Norfolk and Waveney
University Hospitals Group

Extraordinary Group Board meeting in Public on Clinical Strategy Case for Change

Introduction

Thank you to everyone who attended our Group Board meeting in public on 2 November 2026 and to those who asked questions. We recognise that the future of hospital services matters enormously to patients, families, staff and communities across Norfolk and Waveney and neighbouring areas.

During the meeting, we committed to providing written responses to questions and comments we were unable to answer in the time available. These are set out below.

The Group Board agreed that there is a compelling case for change in how hospital services are delivered and supported further consideration of the clinical scenarios. The NHS Norfolk and Suffolk Integrated Care Board subsequently considered the Case for Change on 4 November 2026 and supported further work to develop a pre-consultation business case.

No decisions have been made to close, relocate or reorganise individual hospital services, and no preferred future model has been selected.

We know people have important questions about clinical safety, maternity care, emergency services, travel, staffing and the future of our hospitals. Some of these questions require further detailed assessment, which will form part of the next stage of work.

We are committed to being open about what we know, what still needs to be tested and how patients, staff and communities can help shape the work ahead.

Neighbourhood

Peter Harrison (speaking as Chair for League of Friends at Beccles)
Please don't forget that there is capacity at Beccles Hospital for outpatients. Both the older person consultants and respiratory are keen to start clinics at Beccles.

Thank you for highlighting the opportunities at Beccles Hospital. Making better use of existing community facilities is exactly the type of opportunity we want to explore as part of developing more care closer to people's homes. This could include outpatient appointments, tests and follow-up care where these can be provided safely and effectively outside our main hospitals. We welcome the suggestion about older people's and respiratory clinics at Beccles and will ensure it is considered with the relevant clinical and community teams. Any new clinics would need to have the appropriate staff, equipment and support in place.

David Beavan
[On Neighbourhood Max] This is all brilliant. The only question is "How soon?"

We want patients to benefit from improvements in neighbourhood care as soon as it is safe and practical to introduce them. Some improvements can be developed through existing services and partnerships, without waiting for decisions about the longer-term clinical strategy. Others will require further planning, investment and agreement between hospitals, GPs, community services and social care. The next phase of work will help establish which changes can happen sooner, which will take longer and what needs to be in place to make them successful. We will share more detailed timescales as this work develops.

Duncan Peacock
Are primary and social care getting local enhanced investment to pay for this?

Moving more care into the community cannot simply mean asking GPs, community teams and social care services to take on additional work without the staff, facilities and resources to support it. Any proposals to provide more care outside hospital will need to identify the investment and capacity required across all the services involved. This will form part of the more detailed work undertaken with the Integrated Care Board and our health and care partners. We recognise that improvements in hospital care depend on having strong, properly supported community and social care services.

Cllr Alun Ryves
Is there a risk that moving care closer to home will result in fragmentation and duplication and reduced efficiency at the expense of a well-resourced local hospital?

We recognise this risk, which is why services need to be planned together rather than developed separately. The aim is to make care easier for patients to access and better coordinated, not to create additional appointments, duplicate services or weaken local hospitals. For example, someone living with several long-term conditions might benefit from having more of their routine appointments and checks coordinated locally, rather than making repeated journeys to hospital. Our hospitals will continue to play a central role. Any proposals to provide more care in the community must demonstrate that they improve patient care, make effective use of staff and resources, and maintain safe links with hospital specialists.

HART, Karina (East of England Community Health and Care NHS Trust)
How will the new model work together with the Community Trust?

Our community health partners will be central to developing any future model of neighbourhood care. Hospital teams, community services, GPs, social care and other partners will need to work together to decide which services can safely be provided closer to home and how patients will move between services when they need different levels of care. This includes agreeing how staff will work together, how information will

be shared and how people can access hospital specialists when needed. The intention is to create better-connected services around patients, rather than separate hospital and community systems.

Cllr Alun Ryves
Given the high levels of deprivation recognised in the slide show, what weight will be given to the greater need of that population please in West Norfolk?

