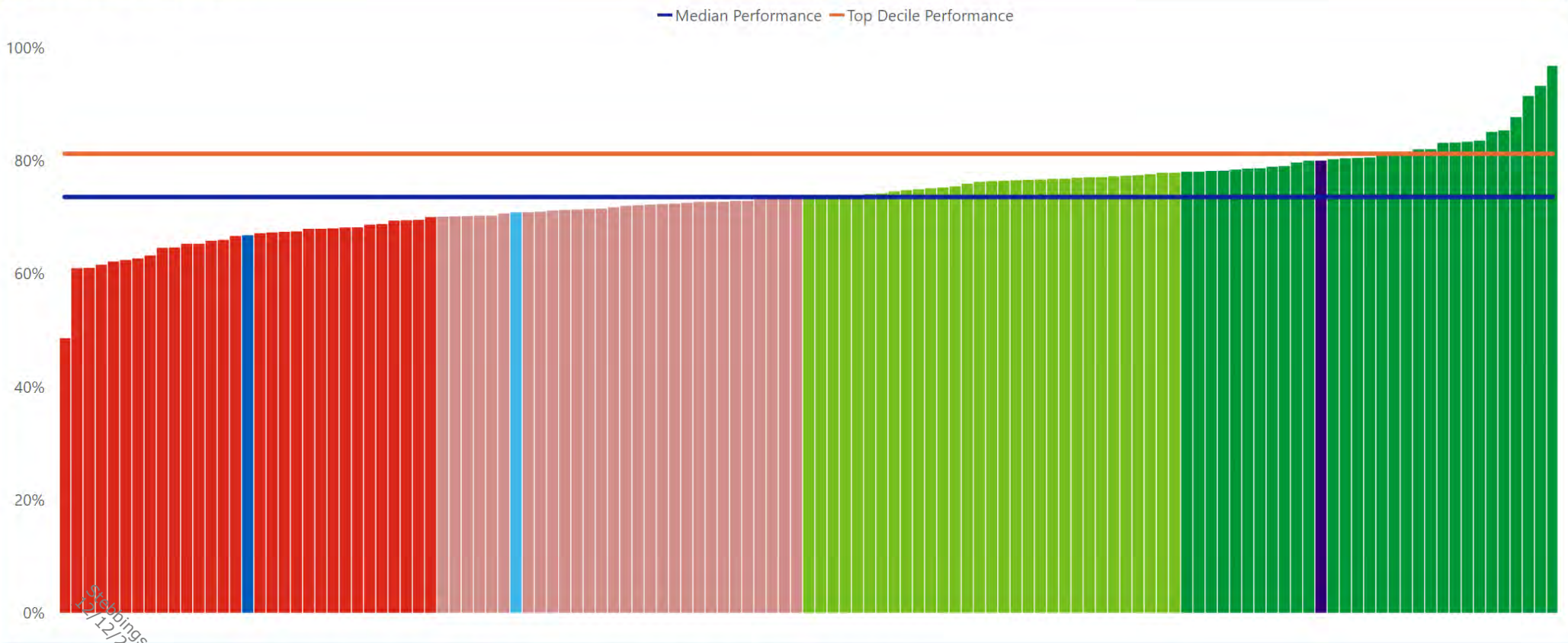
Metric Name	Percentage of patients treated for cancer within 62 days of referral
Basis	Rolling 12-month
Description	Percentage of patients receiving a first treatment for cancer within 62 days following an urgent referral.
Purpose	This measures the percentage of patients beginning treatment in a timely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

NHS
Norfolk and Waveney
University Hospitals Group

Benchmarking

Oct-25

ED 4 Hours - Current



Current Performance

JPUH 70.83%

NNUH 79.98%

QEH 66.78%

81.20% Top Decile

73.55% Median

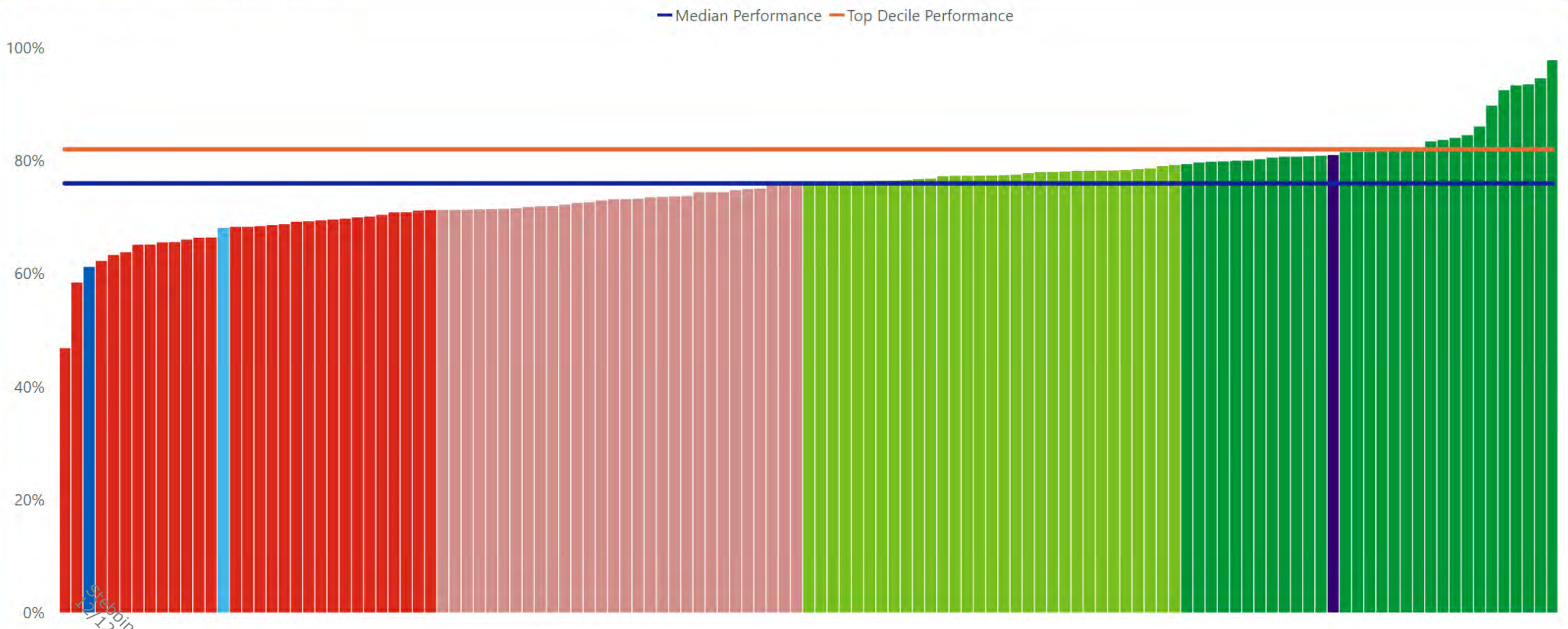
Metric Name	Percentage of emergency department attendances admitted, transferred or discharged within four hours
Basis	End of Period.
Description	Percentage of emergency department attendances managed within 4 hours
Purpose	This measures performance against the NHS constitutional pledge and is a key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

NHS
Norfolk and Waveney
University Hospitals Group

Benchmarking

Oct-25

ED 4 Hours - Rolling 3 Months



Current Performance

JPUH 68.07%

NNUH 80.97%

QEH 61.18%

81.97% Top Decile

75.95% Median

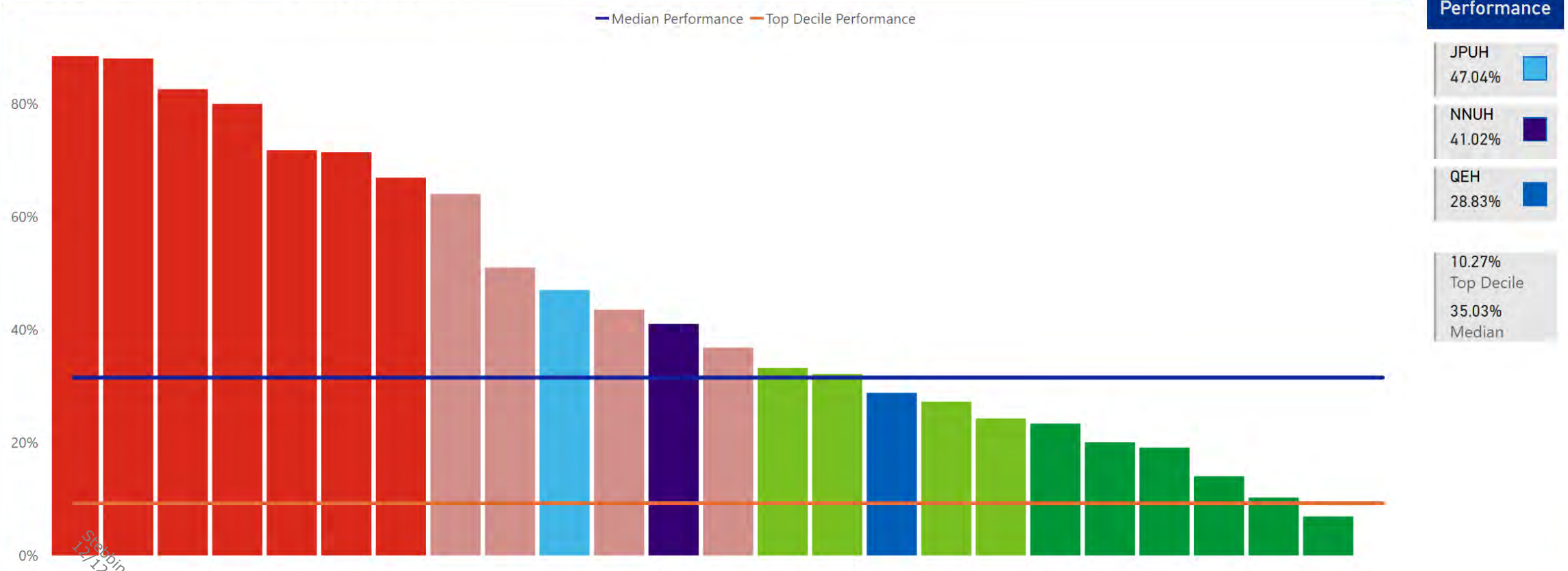
Metric Name	Percentage of emergency department attendances admitted, transferred or discharged within four hours
Basis	Rolling 3-month
Description	Percentage of emergency department attendances managed within 4 hours
Purpose	This measures performance against the NHS constitutional pledge and is a key 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.

NHS
Norfolk and Waveney
University Hospitals Group

Benchmarking

Oct-25

Ambulance Handovers - 30 Minutes Current

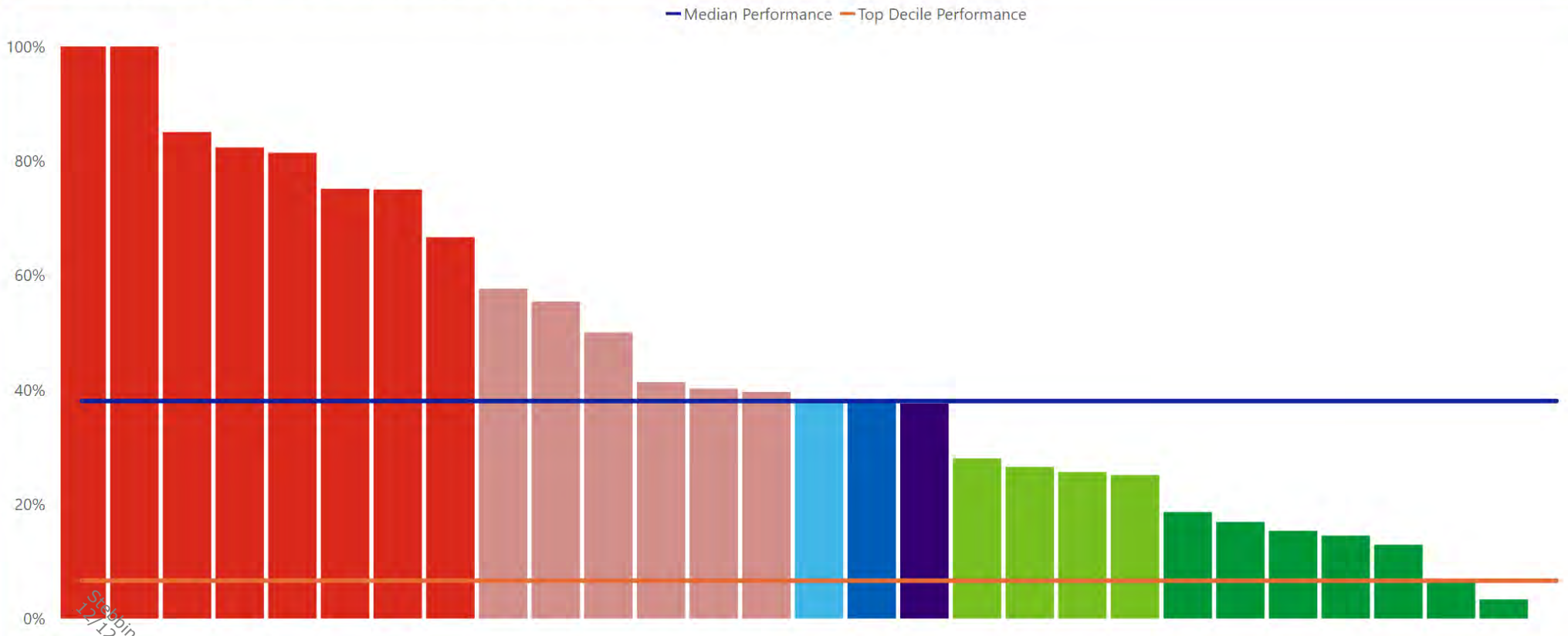


Metric Name	Percentage of ambulance handovers completed in over 30 minutes
Basis	End of Period
Description	Percentage of ambulance handovers completed outside of 30 minutes within the East of England
Purpose	This measures performance against the NHS constitutional pledge and is a key metric for showing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

Benchmarking

Oct-25

Ambulance Handovers - 30 Minutes Rolling 3 Months



Current Performance

JPUH 38.22%

NNUH 37.59%

QEH 37.83%

6.61% Top Decile

38.02% Median

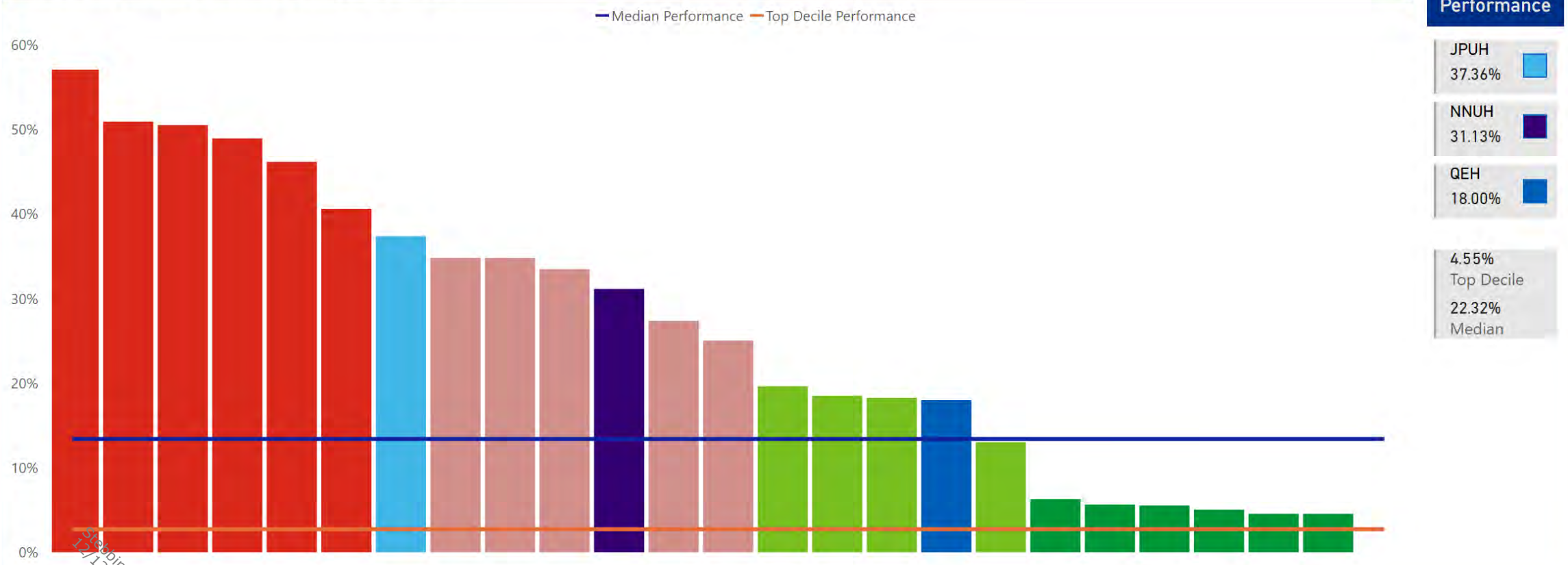
Metric Name	Percentage of ambulance handovers completed outside of 30 minutes
Basis	Rolling 3 months
Description	Percentage of ambulance handovers completed in over 30 minutes within the East of England
Purpose	This measures performance against the NHS constitutional pledge and is a key metric for showing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

