NHS
Norfolk and Suffolk
Integrated Care Board

A special meeting of the NHS Norfolk and Suffolk Integrated Care Board

Wednesday 4 November 2026, 4.30pm

The meeting will be held online and is available to watch live on YouTube.

Chair: Will Pope

Item	Agenda Item	Purpose	Lead
1.	**Welcome, introductions and apologies**	N/A	**Chair**
2.	**Declarations of interest** To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests.	N/A	**Chair**
3.	**Norfolk and Waveney Hospital University Group Case for Change**	Decision	**Richard Watson** Deputy Chief Executive and Executive Director of Strategy, Digital and Commissioning; and **Amanda Lyes** Executive Director of People, Governance & Corporate Services

Date, time and venue of future Public Board Meetings:

- Wednesday 16 December 2026 – 2pm Online
- Wednesday 27 January 2027 – 10.00 am Anglia Room, Breckland Council, Elizabeth House, Walpole Loke, Dereham, Norfolk, NR19 1EE.
- Wednesday 24 March 2027 – 10.00am King's Lynn Town Hall, Saturday Market Place, PE30 5DQ

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 3
Date: 04 November 2026

Title: Norfolk and Waveney Hospital University Group Case for Change

Lead Directors: Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital and Commissioning and Amanda Lyes, Executive Director of People, Governance & Corporate Services

Author: Lizzie Mapplebeck, Associate Director of Strategic Planning, Resilience and Change

Purpose: To determine whether the Norfolk and Waveney University Hospital Group (NWUHG) Case for Change provides sufficient evidence to justify developing and assessing options for acute hospital services in the best interests of patients and the population of Norfolk and Waveney. If so, to task the Executive Committee with commissioning and overseeing the development of a Pre-Consultation Business Case (PCBC).

Recommendation: The Board is asked to:

1. **Agree** that the Case for Change provides sufficient evidence to justify the ICB commissioning work to develop and assess options for acute hospital service changes in the best interests of patients and the population of Norfolk and Waveney. This does not approve a preferred service configuration or authorise formal public consultation;
2. **Task** the Executive Committee, subject to agreement of the Case for Change, with commissioning and overseeing an ICB-led PCBC to develop and appraise reconfiguration options against population health needs and best interests and to ensure the completed PCBC returns to the Board for a separate decision before formal consultation;
3. **Note** the NWUHG's preliminary scenario evaluation, provided for context only. These are not fully developed options, and the Board is not being asked to approve or endorse any scenario or future service configuration;
4. **Note** that the Healthwatch Norfolk report is forthcoming and recognise that its findings will be considered and reflected in the development of the PCBC.

1. Executive summary

The Norfolk and Waveney University Hospitals Group (NWUHG) has developed a Case for Change as the first stage of its review of acute hospital services across Norfolk and Waveney. This paper asks the Board to determine whether the evidence establishes a sufficiently compelling need for change and, if so, to task the Executive Committee with commissioning and overseeing the development of the PCBC. The accompanying scenario evaluation document is included for context only and is not presented for approval or endorsement.

Subject to the Board confirming the Case for Change and commissioning the next stage, the Executive Committee will oversee an ICB-commissioned, commissioner-led PCBC that develops and appraises a full range of options through an open, evidence-led approach. It will agree the detailed commissioning and mobilisation arrangements, subject to the safeguards in section 4.

Subject to Board approval, the Case for Change will be shared with NHS England for a strategic sense check. The commissioner-led next phase will include ongoing clinical leadership, patient and public involvement, equality and health inequalities assessment, scrutiny engagement, financial and workforce appraisal, legal oversight and NHS England assurance.

2. Background and context

The NWUHG has been developing a Case for Change since July 2026 to establish whether changes to acute hospital services are needed. Its work has been clinically led, including input from a Clinical Advisory Group and supporting clinical working groups, alongside external clinical and commissioner engagement and an engagement programme led by Healthwatch Norfolk.

The Case for Change brings together evidence relating to population need and demand, quality and operational performance, workforce sustainability, service fragility, financial pressures, estate constraints, travel and access, inequalities, neighbourhood health and the opportunity created by investment through the New Hospital Programme. The Case for Change reasons that maintaining the current model would not preserve the status quo and could result in unplanned or reactive service change.

The accompanying scenario evaluation paper sets out potential approaches identified by the NWUHG for further consideration. It is provided for context only, not for Board approval, and does not constitute an approved long list or shortlist of options. Through the formal PCBC process, these scenarios would need to be tested alongside other credible options, including a do-minimum comparator.

3. Basis for the Board’s decision

The Board is being asked to determine whether the Case for Change is sufficiently compelling to justify further options development and, if so, to task the Executive

Committee with commissioning and overseeing the PCBC process described in section 4. In reaching these decisions, the Board is invited to consider whether:

- the evidence provides a clear and credible account of why change may be required to meet patients' needs and those of the wider population;
- the risks of maintaining the current arrangements, including the prospect of reactive or unplanned change, are sufficiently described;
- the work is appropriately aligned with the ICB's strategic commissioning responsibilities and wider system priorities;
- the proposed PCBC scope provide a reasonable basis for commissioning further options development;
- there is a clear and lawful route for commissioner oversight, public involvement, scrutiny and assurance before any future proposal is brought forward for consultation.

Subject to Board approval, the Case for Change will be shared with NHS England for a strategic sense check to inform the next phase of options development. This is separate from the subsequent assurance of the PCBC.

4. Proposed PCBC commission and scope of the next phase

The ICB retains responsibility for decisions affecting commissioned NHS services. Subject to Board approval, the Executive Committee will develop a plan for, commission and oversee the PCBC, working with the NWUHG and NHS England. Commissioner accountability for the process and subsequent decisions will remain with the ICB.

The PCBC will develop and assess options and bring together the evidence required for assurance and a later Board decision on whether to progress to formal public consultation. Its scope will include, as a minimum:

- development of a comprehensive long list of options, including a credible do-minimum comparator;
- agreement of clear criteria for screening and comparing options, applied transparently;
- detailed clinical, quality, workforce, activity, capacity, financial, estate, digital and implementation analysis;
- assessment of travel, access, equality and health inequalities impacts, including cross-boundary patient flows;
- continuing involvement of patients, the public, staff, local authorities, scrutiny bodies and system partners at a point when options remain open to influence;
- independent clinical challenge and NHS England assurance, including the strategic sense check and subsequent assurance stages; and
- development of a clear audit trail showing how evidence, engagement, risks and mitigations have informed the shortlist and any preferred proposal.

The Executive Committee will bring an update to the next Board meeting on the PCBC mobilisation plan and commissioning arrangements, including more detailed timescales.

5. Principal risks and mitigations

Predetermination: There is a risk that progression is interpreted as support for a particular configuration. This will be mitigated through explicit option-neutral governance, transparent criteria and clear communication that no preferred option has been approved.

Statutory and legal challenge: There is a risk of challenge if involvement, equality, scrutiny or decision-making duties are not discharged at the correct stages. This will be mitigated through commissioner-led governance, legal oversight, a clear audit trail and early engagement with NHS England and relevant scrutiny bodies.

Insufficient evidence or deliverability: There is a risk that options progress without adequate clinical, workforce, financial, estate or system evidence. The PCBC workplan will require defined evidence standards, independent challenge and formal decision gateways before any consultation recommendation.

Capacity and affordability: There is a risk that the ICB do not have sufficient capacity or specialist capability to deliver an assurance-ready PCBC. A costed programme, clear accountabilities and dedicated resource arrangements will be required before commencement of substantive development of the PCBC.

7. Next steps

If the Board confirms that the Case for Change is sufficiently compelling and tasks the Executive Committee with commissioning the PCBC, the Executive Committee will be responsible for commissioning and overseeing that work. The next steps will be to:

- submit the Case for Change to NHS England for the strategic sense check;
- commission and mobilise an ICB-led PCBC programme under the Executive Committee's responsibility, and confirm governance, accountabilities and decision gateways;
- develop and approve a costed mobilisation plan setting out the detailed scope, methodology, timetable, resource model, funding source and impact on other ICB priorities before substantive options appraisal begins;
- continue engagement with patients, the public, staff, system partners and relevant scrutiny bodies;
- develop and appraise a comprehensive range of options through an open, evidence-led process; and
- return the completed PCBC to the ICB Board for a separate decision on whether any proposals are sufficiently developed and assured to proceed to formal public consultation.

8. Papers accompanying this report

Appendix 1: NWUHG – Our Clinical Strategy: Part 1 Case for Change

For information only

Appendix 2: NWUHG – Our Clinical Strategy: Part 2 Scenario Appraisal

Appendix 3: Healthwatch Norfolk - Shaping the Future of Healthcare in Norfolk and Waveney: Interim Report 29/10/2026

Norfolk and Waveney University Hospitals Group

Our Clinical Strategy

Part 1

Case for Change

Status: Final

Date: 29 October 2026

Foreword

More than one million people rely on hospital services across Norfolk and Waveney. Our local populations live across a large area of coastal communities, market towns, villages and urban centres. Deprivation and poor access to care affect communities in different ways, and over the next decade, population growth, ageing and an increasing burden of disease will add to these pressures.

There is much good care being delivered across our hospitals, but we cannot be satisfied with our present position. People with frailty and multiple conditions too often depend on hospital care when coordinated support closer to home would better meet their needs. The quality and timeliness of care for people with complex or urgent needs are not consistent across our hospitals. The birth rate has fallen in recent years and is projected to continue to fall making it harder to sustain these services. These problems sit alongside a structural financial deficit. Even if we deliver our current medium-term financial plan, we project a deficit of approximately £53 million by 2034/35.

We formed Norfolk and Waveney University Hospitals Group because these issues cannot be resolved sustainably by three trusts working separately. Group-wide work in areas including emergency surgery and oncology has begun to show what a more coordinated approach can offer. The allocation of £2.8 billion to replace the Queen Elizabeth and James Paget hospitals gives us a further reason to develop a coherent Group model for the wider system of care.

Developing the Case for Change

Around 60 clinicians from across the Group have contributed to this work since the summer, agreeing eight design principles for future care and an approach to assessing scenarios. Patient and community involvement is equally important in developing our thinking.

A substantial shift towards neighbourhood care is part of that model. We have developed an ambitious approach, referred to in our modelling as 'neighbourhood max', drawing on established practice elsewhere. Our modelling indicates that it could reduce the requirement for beds by up to 11 wards across the Group and make a net financial contribution of around £25 million. These benefits depend on creating the workforce, community capacity, facilities, digital connections and shared ways of working needed to deliver the model across Norfolk and Waveney.

For hospital care, our starting point is clear: patients should continue to receive as much care as possible at or closer to their current local hospital, where this can be done safely and sustainably. The scenarios we have examined indicate that approximately 97% of activity could remain where it is currently provided or provided even closer to where our patients live. This includes outpatient care, diagnostics, planned care, most emergency care for adults and children, medical admissions and ante and post-natal care.

Unplanned and women's and children's care

How we organise care for the 3% of our patients with complex or time-critical needs is a central consideration in this Case for Change. This is for patients who have conditions like cardiac arrests, strokes, complex trauma or gastro-intestinal bleeds and includes women giving birth. We need to provide consistent access to senior clinical decision makers for those patients 24/7 to achieve the best clinical outcomes.

Configuration of emergency care matters particularly in Norfolk and Waveney. Emergency departments and critical care beds would remain at all three sites, and our early modelling suggests that keeping an unselected medical take at all three hospitals would mean that only the sickest patients transfer between hospitals; around 20 per day. We recommend that this scenario is developed further in our evaluation in Part Two.

Maternity needs careful consideration. In 2024/25, the Queen Elizabeth and James Paget were two of only 12 hospitals in England with fewer than 2,000 annual births. Group-wide births are projected to fall by between 9% and 13% by 2031/32. If the rising proportion of caesarean births continues, our modelling suggests that the average number of births without intervention could fall below two a day at each of the smaller units. Lower activity makes it harder to sustain clinical experience and training while increasing the cost of maintaining services 24/7.

We have therefore examined both two-site and single-site models for births alongside maintaining the three birth units we currently have. A two-site model would preserve a second delivery location, but would require catchment areas to change in order to create balanced birth volumes, making both units viable. A single-site model could support the most resilient round-the-clock senior decision making cover, but would also increase travel for some women and families. Any such scenario would need detailed examination of clinical outcomes, ambulance and transfer pathways, equality and access, together with potential measures such as strengthened local maternity care and accommodation for women who need to be near the delivery unit. We are recommending that all scenarios for three, two and one birthing sites are taken forward for further evaluation.

New Hospitals Programme

There are consequences for the New Hospital Programme that we need to address openly. Our current plan is to submit Outline Business Cases for the two new hospitals in October 2027. If a service proposal requires public consultation, the business cases for the new hospitals will have to follow the decision made after that process. On the present timetable, our earliest planning assumption would move submission to around March 2028, subject to timely assurance and decision-making. Construction inflation and the potential need for an extension at Norfolk and Norwich University Hospital, particularly if maternity, neonatal and children's inpatient activity transfers, are provisionally estimated to require approximately £200 million in additional capital. The scope, cost and funding route need further work with the New Hospital Programme and NHS England.

Next steps

This Case for Change is intended to support the next decisions, not to settle the outcome of consultation or provide detailed appraisal. We will ask the Group Board to consider the case and the scenarios on 2 November, before presenting the work to the Norfolk and Suffolk Integrated Care Board on 4 November.

If further development is commissioned, the next stage will be to do a lot more detailed work on these scenarios and other scenarios that could emerge including testing the clinical model, their effects on different communities, the practical mitigations and the full financial and capital consequences. We owe patients, staff and the public a clear account of those choices before any final decision is made about how services should be organised.

Professor Lesley Dwyer, Chief Executive, Norfolk and Waveney University Hospitals Group
David Roberts, Chair, Norfolk and Waveney University Hospitals Group
October 2026

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1. Executive Summary

1.1 Purpose of the document

This Case for Change explains why health and hospital services across Norfolk and Waveney need to change. It brings together evidence about the needs of our population, the quality and performance of current services, workforce pressures, financial sustainability, the condition of our estate and inequalities in health and access to care. It also considers the implications of national policy, neighbourhood health and the £2.8 billion allocated through the New Hospital Programme to replace The Queen Elizabeth Hospital King's Lynn and James Paget University Hospital.

The case brings together three connected areas of change: more care and support through neighbourhood services, immediate action to stabilise fragile services, and a review of how the six interdependent acute service groups are organised. These respond to different pressures. Neighbourhood care can reduce avoidable hospital use, while shared teams and regional partnerships can strengthen many fragile services. The acute configuration work tests whether these improvements would enable our current arrangements to provide reliable, round-the-clock care for patients with the greatest clinical risk, or whether a different organisation of services would offer greater resilience.

This Case for Change does not select a preferred model or determine where individual services should be provided. Part Two assesses a range of potential scenarios against agreed clinical and organisational criteria.

1.2 Key findings

Norfolk and Waveney serves a population of approximately 1.06 million across urban centres, market towns, rural areas and coastal communities. Health needs are increasing and becoming more complex. Norfolk's population is projected to grow by approximately 11% between 2025 and 2045, with nearly three-quarters of the increase among people aged 65 and over. By 2045, around 30% of residents are expected to be aged 65 or over. This will increase demand associated with frailty, dementia, multiple long-term conditions, rehabilitation and end-of-life care.

The effects will be felt across the whole health and care system. If current patterns of use continue, population growth alone is expected to generate more than 1,000 additional general practice appointments each day, around 900 additional accident and emergency attendances each month and approximately 500 additional emergency admissions each month. Demand is already rising, while shortages in community and social-care capacity contribute to delayed discharge and pressure within our hospitals.

Our present arrangements do not provide consistently safe, timely and effective care. The Care Quality Commission rates safety as Requires Improvement at all three hospitals. JPUH and QEH are in segment 4 of the NHS National Oversight Framework, ranked 125th and 132nd respectively out of 134 trusts.

This variation is visible in patients' access to care. In August 2026, 82.1% of patients attending NNUH were admitted, transferred or discharged within four hours, compared with 67.8% at JPUH and 63.2% at QEH. Performance also varies in stroke diagnosis and access to specialist stroke care. None of our trusts met the national objective for beginning cancer treatment within 62 days of an urgent referral in July 2026, and diagnostic waits were above the England average at all three trusts.

Patient flow is not sufficiently reliable. In August 2026, an average of approximately 191 patients each day remained in our hospitals after they no longer met the criteria to reside, representing around 5,908 delayed bed days across the month. During the same period, 662 patients waited more than 12 hours in an emergency department after a decision had been made to admit them.

These pressures are connected: delays in arranging rehabilitation, community services, social care or other support restrict the beds available for people who need acute hospital care.

Some services have limited resilience and require action before any wider reconfiguration can be implemented. Our assessment identified 11 fragile services requiring further action and two additional services requiring monitoring. The principal causes include activity volumes that are insufficient to maintain skills and rotas, shortages in workforce capacity, gaps in specialist capability and physical constraints such as limited theatre, laboratory, equipment or estate capacity. Several services face more than one of these pressures.

Maternity and neonatal services illustrate how demand is changing. QEH and JPUH were two of only 12 hospitals in England with fewer than 2,000 annual births in 2024/25. Group modelling indicates that total births could fall by between 9% and 13% between 2025/26 and 2031/32, while the proportion involving caesarean section is increasing. Smaller services must continue to provide midwifery, obstetric, anaesthetic, theatre, neonatal and paediatric support throughout the day and night, despite declining overall activity and increasing clinical complexity. This creates challenges for staffing, training, maintenance of skills and emergency response.

Even if our current operational and financial plans are delivered in full, our modelling projects a recurrent structural deficit of £53 million by 2034/35. The 'Do as Planned' scenario includes the cost improvements in our Medium Term Financial Plan, action to stabilise fragile services and the New Hospital Programme's assumed shift of activity away from hospital. This position presents a substantial affordability challenge for the business cases for the new hospitals.

Our estate compounds these difficulties. QEH and JPUH contain extensive reinforced autoclaved aerated concrete and require continuing inspection, structural support and disruptive remedial work. NNUH operates within a long-term Private Finance Initiative arrangement that carries substantial financial commitments and makes changes to the estate more complex. Short-term interventions keep the hospitals operational but cannot provide the adaptable clinical environments required for the future.

The £2.8 billion allocated to replace QEH and JPUH creates an opportunity to address these constraints. The new hospitals will serve our communities for decades, so their designs need to reflect the care we intend to provide, the capacity needed at each site and the links to neighbourhood services. Rebuilding the present model on a like-for-like basis could lock current workforce dependencies, service fragilities and operating costs into our new estate.

Advances in clinical practice and life sciences are changing where care can be delivered. Improvements in diagnosis, less invasive treatment and day surgery create opportunities for suitable patients to receive care locally or without an overnight stay. More complex care still depends on experienced specialist teams and supporting infrastructure, which recruitment and retention pressures make harder to sustain across sites. A new electronic patient record will support coordinated pathways, provided it is implemented effectively and connects with partner services.

Our analysis also indicates that around 97% of activity across the Group involves patients classified as having lower-complexity needs. This suggests that a large proportion of care could be provided through consistent pathways at each hospital or closer to home, while a smaller group of patients would benefit from timely access to concentrated specialist expertise, advanced diagnostics and critical care.

Travel and accessibility must remain central to this work. Rurality, limited public transport, deprivation, disability and the cost and complexity of travel already affect access to care. Early modelling shows that moving services could result in additional journeys for some communities; future models must therefore consider the whole patient pathway, including which services can

be provided locally, how patients reach specialist care and what transport and other mitigations would be required.

1.3 Case for change

Maintaining the present model will not preserve the current position. Demand and patient complexity will increase, while workforce shortages, fragile services, financial pressures and estate constraints will make existing arrangements progressively more difficult to sustain. We will pursue operational improvement, neighbourhood development and networked staffing in every scenario. The remaining question is whether these actions can also provide dependable senior decision-making and the full range of supporting services for complex acute care across all three sites.

Our response therefore needs to address neighbourhood health, fragile services and acute hospital care as parts of one model. Each part has a distinct purpose, and the benefits of one cannot simply be assumed to resolve the risks addressed by another.

Neighbourhood health should provide more prevention, proactive support, assessment, monitoring, rehabilitation and follow-up closer to home. It should improve coordination between hospitals, primary care, community and mental health services, social care and voluntary organisations. This could prevent some deterioration and admissions, support earlier discharge and reduce the number of journeys patients must make to hospital. It will require sufficient workforce, funding, digital capability, estate and clinical governance outside hospital.

Fragile services require more immediate action. Working as a Group gives us greater scope to create shared teams, network rotas, standardise pathways and make specialist expertise available across hospital boundaries. Some services will require regional partnerships or investment in physical capacity. Stabilising these services cannot wait for the longer-term review of acute hospital configuration.

We also need to consider how the organisation of our core acute services affects the care of our sickest patients. The initial focus is emergency care for the sickest patients, acute medicine, emergency surgery, critical care, obstetric care during labour and birth, and inpatient paediatrics. These services depend on diagnostics, anaesthesia, theatres, specialist advice and appropriately skilled staff throughout the day and night.

Our vision is to provide everyone in Norfolk and Waveney with safe, high-quality care in the right place at the right time. People living with frailty or several long-term conditions would receive earlier, coordinated support closer to home; suitable patients would avoid unnecessary admission or recover at home sooner. People needing emergency or complex treatment would reach experienced clinical teams, diagnostics and critical care without avoidable delay. Planned care would be less exposed to emergency pressures, maternity services would have resilient staffing and support, and staff would have better opportunities to maintain skills and develop their careers. These are the benefits against which future models should be assessed, alongside travel, equality and affordability.

1.4 Next steps

Work to develop neighbourhood health and stabilise fragile services will continue under every future scenario. These changes form the basis of the “do as planned” scenario considered in this document.

Part Two, a separate document, will examine potential approaches to both expand neighbourhood health further and consider acute service reconfiguration across our three hospitals. The scenarios will be assessed against safety and clinical quality, access, health inequalities, patient and family experience, workforce sustainability, system capacity, financial

viability, travel, deliverability and use of resources. The assessment will also consider the consequences for services outside hospital and for neighbouring NHS providers.

Patients, carers, communities and staff will continue to be involved as the work develops. Healthwatch Norfolk has been commissioned to lead the programme's engagement approach.

The Group Board, NHS Norfolk and Suffolk Integrated Care Board and the NHS England regional team will continue to provide governance, commissioning oversight, challenge and assurance. If the ICB concludes that the Case for Change is sufficiently compelling, it will commission further options development. Any subsequent proposals for substantial service change would remain subject to the necessary clinical assurance, engagement, scrutiny and consultation before decisions are made.

2. Introduction

We have a once-in-a-generation opportunity to shape the future of hospital care in Norfolk and Waveney, with £2.8 billion allocated to replace James Paget and Queen Elizabeth Hospitals. More than one million people rely on our hospitals, and our 18,000 staff work hard to provide care across three sites. Yet we do not consistently deliver the quality, access or resilience that patients and staff should expect. Our current arrangements also leave us unable to operate within our allocated resources without additional financial support.

The needs of our population are changing. More people are living to older ages and with several long-term conditions. Too many receive care in hospital when earlier, coordinated support closer to home could better meet their needs. Developing neighbourhood services is central to improving care and managing future demand. A new electronic patient record will support more joined-up care by making information available across services and sites.

Advances in clinical practice and life sciences are also changing what care can be provided, and where. New approaches to diagnosis and treatment create opportunities for more care to be delivered without an overnight stay or, where appropriate, closer to home. Other treatments require specialist equipment, experienced teams and enough activity to maintain their skills. Our future hospitals and services need to accommodate both developments.

Workforce pressures make this more urgent. We struggle to recruit and retain sufficient staff with the right skills across our three hospitals, particularly in smaller specialist teams. Vacancies can make it difficult to maintain senior and specialist cover throughout the day and night, and place further demands on the staff who remain.

We need to improve the reliability of care for patients with the most complex and time-critical needs. We will test whether more consistent access to senior clinical decision-makers, together with bringing complex care together where appropriate, would improve outcomes. This question extends across unplanned care, complex planned care and maternity services.

Maternity care presents a particular challenge. Birth numbers across the Group are projected to fall, while the care required for many women and babies is becoming more complex. At smaller units, declining activity may make it harder to sustain specialist skills, training and the supporting services needed for safe care. We therefore need to review how maternity services should be organised for the future.

Some specialties face more immediate risks. Difficulties recruiting to small teams and maintaining viable rotas mean that several services cannot rely on their current arrangements indefinitely. Their responses will differ: some may need Group-wide teams, others regional partnerships or changes to patient pathways. We need to address this fragility while we examine the longer-term organisation of acute care.

Our geography makes these decisions particularly consequential. Rural and coastal communities, distances between population centres and uneven transport links already affect access to care. We will need to understand how any proposed changes would affect different communities, particularly people who already face barriers.

We are at a pivotal moment; the formation of the Norfolk and Waveney University Hospitals Group, the development of neighbourhood health and planned investment in our estate allow us to consider all of these issues together. To access the capital allocated for new hospitals, we need business cases that demonstrate a clinically and financially sustainable model of care. This Case for Change sets out why that model must differ from our current arrangements and provides the basis for testing the scenarios.

2.1 Purpose

The purpose of this Case for Change is to explain why health and hospital services across Norfolk and Waveney need to change and presents our initial thinking on what this could look like. Addressing the quality and safety issues affecting the Group is imperative; we have therefore begun to develop a range of feasible scenarios to address these challenges, which are set out in part two of this document. The Case for Change purposefully does not have a definite conclusion on any of these scenarios.

The first part of the Case for Change brings together evidence about the needs of our population, the quality and performance of current services, workforce pressures, financial sustainability, the condition of our estate, and inequalities in health and access to care. It also considers how national policy, the development of neighbourhood health services and investment through the New Hospital Programme affect the choices we now face.

The second part of the Case for Change takes this information and analyses a series of scenarios, starting from doing nothing more than is already planned and then ranging through making minimal change to several scenarios presenting different ways that care could be organised in the future. It evaluates all scenarios against a series of criteria that our clinicians think are important.

The document is intended to establish a shared understanding of the challenges and opportunities. It does not put forward a preferred configuration of services or make decisions about where individual services should be provided. It does suggest the scenarios we think are worthy of taking forward for further consideration, because they will enable us to deliver consistently higher standards of care for our patients, improve our long-term financial sustainability, and will allow us to progress with the building of our new hospitals.

Our commissioner, Norfolk and Suffolk Integrated Care Board, have the formal role to lead on service change in the NHS. They will be presented with this Case for Change, as well as scenarios for consideration; if they believe that the Case for Change is compelling, then they will commission further work on options for the future.

If further work is commissioned and developed options lead to proposals for service change, Norfolk and Suffolk ICB, working with our Group, will determine the appropriate form and extent of patient and public involvement in line with its statutory duties. We would seek the views of the relevant Health Overview and Scrutiny Committees, including any joint committee established for affected areas, and consult them formally where required.

We remain committed to involving our clinical leaders, patients, communities, staff, and our partner organisations throughout this process.

2.2 Aims

This Case for Change aims to:

- describe the population we serve and how its health and care needs are changing;
- explain how services are currently provided across our three hospitals and the wider health and care system;
- set out the principal challenges affecting quality, outcomes, access, workforce, operational performance, finance and the estate;
- explain why some services are already fragile or may become difficult to sustain, and describe potential solutions to this fragility;
- describe the opportunity to provide more prevention, proactive care and selected services through neighbourhood models;

- establish a shared vision and a set of principles against which future models of care can be developed and assessed; and
- provide a clear and transparent basis for further engagement, options development, appraisal and assurance.

Through this work, we want to create a common basis for discussion across our hospitals and with the organisations and communities that depend on them. Further stages will need to examine the benefits, risks and effects of different options before any decisions are made.

2.3 Scope

This Case for Change concerns services provided by our three hospitals: Norfolk and Norwich University Hospitals NHS Foundation Trust, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and James Paget University Hospitals NHS Foundation Trust. It considers these services within the wider Norfolk and Waveney health and care system, recognising their dependence on primary care, community and mental health services, social care, ambulance services, neighbouring providers and voluntary and community organisations.

The work covers three connected areas:

- the development of neighbourhood health and its scope to prevent ill health, intervene earlier and provide selected services closer to home;
- services that are already fragile or are at risk of becoming unsustainable; and
- the future organisation of acute hospital services across our three hospitals.

Within acute hospital services, the initial clinical work focuses particularly on six service groups where patients may be seriously unwell or where timely access to the right expertise and supporting services is particularly important:

- emergency department care for the sickest patients (referred to as majors and resus);
- acute medicine, including care for heart attacks and stroke;
- emergency surgery, including trauma and fractured neck of femur;
- critical care, including level 2 high-dependency and level 3 intensive care;
- obstetric care during labour and birth; and
- inpatient paediatrics.

Other services will be considered where they are fragile, where they could be provided differently through neighbourhood models or where they are clinically or operationally dependent on these six service groups.

The Case for Change does not:

- select a preferred model of care;
- determine the future location of individual services;
- provide detailed workforce, activity, financial or estate plans for a particular option;
- replace the business cases, impact assessments or public consultation that may be required at later stages; or
- prevent us from taking necessary action to maintain patient safety or improve current services while the longer-term work continues.

2.4 Governance and assurance

We have developed this Case for Change within the legal and assurance framework governing NHS service change. At this stage, we are setting out a clear, clinically evidenced Case for Change, describing current and future population needs, the benefits sought and the relevant workforce, financial, estate and digital dependencies, without predetermining any future configuration.

Our approach has taken account of the duties to involve patients and the public, reduce health inequalities, and meet the Public Sector Equality Duty. We have established clear clinical and programme governance, drawn together quantitative and qualitative evidence, recorded material assumptions and gaps, and considered quality, workforce, affordability, capacity, travel and equality.

This provides an auditable basis for further engagement, independent clinical challenge and the NHS England assurance process, including the strategic sense check and later assessment against the five tests for service change where applicable. It also helps ensure that future options can be developed and considered through a process that is open, fair and capable of demonstrating how evidence, engagement and identified risks have informed the work.

Programme governance

We have established a Programme Board (which meets as a part of the Trust Design Authority) to support development of the Case for Change; this has brought together representatives from the Group, the ICB and the NHS England regional team to oversee and steer the work. It has reviewed progress, evidence, risks and dependencies; provided constructive challenge; and helped ensure that the right work was undertaken in the right sequence, with appropriate engagement and assurance.

Our Group Board is responsible for assuring the clinical, operational, workforce and financial case for change and approving proposals within their statutory responsibilities.

NHS Norfolk and Suffolk ICB, as principal commissioner, oversees the case for change and makes or coordinates the commissioning decision.

The NHS England regional team provides advice, challenge and external assurance, including review before consultation.

A clinically led approach

We have taken a clinically led approach to translate our vision into credible scenarios for future care, working with a broad range of around 60 senior clinicians from all three hospitals to form our Clinical Advisory Group (CAG). The CAG has provided clinical leadership across the work, and a forum in which the implications of potential changes can be considered across services and hospital sites.

Developing the Case for Change through the CAG has ensured that the work is grounded in a strong understanding of how services operate, the standards they must meet, and the relationships between different parts of patient pathways. The CAG has also taken account of what matters to patient and communities, the needs of our workforce, and any practical constraints within which we operate.

The Clinical Advisory Group is supported by five Clinical Working Groups covering:

- Perinatal care
- Paediatrics
- Unplanned care
- Planned care

- Critical care

The working groups have examined relevant services and pathways in greater detail. They have considered current quality and safety, future demand, clinical interdependencies and the evidence for different models of care.

The approach combined clinical judgement with patient and community insight, operational evidence and national best practice. Our principal considerations are:

- the quality and safety of care and the outcomes achieved for patients;
- what patients and communities have told us is important to them, including through survey feedback;
- access to services, including journey and transfer implications considered with the East of England Ambulance Service;
- the potential effect on inequalities, deprivation and groups that already experience barriers to care;
- whether the future model can be staffed sustainably, with a workforce based principally on permanent NHS staff;
- whether the model is affordable for the local NHS; and
- how the model supports a credible case for securing investment through the New Hospital Programme.

Clinical safety and quality are fundamental requirements. The other considerations help us distinguish between clinically credible models and understand their wider benefits, disadvantages and practical implications.

2.5 Patient and community engagement

Engaging with patients, carers and communities is a vital part of this work. Decisions about future services will affect how, where and when people receive care. We therefore need to understand what matters to different communities, identify impacts that may not be visible in routine data, and involve people early enough for their views to influence the development and assessment of future service models.

Previous engagement across Norfolk and Waveney provides a clear starting point for this work; further details on this engagement are outlined in the appendix. People want shorter waits, faster diagnosis and treatment, and fewer delays as they move through services. They also want organisations to communicate more effectively, coordinate care and avoid requiring patients and families to repeat the same information. There is support for providing more care closer to home where this can be done safely, alongside a greater emphasis on prevention and helping people to remain well.

People support the use of digital services where these improve access and convenience, but expect non-digital alternatives to remain available. Previous engagement has also identified the additional barriers experienced by some rural communities, disabled people, people experiencing homelessness and other underserved groups.

We have commissioned Healthwatch Norfolk to lead the engagement approach for this programme. Its work will inform the continuing development and assessment of the emerging scenarios and help us understand the benefits, concerns and potential mitigations associated with different approaches. The findings, including how people participated and the views they expressed, will be presented in a separate engagement report.

3. About the Norfolk and Waveney System

3.1 Geography

Norfolk and Waveney covers Norfolk and the Waveney area of East Suffolk. It includes the urban centres of Norwich, King's Lynn, Great Yarmouth and Lowestoft, as well as market towns, extensive rural areas and coastal communities. The area can be understood through eight geographies: Breckland, Broadland, Great Yarmouth, King's Lynn and West Norfolk, North Norfolk, Norwich, South Norfolk and Waveney.

Norfolk and Norwich University Hospital provides local acute services for Norwich and surrounding parts of Norfolk, as well as specialist services for patients from a much wider area.

The Queen Elizabeth Hospital King's Lynn serves populations across West and North Norfolk, North Cambridgeshire and South Lincolnshire. Its cross-border catchment includes King's Lynn, Wisbech, Hunstanton, Downham Market and Swaffham, together with surrounding rural communities.

James Paget University Hospital serves populations across Great Yarmouth, Lowestoft and the wider Waveney area. Demand is also affected by people visiting the coastal area.

3.2 Our hospitals

Our three hospitals provide a common core of acute services, alongside specialist services that are available only at particular sites. Their catchment areas overlap and vary by service: a patient may use one hospital for general acute care but travel to another for specialist treatment.

Each of our three main acute hospitals provides:

- a 24-hour major emergency department, with resuscitation facilities and arrangements for assessing and treating children;
- acute medical assessment, inpatient general medicine and stroke care;
- planned and emergency surgery, including general surgery and trauma and orthopaedics;
- adult intensive and high-dependency care;
- consultant-led and midwife-led maternity care;
- urgent assessment and inpatient care for children;
- neonatal care, although the level of care available differs between sites;
- cancer and haematology services; and
- supporting diagnostic services, including imaging, pathology and endoscopy.

All three hospitals also provide outpatient, day-case and same-day emergency care. The scale and range of individual specialties differ between sites.

NNUH provides the broadest range of specialist and tertiary services within our Group. It is a designated Trauma Unit in the East of England Trauma Network and can manage many serious injuries, although patients requiring services available only at the regional Major Trauma Centre may be transferred to Addenbrooke's Hospital. Services concentrated at NNUH include radiotherapy, vascular and plastic surgery, thoracic surgery, specialist interventional radiology, complex cardiology, bone marrow transplantation and a number of specialist paediatric services. The Jenny Lind Children's Hospital provides specialist paediatric and neonatal surgery. NNUH

also has a Level 3 regional neonatal intensive care unit and is one of two Maternal Medicine Centres in the East of England.

JPUH provides the Group's hyperbaric medicine service. The category 1 hyperbaric chamber can provide hyperbaric oxygen treatment while ventilating and monitoring critically ill patients, a capability available at only a small number of hospitals nationally.

3.3 The Group model

The formation of the Norfolk and Waveney University Hospitals Group changes the basis on which we can make decisions. We now have common Board and executive leadership across our three Trusts, while each Trust remains a separate statutory organisation with local leadership and responsibility for its hospital and communities. This gives us a structure through which decisions can be considered in the interests of patients across Norfolk and Waveney, while retaining a clear understanding of local need.

The Group allows us to develop one clinical strategy and a common set of standards for care. A Group-wide view allows us to plan activity and capacity across three hospitals. We can identify where collective capacity could reduce waiting times, where planned care needs greater protection from emergency pressure and where small or vulnerable services would benefit from working as a single network. It gives us a better basis for assessing service interdependencies, including the diagnostics, critical care, anaesthetic, paediatric and other supporting services required for a clinical model to operate safely. Decisions will still need to consider access, ambulance capacity, travel, inequalities and the consequences for each local community.

Our combined workforce is one of the biggest opportunities created by our Group model. Larger clinical and professional communities can support joint recruitment, rotational posts, shared training, improved supervision and broader career pathways. Group working can also make specialist expertise available across sites through physical and virtual working and provide a more structured response when individual rotas or teams become vulnerable. Cross-site working should be designed around better care and staff development.

The Group also provides a stronger platform for education, research and innovation. We can develop a more coherent university hospital system, widen access to research across our catchment and use the different characteristics of our population to contribute to research into ageing, multimorbidity, rural health and coastal inequalities. A shared approach can reduce duplication in research infrastructure and give staff across all three hospitals more opportunities to participate in education, improvement and research.

3.4 Other health and care providers

Mental health and learning disability services are provided by Norfolk and Suffolk NHS Foundation Trust. Community health services are provided by East of England Community Health and Care NHS Trust, East Coast Community Healthcare and, for some children's and young people's services, Cambridgeshire Community Services NHS Trust, as well as the James Paget. East of England Ambulance Service NHS Trust provides ambulance services.

Primary care is delivered through general practice, community pharmacy, dentistry and optometry. Norfolk County Council and Suffolk County Council lead adult and children's social care, while district, borough and city councils influence health through housing, environmental health, leisure, community development and benefits services. Independent providers deliver a large proportion of residential, nursing and domiciliary care. Voluntary, community, faith and social-enterprise organisations contribute to prevention, social prescribing and community support.

No single organisation can respond to the needs of our population on its own. Changes to hospital services depend on sufficient capacity and clear interfaces across primary care,

community services, mental health, social care, ambulance services and the voluntary sector. The design of acute and neighbourhood care must therefore be rooted in partnership, rather than being delivered as separate initiatives.

3.5 Commissioning arrangements

Until 31 March 2026, NHS Norfolk and Waveney Integrated Care Board was responsible for planning and funding most NHS services across Norfolk and Waveney. On 1 April 2026, its responsibilities transferred to NHS Norfolk and Suffolk Integrated Care Board.

The new ICB covers the whole of Norfolk and Suffolk, serving about 1.7 million people and planning and funding services through an annual budget reported at about £4.9 billion. It works with NHS providers, primary care, local authorities, independent providers and voluntary organisations.

The Norfolk and Suffolk Population Health and Commissioning Strategy for 2026/27 to 2030/31 prioritises improved healthy life expectancy, reduced health inequalities and consistently high-quality care. It also commits to prevention, care closer to home and greater use of data and technology, and expects NHS providers to develop five-year integrated delivery plans that reflect population need and emerging neighbourhood health plans.

Our strategy must therefore be developed with the ICB, primary care, community and mental health providers, the ambulance service, local authorities, social care and the voluntary and community sector. Changes to hospital care will only be safe and deliverable where the services on which patients depend before and after hospital treatment are developed alongside them.

3.6 Place partnerships

The arrangements introduced in April 2026 include five place partnerships, known as Alliances: Great Yarmouth and Waveney, Norfolk Central, West Norfolk, Ipswich and East Suffolk, and West Suffolk. Great Yarmouth and Waveney, Norfolk Central and West Norfolk most directly cover the Norfolk and Waveney footprint. They bring together the integrated care board, NHS providers, primary care, councils, emergency services, patient representatives and voluntary, community, social-enterprise and faith organisations.

These arrangements create the structure through which neighbourhood care can be planned around defined populations.

3.7 Demand for care

People in Norfolk and Waveney live longer than the national average, but they also spend more years in ill health. NHS England's weighted-capitation formula indicates that general and acute healthcare need per head was about 14% above the England average. The increasing and ageing population will raise demand across primary care, hospital, community and social care services unless the pattern of need or the model of care changes.

If current patterns of service use continue, population growth alone is estimated to result in more than 1,000 additional general practice appointments each day, about 900 additional accident and emergency attendances each month, around 500 additional emergency admissions each month and approximately 1,800 additional people each year living with four or more long-term conditions[1].

[1] https://improvinglivesnw.org.uk/wp-content/foliolabs-files/docman-files/archived-documents/ICB_Norfolk_Waveney_Integrated_Care_system_FINAL.pdf

Recent activity data indicate that pressure is already increasing across the area; primary care appointments rose by 8% between 2023 and 2025[2], and accident and emergency attendances are up by 42% since 2017/18[3].

Demand is being driven by more than population growth. The main pressures include rising frailty, dementia and multimorbidity; unmet need and waiting lists following the pandemic; mental health and neurodevelopmental demand; seasonal respiratory illness; limited access to dentistry and some primary and community services; and shortages in social care and community capacity that delay discharge and increase pressure on hospitals. The 2025 Norfolk Pharmaceutical Needs Assessment found that recorded prevalence in Norfolk was higher or worse than England on 15 of 21 conditions examined.

[2] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/september-2025
[3] https://www.norfolkandsuffolk.icb.nhs.uk/wp-content/uploads/2026/03/Population-Health-and-Commissioning-Strategy-April-2026.pdf

4. Why change is needed

Our hospitals provide much good care, but the current pattern of services does not consistently deliver the timely, safe and sustainable care that people across Norfolk and Waveney should expect. The concern is particularly acute where patients are seriously unwell, their condition may deteriorate quickly or care depends on several specialist teams being available together.

Quality of care is variable across our hospitals, with particular issues concentrated at QEH and JPUH. Working as a Group, we need to correct any inequalities so that everyone across Norfolk and Waveney can access the highest quality care.

4.1 Organisational performance

Our hospitals face significant operational and financial pressures, and all three of our trusts have sustained and material performance concerns, indicating that the current pattern of services does not provide a stable basis for meeting future demand.

Care Quality Commission

All three hospitals are rated Requires Improvement for safety by the Care Quality Commission. Inspections have identified recurrent weaknesses in staffing, clinical records, risk management and the systems intended to prevent avoidable harm.

At NNUH, CQC found that "services did not always have enough staff to care for patients and keep them safe", alongside deficiencies in surgical safety checks, medicines management and secure record-keeping. At JPUH, the latest maternity assessment found that clinical records were not always managed safely and that "not all staff undertook required training to safely treat and care for women". At QEH, CQC concluded that weaknesses in medical care created "an increased risk that people could be harmed". Its assessment of urgent and emergency care also found that patients at risk of deterioration were not always monitored promptly or consistently, and CQC issued a warning notice for breaches including safe care and treatment.

These findings do not mean that every service is unsafe, but they demonstrate that we are not yet providing consistently safe care across our three hospitals.

National Oversight Framework

James Paget University Hospitals and The Queen Elizabeth Hospital King's Lynn are in segment 4 of the NHS National Oversight Framework, ranked 125 and 132 respectively out of 134 trusts.

Table 1: overview of JPUH and QEH National Oversight Framework positions, as of Q1 2026/27

Performance area	James Paget University Hospitals	The Queen Elizabeth Hospital King's Lynn
Overall NOF position	**SEGMENT 4 125th of 134 trusts**	**SEGMENT 4 132nd of 134 trusts**

Performance area	James Paget University Hospitals	The Queen Elizabeth Hospital King's Lynn
Access to services	Fourth quartile **Planned care:** 60.1% waiting 18 weeks or less **Diagnostics:** 34.5% waiting more than six weeks **Emergency care:** 72.4% admitted, transferred or discharged within four hours **Cancer:** 66.9% treated within 62 days; 72.7% diagnosed or ruled out within 28 days	Fourth quartile **Planned care:** 62.8% waiting 18 weeks or less **Diagnostics:** 37.3% waiting more than six weeks **Emergency care:** 64.1% admitted, transferred or discharged within four hours **Cancer:** 51.0% treated within 62 days; 66.7% diagnosed or ruled out within 28 days
Experience of care	Third quartile	Fourth quartile **Inpatient survey:** NOF score 3 of 4 **Staff advocacy:** 133rd of 134 trusts
Patient safety	Third quartile **Staff raising concerns:** 108th of 134 trusts **Infections:** C. difficile and E. coli each score 4, the lowest NOF scoring band	Third quartile **Staff raising concerns:** 134th of 134 trusts
People and workforce	Fourth quartile **NHS staff standards:** 130th of 134 trusts **Education and training survey satisfaction:** 132nd of 134 trusts	Fourth quartile **NHS staff standards:** 134th of 134 trusts **Staff engagement:** 133rd of 134 trusts
Finance, productivity and capability	**Finance, productivity and innovation:** Third quartile **Financial deficit:** Yes **NHS England capability rating:** Amber/Red	**Finance, productivity and innovation:** Fourth quartile **Financial deficit:** Yes **NHS England capability rating:** Red

At JPUH, our Q1 2026/27 NOF position reflects weaknesses across several aspects of our performance. Access pressures include long waits for planned care: between April and June 2026, 60.1% of patients waiting for planned care had waited 18 weeks or less, well below the NHS constitutional standard of 92%. Our overall performance in effectiveness and experience place us in the bottom half of acute trusts, indicating that we are providing worse clinical outcomes than other trusts across the country. We are also in the bottom half for the NOF patient safety measures, with poor staff confidence in raising concerns. There are also significant workforce concerns; JPUH ranked 130th for NHS staff standards and 132nd for satisfaction in the National Education and Training Survey. The overall position at JPUH reflects the combined effect of delays in accessing care, concerns about safety and outcomes, and underlying workforce and financial pressures.

QEH's position in the Q1 2026/27 NOF is a significant concern. Between April and June 2026, it was in the bottom quartile nationally for access to services, patient experience, finance and productivity, and people and workforce. Access pressures extend across several stages of care. 37.3% of diagnostic referrals had waited more than six weeks, only 64.1% of emergency department patients were admitted, transferred or discharged within four hours, 51.0% of cancer

patients began treatment within 62 days, and 66.7% received a diagnosis or had cancer ruled out within 28 days. For our patients, this means delays in assessment, diagnosis and treatment across urgent, planned and cancer care. We must also address the financial and workforce pressures that limit QEH's capacity to recover and improve. NHS England's Red capability rating reinforces the scale of this challenge.

Table 2: overview of NNUH National Oversight Framework position

Performance area	Norfolk and Norwich University Hospitals
Overall NOF position	**SEGMENT 3** **85th of 134 trusts**
Access to services	Third quartile **Planned care:** 62.4% waiting 18 weeks or less **Diagnostics:** 24.2% waiting more than six weeks **Emergency care:** 81.3% admitted, transferred or discharged within four hours **Cancer:** 64.4% treated within 62 days; 79.8% diagnosed or ruled out within 28 days
Experience of care	Fourth quartile
Patient safety	Fourth quartile **Staff raising concerns:** 131st of 134 trusts **Infections:** C. difficile has the lowest NOF score of 4
People and workforce	Third quartile
Finance, productivity and capability	**Finance, productivity and innovation:** First quartile **Financial deficit:** No **NHS England capability rating:** Amber/Green

Within our Group, NNUH has the strongest overall NOF position, although its results continue to identify important areas for improvement. Finance, productivity and innovation is a relative strength; we are placed in the highest-scoring quartile nationally.

Between April and June 2026, 81.3% of emergency department patients were admitted, transferred or discharged within four hours, close to the national 82% benchmark. Access overall is in the third quartile: 62.4% of patients had waited 18 weeks or less for planned care, 24.2% of diagnostic referrals had waited more than six weeks, and 64.4% of cancer patients began treatment within 62 days of referral. Patient safety and experience of care are both in the lowest-scoring quartile, while effectiveness of care and population health, and people and workforce, are in the third quartile.

As a Group, we need to respond to a set of connected problems affecting patient flow, access to diagnostics and treatment, staff experience and our ability to deliver consistently high-quality care.

4.2 Clinical quality and outcomes

People should receive consistently safe, timely and effective care wherever they live in Norfolk and Waveney. Our current model does not yet provide that assurance. Evidence from regulators,

national clinical audits, workforce reviews and local patient experience shows significant variation between services and sites. It also identifies weaknesses in some time-critical pathways, difficulties sustaining specialist workforces and problems when people move between hospital, community and social care.

There are many examples of good care across our hospitals, alongside services that have improved following regulatory intervention. However, this good practice is not reproduced consistently, and some services remain dependent on small teams, ageing infrastructure or local arrangements that are difficult to sustain. This creates risks for patients and limits our ability to improve outcomes across the population.

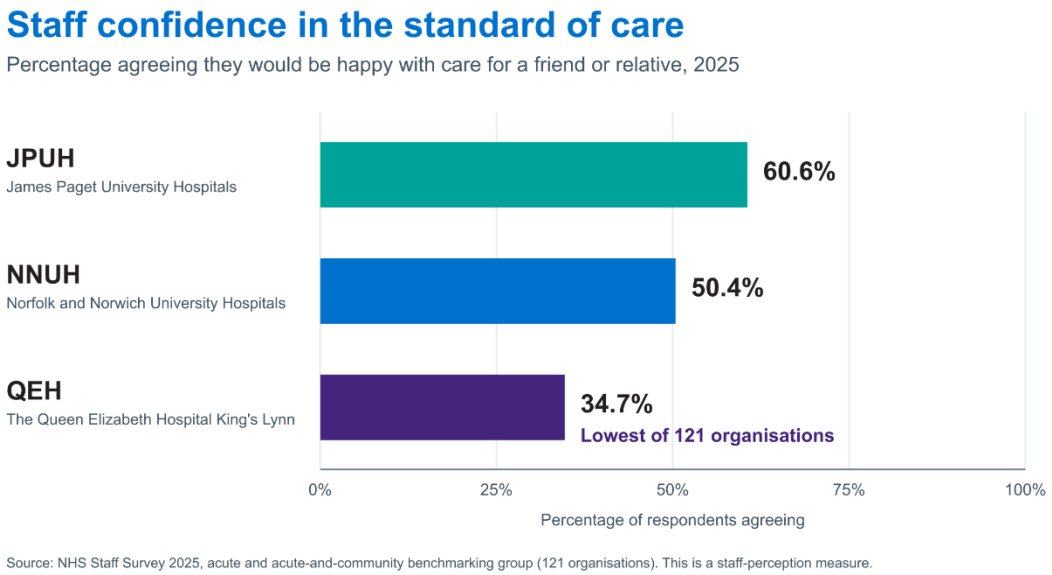
Workforce pressures are one cause of this variability. At JPUH, Board reporting recorded 399 nursing "red flags", the majority associated with staffing shortfalls, particularly shortages of registered nurses. The nursing establishment review also identified episodes of missed care on the stroke ward and Freedom to Speak Up concerns about unsafe staffing, reduced standards of care and poor patient outcomes.

NHS England has also previously convened a Rapid Quality Review focused on general surgery. This reflects the seriousness of the concerns about that service and the need for further scrutiny of its quality, safety and governance.

Safety and staff feedback

CQC currently rates the safety of all three of our hospitals as Requires Improvement. Overall ratings differ: JPUH is rated Good, while NNUH and QEH are rated Requires Improvement. These ratings show that each hospital has areas in which systems for managing risk, staffing, learning or care delivery do not yet provide the level of assurance expected.

The experiences of our staff support this conclusion. In the 2025 NHS Staff Survey, only 34.7% of QEH respondents, 50.4% of NNUH respondents, and 60.6% of JPUH respondents said they would be happy with the standard of care if a friend or relative needed treatment. On this metric, QEH recorded the lowest result among the 121 organisations in the acute and acute-and-community benchmarking group.



Source: NHS Staff Survey 2025, acute and acute-and-community benchmarking group (121 organisations). This is a staff-perception measure.

When asked whether patient care was their organisation's top priority, 54.5% of QEH respondents, 54.3% of NNUH respondents and 67.8% of JPUH respondents agreed, compared with an acute-trust average of 71.6%. These are measures of staff perception rather than direct clinical outcomes, but they provide an important indication of workforce confidence in the care being delivered.

Emergency care

We do not provide consistently timely emergency care across our three hospitals. Performance varies substantially between sites, meaning that patients can experience different waits depending on where they receive care.

In August 2026, 82.1% of patients attending NNUH were admitted to a ward, transferred or discharged within four hours of arriving at A&E. This compared with 67.8% at JPUH and 63.2% at QEH[4]. The England average was 75.0%. NHS England expects every trust to achieve at least 82% by March 2027.

There is a similar variation in very long waits. At NNUH, 3.6% of patients waited more than 12 hours from arrival before being admitted, transferred or discharged. This is compared with 8.1% at JPUH and 13.4% at QEH, and an England average of 9.7%[5]. JPUH, and particularly QEH have further to go in providing consistently timely urgent and emergency care.

Following an inspection in April 2026, the Care Quality Commission rated urgent and emergency services at QEH as Requires Improvement. Inspectors found that patients were not always monitored for deterioration in a timely and consistent way. The CQC concluded that delays had a detrimental effect on patients' experience and outcomes.

Variation in time-critical pathways

Our emergency-care figures show substantial variation in how quickly patients receive care across our hospitals. For someone who is seriously ill, timely treatment depends on senior emergency and acute medical staff being available alongside surgeons, anaesthetists, diagnostics, theatres and critical care, often at short notice. Maintaining this combination of expertise and facilities across three sites places pressure on specialist rotas. Vacancies or gaps in supporting services can make care less reliable and affect how quickly patients are assessed and treated.

Stroke is a particular concern; Norfolk and Waveney has a high prevalence of stroke, and the effectiveness of treatment depends heavily on the speed and organisation of the pathway. National guidance expects people with suspected stroke to receive brain imaging within one hour and to be admitted to a specialist stroke unit within four hours, unless another care setting is clinically required.

JPUH and QEH remain substantially below the national average for rapid imaging for specialist stroke care. Latest quarterly SSNAP data continue to show variation in the speed with which patients access diagnosis and specialist stroke care. Between January and March 2026, 58.4% of patients treated at JPUH received brain imaging within one hour, and 61% at QEH; this is compared with 63.3% at NNUH, and 63.9% nationally. The difference was more pronounced for admission to a stroke unit within four hours: this was achieved for 33.3% of patients at QEH, compared with 54.1% at NNUH, 55.9% at JPUH and 48.9% nationally.