We recognise that some communities in West Norfolk face significant health inequalities, and these must be a central consideration in our work. People living in areas of greater deprivation can experience poorer health, greater difficulty accessing services and additional barriers such as transport costs. As we develop and assess potential options, we will examine how different communities could be affected, including whether changes would make it easier or harder for people to receive care. This means looking beyond overall population figures to understand local needs and the experiences of people who already face barriers to healthcare. Our aim must be to reduce inequalities, not make them worse.

Cllr Pallavi Devulapalli
None of the shift to better health is the responsibility of the acute.

Improving people's health and preventing illness is a shared responsibility. Hospitals have an important role, but lasting improvements also depend on GPs, community health services, social care, public health, local authorities and voluntary organisations working together. Our clinical strategy must therefore support, and be developed alongside, wider plans to improve health and care across Norfolk and Waveney.
We recognise that many of the factors affecting people's health, including housing, employment and access to support, sit beyond hospital services.

Katie Louch
While the focus understandably needs to be on the elderly population, in King's Lynn there is a current push to encourage younger people/families to move to the area - How will you ensure that this section of the population do not fall through the cracks? No matter what your age/demographic is, you have to acknowledge the fact that there are people in every group who have chronic conditions - in my own experience I have found that younger people especially are often not prioritised, are left unable to get timely, face to face appointments with any service and are often forgotten about or are lost in a system which is not "built for them".

Although our population is ageing, our plans must meet the needs of people of all ages, including children, young adults, working-age people and families. We recognise that younger people can also live with complex or long-term health conditions and may experience difficulties accessing timely, joined-up care. The next stage of work will consider how different age groups use services, their changing needs and the barriers they experience. This includes the needs of growing communities and families moving

into the area. We also want to hear directly from younger patients and families, including people who have found it difficult to access care. Their experiences will help us understand where services need to improve.

Digital

Adam Coombes
Are you considering virtual wards based on the digital layer?
and
Ruth Kerrison Winter
How will virtual care work within the area considering there are significant issues with connections and connectivity across the county?

We recognise that reliable internet and mobile phone connections are not available everywhere, particularly in some rural and coastal communities. Digital technology can make care more convenient for some patients, but it must not become a barrier for others. Any plans to expand virtual care will need to consider local connectivity, people's ability and confidence to use technology, and whether they have access to suitable devices. Where digital care is not suitable or accessible, patients must still be able to receive care through other appropriate arrangements, including face-to-face appointments. No patient should be disadvantaged simply because they cannot access or use digital technology.

Maternity

Denise
Why are hospital births so low is this because of issues with the hospital itself, i.e. lack of staff or is there another reason in that they do not want children and how are these figures determined is it by analysing who is buying houses or just a procrastination?

The number of babies born in hospital is influenced by several factors, including how many women of childbearing age live in an area and changes in birth rates over time. Our initial analysis draws on national population projections from the Office for National Statistics (ONS), alongside information about births at our hospitals. These projections are based on historical population and birth trends. They are estimates of what might happen in the future, not definite predictions. We recognise that local circumstances, including new housing developments and changes in the population, could affect future birth numbers. That is why we have asked public health colleagues to provide an independent assessment and why further detailed modelling will be needed before any proposals are developed.

Ruth Kerrison Winter
If maternity services are removed from QE or JP, how will high risk pregnancies and deliveries be managed especially within medically high-risk scenarios? The safety of mothers and babies must be the starting point for any consideration of future maternity services.

No decision has been made to remove maternity services from QEH or James Paget. The options being explored include continuing hospital births at all three sites, at two sites or at one site. If any change were proposed, we would need to demonstrate how women with high-risk pregnancies would receive specialist care, how emergencies during pregnancy or childbirth would be managed and how mothers and babies would be transferred safely when necessary. This would include looking at ambulance response times, neonatal care, staffing, specialist facilities and the impact of longer journeys, particularly for families in rural and coastal communities.

Theresa B
Does the projected decrease [in birth numbers] take into consideration the huge number of new homes being built in west Norfolk?

