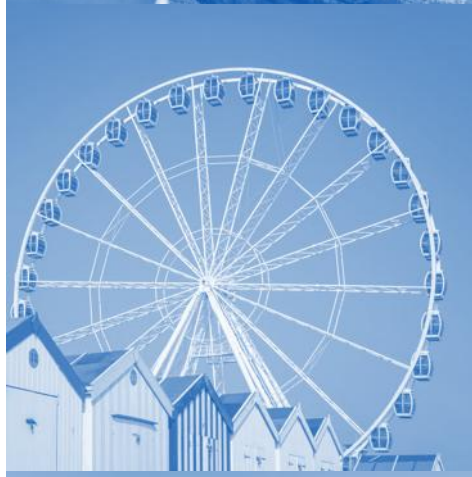
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Our **Case for Change**

Group Board in Public

2 November 2026

What is a Case for Change?

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Purpose of a Case for Change

The first key document in a service reconfiguration programme. It explains why services need to change, using evidence about population needs, current provision and the challenges facing the health and care system.

It makes the case for action and explores options without necessarily setting out a preferred solution.

What a Case for Change should demonstrate

Strategic fit
Vision aligned with local and national plans and change drivers.

Clinical evidence
Standards, local performance, outcomes, need and inequalities.

Intended benefits
The improvements that service change aims to deliver.

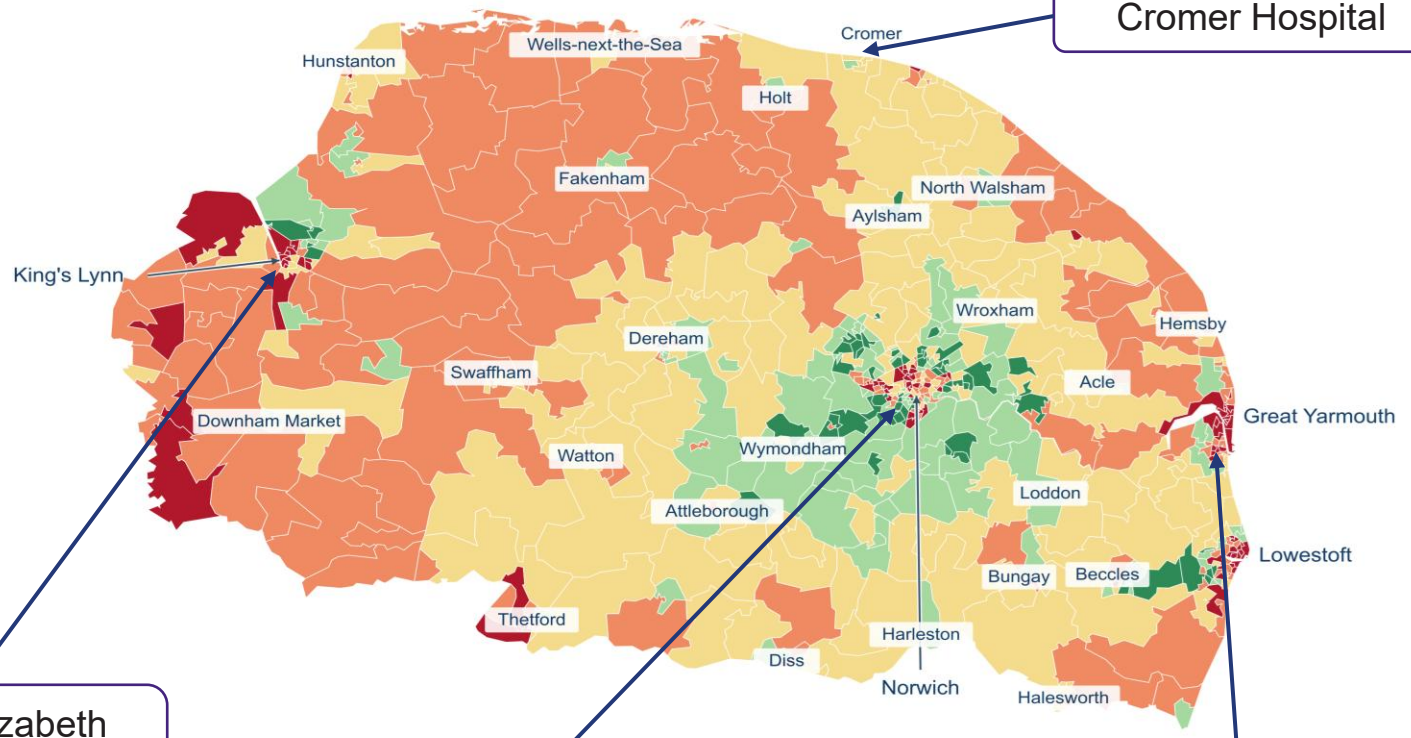
Engagement plan
How patients, staff, the public and partners have shaped the work.