NHS
Norfolk and Waveney
University Hospitals Group

Benchmarking

Oct-25

Ambulance Handovers - 45 Minutes Current



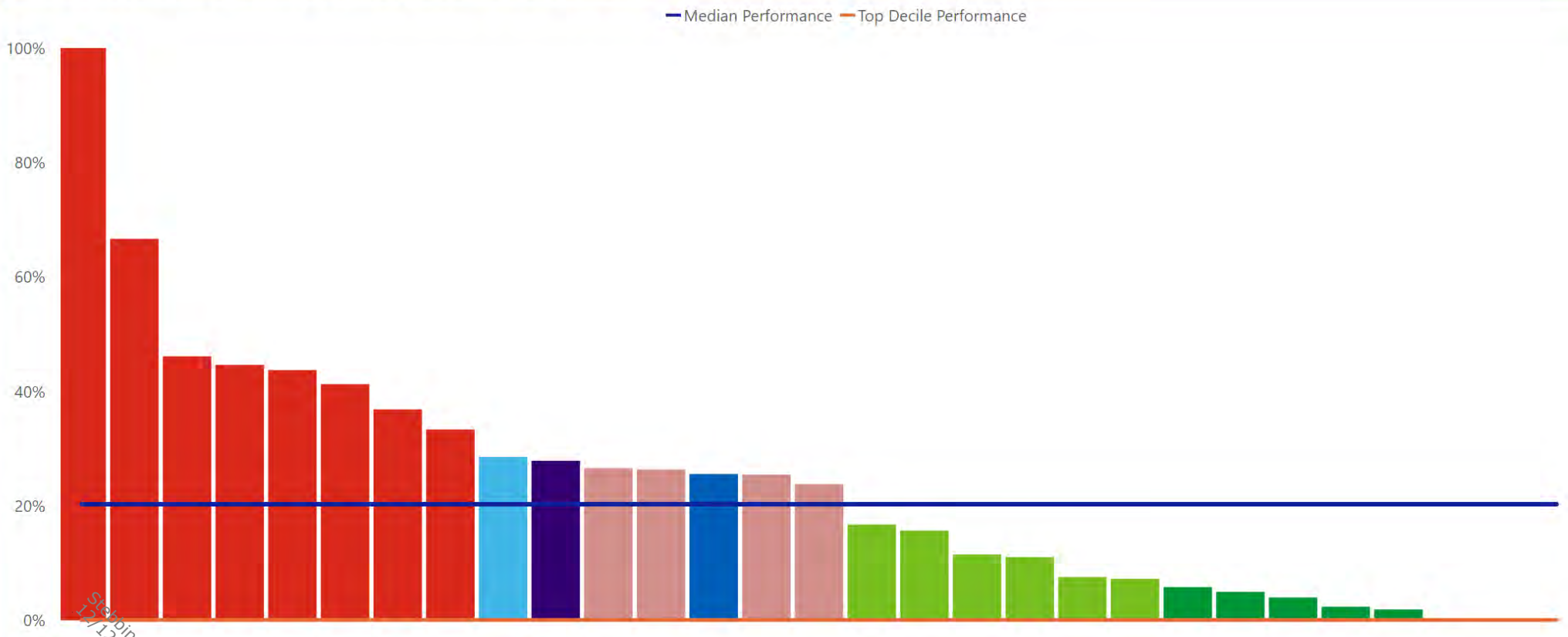
Metric Name	Percentage of ambulance handovers completed in over 45 minutes
Basis	End of Period
Description	Percentage of ambulance handovers completed outside of 45 minutes within the East of England
Purpose	This measures performance against the NHS constitutional pledge and is a key metric for showing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

NHS
Norfolk and Waveney
University Hospitals Group

Benchmarking

Oct-25

Ambulance Handovers - 45 Minutes Rolling 3 Months



Current Performance

JPUH 28.53%

NNUH 27.89%

QEH 25.57%

0.00% Top Decile

20.27% 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

NHS
James Paget University Hospitals
NHS Foundation Trust

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.
H	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?
L	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.	
H	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?
L	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.
F	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.
P	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.

OUR **PATIENTS**

OUR **PEOPLE**

OUR **PARTNERS**

OUR **PERFORMANCE**

Understanding the Matrix

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

Norfolk and Waveney
University Hospitals Group

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: Group Finance Report Month 7

Sponsor:	Group Chief Finance Officer
Author:	Group Chief Finance Officer
Previous scrutiny:	• Group Risk Assurance Committee dated 27 November 2025
Purpose:	The paper is presented for **Assurance**.

Executive Summary and Purpose

The Group position for month 7 is a breakeven against a surplus plan of £1.1m at the control total, which is an adverse variance of £1.1m. NNUH had a deficit of £2.7m in month, an adverse variance of £3.8m, although there was a cost of redundancy of £8.4m in month which was not in the original plan, therefore excluding this cost NNUH would have been in surplus. This is derived from the favourable variance on clinical income relating to the position agreed with the ICB, which also materially impacts QEH and to a lesser extent JPUH.

QEH had a £2.5m surplus in month a favourable variance of £2.4m. The favourable variance on income was offset by the continued adverse variance predominantly on pay relating to additional investments that have been made, but also the lack of delivery of the workforce reduction targets set in the plan. JPUH had a small surplus and favourable variance against the plan in month and continues to deliver towards the agreed year-end breakeven position.

Due to the redundancies at NNUH the year-to-date (YTD) position remains a deficit of £12.2m an adverse variance of £8.1m. The focus for all three organisations is delivering the efficiencies and ensuring the controls that have been put in place will secure the forecast for the year.

The clinical income for the Group has been resolved following an agreement with the ICB as described to the Board last month. The YTD position is broadly on plan with a small favourable variance overall. Other income was a favourable variance in month of £4.2m, mainly due to the pass-through costs for drugs and devices with the commissioners, Cancer Alliance funding and Research & Development income. The total favourable variance to date is £16.9m which is offset by expenditure, mainly in non-pay.

The pay expenditure in month was an adverse variance of £6.7m, however when removing the redundancy costs in NNUH of £8.4m the pay position was a favourable variance. The key issue moving forwards on pay is with QEH as they have not reduced the substantive workforce in line with the original plan and have invested in additional staffing for the Emergency Department. The non pay was an adverse variance some of which relates to pass-through costs associated with the additional other income, however there was an increase in insourcing costs at QEH.

A full capital report was shared with the Group Executive at month 6 with the forecast outturn slide as at month 7 added to this report. This shows that at month 7 a planned expenditure of £202.5m with an expected underspend of £24.2m. This does not consider any potential underspend on the EPR or

other programmes and the impact that this would have on these programmes into next financial year. The main underspends to date are on system capital, which is a timing issue. However, there are some programmes that the position could change depending on key decisions, for example the EPR. The forecast at month 7 shows an underspend mainly on the UEC and elective recovery, although there is work ongoing with regards to the EPR forecast which will be reported elsewhere to Group Board.

The key risks are included in the report with financial performance against plan scoring 11, which is a reduction from last month due to the agreement on income with the ICB. A new risk this month that was discussed at Group Risk Assurance Committee is on capital and the potential impact of underspending the Capital Departmental Expenditure Limit (CDEL) for the year.

Board Action Required

Note: The Group Board is recommended to note the contents of the position as at month 7 including the risk.

NHS
Norfolk and Waveney
University Hospitals Group

Norfolk and Waveney University Hospitals Group

Group Finance Report
October 2025

20 November 2025

Marcus Thorman, Group Chief Finance Officer

Norfolk and Waveney University Hospitals Group

1. Executive Dashboard

The October position is breakeven on a control total basis, £1.1m adverse to the planned £1.1m surplus. The adverse variance of NNUH (£3.8m) is offset by favourable variances at JPUH (£0.3m) and QEH (£2.4m). Year to date position is a £12.2m deficit on a control total basis, £8.1m adverse to the planned £4.2m deficit. NNUH is £7.7m adverse and QEH is £1.1m adverse, offset by a YTD £0.8m favourable variance at JPUH.

October: The October position is breakeven on a control total basis, £1.1m adverse to the planned £1.1m surplus. The adverse variance of NNUH (£3.8m) is offset by favourable variances at JPUH (£0.3m) and QEH (£2.4m).

Year to date: Year to date position is a £12.2m deficit on a control total basis, £8.1m adverse to the planned £4.2m deficit. NNUH is £7.7m adverse and QEH is £1.1m adverse, offset by a YTD £0.8m favourable variance at JPUH.

Activity: Value-based activity performance for October was favourable by £5.0m, JPUH is favourable by £1.0m and QEH is favourable by £4.0m. NNUH is on plan. Year to date value-based activity performance is favourable by £6.6m, JPUH is favourable by £8.3m offset by adverse variances at NNUH (£1.0m) and QEH (£0.7m)

CIP: Year to date CIP delivery is £43.3m, £3.5m adverse to the planned £46.9m, this is driven by an adverse variance at NNUH of £6.2m. JPUH (£1.6m) and QEH (£1.0m) are both ahead of plan.

Capital Expenditure: Year to date total capital spend is £61.4m, £51.4m behind the planned spend of £112.9m, All three Trusts are behind plan, NNUH having the largest variance of £35.1m. QEH is underspent by £12.7m.

Cash: Cash held on 31st October was £121.6m, £51.1m favourable to the planned £70.5m, this is mainly driven by a favourable cash balance of £38.5m at NNUH, and favourable variances of £8.0m at JPUH and £4.6m at QEH.

Forecast Outturn: Forecast Outturn for the Group remains breakeven, no movement from the breakeven plan.

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	In Month			Year To Date		
	Actual	Plan	Variance	Actual	Plan	Variance
SOCI	£m	£m	£m	£m	£m	£m
Clinical Income	127.8	122.0	5.8	848.0	846.8	1.2
Other Income	19.1	14.8	4.2	115.8	98.9	16.9
TOTAL INCOME	**146.8**	**136.8**	**10.1**	**963.8**	**945.7**	**18.1**
Pay	(95.0)	(88.3)	(6.7)	(633.8)	(621.4)	(12.4)
Non Pay	(37.7)	(33.8)	(4.0)	(248.8)	(235.0)	(13.7)
Drugs (Net Expenditure)	(5.4)	(5.0)	(0.4)	(35.7)	(34.3)	(1.4)
TOTAL EXPENDITURE	**(138.1)**	**(127.1)**	**(11.1)**	**(918.2)**	**(890.7)**	**(27.5)**
Non Opex	(8.6)	(8.6)	(0.1)	(57.8)	(59.2)	1.4
Control Total Surplus / (Deficit)	0.0	1.1	(1.1)	(12.2)	(4.2)	(8.1)
Statutory Surplus / (Deficit)	(5.8)	1.0	(6.8)	(8.5)	(1.0)	(7.5)

Other Financial Metrics						
	£m	£m	£m	£m	£m	£m
Cash at Bank (before support funding)	121.6	70.5	51.1	121.6	70.5	51.1
Capital Programme Expenditure	9.5	17.1	(7.6)	61.4	112.9	(51.4)
CIP Delivery	7.7	7.7	(0.0)	43.3	46.9	(3.5)
Aligned Payment Incentive (API) contract performance	46.4	41.4	5.0	288.4	281.8	6.6

NHS
Norfolk and Waveney
University Hospitals Group

2.1 Statement of Comprehensive Income – Current Month

The October position is breakeven on a control total basis, £1.1m adverse to the planned £1.1m surplus. The adverse variance of NNUH (£3.8m) is offset by favourable variances at JPUH (£0.3m) and QEH (£2.4m).

Oct-25	JPUH			NNUH			QEH			N&W GROUP		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m
Clinical Income	26.4	26.6	(0.2)	74.3	70.8	3.5	27.0	24.5	2.5	127.8	122.0	5.8
NT Drugs Income	1.1	1.1	0.0	6.8	6.6	0.2	1.8	1.6	0.2	9.6	9.2	0.4
Total Clinical Income	**27.5**	**27.7**	**(0.1)**	**81.1**	**77.4**	**3.7**	**28.8**	**26.1**	**2.7**	**137.4**	**131.1**	**6.3**
Other Income Incl. Non NHS Clinical Income	2.6	2.2	0.4	13.6	10.9	2.7	2.9	1.8	1.2	19.1	14.8	4.2
Total Operating Income	**30.1**	**29.8**	**0.3**	**94.7**	**88.3**	**6.4**	**31.7**	**27.9**	**3.8**	**156.5**	**146.0**	**10.5**
Substantive	(17.7)	(18.2)	0.5	(45.5)	(48.4)	2.9	(17.8)	(17.1)	(0.7)	(80.9)	(83.6)	2.7
Bank	(1.0)	(1.1)	0.1	(3.4)	(0.2)	(3.2)	(1.2)	(1.3)	0.0	(5.7)	(2.6)	(3.0)
Agency	(0.4)	(0.5)	0.1	(0.7)	(0.4)	(0.3)	(0.4)	(0.4)	(0.0)	(1.5)	(1.3)	(0.2)
Other Employee Expenses	(0.2)	(0.1)	(0.1)	(6.8)	(0.7)	(6.1)	0.0	0.0	0.0	(7.0)	(0.8)	(6.1)
Total Employee Expenses	**(19.2)**	**(19.9)**	**0.6**	**(56.4)**	**(49.7)**	**(6.7)**	**(19.4)**	**(18.8)**	**(0.6)**	**(95.0)**	**(88.3)**	**(6.7)**
Drugs Costs	(2.4)	(2.3)	(0.1)	(10.1)	(9.5)	(0.6)	(2.6)	(2.4)	(0.2)	(15.0)	(14.2)	(0.9)
Clinical Supplies	(3.0)	(2.4)	(0.7)	(9.5)	(8.9)	(0.6)	(4.4)	(3.1)	(1.3)	(16.9)	(14.4)	(2.5)
Non Clinical Supplies	(5.0)	(5.1)	0.2	(11.3)	(9.0)	(2.3)	(1.4)	(2.2)	0.8	(17.7)	(16.3)	(1.4)
PFI	0.0	0.0	0.0	(3.1)	(3.1)	(0.0)	0.0	0.0	0.0	(3.1)	(3.1)	(0.0)
Total Expenditure Excl. Employee Expenses	**(10.4)**	**(9.8)**	**(0.6)**	**(34.0)**	**(30.5)**	**(3.5)**	**(8.4)**	**(7.6)**	**(0.7)**	**(52.8)**	**(47.9)**	**(4.8)**
Total Operating Expenditure	**(29.6)**	**(29.7)**	**0.1**	**(90.4)**	**(80.2)**	**(10.2)**	**(27.8)**	**(26.4)**	**(1.3)**	**(147.8)**	**(136.3)**	**(11.5)**
Total Operating Surplus/(Deficit)	**0.5**	**0.1**	**0.3**	**4.3**	**8.1**	**(3.8)**	**4.0**	**1.5**	**2.5**	**8.7**	**9.7**	**(1.0)**
Total Non Operating Expenditure	(0.2)	(0.2)	0.0	(6.8)	(6.3)	(0.5)	(1.5)	(1.4)	(0.1)	(8.5)	(7.9)	(0.5)
Adjust PFI revenue costs to UK GAAP basis	0.0	0.0	0.0	(0.2)	(0.7)	0.5	0.0	0.0	0.0	(0.2)	(0.7)	0.5
Control Total Surplus/(Deficit)	**0.2**	**(0.1)**	**0.3**	**(2.7)**	**1.1**	**(3.8)**	**2.5**	**0.1**	**2.4**	**0.0**	**1.1**	**(1.1)**
Control Total Adjustments												
Donated/Peppercorn lease Income & Equipment	1.1	0.0	1.1	0.0	0.0	0.0	(7.0)	(0.6)	(6.4)	(5.9)	(0.6)	(5.3)
Donated/ Peppercorn lease Assets Dep'n	0.1	(0.0)	0.1	(0.2)	(0.1)	(0.1)	0.0	0.0	0.0	(0.1)	(0.1)	0.0
Adjust PFI revenue costs to UK GAAP basis	0.0	0.0	0.0	0.2	0.7	(0.5)	0.0	0.0	0.0	0.2	0.7	(0.5)
Statutory Surplus / (Deficit)	**1.4**	**(0.1)**	**1.5**	**(2.7)**	**1.7**	**(4.4)**	**(4.5)**	**(0.5)**	**(4.0)**	**(5.8)**	**1.0**	**(6.8)**

	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m
Cash at Bank (before support funding)	30.5	22.5	8.0	82.3	43.8	38.5	8.8	4.2	4.6	121.6	70.5	51.1
Capital Programme Expenditure	3.4	3.8	(0.4)	4.4	6.4	(2.0)	1.7	6.9	(5.2)	9.5	17.1	(7.6)
CIP Delivery	2.2	2.1	0.1	3.6	3.9	(0.3)	1.9	1.7	0.2	7.7	7.7	(0.0)
Aligned Payment Incentive (API) contract performance	16.9	15.9	1.0	20.1	20.1	0.0	9.4	5.4	4.0	46.4	41.4	5.0

Norfolk and Waveney University Hospitals Group

2.2 Statement of Comprehensive Income – Year to Date

Year to date position is a £12.2m deficit on a control total basis, £8.1m adverse to the planned £4.2m deficit. NNUH is £7.7m adverse and QEH is £1.1m adverse, offset by a YTD £0.8m favourable variance at JPUH.

