Norfolk and Waveney University Hospitals Group

Our Clinical Strategy

Part 2

Scenario Appraisal

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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

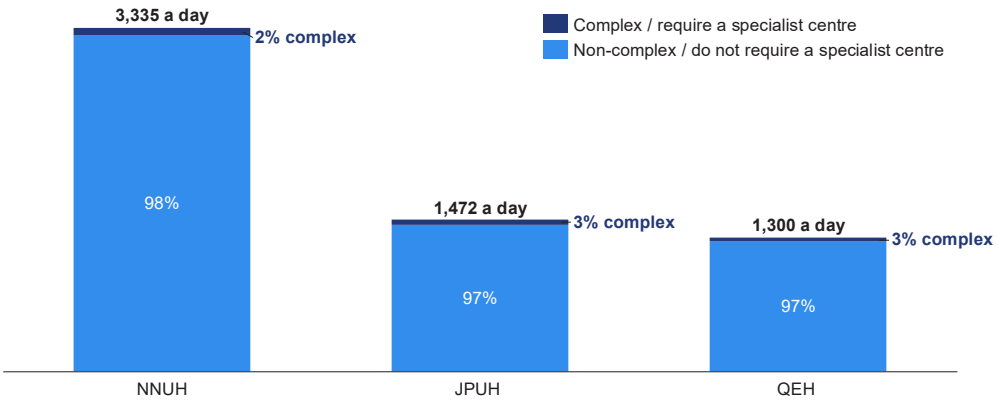
The CAG agreed an anchor objective to **maximise the number of patients treated at their local hospital site or within their neighbourhood**, while staying within the Group's financial constraints. The clinical groups defined a set of minimum requirements that form a base model for all sites under any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

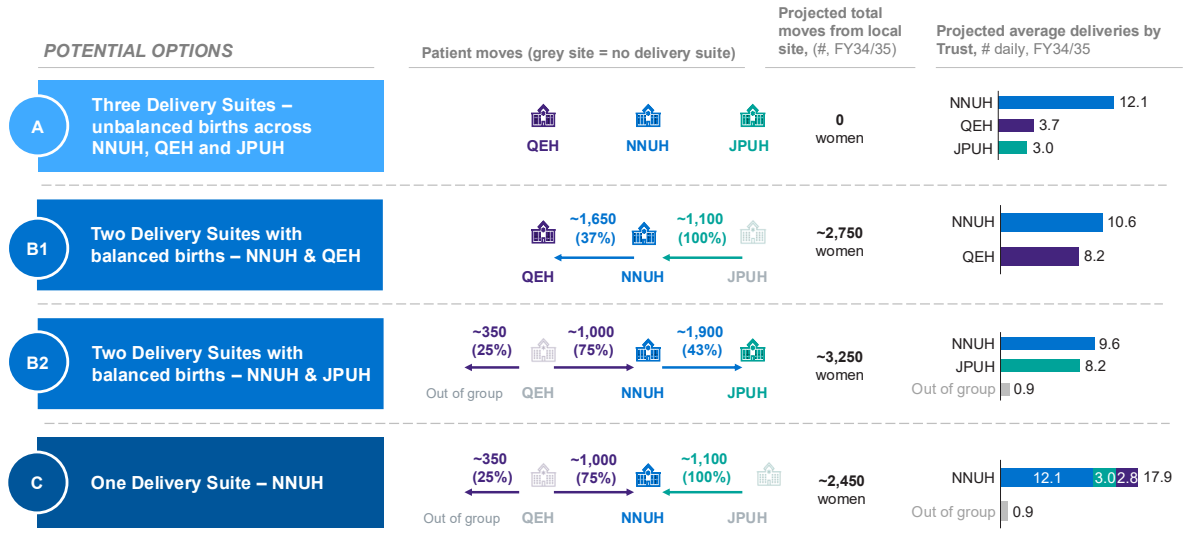
1.8 Women and children's services

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

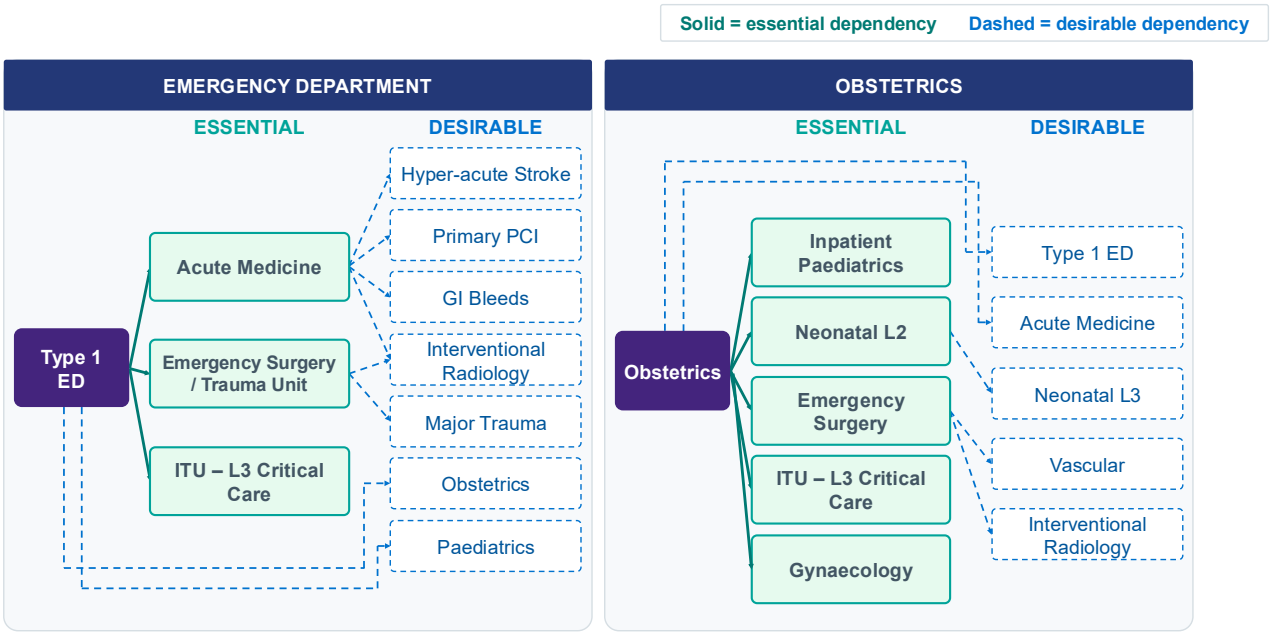
Since September, we have held four two-hour CAGs, three rounds of two-hour CWGs in each of the four workstreams, and data drop-in sessions at all three Trusts – over 40 hours of clinical engagement in total.

