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East of England Clinical Senate

Review of the Case for Change for Norfolk and Waveney University Hospitals Group



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Foreword

Norfolk and Waveney stands at an important point in the development of its health and care services. The challenges facing the system are significant: an ageing and growing population, increasing complexity of need, workforce pressures, variation in access and outcomes, fragile clinical services and substantial estate constraints. At the same time, the investment available through the New Hospital Programme presents a once-in-a-generation opportunity to improve the quality, safety and sustainability of care for the communities served.

The East of England Clinical Senate was pleased to be invited to undertake an independent clinical review of the Norfolk and Waveney University Hospitals Group's Case for Change. Our role is to provide objective, multidisciplinary clinical advice and constructive challenge, supporting the development of proposals that are evidence-based, deliverable and, above all, in the best interests of patients and the wider population.

The Expert Review Panel concluded that there is a credible and persuasive strategic case for change. Maintaining existing arrangements without intervention is unlikely to be sustainable, and there is a compelling need to consider how services can be organised differently to deliver better outcomes. However, recognising the need for change is not the same as endorsing any particular model of future service provision. The next stage must demonstrate clearly how the available options will improve patient safety, clinical outcomes, experience, access and equity, supported by robust evidence and transparent appraisal.

A central message from our review is that the future of acute hospital services cannot be considered in isolation. Sustainable transformation will require genuine collaboration across the whole health and care system, including primary care, community and mental health services, social care, hospices and the voluntary sector. Ambitions to deliver more care closer to home must be matched by demonstrable capacity, investment and readiness in those services. Equally, immediate action to stabilise fragile services must not be delayed while longer-term plans are developed.

The geography and diversity of Norfolk and Waveney make it particularly important that the implications for travel, accessibility and health inequalities are fully understood. Meaningful engagement with patients, families, unpaid carers, staff and local communities must be central to developing the future model, ensuring that those most affected can genuinely influence the decisions being considered.

The recommendations in this report are offered in a spirit of constructive support. They are intended to strengthen the evidence base, inform the next stage of development and help ensure that any future changes are clinically sound, equitable and capable of safe implementation.

I would like to thank the members of the Expert Review Panel for their expertise, thoughtful scrutiny and commitment, and the Norfolk and Waveney University Hospitals Group leadership and clinical teams for their openness and engagement throughout the review.

Ultimately, the success of this programme must be judged not by changes to buildings or organisational structures, but by the difference it makes to the lives of the people of Norfolk and Waveney. I hope this report provides a valuable contribution to that ambition, and the Clinical Senate looks forward to continuing to offer independent clinical advice as the proposals develop.



Dr Sunil Gupta, Chair of the East of England Clinical Senate

Executive Summary

Summary of the report and recommendations

The East of England Clinical Senate was commissioned to review the Norfolk and Waveney University Hospitals Group Case for Change. The review considered whether the evidence provides a credible basis for progressing work on neighbourhood health, the stabilisation of fragile services and the future organisation of acute hospital services across Norfolk and Norwich University Hospital, The Queen Elizabeth Hospital, King's Lynn and James Paget University Hospital.

The panel found a credible and persuasive strategic case for change. The population of Norfolk and Waveney is growing, ageing and experiencing increasingly complex health needs. Current services are affected by variation in access, quality and outcomes; workforce shortages; fragile clinical services; financial pressure; delayed discharge; and significant estate constraints. The £2.8 billion New Hospital Programme investment to replace QEH and JPUH provides an important opportunity to address these challenges, but new buildings alone will not resolve existing service fragility or create a sustainable operating model.

The Clinical Senate supports the Group in progressing to the next stage of development. This support is for the need to change and should not be interpreted as endorsement of any particular future service configuration. The pre-consultation business case should define the intended clinical and operating model clearly, assess all credible alternatives—including a "do minimum" option—and demonstrate how each option would improve clinical outcomes, patient experience, population health, value and equity.

The proposed model depends on neighbourhood, primary care, community, mental health, social care, hospice, ambulance and voluntary-sector services being able to deliver more care outside hospital. The next stage should provide transparent evidence for the assumed reductions in hospital activity and bed requirements and confirm that the necessary workforce, funding, infrastructure, digital capability, governance and partner commitments are in place or deliverable. Community alternatives should be operating safely and effectively at the required scale before acute capacity is reduced or services are moved.

The panel also identified the need for complete mapping of clinical interdependencies; specific plans for children and young people, maternity, neonatal, mental health and other fragile or time-critical services; and a comprehensive assessment of travel, access, inequalities, unpaid carers, workforce impacts and cross-boundary consequences. Implementation should be supported by explicit safety gates, measurable outcomes, accountable risk ownership, realistic downside

scenarios, contingency arrangements and an interim plan to stabilise services that are already fragile.

Taken together, the panel's recommendations are intended to help the Group translate a strong strategic rationale into a clinically led, evidence-based and deliverable model. Progress should remain focused on demonstrable improvements for local people, including safer and more resilient services, better access and experience, reduced inequalities, care closer to home where appropriate and timely access to specialist expertise where this offers better outcomes.

Key recommendations

- Define the future clinical and operating model and assess it transparently against credible alternatives, including a "do minimum" option and realistic downside scenarios.
- Demonstrate that each option will improve clinical outcomes, quality, safety, resilience, patient experience, population health and value.
- Evidence that neighbourhood and system partners have the capacity, workforce, funding, infrastructure, governance and delivery capability required before hospital activity or capacity is transferred.
- Map clinical interdependencies fully and develop safe, sustainable models for fragile and time-critical services, including emergency, mental health, maternity, neonatal, paediatric and critical care pathways.
- Assess and mitigate the effects on travel, access, inequalities, unpaid carers, staff, ambulance services, neighbouring systems and cross-boundary patient flows.
- Develop deliverable workforce, digital, data, research and organisational culture plans that support integrated working across hospital and out-of-hospital services.
- Establish clear implementation milestones, safety gates, risk ownership, measurable benefits, contingencies and arrangements for evaluating temporary and permanent changes.
- Stabilise fragile services now while longer-term transformation and new hospital infrastructure are developed.

Context of the Clinical Senate review and methodology

Background and context of the Clinical Senate review

Following the East of England's review of the Norfolk and Waveney University Hospitals Group Strategic Ambition,[1] the Clinical Senate has been commissioned to review the Case for Change and report its findings to the programme board.

The Case for Change explains why health and hospital services across Norfolk and Waveney need to change. It brings together evidence about the needs of the population, the quality and performance of current services, workforce pressures, financial sustainability, the condition of the estate and inequalities in health and access to care. It also considers the implications of national policy, neighbourhood health and the £2.8 billion allocated through the New Hospital Programme to replace The Queen Elizabeth Hospital, King's Lynn and James Paget University Hospital. The Case for Change establishes the basis for considering three connected areas of change: developing neighbourhood health, addressing services that are already fragile or at risk of becoming unsustainable, and reviewing how core acute hospital services are organised across the three hospital sites operated by Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust (QEH) and James Paget University Hospitals NHS Foundation Trust (JPUH).

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

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

[1] Awaiting publication

The present arrangements do not provide consistently safe, timely and effective care. The Care Quality Commission rates the safety of services at all three trusts as Requires Improvement. JPUH and QEH are in segment 4 of the NHS National Oversight Framework, ranked 131st and 133rd respectively out of 134 trusts.[2]

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

Patient flow is not sufficiently reliable. In August 2026, an average of 191 patients each day remained in the Group's hospitals after they no longer met the criteria to reside, representing approximately 5,900 delayed bed days during the month. During the same period, 662 patients waited more than 12 hours in an emergency department after a decision had been made to admit them.

