# Our case for establishing a Group model

NHS
Norfolk and Waveney
Acute Hospital Collaborative

# Table of Contents


1. PURPOSE OF THE DOCUMENT ..... 2
2. EXECUTIVE SUMMARY ..... 3
3. THE CONTEXT FOR COLLABORATION AND FORMING A GROUP ..... 8
4. THE CASE FOR BECOMING A GROUP ..... 14
5. RISKS ASSOCIATED WITH A GROUP MODEL AND THEIR MITIGATIONS ..... 31
6. CONCLUSIONS AND NEXT STEPS ..... 34

## 1. Purpose of the document

This document outlines the outputs of the Norfolk and Waveney Acute Hospital Collaborative (NWAHC) case for establishing a Group model. The pursuit of the Group model is part of the response to the collective challenges faced across Norfolk and Waveney, with financial and clinical pressures being compounded by an ageing and growing population.

The focus of this review was solely on three acute Trusts in Norfolk and Waveney: Norfolk and Norwich University Hospitals NHS FT (NNUH), James Paget University Hospitals NHS FT (JPUH), The Queen Elizabeth Hospital King's Lynn NHS FT (QEHKL). The Trusts are already members of the Acute Hospital Collaborative (AHC) provider collaborative to enable aligned decision making on cross cutting issues.

The review was undertaken by Carnall Farrar Ltd and took place from November 2024 to January 2025, following the respective Trust Boards confirming their commitment to further exploration of the development of a Group model. The outputs of this are summarised and outlined in this document, covering the case for establishing a Group model, opportunities identified for greater collaboration and the next steps required.

## 2. Executive summary

### Introduction and context

Norfolk and Waveney are home to a population of around 1.2 million people, with a significant proportion being elderly.[1] The Integrated Care Board commissions services from various NHS providers and GP practices, working primarily with Norfolk and Suffolk County Councils. The region faces high prevalence of long-term conditions and significant health inequalities, which are further complicated by social determinants of health, rurality, and deprivation.

The focus of this review was solely on the three acute Trusts in Norfolk and Waveney: Norfolk and Norwich University Hospitals NHS FT (NNUH), James Paget University Hospitals NHS FT (JPUH), and The Queen Elizabeth Hospital King's Lynn NHS FT (QEHKL). Together the three hospitals undertake the majority of acute patient activity across Norfolk and Waveney. The three Trusts currently face significant challenges which, without action to address them, will worsen over time.

All three acute hospitals are currently rated as "Requires Improvement" by the Care Quality Commission and forecasting an indicative £53.2m underlying deficit by 2029/30.[2] The providers have come together to determine how they can best address their shared and pressing challenges by working together.

The Trusts are already members of the Acute Hospital Collaborative (AHC) to enable aligned decision-making on cross-cutting issues, which was established in September 2020. This arrangement is part of the delivery mechanism for the Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy which is focused on four main objectives in response to the population health challenges in Norfolk and Waveney: driving integration, prioritising prevention, addressing inequalities and enabling resilient communities.

To date, collaboration has been successful, resulting in the co-delivery of the Acute Clinical Strategy Programme, Electronic Patient Record Programme, and shared services and roles. However, it has become evident that the current collaborative mechanisms are insufficient to facilitate the pace of decision-making required. Within the current management and governance arrangements, commitment to share resources, best practice, and reduce unwarranted variation (e.g. waiting list differences) can be difficult to agree and implement in practice. As a result, all three Trusts recognise that they and the system would benefit significantly from a more integrated organisational arrangement.

The pursuit of the Group model is part of the response to the collective challenges faced across Norfolk and Waveney, with financial and clinical pressures being compounded by an ageing and growing population.

### Case for becoming a group

There is considerable evidence available to substantiate the basis for a Group model, including national guidance and examples from other provider Groups. A Group model is an organisational structure where multiple healthcare providers work together under a unified governance framework.

The Group model aims to improve efficiency, standardise practices, and enhance patient care.
It features central leadership responsible for strategic direction and governance, while local units maintain operational management and ensure that delivery of care reflects the needs of patients at Place and is integrated with local partnerships. The model emphasises standardising systems, policies, and procedures to ensure consistency and improve the quality of care.

The Group model offers flexibility, advantages, and opportunities for collaboration, enabling the delivery of consistent care quality and outcomes. It supports the development of a common care model, coordinated planning, and provides unified leadership to address the challenges faced by the three acute Trusts.

[1] Office for National Statistics, 2024; CF Analysis
[2] Care Quality Commission; CF Analysis

For NNUH, JPUH and QEHKL, eleven opportunity areas for collaboration across three broad themes have been identified, which have the potential to transform clinical care and deliver consistent access to high quality services through the adoption of best practice.

These are:

### A) Transform health and care services based on the needs of patients and population

**Address growing demand for health and care by playing an active system role across Norfolk and Waveney in preventative and proactive healthcare for people with long term conditions:** Norfolk and Waveney have a higher burden of long-term conditions and multimorbidity than the national average. The consequence of this is an increased use of hospital-based services, which reactively manage deterioration and acute exacerbation as opposed to the proactive anticipatory management that could avoid use of hospital-based services. Working with the wider system, the acute Trusts in Norfolk and Waveney need to play an active role in the developing and implementing an anticipatory model of care, improving the connectivity between teams and pathways into hospital and standardising discharge pathways.

**Deliver a consistent best practice model of urgent and emergency care with a particular focus on frailty:** There were high rates of A&E attendances and emergency admissions in 2023/24, especially among the elderly. Without intervention, emergency admissions are projected to rise by 22% by 2033, with the greatest increase in the 85+ age group.[3] Collaborative efforts, including outreach programs and scaling up Older People's Emergency Departments, are needed.

### B) Deliver high quality outcomes building on combined knowledge, skills and experience

**Implement safe and sustainable care models initially in maternity and stroke care with development of models for other specialties to follow to deliver clinical, financial and environmental sustainability:** Across the three Trusts, there are a number of services that are potentially fragile and will become unsustainable in the future. One example is maternity where, since 2019/20, all Trusts have seen a decrease in the number of deliveries per year, with JPUH and QEHKL seeing under 2,000 deliveries each in 2023/24.[4] Another example is stroke where prevalence is increasing and care between providers is significantly varied. Best practice care models aligned to system demand should be co-designed with public engagement and implemented, leveraging opportunities for optimisation of estate through the work underway at QEHKL and JPUH which are both part of the New Hospital Programme (NHP).

**Level up outcomes and access by optimising elective care pathways, making best use of collective capacity, improving access to services, reducing waiting times and enhancing patient care:** There are long waits for elective care in Norfolk and Waveney. Coupled with lower levels of productivity than peers and fragmentation of services, there is an opportunity for Trusts to work together to improve performance. These opportunities include mutual aid, process standardisation, and service consolidation to better protect capacity for planned care from unplanned demand.

**Deliver better outcomes for people with cancer at all stages of the pathway, starting with earlier diagnosis:** Cancer prevalence in Norfolk and Waveney has increased by 70% in the last 10 years, outstripping the national average by 24%.[5] Breaches of the 28-day standard for waits from urgent referral to diagnosis target are common for certain types of suspected cancer. A single service model for cancer would provide consistent access to high quality cancer care closer to home. Co-ordination of demand would support realising efficiency benefits of working at scale and streamline service delivery.

### C) Achieve greater sustainability by working at scale

**Make most effective use of workforce capacity and allowing the easier movement of staff to improve service resilience and staff development opportunities:** Norfolk and Waveney acute Trusts have seen an increase in staff vacancies, leading to high spending on bank and agency staff. Collaboration across the three Trusts would allow for better workforce management, strategic decision-making, and potential cost savings.

[3] HES ECDS, HES APC; CF Analysis
[4] HES APC; CF Analysis
[5] Fingertips; CF Analysis

**Improve the offer for staff, to train, develop and retain healthier and happier staff:** Medical staff across the three Trusts have mixed views on training and development opportunities, with Trusts being rated below national and peer average on several metrics. QEHKL and JPUH have higher absences due to sickness than the national average. There is an opportunity to improve workforce support and resilience through a collaborative approach to staff recruitment, workforce deployment, training and development.

**Create a University Hospital System to enhance potential for research, training and innovation:** Whilst NNUH and JPUH are university teaching Trusts, all three already train medical students, thus there is an opportunity to create a University Hospital System that provides a stronger education, research and training offer for the system. As part of this, a Centre for Coastal and Rural Health could be established, making Norfolk and Waveney a national hub for research and innovation into elderly and frail populations living in coastal and rural areas, which are more likely to be deprived.

**Use collective assets to leverage joint negotiation, purchasing and investment power of the three Trusts:** With significant spend on supplies and services, there is an opportunity to align contracts, pool budgets and make strategic investments to more effectively use scarce resources. By pooling their resources, the Trusts can purchase supplies and services in larger quantities, resulting in bulk discounts and lower per-unit cost. Joint negotiation will allow the three organisations to leverage their combined demand to negotiate better terms with suppliers.

**Realise the benefits of system-wide service transformation that are possible through enabling programmes such as estates and digital:** Three acute Trusts in Norfolk and Waveney are digitally immature, relying on paper records, and are facing high backlog costs. Transformation programmes through the NHP and EPR programmes are already in train to improve digital and estates, unlocking data-driven decision-making and service transformation. As part of this, new care models and pathways are being developed, and it is essential that these are aligned across all three organisations. Consequently, closer working on these shared programmes is needed.

**Have an aligned approach to strategy, transformation and planning functions:** Collaboration between the three organisations presents significant opportunities to unify strategic objectives, standardise Quality Improvement, and integrate operational processes. This will lead to a more coordinated, efficient, and impactful collaboration across Norfolk and Waveney.

## Risks and mitigations

Transitioning to a group model presents several potential risks that must be carefully considered. Identifying these risks effectively is crucial to outline and implement strategies that will effectively mitigate these challenges.

### Financial

Financial barriers, current financial frameworks and lack of clarity on implementation costs pose risks to achieving opportunities. Robust financial planning, stakeholder communication, and risk mitigation are crucial for financial stability and success.

### Operational

Each organisation will come from varying starting points and have different speeds of implementation. Thus, standardising procedures across all departments is unlikely to always yield positive results, whilst varying challenges between acute Trusts could hinder integration. Utilising existing similarities between the Trusts will facilitate smoother integration and reduce the potential duplication of effort. Establishing specific goals, timeframes, and a robust operating model will further support the integration process.

### Culture

Cultural risks arise from the differences in identity among the three acute Trusts, staff and patient disengagement could arise due to a lack of communication, resulting in a longstanding negative impact on morale. It will be important to be respectful of individual hospital cultures while at the same time fostering a spirit of collaboration, shared values, behaviours and engagement among staff, leveraging existing strengths and ensuring high levels of communication are essential.

### Reputational

There is potential that the anticipated enhancements in performance and efficiency are not realised, putting the credibility of the group at risk. Investment and a phased approach to facilitate this process is necessary to achieve the outlined opportunities, reducing the risk of significant financial strain and its associated impact. To garner sufficient support, stakeholders must be effectively engaged, ensuring their expectations of the Group model are realistic.

### Strategic and external

Externally, gaps in community partnerships to ensure equity across the Norfolk & Waveney Integrated Care System (ICS) and inadequate geographical infrastructure, e.g. transport links, pose risks to ensuring equity in access to safe and high-quality care. Previous collaboration attempts faced challenges due to patient reluctance to travel and local clinician preferences.

Strategically, concerns exist about impacting strategic partners and destabilising services with existing oversight through geographically focused partnerships of NHS, local councils and voluntary organisations, residents, people who access services, carers and families (at "Place"). The short timeline to implement the Group model heightens errors and potentially hinders the New Hospital Programme's progress (NHP). The group must shape the partnerships agenda for the local health economy, but resistance from specific services is likely if they are not engaged early.

### Mitigations

The governance structure adopted by a group is a critical enabler of acute service transformation to ensure sustainability of service delivery and the optimal use of resources. It supports the seamless delivery of patient care across providers and the alignment of service provision to provide a consistent and cohesive offer to patients.

Operational strategies require flexibility, allowing services to specialise and generalise based on needs. Prioritising patients, staff, and financial resources is crucial for sustainable progress. Effective communication ensures clarity and alignment among stakeholders. Whereas a robust operating model would facilitate integration and align with the group model's vision.

Operating as a group is critical to maximising the opportunities of working at scale. It binds all three Trusts together and creates the framework that supports a single strategic vision and set of aligned priorities. This translates into a shared commitment delivered by a unified leadership, which can support rapid decision-making when required.

The group model supports the development of a single system-level strategic plan across multiple sites, addressing both local and system-wide needs. It also streamlines decisions by reducing the number of separate board approvals required, allowing for faster decision-making and implementation of policies.

## Barriers and steps to break them down

To address these barriers, a number of key considerations need to be made:

### 1. Prioritisation of opportunities and their delivery

To ensure effective collaboration, a specific set of interventions will be identified through an evaluation process. This process will prioritise initiatives with the greatest impact, urgent requirements, quick results, and efficient use of resources. This will clarify the collaboration's scope and resource needs for the initial phase.

### 2. Aligned governance arrangements, particularly for future collaborative programmes

A collaborative approach with the EPR system deployment requires an aligned governance arrangement to leverage economies of scale. The investment, forecasted to deliver a break-even investment and expenditure position, will provide significant quality, societal, cash releasing and non-cash releasing benefits. Working within a Group will be a critical enabler in ensuring the investment into the EPR system is fully realised.