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)

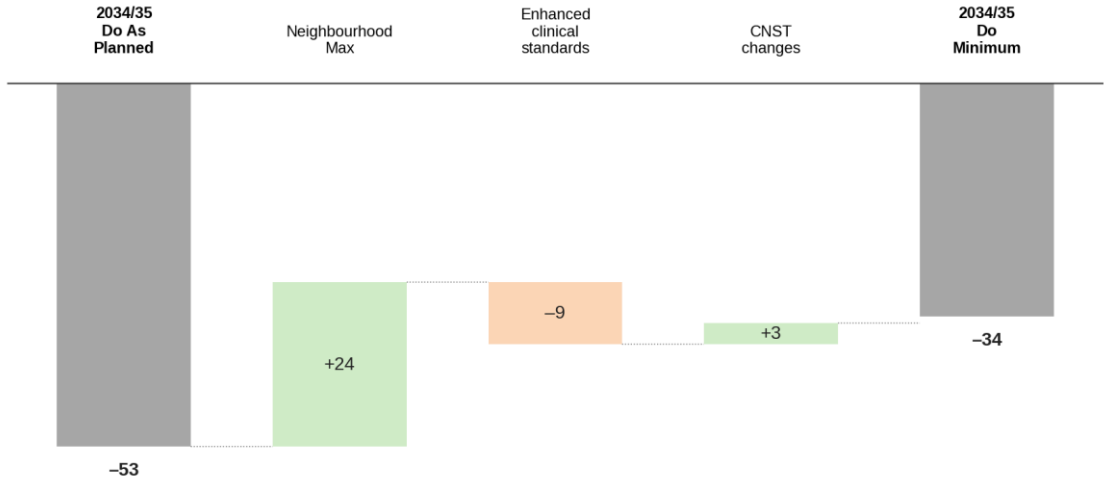
Financial position

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

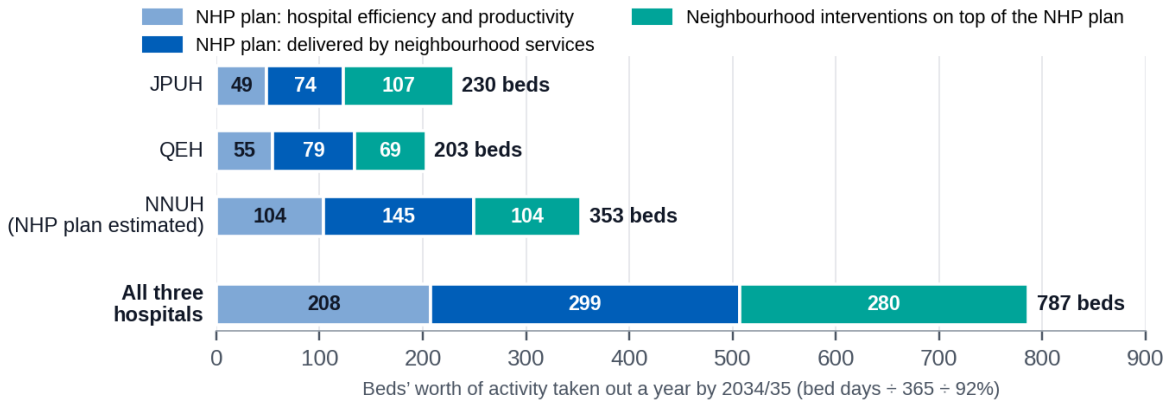


Table 5: Beds by hospital, 2034/35 (bed days ÷ 365 ÷ 92% occupancy)

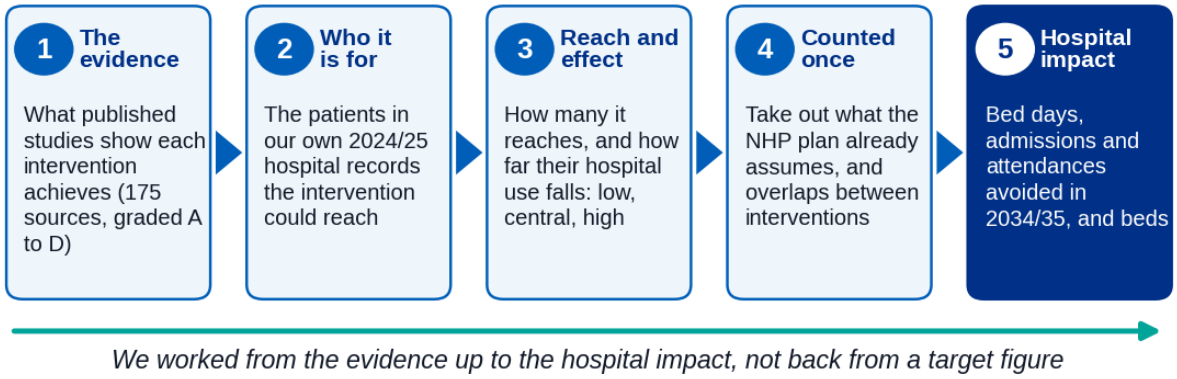
	JPUH	QEH	NNUH (NHP plan estimated)	All three
Today (2024/25)	**577**	**597**	**1,262**	**2,436**
Growth in demand to 2034/35	+101	+106	+150	+358
NHP plan: hospital efficiency and productivity	−49	−55	−104	−208
NHP plan: delivered by neighbourhood services	−74	−79	−145	−299
Neighbourhood interventions 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.

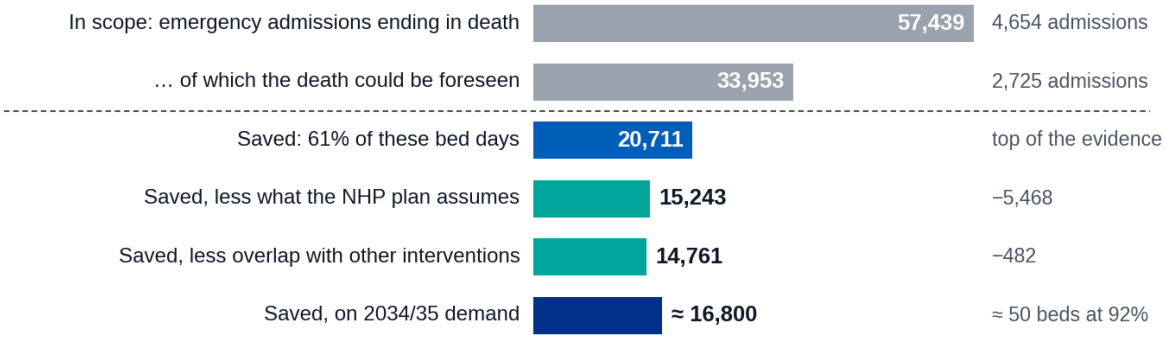
4.4 A worked example: palliative and end-of-life care at home