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

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

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

The condition and configuration of the Group's estate compounds these difficulties. QEH and JPUH contain extensive reinforced autoclaved aerated concrete and require continuing inspection, structural support and disruptive remedial work. NNUH

[2] NHS England » Acute trust league table – Q1 2026/27

operates within a long-term Private Finance Initiative arrangement that carries substantial financial commitments and makes changes to the estate more complex. Short-term interventions keep the hospitals operational but cannot provide the adaptable clinical environments required for the future.

The £2.8 billion allocated to replace QEH and JPUH creates an opportunity to address these constraints. It also requires the Group to define the clinical and operating model that the new buildings will support. Replacing existing facilities on a like-for-like basis would risk carrying current fragilities, duplication and operating costs into the new hospitals.

The Group's analysis also indicates that around 93% of activity across the Group involves patients classified as having lower-complexity needs. This suggests that a large proportion of care could be provided through consistent pathways at each hospital or closer to home, while a smaller group of patients would benefit from timely access to concentrated specialist expertise, advanced diagnostics and critical care.

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

Maintaining the present model will not preserve the current position. Demand and patient complexity will increase, while workforce shortages, fragile services, financial pressures and estate constraints will make existing arrangements progressively more difficult to sustain. Without planned intervention, service changes may instead occur through vacancies, regulatory action, loss of training recognition or the temporary withdrawal of provision. This would leave less time to assess alternatives and could produce more disruptive outcomes for patients and staff.

The Case for Change presents neighbourhood health, fragile services and acute hospital care as interdependent components of a single system model. Neighbourhood health should provide more prevention, proactive support, assessment, monitoring, rehabilitation and follow-up closer to home. It should improve coordination between hospitals, primary care, community and mental health services, social care and voluntary organisations. This could prevent some deterioration and admissions, support earlier discharge and reduce the number of journeys patients must make to hospital. Delivery of the neighbourhood health model will require sufficient workforce, funding, digital capability, estate and clinical governance outside hospital settings.

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

The Group also need to consider whether the organisation of its core acute services makes the best use of its collective workforce, expertise and estate. The initial focus is emergency care for the sickest patients, acute medicine, emergency surgery, critical care, obstetric care during labour and birth, and inpatient paediatrics. These services depend on diagnostics, anaesthesia, theatres, specialist advice and appropriately skilled staff 24 hours a day, seven days a week.

The Group's vision is to provide everyone in Norfolk and Waveney with safe, high-quality care in the right place at the right time. This means providing care closer to home wherever it can be delivered safely and effectively, while ensuring timely access to specialist expertise where this offers better outcomes. It also means creating worthwhile careers, with opportunities for staff to develop, learn and progress.

Methodology

The Case for Change was provided to the Clinical Senate management team on 5th October 2026 and immediately shared with the Expert Review Panel members. (See Appendix 2, page 38). In addition, draft key lines of enquiry (KLOEs) were shared with the review panel, prior to a MS Teams pre-meet of the review panel, to orientate the members, discuss the KLOEs and address any questions. The final KLOEs (KLOEs, see appendix 1, page 30) were sent to the programme board on 8th October 2026, in preparation for the review panel.

The Expert Review Panel took place via MS Teams on Wednesday 14th October

Please see appendix 2, page 38 for the review meeting agenda, the review members and their declaration of interests, can be found in appendix 2, pages 39, 40 & 41 and the presenting team can be found in appendix 2 page 42.

The notes from the meeting and comments made were synthesised into a first draft, which was circulated to the review panel for comment. The final draft was then prepared for submission to the Group programme board for matters of accuracy on 26th October 2026. The final report was sent to the programme board on Tuesday 3rd November.

The final reports remain the property of the Norfolk and Waveney University Group and will be published on the Clinical Senate website on agreement with the group.

Key Questions

Our key questions and many of our key lines of enquiry (KLOEs) focus on the future state and the end state that the Norfolk and Waveney University Hospitals Group is seeking to achieve. However, the panel consider it important to raise these points now so that they can inform the next stage of the process, in sufficient time to inform development of the pre-consultation business case rather than requiring retrospective amendment once it has been drafted.

- What precisely is the proposed end-state, and what credible alternative configurations have been considered?
- What evidence demonstrates that consolidation will improve clinical outcomes rather than merely address organisational or workforce difficulties?
- Can neighbourhood and community services demonstrably absorb the activity assumed to move out of hospital and what happens if they cannot?
- What are the complete clinical interdependencies and consequences of moving any acute or time-critical service?
- What would happen under a credible downside scenario in which workforce gains are lower, community development is slower, demand is higher and financial benefits are smaller than assumed?
- What are the explicit safety gates before irreversible changes are implemented, particularly any reduction in acute capacity?

The panel wishes to make clear that it is not endorsing or advocating any particular model. The next stage should present and assess all credible options, including a “do minimum” option, and provide a clear rationale for progressing some options rather than others. This would support the understanding of any future review panel.

Overall assessment and strategic Case for Change

The Clinical Senate recognises that the Norfolk and Waveney University Hospitals Group has presented a credible and persuasive strategic case for change. Increasing demand, greater population complexity, workforce pressures, clinical service fragility, financial pressures, and estate and infrastructure constraints provide a persuasive rationale for reviewing existing service configurations.

The panel considered, however, that the Case for Change was framed predominantly through an acute hospital lens, including in its description of the proposed shift of outpatient activity into neighbourhood settings. The next stage should explain more clearly how pathways and models of care may change, including through approaches such as patient-initiated follow-up, and how a genuinely collaborative, whole-system approach will support the ambitions of the 10 Year Health Plan.

R.1 Strengthen the whole-system narrative

Develop the Case for Change so that it describes an integrated approach across acute hospitals, primary care, community services, mental health, social care and the voluntary sector, rather than presenting change predominantly through an acute hospital lens.

R.2 Clarify the intended outcomes and strategic direction

Explain more clearly what the programme is seeking to achieve for patients, staff and communities, including the balance between safe care closer to home and timely access to specialist hospital services.

Evidence base, assumptions and learning

There is substantial local,[3] national[4,5,6] and international[7] evidence concerning the transfer of care from acute hospitals into community settings. The evidence identifies both the potential benefits of such changes and the barriers to successful implementation. The Case for Change should draw systematically on this evidence and demonstrate how relevant learning, including unsuccessful approaches and unintended consequences, has informed the proposed model.

Relevant examples include resources from the Q community on transferring diabetes care into a GP federation[8] and case studies[9] demonstrating how communities, frontline teams and community partners have used micro-funding to address locally identified health challenges.

Further learning may be drawn from NHS Alliance[10] commentary on hospital group models, Nuffield Trust[11] analysis of pressures affecting maternity services, and relevant material published through NHS IMPACT and the Futures platform.[12]

The Case for Change should identify specific learning derived from these sources and explain how it has influenced the proposed approach.

R.3 Demonstrate learning from elsewhere

Show how local, national and international evidence, including learning from unsuccessful programmes and unintended consequences, has informed the Case for Change and the development of the proposed model.