People with suspected cancer need prompt access to diagnostic tests, specialist assessment and treatment. Long waits create distress and uncertainty for patients and may delay the point at which treatment can begin. Our current performance shows that we do not yet provide consistently timely cancer care across Norfolk and Waveney.

NHS England’s Acute Provider Performance July 2026 summary indicates that 80.4% of patients at NNUH received a diagnosis, or had cancer ruled out, within 28 days of an urgent referral. This compared with 78.6% at JPUH and 73.3% at QEH. NNUH was therefore the only one of our three trusts meeting NHS England's 80% objective for this part of the pathway.

[4] https://data.england.nhs.uk/providers/acute-provider-table
[5] https://data.england.nhs.uk/providers/acute-provider-table

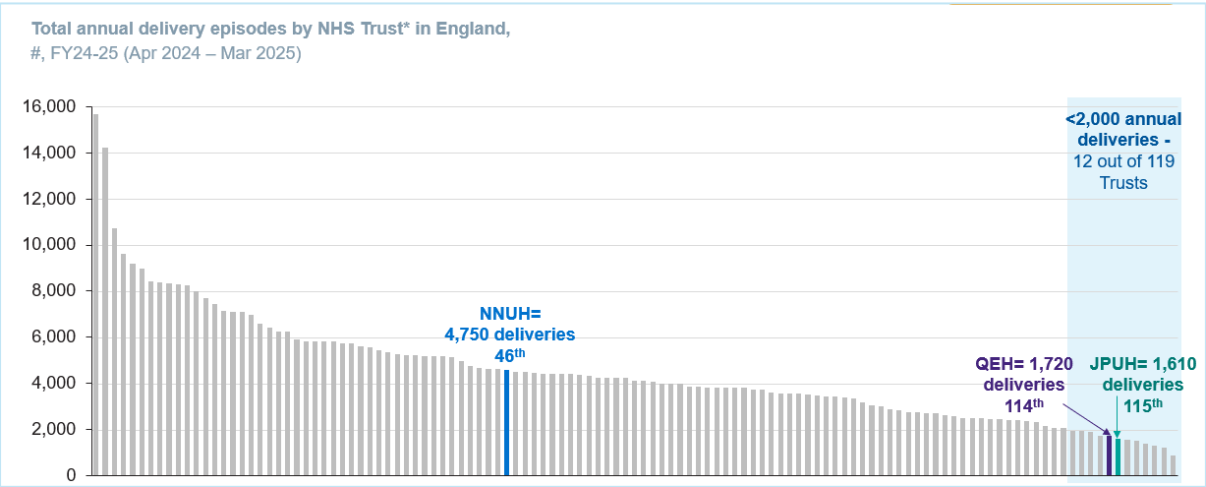
None of our trusts met the objective for beginning treatment within 62 days of an urgent referral. Performance was 70.8% at NNUH, 65.2% at JPUH and 59.5% at QEH, against an England average of 71.2% and an NHS England objective of 80% by March 2027.

Diagnostic capacity is an important consideration in cancer care. Across all diagnostic pathways, 28.4% of patients at NNUH, 33.1% at JPUH and 42.0% at QEH had been waiting more than six weeks for a diagnostic test in July 2026. The England average was 23.1%.

Maternity and neonatal care

Maternity services face a combination of lower birth volumes, changing clinical need, workforce pressure and estate constraints. In 2024/25, QEH and JPUH were two of only 12 hospitals in England with fewer than 2,000 annual births[6]. Since 2020, the number of caesareans delivered has increased by 14%, to a total of 42.5%. This reflects a national trend in the increase of caesarean births, and demonstrates that lower birth numbers have not led to a corresponding reduction in clinical workload. Small services must maintain safe staffing, theatre, anaesthetic, paediatric and neonatal cover throughout the day and night, irrespective of the number of births.

This combination of lower birth rates and more complex births creates challenges in consistently sustaining the required rotas, expertise, training opportunities, theatre capacity and specialist support.



Baroness Amos' 2026 National Maternity and Neonatal Investigation examined QEH as part of its investigation. Based on the position and data used within the investigation, it reported an adjusted neonatal mortality rate of 0.8 per 1,000 live births in the 12 months ending October 2024, higher than comparable trusts, while the adjusted stillbirth rate of 2.6 per 1,000 births was comparable with similar trusts.

The Amos Review identified wider factors affecting quality. Staff described periods when staffing was significantly below planned levels, the loss of experienced staff, large community caseloads and staffing arrangements that had not kept pace with increasingly complex births and rising caesarean-section rates. Families described occasions when symptoms or concerns about their babies were minimised, decisions were insufficiently explained and changes to care plans were made without adequate involvement.

Maternity and neonatal care at QEH was also reported to be constrained by the physical environment. The investigation identified cramped areas, limited space for confidential conversations and accessibility problems. Water-safety and infection-control concerns had caused some facilities to be taken out of use. At the time of the visit in 2026, improvements in quality, staffing and environment were recognised.

[6] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2024-25

The consequences of avoidable harm in maternity are first and foremost borne by women, babies and families, but they also create a substantial and long-term financial burden for the NHS. In 2024/25, our three trusts' maternity contributions to the Clinical Negligence Scheme for Trusts totalled £14.7 million. Reducing avoidable harm and sustaining effective governance, training and learning are therefore important both for improving outcomes and for protecting resources that could otherwise be invested in patient care.

Flow

We do not consistently move patients through and out of our hospitals as quickly as their clinical needs require. Some people remain in an acute hospital bed after they no longer meet the criteria to reside, while others face prolonged waits in emergency departments after a decision has been made to admit them. These pressures are connected: when patients cannot leave hospital promptly, fewer beds are available for people who need to be admitted.

In August 2026, an average of approximately 191 patients each day remained across our three hospitals despite no longer meeting the criteria to reside: 72 at JPUH, 66 at NNUH and 53 at QEH[7]. Across the month, this represented approximately 5,908 delayed bed days. No longer meeting the criteria to reside does not mean that a person requires no further care. Many people will continue to need rehabilitation, reablement, community health services, social care, equipment or an appropriate place in which to recover. Their discharge therefore depends on timely coordination and sufficient capacity across hospital, community and social care services.

Pressure on available beds is also experienced by patients waiting in our emergency departments. In August 2026, 662 patients waited more than 12 hours after a decision had been made to admit them: 373 at JPUH, 151 at QEH and 138 at NNUH[8].

Together, these measures show that patient flow is not sufficiently reliable. People who have completed the acute phase of their care can remain in hospital while the support needed for discharge is arranged, while patients requiring admission can spend many hours waiting for a bed. Addressing this will require improvement within our hospitals and closer working with primary care, community health services, social care and voluntary-sector partners.

Neighbourhood care

Older people with frailty or several long-term conditions frequently move between hospital, community services, primary care, social care and unpaid family support. Poor coordination can contribute to delayed discharge, loss of independence, avoidable readmission and distress for patients and carers.

Local engagement has identified concerns about integration and continuity, and a desire for a clearer "front door" to services. The consequences are visible at both ends of the hospital pathway. Neighbourhood models of care will be important in providing earlier and more coordinated support, avoiding some admissions and enabling more people to recover safely outside hospital.

Neighbourhood health in Norfolk and Waveney is less developed than it needs to be to support a substantial shift towards prevention, proactive care and coordinated support closer to home. Local initiatives provide a foundation, but a consistent model has not yet been established at scale across the wider footprint.

None of the 43 places selected for the first wave of the National Neighbourhood Health Implementation Programme (NNHIP) are in Norfolk and Waveney. This means that Norfolk and Waveney is not currently part of the national cohort receiving focused support to accelerate

[7] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2026/09/Daily-discharge-sitrep-monthly-data-webfile-05-CSV-aug26.csv
[8] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2026/09/August-26-AE-by-provider-r5ic5.xls

implementation and test new approaches. We therefore need to work with our partners to develop a clearer and more consistent neighbourhood model, connecting hospital services more effectively with primary care, community and mental health services, social care and the voluntary sector.

4.3 What good looks like

High-quality care should be safe, timely and reliable, regardless of where a patient lives, which hospital they attend or when they need support. It requires more than the presence of a service on a particular site. Each service needs the workforce, expertise, patient volumes, diagnostics, supporting specialties, facilities and clinical governance needed to provide care consistently.

Our future model should therefore make effective use of the combined capabilities of our three hospitals, and connect hospital care with primary, community, mental health and social care. Services should remain local where this provides safe and effective care. Where outcomes depend on scarce expertise, specialist equipment or sufficient clinical experience, we should test whether networked provision, stronger on-site cover or bringing some activity together provides the most reliable pathway. The standard is the patient's outcome across the whole pathway, rather than the continued presence of a particular service on every site.

Urgent and emergency care

Good urgent and emergency care provides rapid assessment, early clinical decision-making and prompt access to the diagnostics, treatment and specialist advice a patient needs. Patients who can be treated without admission should be able to return home safely on the same day. Those who need a hospital bed, emergency operation or critical care should not remain in an emergency department because capacity elsewhere in the pathway is unavailable.

The NHS Standard Contract requires trusts to ensure that at least 82% of patients attending an emergency department are admitted, transferred or discharged within four hours by March 2027, with no more than 2% waiting longer than 12 hours from arrival. The national medium-term framework raises the four-hour expectation to 85% by 2028/29.

A strong model would include rapid streaming at the front door, access to senior clinical decision-makers, same-day emergency care, timely diagnostics and dependable specialist support. It would also provide sufficient emergency theatre, critical care and inpatient capacity, alongside effective discharge arrangements. These components are interdependent: improving the emergency department alone will not resolve long waits where patients cannot be admitted or discharged promptly.

There are examples elsewhere of improvement through redesigning the whole pathway. At West Cumberland Hospital, the development of same-day emergency care was reported to have reduced hospital admissions by 30%, with between 60% and 70% of patients using the service avoiding an unnecessary admission.

Case study: West Cumberland

West Cumberland Hospital in Whitehaven faced pressure on its emergency department and inpatient beds. Some patients needed urgent assessment or treatment but did not necessarily need an overnight stay. The challenge was to identify those patients early, while retaining access to emergency care locally.

North Cumbria Integrated Care NHS Foundation Trust introduced a same-day emergency care (SDEC) service at the hospital in March 2020. Its approach was to assess patients before deciding whether to admit them, with senior clinicians involved early in that decision. The service brings together medical and surgical teams and can receive referrals from GPs, NHS 111, ambulance crews and the emergency department. Patients can undergo assessment and treatment during the day and return home where it is clinically safe to do so. The facilities were

subsequently expanded to include ambulatory care space, a procedure room and a 23-hour assessment unit. The trust also used staff feedback to refine how teams worked together.

The trust reported that SDEC reduced the number of people needing admission at West Cumberland by 30%. NHS England later reported that 60 - 70% of patients treated through the expanded unit avoided an unnecessary admission. The trust has since proposed stronger consultant cover and longer opening hours, recognising that further expansion depends on recruiting the necessary clinical staff.

Northumbria is the best example of a large-scale redesign of emergency care services across a large rural county, with many similarities to Norfolk.

Case study: Northumbria

Northumbria Healthcare serves a dispersed urban and rural population across Northumberland and North Tyneside. Before 2015, emergency admissions were received through emergency departments at North Tyneside, Wansbeck and Hexham general hospitals. Specialist services were distributed across the sites, some patients required transfer for treatment, and the model could not provide the same level of senior clinical presence at every hospital throughout the day and night. The challenge was to improve early access to senior decision-makers and diagnostics for seriously ill patients while retaining convenient local care for less serious needs.

In June 2015, the trust opened the Northumbria Specialist Emergency Care Hospital at Cramlington and concentrated emergency assessment and admission there. Emergency medicine and critical care consultants are available on site at all times, with other senior specialists providing extended seven-day cover. Patients are admitted directly to the relevant specialty after assessment, with an expectation that those needing continuing but less acute care can be transferred to a local general hospital. North Tyneside, Wansbeck and Hexham retained urgent treatment services, diagnostics and most planned care. The change therefore separated emergency from planned activity without removing hospital provision from the local sites.

The outcomes

A peer-reviewed evaluation[9] compared 18,586 adult emergency admissions before centralisation with 16,126 in the first year and 17,727 in the second year afterwards. By year two, admission to the specialist hospital was associated with a lower adjusted probability of death within 60 days, with an odds ratio of 0.94. The clearest benefit was among patients aged 80 and over. The daily probability of discharge increased, while readmission and emergency-department reattendance fell.

Time-critical and specialist care

For conditions such as stroke, major trauma, sepsis and some surgical emergencies, the speed and organisation of care can materially affect survival and long-term disability. Good care requires the whole pathway to work: recognition of the condition, ambulance response and pre-alert, rapid diagnosis, senior clinical assessment, definitive treatment, access to critical care where necessary and specialist rehabilitation.

NICE expects people with acute stroke to be admitted directly to a specialist stroke unit within four hours, unless another setting is clinically appropriate. Patients should also receive brain imaging within the timescale required by their presentation. Meeting these standards consistently

9 https://researchportal.northumbria.ac.uk/ws/portalfiles/portal/26904097/emermed_2019_208539.full.pdf

requires access to imaging, specialist stroke staff and agreed pathways for thrombolysis, thrombectomy and onward rehabilitation throughout the week.

Experience in London, Greater Manchester and Northeast England demonstrates the potential benefits of organising acute stroke care around specialist units with sufficient expertise and activity. Following the introduction of hyperacute stroke services in London, adjusted mortality at 90 days fell by 1.1 percentage points and hospital stays became shorter. Researchers estimated that the change was associated with 168 fewer deaths over 21 months. Further centralisation in Greater Manchester was subsequently associated with lower mortality among patients treated in a hyperacute stroke unit and approximately 6,750 fewer hospital bed days each year. These models demonstrate that outcomes can be improved by ambulances bypassing the nearest hospital and taking patients to the most appropriate hospital, when specialist teams, imaging and treatment protocols are available reliably and at sufficient scale.

Similar principles apply to emergency surgery. National Emergency Laparotomy Audit standards expect patients to receive prompt assessment, risk stratification and diagnostic imaging. Patients at high risk should receive direct consultant-delivered care from both a surgeon and an anaesthetist, with appropriate access to critical care. A sustainable service therefore needs sufficient consultant availability, theatre access, anaesthetic and critical-care support, skilled nursing and allied health professionals, and enough activity to maintain clinical experience and training.

Case study: South Tyneside and Sunderland

The Path to Excellence programme began in response to concerns that the existing pattern of services in South Tyneside and Sunderland was not clinically or operationally sustainable. Recruitment difficulties, reliance on locums, smaller patient volumes and limited specialist cover affected stroke, consultant-led maternity and emergency paediatrics.

Stroke performance illustrated the variation. Before acute care was combined, only 22% of patients in South Tyneside and 41% in Sunderland received brain imaging within an hour. Direct admission to a stroke unit within four hours was achieved for 6% and 72% respectively. The services were graded E in South Tyneside and D in Sunderland by SSNAP.

Following clinical review, public engagement and consultation, acute inpatient stroke care was brought together at Sunderland Royal Hospital, initially in December 2016 and subsequently on a permanent basis. This enabled seven-day access to stroke specialists, while rehabilitation and community support continued locally.

In 2019, high-risk and consultant-led births were concentrated at Sunderland alongside neonatal support; South Tyneside retained antenatal and postnatal care and a midwifery-led birthing centre. The paediatric model combined a 24-hour emergency service at Sunderland with daytime assessment and urgent care at South Tyneside. The two provider trusts also merged in April 2019, creating a single organisation to manage the pathways.

The outcomes

The clearest reported results concern stroke. After centralisation, 70% of patients received brain imaging within an hour, average time to imaging fell to 35 minutes and 74% were admitted directly to a stroke unit within four hours. The proportion of eligible patients receiving thrombolysis rose to 85%, while 98% spent at least 90% of their admission on a stroke unit. The combined service improved to SSNAP grade B, one point below grade A.

Planned care, cancer and diagnostics

Good planned care provides equitable and timely access from referral through diagnosis and treatment. Patients should not face repeated delays because emergency pressures displace

planned activity or because available capacity is divided between organisations and sites. Where clinically appropriate, common pathways, pooled capacity and shared waiting lists across our Group should allow patients to receive care sooner, while preserving continuity and informed choice.

National expectations provide clear measures of the improvement required. By 2028/29, 92% of patients should begin consultant-led treatment within 18 weeks. For cancer, at least 80% of patients should receive a diagnosis, or have cancer ruled out, within 28 days. The proportion beginning treatment within 62 days of an urgent referral is expected to reach 80% by March 2027 and 85% by 2028/29. Diagnostic performance must also improve: the proportion of patients waiting more than six weeks for a test is expected to fall to no more than 14% nationally during 2026/27 and to 1% by 2028/29.

Meeting these standards will require more than additional activity. We need sufficient diagnostic capacity and timely reporting, supported by effective multidisciplinary decisions and coordinated access to treatment. Applying common clinical standards and making better use of capacity across our sites would reduce avoidable variation in how quickly patients move through their pathway. It would also make planned services less vulnerable to disruption when individual sites experience operational or workforce pressures.

There is further scope to provide more treatment without an overnight hospital stay. Getting It Right First Time (GIRFT) guidance notes that advances in minimally invasive and robotic surgery, anaesthesia and enhanced recovery mean that procedures previously requiring inpatient admission are now routinely undertaken as day cases in some NHS centres. These include robotic or laparoscopic prostatectomy, nephrectomy and hysterectomy, as well as selected joint replacements and other major procedures.

Robotic technology alone does not create an effective day-case service. Patients must be selected and prepared appropriately, with suitable anaesthesia, pain relief and early mobilisation, followed by reliable support after discharge. Developing these pathways consistently and coordinating the use of our technology, theatres and specialist workforce would allow suitable patients to recover at home, release inpatient beds for people who need them and improve the resilience and productivity of planned care.

Maternity and neonatal care

Good maternity and neonatal care combine accessible local support with reliable access to the expertise required when risk or complexity increases. Women and families should be listened to, involved in decisions and able to obtain prompt reassessment when they are concerned. Staff should work in a culture in which escalation is encouraged, incidents are investigated thoroughly and learning leads to measurable change.

Birth services need safe and sustainable midwifery, obstetric, anaesthetic, theatre, paediatric and neonatal arrangements throughout the day and night. The required level of support is determined by clinical need and complexity as well as by the number of births. Smaller units are unlikely to be able to demonstrate that they can maintain the necessary rotas, skills, supervision and emergency response despite lower activity.

For us, good care would connect antenatal, birth and postnatal services across hospital and community settings, with clear access to maternal medicine, neonatal care and regional specialist services. Any future model would need to consider clinical outcomes, travel and access, ambulance and transfer arrangements, workforce resilience, training, choice and the experience of women and families together.

Case study: Barking, Havering and Redbridge

Barking, Havering and Redbridge University Hospitals NHS Trust illustrates how consolidating maternity services, when accompanied by sufficient staffing, capacity and clinical governance,

can support more reliable care. In 2011, the Care Quality Commission identified serious weaknesses in the Trust's maternity services, including insufficient staffing, poor care, weak leadership and inadequate learning from incidents. In March 2013, obstetric births ceased at King George Hospital. Births were concentrated at Queen's Hospital or redistributed to other units in north-east London, while antenatal care and ultrasound services continued locally at King George Hospital

Consolidation created a larger maternity service at Queen's Hospital, but did not by itself resolve the challenges of providing safe care. Following a further CQC assessment in 2024, the Trust strengthened the workforce and the arrangements supporting the service. It invested in 38.85 additional whole-time-equivalent clinical posts, informed by the Birthrate Plus staffing methodology. It also introduced dedicated medical cover for maternity triage, a supernumerary coordinator on every shift, a flow matron and a discharge coordinator. Additional elective obstetric theatre sessions were introduced to respond to rising caesarean-section activity, alongside stronger governance, performance monitoring and reporting to the Trust Board.

The outcomes

By 2025, Queen's Hospital was supporting a high-volume maternity service, with 7,920 births recorded between October 2023 and October 2024. The CQC found that it had sufficient midwifery and medical staff, with reported midwifery fill rates of between 93% and 98% during May to July 2025. Inspectors also found improved management of maternity triage and patient flow, clearer leadership and stronger oversight of risk. In December 2025, CQC rated the maternity service Good overall, with Good ratings for effectiveness, caring, responsiveness and leadership.

Patient flow and neighbourhood care

Good hospital care includes safe and timely discharge. Patients should not remain in an acute bed because responsibility is unclear or because community health services, social care, rehabilitation, equipment, medicines or transport are unavailable. Discharge planning should begin early and should involve the patient, their family and the services that will support them after they leave hospital.

National neighbourhood-health policy expects primary care, community services, mental health services, hospitals, social care and the voluntary sector to work through agreed local footprints and multidisciplinary teams. Initial priorities include people with moderate or severe frailty, care-home residents, people who are housebound and those approaching the end of life. The model includes proactive identification of risk, planned support and access to an urgent community response when a person's condition deteriorates.

This is particularly important in Norfolk and Waveney because many residents live with frailty or several long-term conditions and depend on support from several organisations. A mature neighbourhood model would identify deterioration earlier, coordinate care around the individual and provide selected assessment, monitoring, treatment and rehabilitation closer to home. It would retain rapid access to hospital diagnostics and specialist advice when these are needed.

Experience elsewhere shows what more integrated arrangements can achieve. Swindon's discharge-to-assess model brings together hospital, community, social care and voluntary-sector partners, with the intention that eligible patients are assessed in their usual place of residence within 24 hours of leaving hospital. At North Tees and Hartlepool, the use of shared data to identify and resolve barriers to discharge was associated with a 36% reduction in stays of 21 days or more despite an increase in admissions.

Case study: Surrey Downs

Surrey Downs provides an example of how safe discharge, admission avoidance and proactive neighbourhood care can form part of a single model. Epsom and St Helier University Hospitals

NHS Trust, Surrey County Council and local GP federations established a formal partnership bringing together integrated neighbourhood teams with urgent community response, virtual wards, discharge-to-assess services, recovery at home and care-home liaison. This allows people to receive coordinated support before a crisis, leave hospital earlier when clinically appropriate and continue their assessment and rehabilitation at home.

The outcomes

Overnight hospital admissions have remained more than 30% below pre-pandemic levels since 2019. Among older people receiving proactive support from integrated neighbourhood teams, a six-month before-and-after comparison found 35% fewer A&E attendances and 31% fewer non-elective admissions. Earlier evaluation of an integrated frailty unit at Epsom Hospital reported that average length of stay fell from 40 to 13 days, the proportion of patients discharged to their own home increased from 20% to 70%, and 30-day readmissions fell from 25% to 15%.

4.4 What will happen without change

Demand, patient complexity, workforce availability and the condition of our estate are changing. Maintaining the status quo across health services in Norfolk and Waveney will not preserve our present position. Without planned change, the pressures already visible in waiting times, patient flow, clinical outcomes, staff experience and service fragility will become increasingly difficult to manage.

An older population will increase pressure across the pathway

Norfolk's population is projected to grow by approximately 11% between 2025 and 2045. Nearly three-quarters of the net increase is expected to be among people aged 65 and over, with this age group accounting for approximately 30% of residents by 2045. This is likely to increase the number of people living with frailty, dementia and several long-term conditions.

These patients often require support from primary care, community services, hospitals and social care at the same time. They are more likely to need urgent assessment, admission, rehabilitation and help returning home. Without stronger preventative and neighbourhood support, hospitals will continue to be used as the point at which unmet or poorly coordinated need becomes visible.

The consequences would extend beyond higher numbers of attendances and admissions. Patients with complex needs may require longer assessments, input from several specialties and more complicated discharge arrangements. If community and social-care capacity do not develop alongside hospital services, more patients are likely to remain in hospital after the acute phase of their care. This would further restrict bed availability, increase emergency-department waits and make planned activity more susceptible to cancellation.

Emergency care will become less resilient

Our emergency-care performance varies materially between sites. Demand is increasing, including among people with lower-complexity needs, while high occupancy, delays in admission and delayed discharge make prompt assessment and treatment more difficult. Continued growth under the present model would place further pressure on emergency departments, acute medicine, diagnostics, inpatient beds, theatres and critical care.

Workforce constraints compound these pressures. Maintaining separate 24-hour arrangements across several sites requires sufficient senior and specialist staff on every rota. In smaller teams, a vacancy, sickness absence or period of leave can have a disproportionate effect. Services can become dependent on temporary staff, additional shifts and informal workarounds, reducing continuity and placing greater pressure on the substantive workforce.

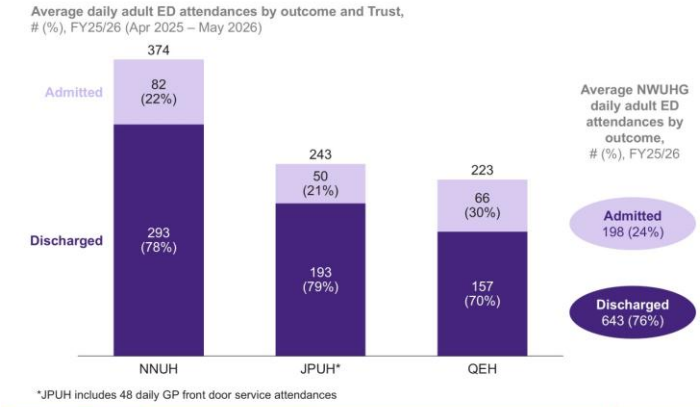
Some services also face a problem of scale. They must maintain round-the-clock capability despite relatively low or variable activity, while giving clinicians sufficient experience to retain specialist skills and support training. Elsewhere, demand exceeds the capacity available. Without

greater coordination, we risk retaining both problems: services that are too small to be resilient and services that are too congested to provide timely care.

Better flow, expanded same-day emergency care and neighbourhood support could reduce some demand for inpatient beds. Shared staffing and remote specialist advice may also make the present model more resilient. We should pursue these changes, but their effectiveness cannot be assumed to remove every requirement for on-site expertise and immediate access to supporting services. We therefore need to establish which clinical decisions and interventions can safely be networked, and which need a reliably staffed team and infrastructure in the same place.

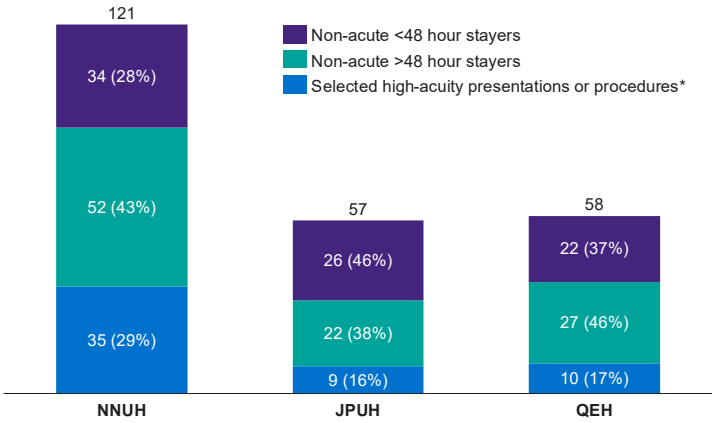
The profile of emergency activity indicates that a substantial proportion of patients do not require prolonged hospital care. Across our Group, around 75% of people attending an emergency department are discharged from the department on the day they attend. Among adults admitted as an emergency, an average of 37% are discharged within 48 hours. These figures suggest that some patients could avoid admission through earlier senior assessment, rapid access to diagnostics and treatment, stronger same-day emergency care and coordinated support outside hospital.

c75% of attendances are discharged from ED
Attendances and admissions at night are low



Inpatients: At JPUH and QEH just under half of adult non-elective admissions have a length of stay of less than 48 hours which is a proxy for low complexity

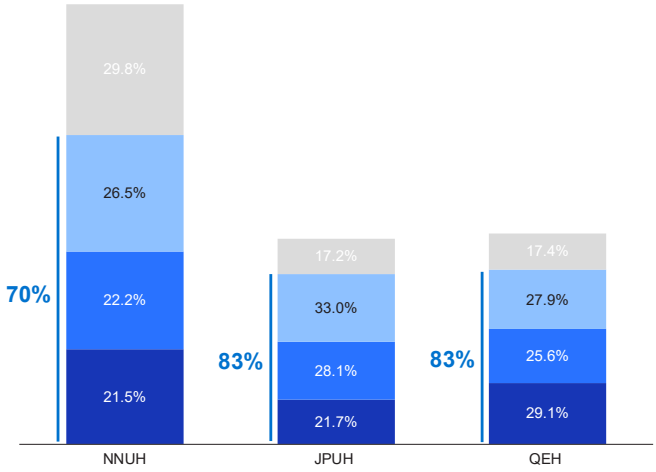
Daily non-elective adult inpatient spells by Trust,
(%), Apr 2025 – Feb 2026



Under the complexity measure used in our analysis, highly complex patients account for a similar proportion of admissions at JPUH and QEH, at 16% and 17% respectively. The proportion is higher at NNUH, consistent with its role in providing more specialist care. Of those whose admission lasts more than two days, 25% are aged over 65. In paediatric emergency care, more than nine in every ten children are discharged from the emergency department. These patterns show the need to distinguish between patients who require specialist inpatient care and those whose needs could be met through rapid assessment, treatment and discharge.

Inpatients: For the remaining ~83% of inpatient admissions, we have split the cohort by age band due to limitations in the quality of coding across the three Trusts

Average proportion of daily adult NEL inpatient spells by acuity band and Trust,
#, Apr 2025 – Feb 2026



Average proportion of daily adult NEL inpatient spells by acuity band and Trust,
%, Apr 2025 – Feb 2026

	NNUH	JPUH	QEH
Transfers, Critical Care, *High Acuity & **Acute Procedures	29.8%	17.2%	17.4%
Remaining Adult Medical Patients 18–64 years	26.5%	33.0%	27.9%
Remaining Adult Medical Patients 65–80 years	22.2%	28.1%	25.6%
Remaining Adult Medical Patients 80+ years	21.5%	21.7%	29.1%
Total	100.0%	100.0%	100.0%

***High acuity presentations** consist of arrest, fractured NOF, GI bleed, major trauma, MI, stroke*

****Acute procedures** consist of theatre, cath lab, PCI, thrombectomy, thrombolysis*

Most emergency attendances occur during the day. Between midnight and 8am, JPUH and QEH each receive an average of around four patients an hour, of whom approximately one is admitted. People attending during these hours are more likely than not to arrive by ambulance. Activity is slightly higher at NNUH. It is important to differentiate between patients who arrive at night and those who receive their care in ED that night due to delays during the day.

Maternity services will face a widening gap between volume and complexity

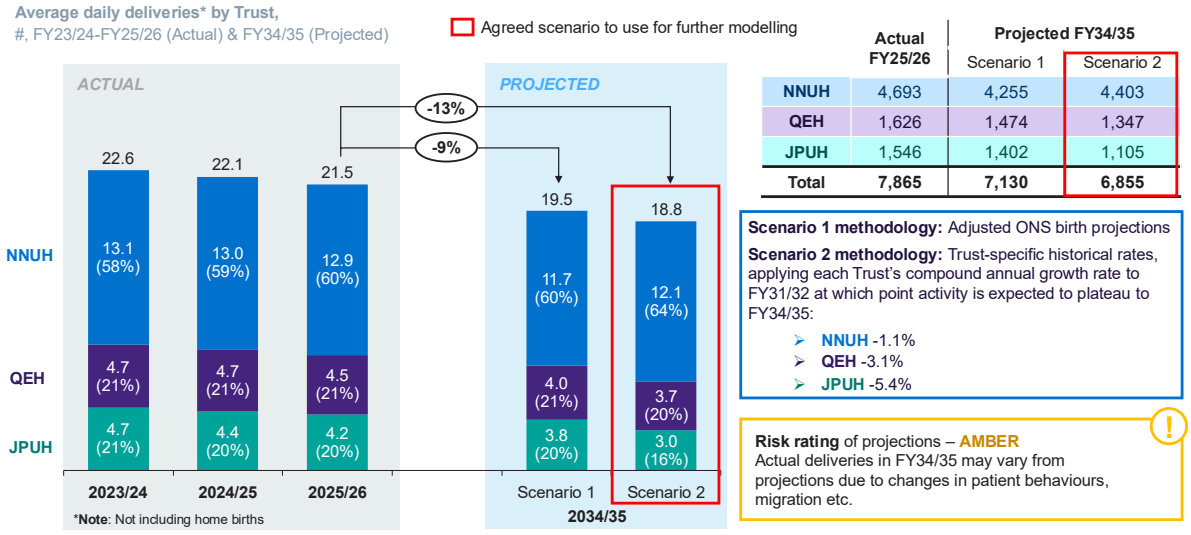
At QEH and JPUH, lower birth volumes have not removed the need for continuous midwifery, obstetric, anaesthetic, theatre, neonatal and paediatric support. At the same time, the proportion of births involving caesarean section has increased, and maternity services are caring for women with more complex clinical and social needs.

Birth volumes are expected to fall further: our modelling projects a reduction of between 9% and 13% across the Group between 2025/26 and 2034/35. Under the continuation of recent local trends, annual deliveries would fall to approximately 1,347 at QEH and 1,105 at JPUH - equivalent to averages of 3.7 and 3.0 births a day respectively. Under the same modelling, the number of non-assisted vaginal births would fall to an average of around 1.3 a day at QEH and 0.7 a day at JPUH.

The combination of falling activity and increasing complexity creates a particular clinical and workforce challenge. Staff must retain the skills to manage the full range of births, including uncommon but serious complications, yet smaller numbers provide fewer opportunities to gain and maintain that experience. This affects midwives and the wider multidisciplinary team, as well as the quality of training that smaller services can provide. At the same time, safe staffing and essential supporting services cannot be reduced in direct proportion to the number of births. Each unit must maintain resilient cover throughout the day and night, making rotas progressively harder and more costly to sustain.

Without change, gaps in staffing or supporting services could lead to greater dependence on temporary staff, more transfers between hospitals, restrictions on parts of the service or short-notice changes to where care is available. Such changes would be more disruptive for women, families and staff than a planned model based on clinical evidence and developed with proper consideration of safety, access, equality and choice.

Women & children: Deliveries across the Group are expected to decline by 9–13% by FY34/35, before stabilising at ~19 average daily deliveries



	Actual FY25/26	Projected FY34/35 Scenario 1	Projected FY34/35 Scenario 2
NNUH	4,693	4,255	4,403
QEH	1,626	1,474	1,347
JPUH	1,546	1,402	1,105
Total	**7,865**	**7,130**	**6,855**

Scenario 1 methodology: Adjusted ONS birth projections

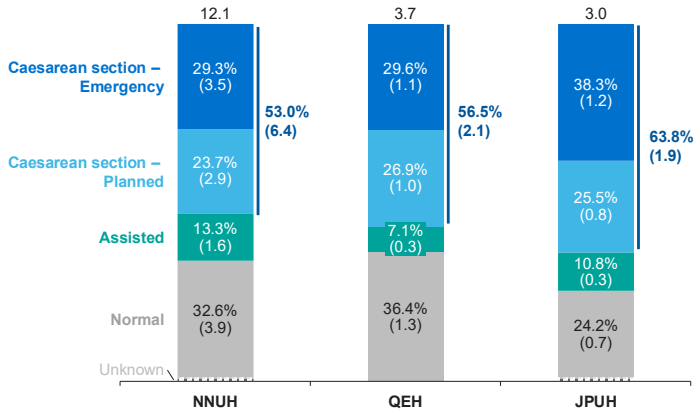
Scenario 2 methodology: Trust-specific historical rates, applying each Trust's compound annual growth rate to FY31/32 at which point activity is expected to plateau to FY34/35:

- **NNUH** -1.1%
- **QEH** -3.1%
- **JPUH** -5.4%

Risk rating of projections – **AMBER**
Actual deliveries in FY34/35 may vary from projections due to changes in patient behaviours, migration etc.

Obstetrics, Neonatal, & Paediatrics: If historical trends continue, the proportion of caesarean sections is projected to increase to more than 50% in all Trusts by FY31/32, resulting in average daily normal deliveries dropping to 0.7 at JPUH and 1.3 at QEH

Projected average deliveries per day by delivery method by Trust, # (%), FY31/32 (Apr 2031 – Mar 2032)



- ***METHODOLOGY:*** The projected proportion of deliveries by delivery method is calculated based on **observed trends over the last 10 years** (FY15/16 – FY25/26), triangulating Trust-specific insights from analysis of provider-level HES data and internal inpatient data. Projected proportions are applied to the average daily deliveries from Scenario 2
- Over the last 10 years, the **average annual rate of increase** in caesarean sections across the Group (+1.9pp p.a.) **aligns closely with the England average** (+1.9pp p.a.), growing by the largest rate at JPUH (+2.5 pp) where almost half of all deliveries were c-section in 2025/26. In comparison, the proportion of c-sections grew by 1.7pp p.a. at NNUH and 1.9pp p.a. at QEH

Mode of delivery	NNUH	QEH	JPUH
Emergency c-section	1,292	399	423
Planned c-section	1,042	363	282
Assisted	586	96	119
Normal	1,435	491	268
Unknown	48	0	13
Total	4,403	1,348	1,105

Variation in time-critical and specialist care will persist

For stroke and other time-critical conditions, delays in diagnosis or access to specialist care can affect survival, disability and recovery. Our current results show that these pathways do not operate with the same reliability at every hospital. An ageing population is likely to increase the number of people at risk of stroke, while shortages in specialist staff may make it harder to provide consistent cover.

Without redesign, existing variation could become embedded. Scarce specialist staff and diagnostic resources would remain spread across services that do not always have sufficient resilience to provide the same standard throughout the week. Patients may continue to experience different access to expertise and treatment depending on where and when they present.

The same risk applies to emergency and complex surgery. The Royal College of Surgeons' 2025 review of General Surgery at QEH found that the service had received no Deanery surgical trainees during the preceding year because of the reported quality of the training experience. The review heard that trainees had insufficient access to operative experience and training, while resident and specialty doctors described limited local development opportunities and feeling unsupported. In some cases, trainee involvement had been reduced because of concern about how complications would be judged.

If a service cannot offer adequate supervision, operative experience and a supportive learning environment, it becomes harder to attract trainees and develop future consultants. Pressure then falls on a smaller substantive workforce, increasing dependence on locally employed or temporary doctors and making the service still more difficult to sustain.

Inequalities may widen

The consequences of an unreliable model are not distributed evenly. People living in rural or coastal communities, those without access to a car, disabled people, unpaid carers and people living in deprivation may find it harder to navigate fragmented services or make repeated journeys for assessment and treatment.

An unplanned service interruption or short-notice transfer can therefore have effects beyond clinical care, including additional travel, cost, time away from work and difficulty visiting a relative

in hospital. Conversely, failure to develop neighbourhood care could leave communities with the greatest health needs dependent on hospital services that are harder for them to reach.

Without explicit consideration of inequalities, existing differences in access and outcomes may be reproduced or widened.

Financial and estate pressures will limit the scope for improvement

Our financial position means that we cannot rely indefinitely on additional staffing, temporary capacity and short-term recovery measures. Continuing to operate through fragmented or duplicated arrangements where these do not provide sufficient quality or resilience would retain their associated costs while leaving our underlying problems unresolved. Clear financial and clinical viability will be important to underpin the business cases for new hospitals at Queen Elizabeth and James Paget.

Why improvement within the current model may not be sufficient

We expect neighbourhood services, better discharge arrangements and Group-wide networking to improve access and resilience. These actions form part of every scenario. They do not automatically resolve the fixed requirement to provide 24-hour senior decisions, emergency theatre, anaesthesia, diagnostics and critical care for a smaller number of patients with high-risk or complex needs. Nor do they by themselves answer whether declining births can sustain the full range of maternity and neonatal skills and cover at each site. The questions are clinical and operational, as well as financial, and their answers may differ by service.

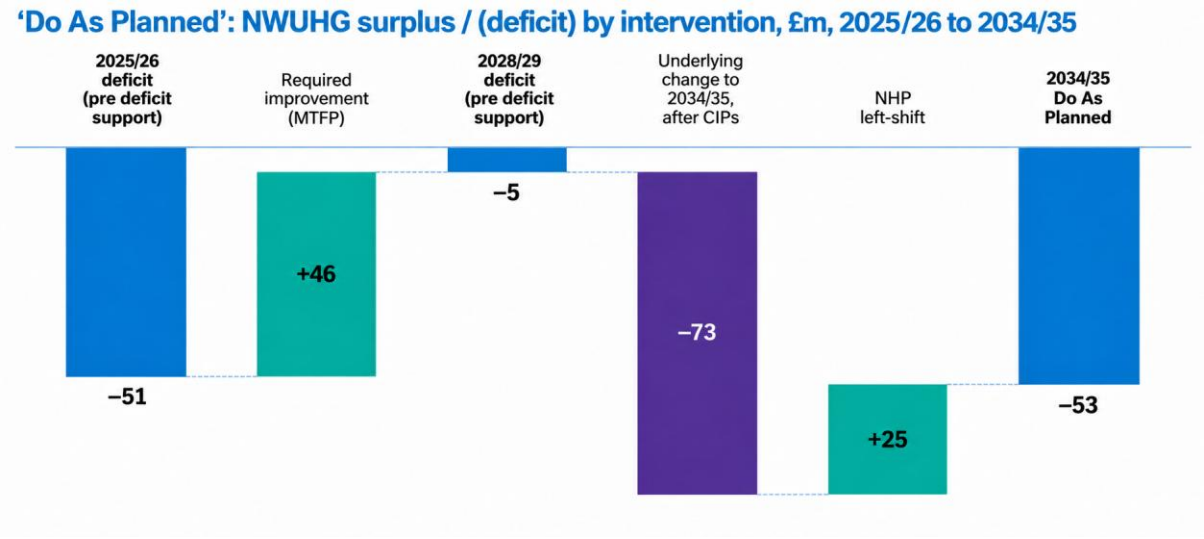
4.5 Financial position

Under our current plans, our projections indicate a recurrent structural deficit of £53m by 2034/35. Our 'Do as Planned' scenario assumes that we deliver the savings in our Medium Term Financial Plan (MTFP), stabilise fragile services and achieve the New Hospital Programme's assumed shift of activity away from hospital.

In 2025/26, our deficit before deficit support funding was £51m, compared with £31m in 2024/25. The MTFP projects that we will reduce the deficit to £5m by 2028/29. This depends on delivering £263m of cost improvements over three years, equivalent to an average of 5.0% of gross expenditure each year against our historical average of 3.9%. It also assumes that 85% (£223m) of the savings will be recurrent, compared with 56% historically. If delivered in full, the plan would improve our net position by £46m after allowing for projected changes in activity, income and expenditure.

Beyond 2028/29, the model assumes a lower rate of cost improvement. Growth in demand and expenditure is projected to add £73m to the deficit by 2034/35. The NHP's assumed shift of activity away from hospital, phased in from 2029/30, would offset £25m of this pressure. This leaves a projected deficit of £53m in 2034/35, despite full delivery of our current plans.

We cannot regard this as a financially sustainable position. It would present a substantial affordability challenge for the business cases for the new hospitals at QEH and JPUH. Part Two examines whether a more extensive neighbourhood model or changes to how we organise hospital services could improve our financial position, alongside their effects on quality and access.



4.6 Estates

As they currently exist, our estates are not fit for the future. Despite significant investment in community diagnostic, orthopaedic and endoscopy facilities, as well as plans for an urgent treatment centre, constraints exist across our three main hospital sites.

The constraints differ across our three main hospital sites. At QEH and JPUH, the most immediate concern is the extensive presence of reinforced autoclaved aerated concrete (RAAC), which requires continuing inspection, strengthening and intrusive construction work to keep the buildings safe and operational. NNUH does not face the same RAAC risk, but its main hospital is governed by a long-term Private Finance Initiative (PFI) arrangement that carries substantial financial commitments and makes changes to the estate more complex. Taken together, these constraints limit our ability to adapt clinical space, introduce new technology and organise services around changing patient needs.

The Queen Elizabeth Hospital King's Lynn

At QEH, much of the main hospital was constructed using RAAC. The estate is now more than 40 years old, and its structural condition requires an extensive programme of inspection and physical support. During 2024/25, we installed steel failsafe structures beneath affected roof panels, maintained decant wards so that work could proceed in clinical areas and continued work to protect RAAC external walls. In 2025/26 alone, we spent £29.3 million on the RAAC failsafe programme.

This work has allowed us to continue providing care, but it manages rather than removes the underlying problem. Departments and wards must be moved or temporarily reconfigured while structural work is undertaken, and clinical and support services have to operate around construction activity. These arrangements consume capital, management time and usable space without addressing the fundamental limitations of the building. They cannot provide the flexibility, efficiency or clinical environment that will be required over the coming decades.

James Paget University Hospitals

JPUH faces a similar structural challenge. RAAC is present across substantial parts of the main hospital roof, requiring repeated structural surveys and an ongoing programme of strengthening.

These measures reduce the immediate structural risk, but the need to undertake major building work within an operational hospital creates disruption and limits how space can be used. JPUH continues to identify its ageing estate, including RAAC, as a Board-level risk because of the

potential effect on service provision and the need for timely replacement of the hospital. Continuing remediation is essential, but it does not turn the existing building into a sustainable long-term estate.

Norfolk and Norwich University Hospitals

The challenge at NNUH is different. The main hospital opened in 2001 and was built and is maintained through a PFI arrangement with Octagon Healthcare. This provided a modern hospital, but it also created a long-term contractual and financial framework within which we must manage, maintain and alter the estate. In 2025/26, the unitary payment to the PFI operator was £94.1 million. This included financing, repayment, services and lifecycle maintenance.

The PFI agreement makes provision for the Trust to exercise a break clause to end the agreement in 2037. A programme is underway to improve the condition of the site ahead of the contract ending. There are precedents elsewhere in the NHS for negotiating with PFI providers to return parts of an estate to NHS control before the full contract expires, enabling NHS capital to be invested in replacement or improved facilities. Any similar approach would require detailed legal, commercial and value-for-money assessment.

Short-term interventions are necessary to keep our hospitals safe and operational, but they cannot provide the adaptable, efficient and clinically appropriate estate required to support future models of care. Our estate plans must therefore be shaped by a clear Group-wide clinical strategy, rather than allowing the limitations of our existing buildings and contracts to determine how care is provided.



Image: Norfolk and Norwich University Hospitals estate

4.7 Matching care to patient need

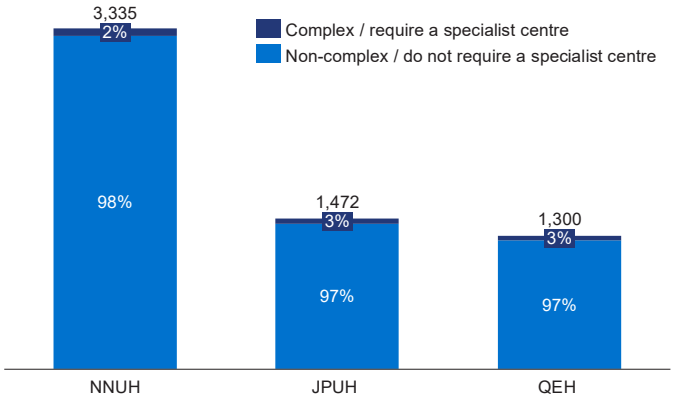
Our analysis indicates that approximately 97% of all activity across the Group comprises low complexity patients. This does not mean that their care is less important or that it can automatically be provided outside an acute hospital. It does, however, suggest that much of our activity could be delivered in each of our hospitals through consistent, standardised pathways, with appropriate care provided locally or closer to home where this is clinically safe.

A smaller proportion of activity involves patients who need complex intervention, specialist multidisciplinary teams, advanced diagnostics or critical care. These patients can create a

disproportionate requirement for round-the-clock workforce and infrastructure even though they account for fewer episodes. Our future model should therefore distinguish clearly between services that need to be widely accessible and those for which bringing expertise and supporting resources together would improve quality, outcomes and resilience. Patients must still be able to move quickly between these levels of care when their condition changes or greater specialist support is required.

In all scenarios, at least 97% of patients will continue to be treated in the hospital or community closest to where they live

Average daily activity by complexity and Trust,
#, Apr 2025 – Feb 2026



Activity includes adult and paediatric unplanned (ED & SDEC attendances, inpatient admissions), planned (outpatients, elective admissions, day cases) and women's and children's (deliveries, neonatology)

The 3% of patients whose care could benefit from consolidating onto fewer sites include:

Unplanned:
- High acuity presentations consist of arrest, fractured NOF, GI bleed, major trauma, MI, stroke
- Acute procedures consist of theatre, catheter lab, PCI, thrombectomy, thrombolysis
- All critical care
- Paediatric spells >24 hours,
- 18-80 adults >48 hours

Planned:
QEH and JPUH elective inpatient activity apart from T&O at JPUH

Obstetrics & neonatology:
All deliveries and neonatal care

5 External drivers of change

The need to change our services is reinforced by national investment, policy and evidence about how population health is changing. Together, these external drivers require us to plan hospital, neighbourhood and specialist care as a coherent model for the future.

5.1 National Hospitals Programme

Responding to the significant estate issues at QEH and JPUH, the government has included both hospitals in Wave 1 of the New Hospital Programme, with £2.8 billion in capital funding allocated to rebuild our hospitals to be fit for the future.

The New Hospital Programme creates urgency as well as opportunity. For Wave 1 sites, the national implementation plan indicates an expected construction start in the next few years. The programme's Hospital 2.0 approach is intended to produce flexible, digitally enabled and future-proofed hospitals. To make effective use of that investment, we need to be clear about the care the buildings are intended to support.

The investment should not be used to reproduce current models of care in newer buildings, without before testing whether these models of care are fit for the future. Decisions on layouts, capacity, adjacencies and supporting infrastructure will shape care for decades. Designing principally around current activity and organisational boundaries could lock in workforce fragility and duplicative operating costs.

A Group-wide clinical strategy allows us instead to design buildings around the care we intend to provide: supporting more prevention and care closer to home, protecting capacity for planned care, connecting local services to specialist expertise and bringing together services where this would improve quality, safety or resilience.



Image: vision of new James Paget University Hospitals



Image: outline of new Queen Elizabeth Hospital

5.2 National policy

National policy establishes a clear direction for the NHS. The 10 Year Health Plan for England describes three shifts: from hospital to community, from analogue to digital and from sickness to prevention. These shifts require hospitals to work differently. Acute expertise will increasingly need to support care beyond the hospital site, while hospital facilities focus on the patients and interventions that genuinely require specialist teams, complex diagnostics, critical care or acute infrastructure.

The Medium Term Planning Framework for 2026/27 to 2028/29 translates this direction into current planning expectations. It asks integrated care boards and providers to develop credible five-year plans, improve access and productivity, and accelerate neighbourhood health. Its immediate priorities include reducing avoidable admissions and bed use among people with frailty and other complex needs, and enabling people receiving planned care to access more specialist support closer to home. This is not a separate agenda from hospital improvement. Better care outside hospital is necessary to reduce avoidable pressure on acute services, while reliable access to hospital expertise is necessary if neighbourhood teams are to manage greater clinical complexity safely.

The Neighbourhood Health Framework develops this further. It expects the NHS, local authorities, social care and voluntary and community organisations to organise services around defined local populations. The intended model is more proactive and multidisciplinary, with particular attention to people with moderate or severe frailty, care-home residents, people who

are housebound and those approaching the end of life. It also establishes national expectations for better co-ordination of urgent care, discharge and support for people with complex needs. For us, neighbourhood health therefore means more shared pathways, access to specialist advice, appropriate diagnostics, common information and clear clinical responsibility across organisational boundaries.

A new electronic patient record will support these shifts by providing timely, usable information across hospital sites and connecting with partner services. Better access to a patient's history, test results and care plan should aid decision-making, reduce avoidable repetition and support safer transfers and follow-up. These benefits depend on interoperability, staff training, data quality and clear clinical responsibility.

National expectations for quality are also becoming more explicit. The 2026 Quality Strategy places consistent quality, improved outcomes and reduced inequalities at the centre of planning and delivery. Service-specific requirements will also shape our future model. Baroness Amos' National Maternity and Neonatal Investigation identified recurring concerns about listening to women and families, staffing that does not match demand, increasingly complex need, leadership and governance, inequalities, unsuitable estates and disconnected information systems. These findings have direct implications for the way we plan maternity and neonatal services, rather than being matters that can be addressed through estate replacement alone.

The future model must also improve the experience of working in our hospitals. The NHS People Promise describes the conditions staff should be able to expect, including a compassionate and inclusive culture, a voice that is heard, a safe and healthy workplace, opportunities to learn, flexible working and a strong sense of teamwork. Our clinical and workforce strategy should translate these principles into sustainable rotas, larger professional networks where appropriate, better education and development, modern working environments and careers that enable staff to develop without having to leave Norfolk and Waveney.

Research and innovation are also part of the opportunity. The Life Sciences Sector Plan seeks to expand clinical research, make better use of health data and accelerate the adoption of effective medicines, medical technologies and digital tools within the NHS. Working as a university hospitals group gives us a stronger basis from which to expand access to research, develop partnerships with academic and industry organisations and evaluate innovations across a larger and more varied population. This is relevant to clinical quality and workforce development, as well as to the wider economic contribution of health and life sciences.

5.3 Chief Medical Officer's reports on health

The Chief Medical Officer's 2023 report on health in an ageing society concluded that older people are becoming increasingly concentrated in rural, coastal and other peripheral areas, and specifically identified North Norfolk as an area likely to age rapidly. It argued that NHS services, research and professional training need to respond to multimorbidity and that the expansion of health and care services should reflect where older people live. His 2021 report on coastal communities identified poorer health outcomes, workforce shortages, transport barriers and a mismatch between healthcare need and service capacity in many coastal areas.

These are recognisable features of Norfolk and Waveney and strengthen the case for a model designed around healthy ageing, frailty, prevention and the needs of rural and coastal communities.

6. Initial inequality review

6.1 Population

Norfolk and Waveney had an estimated population of about 1.06 million in 2024, with the population continuing to grow. Current projections indicate that Norfolk's population will increase by about 11% between 2025 and 2045[10]. Nearly three-quarters of the net increase is expected to be among people aged 65 and over, and around 30% of residents are expected to be aged 65 or over by 2045[11]. This will increase need for services associated with frailty, dementia, multiple long-term conditions and end-of-life care. It will also increase the importance of prevention, earlier intervention and coordinated support for people whose needs span several organisations.

Population health in Norfolk and Waveney is shaped by many different factors, including high levels of deprivation, the county's rural and coastal geography, and the ageing population. Norfolk and Waveney was identified as the 15th most deprived of England's 42 Integrated Care Board areas[12]. 120,600 (13.6%) of residents live in Core20 areas, with deprivation being concentrated in parts of Great Yarmouth, Lowestoft, Norwich and King's Lynn[11]. Health outcomes vary significantly between our communities; across Norfolk, the gap in life expectancy between the most and least deprived communities in 2021-23 was approximately 7.5 years for men and 4.9 years for women[13].