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)



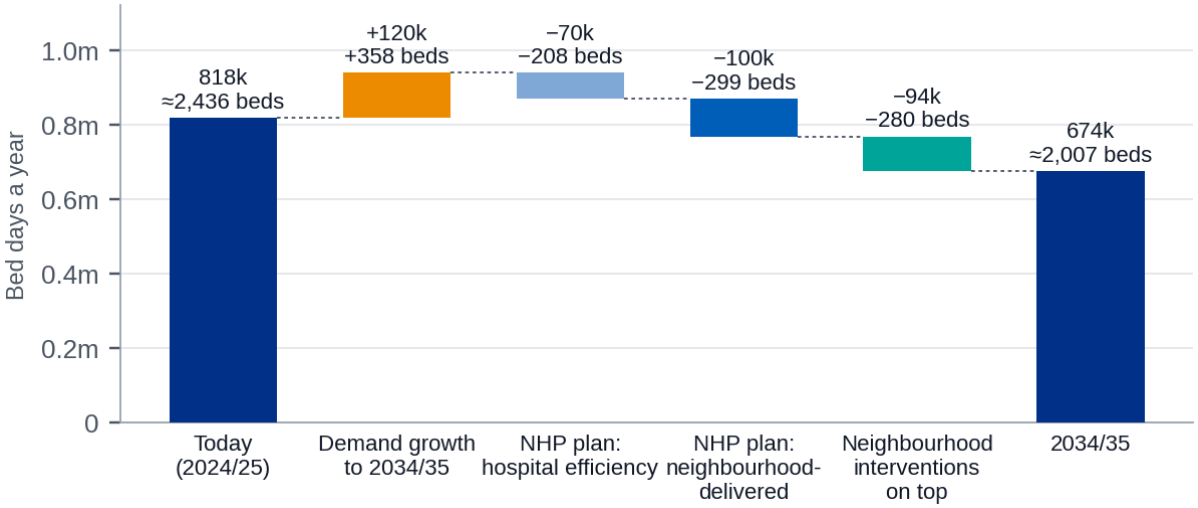
The first five bars are on 2024/25 activity; the last applies the NHP's growth in demand to 2034/35. Steps 4 and 5 are described below.

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.

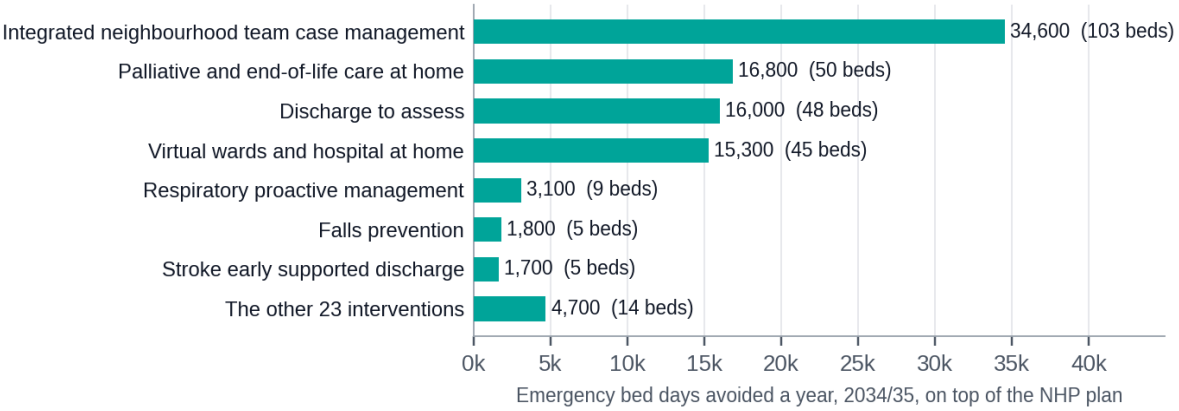
Figure 11: Bed days a year, all three hospitals, 2024/25 to 2034/35



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



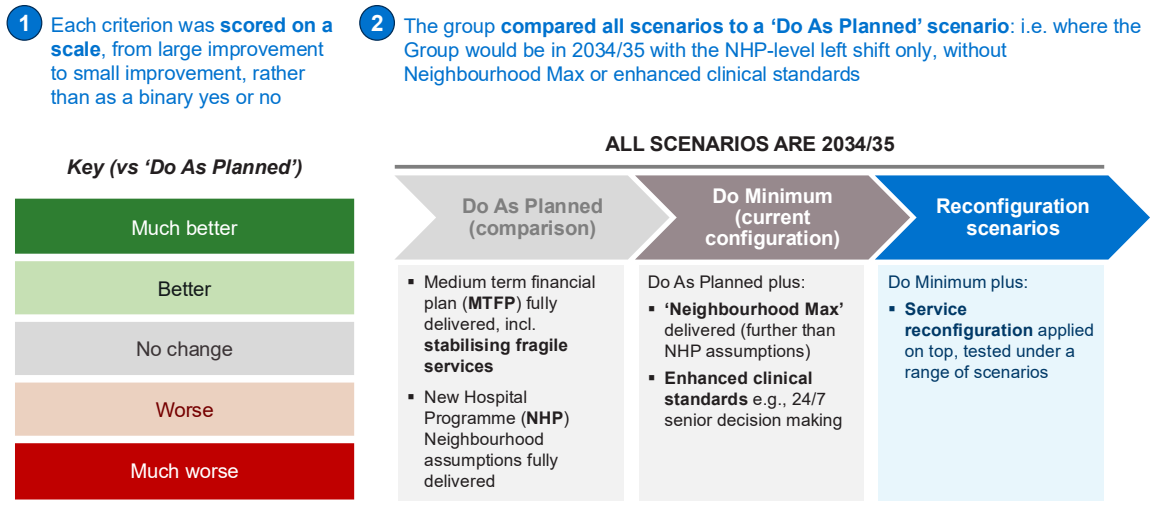
Table 6: Evaluation criteria agreed by the Clinical Advisory Group

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

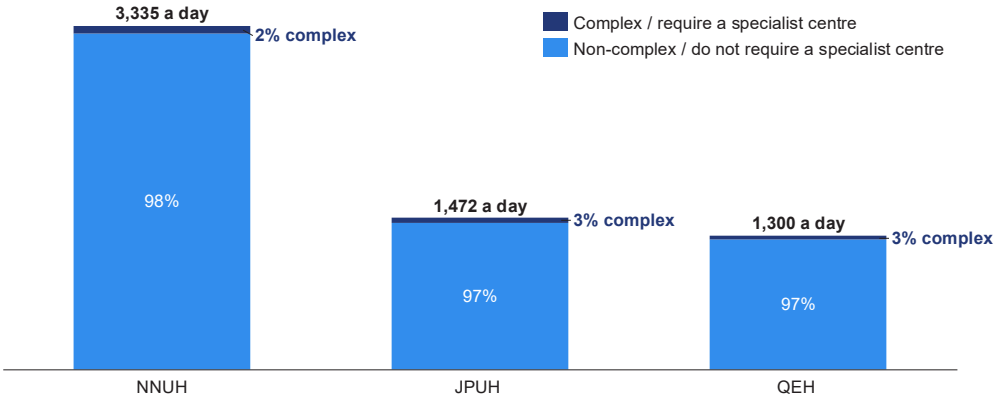
Service area	Base service model
Maternity	**Community and neighbourhood hubs (antenatal and postnatal care)** • Midwives based in community hubs across Norfolk and Waveney, with access to obstetricians on site or virtually • Hubs offer ultrasound scans, community midwife appointments, glucose tolerance 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.