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[3] Our strategy
[4] Leading NHS groups - The Health Foundation
[5] Collaborative-Care-Creating-Value-from-Scale-FINAL.pdf
[6] Mixed methods evaluation of a hospital group model using an embedded research approach: study protocol - PMC
[7] Group practice impacts on patients, physicians and healthcare systems: a scoping review | BMJ Open
[8] https://q.thenhsalliance.org/evidence-and-insights/opinion-pieces/how-disruptive-innovators-could-lead-the-way-for-neighbourhood-health
[9] https://q.thenhsalliance.org/evidence-and-insights/evidence-and-briefings/improvement-as-infrastructure-case-studies-in-neighbourhood-health?dm_i=501H,16NDW,2EK39W,5NZF4,1,0,0,0
[10] https://thenhsalliance.org/resources/greater-than-the-sum-of-its-parts-sharing-board-leadership-between-nhs-trusts#leadership
[11] https://www.nuffieldtrust.org.uk/news-item/pressures-on-maternity-services-understanding-the-full-picture?utm_source=Nuffield+Trust+weekly+newsletter&utm_campaign=9fa47d0eb7-EMAIL_CAMPAIGN_2026_10_09&utm_medium=email&utm_term=0_39741ccd5c-9fa47d0eb7-93229335
[12] Humber and North Yorkshire Health and Care Partnership Connecting IRIS across Humber and North Yorkshire - NHS IMPACT Improvement Stories - NHS IMPACT (Improving Patient Care Together) - Futures

The presentation to the panel briefly describes the additional bed capacity that may be required in the future new hospitals, if no action is taken. It also identified 18 interventions that could reduce the modelled requirement. Four principle interventions; proactive case management by the integrated neighbourhood team, virtual wards and hospital at home, palliative and end-of-life care at home and discharge to assess, were reported as accounting for 88% of modelled reduction in emergency bed requirements. It also notes that delivery of these benefits depend on community health services, hospices and adult social care.

The panel was not shown the evidence supporting these figures, the methodology used to translate the interventions into reduced bed requirements, or the associated capacity, workforce and funding implications for community health services, hospices and adult social care. The next stage should provide the source evidence, define clearly what the 88% figure represents, establish measurable baselines and anticipated benefits, and confirm how the relevant partner organisations will deliver the assumed activity.

During the previous East of England Senate review of Norfolk and Waveney University Hospital Group's clinical strategy,[13] the panel heard that hospice capacity within the region was insufficient. The panel considered that the next stage should quantify current and future hospice and palliative-care capacity, describe how any identified gaps will be addressed, and set out the mitigations required to support people to die in their preferred place.

R.4 Strengthen the evidence base

Provide transparent sources for activity, capacity and bed assumptions; explain how each proposed intervention translates into reduced hospital demand; and quantify the associated capacity, workforce, funding and delivery requirements for community health services, hospices and adult social care.

Population health, neighbourhood care and system readiness

The model relies heavily on neighbourhood services reducing acute activity through prevention, earlier intervention and care closer to home. These are longer-term ambitions unless there is evidence that they are already being delivered at the required scale. The programme team should therefore distinguish immediate actions to address current emergency department (ED) demand from longer-term neighbourhood transformation.

[13] Report to be published

The next stage should identify and map existing community assets, assess whether relevant assets holders are linked into the Group, and explain how the Group will work with local communities and local authorities to develop a community asset-based approach[14] to integrated care.

The effect of care closer to home proposals on unpaid carers should be assessed. This should identify both potential benefits and additional responsibilities and set out how carers' health and wellbeing will be supported.

Evidence from existing integrated neighbourhood teams and other systems should be used to demonstrate successful and unsuccessful approaches, the organisations and professional groups that must be involved, and where delivery risk and accountability will sit.

The next stage should demonstrate whether neighbourhood services, local authorities, primary care, community providers, hospices, social care, and voluntary, community, faith and social enterprise organisations are ready, willing and able to absorb the proposed activity. It should set out their current maturity, workforce, funding, infrastructure, governance and delivery milestones, together with mitigations if the required capacity is not available by 2035.

R.5 Evidence system readiness

Demonstrate that neighbourhood, primary care, community, mental health, social care, hospice and voluntary, community, faith and social enterprise organisations have the workforce, funding, infrastructure, governance and delivery capability required to implement the assumed changes.

R.6 Quantify hospice and end-of-life capacity

Provide a specific, quantified plan for hospice, palliative-care and end-of-life capacity, including how people will be supported to die in their preferred place.

Neighbourhood health planning, should draw on relevant national[15] and international[16] evidence and learning. Data on people who spend less than 24 hours in the ED, should be used to identify the service models and pathways required to provide care in the most appropriate setting.

The Group should also describe how it will improve population health, prevent illness and measure impact. Assumptions should reflect relevant emerging prevention, treatment (e.g. GLP-1 medicines) and technological developments and should be tested against credible downside scenarios.

[14] Asset-based approaches for integrated care - SCIE
[15] Co-Production Project | The Bridge Renewal Trust
[16] read-executive-summary.pdf

R.7 Strengthen the population health and inequalities assessment

Explain how the proposed changes will improve population health and reduce inequalities, particularly for rural, coastal, deprived, disabled, digitally excluded and transient communities. The assessment should also consider unpaid carers and differences in neighbourhood-service readiness across localities.

Acute configuration and clinical interdependencies

Emergency and mental health pathways

The next stage should set out the short-term action required to address current high levels of emergency department (ED) attendance, particularly among people who spend less than 24 hours in the department. This should include analysis of the relevant patient cohort and consideration of alternatives to attendance and conveyance, such as advance care planning with care homes.

The Group should ensure that appropriate data are collected and used to develop service models and pathways that enable people to receive care in the most appropriate setting.

If the function of the ED changes, the Group should demonstrate how people who currently rely on the ED, including those experiencing mental health crisis or without an existing mental health diagnosis, will continue to receive timely and appropriate assessment and care.

The proposal to place ED consultants at the front door should be tested alongside alternatives to conveyance. These could include access to emergency-medicine advice for ambulance clinicians, supported by direct referral routes into appropriate community services.

R.8 Develop integrated urgent and emergency care pathways

Use data on patients spending less than 24 hours in the ED to design alternatives to attendance and conveyance, including advance care planning with care homes, access to emergency-medicine advice for ambulance clinicians and direct referral routes into community services.

Community mental health providers

The next stage should demonstrate that local mental health providers have been meaningfully involved in the proposed changes and have agreed the pathways, capacity and resources required to manage any resulting transfer of activity. Particular attention should be given to arrangements for people who currently access mental health assessment or support through the ED.

The Group should work collaboratively with community and mental health providers to develop integrated pathways across acute, community and mental health services. The Group should participate actively in mental health transformation programmes, while mental health providers should be represented in acute transformation planning. Without effective joint planning, the proposals could increase clinical risk, fragment pathways and prevent the intended reduction in avoidable ED attendance from being achieved.

R.9 Align acute and mental health transformation

Develop jointly agreed pathways between acute, community and mental health providers, including arrangements for people presenting in mental health crisis or without an existing diagnosis where the ED may no longer operate as the principal point of access.

Children and young people's services

Although the population is ageing, children and young people's physical and mental health services must remain safe, accessible and sustainable. The panel did not see sufficient evidence describing the future model or its implications for children, young people and families who may need to travel further for care.

Birth-rate projections should be tested against credible alternative scenarios, including changes in migration and other demographic factors outside the Group's control. Local physical and mental health services should be maintained wherever this is clinically appropriate, with access to specialist networked care where required.

The panel heard that discussions were ongoing with Cambridge Children's Hospital. The next stage should clarify which services will continue to be provided locally across the three hospitals, which will be delivered through networked arrangements and which conditions require referral to highly specialised services.