Key dependencies
Finance, workforce, estate, digital and other practical constraints.

The **Case for Change** starts scenario development, informs business cases, and provides a strategic sense check.

Source: NHS England, Major Service Change: An Interactive Handbook (2026), Planning and Case for Change.

Our challenge: Our geography, population and inequalities make delivering sustainable healthcare uniquely challenging. 1m+ people living in a huge area dispersed around coast, rural and three urban areas. 120,000 people in the 20% most deprived groups



JPUH serves the highest-disease-prevalence population of any acute trust in England.

Population growing faster than much of the **country —** and ageing faster too

National IMD decile

- 1–2 Most deprived
- 3–4 More deprived
- 5–6 Middle
- 7–8 Less deprived
- 9–10 Least deprived

Norfolk and Waveney: Index of Multiple Deprivation, 2025

Our care today: We know we are not consistently delivering the quality of care our population deserves, and our current model is financially unsustainable

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- CQC rates safety as Requires Improvement at all three hospitals.
- QEH has had medical undergraduate placements and surgical trainees removed
- JPUH and QEH are in Segment 4 of the NHS National Oversight Framework, ranked 125th and 132nd respectively out of 134 trusts.
- We do not meet most of the national constitutional standards
- In August 2026:
    - 191 patients each day remained in our hospitals after they no longer met the criteria to reside (representing 5,908 delayed bed days across the month).
    - 662 patients waited more than 12 hours in ED after a decision to admit.
- Some services are fragile, with insufficient activity volumes to maintain skills, shortages in workforce capacity, gaps in specialist capability and physical constraints.
- QEH and JPUH estate contains extensive reinforced autoclaved aerated concrete.

NOF position

Q1 2026/27, 134 acute trusts

JPUH

125 / 134

Segment 4, lowest segment

Capability: Amber/Red

Q4 in 2 of 6 domains

QEH

132 / 134

Segment 4, lowest segment

Capability: Red

Q4 in 4 of 6 domains

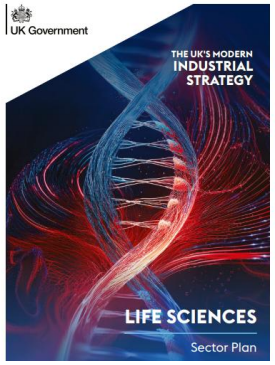
Q4 = lowest quartile. Source: NHS England NOF.