Year to Date	JPUH			NNUH			QEH			N&W GROUP		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m
Clinical Income	181.8	186.7	(4.9)	493.7	488.4	5.3	172.5	171.7	0.8	848.0	846.8	1.2
NT Drugs Income	7.3	7.5	(0.3)	45.7	45.8	(0.1)	11.4	10.9	0.5	64.3	64.3	0.0
Total Clinical Income	**189.1**	**194.3**	**(5.2)**	**539.4**	**534.2**	**5.2**	**183.9**	**182.7**	**1.2**	**912.4**	**911.1**	**1.2**
Other Income Incl. Non NHS Clinical Income	16.7	15.6	1.1	84.0	70.7	13.3	15.1	12.6	2.5	115.8	98.9	16.9
Total Operating Income	**205.8**	**209.8**	**(4.1)**	**623.4**	**604.9**	**18.5**	**199.0**	**195.3**	**3.7**	**1,028.1**	**1,010.0**	**18.1**
Substantive	(127.6)	(128.7)	1.1	(318.7)	(337.4)	18.7	(124.4)	(121.2)	(3.2)	(570.7)	(587.3)	16.6
Bank	(8.0)	(8.3)	0.3	(24.6)	(1.2)	(23.4)	(9.4)	(9.6)	0.2	(42.0)	(19.1)	(22.9)
Agency	(2.9)	(3.6)	0.7	(5.6)	(3.2)	(2.4)	(2.7)	(3.3)	0.6	(11.2)	(10.1)	(1.1)
Other Employee Expenses	(0.6)	(0.5)	(0.1)	(9.2)	(4.3)	(4.9)	0.0	0.0	0.0	(9.8)	(4.8)	(5.0)
Total Employee Expenses	**(139.1)**	**(141.1)**	**2.0**	**(358.1)**	**(346.2)**	**(12.0)**	**(136.5)**	**(134.1)**	**(2.4)**	**(633.8)**	**(621.4)**	**(12.4)**
Drugs Costs	(16.0)	(16.4)	0.3	(67.3)	(66.4)	(0.9)	(16.7)	(15.9)	(0.8)	(100.0)	(98.6)	(1.4)
Clinical Supplies	(16.0)	(16.7)	0.7	(61.3)	(61.2)	(0.1)	(29.0)	(23.2)	(5.8)	(106.3)	(101.1)	(5.2)
Non Clinical Supplies	(34.6)	(36.1)	1.6	(75.1)	(61.3)	(13.8)	(11.1)	(15.2)	4.1	(120.8)	(112.7)	(8.1)
PFI	0.0	0.0	0.0	(21.6)	(21.2)	(0.4)	0.0	0.0	0.0	(21.6)	(21.2)	(0.4)
Total Expenditure Excl. Employee Expenses	**(66.7)**	**(69.2)**	**2.6**	**(225.3)**	**(210.1)**	**(15.2)**	**(56.8)**	**(54.3)**	**(2.5)**	**(348.8)**	**(333.6)**	**(15.2)**
Total Operating Expenditure	**(205.7)**	**(210.3)**	**4.5**	**(583.5)**	**(556.3)**	**(27.2)**	**(193.3)**	**(188.4)**	**(4.9)**	**(982.5)**	**(955.0)**	**(27.6)**
Total Operating Surplus/(Deficit)	**0.0**	**(0.5)**	**0.5**	**39.9**	**48.7**	**(8.8)**	**5.7**	**6.9**	**(1.2)**	**45.6**	**55.0**	**(9.5)**
Total Non Operating Expenditure	(1.3)	(1.6)	0.3	(42.4)	(43.6)	1.2	(9.7)	(9.8)	0.1	(53.5)	(55.1)	1.5
Adjust PFI revenue costs to UK GAAP basis	0.0	0.0	0.0	(4.3)	(4.1)	(0.1)	0.0	0.0	0.0	(4.3)	(4.1)	(0.1)
Control Total Surplus/(Deficit)	**(1.3)**	**(2.1)**	**0.8**	**(6.8)**	**0.9**	**(7.7)**	**(4.1)**	**(2.9)**	**(1.1)**	**(12.2)**	**(4.2)**	**(8.1)**
Control Total Adjustments												
Donated/Peppercorn lease Income & Equipment	0.7	(0.5)	1.2	(0.1)	0.1	(0.1)	(0.5)	(0.1)	(0.4)	0.1	(0.6)	0.7
Donated/ Peppercorn lease Assets Dep'n	0.3	0.2	0.0	(1.4)	(1.3)	(0.1)	0.5	0.5	(0.0)	(0.6)	(0.5)	(0.1)
Adjust PFI revenue costs to UK GAAP basis	0.0	0.0	0.0	4.2	4.1	0.1	0.0	0.0	0.0	4.2	4.1	0.1
Statutory Surplus / (Deficit)	**(0.3)**	**(2.3)**	**2.0**	**(4.0)**	**3.8**	**(7.8)**	**(4.1)**	**(2.5)**	**(1.5)**	**(8.5)**	**(1.0)**	**(7.4)**

	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m
Cash at Bank (before support funding)	30.5	22.5	8.0	82.3	43.8	38.5	8.8	4.2	4.6	121.6	70.5	51.1
Capital Programme Expenditure	21.1	24.8	(3.6)	13.5	48.6	(35.1)	26.8	39.5	(12.7)	61.4	112.9	(51.4)
CIP Delivery	15.2	13.6	1.6	17.6	23.8	(6.2)	10.5	9.5	1.0	43.3	46.9	(3.5)
Aligned Payment Incentive (API) contract performance	115.4	107.1	8.3	131.2	132.2	(1.0)	41.8	42.5	(0.7)	288.4	281.8	6.6

Norfolk and Waveney University Hospitals Group

2.3 Statement of Comprehensive Income – Forecast Outturn (FOT)

Forecast Outturn for the Group remains breakeven, no movement from the breakeven plan.

Year to Date	JPUH			NNUH			QEH			N&W GROUP		
	FOT £m	Plan £m	Variance £m	FOT £m	Plan £m	Variance £m	FOT £m	Plan £m	Variance £m	FOT £m	Plan £m	Variance £m
Clinical Income	316.2	323.6	(7.3)	836.5	836.5	0.0	298.4	294.4	4.0	1,451.2	1,454.5	(3.3)
NT Drugs Income	12.9	12.9	0.0	79.4	79.4	0.0	18.7	18.7	0.0	111.0	111.0	0.0
Total Clinical Income	**329.2**	**336.5**	**(7.3)**	**915.9**	**915.9**	**0.0**	**317.1**	**313.1**	**4.0**	**1,562.2**	**1,565.5**	**(3.3)**
Other Income Incl. Non NHS Clinical Income	26.9	26.7	0.2	124.2	124.2	0.0	22.4	21.3	1.1	173.6	172.3	1.3
Total Operating Income	**356.1**	**363.2**	**(7.1)**	**1,040.1**	**1,040.1**	**0.0**	**339.6**	**334.5**	**5.1**	**1,735.8**	**1,737.8**	**(2.0)**
Substantive	(217.8)	(221.3)	3.5	(577.6)	(577.6)	0.0	(206.7)	(206.7)	0.0	(1,002.1)	(1,005.6)	3.5
Bank	(14.4)	(13.9)	(0.5)	(2.8)	(2.8)	0.0	(16.1)	(15.7)	(0.4)	(33.3)	(32.4)	(0.9)
Agency	(4.9)	(6.0)	1.1	(4.9)	(4.9)	0.0	(4.5)	(4.5)	0.0	(14.3)	(15.3)	1.1
Other Employee Expenses	(1.1)	(0.9)	(0.2)	(8.8)	(8.8)	0.0	0.0	0.0	0.0	(9.9)	(9.7)	(0.2)
Total Employee Expenses	**(238.2)**	**(242.1)**	**3.9**	**(594.1)**	**(594.1)**	**0.0**	**(227.3)**	**(226.9)**	**(0.4)**	**(1,059.6)**	**(1,063.1)**	**3.5**
Drugs Costs	(27.6)	(28.0)	0.4	(114.0)	(114.0)	0.0	(26.8)	(26.8)	0.0	(168.4)	(168.9)	0.4
Clinical Supplies	(28.9)	(28.4)	(0.5)	(106.1)	(106.1)	0.0	(37.8)	(37.8)	0.0	(172.8)	(172.3)	(0.5)
Non Clinical Supplies	(60.1)	(61.9)	1.8	(106.7)	(106.7)	0.0	(30.8)	(26.1)	(4.7)	(197.6)	(194.7)	(2.9)
PFI	0.0	0.0	0.0	(36.6)	(36.6)	0.0	0.0	0.0	0.0	(36.6)	(36.6)	0.0
Total Expenditure Excl. Employee Expenses	**(116.6)**	**(118.3)**	**1.7**	**(363.4)**	**(363.4)**	**0.0**	**(95.5)**	**(90.8)**	**(4.7)**	**(575.5)**	**(572.5)**	**(3.0)**
Total Operating Expenditure	**(354.8)**	**(360.4)**	**5.6**	**(957.5)**	**(957.5)**	**0.0**	**(322.8)**	**(317.7)**	**(5.1)**	**(1,635.1)**	**(1,635.6)**	**0.5**
Total Operating Surplus/(Deficit)	**1.3**	**2.8**	**(1.6)**	**82.6**	**82.6**	**0.0**	**16.8**	**16.8**	**(0.0)**	**100.7**	**102.2**	**(1.6)**
Total Non Operating Expenditure	(1.3)	(2.8)	1.6	(75.2)	(75.2)	0.0	(16.8)	(16.8)	0.0	(93.2)	(94.8)	1.6
Adjust PFI revenue costs to UK GAAP basis	0.0	0.0	0.0	(7.4)	(7.4)	0.0	0.0	0.0	0.0	(7.4)	(7.4)	0.0
Control Total Surplus/(Deficit)	**(0.0)**	**(0.0)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**	**(0.0)**	**(0.0)**	**(0.0)**	**(0.0)**	**(0.0)**	**0.0**
Control Total Adjustments												
Donated/Peppercorn lease Income & Equipment	1.4	(0.8)	2.2	0.0	0.0	0.0	0.3	0.3	0.0	1.6	(0.6)	2.2
Donated/ Peppercorn lease Assets Dep'n	0.4	0.4	(0.0)	(2.4)	(2.4)	0.0	(0.9)	(0.9)	0.0	(2.9)	(2.8)	(0.0)
Adjust PFI revenue costs to UK GAAP basis	0.0	0.0	0.0	7.4	7.4	0.0	0.0	0.0	0.0	7.4	7.4	0.0
Statutory Surplus / (Deficit)	**1.8**	**(0.4)**	**2.2**	**5.1**	**5.1**	**0.0**	**(0.6)**	**(0.6)**	**(0.0)**	**6.2**	**4.0**	**2.2**
	FOT £m	Plan £m	Variance £m	FOT £m	Plan £m	Variance £m	FOT £m	Plan £m	Variance £m	FOT £m	Plan £m	Variance £m
Cash at Bank (before support funding)	46.4	44.2	2.2	44.4	47.1	(2.7)	80.4	80.3	0.1	171.2	171.6	(0.4)
Capital Programme Expenditure	48.8	51.9	(3.1)	79.6	77.9	1.7	18.3	18.3	0.0	146.7	148.1	(1.4)
CIP Delivery	25.9	25.9	0.0	43.6	43.6	0.0	72.2	72.2	0.0	141.7	141.7	0.0
Aligned Payment Incentive (API) contract performance	198.3	185.1	13.2	231.4	231.4	0.0	0.0	0.0	0.0	429.7	416.5	13.2

Norfolk and Waveney University Hospitals Group

3. Statement of Financial Position

The Statement of Financial Position at the end of October has increased by £28.1m compared to the opening balance. This is a result of the PDC received by QEH and JPUH offset by the year-to-date statutory deficit.

	JPUH			NNUH			QEH			N&W GROUP		
	Mar-25 £m	Oct-25 £m	YTD Movement £m	Mar-25 £m	Oct-25 £m	YTD Movement £m	Mar-25 £m	Oct-25 £m	YTD Movement £m	Mar-25 £m	Oct-25 £m	YTD Movement £m
Property, plant and equipment	146.0	160.6	14.6	413.8	405.2	(8.6)	156.3	175.3	19.0	716.1	741.1	25.0
Right of use assets - leased assets	1.5	2.1	0.6	43.7	46.7	3.0	0.2	0.2	0.0	45.4	49.0	3.6
Receivables: due from DHSC group bodies	0.0	0.0	0.0	3.2	3.4	0.2	0.0	0.0	0.0	3.2	3.4	0.2
Receivables: due from non-DHSC bodies	0.6	0.6	(0.0)	60.5	57.2	(3.3)	0.4	0.4	0.0	61.5	58.2	(3.3)
Total non-current assets	**148.1**	**163.3**	**15.2**	**521.2**	**512.5**	**(8.7)**	**156.9**	**175.9**	**19.0**	**826.2**	**851.7**	**25.5**
Inventories	3.7	3.7	0.0	15.8	16.9	1.1	3.2	3.2	0.0	22.7	23.8	1.1
Receivables: due from DHSC group bodies	5.2	5.6	0.5	22.9	27.0	4.1	2.8	2.2	(0.6)	30.9	34.8	4.0
Receivables: due from non-DHSC group bodies	8.0	9.3	1.3	25.1	33.7	8.6	5.9	8.0	2.1	39.0	51.0	12.0
Cash and cash equivalents	39.4	30.5	(8.9)	93.4	78.2	(15.2)	21.9	8.8	(13.1)	154.7	117.5	(37.2)
Total current assets	**56.3**	**49.1**	**(7.1)**	**157.2**	**155.8**	**(1.4)**	**33.8**	**22.2**	**(11.6)**	**247.3**	**227.1**	**(20.1)**
Trade and other payables: capital	(17.3)	(4.4)	12.9	(16.6)	(9.4)	7.2	(3.4)	(2.2)	1.2	(37.3)	(16.0)	21.3
Trade and other payables: non-capital	(32.1)	(30.3)	1.9	(125.8)	(113.1)	12.7	(46.8)	(35.0)	11.8	(204.7)	(178.4)	26.4
Borrowings - PFI	0.0	0.0	0.0	(18.0)	(18.0)	0.0	0.0	0.0	0.0	(18.0)	(18.0)	0.0
Borrowings: leases current	(0.9)	(0.8)	0.2	(8.5)	(8.6)	(0.1)	(0.2)	(0.2)	0.0	(9.6)	(9.6)	0.1
Current provisions	(0.4)	(0.4)	(0.0)	(1.5)	(3.3)	(1.8)	(0.2)	(0.1)	0.1	(2.1)	(3.8)	(1.7)
Deferred Income	(3.7)	(11.4)	(7.6)	(23.4)	(41.4)	(18.0)	(1.8)	(4.8)	(3.0)	(28.9)	(57.6)	(28.6)
Total current liabilities	**(54.5)**	**(47.2)**	**7.3**	**(193.8)**	**(193.8)**	**0.0**	**(52.4)**	**(42.3)**	**10.1**	**(300.7)**	**(283.3)**	**17.4**
Total assets less current liabilities	**149.9**	**165.2**	**15.4**	**484.6**	**474.5**	**(10.1)**	**138.3**	**155.8**	**17.5**	**772.8**	**795.5**	**22.8**
Borrowings - PFI	0.0	0.0	0.0	(351.0)	(348.6)	2.4	0.0	0.0	0.0	(351.0)	(348.6)	2.4
Borrowings: leases non-current	(0.7)	(1.2)	(0.6)	(31.9)	(30.6)	1.3	(0.1)	(0.1)	0.0	(32.7)	(31.9)	0.7
Provisions	(0.7)	(0.7)	0.0	(6.5)	(3.9)	2.6	(1.0)	(1.4)	(0.4)	(8.2)	(6.0)	2.2
Deferred Income	0.0	0.0	0.0	(1.1)	(1.1)	0.0	0.0	0.0	0.0	(1.1)	(1.1)	0.0
Total non-current liabilities	**(1.4)**	**(1.9)**	**(0.5)**	**(390.5)**	**(384.2)**	**6.3**	**(1.1)**	**(1.5)**	**(0.4)**	**(393.0)**	**(387.6)**	**5.4**
Total assets employed	**148.5**	**163.3**	**14.8**	**94.1**	**90.3**	**(3.8)**	**137.2**	**154.3**	**17.1**	**379.8**	**407.9**	**28.1**
Financed by												
Public dividend capital	220.0	235.2	15.2	390.9	390.9	0.0	390.5	411.7	21.2	1,001.4	1,037.8	36.4
Retained Earnings (Accumulated Losses)	(73.6)	(74.0)	(0.3)	(323.1)	(326.5)	(3.4)	(256.4)	(260.5)	(4.1)	(653.1)	(661.0)	(7.8)
Revaluation reserve	2.1	2.1	(0.0)	26.3	25.9	(0.4)	3.1	3.1	0.0	31.5	31.1	(0.4)
Total Taxpayers' and others' equity	**148.5**	**163.3**	**14.8**	**94.1**	**90.3**	**(3.8)**	**137.2**	**154.3**	**17.1**	**379.8**	**407.9**	**28.1**

Month 7 Capital Forecast Outturn

Norfolk and Waveney University Hospitals Group

Month 7 forecast outturn for Total Capital Departmental Expenditure Limit (CDEL) is a £24.2m underspend compared to revised plan (£15.5m underspend prior month) of which £3.8m is within System CDEL and £20.3m in nationally funded programmes. These variances relate to agreed NHSE funding changes notified since plan submission.