Several existing paediatric services, including paediatric audiology and respiratory services, were reported to be fragile. Proposed networked or partnership models should be supported by activity, workforce and outcome data and by an assessment of whether they would mitigate or exacerbate inequalities.

Engagement with East Anglia's Children's Hospices and the Paediatric and Neonatal Decision Support and Retrieval Service should inform the future model for children requiring palliative, end-of-life, specialist retrieval or transfer support.

The next stage should also assess neonatal capacity and demand, paediatric same-day emergency care and paediatric assessment-unit provision, together with the implications for the Paediatric and Neonatal Decision Support and Retrieval Service.

R.10 Develop a comprehensive children and young people's model
Set out the future model for local paediatric physical and mental health services, including fragile specialties, neonatal capacity, paediatric same-day emergency care or assessment units, retrieval services, specialist networks and palliative and end-of-life care.

Maternity

Current maternity services may need to change in response to the projected reduction in births. The panel did not see sufficient evidence demonstrating how women, birthing people and Local Maternity and Neonatal Voices Partnerships have influenced options that may involve the movement or centralisation of maternity services.

If services are centralised, the next stage should set out options for maintaining accessible local maternity care. This should identify where antenatal, intrapartum and postnatal care would be provided and demonstrate that sufficient community-midwifery capacity would be available.

R.11 Co-produce the future maternity and neonatal model
Demonstrate how women, birthing people and Local Maternity and Neonatal Voices Partnerships have influenced the options, and describe how accessible antenatal, intrapartum and postnatal care will be maintained, including the required community-midwifery capacity.

Cross-boundary impacts

The next stage should assess the unintended consequences of each option for neighbouring trusts and systems outside Norfolk and Waveney. This should include communities living close to system boundaries, potential changes in patient choice and flows, alignment with other New Hospital Programme developments, hospice services and community-based step-up and step-down capacity.

For example, if maternity services were moved to Norfolk and Norwich University Hospital, the assessment should consider the potential effect on neighbouring

maternity providers, including their capacity to accommodate any additional demand arising from changes in patient choice or travel patterns.

Neighbouring systems should be engaged through open, timely and transparent communication, with their capacity and delivery commitments reflected in the option appraisal.

R.12 Assess cross-boundary and regional impacts

Model the effect of each option on neighbouring trusts and systems, patient choice and flows, ambulance and transfer services, hospice and community capacity, regional clinical networks and other New Hospital Programme developments. Secure timely engagement and documented delivery commitments where impacts fall outside Norfolk and Waveney.

Travel, access and inequalities

The panel was concerned about the effect of longer journeys on patients, families, unpaid carers, staff and ambulance services. Analysis should present journey-time ranges and distributional impacts rather than averages alone, as average increases may obscure substantially longer journeys for the communities most affected.

Where the model assumes that more patients will receive care locally rather than being conveyed to an emergency department, the next stage should assess the implications for ambulance conveyance and turnaround times, crew availability and direct referral into community services. It should also address barriers that may prevent ambulance clinicians from accessing alternatives to hospital attendance without a GP referral.

The next stage should assess the effect on patients, families and unpaid carers when care is provided a considerable distance from home. This should include the practical and financial consequences of travel, involvement in care and discharge planning, and the additional complexity of arranging timely out-of-area discharge where links with local services may be less effective.

R.13 Undertake comprehensive access, travel and carer impact assessment

Assess and mitigate the full effects of each option on patients, families, unpaid carers, staff and ambulance services. Use authoritative journey-time data and ranges rather than averages; address private, public, patient and staff transport, rural and coastal geography, seasonal pressures, costs, accessibility, cross-site

working and out-of-area discharge; and set out the practical, financial and wellbeing support required.

The next stage should also assess the effect of cross-site working on staff, particularly in the context of travel costs and substantial distances between hospital sites. The analysis should consider whether travel between sites during the working day would reduce clinical capacity, disrupt clinics or affect staff wellbeing, recruitment and retention.

The programme board referred to the possible provision of transport between sites. If this proposal is taken forward, the service should be fully specified, sustainably funded and assessed for reliability, accessibility and alignment with shift patterns. Any transport arrangement on which staff may depend should not be introduced on a temporary basis without a clear long-term plan.

The following table (Table 1) is used to illustrate the potential impact on staff and carers. Travel distances and journey times should be verified from authoritative sources before being used in decision-making.

From	To	Distance	Average Driving Time
Queen Elizabeth Hospital (King's Lynn)	**Norfolk & Norwich University Hospital**	41.1 miles	1 hour 2 minutes
Norfolk & Norwich University Hospital	**James Paget University Hospital**	28.8 miles	41 minutes
Queen Elizabeth Hospital (King's Lynn)	**James Paget University Hospital**	68.2 miles	1 hour 35 minutes

Tabel 1

Public Transport Alternative

If you are travelling without a car, please note that public transport journeys take significantly longer and typically require transfers in central Norwich:

King's Lynn to **Norwich Hospital**: Roughly 1 hour 50 minutes to 2 hours 15 minutes via bus or combined train/bus links.

Norwich Hospital to **James Paget**: Roughly 1 hour 12 minutes by bus via Great Yarmouth Market Gates. [1, 2, 3]

The travel analysis should reflect the rural and coastal geography of Norfolk and Waveney and account for seasonal increases in visitor numbers that may significantly affect journey times.

Workforce, education, training and culture

The next stage should set out the membership of the clinical advisory group and demonstrate that it reflects the full multidisciplinary workforce. In addition to nursing, primary care and allied health professional representation, membership should include relevant healthcare scientists, staff at different levels of seniority and colleagues with frontline operational experience, including porters, cleaners, catering staff and care workers.

The programme board should demonstrate how advice from the clinical advisory group has influenced the proposals and explain where, and for what reasons, particular advice has not been adopted.

During the presentation, the panel heard that evidence provided to the clinical advisory group had also been scrutinised by external parties. The panel considered this to be good practice and recommended that it continue. The programme board should demonstrate how external challenge has been considered and how it has informed changes to the proposals.

Education and training

Workforce plans should address recruitment, retention, skills, education and training across the future model. Where locally employed doctors may provide overnight surgical opinions, the programme board should explain how these roles will remain attractive, appropriately supported and professionally sustainable, and how loss of skills and competence will be avoided.

The next stage should also set out how staff will be recruited, retained and supported in fragile or geographically isolated services. Workforce development should begin sufficiently early to ensure that staff are prepared for new roles, pathways and models of care before implementation.

Research

Research capability should be incorporated into future buildings and operating models, including appropriate facilities for the secure storage and administration of clinical-trial medicines. Failure to provide suitable infrastructure could restrict research participation and patient access to clinical trials.

The Group model has the potential to expand opportunities for research, innovation and commercial partnerships. The pre-consultation business case should explore these opportunities.

Culture

Quality-improvement initiatives may fail to achieve their intended impact where organisational culture, leadership behaviours and ways of working are not addressed. The next stage should set out how the different cultures of the three hospitals will be brought together, how concerns about organisational dominance or takeover will be managed, and how staff across all sites, services and professional groups will contribute to cultural change, quality improvement and engagement.

R.14 Develop an integrated workforce, education, research and culture plan.
Provide a quantified and deliverable workforce plan covering recruitment, retention, safe staffing, skills, education, training cross-site working and prevention of deskilling. Demonstrate multidisciplinary clinical leadership and external challenge; embed research and clinical-trial infrastructure in future models and buildings; set out how the cultures of the three hospitals will be brought together through inclusive leadership, engagement and quality improvement.