### 3. Create broader accountability through a target operating model for the Group

An operating model is needed to prioritise actions, taking on easy wins and enabling prioritisation of actions to address bigger challenges to deliver larger benefits. It will provide a framework for strong site-based leadership and Place-based approaches with system partners. This will be achieved through matrix structures that facilitate easier information sharing and accountability at all organisational levels.

### 4. Establish a joint vision and commitment to one another

Having a joint vision will work in the collective interest of Norfolk and Waveney. Each acute Trust has its own unique culture, underpinned by the population that it serves and its staff. The shared vision would be the foundation for joint working that will embed a collaborative agenda. Organisational development and fostering a shared sense of responsibility will further support this process.

### 5. Enhance capability and capacity for transformational change

A shared approach to quality improvement is crucial for delivering the strategy. Identification and implementation of best practice across the organisation will provide a mechanism for taking consistent, measurable action at pace. This will provide a link between transformative action and strategy, creating a common language between staff, and a drive to achieve shared priorities.

Establishing a group model is essential to overcome shared challenges and realise the benefits of collaboration. The next necessary steps include further design work, engaging stakeholders, and implementing the required changes to form the group model. The Trusts are dedicated to working together to achieve their collective vision and mission for transforming acute health service provision, delivering high quality outcomes by building on combined knowledge, skills and experience, and achieving great sustainability by working at scale.

Opportunities for collaboration have been identified across three broad themes, which have the potential to transform clinical care and ensure consistent access to high-quality services. These opportunities leverage the benefits of scale in delivering sustainable services and creating an attractive proposition for staff.

## 3. The context for collaboration and forming a Group

As an Integrated Care System in the East of England, Norfolk and Waveney is home to a population of around 1.2m people in 5 Place Boards. The Integrated Care Board commissions services from eight NHS acute, community and mental health providers, and 105 GP practices in 17 primary care networks, working primarily with two county councils: Norfolk County Council and Suffolk County Council.

One in four people living in Norfolk and Waveney are aged 65 and over, with the elderly population set to grow more than any other group over the next 10 years (Figure 1). By 2033, there will have been a growth of 17% in the population aged 65-84 and 46% in the population aged 85+, which substantially outstrips growth in any other population group, and the national growth rates for those age groups.[6] The demand for healthcare is at its highest in the older age groups so this demographic picture, without substantial changes to preventative measures, will lead to a marked increase in demand.

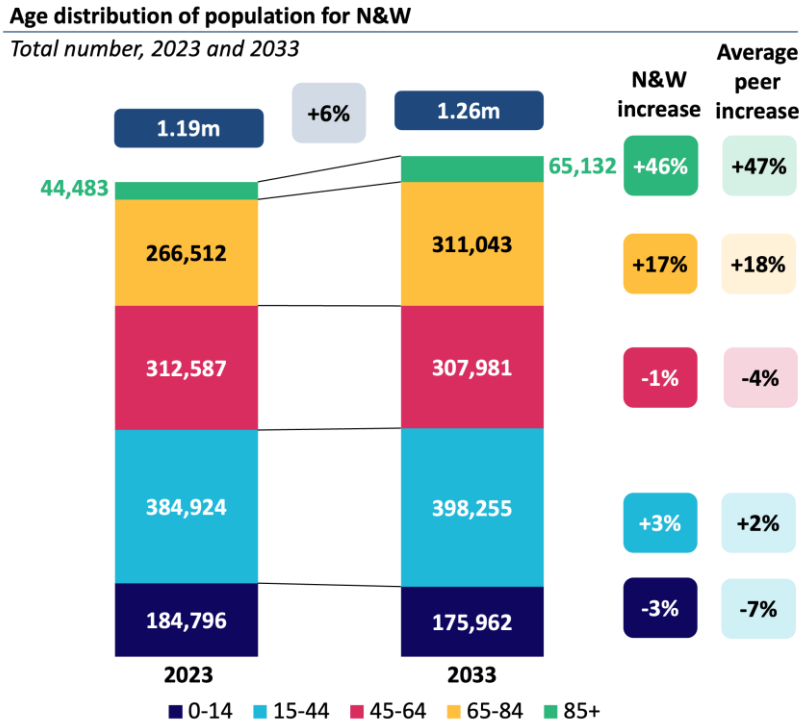


*Figure 1: Age distribution of population for N&W. Source: ONS; CF Analysis*

Despite people in Norfolk and Waveney living longer than the national average, they spend more years of life in ill health than the average nationally.[7] The total allocation in 2023/24 for Norfolk and Waveney is £2.3bn and over half of this is spent on delivery of acute services.[8] This is of particular note given that Norfolk and Waveney already has one of the highest general and acute care needs index in the country, ranking six of 42 ICBs.

There is a high prevalence of long-term conditions amongst the population with higher rates of asthma, COPD, hypertension, rheumatoid arthritis and stroke than the national average (Figure 2).[9] Prevalence of long-term conditions is closely correlated with age therefore, with an ageing population, long term conditions would be expected to increase in line with this. The prevalence of long-term conditions applies an additional demand on to the health system to provide the most suitable care at the right time.

[6] ONS; CF Analysis
[7] Fingertips; CF Analysis
[8] Provider Financial Records 2019-2024; CF Analysis
[9] Fingertips, QOF Data NHS England; CF Analysis

**Prevalence of QOF conditions in N&W local authorities**

*% of people registered to a GP with specified condition, 2023/24*

Better than peer average | Similar to peer average | Worse than peer average

| | Asthma | COPD | Depression* | Hypertension | Rheumatoid Arthritis | Stroke |
|---|---|---|---|---|---|---|
| Breckland | 7.66 | 2.22 | 13.82 | 18.45 | 1.06 | 2.42 |
| Broadland | 8.31 | 1.61 | 12.53 | 17.32 | 1.13 | 2.35 |
| East Suffolk | 7.90 | 2.48 | 14.30 | 19.29 | 0.99 | 2.63 |
| Great Yarmouth | 8.15 | 3.46 | 14.02 | 18.75 | 1.02 | 2.54 |
| King's Lynn and West Norfolk | 8.03 | 2.62 | 12.20 | 19.28 | 1.04 | 2.94 |
| North Norfolk | 8.88 | 2.69 | 12.68 | 21.76 | 1.31 | 3.22 |
| Norwich | 7.34 | 1.81 | 13.84 | 12.03 | 0.74 | 1.71 |
| South Norfolk | 7.52 | 1.60 | 11.33 | 16.48 | 0.96 | 2.23 |
| ICB Average | 7.93 | 2.31 | 13.3 | 17.53 | 0.92 | 2.46 |
| Peer Average | **7.40** | **2.21** | **13.25** | **17.34** | **0.72** | **2.41** |

*Figure 2: Prevalence of QOF conditions in N&W local authorities. Source: Fingertips, QOF Data NHS England; CF Analysis*

Health issues are made more complex by social determinants of health, rurality and deprivation. There are high levels of deprivation throughout Norfolk and Waveney with Great Yarmouth and Norwich having the highest, whereas Broadland and South Norfolk have the highest levels of affluence (Figure 3).[10] Almost half of Norfolk and Waveney's population resides in rural areas, with North Norfolk having the highest level of rurality (Figure 3).[11] This rurality is associated with highest prevalence of asthma, hypertension, rheumatoid arthritis, and stroke of any local authority in Norfolk and Waveney (Figure 2).[12]

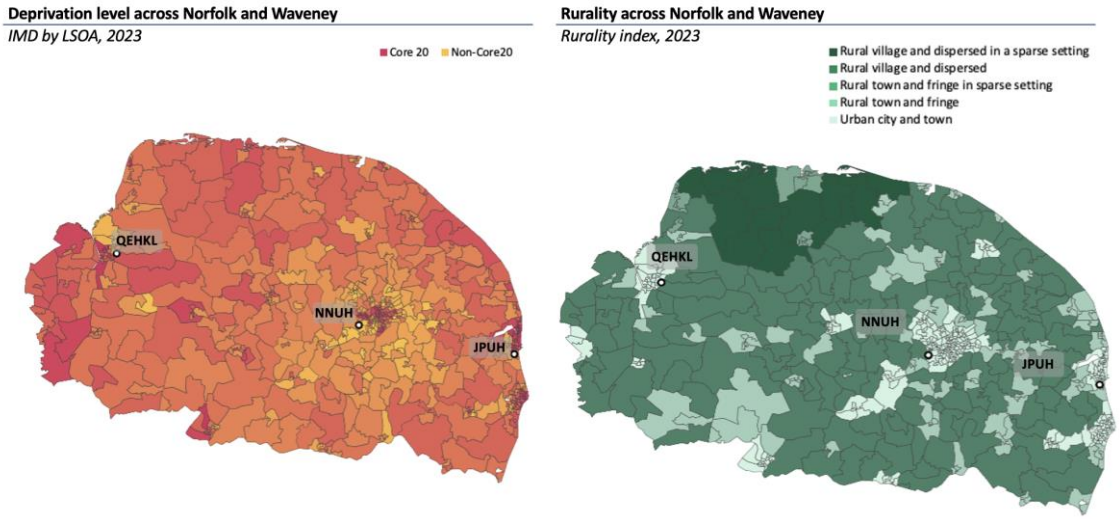


*Figure 3: Deprivation and rurality level across N&W. Source: ONS; CF Analysis*

## National context

### Health and Care Act (2022)

The 2022 Health and Care Act established Integrated Care Boards (ICBs) as statutory bodies and introduced a new legislative framework to foster collaboration between health and care system partners, including NHS Trusts. Provider collaboratives are pivotal in the development of Integrated Care Systems (ICSs), especially in fulfilling the quadruple aim duties:

- Improve outcomes in population health and healthcare

[10] ONS; CF Analysis
[11] ONS; CF Analysis
[12] Fingertips, QOF Data NHS England; CF Analysis

- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

The Health and Care Act guidance issued in 2024 provided detailed information on delegation to and between providers and provided an overview of the collaborative arrangements that are possible between Trusts, including Committees in Common and Joint/Shared Roles. The three Norfolk and Waveney acute hospitals have operated under a Committees in Common structure since 2021.

### Working together at scale: guidance on Provider Collaboratives (2021)

Prior to the implementation of the broader legislative framework, NHS England published guidance on provider collaboratives in 2021. This outlines the expected collaborative practices among providers, principles to support local decision-making, and various functional and organisational options that systems may consider in fulfilling the quadruple aim duties. By April 2022, NHS Trusts were mandated to participate in at least one provider collaborative.

The guidance does not impose any specific obligations on certain types of provider collaboratives, and there are only limited restrictions on the functions they can perform. They should be inclusive and adaptable over time to include the most suitable arrangement of members to serve their populations and maximise the benefits of scale.

Collaboratives are expected to collaborate with Place-based partnerships to support and enhance each other's work. Place-based partnerships coordinate the planning and delivery of integrated services locally, while provider collaboratives focus on scaling up and mutual aid across different locations, usually aligned with a local authority area. Within specific places, even more localised arrangements can be established around neighbourhoods to provide joined-up, proactive, and personalised care. The size and geography of ICSs) influence the scale at which system objectives and activities should be implemented, compared to the responsibilities delivered at a local level.

### Operational Planning Guidance 2024/25

The Operational Planning Guidance for the 2024/25 financial year emphasised collaboration by incorporating it as a recurring theme across various national objectives, such as achieving a balanced financial position, addressing quality and safety concerns, and supporting transformation initiatives. This collaboration involves collaborative arrangements with NHS organisations and broader system partners, particularly through provider collaborative agreements. The guidance reiterates the expectation that all NHS Trusts should be actively engaged in at least one collaborative effort aimed at fully realising the advantages of scale and transforming services for the future.