Location	Number of residents living in deprivation	Percentage of residents
Great Yarmouth	34,600	34.4%
Norwich	46,500	31.6%
Kings Lynn and West Norfolk	28,400	18.8%

Taken from Insights and Analytics, Norfolk County Council (2026). Norfolk Population Health Overview. [online] Available at: https://www.norfolkinsight.org.uk/jsna/population/.

Norfolk and Waveney has a substantial rural and coastal population, with 50% of the county's population living outside of the four main built-up areas, which has implications on travel and access to healthcare services. To add additional complexity, the ageing population in rural areas is increasing more rapidly than in urban areas[14]. Not only does the rural nature of Norfolk impact the ability for residents to access healthcare, but it also impacts workforce within health and social care. Norfolk also has a high proportion of veteran populations, concentrated across Breckland, King's Lynn, and Broadland.

[10] https://www.norfolkandsuffolk.icb.nhs.uk/about/icb/who-we-are/
[11] https://www.norfolkinsight.org.uk/jsna/population/
[12] https://www.norfolkinsight.org.uk/wp-content/uploads/2025/11/IMD_2025_Overview_v3.pdf
[13] https://www.gov.uk/government/publications/government-response-to-the-house-of-lords-inquiry-into-preterm-birth-reducing-risks-and-improving-lives/government-response-to-the-house-of-lords-inquiry-into-preterm-birth-reducing-risks-and-improving-lives
[14] https://committees.parliament.uk/writtenevidence/132471/pdf/.

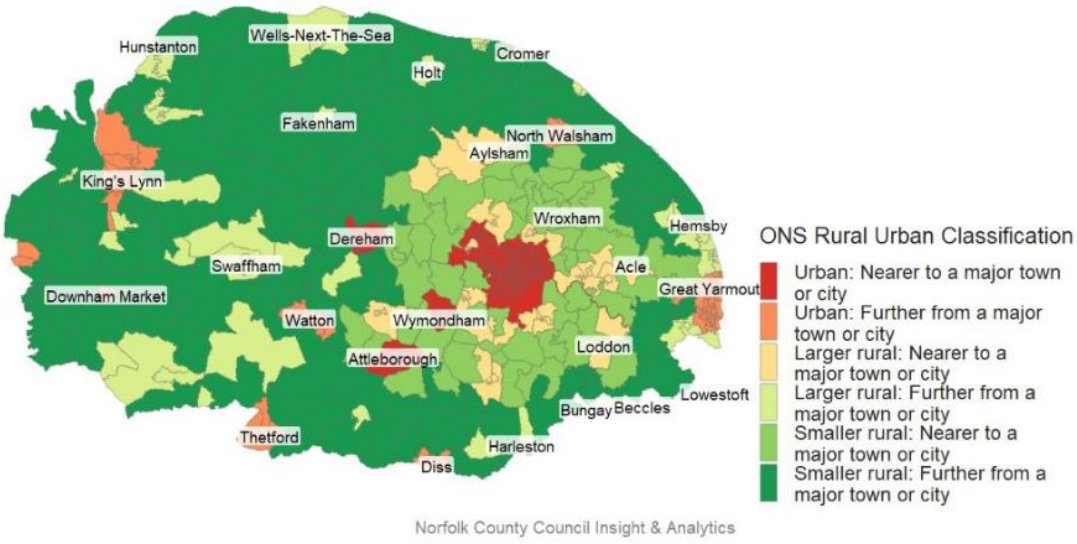


Image: Rural and urban distribution in Norfolk

6.2 Impact of inequalities on acute care

Inequalities are visible in acute care in several connected ways. Some populations have a greater underlying need for healthcare and are more likely to require urgent or higher-intensity treatment. Others encounter barriers to planned, preventative or community care, which may affect how and when they reach acute care settings. These barriers and differences in health need can be reflected in higher emergency-department attendance, greater ambulance use, more emergency admissions and later presentation of an illness.

Evidence identifies barriers associated with the availability of primary and community care, transport, travel costs, digital access, communication needs, accessibility and familiarity with NHS services. For many communities, they are impacted by multiple barriers which compound and amplify the inequality. Therefore, for some people, emergency care is perceived as the most accessible or dependable route into the health system. This means that any future configuration of services needs to be carefully considered.

6.3 Populations and characteristics requiring consideration

Health inequalities do not affect everyone in Norfolk and Waveney equally. Our evidence review indicates that some people are more likely to experience barriers to accessing care, different patterns of service use or poorer outcomes because of the interaction between their health needs, protected characteristics, socioeconomic circumstances and where they live. As part of this work, we have considered what the evidence tells us about how different populations use acute and emergency services, and any barriers to these services.

1. Children and young people

Young children, particularly those aged under five, are high users of emergency care[15]. In Norfolk and Waveney, children aged under five had a 25% higher adjusted emergency-department attendance rate than people aged 15 - 35[16]. National evidence also shows that under-fives account for a greater proportion of emergency attendances than their share of the population[17]. A material proportion of paediatric emergency activity involves assessment, observation or a stay of less than one day rather than longer inpatient treatment[15].

[15] https://www.nuffieldtrust.org.uk/news-item/the-rising-challenge-of-children-s-urgent-and-emergency-care
[16] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0303270
[17] https://www.nuffieldtrust.org.uk/sites/default/files/2021-01/under-5-s-summary-report-web.pdf

As we develop future models, we will need to distinguish between children requiring inpatient care and those who could safely receive rapid assessment or short-term observation. The evidence indicates that paediatric assessment units can allow some children to be observed without admission to an inpatient ward. However, it does not establish how increased travel or service consolidation would affect children and their families. Appropriate local assessment or short-stay provision could therefore be tested as a potential mitigation if inpatient services were delivered differently.

2. Deprivation

People living in more deprived areas use emergency services more frequently and are more likely to experience unplanned hospital admissions[18]. This pattern is present within Norfolk and Waveney[16], as well as nationally[19].

People from more deprived communities may reach emergency departments via different routes, with greater ambulance use and less GP referrals[20,21]. Barriers to accessing healthcare for this population include the cost of travel, digital exclusion, and difficulty obtaining earlier or preventative care[22]. As this population has a higher use of emergency departments, changes to locations of acute care could impact them more often and create further financial or practical barriers to accessing all healthcare. Accessible neighbourhood services, appropriate appointment times, and affordable transport will be important considerations.

3. Disability

Approximately one-fifth of residents in Norfolk and Waveney have a disability that limits their day-to-day activities[23]. Although the evidence does not establish that those with a disability have higher usage of acute services, it identifies greater unmet healthcare needs and additional barriers. These barriers include inaccessible transport, travel costs, inaccessible environments, and long waiting times[24, 25]

Changes to familiar routes and environments can also create further difficulties, particularly for those with motor, sensory, and communication needs[23]. Future models will need to provide accessible transport and environments, alongside reasonable adjustments, for those with disabilities.

4. Ethnicity

Norfolk and Waveney is less ethnically diverse than the national average, with 94.7% (867,156) of residents being white**Error! Bookmark not defined.**. Despite this, the inequalities faced by our ethnic minority groups are significant enough to warrant full consideration of any barriers to accessing care. The inequalities experienced by ethnic minority groups are not uniform, and broad conclusions should not be applied to every group. The clearest evidence concerns maternity care. Black women had higher rates of emergency caesarean section across every deprivation quintile[26] and were more likely to be admitted to intensive care during pregnancy or within six weeks of giving birth[27]. South Asian women were less likely than White women to give

[18] https://bmjopen.bmj.com/content/12/10/e063441
[19] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england
[20] https://bmjopen.bmj.com/content/bmjopen/15/12/e108770.full.pdf
[21] https://www.sciencedirect.com/science/article/pii/S0167629622000844
[22] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/relationship-poverty-nhs-services
[23]https://www.norfolkinsight.org.uk/wpcontent/uploads/2023/12/CORE20_Plus_Groups_accessible.pdf
[24] https://link.springer.com/content/pdf/10.1186/s12889-024-19285-0.pdf
[25] https://bmjopen.bmj.com/content/7/8/e016614
[26] https://www.nuffieldtrust.org.uk/resource/are-emergency-c-sections-more-likely-among-certain-ethnic-groups
[27] https://obgyn.onlinelibrary.wiley.com/journal/14710528

birth in midwife-led settings[28]. Women from these groups were more likely to need further intervention, and need consultant-led deliveries, instead of midwife-led and lower risk delivery.

Higher utilisation of emergency-departments has also been identified among ethnic populations[29,30,31,32,33]. However, these patterns are not consistent across every group, and deprivation may explain some of the observed differences.

As future models are developed, we will need to use disaggregated local ethnicity data rather than treating ethnic minority communities as a single population. Consideration should be given to access to consultant-led maternity care and care for those who are more likely to have higher risk pregnancies, and those who are requiring more urgent care. The evidence also identifies continuity, trusting relationships and appropriate antenatal and postnatal care as important opportunities to address existing inequalities and mitigate some potential impact from service change.

5. Gypsy, Roma and Travellers

Norfolk County Council estimate there are over 4,000 Gypsies and Travellers residing in Norfolk, with this population increasing during the summer months[34]. The Gypsy, Roma and Traveller community experience many barriers to accessing healthcare. This community have limited access to general practice, preventative services and wider healthcare. Barriers to these services include difficulties registering with a GP, language and literacy needs, poor communication, digital exclusion, and limited awareness of available services[34,35,36] Office for Health Improvement and Disparities, 2022

These barriers may contribute to some Roma people relying on emergency services or presenting with conditions that could have been treated earlier. However, the evidence does not quantify emergency-department use or demonstrate that Roma people attend more frequently than other populations. Local evidence also identifies low antenatal uptake as a potential service gap for Gypsy, Roma and Traveller women, but does not quantify local maternity use or emergency presentation[34].

Further work should examine local service use, geographic distribution, transport and access to maternity and emergency care for this population and understand how to improve their access to GP and preventative services.

6. Homeless

Although exact figures are unclear, homelessness is rising within Norfolk with 10.5 households per 1,000 being assisted under the Homelessness Reduction Act[37]. The evidence shows that those experiencing homelessness are more likely to have an inpatient admission, while

[28] https://pmc.ncbi.nlm.nih.gov/articles/PMC11600555/
[29] https://pureadmin.qub.ac.uk/ws/portalfiles/portal/249769241/ethnicity_27_09_21.pdf
[30] https://bjgp.org/content/68/668/e157
[31] https://www.sciencedirect.com/science/article/pii/S2589537021003576
[32] https://www.mdpi.com/1660-4601/18/23/12599
[33]https://www.researchgate.net/publication/346980800_Characteristics_of_frequent_paediatric_users_of_emergency_departments_in_England_an_observational_study_using_routine_national_data
[34] https://www.norfolkinsight.org.uk/wp-content/uploads/2024/02/GRT_HIA_external.pdf
[35] https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2026.1716479/full
[36] https://www.gov.uk/guidance/improving-roma-health-a-guide-for-health-and-care-professionals#barriers-in-accessing-healthcare-and-its-effects-on-roma-peoples-health
[37] https://www.norfolkinsight.org.uk/jsna/place/

emergency-department attendance among people sleeping rough is substantially higher than among housed people[38]. People who are homeless are more likely be 'frequent attenders'[39]. Identified barriers causing this higher use may include difficulties registering with a GP, inadequate signposting, digital exclusion, unstable accommodation, and discharge without an effective connection to primary care impacting continuity[40,41].

Changes that increase travel, require digital communication or make pathways more complex may be particularly difficult for people without stable accommodation or reliable access to a telephone or the internet. The evidence identifies specialist homeless-health support, GP registration, connection to primary and community care following discharge and coordination between hospital, housing and social-care services as areas to consider. Further assessment should examine how people experiencing homelessness currently reach acute services and how they would access any alternative location.

7. Learning disability

It is predicted that approximately 17,653 adults in Norfolk have a learning disability, with 2,892 of these being moderate to severe[42]. People with learning disabilities have higher acute and emergency hospital use compared to those without. Specifically, national evidence found substantially higher emergency admissions for ambulatory-care-sensitive conditions and more hospital bed days among people with learning disabilities than among people without learning disabilities[43].

Potential factors associated with higher use include difficulties recognising health problems, obtaining timely treatment and communicating changes in health, alongside shorter consultations, inconsistent access to annual health checks and limited continuity of primary care[43,44]. Women with learning disabilities may also require additional support to understand maternity information, make informed choices and navigate services[45,46].

A more complex pathway, unfamiliar site or transfer between organisations could create additional difficulties if communication needs and reasonable adjustments are not consistently recorded and shared.

8. Mental health

Mental health is another important consideration for healthcare within Norfolk and Waveney. In 2023, 17% of adults had common mental health disorders and 1% had a serious mental health illness, with a higher than national average emergency admission for self-harm of 130 per 100,000[47]. Evidence found that those experiencing mental-health crisis use Type 1 emergency departments as a route to mental health care, with those experiencing mental health crisis having higher emergency department attendances than the national average[48,49,50]. This finding is

[38] https://www.gov.uk/government/publications/health-matters-rough-sleeping/health-matters-rough-sleeping
[39] https://academic.oup.com/eurpub/article/33/2/161/6978616
[40] https://bjgp.org/content/bjgp/early/2019/07/15/bjgp19X704633.full.pdf
[41] https://academic.oup.com/jpubhealth/article-abstract/39/1/26/3065715
[42] https://www.norfolkinsight.org.uk/wp-content/uploads/2025/01/Adults_with_Learning_Disabilities_Briefing.pdf
[43] https://onlinelibrary.wiley.com/doi/abs/10.1111/jir.12722
[44] https://pubmed.ncbi.nlm.nih.gov/28930382/
[45] https://www.sciencedirect.com/science/article/pii/S0266613824000858
[46] https://bmjopen.bmj.com/content/7/3/e015526
[47] https://www.norfolkinsight.org.uk/jsna/adult-health-and-wellbeing/
[48] https://www.norfolkinsight.org.uk/wp-content/uploads/2025/09/Suicide_Audit_2024.html
[49] https://www.norfolkinsight.org.uk/wp-content/uploads/2026/07/Mental_Health_Needs_Assessment_July_2026.pdf
[50] https://onlinelibrary.wiley.com/doi/10.1111/inm.12968?msockid=289d35fffe4b6f9c34b122cbffe66e13

amplified for those in ethnic minority groups, with evidence showing they have a greater proportion of involuntary mental health inpatient admissions and crisis presentations, compared to their white counterparts[51,52].

Future models should consider how people experiencing crisis or self-harm reach urgent care and how they are supported following attendance. The evidence does not directly assess how travel distance or service consolidation affects mental-health crisis presentations, so local crisis pathways, repeat attendance, travel and community alternatives will require further assessment.

9. Migrants

The 2021 census states that the migrant population in Norfolk was 9.7%, lower than the national average of 17.4%. Within that population, 670 individuals were Asylum seekers, mostly living in Norwich and Great Yarmouth[53]. This population face significant inequalities, particularly in maternity care. Migrant women face barriers such as communication difficulties, problems accessing and navigating maternity care and a lack of continuity[54,55,56]. Women who have recently migrated, have irregular immigration status or have no recourse to public funds have also been found to experience higher risks of adverse maternal or perinatal outcomes[57], including emergency caesarean section and severe maternal morbidity among women with no recourse to public funds[55].

The evidence identified by our review relates primarily to maternity care and does not establish migrant communities' use of other acute services. Future assessment should therefore examine local service use and consider how communication, service navigation, access and continuity could be affected by changes to maternity and acute-care pathways.

10. Older age

Norfolk and Waveney has an ageing population. In 2023, around one resident in four was aged 65 or over, and this age group accounted for 76% of occupied bed days associated with emergency admissions between 2021/22 and 2023/24[11]. Current projections indicate that nearly three-quarters of the expected population increase between 2025 and 2045 will be among people aged 65 and over[11].

Some local evidence suggests that older people who live alone, or experience social isolation, may be more likely to access care in an emergency department[58]. Further assessment will be required to understand the implications of future service models for older people.

11. Rurality

Norfolk has highly rural population. Those living in more rural locations face additional barriers to accessing acute care because of longer distances[59], poorer public transport[60] and fewer alternative providers[61]. Evidence also identifies an association between greater distance from an

[51] https://link.springer.com/content/pdf/10.1186/s12916-020-01711-w.pdf
[52] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/state-childrens-health-england
[53] https://www.norfolkinsight.org.uk/wp-content/uploads/2023/07/Norfolk_Refugee_Asylum_Seeker_Briefing.pdf
[54] https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2026.1772211/full
[55] https://onlinelibrary.wiley.com/doi/abs/10.1111/phn.13240
[56] https://pmc.ncbi.nlm.nih.gov/articles/PMC13101210/
[57] https://link.springer.com/content/pdf/10.1186/s12939-026-02793-3.pdf
[58] https://www.norfolkinsight.org.uk/wp-content/uploads/2025/01/Norfolk_JSNA_Social_Isolation_and_Loneliness.pdf
[59] https://www.nuffieldtrust.org.uk/research/rural-remote-and-at-risk
[60] https://www.gov.uk/government/publications/future-of-rural-england-report/future-of-rural-england-report
[61] https://www.nuffieldtrust.org.uk/sites/default/files/2017-02/acute-care-in-remote-settings.pdf

emergency department and lower emergency-department attendance[16,62].
Lower attendance should not be assumed to demonstrate lower need, as distance may influence whether and how people access care.

The evidence indicates that consolidation could create a greater access burden for some rural communities. Further assessment will be required to understand how future service models could affect our rural communities.

12. Substance misuse

Alcohol and drug misuse is an important factor among some people who attend emergency departments frequently[63,64]. These patients may have complex and recurring needs, but we do not yet understand their use of wider acute services or the barriers they experience in Norfolk and Waveney well enough.

Further assessment should consider how changes to access, location and care pathways could affect people experiencing substance misuse.

6.4 Implications for future service development

We know that inequalities already shape people's need for, use of and access to acute care. Young children, people living in deprived communities, people experiencing homelessness and people with learning disabilities are among the groups more likely to use emergency or acute hospital services. Some women from ethnic minority and migrant communities are more likely to require emergency or higher-intensity maternity care. Our emergency departments also provide an important route to urgent support for people experiencing a mental-health crisis or self-harm.

People can face different barriers to obtaining timely care. These include longer distances and limited public transport in rural communities; travel costs and digital exclusion among people experiencing deprivation; and inaccessible transport, environments or communication for disabled people. Some migrant and Gypsy, Roma and Traveller communities can face language, literacy, registration and service-navigation barriers. People experiencing homelessness may encounter fragmented services and a lack of continuity, while people with learning disabilities or autism may experience difficulties with communication, recognising deterioration or securing timely care. These barriers can overlap and have a greater effect on people experiencing several sources of disadvantage.

As we develop future models of care, we must seek to reduce these barriers and avoid widening existing inequalities. Neighbourhood health services could provide earlier, preventative and planned support closer to home, particularly in deprived, rural and coastal communities and for people who find it difficult to access general practice or other alternatives to hospital. These services will need to remain connected to acute and specialist care so that people can be escalated quickly when their needs cannot be met safely within the community.

Local hubs and assessment services may help maintain access where this can be done safely. Short-stay paediatric assessment units can allow some children to be assessed and observed without admission to an inpatient ward.

[62] https://www.tandfonline.com/doi/full/10.1080/13607863.2022.2107176#d1e472
[63] https://pubmed.ncbi.nlm.nih.gov/33724349/
[64] https://pubmed.ncbi.nlm.nih.gov/28209195/

There is also an opportunity to address inequalities in maternity care before emergency or higher-intensity care is required. This includes providing continuity and trusting relationships with maternity staff, appropriate monitoring during pregnancy and proactive multidisciplinary support. Women's concerns must be heard and escalated, with effective use of maternity early-warning systems, clear postnatal plans and adequate assessment during postnatal visits.

Other responses may include affordable and accessible transport, support with additional travel costs, non-digital routes to information and appointments, interpreting and navigation support, and consistently accessible environments and communication. Information and reasonable adjustments should follow patients between services and hospital sites. Some populations may also require specialist support, including people experiencing homelessness, people with learning disabilities or autism, and those attending an emergency department during a mental-health crisis.

Improvements in clinical quality may justify some changes to how acute services are organised. Where changes involve greater travel, fewer delivery locations or more complex pathways, they may place a disproportionate burden on people who already use the affected services more frequently or face barriers to care. Lower service use among a population living further from a hospital should not automatically be interpreted as lower need, because distance may itself affect whether and how people obtain care.

As future service models are developed, we will need to identify which populations would travel further, who may find alternative pathways difficult to use and whether each model could widen or reduce existing inequalities. We will assess how clinical benefits and adverse effects are distributed and develop mitigations alongside any potential models. Their likely effectiveness will need to be tested through local data, engagement and an Equality and Health Inequalities Impact Assessment rather than assumed.

6.5 Further assessment and consideration

Our review identifies the main equality and health inequality issues that need to inform the development of future service models. At this stage, it cannot predict the impact of a specific configuration or support a conclusion for or against an individual scenario.

As scenarios become more clearly defined, we will need to undertake a full Equality and Health Inequalities Impact Assessment supported by detailed local analysis. This will examine population and service-use data, where affected communities live, changes in travel times, public and patient transport, ambulance and transfer pathways, and the accessibility and capacity of alternative services. We will also consider the cumulative effect on people who experience several overlapping sources of disadvantage.

We will continue to involve patients, families, carers, staff, community organisations and populations likely to be affected. This will help us understand barriers that routine data may not capture and develop proportionate mitigations with the communities concerned.

The accompanying evidence review and appendix provide the detailed methodology, research questions, findings and limitations underpinning this section. We will continue to update the evidence base as service models develop and more detailed assessment becomes possible.

7. Travel and accessibility

Travel and accessibility will be important considerations in developing future models of care across our three hospitals. We have therefore undertaken early analysis to understand how journey times might change if selected services were provided at a different hospital site.

The scenarios tested do not represent preferred future models; their purpose is to identify the potential scale and distribution of travel impacts before scenarios are developed.

The analysis considers where current patients live and how their journeys might change under a range of hypothetical service movements between NNUH, JPUH, and QEH. It examines journey times by car and public transport, together with the implications for ambulance journeys and transfers where relevant.

Travel is one consideration in determining how services should be organised, but it cannot be the only consideration in determining where services are provided from. Any scenario involving longer journeys will need to demonstrate whether those journeys are associated with a material improvement in safety, outcomes or resilience, and for whom. It must also show which parts of the pathway can remain local or move closer to home. Pathway-specific analysis will need to cover the frequency and urgency of journeys, ambulance capacity, patient and visitor costs, equality impacts and practical mitigations. If it is proposed that services are moved to different locations, then mitigations to lessen the impact on patients and their families and carers should be developed. This early geographic analysis informs scenario development but does not determine the outcome.

Travel is already a barrier to access

Travel is already a significant consideration for many of our patients across Norfolk and Waveney. Our analysis indicates that current median public-transport journeys to QEH and JPUH are approximately 56 and 51 minutes respectively, even when the best weekday departure is selected. This is likely to have the greatest impact for people without access to a car, disabled people and those who need to make repeated journeys for care. As we develop future service models, we must consider how access can be improved overall. Providing appropriate diagnostics, outpatient care, monitoring, rehabilitation and follow-up through neighbourhood services or other local settings could reduce the number and frequency of hospital journeys. Where additional travel for acute or specialist care may be necessary, we will need to develop mitigations from the outset, including transport support, help with costs, local assessment or treatment facilities, safe transfer arrangements and support for patients and families returning home.

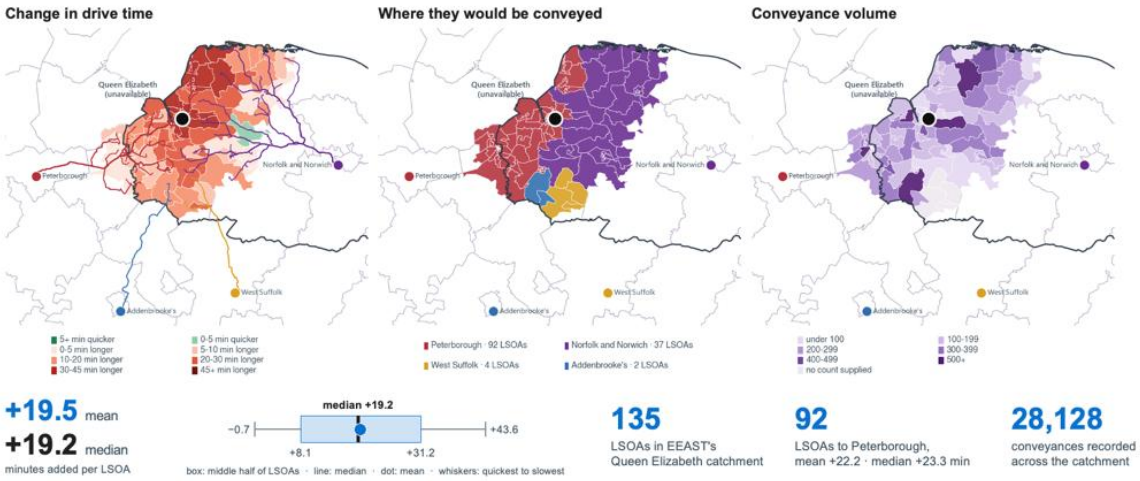
If selected services at QEH were unavailable: ambulance journeys

Working with the East of England Ambulance Service, we have undertaken modelling work to understand the geographic implications of an illustrative scenario in which selected services at QEH at unavailable, with every area in its ambulance catchment assigned to the nearest remaining hospital by driving time. Across the 135 LSOAs (Local Super Output Areas, which are geographies containing c. 3,000 people) modelled, the mean additional drive time would be 19.5 minutes. Most areas would be directed outside our Group: 92 would be assigned to Peterborough, compared with 37 to NNUH, four to West Suffolk Hospital and two to Addenbrooke's. For the areas assigned to Peterborough, the median increase would be 23 minutes.

The underlying data include 28,128 recorded ambulance conveyances across the QEH catchment, showing the scale of activity associated with this geography. This does not mean that every conveyance would be redirected under a future service model, as the impact would

depend on the services affected and the clinical needs of individual patients. It demonstrates that a significant change at QEH could have consequences for ambulance journey times, vehicle availability and hospitals beyond our Group. We would need to assess these effects in detail with East of England Ambulance Service Trust (EEAST), neighbouring providers and commissioners.

If selected services at QEH were unavailable, where would ambulances go?

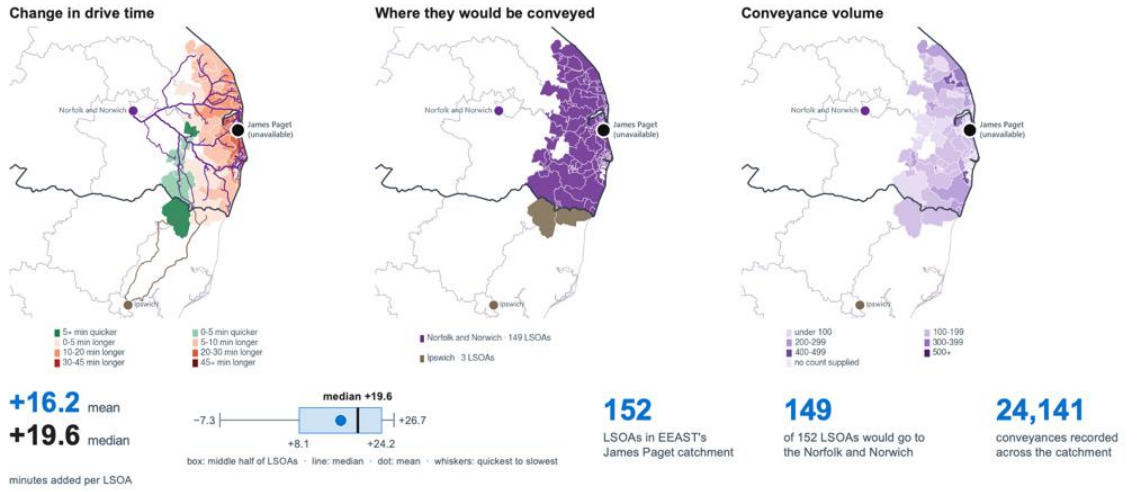


If selected services at JPUH were unavailable: ambulance journeys

The equivalent scenario for JPUH covers 152 LSOAs and produces a mean additional drive time of 16.2 minutes. The effect is concentrated principally within our Group: 149 of the 152 areas would be assigned to NNUH, with the remaining three assigned to Ipswich Hospital. The underlying data include 24,141 recorded conveyances across the JPUH catchment.

This would create a different system effect from the QEH scenario. Most activity would be directed towards one of our hospitals, rather than dispersed among several alternative providers. We would therefore need to assess the additional ambulance time alongside the capacity required at NNUH across emergency care, diagnostics, specialist services and inpatient beds. We would also need to understand the effect on ambulance availability for Great Yarmouth, Waveney and the surrounding rural and coastal communities.

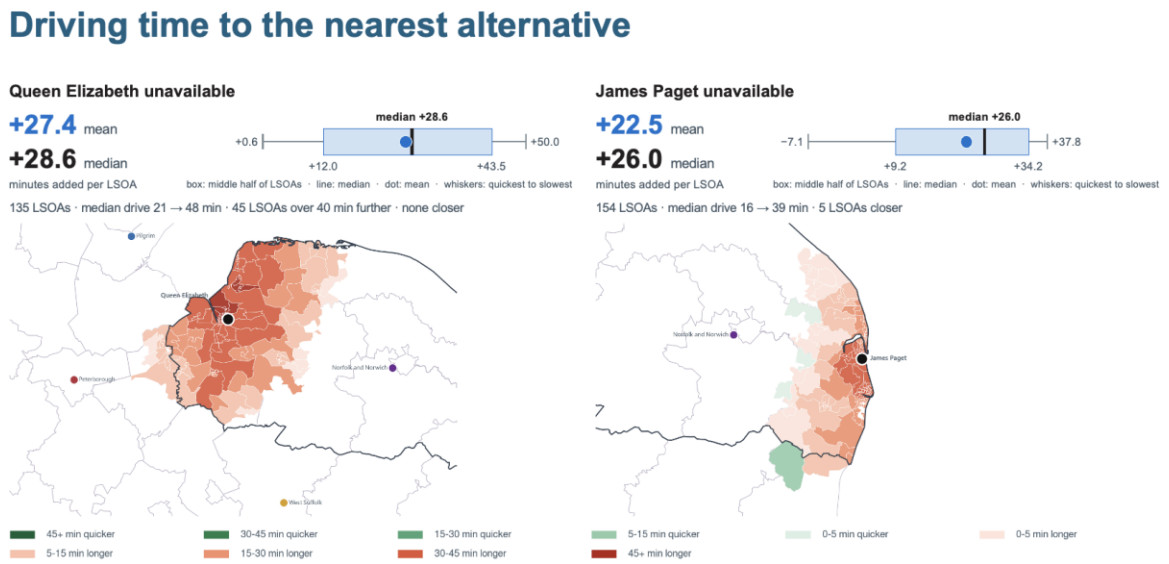
If selected services at JPUH were unavailable, where would ambulances go?



Driving time to the nearest alternative

Our geographic drive-time analysis illustrates the potential effect on people travelling by car if selected services at either QEH or JPUH were unavailable. For the QEH catchment, the median journey to the nearest alternative hospital would lengthen from 21 to 48 minutes. Calculated separately for each of the 135 LSOAs, the median additional drive time is 28.6 minutes. Forty-five of the 135 LSOAs would be more than 40 minutes further from the nearest alternative, and none would have a shorter journey. For the JPUH catchment, the median would increase from 16 to 39 minutes, a rise of 26 minutes, although five of the 154 LSOAs would be closer to an alternative hospital.

These findings show why we cannot rely on an average journey time alone. Some communities would experience much larger increases than others. The analysis uses free-flow driving times and does not include congestion, parking or the time required to enter and leave a hospital site. It is a geographic comparison rather than an estimate of the number of patients affected. When we assess defined service models, we will need to combine journey times with actual patient origins, service use and the frequency and urgency of travel.

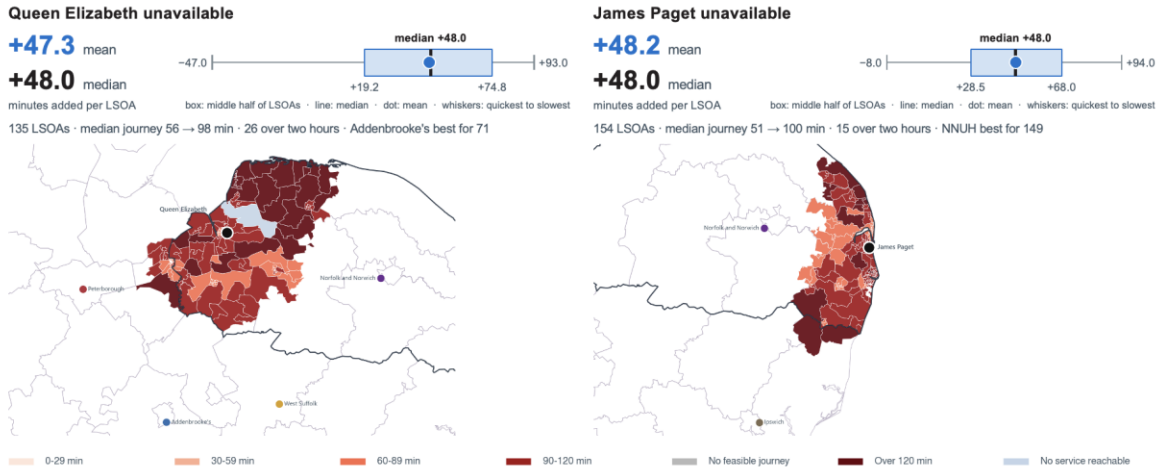


Public transport to the best remaining alternative

Our public-transport analysis indicates a greater access challenge. If selected services at QEH were unavailable, the median journey to the best remaining hospital would increase from 56 to 98 minutes. Twenty-six of the 135 LSOAs would have journeys exceeding two hours, and Addenbrooke's would be the best available public-transport destination for 71 areas. If selected services at JPUH were unavailable, the median would increase from 51 to 100 minutes; 15 of the 154 LSOAs would have journeys exceeding two hours, and NNUH would be the best alternative for 149 areas.

For us, this demonstrates that the nearest hospital by road may differ from the most accessible hospital by public transport. It also indicates a potentially disproportionate effect on people who cannot drive or obtain a lift. The modelling uses timetabled weekday services and selects the best departure available during the day, with walking included in the journey. Fixed appointment times, evening or weekend travel may be less convenient, while some areas have no feasible or reachable public-transport connection. Our future analysis will therefore need to consider timetables, changes between services, walking distances, fares, accessibility and the practicalities of travelling when unwell or accompanying a patient.

Public transport time to the best remaining alternative

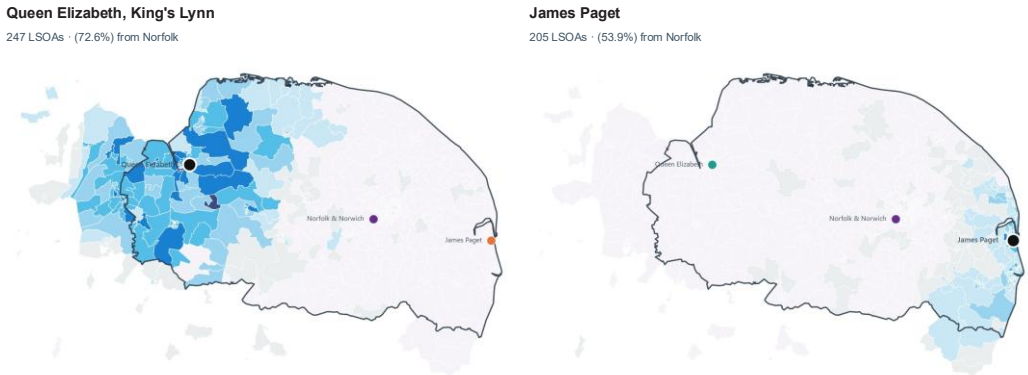


Where maternity activity is generated

Our maternity services at QEH and JPUH serve populations extending beyond their immediate towns and across administrative boundaries. In 2025/26, QEH recorded deliveries from 247 LSOAs, with 72.6% of activity generated within Norfolk. The remaining activity reflects its wider catchment, including communities in Cambridgeshire and Lincolnshire. JPUH recorded deliveries from 205 LSOAs, with 53.9% generated within Norfolk; a substantial proportion came from Waveney and other parts of Suffolk, reflecting that over 50% of JPUH's catchment area is outside of Norfolk.

As we consider the future of maternity services, we must take account of women who may need to travel in labour or attend hospital at short notice, as well as families making antenatal, postnatal or neonatal journeys. Our assessment cannot be confined to the Norfolk boundary or based solely on distance from each hospital. We will need to consider where women using each service live, the urgency and frequency of their journeys, access to a car or ambulance, public transport and the availability of safe alternatives closer to home.

Where deliveries at each site are generated



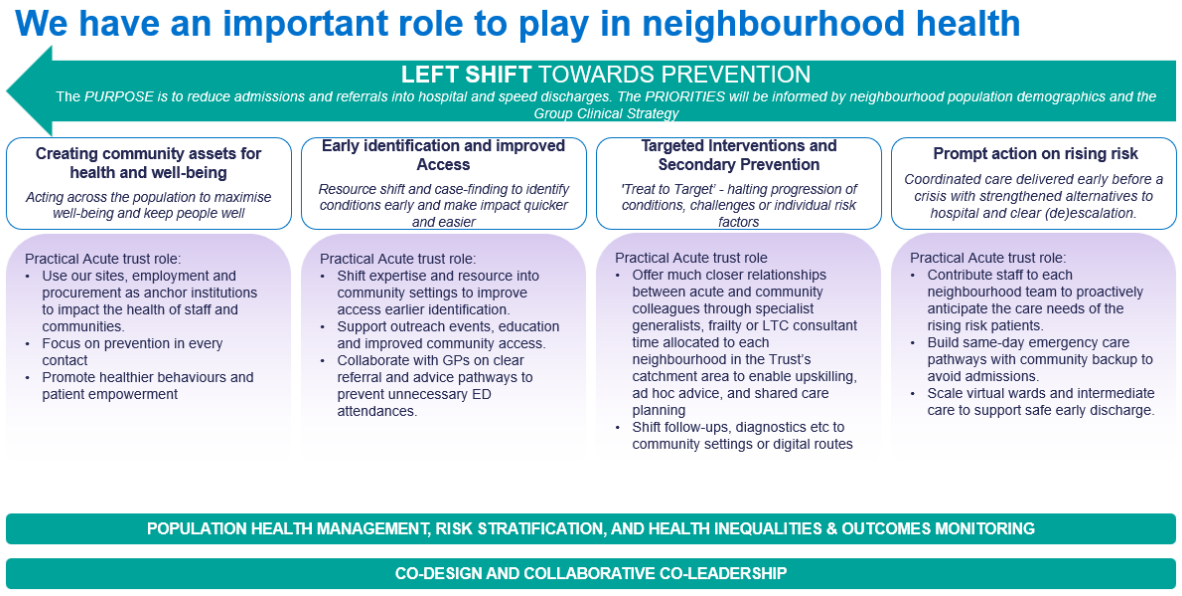
8. A coordinated model for change

People across Norfolk and Waveney should be able to rely on safe, high-quality care wherever they live. The evidence in this Case for Change identifies three connected obstacles: too much care depends on hospital admission or prolonged stays when suitable support could be closer to home; some services are fragile now; and the reliability of high-risk acute care varies across sites. The future model needs to address all three rather than treating them as separate agendas.

Neighbourhood health would provide earlier and more coordinated care, closer to home. Addressing immediate fragility would protect services through shared teams, regional partnerships, pathway changes or targeted investment. Acute-service appraisal would test where 24-hour capability and specialist activity should be organised so that the sickest patients receive dependable care. The last question cannot be answered solely by success in the first two areas.

Plans to develop neighbourhood care and stabilise fragile services are already underway and will proceed under every future scenario. They form our 'do as planned' comparator in Part Two of this document. The additional merits of any acute scenario will need to be assessed against that comparator, including whether it delivers benefits that can justify its costs and access impacts.

8.1 Neighbourhood health



Some people currently receive care in hospital that could be provided safely and effectively closer to home. Others reach hospital after opportunities for earlier intervention, ongoing support or better coordination between services have been missed. This can contribute to avoidable deterioration, emergency admission and longer hospital stays, particularly for people living with frailty, several long-term conditions or complex social needs.

For us, neighbourhood health is integral to acute service redesign. It provides an opportunity to bring primary care, community health services, mental health services, social care, hospital specialists and voluntary and community organisations together around the needs of local populations. This could strengthen prevention, proactive care and continuity, while enabling selected lower-acuity services, diagnostics, monitoring, rehabilitation and follow-up care to be provided closer to where people live.

Neighbourhood models will need clear and timely routes into specialist advice, diagnostics and hospital care when these are required. Hospital clinicians will remain an important part of the model, including through support for multidisciplinary teams, shared care and virtual clinical advice.

The pace and scale of change will depend on the workforce, funding, digital capability, estate, clinical governance and delivery capacity available outside hospital. Changes will therefore need to be phased so that neighbourhood capacity and acute service redesign develop together, with safe alternatives in place before reliance on hospital-based care is reduced.

We want and need to work in genuine partnership

What we could give	Theme	What we could get
Move from being the centre of the system to a partner in a neighbourhood-led model	**Role in the system**	A clearer, more sustainable role focused on high acuity, specialist and complex care
Relinquish some control over service configuration to Place-based decision-making	**Control and decision-making**	Shared ownership of decisions and greater system alignment on priorities and resources
Make clinical expertise, workforce and assets available to the wider system	**Resources**	Reciprocal support from system partners reducing acute pressure
Support pathway redesign beyond hospital boundaries	**Clinical model**	Reduced inappropriate demand on acute services and better patient outcomes
Model collaborative behaviours: curiosity, listening, flexibility, and openness	**Culture and behaviours**	Increased trust from partners, enabling more ambitious system-wide change
Act as a host for system enablers where appropriate (e.g. digital, analytics, coordination infrastructure)	**Use of infrastructure**	Greater system coherence and capability, reducing duplication and inefficiency
Move beyond organisational metrics to shared population outcomes	**Performance mindset**	Alignment of system effort around outcomes rather than activity, supporting sustainability
Accept short-term ambiguity and redistribution of activity as the system transitions	**Risk and uncertainty**	Long-term stability, sustainability and reduced operational pressure

A network of neighbourhood hubs

Our work to-date indicates that neighbourhood health will require a network of local hubs. These facilities would allow more care to be provided closer to home, support coordination between organisations and give integrated neighbourhood teams a physical base from which to work. They would complement care delivered in people's homes, GP practices and other community settings, with access to hospital services when specialist or acute care is required.

At neighbourhood level, hubs would typically serve populations of around 30,000 to 50,000. Their precise functions will vary according to local need, but they could provide shared space for primary and community care, mental health services, social care and voluntary organisations. They will also support multidisciplinary working, care coordination, prevention, frailty services and the management of virtual wards. Some could include limited diagnostics and outpatient activity. This model makes greater use of existing community hospitals, primary care premises, council buildings and other local assets, rather than depending entirely on new construction.

A smaller number of larger place-based hubs or Treatment Centres could provide services that require a broader population base. These could include routine diagnostics, regular specialist clinics, urgent and ambulatory care, and higher-volume planned services that do not require the infrastructure of an acute hospital. Acute clinicians could work in these settings through local clinics, outreach and virtual support, reducing the need for patients to travel to a main hospital for routine elements of their care.

Initial analysis has identified six possible principal locations: Norwich, King's Lynn, Great Yarmouth, Thetford, Cromer/North Walsham, Dereham/Wymondham, and Wisbech. Together, these locations would provide coverage across Central, West, East, South, North and Mid-

Norfolk. Early modelling suggested that a network of this kind could place 97% of the population within 15 miles of specialist services.



In Part Two of this Case for Change, we have considered how we can significantly expand the volume of our patients whose care we can improve through the neighbourhood model, by working together more effectively with our health and social care partners.

8.3 Addressing fragile services

Some of our services are already fragile or are at risk of becoming unsustainable in the near term. Fragility may arise from low patient volumes, small specialist teams, gaps in clinical rotas, dependence on temporary staff, limited access to specialist skills or insufficient estate, equipment and other physical capacity. Several of these pressures may be present within the same service.

The effects can become visible through variation in quality and outcomes, difficulty providing reliable cover, delayed or cancelled care and reduced continuity for patients. Fragility also places pressure on staff, limits opportunities for training and professional development and can make services increasingly costly to maintain.

Working as a Group allows us to assess these services across all three hospitals rather than treat the pressures at each trust separately. Shared teams, joint rotas, common pathways and regional partnerships may resolve many of the identified fragilities without changing the location of a core acute service. Other risks, particularly where a service depends on several scarce capabilities being available together at all hours, may point to questions about the wider acute configuration.

The appropriate response will differ between services. It will need to reflect clinical evidence, patient need, workforce availability, service interdependencies and the consequences for access and health inequalities.

9. Fragile services

One of our immediate priorities is to identify the services at greatest risk of becoming unsafe or unsustainable, either now or in the near future. Where current pressures mean that a service cannot safely continue in its present form, we need to act before any wider reconfiguration of acute services is agreed and implemented.

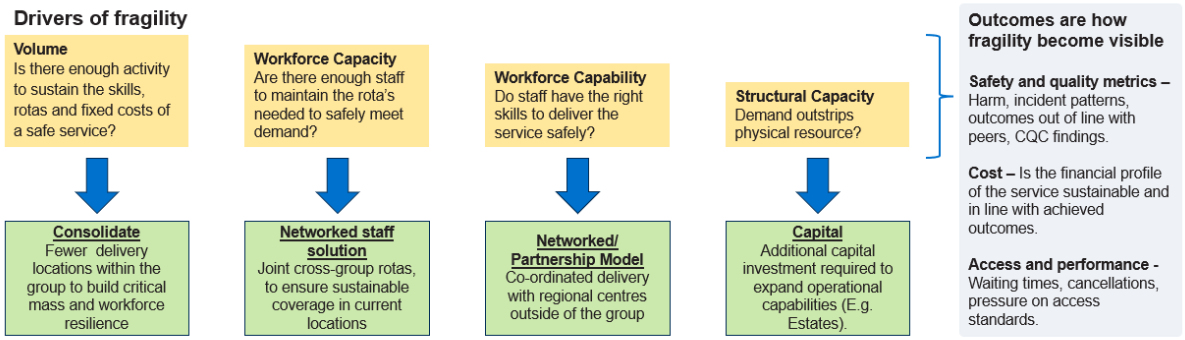
To identify the services facing the most immediate and significant risks, the Clinical Advisory Group (CAG) agreed a definition of fragility, against which services could be assessed.

The definition of fragility agreed by CAG in this context is a service whose current arrangements cannot reliably sustain safe, effective or accessible care until longer-term transformation can address the underlying problem.

Fragility does not mean that a service has ceased to operate, or that all aspects of the service are unsafe. It means that the service has limited resilience and is at material risk of becoming unsustainable if the underlying pressure is not addressed.

Broadly we can group fragility across our Group based on four key drivers:

1. At some sites, the volume of activity may be too low to sustain the clinical skills, workforce rotas and fixed costs required for a safe and resilient service.
2. Services may lack the workforce capacity to maintain safe and effective rota cover for their level of demand.
3. There may be workforce skills and capability gaps which creates unsustainable care pathways and unacceptable risks to care standards.
4. In some services the demand has outstripped the physical capacity needed to tackle the volume of care activities required.



The effects of fragility become visible in a service's outcomes and performance. They may appear in safety and quality measures, including avoidable harm, recurring incident patterns, outcomes that compare poorly with peers or adverse regulatory findings. They can also be seen in longer waiting times, cancellations and repeated difficulty meeting access standards. Financial performance provides a further test: a service that requires disproportionate expenditure, frequent temporary staffing or repeated recovery support without achieving the expected outcomes may not be sustainable in its current form.

We have identified the services at risk of being unable to meet safe, effective and accessible care going forward. The findings of this fragility assessment will be further explored on a service-by-service basis, with a set of actions agreed upon.

Our assessment distinguishes between services that require action now or in the near term, and services that remain sustainable but require monitoring.

We have identified 11 services that are deemed fragile and in need of immediate further action. Two further services require further monitoring in case escalation is required.

9.1 Causes of fragility

Service fragility arises when current arrangements cannot reliably sustain continuity of care to the required clinical standards. The principal concern is the resulting risk to patient safety, quality and outcomes. The underlying drivers can be grouped into four broad categories: service volume, workforce capacity, workforce capability and structural capacity.

Volume of demand - Volume can be a driver of fragility where there is insufficient activity to sustain the clinical skills, rotas and fixed costs required for a safe and effective service. This may arise where activity is divided across several sites, where particular procedures are undertaken infrequently, or where the available caseload does not provide the range and frequency of practice needed to maintain specialist capability and support training.

Workforce capacity – The issue of workforce capacity exists when there is a demand for a service, but there are not enough staff currently established to sustain the current rota. The gaps in workforce capacity can arise and be seen through vacancies in the whole-time establishment, experience with recruitment difficulties, dependencies on temporary cover, or insufficient staff at a particular grade.

Workforce capability – Workforce capability is distinct from capacity, as the primary issue here is not the number of people, but whether the service has the right mixture of skills to deliver the complexity of care that might present itself. The service will be deemed fragile if there is not the right specialist cover for the area of medicine, adequate ongoing training and credentialing, appropriate supervision and support structures, sufficient sub-speciality resilience and requirement of care professionals to carry out care activities outside of their skills and capabilities.

Physical capacity – A service may have the workforce capacity and capability needed to meet demand, but remains unable to deliver the required volume of care because its physical infrastructure is insufficient. Constraints may include a limited estate footprint, inadequate theatre or laboratory capacity, unsuitable clinical space, equipment limitations or outstanding capital works.

Some services may be affected by a single driver of fragility, while others face several interconnected pressures. Where multiple drivers are present, the risks to the continuity, safety and quality of care may be greater and require a more urgent or comprehensive response.

Acute medical services often have complex care pathways that touch upon many other services and therefore have interdependencies with other areas of care. Whilst this does not cause fragility in and of itself, it could be an amplifier of the consequences and exacerbate the true drivers of fragility that are inherent in the service.

9.2 Approach to identifying fragile services

After agreeing our definition of fragility via the Clinical Advisory Group, we conducted an assessment with a shortlist of services identified as potentially fragile.

The agreed assessment framework was then applied consistently to each shortlisted service. It considered the underlying driver of fragility, the clinical and operational interdependencies that could increase its consequences, and the outcomes through which fragility may become visible. For each service, we recorded a fragility position, the dominant driver, the degree of immediacy, a potential route to greater resilience, and a confidence level.

Structured engagement was undertaken with senior clinical leaders, service directors, network leads and service managers.

Our assessment findings were derived principally from this clinical engagement. Quantitative evidence - including workforce, activity, cost, waiting-list and access information - was used to corroborate, qualify or challenge the clinical judgement where possible. Patient experience was considered through complaints, patient-liaison and safety-incident information where available. Staff experience was reflected through the clinical and managerial engagement and through workforce measures such as vacancies, turnover, sickness absence and use of temporary staffing.

The assessment identified 11 services as meeting the fragility definition. Two further services were not assessed as fragile overall but have material dependencies or specific risks that require monitoring or action.

9.3 Assessing fragile services

For each fragile service, we have described the principal driver of fragility, the immediacy of the issue and the potential route to greater resilience. The proposed routes are intended to support further clinical and operational consideration; they are not fixed decisions about future service configuration.

Services assessed as fragile

ENT (including oral surgery)

ENT, including oral surgery, is provided at all three hospitals. It is considered fragile because of reported pressure on the middle-grade and first-on-call rotas, with senior staff covering gaps, training requirements not being met and on-call work displacing planned clinics.

The service requires an immediate response, because the reported rota-compliance issue is an existing issue and first-on-call arrangements require confirmation at each site. The potential response is a Group-wide review of middle-grade capacity and a networked approach to cover, with clear establishment, grading and prospective-cover arrangements across the three hospitals.

Paediatric cystic fibrosis

Paediatric cystic fibrosis is provided at NNUH as the Group's specialist service within a regional network, covering patients from JPUH and QEH. It is considered fragile because both specialist consultants have left and the service no longer meets the relevant specialist consultant requirement. The service has to meet a nationally mandated service specification from Specialised Commissioning; as it does not currently meet this specification, urgent work to find a solution in combination with commissioners is required.

The service requires an immediate response because the reported shortfall against the service specification is current and there is no equivalent specialist workforce elsewhere in the Group that could be redeployed as a complete solution. The potential response is a regional approach, progressing the existing service plan with Cambridge and the relevant commissioners, taking account of the close workforce link with paediatric respiratory medicine.

Paediatric audiology

Paediatric audiology is provided at all three sites. It is considered fragile because of capability and clinical-quality concerns at QEH, where the service was paused, and a five-year patient recall is under way after some children were found to have received inappropriate amplification. NNUH support means the position is improving and the rise in QEH waits relates to all-age audiology rather than specifically the paediatric service.

The service requires an immediate response because the service pause and patient recall show that the issue has already required formal action. The potential response is a sustainable Group

and regional capability model, with appropriate training, supervision, credentialing and cross-site staffing, alongside clear patient-safety governance and assurance over completion of the recall. NHSE is already conducting an NHSE regional-review and any potential response must be a co-created solution alongside NHSE's review findings, because the workforce supply, training route and service model extend beyond the Group.

Histopathology

Histopathology is already consolidated at NNUH and supports clinical pathways across all three of our hospitals. The service is considered fragile because the gap between demand and its available estate, workforce and digital capacity is widening. The persistent vacancy gap and rising sickness absence relate to pathology as a whole. Histopathology supports a wide range of other services in the Group, including cancer pathways. The consequence of deterioration in histopathology is therefore Group-wide.

The service requires a near-term response because, although it remains operational, the constraints are current and affect a wide range of dependent pathways. The potential response is an integrated estates, equipment, digital and workforce plan taken forward through the relevant capital and transformation programmes.

Spinal surgery (within Trauma and Orthopaedics)

Spinal surgery is provided at NNUH and JPUH. It is considered fragile because theatre and estate constraints, including outstanding works, are limiting timely access, with the JPUH waiting list rising from 82 to 187 and the median wait from 9 to 22 weeks.

The service requires a near-term response because access is deteriorating and current capacity is reported to be insufficient to recover the position, although the evidence does not indicate that individual procedures are unsafe. The potential response is a capacity plan covering theatre availability, estate and outstanding works, alongside undertaking an assessment of workforce requirements and validating that the capacity is sufficient for current waiting-list baseline at each site.