Public engagement and local community impact

Open, honest and transparent communication and engagement will be essential to the success of the programme. The programme board should explain clearly to local communities, staff, unpaid carers, elected representatives, local authorities and emerging mayoral authorities why change is needed, including the safety and sustainability risks associated with maintaining current arrangements and the consequences of not acting.

Engagement should include seldom-heard groups and may be strengthened through targeted funding or small-grant arrangements with trusted community organisations. The programme board should demonstrate how feedback from patients, the public, staff and unpaid carers has influenced the proposals, rather than reporting engagement activity alone.

Each hospital's role as an anchor institution should be considered explicitly. The next stage should assess how the proposed changes could sustain employment, develop

skills and support local economic benefits, including opportunities to use local suppliers where appropriate.

The programme represents a once-in-a-generation opportunity to improve health and healthcare for the population of Norfolk and Waveney and to develop services that are sustainable for the future. The public narrative should set out this opportunity clearly and credibly, while being transparent about the choices, risks and trade-offs involved. Engagement should enable local communities to understand, challenge and influence the proposals throughout the process.

R.15 Provide a clear and transparent public narrative
Explain why change is required, the safety and sustainability risks of maintaining current arrangements, the consequences of not acting, and the opportunities presented by the programme. Demonstrate how meaningful engagement with communities, patients, staff and unpaid carers has influenced the proposals.

Digital, data and technology

Improving value will require a clear understanding of the current cost, activity, quality and outcomes of service provision, together with robust measures for assessing future performance. The next stage should set out how consistent coding, costing and outcome measurement will be established across the system and used to develop meaningful dashboards linking cost, activity, quality and patient outcomes. This would strengthen the business case, support clinical engagement and help identify unwarranted variation and waste.

The Group should explain how the implementation of electronic patient records will support this approach and whether information will be shared through a common record or through effective interoperability between systems.

The next stage should set out how patient information will be accessed safely and reliably across the three acute trusts, primary care, community services, mental health services, ambulance services, local authorities, social care and voluntary, community, faith and social enterprise organisations. This should include data-sharing agreements, information-governance arrangements, system interoperability and clear accountability for delivery.

The digital strategy should demonstrate how technology will enable the proposed transformation, including new pathways, cross-organisational working, care closer to home and improved access to information for patients, unpaid carers and staff.

Digital inclusion should be addressed explicitly. The next stage should assess the needs of people who have limited access to devices or data, low digital confidence, accessibility requirements or unreliable connectivity, particularly in rural and coastal communities. Accessible non-digital routes, including telephone and written communication, should remain available where required.

Data used to support the proposals should be presented clearly and transparently. Where system-wide averages may obscure variation, the analysis should include ranges and appropriate geographical and population-level breakdowns so that the communities most likely to benefit or be disadvantaged can be identified.

The programme should also explain how artificial intelligence and other emerging technologies may support transformation. Proposed uses should be subject to appropriate clinical-safety, information-governance, equality, bias, evaluation and accountability arrangements and should not remove access to suitable non-digital alternatives.

R.16 Develop a system-wide digital, data and value strategy
Establish interoperable information arrangements across acute, primary, community, mental health, ambulance, social care and VCFSE organisations; develop dashboards linking cost, activity, quality and outcomes; and explain how electronic patient records, artificial intelligence and emerging technologies will support transformation. Address digital inclusion explicitly and retain accessible non-digital routes for people who cannot or choose not to use digital services.

Implementation, risk and immediate stabilisation of fragile services

The proposed changes create substantial shared risks across the Group, the integrated care system and partner organisations. Delivery depends on multiple organisations and workforces changing established ways of working. Failure or delay in one part of the model could therefore affect safety, capacity, benefits realisation and affordability elsewhere.

The programme board should set out risk ownership, dependencies, safety gates, benefits-realisation arrangements and contingencies. This should explain how risks will be allocated transparently and equitably where the organisation carrying a risk is not responsible for delivering the relevant change or may not realise the associated benefit within the same timeframe.

Several services are already fragile or at risk of becoming so, while permanent solutions and the new hospital infrastructure remain several years away. The Case for Change will not, by itself, stabilise these services. Interim action is therefore required to protect patient safety and outcomes, while assessing the effects on upstream and downstream services and maintaining effective links with community care.

Where temporary service changes are introduced, they should be evaluated against clear measures and subject to appropriate engagement and consultation before any decision is made to implement them permanently.

Interim stabilisation also provides an opportunity to test new ways of working, workforce skill mix and partnership arrangements. It can also support early work on organisational culture, leadership behaviours and ways of working, involving staff, patients and local communities.

R.17 Separate immediate and longer-term change

Distinguish the measures required now to stabilise fragile services and manage current demand from longer-term transformation dependent on neighbourhood services and new hospital infrastructure. Define clear risk ownership, safety gates, evaluation measures, contingencies and consultation requirements for interim changes.

Conclusion

The Clinical Senate considers that the Norfolk and Waveney University Hospitals Group has presented a credible and persuasive strategic case for change. The evidence demonstrates that maintaining existing arrangements without planned intervention is unlikely to be sustainable, given increasing and changing population need, variation in access and outcomes, workforce pressures, fragile services, financial constraints and significant estate challenges. The development of the Group model, alongside investment through the New Hospital Programme, provides an important opportunity to improve the quality, safety, resilience and sustainability of care for the population of Norfolk and Waveney.

The panel therefore supports the Group in progressing to the next stage of development. This support should not, however, be interpreted as endorsement of any particular future service configuration. The Case for Change establishes why change is required, but further work is needed to demonstrate precisely how the proposed Group model and each potential configuration would improve clinical outcomes, patient experience, population health and value, while reducing inequalities and avoiding unintended consequences.

The next stage should define the intended clinical and operating model clearly and assess it transparently against credible alternatives, including a “do minimum” option and realistic downside scenarios. It should provide robust evidence of clinical benefit; map clinical interdependencies fully; demonstrate that workforce, community, mental health, social care, hospice, ambulance and other partner capacity is funded and deliverable; and assess the implications for travel, access, unpaid carers, staff and neighbouring systems. Explicit safety gates, measurable outcomes, implementation milestones, risk ownership and contingency arrangements should be established before acute capacity is reduced or services are moved.

Particular importance should be placed on ensuring that the Group model operates as part of an integrated health and care system rather than predominantly as an acute hospital solution. The anticipated benefits of neighbourhood care and care closer to home will depend on meaningful partnership working and on sufficient capacity, workforce, infrastructure, governance and funding being available outside hospital settings. Where these dependencies are not yet assured, the associated risks should be made explicit and mitigated before irreversible decisions are taken.

The panel has made 17 recommendations to strengthen the Case for Change and has identified further matters that should inform development of a pre-consultation business case. Taken together, these recommendations are intended to support the Group in translating a persuasive strategic rationale into a clinically led, evidence-based and deliverable model that can demonstrate improved outcomes for local

people. The Clinical Senate would welcome continued engagement as the proposals develop, while maintaining its independent role in providing constructive clinical challenge and assurance.