System CDEL £3.8m underspend: £3.3m relates to slippage in the NNUH Stroke Thrombectomy scheme due to delays with PFI legal process, which is not recoverable in-year and requires support to mitigate impact into 26/27. £0.6m relates to QEH which is held to offset national programme overspend. The balance relates to small changes in disposals and other schemes.

Nationally funded programmes £20.3m underspend: NNUH elective hub has further delay recognised in FOT (£13.9m), JPUH Frailty Hub is no longer progressing in 25/26 (£7.5m), NNUH ED redevelopment is working to a longer programme timeline (£4.9m), and QEH UTC is forecasting delay (£4.7m). Funding sources for 26/27 in relation to these delayed schemes is yet to be resolved. QEH NHP is forecast to spend £10.0m additional to plan. 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 7 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	9,704	21,005	9,296	40,005	9,772	19,739	8,931	38,442	(69)	1,266	365	1,562
	Right of Use Asset	1,302	8,151	290	9,743	1,302	6,582	550	8,435	(0)	1,569	(260)	1,309
	Other Adjustments: grants/donations/peppercorn lea	(1,598)	(229)	0	(1,827)	(1,598)	(519)	(516)	(2,633)	0	290	516	806
	Disposals	0	0	0	0	0	(237)	0	(237)	0	237	0	237
Total System CDEL		**9,408**	**28,927**	**9,586**	**47,921**	**9,477**	**25,565**	**8,965**	**44,007**	**(69)**	**3,362**	**621**	**3,914**
Nationally Funded Scheme	Front Line Digitisation	6,351	14,981	6,100	27,432	6,351	14,980	6,100	27,431	0	1	0	1
	NHP	14,929	0	10,000	24,929	14,929	0	19,556	34,485	0	0	(9,556)	(9,556)
	RAAC Plank	9,848	0	36,223	46,071	10,320	0	36,223	46,543	(472)	0	0	(472)
	UEC	9,768	5,906	10,616	26,290	3,148	1,041	5,870	10,059	6,620	4,865	4,746	16,231
	Elective Recovery	210	16,849	0	17,059	186	2,920	0	3,106	24	13,929	0	13,953
	Diagnostics	2,941	2,079	400	5,420	2,613	2,079	226	4,918	328	0	174	503
	Estates Safety	1,410	2,742	2,992	7,144	1,410	2,742	2,977	7,129	0	(0)	15	15
	Other	0	289	0	289	347	289	0	636	(347)	(0)	0	(347)
Total Nationally Funded		**45,457**	**42,846**	**66,331**	**154,634**	**39,304**	**24,050**	**70,952**	**134,307**	**6,153**	**18,795**	**(4,621)**	**20,327**
Total CDEL		**54,865**	**71,773**	**75,917**	**202,555**	**48,781**	**49,616**	**79,917**	**178,314**	**6,084**	**22,157**	**(4,000)**	**24,241**

Plan values reflect revised plan including in-year funding changes notified by NHSE where apparent from Trust reporting, see Appendix C. 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. NHSE reporting values are included in Appendix A.

Finance

Risk	Metric	Consequence	Likelihood	Control	Total
1	Risk of not delivering breakeven financial plan in 2025/26	5	3	3	11
2	Risk of not delivering efficiency targets in line with the plan in 2025/26	5	3	3	11
3	Risks of failing to deliver a CDEL compliant capital programme	5	3	3	11

Commentary:

- Financial Performance: Year to date all three Trusts are in deficit. Performance has improved during the year but continued focus on controls is required if the forecast is going to be delivered for the year. The income performance has improved in month with agreement of the ICB, offset by the redundancies at NNUH. QEH expenditure remains a concern.
- Bank rate reduction: Year to date all Trusts have seen a reduction against 2024/25 run rate, however continued work required on reducing the run rate of variable pay.
- WTE Reduction: The actual WTE is higher than plan at Month 7 mainly due to QEH not delivering the reduction in WTE as per the plan. Progress has been made at the other two Trusts and a recovery plan is being worked on at QEH.
- Cash:
  - Deficit support funding is at risk for quarter 4 if the Group is unable to forecast a balanced financial position for the year. This would potentially mean £11m of cash would not be received in the Group and could mean QEH would be unable to pay suppliers and staff in March 2026.
  - The impact of any capital delays could impact the cash position if NHSE is not in agreement to broker CDEL and cash in 2026/27 for each programme.

Actions:

- Continued focus on identifying recurrent and non recurrent initiatives to achieve the forecast outturn of breakeven.
- Implementation of further controls on use of temporary staffing, with a focus on medical staffing
- Discussions with NHSE on both the forecast outturn on revenue and capital to ensure the cash position does not deteriorate.

Norfolk and Waveney
University Hospitals Group

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: Executive Managing Director's Report, James Paget University Hospitals NHS Foundation Trust

Sponsor:	Group Chief Executive
Author:	Jon Barber, Interim Executive Managing Director, JPUH
Previous scrutiny:	Direct
Purpose:	The paper is presented for **Assurance**.

Executive Summary and Purpose

This report provides a focused update on leadership, workforce, operational performance, and system engagement at James Paget University Hospital. Workforce engagement remains a concern, with the 2025 National Staff Survey response rate falling to 38.2% despite sustained local initiatives, prompting a planned return to paper-based surveys in inpatient areas in 2026. Non-clinical workforce reduction continues through vacancy control, restructuring, and agreed exits, alongside exploration of productivity gains through Ambient Voice Technology. The Trust is entering a period of significant leadership transition, with senior departures and a mix of substantive, interim, and portfolio cover arrangements in place. A recent leadership summit addressed current National Oversight Framework positioning and preparation for an anticipated CQC Well Led inspection.

Operationally, the new Same Day Emergency Care unit and Acute Medical Unit have strengthened urgent and emergency care flow, although early escalation capacity has been required due to seasonal demand. The Trust continues to demonstrate innovation and good practice, including recognised service redesign, strong research participation, award-winning diagnostic infrastructure, and international maternal safety work. Place-based development is progressing with ICB support through the Neighbourhood Health programme, alongside continued winter resilience activity. Recent external reviews and stakeholder engagement have been broadly positive, supporting confidence while reinforcing the need for sustained oversight during a period of change.

Board Action Required

Note: The Group Board is recommended to note the contents of this report for assurance.

1. Site Specific Updates

Hospital Leadership Team

The 2025 NHS National Staff Survey has closed with a disappointing 38.2% response rate (41% last year), despite concerted efforts to increase engagement including through 'You said, We Did' communications, a performance dashboard, stands, floorwalkers and hampers for teams with the best performance sponsored by the James Paget Charity. A reversion to paper-based surveys for inpatient areas will be trialled next year.

Work continues on the non-clinical workforce reduction:

- 47.94 WTE released from long-term vacancies and restructuring.
- 16.2 WTE MARS (Mutually Agreed Resignation Scheme) leavers by the end of December 2025.
- 5.54 WTE voluntary redundancy leavers by the end of March 2026.
- Ambient Voice Technology (AVT) to be piloted within Cardiology Services with a view to AVT enabling further headcount reductions following broader roll-out.

Director Roles and Portfolios

Four current directors are retiring or leaving the Trust between December 2025 and February 2026: the Chief Medical Officer, Mr Vivek Chitre; the Chief Finance Officer, Ed Taylor; the Director of People & Culture, Sarah Goldie; and the Director of Strategic Projects, Mark Flynn (Digital, Estates and Facilities, Health & Safety, New Hospital Programme). In addition, the Chief Nurse role has been filled as an interim role for nine months by Jacky Copping.

- Chief Nurse appointed substantively 7 November 2025– Jacky Copping (previously interim Chief Nurse).
- Director of Finance appointed 17 November 2025, start date 2 March 2026 – James Taylor (external appointment).
- Chief Medical Officer interviews 1 December 2025, start date 1 January 2026 – Rob Major (current Deputy Chief Medical Officer).
- Director of People and Culture interviews 2 December 2025 and offer made, start date anticipated early March (to be confirmed) – (external appointment).
- Jon Barber covering as Interim Managing Director until Jonathan Gardiner commences on 12 January 2026.
- Estates and Facilities portfolio now managed by Chief Delivery Officer, Alison Stace.
- Digital portfolio transferring to Chief Operating Officer, Charlotte Dillaway, from January 2026.
- New Hospital Programme now managed at Group level by Group Chief Delivery Officer, Jo Segasby.
- Leadership summit held with 60 senior leaders on 26 November 2025 to further develop our local response to our poor National Oversight Framework (NOF) segmentation and to

review our preparedness for a Care Quality Commission (CQC) Well Led inspection, which is likely in the next few months.

- Richard Watson, the Integrated Care Board's (ICB's) Deputy Chief Executive, visited the hospital on 5 November 2025 and met with the site leadership team.

Local Developments

Our new Same Day Emergency Care (SDEC) unit and Acute Medical Unit (AMU) opened on 4 November 2025 and are seeing a high volume of urgent and emergency care (UEC) patients, up to 120 per day. This is contributing to our continued improvement in UEC performance. A Task and Finish Group is meeting fortnightly to provide real time response to feedback from staff and patients and to evaluate the impact of this new service.

- Due to increased UEC demand, particularly respiratory illness, we have opened our planned escalation ward (Ward 22) three weeks earlier than anticipated.
- The James Paget's innovative One Stop Hepatocellular Carcinoma Care Surveillance Clinic was chosen as one of four presentations from across the UK at the British Liver Nurse Association annual meeting in Belfast. The collaborative team of imaging and hepatics provides a one-stop surveillance clinic whereby imaging, blood monitoring and clinic review operate at the same appointment, condensing the many disseminated appointments to semi-annual, and improving patient experience.
- James Paget's clinical research team passed the milestone of 1,000 patients taking part in the national NGRID2 programme, a maternity study which screens newborn babies with the aim of identifying those that are genetically 'high risk' of developing type 1 diabetes, which affects 1 in every 250 children born in the UK each year. James Paget is one of 17 hospitals across the country taking part.
- James Paget's Community Diagnostic Centre (CDC), along with the CDC at the Queen Elizabeth Hospital King's Lynn, won the award for Best Healthcare Development under £25m at the Building Better Healthcare Awards. The award recognises the work of the Estates and Facilities teams at both hospitals, who worked closely alongside partners LSI Architects, R G Carter, WSP, Rossi Long Consulting and Lexica to deliver the new centres, which opened in 2024.
- Midwifery staff from the James Paget recently completed a trip to Sierra Leone to support the work of the charity Life for African Mothers (LFAM), by training local midwives on preventing post-partum haemorrhage and practising neonatal resuscitation. The team passed on their knowledge and experience of safe and respectful maternal care through a series of maternity skills workshops.

Place and Neighbourhood Development

The Neighbourhood Health project is progressing with ICB support. Planning between James Paget and Norfolk Primary Care is progressing well to use data insights (population health management) to offer targeted intervention for patients who are high-intensity users of health and

care services. The initial focus is on patients with frailty and poorly controlled diabetes. The ICB has committed £550k to Great Yarmouth and Waveney (GY&W) to support implementation.

- The ICB has also agreed to fund capacity from a public health consultant to support the development of measures that demonstrate admission avoidance and reduced length of stay.
- A meeting is being arranged with all GY&W Place Leaders, the ICB, etc. to define the shared objectives going forward. This will build upon the strong cross-sector partnership working in the Place.
- Currently, the GY&W Place Board is supporting the delivery of the Norfolk and Waveney Seasonal Plan and continues to work in collaboration to support resilience across health and social care services, and in our communities this winter. GY&W Place Board members are supporting the winter vaccination campaign and promoting the programme to staff and residents, alongside implementing operational schemes to support winter pressures at Place level.

2. Updates from external Stakeholder, Regional or National Meetings

On 10 November 2025, James Paget University Hospital hosted an Education Quality Review by the East of England Deanery, focusing on Anaesthetics. This has been a training department which has scored poorly in General Medical Council (GMC) National Training Surveys for the past two years. Feedback on the day was brief and very positive, with no areas of immediate concern identified. The draft report has been received and is undergoing factual accuracy review.

Comments in the report include "*Resident doctors were positive about the culture within the department and noted they feel comfortable raising concerns… Overall, feedback from the engagement meetings was very positive and there were no educational requirements following the visit*".

- The previous Executive Managing Director, Dr Shane Gordon, and Deputy Chief Medical Officer Dr Rob Major attended the Employer Engagement event at RAF Marham on 13 November 2025, hosted by Group Commander Leonie Boyd. The James Paget is a Gold Award partner in the Defence Employer recognition scheme.
- The Maternity Safety Support Programme undertook a planned review of maternity and neonatal services on 24 November 2025, including regional and national specialist advisers. The James Paget team was supported by the Group Head of Midwifery, Penny Snowden. Feedback from the advisers was broadly positive, with some further information requested prior to making a decision on whether to step down support to regional oversight only.
- Our Executive Managing Director and colleagues from Queen Elizabeth Hospital King's Lynn and Norfolk and Norwich University Hospitals attended the Vanderbilt Pursuing Professionalism conference in Nashville at the end of October 2025. This programme of intervention to support professional behaviour has been adopted in over 20 US states, Australia and Canada and has over 15 years of data demonstrating its positive impact from

low-key peer-to-peer interventions, starting with a ‘cup of coffee chat’ which avoids the need for escalated intervention in over 70% of cases. Possible adoption in Norfolk and Waveney University Hospitals Group (NWUHG) is under consideration by our Chief Medical Officers.

Report to the Group Board (GPJC), dated Wednesday, 17 December 2025

Title: Executive Managing Directors Report Norfolk & Norwich University Hospitals NHS Foundation Trust

Sponsor:	Group Chief Executive
Author:	Marcus Thorman
Previous scrutiny:	Direct
Purpose:	The paper is presented for Noting.

Executive Summary

This report provides the Group Board with a concise update on key developments at the Norfolk and Norwich University Hospitals NHS Foundation Trust since the last reporting cycle. It highlights changes in senior leadership, including the appointment of the Group Chief Financial Officer as Interim Executive Managing Director, alongside strengthening of the transformation portfolio. Operationally, the Trust has achieved notable clinical recognition, progressed pathways and refurbishment programmes, and secured external funding for major green energy infrastructure. Workforce vaccination uptake remains strong.

The report also outlines local service developments, engagement across place-based programmes, and issues arising from regional and national partners, including regulatory engagement from NHS England's Workforce, Training and Education team and scrutiny from local authority committees. These updates provide contextual intelligence for the Group Board's oversight of performance, quality, workforce and strategic planning across the Group.

Recommendation

The Committee is recommended to note this report for information.

Site Specific Updates

Hospital Leadership Team

Provide any detail on changes in teams/structures which may be relevant. This section could include any leadership development plans

- Marcus Thorman Group CFO appointed as Interim Executive Managing Director of NNUH
  13
  November 2025
- Deputy Director of Transformation Improvement Appointed: Dr Sundari Ampikaipakan was named the new Deputy Director of Transformation Improvement on 06 November 2025.

Local Developments

Provide any detail on changes to services or other local changes, i.e. new facilities opening or new pathways being established.

Should also include reference to any awards or recognition for hospital teams

- One of the notable events in November was the Long Service Awards, during which we recognised 50 colleagues whose collective tenure amounts to an impressive 1,375 years of service to the NNUH.
- A national Emergency Laparotomy report in November recognised NNUH's emergency abdominal surgery as among the best nationally, highlighting the surgical and anaesthetic teams' work as best practice for quality of care.
- Maternity and virtual ward teams at the NNUH were Highly Commended in the Digitising Patient Care Award at the HSJ Awards for Hyperemesis Gravidarum - An Ambulatory Approach to Care.
- The NNUH has joined the remote monitoring study for MND patients and is the only hospital in the East of England to be taking part in the DENIM world-first clinical trial, which is focusing on improving non-invasive ventilation (NIV) support for people living with MND.
- As at 25 November, 69% of all NNUH front line staff have protected themselves against flu – higher than last year’s total of 59.8% meaning we retain top position in the national league table for frontline workers.
- A seven-year-old was the first patient to don a lab coat and join a “Harvey’s Lab” Tour on Tuesday 18 November. The tours, which are part of a national initiative co-ordinated by the Institute of Biomedical Science (IBMS), aim to ease children’s fears, offer reassurance and help them feel more confident and informed about their healthcare by showing children and families first-hand what happens when their blood tests are sent to the laboratory.
- Kimberley Ward has been de-populated to allow the relocation of Brundall Ward to Kimberley Ward. Brundall Ward is now closed to complete a 16-week ward refurbishment programme.

- The OBC for investment of £1.22m from the Trust for Green Energy Infrastructure was approved at Hospital Management Group. This investment leverages £9m grant from central government through Salix and the Carbon Energy Fund Framework and will be delivering the heating requirements of the Trust through an air source heat pump. The project will be delivered by 2028 and will have revenue benefits for the Trust.
- Incentive quality metrics for maternity (CNST) are on track to be met, with the reporting period concluding at the end of November. A report on behalf of the Group position will be required to ensure the financial benefit can be achieved

Place and Neighbourhood Development

Provide details of local plans or development and engagement with stakeholders on place and neighbourhood development.

- System-level work continues to strengthen integrated neighbourhood care models, with particular emphasis on primary care, community, and acute collaboration: 63 practices and 12 PCNs are within scope.
- The Place Board is positioned to become the local planning and accountability body, aligning with ICS commissioning structures and Suffolk partners.