Plastic surgery

Plastic surgery provides specialist and reconstructive support to several surgical and cancer pathways. It is considered fragile because particular sub-specialties and specialist theatre capability depend on one or a small number of people.

The service requires a near-term response because the current model has limited resilience and affects several dependent pathways. The potential response is to network specialist expertise and address specific estate capacity issues. Training, supervision, credentialing and specialist theatre support should be addressed, as well as specialist theatre continuity, allied health professional capacity, administrative capacity and outpatient space.

Urology

Urology is provided at all three hospitals and already operates as a networked service, with a single service director, clinical staff working across sites and a quarterly network governance meeting. It is considered fragile because of recruitment and retention pressure at QEH, accompanied by rising staff turnover and a growing waiting list, while admitted activity is falling. This pattern is not uniform across the Group; JPUH, in particular, shows a different position. The network is not yet complete: staffing is managed across the three sites, but operational and financial accountability still sits with each hospital separately, limiting our ability to deploy staff flexibly in response to demand and to support QEH where pressures are greatest. Paediatric urology also follows different pathways at each hospital and is delivered through the adult urology service at QEH, adding further complexity to an already pressured model.

The service requires a near-term response because workforce and access pressures are current, particularly at QEH, although the service continues to operate and the position differs between

sites. The potential response is to build on the existing network by bringing operational and financial accountability together at Group level, so that staff can be deployed where they are needed, and to agree a Group pathway for paediatric urology.

Paediatric respiratory medicine

Paediatric respiratory medicine is provided at NNUH and shares elements of its specialist workforce with the cystic fibrosis service. It is considered fragile because consultant capacity has fallen from three posts to one, and the remaining consultant does not provide cystic fibrosis cover. This is contributing to long waits for clinics and delays in sleep-study reporting, alongside a gap in respiratory physiologist capacity.

The service requires a near-term response because the current workforce model is already affecting access and reporting, although the service has not been suspended and no separate specification breach has been identified. The potential response is to address respiratory medicine and cystic fibrosis as a linked regional workforce issue, including consultant and respiratory physiology capacity, rather than developing separate solutions.

Paediatric gastroenterology

Paediatric gastroenterology is a specialised commissioned service provided at NNUH. It is considered fragile on the judgement of the accountable clinical lead, although the service specific evidence is limited and the rise in activity (306 to 416 spells) and real unit cost may reflect demand or case mix rather than workforce fragility.

The service requires a near-term response based on clinical judgement, with moderate confidence because the supporting service specific evidence is limited. The potential response is a focused follow-up with accountable clinical leadership, followed by consideration of a regional model through the commissioning transition.

Clinical haematology

Clinical haematology is provided at all three hospitals. It is considered fragile because high clinic workloads, dependence on a full consultant establishment, specialist nursing capacity, non-malignant pathways at QEH, on-call resilience and reliance on pharmacy capacity for chemotherapy are not sustainable over the longer term without change, with the QEH waiting list rising from 50 to 192 and the median wait from 5.5 to 17 weeks. Additional dependencies include physical capacity, diagnostic support, pharmacy support, specialist nursing and stem-cell transplant sub-specialties.

The service has a plan in place because, although workforce fragility has been identified, an agreed response - the Single Networked Oncology Service - is already being mobilised. The potential response is to deliver that programme while making sure that pharmacy and chemotherapy capacity, contingency arrangements for consultant absence and the different site-level pressures are included in implementation, ensuring review of established tertiary relationships between QEH and Addenbrookes where these support current service resilience.

Oncology

Oncology is provided at all three hospitals. It is considered fragile because of a substantial consultant establishment gap, which is most acute at QEH where cover has been arranged on a short-term basis.

The service has a plan in place via the Single Networked Oncology Service, which has been approved and is being mobilised across the Group. The potential response is to implement the networked model while maintaining clear assurance over interim consultant cover, mobilisation milestones and contingency arrangements until the new model is established.

Service and scope	Principal driver	Solution type	Potential actions to reduce fragility
ENT (including oral surgery) JPUH, QEH and NNUH	**Workforce capacity** Middle-grade rota	**Group networked staff solution**	Network middle-grade cover across the Group and confirm first-on-call arrangements against deanery requirements.
Paediatric cystic fibrosis NNUH centre covering JPUH and QEH	**Workforce capacity** Specialist consultant gap	**Networked/ partnership model**	Progress the existing plan with Cambridge and commissioners through a regional model.
Paediatric audiology NNUH, QEH and JPUH	**Workforce capability** Clinical quality concerns	**Networked/ partnership model**	Build Group and regional capability through training, supervision and credentialing.
Histopathology Consolidated at NNUH for all three hospitals	**Physical and workforce capacity**	**Capital required**	Coordinate estates, digital and workforce action through the capital and transformation programmes.
Spinal surgery JPUH and NNUH	**Demand exceeds physical capacity**	**Capital required**	Increase theatre and estate capacity, progress outstanding works, plan workforce and validate waits.
Plastic surgery Evidence principally relates to NNUH	**Workforce capability** Limited sub-specialty resilience	**Group networked staff solution**	Network specialist expertise and strengthen training, credentialing and theatre capability.
Urology JPUH, QEH and NNUH	**Workforce capacity and pathway design**	**Group networked staff solution**	Build on the existing network by bringing operational and financial accountability together at Group level, and agree a Group pathway for paediatric urology.
Paediatric respiratory medicine NNUH	**Workforce capacity** Linked to cystic fibrosis	**Networked/ partnership model**	Develop a linked regional workforce model with cystic fibrosis, including respiratory physiology.
Paediatric gastroenterology NNUH	**Workforce capacity**	**Networked/ partnership model**	Complete service-specific engagement and use the commissioning transition to develop a regional model.
Clinical haematology JPUH, QEH and NNUH	**Workforce capacity**	**Group networked staff solution**	Mobilise the Single Networked Oncology Service, confirm pharmacy and chemotherapy dependencies and review tertiary service from Cambridge for QEH.
Oncology JPUH, QEH and NNUH	**Workforce capacity** Most immediate at QEH	**Group networked staff solution**	Mobilise the Single Networked Oncology Service and assure interim QEH consultant cover.

Services not assessed as fragile overall, but where action is recommended

Hyperbaric care

Hyperbaric care is provided at JPUH by a separately commissioned provider operating from trust premises and is not considered fragile; the clinical lead has described a long-standing 24-hour consultant rota and access to critical care through co-location.

The service requires monitoring because it depends on decisions about the future critical-care model at JPUH. The potential response is to involve the commissioned provider and relevant commissioners in the critical-care review, and to test any future scenario against the requirements for clinical support, specialist workforce, estate and equipment.

Gynaecology

Gynaecology is provided at all three hospitals and is considered sustainable overall, but has specific workforce risks in colposcopy, where nurse-led capacity is limited and recruitment is under way, and in urogynaecology at QEH, which depends on one consultant.

The service requires monitoring because the identified workforce risks could reduce resilience, although the overall service is not classified as fragile. The potential response is to support the mitigations already under way, set clear watch measures and escalation triggers for colposcopy and urogynaecology, and obtain an accountable clinical review of the JPUH position.

9.4 Resolving fragility through greater collaboration

Our assessment indicates that most of the fragility identified across the Group is associated with workforce capacity, specialist capability or the way services and pathways are organised across sites.

These issues are unlikely to be resolved sustainably by our individual hospitals acting alone. Group-wide clinical leadership, shared workforce planning, networked rotas, cross-site teams, co-operation with commissioners at local and national level for services with common areas of fragility at this level, and common pathways with consistent approaches to training and credentialing provide potential routes to greater resilience.

Some services also require partnership beyond the Group. The specialist paediatric services are linked to regional workforce and commissioning arrangements at the emergent Children's Hospital in Cambridge, while oncology and clinical haematology are already being addressed through the Single Networked Oncology Service.

Where the principal constraint is physical capacity, particularly in histopathology and spinal surgery, the response should be taken forward through the relevant estates, capital and transformation programmes alongside workforce planning.

Most of the specific actions above concern networking, regional partnership, workforce development or capital investment, and should proceed irrespective of the longer-term acute model. Acute reconfiguration raises a separate question about services that need dependable 24-hour cover: emergency care, acute medicine, emergency surgery, critical care, maternity and inpatient paediatrics. Group-wide working may strengthen these services, but we need to establish whether each site can reliably provide the senior cover, specialist skills, clinical experience and supporting infrastructure they require. Where it cannot, we need to assess whether a different arrangement across our three hospitals would provide safer and more sustainable care.

10. Shaping the future model of care for acute hospital services

Alongside neighbourhood health and the immediate action on fragile services, we need to consider how acute hospital care should be organised across our three hospitals.

The initial focus is on six groups of services in which patients may be seriously unwell or where delay, deterioration or limited access to specialist expertise can carry significant clinical risk:

- emergency department care for the sickest patients (referred to as majors and resus);
- acute medicine, including care for heart attacks and stroke;
- emergency surgery, including trauma and fractured neck of femur;
- critical care, including level 2 high-dependency care and level 3 intensive care;
- obstetric care during labour and birth, rather than the wider range of antenatal and postnatal care; and
- inpatient paediatrics, rather than routine emergency, outpatient or day-case care.

These services are closely interdependent. Their safe delivery relies on access to diagnostics, theatres, anaesthetic services, critical care, specialist opinion and an appropriately skilled workforce throughout the day and night.

The work will consider the role each hospital should play within a coordinated network: what must be available locally, which pathways could be strengthened through shared teams and rapid specialist advice, and whether bringing together some activity would improve safety, outcomes or resilience. We will assess the consequences for travel, equality, ambulance services, workforce, training, finance and the capacity of neighbouring providers. No decision has been made about the future location of these services; the purpose of Part Two is to compare credible scenarios, including a strengthened current model.

10.1 Vision

The changes described in this Case for Change should be guided by a clear account of what we want to achieve for patients, communities and staff. Our vision provides a common direction for decisions about patient care, service configuration and delivery. It focuses on the experience and outcomes we want to provide across Norfolk and Waveney, while recognising that different services will require different models of delivery.

Vision: To provide everyone in Norfolk and Waveney with safe, high-quality care, in the right place, at the right time: providing care closer to home wherever this can be done safely and effectively, while ensuring timely access to specialist expertise when this provides better outcomes. We will support our staff to have worthwhile careers, with great opportunities to develop, learn and progress.

10.2 Development approach

We have taken a clinically-led approach to translate our vision into credible scenarios for future care, working with a broad range of senior clinicians from all three hospitals to form our Clinical Advisory Group (CAG).

Developing the Case for Change via the CAG has ensured that the work is grounded in a strong understanding of how services operate, the standards they must meet, and the relationships between different parts of patient pathways. The CAG has also taken account of what matters to patients and communities, the needs of our workforce, and any practical constraints within which we operate.

10.3 Design principles

The vision describes what we want future care to achieve. The design principles, developed by the Clinical Advisory Group, provide the framework through which potential models will be developed and assessed.

What these principles are for

These principles will guide the development and assessment of potential future models of hospital care across Norfolk and Waveney. They bring together what patients and communities have told us matters to them with the clinical judgement of our Clinical Advisory Group about what is necessary to provide safe, high-quality and sustainable care.

They are not decisions about individual services or where those services will be provided in the future. Instead, they establish the tests that potential models of care will need to meet.

The principles apply to the whole patient pathway and to the combined effect of change across the health and care system. Assessment should therefore consider the consequences for other hospital services, neighbourhood care, ambulance services, primary care, community services and social care, as well as the service being examined.

The principles need to be considered together, not individually. There will sometimes be tension between them. For example, providing care closer to home may improve access, while concentrating a specialist service may improve clinical outcomes by bringing together expertise, technology and sufficient patient volumes. Where this happens, we will assess the evidence and impacts transparently.

Design principles



1. Safety and quality will be fundamental to every decision

Every future model of care must provide safe, high-quality and evidence-based care, now and in the future.

Patient safety and clinical quality will underpin all of the other principles. Services should meet relevant national standards and guidance and be designed to deliver the best possible outcomes and experience for patients.

This means considering not simply whether a service can be provided in a particular location, but whether it can be provided there safely, consistently and sustainably, with the workforce, expertise, diagnostic capability, supporting services and patient volumes required to maintain high-quality care.

Where different models are clinically safe, we will consider the wider benefits and impacts, including access, health inequalities, patient experience, workforce and sustainability.

2. Care should be provided as close to home as is safe and appropriate

We will provide as much care as possible close to where people live, while recognising that some specialist services provide better and safer outcomes when expertise and resources are brought together.

Working with primary care, community services, social care, mental health services, ambulance services and voluntary and community partners, we will seek to prevent ill health, support people to remain well and expand the care available through a network of neighbourhood health facilities across our catchment.

This could include outpatient appointments, diagnostics, monitoring, rehabilitation, follow-up care and other services currently provided in hospitals where evidence demonstrates they can be provided safely and effectively closer to home.

Virtual care will form part of an integrated model spanning hospital, community and primary care. It should complement face-to-face care and enable clinicians and patients to move more easily between settings.

Where evidence demonstrates that concentrating specialist expertise, technology or supporting services would materially improve safety, outcomes or resilience, this would necessarily take precedence over more local provision. The test is not simply 'local versus centralised', but what balance of local and specialist care produces the best overall outcomes for patients. For some services, even if a procedure or operation is concentrated on one or two sites, most of the patient pathway will still be delivered as close or closer to patients homes.

3. People will have timely access to urgent and emergency assessment, 24 hours a day

People with an urgent or emergency healthcare need will continue to have access to urgent and emergency assessment 24 hours a day, seven days a week at each of our three hospitals.

At each of our three hospital sites, patients self-presenting with an urgent or emergency need will have access to appropriately skilled clinicians who can assess them, initiate immediate treatment where required and determine the safest next-step in their care.

24/7 access does not necessarily mean that every specialty or consultant is physically present on every hospital site at all times. The level and type of clinical presence required will be determined by patient need and acuity; demand and activity by time of day; the clinical decisions that need to be made; national standards and evidence; diagnostics and supporting services; rapid access to specialist advice; and workforce sustainability and resilience.

A senior clinical decision-maker means an appropriately experienced clinician with the competence and authority to assess the patient, make or oversee the necessary clinical decisions and determine the appropriate pathway of care. The profession and grade required may differ according to the patient's condition and specialty.

4. Patients with complex or specialist needs will have timely access to the expertise they require

Patients whose condition carries greater clinical risk or requires specialist expertise should have timely access to the multidisciplinary teams, diagnostics, interventions and supporting services necessary to provide safe, high-quality care.

Complex need should not be defined simply by diagnosis or age. It can arise from a combination of clinical acuity, multiple conditions, frailty, mental health, physical disability, cognitive need, social circumstances and risk of deterioration or complications.

Different specialties will require different models of 24/7 cover. We will determine the appropriate level of on-site, networked and on-call specialist provision service by service, informed by evidence, activity and national standards.

Where specialist expertise or supporting services are brought together at fewer sites, we will explicitly assess the consequences for clinical outcomes, access, health inequalities, transfer times, ambulance capacity, workforce, training, resilience and patient and family experience.

We will ensure that specialists are available to provide virtual support in clinical decision making to sites where senior decision makers from that specialty are not physically present.

5. Rapid diagnosis, treatment and clinical decision-making

Patients should have timely access to the diagnostics and interventions necessary to make clinical decisions, begin treatment and enable safe discharge.

This includes, where clinically required, services such as CT, MRI, ultrasound, endoscopy and interventional radiology.

The required response time will depend upon the clinical situation. Each pathway should identify the clinically appropriate response time according to patient need, evidence and relevant national standards. First and foremost response times should be most rapid where this is necessary for patient safety but response times also need to timely when they can aide in discharge decision making.

Diagnostic and intervention capacity must be considered across the whole pathway, including the impact on treatment, length of stay, discharge and the ability to avoid unnecessary admission.

6. Services will be designed around the whole patient journey - including discharge

Hospital care does not begin or end at the hospital door. Future services will be designed around the whole patient pathway - from prevention and access through diagnosis and treatment to recovery, rehabilitation and discharge.

The ability to safely change hospital services will depend partly upon capacity and capability elsewhere in the health and care system.

We will work with primary care, community health services, mental health, ambulance services, social care, local authorities, voluntary and community organisations and neighbouring NHS systems and providers.

Options will assess not only what happens within hospital but whether sufficient community, social care and other capacity exists to support admission avoidance, step-down care, rehabilitation and timely discharge.

7. We will develop and sustain the workforce needed to provide high-quality care

Our future model of care must enable us to recruit, retain, develop and deploy the clinical, professional, administrative, operational, estates, facilities and other support workforce required to provide safe and sustainable services.

Our people should increasingly work as one Norfolk and Waveney hospital community, while retaining strong relationships with individual hospitals and local communities. More of our

staff will also work across organistional boundaries physically and or virtually supporting care delivery in community settings.

We will seek to remove unnecessary organisational barriers to working across sites and enable staff to maintain, develop and share skills. Cross-site working should be designed around better care and professional development, not simply used as a solution to workforce shortages.

Where cross-site working is required, job and work plans should minimise unnecessary travel and disruption. Future models must protect and enhance education, supervision and training opportunities for resident doctors, nurses, allied health professionals and other learners.

We want our staff to have worthwhile, fulfilling careers in Norfolk and Waveney, with great opportunities to develop, learn and progress in a supportive and inclusive environment.

8. Fair access and reducing health inequalities will be designed into services

Everyone should have a fair opportunity to access high-quality care, and future models should seek to reduce rather than widen existing health inequalities.

This principle applies across all of the other principles rather than being a final check after an option has been designed. Access means more than geographical distance.

We need to work pro-actively in identifying high-risk patient groups with a clear focus on long-term preventative measures which will make the biggest impact on health inequalities.

We will consider journey time, public transport, car availability, journey complexity, travel costs, disability and accessibility, rurality, coastal communities, deprivation, caring responsibilities, visiting, frequency of journeys and evening/weekend accessibility.

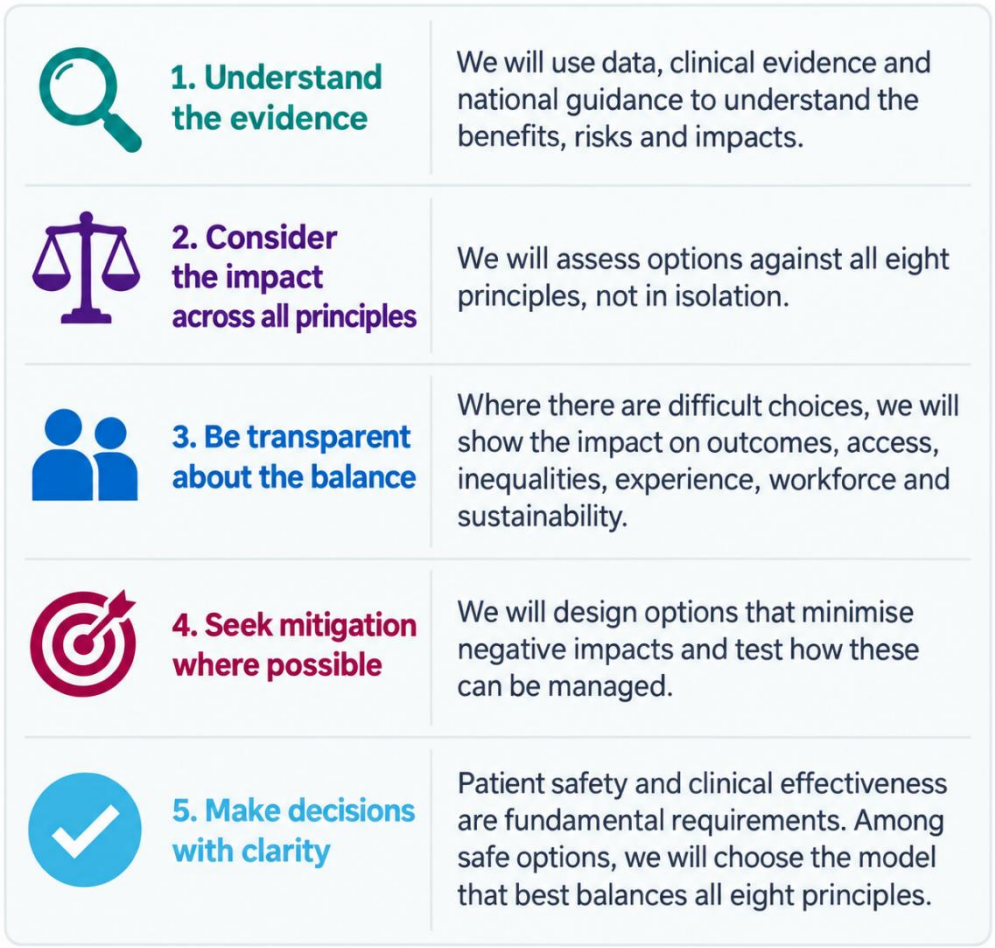
Where patients need to be transferred between hospital sites, the pathway must consider not only safe clinical transfer to the receiving hospital but how the patient can reasonably return home or to their local community when hospital transport is no longer clinically required.

How the principles work together and how trade-offs will be managed

The principles will not be applied as a hierarchy or a simple checklist. Potential models may perform differently against different principles, and the assessment will need to consider their combined effect across the whole pathway and health and care system.

Patient safety and the ability to provide clinically effective care sustainably will be fundamental requirements. Among the models capable of meeting those requirements, we will consider the overall balance of clinical outcomes, access, health inequalities, patient and family experience, workforce sustainability, system impact, deliverability and use of resources.

Where a model provides a significant clinical benefit but creates an adverse impact, that impact will be quantified wherever possible. It will be considered through an equalities lens and tested to establish whether reasonable mitigation is available. Any material impact that cannot be mitigated will remain visible to those responsible for making decisions.



10.4 Assessing future scenarios

The evidence in this Case for Change establishes the need for a coordinated response. A growing and ageing population, variation in care and access, workforce pressures, fragile services and estate constraints make the present model harder to sustain. The evidence also identifies an opportunity; more people could receive timely, coordinated care near home, while those needing complex or urgent treatment could have more dependable access to senior expertise and supporting services.

Some changes cannot wait. We will continue to develop neighbourhood care and take action to stabilise fragile services under every future scenario. We cannot however assume that these actions alone will provide sustainable 24-hour cover and consistently high-quality care across the six core acute service groups. That is why the current configuration and alternatives need to be compared formally, rather than allowing pressures or the timetable for new buildings to determine the answer.

Part Two of this document sets out the potential scenarios to acute reconfiguration across our three hospitals. It describes the scenarios considered and assesses their implications for clinical quality, access, health inequalities, workforce, system capacity, finance and deliverability. The findings will inform further development, engagement and assurance before any decisions are made about service locations or the design of the new hospitals.

11. Appendices

Appendix 1: Previous patient and community engagement

We have drawn on previous engagement with patients, families, unpaid carers and communities to inform the Case for Change. This appendix records the main findings relevant to access, hospital experience, maternity and neonatal care, and support outside hospital. It explains how those findings have shaped the issues we are examining.

Priorities for health and care across Norfolk and Waveney

Engagement undertaken for the Norfolk and Waveney Joint Forward Plan found that people wanted to feel safe when using services, to receive accessible care tailored to their needs and to avoid repeatedly telling their story as they move between organisations. The Norfolk and Suffolk Integrated Care Board's later synthesis of public engagement also identifies a desire for a clearer route into services, stronger links with social care and voluntary organisations, earlier help to prevent illness, and digital services that do not exclude people who need personal contact. [1, 2]

For the Case for Change, this points to the importance of continuity and coordination across hospital and neighbourhood services. Providing more care closer to home will only improve experience if people can find the right service, information follows them and there is a clear route to hospital assessment or specialist advice when their condition requires it.

Access to local and urgent services

Healthwatch Norfolk's review of proposals affecting the Norwich Walk-In Centre, GP out-of-hours services and the Vulnerable Adults Health Inclusion Hub gathered more than 2,100 responses through surveys and face-to-face work. Respondents valued familiar services that provided same-day help and were concerned that reduced access would increase use of emergency departments. Concerns about changes to out-of-hours provision were particularly marked for older and disabled people, rural residents and people who rely on public transport. People using the inclusion hub valued a known location and continuity with staff. [3]

That review concerned specific primary and urgent-care services. It shows why any model that changes where care is available must test the accessibility and capacity of alternative provision. [3]

Experience of hospital care

Healthwatch Norfolk's visits to NNUH provide examples of what patients value and where their experience falls short. In August 2024, 11 people reviewed the acute medical unit. Most spoke positively about the care and staff, while some described uncertainty about what would happen next or disruption at night. A separate visit in May 2025 gathered 13 reviews of the hospital; patients praised staff and the reliability of appointments, but raised concerns about parking and toilet facilities. [4, 5]

QEH's 2024/25 Quality Account reports that its adult inpatient survey identified pain management, communication and discharge as areas for improvement. It also records four public engagement events across Norfolk, Cambridgeshire and Lincolnshire, reflecting the QEH's cross-border catchment. Together with the Healthwatch findings, this reinforces the need to consider the whole patient journey: timely assessment, clear explanations, a suitable physical environment and support after discharge. [6]

JPUH's 2024 adult inpatient survey received responses from 513 people. Patients rated kindness and compassion at 9.2 out of 10, but involvement of family and carers in discharge discussions, where this was needed, scored 5.9 out of 10. Information about medicines to take at home scored 3.9 out of 10 and was somewhat worse than expected compared with other trusts. These

results reinforce the importance of involving carers and giving patients clear, practical information before they leave hospital. [7]

The 2024 National Cancer Patient Experience Survey received 940 responses from NNUH patients. The trust reported an overall rating of 8.9 out of 10, with positive responses on information before diagnostic tests and advice from patients' main contact. This illustrates the value patients place on clear information and a named route for advice. [8]

Maternity neonatal and early years care

In October 2024, Healthwatch Norfolk gathered 18 reviews of maternity and neonatal services at NNUH. Respondents were generally positive about communication and care from staff. Two raised staffing concerns; Healthwatch also observed limited space and privacy for some neonatal families. [9]

Healthwatch's 2025 review of the Norfolk and Waveney Maternity and Neonatal Voices Partnerships found established local engagement with families, including bereaved parents, but identified less-developed neonatal involvement and limited capacity to reach diverse groups. [10]

The importance of support beyond the birth itself is also evident in Healthwatch Norfolk's survey of 277 parents and carers about health visiting. Families wanted more regular contact, especially between the six-to-eight-week and one-year reviews, and 93% said they would prefer home visits for future support. Any maternity or neonatal model should therefore be considered alongside access to antenatal, postnatal and early-years care in the community. [11]

Unpaid carers and discharge

The Norfolk and Waveney All Age Carers Strategy was co-produced with carers and calls for clear, realistic information, a reliable point of contact and recognition of carers as partners in care. It also identifies rural transport as a consideration when services are planned. The strategy records a separate project prompted by carers' experiences of hospital discharge. These views matter when we assess pathways intended to avoid admission or support earlier discharge: the availability of community care and the effect on unpaid carers cannot be assumed. [12]

How this engagement informs the Case for Change

Across these sources, people consistently place weight on timely access, clear communication, continuity between services and care close to home where it is safe and appropriate. They also describe practical barriers, including travel, parking, digital access and the demands placed on carers. We have used these concerns to inform the questions we ask of neighbourhood care and future hospital models.

Sources

[1] Norfolk County Council, Joint five-year plan for a healthier Norfolk and Waveney

[2] NHS Norfolk and Suffolk ICB, Population Health and Commissioning Strategy 2026/27 to 2030/31, section 2.1.2

[3] Healthwatch Norfolk, Norfolk health services review

[4] Healthwatch Norfolk, Acute Medical Unit NNUH feedback, August 2024

[5] Healthwatch Norfolk, NNUH feedback report, May 2025

[6] The Queen Elizabeth Hospital King's Lynn, Quality Account 2024/25, pages 37 to 39

[7] Care Quality Commission, James Paget University Hospitals, Adult inpatient survey 2024

[8] NNUH, Cancer Patient Experience Survey 2024

[9] Healthwatch Norfolk, NNUH maternity services feedback, October 2024

[10] Healthwatch Norfolk, Maternity and Neonatal Voices Partnerships review, 2025

[11] Healthwatch Norfolk, Parent and carer experiences with health visitor services, 2023

[12] Carers Voice Norfolk and Waveney, All Age Carers Strategy, 2025

Appendix 2: Initial equality review

Methodology

1. Purpose and scope

The purposed of this piece of work is to undertake a rapid, literature-led review of equality and health inequalities in the use of the emergency and acute services in scope.

This evidence scan aims to identify which population groups use or rely on the services in scope the most; identify whether groups differ in the type or urgency of care they require and how they access services; identify what may explain these differences; identify existing evidence that shows the location of higher-use or priority populations and the access or travel constraints they face; and identify which groups may be particularly sensitive if services were later relocated, consolidated or delivered differently.

This piece of work will inform options development and identify requirements for the later, full, Equality and Health Inequalities Impact Assessment.

The research questions being tested are:

- Which population groups use the services in scope most, in absolute terms or relative to population size?
- Do population groups differ in the type or urgency of care they require and in how they access the services?
- What does existing evidence suggest about the clinical, service-access and wider social factors associated with these differences?
- What does existing evidence show about where higher-use or priority populations are concentrated, and what travel, transport or access constraints affect them?
- If a service were relocated, consolidated or delivered differently, which population groups might face a disproportionate change in access or travel burden?
- What further analysis, engagement and option-specific assessment will be required once options have been defined?

2. Confirm the protocol

Services in scope:

- Type 1 Emergency Departments (not Urgent Treatment Centres),
- Emergency Medicine (not frailty and SDEC),
- Emergency Surgery,
- Paediatric Inpatient (not day care and SDEC),
- Obstetrics and Maternity Care
- Level 3 ITU

3. Search term optimisation

Search term optimisation on Google's advanced search and PubMed covering the population characteristic, inequalities, service, access, barriers, travel, and service change.

Search terms were tested and refined until relevant results were produced. Ensured the search term tested, the outcomes, and the reason for not included were recorded.

15 final search terms were defined.

4. Evidence search

Research was conducted on relevant local and national sources, followed by wider evidence search on PubMed.

Sites searched included:

- Norfolk Insight and Norfolk JSNA;
- Healthy Suffolk and Suffolk JSNA;
- Norfolk and Suffolk ICB;
- CQC;
- Healthwatch Norfolk;
- NHS England;
- ONS and GOV.UK;
- The King's Fund;
- The Nuffield Trust;
- The Health Foundation.
- PubMed

First 30 results from each search were examined, searching stopped earlier after 10 consecutive clearly irrelevant results.

5. Exclusion/Inclusion

All 990 results were marked include, exclude, or unclear. The reason for including or excluding was recorded.

Exclusion Criteria:

- Published before 2015
- Outside of the UK
- Services out of scope
- Focuses on clinical effectiveness
- Reports activity without examining population differences or access

6. Information extraction

Following the inclusion/exclusion activity, there were 87 included results of the evidence scan. These 87 results were reviewed, and the population, data, author, geography, principal findings, and limitations of the evidence were recorded.

Following this, statements for each population characteristic was pulled relating to the research questions. These were inserted into an impact table (Appendix A).

7. Targeted search

Two separate targeted searches took place. The first following the initial review of the impact table, the following gaps were identified:

- Disability and maternity care access
- Ethnicity and mental health presentations in the emergency department
- Substance misuse and acute service use

Following review at the Clinical Advisory Group on the 16th of September, and the Board Development Session on the 21st of September, the following populations were considered for targeted search:

- Veterans
- Gypsy, Roma, Traveler community
- Substance misuse (second targeted search)
- Lowestoft and South Waveney population

Equality Evidence Scan Impact Table

Characteristic	Statement	Data/Key Findings	Source	Limitations
Children and Young People	Young children, particularly those under five, are disproportionately high users of emergency departments	In Norfolk & Waveney, children aged under five had 25% higher adjusted ED attendance rates than people aged 15–35 (incidence rate ratio (IRR) 1.25, 95% confidence interval (CI) 1.23–1.28).	Association between emergency department attendances, sociodemographic factors and long-term health conditions in Norfolk & Waveney (Jones et al., 2024)	Very large local linked-data study of 1,027,422 residents, providing particularly strong geographic relevance. However, it is cross-sectional and cannot determine why under-fives attend more frequently or whether their clinical need differs.
		Under-fives accounted for 10% of emergency attendances despite representing less than 6% of the population in 2018/19.	Can variation help to explain the rise in emergency admissions for children aged under five up to 2018/19? (Keeble and Fisher, 2020)	National longitudinal HES analysis, but routine hospital data have difficulty distinguishing some short-stay observation/assessment activity from inpatient care
		Emergency admissions increased by 30% for children under one and 28% for one-to-four-year-olds between 2006/07 and 2015/16. Mean length of stay after emergency admission fell by 17%, while zero-day admissions became increasingly common.	The rising challenge of children's urgent and emergency care (Criddle and Howe, 2017)	A secondary commentary drawing on national hospital activity. Does not establish why admissions increased or whether increased short stays represent greater need, service configuration or changing admission practice
	A large proportion of emergency paediatric admissions are short stays or observation episodes, and admission rates are influenced by how paediatric assessment services are configured.	Short-stay emergency admissions have increased, especially in infants. Hospitals showed differences in short-stay admission rates depending on the type of short-stay assessment unit available; the report notes other research showing that opening a paediatric assessment unit can change ward admission volume.	Can variation help to explain the rise in emergency admissions for children aged under five up to 2018/19? (Keeble and Fisher, 2020)	Important methodological limitation: existing national datasets cannot reliably identify observation activity occurring in paediatric assessment units, making it difficult to separate genuine inpatient admission from short-stay assessment.
		The underlying Quality Watch analysis found that short-stay emergency admissions of less than a day had become increasingly common. It suggests this may reflect increasing use of paediatric short-stay units, which allow observation and can reduce full inpatient admissions.	Focus on: Emergency hospital care for children and young people (Keeble and Kossarova, 2017)	National descriptive analysis rather than causal evaluation. The report explicitly presents short-stay-unit use as a possible explanation, so it is difficult to state that it definitively caused the observed trend.

Characteristic	Statement	Data/Key Findings	Source	Limitations
		Between 2006/07 and 2015/16, mean length of stay following CYP emergency admission fell by 17%, while zero-day admissions became increasingly common. The source states that many children can be safely managed in a Short-Stay Paediatric Assessment Unit (SSPAU) rather than being admitted to an inpatient ward.	The rising challenge of children's urgent and emergency care (Criddle and Howe, 2017)	Secondary analysis/commentary based on Quality Watch data. It describes trends and the potential role of SSPAUs but does not causally quantify how much of the reduction in inpatient admission is due to SSPAUs
Deprivation	People living in more deprived areas have higher emergency department utilisation.	In Norfolk & Waveney, people in the least deprived areas had an adjusted ED attendance rate around 39% lower than people in the most deprived areas (IRR 0.61).	Association between emergency department attendances, sociodemographic factors and long-term health conditions in the population of Norfolk and Waveney, England: Cross sectional study (Jones et al., 2024)	Large local cross-sectional study using linked routine data, giving very strong geographic relevance and statistical power. However, LTC and ethnicity information was incomplete for parts of the population, and the observational design cannot establish why deprivation is associated with higher attendance.
		Among people with multimorbidity, ED attendance was 8.9% in the most deprived areas compared with 6.3% in the least deprived areas.	Household and area determinants of emergency department attendance and hospitalisation in people with multimorbidity: a systematic review (MacRae et al., 2022)	Systematic review, but relatively few heterogeneous studies were available.
		National evidence reports A&E attendance among the most deprived groups is nearly twice as high, and emergency admissions 68% higher, than among the least deprived.	Independent investigation of the NHS in England (Darzi, 2024)	High-authority national review synthesising multiple datasets and studies, but not a primary empirical study itself. The headline estimates originate from underlying sources with differing methodologies

Characteristic	Statement	Data/Key Findings	Source	Limitations
	These with food insecurity have higher usage of the emergency department	A systematic review found that people with multimorbidity in the most deprived areas had more ED use than those in the least deprived areas—8.9% versus 6.3%—and higher hospitalisation rates. Food insecurity was also associated with hospitalisation. Evidence concerning household income was inconclusive, and no significant association was found for rurality or marital status.	Household and area determinants of emergency department attendance and hospitalisation in people with multimorbidity: a systematic review (MacRae et al, 2022)	Only 10 heterogeneous studies were included, and they were not restricted to the UK. This also partly overlaps with the existing strong finding concerning deprivation and ED use, although it identifies multimorbidity as a potentially important intersecting characteristic.
	People living in more deprived areas access ED through different pathways, with lower use of GP referral and greater ambulance arrival than people living in less deprived areas.	In a UK study of 482,787 adult ED attendances, 4.7% of patients from the most deprived areas arrived following GP referral compared with 14.7% of those from the least deprived areas; ambulance arrival was 32% versus 24%. These differences persisted after adjustment.	Socioeconomic inequality and access to emergency care: understanding the pathways to the emergency department in the UK (Madia et al., 2025)	Large observational study but based on a single teaching hospital in a relatively affluent area of East England, limiting generalisability to other settings. Deprivation was area-based and the observational design cannot establish that deprivation caused differences in referral pathways or ambulance use.
		Among ED attendances, patients from the most deprived areas were more likely to self-refer (35.1% vs 30.6%) and less likely to have been referred by a GP (2.4% vs 3.7%) than those from the least deprived areas	Socioeconomic inequality in access to timely and appropriate care in emergency departments (Turner et al., 2022)	Large national study, but deprivation was measured at area rather than individual level and the main analysis was restricted to patients arriving by ambulance, limiting conclusions about inequalities across all ED attendances. Observational data cannot establish causality and unmeasured differences in clinical severity may remain.
	People experiencing poverty can face practical barriers to accessing healthcare outside hospital, including the costs of travel and contacting services and barriers	The King's Fund review of poverty and NHS services identifies travel costs, costs of contacting general practice and internet/digital access as barriers associated with poverty. It reports marked socioeconomic differences in home internet access. Due to these reasons, those from more deprived groups were more likely to report turning to urgent/emergency routes because they had been unable to access general practice.	Illustrating the relationship between poverty and NHS services (Mallorie, 2024)	Evidence synthesis drawing on multiple datasets and literature rather than a single primary study. Uses different measures of poverty and area-level deprivation and describes associations rather than isolating causal relationships; observed service use also does not capture unmet need among people who do not access care.

Characteristic	Statement	Data/Key Findings	Source	Limitations
	associated with digital access; these barriers may affect how easily people can use alternative routes to care.			
	Children and young people from more deprived areas have substantially higher A&E attendance and unplanned hospital admission rates.	CYP in the most deprived areas were 58% more likely to attend A&E and 55% more likely to experience an unplanned admission than those in the least deprived areas.	Admissions of inequality: emergency hospital use for children and young people (Kossarova et al., 2017)	Large national analysis of routine hospital data, with direct comparison by deprivation. However, the data are relatively historical and cannot determine how much of the inequality reflects other factors such as primary/community care access and environmental exposure.
		Under-five short-stay emergency admissions remained higher among children from more deprived areas.	Can variation help to explain the rise in emergency admissions for children aged under five up to 2018/19? (Keeble and Fisher, 2020)	National longitudinal administrative-data analysis, but HES cannot reliably distinguish some paediatric assessment/observation activity from inpatient admission.
		Among 3,665,414 infants in England, area-level deprivation was positively associated with A&E attendance rates. Infants from socioeconomically disadvantaged young-parent families were also identified among groups with higher emergency-care use.	Determinants of accident and emergency attendances and emergency admissions in infants: birth cohort study (Nath et al., 2020)	Very large, linked birth-cohort study with multivariable modelling, giving strong statistical power. However, explores the relationship between deprivation and ED attendance, does not explore onwards admission to hospital.
Disability	People with disabilities experience additional practical barriers to accessing healthcare, including transport, cost of	People with disabilities were more likely to report unmet healthcare need than non-disabled people. Reported barriers included transportation, long waiting lists and cost; disabled women had particularly high unmet need on some measures, including 7.2 times the odds of unmet need due to cost of care/medication compared with non-disabled men	Access to healthcare for men and women with disabilities in the UK: secondary analysis of cross-sectional data (Sakellarious et al., 2017)	Cross-sectional and based on self-reported access. Healthcare is considered generally rather than specifically Type 1 ED, emergency surgery, ICU or paediatric inpatient care, so the findings cannot be directly attributed to those individual services.

Characteristic	Statement	Data/Key Findings	Source	Limitations
	travel, and waiting times.	People with disabilities reported practical barriers to accessing healthcare including cancelled/delayed appointments, reduced face-to-face care, inaccessible remote/digital systems, difficulties using public transport and disabled parking, and physically inaccessible queuing arrangements. In some cases, delayed or inaccessible care was reported to result in unmet medical needs and deterioration in existing conditions.	The impact of UK social distancing guidance on the ability to access support and the health and wellbeing of disabled people during the COVID-19 pandemic: a qualitative exploration (Nicholls et al., 2024)	COVID-specific qualitative evidence, so the scale/nature of access barriers may not reflect routine service delivery. Not specific to the acute services in scope.
		Local evidence identifies disabled people as a population for whom accessibility and reasonable adjustments need to be considered when accessing healthcare. People dependent on public transport had fewer alternatives, while changes to familiar routes/environments created additional difficulties, particularly for people with sensory or mobility impairments. Therefore, when moving services further away, support needs to consider poor transport in Norfolk and Waveney.	Core20 Plus Groups (Norfolk Insights)	Contextual/local evidence summary rather than a primary comparative acute-service study.
Ethnicity	Women from ethnic minority groups (EMG) are more likely to require emergency or higher-intensity care around	Black women had the highest rates of emergency C-section across every deprivation quintile in England; even Black women in the least deprived group had higher rates than the most deprived group of every other ethnicity.	Are emergency C-sections more likely among certain ethnic groups? (Ogunlana and Taylor, 2025)	Secondary analysis of national HES data, giving broad population coverage but relying on routinely coded ethnicity and procedure data. Around 7% of deliveries initially had missing ethnicity. The analysis cannot fully adjust for clinical factors such as parity, underlying health or indication for caesarean, so it demonstrates an inequality but does not explain its cause.

Characteristic	Statement	Data/Key Findings	Source	Limitations
	childbirth, including emergency caesarean section and intensive care admission.	South Asian women were less likely than White women to give birth in midwife-led settings (20.6% vs 27.5%), including after adjustment (aOR 0.61). Interviews identified assumptions around hospital birth and limited information about birthplace options.	The relationship between ethnicity and place of birth in England: a mixed-methods study (Rivers et al., 2024)	Mixed-methods design strengthens interpretation by combining quantitative and qualitative evidence, but the study was conducted in one urban NHS trust, limiting generalisability. The interview sample was small and there were insufficient Black women for robust comparison. Observed differences cannot determine the relative contribution of preference, clinical eligibility or access barriers.
		Black women were 2.21 times as likely to have an ICU admission during pregnancy or up to 6 weeks after birth; association remained after adjustment (aOR 1.69). Obstetric haemorrhage accounted for a larger proportion of ICU admissions among Black women.	Associations between ethnicity and admission to intensive care among women giving birth: a cohort study (Jardine et al., 2021)	Large national observational cohort of 631,851 women giving birth in England and Wales, with linked data, providing strong statistical power and adjustment for multiple factors. However, residual confounding is possible and causality cannot be established.
	Black and Asian women may be more likely than White women to give birth prematurely.	Government figures report that 8.5% of live births to Black women and 8.3% to Asian women were preterm, compared with 7.8% for White women. The report also identifies smoking, obesity, pre-eclampsia and infection as relevant risk factors, while acknowledging that many preterm births have no apparent risk factor.	Government response to the House of Lords inquiry into preterm birth: reducing risks and improving lives (Department of Health and Social Care, 2025)	A single secondary government report rather than the underlying analytical dataset. Broad categories such as “Black” and “Asian” may obscure important differences between individual ethnic groups.
	There are ethnic minority groups have higher utilisations of the Emergency Department and higher number of emergency admissions.	Patients from underrepresented ethnic groups with severe asthma were more likely than White patients to have recently attended ED for asthma (OR 1.55, 95% CI 1.26–1.92) and to have been hospitalised for asthma (OR 1.31, 95% CI 1.07–1.59), despite similar exacerbation rates. They also had higher levels of uncontrolled asthma in both datasets	Ethnic Differences in Severe Asthma Clinical Care and Outcomes: An Analysis of United Kingdom Primary and Specialist Care (Busby et al., 2022)	Large UK observational analysis using two independent datasets spanning primary and specialist severe-asthma care, which strengthens consistency of the findings. However, ethnicity was grouped into White versus a combined “underrepresented ethnic group”, masking differences between individual ethnicities. The population is specifically people with severe asthma, so findings cannot be generalised to overall ED utilisation by ethnicity.

Characteristic	Statement	Data/Key Findings	Source	Limitations
		Patients from ethnic minority groups appear to utilise emergency services more than white patients. This seen almost consistently throughout the age groups. However, there is the argument that deprivation is the stronger factor for ED attendance, and that individuals from EMG	Population and patient factors affecting emergency department attendance in London: retrospective cohort analysis of linked primary and secondary care records (Hull et al., 2018)	This study was carried out in an urban environment, with a different geography and ethnic profile to Norfolk, therefore less generalisable to Norfolk and Waveney. However, this is a large study observing ED utilisation and comparing through ethnicity.
		Analysis of 203,182 first emergency admissions found differences between Asian, Black, Mixed, Other and White patients in age, deprivation, comorbidity and outcomes. Asian and Black patients admitted as emergencies were younger than White patients.	Ethnicity and acute hospital admissions: Multi-center analysis of routine hospital data (Wan et al., 2021)	Large multicentre routine-data analysis, providing strong statistical power but based on a highly ethnically diverse urban population that may not generalise to Norfolk & Waveney. Around 10.7% had undisclosed ethnicity.
	Paediatric ED utilisation differs by ethnicity, with those from ethnic minority groups being more likely to use overall	Ethnic inequalities in emergency admissions among people with multiple long-term conditions. Specifically, Black and Asian children and young people with MLTCs had higher emergency admission rates than their White counterparts. The underlying national study reported adjusted emergency admission rate ratios among CYP with LTCs of 2.49 for Black CYP (99% CI 2.39–2.60) and 1.13 for Asian CYP (99% CI 1.08–1.19), compared with White CYP. Mixed-ethnicity CYP had a lower rate (IRR 0.93, 99% CI 0.89–0.97).	Ethnic Inequalities in Healthcare Use and Care Quality among People with Multiple Long-Term Health Conditions Living in the UK (Hayanha et al., 2026)	Systematic review of 14 UK studies; five studies contributed to the review's synthesis of ethnic inequalities among people with >2 LTCs. Emergency-admission evidence for CYP came from a national English HES study of 763,199 CYP aged 10–24 years
		Compared with White children, Asian children were slightly more likely to be frequent ED users (OR 1.03, 95% CI 1.01–1.05) and Mixed-ethnicity children were also more likely (OR 1.04, 95% CI 1.01–1.06). Black children were less likely to be frequent users (OR 0.88, 95% CI 0.86–0.90), as were children in the other ethnicity group (OR 0.90, 95% CI 0.87–0.92).	Characteristics of frequent paediatric users of emergency departments in England: an observational study using routine national data (Greenfield et al., 2021)	Very large national observational study using routine HES data, giving strong statistical power and direct relevance to English ED utilisation. However, ethnicity was missing for 9.8% of children. The increases for Asian and Mixed children are small in magnitude despite statistical significance.

Characteristic	Statement	Data/Key Findings	Source	Limitations
	Antenatal and postnatal care provide important opportunities to improve women's health and reduce health inequalities, particularly among ethnic minority groups	Exploratory research included 46 ethnic-minority women and 25 maternity staff. Continuity with the same midwife helped women feel more in control, discuss concerns and trust advice. Strong relationships reportedly enabled immediate and preventive action. Positive experiences included being listened to during both antenatal and postnatal appointments. The report also cites 2024 evidence that Black women were almost 3 times and Asian women 2 times as likely to die in childbirth as White women.	Confidence in maternity care services: engagement with ethnic minority women and maternity staff (Office for Equality and Opportunity, 2025)	Exploratory qualitative study with a small, geographically limited sample. Experiences are self-reported; it does not estimate intervention effect sizes or establish causality. The mortality figures come from a separate MBRRACE-UK report cited within the source.
		In England in 2023, preterm births represented 8.5% of live births among Black women, 8.3% among Asian women and 7.7% among White women. The report identifies the 6–8-week postnatal check as an important opportunity to address physical and mental health and future pregnancies. Antenatal booking is also used to identify smoking and provide opt-out cessation support. More than £20 million annually was allocated to local maternity and neonatal inequality work.	Government response to the House of Lords inquiry into preterm birth: reducing risks and improving lives (Department of Health and Social Care, 2025)	Policy response rather than primary effectiveness research. Focuses principally on preterm birth, so it cannot establish effects across all dimensions of women's health. It also acknowledges inconsistent implementation of services and guidance.
		Analysis of 2023/24 maternity episodes found that Black and Asian women had higher emergency C-section rates than White women. Black women had the highest rates across every deprivation quintile; even the least-deprived Black group had higher rates than the most-deprived group in every other ethnicity. The authors argue that appropriate monitoring throughout pregnancy should reduce the need for some emergency interventions.	Are emergency C-sections more likely among certain ethnic groups? (Ogunlana and Taylor, 2025)	Descriptive observational analysis. Approximately 7% of deliveries had missing ethnicity data; some records were reallocated using prior data. It lacks reasons for C-sections and does not adequately adjust for health status or parity. It cannot show that antenatal care caused the differences.

Characteristic	Statement	Data/Key Findings	Source	Limitations
		In 2022–24, 252 women died during pregnancy or within six weeks, a rate of 12.80 per 100,000 maternities. Maternal mortality was 2.7 times higher among Black women than White women (32 versus 12 per 100,000) and 1.9 times higher in the most-deprived areas than the least deprived (18 versus 9 per 100,000). Among 178 deaths reviewed in detail, assessors found that improvements in care may have made a difference for 61%. The report identifies inadequate maternal assessment during early postnatal visits, insufficient postnatal monitoring and management, loss of pregnancy-period support after birth, and gaps in communication and continuity. It recommends proactive multidisciplinary care, listening and escalation, maternity early-warning scores for pregnant and recently pregnant women, clear postnatal plans, and access to postnatal contraception.	Saving Lives, Improving Mothers' Care: MBRRACE-UK Maternal Report 2026 (Felker et al., 2026)	Confidential-enquiry and observational evidence rather than a controlled intervention study. "Care may have made a difference" reflects expert case review, not a causal effect estimate. Findings concentrate on deaths and severe morbidity and may not describe all maternity experiences. The report does not compare maternity care with every other health-inequality intervention.
Gypsy, Roma, and Traveller community (GRT)	Gypsy, Roma and Traveller communities face barriers to accessing GP, preventative and wider healthcare services.	The assessment identifies difficulties registering with GPs, poor communication, limited cultural competence, digital exclusion, low health literacy, fear and distrust. Digital exclusion can result in missed invitations to health checks, immunisations and outpatient appointments.	Norfolk Gypsy, Roma Traveller Health Inequalities Assessment (Paice, 2022)	Brief assessment rather than primary research. No systematic search or appraisal is reported, some evidence is dated, and distinct Gypsy, Roma and Traveller communities are grouped togethe
		In 11 focus groups involving 64 Roma participants, eight groups reported limited knowledge of available services, and participants reported uncertainty about accessing preventative services and difficulty obtaining GP appointments. Language barriers were reported across all 11 groups; digital	Engaging in a dialogue with the Luton Roma community on access to healthcare services and co-producing solutions (Ali et al., 2026)	Luton-specific, purposively recruited qualitative sample. Findings cannot estimate prevalence or be generalised quantitatively to Norfolk or all Gypsy, Roma and Traveller communities.

Characteristic	Statement	Data/Key Findings	Source	Limitations
		booking and lack of interpreters also created difficulties.		
		England guidance identifies registration refusal, discrimination, digital exclusion, language and literacy needs, unfamiliarity with the NHS, limited cultural awareness and stigma.	Improving Roma health: a guide for health and care professionals (Office for Health Improvement and Disparities, 2022)	Professional guidance, not a primary empirical study. Does not quantify prevalence or compare service-use rates. It concerns Roma communities and should not automatically be generalised to all Gypsy and Traveller populations.
	Gypsy, Roma and Traveller women may face barriers to antenatal and maternity care	The assessment identifies low uptake of antenatal services as a potential service gap and identifies language, literacy, communication, distrust and taboos concerning prenatal, maternity and gynaecological health. It also reports nationally poorer maternal and neonatal outcomes.	Norfolk Gypsy, Roma Traveller Health Inequalities Assessment (Paice, 2022)	Does not quantify local antenatal uptake, maternity attendance, emergency maternity use or comparative mode of delivery. The reported outcomes are drawn from secondary sources.
	Barriers to earlier healthcare may contribute to some Roma people relying on emergency services or presenting at A&E with conditions	Luton Roma participants reported limited awareness of preventative services, difficulty securing GP appointments and uncertainty about where to seek care. One participant described contacting the emergency service when seeking gynaecological care. Emergency care was frequently discussed, with reports of long waits, dissatisfaction and communication problems.	Engaging in a dialogue with the Luton Roma community on access to healthcare services and co-producing solutions (Ali et al., 2026)	Shows experiences and possible pathways into emergency care but does not measure attendance frequency or show that Roma people attend ED more frequently than other groups.

Characteristic	Statement	Data/Key Findings	Source	Limitations
	that could have been treated earlier.	The guidance explicitly states that distrust, health-related taboos, misinformation about hospitals and previous exclusion from services can lead to overuse of emergency services or presentation at A&E with a serious condition that could have been treated earlier.	Improving Roma health: a guide for health and care professionals (Office for Health Improvement and Disparities, 2022)	Guidance-based statement without quantified ED attendance or a non-Roma comparison group.
Homeless	People experiencing homelessness are much higher users of ED and emergency hospital care than the housed population.	Government evidence reports that people experiencing homelessness are 3.2 times more likely to have an inpatient hospital admission than the general population, while A&E attendance is at least 8 times higher among people sleeping rough than among housed people. People experiencing both homelessness and alcohol dependence were reported to be 28 times more likely to have an emergency hospital admission.	Health matters: rough sleeping (Public Health England, 2020)	Government evidence synthesis rather than a single primary cohort. “Homelessness” and “rough sleeping” are not interchangeable, and some figures relate specifically to rough sleepers or particular subgroups. Underlying estimates may use different periods/data sources. It strongly establishes high utilisation but does not explain causality.
		A national study analysed 109,254 people experiencing homelessness attending Type 1 EDs in England. Frequent previous ED users were more likely to leave without treatment and reattend within seven days. People not registered with a GP were more likely to leave untreated or die in ED.	Emergency department outcomes for patients experiencing homelessness in England: retrospective cross-sectional study (Moss et al., 2023)	Large national routine-data study directly relevant to Type 1 ED. Homelessness identification in administrative data may be incomplete; the study only includes people who reached ED and cannot compare to usage of GP usage
		The article reports increasing ED attendances and admissions among homeless people and describes patients as frequently having multiple unmet health, housing and social-care needs and barriers to accessing other healthcare.	Meeting the needs of homeless people attending the emergency department (Dorney-Smith et al., 2026)	Clinical review rather than primary epidemiological research. Useful for understanding barriers and service response but weaker for quantifying utilisation or establishing causal mechanisms.