Next Steps

The panel has identified additional matters that it would expect to be addressed in a pre-consultation business case. Without prescribing the detailed content, the panel considers that the following would support the next stage of the approval process:

- A description of the composition of the Clinical Advisory Group, including the professional disciplines, levels of seniority and relevant expertise represented.
- Patient stories and pathway-based vignettes illustrating current experience and how this would change under each option. These should reflect a range of perspectives, including those of unpaid carers, people with a learning disability or autism, seldom-heard communities, Gypsy, Roma and Traveller communities, visitors and other transient populations, and frail older people.
- Evidence from relevant pilots, including their outcomes, limitations and how learning has informed the proposed model.
- Documented assurance and delivery commitments from partner organisations responsible for managing any transfer of activity or additional demand, including neighbouring NHS trusts, primary care, community and mental health providers, social care, ambulance services and hospices. This should demonstrate that the necessary capacity, workforce, funding, infrastructure and governance are in place or deliverable.
- Evidence of open, honest and transparent communication and meaningful engagement with all affected parties, including staff, patients, unpaid carers, MPs, local authorities, partner organisations and local communities.

The following recommendations are not exhaustive. The Programme Board and the Group remain responsible for determining how they write a pre-consultation business case.

Recommendations for future Pre-Consultation Business Case (PCBC) development

R.1 Define the end-state and assess credible options

Describe the proposed future clinical and operating model clearly and compare it with realistic alternative configurations, including a credible "do minimum" or downside scenario.

R.2 Demonstrate clinical benefits and safety

Provide evidence that each option will improve clinical outcomes, quality and resilience—not simply resolve organisational, estate or workforce pressures—and define explicit safety gates before capacity is reduced or services are moved.

R.3 Map clinical interdependencies fully

Assess the consequences of changing any acute or time-critical service, including dependencies involving emergency care, critical care, diagnostics, surgery, maternity, neonatal, paediatric and mental health services.

R.4 Develop specialty-specific future models

Set out deliverable future pathways for urgent and emergency care, mental health, children and young people, maternity, neonatal and other fragile or time-critical services, including local provision, networked arrangements, retrieval and transfer, workforce, capacity, accessibility, co-production and outcome measures.

R.5 Secure partner agreement and delivery commitments

Obtain documented assurance from organisations responsible for delivering activity outside the Hospital Group, including primary care (GPs), community and mental health providers, social care, ambulance services, hospices, home care agencies, care/nursing/residential homes, carers support and neighbouring trusts.

R.6 Map and mobilise community assets

Undertake a systematic assessment of existing community assets and develop an asset-based approach with local authorities, communities and voluntary, community, faith and social enterprise organisations.

R.7 Develop a deliverable workforce plan

Set out workforce requirements, recruitment and retention assumptions, skills development, education and training, multidisciplinary involvement and measures to prevent deskilling.

R.8 Establish an organisational culture and clinical leadership programme

Set out how the different cultures of the three hospitals will be brought together, how perceptions of organisational takeover will be

avoided, and how staff at all levels will contribute to quality improvement, clinical leadership and the development of the future Group model.

R.9 Undertake comprehensive access and travel analysis
Assess the full effect on patients, carers, staff and emergency and non-emergency ambulance services using authoritative journey-time data, ranges rather than averages, public transport availability, cost and the particular impact on disadvantaged communities.

R.10 Assess cross-boundary and regional impacts
Model the effect of each option on neighbouring trusts, patient flows, ambulance services, regional networks and other New Hospital Programme developments.

R.11 Provide robust financial and capacity modelling
Show the capital and revenue consequences, affordability, productivity assumptions, required investment outside hospital and sensitivity to lower workforce gains, higher demand, slower community development and reduced financial benefits.

R.12 Set out implementation, governance and risk arrangements
Identify dependencies, accountable organisations, delivery milestones, contingencies, benefits-realisation arrangements and how risks and benefits will be shared across the system.

R.13 Include an interim plan for fragile services
Specify how current fragile and time-critical services will be stabilised before permanent solutions are available, with temporary changes evaluated and appropriately consulted upon.

R.14 Demonstrate meaningful engagement
Use patient stories and pathway-based examples to show how each option would affect people, including carers, people with learning disabilities or autism or sensory impairment, seldom-heard communities and older people. Evidence how engagement has changed the proposals.

R.15 Address research, digital and infrastructure requirements
Ensure that future models and buildings support digital inclusion, research participation, clinical trials and the operational infrastructure required to sustain the proposed services.

R.16 Develop a system-wide digital, data and value strategy
Establish interoperable information arrangements across acute, primary, community, mental health, ambulance, social care and voluntary-sector services; develop dashboards linking cost, activity, quality and outcomes; and explain how electronic patient records, artificial intelligence and emerging technologies will support transformation while retaining non-digital alternatives.

R.17 Assess the wider social, economic and environmental impact
Evaluate each hospital's role as an anchor institution, including employment, skills, local procurement and economic effects, and assess the environmental consequences of changes to patient, visitor and staff travel, estate use and digital infrastructure.

Appendix 1

Key Lines of Enquiry (KLOEs)

1. Strategic narrative, end-state and options

- Is there a clear and consistent strategic narrative linking neighbourhood care, local hospital provision and concentrated specialist care?
- Does the Case for Change describe the intended future state clearly, including what the clinical models will deliver, how they will operate, how they will be structured and how organisations will work together?
- What are the realistic clinical model options, and are their respective benefits, risks, trade-offs and unintended consequences presented transparently rather than as a predetermined solution?
- Which services genuinely require consolidation because outcomes depend on volume, expertise, co-location or resilience, and which should remain locally accessible?
- What are the critical components of the programme, what could be phased or deferred, and what sequencing is required to protect quality and safety?
- Could the objectives be achieved without a single large-scale reorganisation, and has a phased or adaptive approach been considered?
- How is the proposed direction aligned with national, regional, ICB and partner strategies, including the three shifts from hospital to community, treatment to prevention and analogue to digital?

2. Evidence base, assumptions and learning

- Is the proposed nature and scale of change supported by sufficiently robust clinical, activity, workforce, quality, outcome and population evidence?
- How was the assertion that approximately 93% of Group activity is “lower complexity” defined, validated and translated into clinically meaningful service design?
- What thresholds and comparative evidence were used to identify fragile services, and is fragility site-specific or Group-wide?
- Does the evidence show that consolidation would resolve the underlying causes of fragility rather than redistribute them?
- What evidence demonstrates that the proposed model is likely to work under operational pressure, and what sensitivity testing has been undertaken where key assumptions are uncertain?

- What has been learned from comparable NHS transformations elsewhere, including both successful and unsuccessful approaches, and how has that learning changed the proposals?
- How will data be used to test assumptions, monitor performance, evaluate outcomes and support continuous learning as the model develops?

3. Population health, inequalities and public health

- Does the Case for Change reflect the demographic profile, ageing population, complexity, geography, deprivation, health outcomes and projected needs of Norfolk and Waveney through to 2045?
- How has public health intelligence and advice informed the proposed model, patient segmentation and distribution of services?
- How have impacts been assessed by geography and population rather than through system-wide averages, including rural and coastal communities, deprived populations, disabled people, older and frail people, and seldom-heard or transient groups?
- How will the proposals reduce unwarranted variation and improve healthy life expectancy and population outcomes without widening existing inequalities?
- How have communities with the greatest need and those least likely to engage been actively involved, and what evidence is there that their views have influenced the proposals?
- How will limited access to transport and differing ability or willingness to travel be addressed for communities that may be disadvantaged by changes to the location of care?

4. Patient, carer and public experience

- Does the Case for Change reflect patient, relative and carer expectations for safe, effective, personalised and integrated care, including patient-reported experience and outcomes?
- Has the model been meaningfully co-produced with patients, carers, the public and partner organisations, and how will their evidence materially change the options?
- Can the end-to-end patient journey be demonstrated for key groups, including frail older people, people with multiple long-term conditions, maternity patients, children, stroke patients and patients requiring emergency care?