We have asked our public health colleagues to provide an independent view on projected population and birth numbers. This analysis has been informed by ONS projections and trends seen in our hospital birthing rates. Our data are informed by historic trends, and ONS data is informed by historical demographic data, age-specific fertility rates, expert panel consultations, and administrative registries. These projections provide an initial guide and take into consideration historical development but will need to be developed and tested to a finer degree of detail reflecting local variation and development.

Nikki Fox
How many times has the Queen Elizabeth or James Paget Hospital taken babies from the Norfolk and Norwich Hospital in the past six months because there is no space at NNUH? Just wondering how big the expansion would have to be at NNUH if one delivery option was considered.

We recognise that NNUH already experiences periods of pressure on maternity capacity and that women are sometimes transferred between hospitals. Any future scenario involving more births at NNUH would require detailed assessment of the additional staff, facilities, maternity and neonatal capacity, and investment needed. We cannot assume that NNUH could accommodate additional births within its existing facilities. Current maternity transfers, including the reasons they take place, will form an important part of this work. No decision has been made to move births from QEH or James Paget.

Scenarios and decision making

Eleanor Howie
You say that no decision has been taken to change services yet, but that does not appear to be the communication that is being given?

Our communications have been consistent – that no decision has been made about service change. We recognise that media coverage and public comment beyond our direct control may have suggested otherwise and that this has caused concern. However, as the NWUHG and Norfolk and Suffolk ICB Board meetings have made clear, it is only the Case for Change that has been accepted. The ICB also agreed to the development of a pre-consultation business case (PCBC). The PCBC would include:

- detailed clinical, quality, workforce, activity, capacity, financial, estate, digital and implementation analysis
- and assessment of travel, access, equality and health inequalities impacts, including cross-boundary patient flows

Once complete, the PCBC would be considered by the ICB Board for a separate decision on whether any proposals are sufficiently developed and assured to proceed to formal public consultation. Any decision to change services would only be made after the outcome of consultation has been fully considered.

Eleanor Howie
Can you provide assurances that no decision has yet been made and that input regarding the matters you have mentioned (including the impact on people in remote areas) will be taken into account before services are withdrawn?

Please see response above.

Caves, Natalie
Why only 3 proposals? Why do options 2&3 (reducing number of delivery suites) also go hand in hand with transferring overnight surgery from QEH & JPUH to NNUH? Surely you can still have emergency surgery even without maternity?

The three scenarios in the Case for Change are starting points for further clinical assessment. They are not agreed proposals, and no preferred future model has been selected. Maternity and emergency surgery have been considered together in some of the early work because they share important clinical support, including anaesthetics, operating theatres and critical care. However, we recognise that these services have different requirements. The next stage will need to examine their individual needs, the relationships between them and whether alternative arrangements could provide safe, high-quality care. No decision has been made to remove maternity services or overnight emergency surgery from QEH or James Paget.

Caves, Natalie
I know that not many patients present for emergency surgery after 10pm but when they do they are acutely unwell and can't wait. Transferring these patients is a significant mortality risk. I would suggest that keeping emergency surgery after 10pm is an issue in its own right and shouldn't be tied in with the maternity data.

We recognise that some patients who need emergency surgery are seriously unwell and that delays in treatment or transfers between hospitals can carry significant risks. The fact that relatively few patients may require emergency surgery overnight does not make their needs any less important. Any proposal to change where emergency surgery is provided would need to demonstrate that patients could receive safe and timely treatment, including in situations where immediate surgery is required. This means examining the clinical teams and facilities available at each hospital, how patients would be assessed and stabilised, ambulance availability, journey times and the risks associated with transfers. The assessment must consider the risks of changing current arrangements as well as the risks of continuing with them. No decision has been made to change overnight emergency surgery.

HART, Karina (East of England Community Health and Care NHS Trust) Will any decision be made together with the neighbouring ICB's (Cambridgeshire, Peterborough)?

The impact of any scenario on our neighbouring providers and patients in neighbouring care systems will form a crucial element of our engagement, model development, assurance and independent scrutiny, for example through the formation of a joint Health Overview Select Committee.