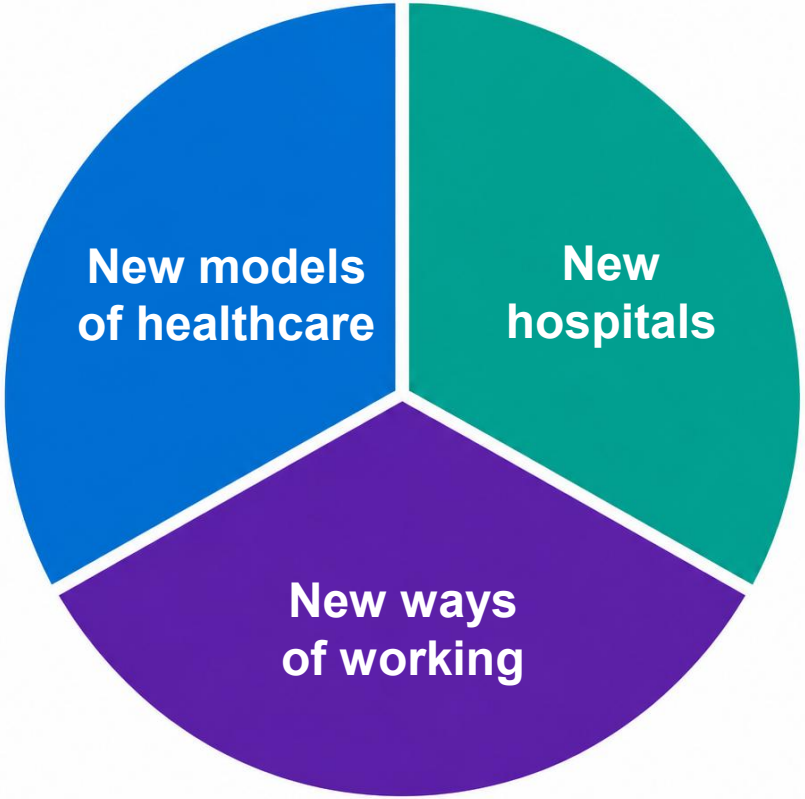
Why now? Government policy, the formation of our group, and £2.8bn New Hospital Programme investment into Norfolk give us a once-in-a-generation opportunity to transform how we deliver care

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NEW QEH
BUILDING OUR FUTURE TOGETHER

FUTURE PAGET

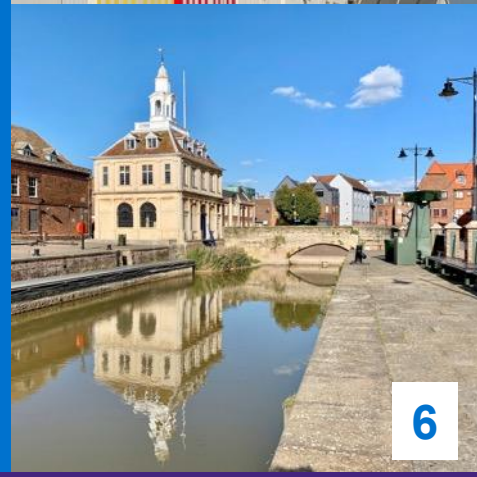
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Neighbourhood Care

Neighbourhood is central to the Government's 10 Year Plan. Too much care is delivered in hospitals when it would be better delivered in the neighbourhood – this is what our patients want and will deliver better care outcomes.

Without a shift towards neighbourhood care, we will need 600 more hospital beds and face a £50+ million deficit by the mid-2030s. We have developed an ambitious approach, referred to as 'neighbourhood max', showing what we could achieve just by doing what the best in the NHS are doing already.

Shaping hospital campuses for neighbourhood care

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Layer 1: Virtual Response The system's "front door," featuring online advice, digital GPs, and early triage.

Layer 2: Local and Community-Based Care
Integrated primary, community, allied health, mental health, social care and prevention services that support people close to home, including rural, remote and Indigenous communities.

Layer 3: Community Urgent Response
Rapid response and urgent care centres designed to absorb demand without hospital admission.

Layer 4: Regional Diagnostics and Ambulatory Treatment
Scaled diagnostic, cancer, dialysis, infusion, imaging, procedural and ambulatory platforms that serve multiple communities without requiring full hospital infrastructure.

Layer 5: Specialist and Emergency Hospital Care
Hospitals transition from the "default location" to a component reserved for complex and critical care.

The Digital Data Layer
System agility is driven by interoperability, vendor independence, analytics, and AI readiness.

Neighbourhood Care

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Neighbourhood health will only be realised if we create the workforce, community capacity, facilities, digital connections and shared ways of working needed to deliver a shared model across Norfolk and Waveney with primary, community, VCSE, housing, social care and all our partners.

LEFT SHIFT TOWARDS PREVENTION

Creating community assets for health and well-being

Acting across the population to maximise well-being and keep people well

Early identification and improved Access

Resource shift and case-finding to identify conditions early and make impact quicker and easier

Targeted Interventions and Secondary Prevention

'Treat to Target' - halting progression of conditions, challenges or individual risk factors

Prompt action on rising risk

Coordinated care delivered early before a crisis with strengthened alternatives to hospital and clear (de)escalation.