## Acute provider landscape

Together the three hospitals, Norfolk and Norwich University Hospitals NHS FT (NNUH), James Paget University Hospitals NHS FT (JPUH), The Queen Elizabeth Hospital King's Lynn NHS FT (QEHKL), undertake the majority of acute patient activity across Norfolk and Waveney (Figures 4 & 5).[13]

[13] HES APC; CF Analysis

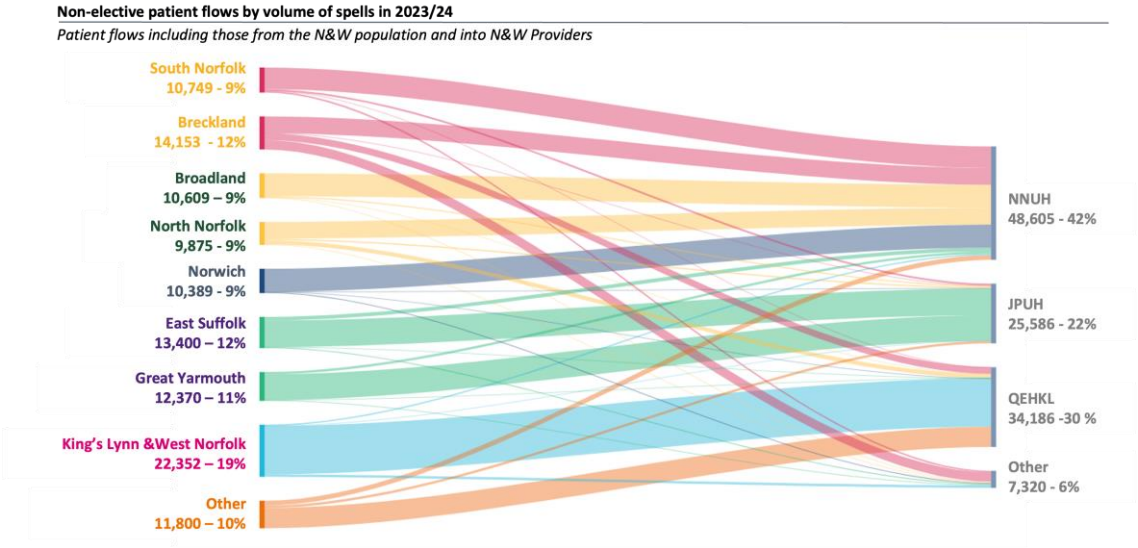


*Figure 4: Non-elective patients flow by volume of spells in 2023/24. Source: HES APC; CF Analysis*

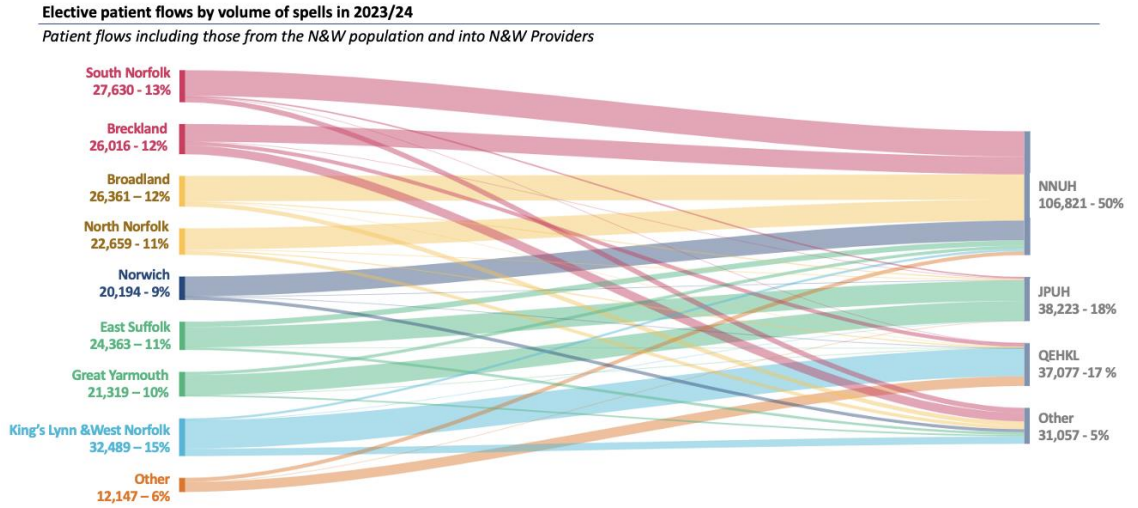


*Figure 5: Elective patients flow by volume of spells in 2023/24. Source: HES APC; CF Analysis*

NNUH offers a wide range of acute services for the population of Norfolk and the surrounding areas and specialist services for a larger catchment including cancer, orthopaedics, plastic surgery, ophthalmology, rheumatology, paediatric medicine and surgery, neonatal intensive care and foetal medicine. The Trust is made up of the Norfolk and Norwich University Hospital and Jenny Lind Children's Hospital on its main site, and the Cromer and District Hospital in North Norfolk. NNUH also runs many services in the community such as the Norfolk and Norwich Kidney Centre, Central Norwich Eye Clinic, Adelaide Street Pain Management Centre, mobile breast screening lorries, eye screening vans, mobile cancer treatments and Community Midwifery.

JPUH provides acute services in Great Yarmouth, Lowestoft and Waveney, as well as to the many visitors. The hospital was opened in 1982 and is part of the NHP, set to receive full funding to be completely rebuilt by 2030. The main site in Gorleston is supported by the Newberry Clinic and other outreach clinics in the local area. With 500 inpatient beds, the Trust provides acute services for the local population as well as some specialist services notably hyperbaric therapy.

Both NNUH and JPUH are University Teaching Trusts, and all three Trusts train medical students from the University of East Anglia, Cambridge University and overseas. All Trusts are actively engaged in clinical research, leveraging their expertise to advance medical knowledge and innovate patient care practices.

QEHKL is situated in King's Lynn and provides district general hospital services for acute and planned care to the population of King's Lynn and West Norfolk, Breckland, North Norfolk and Fenland (part of Cambridge and Peterborough ICS). In view of its geographic position on the borders of Norfolk, Cambridgeshire and Lincolnshire, the Trust is commissioned by Integrated Care Boards (ICBs) from all three counties.

The main hospital building on the QEH site was opened in 1980 and is also part of the NHP, with the new hospital set to open in 2030. The Trust delivers a range of services at the North Cambridgeshire Hospital site in Wisbech and from Maternity hubs throughout its catchment area. These are a key part of the Trust's commitment to collaborative working with local communities and partners at Place.

The three Trusts in Norfolk and Waveney currently face significant challenges which, without action to address them, will worsen over time. All three acute hospitals are currently rated as "Requires Improvement" by the Care Quality Commission and are forecasting an indicative £53.2m underlying deficit by 2029/30 (Medium Term Financial Plan) despite efforts to reduce this from the current deficit of £131.3m (Financial Out Turn).[14]

In 2023/24 the three Trusts delivered 307k A&E attendances, 106k non-elective admissions, 182k elective admissions, and 1.4m outpatient appointments. With no change to service delivery, an additional 80 A&E attendances, 62 non-elective admissions, 68 elective admissions, 125 outpatient first appointments and 341 outpatient follow-ups will be needed every day by 2033/34 (Figure 6).[15] With the system already facing significant financial and operational challenges, it is clear that the scale of challenge faced requires bold and decisive action.

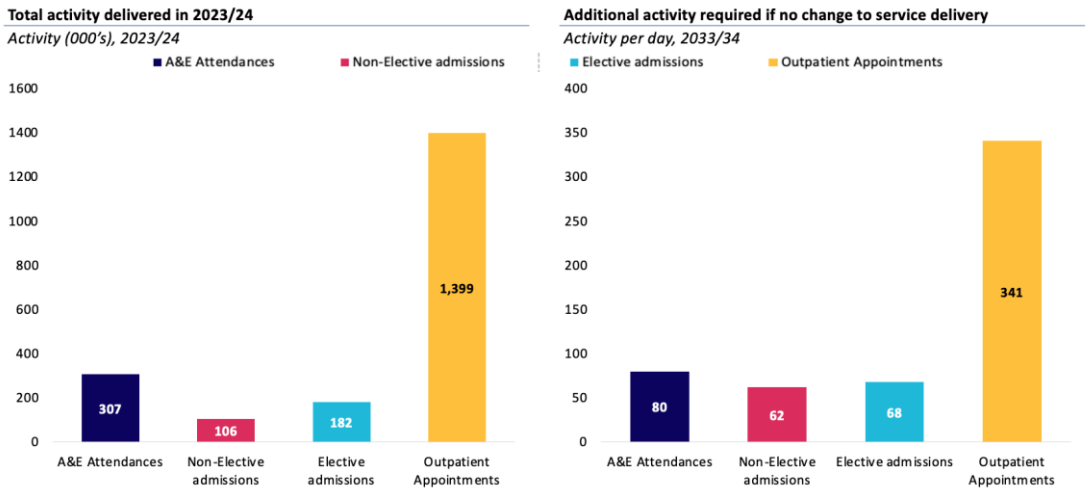


*Figure 6: Total activity and additional activity required with no change to service deliver. Source: HES APC, HES ECDS; CF Analysis*

The providers in Norfolk and Waveney have come together to determine how they can best address their shared and pressing challenges by working together. This document outlines in more detail the opportunities and benefits which could be realised through strengthened collaboration and the subsequent steps which need to be taken by the Trusts to realise these.

## Provider collaboration through NWAHC

QEHKL, NNUH and JPUH are already members of the AHC Provider Collaborative which was established in September 2020 to help develop alignment and decision making around cross cutting issues. This arrangement is part of the delivery mechanism for the Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy which is focused on four main objectives in response to the population health challenges in Norfolk and Waveney: driving integration, prioritising prevention, addressing inequalities and enabling resilient communities. As a result of the AHC, there has been good

[14] NNUH, QEHKL & JPUH Trust Board Papers 2024
[15] HES APC, HES ECDS; CF Analysis

progress in working together, including co-delivery of the Acute Clinical Strategy Programme, Electronic Patient Record Programme, some shared services e.g. Urology and shared roles.

Whilst the existing Committees in Common has been a useful vehicle for collaborative efforts to date, it has become increasingly clear that this is not sufficient to make decisions at the pace required. Within the current management and governance arrangements commitment to share resources, best practice and reduce unwarranted variation (e.g. waiting list differences) can be difficult to agree and implement in practice. As a result, all three Trusts recognise that they and the system could benefit significantly from a more integrated organisational arrangement.

Significant work is underway to form Speciality Clinical Networks across 22 specialities, with Phase 1 of the work planned for completion by March 2025. These networks, consisting of specialty clinical, nursing and operational leads, will pave the way for joint operational planning and strategic development of services together as an acute hospital collaborative, working in conjunction with wider health and care partners. The expectation is that all specialties will form informal clinical networks as a minimum, sharing policies and protocols, implementing informal support arrangements, sharing some services and care pathways where appropriate, and encouraging cross-site working or joint research opportunities.

In so doing, a collective vision, joint mission, and underpinning principles have been agreed as part of the Joint Acute Clinical Strategy, which should continue to guide the work as the three organisations move towards a Group model.

**Our Collective Vision:**
*Together, we will consistently provide equitable access for our patients to sustainable, high quality acute care through maximising the benefits of partnership.*

**Our Joint Mission:**
*To radically transform and innovate acute health service provision for the next generation.*

**Our Underpinning Principles for Clinical Transformation:**

1. Clinically led approach
2. Population health focussed
3. Continuous engagement of the public, patients and carers
4. Responds to the core national plans and the system clinical strategic objectives
5. Efficient use of resources, ensuring affordability and quality
6. Localise services wherever possible, consolidate where necessary
7. Hospital care only where no other safe alternative exists, maximising virtual care opportunities
8. Collaboratively develop multidisciplinary, community-based alternatives with Place partners where these alternatives should exist
9. Sustainably addresses health inequalities and variations in access, quality and outcomes
10. Efficient, standardised clinical pathways that ensure best clinical outcomes, enabled through digital transformation

## 4. The case for becoming a Group

The NHS Group Model unites multiple healthcare providers under a central governance framework to enhance efficiency, standardise practices, and improve patient care. Central leadership handles strategy and governance, while local units manage operations and ensure integration with local partners to meet the needs of their patients. This model focuses on standardising systems, policies, and procedures for consistent and high-quality care.

There is considerable evidence available to substantiate the basis for a Group model, including national guidance and examples from other provider Groups. 'The Dalton Review'[16], 'The Carter Review'[17], New Care Models Vanguards[18], 'NHS Group Models: Working together for a more sustainable NHS' (2017), NHS publications[19] and national guidance[20] and publications by The Kings Fund[21] all illustrate the benefits of moving to a Group model. The wide variety of Group model forms that have emerged to date serve to highlight flexibility and choice that exist in pursuing this type of arrangement.

National guidance and case examples from providers who have already formed Group models set out a compelling case for the flexibility, advantages and opportunities that can be realised through the development of similar arrangements between NNUH, JPUH and QEHKL.

Delivering the scale of transformation required to meet the needs of the Norfolk and Waveney population requires extensive collaboration at a local/Place level, and the dedication of significant capacity and capability. By optimising effective working on other opportunities, a group model has the potential to release some of this capacity and capability to focus on Place-based care. Combined with a clear prioritisation across the three acute providers, this can support the accelerated delivery of a critical agenda.

A group model also creates the conditions to establish a common set of standards built on existing best practice and drawing on experience from elsewhere. These standards are then owned by all and can form the basis of a shared commitment to the population.

A group model supports the development and deployment of a consistent delivery approach focussed on improving care quality and outcomes. This consistency can then support the warranted variations in care that are needed to ensure it reflects population need at a local level.

The governance structure adopted by a group is a critical enabler of acute service transformation to ensure sustainability of service delivery and the optimal use of resources. It supports the seamless delivery of patient care across providers, and the alignment of service provision to provide a consistent and cohesive offer to patients. This is achieved through the development of a common care model for the group, and coordinated planning of activity across multiple sites, addressing both local and system-wide needs. Working at Place, the group can better anticipate challenges and align services with the population healthcare demand.

A shared vision and values are critical to the delivery of shared care models and the delivery of consistency. A unified group helps to foster a cohesive culture by defining and emphasising shared values, promote a collective identity to boost staff morale and highlight common goals. It helps to remove silos between sites, enabling coordination of services and resources and supports staff to work collaboratively across locations, enhancing flexibility and system efficiency.

Operating as a group is critical to maximising the opportunities of working at scale. It binds all three Trusts together and creates the framework that supports a single strategic vision and set of aligned priorities. This then translates into a shared commitment delivered by a unified leadership which can support rapid decision making when required.

[16] Dalton Review (2014)
[17] Carter Review (2015)
[18] New Care Models Vanguards – developing a blueprint for the future of NHS and care services' Teneo (2019)
[19] 'NHS Group Models: Working together for a more sustainable NHS' (2017)
[20] 'Working together at scale: guidance on provider collaboratives' (2021)
[21] 'Provider collaboratives: explaining their role in system working' (2022)

The group model supports the development of a single system level strategic plan across multiple sites, addressing both local and system-wide needs and the development of a single set of investment decisions to support the delivery of service transformation at scale.