Duncan Peacock
I don't think digital can prevent emergency surgery need. Also many of our patients in a high deprivation area, don't engage with medical care till it's too late (JPUH)

We agree that digital technology cannot prevent every emergency or remove the need for urgent surgery. Digital services may help some people receive earlier advice, monitoring or treatment, but they are only one part of improving care. We also recognise that people living in areas of deprivation may face additional barriers to seeking help or accessing healthcare. Some may therefore arrive at hospital with more advanced illness. Any future model must account for these realities. It must ensure that people who become seriously unwell can receive timely emergency assessment and treatment, regardless of where they live or when they seek help.

Cllr Alun Ryves
As elected representatives in West Norfolk, we would like to know the timetable and the decision making process?

The timetable for this work is dependent on the immediate decisions to be made. The Case for Change was considered by the Norfolk and Suffolk Integrated Care Board (ICB) Board in Public on 4 November 2026 and will be presented to the Norfolk Health Overview Select Committee at its meeting of 19 November 2026. The ICB will make a decision on whether to progress this work and the timelines will form a central element of these next steps.

Cllr Pallavi Devulapalli
Could the public have access to the data on which the review group is basing their recommendations? We really need to see the data that supports the work of the clinical review group, to ensure transparency and openness of the process.

We recognise the importance of transparency and ensuring that the evidence informing our clinical strategy can be understood and scrutinised. The Clinical Advisory Group has considered a wide range of information, including patient activity, population health, workforce, finance and external clinical evidence. The Case for Change summarises the key evidence, analysis and sources underpinning this work including the key insights from these data and how they informed the information presented. The detailed analysis remains under development and will subject to further development, clinical review and validation should this work progress. We will make the relevant evidence and supporting analysis available at appropriate stages, particularly as we develop and assess options for potential service change. This will help ensure that patients, the public and wider stakeholders can understand and meaningfully contribute to the development of proposals before any final decisions are made.

Ruth Kerrison Winter
Does the evidence distinguish a full consultant-led, 24/7 Type 1 emergency department from other forms of urgent and emergency care, and assess its dependencies on ICU, emergency surgery, anaesthetics, diagnostics and maternity/neonatal services? Please explain how the Clinical Advisory Group's publicly reported recommendation for permanent 24-hour emergency care at all three hospitals is being incorporated.

The clinical approach being explored retains 24-hour consultant-led emergency departments and critical care at all three hospitals. However, emergency departments depend on other hospital services, including anaesthetics, critical care, diagnostics and emergency surgery. The next stage of work must examine these relationships carefully, including the services and specialist support needed to provide safe emergency care at each hospital. We also need to understand how patients with particularly serious or complex conditions would receive specialist treatment, including

whether transfers would be necessary and how these could be provided safely. No changes to individual emergency services have been agreed.

Workforce

Katie Louch
Has the increased pressure on the workforce been taken into account when discussing the transfer of care to the community or to other hospitals? Transfers require a network of skilled staff at the departure and arrival site who can respond to patient need and can act quickly and effectively in order to maintain patient safety. Every transfer carries a certain risk and this risk increases when the length of journey is taken into account due to lack of resources on the road - an ambulance for instance is not designed for long transfers - especially those which may realistically take over an hour - for instance, An emergency transfer from the QE to the NNUH has the potential to be a rapidly changing situation and does not occur very often at present, however with the proposed ideas these lengthy transfers are likely to become a more common occurrence. As a result Increased pressure will fall onto hospital staff, air ambulance/ambulance and community services as a result - will discussions be held with these services? How will clinician/staff and patient wellbeing be taken into account?

We recognise that transferring patients between hospitals is not simply a matter of arranging transport. It requires appropriately trained staff, suitable vehicles, clinical support and enough capacity at both hospitals. Longer journeys can also be difficult for patients and families, particularly when someone is seriously unwell. Any potential changes that could increase transfers would need detailed assessment with ambulance providers, hospital clinicians, community services and other partners. This would include examining journey times, the risks associated with transfers, staffing requirements, ambulance availability and the effect on other patients who need emergency transport. We must also consider the impact on staff wellbeing, workloads, recruitment and retention, alongside the experience of patients and their families. These issues will be an important part of assessing whether any proposed model is safe and practical to deliver.