Updates from external Stakeholder, Regional or National Meetings

*Provide details of stakeholder events or meetings which could have an impact on local hospital/*services. Group items will be picked up in the Group CEO report.

- The NHS England Workforce, Training, and Education (WT&E) team attended the NNUH on 6th November for Medicine and Surgery Engagement Meetings with resident doctors. Two safety concerns were raised, and a response was submitted on 17 November. A further response is required by 3rd December.
- Members of the Health Overview Select Committee requested a report be presented at the meeting on 6th November on delays at the Histopathology Department at the NNUH and the actions being taken to reduce and mitigate the delays identified.
- Ed Garratt OBE, Chief Executive NHS Norfolk and Waveney ICB and Steffan Aquarone Liberal Democrat MP for North Norfolk visited Cromer hospital on 21 November and met with the site leadership team.

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: Executive Managing Director's Report, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH)

Sponsor:	Group Chief Executive
Author:	Chris Bown, Interim Executive Managing Director, QEH
Previous scrutiny:	• Direct
Purpose:	The paper is presented for **Briefing**.

Executive Summary and Purpose

The purpose of this report is to provide the Group Board with an update on the current position of the Queen Elizabeth Hospital (QEH) across key domains, including operational performance, financial status and service delivery. This update is intended to ensure that the Group Board has full visibility of progress against agreed objectives, emerging risks, and actions being taken to maintain service quality and organisational resilience. It also highlights areas requiring continued oversight and decision-making to support delivery of the Trust's priorities within the wider Group framework.

The report covers:

- Ongoing operational and financial performance challenges (also see Group Integrated Performance and Finance reports).
- The national Maternity and Neonatal Inspection of the QEH.
- Actions taken on supporting fragile services (Pharmacy, Audiology, Chronic Pain, Diagnostic Coding).
- Resident Doctors 10-point plan and industrial action update.
- Staff Flu vaccinations and NHS staff survey updates.
- Place, Neighbourhood and partnership working.
- North Cambridgeshire Hospital (NCH) development.
- National approval of the new hospital outline business case (SOC).

Board Action Required

The Group Board is asked to note the report. There are no items for escalation.

Performance

Operational Performance

QEH faces operational performance challenges and recovery plans have been implemented in key areas including urgent and emergency care (UEC), Referral to Treatment (RTT), Diagnostic Waiting Times and Activity (DM01) and Cancer. Planned care performance is currently supported by insourcing, targeted validation, and pathway redesign.

Significant progress has been made in reducing 4-hour UEC waiting times and elective waiting lists and improving diagnostic performance, through focused leadership and external support. However, it is fully recognised that there is a significant challenge going forward particularly in reducing Emergency Department (ED) 12-hour waits and there are clearly agreed actions which need to be delivered to achieve this. It is expected that the agreed 2025/26 trajectories will be delivered.

Going forward, delivering the consolidated UEC improvement plan and sustaining elective recovery trajectories remains central to the Trust's performance improvement programme. Work is in train to enhance the standardisation and visibility of all improvement plans within the organisation to enable clear delivery of priorities to improve National Oversight Framework (NOF) performance. This will ensure alignment with the emerging outputs of the Group work in relation to Recovery.

Finance – Month 8: At Month 8, the Trust is reporting a year-to-date surplus of £3.5m, which represents a £1.4m adverse variance to plan. The year-to-date deficit to plan position remains at the same level as M7. While income recovery plans have continued to deliver an improved income position of £1.9m surplus in month, pay and non-pay has overspent in month by the same value, offsetting the benefit.

Cost Improvement Programme (CIP) delivery is £0.97m ahead of plan year to date which is a deterioration from M7. Non recurrent delivery of CIP continues to over deliver against plan by £4.9m. While this provides a positive contribution to the 2025/26 position, it presents a significant risk for 2026/27, as the Trust requires recurrent efficiencies to achieve financial sustainability. Planning for 2026/27 must therefore prioritise recurrent schemes including headcount reductions.

The forecast outturn remains breakeven, albeit with notable risks, including continued delivery of efficiencies and strengthened grip and control measures on vacancies, temporary staffing, and non-pay expenditure.

The cash position has been stabilised through support from NNUH, with agreement to defer payment of all outstanding invoices until year-end. This debt will require settlement, necessitating a move to a surplus run rate before March 2026 to increase cash reserves and enable repayment. The cash forecast assumes receipt of Q4 deficit support funding; failure to secure this will require implementation of a prioritised supplier payment process to manage liquidity through year-end.

Capital expenditure at Month 8 is £15.7m below plan, of which £10.6m relates to nationally funded schemes, the largest being the Urgent Treatment Centre (£6.2m). We expect the lease for the King's Lynn Health Hub to be recognised on our balance sheet in the next month, which will achieve our forecast position for this scheme. The remaining funding for the UTC is expected to be released in 26/27. CDEL schemes are forecasting an underspend of £0.6m, and re-prioritisation is underway to bring forward works into 2025/26 to utilise funding and deliver a breakeven position. Reinforced Autoclaved Aerated Concrete (RAAC) funding is forecast to underspend by £4.5m due to slippage on timescales caused by adverse weather. This outstanding work will now be completed in 2026/27 with the commensurate funding returned to NHS England this financial year.

Service issues

Maternity and Neonatal Inspection: The review of maternity and neonatal services at The Queen Elizabeth Hospital, commissioned by the Secretary of State for Health and Social Care, Wes Streeting, and led by Baroness Valerie Amos, was conducted on 25 and 26 November 2025. Baroness Amos attended the QEH site on Tuesday 25 November 2025. A third date will be convened in 2026 to enable the obstetric and midwifery expert advisor to visit the Service. There was no formal feedback following the day; however, all sites involved in the review have been informed that a high-level report would be produced that summarised the findings of the site visits undertaken to date. The data portal has not been provided to the organisation; however, the data is ready once the portal is open. The staff attended a feedback session with the leadership team, and all appeared positive; however, psychological support is in place if needed. Few service users attended the first session; this was due to a late change in the session's time. A further listening event will be planned to coincide with the site visit in the new year. Reflections and Initial Impressions were published on 9 December 2025 but were not specific to the QEH.

Pharmacy Services: The Hospital Pharmacy Aseptic Suite is currently operating under temporary revised arrangements pending the recruitment of an Authorised Aseptic Pharmacist. Continuity of patient care has been maintained through the implementation of alternative processes, including the constitution of Monoclonal antibodies (mAbs) closer to patient treatment areas, consistent with practice adopted in other centres.

Clinical teams have actively engaged in pathway and scheduling adjustments to ensure predictability and avoid delays. External pharmacy expert support has been secured to provide assurance and technical oversight during this interim period.

Overall, high-priority treatments have continued safely, with improved confidence in service continuity while full in-house aseptic capability is restored.

Audiology: The Audiology service continues to operate at reduced capacity due to longstanding workforce vacancies across both paediatric and adult pathways. Paediatric referrals have remained suspended since February 2025 following an external review. An administrative validation exercise has removed approximately 400 patients from the waiting list; a full clinical triage is scheduled for December and January and will be undertaken by an external provider.

Interim leadership is currently provided by a nominated NNUH lead, supported by an external subject matter expert for two days per week. Plans remain in place to transition to a Group model from April 2026.

Community audiology provision in West Norfolk is limited. Active discussions are ongoing with commissioners regarding the future strategic delivery of this service, recognising that age-related hearing loss activity is predominantly managed in community settings within other health systems.

High-risk audiology patients, primarily children, continue to access services via NNUH. Work is progressing to address the backlog of long-waiting diagnostics and to define the future service model.

Chronic Pain Service: The service has experienced the loss of its substantive consultant workforce through retirement and resignation. Clinical activity is currently being delivered via temporary locum cover and internal arrangements utilising part-time consultant capacity. A new clinical lead is now in post and one additional clinician is nearing completion of training.

There is a backlog of approximately 1,000 patients awaiting a new appointment. A clinical triage and validation exercise is underway to prioritise patients according to clinical need and reduce the waiting list size.

Clinics continue to operate; however, the service remains reliant on temporary medical cover while internal capacity and new pathway models are established. Although the service is fragile, planned mitigations are in place to support patient safety and maintain access.

Longer-term service delivery is being developed via the Specialty Clinical Network.

Coding: HSMR has increased during the year due to coding delays rather than a change in underlying mortality. While deaths have been coded throughout, the majority of delays have occurred within the non-death inpatient population. As expected, death values are derived from comorbidity coding across the full case mix, the absence of timely coding for survivors suppressed risk adjustment while observed deaths continued to enter the dataset in real time. This resulted in a progressive and artificial rise in HSMR as deaths were counted but the comorbidity profile of the wider inpatient cohort was incomplete.

As backlog clearance progresses and full inpatient comorbidity coding becomes current, HSMR is expected to stabilise and reduce.

The starting backlog was 9,949 non-elective spell at mid-October 2025. Additional capacity which has been sourced has coded 4,279 spells leaving 5,670 of the original starting number. During the same period, elective work has been maintained and there has been a reduction in non-elective spells in other months September and October (notably strokes for national reporting requirements).

The existing backlog has grown month on month with the overall total now at 8,487 plus the November backlog which will be confirmed when elective coding is completed in mid December.

Additional coding capacity has been sourced from within the Group on a bank basis (QEH / JPUH) and externally via individuals who are known to the Trust. Work is in train via procurement to further enhance the external resource with the intention to bring this on-board week commencing 15th December. Once confirmed, an updated trajectory for backlog clearance will be developed and monitored with a view to seeing sustainable improvements by January 2026 to enable an up-to-date submission of HSMR data for the period between April 25 to December 25 which will be published in March 26.

Industrial Action: Across the five days of previous industrial action by resident doctors, an average of 63% of eligible doctors participated, with rates ranging from 59% on Friday to 66% on Sunday. Foundation Year 1 and 2 doctors were the most likely to take action, with participation exceeding 80% on all strike days. In contrast, Registrar participation ranged between 15% and 33%.

The Trust's initial assessment indicates that 767 new appointments were undertaken (42 cancelled), equating to 94.8% of planned activity, and 500 elective cases were delivered (4 cancelled), representing 99% of normal activity. Total cancellations, including follow-up appointments, amounted to 111.

Data validation remains in progress as the Trust and regional teams address an issue with Healthcare Operational Data Flow (HODF) data that arose at the commencement of the industrial action period.

The Trust is now preparing for the upcoming industrial action on 17 to 22 December 2025.

National Staff Survey: The Trust has exceeded its previous best with a NSS response rate of 52.6% of eligible staff (2,191 people), almost 6% up on last year and 5% above the acute hospital average.

Flu: The Trust is currently reporting 50.8% for frontline staff (8 December 2025). To improve flu vaccination uptake, we have increased the number of roving clinics, specifically targeting areas with low vaccination rates.

10-point plan for Resident Doctors

QEH participated in the national baseline assessment against the Resident Doctors 10-Point Plan, achieving 51% compliance. The Medical Director is the nominated Senior Lead, supported by a job-share arrangement for Resident Doctor Peer Leads. Engagement has included the Executive Managing Director attending a listening event and regular attendance by the Medical Director or Deputy at the Resident Doctors Forum. The Medical Director has also met with Regional Medical Director to discuss the Trust's plan, which has been presented at Hospital Management Group and remains a standing agenda item. A repeat survey has been completed, and the results are expetced w/c 15 December 2025.

Place, neighbourhood and partnership working

Place and Neighbourhood Development: The trust has continued to strengthen Place-based working across West Norfolk, Fenland and the wider cross-border system including Cambridgeshire and Peterborough. Our focus remains on improving access, tackling inequalities and supporting neighbourhoods to shape local models of care.

Health Inequalities Funding: The King's Lynn & West Norfolk Health and Wellbeing Partnership has agreed a clearer process for allocating health inequalities funding. Work is ongoing to explore the proactive use of tools such as Eclipse to identify individuals who would benefit from early preventative interventions, including vaccinations and screening.

King's Lynn Ten-Year Vision and Pride in Place Investment Plan: The King's Lynn Ten-Year Vision and Pride in Place Investment Plan has been finalised and approved locally for submission to government. Priority themes strongly align with local health inequalities objectives and include:

- Neighbourhoods and affordable housing
- Employment and skills
- Health and wellbeing infrastructure
- Safer streets
- Community capacity building

Consultation on detailed master planning will commence this winter.

Physical Activity and Prevention – Sport England Place Partnership: West Norfolk has successfully secured Sport England Place funding. The award plan focuses on supporting individuals with long-term conditions and low physical activity levels across priority neighbourhoods.

Wisbech Integrated Neighbourhood Board: The Board continues to focus on:

- Prevention: obesity, cervical screening access, cancer awareness
- Mental health: including the "Alright Mate?" men's peer support initiative
- Loneliness and isolation
- Building stronger connections between health services, VCSE organisations, and neighbourhood assets

West Place Board: Work is underway to develop the Board's approach to Neighbourhood Health, aligned with the ICB's strategic direction for phased implementation. The initial focus is on strengthening collaboration between NHS and social care, enhancing primary and community care, and ultimately integrating voluntary sector and education partners to deliver improved long-term outco

NCH Service Development

The North Cambridgeshire Hospital (NCH) site in Wisbech serves a population experiencing significant health inequalities, high levels of deprivation, and poorer health outcomes compared to

national averages. Current services provided by the Trust include Endoscopy, Radiology, Phlebotomy, and a range of Outpatient clinics.

However, longstanding challenges, such as ageing infrastructure, underutilisation of facilities, and operational inefficiencies, continue to impact service quality and sustainability.

Strategic Context: Wisbech and Fenland face significant health challenges, including an ageing population, high prevalence of chronic conditions, and limited transport and infrastructure. In response, the Trust, working in collaboration with the Cambridgeshire & Peterborough Integrated Care Board (C&P ICB) and system partners, is undertaking a strategic review to align North Cambridgeshire Hospital (NCH) services with ambitions for integrated, accessible, and sustainable care.

This review supports a Place-Based Population Health approach aimed at reducing health inequalities and improving outcomes for local communities.

Population Health Alignment: Wisbech ranks among the bottom 10% nationally for deprivation, with life expectancy three years lower than Cambridge and premature mortality 30.9% higher than the England average. The strategic intent prioritises integrated care models and targeted interventions to address these disparities.

A demand and capacity tool is currently in development to inform future service planning and ensure resources are aligned to population health needs. The trust are fully involved in the planning of future services and will ensure alignment with the developing Group Strategic Ambitions.

New Hospital Programme

Department of Health and Social Care (DHSC) Joint Investment Committee: On 19 November 2025, the Trust received formal confirmation from the Deputy Director for Investment, Major Projects and Capital Delivery Portfolios of the approval of the Strategic Outline Case (SOC) for the construction of a new hospital on the Queen Elizabeth Hospital site. This approval underpins the commitment to eradicate all RAAC buildings from the Trust's estate by 2032, in line with current delivery timeframes.

The SOC was approved by the Joint Investment Committee on 22 October 2025.

Conclusion

The Trust remains focused on performance and productivity improvement and ensuring that services remain safe despite the challenges the organisation faces.

Recommendation and Decision

The Group Board is asked to note the report.

Chris Bown

Executive Managing Director (interim)

Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

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Norfolk and Waveney
University Hospitals Group

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: Joint Emergency Preparedness, Resilience and Response (EPRR) Report

Sponsor:	Group Chief Delivery Officer
Author:	QEHKL Emergency Planning and Business Continuity Manager
Previous scrutiny:	Group CDO and individual Hospital Management Group equivalents
Purpose:	The paper is presented for **Assurance**.

Executive Summary and Purpose

This report provides a consolidated overview of Emergency Preparedness, Resilience and Response arrangements across the three acute NHS Foundation Trusts within the Group. All organisations are Category 1 Responders under the Civil Contingencies Act 2004 and must maintain statutory arrangements for risk assessment, emergency planning, business continuity, multi-agency cooperation, and training.

Each Trust has completed its 2025–26 NHS Core Standards self-assessment and has been rated Substantially Compliant, with clear action plans in place for the remaining partially compliant standards. Exercises, training programmes, and incident responses across the reporting period demonstrate active preparedness. Work continues to strengthen incident coordination, infectious disease planning, evacuation and shelter arrangements, Hazmat (hazardous material) and CBRN (chemical, biological, radiological, nuclear) capability, and Digital Data Security and Protection Toolkit (DSPT) compliance.

The report supports the Group Board's assurance that the Trusts maintain appropriate arrangements for emergency preparedness and that required improvements are defined, resourced, and monitored.

Board Action Required

The Group Board is recommended to note the assurances provided on the current Emergency Preparedness, Resilience and Response arrangements across the three constituent Trusts.

1. Purpose of Report

The purpose of this report is to provide consolidated assurance on Emergency Preparedness, Resilience and Response arrangements for the three constituent NHS Foundation Trusts within the Group. It summarises compliance with the NHS Core Standards for EPRR, statutory duties under the Civil Contingencies Act 2004, key activities, risks, and planned work for 2026.

The report covers the following organisations:

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

2. Statutory Framework and Duties

All three Trusts are designated Category 1 Responders under the Civil Contingencies Act 2004. They must comply with the Act and with NHS England's Core Standards for EPRR. Collectively, these frameworks require each Trust to maintain effective arrangements to prepare for, respond to, and recover from major incidents and civil contingencies.