- How will continuity of care and trusted patient-professional relationships be maintained for people with complex or long-term needs?
- What additional responsibilities or burdens might fall on carers through virtual wards, hospital-at-home or other community models, and what support will be available?
- Can the proposed options, benefits, risks and changes to access be explained clearly and accessibly to the public?

5. Neighbourhood care, primary care and system readiness

- What evidence demonstrates that primary care, physical and mental health services, hospices, adult social care, local authorities and VCFSE partners have the capacity, workforce, funding, governance and implementation capability required to deliver the assumed shift of care?
- Are primary care organisations ready and able to lead or support neighbourhood health models while meeting existing demand?
- What is the maturity of neighbourhood services and other system partners, and how have differences in readiness across places been reflected in the plan?
- How will neighbourhood hubs be governed and coordinated with acute services, ambulance services, diagnostics, mental health services and social care?
- Are proposed place-based treatment and diagnostic centres located appropriately for urban, rural and coastal communities, with realistic access by private, public and patient transport?
- What specific interventions will increase community capacity and reduce hospital dependency, and what evidence supports their deliverability and impact?
- How will virtual wards, hospital-at-home, proactive case management, palliative and end-of-life care at home, and discharge-to-assess operate safely and at the required scale?
- What explicit go/no-go criteria, measures, thresholds and evidence will be used to confirm that community alternatives are operating safely and effectively at the required scale before acute capacity is removed?

6. Acute service configuration and clinical interdependencies

- Does the Case for Change describe the proposed acute clinical models and the full set of co-dependent services required to deliver safe, high-quality care?
- For each potential movement or concentration of acute medicine, emergency surgery, critical care, obstetrics, paediatrics or other services, has a complete dependency map been established?
- Does that mapping include emergency departments, diagnostics, imaging, pathology, anaesthesia, theatres, critical care, specialist advice, retrieval and transfer, and the implications for other services remaining on each site?
- How will the model maintain safe links with regional tertiary centres outside Norfolk and Waveney, including time-critical referral and transfer pathways?
- How have ambulance capacity, conveyance patterns, handovers, repatriation and inter-site transfers been modelled?
- What additional investment in emergency transport, patient transport services and transfer infrastructure would be required to deliver the model safely and reliably?
- How have the effects of increased patient movement on access, system capacity and the overall viability of the model been assessed?
- What are the potential consequences for local hospitals, communities and services if activity or expertise is concentrated elsewhere?

7. Fragile and time-critical services

- For emergency care, including majors and resuscitation, how will timely access, stabilisation, transfer and definitive treatment be maintained or improved?
- For acute medicine, including heart attack and stroke, how have time to diagnosis and definitive treatment been modelled?
- For emergency surgery, including trauma and fractured neck of femur, are theatre, anaesthetic, imaging, critical care and rehabilitation dependencies explicit?
- For critical care levels 2 and 3, is the proposed capacity, staffing model, transfer network and resilience sufficient across all sites?
- For obstetric and neonatal care, does the model provide sustainable services and align with current national learning and safety expectations?

- For inpatient paediatrics, how will safe local access, specialist support, escalation and transfer be assured?
- For each fragile service, what measurable improvement is expected, what risks arise during transition and what contingency applies if the intended benefits are not achieved?

8. Workforce, education, training and culture

- Does the Case for Change include realistic, quantified and achievable workforce plans for each option, including future establishments, safe staffing, rotas, skill mix and site requirements?
- Are recruitment, retention, training accreditation, education capacity, succession planning and “grow your own” approaches sufficiently developed?
- Does the workforce analysis include all relevant groups, including nursing, allied health professionals, healthcare scientists, support workers, primary and community care staff, and non-medical clinical leaders?
- What alternative models of care have been considered, including nurse-led, allied health professional-led and clinical nurse specialist-led pathways?
- How willing and able are staff to work across sites or move between hospital and community settings, and how have travel costs, pay, childcare and other practical constraints been assessed?
- What benefits and development opportunities would cross-site working offer staff, and how will expertise be shared without destabilising local teams?
- How have staff at all levels and across different professional groups been involved in shaping the proposals, and how will wellbeing, uncertainty and the impact of prolonged transformation be managed?
- What cultural and leadership changes are required, how achievable are they, and what happens if assumed workforce benefits do not materialise?

9. Quality, safety, outcomes and transition

- Does the Case for Change demonstrate how each proposed model will improve clinical quality, patient safety, outcomes, experience and value?
- What clinical, patient-reported, population and workforce measures will be used to assess benefits and harms?
- How will the model address current variation in access, quality and outcomes while preserving continuity and holistic, personalised care?
- What are the clinical risks during transition, including temporary service gaps, loss of expertise, workforce disruption and mismatched capacity between hospital and community services?

- What safeguards, escalation routes, decision points and contingency plans will apply if implementation milestones or quality thresholds are not met?
- How will the model maintain sufficient flexibility, surge capacity and resilience to respond to demand, workforce shortages and changing circumstances?

10. Mental health, maternity and neonatal alignment

- How are acute, community and secondary care mental health transformation plans aligned so that pathways do not become fragmented across organisational boundaries?
- What are the current links between the Group and local mental health services, and how will joint planning, communication and accountability improve?
- How have maternity, perinatal and neonatal pathways been tested against recent national investigations, reviews and recommendations?
- How will increasing complexity, demand, workforce pressures, access challenges and continuity expectations be addressed in maternity and neonatal services?
- What evidence demonstrates that the proposed configuration will improve maternity and neonatal safety, outcomes and long-term sustainability?

11. Digital, data, research and innovation

- Is there an overarching digital and information strategy across the three trusts and partner organisations, with clear governance, interoperability and delivery plans?
- Will a shared electronic patient record or full interoperability enable clinical information to be accessed safely and reliably across acute, primary, community, mental health, ambulance and social care services?
- Are data-sharing agreements, information governance arrangements and digital access sufficiently mature to support real-time cross-organisational working?
- To what extent will technology enable staff to work seamlessly across organisational boundaries, care settings and geographical locations?
- How will the model support effective communication with general practice, patients and carers, and provide a single point of access or “no wrong door”?
- How will digital design account for people and places with poor connectivity, limited digital access or low digital confidence?

- How will research, evaluation and innovation be embedded in both hospital and out-of-hospital settings?
- How will findings from research, evaluation and innovation be applied during implementation to refine the model and address emerging risks?
- How will the university hospital model strengthen research capability, service quality, recruitment, retention and workforce development?
- What wider technological and service innovations, beyond digital solutions alone, have been considered?

12. Finance, activity, productivity and affordability

- Are activity, demand, capacity, workforce, estate and financial assumptions transparent, internally consistent and supported by appropriate evidence?
- How dependent is the model on delivery of neighbourhood-care benefits, cost improvement programmes, workforce savings or other assumptions that remain uncertain?
- What downside scenarios have been modelled if community capacity, activity reductions, productivity gains or workforce benefits are only partially realised?
- How have the high, central and low cases been tested, including the timing and reversibility of any acute bed or service reductions?
- Are clinical desirability and clinical safety clearly distinguished from preliminary or unvalidated financial assumptions?
- Which elements are essential, desirable or deferrable if financial constraints arise, and what would be the clinical consequences of delay or partial implementation?
- Have the costs of consultation, organisational change, transition, double running, workforce support and enabling infrastructure been included?