New Hospital Programme

James Wild
The case for change document says that if changes required public consultation that would mean a delay in submitting OBC for new hospitals from Oct 2027 to March 2028, and will add £200 million cost including for a potential extension at NNUH. Has the Group been given any indication such funding is likely to be granted?

Rebuilding two of our hospitals is a unique opportunity to ensure that our hospital services are fit to meet the future health needs of our patients and communities. The outline business cases (OBC) will require a defined scope of services for the new

hospitals and so would need to wait for the outcome of any anticipated public engagement. The indicative additional potential cost includes both inflationary impact of any delay as well as cost of any build at NNUH. There are active discussions happening with the national NHP team to fully understand and minimise any potential delays to the programme with further work required to confirm any funding route for the NNUH.

Cllr Alun Ryves
What will the implications be for the hospital builds if a new emergency/maternity centre is planned for Norwich?

The Case for Change explores different ways that some specialist services might be organised in the future. Any option involving additional services at NNUH would require careful assessment of the facilities, staff and investment needed. It would also be necessary to understand the implications for the design and capacity of the replacement hospitals at QEH and James Paget. Our aim is to ensure that all three hospitals can provide safe, high-quality care for the communities they serve, and that the significant investment in new hospitals delivers lasting benefits. These questions will be considered as the clinical strategy and hospital development plans progress together.

Duncan Peacock
"The group must also consider the implications for NNUH not just the 2 replacement hospitals" Does this mean that at proportion of money will be spent at NNUH, will this lead to smaller plans for the new hospitals, especially given inflation?

No decision has been made to redirect funding from QEH or James Paget to NNUH. The replacement hospital programmes remain a priority, and work on their planning and development is continuing. If future proposals require additional facilities at NNUH, the costs and funding arrangements would need to be assessed alongside the implications for both new hospitals. We will need to demonstrate how any proposals support the long-term needs of all three hospitals and the communities they serve.

Scott Hussey
Can you confirm that the proposed scenarios will be part of the new hospitals programme and as such will affect the planning and design of the hospitals? Have you projected population and demographic changes decades ahead?

The clinical strategy will help inform the design of the replacement hospitals at QEH and James Paget, and how they work alongside NNUH. We have a significant opportunity through the £2.8 billion New Hospitals Programme to develop facilities that meet the healthcare needs of future generations, rather than simply reproduce the hospitals we have today. This means considering how the population may change, including ageing, housing growth, changing health needs and advances in treatment.

The scenarios in the Case for Change will help us explore these questions, but they are not agreed plans for future services. Further detailed modelling will be required to understand future demand and ensure that the new hospitals have the facilities and flexibility needed to support patients over the longer term.

Engagement

Denise

Regards Healthwatch, it seemed this survey was biased towards getting an answer to confirm a suspicion and lots of other people have not completed this survey. We support the hard work going into this but patient groups are not being heard.

The Healthwatch survey and focus groups have been designed to inform the development of NWUHG's Case for Change and, in due course, the Norfolk and Suffolk ICB's development of a pre-consultation business case. These sought to understand the public's current experiences of accessing health care, including what works well, barriers to access and patient priorities, now and in the future. Healthwatch's work has not tested public views of potential future models of care. The survey has been promoted widely across Norfolk, Waveney, North Cambridgeshire and South Lincolnshire via a variety of means, including local media, parish clerks, community Facebook groups, GP surgeries, local council newsletters, libraries and the Voluntary Sector Assembly. Specific less heard groups have been targeted including military veterans, younger people, travellers, carers, migrants, and those experiencing deprivation, mental ill health and homelessness.

Ruth Kerrison Winter

How will the Board account for Healthwatch engagement that closes on 6 November, after this decision? Please confirm when the engagement findings and population, workforce, capacity, ambulance-transfer, travel/access and equality assessments will be published, and how they will address West Norfolk, rural/coastal communities, Emneth/Wisbech and potential alternatives involving North Cambridgeshire Hospital.