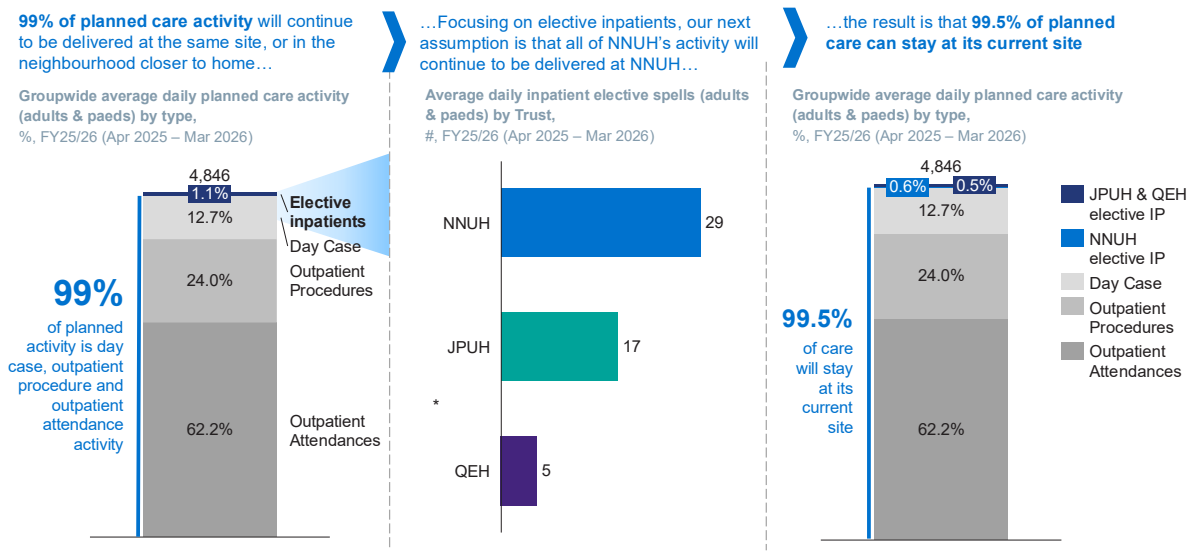
8.1 Exploring future models of planned care

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



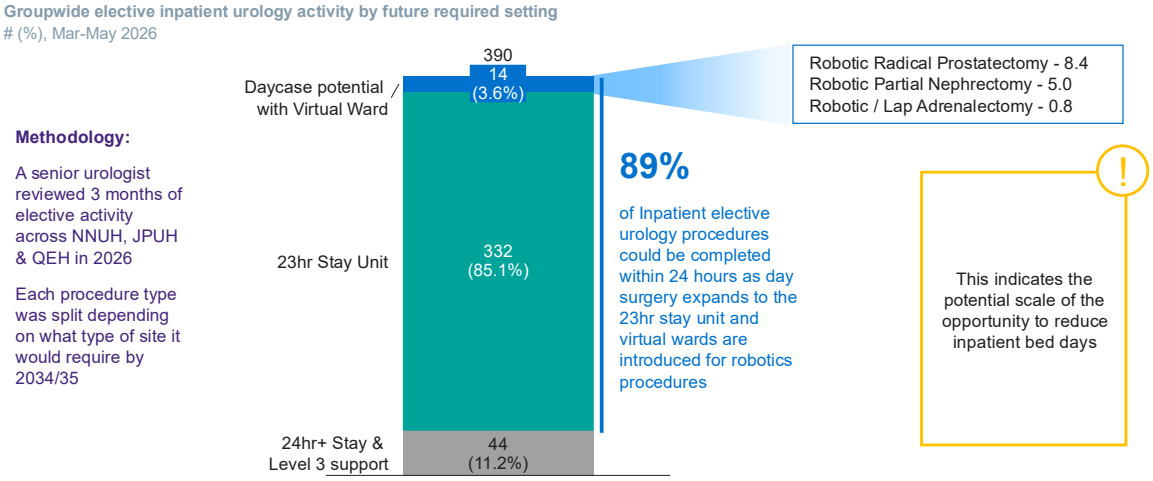
The planned care CWG also explored the potential for likely innovations by 2034/35 to transform how existing planned care activity is performed. A specialty-level deep-dive was conducted by a senior urologist who reviewed three months of elective inpatient urology across all three sites and assessed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