Characteristic	Statement	Data/Key Findings	Source	Limitations
	People experiencing homelessness face barriers to accessing primary care and digital exclusion, leading to increased ED utilisation.	People experiencing homelessness described being refused GP registration, being discharged from hospital onto the street without access/referral to primary care, fragmented services, inadequate signposting, lack of continuity due to unstable accommodation, and perceived stigma/discrimination. Rigid appointment systems were also identified as difficult to navigate.	Provision and accessibility of primary healthcare services for people who are homeless: a qualitative study of patient perspectives in the UK (Gunner et al., 2019)	Small qualitative sample from three shelters and one specialist centre. Does not demonstrate that these barriers cause higher ED utilisation.
		In a study of 2,505 homeless people across 19 English areas, rough sleepers were substantially less likely to be GP registered than homeless people in accommodation (OR 0.45).	Factors associated with access to care and healthcare utilization in the homeless population of England (Elwell-Sutto et al., 2017)	Cross-sectional; cannot establish causality. Importantly, poorer healthcare access did not simply translate into more hospital use in this study — some vulnerable people appeared to be missing hospital care altogether.
	Specialist homeless-health-team involvement was followed by reduced unplanned ED attendance and increased access to planned hospital care.	In the 120 days following the index admission and Pathway-team involvement, unplanned ED attendances decreased and planned admissions doubled. Housing status was maintained or improved for more than 60% of patients at discharge.	Secondary care usage and characteristics of hospital inpatients referred to a UK homeless health team: a retrospective service evaluation (Field et al., 2019)	Uncontrolled, retrospective service evaluation. It cannot establish that the Pathway teams caused the changes. Increasing planned admissions and bed days may represent improved access to necessary care rather than an overall reduction in hospital use.
Learning Disability	Individuals with learning disabilities have higher ED usage and have acute admissions.	The Norfolk briefing states that people with learning disabilities have more difficulty identifying health problems and getting treatment than people without learning disabilities. Conditions are left untreated and therefore require more acute/emergency attention.	Adults with Learning Disabilities, Norfolk JSNA Briefing Document (Norfolk County Council, 2024)	Local Joint Strategic Needs Assessment (JSNA) briefing synthesising existing national/local evidence rather than a dedicated acute-hospital study. Does not quantify the relative contribution of delayed recognition versus difficulty accessing treatment.

Characteristic	Statement	Data/Key Findings	Source	Limitations
		Individuals with Autism have a higher healthcare utilisation, a higher likelihood of hospitalisation, and a greater number of emergency-room, primary-care, outpatient and inpatient visits.	Core20 Plus Groups (Norfolk County Council, 2023)	This is a local evidence summary rather than a primary utilisation study. It reports national evidence but does not provide a Norfolk-specific ED attendance rate, effect size or detailed methods for the underlying utilisation comparison.
		People with intellectual disabilities experienced 77.5 emergency admissions for ambulatory-care-sensitive conditions per 1,000 person-years. After age/sex standardisation, they had 4.8 times the expected number of emergency admission episodes and 5.4 times the expected bed-days compared with people without intellectual disabilities.	An observational cohort study of numbers and causes of preventable general hospital admissions in people with and without intellectual disabilities in England (Glover et al., 2020)	Ambulatory-care-sensitive admissions indicate potential preventability but do not prove individual admissions could have been avoided. Observational data cannot determine the precise reasons for the excess.
	Barriers to recognising health problems and obtaining timely, accessible healthcare may contribute to higher acute and emergency care use among people with learning disabilities.	People with intellectual disabilities had 4.8 times the expected emergency admissions for ambulatory-care-sensitive conditions. These admissions are used as indicators of issues potentially related to accessibility of primary care, health literacy and self-care/carer support. Q3: supports the relationship between higher emergency admission and earlier opportunities to identify and manage conditions outside hospital.	An observational cohort study of numbers and causes of preventable general hospital admissions in people with and without intellectual disabilities in England (Glover et al., 2020)	Cannot prove that access barriers caused the higher admission rate; ACS admissions are an indirect indicator.
		Those with intellectual disabilities has shorter consultation opportunities, variable access to annual health checks, and lower continuity of care (less likely to see the same clinician leading to failure to understand communication needs or recognise change or deterioration).	An evaluation of the effectiveness of annual health checks and quality of health care for adults with intellectual disability: an observational study using a primary care database (Carey et al., 2017)	Routine primary-care data may under-identify people with milder learning disabilities, and severity/living arrangements were incompletely recorded. The observational design cannot establish that differences in continuity, consultation length or health checks caused differences in emergency admission.

Characteristic	Statement	Data/Key Findings	Source	Limitations
	Women with learning disabilities can require additional communication and navigation support to access maternity services effectively.	Women with learning disabilities described difficulty understanding maternity information and making sense of available choices and often relied on additional support to navigate care.	'We both just wanted to be normal parents': a qualitative study of the experience of maternity care for women with learning disability (Malouf et al., 2017)	Nine participants; qualitative and cannot quantify delayed access or missed appointments.
		The study found that parents with learning disabilities benefited from tools such as a Maternity Passport and other adapted resources designed to improve communication and help staff understand individual needs. It also identified the need for better recording of individual requirements, staff training and consistent reasonable adjustments. A future model would therefore need systems that ensure accessible information and individual adjustments follow the patient across the whole pathway.	Implementing and evaluating resources to support good maternity care for parents with learning disabilities: A qualitative feasibility study in England (Cox et al., 2024)	Small feasibility study and does not directly evaluate service relocation or consolidation; reconfiguration implications are therefore inferred from the access barriers identified.
Mental Health	People experiencing mental-health crisis use Type 1 ED as a route to urgent care, including for self-harm	Establishes ED as one route through which people experiencing mental-health crisis access urgent care. However, does not establish how much more or less they use ED than the general population	What are the experiences and perceptions of service users attending Emergency Department for a mental health crisis? A systematic review (Sacre et al., 2021)	Systematic review of only 10 qualitative/mixed-method studies. Appropriate for understanding pathways and experiences but not designed to quantify utilisation rates or compare people with/without SMI.
		Norfolk Suicide Audit evidence identifies repeated emergency/self-harm-related contacts among people who subsequently died by suicide. Highlighting that within the severe mental health subgroup, and those who were high risk, there is a higher emergency department utilisaiton.	Norfolk Suicide Audit 2024 (Norfolk County Council, 2025)	Local audit of a highly selected population—people who died by suicide. Valuable for identifying patterns before death but cannot estimate repeat ED use among the wider serious mental illness population. Numbers may also be small for subgroup analysis.

Characteristic	Statement	Data/Key Findings	Source	Limitations
		The Norfolk Mental Health Needs Assessment identified repeat A&E attendance among people presenting with self-harm. Repeated A&E attendances are identified. In younger-people admission for self-harm is higher than the national average.	Mental Health Needs Assessment (Norfolk County Council, 2026)	Local evidence is highly relevant geographically, but the analysis relates specifically to self-harm and should not be extrapolated to all mental-health presentations or all people with SMI.
	Ethnic inequalities are present in access to earlier mental-health services in some populations, with some groups more likely to reach more acute or involuntary pathways.	Among women giving birth in England, Black African, Asian and some other ethnic minority women had lower access to community mental-health services and a greater proportion of involuntary inpatient admissions than White British women	Differences in access and utilisation of mental health services in the perinatal period for women from ethnic minorities-a population-based study (Jankovic et al., 2020)	Large national population study, but numbers of involuntary admissions were relatively small, and these rates could not be standardised by age/ethnicity. Routine ethnicity data were incomplete for some women, and the study does not establish why some ethnic groups had lower access to community mental-health services
		In Children and Young People (CYP), existing King's Fund evidence reports that Black and Asian children reached services through crisis referrals more often, indicating missed opportunities for earlier support.	What is the state of children's health in England? (Buckingham and Jefferies, 2025)	Secondary evidence synthesis rather than primary research. The finding on higher crisis referrals among Black and Asian CYP is based on underlying national data and does not establish why these differences occur or whether they reflect differences in underlying need, access or other factors; it is also not specific to ED attendance.
	People with co-occurring physical and mental-health conditions may be particularly high users of ED.	People reporting both a physical and mental-health condition attended ED 4.63 times as frequently as other groups. They also used general practice more frequently. Increasing numbers of mental-health symptoms were associated with greater ED use; depression was the only individual symptom significantly associated with ED attendance.	Predictors of emergency department and GP use among patients with mental health conditions: a public health survey (Saini et al., 2019)	One self-reported survey across 28 neighbourhoods in North-West England. Higher use of both ED and general practice means the study does not demonstrate that ED use resulted from poor primary-care access.

Characteristic	Statement	Data/Key Findings	Source	Limitations
Migrant	Migrant women experience barriers that affect their ability to access, navigate and participate in maternity care, including communication difficulties, problems accessing care and lack of continuity.	The systematic review found that ethnic-minority and migrant women reported predominantly negative maternity-care experiences, including problems with communication, access to care, and continuity of care.	UK maternity care experiences of ethnic minority and migrant women: systematic review (Obionu et al., 2023)	Systematic review across seven databases, but only nine studies met inclusion criteria and findings combine ethnic-minority and migrant women, so not every finding can be attributed specifically to migrant status.
		The study identified barriers associated with complex immigration/NRPF rules, NHS maternity charging, limited professional understanding of healthcare entitlements, inconsistent specialist support and limited staff training. Only a minority of surveyed professionals had received relevant training. Q2: demonstrates administrative barriers affecting how some migrant women access maternity care.	Navigating No Recourse to Public Funds and NHS maternity charging: health and social care professionals' experiences of supporting pregnant women in the UK (Dasgupta et al., 2026)	Focuses on a specific migrant subgroup and predominantly professional perspectives. It does not measure whether these barriers result in reduced access to obstetric units or quantify their effect on birth outcomes
		The cohort included recently arrived migrants and non-English-speaking women. Non-English-speaking women were substantially less likely to access maternity care within recommended timeframes; in one sample, more than 70% had not booked by 12 weeks, compared with 24% nationally. Q2: provides direct evidence of later access to maternity care among some non-English-speaking/socially complex women.	A multisite audit to assess how women with complex social factors access and engage with maternity services (Rayment-Jones et al., 2026)	Small sample of 182 women and not exclusively migrant women. Focuses mainly on antenatal booking/access, so it is contextual to the obstetric pathway rather than direct evidence about accessing a birth unit.
	Migrant women, particularly those with NRPF, irregular immigration status or recent migration, have been found to	Study of 67,308 pregnancies found increased risk of a composite adverse perinatal outcome among women who were born outside the UK (aRR 1.20, 95% CI 1.15–1.25) and particularly among women who had recently migrated (aRR 1.32, 95% CI 1.14–1.53). Migration status was considered alongside other	The role of poverty-related social determinants in maternal and perinatal health inequities: a cross-sectional study using the eLIXIR born in South London, UK maternity-child data linkage (Burton et al., 2026)	Uses a composite outcome, so it cannot be used as independent confirmation specifically of emergency caesarean or severe maternal morbidity. Cross-sectional observational design cannot establish causality

Characteristic	Statement	Data/Key Findings	Source	Limitations
	experience higher risks of adverse maternal or perinatal outcomes, including emergency caesarean section and severe maternal morbidity in women with NRPF.	structural social determinants including ethnicity and deprivation.		
		In linked South London maternity data, migrant women with NRPF had increased risks of emergency caesarean (aRR 1.74) and severe maternal morbidity (aRR 1.49). Q2: directly demonstrates differences in type/urgency of obstetric care.	Perinatal outcomes among migrant women with no recourse to public funds or irregular status: A retrospective cohort study using the eLIXIR 'born in South London' data linkage (Rayment-Jones et al., 2026)	Specific migrant subgroup and urban population. Observational study; cannot establish that immigration status or access barriers caused the increased emergency caesarean/morbidity.
Older Age	Older people living alone may be more likely to access emergency care.	The Norfolk JSNA reports that older people living alone were 50% more likely to access emergency-care services and 40% more likely to have more than 12 GP appointments annually.	Loneliness and Social Isolation (Norfolk County Council, 2026)	A briefing document that appears to rely on one local secondary source.
Rural	Rural populations face additional travel and access barriers to acute care because of longer distances,	For 19 small acute hospitals, more than half of the population would need to drive over 30 minutes to reach the next acute hospital. Showing why loss or relocation of local acute provisions could create greater travel burden	Rural, remote and at risk: Why rural health services face a steep climb to recovery from Covid-19 (Palmer and Rolewicz, 2020)	Exploratory analysis of rural/remote hospital services, providing useful direct geographic evidence but covering relatively few remote organisations. Undertaken in the Covid context and does not measure individual patient transport availability or the realised impact of reconfiguration.

Characteristic	Statement	Data/Key Findings	Source	Limitations
	poorer public transport and fewer alternative providers; consolidation may therefore create a greater access burden for some rural communities.	Remote acute hospitals face challenges because their populations cannot readily access alternative hospital services. States that there should be suitable alternatives to improve access including taking the professional to the patient, improving transport links, combining GP, ambulance, and hospital services to improve care.	Acute care in remote settings: challenges and potential solutions (Nuffield Trust, 2016)	Service-focused evidence/report rather than population-level causal research. Strong for identifying the distinctive configuration constraints of remote hospitals, but less strong for quantifying patient-level access impacts.
		Rural populations face longer journeys and more limited public transport when accessing healthcare, creating additional time and cost burdens. Therefore, it is not just the geographical distance creating the practical burden. This source also emphasises the importance of neighbourhood care in rural locations to minimise this impact.	Future of Rural England Report (DEFRA, 2026)	Government evidence synthesis/policy report rather than an acute-service-specific empirical study. Useful for establishing rural transport constraints but does not quantify their effect on utilisation of the specific hospital services in scope.
	Greater distance or rural residence does not necessarily result in higher mortality among emergency general-surgery patients	Across 1.57 million Scottish emergency general-surgery admissions, patients living farthest from hospital and in the most rural areas had lower adjusted mortality than patients living closest or in urban areas. This apparent survival advantage was not found among patients requiring emergency laparotomy or transfer. Transferred patients had higher mortality.	Emergency general surgery: impact of distance and rurality on mortality (Wohlgemut et al, 2022)	One retrospective Scottish study covering 1998–2018. The counterintuitive result could reflect differences in case selection, admission thresholds or unmeasured need. It does not measure patients who failed to reach hospital and should not be interpreted as showing that distance is harmless.
	Distance from an emergency department is associated with lower ED attendance in	In Norfolk & Waveney, ED attendance decreased as distance from the nearest ED increased. The authors interpret this as presumably reflecting reduced accessibility.	Association between emergency department attendances, sociodemographic factors and long-term health conditions in the population of Norfolk and Waveney, England:	Large local cross-sectional linked-data study, making it highly relevant to this programme. However, distance is observationally associated with attendance, and the study cannot determine whether lower attendance further from ED represents lower clinical need, use of other services, suppressed demand or unmet need. It therefore must not be

Characteristic	Statement	Data/Key Findings	Source	Limitations
	Norfolk & Waveney.		Cross sectional study (Jones, et al., 2024)	interpreted as evidence that greater distance reduces unnecessary attendance.
		People with dementia living in rural areas showed differences in A&E/emergency hospital utilisation compared with those living in other areas. They were also less likely to have an emergency admission. Again, cannot show whether this is due to difficulties with access, or use of alternative services.	Social and spatial inequalities in healthcare use among people living with dementia in England (2002–2016) (Watson et al., 2022)	Large observational English cohort, but specific to people with dementia and includes activity dating back to 2002. Cannot determine whether rurality itself caused differences in utilisation.
Substance Misuse	Alcohol and drug misuse is high amongst frequent attenders to the emergency department.	Among approximately 1.2 million people, 6.7% had a recorded alcohol disorder but accounted for 11.7% of ED attendances. Mean ED attendance was 2.78 for acute alcohol disorder and 4.33 for chronic alcohol disorder, compared with lower use among those without an alcohol disorder.	Burden of Alcohol Disorders on Emergency Department Attendances and Hospital Admissions in England (Phillips et al., 2019)	Uses records of alcohol disorders rather than every person misusing alcohol. Observational evidence demonstrates association, not causation. It does not cover drugs generally.
		Interviewed 30 people who had attended ED at least 10 times in the previous year for alcohol-related reasons. Repeated attendance was associated with long-standing health problems, injury and pain, inaccessible primary care, limited knowledge or dislike of addiction services, travel difficulties, and the availability of immediate ED care and ambulance transport.	Qualitative exploration of why people repeatedly attend emergency departments for alcohol-related reasons (Parkman et al., 2023)	Participants were recruited specifically because they were frequent alcohol-related attenders. It explains repeated attendance but cannot estimate how common alcohol misuse is among all ED attenders or compare attendance with the general population.

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Norfolk and Waveney University Hospitals Group

Norfolk and Waveney University Hospitals Group

Our Clinical Strategy

Part 2

Scenario Appraisal

Status: Final
Date: 29 October 2026

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1. Executive Summary

1.1 Purpose and context

This document follows on from the Case for Change (Document 1), which set out the evidence that our current arrangements will not enable NWUHG to effectively or sustainably meet future need.

The objective of this phase was to generate a range of potential reconfiguration scenarios for further consideration, through a clinically led process of exploration and evaluation. Scenarios have been developed with clinicians from all three hospitals through the Clinical Advisory Group (CAG), Clinical Working Groups and data drop-in sessions – over 40 hours of clinical engagement in total. The output is a recommended shortlist of scenarios to take forward for further development, engagement and assurance; it does not select a preferred configuration.

1.2 Baseline scenarios: 'Do As Planned' and 'Do Minimum'

The first step was to understand what the Group could achieve without changing where services are provided, using two reference scenarios:

- **'Do As Planned' – £53m deficit by 2034/35.** The position the Group would reach if the Medium Term Financial Plan (MTFP) and the New Hospital Programme (NHP) 'left shift' assumptions are fully delivered. It does not deliver the non-negotiable enhanced clinical standards our patients need, or assume maximum delivery of neighbourhood health.
- **'Do Minimum' – £34m deficit by 2034/35.** 'Do As Planned', plus 'Neighbourhood Max' and enhanced clinical standards, including 24/7 senior decision-making. 'Neighbourhood Max' improves the financial position by £24m, while the enhanced clinical standards increase expenditure by £9m.

The 'do minimum' scenario does not resolve clinical sustainability nor deliver financial sustainability and therefore we need to explore potential reconfiguration scenarios of acute hospital services.

1.3 'Neighbourhood Max': modelling the impact on our hospitals

We modelled 30 neighbourhood interventions, each grounded in published evidence and applied to the records of the patients our hospitals actually treated in 2024/25. By 2034/35 and on top of the reductions already assumed in the NHP plan, **neighbourhood health could take out about 93,900 bed days a year, roughly 280 beds at 92% occupancy**, avoid about 8,300 emergency admissions and 17,400 A&E attendances, and move about 271,000 outpatient attendances and 10,500 day cases into community settings. The figures are the top of the evidence, assume full delivery by 2034/35, and rest on four interventions that provide 88% of the figure.

1.4 Evaluation criteria and evaluating the baseline scenarios

The CAG developed twenty evaluation criteria that consider quality, safety, workforce, patient impact, system impact and financial sustainability. Each scenario was compared against the 'Do As Planned' position on a five-point scale, from 'much better' to 'much worse'. The financial and capital impacts were quantified separately.

The 'Do Minimum' delivers real improvements in routine care, senior cover and care close to home without moving any services. But it leaves two problems unresolved: **complex care remains spread across three sites, and the workforce position gets worse rather than better.** These are the gaps that the reconfiguration scenarios need to address.

1.5 Developing reconfiguration scenarios

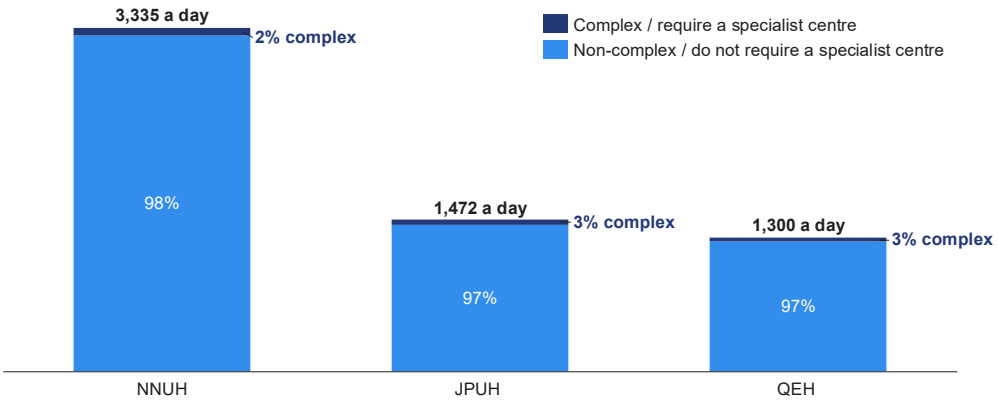
The CAG agreed an anchor objective to **maximise the number of patients treated at their local hospital site or within their neighbourhood**, while staying within the Group's financial constraints. The clinical groups defined a set of minimum requirements that form a base model for all sites under any reconfiguration scenario (Table 1).

Table 1: Minimum requirements for all sites under any reconfiguration scenario

Service area	Base service model
Maternity	**Community and neighbourhood hubs (antenatal and postnatal care)** • Midwives based in community hubs across Norfolk and Waveney, with access to obstetricians on site or virtually • Hubs offer ultrasound scans, community midwife appointments, glucose tolerance tests, postnatal checks and neonatal outreach, reducing the need to travel to hospital • A single home birth team distributed across the geography • Neonatal outreach to help families return home sooner • Vulnerable women's teams replicated across all three Trusts
Unplanned care	• 24/7 urgent treatment centre • SDEC for surgery, medicine and paediatrics, 08:00–22:00 (except for paediatric SDEC which is 24/7) • Full range of diagnostics • Medical beds and all non-complex emergency admissions of under 48 hours
Planned care	• Full range of outpatients and diagnostics • Day surgery, including 23-hour enhanced recovery and robotics

Applied to the Group's 2025/26 activity, **at least 97% of patients will continue to be treated in the hospital or community closest to where they live, under any reconfiguration scenario** (Figure 1).

Figure 1: Average daily activity by complexity and Trust, number, April 2025 to February 2026



Activity includes adult and paediatric unplanned care (ED and SDEC attendances, inpatient admissions), planned care (outpatients, elective admissions, day cases) and women's and children's care (deliveries, neonatology). Source: NWUHG inpatient, ED and outpatient datasets.

The remaining 3% are complex patients that could potentially benefit from services being consolidated onto fewer sites. To narrow the potential scenarios further, the CAG agreed fixed points that apply to every scenario:

- **Unplanned care:** NNUH will provide complex care and treat patients with the highest-acuity conditions: stroke, cardiac arrest, complex trauma (including fractured neck of femur and GI bleeds) and those requiring interventional radiology
- **Critical care:** the number of high-dependency and intensive care beds on each site will be determined by the clinical services provided on that site
- **Women and children:** NNUH is the hospital for complex births in Norfolk. Any site that delivers babies must have 24/7 emergency surgery, and a site with no delivery suite will not have a neonatal unit or inpatient paediatrics

1.6 Planned care

Clinicians have agreed not to reconfigure the current planned care model – this means that over 99% of planned care patients will continue to be treated at their local site, or closer to home in the neighbourhood. All sites will provide 23-hour enhanced recovery and robotic surgery, enabling more elective inpatient activity to be delivered as day cases. QEH and JPUH elective inpatient activity is being consolidated at NNUH, but JPUH retains inpatient joint replacement surgery (T&O). The planned care model does not deliver any savings relative to the 'Do Minimum'.

1.7 Unplanned care

The CAG evaluated three scenarios: as-is ('Do Minimum'), and an unselected or a selected medical take at QEH and JPUH. The key difference is the complexity of patients QEH and JPUH can admit:

- **Unselected medical take:** the site admits all medical presentations except the most complex, which go to NNUH. This requires a 24/7 emergency department, critical care (HDU with some ITU) and full medical on-take capability. Around 22 patients a day would transfer from JPUH and QEH.
- **Selected medical take:** the site admits only medical patients with a low likelihood of needing critical care. Transfers from JPUH and QEH would roughly double to 47 a day, with around 18 QEH patients a day going to hospitals outside the Group.

The CAG's recommendation is to take forward the 'Do Minimum' scenario alongside the unselected medical take reconfiguration scenario. The unselected take scores better on safety for complex care, outcomes, 24/7 senior cover and all three workforce criteria, but worse on patient access, neighbouring systems and the ambulance service. There was consensus that the **selected take should not be taken forward**, as its benefits do not outweigh the negative impact on patient access, neighbouring systems and the ambulance service.

Under the unselected take, QEH and JPUH would keep their ED, critical care and unselected take services. The key question for the next phase is whether the impact on neighbouring hospitals and the ambulance service can be reduced; changing the ambulance conveyance strategy, for example, could increase the share of QEH patients going to NNUH from around 29% to 63%.

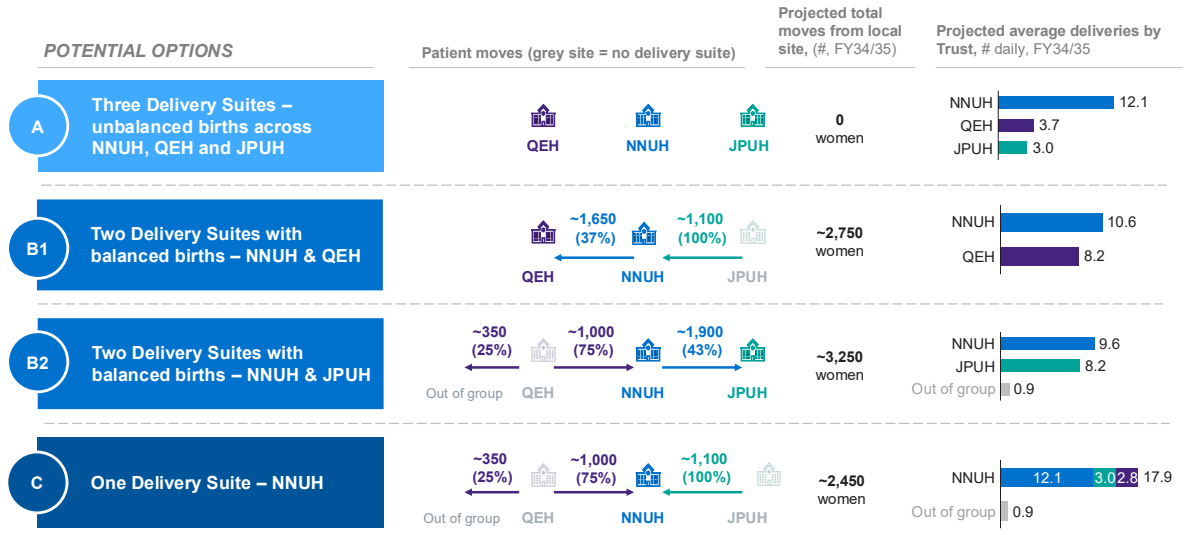
1.8 Women and children's services

Deliveries across the Group are projected to fall from around 7,900 in 2025/26 to around 6,900 by 2034/35. The CAG agreed that a sustainable delivery suite requires around 3,000 deliveries a year (although there is no national guidance, it was felt to be the minimum volume to ensure clinical competence in a financially sustainable way). **Only NNUH's delivery suite is projected to be of a sustainable size by 2034/35.** QEH and JPUH would each perform fewer than four deliveries a day, while still needing to provide cover around the clock.

From an initial long list, the CAG ruled out three scenarios before scoring, leaving four reconfiguration scenarios (Figure 2):

- **Scenario A: three delivery suites ('Do Minimum').** No change in where women give birth; QEH and JPUH remain well below a sustainable size
- **Scenario B1: NNUH and QEH.** Two balanced units; around 2,750 women change birth site each year
- **Scenario B2: NNUH and JPUH.** Two balanced units; around 3,250 women change birth site each year, including around 350 QEH births leaving the Group
- **Scenario C: NNUH only.** Around 2,450 women change birth site each year, with around 350 leaving the Group

Figure 2: Overview of four women and children's reconfiguration scenarios and impact on activity.



The scores show a consistent trade-off: fewer delivery suites yields greater gains on safety for complex care, senior cover and workforce, but at a greater cost to travel times and patient choice. The CAG did not reach a consensus to rule out any scenario, so **the recommendation is to take all four forward for continued modelling.** The one site scenario would deliver the highest standard of care for women with complex births, providing mitigations to access can be developed.

1.9 Financial and capital evaluation

Using a top-down approach, the **unselected medical take reduces expenditure by approximately £18m a year** compared to the 'Do Minimum', and the selected take by around £32m. In women's and children's services, the **two-site scenarios reduce expenditure by around £6m-£8m a year** and the **single delivery site scenario by around £18m** (Figure 3).

Figure 3: Annual saving against the 'Do Minimum' by reconfiguration scenario, £m, 2034/35

Recap:
The preliminary financial modelling projects the Group will have a structural deficit in 2034/35 under the 'do-minimum' scenario of:

£34m

Projected net financial saving and share of deficit closed, by reconfiguration scenario relative to the 'do-minimum' scenario
£m and % (FY 2034/35)

Scenario	Net saving	% of deficit
Women and Children		
B1 Two suites at NNUH & QEH (balanced)	~£8m	~24%
B2 Two suites at NNUH & JPUH (balanced)	~£6m	~18%
C One suite at NNUH	~£18m	~53%
Unplanned Care		
2 Scenario 2 (2x Unselected)	~£18m	~53%
3 Scenario 3 (2x Selected)	~£32m	~94%

Viability tested against the women and children fixed points: a site that delivers births must have emergency surgery, and a site without a delivery suite has no neonatal unit or inpatient paediatrics. Under unselected or selected medical take, emergency surgery at that site is SDEC only.

- **The selected medical take would close almost all of the financial deficit on its own**, but is not recommended by the CAG because of its impact on patient access, neighbouring systems and ambulance service
- **The unselected medical take scenario closes around half of the gap,** while limiting the negative impact compared with the selected medical take
- **Combined with any of the maternity reconfiguration scenarios, the unselected medical take closes most or all of the deficit gap.** A two-site maternity model leaves a structural deficit of around £8m-10m a year; with a single delivery suite at NNUH the gap is eliminated
- **Reconfiguration of both unplanned care and women's and children's services is needed** to address the structural deficit

These figures are preliminary and exclude the costs of mitigations and enablers, double-running and transition costs.

As 97% of activity remains local, most of the planned accommodation at QEH and JPUH would still be required, including emergency departments and critical care. Changes to maternity, neonatal and inpatient children's services would have a more substantial effect on the new hospital designs and require an extension at NNUH.

We currently estimate an additional capital requirement of £140 million to £225 million for scenarios retaining two birth suites, and £263 million to £354 million for scenarios with one birth suite. Subject to detailed design, the best-case estimate for the one-birth-suite model could fall from £263 million to approximately £200 million.

If these changes result in a public consultation, there will be a delay of a minimum of 6 months to the submission of the Outline Business Cases for the new hospital builds at Queen Elizabeth and James Paget Hospitals. This would mean that they open in 2034.

1.10 Scenarios recommended for further development

Bringing these conclusions together, four whole-system scenarios emerge, each involving a different balance between local access and choice on the one hand, and safety, workforce sustainability and financial sustainability on the other (Table 2). The planned and unplanned care model is the same in all four; **only the number of maternity sites varies**.

Table 2: Summary of the four scenarios recommended for further development

	Scenario A: three maternity sites	Scenario B1: two maternity sites (NNUH and QEH)	Scenario B2: two maternity sites (NNUH and JPUH)	Scenario C: one maternity site (NNUH)
Delivery suites, neonatal units, inpatient paediatrics	All three sites	NNUH and QEH	NNUH and JPUH	NNUH
Medical take	Unselected at all three sites			
24/7 emergency surgery	All three sites	NNUH and QEH	NNUH and JPUH	NNUH only
Emergency Department	All three sites	All three sites	All three sites	All three sites
Critical Care	All three sites	All three sites	All three sites	All three sites
Main benefits	No impact on travel times & patient access No maternity impact on ambulance or neighbouring systems	Two units of a sustainable size; Keeps births in west Norfolk; Improves workforce sustainability; Better safety, outcomes and workforce resilience; No impact on neighbouring systems	Two units of a sustainable size; Improves workforce sustainability; Better safety, outcomes and workforce resilience;	Greatest improvement in quality and safety, particularly for complex births; Greatest workforce sustainability; Closes structural deficit gap;
Main trade-offs	QEH and JPUH units remain well below a sustainable size; Does not improve care for complex patients; Workforce resilience worsens; Limited impact on deficit gap;	~1,650 women redirected from NNUH to QEH, reducing patient choice; Impact on travel times, health inequality for JPUH patients; Impact on ambulance service;	Greatest impact on women that move as ~3,250 women change birth site each year, including 1,900 NUH patients; Large impact on travel time for QEH patients; Greatest impact on ambulance service;	Large impact on travel time for QEH patients; Impact on ambulance service; Impact on health inequality and patient choice for JPUH & QEH patients;
Quality impact overall assessment	Slightly better	Better	Better	Much better
Remaining structural deficit (from £34m)	~£16m	~£8m–£10m	~£8m–£10m	Gap closed (~£2m surplus(

1.11 Mitigations and enablers

Each reconfiguration scenario has disadvantages that would need to be mitigated, and each depends on a set of enablers being in place before services change. Potential mitigations include earlier senior clinical decisions, a Group-wide workforce model, better pre-hospital triage and appropriately staffed transfer arrangements for unplanned care; and, for women's and children's services, antenatal and postnatal care closer to home, a single maternity triage system and 24-hour paediatric same-day emergency care. Critical enablers include transport and cross-site pathways, the electronic patient record, workforce and estate capacity at NNUH, and neighbourhood, community and social-care capacity. The next phase of work will confirm, cost and assign owners to each one.

1.12 Conclusion

The scenario evaluation indicates that there are models capable of addressing the clinical and financial sustainability challenges set out in Part One of the Case for Change. The scenarios are ambitious and depend on substantial changes to care within hospitals and neighbourhoods. All scenarios have been developed with the aim of improving the quality and sustainability of care for people across Norfolk and Waveney within the resources available to us; they present six main areas of improvement (Figure 4).

Figure 4: Overview of the six main areas of improvement within the reconfiguration service models.

- ✓ **Kept the highest proportion of patients cared for locally,** in any model that has consolidated complex Emergency Care
- ✓ Made **major improvements in maternity and neonatal care** outcomes
- ✓ Implemented a **new model of care for older people** in neighbourhood settings, leading to up to ten fewer wards of patients
- ✓ **Expanded the complexity and volume of day surgery** undertaken on all three sites through robotics and enhanced recovery
- ✓ Significantly **reduced the number of inpatient admissions** for emergency care through major expansion of Same Day Emergency Care for adults and children
- ✓ Achieved **recurrent financial balance** (dependent on scenario chosen) to allow the system to invest in neighbourhood healthcare

Each scenario has strengths, risks and dependencies that require further examination. We recommend that the Case for Change and scenario evaluation be presented to the Norfolk and Suffolk Integrated Care Board for a decision on whether to commission the further work needed to develop a business case, enabling more detailed appraisal and engagement.

2. Introduction and context

2.1 Purpose of this document

This document follows on from the Case for Change (Document 1) that outlines why the Group needs to change how acute services are delivered across Norfolk and Waveney (see 2.2 for summary).

The objective of this phase was to generate a range of potential reconfiguration scenarios for further consideration, through a clinically led process of exploration and evaluation.

This document summarises the extensive engagement process that clinicians from all three Trusts have been through to develop, test and narrow down potential scenarios for the future configuration of services across our three hospitals, and what each would mean for patients, staff and the Group's financial position. The output is a recommended shortlist of scenarios to take forward for further development, engagement and assurance.

This scenario appraisal does not:

- Select a preferred configuration or determine the future location of individual services;
- Replace the detailed clinical, financial, workforce, estates and impact assessments that will be required for any scenario taken forward; or
- Replace the engagement, scrutiny, assurance and, where required, public consultation that must precede any decision on material service change.

2.2 Summary of Case for Change (Document 1)

The Case for Change (Document 1) set out the evidence that our current arrangements will not enable NWUHG to effectively or sustainably meet future need. In summary, it found that:

- **Too many people are cared for in hospital currently who would get better outcomes if they were looked after closer to home.** Demographic change will exacerbate this with the Norfolk & Waveney population projected to grow by around 11% between 2025 and 2045, and nearly three-quarters of that growth among people aged 65 and over. Neighbourhood care is the solution, and the Group needs to respond to national direction of travel on left shifts including the benefits of new EPR.
- **We do not consistently provide safe, timely and effective care, especially for our sickest and most at risk patients (Board Assurance Framework Principle Risk 1).** The Care Quality Commission rates safety as Requires Improvement at all three hospitals, and JPUH and QEH sit in segment 4 of the NHS National Oversight Framework. Access and flow vary significantly between our sites.
- **Maternity units are projected to become unsustainable.** QEH and JPUH were two of only 12 hospitals in England with fewer than 2,000 births in 2024/25, and births are projected to continue to decline across the Group. This will leave us with units that do not have sufficient births to maintain safety, quality and training. A review of maternity provision is needed.
- **Fragile services are failing or will fail in the near future.** We have identified 11 fragile services that are subscale services with difficulty in recruiting to specific specialities. This will require a mix of regional solutions, Group solutions and changes to patient pathways for others.

- **Our estate constrains what we can do.** QEH and JPUH contain extensive RAAC, and NNUH operates within a long-term PFI arrangement. The £2.8 billion allocated through the New Hospital Programme to replace QEH and JPUH is an opportunity, but it requires us to define the clinical model the new buildings will support.
- **The Group has a structural deficit problem.** In 2025/26 the Group's deficit, before deficit support funding, was £51m. Even if the Group fully delivers its ambitious Medium Term Financial Plan (MTFP) and delivers the New Hospital Programme (NHP) assuming on the left-shift, it is still projected to have a £53m deficit by 2034/35.
- **Most of our activity is lower complexity.** Around 97% of activity across the Group involves patients with lower-complexity needs, suggesting that much care could be provided consistently at each hospital or closer to home, while a smaller group would benefit from concentrated specialist expertise.

The Case for Change (Document 1) concluded that our response must address **neighbourhood health, fragile services and acute hospital care as parts of one model**. Work on neighbourhood health and fragile services will proceed under every future scenario. It also set out our vision, and eight design principles agreed by the CAG that any future model must be tested against.

The first step was to develop a realistic understanding of what care would look like if the Group achieves the neighbourhood vision and enhanced clinical standards across current the three site model – this was called the 'Do Minimum' scenario. If the 'Do Minimum' scenario did not resolve the Groups clinical and financial viability issues outlined above, then the Group would need to explore scenarios for reconfiguration of acute hospital services.

2.3 Overview of clinical engagement process

The potential reconfiguration scenarios that are outlined and evaluated in this paper have been developed through an intensive co-creation process with a wide range of clinicians from all three hospitals, through:

- **The Clinical Advisory Group (CAG)**, comprising around 60 senior clinical leads from JPUH, NNUH and QEH, which agreed the design principles, the scenarios to explore and the evaluation criteria, and evaluated the scenarios.
- **Clinical Working Groups (CWGs) across five workstreams: Women & Children, unplanned care, planned care, paediatric care and critical care,** involving a wider range of clinical staff from all three hospitals, which validated the baseline activity analysis, explored its implications, and developed the assumptions on what would need to change under each scenario, including where additional resource is required to enhance clinical standards and where resource could or could not be released if services were consolidated
- **Data drop-in sessions at all three Trusts** for clinicians to understand the data and assumptions in detail

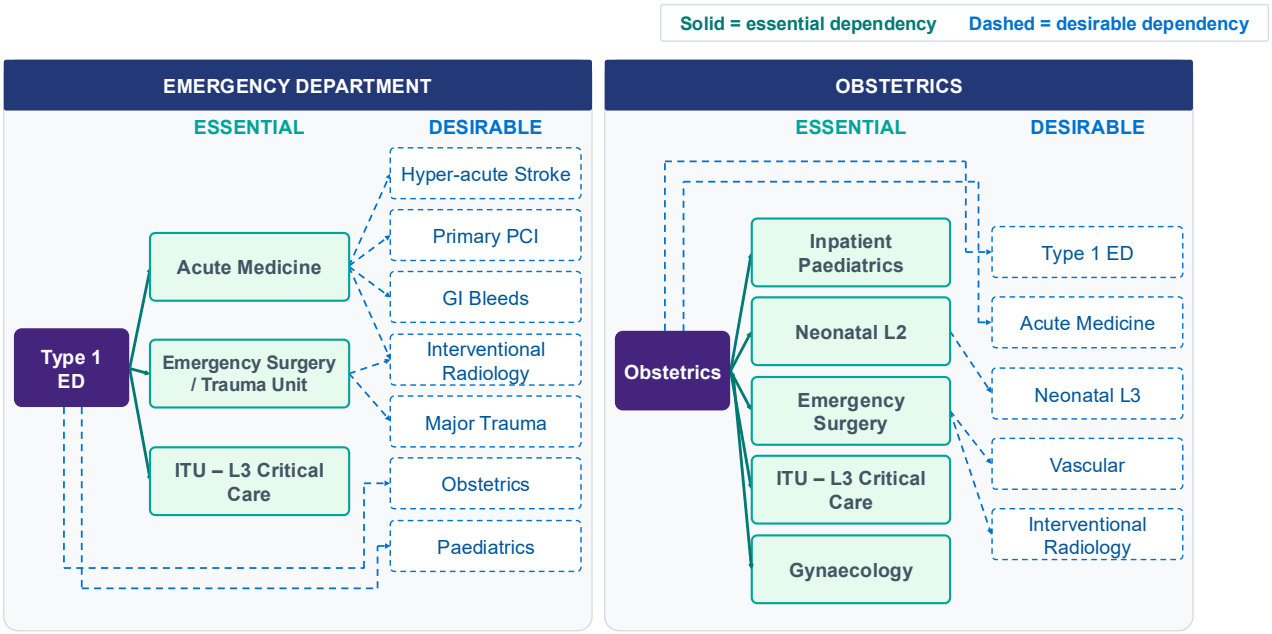
Since September, we have held four two-hour CAGs, three rounds of two-hour CWGs in each of the four workstreams, and data drop-in sessions at all three Trusts – over 40 hours of clinical engagement in total.

2.4 Scope of services in reconfiguration

The scope is the six groups of interdependent services in which patients may be seriously unwell, or where delay or limited access to specialist expertise carries significant clinical risk: emergency department care for the sickest patients; acute medicine; emergency surgery; critical care; obstetric care during labour and birth; inpatient paediatrics. We have also considered planned care, because its configuration affects what activity can be provided locally.

Clinicians agreed the two acute services that have the biggest impact on the reconfiguration model are the Emergency Department and Obstetrics, given the large number of interdependencies with other services – as shown in Figure 5:

Figure 5: Interdependencies between the Emergency Department, Obstetrics and other acute services



Given this, the approach to develop the reconfiguration scenarios was developed using three focused on three groups:

- **Unplanned care**, including critical care
- **Women and children** (obstetrics, neonatology, paediatrics)
- **Planned care**

2.5 Overview of scenario appraisal approach

The following chapters provide an overview of the clinician-led approach to develop recommendations on potential scenarios. This has involved six key steps:

1. **Defining the 'Do Minimum' scenario:** the position the Group will be in by 2034/35 if it maximises the shift to neighbourhood care ('Neighbourhood Max') and achieves the necessary increase in clinical standards, without changing where services are provided (Sections 3 and 4). This defines a realistic baseline against which any reconfiguration scenario can be compared.

2. **Agreeing the evaluation criteria:** building on the eight design principles, the CAG agreed the criteria against which every scenario would be assessed and a five-point relative scoring scale, with each scenario compared against the 'Do As Planned' position (Section 5).
3. **Evaluating the 'Do Minimum':** the CAG scored the baseline scenarios against the criteria to establish what could be achieved without reconfiguration, and where the clinical and financial challenges would remain (Section 6).
4. **Developing reconfiguration scenarios:** the CAG agreed an anchor objective and minimum requirements for every site, which narrowed the range of credible scenarios (Section 7). Scenarios were then developed for planned care, unplanned care, and women and children's services (Sections 8 to 10).
5. **Evaluating the scenarios in two ways:** a clinician evaluation, in which the CAG scored each reconfiguration scenario against the agreed criteria (Sections 9 and 10), and a financial evaluation, which estimated the top-down saving of each scenario against the 'Do Minimum' and its capital implications (Section 11).
6. **Agreeing recommendations and next steps:** the results were combined into four whole-system scenarios recommended for further development (Section 12), together with the mitigations and enablers each would require (Section 13) and the next steps (Section 14).

3. Baseline scenarios: 'Do As Planned' and 'Do Minimum'

The 'Do Minimum' scenario projects that the Group will have a **structural deficit of £34m by 2034/35** if it achieves its vision of enhancing clinical standards and maximising the benefits of neighbourhood health across the current model of delivery, alongside fully delivering the Medium Term Financial Plan (MTFP). Clinicians agreed the projected financial position is not a sustainable, and therefore we need to explore potential reconfiguration scenarios of acute hospital services.

3.1 Overview of baseline scenarios

The reconfiguration scenarios developed in this process have been evaluated against two reference points scenarios that assume all acute hospital services remain in their current configuration. The following sections provide an explanation of the assumptions behind each scenario and the financial modelling.

Table 3: Overview of the 'Do As Planned' and 'Do Minimum' scenarios

Scenario	Overview	Projected structural deficit (annual loss) in 2034/35
'Do As Planned' (from Document 1)	The position the Group would reach by 2034/35 if: ▪ The Group's Medium Term Financial Plan (MTFP) is fully delivered, requiring £263m of cost improvement programmes (CIPs) over three years and the stabilisation of fragile services, to reduce the deficit to £5m by 2028/29 ▪ The New Hospital Programme (NHP) has built in assumptions around the 'left shift' of activity from hospitals to neighbourhood services, phased in from 2029/30	£53m deficit / year
'Do Minimum'	'Do As Planned', plus: • 'Neighbourhood Max' delivered, beyond the NHP assumptions • Enhanced clinical standards, including 24/7 senior decision-making	£34m deficit / year

3.2 'Do as Planned' scenario

Assumptions

As set out in Document 1, the 'Do as Planned' is the position the Group would reach by 2034/35 assuming:

- The Group's Medium Term Financial Plan (MTFP) is full delivered, requiring £263m of cost improvement programmes (CIPs) over three years and the stabilisation of fragile services, to reduce the deficit to £5m by 2028/29
- The New Hospital Programme (NHP) assumptions on the 'left shift' of activity from hospitals to neighbourhood services are fully realised. These would be phased in from 2029/30 following delivery of the MTFP
- All services continue to be delivered where they are today

Financial position

In 2025/26 the Group's deficit, before deficit support funding, was £51m – up from £31m of in 2024/25.

The Group's MTFP outlines that the Trusts will reduce the deficit to £5m by 2028/29; which means delivering £263m of cost improvement programmes (CIPs) over three years, including the stabilisation of fragile services. This is equivalent to an average CIP rate of 5.0% of gross expenditure each year, compared with a historic average of 3.9%. The plan also assumes that 85% (£223m) of savings will be recurrent, compared with 56% historically. If delivered in full, the MTFP will reduce the underlying deficit (before deficit support funding) to £5m by 2028/29 - a net improvement of £46m.

Beyond 2028/29, growth in demand and costs is projected to outpace further CIP delivery, worsening the position by £73m by 2034/35.

The activity avoidance assumed by the NHP, phased in from 2029/30, offsets £25m of this increase in expenditure, resulting in a **structural deficit of £53m a year by 2034/35.**

Figure 6: 'Do As Planned': NWUHG surplus / (deficit) by intervention, £m, 2025/26 to 2034/35



Source: NWUHG financial modelling, top-down projections developed with the NWUHG finance team. Assumptions are being confirmed and will be validated in later phases of the programme.

Conclusion

As outlined in the Case for Change (Document 1), the 'Do as Planned' scenario is not viable itself for three reasons:

- **It does not deliver the non-negotiable enhanced clinical standards our patients need.** Clinicians were clear that, whatever the configuration, every site must provide 24/7 senior decision-making in unplanned care and in women and children's services.
- **It does not assume maximum delivery of neighbourhood health.** 'Do as Planned' includes only the left-shift assumptions in the NHP. The Group is committed to a more ambitious neighbourhood model.
- **It leaves the Group with a large recurrent structural deficit of £53m.** This means that it is unlikely any business case submitted for the New Hospitals at Queen Elizabeth and James Paget will be approved.

While the 'Do as Planned' scenario is not considered as a viable scenario, it is used as **the baseline that clinicians evaluated all the potential scenarios against**. This enables the clinicians to understand the impact of raising clinical standards, maximising neighbourhood health, and reconfiguring acute hospital services against a common baseline (Section 5.1).

3.3 'Do Minimum' scenario

The second comparison scenario – the 'Do Minimum' – projects the Group's position if it also achieves the neighbourhood care vision and delivers enhanced clinical standards, on top of the 'Do as Planned' assumptions. It represents the best financial position the Group can achieve without changing where acute hospital services are provided.

Assumptions

The 'Do Minimum' scenario assumes:

- **Clinical standards improve at every site to an enhanced level agreed by clinicians as required to deliver safe and high-quality care.** The clinical working groups outlined additional staffing required across unplanned care and women and children's services to create sufficient cover for 24/7 senior decision-making:
  - **Additional unplanned care staffing:** ~15 ED consultants across all three Trusts to provide enhanced levels of senior decision-making cover and 3 surgical registrars to improve staffing cover overnight
  - **Additional unplanned women and children's staffing:** ~10 WTE obstetrics residents, ~18 WTE midwifes / nurses, ~10 WTE paeds & neonatal nurses
- **The shift to neighbourhood care goes further than the NHP assumes,** by delivering additional 'left shift' and activity avoidance across all three Trusts. The initiatives and assumptions behind this assumption are described in full in Section 4: 'Neighbourhood Max'.
- 'Do as Planned' assumptions (full delivery of the MTFP, stabilisation of fragile services, full delivery of New Hospital Programme (NHP) 'left-shift' assumptions)

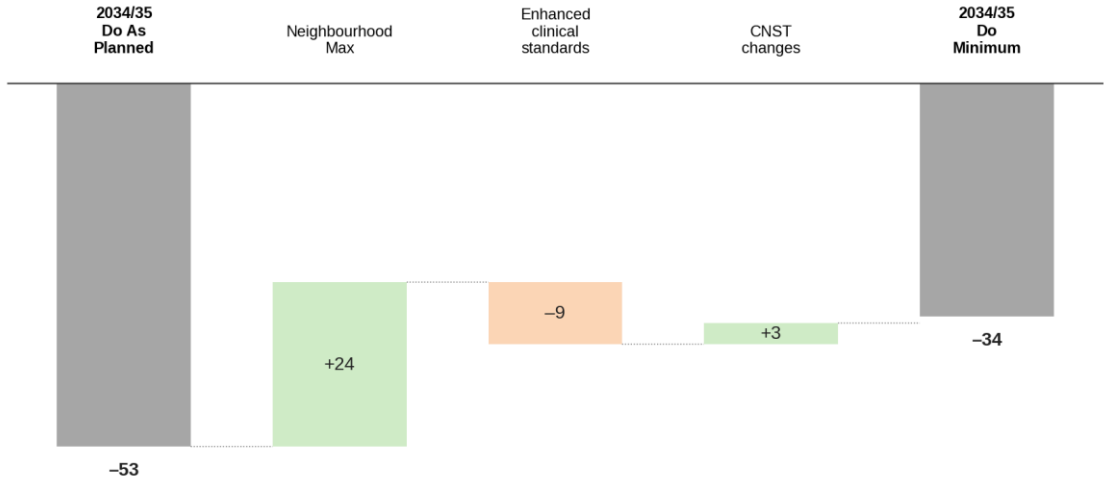
Financial position

The 'Do Minimum' builds on the projected £53m deficit in 2034/35 under the 'Do As Planned' scenario.

The activity avoidance associated with delivering 'Neighbourhood Max' improves the financial position by £24m. Delivering the enhanced clinical standards increases expenditure by £9m, and results in quality and safety benefits, for example reduced CNST premiums of approximately ~£3m per year.

The 'Do Minimum' therefore leaves a structural deficit of £34m a year by 2034/35 (Figure 7).

Figure 7: 'Do Minimum': NWUHG surplus / (deficit) by intervention, £m, 2034/35



Source: NWUHG financial modelling. Neighbourhood Max follows the same phasing as the NHP and includes only activity avoidance beyond the NHP assumptions. Assumptions are being confirmed with the NWUHG finance team.

How the Neighbourhood Max saving is built up

The Neighbourhood Max saving is the net effect of two things: the cost the Group no longer incurs when activity is avoided or moved out of hospital, and the income the Group no longer receives for that activity. The saving arises in four areas:

- **Emergency bed days:** about 93,900 fewer emergency bed days a year by 2034/35 (around 280 beds at 92% occupancy), allowing wards to be closed or repurposed. This is the largest source of saving.
- **Emergency admissions and A&E attendances:** about 8,300 fewer emergency admissions and 17,400 fewer A&E attendances a year.
- **Outpatients:** about 271,000 outpatient attendances a year moved into community settings.
- **Day cases:** about 10,500 day cases a year moved into community settings.

Against this, the Group loses the **income** attached to the avoided activity. The income the Group is losing can be used by the ICB to fund the costs of delivering the enhanced neighbourhood activity (Table 4).

The net saving therefore depends on how far costs associated with delivering the lost activity can be taken out (in particular, closing beds rather than refilling them) and on the payment mechanism in place in 2034/35. As a significant proportion of the avoided or moved activity relates to non-elective care where the Group loses money on every patient, there is a net financial benefit of the neighbourhood shift.