Healthwatch will submit a final report to both NWUHG and Norfolk and Suffolk ICB in January. This will inform further work, including the ICB's development of a pre-consultation business case (PCBC). The PCBC will draw on analysis conducted by NWUHG in developing its Case for Change and would include:

- detailed clinical, quality, workforce, activity, capacity, financial, estate, digital and implementation analysis;
- and assessment of travel, access, equality and health inequalities impacts,

including cross-boundary patient flows, including those into and from North Cambridgeshire.

Once complete, the PCBC would be considered by the ICB Board for a separate decision on whether any proposals are sufficiently developed and assured to proceed

to formal public consultation. Any decision to change services would only be made after the outcome of consultation has been fully considered.

Other

Denise
The concerns around safety is a concern for many of the people who contact Joan's Army and reducing a maternity service presents an added concern. Similarly moving services out to N&N means the local transport and hospital transport system will have to grow and this might be counter productive where costs are concerned and hence would cause considerable concerns to those needed care. Why not bring back those cottage hospitals we once had to offer some additional services there? The issue regarding elderly care would make sense to keep smaller cottage hospitals to support those elderly needing help or assessments of needs and reduce the bed blocking issues you have.

We recognise the important role that community hospitals can play in providing care closer to people's homes, particularly for older people and those who need rehabilitation or support after an illness. Our aim is to explore how more care can be provided locally where it is safe and appropriate to do so. This could include making better use of existing community facilities for appointments, assessments, treatment and rehabilitation, working alongside community health and social care partners. However, community hospitals cannot replace every service provided by an acute hospital, particularly where patients need specialist equipment, emergency treatment or intensive care. We will consider opportunities to strengthen local services as part of the next stage of work, including how they could help people recover closer to home and avoid unnecessary stays in hospital. We also recognise the concerns about maternity safety and transport. These must be fully assessed before any proposals affecting hospital services are brought forward.

Ruth Kerrison Winter
I can fully understand the case for change, but how will this sit alongside the improvements required following scrutiny from the CQC at QEH?

Improving the quality and safety of care at QEH remains an immediate priority. The Case for Change is about planning how services can meet the needs of patients in the future. It does not replace or delay the work already underway to address concerns identified through Care Quality Commission inspections and other reviews. We must continue making improvements to the care patients receive today while also considering how to build stronger, more sustainable services for the years ahead. The lessons from quality reviews, including CQC findings, will be important in developing and assessing any future options. Patients should not have to wait for new hospitals or longer-term changes to see improvements in their care.

Chris Brewis
SE Lincs and NE Cambs – please mention them.

We recognise that QEH serves communities beyond West Norfolk, including South Lincolnshire and North East Cambridgeshire. The needs of these communities must be fully considered in our planning. This includes looking at where people currently receive care, travel times, transport links and how any potential changes could affect access to hospital services. We will also need to work with neighbouring NHS organisations and local authorities so that the experiences of patients living outside Norfolk and Waveney are properly reflected in the next stage of work.

Mark Whitmore
Can you provide the website links to the background papers please?

The Case for Change documents and supporting Board papers are available through our published Board meeting papers. These include the evidence setting out why further work is needed and the potential scenarios identified for more detailed consideration. We will continue to make relevant supporting information available as the work progresses. All documents can be found on our website: Norfolk and Waveney University Hospitals Group -

Cllr Alun Ryves
Will transcript and slide show be available, also will this meeting be available on You Tube?

We recognise the importance of making the Board's discussions accessible to people who were unable to attend. The presentation and supporting papers are available through our website, alongside the written responses to questions raised at the meeting. All documents can be found on our website: Norfolk and Waveney University Hospitals Group -

Ruth Kerrison Winter
When will the complete Case for Change, proposed resolution and supporting evidence be published? If these are not available sufficiently in advance for meaningful public scrutiny, will the Board defer approval to allow that scrutiny?

The Case for Change documents and supporting Board papers are available through our published Board meeting papers. These include the evidence setting out why further work is needed and the potential scenarios identified for more detailed consideration. We will continue to make relevant supporting information available as the work progresses. All documents can be found on our website: Norfolk and Waveney University Hospitals Group -

9 November 2026