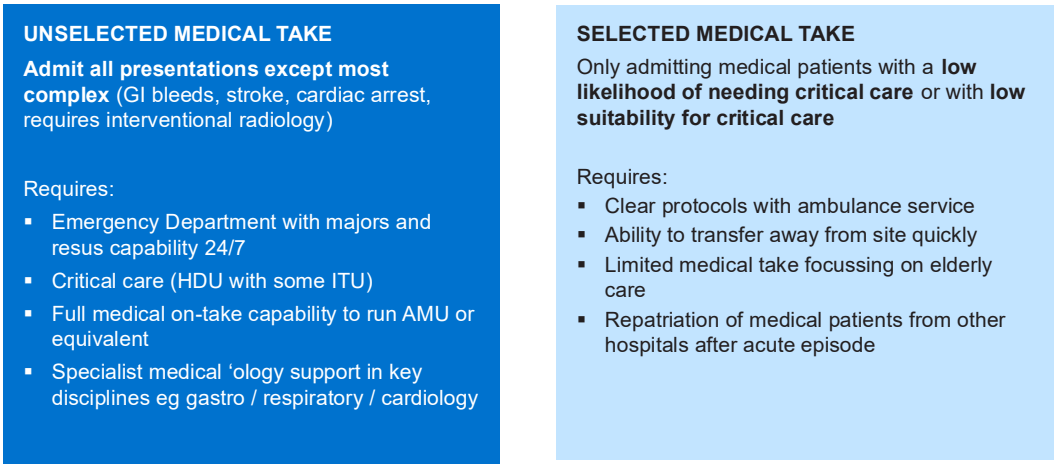
9.1 Scenario development

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

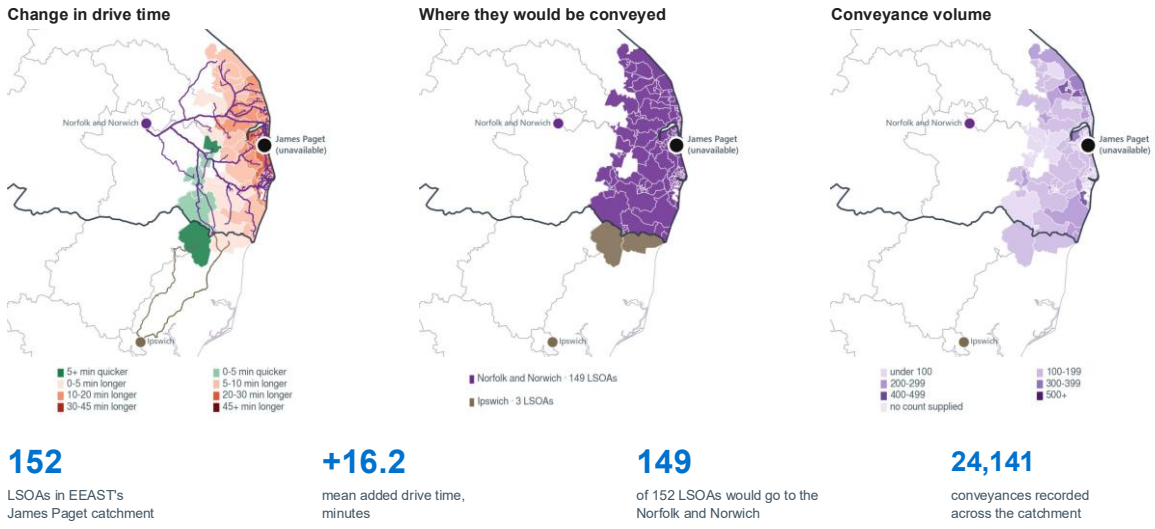
	Scenario 2: Unselected medical take	Scenario 3: Selected medical take
Emergency surgery	SDEC only, with no emergency operating overnight; one surgical registrar on site overnight	SDEC only, with no emergency operating overnight and no patients needing overnight admission
Critical care	Retained, with 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

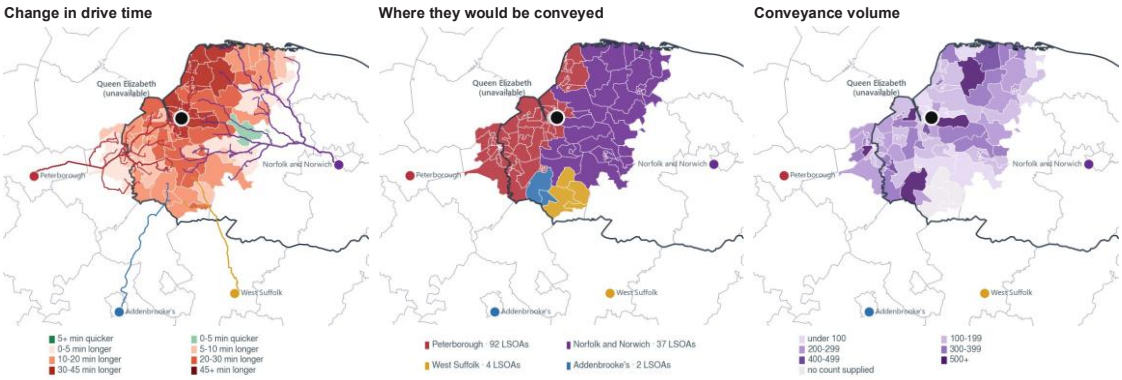
+16.2
mean added drive time, minutes

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

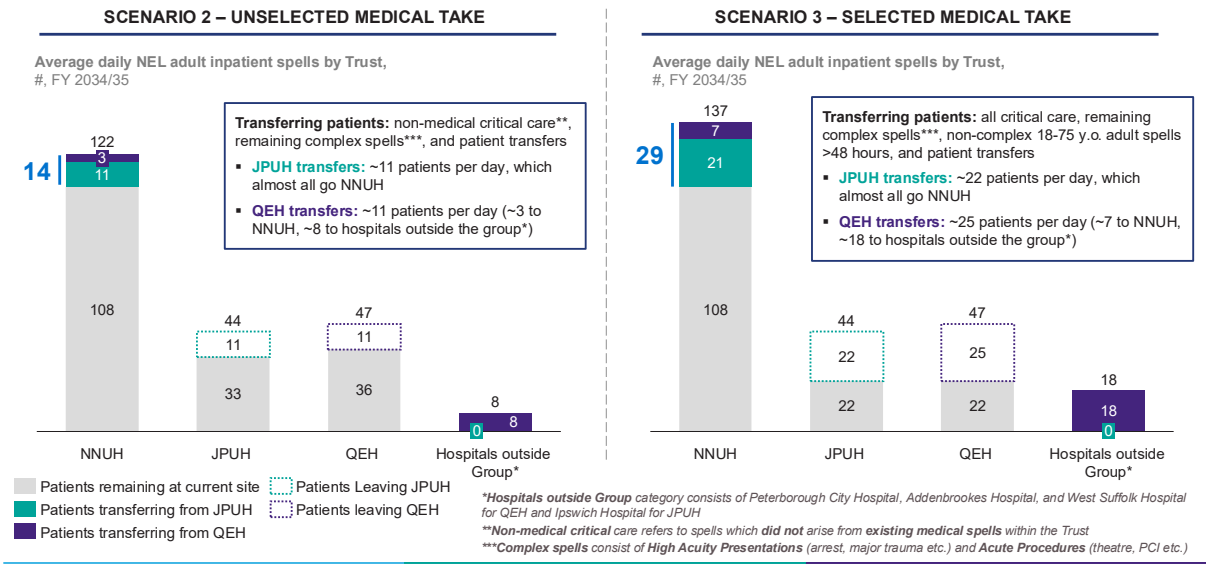
28,128
conveyances recorded across the catchment

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.