Key statutory and regulatory duties include:

- Assess risks and prioritise hazards affecting services and patients.
- Maintain emergency plans, including major incident, critical incident, and site-specific response plans.
- Maintain business continuity arrangements, supported by current business continuity plans and business impact analyses.
- Warn, inform, and advise patients and the public about civil protection matters and during incidents.
- Co-operate with and share information with local responders, including participation in Local Resilience Forum and Local Health Resilience Partnership processes.
- Maintain robust command and control arrangements for incident management.
- Undertake regular training and exercising to test and strengthen plans and capabilities.
- Maintain appropriate Chemical, Biological, Radiological, Nuclear and Hazardous Materials (CBRN and Hazmat) capability.

3. Group Summary Position

Each Trust has completed its 2025–26 NHS Core Standards self-assessment and participated in regional assurance processes. All three organisations are assessed as Substantially Compliant. This reflects high levels of compliance with the applicable standards, with a small number of partially compliant areas supported by action plans and clear trajectories to completion.

Headline Core Standards positions are as follows:

- James Paget University Hospitals NHS FT (JPUH): 56 fully compliant standards, 6 partially compliant standards.
- Norfolk and Norwich University Hospitals NHS FT (NNUH): 56 fully compliant standards, 6 partially compliant standards.
- Queen Elizabeth Hospital King's Lynn NHS FT (QEHKL): 58 fully compliant standards, 4 partially compliant standards.

Common cross-Group themes requiring continued attention include:

- Infectious disease and pandemic planning, including integration of High Consequence Infectious Disease arrangements.
- Evacuation and shelter planning and associated staff training.
- Cyber Assurance Framework and Data Protection Security Toolkit compliance.
- Hazmat and CBRN training and exercising programmes.
- Loggist training, decision-logging arrangements, and incident coordination centre operating procedures.

4. Trust-Level Position Summaries

4.1 James Paget University Hospitals NHS FT

JPUH is assessed as Substantially Compliant with the NHS Core Standards for EPRR. Out of 62 applicable standards, 56 are fully compliant. The remaining partially compliant standards relate to incident coordination centre arrangements, decision logging and loggist capacity, incident communication planning, Digital DSPT requirements and Hazmat and CBRN processes.

Key features of the JPUH position include:

- Strong engagement from senior managers, executives, and clinicians in EPRR planning, exercising and incident management.
- Active participation in Local Health Resilience Partnership and Norfolk Resilience Forum processes, including peer review of partner plans.
- Clear work plans with target completion dates between February and June 2026 for the partially compliant standards.
- Ongoing development and refinement of plans and policies, with regular review through the Resilience Committee and related forums.

4.2 Norfolk and Norwich University Hospitals NHS FT

NNUH is assessed as Substantially Compliant, with 56 of 62 standards fully compliant and six partially compliant. The partially compliant areas relate to infectious diseases planning, new and emerging pandemics planning, evacuation and shelter plans, the business continuity policy statement, Digital DSPT compliance and Hazmat training.

Key features of the NNUH position include:

- Completion of self-assessment, peer review, and one-to-one sessions with ICB and NHS England regional EPRR teams, confirming Substantial Compliance.
- A structured programme of work to bring partially compliant standards to full compliance between February and November 2026.
- An extensive schedule of internal, joint, and regional exercises testing pandemic, cyber, capacity and infrastructure-related scenarios.
- Ongoing review and enhancement of the emergency planning and business continuity portfolio, with particular focus on business continuity plan coverage.

4.3 Queen Elizabeth Hospital King's Lynn NHS FT

QEHKL is assessed as Substantially Compliant, with 58 of 62 standards fully compliant and four partially compliant. The partially compliant standards relate to infectious diseases planning, evacuation and shelter planning, Digital DSPT requirements and PPE access and FFP3 capability linked to High Consequence Infectious Disease preparedness.

Key features of the QEHKL position include:

- High levels of assurance reported by the ICB following review of the Core Standards return and supporting evidence.
- Defined action plans with completion dates to June 2026 for the partially compliant areas.
- Active collaboration with Group EPRR colleagues to develop joint policies and plans while retaining appropriate site-specific detail.
- Use of risk registers and governance pathways to maintain transparent oversight of EPRR risks and mitigations.

5. Training, Exercising and Capability Development

Across the Group, there has been a comprehensive programme of training and exercising during the reporting period. This has supported assurance that plans are workable, staff understand their roles and learning is captured and acted upon.

Examples of exercises undertaken include:

- Pandemic and infectious disease exercises, including Pegasus and other scenario-based tests.
- Command and control and system-pressure exercises, including command-post and winter resilience scenarios.
- CBRN and Hazmat exercises focused on decontamination, casualty handling, and use of specialist equipment.
- Cyber incident exercises at Trust and regional level.
- Local operational exercises such as decontamination tent deployment, paediatric abduction scenarios, and water-borne pathogen testing.

Training activity across the Group has included:

- Principles of Health Command for strategic and tactical leaders.
- Strategic and tactical on-call training programmes and refreshers.
- Loggist skills training and development of a wider loggist cohort.
- Hazardous materials and CBRN-related clinical and operational training.
- Inclusion of EPRR awareness in corporate induction programmes.
- Specialist input and training support from the East of England Ambulance Service and regional EPRR teams.

6. Incidents and Operational Pressures

During the reporting period, Trusts have experienced a range of operational pressures and incidents that have required activation of EPRR arrangements, including critical incidents, business continuity incidents, and responses to industrial action.

Key headlines include:

- JPUH declared five Critical Incidents totalling approximately twenty days, primarily driven by patient flow and capacity pressures.
- Industrial action created sustained operational pressure, particularly at NNUH, requiring enhanced planning, coordination, and multi-agency engagement.
- Multiple business continuity incidents across the Group required EPRR support, review of business continuity plans and implementation of mitigations.

7. Risk and Business Continuity

Each Trust maintains an EPRR risk register aligned to the Community Risk Register and local hazard profile. Business continuity plans are underpinned by Business Impact Analyses, with testing through live incidents and exercises. Learning is used to update plans and inform future training.

Common risk themes across the Group include:

- Coverage and consistency of business continuity plans across all departments and services.
- Sustainability of command rotas, particularly for prolonged incidents and periods of high operational pressure.
- Loggist capacity and capability, including recruitment, training, and retention.
- Digital resilience and cyber security maturity, including reliance on core systems and networks.
- Hazmat and CBRN capability, including equipment, training, and interdependencies with partners.
- Infrastructure considerations, including RAAC-related risks where applicable.
- Interdependencies with local responders and wider system partners.

8. Governance and Oversight

EPRR governance within each Trust is well established. Each has an Accountable Emergency Officer, a Senior Responsible Officer for EPRR and formal Resilience Committees or equivalent forums with standard escalation routes into executive structures and Boards.

Key governance features include:

- Designated Accountable Emergency Officer and Senior Responsible Officer roles in each Trust.
- Resilience Committees or equivalent governance groups overseeing EPRR work programmes and risk registers.
- Standard reporting into Hospital Management Groups and executive teams.
- Participation in Local Health Resilience Partnership and Norfolk Resilience Forum processes.
- Annual peer review, confirm-and-challenge sessions, and one-to-one assurance discussions with ICB and NHS England regional EPRR teams.

As Group governance arrangements mature, EPRR oversight will align with Group-level risk and assurance structures, including routine reporting to the Group Risk Assurance Committee and Group Board.

9. Forward Actions for 2026

The Group-wide EPRR work programme for 2026 focuses on bringing all partially compliant standards to full compliance and further strengthening Group-wide consistency and interoperability.

Priority actions include:

- Achieving full compliance with all remaining partially compliant NHS Core Standards at each Trust.
- Finalising and implementing refined standard operating procedures for incident coordination centres.
- Updating and aligning infectious disease and pandemic plans across the Group.

- Strengthening loggist training and decision-logging arrangements.
- Completing planned Hazmat and CBRN training and exercising programmes.
- Continuing RAAC-related planning, monitoring, and scenario testing where applicable.
- Completing Digital DSPT and Cyber Assurance Framework work programmes.
- Finalising evacuation and shelter plans and associated training for staff.
- Developing joint Group EPRR policies and plans with site-specific action cards to retain local specificity.

10.Conclusion and Recommendation

All three constituent Trusts remain Substantially Compliant with the NHS Core Standards for Emergency Preparedness, Resilience and Response. Statutory duties are being discharged, material gaps are understood and resourced, and improvement work is underway with clear target dates.

The Group Board is recommended to note the assurances provided on the current Emergency Preparedness, Resilience and Response arrangements across the three constituent Trusts.

Norfolk and Waveney
University Hospitals Group

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: NWUHG Directors' Code of Conduct

Sponsor:	Group Chair
Author:	Group Secretary
Previous scrutiny:	Direct
Purpose:	The paper is presented for **Approval**.

Executive Summary and Purpose

This report presents the proposed Directors' Code of Conduct for the Norfolk and Waveney University Hospitals Group for formal adoption by the three statutory Boards. The Code consolidates the legal, ethical, and behavioural expectations on Directors arising from the NHS Act 2006, the Trust Constitutions, Standing Orders, and the Provider Collaboration Agreement. It synthesises the Seven Nolan Principles of Public Life, the NHS Constitution Values, and the Institute of Directors Principles of Director Conduct into a unified behavioural framework.

The Code establishes clear standards of conduct, fiduciary duty, conflicts of interest, propriety, stewardship of public resources and the requirements of the Fit and Proper Person test. It clarifies the role of the Secretary in supporting compliance, maintaining statutory registers, and ensuring the lawful recording of decisions. Adoption will strengthen consistency within the Group governance model and support Directors in discharging their concurrent duties across the three Trusts.

Board Action Required

The General Purpose Joint Committee is recommended to approve and adopt the Directors' Code of Conduct.

1. Introduction

The Group governance architecture requires consistent behavioural and ethical standards across all statutory Directors who hold office concurrently on the Boards of the three NHS Foundation Trusts. The existing constitutional provisions on conduct, conflicts, probity, and eligibility differ in emphasis between the Trusts. The Group model also introduces concurrent duties when acting as the General Purpose Joint Committee.

The Directors' Code of Conduct brings these requirements together within a single consolidated instrument. It draws on national public sector standards, Board members' obligations under NHS Foundation Trust law, the PCA and the expectations of NHS England in relation to leadership, accountability, and culture.

2. Analysis and Discussion

The draft Code integrates the three principal sources of Director-level ethics and values for NHS organisations. These are the Nolan Principles, the NHS Constitution Values, and the IoD Principles of Director Conduct. The unified framework provides a clear and consistent articulation of conduct required of Directors across all Group governance settings.

The Code also incorporates statutory and constitutional duties, including

- concurrent fiduciary duties owed to each Trust,
- the requirement to act in the best interests of the combined population when acting as the Group Board,
- compliance with Standing Orders, SFIs and SoRD,
- obligations relating to propriety, public resources, and regularity,
- conflicts of interest and disclosure requirements,
- the Fit and Proper Person criteria,
- responsibilities for internal control, cyber security, data quality, counter fraud, DSPT compliance and Speaking Up.

No material risks arise from adoption. The Code supports compliance with PR7 Governance and Leadership and PR1 Quality of Care. There are positive impacts for culture, transparency, and public accountability. No adverse equality implications have been identified.

3. Conclusion

Adoption of the Directors' Code of Conduct will standardise expectations across the three Trusts and will support a consistent approach to conduct, leadership, and accountability under the Group governance model. It strengthens the legal and ethical foundation for statutory decision making and clarifies Directors' responsibilities in relation to internal control, probity, public funds, and public value. It also provides a clear basis for induction, appraisal, and performance review.

There are no material financial or estates implications. Legal implications are positive through strengthened alignment with Schedule 7 of the NHS Act 2006 and with constitutional duties. The Code supports a safe organisational climate and aligns with expected standards for NHS leadership.

4. Recommendation and Decision

The Group Board is recommended to **Approve** the Directors' Code of Conduct and require all NWUH Group Directors to sign and abide by the Code.

5. List of Appendices (Attachments)

- Appendix A – NWUHG-GPJC-Code-001 - The Directors' Code of Conduct for the Norfolk and Waveney University Hospitals Group.docx

Norfolk and Waveney University Hospitals Group

The Directors' Code of Conduct for the Norfolk and Waveney University Hospitals Group

Date: 30 November 2025

File: NWUHG-GPJC-Code-001

1. Purpose and Status

This Code sets out the personal, ethical, and professional standards required of every Director of the three NHS Foundation Trusts that constitute the Norfolk and Waveney University Hospitals Group. It applies when Directors act as statutory members of each Trust Board and when they act collectively as the General Purpose Joint Committee established under the Provider Collaboration Agreement.

The Code complements the statutory duties of Directors under the NHS Act 2006, the Health and Social Care Act 2008, the Health and Care Act 2022 and, where relevant, the Companies Act 2006. It also aligns with each Trust's Constitution, the Standing Orders, Standing Financial Instructions and Schemes of Reservation and Delegation.

The Code supports lawful decision making, promotes integrity and transparency and reinforces exemplary public service conduct.

Each Director shall confirm annually in writing that this Code has been read and will be complied with.

2. Ethical and Behavioural Framework

The ethical standards expected of Directors arise from three complementary frameworks: the Seven Nolan Principles of Public Life, the NHS Constitution Values, and the Institute of Directors Principles of Director Conduct. These frameworks overlap and are complementary. To support clarity and consistency, they are synthesised into the following unified framework of behavioural expectations for Directors. The three source frameworks remain authoritative and should be read alongside this synthesis.

2.1. Public Interest and Purpose

Directors shall

- act solely in the public interest and place the needs of patients, families, and the wider population at the centre of decision making;
- promote the success of each Trust and the Group and uphold the NHS Constitution;
- demonstrate visible commitment to public service and public value.

2.2. Integrity and Honesty

Directors shall

- act with integrity, honesty, and good faith;
- exercise independent judgement, avoid improper influence, declare and manage interests openly, and refrain from accepting benefits or obligations that may create a conflict or perception of bias.

2.3. Objectivity and Fairness

Directors shall

- make decisions impartially, fairly and on merit, using the best evidence and free from bias or discrimination;
- promote equality, diversity, and inclusion and take active steps to mitigate structural or systemic unfairness in decisions.

2.4. Openness and Transparency

Directors shall

- act and take decisions openly and transparently;
- communicate clearly, explain the basis for decisions, and disclose relevant information where lawful and appropriate, in recognition of the public accountability required of their role.

2.5. Accountability and Stewardship

Directors shall

- accept accountability for their actions and decisions and participate fully in scrutiny;
- uphold collective responsibility once decisions are made;
- act as stewards of public resources and take proportionate and sustainable decisions that balance present needs with long term public value.

2.6. Respect, Compassion and Behavioural Standards

Directors shall

- treat individuals with respect, courtesy, and compassion;
- foster an environment that supports psychological safety, inclusive participation, and constructive debate;
- challenge inappropriate behaviour and uphold high standards of professionalism expected of public office.

2.7. Quality, Safety, and Improvement

Directors shall

- make quality the organising principle of decision making (quality is defined as patient safety, patient experience, and clinical effectiveness);
- promote improvement, learning, innovation, and evidence based decision making to enhance outcomes and reduce harm.

2.8. Cultural Leadership and Organisational Climate

Directors shall

- model behaviours that support a healthy organisational culture;
- encourage openness, inclusion, and learning, and shall ensure that culture supports effective governance, ethical practice, and the wellbeing of staff and patients.

This unified framework synthesises the expectations contained in the Seven Nolan Principles of Public Life, the NHS Constitution Values, and the Institute of Directors Principles of Director Conduct. The three sources remain authoritative and must be read together to guide the conduct, judgement, and behaviour of Directors

3. Legal Duties of Directors

3.1. Statutory and fiduciary duties

Directors

- hold office concurrently on the Boards of all three NHS Foundation Trusts;
- owe statutory and fiduciary duties individually and collectively to each Trust;
- shall act to promote the success of each Trust for the benefit of the public and the members of each Trust as a whole.

3.2. Concurrent duties across the three Trusts

- Directors shall recognise that they hold distinct legal office in each Trust simultaneously. Decisions taken in any capacity must comply with the statutory duties, Constitution and Standing Orders of each Trust.

3.3. Duties when acting as the Group Board

- When acting as the General Purpose Joint Committee, Directors exercise lawful delegation from the three Trust Boards and shall act in the best interests of the combined populations served by the Group.
- Directors shall not prioritise the interests of any single Trust.

3.4. Compliance with governance instruments

- Directors shall comply with the Constitutions, Standing Orders, Standing Financial Instructions and Schemes of Reservation and Delegation of each Trust and the Provider Collaboration Agreement.

3.5. Propriety and responsible use of public funds

Directors shall

- act with propriety, regularity, and care in the stewardship of public resources;
- avoid waste, extravagance or misuse of assets and ensure that resources are applied for their intended purpose.

4. Conduct Expectations

4.1. Personal conduct

Directors shall

- act with dignity, courtesy, and respect;
- uphold the NHS Constitution and model behaviours that create a compassionate and inclusive organisational culture;
- avoid conduct that may bring a Trust or the Group into disrepute.

4.2. Meetings and decision making

Directors shall

- prepare thoroughly, participate constructively, and respect the authority and role of the Chair;
- support collective responsibility for decisions once made;
- ensure that decisions are based on sound evidence, appropriately documented, and clearly rationalised.