The prioritisation of resources through a common framework ensures this is used to the maximum benefit of the population as a whole, rather than to meet the needs of sometimes conflicting organisational priorities.

A group model streamlines decisions by reducing the number of separate board approvals required, allowing for faster decision making and implementation of policies, initiatives and delivery of change, which is essential given the scale of opportunity that needs to be delivered.

The benefits a group brings through standardisation of process to drive improvements in quality and efficiency, through the delivery of consistent pathways are essential to enable the delivery of benefit from shared endeavours including the deployment of a single electronic patient record.

A group model is also the most effective way to address barriers to collaboration at scale, such as the sharing of information, and financial flows that can be a disincentive to transformation.

Collaboration does not happen by default and leadership and governance arrangements are required to strengthen and drive collaborative efforts. A group model provides a structure which would help the three Trusts to strengthen collaboration and respond to the opportunities outlined in the case for collaboration. While the formation needs to be agreed through further design work, there is significant energy and enthusiasm to engage in the process so far with a collective willingness and motivation to act on the case.

### Opportunities for collaboration

For NNUH, JPUH and QEHKL, eleven opportunity areas for collaboration across three broad themes have been identified, which have the potential to transform clinical care and deliver consistent access to high quality services through the adoption of best practice. They leverage the benefits of scale in delivering sustainable services and creating a compelling offer for staff and create the opportunity to deliver improvements in productivity.

They are:

**A) Transform health services based on the needs of patients and population**

- Address growing demand for health and care by playing an active system role across Norfolk and Waveney in preventative and proactive healthcare for people with long term conditions
- Deliver a consistent best practice model of urgent and emergency care with a particular focus on frailty

**B) Deliver high quality outcomes building on combined knowledge, skills and experience**

- Implement safe and sustainable care models initially in maternity and stroke care with development of models for other specialties to follow to deliver clinical, financial and environmental sustainability
- Level up outcomes and access by optimising elective care pathways, making best use of collective capacity, improving access to services, reduce waiting times and enhance patient care
- Deliver better outcomes for people with cancer at all stages of the pathway, starting with earlier diagnosis

**C) Achieve greater sustainability by working at scale**

- Make most effective use of workforce capacity allowing the easier movement of staff to improve service resilience and staff development opportunities
- Improve the offer for staff, to train, develop and retain healthier and happier staff
- Create a University Hospital System to enhance potential for research, training and innovation
- Use collective assets to leverage joint negotiation, purchasing and investment power of the three Trusts

- Realise the benefits of service transformation that are possible through enabling programmes such as estates and digital
- Have an aligned approach to strategy, transformation and planning functions

In parallel with working on this shared agenda, the Trusts will also be focussing on the delivery of Place-based care in partnership with their local communities. Work in this area can be accelerated as there are more routes to share and align on best practice, and as the shift to doing things once for Norfolk where this is appropriate releases capacity that can be dedicated elsewhere which will support the development of two new hospitals.

While some opportunities are discrete, others are overlapping in their impact, and this will need to be taken into consideration when considering their phasing. Some collaborative opportunities are also already in train, however this case for change focuses on the ability for a Group model to strengthen delivery, for example through streamlined and faster pace of decision making.

### A) Transform health services based on the needs of patients and population

The population of Norfolk and Waveney is elderly with 1 in 4 aged 65 and over in 2023, with this population consuming more acute healthcare than any other group.[22] Of the emergency admissions in Norfolk and Waveney, 76% of the associated occupied bed days were from patients aged over 65, between 2021/22 and 2023/24.[23]

N&W has a higher proportion of older people than the rest of England, and it has the second highest proportion of people aged 85 and over in England after Dorset.[24]

Norfolk and Waveney have a higher burden of long-term conditions and multimorbidity than the national average.[25] The consequence of this is an increased use of hospital-based services, which reactively manage deterioration and acute exacerbation as opposed to the proactive anticipatory management that could avoid use of hospital-based services.

#### Address growing demand for health and care by playing an active system role across Norfolk and Waveney in preventative and proactive healthcare for people with long term conditions

Over the next ten years, the proportion of people over the age of 65 will increase from one in four (26%) to three in ten (29.9%) by 2033 with N&W having the third highest proportion aged 65 and over.[26]

The increase in the elderly population combined with the extent of prevalence of long-term conditions means that demand for hospital resource will grow, putting additional pressure on services that are not able to meet current levels of demand.

With no change in care model, by 2033 there is set to be an increase in emergency admissions of 22% across all three acute Trusts in Norfolk and Waveney, with the greatest increase being in the 85+ age group (Figure 7).[27]

[22] HES, ONS; CF Analysis
[23] HES, ONS; CF Analysis
[24] ONS; CF Analysis
[25] Fingertips, QOF Data NHS England; CF Analysis
[26] ONS; CF Analysis
[27] HES, ONS; CF Analysis

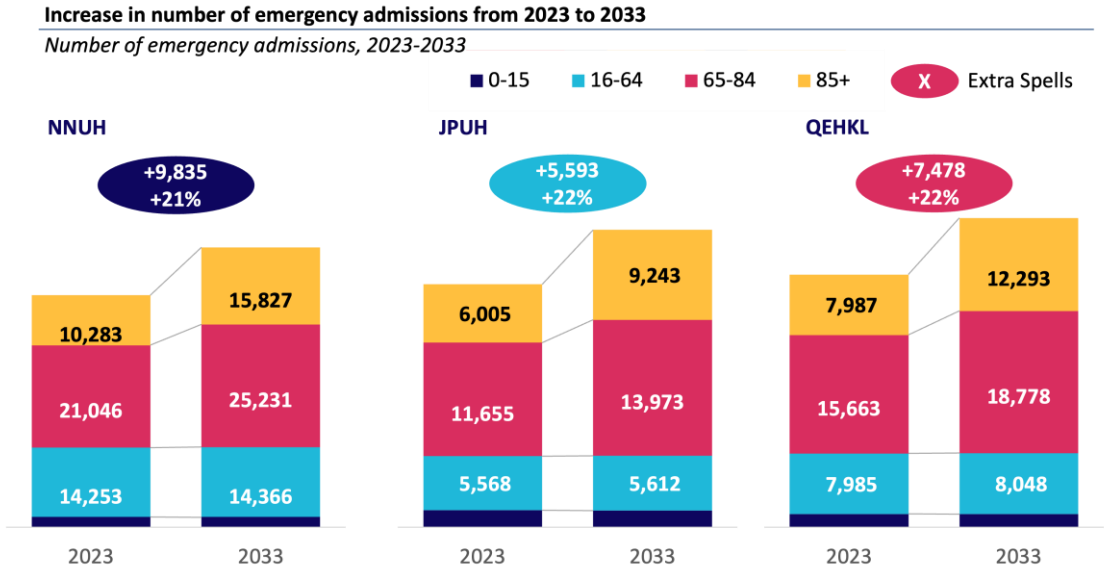


*Figure 7: Increase in emergency admissions from 2023 to 2033. Source: HES, ONS; CF Analysis*

Greater collaboration between NNUH, JPUH and QEHKL will support efforts to prioritise the health of elderly people in response to the growing level of need in this group. While the health of the older population is outside of the direct and sole influence of the acute providers, they have significant capacity and capabilities to support health and care partners and enable the left-shift agenda to move care from hospitals into the community.

Making Place-based partnerships a priority ensures that the needs of local populations, at place and neighbourhood level, are being recognised by leveraging collective expertise, insight, and relationships. The objectives of a Place-based partnership centre on improving the quality, co-ordination and accessibility of health and care services and this needs to be a focus in order fully to respond to the case for collaboration.

Working with the wider system, the acute Trusts in Norfolk and Waveney need to play an active role in the preventative healthcare approach. An anticipatory model of care could be developed and implemented that encompasses case finding to manage actively at-risk patients, care planning, structured education and self-management, and access to specialist opinion involving a health and social care multi-disciplinary team at a PCN level. For people with more complex needs, the anticipatory model should be supplemented by care planning and navigation / co-ordination, rapid response, reablement and a healthy living environment. The role of an acute Trust in this endeavour could include for example community outreach and Multi-Disciplinary Team (MDT) participation, supporting integrated local neighbourhood teams to target high-resource populations and keep people healthier at home for longer.

Working closely with community and primary care services will help focus on the management of chronic conditions in the elderly population and ensure there are aligned, best practice pathways to access secondary and specialist care. To support this, improving the connectivity between teams and pathways into hospital and standardising discharge pathways would enable people to be discharged home sooner.

JPUH and QEHKL have an opportunity to reduce their length of stay for those over 65 to achieve peer median levels from 9.8 and 9.0 days respectively. For JPUH this is equivalent to 53 beds and for QEHKL this is equivalent to 38 beds. Had this opportunity been implemented in 2023/24, assuming a standard bed day cost of £345, this would have had a potential saving of £18.8m.[28]

[28] HES APC, HES ECDS, Model Hospital; CF Analysis

### Deliver a consistent best practice model of urgent and emergency care with a focus on frailty

Urgent and emergency pathways are one of the greatest points of pressure for the system. There are challenges with both timely access and poor outcomes. In all three organisations, access is falling short of national standards, especially with respect to emergency department waits.

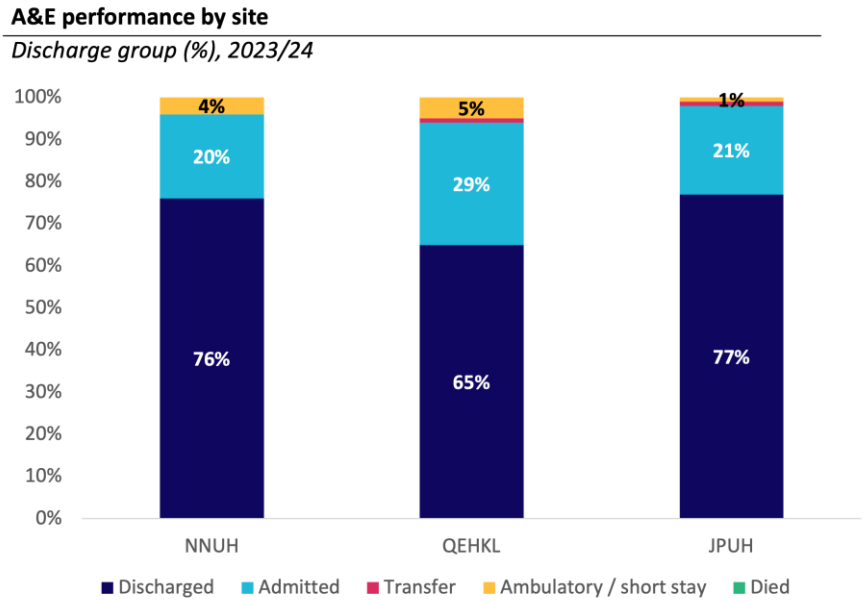


*Figure 8: A&E performance by site. Source: HES APC, HEs ECDS; CF Analysis*

Very elderly people present a unique set of challenges for clinicians, with common complaints including falls and frailty for those conveyed to the emergency department. However, ED is often not the most appropriate location for elderly people to receive care. For example, 92,000 people aged over 65 conveyed to ED with conditions that could have been seen by an alternative service in 2023 were not admitted and received guidance only.[29] Many of the people who were conveyed to ED with conditions related to falls and frailty but received advice and guidance only, should instead have been conveyed to alternative services in a community setting, or an acute service at a lower acuity (Figure 8).

The establishment of a consistent model across Norfolk and Waveney would make emergency care accessible and equitable for elderly people across Norfolk and Waveney. This should begin with scaling the model for Older People's Emergency Departments to provide accessible emergency care across Norfolk and Waveney and the development of Frailty Same Day Emergency Care (SDEC) units. This should build on the existing approach at NNUH and QEHKL.

Over time, the end-to-end care model for emergency care in the acute setting should be reviewed, leveraging the learnings from the existing effort and best practice from elsewhere. In so doing, the three Trusts need to recognise the access challenges posed by the rurality of certain populations, this could involve an outreach programme, bringing care closer to home to focus specifically on rural populations.

If a joint approach was successfully implemented, the benefits would mean patients have access to the right care at the right time, with the potential to avoid attendances altogether. The estimated potential savings in 2023/24 would have been £20.9m.[30]

### B) Deliver high quality outcomes building on combined knowledge, skills and experience

Across the three providers, analysis highlights a number of fragile services across the three acutes. Service fragility is determined by service volumes, in terms of inpatient activity, and staffing levels. The balance between these two factors, as well as comparative scale of the providers, are critical in ensuring

[29] HES ECDS; CF Analysis
[30] National Schedule of NHS Costs 2023/24; CF Analysis

quality, safety and resilience. Greater collaboration, including single managed services, mutual aid and service consolidation, is a route to improving fragility and reducing the level of variation.

Collaboration on fragile services would help to understand relative strengths and weaknesses of providers and align all three providers around best practice. No single organisation does everything well and so collaboration would help to reduce variation, pulling through elements that work well, and which could be adapted to meet population needs.

This case for collaboration focuses on the areas where the most pressing needs have been identified, however there is an opportunity for a more comprehensive review of clinical services and their sustainability to be undertaken. This may result in a more radical transformation of care models being agreed across Norfolk and Waveney, which would necessitate wider clinical and public engagement on both the case for change and service changes needed as a result.