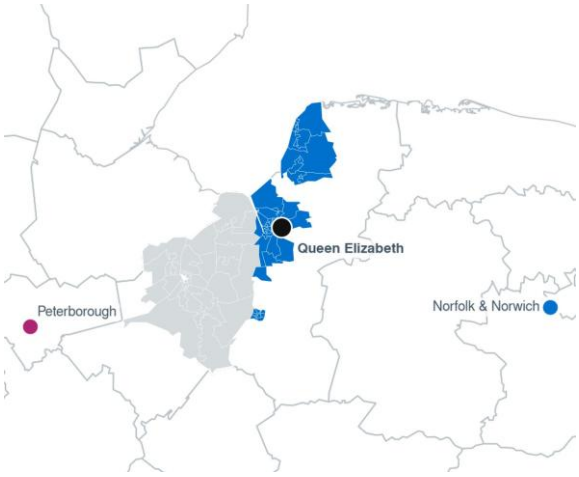
9.5 Mitigations

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

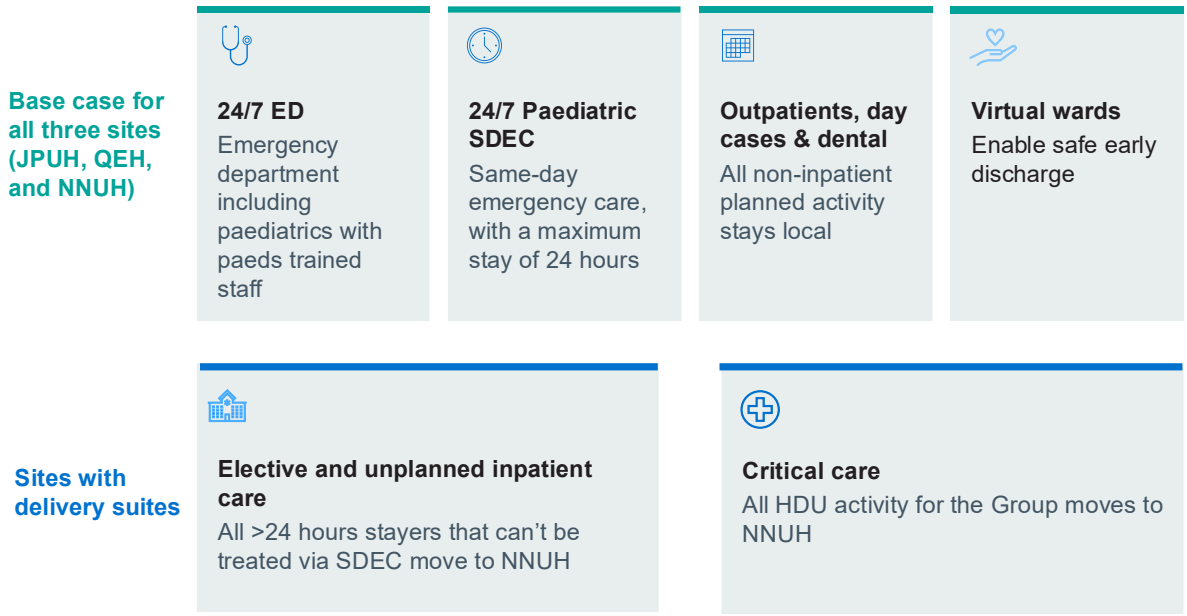
Maternity

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)

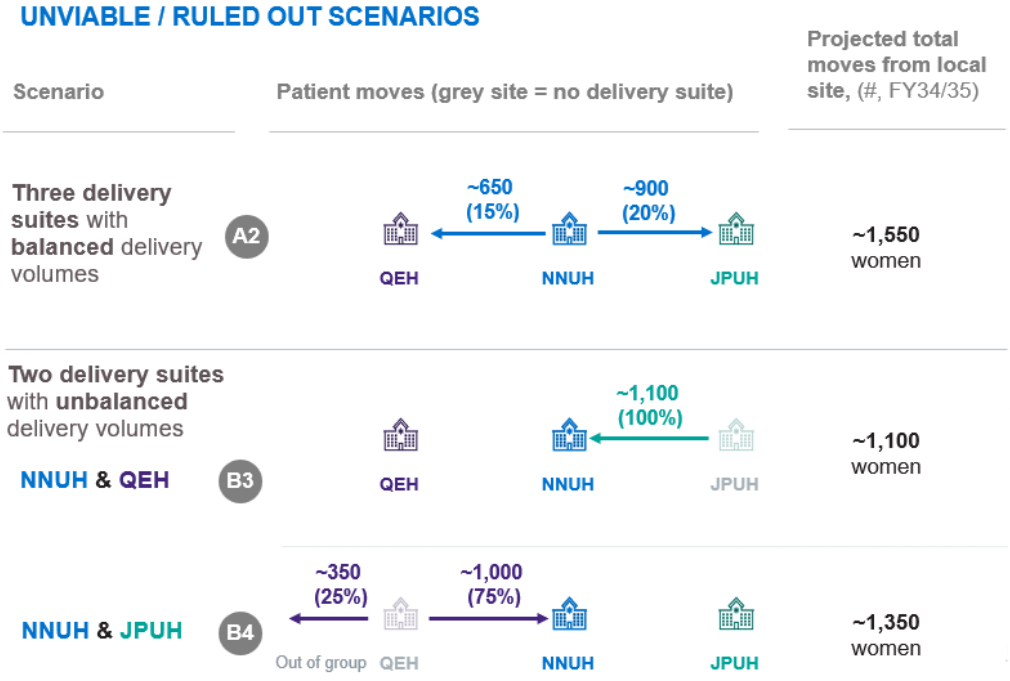
- **One site:** NNUH only (C)

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:

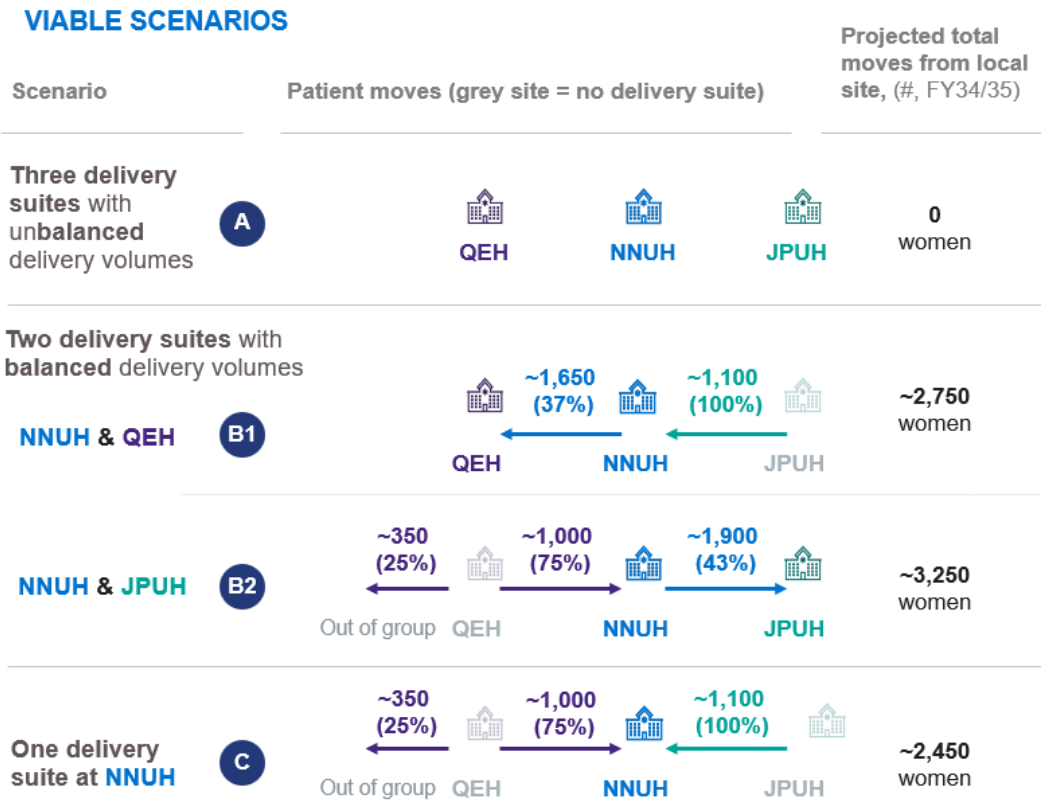
- **Scenario A: three delivery suites ('Do Minimum').**
  No change in where women give birth; QEH and JPUH remain well below a sustainable size.