Table 4: Neighbourhood Max: cost saving, income forgone and net saving by activity type, £m, 2034/35

	Activity avoided or moved, 2034/35	Cost saving (£m)	Income forgone (£m)	Net saving (£m)
Emergency bed days	**~93,900 bed days (~280 beds)**	**£50m**	**£34m**	**£16m**
Emergency admissions and A&E	**~8,300 admissions; ~17,400 attendances**	**£7m**	**£5m**	**£2m**
Elective care (outpatients & day cases)	**~271,000 outpatient attendances; ~10,500 day cases**	**£61m**	**£54m**	**£7m**
Total		**£118m**	**£93m**	**£25m**

Conclusion

Clinicians agreed that the 'Do Minimum' scenario does not enable the Trust to resolve the **financial and clinical viability challenges** outlined in the Case for Change as the Group cannot operate with a projected £34m annual deficit.

Therefore, the clinicians agreed to explore potential hospital reconfiguration scenarios to see if they would allow the delivery of enhanced clinical standards in a financially sustainable delivery model.

In the following chapters, the 'Do Minimum' is used to compare potential reconfiguration scenarios against the current three-site model with enhanced clinical standards (Sections 9 and 10). It is also used as the baseline to calculate the **financial impact** of reconfiguration scenarios, by quantifying the top-down change in costs when the location of where services are delivered is changed (Section 11).

4. ‘Neighbourhood max’: modelling the impact on our hospitals

4.1 Summary

The Case for Change sets out why neighbourhood health is central to our future model of care. This paper sets out how much hospital activity it could take out of our three sites, and how we reached that answer.

We modelled 30 neighbourhood interventions, each grounded in published evidence and applied to the records of the patients our hospitals actually treated in 2024/25. Each intervention was assigned a range of potential impact from low to high, and the results set out below pertain to the ‘high impact’ scenario.

By 2034/35 and on top of the reductions already assumed in the New Hospital Programme (NHP) plan, neighbourhood health could take out about 93,900 bed days a year, roughly 280 beds at 92% occupancy: 107 at JPUH, 69 at QEH and 104 at NNUH. It could also avoid about 8,300 emergency admissions and 17,400 A&E attendances a year, and move about 271,000 outpatient attendances and 10,500 day cases into community settings.

The estimate of potentially avoidable bed days is constituted of multiple components. The NHP plan already takes out about 507 beds' worth of activity by 2034/35. That plan is a mix of two kinds of change: about 208 beds come from hospital efficiency and productivity (such as same-day emergency care and shorter planned stays), and about 299 from changes delivered by neighbourhood services (such as frailty, falls and long-term condition management). Our neighbourhood interventions add 280 beds on top. Of the 787 beds' worth taken out in total (230 at JPUH, 203 at QEH and 353 at NNUH), about 579 (74%) depend on neighbourhood services. Figure 8 and Table 5 show the split for each hospital.

Figure 8: Beds’ worth of activity taken out by 2034/35, by hospital and by source

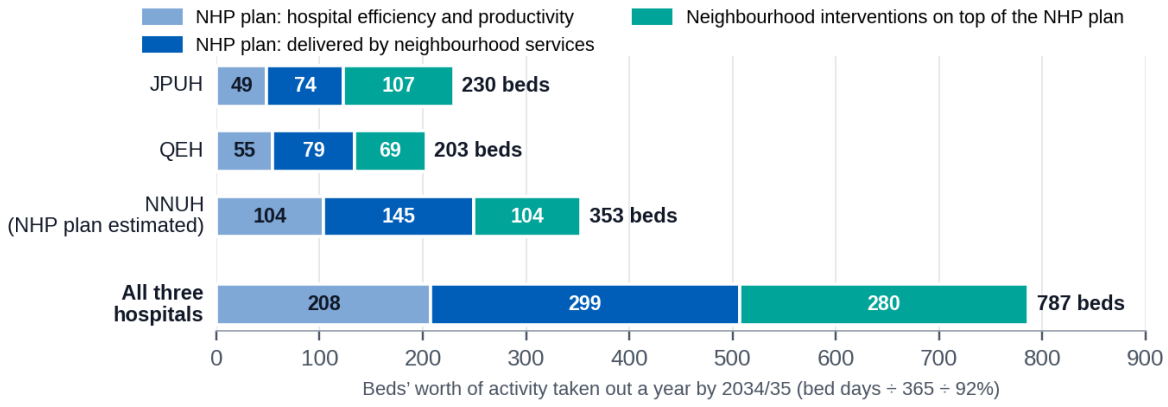


Table 5: Beds by hospital, 2034/35 (bed days ÷ 365 ÷ 92% occupancy)

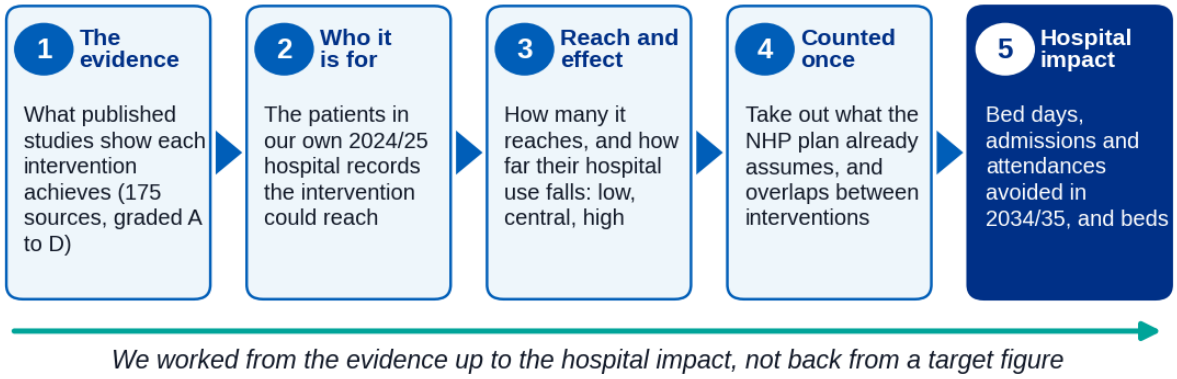
	JPUH	QEH	NNUH (NHP plan estimated)	All three
Today (2024/25)	**577**	**597**	**1,262**	**2,436**
Growth in demand to 2034/35	+101	+106	+150	+358
NHP plan: hospital efficiency and productivity	−49	−55	−104	−208
NHP plan: delivered by neighbourhood services	−74	−79	−145	−299
Neighbourhood interventions on top of the NHP plan	−107	−69	−104	−280
2034/35	**448**	**500**	**1,059**	**2,007**
Of the reductions, delivered by neighbourhood services	**181 of 230**	**148 of 203**	**249 of 353**	**579 of 787**

The above figures must be interpreted with two facts in mind. First, NNUH has no NHP scheme, so its NHP rows are our estimate, built from the rates in the JPUH and QEH plans; this lets all three hospitals be read on the same basis. Second, our interventions count only what is additional to the NHP plan. Where the plan already claims more of the same community-delivered reductions, the interventions add less on top: the plan takes out about a third of what they would otherwise achieve at JPUH, nearly half at NNUH and three-fifths at QEH. That is why NNUH, twice the size of JPUH, gains about the same. The full contribution of neighbourhood services is the NHP plan's community-delivered part plus the interventions on top.

4.2 How we approached the modelling

We started with the interventions and worked up to the hospital impact. We did not start from a target, such as a number of beds to close, and work backwards to find interventions that might deliver it. We chose this approach for three reasons.

Figure 9: How each figure is built, from the evidence up



- **Neighbourhood health is a whole-system change.** The care that avoids an admission happens in general practice, community services, social care, hospices and the voluntary sector, not in our hospitals. A target expressed in hospital beds tells

none of those partners what they need to do. Building up from the interventions shows each partner what its service is expected to deliver, and what the hospitals can expect in return.

- **Any modelled reduction must be traceable back to the intervention driving it.** Every bed day in our figures can be traced to a named intervention, a defined group of patients in our own records, and the published evidence for its effect. If a figure is challenged, it can be followed back step by step; if delivery falls short, we can see which link in the chain has broken.
- **Modelling impact from the bottom up ensures objectivity.** We did not choose a number and then look for evidence to support it. We started from what has actually been achieved, in trials, evaluations and named NHS services, and let that evidence set the range. Where the evidence is weak we have graded it as weak; where it shows no effect, or harm, we have taken that into account.

Two rules apply throughout. First, we count only what is additional to the NHP plan, which already assumes some reductions that depend on community services; counting those again would overstate the opportunity. Second, each bed day is counted once, however many interventions might act on the same patient.

4.3 What we modelled

The 30 interventions span the four components of neighbourhood health set out in Part 1, from smoking cessation and falls prevention to virtual wards and discharge to assess. Some avoid hospital care altogether; others provide the same care in a community setting. They were drawn from 119 potential schemes our own teams have been developing as part of the Neighbourhood Programme, the NHP's assumptions, national service frameworks for specific conditions, and the wider evidence. For each one we defined:

- **who it is for**, in terms we can find in hospital records (for example, emergency admissions for a fall among people aged 65 and over);
- **its reach**: the share of those patients it could realistically get to; and
- **its effect**: how far their use of hospital falls, from the evidence.

The evidence base runs to 175 sources, each graded from A (systematic reviews, trials and controlled evaluations) to D (claims without measured impact). Appendix 2G lists every intervention with its effect, reach and evidence grade; Appendix 2D gives the central and low cases.

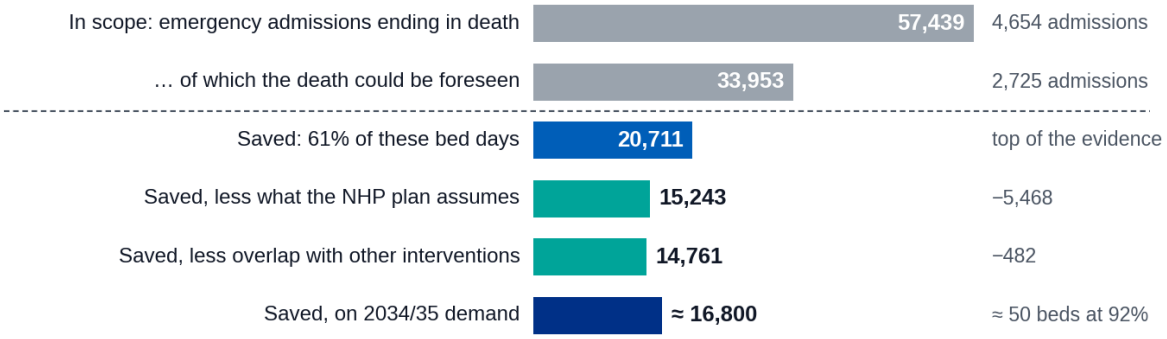
4.4 A worked example: palliative and end-of-life care at home

Many people who die in our hospitals were admitted as an emergency in their final days or weeks. For some, death could have been foreseen. With specialist palliative care at home (home nursing, an out-of-hours response and hospice-at-home capacity), many would be cared for at home, which is where many people say they would prefer to die. The steps below, summarised in Figure 10, follow the calculation through for our three hospitals.

1. **Who it is for.** In 2024/25, 4,654 emergency admissions to our hospitals ended in death, using 57,439 bed days. We kept only deaths that could reasonably have been foreseen: a condition for which palliative care is recognised, or an emergency admission in the previous year. That leaves 2,725 admissions and 33,953 bed days. Sudden deaths, such as a heart attack with no previous history, are outside the group.
2. **Reach.** We assume everyone in the group could be offered specialist care at home: a target, rather than coverage any service has yet achieved. A separate intervention, earlier identification and advance care planning, also acts on some of the same people; that overlap is taken out in step 4.

3. **Effect.** A matched evaluation of Marie Curie home nursing in England found that people receiving it spent 1.6 days in hospital against 4.1 days for similar people without it: 61% fewer. A Cochrane review of 23 studies confirms that home palliative care works in this way. People who receive these services may differ from those who do not, so 61% is the top of the evidence. Applied to the group, it saves 20,711 bed days.

Figure 10: Palliative and end-of-life care at home, all three hospitals (bed days a year)



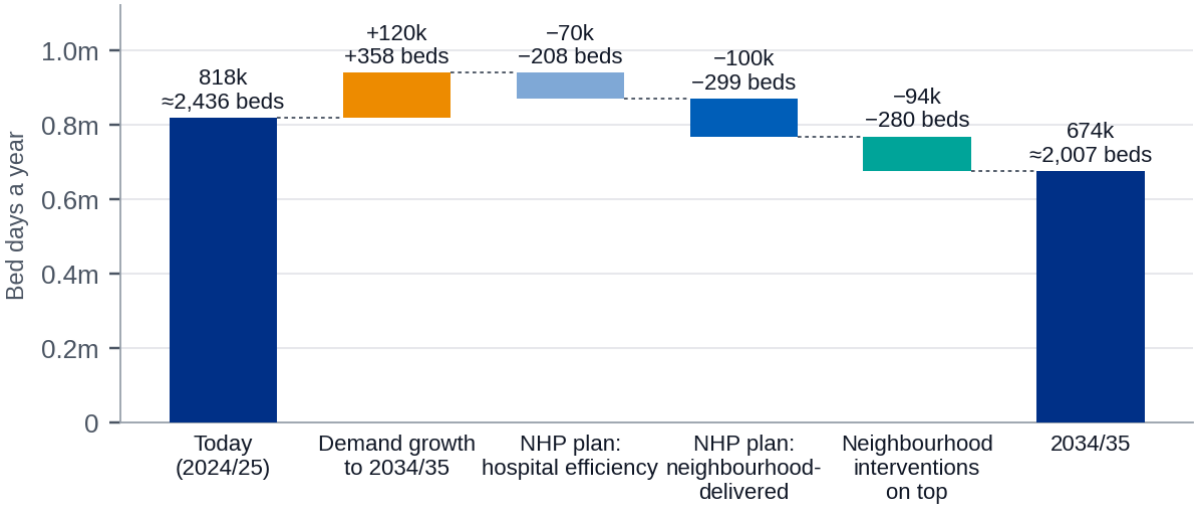
The first five bars are on 2024/25 activity; the last applies the NHP's growth in demand to 2034/35. Steps 4 and 5 are described below.

4. **Counted once.** The NHP plan already assumes fewer admissions in the last fortnight of life, and acts on these patients first, so we take out 5,468 bed days; a further 482 overlap with other interventions, including earlier identification. That leaves 14,761 bed days saved a year on today's activity, and about 1,400 fewer admissions.
5. **Growth and beds.** On 2034/35 demand this is about 16,800 bed days, or 50 beds. As a sense check, the share of Norfolk and Waveney deaths that follow an emergency admission to our hospitals would fall from 36% to 25%.

4.5 What it adds up to

Figure 11 brings the pieces together for our three hospitals. It counts emergency stays and planned stays of one night or more; we leave out day cases, which use trolleys and chairs rather than ward beds. The neighbourhood interventions act on emergency stays; the NHP plan also shortens planned stays.

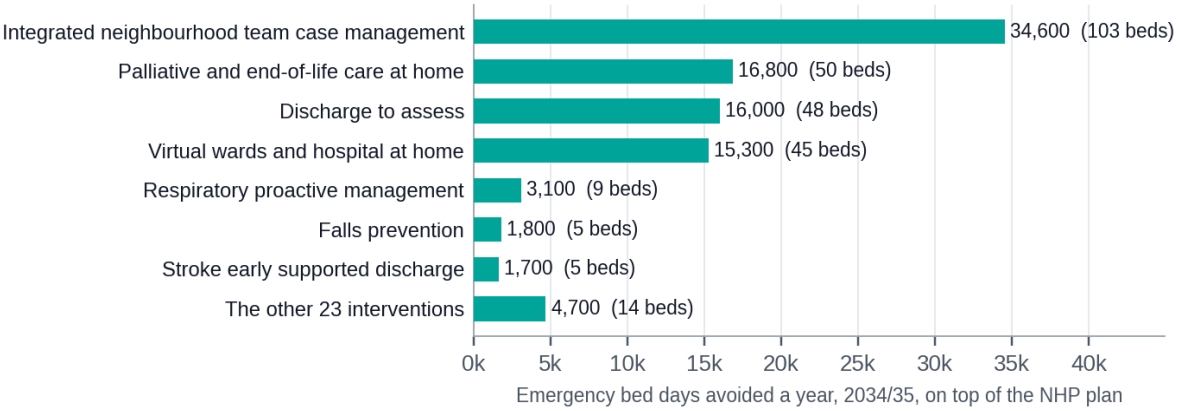
Figure 11: Bed days a year, all three hospitals, 2024/25 to 2034/35



Emergency and planned stays of one night or more. The NHP plan at NNUH is our estimate, because NNUH has no NHP scheme of its own (Appendix 2B).

How we convert bed days into beds. A bed occupied every night accounts for 365 bed days a year, so bed days ÷ 365 gives the average number of beds in use. Hospitals cannot run full and still admit patients promptly, so we divide again by 0.92, the NHS planning standard of 92% occupancy. This is a rough conversion of average activity, not a bed plan: it makes no allowance for winter peaks or specialty mix. At 85% occupancy the figures would be about 8% higher (303 beds for the neighbourhood interventions rather than 280).

Figure 12: Emergency bed days avoided a year in 2034/35, by intervention, on top of the NHP plan



Four interventions provide 88% of the figure (Figure 12). Most of the rest add little to bed days, for one of two main reasons: they act mainly on outpatient or A&E activity, or the NHP plan already assumes as much as the evidence supports (medicines reviews and smoking cessation, for example).

4.6 What the figures do and do not tell us

The figures show the size of the opportunity if neighbourhood health is delivered as well as the best examples elsewhere. The key caveats are below; Appendix 2H has the full list.

- **They are the top of the evidence.** Every intervention is assumed to match the best results achieved by named services. Two choices matter most: discharge to assess at

60% of bed days, and integrated neighbourhood team case management at the top of its evidence.

- **They assume full delivery by 2034/35.** Every intervention is assumed to be fully in place, with the workforce, funding, estate and digital capability it needs outside hospital (Part 1, section 8.1). Most take three to five years to reach full effect. We have not modelled whether that capacity will exist.
- **Freed capacity is not automatically saved.** Beds no longer needed will fill with other demand, such as patients waiting in A&E, unless we plan to close or repurpose them. Outpatient and day-case activity moved into the community still needs staff and space there.
- **The result rests on four interventions.** These four provide 88% of the neighbourhood interventions' figure. If any of them is not delivered at scale, the figure falls accordingly.
- **The figures sit on top of the NHP plan.** They assume the NHP plan is delivered, including the 299 beds' worth that depend on neighbourhood services. The NHP plan at NNUH is our estimate.
- **Beds are approximate.** They are average beds at 92% occupancy, and are not directly comparable with the NHP's own bed numbers, which use a different count and a 2041/42 horizon (Appendix 2F).
- **The evidence comes from elsewhere.** Results here may differ, so each intervention should be evaluated locally as it is introduced.

5. Evaluation criteria and scoring approach

As set out in Section 3, the 'Do Minimum' scenario does not enable the Group to resolve both the clinical and financial viability challenges outlined in the Case for Change (Document 1). The clinicians therefore agreed to explore potential scenarios for reconfiguration of acute hospital services that could resolve the challenges.

The first step in achieving this was to agree a set of evaluation criteria.

5.1 Defining the evaluation criteria

The CAG started by reviewing the eight core design principles at the start of the programme.

As set out in full in the Case for Change (Document 1), the eight design principles (Figure 13) draw on what patients and communities have told us matters to them and on clinicians' judgement of what is required to provide safe, high-quality and sustainable care. The principles set the bar for any future delivery model.

The CAG used the design principles to develop an extensive list of **20 criteria across six areas**: safety, quality, patient impact, workforce, system impact, and finance (Table 6).

Figure 13: Design principles agreed by the Clinical Advisory Group



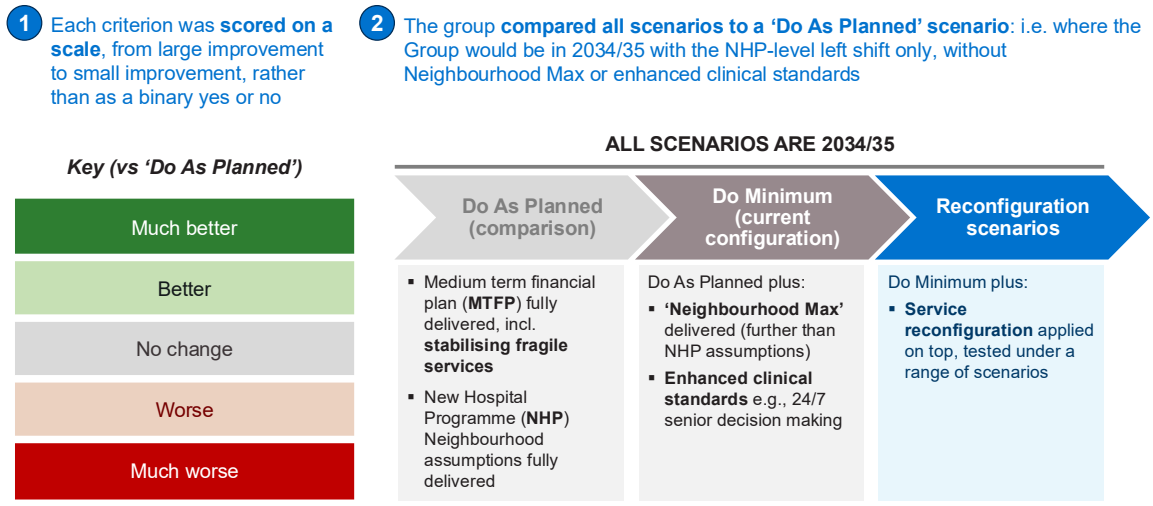
Table 6: Evaluation criteria agreed by the Clinical Advisory Group

Area	Criteria	Evaluation methodology
Safety	Will this improve safety for complex care?	Clinicians evaluated each scenarios against all criteria using a **relative scoring approach** compared against the 'Do As Planned' position on a **five-point scale**, from 'much better' to 'much worse'
	Will this improve safety for normal routine care?	
Quality	Will patient outcomes improve?	
	Availability of 24/7 assessment by senior decision maker	
	Availability of 24/7 treatment by senior decision maker	
	Ability to manage complex patients	
Patient impact	Impact on patient access (travel times)	
	Impact on patient access (number of patients affected)	
	Impact on health inequalities	
	Impact on patient choice	
Workforce	Workforce sustainability / ability to recruit & retain	
	Ability to train and develop	
	Service resilience based on staffing cover	
System impact	Care close to home / in the neighbourhood	
	Ability to join up primary & secondary care	
	Impact on New Hospital Programme (timeline & cost)	
	Impact on neighbouring systems	
	Impact on ambulance service	
Finance	Impact on Group financial position	High level quantitative analysis of impact (see Chapter 11)
	Impact on capital affordability	

5.2 Evaluation approach

The majority of the criteria (all except impact on Group financial position and capital affordability) were evaluated by the CAG using a **relative scoring approach** where each scenario was compared against the 'Do As Planned' position on a five-point scale, from 'much better' to 'much worse', rather than as a binary yes or no (Figure 14).

Figure 14: Five-point relative scoring scale used by the CAG



The impacts on the financial position and capital requirements were not scored by the clinicians; the methodology and impact under each scenario were quantified separately and are set out in Section 11.

6. Evaluating the baseline scenarios

Before exploring potential reconfiguration scenarios, the CAG scored the two baseline scenarios against the non-financial criteria set out in Section 5.1. This shows what could be achieved without changing where services are provided, and the gaps that any reconfiguration scenario would need to close. The financial impact was assessed separately (see Section 11).

6.1 'Do As Planned'

The 'Do As Planned' is the reference point for the evaluation, so by definition it scores 'no change' against every criterion. As discussed in Section 3, it is not a viable future scenario in its own right (Section 3.2).

6.2 'Do Minimum'

The CAG's evaluation of the 'Do Minimum' scenario for unplanned care and for women and children's services, compared to the 'Do as Planned' scenario is shown in Figures 15 and 16 below.

Unplanned care

The clinicians agreed the 'Do Minimum' would **improve** safety for routine care, patient outcomes and the availability of 24/7 assessment and treatment by a senior decision maker compared to the 'Do as Planned' scenario, as the enhanced clinical standards and increased senior decision-making cover take effect.

Additionally, it scores **much better** on care close to home, reflecting the impact of the 'Neighbourhood Max' initiatives, and better on health inequalities and joining up primary and secondary care.

Because no services move, there is no change on travel times, the number of patients affected, patient choice, neighbouring systems or the ambulance service. It was agreed it does not improve safety or quality for complex patients because they would remain spread across all three sites.

Finally, the 'Do Minimum' **scores worse** on all three workforce criteria (sustainability and recruitment, training and development, and service resilience) as the enhanced clinical standards will increase workforce requirements, making it more challenging to recruit, train and provide effective staffing cover across three sites.

Figure 15: CAG evaluation of the 'Do Minimum' against the 'Do As Planned': unplanned care

Scenarios	'Do as planned' (2034/35)	'Do Minimum' (2034/35)
Description	**3x sites as is + MTFP delivery + NHP 'left-shift'**	**'Do as Planned'** + 'Neighbourhood max' + enhanced clinical standards
ED - complex (Type 1)	x3	x3
Unselected medical take	x3	x3
Emerging scenario for further validation	N/A	✓

Area	Criteria		
Safety	Will this improve safety for complex care?		
	Will this improve safety for normal routine care?		
Quality	Will patient outcomes improve?		
	Availability of 24/7 assessment by senior decision maker		
	Availability of 24/7 treatment by senior decision maker		
	Ability to manage complex patients		
Patient impact	Impact on patient access (travel times)		
	Impact on patient access (number of patients affected)		
	Impact on health inequalities		
	Impact on patient choice		
Workforce	Workforce sustainability / ability to recruit & retain		
	Ability to train and develop		
	Service resilience based on staffing cover		
System impact	Care close to home / in the neighbourhood		
	Ability to join up primary - secondary care		
	Impact on NHP - timeline & cost		
	Impact on neighbouring systems		
	Impact on ambulance service		

Key (vs 'do as planned'): Much better | Better | No change | Worse | Much worse

Women & Children

The evaluation of the 'Do Minimum' is similar for pattern is similar for Women and Children. The 'Do Minimum' improves safety for routine care, outcomes and 24/7 senior cover, and scores much better on care close to home, with no change on access, choice or system impacts because births stay local. It does not improve safety for complex births or the ability to manage complex patients, and it scores worse on workforce sustainability and service resilience, because the QEH and JPUH units would remain well below a sustainable size.

Figure 16: CAG evaluation of the 'Do Minimum' against the 'Do As Planned': women and children's services

Example scenarios		'Do as planned' (2034/35)	'Do Minimum' (2034/35)
Description		3x sites as is + MTFP delivery + NHP 'left-shift'	'Do as Planned' + 'Neighbourhood max' + enhanced clinical standards sites
Births / Neonatal / IP Paeds		x3	x3
Emergency surgery 24/7		x3	x3
Area	**Criteria**		
Safety	Will this improve safety for complex care?		
	Will this improve safety for normal routine care?		
Quality	Will patient outcomes improve?		
	Availability of 24/7 assessment by senior decision maker		
	Availability of 24/7 treatment by senior decision maker		
	Ability to manage complex patients		
Patient impact	Impact on patient access (travel times)		
	Impact on patient access (number of patients affected)		
	Impact on health inequalities		
	Impact on patient choice		
Workforce	Workforce sustainability / ability to recruit & retain		
	Ability to train and develop		
	Service resilience based on staffing cover		
System impact	Care close to home / in the neighbourhood (Antenatal & Postnatal care)		
	Ability to join up primary - secondary care		
	Impact on NHP - timeline & cost		
	Impact on neighbouring systems		
	Impact on ambulance service		

Key (vs 'do as planned'): Much better | Better | No change | Worse | Much worse

Planned care

The 'Do Minimum' was not scored for planned care, as the planned care working group clinicians agreed the planned care model does not require reconfiguration – see Section 8.

Conclusion

In summary, the 'Do Minimum' delivers real improvements in routine care, senior cover and care close to home without moving any services. But it leaves two problems unresolved: complex care remains spread across three sites, and the workforce position gets worse rather than better. These are the gaps that the reconfiguration scenarios in Chapters 8 to 10 were developed to address.

3.2 'Financial evaluation of baseline scenarios

As stated in Section 3, the financial evaluation of the 'Do as Planned' showed that both positions result in unsustainable financial positions for the Group by 2034/35 (Table 7).

The 'Do As Planned' is projected to leave the Group with a £53m structural deficit per year (annual loss) by 2034/35, despite assuming full delivery of the highly ambitious Medium Term Financial Plan (MTFP) and the New Hospital Programme's (NHP) assumptions on 'left shift' of activity.

The 'Do Minimum' scenario assumes the Group pushes the delivery of the 'Neighbourhood Max' scenario and enhanced clinical standards on top of the 'Do as Planned'. This result is a projected £34m structural deficit per year (annual loss) by 2034/35.

Table 7: Overview of the 'Do As Planned' and 'Do Minimum' scenarios

Scenario	Overview	Projected financial position in 2034/35
'Do As Planned' (from Document 1)	The position the Group would reach by 2034/35 if: ▪ The Group's Medium Term Financial Plan (MTFP) is full delivered, requiring £263m of cost improvement programmes (CIPs) over three years and the stabilisation of fragile services, to reduce the deficit to £5m by 2028/29 ▪ The New Hospital Programme (NHP) has built in assumptions around the 'left shift' of activity from hospitals to neighbourhood services, phased in from 2029/30	£53m deficit
'Do Minimum'	'Do As Planned', plus: • 'Neighbourhood Max' delivered, beyond the NHP assumptions • Enhanced clinical standards, including 24/7 senior decision-making	£34m deficit

7. Developing reconfiguration scenarios

7.1 Scenario development approach

The starting point for the scenario development was the previous work undertaken by the Group in early 2026, which identified five broad scenarios for the configuration of acute services, ranging from retaining all core acute services at all three sites to consolidating them at a single site.

However, this initial work range did not provide a concise set of potential scenarios or provide the necessary clinical engagement to progress the scenarios to the next phase. This phase of work was launched with the objective to define and evaluate scenarios through a principle-led approach that engaged clinicians from a wide range of services across all three Trusts.

The CAG agreed that all potential scenarios need to align with:

- **The 8 design principles:** As set out in full in the Case for Change (Document 1), the CAG agreed eight design principles (Figure 13) that draw on what patients and communities have told us matters to them and on clinicians' judgement of what is required to provide safe, high-quality and sustainable care.
- **An anchor objective:** The CAG agreed that the overarching goal of any hospital reconfiguration is to **maximise the number of patients treated at their local hospital site or within their neighbourhood**, while staying within the Group's financial constraints.

7.2 Maximising the volume of patients treated locally

To achieve the anchor objective of maximising the number of patients who will always be cared for locally in the community or at the hospital that is closest to their place of residence, the clinical groups defined a set of **minimum requirements.**

These requirements form a **base model** for all sites under any reconfiguration scenario and create a **clear vision** for how care will be different by 2034/35 across maternity, unplanned, and planned care (Table 8).

Delivering the requirements doesn't mean that care will be delivered in the same way as today as they require major changes in clinical practice.

Planned care

All sites will have enhanced recovery and robotics, which will mean that many people admitted as inpatients now will be able to be looked after in day surgery in the future.

Unplanned Care

All sites will run medical, surgical and paediatric same day emergency care (SDEC) services which are consultant delivered and with quick access to both diagnostics and availability for interventions (e.g. emergency operating theatres). This will mean that approximately 50% of inpatient stayers that are currently admitted for less than 2 days will instead be treated as day admissions via SDEC.

Maternity

Delivery units for births will be supported by a strong foundation of enhanced ante and post-natal care, largely delivered in the community. This is critical to achieving the best maternal outcomes.

Table 8: Minimum requirements for all sites under any reconfiguration scenario

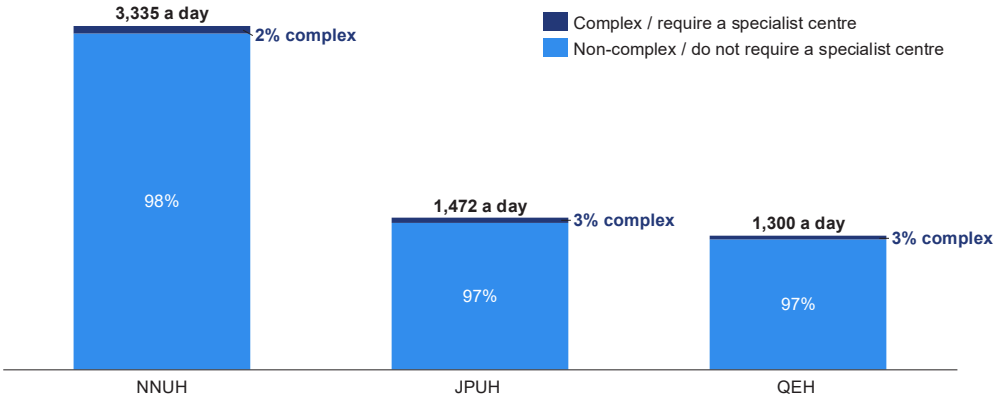
Service area	Base service model
Maternity	**Community and neighbourhood hubs (antenatal and postnatal care)** • Midwives based in community hubs across Norfolk and Waveney, with access to obstetricians on site or virtually • Hubs offer ultrasound scans, community midwife appointments, glucose tolerance tests, postnatal checks and neonatal outreach, reducing the need to travel to hospital • A single home birth team distributed across the geography • Neonatal outreach to help families return home sooner • Vulnerable women's teams replicated across all three Trusts
Unplanned care	• 24/7 urgent treatment centre • SDEC for surgery, medicine and paediatrics, 08:00–22:00 (except for paediatric SDEC which is 24/7) • Full range of diagnostics • Medical beds and all non-complex emergency admissions of under 48 hours
Planned care	• Full range of outpatients and diagnostics • Day surgery, including 23-hour enhanced recovery and robotics

7.3 Routine care

When these minimum requirements are applied to the Group's 2025/26 activity – we find that **at least 97% of patients** across planned, unplanned and maternity care is routine care that **will continue to be treated in the hospital or community closest to where they live, under any reconfiguration scenario (Figure 17)**.

The 97% of patients that would remain local whichever scenario is chosen, includes outpatients, diagnostics, day surgery, urgent treatment, same-day emergency care, short medical stays, inpatients not requiring critical care, and antenatal and postnatal care.

Figure 17: Average daily activity by complexity and Trust, number, April 2025 to February 2026



Activity includes adult and paediatric unplanned care (ED and SDEC attendances, inpatient admissions), planned care (outpatients, elective admissions, day cases) and women's and children's care (deliveries, neonatology). Source: NWUHG inpatient, ED and outpatient datasets.

7.4 Complex care

The remaining 3% are complex patients that require a specialist centre and could therefore potentially benefit from services being consolidation onto fewer sites. This cohort includes:

- **Unplanned care:** high-acuity presentations and procedures:
  - Cardiac arrest and primary PCI
  - Stroke
  - GI Bleed
  - Complex Trauma
  - Fractured neck of femur (to ensure prompt operation by specialist surgeon and dedicated ortho-geriatricians but with repatriation soon after surgery)
  - Paediatric inpatient spells over 24 hours
  - Adult inpatient spells over 48 hours for patients aged 18 to 80
  - Patients needing emergency surgery operating between 22:00 and 08:00
- **Planned care:** elective inpatient activity (mostly complex cancer surgery) at QEH and JPUH, apart from trauma and orthopaedics at JPUH
- **Obstetrics and neonatology:** all deliveries and neonatal care

This means that the **maximum proportion of patients that could move from QEH or JPUH under any reconfiguration scenario is 3%.** The rest of this document focuses what the model of care could look like for the ~3% of patients whose care could benefit from consolidation, and only evaluates scenarios where at least 97% of patients remain at their local site.

7.5 Fixed points for all reconfiguration scenarios

To narrow the potential scenarios for the 3% of complex patients further, the CAG agreed a number of fixed points that apply to every scenario (Figure 18):

- **Unplanned care:** NNUH will provide complex care and treat patients with the highest-acuity conditions: stroke, cardiac arrest, complex trauma (including fractured neck of femur and GI bleeds) and those requiring interventional radiology
- **Critical care:** the number of high-dependency and intensive care beds on each site will be determined by the clinical services provided on that site
- **Women and children:** NNUH is the hospital for maternal medicine and complex births in Norfolk, given the range of clinical support available. Any site that delivers babies must have 24/7 emergency surgery, and a site with no delivery suite will not have a neonatal unit or inpatient paediatrics

Figure 18: Fixed points for all reconfiguration scenarios

Unplanned care	**NNUH will provide complex care and treat patients with the highest-acuity conditions**: stroke, cardiac arrest, complex trauma (including fractured NOF and GI bleeds) and those requiring interventional radiology
Critical care	The disposition of **high dependency and intensive care beds** on each site would be based on the clinical services provided on the site
Women and children	▪ A place with **no delivery suite** will not have a neonatal unit or inpatient paediatrics ▪ NNUH is the hospital for **complex births** in Norfolk because of the range of clinical support available ▪ A site that delivers births **must have emergency surgery 24/7** CAG has **ruled out:** ▪ **Balancing births across 3 sites**, as there are not enough low-complexity or planned Caesareans to create an even distribution ▪ **Midwife-led units and Caesarean section hubs** because insufficient women would be eligible without providing full back up of obstetric, neonatal, paediatric, emergency surgery and adult critical care

8. Planned care

Clinicians have agreed not to reconfigure the current planned care model – this means that **over 99% of planned care patients will continue to be treated at their local site, or closer to home in the neighbourhood,** helping the Group to achieve its anchor objective.

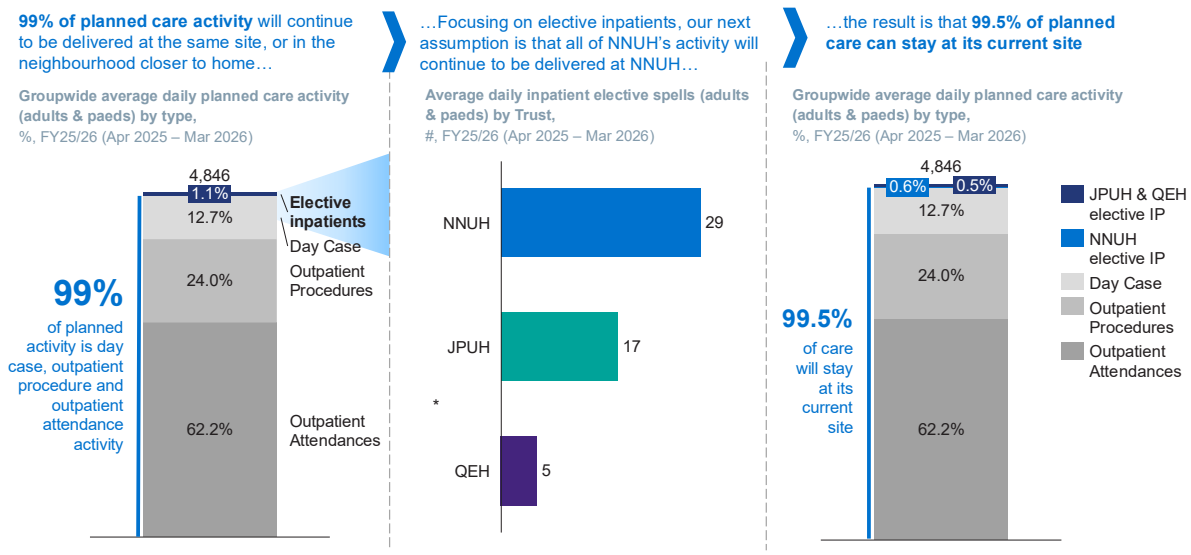
8.1 Exploring future models of planned care

As part of the baseline activity exercise, the planned care working group developed a baseline of current planned activity across the Group and explored the implications for where planned care could be delivered in future (Figure 19).

The key insights from the baseline were:

- **99% of planned care is outpatient or day case activity which will continue to be delivered at its current site.** Of the Group's ~5,000 planned care contacts a day in 2025/26, 62% were outpatient attendances, 24% outpatient procedures and 13% day cases. The CWG agreed all this activity should continue to be delivered at the same site, or move into the neighbourhood closer to home.
- **Of the remaining ~1% - the majority is already delivered at NNUH and will continue to be delivered at NNUH.** This is around 51 spells a day: 29 at NNUH, 17 at JPUH and 5 at QEH. The CWG agreed there is potential to consolidate delivery of elective inpatient activity across NNUH, JPUH and QEH, but that JPUH's inpatient joint replacement (T&O) function should be retained.
- **The result is that at least 99.5% of all current planned care will stay at its current site**

Figure 19: Baseline of current planned care activity across the Group



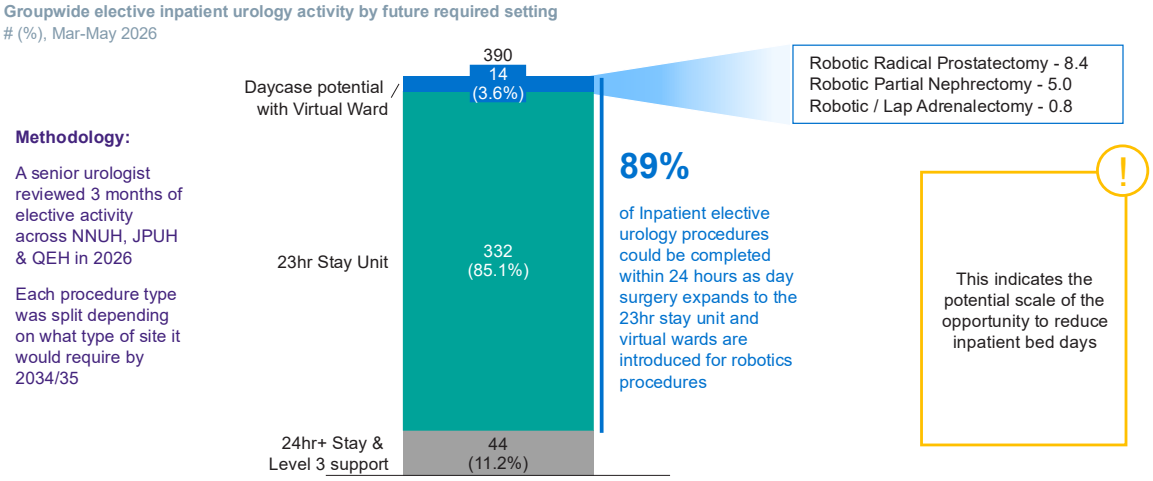
The planned care CWG also explored the potential for likely innovations by 2034/35 to transform how existing planned care activity is performed. A specialty-level deep-dive was conducted by a senior urologist who reviewed three months of elective inpatient urology across all three sites and assessed what setting each procedure Healthcare Resource

Group (HRG) would likely need by 2034/35, assuming all sites had **23-hour enhanced recovery and robotic surgery (Figure 20)**.

The urologist estimates that 89% of current elective inpatient activity **could be delivered within 24 hours as day surgery expands to the 23hr stay unit and virtual wards are introduced for robotics procedures 24 hours.** Only 11% (44 cases) would need a stay of more than 24 hours or level 3 support.

This indicates the significant opportunity for technological innovations to reduce inpatient bed day requirements.

Figure 20: Urology deep-dive: setting required for current elective inpatient activity by 2034/35



8.2 Proposed planned care model

The Planned Care Clinical Working Group **aligned on an agreed vision and proposed model for planned care that would be same under every scenario**. This model involves:

- All sites deliver the full range of outpatients and diagnostics, and day surgery
- All sites providing 23-hour enhanced recovery and robotic surgery, enabling more elective inpatient activity to be delivered as day cases
- QEH and JPUH elective inpatient activity is being consolidated at NNUH, but JPUH retains inpatient joint replacement surgery (T&O) as this aligns with new build facility plans
- Neighbourhood hubs and diagnostic centres support delivery of services in the community, and act as centres for disease prevention and health enhancement, linking closely with primary care

8.3 Implications of agreed model

Expanding the complexity and volume of day surgery on all three sites supports the anchor objective: activity that might otherwise be counted among the ~3% that could move is instead treated locally. It also strengthens the case for the new hospitals at QEH and JPUH by giving each a clear and sustainable elective role.

The planned care model does not, however, generate savings relative to the ‘Do Minimum’, and so does not contribute to closing the structural deficit outlined in Section 3.

The proposed model will also mean that a small volume of complex inpatient surgery (largely cancer related) will transfer in scenarios where there is no emergency surgery operation at night (sites without a maternity delivery suite).

9. Unplanned care

Two potential reconfiguration scenarios were considered by the CAG: a selected and unselected medical take. The CAG has agreed to **recommend the unselected medical take scenario as this will enable the maximum number of patients to continue to be treated at their local site,** whilst increasing quality and safety for the most complex patients that require a specialist site.

The **selected** medical take scenario was **not recommended to take forward** due to the adverse impacts on access, neighbouring systems and the ambulance service.

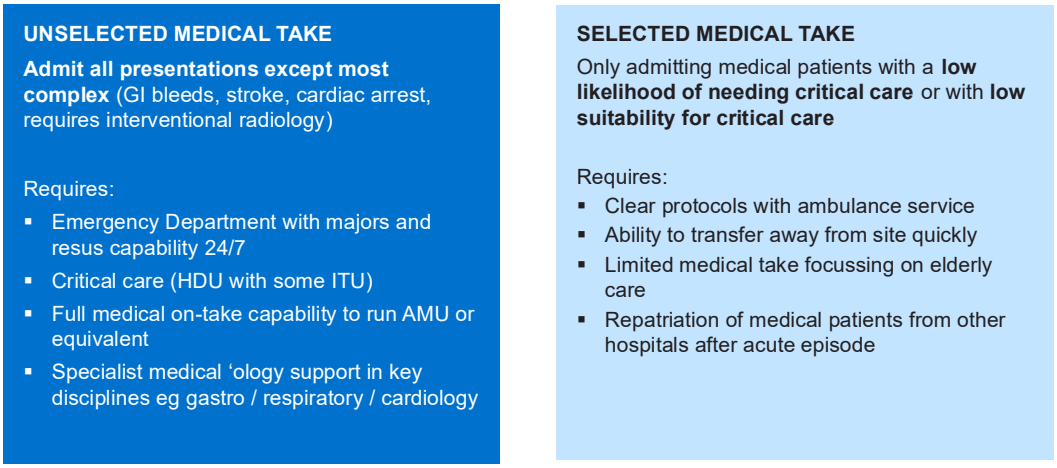
9.1 Scenario development

All unplanned care scenarios were based on the following assumptions and fixed points:

- **NNUH will provide complex care and treat patients with the highest-acuity conditions**: stroke, cardiac arrest, complex trauma (including fractured NOF and GI bleeds) and those requiring interventional radiology
- The disposition of **high dependency and intensive care beds** on each site would be based on the clinical services provided on the site
- All sites will have as a minimum:
    - 24/7 urgent treatment centre
    - SDEC for surgery, medicine and paediatrics; adult SDEC open 08:00–22:00, and paediatric SDEC open 24/7
    - Full range of diagnostics
    - Medical beds and all non-complex emergency admissions of under 48 hours

After reviewing the unplanned care data, clinicians agreed two scenarios for what the medical take could look like at hospital sites: an **unselected medical take** and a **selected medical take**. Figure 21 below outlines the differences between the two.

Figure 21: Unselected and selected medical take: what each admits and what it requires



The key difference between the two scenarios is the complexity of patients each site can admit:

- **Unselected medical take:** the site admits all medical presentations except the most complex (GI bleeds, stroke, cardiac arrest and patients requiring interventional radiology), which go to NNUH.
  To do this safely, the site needs a 24/7 emergency department with majors and resus capability, critical care (HDU with some ITU), full medical on-take capability to run an acute medical unit or equivalent, and specialist medical support in key specialties such as gastroenterology, respiratory medicine and cardiology.
- **Selected medical take:** the site admits only medical patients with a low likelihood of needing critical care, or who would not be suitable for it. This needs clear protocols with the ambulance service, the ability to transfer patients off site quickly, a limited medical take focused on care of older people, and repatriation of medical patients from other hospitals once their acute episode is over.

The selected take therefore needs less on-site infrastructure but depends on more patients being conveyed or transferred elsewhere, which places greater demand on the ambulance service and on NNUH.

Building on the agreed starting point and these two reconfiguration models, the CAG clinicians agreed to **evaluate three potential scenarios:**

- **Scenario 1: As-is.** All three sites continue as today, with a Type 1 emergency department, full medical take, emergency surgery and critical care, with only the highest complexity patients transferring to NNUH
- **Scenario 2: Unselected medical take at QEH and JPUH.** Both sites admit all acute medical patients except the most complex patients and both sites retain an Emergency Department and Critical Care
- **Scenario 3: selected medical take at QEH and JPUH.** Both sites admit only medical patients meeting agreed criteria, with a low likelihood of needing, or low suitability for, critical care.

The key difference between the two reconfiguration scenarios is the complexity of patients QEH and JPUH can admit, and therefore what services each site needs to have in order to do so safely – the full detail of what this looks like is outlined in Table 9 below:

Table 9: Unselected and selected medical take: what would change at QEH and JPUH

	Scenario 2: Unselected medical take	Scenario 3: Selected medical take
Who QEH and JPUH admit	All acute medical presentations except the most complex (e.g. GI bleeds, stroke, cardiac arrest, patients requiring interventional radiology)	Only patients meeting agreed criteria, defined specialties, acuity and referral routes, focused on elderly care
Who transfers to the centre (NNUH)	Complex care (e.g. GI bleeds, stroke, cardiac arrest, patients requiring interventional radiology), non-medical critical care and transfers	Same as unselected, plus any >48 hour stayers that might require critical care
Emergency department	24/7 majors and resus, without complex patients (e.g. trauma, GI bleeds, stroke)	No ED: urgent treatment centre and SDEC only, with no majors or complex patients

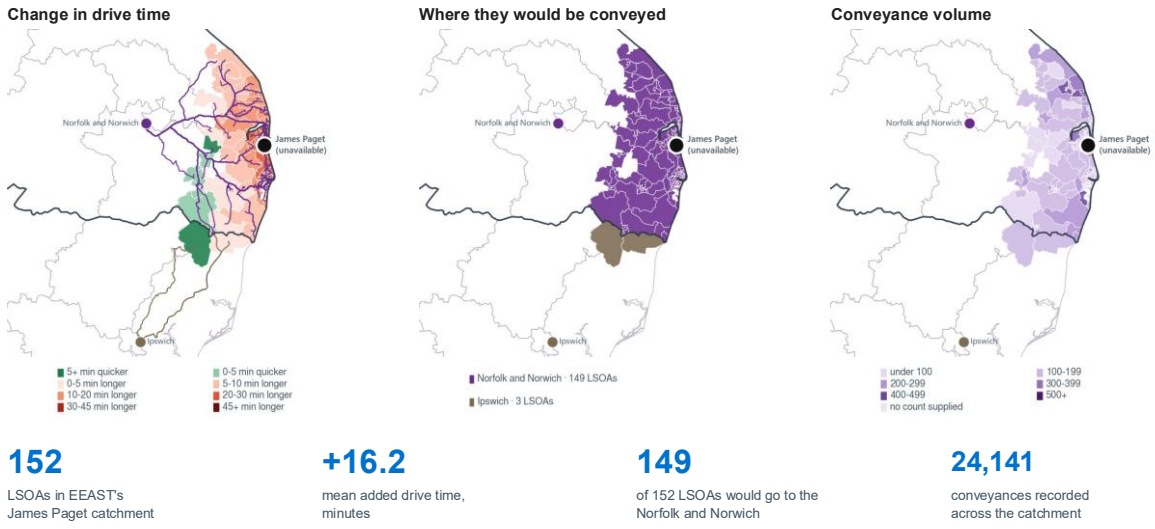
	Scenario 2: Unselected medical take	Scenario 3: Selected medical take
Emergency surgery	SDEC only, with no emergency operating overnight; one surgical registrar on site overnight	SDEC only, with no emergency operating overnight and no patients needing overnight admission
Critical care	Retained, with fewer ITU beds and more HDU beds	Removed
Requirements	Critical care (HDU with some ITU); a full acute medical unit; specialist support in key areas such as gastroenterology, respiratory medicine and cardiology	Clear ambulance protocols; rapid transfer away from site; repatriation after the acute episode

9.2 Impact on patient flows

The travel time criteria was evaluated based on insights from travel time analysis by the East of England Ambulance Service (see Document 1 for detail). Figures 22 and 23 show, for each area currently served by JPUH and QEH, which hospital would be nearest by ambulance if services were no longer provided there. For JPUH, the nearest hospital for almost all patients is NNUH, indicating they would likely remain within the Group; for QEH, around two thirds of patients would have a nearest hospital outside of the Group, mainly Peterborough:

- **JPUH:** ~98% of JPUH patients go to NNUH, ~2% go to Ipswich
- **QEH:** ~29% of QEH patients remain within the Group and transfer to NNUH, ~67% to Peterborough, ~3% go to Addenbrookes Hospital, and ~1% to West Suffolk Hospital

Figure 22: Nearest alternative hospital by ambulance travel time by areas currently served by JPUH, if services were no longer provided there



152
LSOAs in EEAST's James Paget catchment

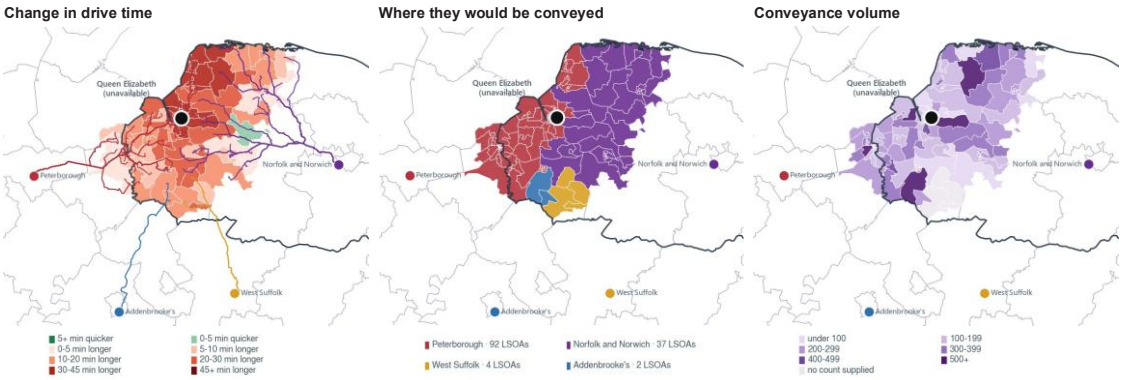
+16.2
mean added drive time, minutes

149
of 152 LSOAs would go to the Norfolk and Norwich

24,141
conveyances recorded across the catchment

Source: EEAST July 2026 workbook; statistics recomputed from their LSOA rows

Figure 23: Nearest alternative hospital by ambulance travel time by areas currently served by QEH, if services were no longer provided there



135
LSOAs in EEAST's Queen Elizabeth catchment

+19.5
mean added drive time, minutes

92
LSOAs re-allocated to Peterborough, a median of 23 minutes further

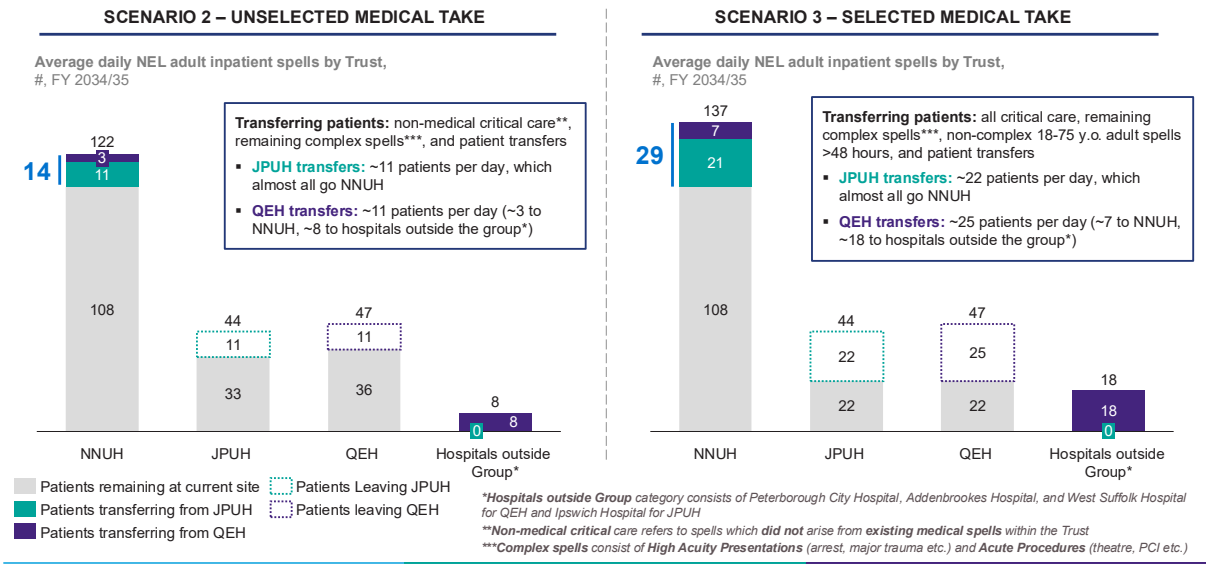
28,128
conveyances recorded across the catchment

Source: EEAST July 2026 workbook; statistics recomputed from their LSOA rows

The unselected and selected medical takes have different levels of impact on patient flows and where activity is delivered (see Figure 24):

- **Unselected take**, 11 patients a day would transfer from each of QEH and JPUH – **22 patients in total**. Almost all JPUH transfers would go to NNUH; of the QEH transfers, around three would go to NNUH and eight to hospitals outside the Group (largely Peterborough). In total, NNUH would receive around 14 additional patients a day.
- **Selected take**, total transfers would roughly double to **47 a day**, with 22 from JPUH and 25 from QEH. Of the 25 daily transfers from QEH, around seven would go to NNUH and 18 to hospitals outside the Group. In total, NNUH would receive around 29 additional patients a day.