NHS England will expect all service change proposals to comply with the Department of Health and Social Care's four tests for service change throughout the pre-consultation, consultation and post-consultation phases of a service change programme. The four tests are:

- strong public and patient engagement,
- consistency with current and prospective need for patient choice,
- a clear clinical evidence base,
- support for proposals from clinical commissioners.

**Implement safe and sustainable care models initially in maternity and stroke care with development of models for other specialties to follow to deliver clinical, financial and environmental sustainability**

Stroke and maternity services are two areas nationally where sustainability issues are challenging service delivery – this is no different in Norfolk and Waveney.

For stroke, Norfolk and Waveney has the fifth highest stroke prevalence in the country, with highest rates in King's Lynn and West Norfolk, and North Norfolk, which sit in the catchment of QEHKL and NNUH. Strokes are the main cause of adult disability in England with around two thirds of people surviving their stroke, but half of stroke survivors being left with long-term disability and dependent on others for everyday activities.

The most important care for people with any form of stroke is prompt admission to a specialist stroke unit. This applies to those with either an ischaemic or haemorrhagic stroke of any severity and for people of any age. National guidance sets a minimum guideline of 600 stroke admissions a year to sustain expertise and be within 30–60-minute drive in a blue light ambulance to deliver time-critical treatments. In rural communities, choices must be made about how best to deliver this.

In addition, medical advancements such as the development of mechanical thrombectomy for acute large artery stroke create further specialisation for this condition. In Norfolk and Waveney, NNUH has approval and secured funding from NHS England and the N&N Hospitals Charity to offer mechanical thrombectomy as a major expansion to Norfolk & Waveney neuroscience services by Autumn 2025. Establishing robust research networks and driving up the quality of the stroke units is the single biggest factor to improve stroke outcomes.

Stroke care at each acute provider in Norfolk and Waveney varies between sites. At all acute hospitals in Norfolk and Waveney, the percentage of patients scanned within an hour falls below the national average. Specifically, 52% of patients in 2023/24 are scanned within this timeframe at QEHKL, 56.9% at JPUH, and 57% at NNUH.[31]

In terms of the key elements of care, less than half of patients in 2023/24 are admitted to a stroke unit within 4 hours: 55.7% at JPUH, 43.5% at NNUH, and 40.5% at QEHKL, although most are assessed by a stroke specialist within 24 hours, with 91.7% seen at JPUH, 86.5% at QEHKL, and 84.8% at NNUH. Finally,

[31] SSNAP Annual Portfolio National Results; CF Analysis

there is a difference in the percentage of eligible patients receiving thrombolysis: 98.5% at JPUH, 89.6% at NNUH, and 78.3% at QEHKL.[32]

Several models of service transformation to improve access have been suggested and implemented successfully elsewhere, including redirecting patients to comprehensive stroke centres and telemedicine-based systems. To deliver better outcomes, the model of care for stroke services in Norfolk and Waveney needs rapid transformation. QEHKL would potentially save an estimated £887k annually by enhancing their productivity. This would be achieved by reducing their weighted activity unit (WAU) cost to the median of their peers.[33]

For maternity, given the profile of the population in Norfolk and Waveney, there has been a decrease in the number of deliveries per year, along with a declining birth rate. QEHKL and JPUH have under 2,000 deliveries each in 2023/24.[34] This makes them some of the smallest services nationally, ranking 111 and 112 of 122 providers of maternity services. In 2023/24 JPUH delivered a total of 1,717 babies with an associated WAU cost of £5,950, compared to a peer median of 2,285 total deliveries and a WAU cost of £3,588. JPUH has a CQC rating of inadequate from May 2023, with QEHKL and NNUH rated Good in March and February 2024 respectively.[35]

Low birth volumes have been associated with higher rates of perinatal mortality even for low-risk births. Where small units can exist, they do have much higher unit costs and must have appropriate staffing levels to operate safely. The mortality rate per 1,000 stillbirths and live births within Norfolk was 82.2 between 2019 and 2021, compared to the national average of 78.3.[36]

Simultaneously, the nature of maternity demand is changing in Norfolk and Waveney, with a requirement to support more complex births and an increasing volume of caesarean deliveries. Whilst the number of deliveries over the last 5 years has decreased, the volume of more complex deliveries – planned and emergency caesarean sections have increased by 13% and 17% respectively.[37]

Along with changes to service demand, staffing pressures have a significant impact on maternity units in Norfolk and Waveney. Trusts have varying vacancy rates for midwives with QEHKL having a midwife vacancy rate of 2.3%[38] compared with rates of 1.8% at NNUH and 2.0% at JPUH between April and September 2024.[39]

Together, this evidence points toward a need for the maternity model of care to be reviewed in line with best practice and national guidance. In particular the Better Births national maternity review advises that for rural populations, commissioners and providers should consider how they can follow the principle of localising where possible and centralising where needed. In addition, they should think about how they can use their workforce more innovatively including sharing staff across multiple sites and enhancing the consultant workforce with a view to reducing reliance on other grades of doctors. Innovative working practices can also be incorporated into the care including making use of technology, e.g. consultations by video link between the centre and smaller unit.

Based on the number of births and current costs per WAU in 2023/24, £6.4m in cost savings would be achieved by reducing the cost per WAU for both NNUH and JPUH to their peer medians.[40]

### Level up outcomes and access by optimising elective care pathways, making best use of collective capacity, improving access to services, reduce waiting times and enhance patient care

Following the Covid-19 pandemic, the Norfolk and Waveney system has been slower to recover elective care than elsewhere. There are significant numbers of people with long waits for treatment; NUUH has

[32] SSNAP Annual Portfolio National Results; CF Analysis
[33] Model Hospital; CF Analysis
[34] HES APC; CF Analysis
[35] HES APC, Model Hospital; CF Analysis
[36] Fingertips; CF Analysis
[37] HES APC; CF Analysis
[38] QEHKL Vacancy Rate 2024/25; Pippa Street, Chief Nurse
[39] Provider Workforce Return 2019-2024; CF Analysis
[40] HES APC, Model Hospital; CF Analysis

the 5th longest waiting list over 52 weeks in the country[41]. Long waits lead to worse patient outcomes; for instance, when surveyed on this issue, 40% of patients consider their condition to have worsened in the time between referral and admission, and 57% said it affected their wellbeing.[42]

Furthermore, the productivity of capacity that is used for elective care is poor. Theatre utilisation in 2023/24 stands at 79% at NNUH, 77.5% and JPUH and 81.3% at QEHKL. NNUH and JPUH sit below the national average of 79.8%, all sites sit below the target of 85%.[43]

Beyond productivity challenges, there is fragmentation of elective work, with the majority of specialities being delivered across three sites and in some instances in relatively small volumes. For example, notwithstanding national staff shortages, in Oral surgery 3,094 appointments were delivered in NNUH whilst only 211 were delivered at JPUH and 882 at QEHKL in 2023/24. For the same period, NNUH delivered 3,383 Ophthalmology spells compared to 8,705 and 7,447 for JPUH and QEHKL respectively (Figure 9).[44]

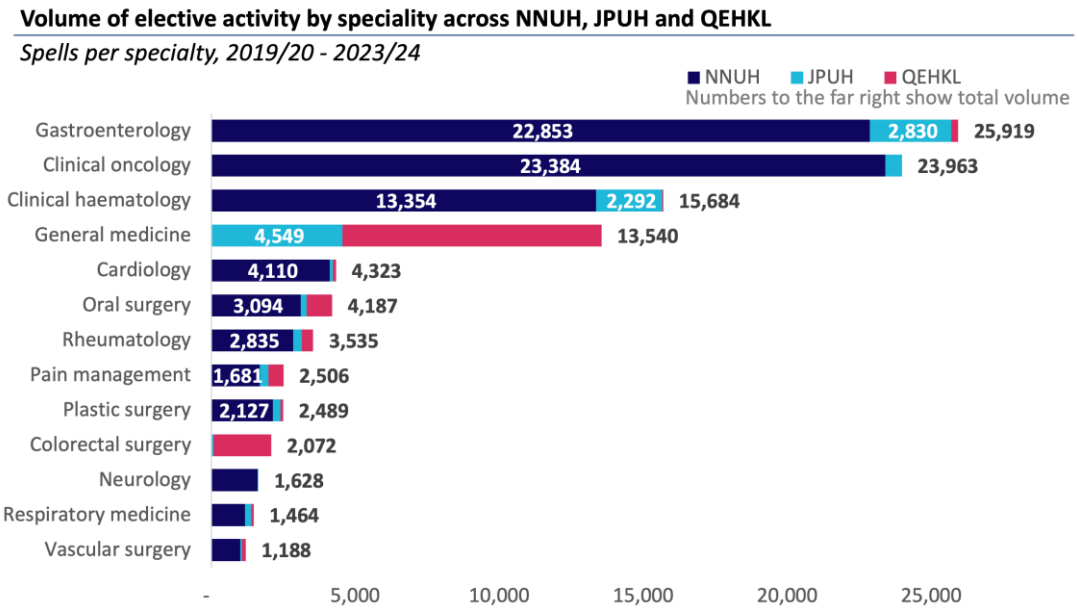


*Figure 9: Elective activity volume by specialty and site. Source: HES APC; CF Analysis*

Given the fragmentation of elective care and the challenges to performance across Norfolk and Waveney, opportunities exist across a spectrum of collaboration. This includes sharing best practice, data and information, standardising quality, and performance standards, creating rotational posts and shared roles between organisations, standardising pathways, and ensuring robust protocols and procedures are in place, networking and consolidating services. More specifically:

- Further use of mutual aid across providers, to address long waits for elective care, particularly at NNUH
- Aligning and standardising processes and criteria to provide equity of access, helping Trusts to make best use of their collective capacity,
- The delivery of High-Volume Low Complexity (HVLC) activity through elective hubs, building on the proven case for delivering planned care through dedicated sites, creating a greater degree of separation between emergency and elective activity,
- Considering where fragmentation of service provision is resulting in fragility and provide more sustainable services at scale.

If a joint approach was successfully implemented, the benefits would mean more timely access to care for patients, more efficient use of resources and better experience for staff. At both NNUH and JPUH, the potential increase in operations in 2024 is 2704 and 286 cases per year respectively, assuming each

[41] Consultant-led RTT waiting times NHSE monthly collection; CF Analysis
[42] https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey
[43] Model Health System NHS England; CF Analysis
[44] HES APC; CF Analysis

Trust achieved their peer median cases per session (Figure 10). The estimated possible income that this would result in is £6.7m.[45] This activity could be delivered within the existing cost base and consequently there is also an opportunity to increase activity levels above and beyond this and deliver the nationally set elective recovery targets.

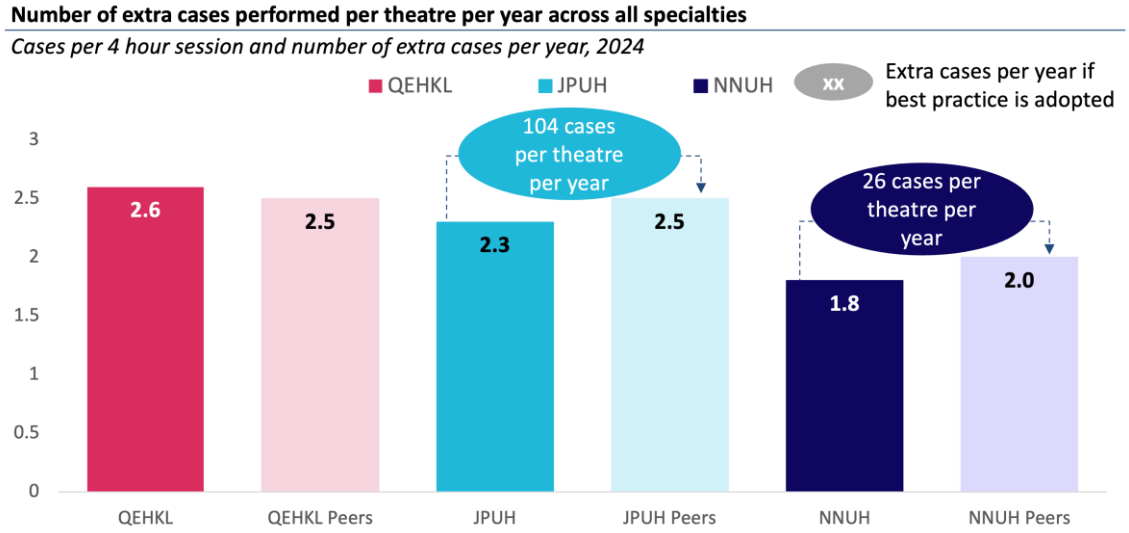


*Figure 10: Number of theatre cases per 4-hour session. Source: Model Health System NHS England; CF Analysis*

### Deliver better outcomes for people with cancer at all stages of the pathway, starting with earlier diagnosis

In Norfolk and Waveney, the prevalence of cancer has increased by 70% from 2.63% in 2013/14 to 4.52% in 2023/24. Over the last ten years, this rate of growth has outstripped the national average (Figure 11).[46]

For certain types of suspected cancer such as skin, lower gastrointestinal (GI) head and neck, urological and gynaecological, breaches of the 28-day standard for waits from urgent referral to diagnosis target are common in Norfolk and Waveney. The proportion of patients that breach the target for suspected skin cancer and gynaecological cancer exceeds the national average, with over half of people with suspected skin cancer waiting over 28 days for diagnosis.[47]

Furthermore, since the pandemic, in line with national trends, there has been an increase in cancers diagnosed in A&E in Norfolk and Waveney. The rate of growth in Norfolk and Waveney has outstripped the national average with rates in August 2024, 73% higher than peer average and 57% greater than national average.[48]