- **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

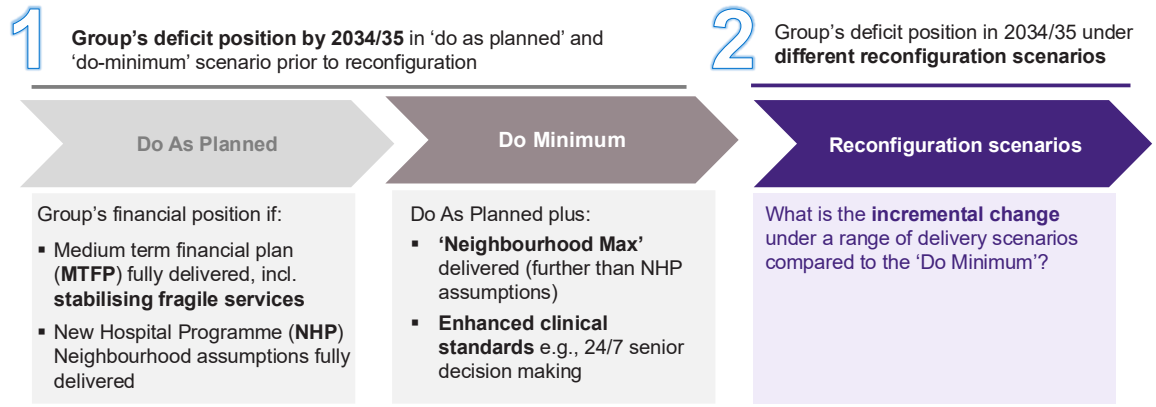
11.1 Financial evaluation methodology

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

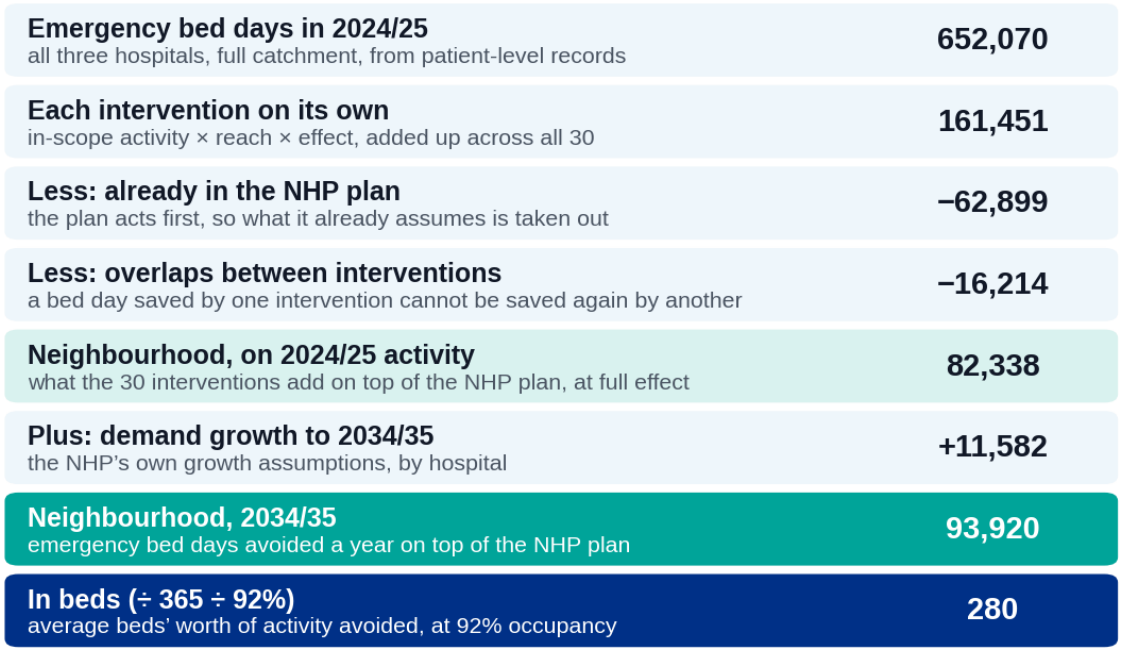
Appendix 2: Neighbourhood modelling, method, results, assumptions and caveats

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:

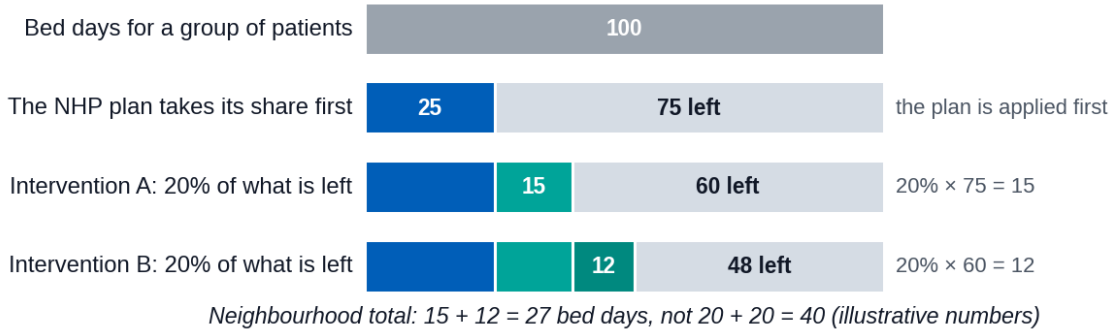
- **Matched measures.** Where an NHP measure and a neighbourhood intervention act on the same patients (the NHP's end-of-life admissions and palliative care at home, for example), the part of the NHP measure that is delivered in the community is subtracted from the intervention. Where the trusts' own 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.