Our neighbourhood modelling indicates that **four interventions drive almost 90% of avoided bed days.**

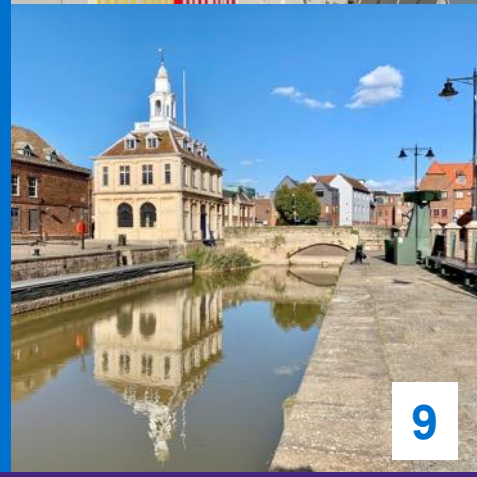
1. Proactive Case Management (Integrated Neighbourhood Teams)
2. Virtual care
3. Palliative and end-of-life care at home
4. Discharge to assess

A **'neighbourhood max'** approach could reduce the need for up to **11 hospital wards** and **deliver a £25 million net financial contribution**

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Developing our Case for Change

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.

We have undertaken a clinically-led analysis that indicates 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.

Clinical Proposal Development

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A clinically-led programme

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.



Independent patient and public engagement

Working with healthwatch Norfolk

Our Aim:
To ensure the views and experiences of patients, carers, the public and our communities are heard and meaningfully considered in the development of the new clinical strategy and the Case for Change.

What has been commissioned:
Healthwatch to lead and facilitate engagement across the three hospitals' geography, including a survey (online and in print) and focus groups in key areas.

Survey –29/10 update:

- Over 4,400 responses
- Spread across catchment area, with majority of responses from King's Lynn
- Greater proportion respondents age 55+
- Increasing numbers responding in the working age group
- 46% report living with long term conditions

Emerging Themes

- Poor connection to local provision of services
- Care is taking too long
- Care is not being personalised
- Lack of trust in decision makers
- People want 24/7 access to urgent and emergency care

Reach

Engage widely across our communities

- Engage with patients, carers, members of the public and VCSE organisations, including seldom heard groups.
- Facilitate additional community discussion groups to gather more in-depth feedback from key groups.

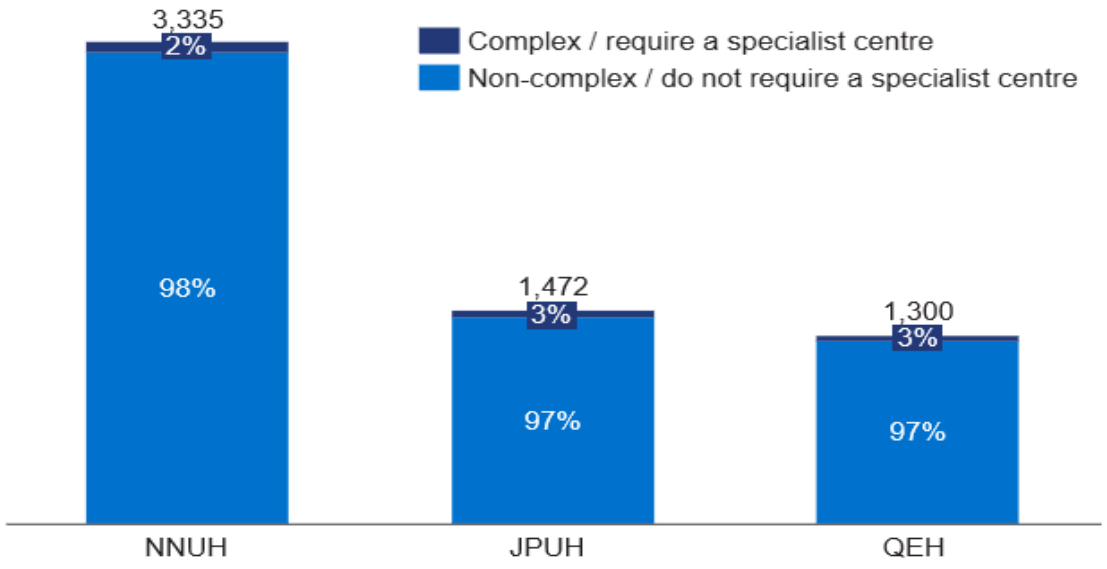
Key milestones

September 2026	October 2026	November 2026	December 2026	January 2027	February 2027
Project commenced	Engagement activity across communities	Interim report summary	Engagement activity across communities	Final report	Group response to recommendations (within 1 month)