[45] Model Health System NHS England; CF Analysis
[46] Fingertips; CF analysis
[47] Cancer waiting times NHS Digital 2024; CF Analysis
[48] HES ECDS; CF Analysis

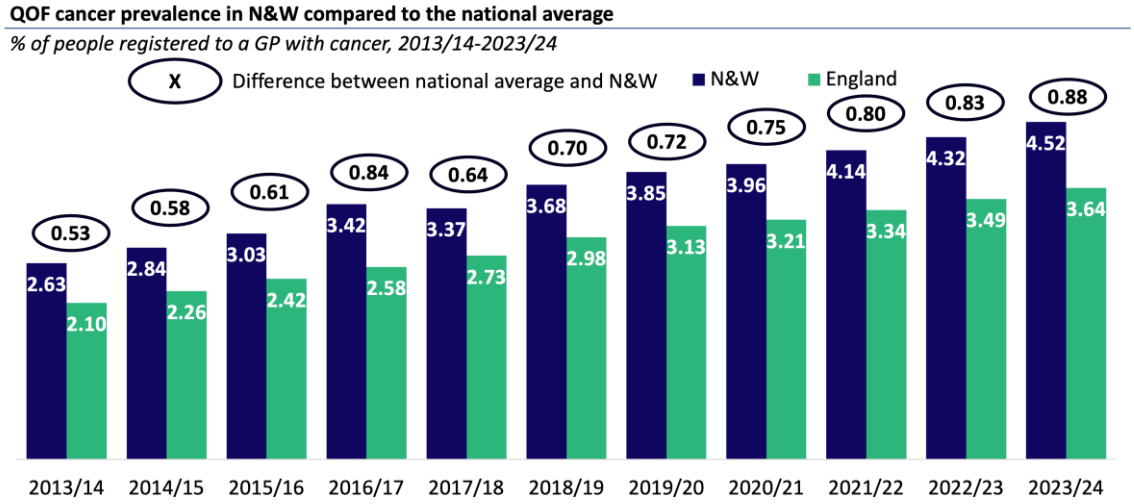

*Figure 11: Percentage of people registered to a GP with cancer in N&W. Source: Fingertips; CF Analysis*

Work is already underway to collaborate on cancer care in Norfolk and Waveney, however there is an additional opportunity to establish a single service model for cancer to provide consistent access to high quality cancer care closer to home. Co-ordination of demand would support realising efficiency benefits of working at scale and streamline service delivery.

Cancer services at NNUH are already one of the largest in the country, ranking fifth of all providers.[49] Operating at scale in conjunction with JPUH and QEHKL would make the service the third largest cancer service in the country. For many surgical procedures, outcomes are improved when the operation is performed by high-volume surgeons and at high-volume hospitals. While this phenomenon has been demonstrated for a wide variety of procedures, the influence of volume is most pronounced for high-risk procedures associated with a significant risk of complications.

A single staffing model would help to tackle workforce gaps and pool resources and expertise. This could include the establishment of joint posts with expertise cross covering the specialist centre and outreach clinics. This would be supported digitally through advancements such as a single Patient Tracking List (PTL), leveraging the benefits of the new shared Electronic Patient Record (EPR) (April 2026). This would enable streaming of cases to the most appropriate provider based on complexity and therefore optimise the efficiency of the service model.

If a joint approach was successfully implemented, the benefits would mean more cancers diagnosed at an earlier stage, resulting in a better prognosis for patients, reduced variation in access, and improvement in patient outcomes. Based on desktop research about the average spend at different stages of cancer diagnosis, increasing the number of cancers diagnosed at stage 1 or 2 to 75% (from a baseline of 55%), would provide an annual cost saving of £24.6m across the three Trusts.[50]

### C) Achieve greater sustainability and return on investment by working at scale

The local NHS is facing significant financial pressures, with the three acute Trusts having a combined total deficit of £39.4m, a £29.5m negative variance to plan as of October 2024.[51] Coupled with the expected rates of demand growth as a result of demographic change, this is a significant challenge to the delivery of sustainable services for the long term.[52]

There is an imperative to deliver best value for every pound spent while continuing to deliver safe and effective care for patients. Collaborating to work at scale has the potential to have a significant impact on the cost effectiveness of acute healthcare provision, through avoiding duplication, pooling resource and sharing expertise. The benefits of this approach are clear in existing programmes such as the single electronic patient record and could be maximised though work in other areas.

[49] HES APC; CF Analysis
[50] CF Analysis
[51] Provider Financial Returns 2019-2024; CF Analysis
[52] ONS; CF Analysis

In many corporate areas, the spend across Norfolk and Waveney falls below the median spend at other acute providers and consequently there is not a significant opportunity to make cost savings. Rather, the opportunity exists to make better use of investment in these areas to provide consistency and align practices to be best in class approaches.

As well as the need to create a financially sustainable future service delivery model, there is also a need to create a clinically sustainable model. Sustaining reliable on-call services is increasingly challenging. Nationally, as well as locally, there are several shortage specialties, with significant difficulties to recruit new staff. This coupled with an increasing choice by clinicians to work longer before retirement with an expectation to come off on-call rotas, or at the very least have a significantly lower commitment to on-call, adds to the fragility of on-call services especially for those specialties with smaller teams. Collaborative working is one way to increase the clinical sustainability of services.

### Make most effective use of workforce capacity allowing the easier movement of staff to improve service resilience and staff development opportunities

The Trusts are also major employers in the system, with NNUH employing 8,639 Whole Time Equivalents (WTE), QEHKL 3,681 WTEs and JPUH 3,764 WTEs substantively as of June 2024.[53] Combined, the three Trusts spent £1.012bn on workforce costs in 2023/24. Of this, NNUH spent £553m of which £526m was on salaries, JPUH spent £224m of which £214m was on salaries, and QEHKL spent £233m, with £225m on salaries.[54] Workforce costs are overwhelmingly the highest area of spend across the three organisations and the workforce development agenda is a key focus for each. As a result, the workforce agenda between the three Trusts is significant and has far reaching consequences.

All three acute Trusts in Norfolk and Waveney have seen an increase in the number of staff vacancies since 2021. As of August 2024, NNUH had the greatest vacancy rate of 9.8%, QEHKL was 9.5% and JPUH was 4.5%. High vacancy rates result in a high spend on bank and agency staff at all Trusts. The highest proportional spend between April to October 2024 is seen at QEHKL where 10.9% of staff pay was on bank staff and 4.7% on agency staff. NNUH spent 9.1% of staff pay on bank staff and 2.4% on agency staff. JPUH spent 7.2% of staff pay on bank staff and 4.2% on agency staff (Figure 12).[55]

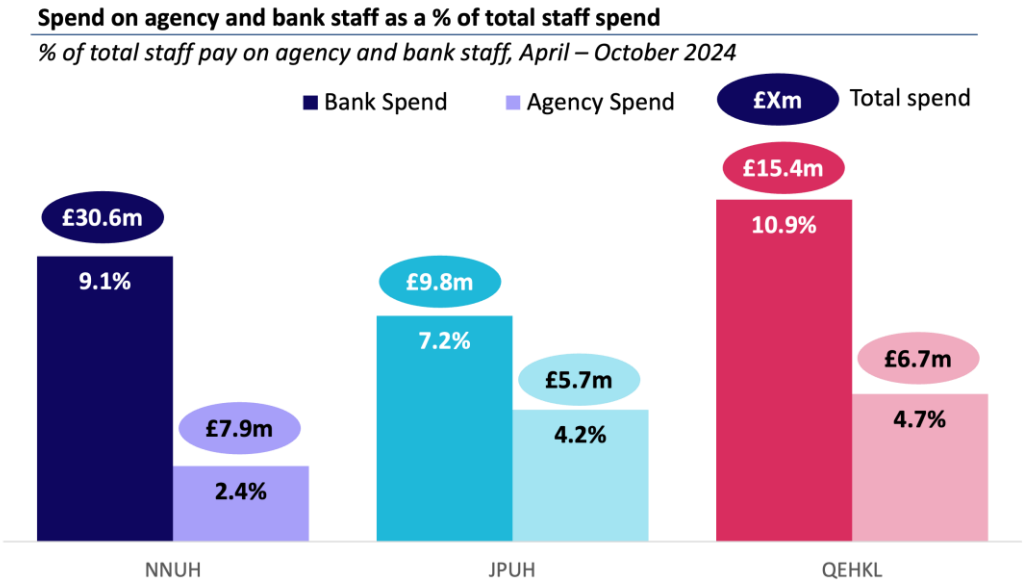


*Figure 12: Total spend and percentage of staff pay spent on bank and agency staff in April-August 2024. Source: Provider Financial Returns 2019/20-2024/25; CF Analysis*

There is a strong body of research linking good staff experience and improved patient satisfaction, with a range of factors that are predictive. High work pressure for staff, staff perceptions of unequal

[53] Provider Workforce Returns 2019-2024, Total WTE Substantive Staff; CF Analysis
[54] Provider Financial Returns 2019-2024; CF Analysis
[55] Provider Workforce Returns 2019-2024; CF Analysis

treatment, and discrimination against staff are all damaging for patient satisfaction and addressing these should be seen as priority for all organisations.

Working together could mean a more coordinated deployment of staff across all sites. Allowing resources and workforce capacity to be managed across sites will address critical workforce gaps, tackle absences, and provide sustainable services. Additionally, the ability to have a single workforce plan would enable more strategic decision making to take place. Maintaining high retention rates within staffing establishment provides an increased stability index, this is estimated to save QEKHL £30.2k and NNUH £227.8k annually.[56]

In Urology, early learnings in service collaboration have led to the development of plans to enable cross-site working for staff to make better use of workforce capacity and aid the fostering of a culture of a collaborative and single workforce across QEH and NNUH sites. While there is more to do to embed this approach fully, the learning is clear and the approach could be rolled out to other clinical services.

This opportunity would be supported by a joint approach to People Services / Human Resources across the three organisations. Previous work on corporate services has identified that the time to recruit varies across the system, costing around £2.2m a year on bank and agency staff.[57]

### Improve the offer for staff to train and retain healthier happier staff

Rates of staff turnover are high at both NNUH and QEHKL with a stability index ranking of 116 out of 140 providers and 70 respectively. Issues with vacancies are further compounded by staff absences due to illness. In July 2024, 6.2% of the workforce at QEHKL, 6.1% at JPUH, and 4.4% at NNUH were absent from work due to sickness (Figure 13).[58] Notably, JPUH and QEHKL have experienced an increase in staff absences related to illness since 2019, while the NNUH has maintained a consistent level. The annual cost saving from reducing sickness rates to the 4.5% national average for JPUH and QEHKL would be £3.0m and £3.1m respectively.[59]

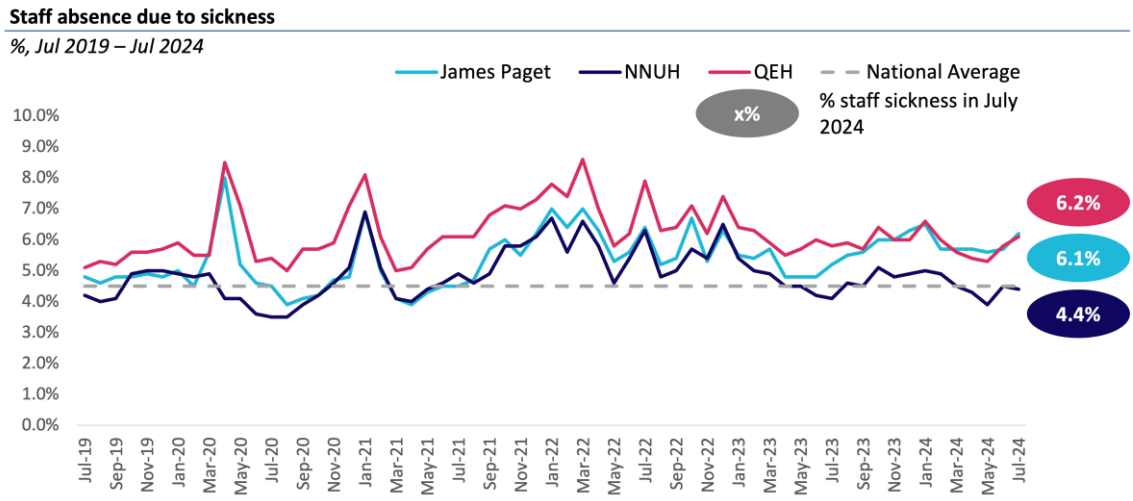


*Figure 13: Staff sickness as a percentage between July 2019 – July 2024. Source: NHS Sickness Absence Dashboard; CF Analysis*

To improve workforce resilience, there is an opportunity to create a more supportive working environment by sharing best practices across the workforce and establishing mutual support systems. Pooling resources that are dedicated to improving health and wellbeing of staff would also enable a higher quality offer to be delivered.