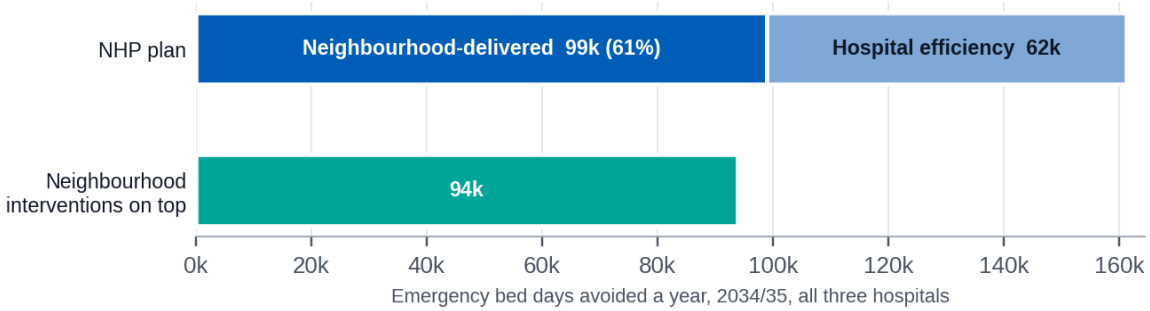
B. The NHP plan, and our estimate for NNUH

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.

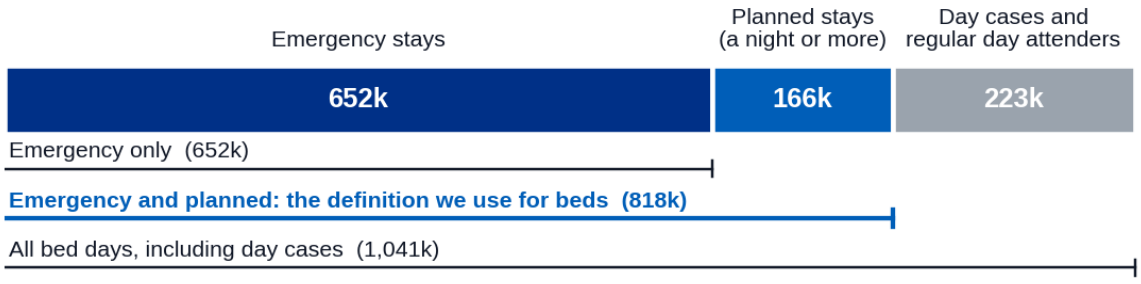
Figure A3: The NHP plan and the neighbourhood, emergency bed days a year, 2034/35



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

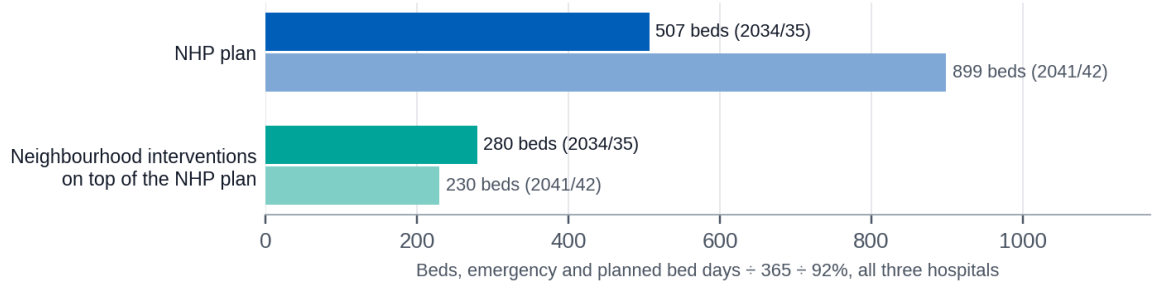
Neighbourhood figures are in addition to the NHP plan. The NHP plan also moves some outpatient and A&E activity (for example, A&E attendances redirected to other services), which is not shown here. NNUH's NHP plan is our estimate. The

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.

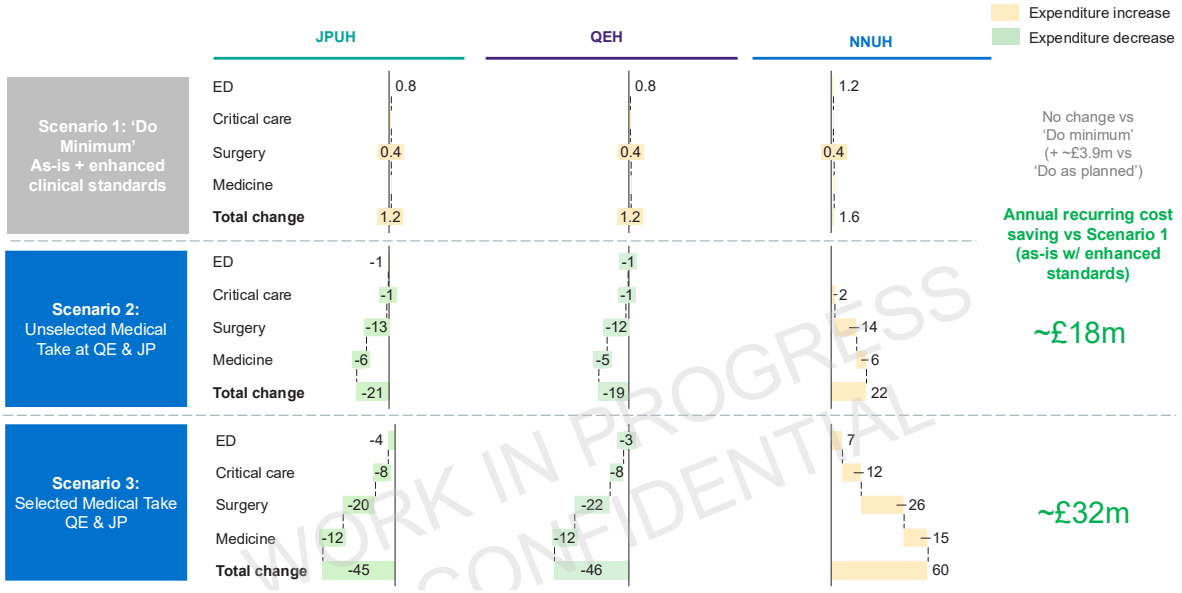
These are preliminary estimates. They exclude the costs of mitigations and enablers, double-running and transition costs, and will be refined as the scenarios are developed further.

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