Non-Complex Care

- 97% of the care we provide is non-complex and routine
- 75% ED attendance discharged home
- 1/3 admissions are less than 48 hours
- There is 1 admission p/h at night at QEH and JPUH
- To deliver this locally requires major improvements to clinical practice to maximise services, like Same Day Emergency Care (SDEC)

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)

Complex Care:

We need to consider what we do for the most complex 3% to improve outcomes and the quality and safety of specialist care

Unplanned Care

- High acuity presentations / procedures includes - cardiac arrest / primary PCI, GI bleed, major trauma, stroke, etc.
- Paediatric spells >24 hours,
- 18-80 adults >48 hours
- Emergency Surgery operating 22:00-08:00

Maternity Care

- All deliveries and neonatal care

Planned Care

- QEH and JPUH elective inpatient activity (exclude Trauma & Orthopaedics at JPUH retained in James Paget Orthopaedic Centre)

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Unplanned Care







Unplanned care – Proposed for Further Consideration

Configuration of emergency care matters particularly in Norfolk and Waveney given our population and geography. We recognise that local access to emergency care and diagnostics is essential.

Our proposal for further consideration is that 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.**

24/7 Emergency Department & Urgent Treatment Centre	Adult Same Day Emergency Care (SDEC)	Paediatric Same Day Emergency Care (SDEC)	Critical Care
• Emergency department with designated paediatrics department • Acute Medical Unit	• Consultant delivered • Surgery and medicine **08:00–22:00** • Specialist support in key areas • Virtual care enabling safe discharge	• Same-day emergency care with a maximum stay of 24 hours • Virtual care enabling safe discharge	• 24/7 Critical Care

Full range of diagnostics

Unplanned care: Most people who are admitted to hospital for an emergency have a medical condition. We have explored different models of how we can improve outcomes. An unselected medical take retaining emergency and critical care at all three hospitals protects access and minimises impact on other providers