Staff at all organisations have mixed views on the training and development opportunities at their hospital Trust, with Trusts being rated as below national and peer average on several metrics. There are

[56] FTE and Stability Index of Staff NHS Digital; CF Analysis
[57] Model Hospital; CF Analysis
[58] NHS Sickness Absence Dashboard; CF Analysis
[59] National Sickness Absence Rate June 2023, NHS Digital

particularly low scores for adequate experience and clinical supervision, as per the GMC Training Survey (Figure 14). There is variation in the proportion of positive responses given by staff in training at the three providers, with the lowest scores being around post-qualification retention.[60]

**GMC Survey feedback**

*% of positive responses to GMC Training survey*

| | England | NNUH | JPUH | QEHKL |
|---|---|---|---|---|
| Adequate Experience | 77.8 | 73 | 74.3 | 73.2 |
| Clinical Supervision | 89.1 | 87.7 | 83.6 | 84.1 |
| Clinical Supervision (OOH) | 86.6 | 84.8 | 83.6 | 81.1 |
| Educational Governance | 71.2 | 66.9 | 69.5 | 66.7 |
| Educational Supervision | 86.3 | 83.7 | 84.4 | 82.3 |
| Facilities | 63.9 | 58.2 | 72.3 | 63 |
| Feedback | 74.3 | 69.7 | 69 | 71.2 |
| Handover | 68.9 | 66.6 | 71.1 | 68.3 |
| Induction | 81 | 78.6 | 81.1 | 76.8 |
| Local Teaching | 71.3 | 66.4 | 63.3 | 66.5 |
| Regional Teaching | 65.9 | 60.3 | 59.3 | 64.8 |
| Reporting Systems | 72.7 | 69.5 | 71.6 | 67 |
| Results | 77.7 | 73.7 | 73.0 | 70.9 |
| Rota Design | 58.7 | 56.8 | 54.1 | 50.7 |
| Study Leave | 71.3 | 67.1 | 66.9 | 61.2 |
| Supportive Environment | 74.7 | 69.5 | 71.4 | 68 |
| Teamwork | 74.6 | 69.9 | 72.6 | 66.3 |
| Work Load | 48.8 | 44.6 | 45 | 40.8 |

Lower than national average (lowest quartile)
Lower than national average
Similar to national average (±2.5%)
Better than national average
Better than national average (highest quartile)

*Figure 14: Percentage of positive responses to GMC Training survey. Source: GMC National Training Survey; CF Analysis*

Standardising the training and development programme for staff and offering a broader experience through rotations and exposure to various services and environments would lead to upskilling, enhance career progression, and foster professional growth for individuals working in Norfolk and Waveney.

Furthermore, aligning policies and the staff offer will create equity and alignment across organisations, levelling the playing field for recruitment and reducing competition amongst organisations for talent. Efforts such as these are already planned and have commenced as part of the Joint Policy & Document Alignment Group between the three organisations.

### Create a University Hospital System to enhance potential for research, training and innovation

All three Trusts are research active, and in the past year have enrolled 6,080 patients onto clinical trials which represents 0.51% of the population.[61] Trusts also have a commercial portfolio with varying degrees of maturity. Currently, all Trusts receive varying income from research and development which ranges from 0.2-0.8% of income in 2023/24 (Figure 15).[62]

[60] GMC National Training Survey; CF Analysis
[61] NNUH, QEHKL & JPUH Annual Report Summary, ONS; CF Analysis
[62] Provider Financial Returns 2019-2024; CF Analysis

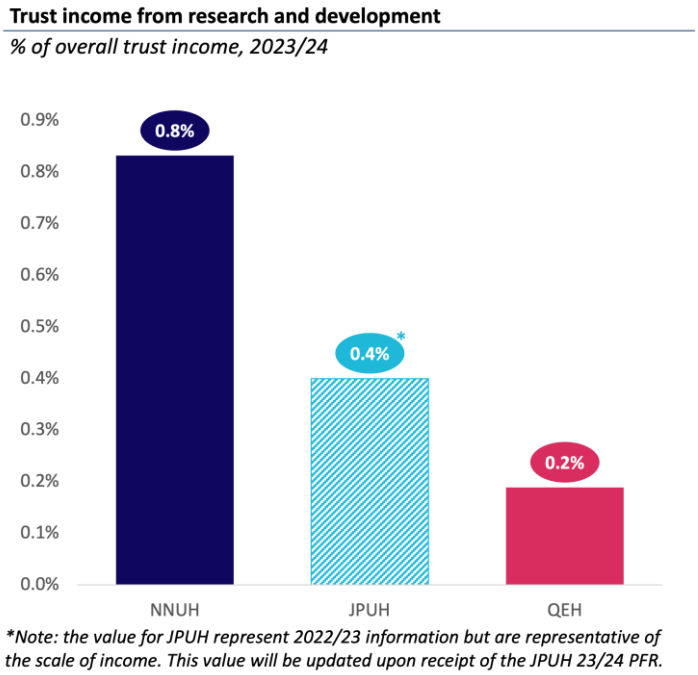


*Figure 15: Percentage of overall Trust income from research and development in 2023/24. Source: Provider Financial Returns 2019/20-2024/25; CF Analysis*

The research programmes to date have tended to be determined by individual clinical interests rather than a strategic vision. Research delivery is heavily reliant on this individual energy, combined with local dedicated resource, to secure National Institute for Health and Care Research (NIHR) funded research opportunities through a competitive process.

Clinical research brings significant benefits to the patient population and studies have shown that Trusts with the best emergency mortality outcomes were those that were most active in clinical research.[63] A systematic review by the Health Services and Delivery Research programme, suggested that engagement with clinical research by individuals and healthcare organisations increased the likelihood of a positive healthcare performance.

There are opportunities to leverage existing research infrastructure and grow this through the opportunities presented by increased scale. Realising this opportunity would involve working with a number of external partners and strengthening existing relationships, including the University of East Anglia, the Quadram Institute, Norwich Research Park, Earlham Institute, the John Innes Centre, and The Sainsbury Laboratory (TSL).

For example, North Norfolk has the highest proportion of people aged 85 years and over, and one of the fastest rates of growth in its elderly population in the country.[64] This population base creates a unique research opportunity that could be exploited by the three Trusts working together to set a collective research agenda focussed on the needs of this group. In so doing, this will allow partners at Place to be actively involved in the research agenda.

Establishing a shared research agenda and increasing the profile of academic activity would deliver research led care to all people in Norfolk and Waveney, improving not just the care offer but also outcomes and the hospital environment. It will also strengthen the opportunities to create a shared education and training focus that ensures the workforce pipeline of the future, as well as allowing existing researchers at the Trust to access research centres of excellence.

Sharing current knowledge, skills and research management expertise would leverage this more effectively, building a more significant profile in engagement with other partners and reducing project

[63] Research Activity and the Association with Mortality, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4342017/
[64] ONS; CF Analysis

set up costs. This profile would also be more likely to attract an academic partner to open up new areas of research opportunity.

### Use collective assets to leverage joint negotiation, purchasing and investment power of the three Trusts

In 2023/24, £207 million was spent on general supplies and services, clinical supplies and services, and drugs at NNUH, £54 million at JPUH, and £41 million at QEHKL. This represents 21.7% of the total spend at NNUH, 15.5% of the total spend at JPUH, and 11.5% of the total spend at QEHKL. After pay costs, this accounts for the highest area of spend.[65]

The cost of supplies and services per WAU is higher than the national average at all Trusts (Figure 16).[66] By pooling their resources for procurement and NHS Shared Business Services NNUH, JPUH and QEHKL can purchase supplies and services in larger quantities, resulting in bulk discounts and lower per-unit cost. Joint negotiation allows the hospital Trusts to leverage their combined demand to negotiate better terms with suppliers. This can include lower prices, improved payment terms, and better service agreements.

Furthermore, working together on procurement will allow purchasing processes to be standardised, adopting best practices. As a result, the function will see improved efficiency and reduced waste.

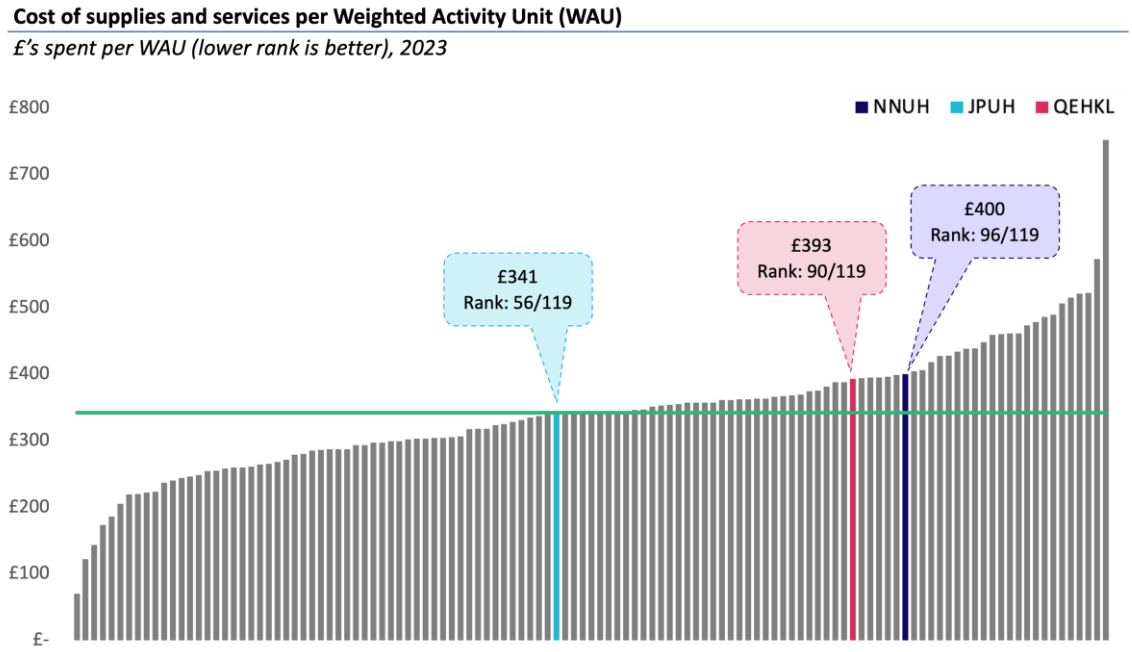


*Figure 16: £ spent per WAU on supplies and services per Weighted Activity Unit (WAU). Source: Model Hospital Data; CF Analysis*

By combining their financial resources, the three organisations can invest in larger, more impactful projects that they might not be able to afford individually. This can include new technologies, infrastructure improvements, or commercial joint ventures.

For example, in HR, opportunities exist to make better use of systems including for rostering, where JPUH (£82.1k) has considerably higher spend per £100m income than NNUH (£45.0k) and QEHKL (£40.1k).[67]

Furthermore, there are significant opportunities to leverage innovation such as Robotic Process Automation and Conversational Artificial Intelligence in the delivery of corporate functions. For

[65] Provider Financial Returns 2019-2024; CF Analysis
[66] Model Hospital Data; CF Analysis
[67] Model Hospital; CF Analysis

example, in 2023/24, QEHKL was the only Trust not using such technology for servicing the IT helpdesk. Work to align and standardise the service desk is already in train.

### Realise the benefits of service transformation that are possible through enabling programmes such as estates and digital

The three acute Trusts in Norfolk and Waveney are among the least digitally advanced in the country, still relying on paper-based patient records. A high reliance on paper means that information cannot be efficiently and securely shared between the healthcare professionals involved in a patient's care and leads to high costs of storage, transport and management of patient records.

Furthermore, operationally collected clinical data is not readily available for secondary purposes with clinical teams unable to readily view their own activity and performance information in order to monitor and improve their own clinical practice.

These findings have been reinforced in an assessment in 2019 by HIMSS Analytics® against its Electronic Medical Record (EMR) Adoption Model (EMRAM), which allows peer-to-peer assessment and tracking of progress against other healthcare organisations across Europe and around the world. The EMRAM scores for JPUH, NNUH and QEHKL respectively were 0.05, 0.05 and 0.04 against a UK-wide score of 2.3-2.5, with a maximum score of 7 possible.

Working together, the three Trusts have signed off on a contract to build and launch an advanced electronic patient records system across the three Trusts by March 2026. Over the ten-year investment period it is forecast that £190m (total capital costs plus total revenue costs) incremental expenditure will be invested in the EPR.[68]

This investment would enable the delivery of the Acute Clinical Strategy, facilitate system-wide load balancing for surgery and medical outpatients, and provide the necessary data insights to effectively manage patient care. It would allow for a better understanding of the geographic, demographic, and disease-specific needs within Norfolk and Waveney. Additionally, it would reduce the risks faced by patients in acute integrated services and improve staff morale by eliminating the inefficiencies of using multiple non-integrated systems.

The adoption of new technologies, healthcare applications, personalised healthcare services, and artificial intelligence would be significantly more accessible. Overall, this would result in the delivery of safer care and better patient outcomes.

The estate is also of poor quality with substantial backlog maintenance costs including high-risk backlog costs exceeding £74 million for QEHKL and £24 million for JPUH in 2022/23. As QEHKL and JPUH are Reinforced Autoclaved Aerated Concrete (RAAC) Trusts, they are both prioritised as part of the government's recent review into the New Hospital Programme (NHP).[69]

Within the context of a developing a Group model, there is significant potential to strengthen clinical collaboration, enhance workforce resilience, and optimise the use of shared expertise and resources across organisations for patients and their communities. This will also enable us to address the financial challenges through shared expertise and resource. This will improve the quality of patients access to high quality healthcare.