4.3. Communication

Directors shall

- Communicate clearly, accurately, and responsibly;
- avoid misrepresentation, maintain confidentiality where required, and represent the Trusts and the Group with integrity.

4.4. Representation

Directors shall

- only speak on behalf of a Trust or the Group where authorised to do so;
- avoid expressing personal opinions as if they reflect the corporate position.

4.5. Visits and engagement

Directors

- may visit Trust premises in an agreed and planned manner that respects operational responsibilities; and,
- shall avoid interference in day to day management.

5. Conflicts of Interest

- Directors shall comply with the Constitutions and Standing Orders in relation to interests, gifts, and hospitality.

5.1. Duty to avoid conflict

- Directors shall avoid situations where they have, or may have, an interest that conflicts with the interests of a Trust or the Group.

5.2. Duty not to accept benefits

- Directors shall not accept any benefit from a third party as a result of their role.

5.3. Disclosure

- Directors shall disclose material interests, including those of a spouse or partner, for entry in the Register of Directors' Interests.

5.4. Timing

- Declarations must be made at the earliest opportunity and before the Trust enters into any transaction or arrangement.

5.5. Recusal

- A Director with an interest shall withdraw from the discussion and decision and shall not count toward quorum or vote on the matter.

5.6. Verification

- The Secretary may verify declarations against public registers and other sources.

6. Fit and Proper Person and Eligibility

Directors shall

- satisfy the Fit and Proper Person requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations;
- shall be of good character, possess the necessary qualifications, competence, skills, and experience, and not have been involved in serious misconduct.

7. Compliance and Internal Control

Directors shall

- ensure the effectiveness of the system of internal control, including financial controls, operational controls, information management, cyber security, data quality assurance, counter fraud arrangements, and compliance with data protection law;
- ensure the effectiveness of Speaking Up arrangements;
- scrutinise exception reporting including single tender waivers and bad debts;

- ensure that auditors and regulators have full and unfettered access.

8. Disqualification and Sanctions

- Directors must sign and deliver a declaration accepting this Code within two calendar weeks of appointment. Failure to do so is grounds for disqualification.
- Directors may be disqualified for refusal to undertake required training, for bankruptcy, for an order under the Company Directors Disqualification Act 1986 or for any constitutional ground.
- Sanctions for breaches of the Code may include guidance and counselling, remedial training, censure, suspension, removal from committees or roles, or referral to NHS England or the Care Quality Commission.
- Indemnity is available only where the Director acted honestly and in good faith.

9. Adoption and Review

- This Code shall be adopted by resolution of each Trust Board.
- Compliance will be reviewed annually through declarations, appraisal, and internal audit from time to time.
- The Code will be reviewed at least every three years or sooner if required.

10. Role of the Secretary

The Secretary is the Board's impartial Board governance officer who receives Directors' compliance statements, maintains the statutory registers, and advises on propriety, conflicts, and adherence to the Code. The Secretary ensures decisions are taken and recorded lawfully for each Trust and the Group Board and supports the Chair in safeguarding the integrity of governance arrangements.

Director's Declaration

I, [Name], as a Director of [Trust or NWUHG Group Board], confirm that I have read, understood, and agree to comply with the Directors' Code of Conduct for the Norfolk and Waveney University Hospitals Group. I agree to uphold the unified ethical and behavioural framework described in this Code and to discharge the statutory and constitutional duties of Directors of NHS Foundation Trusts in the public interest.

Signature
Date

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: Group Audit Committees in Common Terms of Reference

Sponsor:	Group Chair
Author:	Group Secretary
Previous scrutiny:	• Group Audit Committees in Common • Group Secretary
Purpose:	The paper is presented for **Approval**.

Executive Summary and Purpose

The Group Board is asked to approve the Terms of Reference for the Group Audit Committees in Common. The reflects:

- Alignment with Schedule 7 of the NHS Act 2006, the Provider Collaboration Agreement, the Trust Constitutions and Standing Orders
- Clarity on Board governance, statutory accountability and the non-delegable nature of Mandatory Reserved Functions
- Duties relating to internal control, risk management, information management, cyber security, counter fraud, workforce controls and regulatory compliance
- Inclusion of evidence standards and triangulation requirements consistent with developing practice across the Group
- A clear description of escalation routes and the annual programme of work
- Requirements for annual and periodic external review of effectiveness

The Terms of Reference have been reviewed by the Audit Committees in Common and are recommended for adoption.

Board Action Required

Approve: The Group Board is recommended to approve the Committee Terms of Reference for adoption and implementation.

Norfolk and Waveney
University Hospitals Group

Terms of Reference – Group Audit Committees in Common

Document Control

Document Author:	Group Secretary
Document Type:	Terms of Reference
Approval Body:	General Purpose Joint Committee (Group Board) acting on behalf of the Boards of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust, James Paget University Hospitals NHS Foundation Trust, and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.
Version Issue Date:	17 December 2025
Review Frequency:	Annually

Version History

Version	Date	Revision Description	Editor
0.1	November 2025	These Terms of Reference (ToR) establish the operational mandate, membership, and conduct for the Group Audit Committees in Common (Group N&R CiC), derived from the respective Audit Committees of the three sovereign NHS Foundation Trusts (JPUH, NNUH, and QEHKL, collectively the Trusts).	Group Secretary

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1. Status, Authority and Accountability

1.1 Establishment and Status

These Terms of Reference establish the mandate, membership and conduct of the Group Audit Committees in Common. The Committees in Common support the statutory Audit Committees of the three sovereign NHS Foundation Trusts, enabling efficient and consistent discharge of duties across the Group.

1.2 Lawful Basis for Governance

The Committees in Common operate within the lawful perimeter created by Schedule 7 of the NHS Act 2006, each Foundation Trust Constitution, each set of Standing Orders, and the Provider Collaboration Agreement dated 23 October 2025. The Provider Collaboration Agreement enables joint working but does not alter statutory accountability or transfer any reserved functions.

1.3 Statutory Purpose

Each Trust Board must establish an Audit Committee to provide independent and objective oversight of governance, risk management, and internal control. The Committees in Common undertake this scrutiny on a co-ordinated basis. Governance refers strictly to the lawful discharge of Board duties.

1.4 Accountability

The Committees in Common remain accountable to each sovereign Trust Board. They must report findings, conclusions, and recommendations to the General Purpose Joint Committee for information, and separately to each Trust Board for assurance and decision-making.

1.5 Nature of Assurance

The Committees in Common seek assurance on behalf of Boards. Assurance arises from evidence, systems, controls, and independent review. Reassurance is insufficient. The Committees in Common evaluate the reliability, independence and completeness of evidence used to inform Board confidence.

1.6 Scope of Authority

The Committees in Common are authorised to investigate matters within their remit, request information, require attendance, and commission internal audit work. The Committees in Common do not have executive powers.

1.7 Mandatory Reserved Functions

The Committees in Common shall not exercise Mandatory Reserved Functions. Approval of the annual report and audited accounts is a statutory function of each Trust Board. The Committees in Common review and recommend these items only.

2. Membership and Chairing

2.1 Composition

Membership comprises all Non-executive Directors appointed as members of the sovereign Trust Audit Committees. Membership is limited to Non-executive Directors.

2.2 Independence

Executive Directors are excluded. The Chair of the Group Board shall not chair the Committees in Common. Members must satisfy independence requirements set out in NHS England's Code of Governance.

2.3 Chair

The Chair shall be appointed jointly by the three Trust Boards. A planned approach to Chair succession should be reviewed annually by the Group Board Chair.

2.4 Financial Competence

At least one member must have recent and relevant financial experience, ideally with professional accountancy qualification.

2.5 Casting Vote

The Chair does not hold a casting vote. Decisions reflect the simultaneous consideration of three sovereign Audit Committees.

2.6 Conflict of Interest

Members must declare interests in accordance with each Trust's Standing Orders. A material conflict requires withdrawal from the relevant business.

2.7 Quorum

Quorum is at least two voting members present. If quorum is not reached, the meeting may scrutinise items but may not take decisions or make formal recommendations.

3. Attendance and Private Meetings

3.1 Regular Attendees

The Chief Finance Officer, the Head of Internal Audit, a representative of External Audit and the Local Counter Fraud Specialist attend regularly. The Internal Audit and Counter Fraud providers have unrestricted access to the Chair.

3.2 Non-Member Participants and the Group Secretary

Other attendees may be invited to meetings where their specific input or expertise is required. Participants shall not have any voting rights, nor shall they be counted towards the quorum.

The Group Secretary is the Board's impartial governance officer responsible for providing independent governance advice to the Chair and the Committee. The Secretary ensures decisions are taken and recorded lawfully for each Trust and the Group Board and supports the Chair in safeguarding the integrity of governance arrangements.

The Secretary attends as an expected non-member participant and shall not have any voting rights, nor shall they be counted towards the quorum.

3.3 Group CEO and Group Chair

The Group Chief Executive and Group Board Chair may attend for relevant items.

3.4 Private Meetings

At least once per year the Committees in Common must meet privately with Internal Audit, External Audit, and the Local Counter Fraud Specialist.

3.5 Access to Systems and Records

The Committees in Common may request any information relating to governance, risk management, financial control, counter fraud, information management and cyber resilience, workforce control, safety, and statutory compliance.

4. Meetings and Conduct

4.1 Frequency

The Committees in Common meet at least four times per year, with an additional meeting to review the annual report and accounts.

4.2 Administration

Agendas and minutes must state that the meeting is held as the Group Audit Committees in Common. Minutes must be filed separately to each Trust's corporate record.

4.3 Evidence Standards

Triangulation of management reports, audit findings, regulatory intelligence, operational data, and benchmarking must be used where material risk exists.

4.4 Reporting

After each meeting the Committees in Common provide a written report to each Trust Board and to the Group Board for information.

4.5 Forward Work Programme

An annual plan ensures coverage of principal risks, internal control, internal audit, counter fraud, information security, workforce control, cyber resilience, and compliance.

4.6 Escalation

Any significant risk, control failure or assurance gap that may threaten statutory compliance or achievement of strategic aims must be escalated by the Chair to the sovereign Audit Committee Chairs and the Group Board Chair.

5. Duties and Responsibilities

The Committees in Common provide independent and objective scrutiny and seek assurance for each Trust Board on the adequacy and effectiveness of internal control, governance, risk management, audit, compliance, and stewardship of public funds. The Committees review assurance across the three Trusts operating within the Group model established under the PCA, while respecting each Board's statutory responsibilities.

5.1 Governance and Internal Control

The Committees in Common review the effectiveness of the system of internal control that supports achievement of objectives. This includes:

a. financial controls, operational controls, workforce controls, digital and cyber controls, information management and security controls, safety controls and ethical conduct controls
b. review of the adequacy and effectiveness of internal control systems across all three Trusts
c. evaluation of the control environment and its alignment with principal risks, strategic aims and the Trusts' risk appetite
d. scrutiny of breaches or weaknesses in control, including procurement breaches, contract variations, financial losses, cyber incidents, data quality failures and safety control failures

e. review of the adequacy of systems to detect, prevent and respond to control breaches
f. review of the accuracy and completeness of disclosures in the Annual Governance Statement and related governance reports
g. review of the reliability and sufficiency of control arrangements operating below the T-line, ensuring escalation routes to the G-line operate as intended.

5.2 Standing Orders, Standing Financial Instructions and Delegation

The Committees in Common scrutinise Standing Orders, the Standing Financial Instructions and the Schemes of Reservation and Delegation to ensure:

a. relevance, clarity and internal consistency
b. alignment with statutory requirements, the PCA and the Group Governance Framework
c. appropriate delegated authority limits and effective control mechanisms
d. assurance that compliance systems operate reliably and that material non-compliance is identified, escalated and addressed.

5.3 Risk Management and Assurance

The Committees will:

a. review the process for identifying and managing key risks
b. consider the relationship between risk management, control systems, audit activity and assurance
c. review the alignment between Strategic Risk Registers, principal risks, risk appetite, internal controls and risk trajectory
d. assess the adequacy and robustness of management's response to escalating risk
e. review assurance source reliability, including independence, completeness and quality of evidence
f. evaluate whether risk management operates effectively at Trust and Group level and that escalation, reporting and cross-organisational triangulation meet expectations for NHS Foundation Trusts and the PCA.

The Committees do not undertake the role of the Group Risk Assurance Committee but evaluate the assurance available on the effectiveness of the control environment underpinning risk management.

5.4 Quality and Patient Safety Control Systems

The Committees in Common do not oversee clinical governance. They seek assurance that:

a. systems of internal control supporting clinical effectiveness, patient safety and patient experience operate effectively within management groups and relevant Board Committees

b. material control weaknesses affecting patient safety or quality are escalated appropriately across the Group
c. learning from incidents, audits and inspections is embedded within the internal control environment.

5.5 Internal Audit

The Committees will:

a. approve the internal audit strategy, annual plan and its alignment to risk
b. approve internal audit's charter, scope, resourcing and independence
c. review internal audit findings, recommendations and management responses
d. ensure timely implementation of audit actions and seek assurance that controls are strengthened where necessary
e. review internal audit's performance, effectiveness and contribution to the assurance environment
f. consider the Head of Internal Audit's annual opinion and its implications for governance, risk management and internal control
g. commission additional internal audit reviews where assurance is insufficient or where emerging risks require examination.

5.6 External Audit

The Committees will:

a. participate in the appointment, reappointment and removal of external auditors
b. approve the external audit plan, scope and fees
c. examine the integrity of financial reporting, significant judgements, estimates and the going concern assessment
d. review findings from external audit, including the management letter and the Value for Money commentary
e. monitor management responses and ensure timely implementation of actions
f. assess the independence and effectiveness of external audit and ensure the reliability of the Annual Report and Accounts.

5.7 Financial Reporting

The Committees will:

a. review the financial statements and the significant judgements and estimates

b. ensure consistency of financial reporting with accounting policies and compliance with the NHS Group Accounting Manual
c. scrutinise the Annual Report and Accounts, including narrative disclosures
d. review the clarity, accuracy and reliability of financial reporting to each Board
e. review losses, special payments and the adequacy of controls to prevent recurrence
f. review related party transactions and compliance with statutory requirements.

The Committees ensure financial reporting is accurate, transparent and aligned with Board duties of stewardship.

5.8 Counter Fraud, Bribery and Corruption

The Committees will:

a. approve the annual counter fraud plan
b. review the work of the Local Counter Fraud Specialist
c. consider outcomes of investigations and oversee management responses
d. review compliance with the NHS Counter Fraud Authority Functional Standard
e. ensure appropriate referral, reporting and recovery actions are taken
f. seek assurance that fraud risks are proactively identified, mitigated and escalated.

5.9 Information, Digital and Cyber Controls

The Committees will review:

a. ICT control effectiveness, resilience and integrity
b. data integrity, data quality, accuracy and completeness
c. access control, system permissions and segregation of duties
d. backup, restoration and recovery capabilities
e. DSP Toolkit compliance
f. reporting, management and escalation of cyber incidents
g. digital risks that threaten business continuity, operational performance or integrity of the control environment.

5.10 Workforce and Culture Controls

The Committees will review:

a. establishment control and workforce planning controls
b. rostering, time recording and payroll controls
c. training compliance, mandatory training systems and role-specific competencies
d. safeguarding checks, professional registration and right-to-work compliance

e. culture indicators that may affect control performance, including behaviours that weaken or strengthen the internal control environment.

5.11 Statutory and Regulatory Compliance

The Committees will:

a. review compliance with statutory and regulatory obligations including NHS England, CQC, HSE, ICO and Charity Commission where relevant
b. seek assurance that compliance failures are investigated, addressed and escalated where material
c. ensure that regulatory and statutory reporting is accurate, timely and supported by evidence.

5.12 Observability, Data Quality and Transparency

The Committees in Common seek assurance that:

a. data used for decision-making are complete, accurate, timely and transparent
b. data quality control systems operate reliably across the Group
c. independent review of data quality or observability is commissioned where material decisions require additional assurance.

5.13 Integrated Planning and Triangulation

The Committees will:

a. review triangulation across finance, workforce, activity, productivity and quality consistent with national planning expectations
b. consider whether internal control supports effective integrated planning across the Group
c. review the reliability of evidence used in triangulation processes and in Integrated Performance Reports
d. seek assurance that material inconsistencies are investigated, explained and resolved.

6. Relationship with Other Committees

The Committees coordinate assurance with:

a. the Group Risk Assurance Committee on risk and internal control
b. the Strategy and Partnerships Committee on planning and transformation dependencies
c. the Remuneration Committees in Common on audit matters relevant to remuneration
d. the GPJC in respect of matters delegated under the PCA
e. management groups below the T-line to ensure effective escalation and triangulation of assurance.

The Committees avoid duplication and ensure that assurance sources are aligned, coherent and complete.

7. Reporting

After each meeting the presiding Chair submits a written report to:

a. each statutory Trust Board
b. the GPJC on matters referred by delegation
c. the Council of Governors on matters relating to auditor appointment and performance.

An annual report is submitted to each Trust Board covering:

a. the work of the Committees in Common
b. internal and external audit outcomes
c. the effectiveness of internal control
d. counter fraud activity
e. risk, control and assurance themes
f. the Committees' self-assessment and effectiveness review.

Papers are circulated at least five working days before the meeting unless urgent.

8. Frequency of Meetings

The Committees meet at least five times per year. Additional meetings may be convened by the presiding Chair or at the request of any Committee Chair or the Internal or External Auditor.