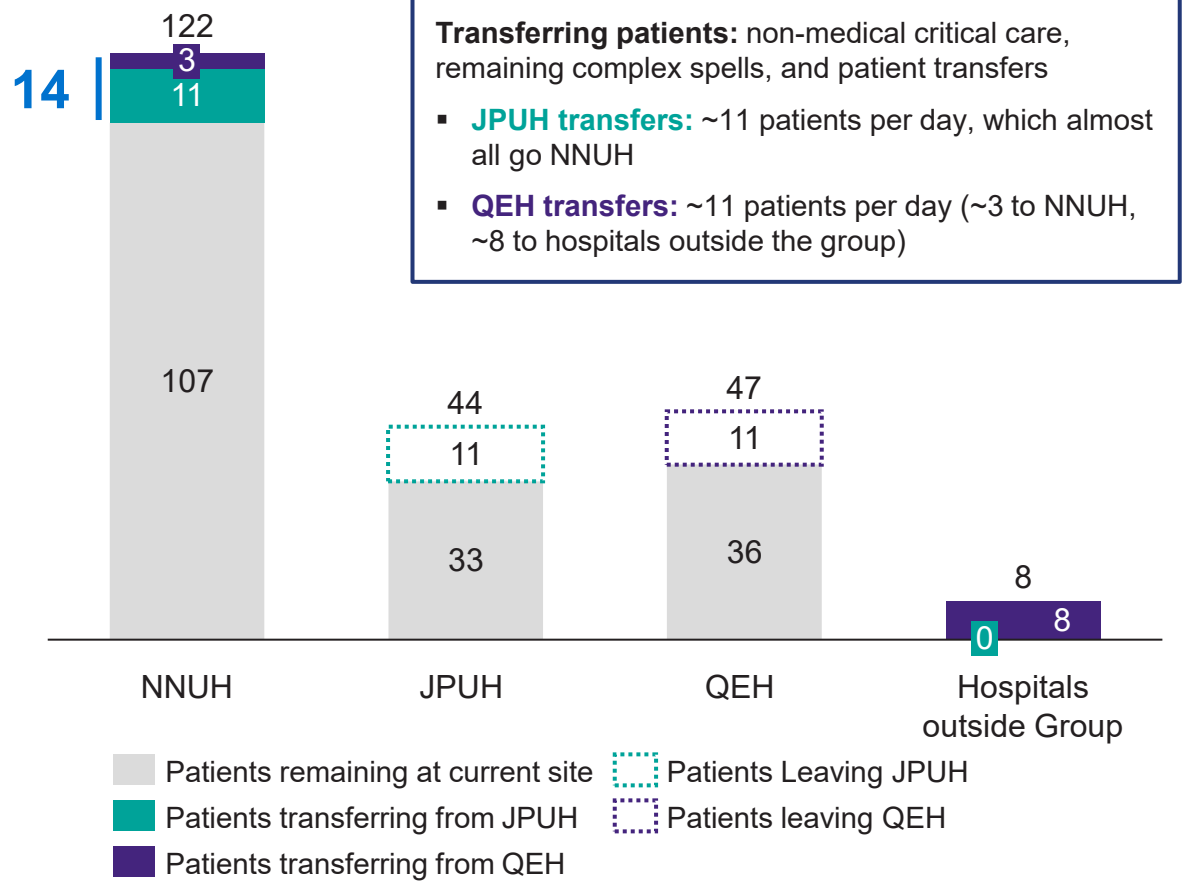
PROPOSED FOR FURTHER CONSIDERATION

All hospitals receive all presentations except most complex (GI bleeds, stroke, complex cardiology interventions, requires interventional radiology, etc.)

Requires:

- ED with majors and resus capability 24/7
- Full medical take capability to run AMU or equivalent
- Specialist medical 'ology' support in key disciplines
- Critical care

Average daily Non-Elective adult inpatient spells by Trust under unselected medical take scenario ,
#, FY 2034/35



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Maternity Care







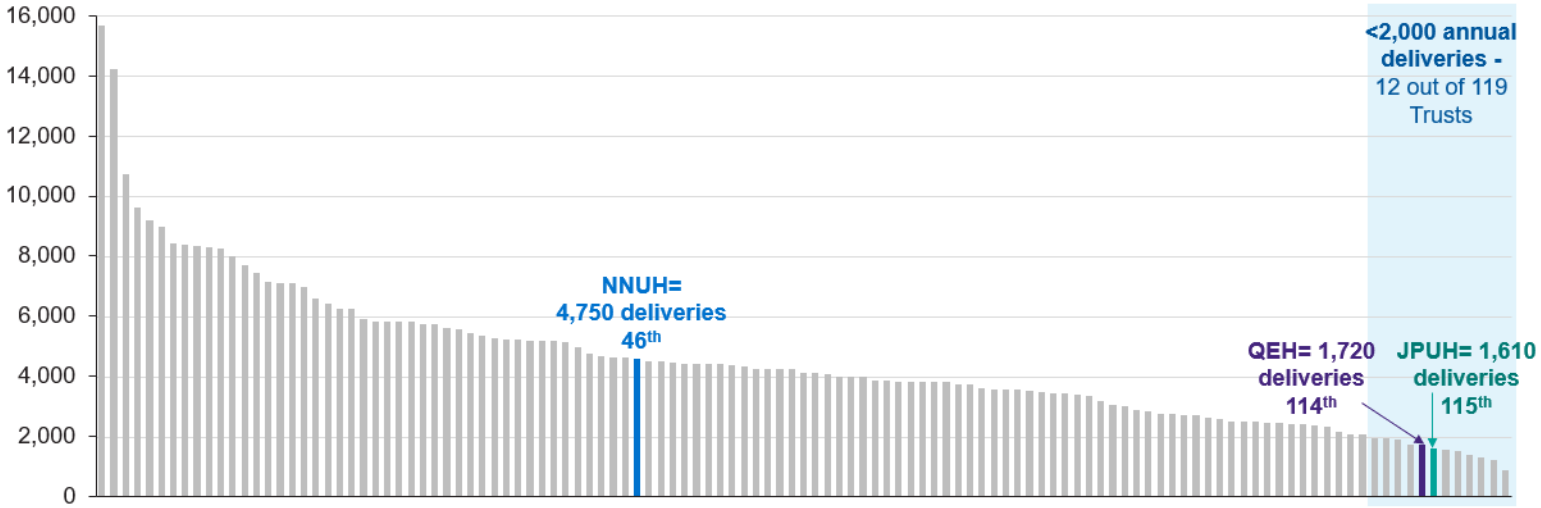
The future of maternity: Our current three-site model is unsustainable – by the mid 2030s, QEH and JPUH will each deliver fewer than 4 babies a day, with only 1–2 through normal birth. A single-site model improves safety and specialist staffing but requires access mitigations, while a two-site model delivers the clinical benefits to a lesser extent.