Figure 24: Average daily non-elective adult inpatient spells and transfers by hospital, unselected and selected medical take, number, 2034/35



9.3 Scenario evaluation

The CAG scored each scenario against the 'Do as Planned' position (see Figure 25 for full scoring).

Scenario A – Do Minimum: As set out in Section 6, the 'Do Minimum' adds enhanced clinical standards and 'Neighbourhood Max' to the 'Do as Planned'. It scores better on routine care, outcomes, 24/7 senior cover and care close to home. However, it does not improve complex care which stays spread across the three sies, and it scores worse on all three workforce criteria. It is the starting point on which the two reconfiguration scenarios are built.

Scenario 2 – Unselected medical take: The unselected take scores better on safety for complex care, patient outcomes, 24/7 senior assessment and treatment, and the ability to manage complex patients than the 'do minimum'. This reflects concentrating the highest-acuity presentations, such as trauma, GI bleeds and stroke, at NNUH, where senior decision makers are available around the clock, while QEH and JPUH keep a non-complex ED and an unselected medical take so that most routine care stays local. It also scores better on all three workforce criteria. Its main weakness is patient access: it scores much worse on travel times and worse on the number of patients affected, with around 22 patients a day transferring from QEH and JPUH. It also scores worse on neighbouring systems and the ambulance service, reflecting the additional transfers and the around eight QEH patients a day expected to go to hospitals outside the Group.

Scenario 3 – Selected medical take: The selected take scores as well as the unselected take on complex care and 24/7 senior cover, and much better on all three workforce criteria as all complex care is consolidated on one site. However, it scores worse than the unselected take on key criteria: worse on safety for routine care, less well on patient outcomes, much worse on patient access in terms of the number of patients affected, and worse on health inequalities. It also scores much worse on neighbouring systems and the ambulance service, as transfers would roughly double to around 47 a day, with around 18 QEH patients a day going to hospitals outside the Group.

Figure 25: Unplanned care: scoring against the evaluation criteria

Recommended | Not taken forward

All scenarios assume NHP/ Neighbourhood max + enhanced clinical standards

Scenarios	Scenario 1 – Do Minimum 2034/35	Scenario 2	Scenario 3
Description	Do Minimum (3x sites as is)	2x Unselected MT NNUH: As-is QE & JP: Non-complex ED + unselected medical take	2x Selected MT NNUH: As-is QE & JP: UTC & SDEC + selected medical take
ED - complex (Type 1)	x3	x1	x1
ED w/o complex patients		x2	
Unselected medical take	x3	x3	x1
Selected medical take			x2
Emerging scenario for further validation	✓	✓	✗

Area	Criteria
Safety	Will this improve safety for complex care?
	Will this improve safety for normal routine care?
Quality	Will patient outcomes improve?
	Availability of 24/7 assessment by senior decision maker
	Availability of 24/7 treatment by senior decision maker
	Ability to manage complex patients
Patient impact	Impact on patient access (travel times)
	Impact on patient access (number of patients affected)
	Impact on health inequalities
	Impact on patient choice
Workforce	Workforce sustainability / ability to recruit, retain & train
	Ability to train and develop
	Service resilience based on staffing cover
System impact	Care close to home / in the neighbourhood
	Ability to join up primary - secondary care
	Impact on NHP - timeline & cost
	Impact on neighbouring systems
	Impact on ambulance service

Key (vs 'do as planned'): Much better | Better | No change | Worse | Much worse

9.4 Outcome

Overall, the CAG concluded that both the 'Do Minimum' and the unselected take are viable scenarios to take forward for further validation. There was consensus that the **selected take should not be taken forward**, as its workforce, quality and safety for complex patients benefits do not outweigh the negative impact on patient access, neighbouring systems and the ambulance service from significant numbers of patients transferring.

Therefore, the CAG's recommendation is to take forward the 'Do Minimum' scenario alongside the unselected medical take reconfiguration scenario for the next phase of analysis.

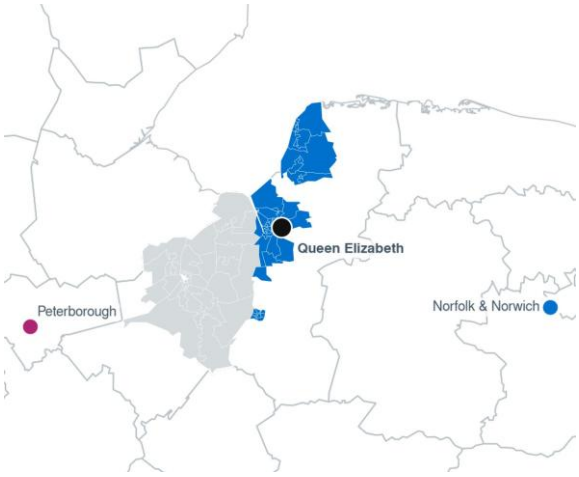
9.5 Mitigations

The key question for this next phase is whether the impact of the unselected medical take on neighbouring hospitals and the ambulance service can be reduced. Based on the nearest hospital alone, around two thirds of patients who would no longer be cared for at QEH would go to hospitals outside the Group, mainly Peterborough.

Potential mitigations to keep more of these patients within the Group include changing the ambulance conveyance strategy for patients where the where the difference in time between a blue light ambulance travelling to Peterborough is only marginally higher than travelling to Norwich.

For example, 54 of 92 LSOAs that are closer to Peterborough than Norwich, are less than 10 minutes further from Norwich than Peterborough (Figure 26). If conveyances from these LSOAs were redirected to Norwich rather than Peterborough, it would increase the share of QEH patients going to NNUH from around 29% to 63%, and it would reduce the impact on Peterborough to less than 5 patients a day. This mitigation would need to be fully assessed by East of England Ambulance Service. Other mitigations are explored in detail in Chapter 13.

Figure 26: Additional drive time for QEH patients by LSOA for ambulance conveyances to Norwich, compared to Peterborough.



Less than 10 minutes further to Norwich (54 areas)
10 minutes or more further (38 areas)

54 of 92
local areas less than 10 minutes further to Norwich than Peterborough

19,077
conveyances across all 92 areas; the 9,561 are 50.1% of these

8,267 Queen Elizabeth conveyances previously modelled to go to Norwich	+	**9,561** added from the 54 areas less than 10 minutes further	=	**17,828** Queen Elizabeth conveyances now modelled to go to Norwich

29% → 63% share of Queen Elizabeth conveyances modelled to go to Norwich

These are Queen Elizabeth catchment conveyances only; they are not the Norfolk and Norwich's total ambulance activity.

EEAST drive times; Norfolk and Norwich on EEAST's Optimistic basis

10. Women and children's services

CAG clinicians recommend four scenarios to be taken forward for further evaluation, including a three-site scenario, variations on two-site scenarios and a single site scenario. Each scenario has its own benefits and trade-offs that will need be evaluated in further detail in the next stage of work.

10.1 Summary of projected demand

As outlined in the case for change (Document 1), deliveries are projected to fall by 9–13% across the Group by 2034/35, before levelling at around 19 a day as birth rates plateau. This means total Group deliveries per year will fall from around 7,900 in 2025/26 to around 6,900 in 2034/35 (Table 10).

Table 10: Annual deliveries by Trust, actual 2025/26 and projected 2034/35

	Actual 2025/26	Projected 2034/35: ONS-based	Projected 2034/35: Trust trend (used for modelling)	Average per day, 2034/35
NNUH	4,693	4,255	4,403	12.1
QEH	1,626	1,474	1,347	3.7
JPUH	1,546	1,402	1,105	3.0
Total	**7,865**	**7,130**	**6,855**	**18.8**

Excludes home births. Trust trend applies each Trust's compound annual growth rate from 2015/16 to 2025/26 (NNUH −1.1%, QEH −3.1%, JPUH −5.4%). Projections carry an amber risk rating, as actual deliveries may vary with patient behaviour, migration and other factors. Source: NWUHG inpatient datasets; ONS population and birth projections (2022-based); Trust analysis.

Deliveries are projected to fall from around 7,900 in 2025/26 to around 6,900 by 2034/35. The CAG agreed that a sustainable delivery suite requires around 3,000 deliveries a year or 7-8 births per day (although there is no national guidance on the number, the CAG felt this is the minimum volume to ensure clinical competence whilst achieving financial sustainability). **Only NNUH's delivery suite is projected to be of a sustainable size by 2034/35.** QEH and JPUH would each perform fewer than four deliveries a day, while still needing to provide cover around the clock.

10.2 Scenario development

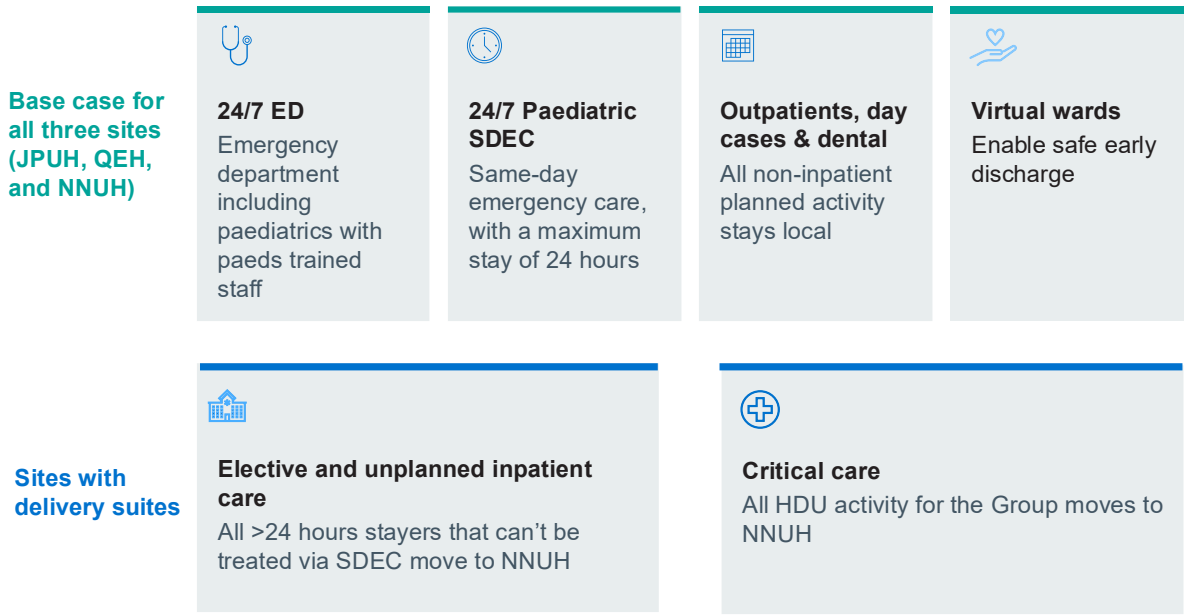
Maternity

All maternity scenarios were based on the following assumptions and fixed points:

- NNUH is the hospital for **complex births** in Norfolk, given the range of clinical support available there
- Every site that delivers births **must have an emergency surgery 24/7**
- **A balanced number of births** is modelled over 3,000 per annum, per site
- Neonatal care and inpatient paediatrics follow the delivery suite, in line with the paediatric model outlined in Figure 27

Figure 27 sets out the base-case model for paediatric care. Every site will provide a core paediatric offer of 24/7 paediatric SDEC, to increase the proportion of children treated locally. Sites with a delivery suite will also have a neonatal unit and inpatient paediatric bed. Children who need admission at a site without these services will be transferred.

Figure 27: Base-case paediatric model by site, showing the core offer at each site and the additional services at sites with a delivery suite



All scenarios assume that the Group's minimum requirements of their neighbourhood vision are delivered (Chapters 3 and 4), including:

- Community and neighbourhood hubs (antenatal and postnatal care)
- Midwives based in community hubs across Norfolk and Waveney, with access to obstetricians on site or virtually
- Hubs will offer ultrasound scans, community midwife appointments, glucose tolerance tests, postnatal checks and neonatal outreach, reducing the need to travel to hospital
- A single home birth team distributed across the geography
- Neonatal outreach to help families return home sooner
- Vulnerable women's teams replicated across all three Trusts
- Enhanced hospital and neonatal provision
- Enhanced senior decision-making through additional consultants and midwives
- Early pregnancy service and daytime acute gynaecology

10.3 Long list development

Working from these fixed points, the CAG developed a long list of seven potential maternity reconfiguration scenarios where:

- **Three sites:** as today, with unbalanced volumes (A1), or with births spread so each unit is a balanced size (A2)
- **Two sites:** NNUH with QEH, or NNUH with JPUH, with each pair either balanced (B1, B2) or unbalanced (B3, B4)

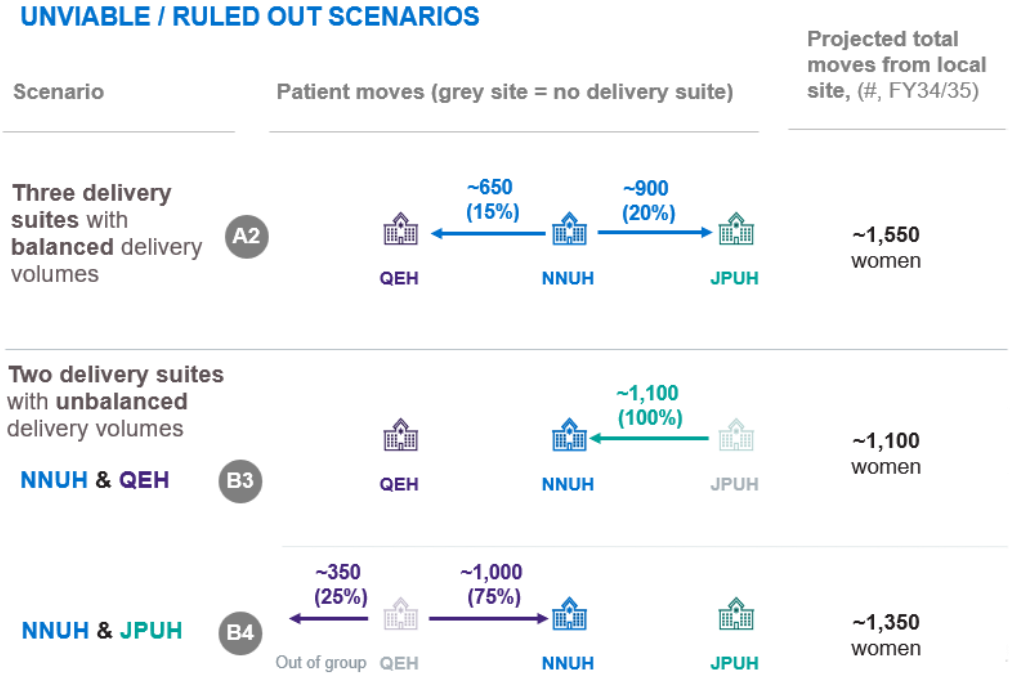
- **One site:** NNUH only (C)

The CAG also considered two other models: standalone midwife-led units and caesarean section hubs.

Before scoring, the CAG tested each scenario for basic feasibility. Three scenarios and both of the other models were ruled out (Figure 28):

- **Three delivery suites with balanced volumes (A2)** was ruled out because around 1,550 women would need to move from NNUH to QEH or JPUH, and NNUH would struggle to maintain enough normal births alongside its high-risk births to remain sustainable. There are not enough low-complexity births or planned caesareans to create an even distribution.
- **Two delivery suites with unbalanced volumes (B3 and B4)** were ruled out because in each case, the smaller unit would be too small to sustain a safe maternity service.
- **Standalone midwife-led units and caesarean section hubs** were ruled out by the CAG because too few women would be eligible without full back-up from obstetric, neonatal, paediatric, emergency surgery and adult critical care services.

Figure 28: Women and children's scenarios ruled out before scoring



Projected moves from local site, FY2034/35. Source: NWUHG inpatient datasets, QEH maternity dashboard, discussions with NWUHG colleagues, Trust analysis.

The projections assume that three-quarters of QEH births would remain within the Group if QEH had no delivery suite, reflecting clinical leads' view that continuity of care and improved clinical standards would shape where women choose to give birth. If travel time alone informed this choice, only around 29% of QEH births would remain within the Group.

10.4 Scenarios evaluated

This left four scenarios for the CAG to evaluate (Figure 29), each based on the fixed points in Section 7.5. Together they range from keeping all three delivery suites to bringing all births onto one site:

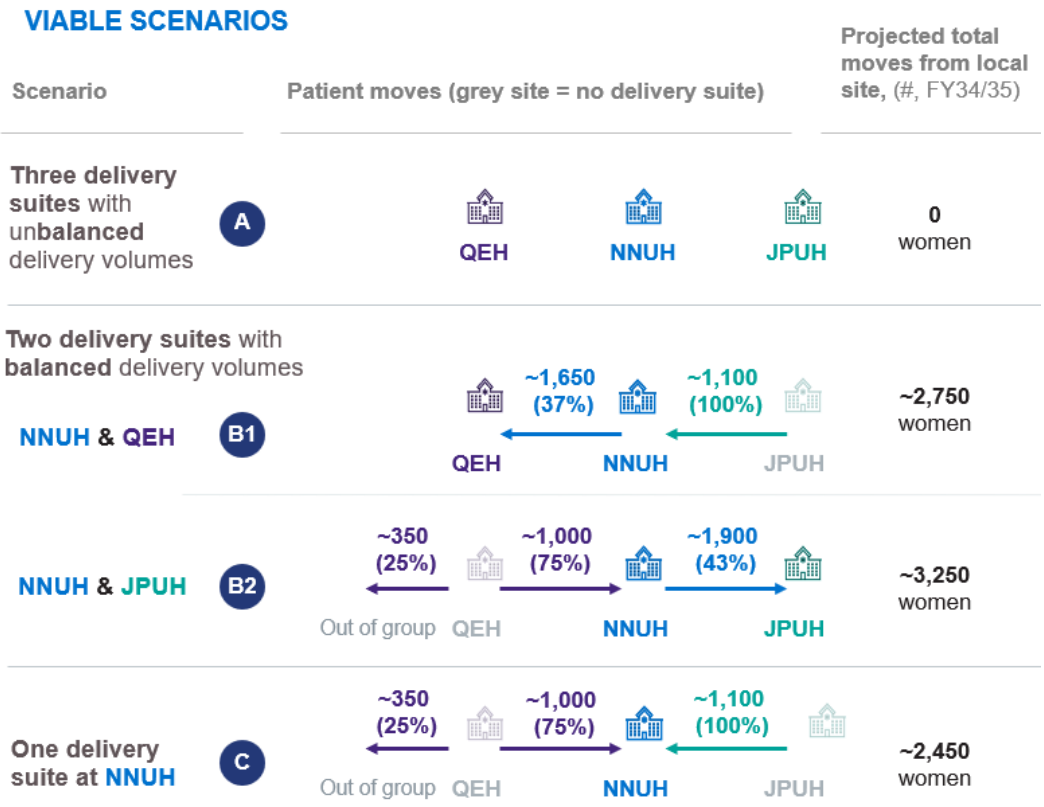
- **Scenario A: three delivery suites ('Do Minimum').**
  No change in where women give birth; QEH and JPUH remain well below a sustainable size.

- **Scenario B1: two delivery suites at NNUH and QEH.**
  JPUH births move to NNUH (around 1,100) and around 1,650 women who would have used NNUH are redirected to QEH to create two balanced units (around 10.6 and 8.2 births a day). Around 2,750 women change birth site each year.

- **Scenario B2: two delivery suites at NNUH and JPUH.**
  QEH births move to NNUH (around 1,000) or out of the Group (around 350), and around 1,900 women are redirected from NNUH to JPUH. Around 3,250 women change birth site each year.

- **Scenario C: one delivery suite at NNUH.** All JPUH births (around 1,100) and three-quarters of QEH births (around 1,000) move to NNUH, with around 350 leaving the Group. Around 2,450 women change birth site each year, and NNUH would deliver around 17.9 babies a day.

Figure 29: Women and children's scenarios evaluated by the CAG



Projected moves from local site, FY2034/35. Source: as Figure 28.

10.5 Scenarios evaluation

The CAG scored each scenario against the 'Do as Planned' position (see Figure 30 for full scoring). The scores show a consistent trade-off: fewer delivery suites yield greater improvements on safety for complex care, senior cover and workforce, but at a greater impact on travel times and patient choice.

Scenario A – Three delivery suites (Do Minimum): As set out in Section 6, keeping all three delivery suites with enhanced clinical standards improves routine care, outcomes and senior cover, while births stay local. However, it scores worse on workforce sustainability and service resilience with JPUH and QEH remaining below a sustainable size but would still require full maternity, neonatal, and paediatric cover.

Scenario B1 – Two delivery suites at NNUH and QEH: B1 scores better on safety for complex care, the ability to manage complex patients, workforce sustainability and service resilience because it creates balanced units of around 10.6 and 8.2 deliveries a day. Keeping a delivery site at QEH means there is no impact on neighbouring systems, as women in west Norfolk would not need to give birth outside the Group. However, it scores much worse on patient choice, as around 1,650 women who would otherwise have used NNUH would be redirected to QEH. It also scores worse on travel times, the number of patients affected, health inequalities and the ambulance service, with around 2,750 women changing birth site each year.

Scenario B2 – Two delivery suites at NNUH and JPUH: B2 scores similarly to B1 on safety, quality and workforce as it also creates two balanced units. It scores much worse on travel times, the number of patients affected, patient choice and the impact on the ambulance service, and worse on neighbouring systems. Around 3,250 women would change birth site each year, more than in any other scenario, including around 350 QEH births leaving the Group and around 1,900 women redirected from NNUH to JPUH.

Scenario C – One delivery suite at NNUH: C has the highest scores of the four scenarios for safety for complex care, 24/7 senior assessment and treatment, the ability to manage complex patients, workforce sustainability and service resilience. This is because deliveries, neonatal care and inpatient paediatrics are brought together at a single site performing around 17.9 deliveries a day. However, it scores much worse on travel times, particularly form west Norfolk, and worse on the number of patients affected, health inequalities, patient choice, neighbouring systems and the impact on the ambulance service. Around 2,450 women would change birth site each year, with around 350 leaving the Group.

Figure 30: Women and children's services: scoring against the evaluation criteria

Recommended Not taken forward —— All scenarios assume NHP/ Neighbourhood max + enhanced clinical standards ——

Example scenarios	Scenario A – Do Minimum 2034/35	Scenario B1	Scenario B2	Scenario C
Description	3x birthing sites	2 x birthing units at NNUH & QE (balanced births)	2 x birthing units at NNUH & JP (balanced births)	1 x birthing unit at NNUH
Births / Neonatal / IP Paeds	x3	x2	x2	x1
Emergency surgery 24/7	x3	x2	x2	x1
Emerging scenario for further validation	✓	✓	✓	✓

Area	Criteria				
Safety	Will this improve safety for complex care?*				
	Will this improve safety for normal routine care?				
Quality	Will patient outcomes improve?				
	Availability of 24/7 assessment by senior decision maker				
	Availability of 24/7 treatment by senior decision maker				
	Ability to manage complex patients				
Patient impact	Impact on patient access (travel times)				
	Impact on patient access (number of patients affected)				
	Impact on health inequalities				
	Impact on patient choice				
Workforce	Workforce sustainability / ability to recruit, retain & train				
	Ability to train and develop				
	Service resilience based on staffing cover				
System impact	Care close to home / in the neighbourhood (Antenatal & Postnatal care)				
	Ability to join up primary - secondary care				
	Impact on NHP - timeline & cost				
	Impact on neighbouring systems				
	Impact on ambulance service				

Key (vs 'do as planned'): Much better | Better | No change | Worse | Much worse

10.6 Outcome

Overall, the CAG did not reach a consensus to rule out any of the reconfiguration scenarios at this stage. Therefore, the recommendation is to take all four scenarios forward for continued modelling:

- **Three sites (A) remains as the comparator.** It keeps births local but leaves two units well below a sustainable size, with worsening workforce resilience.
- **Two sites at NNUH and QEH (B1):**
  - *Strengths:* two balanced units of a sustainable size; keeps births in west Norfolk, where the nearest alternatives are outside the Group; better safety, outcomes and workforce resilience; no impact on neighbouring systems.
  - *Weaknesses:* around 1,650 women who would have used NNUH are redirected to QEH, significantly reducing patient choice; all JPUH births move to NNUH; travel, health inequality and ambulance impacts are worse.
- **Two sites at NNUH and JPUH (B2):**
  - *Strengths:* two balanced units of a sustainable size, with safety, quality and workforce scores similar to B1. Keeps a delivery suite in the east of the region.
  - *Weaknesses:* around 3,250 women change birth site each year, the most of any scenario, including around 1,900 moving from NNUH to JPUH; around 350 QEH births leave the Group; travel, patient choice and the impact on the ambulance service score much worse.
- **One site at NNUH (C)**

- *Strengths:* the largest gains in safety for complex births, 24/7 senior assessment and treatment, and workforce; a single neonatal unit and inpatient paediatric service.
- *Weaknesses:* travel times are significantly worse, especially from west Norfolk; around 350 births a year leave the Group; NNUH deliveries rise by about half, with capacity and capital still to be assessed.

With births falling, the Group cannot support three delivery suites of a sustainable size in any scenario. The four scenarios represent different ways of responding to this. Keeping three protects local access but leaves two units below a sustainable size. Each of the two-site and one-site scenarios creates sustainable units, but at the cost to travel, patient choice and the number of women affected. The one site scenario would deliver the highest standard of care for women with complex births, providing mitigations to access can be developed, explored further in Chapter 13.

11. Financial & capital evaluation

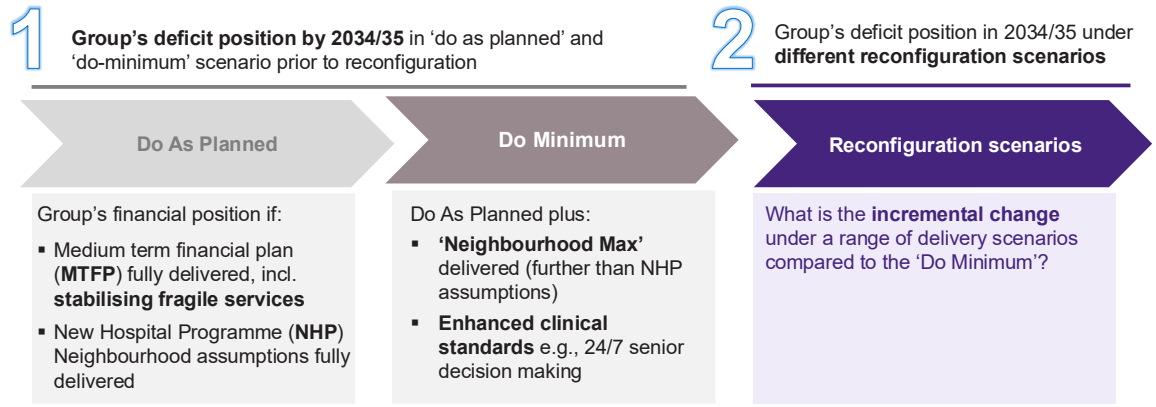
11.1 Financial evaluation methodology

Modelling approach

The financial impact of the different reconfiguration scenarios has been develop using a top-down approach, with assumptions agreed with the NWUGH finance team. The approach (Figure 31) involved:

- **Agreeing a baseline** of the current expenditure and income across the Group in FY25/26
- **Projecting the Group's deficit position by 2034/35 under the 'Do as Planned' and 'Do Minimum' baseline scenarios, prior to any reconfiguration.** As outlined in Section 3 in detail, the 'Do as Planned' scenario assumes full delivery of the Medium Term Financial Plan (MTFP), and delivery of 'left shift' in the New Hospital Programme (NHP) assumptions. The 'Do Minimum' builds on this by assuming further activity avoidance from 'Neighbourhood Max' and the cost of enhancing clinical standards
- **Quantifying the incremental change** in expenditure under each reconfiguration scenario compared to the 'Do Minimum' scenario, reflecting the changes in where activity is delivered and the workforce requirements of each site

Figure 31: Approach to the financial evaluation



As outlined in detail in Section 3, the projected Group financial position in 2034/35 under the two baseline scenarios is:

- 'Do as Planned': £53m deficit
- 'Do Minimum': £34m deficit

Service-level methodology

Unplanned Care: The unplanned care modelling identifies the patients that would be cared for on each site under the unselected and selected medical take scenarios, using the Group's projected activity in 2034/35. It then calculates the cost differential compared to the 'Do Minimum' by understanding:

- **Reduced expenditure at the sites where activity or services move from:** the bed days and/or associated staffing costs that would no longer be required at QEH and JPUH

- **Additional expenditure at the sites that the activity or services move to:** the extra capacity and staffing needed at NNUH to care for the patients it receives
- **Transfers:** the additional cost of moving patients between sites

Women and children's services: For **paediatric inpatient care**, the women's and children's model calculates savings on the same basis as the unplanned care model. For **obstetrics**, the model calculates the change in costs under each scenario when births move to a new site or to hospitals outside of the Group by estimating:

- **Reduced expenditure at the sites that do not have a delivery suite:** the round the clock obstetric, midwifery, neonatal and paediatric cover that would no longer be needed
- **Additional expenditure at the receiving sites:** the extra staffing needed where births, neonatal care and paediatric activity increase

11.2 Financial impact of the reconfiguration scenarios

Figure 32 shows the estimated annual saving compared to the 'Do Minimum' scenario for each reconfiguration scenario, and how far each scenario goes to reducing the **projected £34m Group deficit** by 2034/35.

In women's and children's services, the **two-site scenarios reduce expenditure by around £6m-£8m a year** (~20% of deficit) while the **single delivery site scenario reduces expenditure by around £18m** (~50% of deficit)**.** For unplanned care, the **unselected medical take** reduces expenditure by approximately **£18m a year** (~50% of deficit), while the **selected take reduces expenditure by around £32m a year** (~90% of deficit).

Figure 32: Annual saving against the 'Do Minimum' by reconfiguration scenario, £m, 2034/35

Projected net financial saving and share of deficit closed, by reconfiguration scenario relative to the 'do-minimum' scenario
£m and % (FY 2034/35)

Recap:
The preliminary financial modelling projects the Group will have a structural deficit in 2034/35 under the 'do-minimum' scenario of:

£34m

Scenario	Net saving	% of deficit
Women and Children		
B1 Two suites at NNUH & QEH (balanced)	~£8m	~24%
B2 Two suites at NNUH & JPUH (balanced)	~£6m	~18%
C One suite at NNUH	~£18m	~53%
Unplanned Care		
2 Scenario 2 (2x Unselected)	~£18m	~53%
3 Scenario 3 (2x Selected)	~£32m	~94%

Viability tested against the women and children fixed points: a site that delivers births must have emergency surgery, and a site without a delivery suite has no neonatal unit or inpatient paediatrics. Under unselected or selected medical take, emergency surgery at that site is SDEC only.

These figures are preliminary estimations calculated using a top-down approach. Additional detail on the methodology of how we have calculated these in each scenario is contained in Appendix 3.

The next phases of the programme will need to validate these projections, including the costs of mitigations and enablers (Chapter 13), any double-running and transition costs.

11.3 Financial evaluation conclusions

Combining the financial evaluation with the clinician's evaluation against the agreed criteria (see Sections 9 and 10) gives the following conclusions:

- **The selected medical take would close almost all of the financial deficit on its own**, saving around £32m against a £34m structural deficit (Section 11). **However, it is not recommended** by the CAG to take forward because of its impact on patient access, neighbouring systems and ambulance service (Chapter 9)
- **The unselected medical take scenario closes around half of the gap,** saving around £18m a year while limiting the negative impact compared with the selected medical take. QEH and JPUH would keep their ED, critical care and unselected take services, so far fewer patients would need to transfer or travel further for their care, and the pressure on neighbouring hospital and ambulance services would be lower.
- **Combined with any of the maternity reconfiguration scenarios, the unselected medical take closes most or all of the deficit gap.** With a two-site maternity model, it leaves a structural deficit of around £8m-10m a year. With a single delivery suite at NNUH the gap is eliminated.
- **Reconfiguration of both unplanned care and women's and children's services is needed** to address the structural deficit. Neither the 'Do Minimum' nor reconfiguration of a single service closes the gap alone without trade-offs the CAG agreed to be unacceptable.

11.4 Estate and capital implications

Estate implications

The programme has assessed the impact of emerging scenarios on the designs of the new hospitals at QEH and JPUH, and what additional capacity might be needed at NNUH if some patients received care there. 97% of activity is expected to remain at the hospital where it is currently delivered, or closer to home, therefore most of the planned accommodation at QEH and JPUH would still be required. **The principal design choices concern inpatient capacity and, in some scenarios, maternity, neonatal and children's services.**

Inpatient services

All three emerging scenarios retain an unselected medical take at each hospital. QEH and JPUH would therefore **continue to need emergency departments and critical care facilities**; the proposed changes to medical and surgical pathways are not currently expected to alter the overall scope of either new-hospital scheme materially. Greater use of same-day emergency care may, however, require ward and assessment areas to be laid out differently. Under the 'neighbourhood max' model, the projected reduction in inpatient demand could **remove two 32-bed wards from each new hospital**. That is broadly equivalent to reducing the height of one wing of each hospital by one floor.

Neighbourhood modelling also indicates a **reduction equivalent to almost six wards at NNUH.** Unlike the QEH and JPUH new hospital plans, NNUH's existing estate has no assumed New Hospital Programme reduction in inpatient beds. The space released could help accommodate the transfer of the most complex medical and surgical patients envisaged in all three scenarios. This would still require detailed clinical and estates planning: critical care, in particular, needs specialist infrastructure and cannot simply be moved into a vacant ward and will require extensive refurbishment of an area. The initial site assessment has

considered how **additional critical care capacity might be created** by relocating an existing ward and reconfiguring high-dependency and intensive-care space, while services continue to operate during the works.

Maternity, neonatal and inpatient paediatrics

Changes to maternity, neonatal and inpatient children's services would have a more substantial effect on the new hospital designs. If these services transferred from JPUH, or from both JPUH and QEH, the corresponding accommodation could be omitted from one or both schemes. At NNUH, the site assessment has identified land beside the existing women's and children's services as a potential location for an extension, allowing the services to remain connected, with the extension scaled depending on whether the chosen scenario is either or both hospital's services relocating,

Building new accommodation first could also provide space to move existing wards temporarily while parts of the current estate are refurbished. This is work that is difficult to undertake without somewhere suitable for patients and staff to go. The location, size and phasing of any extension, including its effects on parking and the PFI estate, require further feasibility work.

Capital implications

The timing of a service decision affects both the QEH and JPUH new hospital schemes. If a scenario requires public consultation, the Outline Business Case for each hospital must reflect the service model chosen after the ICB has considered the consultation findings and reached a decision. The current timetable envisages submission of both business cases in October 2027. A later submission would add construction-cost inflation, at several million pounds per month each hospital scheme is delayed.

Three factors determine the additional capital requirement. The first is inflation arising from delay. The second is the cost of designing alternative schemes while a decision remains outstanding; pausing design work until after the ICB's decision would avoid those additional design fees, but would extend the programme and incur greater inflation. The modelled timetables therefore assume that designs for the relevant scenarios progress in parallel with any consultation, without prejudging its outcome. Design costs will depend on how many alternatives are taken forward. The third factor is the cost of relocating activity: reducing space in the QEH or JPUH schemes releases capital at a marginal rate, while replacement facilities in different locations must be costed in full, unless the space can be created by repurposing existing facilities.

We have modelled three possible dates for submission of revised Outline Business Cases: April 2028 in the best case, July 2028 in the middle case and September 2028 in the worst case. The dates reflect differences in the time needed to launch consultation, reach a decision afterwards and complete the business cases. Across the modelled cases, potential hospital opening dates include Q3 2033, Q3 2034 and 2035. Other programme sequencing also affects these dates, so differences in opening times cannot be attributed solely to consultation.

Working with the national New Hospital Programme team, we estimate an additional capital requirement of £140 million to £225 million for scenarios retaining two birth suites, and £263 million to £354 million for scenarios with one birth suite. These ranges include the effects of the three factors described above. In the best-case timetable for the one-birth-suite scenario, the estimated additional requirement is £263 million.

The NNUH estimate remains subject to detailed design. Initial work has identified a potential reduction of around 20% in the cost of the new facilities there. If achieved, this would reduce the additional capital requirement in the best-case one-birth-suite scenario from £263 million to approximately £200 million. Current modelling indicates that the additional investment in the one-birth-suite scenario could be recovered through recurrent benefits in less than ten years, subject to confirmation of both costs and savings.

12. Recommended reconfiguration scenarios to take forward

Based on the clinician's evaluation against the criteria (Section 9 & 10) and the financial evaluation (Section 11), the selected medical take is not being recommended as a viable scenario.

This means that four reconfiguration scenarios are being proposed as recommendations to be considered in the next phase of work. The 'Do Minimum' scenario will also be considered as an scenario.

Each scenario involves a different balance between local access and choice on the one hand, and safety, workforce sustainability and financial sustainability on the other – see Table 11. Section 13 sets out preliminary thinking on the potential mitigations that could reduce their impact and the required enablers.

Table 11: Summary of the four reconfiguration scenarios taken forward

	Scenario A: three maternity sites	Scenario B1: two maternity sites (NNUH and QEH)	Scenario B2: two maternity sites (NNUH and JPUH)	Scenario C: one maternity site (NNUH)
Delivery suites, neonatal units, inpatient paediatrics	All three sites	NNUH and QEH	NNUH and JPUH	NNUH
Medical take	Unselected at all three sites			
24/7 emergency surgery	All three sites	NNUH and QEH	NNUH and JPUH	NNUH only
Emergency Department	All three sites	All three sites	All three sites	All three sites
Critical Care	All three sites	All three sites	All three sites	All three sites
Main benefits	No impact on travel times & patient access No maternity impact on ambulance or neighbouring systems	Two units of a sustainable size; Keeps births in west Norfolk; Improves workforce sustainability; Better safety, outcomes and workforce resilience; No impact on neighbouring systems	Two units of a sustainable size; Improves workforce sustainability; Better safety, outcomes and workforce resilience;	Greatest improvement in quality and safety, particularly for complex births; Greatest workforce sustainability; Closes structural deficit gap;
Main trade-offs	QEH and JPUH units remain well below a sustainable size; Does not improve care for complex patients; Workforce resilience worsens; Limited impact on deficit gap;	~1,650 women redirected from NNUH to QEH, reducing patient choice; Impact on travel times, health inequality for JPUH patients; Impact on ambulance service;	Greatest impact on women that move as ~3,250 women change birth site each year, including 1,900 NUH patients; Large impact on travel time for QEH patients; Greatest impact on ambulance service;	Large impact on travel time for QEH patients; Impact on ambulance service; Impact on health inequality and patient choice for JPUH & QEH patients;

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	Scenario A: three maternity sites	Scenario B1: two maternity sites (NNUH and QEH)	Scenario B2: two maternity sites (NNUH and JPUH)	Scenario C: one maternity site (NNUH)
Quality impact overall assessment	Slightly better	Better	Better	Much better
Remaining structural deficit (from £34m)	~£16m	~£8m–£10m	~£8m–£10m	Gap closed (~£2m surplus(

13. Mitigations and enablers

Each reconfiguration scenario has disadvantages that would need to be mitigated, and each depends on a set of enablers being in place before services change. Section 13.1 sets out potential mitigations for unplanned care and Section 13.2 those for women's and children's services. Section 13.3 sets out the critical enablers and dependencies that apply across both.

13.1 Mitigations for unplanned care

Clinical care at every site

Earlier senior clinical decisions would help us assess patients promptly, choose the right pathway and avoid repeated assessments. Depending on the service, this would require greater availability of consultants, senior registrars and experienced nurses, particularly outside normal working hours. The requirement applies both to patients who may be able to return home and to those whose condition calls for rapid admission or specialist treatment. We would need to establish the level of cover at each site and whether the workforce can sustain it.

Senior medical cover would have limited effect if the wider team remained unavailable at the times patients need it. Seven-day access to diagnostics and reporting, pharmacy, physiotherapy, occupational therapy and discharge support would be needed to make clinical decisions effective. Coordination with social care is also important when a patient is ready to leave hospital but needs support at home or a placement. The hours and capacity of these services would need to match the proposed clinical pathways, rather than relying on weekday arrangements to support a seven-day model.

Any scenario that brings more complex activity together still needs to provide safe care for patients who remain at local hospitals. The clinical specification must define which patients each site can assess, admit and treat, and what staff must be present to do so. If a hospital continues to admit surgical patients overnight, for example, clinical discussions identified the need for a resident middle-grade surgeon with consultant support available. Similar requirements would need to be specified for other locally retained services. Remote advice may strengthen a local team, but cannot replace an intervention that a patient needs immediately on site.

A Group-wide workforce model could make specialist expertise available across our hospitals and in community settings. Shared teams and rotas would require common clinical standards, clear responsibility for patients and sufficient time for staff to work across sites. Workforce sustainability at JPUH and QEH is important, as if changes made local posts less attractive or increased travel demands on staff without adequate support, they could worsen the recruitment and retention pressures that the model is intended to address.

Assessment before and outside hospital

Better pre-hospital triage could help ambulance crews and community clinicians make a decision about where a patient should receive care before conveyance. Access to a senior hospital clinician by telephone or video could identify patients suitable for urgent community response, frailty care or a planned assessment pathway, while directing those who need specialist treatment to the appropriate hospital. This would require agreed clinical criteria and a dependable route to reassessment if a patient's condition changes. It would not remove the need for prompt ambulance conveyance when hospital care is required.

Digital and virtual services could support these decisions and help clinicians at different sites work as one team. Potential uses include specialist video advice to a local emergency department, virtual follow-up after discharge and virtual wards for patients who can be monitored and treated safely at home. These arrangements depend on shared, current clinical information and a named team responsible for each patient's care. They also need arrangements for face-to-face assessment, escalation and support for people who cannot use a digital service.

A stronger neighbourhood model would address some of the need that currently reaches hospital, particularly among people with frailty or several long-term conditions. Proactive case management, community outreach and step-up care could provide support before a crisis. Step-down care, rehabilitation and social-care coordination could help people leave an acute bed when they no longer need one. Better end-of-life services and advance care planning could reduce transfers that do not reflect a person's wishes. The effect on hospital activity would depend on the workforce and capacity available outside hospital, so it should be assessed rather than assumed.

Transfers and receiving capacity

Where a scenario requires patients to move between hospitals for critical care or complex surgery, transfers become part of the clinical pathway. We would need appropriately staffed urgent and critical-care transfer arrangements, suitable ambulances and clear protocols for referral, acceptance, monitoring and handover. The service must be available when needed, rather than dependent on finding a vehicle or assembling a team after the decision to transfer. Modelling will need to distinguish planned movements from urgent transfers and account for the effect on ambulance capacity across the wider area.

The hospital receiving additional patients would need capacity for their entire pathway. This includes beds and clinical staff, but also diagnostics, theatres, critical care and the services required after an operation or admission. If these resources did not grow in step with transferred activity, patients could face longer waits at the receiving hospital and delays in moving out of emergency or critical care. Capacity will therefore need to be tested under periods of high demand, as well as against annual averages.

13.2 Mitigations for women's and children's services

Maternity care

A change to the location of births does not mean moving all maternity care. Community midwives, local hubs and specialist outreach could retain antenatal and postnatal appointments closer to home, preserving continuity for women who need repeated contact during and after pregnancy. The model would need to specify which assessments are safe locally, how results and care plans are shared, and how women obtain prompt advice or hospital assessment when concerns arise.

A single maternity triage system could help women reach the right service and receive consistent advice about when and where to attend. It would need direct access to clinical information and clear routes to urgent obstetric assessment.

Local assessment and early pregnancy services remain in all three hospitals but their scope will need to reflect the distance to emergency delivery facilities which would be further mitigated by ensuring rapid access to ambulance service if indicated.

Maternity transfers require arrangements suited to women in labour and to babies who need specialist care. Ideas raised for assessment include dedicated ambulances jointly staffed with paramedics and midwives mirroring the mental health ambulance model as well as dedicated midwifery advice for paramedics, and enhanced maternity training for ambulance staff. Their purpose would be to improve assessment and care during a journey, as well as the speed of transfer.

Consideration should also be given to creating a patient and family / carer hotel at the Norfolk and Norwich site so that women who were in early stages of labour when they arrived at the hospital could stay there rather than being asked to go home. This facility would also be useful for relatives who are visiting patients in hospital and unable to travel home.

Children's services

Clinical discussions identified 24-hour paediatric same-day emergency care as an important potential mitigation where inpatient services change and this has now been incorporated into the model in all scenarios. Children may need assessment or observation at any hour, and their condition can change quickly. A service operating only from 08:00 to 22:00 would leave a different overnight pathway for families and ambulance crews. Round-the-clock provision could be provided using paediatric capacity within the Emergency Department footprint.

The length of time a child needs local care cannot always be determined by a fixed threshold. A rigid rule requiring transfer after 24 hours could be unsuitable for a child undergoing a safeguarding assessment, receiving care for a mental-health or eating disorder, or managing a long-term condition with an established local team. Future pathways should allow clinical judgement within clear safety criteria, while specifying when transfer is necessary and who is responsible for the decision.

Local paediatric services also depend on relationships beyond the ward. Links with community nursing, diabetes and respiratory teams, therapists and home-ventilation services help children move between hospital and home and support families managing ongoing conditions. If inpatient care changed location, these teams would still need timely access to specialist advice and a clear role in discharge planning. Preserving those links is important to avoid making a child's pathway more fragmented.

Children's mental-health provision requires separate attention. When a young person attends hospital in crisis late in the day, a delay in specialist assessment can prolong a stay and leave the ward supporting needs for which it may not be best equipped. Clinical discussions identified later access to crisis assessment and stronger community mental-health services as potential mitigations. The future model would need to clarify who responds out of hours, how risk is managed while an assessment is awaited and what support follows discharge.

Receiving capacity, travel and families

The receiving hospital would need capacity for the entire maternity, neonatal and paediatric pathway, on the same basis as for unplanned care (Section 13.1). Maternity and children's scenarios would require specific assessment of neonatal and paediatric capacity.

Additional travel would affect patients and families in different ways. Any scenario involving fewer delivery locations would need to examine public transport, access without a car, the cost and frequency of visits and journeys between our sites. Practical support might include clearer travel information and improved inter-site arrangements, but its availability and

effectiveness would need to be established. When a child receives care away from home, parents may need to manage siblings, work and other caring responsibilities while remaining involved in treatment decisions. Safeguarding needs can make it especially important for families and professionals to remain connected. These effects cannot be represented adequately by the patient's journey time alone.

Our assessment of women and children's scenarios will also need to reflect circumstances that routine activity data may miss. Deprivation, domestic abuse, limited transport, the needs of siblings and the availability of parental support can affect whether a pathway is accessible and safe. Further modelling should distinguish children's age groups, safeguarding cases and long-term conditions, as well as maternity, obstetric and gynaecological pathways. These distinctions are needed to estimate local capacity and transfer requirements and to test who would bear any additional travel burden.

13.3 Critical enablers and dependencies

Some proposed mitigations would become essential operating requirements under a particular scenario. The dependencies below apply more broadly to whether a model of neighbourhood and hospital care can function as intended, for both unplanned care and women's and children's services. They require delivery plans and assurance before benefits dependent on them can be counted.

Transport and cross-site pathways

We would need a transport system capable of supporting routine, urgent and semi-urgent movements between sites. Some patients may travel for an intervention on the same day and return to their original hospital afterwards. That pathway requires an agreed booking and acceptance process, capacity for both parts of the journey and a clear account of which team is responsible for the patient at each stage. Urgent pathways need readily available vehicles and staff, with protocols for escalation when demand exceeds planned capacity.

Transport arrangements also need to work for relatives and staff. A model that relies on clinicians working at more than one hospital needs realistic travel time within rosters and a dependable way for staff to reach the site where they are needed. Families need to be able to visit and participate in care when a patient is treated away from their local hospital. The accessibility and cost of these journeys should form part of the operating model, rather than be left for patients and staff to resolve individually.

Information, communication and triage

Successful implementation of the electronic patient record is an important dependency for services working across sites. Clinicians need access to current records, investigations, medicines and care plans when a patient moves between teams. The record must also exchange relevant information in both directions with the systems used by primary care, community services and other partners. Without that connection, patients and staff may still face repeated assessments, incomplete handovers and uncertainty about who is coordinating care.

The proposed digital and virtual front door would need to support decisions across planned and unplanned care. Ambulance crews, community clinicians and hospital teams require clear routes to senior advice and a shared view of the services available at that time. Digital coordination needs to be matched by clinical coordination: the model needs agreed referral criteria, a team responsible for the decision and a route for urgent escalation. Virtual access

cannot compensate for a pathway that lacks the staff or physical capacity to receive a patient.

Population segmentation and risk stratification could help neighbourhood teams identify people who would benefit from earlier support. Digitally supported triage should give ambulance crews, community clinicians and hospital teams access to clinical advice and accurate information about which services can receive a patient at that time.

Specialist outreach and workforce

Where specialist activity is organised across the Group, visiting clinicians could support inpatients at JPUH and QEH and hold local outpatient appointments. This would reduce some patient journeys and allow local teams to obtain specialist input without transferring everyone to NNUH. Outreach requires protected clinical time, suitable facilities and shared records.

Services that grow at NNUH would need a corresponding workforce plan. This may involve staff working across the Group or recruitment from the wider system, but the plan needs to show how additional activity will be covered without destabilising services that remain elsewhere. Training, supervision and career development at each site will affect whether the model can retain staff over time. The number of posts in a model is therefore only one part of its workforce test.

Estate and receiving-site capacity

NNUH would need sufficient space and operational capacity for any services that expand there. The requirement includes the relevant wards and intensive-care beds, as well as diagnostics, theatres and support space. Estate changes have to be timed so that a receiving service is ready before activity moves. If releasing space requires another service to move out of NNUH, that change needs its own assessment of clinical quality, workforce, access and cost.

Neighbourhood health and partnership working

The future hospital model depends on neighbourhood services being able to provide care that would otherwise require an admission or a longer hospital stay. This requires primary care, community and mental health services, social care, voluntary organisations and our hospital teams to work across agreed local areas with clear responsibility for each patient's care. Multidisciplinary teams would need to identify people at risk of deterioration, coordinate support for those with frailty or several long-term conditions, and obtain timely specialist advice when a patient's needs change.

We will need to define the services available in each neighbourhood and how patients move between them and hospital care. Local assessment, monitoring, rehabilitation and follow-up must have the workforce and capacity to meet the demand assumed in a scenario. Patients also need to have a clear route to urgent diagnostics or hospital treatment when care closer to home is no longer appropriate. Shared information and agreed referral and escalation arrangements are necessary to make those pathways reliable.

The pace of hospital change should reflect what our partners can deliver locally. We should count reductions in admissions or occupied beds in scenario modelling only where the corresponding neighbourhood services have a credible delivery plan, funding and clinical governance. Otherwise, pressure could move to community teams or return to our emergency departments without improving patients' care.

Community and social-care capacity

The neighbourhood model depends on timely support after hospital and on services able to intervene before admission. Community health teams, rehabilitation, equipment, care packages and placements need to have the capacity to receive patients when they are ready to leave an acute bed. We cannot assume shorter hospital stays or fewer occupied beds in a scenario unless the capacity and coordination needed to achieve them are credible.