9. Review of Terms of Reference and Effectiveness

These Terms of Reference are reviewed annually by the Committees in Common and recommended to each Trust Board and the GPJC for approval.

The Committees in Common conduct an annual review of effectiveness covering composition, coverage, evidence quality, and contribution to Board assurance.

10. Secretariat and Records

10.1 Secretariat

The Group Secretary arranges administrative support and the provision of meeting minutes, ensures correct filing, and maintains a log of declarations and actions.

10.2 Record Management

Minutes and documents are retained in accordance with each Trust's records management policy.

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: Group Nomination and Remuneration Committees in Common Terms of Reference

Sponsor:	Group Chair
Author:	Group Secretary
Previous scrutiny:	Group Secretary
Purpose:	The paper is presented for **Approval**.

Executive Summary and Purpose

The Group Board is asked to approve the Terms of Reference for the Group Nomination and Remuneration Committees in Common. The Terms of Reference set out the lawful mandate and operating parameters for the Committees in Common that support the Remuneration Committees of the three sovereign NHS Foundation Trusts.

The document reflects the governance arrangements established under Schedule 7 of the NHS Act 2006, the Provider Collaboration Agreement, the Trust Constitutions and Standing Orders. It clarifies statutory accountabilities, the limits of delegated Joint Functions, the requirement for independence, and the role of the Councils of Governors in the formal appointment of Non-executive Directors.

The Terms of Reference confirm the variable membership configurations required for executive appointments, Chief Executive appointment, and Non-executive Director nomination. They describe the responsibilities of the Committees in Common for succession planning, director appointments and remuneration, performance appraisal, and the maintenance of the shared-post model across the three Trusts. Requirements for quorum, conflict handling, record keeping and annual effectiveness review are defined.

Board Action Required

Approve: The Group Board is recommended to approve the Committee Terms of Reference for adoption and implementation.

Norfolk and Waveney
University Hospitals Group

Terms of Reference – Group Nomination and Reumneration Committees in Common

Document Control

Document Author:	Group Secretary
Document Type:	Terms of Reference
Approval Body:	General Purpose Joint Committee (Group Board) acting on behalf of the Boards of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust, James Paget University Hospitals NHS Foundation Trust, and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.
Version Issue Date:	17 December 2025
Review Frequency:	Annually

Version History

Version	Date	Revision Description	Editor
0.1	November 2025	These Terms of Reference (ToR) establish the operational mandate, membership, and conduct for the Group Nomination and Remuneration Committees in Common (Group N&R CiC), derived from the respective Remuneration Committees of the three sovereign NHS Foundation Trusts (JPUH, NNUH, and QEHKL, collectively the Trusts).	Group Secretary

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1. Status, Authority, and Accountability

1.1 Establishment and Status

The Group N&R CiC is established under the Provider Collaboration Agreement (PCA) to permit the Remuneration Committees of the three Trusts to operate together as Committees in Common (CiC). This mechanism assists the Trusts in exercising Joint Functions related to director appointments and remuneration, relying on the principle that all Voting Directors must be appointed in shared posts of all three Trusts concurrently.

1.2 Accountability and Reporting

Each Trust's Remuneration Committee shall continue at all times to be directly accountable to its respective Trust Board. The CiC shall routinely report its decisions and activities to the General Purpose Joint Committee (GPJC).

1.3 Decision Authority

Decisions of the CiC regarding delegated Joint Functions are binding on each of the Trusts. Resolutions legally reflect the simultaneous decision of the Remuneration Committees of all three Trusts.

1.4 Independence Requirement

The Committee members must at all times satisfy the independence requirements set out in NHS England's Code of governance for NHS provider trusts (2022).

2. Chairing Arrangements

2.1 Chair in Common

The Chair of the General Purpose Joint Committee (GPJC) (who is the Chair in Common of the three Trusts) shall be the Chair of the Group N&R CiC in all its configurations.

2.2 Casting Vote

The Chair of the CiC does not hold a casting vote in this Committee, reflecting the need for simultaneous decisions binding on all three sovereign Remuneration Committees.

3. Membership, Attendance, and Quorum (Variable Capacity)

The CiC membership adjusts its composition based on the statutory requirements for the role being discussed:

Function Being Exercised	Required Membership Configuration	Delegated Authority and Compliance
A. Appointment & Remuneration of Executive Directors (other than the CEO)	All Voting NEDs (including the Chair in Common) AND the Chief Executive Officer (CEO).	The CEO is a required voting member of the Remuneration Committee when appointing other executive directors and advising on their terms. The resulting appointment requires final decision by the NEDs, but formal deciding authority rests with the committee consisting of the Chair, the Group CEO, and other NEDs.

Function Being Exercised	Required Membership Configuration	Delegated Authority and Compliance
B. Appointment & Remuneration of the Chief Executive Officer (CEO)	All Voting NEDs, including the Chair in Common. The CEO is explicitly excluded.	The CEO is not a member of the Remuneration Committee when appointing the CEO or advising on the CEO's remuneration. This appointment requires the approval of the Council of Governors.
C. NED Nomination and Recruitment Process	All Voting NEDs (including the Chair in Common) AND a majority of members of the Council of Governors (CoG) (Nomination Panel).	This process facilitates the statutory power retained by the Council of Governors to formally appoint NEDs.

3.1 Non-Member Participants and the Group Secretary

Other attendees may be invited to meetings where their specific input or expertise is required. Participants shall not have any voting rights, nor shall they be counted towards the quorum.

The Group Secretary is the Board's impartial governance officer responsible for providing independent governance advice to the Chair and the Committee. The Secretary ensures decisions are taken and recorded lawfully for each Trust and the Group Board and supports the Chair in safeguarding the integrity of governance arrangements.

The Secretary attends as an expected non-member participant and shall not have any voting rights, nor shall they be counted towards the quorum.

3.2 Quorum

Quorum shall be satisfied by the attendance of a majority of the members required for the specific capacity (A, B, or C). A member excluded due to a declared conflict of interest shall no longer count towards the quorum for that specific item.

4. Core Duties and Responsibilities

The CiC acts for all three Trusts to ensure a unified, compliant, and effectively managed Group directorate.

4.1 Board Composition and Succession Planning

- To consider and report to the GPJC on any matter concerning the structure, size, and composition of the Boards of the Trusts and their associated committees.
- To manage the long-term planning and nomination pipeline necessary to ensure the continuity and effectiveness of the Boards of Directors.

4.2. Executive Director Appointments and Terms

- To appoint and advise on the remuneration and allowances, and the other terms and conditions of office, for all Voting Executive Directors (EDs), including the Group Chief Executive.
- To ensure all appointed Voting Executive Directors are appointed in shared posts of all three Trusts concurrently.
- To appoint and advise on the terms for Non-Voting Executive Directors.

4.2 Non-Executive Director Nomination and Terms

- To facilitate the process for the nomination and recruitment of Voting NEDs, working in conjunction with the Councils of Governors.
- To advise on the management of NED terms, including seeking necessary approval from NHS England for the extension or resetting of terms for NEDs who have served multiple terms.
- To appoint and advise on the terms for Non-Voting Non-Executive Directors.

4.3 Performance Management and Development

- To ensure compliance with the requirement that the performance of Directors is reviewed annually through appraisal.
- To link executive performance to reward by setting executive remuneration and allowances.
- To ensure the Trusts take steps to secure that Directors are equipped with the skills and knowledge they require for their capacity.
- To oversee the appropriate removal of Executive Directors.

5. Conduct of Meetings

5.1 Decision Recording

Decisions must legally reflect the simultaneous decision of the Remuneration Committees of all three Trusts and that the minutes are filed to the correct corporate record for each Trust.

5.2 Transparency

The annual report must provide information on the Trust's policy on pay and on the work of the committee established under paragraph 33.2 of the Foundation Trust Constitutions (FTCs).

6. Effectiveness Review

6.1 Annual Self-Assessment

The Committees in Common conduct an annual review of effectiveness covering composition, coverage, evidence quality, and contribution to Board assurance.

7. Secretariat and Records

7.1 Secretariat

The Group Secretary arranges administrative support, ensures correct filing, and maintains a log of declarations and actions.

7.2 Record Management

Minutes and documents are retained in accordance with each Trust's records management policy.

Report to the Group Board of Directors dated Wednesday, 17 December 2025

Title: Group Risk Assurance Committee Terms of Reference

Sponsor:	Group Chair
Author:	Group Secretary
Previous scrutiny:	• Group Risk Assurance Committee • Special Purpose Joint Committee
Purpose:	The paper is presented for **Approval**.

Executive Summary and Purpose

The Group Board is asked to approve the Terms of Reference for the Group Risk Assurance Committee. These Terms of Reference were approved previously by the Special Purpose Joint Committee as part of the initial Group governance design. They now require formal approval by the Boards of the three NHS Foundation Trusts, acting together as the General Purpose Joint Committee, to complete the adoption process under the Provider Collaboration Agreement and the Standing Orders of each Trust.

The Terms of Reference confirm the Committee's role as a non-statutory, independent Non-executive Committee designated by the Group Board to provide risk and control assurance. They set out the Committee's remit for oversight of principal risks, alignment with risk appetite, triangulation of assurance sources, escalation of concerns, and review of assurance maturity. The Terms of Reference also clarify authority, quorum, membership, meeting conduct, reporting arrangements and the annual review of effectiveness.

The Terms of Reference remain unchanged since their earlier approval and are presented now for Group Board endorsement so that they may be formally lodged within each Trust's governance framework.

Board Action Required

Approve: The Group Board is recommended to approve the Committee Terms of Reference for adoption and implementation.

Norfolk and Waveney
University Hospitals Group

Terms of Reference – Group Risk Assurance Committee

Document Control

Document Author:	Trust Secretary
Document Type:	Terms of Reference
Approval Body:	Group Board of Directors
Version Issue Date:	October 2025
Review Frequency:	Annually and as required

Version History

Version	Date	Revision Description	Editor
1.0	06 September 2025	First issue – GRAC established as standalone non-executive risk assurance committee, a non-statutory Committee designated by the Group Board to discharge the role, function, duties, and responsibilities set out in these Terms of Reference.	Group Secretary

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1. Introduction

The Group Risk Assurance Committee (GRAC) is a formally constituted committee of the Group Board of Directors, established under the Provider Collaborative Agreement (PCA) and the Constitutions of the three NHS Foundation Trusts.

The Committee provides independent non-executive oversight of the adequacy and effectiveness of the Group's risk management, control, and assurance systems, with specific focus on the principal risks to the achievement of Strategic Aims and Objectives.

2. Purpose and Function

The Committee provides independent challenge and assurance. It does not own or manage risks, nor direct the manner of their treatment. The Committee's role is to provide assurance to the Board, not to manage or own risks directly.

The Committee shall:

- Review, challenge, and provide assurance to the Group Board on the adequacy and effectiveness of risk treatment for principal risks set out in the Board Assurance Report (BAR).
- Scrutinise applied controls and mitigation plans, ensuring they are evidence-based, proportionate, and aligned with the Board's approved risk appetite.
- Scrutinise the delivery of SMART plans linked to strategic objectives, testing whether risk treatments are enabling safe and effective delivery.
- Evaluate the strength, independence, and triangulation of assurance sources (executive, internal audit, external scrutiny).
- Recommend escalation or de-escalation of risks to the Group Board based on assurance testing outcomes and residual risk exposure.
- Promote a risk-mature culture across the Group by supporting transparency, shared ownership, and the routine use of the BAR for informed Board decision-making.
- Where risk treatments appear inadequate, excessive, or misaligned, the Committee may recommend moderations or adjustments. Executive Directors in attendance will consider how best to action such moderations but remain accountable for ownership and management of risks.

3. Scope

The Committee shall provide assurance across the full range of clinical and non-clinical risks, recognising that the Group's Strategic Aims may be impacted by operational, financial, workforce, digital, estates, compliance, and quality risks.

4. Authority and Accountability

The Committee is authorised by the Group Board to:

- Request and review any risk or assurance information relevant to its remit.

- Seek reports and explanations from Executive Directors and senior managers.
- Commission thematic deep dives or independent reviews into areas of significant risk or control weakness.
- Recommend escalation of risks to the Group Board where assurance is insufficient or residual risk exceeds tolerance.

The Committee is advisory to the Group Board. It does not manage or direct risk treatment, which remains the responsibility of the Executive.

5. Membership and Attendees

5.1 Membership

Minimum of four Non-Executive Directors, appointed by the Group Board.

One NED will be appointed Chair by the Board.

5.2 Attendees

Group CEO, Group Chief Delivery Officer, Chief Nurse, Chief Medical Officer, Chief Finance Officer, [Group Risk Lead, Group Directors of People, Digital, and Estates, and Hospital Managing Directors]

5.3 Role of Attendees

Executives and officers attend to provide evidence and explanation of risk treatments and assurance sources. They retain ownership of risks and responsibility for their management.

Executives are expected to attend to present risk and controls evidence and discuss risk in context, but do not count towards quorum or decision-making on NED assurance.

5.4 Exclusions

The Chair of the Group Board shall not be a member.

6. Quorum

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

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

7. Frequency of Meetings

Meetings shall be held not less than four times a year, aligned with key reporting and audit cycles.

The Chair, any member of the Committee, and Group Secretary may request a meeting if they consider that one is necessary.

8. Secretariat Functions

Secretariat support provided by the Group Secretary's office.

Agendas circulated at least three clear working days in advance, accompanied by supporting papers.

Minutes and action logs will be maintained and submitted to the Group Board on request

9. Meeting Transparency and Probity

The Chair shall 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.

Such conflicts of interest shall be managed by the Chair and recorded in the minutes and if appropriate, the public Register of Declarations of Interest.

10. Duties of the Committee

The duties of the Committee shall include:

10.1 Risk and Control Assurance

The Committee will test the integration of risk assurance evidence from multiple sources, including executive self-reporting, risk registers, the Board Assurance Report, the Intelligent Assurance Scorecard, internal and external audit, clinical audit, regulatory inspection, and peer review, to ensure assurance is triangulated and reliable.

The Committee will review the consistency and adequacy of risk escalation criteria applied across Care Organisations (trusts) and Hospital Management Groups, ensuring that thresholds are proportionate, consistently applied, and aligned with the Group's agreed risk appetite

The Committee shall:

- Review the adequacy and effectiveness of systems of risk management, internal control, quality assurance, and compliance.
- Review the Board Assurance Report (BAR) and Intelligent Assurance Scorecard (IAS) to confirm principal risks are being managed effectively.
- Test the reliability of assurance provided by executive-led Management Groups (People & Culture, Finance & Performance, Quality).
- Recommend moderations or adjustments to the Executive if risk treatments appear inadequate, disproportionate, or misaligned.

10.2 Risk Appetite and Escalation

- Monitor adherence to Board-approved risk appetite and tolerances.
- Recommend escalation or de-escalation of risks to the Group Board.
- Commission thematic deep dives into risks where mitigation is weak or assurance is misaligned.

10.3 Assurance Culture

- Evaluate the robustness and independence of assurance sources.
- Promote consistent use of the BAR for strategic decision-making.
- Assess assurance maturity across the Group using recognised standards (HMT Orange Book, HFMA).

11. Reporting Arrangements

The Committee Chair shall provide a report to the Group Board on the activities and findings of the Committee after each meeting. The Report shall include the “3As” of Assurance, Alert, and Advisory matters for which a standard template and digital form will be provided.

The Committee Chair shall escalate significant risks or failures immediately to the Board.

Minutes shall be made available to the Group Board on request.

The Chair shall prepare an Annual Committee Report to the Group Board, covering:

- Effectiveness of risk treatment,
- Adherence to risk appetite,
- Assurance maturity and culture,
- Findings from deep dives and escalation activity.

12. Review of Effectiveness and Terms of Reference

The Committee shall, at least once a year, guided and supported by the Group Secretary review its own constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

13. Distribution Control

Printed copies of this document should be considered out of date. The current version is available from the [future] Intranet.

14. Key References

- NHS Act 2006 (Schedule 7)
- NHS England Code of Governance for NHS Provider Trusts (2023)
- ISO risk management standard ISO 31000 (2018)
- HFMA NHS Audit Committee Handbook (2024)
- HMT Orange Book: Management of Risk (2023)
- NWUHG Risk Appetite Statement (2025)
- NWUHG Group Governance Framework
- Liverpool University Hospitals Group (UHLG) Board Risk Assurance Committee Terms of Reference

15. Model Committee Meeting Agenda

Topic 1. Chair's welcome and Declarations of Interest

Topic 2. Minutes and Actions

Topic 3. Review of Principal Risks (BAR and IAS)

Topic 4. Risk Appetite Monitoring and Threshold Breaches

Topic 5. Deep Dive into Thematic or Persistent Risk Areas

Topic 6. Executive Management Group Assurance Review

a. People & Culture

b. Finance & Performance

c. Quality (Patient Safety, Patient Experience, Clinical Effectiveness)

Topic 7. Review of Assurance Sources and Triangulation

Topic 8. Emerging Risks and Intelligence (digital, cyber, compliance, external scrutiny)

Topic 9. Assurance Culture and Maturity Review

Topic 10. Escalation Recommendations to the Group Board

Topic 11. Committee Workplan and Forward Agenda

Topic 12. Any Other Business

Topics may be taken in an order that suits the availability of required attendees and does not require their attendance for topics not within their specialism.