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CONTEXT

- In 2024/25, **QEH and JPUH were two of only 12** hospitals nationally with **fewer than 2,000** annual deliveries (see chart)
- **Total deliveries are projected to decline further,** by between 9% (ONS projection) to 13% (current trajectory) from FY25/26 to FY31/32.

Total annual delivery episodes by NHS Trust* in England,
#, FY24-25 (Apr 2024 – Mar 2025)



PROPOSED FOR FURTHER CONSIDERATION

All sites will have a 24/7 paediatric SDEC. Any site with a **delivery suite** will have a neonatal unit and inpatient paediatric beds.

- **Three delivery suites** with unbalanced delivery volumes
- **Two delivery suites** with **balanced** delivery volumes
  - NNUH & QEH; or
  - NNUH & JPUH
- **One delivery suite** at NNUH

Maternity Care in the Neighbourhood

Neighbourhood-focused Perinatal Care

- 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



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Planned Care







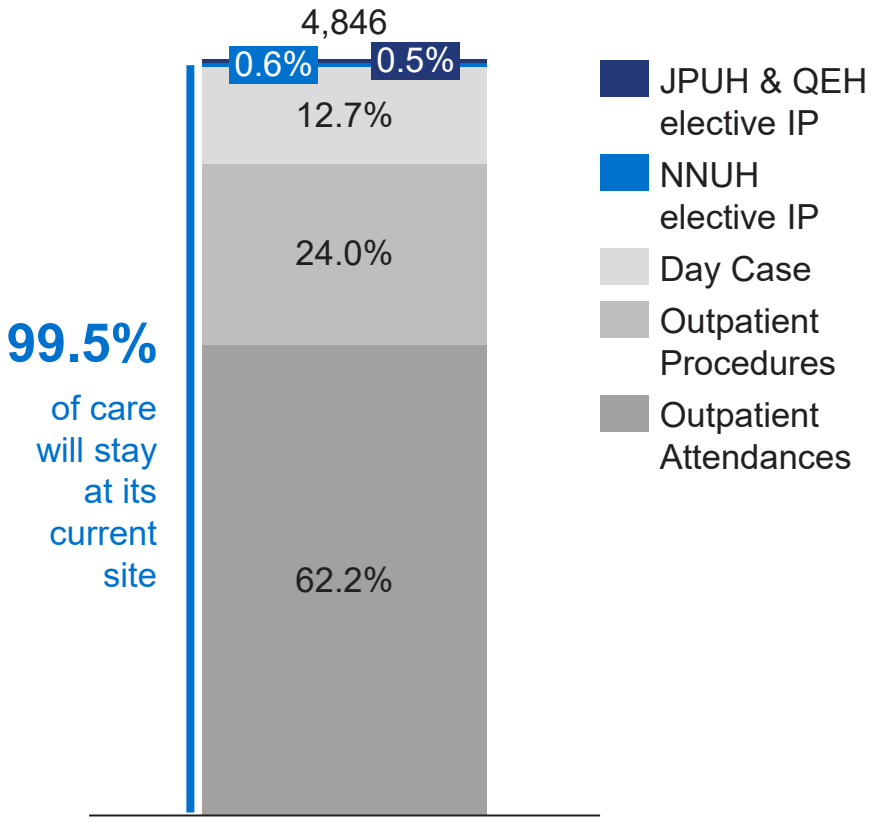
Planned care: Our proposals for further consideration show that 99% of planned care activity could continue to be delivered at its current site

We will improve our care through expanding robotic surgery and introducing 23-hour enhanced recovery across all three hospitals.

This delivers better outcomes and more care as day cases. This would require investment in technology, clinical pathways and appropriate support for patients before and after treatment.

PROPOSED FOR FURTHER CONSIDERATION

- All three hospitals expand robotic surgery and provide 23-hour enhanced recovery, enabling more complex day-case procedures.
- The most complex elective inpatient surgery could be consolidated at NNUH.



Groupwide average daily planned care activity (adults & paeds) by type,
%, FY25/26 (Apr 2025 – Mar 2026)

These are our proposals for further consideration

Norfolk and Waveney University Hospitals Group

I.

Do minimum – Neighbourhood Max. + Quality Standards

Maternity 3 x delivery suites with unbalanced volumes and 24/7 emergency surgery, neonatal units, critical care and inpatient paediatrics

+

Unplanned care
3 x Unselected medical take

+

Complex medicine and surgery transferred to NNUH

II.

Two delivery suites (NNUH and QEH or NNUH and JPUH) + unselected medical take

Maternity 2 x delivery suites at NNUH and QEH/JPUH with balanced volumes plus 24/7 emergency surgery, neonatal units, critical care and inpatient paediatrics

+

Unplanned care
3 x Unselected medical take

+

Complex medicine and surgery transferred to NNUH **INC.** either QEH or JPUH overnight emergency surgery

III.

One delivery suite (NNUH) + unselected medical takes

Maternity 1 x delivery suite at NNUH plus 24/7 emergency surgery, neonatal units, critical care and inpatient paediatrics

+

Unplanned care
3 x Unselected medical take

+

Complex medicine and surgery transferred to NNUH **INC.** overnight QEH and JPUH emergency surgery

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Other Considerations







Potential Financial Impact

- The Group is on a trajectory to a structural deficit of £53m by 2034/35
- Delivering neighbourhood max should reduce this by £25m, to £28m
- Meeting the required enhanced clinical standards adds £9m, partly offset by a £3m saving from improved quality and safety, leaving a **£34m deficit** (Do minimum scenario)
- The deficit can be eliminated depending on which combination of reconfiguration scenarios are chosen

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
Maternity Care	
Two suites at NNUH & QEH (balanced)	~£8m
Two suites at NNUH & JPUH (balanced)	~£6m
One suite at NNUH	~£18m
Unplanned Care	
Unselected medical takes	~£18m

New Hospital Programme – QEH and JPUH

- The New Hospitals Programme remains a major priority, with planning and preparatory works continuing
- Clinical strategy and hospital design need to be developed together so that the new buildings support the care patients will need in the future.
- We are working closely with national programme colleagues to manage dependencies and avoid unnecessary delay.
- The Group must also consider the implications for NNUH, not just the two replacement hospitals.





Next steps

The Case for Change provides the evidence needed to decide whether further work should begin.

NWUHG

1

Develops the Case for Change

Sets out why services may need to change, drawing on population need, current provision and clinical evidence.

ICB

2

Reviews the Case for Change

Assesses whether the arguments are compelling enough to warrant further work.

HOSC

3

Reviews and advises

Scrutinises the evidence, asks questions and considers the effect on local communities.

ICB

4

Considers and commissions

Considers the Case for Change alongside HOSC's advice. If it agrees, the ICB commissions options development, engagement and a Pre-Consultation Business Case.

No decision to change services is taken at this stage

Today we ask the Group Board to consider the Case for Change and the proposals for further consideration, and to approve submission to the NHS Norfolk and Suffolk ICB and onwards to the Norfolk Health Overview Select Committee.

The ICB will decide to commission the Pre-Consultation Business Case.