The development of the New Hospital Programme provides an unprecedented opportunity to reshape care in Norfolk and Waveney for staff and the patients who use hospital services. It will ensure services are modern, sustainable, and responsive to future needs for West Norfolk, South Norfolk, North Cambridgeshire and South Lincolnshire and Waveney. This model will ensure better outcomes for patients and delivers a framework to explore innovative ways of working that improve patient pathways, maximise efficiencies, and drive long-term benefits for local communities. By aligning strategic ambitions, a hospital group can collectively create a more integrated and sustainable healthcare system that mitigates the health inequalities in the system. This supports excellence in

[68] Electronic Patient Record (EPR) Full Business Case (FBC) v2.1
[69] Model Hospital; CF Analysis

patient care and outcomes while ensuring the new hospital is designed to thrive within this evolving landscape.

The three sites within the group model have an important role to play within the continued development and improvement of Place. There will be a need to ensure that this is locally defined and determined and does not undermine the progress already made. This will be through distributed expertise and resources with collaborative workforce across the locality to ensure a reduction in health inequalities, improve equity of access to support the needs to the local population.

We would expect clinical outcomes to improve with the use of national and locally agreed targets. Our Group model will improve the outcomes for patients, reduce unwarranted variation, and make Norfolk a great place to live and work.

As part of the NHP and new hospital builds, each trust has worked to refine its care models with the proposed models emphasising integrated care pathways, technological transformation, and operational efficiency. They align primary, community, and specialised healthcare services for patient-centric care, make operational and infrastructure enhancements, and improve clinical adjacencies, capacity expansion, diagnostic services, patient privacy, and IT infrastructure. It is essential that these care models are aligned across all three organisations and consequently close working on the programme is needed.

Wider efforts on system working will support the NHP by removing silos, identifying interdependencies, and reducing duplication of efforts, thereby streamlining operational processes. Additionally, the shared EPR has enhanced health equity by improving access, supporting virtual care, and reducing travel costs for patients. As a result, the Trusts are expecting to see improvements in proactive care, earlier diagnoses, and increased system capacity, which collectively will help to reduce elective backlogs and improve overall health outcomes.
The current state of digital and estate management in Norfolk and Waveney results in productivity losses for the providers. It is imperative that all three Trusts work together on these programmes to ensure that the potential service transformation benefits are realised in full, and that clinical models are aligned for the future.

### Have an aligned approach to strategy, transformation and planning functions

There is a significant opportunity to consolidate expertise across the three organisations and to work together to generate a comprehensive understanding of the underlying financial, operational and strategic landscape across the three organisations.

Collaborating presents significant opportunities to unify and enhance strategic objectives. A shared strategy could align all three providers under common, ambitious priorities and goals, ensuring a cohesive approach to delivering healthcare services. By adopting a standardised Quality Improvement framework, consistent practices can be established to drive improvements and enhance patient care outcomes.

Additionally, integrating operational processes offers several efficiencies. A single model for the annual planning process can streamline efforts, reduce duplication, and foster collaboration. The establishment of a unified transformation team would further consolidate resources, eliminating redundant activities while maximising the benefit of transformation initiatives. These measures can support a more coordinated, efficient, and impactful collaboration across Norfolk and Waveney.

## 5. Risks associated with a group model and their mitigations

Transitioning to a group model presents several potential risks that must be carefully considered. Identifying these risks effectively is crucial to outline and implement strategies that will mitigate these challenges.

From a credibility and financial perspective, the integration could exacerbate existing financial deficits and undermine stakeholder confidence if not managed effectively. Proactive measures will enhance the resilience and sustainability of the proposed group model.

Culturally and operationally, working with diverse organisational cultures and operational practices across multiples sites may lead to resistance and inefficiencies, potentially impacting staff morale and patient care. Fostering a shared vision and values is essential in alignment of the Trust identities.

Externally and strategically, the geographic diversity and distinct identities of each hospital pose challenges in standardising services and maintaining the unique strength of each Trust, which could affect the overall strategic goals and external partnerships. This could also risk increasing inequality in care, thus the importance of investment, quality and equality impact assessments with measurable outcomes.

Strategies that promote collaboration will aid in optimising resource utilisation and service delivery, thereby achieving strategic objectives and facilitating the smooth integration of the group model.

### Financial

A primary concern is the potential impact from a financial perspective. With the current financial frameworks in place across the three organisations, there are potential barriers to achieving the opportunities outlined.

Moreover, the existing financial situation may not immediately support the implementation of best practices, leading to delays and possible cost overruns. Additionally, there is a lack of clarity regarding implementation costs, which could result in unforeseen expenses and financial strain.

Robust financial planning and clear communication with stakeholders about financial objectives, strategies and progress will help build and sustain trust and confidence in the group's financial management. Without an effective communication and consultation strategy there is risk of reduced staff retention, thus increasing temporary staffing costs.

Identification of potential risks early and the development of proactive mitigation strategies with appropriate investment, while providing training and development for staff to enhance their financial management skills, will support the group's financial stability and success.

### Operational

The three organisations come from varying starting points and will have different implementation paces between one another potentially hindering progress and negatively impacting the overall outcome.

Efforts to standardise procedures must encompass all departments comprehensively, which may not always yield positive results. Additionally, the lack of alignment in key policy areas could hinder the integration process. Furthermore, the varying challenges between acute Trusts may introduce additional challenges, especially when prioritising services such as cancer and elective care.

Whilst focusing on standardising services across the group could potentially yield notable long-term benefits, this may result in declining performance due to a lack of grip oversight, particularly during the transitionary period, which would add further pressure on to struggling services. In turn, this would create a disconnect between operational staff and senior management.

Certain policies and procedures are already shared among the acute Trusts, which will facilitate smoother integration and reduce potential duplication of efforts. Ongoing collaboration across various areas will further expedite the successful integration of the group model.

Establishing specific goals and timeframes to measure progress, along with developing a robust operating model and effectively communicating all policies and procedures, will support the integration process.

### Culture

The cultural risks primarily stem from the differences in identity among the three acute Trusts, a lack of communication could lead to disengagement among staff and patients. Poor communication and engagement with the workforce could also have a longstanding negative impact on staff morale.

The potential negatives of siloed working will continue into a group model if the appropriate stakeholders are not sufficiently engaged, leading to a potential ongoing cultural divide between the organisations, hampering further efforts to increase collaboration.

To foster cultural integration, it is crucial to leverage the strengths of the existing Trust identities while ensuring clear and effective communication with all stakeholders to create a unified sense of belonging. Adopting best practice models should involve learning from previous challenges to avoid repeating past mistakes.

Investing in future changes, especially in cultural aspects, is essential. It is important to prioritise patients, staff, and financial resources accordingly. Clearly articulating the long-term vision is crucial, as the group model is unlikely to yield immediate significant benefits.

### Reputational

There is a potential impact on credibility, should the group fail to deliver the anticipated outcomes, its reputation and trustworthiness could be compromised.

The risk remains that the group may not realise the anticipated enhancements in performance or efficiency. Without the necessary investment to facilitate these changes, the group could face challenges in achieving its objectives, potentially leading to a shortfall in delivering essential services and improvements. This would further undermine credibility.

The urgency to implement changes within a constrained timeline heightens the risk of mistakes and inefficiencies, which may have further financial repercussions.

Adopting a phased approach to changes will allow time to assess and adjust strategies as needed, reducing the risk of significant financial strain and its associated impact. Engaging stakeholders early to garner support and input will ensure that expectations are realistic and aligned to those of the group. Additionally, appropriately resourcing the effort to develop the transition plan and develop the operating model will support successful delivery.

### Engagement and Partnerships

There are potential risks in missing opportunities to engage community partnerships and not properly considering the impact of inadequate geographical infrastructure, such as transport links. Previous attempts at collaboration have faced challenges due to patient reluctance to travel and preferences for local clinicians.

Additionally, there is a risk of tension between horizontal and vertical integration, which could further complicate the process. Being a large hospital group may negatively impact the influence over other external stakeholders, such as GPs. The expectation to achieve a wholly successful group model on the first attempt is high, and not having appropriate measurable targets for comparison could negatively impact the integration's perceived success.

There are concerns about the impact on strategic partners and the potential destabilisation of Place-level services. The short implementation timeline heightens the risk of errors and could hinder the

progress of the NHP, which is already under significant time pressure. The group must seize the opportunity to shape the partnerships agenda, essential for the local health economy. Resistance from specific services is likely if they are not engaged early and effectively.

The options for the structure and form of the Group  will be developed as part of the operating model can support mitigation of the scale of the delivery of Place-based care. For example, the inclusion of site-based management teams and leadership would enable strong Place-based partnerships to be maintained.

To manage operational strategies effectively, maintaining flexibility in services is crucial, allowing certain services to specialise while others generalise based on specific needs. It is essential to prioritise patients, staff, and financial resources to ensure sustainable progress. Effective communication of all policies and procedures is vital to maintain clarity and alignment among all stakeholders. Developing a robust operating model will facilitate the integration process and help achieve the long-term vision of the group model.

Establishing specific goals and timeframes to measure progress is necessary for tracking the effectiveness of the implemented strategies. The acute Trusts already share common policies and procedures, which will aid in smoother integration and minimise the duplication of efforts. Continued collaboration across various areas will further expedite the successful integration of the group model.

### Adopting the group model

The risk of not adopting the group model is significant and multifaceted. Without a unified approach, the group may fail to capitalise on the potential opportunities of transforming health and care services, delivering high quality outcomes building on combined knowledge skills and experience, and achieving greater sustainability by working at scale.

The absence of a structured group model could result in missed chances to forge robust strategic partnerships essential for the local health economy and the broader integration agenda, leading to a disjointed approach where individual visions of the three organisations continue to diverge, lacking a coherent narrative and accountability mechanisms to support collaboration.

Fragmentation would perpetuate historical barriers of competition and siloed development, impeding the establishment of a joint vision and commitment necessary for transformation change, overall limiting the extent to which these opportunities are able to be achieved.

It is therefore crucial to prioritise the adoption of a robust operating model that aligns governance, enhances capability, and fosters a culture of collaboration to ensure sustainable and comprehensive service delivery improvements.

## 6. Conclusions and next steps

The conditions for success are comprehensive to respond to a number of barriers that have historically got in the way of collaboration. These barriers include the fact that the individual visions of the three organisations set the direction and required effort but inherently point in different directions and are organisationally focused. Furthermore, there has not been a coherent narrative of the benefits of working with system partners or set of accountability mechanisms to underpin the collaborative agenda.

Resource availability makes it hard for people to engage in work that is seen as an add-on to their day-to-day operational requirements. Openness and trust are also a barrier, which is rooted in a history of competition and siloed organisational development, compounding the differences between cultures across the organisations.

To address these barriers, a number of key considerations need to be made:

1. Prioritisation of opportunities and their delivery
2. Aligned governance arrangements, particularly for future collaborative programmes
3. Creation of broader accountability through a target operating model for the Group
4. Establishment of a joint vision and commitment to one another
5. Enhancement of capability and capacity for transformational change

### Prioritisation of opportunities and their delivery

The delivery opportunities are too extensive to undertake simultaneously, and to ensure delivery of some areas of collaboration and there is therefore a need to formulate a more specific set of interventions for the initial stage of collaboration. To do this, there will need to be a short evaluation process, which seeks to identify, within the opportunities outlined, the initiatives which will have the greatest impact, respond to urgent requirements, will demonstrate results quickly through the economic use of resources. Once this has been done, there will be a clearer understanding of the scope of the collaboration during the initial phase, and therefore the resource required for delivery of the opportunities

### Aligned governance arrangements, particularly for future collaborative programmes

There is a need to undertake a detailed review of the current governance arrangements and develop and assess options for further shared governance arrangements beyond the existing Committee in Common. The work should understand how different types of accountability structures can be deployed to provide oversight and enable aligned decision-making to support the delivery of the opportunities in the case for collaboration.

### Create broader accountability through a target operating model

An operating model which codifies the broader set of structures and capabilities is required, to take on the easy wins and to enable prioritisation of actions required to address the bigger challenges which will deliver larger benefits. This will provide a framework for working together to create strong site-based leadership and working with system partners to develop Place-based approaches that serve the needs of the local population. This will be achieved through matrix structures that facilitate easier information sharing, underpinned by accountability at each level of the organisation for delivering on the shared vision.

### Establish a joint vision and commitment to one another

Investing in the development of a joint vision to work in the collective interest of the population needs of Norfolk and Waveney will draw staff into the collaboration agenda. This can be achieved through a future programme of organisational development that will facilitate better understanding of the differences and strengths between the organisations and encourage new ideas in the spirit of common purpose. Each of the Trusts has fostered a unique culture which underpins staff interactions and the way the organisations operate within their local community. A joint vison should build on this starting point and seek to embed a shared sense of responsibility to work towards the ambitions of the collaborative agenda, and support one another to achieve it, even when this means having challenging conversations.

### Enhance capability and capacity for transformational change

The delivery of the strategy will depend on the strength of a shared approach to quality improvement. A scaled model will enable identification of best practice across the organisations and provide a mechanism for taking consistent, measurable action at pace. Crucially, this provides a link between transformative action and strategy by creating a common language between staff and a consistent set of communications on the progress being made to achieve shared priorities. This work is already in train between the three Trusts and with the wider system.

Forming a Group model presents significant opportunities for enhancing capability, capacity, and collaborative efforts across the organisations involved. The potential for quality improvement, societal benefits, and financial sustainability is substantial. However, it is important to acknowledge the inherent risks that come with such transformative changes. With carefully considered mitigation strategies and a strong commitment to aligned governance, joint vision, and shared accountability, these challenges can be effectively managed. Ultimately, this approach promises to yield considerable benefits for the population of Norfolk and Waveney, ensuring a more integrated and responsive healthcare system for the future.