13. Implementation, governance, communication and sustainability

- Is there a credible implementation plan with clear phases, dependencies, accountabilities, decision rights, milestones and benefits realisation arrangements?
- What are the critical assumptions and failure points, and what contingency plans would apply if circumstances, funding, workforce or partner readiness changed?

- How feasible is the overall programme, and can it be delivered without compromising current operational performance or staff and patient safety?
- How will governance support continuous learning, transparent risk-based decisions and adaptation rather than a one-off redesign?
- How will stakeholders understand progress, choices, risks and benefits, and how will communication be coordinated across organisations?
- How does the Case for Change address environmental sustainability and carbon reduction, including the effects of patient, visitor and staff travel, estates and digital infrastructure?
- Does the proposal provide sufficient resilience for future demand and change, and is there a clear route for reviewing or revising the model if intended outcomes are not achieved?
- What assurance will the future business case provide that the required expansion of community services, social care, digital infrastructure, diagnostics, transport and workforce capacity is funded, sequenced and deliverable before any consolidation of complex emergency services proceeds?

Appendix 2

Panel day Agenda, Review Team and Declaration of Interest, Presenting team.

East of England Clinical Senate Expert Review Panel – 14/10/2026 Norfolk and Waveney University Hospitals Case for Change Review Panel *(Please note Clinical Senate Panel Only Pre-meet 9-9.45)* MS Teams Meeting(https://teams.microsoft.com/meet/319229516239481?p=1uTFg37FGVpN2US00t)			
Time	**Item No.**	**Item**	**Lead**
8.50	1.	Registration/Join TEAMs (*Clinical Senate Panel Only*)	
9.00	2.	East of England Clinical Senate Expert Review Panel *only* pre-meet	Chair
9.45		Commissioners Join Panel	
9.50	3.	**Welcome, introductions, context and approach to the review**	Chair
10.00	4.	Building the Case for Change	Commissioners
10.30	5.	Discussion and Q&A	All
11.15	6.	Acute Services	Commissioners
11.45	7.	Discussion and Q&A	All
12.45	8.	Commissioners leave the panel – Lunch Break	
13.15	9.	Panel Discussion: Key findings, evidence base and emerging themes for recommendations.	
14. 45	10.	Break	
15.00	11.	Panel Discussion: Recommendations Discussion	
17.00	**11.**	**Meeting Close**	

Review Team

Name	Role
Sunil Gupta	Chair
Jag Ahluwalia	Chief Clinical Advisor, Health Innovation East
Amy Bartlett	Consultant Clinical Psychologist, Essex Partnership University NHS Trust
Sue Broster	Consultant Neonatologist, Cambridge University Hospitals NHS Foundation Trust
Alysha Carter	Patient and Public Partner
Anna Davey	Associate Medical Director for Neighbourhood Health for the Essex ICB and GP
Caroline Finch	Occupational Therapist and Advanced Sensory Practitioner, Hertfordshire Partnership University NHS Foundation Trust
Robert Ghosh	1. Ex- chief medical officer 2. Ex- system strategic lead for a large CCG 3. Urgent and Emergency Care improvement
Lisa Goodwin	Chartered Physiotherapist, Hertfordshire Community NHS Trust
Ramanathan Kirthivason	Stroke Consultant, Mid and South Essex NHS Foundation Trust
Charlotte Klass	Deputy Director Healthcare Public Health, Consultant in Public Health NHS England – East of England region
Clive Lewis	Consultant Cardiologist, Royal Papworth Hospital. Affiliated Assistant Professor, University of Cambridge, Associate Medical Director
Haninder Magon	Consultant Psychiatrist at the Mental Health Urgent Care Centre
Kevin Minier	Patient and Public Partner
Oliver Morrish	Consultant Clinical Scientist, Head of the East Anglian Regional Radiation Protection Service, Cambridge University Hospitals NHS Foundation Trust
Jerusha Murdock-Kelly	Deputy Director of Nursing, Basildon Hospital
Maimuna Mushabe	Paediatrician and Basildon Hospital interim CEO
Joanne Pope	Head of Nursing Quality, NHSE Spec Comm (East Region)
Lynn Prendergast	Independent Social Worker
Nadeem Shaida	Consultant Interventional Radiologist, Cambridge University Hospitals NHS Foundation Trust
Ravikiran Shenoy	Clinical Director and Consultant in Orthopaedics, East and North Hertfordshire Teaching NHS Trust
Cath Slater	Deputy Director of Nursing & Quality, Hertfordshire Community NHS Trust
Paul Tisi	Joint MD & Consultant Vascular & General Surgeon
Nange Antinda Toh	Advanced Clinical Trials Pharmacist
David Vickers	Consultant Paediatrician, East of England Community Health and Care NHS Trust
Amrita Viegas	Consultant Obstetrician, Clinical Director for Maternity Services, Bedfordshire Hospitals NHS Foundation Trust
Alain Vuylsteke	Consultant in Anaesthesia and Intensive Care; Divisional Director, Royal Papworth Hospital
Drew Walsh	Deputy Medical Director, East of England Ambulance Service
Thida Win	Chest Physician
Senate Management team	
Helen Bell	Head of Senate
Christina Wise	Project Officer

Review Panel Declarations of Interest

Name	Financial interest	Non-financial personal interests	Non-financial professional interests	Indirect Interests	Confidentiality agreement
Sunil Gupta	None	None	None	None	✓
Jag Ahluwalia	None	None	None	None	✓
Amy Bartlett	None	None	None	None	✓
Sue Broster	None	None	None	None	✓
Alysha Carter	None	None	None	None	✓
Anna Davey	None	None	None	None	✓
Caroline Finch	None	None	None	None	✓
Robert Ghosh	None	None	None	None	✓
Lisa Goodwin	None	None	None	None	✓
Ramanathan Kirthivason	None	None	None	None	✓
Charlotte Klass	None	None	None	None	✓
Clive Lewis	None	None	None	None	✓
Haninder Magon	None	None	None	None	✓
Kevin Minier	None	None	None	None	✓
Oliver Morrish	None	None	My service, which is part of Cambridge University Hospitals, delivers medical physics services to several organisations across the region, including those that make up the Norfolk and Waveney University Hospitals Group. The services are delivered under contractual agreements	None	✓

			and I work with staff employed by these organisations.		
Name	Financial interest	Non-financial personal interests	Non-financial professional interests	Indirect Interests	Confidentiality agreement
Jerusha Murdock-Kelly	None	None	None	None	✓
Maimuna Mushabe	None	None	None	None	✓
Joanne Pope	None	None	None	None	✓
Lynn Prendergast	None	None	None	None	✓
Nadeem Shaida	None	None	None	None	✓
Ravikiran Shenoy	None	None	None	None	✓
Cath Slater	None	None	None	None	✓
Paul Tisi	None	None	None	None	✓
Nange Antinda Toh	None	None	None	None	✓
David Vickers	None	None	None	None	✓
Amrita Viegas	None	None	None	None	✓
Alain Vuylsteke	None	None	None	None	✓
Drew Walsh	None	None	None	None	✓
Thida Win	None	None	None	None	✓
Helen Bell	None	None	None	None	✓
Christina Wise	None	None	None	None	✓

Presenting Panel

Name	Role
Bernard Brett	Associate Medical Director, Norfolk and Waveney University Hospitals Group
Rob Sherwin	Chief Medical Officer, Norfolk and Waveney University Hospitals Group
Penny Snowdon	Group Director of Midwifery
Johnathan Gardner	Executive Managing Director, James Paget University Hospital