End-of-life care is a related dependency. Earlier conversations about preferences, clear advance plans and accessible support in the community would allow more people approaching an expected death to receive care in their preferred setting, where this is clinically appropriate. This requires coordination between hospital teams, general practice, community nursing, specialist palliative care and social care. It should be assessed as a matter of patient choice and quality of care, rather than treated only as a means of reducing hospital activity.

The next phase of work will confirm these mitigations and enablers with clinical leads, the ambulance service and patient representatives; cost each one and show which are already reflected in the financial model; and set out who owns each one and when it must be in place before any service changes.

14. Conclusion and next steps

The scenario evaluation indicates that there are models capable of addressing the clinical and financial sustainability challenges set out in Part One of the Case for Change. The scenarios are ambitious and depend on substantial changes to care within hospitals and neighbourhoods. All scenarios have been developed with the aim of improving the quality and sustainability of care for people across Norfolk and Waveney within the resources available to us; they present six main areas of improvement:

1. **Keeping care local**

The scenarios seek to retain the highest feasible proportion of care locally, including where complex emergency care is brought together. Most patients would continue to receive care close to home, while those with the most complex needs would have access to the specialist teams and facilities their care requires; improving outcomes for patients needing complex medical and surgery procedures.

2. **Improving maternity and neonatal outcomes**

Changes to maternity and neonatal services could provide more resilient staffing, specialist support and arrangements for managing complications. Their purpose would be to improve the safety and outcomes of care for women and babies. The benefits of any model will need to be tested alongside its effects on travel, access and choice.

3. **Developing neighbourhood care for older people**

A new neighbourhood model could provide earlier, more coordinated support for older people, particularly those living with frailty or multiple long-term conditions. The modelling suggests that, if delivered at the necessary scale, this could reduce demand for inpatient beds by the equivalent of up to ten wards. Achieving this depends on sufficient workforce, funding and capacity outside hospital.

4. **Expanding day surgery**

Across all three hospitals, robotics, less invasive techniques and enhanced recovery could allow a greater range and volume of suitable procedures to be undertaken without an overnight stay. This would improve patient experience and make inpatient beds available for those who need them, provided that assessment, theatre capacity and support after discharge are in place.

5. **Reducing emergency admissions**

A substantial expansion of same-day emergency care for adults and children could allow more patients to be assessed, treated and discharged without admission to an inpatient ward. This would require reliable access to senior decision-makers, diagnostics and follow-up care throughout the pathway.

6. **Achieving recurrent financial balance**

Some scenarios are projected to achieve recurrent financial balance. A sustainable financial position would give the wider system greater scope to invest in neighbourhood healthcare. Financial benefits will need to be assessed alongside clinical outcomes, access, equality and the costs of implementation.

Next steps

Each scenario has strengths, risks and dependencies that require further examination. We recommend that the Case for Change and scenario evaluation be presented to the Norfolk and Suffolk Integrated Care Board for a decision on whether to commission the further work needed to develop a business case, enabling more detailed appraisal and engagement.

Appendix 1: Glossary

#	Meaning
AMU	Acute medical unit
Bed day	One patient in a hospital bed for one night.
CAG	Clinical Advisory Group: senior clinical leads from all three Trusts leading the development and appraisal of scenarios
Central, high and low cases	Alternative scenarios using the central, high and low values of reach and effect. They are alternatives, never added together.
CIPs	Cost improvement programmes
CNST	Clinical Negligence Scheme for Trusts
CWG	Clinical Working Group
DGH	District general hospital
'Do As Planned'	The Group's projected position in 2034/35 if the MTFP and NHP left-shift are delivered in full
'Do Minimum'	'Do As Planned', plus Neighbourhood Max and enhanced clinical standards, with all services remaining on their current sites
ED	Emergency department; a Type 1 ED is a consultant-led 24-hour service with full resuscitation facilities
Effect	The proportional reduction in hospital use among the people an intervention reaches, from the evidence.
Full catchment	All patients treated at our three hospitals, including those living outside Norfolk and Waveney.
HDU / ITU	High-dependency unit (level 2 critical care) / intensive therapy unit (level 3 critical care)
JPUH, NNUH, QEH	James Paget University Hospital; Norfolk and Norwich University Hospital; The Queen Elizabeth Hospital King's Lynn
Moved	The same activity provided in a different setting, such as an outpatient appointment in a community clinic.
MTFP	Medium-term financial plan
Neighbourhood Max	Neighbourhood health interventions beyond those assumed in the NHP plan
NHP	New Hospital Programme
NHP plan	The activity reductions assumed in the New Hospital Programme demand models for JPUH and QEH; estimated by us for NNUH.
Occupancy	The share of beds in use on an average night. At 92% occupancy, 100 beds are needed for 92 patients.
Reach	The share of the people in scope that an intervention gets to.
SDEC	Same-day emergency care
Selected / unselected medical take	A selected take admits only medical patients meeting agreed criteria; an unselected take admits all acute medical patients except the most complex
UTC	Urgent treatment centre

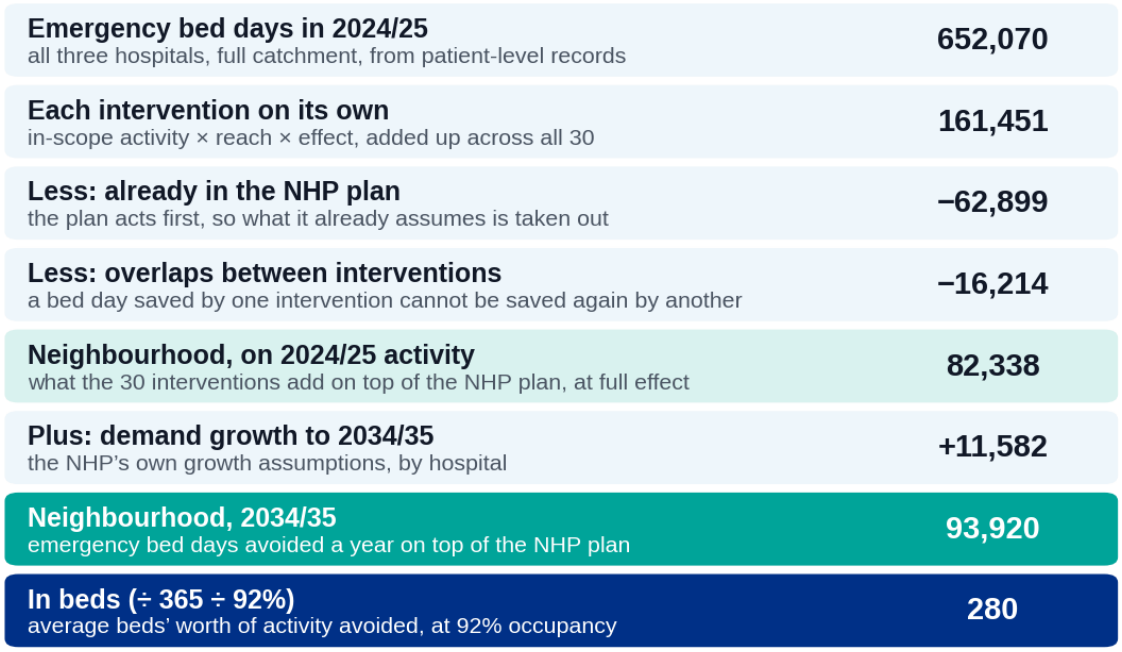
Appendix 2: Neighbourhood modelling, method, results, assumptions and caveats

This appendix sets out the method in full, so that every figure in the main paper can be followed from the hospital records to the final number. Unless stated, figures are for all three hospitals, for a year in 2034/35, with the NHP's growth in demand applied, and every intervention at full effect.

A. The method, step by step

Figure A1 follows the high case from the starting activity to beds. Each step is described below it.

Figure A1: From hospital records to beds, emergency bed days, all three hospitals



Step 1: Activity in scope

We used the three trusts' patient-level records for 2024/25: every emergency admission, A&E attendance, outpatient attendance and planned admission at JPUH, NNUH and QEH. We use the **full catchment**: patients from outside Norfolk and Waveney are included (about a quarter of QEH's activity comes from Fenland and South Holland), with the same parameters applied to them. Each intervention selects its own slice of this activity using fields in the records: diagnosis, age, admission route, length of stay, specialty, and discharge destination.

Step 2: Reach and effect

For each intervention and each case (low, central, high), the activity it could avoid on its own is:

> **Activity in scope × reach × effect = activity avoided by the intervention on its own**

Reach and effect must describe the same people. Where the evidence measures an effect only among people who received a service (an "enrolled cohort"), we apply reach to it. Where the evidence already measures a change across a whole population or a whole slice of activity, the reach is already built into the effect, and we do not apply it again. For a few interventions, reach is set by a national target or a clinical definition rather than by a service's observed coverage: palliative care at home (everyone in the expected-death group), and the cardiovascular

prevention interventions (the gap to national treatment targets). Added up across all 30 interventions, the high case comes to 161,451 emergency bed days on 2024/25 activity.

Step 3: Take out what the NHP plan already assumes

The NHP plan is applied first, at its 2034/35 value. Two adjustments then stop the neighbourhood claiming the same reduction twice:

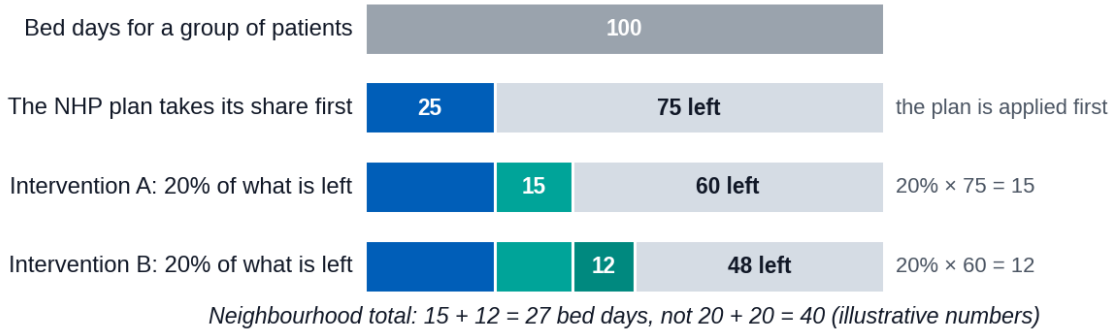
- **Matched measures.** Where an NHP measure and a neighbourhood intervention act on the same patients (the NHP's end-of-life admissions and palliative care at home, for example), the part of the NHP measure that is delivered in the community is subtracted from the intervention. Where the trusts' own NHP plans credit a measure to both hospital and community services, we treat it as half community and half hospital.
- **What the plan leaves.** Every intervention acts only on the activity left after the NHP plan has taken its share, so a patient already removed by the plan cannot be removed again.

Together these take out 62,899 bed days. For some interventions the NHP plan already assumes more than the evidence supports for the intervention, so the intervention adds nothing: outpatient follow-up changes, advice and guidance, the low-acuity alternatives to A&E and medicines optimisation are examples.

Step 4: Count each bed day once

When several interventions could act on the same patient, they are combined so that each acts only on what the others leave (a "multiplicative" combination): two interventions that each avoid 20% of the same bed days avoid 36% together, not 40%. Figure A2 illustrates both rules. This takes out a further 16,214 bed days, leaving **82,338** on 2024/25 activity.

Figure A2: How the NHP plan and overlapping interventions are counted (illustrative)



Step 5: Growth to 2034/35

We use the NHP's own growth in demand for each hospital, from its demand model, interpolated to 2034/35 and rebased to 2024/25. For emergency bed days this is about 17% at JPUH, 18% at QEH and 9% at NNUH. Growth adds 11,582 bed days, giving **93,920**. Figures for individual interventions in 2034/35 (Figure 5) are allocated in proportion to their share of the 2024/25 total.

Step 6: Beds

Bed days ÷ 365 ÷ 0.92 gives average beds at 92% occupancy: 280. Appendix C explains which bed days are converted.

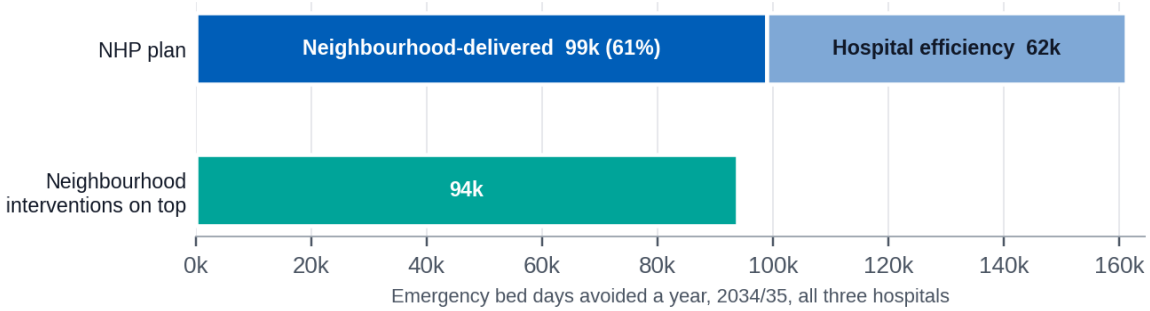
B. The NHP plan, and our estimate for NNUH

The NHP plan is the set of activity reductions (the NHP's "activity mitigators") in the demand models for JPUH and QEH: 87 measures covering emergency admissions, length of stay, outpatients, A&E and planned care. We use it at its 2034/35 value, on 2034/35 demand. The NHP phases its reductions in over the eighteen years from 2023/24 to 2041/42, and 2034/35 is year eleven, so the plan is at eleven-eighteenths of its full value. For JPUH and QEH every measure is taken directly from the NHP models.

NNUH has no NHP scheme. To compare like with like, we estimated what an NHP plan would look like there: for each NHP measure, the rate at which the JPUH and QEH plans reduce the activity it acts on, pooled across the two hospitals, applied to NNUH's own activity of the same kind. The neighbourhood interventions then act on top of it with the same rules as at the other two hospitals. This is an estimate, labelled as such throughout; it is about 84,000 emergency and planned overnight bed days in 2034/35 (77,900 of them emergency), or 249 beds.

Figure A3 splits the NHP plan's emergency bed days by who delivers them. Each of the 87 measures is attributed wholly to community services, wholly to hospital efficiency, or half to each where both are needed. About 61% of its emergency bed days are delivered by neighbourhood services (59% once planned stays are included, as in Table 1). Our neighbourhood interventions are in addition to that.

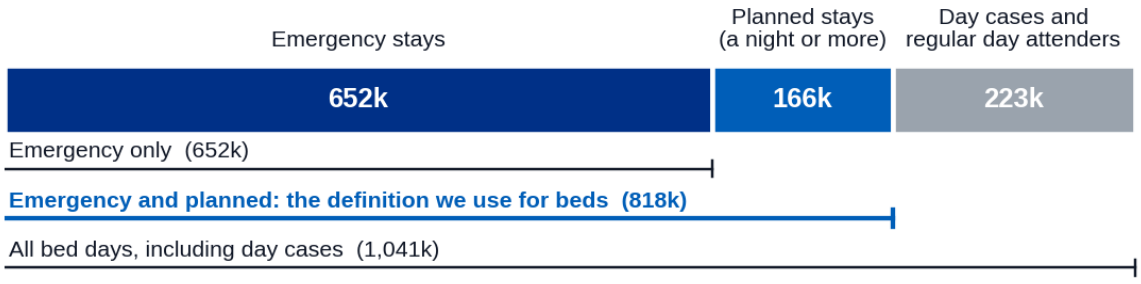
Figure A3: The NHP plan and the neighbourhood, emergency bed days a year, 2034/35



C. Which bed days, and the conversion to beds

Bed days can be counted in three ways (Figure A4). For the bed conversion we use **emergency stays plus planned stays of one night or more**. Day cases and regular day attenders occupy trolleys and chairs rather than ward beds, so we leave them out, from today's activity, from growth and from the NHP plan alike. The neighbourhood figures are the same under the first two definitions because the interventions act on emergency stays; the NHP plan is larger under the second because it also shortens planned stays.

Figure A4: Bed days in 2024/25 under the three definitions, all three hospitals



Each count has its own conventions. Emergency bed days are nights in hospital (discharge date minus admission date), so a same-day stay counts as none. Planned stays follow the NHP's convention of nights plus one. The base excludes maternity and births, and stays in community and mental health hospitals.

Table A1: Beds in 2034/35 under different occupancy assumptions, all three hospitals

		Neighbourhood		
Occupancy	**NHP plan**	**Low**	**Central**	**High**
100% (bed days ÷ 365)	466	33	144	257
92% (NHS planning standard: used in this paper)	507	36	157	280

		Neighbourhood		
Occupancy	NHP plan	Low	Central	High
85% (often cited as safe for patient flow)	548	39	169	303

Emergency and planned overnight bed days, 2034/35 with growth.

Table A2: Beds by hospital, 2034/35, all three cases (bed days ÷ 365 ÷ 92% occupancy)

				Neighbourhood, on top of the NHP plan		
	Today (2024/25)	Growth to 2034/35	NHP plan	Low	Central	High
JPUH	577	+101	−123	−16	−61	−107
QEH	597	+106	−134	−6	−34	−69
NNUH (NHP plan estimated)	1,262	+150	−249	−14	−62	−104
All three hospitals	**2,436**	**+358**	**−507**	**−36**	**−157**	**−280**

Low, central and high are alternatives. Figures may not sum because of rounding.

D. Results in full

The main paper uses the high case. This section gives the low, central and high cases side by side. The central case is our best estimate on the balance of the evidence; the low case uses the bottom of each evidenced range. They are alternatives, never added together.

Table A3: Activity avoided or moved a year, 2034/35, by hospital, all three cases

			Neighbourhood, on top of the NHP plan		
Measure	Hospital	NHP plan	Low	Central	High
Emergency bed days avoided	JPUH	39,012	5,506	20,371	35,838
Emergency bed days avoided	QEH	44,251	1,925	11,490	23,121
Emergency bed days avoided	NNUH	77,943	4,698	20,697	34,960
Emergency bed days avoided	All three	161,207	12,129	52,559	93,920
Emergency admissions avoided	JPUH	2,235	352	1,521	2,651
Emergency admissions avoided	QEH	5,902	81	884	1,931
Emergency admissions avoided	NNUH	7,168	401	2,056	3,759
Emergency admissions avoided	All three	15,305	835	4,461	8,341
A&E attendances avoided	JPUH	2,438	648	1,320	4,673
A&E attendances avoided	QEH	751	641	1,282	4,624
A&E attendances avoided	NNUH	3,003	1,123	2,259	8,101
A&E attendances avoided	All three	6,192	2,412	4,861	17,397
Outpatient attendances moved to the community	JPUH	–	19,718	42,111	65,248
Outpatient attendances moved to the community	QEH	–	11,566	24,409	37,244
Outpatient attendances moved to the community	NNUH	–	50,229	107,926	168,128
Outpatient attendances moved to the community	All three	–	81,512	174,446	270,619
Day cases moved to the community	JPUH	–	906	2,013	3,221
Day cases moved to the community	QEH	–	663	1,474	2,359
Day cases moved to the community	NNUH	–	1,368	3,071	4,942
Day cases moved to the community	All three	–	2,937	6,558	10,522

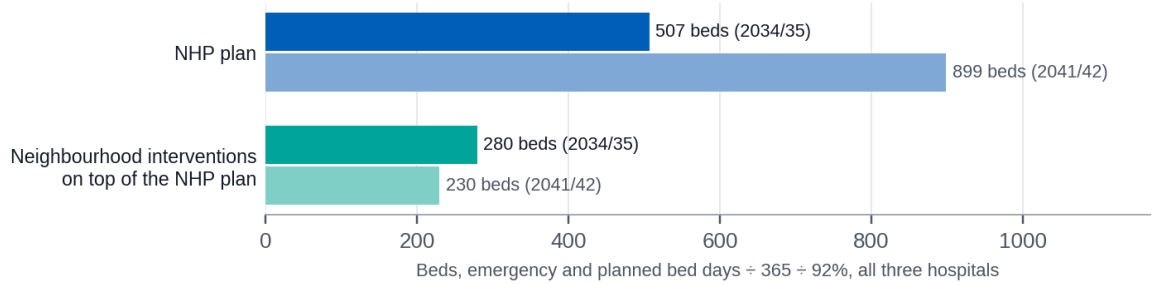
Neighbourhood figures are in addition to the NHP plan. The NHP plan also moves some outpatient and A&E activity (for example, A&E attendances redirected to other services), which is not shown here. NNUH's NHP plan is our estimate. The

neighbourhood avoids almost no outpatient attendances outright because the NHP plan already assumes more than the evidence supports for those interventions; the outpatient figures above are attendances moved, not avoided.

E. Why the neighbourhood figure is lower in 2041/42

The NHP's own horizon is 2041/42. By then demand is higher, but the NHP plan is at its full value rather than eleven-eighteenths of it, and it acts on each patient before the neighbourhood interventions do. So it leaves fewer patients for the interventions, and the neighbourhood figure falls even though demand has grown (Figure A5).

Figure A5: Beds, 2034/35 and 2041/42, all three hospitals



F. How these figures relate to the NHP's own bed numbers

The NHP's validation of its bed numbers for JPUH and QEH counts overnight beds (including maternity, critical care, neonatal and paediatric beds) for 2041/42, with a future occupancy rate applied. Our figures differ in horizon (2034/35), scope (no maternity) and occupancy (92%). When we put our restatement of the NHP plan on the closest basis we can infer (2041/42, overnight stays, 85% occupancy), it comes within about 10% of the NHP's published increases and reductions for each hospital. That basis is our inference, not a published NHP method, so the comparison is a check of consistency rather than a reconciliation.

G. The 30 interventions

Effect is the central value for the intervention's main measure, with the low-to-high range in brackets. Reach is the central value; "target" means it is set by a national target or clinical definition, and "built in" means the evidence already measures the effect across the whole group, so no separate reach applies. Bed days are emergency bed days avoided a year on 2024/25 activity, after the NHP plan and overlaps (Appendix A, step 4); a dash means less than one bed day, because the intervention acts mainly on outpatient or A&E activity or because the NHP plan already assumes its full effect. Evidence grade: A, systematic review, randomised trial or controlled evaluation; B, national data, benchmarked comparison or service evaluation with a comparator; C, service evaluation without a comparator; D, claim or qualitative account. "How": avoids hospital activity, moves the same activity to a community setting, or shortens hospital stays. The full evidence for each intervention is in the accompanying evidence workbook.

							Bed days	
#	Intervention	How	Grade	Main measure	Effect, central (range)	Reach	Central	High
1	Integrated neighbourhood team case management	Avoids	A	Emergency admissions	17% (1%–20%)	15%	15,505	30,293
2	Virtual wards and hospital at home	Avoids	B	Emergency bed days	20% (10%–30%)	20%	9,300	13,381
3	Palliative and end-of-life care at home	Avoids	B	Emergency bed days	40% (10%–61%)	100% (target)	9,188	14,761
4	Discharge to assess and trusted assessment	Avoids	A	Emergency bed days	32% (15%–60%)	30%	6,039	14,036
5	Respiratory proactive management	Avoids	A	Emergency bed days	39% (20%–44%)	22%	1,824	2,729

							Bed days	
#	Intervention	How	Grade	Main measure	Effect, central (range)	Reach	Central	High
6	Community stroke early supported discharge	Shortens stays	C	Emergency bed days	25% (5%–35%)	39%	918	1,453
7	Falls prevention	Avoids	A	Emergency admissions	27% (10%–30%)	11%	859	1,568
8	Treat-in-place pathway for pneumonia and lower respiratory tract infection in care homes	Avoids	A	Emergency bed days	55% (20%–75%)	24%	727	1,473
9	Atrial fibrillation detection and anticoagulation optimisation	Avoids	A	Emergency admissions	64% (49%–74%)	47%	529	611
10	Cardiovascular risk-factor optimisation to target — blood pressure and lipids	Avoids	A	Emergency admissions	20% (17%–27%)	6%	397	534
11	Hospital-to-home transitional care for older people	Avoids	B	Emergency bed days	13% (0%–22%)	5%	367	767
12	Heart failure proactive management	Avoids	A	Emergency bed days	32% (15%–36%)	built in	312	356
13	SGLT2 inhibitor optimisation across heart failure, CKD and type 2 diabetes	Avoids	A	Emergency admissions	20% (14%–23%)	58% (target)	79	90
14	Earlier end-of-life identification and advance care planning	Avoids	B	Emergency bed days	40% (10%–50%)	1%	51	66
15	Weight management and obesity prevention	Avoids	B	Emergency admissions	41% (30%–45%)	built in	49	55
16	Diabetes proactive management	Avoids	B	Emergency admissions	24% (15%–26%)	4%	8	44
17	Advice and guidance and specialist decision support	Avoids	A	Outpatient first attendances	35% (20%–51%)	29%	–	–
18	Community and direct-access diagnostics	Moves	B	Outpatient attendances	35% (20%–40%)	15%	–	–
19	Community pharmacy first	Moves	B	A&E attendances	5% (2%–5%)	2%	–	–
20	Exercise-based cardiac rehabilitation after acute coronary syndrome	Avoids	A	Emergency admissions	18% (0%–39%)	27%	–	–
21	Extended primary care access — evening and weekend	Moves	A	A&E attendances	35% (14%–39%)	19%	–	–
22	Medicines optimisation and structured medication review	Avoids	A	Emergency admissions	38% (24%–41%)	10%	–	–
23	Minor Eye Conditions Scheme — community optometrist urgent eye care	Moves	A	Outpatient first attendances	36% (13%–41%)	27%	–	–
24	Neighbourhood alternative to A&E for low-acuity childhood illness	Moves	A	A&E attendances (paediatric)	15% (5%–20%)	22%	–	–
25	Outpatient follow-up transformation	Avoids	A	Outpatient follow-ups	38% (30%–40%)	9%	–	–
26	Relocation of outpatient and procedural services to community settings	Moves	C	Outpatient attendances	37–90% by service	20%	–	–
27	Renal and CKD proactive management	Moves	C	Outpatient attendances	67% (40%–80%)	88%	–	–
28	Targeted smoking cessation in the most deprived neighbourhoods	Avoids	C	Emergency admissions	32% (10%–35%)	6%	–	120
29	Treatment delivered at or near home	Moves	B	Outpatient attendances	28% (10%–35%)	15%	–	–

							Bed days	
#	Intervention	How	Grade	Main measure	Effect, central (range)	Reach	Central	High
30	Women's health hubs and maternity hubs	Moves	C	Outpatient attendances	50% (30%–60%)	71%	–	–
	Total						46,152	82,338

H. Assumptions and caveats in full

Scope and data

1. The starting point is the three trusts' patient-level activity in 2024/25. Coding gaps (for example, a fall not coded as a fall) mean some patients who could benefit are not in scope, so the figures may be understated for some interventions.
2. Activity is counted for the full catchment, including patients from outside Norfolk and Waveney. Interventions are assumed to work for them as the evidence says, which depends on their own local services.
3. Maternity, births, and stays in community and mental health hospitals are outside the bed-day base.
4. Emergency bed days count nights; planned stays count nights plus one, following the NHP. On the NHP's convention the emergency figures would be roughly 8 to 9% higher.

Evidence and parameters

5. Effects come from published evidence, mostly from other settings and populations. They may not transfer fully to a rural and coastal system with Norfolk and Waveney's workforce constraints.
6. The main paper uses the high case: the best results achieved by named services, which is the upper end of the evidence. The central case (our best estimate on the balance of the evidence) and the low case are given in Appendix D.
7. Some reach values are targets rather than observed coverage, notably palliative care at home (everyone in the expected-death group) and the cardiovascular interventions (the gap to national treatment targets).
8. The expected-death definition used for palliative care is proposed and awaits clinical sign-off. Stricter definitions give smaller figures.
9. Part of what palliative care at home saves may be substitution into hospice or specialist palliative beds, which is why its central effect sits well below the matched evaluation.
10. The high case for discharge to assess (60% of bed days) is the best result reported by any named English service, and the high case for case management also sits at the top of its evidence. These two choices account for a material part of the high case.

Combining interventions and the NHP plan

11. The figures are additional to the NHP plan and assume it is delivered in full, including the roughly three-fifths of its emergency bed days that depend on community services.
12. Where the trusts' NHP plans credit a measure to both hospital and community services, we split it half and half. This split is the largest single modelling convention behind the neighbourhood figures; moving it would move them materially.
13. The NHP plan at NNUH is our estimate, built from the JPUH and QEH plans. Its planned-care element is the least certain part, because it is extrapolated from the other two hospitals' plans to a hospital with a different mix of planned work.
14. Interventions are combined multiplicatively, each acting on what the others leave, so the total is less than the sum of the parts. The combined total does not depend on the order; the order only affects how credit is shared between interventions.

Growth and timing

15. Growth in demand is the NHP's own, from its demand models, interpolated to 2034/35. If demand grows faster or slower than the NHP assumes, all the figures, including the neighbourhood's, move with it.
16. All figures assume every intervention is at full effect by 2034/35. Interventions take three to five years to reach full effect, so most need to start by about 2030 at the latest.
17. At 2041/42 the NHP plan is larger and leaves less for the neighbourhood (Appendix E).

Beds

18. Beds are average beds at 92% occupancy. They make no allowance for seasonal peaks, specialty mix or ring-fenced beds, and are not a bed plan.
19. They are not directly comparable with the NHP's bed numbers, which use 2041/42, include maternity, critical care, neonatal and paediatric beds, and apply their own occupancy rate (Appendix F).
20. Moved activity (outpatient attendances and day cases) frees clinic and day-case capacity rather than ward beds, and creates demand for staff and space in community settings.

Delivery

21. We have not modelled the workforce, funding, estate, digital or social care capacity needed outside hospital. The figures are the opportunity if those are in place, not a forecast that they will be.
22. Four interventions provide 88% of the high case. The programme's impact on beds depends mainly on delivering these at scale.
23. Avoided activity frees hospital capacity only if the beds are not filled by other demand, such as patients currently waiting in A&E or delayed elsewhere. Realising the saving needs a deliberate plan to close or repurpose capacity.

Appendix 3: Financial evaluation

This appendix provides additional detail on the financial evaluation set out in Section 11. The two figures below show the modelled change in annual expenditure at each hospital in 2034/35, broken down by service, for each unplanned care scenario and each women and children's services scenario.

All figures are in £m and compare each scenario with the 'Do Minimum', using the top-down approach described in Section 11.1. Reductions in expenditure (shown in green) arise at the sites that activity or services move away from, where bed days, staffing and round-the-clock cover would no longer be needed. Increases (shown in yellow) reflect the additional capacity and staffing needed at the sites receiving that activity, together with the cost of transferring patients between sites. The Group-wide saving for each scenario is the net of these changes across the three hospitals.

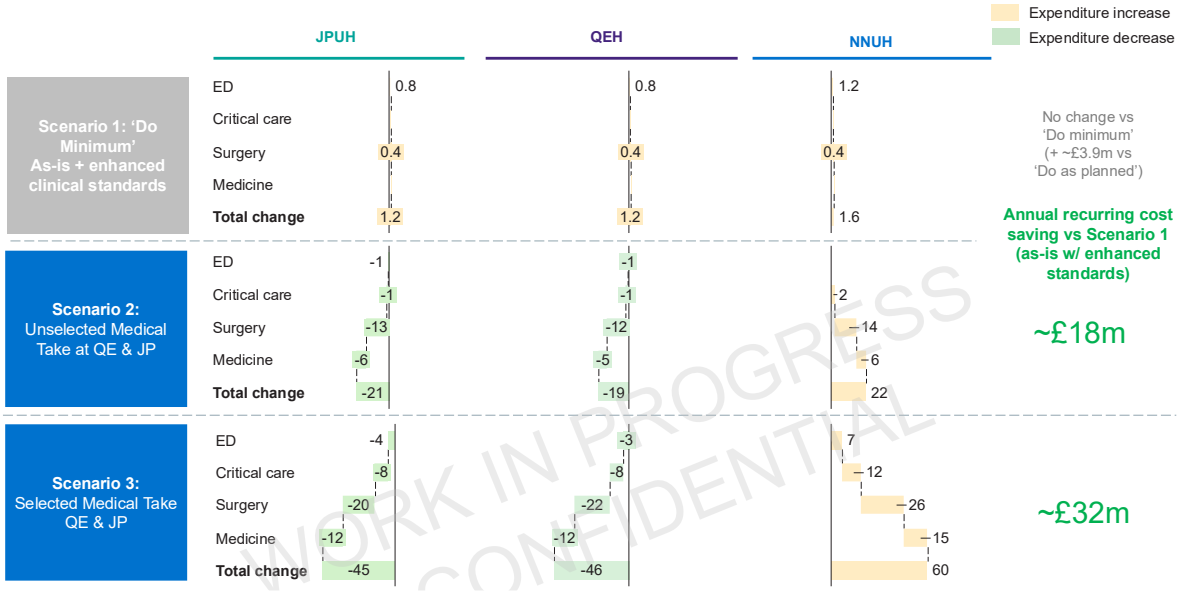
These are preliminary estimates. They exclude the costs of mitigations and enablers, double-running and transition costs, and will be refined as the scenarios are developed further.

Service-level methodology

Unplanned Care: The unplanned care modelling identifies the patients that would be cared for on each site under the unselected and selected medical take scenarios, using the Group's projected activity in 2034/35. It then calculates the cost differential compared to the 'Do Minimum' by understanding:

- **Reduced expenditure at the sites where activity or services move from:** the bed days and/or associated staffing costs that would no longer be required at QEH and JPUH
- **Additional expenditure at the sites that the activity or services move to:** the extra capacity and staffing needed at NNUH to care for the patients it receives
- **Transfers:** the additional cost of moving patients between sites

Figure 33: Modelled changes in expenditure in each unplanned care reconfiguration scenario

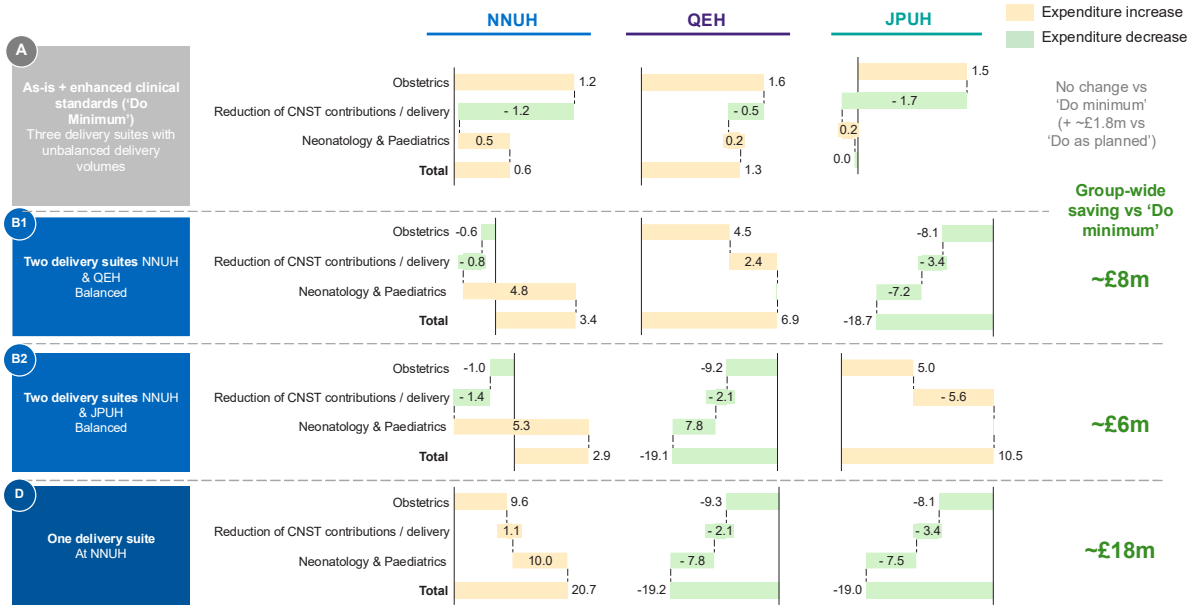


Women and children's services: For **paediatric inpatient care**, the women's and children's model calculates savings on the same basis as the unplanned care model. For **obstetrics**, the model calculates the change in costs under each scenario when births move to a new site or to hospitals outside of the Group by estimating:

- **Reduced expenditure at the sites that do not have a delivery suite:** the round the clock obstetric, midwifery, neonatal and paediatric cover that would no longer be needed
- **Additional expenditure at the receiving sites:** the extra staffing needed where births, neonatal care and paediatric activity increase

The 'Do Minimum' is included for reference. It involves no change in where services are delivered, but adds the cost of enhanced clinical standards: around £4m a year in unplanned care and around £2m a year in women and children's services, compared with the 'Do As Planned'.

Figure 34: Modelled changes in expenditure in each Women and Children's care reconfiguration scenario



Appendix Three
For information only

healthwatch Norfolk

NHS
Norfolk and Waveney
University Hospitals Group

Shaping the Future of Healthcare in Norfolk and Waveney

Interim Report 29/10/2026





Background

Healthwatch Norfolk were asked by the Norfolk and Waveney University Hospitals Group (NWUHG) to gather public views on how healthcare services should develop in the next 10 to 20 years to inform the NWUHG's new Clinical Strategy.

We have been asking:

- What works well now
- What makes it difficult for you to get the care you need
- What matters most when you use hospital services
- How you feel about receiving more care closer to home
- What you think about travelling for specialist care
- What you think should be considered when the NWUHG are planning healthcare for the future.

Methods of Engagement

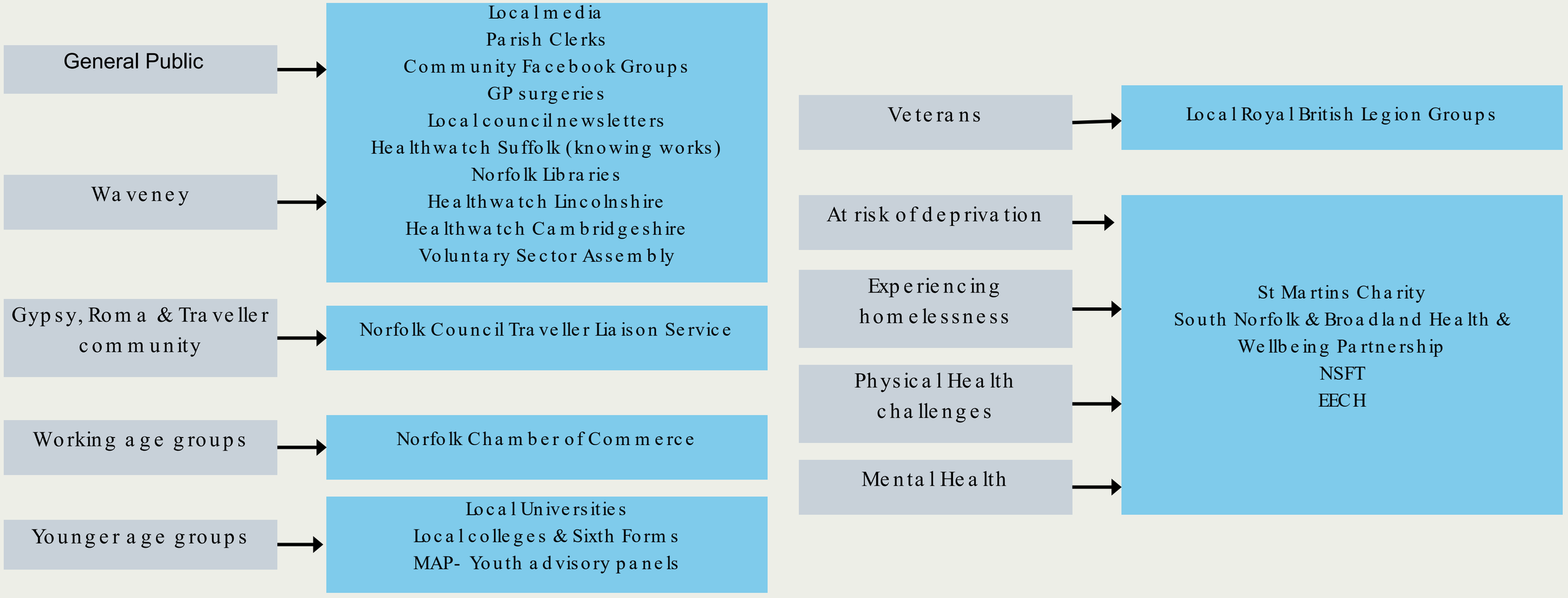
Survey

Focus Groups

Workshops



Distribution of survey



Progress so far

Focus Group Targets

General Public	North Norfolk PPG (30/10) n=tbc General public survey respondents (26/10) n=6
Carer's	Carer's Voice Charity (23/10) n=9
Disability & Mental Health	BUILD (15/10) n=3 Clinks Care Farm (13/10) n=11
Migrant Community	Great Yarmouth Refugee Outreach and Support (20/10) n=9

Workshop Numbers

JPUH	6 Governors (27/10)
QEH	11 Governors (28/10)
NNUH	12 Governors (29/10)

Demographics update

[as of 29/10/2026]

Survey n=4,454

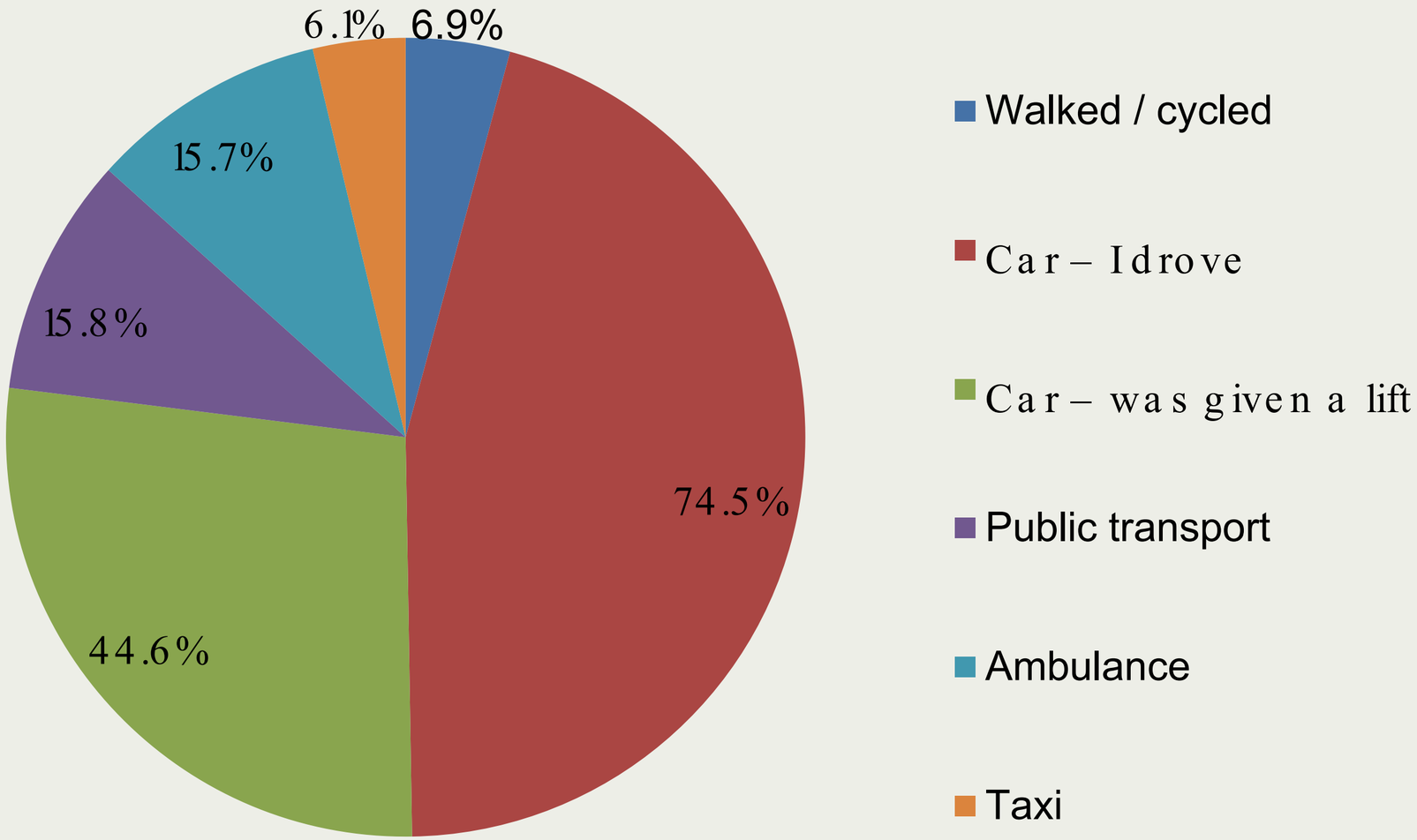
Hospitals

- 67% of respondents were reporting on the Queen Elizabeth Hospital, Kings Lynn
- 40% of respondents were reporting on the Norfolk & Norwich University Hospital
- 16% of respondents were reporting on the James Paget

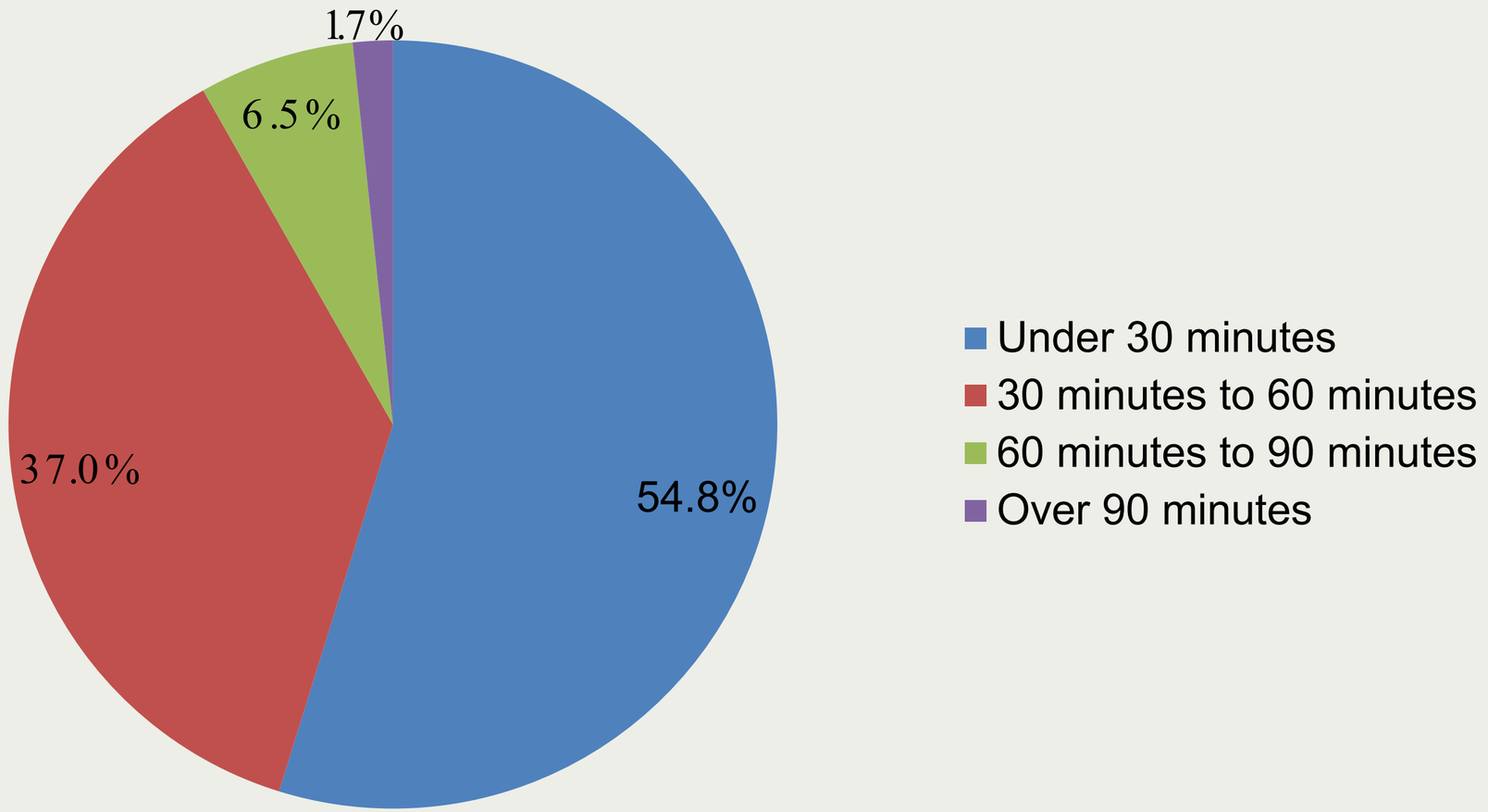
Who

- 81% are patients, 53% carers, family, supporters, 11% volunteers, 12% employees
- 7% 16-34 years, 25% 35- 54 years, 62% 55-80 years, 6% 81+ years
- 72% of respondents were female, 26% male, 0.2% Non-binary
- 92% of respondents were White British
- Just under half of respondents were living with a long-term health condition (46%)

How did you travel to hospital?



How long did it take you travel to hospital?



76% respondents said "*it was a comfortable length of time for me* "

What makes using hospital services difficult?

1. Waiting times
2. Parking
3. Communication between different services
4. Lack of continuity between services
5. Communication before/after appointments



When you need to go to hospital, which are the most important to you?

1. Having access to urgent or emergency care whenever I need it (24 hours a day)
2. Receiving safe, high-quality care
3. Shorter waiting times for diagnosis and treatment
4. Receiving care as close to home as possible
5. Seeing the right specialist quickly



Which three areas do you think should be prioritised?

1. Faster diagnosis and treatment
2. Reducing waiting times
3. More care closer to home
4. Patient safety
5. Better communication and joint working between NHS services



Emerging Themes

Theme 1: There is poor connection to local provision of services

Causes of the issue	Impact on the public
1. Public transport costly, long or complex 2. Disabilities, poor mobility, neurodivergence, mental health issues make travel challenging 3. People rely on their social networks to travel to hospital 4. Lack of parking spaces 5. Car parking can be costly 6. People with caring responsibilities find it difficult to find the time to travel	A. Care close to home makes people feel safer and connected to their support network B. Care close to home increases people's personalisation of support C. Care close to home is more accessible to groups of people

Respondents told us

“There simply aren’t enough spaces for the volume of people that need to use them! I frequently have to wait up to an hour to park once I’ve arrived ."

“People cannot sit and wait for hours. I have a baby and in the space of a week had to visit the hospital 4 times back and forth, one day I had to go back and forth twice, and struggle to get childcare”

“having to go via Cambridgeshire to access Norwich via train. Excel bus service does not directly link to NNUH hospital, often runs late and has unreliable app with no timely updates regarding service delivery. “

Emerging Themes

Theme 2: Care is taking too long

Causes of the issue	Impact on the public
1. Long waits to be seen and for results 2. Lack of available appointments and beds 3. Not enough staff to manage the demand of patients 4. Lack of communication continuity between how different services and departments	A. Waiting increases anxiety B. Waiting makes people lose trust in the quality of their care C. Waiting can delay life saving treatment D. Not knowing where you are in the waiting list can be frustrating

Case Study: When care is taking too long

A patient described waiting two years for a neurological diagnosis, with multiple referrals between specialists and poor communication between services. Changes to waiting lists meant they were lost in the system, while delays in accessing the right specialist care contributed to their condition worsening.

The impact

- Worsening health and chronic pain.
- Delays threatened their ability to remain in employment, causing concern that they could lose their job.
- Repeated referrals, cancelled appointments and disconnected services caused frustration and wasted time.
- The patient had to repeatedly advocate for themselves to get the care they needed.

“I could have lost my job if I didn't get the referrals what I needed.”

Emerging Themes

Theme 3: Care is not being personalised

Causes of the issue	Impact on the public
1. People have to fit into the hospital way of working 2. Lack of communication between services means people's unique needs not always acknowledged 3. Lack of joined up working places burden on patient and family 4. Poor acknowledgement of family system 5. Lack of staff to manage demand needed to work holistically	A. Personalised care increases peoples trust in the quality of care B. Personalised care makes people feel safer, heard, and cared for C. Personalised care is more inclusive of individual complexity D. Relational care and positive interactions with staff influence what is considered high - quality care

Case Study: When reasonable adjustments are not made

A parent described repeated traumatic hospital experiences for their adult son, who has Down syndrome and experiences significant anxiety around hospital visits. Despite visiting the hospital in advance to explain his needs, communication difficulties and likely response to unfamiliar situations, the family felt their concerns were ignored.

During a planned operation, delays meant that an opportunity to carry out the procedure while he was asleep was missed. The situation escalated, with staff physically restraining him while attempting to administer anaesthetic. The experience left both parents deeply distressed.

The impact

- The patient experienced significant fear and distress.
- His parents felt unheard, unsupported and traumatised by what happened.
- Previous negative experiences compounded the family's loss of trust in the hospital.
- The family decided not to return to the hospital for future procedures.

"I made a point of going up the week before to say, look, he won't cooperate. If you think he will, he won't."

"I might as well have been talking to the wall. It was completely ignored."

Emerging Themes

Theme 4: Lack of trust in decision makers

Causes of the issue	Impact on the public
1. Poor communication of changes and decisions 2. Perceived lack of change despite previous feedback 3. Lack of understanding about healthcare processes and structures	A. Lack of trust increases people's hopelessness at change and improvement and skepticism that management are working in their best interests B. Lack of trust reduces people's safety and belief that care is high quality C. Lack of trust increases people’s anger towards services

Respondents told us

“The attitude of management, undertaking and implementing decisions that have a major in - pact on local communities without consultation with the people that are affected.”

“How much you can trust what you are told?”

“knowing the hospital I am attending isn't the bottom on the league tables , ineffective in basic care and poorly managed, and continually not learning from it's mistakes is the number one factor in myself and my family choosing to go to Peterborough city hospital instead of qehkl , we live in Wisbech.”

“Lack of confidence in the hospital “

“It won’t work it never does”

Respondents told us

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“Lack of confidence in the hospital “

“It won’t work it never does”

Next Steps

Current Engagement

- The survey will remain open until **6th November**
- The survey responses are being coded using framework analysis
- The focus groups are being transcribed and workshop notes captured.
- The report will be shared with the Hospital Group in January 2027
- Once a formal response has been provided, the report will be shared with the wider public.

Future Engagement and Consultation

Final Report which shall also include limitations to the engagement exercise
Id Case for Change approved – work with colleagues to:
Discuss and undertake further engagement (January –April 2027):
Work with the local population to discuss all the options posed
Provide feedback both verbally and in report form
Formal public consultation:
Final decision and next stages: